HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

August 30, 2017

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IN FOCUS

KEY TAKEAWAYS FROM HMA REPORT ON ACA HEALTH INSURANCE TAX IMPACT

This week, our *In Focus* section reviews a report published by HMA on August 23, 2017, *"Impacts of Imposing the ACA's Health Insurance Tax on Medicaid Plans."* The report, authored by HMA Senior Fellow Jack Meyer, PhD, and Senior Consultant Andrew Fairgrieve, assesses the indirect impacts on health care premiums in private markets, participation by consumers in those markets, and direct federal and state budget impacts resulting from the imposition of the Health Insurance Tax (HIT) on state Medicaid programs. The report includes estimation of the public-to-private sector cost-shift that would occur as states and the federal government incur added Medicaid spending due to the HIT.

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Key Findings in the Report

1. Under current law, the moratorium on the Health Insurance Tax will lapse in 2018 and the tax on health insurance will be reinstated for 2018 at a higher annual level ($14.3 billion). The tax on health insurance, however, is not a deductible business expense for federal tax purposes. Therefore, insurers must collect $22.0 billion in premiums to generate this $14.3 billion, reflecting the 35 percent corporate income tax rate.[1]
2. Of the $22 billion in additional premiums, $5.5 billion is attributable to Medicaid in 2018.[2]
3. Taxes imposed on health insurers are an allowable cost in calculating how much state Medicaid programs must pay insurers participating in Medicaid. Therefore, while the $5.5 billion is initially paid for by insurers, the actual burden of this tax will fall on states and the federal government, which share the costs of Medicaid. To a substantial degree, the government is taxing itself.
4. At the national level, $3.16 billion of this new government cost will be borne by the federal government and $2.38 billion directly by the states in 2018. The federal government will bear $31.71 billion and the states will bear $23.92 billion due to the HIT over 10 years. This is based on an average federal Medicaid matching rate of 57 percent. For our state-by-state estimates, we used the actual federal matching rate for each state.
5. While insurers must collect $22 billion in premiums to pay the $14.3 billion HIT in 2018, the federal government ultimately will realize a net gain of approximately $11 billion from the HIT in 2018 due to two key offsets: first, the federal government is paying itself in meeting its federal matching rate requirements for Medicaid; and second, the federal government will incur a tax revenue loss due to the downstream effects of the public-to-private sector cost-shift that result in a decline in taxable wages and salaries.
6. States may take a combination of actions in response to higher-than-expected costs (or lower-than-expected revenues), including: 1) a reduction in payments to hospitals, physicians, and other providers; 2) a reduction in optional services under Medicaid; or 3) reductions in spending in other parts of their budgets or increases in taxes.
7. As states reduce payments to hospitals, those hospitals will try to shift that burden onto private payers. Our review of published research found estimates of about 20 percent to about 50 percent for the proportion of public sector health spending shortfalls that would be shifted to the private sector. Using these figures, we projected "low" and "high" estimates of the amount of the cost-shift.
8. Under the high cost-shift scenario, the Medicaid premium cost-shift would result in more than 36,500 privately insured individuals losing

[1] C. Carlson, G. Giese, and S. Armstrong. Analysis of the Impacts of the ACA Tax on Health Insurance in 2018 and Beyond. Oliver Wyman. August 8, 2017

[2] Nonprofit insurers that receive more than 80 percent of their revenue from Medicare, Medicaid, and CHIP are exempt from the tax. Other nonprofit insurers may exclude 50 percent of their premium revenue from the fee calculation.

coverage, with average per capita premium costs rising by $19 and total private sector premiums increasing by $2.66 billion in 2018.

9. 9. Under the low cost-shift scenario, more than 14,000 privately insured individuals would lose health coverage, average per capita premiums would rise by $7, and total private sector premiums would increase by $1.06 billion in 2018.
10. Federal tax revenue would decline by $337.3 million in 2018 and by $3.34 billion over 10 years under the high cost-shift scenario. The corresponding figures for the low cost-shift scenario are $134.9 million in 2018 and $1.34 billion over 10 years.
11. State tax revenue would decline by $168.7 million in 2018 and by $1.67 billion over 10 years under the high cost-shift scenario and $67.5 million in 2018 and $668.9 million over 10 years under the low cost-shift scenario.

10-Year Estimate of Additional Medicaid Premium to be paid as a Result of HIT

Assuming an annual growth rate in Medicaid premiums eligible for the HIT of 3.7 percent, the additional Medicaid premium to be paid as a result of the HIT grows from $5.3 billion in 2018 to more than $7.1 billion by 2026.[3] Of the $55.6 billion cumulative increase in premiums over ten years, shown below, $31.7 billion is covered by federal spending and $23.9 billion is covered by spending by the states as a whole.

Increase in Medicaid Premiums under HIT ($M)	
2017	N/A
2018	$5,321.9
2019	$5,518.8
2020	$5,723.0
2021	$5,934.7
2022	$6,154.3
2023	$6,382.0
2024	$6,618.1
2025	$6,863.0
2026	$7,116.9
10-Yr Impact	**$55,632.6**

HIT-Related Commercial Insurance Market Impact

Under a high cost-shift scenario (50 percent), this Medicaid premium cost-shift would result in more than 36,500 private sector enrollees losing coverage in 2018, with average per capita premium costs rising by $19, and total private sector premiums increasing by $2.66 billion in 2018. The cumulative ten-year increase in total premiums would be $27.8 billion. Under a low cost-shift scenario (20 percent), this Medicaid premium cost-shift would result in more than 14,600 private sector enrollees losing coverage in 2018, with average per capita premium costs rising by $7, and total private sector premiums

[3] Note that the figure of about $5.3 billion for 2018 in the table above is slightly lower than the $5.5 billion noted earlier as the additional Medicaid premium for 2018. Both figures are from the Oliver Wyman report. This may reflect rounding and the possible impact on the former figure of the States that do not have Medicaid managed care and are therefore given a zero value.

increasing by $1.06 billion. The cumulative ten-year increase in total premiums would be $11.1 billion.

High Cost-Shift Scenario	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
HIT-Related Decrease in Coverage	0	-36,579	-36,715	-36,629	-36,405	-36,046	-35,684	-35,320	-35,151	-34,869
HIT-Related Increase in Avg. Premium	$0	$19	$19	$20	$21	$21	$22	$23	$24	$25
Additional Premium – Total Impact ($M)	**$0.0**	**$2,660.9**	**$2,759.4**	**$2,861.5**	**$2,967.4**	**$3,077.1**	**$3,191.0**	**$3,309.1**	**$3,431.5**	**$3,558.5**
						Cumulative 10-Year Impact ($M)				**$27,816.3**

Low Cost-Shift Scenario	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
HIT-Related Decrease in Coverage	0	-14,632	-14,686	-14,652	-14,562	-14,418	-14,274	-14,128	-14,060	-13,947
HIT-Related Increase in Avg. Premium	$0	$7	$8	$8	$8	$9	$9	$9	$10	$10
Additional Premium – Total Impact ($M)	**$0.0**	**$1,064.4**	**$1,103.8**	**$1,144.6**	**$1,186.9**	**$1,230.9**	**$1,276.4**	**$1,323.6**	**$1,372.6**	**$1,423.4**
						Cumulative 10-Year Impact ($M)				**$11,126.5**

HIT-Related Federal, State Income Tax Revenue Impact

The decline in federal income tax revenue is projected to range from $134.9 million to $337.3 million in 2018. The cumulative decline in federal income tax revenue from 2018 to 2026 ranges between $1.34 billion to $3.34 billion. The decline in state income tax revenue (nationwide) is projected to range from $67.5 million to $168.7 million in 2018. The cumulative decline in state tax revenue from 2018 to 2026 ranges between $669 million to $1.67 billion.

High Cost-Shift Scenario	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
HIT-Related Fed. Tax Revenue Impact ($M)	$0.0	-$337.3	-$344.5	-$352.8	-$361.1	-$369.9	-$379.3	-$389.1	-$399.6	-$410.6
HIT-Related State Tax Revenue Impact ($M)	$0.0	-$168.7	-$172.3	-$176.4	-$180.6	-$185.0	-$189.6	-$194.5	-$199.8	-$205.3
						Cumulative 10-Year Impact - Federal ($M)				**-$3,344.2**
						Cumulative 10-Year Impact - State ($M)				**-$1,672.2**

Low Cost-Shift Scenario	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
HIT-Related Fed. Tax Revenue Impact ($M)	$0.0	-$134.9	-$137.8	-$141.1	-$144.4	-$148.0	-$151.7	-$155.6	-$159.9	-$164.2
HIT-Related State Tax Revenue Impact ($M)	$0.0	-$67.5	-$68.9	-$70.6	-$72.2	-$74.0	-$75.9	-$77.8	-$79.9	-$82.1
						Cumulative 10-Year Impact - Federal ($M)				**-$1,337.7**
						Cumulative 10-Year Impact - State ($M)				**-$668.9**

Policy Implications

An important policy implication of our findings is that the re-imposition of the Health Insurance Tax will lead to several unanticipated negative effects. First, there will be an adverse impact on consumers, employers, and public sector programs that purchase health insurance. The Health Insurance Tax (HIT) is a non-deductible business expense. As a result, a total $22 billion in premiums must be collected in order to obtain the after-tax funds to pay the $14.3 billion in taxes in 2018.

Our findings show that, in effect, the federal government is taxing states – as well as itself. While Medicaid plans will pay the tax to the federal government initially, the states will fully cover the extra cost, with the federal government providing its Medicaid match for the HIT-related premium increases. This "boomerang" effect would seem to frustrate the original intent of increasing federal revenue from private funding sources.

To the extent that states reduce payments to hospitals and other providers as Medicaid spending increases due to the HIT, those providers will try to shift that burden onto private payers, another unintended consequence of the HIT. This will result in higher premiums and lower enrollment in private insurance markets.

In response to these higher premiums, there will be a small degree of job loss. Further, employers will shift a large portion of their higher health insurance costs to workers in the form of lower increases in wages and salaries than

would otherwise occur. This results in a revenue loss to both the federal government and the states, as the mix of the employer's total employee compensation package shifts from wages, which are taxable to employees, to increased employer contributions to employee group health insurance, which are not taxable to workers.

In summary, the federal government will only net about $11 billion in 2018 because the apparent federal revenue gains from the tax will be subject to substantial offsets. These offsets take the form of both new spending to cover the federal match for the HIT-related Medicaid premium increases and lost federal tax revenue as employers shift total compensation from taxable wages to non-taxable, higher spending for employee group health insurance.

Link to Report

https://www.healthmanagement.com/wp-content/uploads/HMA-2018-HIT-Medicaid-Impact-August-23-2017.pdf

HMA MEDICAID ROUNDUP

Alabama

Integrated Care Networks MLTSS RFP Delayed. The Alabama Medicaid Agency announced on August 24, 2017, that it is revising the timeline for its Integrated Care Networks (ICN) procurement, which will provide managed long term services and supports (MLTSS) to Medicaid recipients. The deadline for probationary certification for organizations intending to collaborate with ICNs has also been extended. The ICN program is currently slated to begin no later than October 1, 2018. Read More

Arkansas

Department of Human Services to Create New Division to Oversee Medicaid Providers. The *Times Record* reported on August 25, 2017, that the Arkansas Department of Human Services (DHS) will create a new division to streamline oversight of Medicaid providers in the state. The Division of Provider Services and Quality Assurance (DPSQA) will certify, license, monitor, and inspect all Medicaid providers and be tasked with health care workforce development in the state. The reorganization is expected to be fully implemented by early 2018 and will result in approximately 171 employees moving over to the new division and up to 40 DHS contracts impacted. Read More

California

Medi-Cal Expands Access to Substance Abuse Treatment. *California Healthline* reported on August 30, 2017, that Medi-Cal has initiated a five-year pilot project using federal funds to expand substance use disorder (SUD) treatment for Medicaid members. Under the pilot, Medicaid beneficiaries in California have a broader range of SUD treatment options and expanded access to medications, inpatient beds, individualized therapy, and case managers. Massachusetts, Maryland, and Virginia also have received federal approval to expand their SUD treatment programs in, and West Virginia and Michigan are currently seeking approval. Read More

Kaiser Permanente Again Fined for Failure to Provide Patient Data to Medi-Cal. *CaliforniaHealthline* reported on August 28, 2017, that Kaiser Permanante was again fined by the state for failing to provide patient care data to Medi-Cal. The $2.2 million dollar fine comes on the heels of a previous $2.5 million dollar fine in January of this year. Kaiser is in the process of updating its technology systems to comply with administrative data reporting requirements. The Department of Health Care Services utilizes this data to

establish rates, monitor how money is being spent, and determine if adequate care is provided. Read More

Georgia

DCH Names Fulenwider Medicaid Director, Deputy Commissioner. The *Atlanta Business Chronicle* reported on August 29, 2017, Georgia Department of Community Health (DCH) Commissioner Frank Berry has named Blake Fulenwider as the state's new Medicaid director and deputy commissioner of DCH. Fulenwider will be succeeding Linda Wiant, who stepped down as Medicaid director earlier this month. Read More

DCH Seeks $239 Million in Additional Funding for Fiscal Years 2018-2019. *Georgia Health News* reported on August 24, 2017, that the Georgia Department of Community Health (DCH) has submitted a budget request for an additional $239 million in Medicaid and other health-related funding over two years. About $36 million would be used in fiscal 2018 to help fund disproportionate share payments and serve aged, blind, and disabled members. In fiscal 2019, the additional Medicaid funding request comes to $203 million. Read More

Illinois

Cook County Health & Hospitals System to See Rise in Health Plan Enrollment, Revenue. *Crain's Chicago Business* reported on August 28, 2017, that approximately 60 percent of Cook County Health & Hospitals System (CCHHS) revenue will be attributed to CountyCare in 2018, according to the health system. CountyCare is CCHHS's Medicaid health plan, which was recently awarded a new contract under the state's Medicaid managed care reprocurement. CCHHS anticipates a 24 percent increase in revenues next year due to an estimated 85,000 new members that will be enrolled in CountyCare. Under the new Medicaid contract, CountyCare is estimated to generate revenue of $1.2 billion in the next fiscal year. CCHHS also reported a rise in uncompensated care, anticipating fiscal year 2017 totals to surpass $500 million for the first time since 2013. Read More

Massachusetts

MassHealth Selects 26 Community-based Organizations to Become Community Partners in ACO Program. MassHealth announced on August 28, 2017, that they will begin negotiating Community Partners contracts with 26 community-based health care and human services organizations. These Community Partners will be funded over five years to work with MassHealth accountable care organizations (ACOs) and managed care organizations to serve 60,000 Medicaid beneficiaries with complex long-term services and supports or behavioral health needs. MassHealth anticipates completing contract negotiations by early November and implementation to begin in the summer of next year. Read More

MassHealth Announces Accountable Care Organization Selections. Earlier this month, MassHealth executed Accountable Care Organization (ACO) agreements with 17 health care organizations, in a major restructuring of the state's' Medicaid program. The networks of physicians, hospitals, and

community-based health care providers will be financially accountable for more than 850,000 Medicaid beneficiaries beginning March 1, 2018. MassHealth ACOs will receive more than $100 million through the remainder of 2017 to support the transition to value-based payments. Read More

Mississippi

Medicaid Recovers $8.6 Million Through Medical Claims Audit. *The Clarion-Ledger* reported on August 28, 2017, the Mississippi Division of Medicaid recouped more than $8.6 million through a medical claims audit. The bulk of the recovery, $6.3 million, was in third party liability, with another $1.6 million attributed to program integrity. Read More

Nebraska

Civil Protective Custody Program Loses Federal Medicaid Funding. The *Lincoln Journal Star* reported on August 28, 2017, that Lincoln, Nebraska's Bridge program, which provides civil protective services, is set to lose between $50,000 and $60,000 in annual funding after it was determined that these services are not covered by Medicaid. The state's Medicaid agency had previously paid for the service under the social detoxification code until earlier this year, when a Medicaid managed care organization determined that civil protective services did not qualify as a reimbursable Medicaid service. The Bridge program is working with the state's Medicaid agency to find a solution. Read More

New Hampshire

Medicaid Expansion "Platinum" Plans Increase Claims, Premiums on the Exchange. *New Hampshire Union Leader* reported on August 28, 2017, that "Platinum" plans offered as part of New Hampshire's Medicaid expansion program are raising the cost of premiums and claims, according to an actuarial analysis of 2016 claims data. In comparison to individuals with Silver plans, Medicaid expansion enrollees had higher levels of service utilization, possibly due to the lack of co-pays or deductibles under the Platinum plans. The analysis, which was conducted for the state's Insurance Department, was submitted to a legislative commission tasked with determining the future of Medicaid expansion in New Hampshire. Read More

Health Commissioner Says CMS Never Gave Straight Answer on Use of Voluntary Provider Donations for Medicaid Expansion. The *Union Leader* reported on August 24, 2017, that the Centers for Medicare & Medicaid Services (CMS) never gave New Hampshire a straight answer on whether use of voluntary provider donations to support the state's Medicaid expansion was complaint with federal regulations, according to New Hampshire Health and Human Services Commissioner Jeffrey Meyers. He added that the state believes it is in regulatory compliance. As previously reported, CMS could withhold federal funding for the Medicaid expansion program under the waiver if it is non-compliant. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Marketplace experience leads the nation in affordability, stability. An August 2017 policy brief by New Jersey Policy Perspective provides several examples for how New Jersey leads other states in Marketplace affordability, provided that the state's enrollees don't lose $166 million in federal subsidies to reduce their cost share which could upset the balance. It cites the following facts in support of an affordable, stable New Jersey Marketplace:

1. New Jersey's federal marketplace premium growth has been slow, averaging 12 percent between 2013-2017 as compared to the 105 % national average;
2. New Jersey's Marketplace deductibles were 43 percent of the national average at $1,581 as compared to $3,609;
3. New Jersey's Marketplace is relatively stable with a choice of at least two insurers in every county (2017) and a third insurer in 2018; and
4. The number of individuals served in the insurance market grew by 19 percent (with 369,000 enrolled) in the first quarter of 2017 despite federal elimination of advertising and outreach about Marketplace open enrollment.

Read the full report here.

New Jersey Senate inaction enables Governor's plan to reorganize agencies for mental health and addiction services. On August 24, 2017, *NJ.com* reported that the transfer of mental health and addiction services from the Department of Human Services (DHS) to Department of Health (DOH) will proceed. Both houses needed to vote on the proposal by August 28 – the Assembly voted to block the reorganization in July but the Senate cancelled its scheduled August 25 vote because of inadequate attendance. The Division of Mental Health and Addiction Services under DHS represents a budget of $1.2 billion and after the transfer will nearly double the size of DOH. Read more

Non-profit Arc Mercer forms what may be nation's first LGBTQ club for people with special needs. Last month *SouthJersey's The Central Record* reported that Arc Mercer formed a support group for LGBTQ people with disabilities called Special Needs Alliance for Pride (SNAP). This club may be a first for LGBTQ individuals with special needs. Executive Director, Steve Cook, who is gay, recognized the need in his own organization. He researched groups of this kind in the state and nationally without success and formed SNAP. To find out more email SNAPClub@arcmercer.org. Read More

Medicaid agency issues notice to providers about dental services to beneficiaries in long term care facilities. On August 28, 2017, the Division of Medical Assistance and Health Services released a provider newsletter to provide both new information and reminders about dental services for individuals on Medicaid who reside in long term care facilities. The notice includes a description of the dental benefit package, dental treatment plan and record requirements, continuity of care requirements, and diagnostic and procedure codes for billing dental services. The notice can be found here.

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Considers the Future of its Duals Demonstration. The Department of Health, working with the Centers for Medicare & Medicaid Services (CMS), has begun a stakeholder process to review the future of integrated care for New York's dual-eligibles. Throughout the fall DOH will host a series of sessions designed to facilitate the conversation on how to plan for the State's Medicare-Medicaid integrated care programs after the demonstration program, the Fully Integrated Duals Advantage (FIDA) program, ends in 2019. New York remains committed to an integrated care approach for the dual-eligible population despite low enrollment in the FIDA program. The Future of Integrated Care Stakeholder Workgroup will meet four times over the next few months. Stakeholders can participate in person or via webinar/conference call. Below is the schedule of meetings and the topics to be addressed.

- September 7, 2017, 11:30am-2:00pm (Albany): Target Population; Covered Services; Care Coordination/Care Management Elements, Assessment and Service Planning Requirements
- October 16, 2017, 11:30am-2:00pm (New York City): Network Adequacy and Access; Participant Rights and Protections; Marketing Rules and Flexibilities; Quality Standards and Measures
- November 16, 2017, 11:30am-2:00pm (Albany or Rochester, TBA): Payment and Rate Considerations; Outreach, Education, and Engagement of Participants and Providers; MCO/Plan Requirements and Qualifications; Enrollment
- December 8, 2017, 11:30am-2:00pm (New York City): Geographic Scope; Consolidation of Existing Programs; Platform for Integrating with Medicare; Considerations for Transition

To attend in person, RSVP to FutureofIntegratedCare@health.ny.gov. To participate via webinar: Link to Webinar Registration

CareConnect Leaves New York Marketplace. CareConnect, an insurance plan started by Northwell Health, will be leaving the insurance market after four years. Northwell Health established the plan when the Affordable Care Act was enacted, hoping to establish a mechanism for the hospital system to direct patients to Northwell's hospitals and doctors, promising a simple, limited network of health providers as well as lower prices. Northwell now says that the lack of action by Congress to stabilize the insurance market, particularly financing and strengthening the risk adjustment program, makes it impossible to continue. As reported in Bloomberg, CareConnect said new insurers like itself were disadvantaged by the Affordable Care Act risk adjustment program, because they had less information about their customers. The program is designed to transfer money from insurers with healthy customers to those with sick ones, and relies on insurers to assess their own members. CareConnect had to pay significant sums under the program, fueling a $156.6 million loss in 2016. CareConnect provided coverage to 120,000 people, including 30,000 enrolled through NY State of Health, the New York insurance marketplace. Read More

Department of Health Launches Value Based Payment Learning Resources. The New York Department of Health has launched an on-line learning program they call VBP University. VBP University is an educational resource designed to raise awareness, knowledge and expertise in the move to Value Based Payment (VBP). VBP University combines informational videos and supplemental materials that stakeholders interested in VBP can use to advance their understanding of the topic. The program consists of four semesters, and individuals who successfully complete all four semesters will be awarded a certificate of completion. Semester 1 provided background information. Semester 2 has just been posted. Semester 2 focuses on specific topic areas in the move to VBP: governance, stakeholder engagement, business strategy, finance, and data. The curriculum for semester 2 includes videos on each of the topics as well as detailed guidance documents targeted towards Primary Care Physicians, Behavioral Health Providers, and Community Based Organizations. Semester 2 also includes Value Based Payment arrangement fact sheets that provide an overview of each of the NYS VBP arrangements, including the types of care included in the arrangement, the method used to define the attributed population for the arrangement, calculation of associated costs under the arrangement, and the quality measures recommended for use in the arrangement. Read More

Department of Health Announces Regulatory Modernization Initiative. The Department of Health has announced a comprehensive Regulatory Modernization Initiative to review a whole host of regulations governing licensure and oversight of health care facilities with the goal of streamlining and updating existing policies and regulations across a range of areas to best meet the needs of payers, providers, and consumers in the years ahead. The goals are to increase the speed with which providers can complete construction projects; support the delivery of services across an integrated system of care; modernize regulations that ensure access and protect patient safety; and enhance collaboration between the state and health care providers. The first workgroup to launch focuses on Post-Acute Care Management Models. Its second meeting is scheduled for Monday, September 18, 2017, from 12:30 to 3:30 p.m. at the New York Academy of Medicine, 1216 Fifth Avenue, New York, NY. The second workgroup to be announced is the Integrated Primary Care and Behavioral Health Workgroup, focusing on regulatory reforms to facilitate the integration of primary care and behavioral health. Its second meeting will be Friday October 13, 2017 10:30-3:00 in Meeting Room 6 of the Empire State Plaza in Albany. The Department of Health has announced a third workgroup, focusing on regulatory reforms to facilitate the provision of services by telehealth. The first Telehealth Workgroup meeting will be held on Tuesday, September 5th from 10:30 am to 3:00 pm in Meeting Room 6 on the Concourse Level of the Empire State Plaza in Albany. To attend any of the workgroup meetings, RSVP at RegulatoryModernization@health.ny.gov with the relevant work group name in the subject line. All the meetings will be open to the public and webcast. Webcasts are viewable on the day of the event at https://www.health.ny.gov/events/webcasts/.

Value Based Payment Innovator Program Summary Posted. The Department of Health has posted a slide presentation as well as a Frequently Asked Questions document after a recent webinar on the Value Based Payment (VBP) Innovator Program. The VBP Innovator Program applies to experienced VBP providers interested in engaging in full or near full risk VBP arrangements with managed care plans. It is a voluntary program with a rolling application

process. Designated Innovators will engage with their contracted health plans to amend or develop new contracts to reflect the additional functions and risk the Innovator takes on in conjunction with 90-95% of premium pass through. Applications are being evaluated based on five criteria: A commitment to contracting for a high or full risk VBP; Upholding health plan network adequacy; Past success in VBP contracting; The ability to meet minimum attribution thresholds; and Financial solvency and appropriate net worth. Read More

State Enacts Cybersecurity Policy for Insurance Plans. The New York Department of Financial Services enacted a cybersecurity policy that affects all health insurance plans in New York. *Crain's HealthPulse* reports that the regulation is the first of its kind in the country, and was developed in response to the lack of a comprehensive federal policy on cybersecurity. It requires insurers, banks and other entities regulated by DFS to hire a chief information security officer and establish a written policy for protecting consumer data that includes a disaster-recovery plan and a risk-assessment strategy. The policy requires that each Covered Entity maintain a cybersecurity program designed to protect the confidentiality, integrity and availability of the Covered Entity's Information Systems, designed to perform the following core cybersecurity functions: (1) identify and assess internal and external cybersecurity risks that may threaten the security or integrity of Nonpublic Information stored on the Covered Entity's Information Systems; (2) use defensive infrastructure and the implementation of policies and procedures to protect the Covered Entity's Information Systems, and the Nonpublic Information stored on those Information Systems, from unauthorized access, use or other malicious acts; (3) detect Cybersecurity Events; (4) respond to identified or detected Cybersecurity Events to mitigate any negative effects; (5) recover from Cybersecurity Events and restore normal operations and services; and (6) fulfill applicable regulatory reporting obligations.

Ohio

HMA Roundup – Jim Downie (Email Jim)

CareSource to Provide Exchange Coverage for Last Bare County in US. *The New York Times* reported on August 24, 2017, that Ohio-based CareSource will offer Exchange coverage to Paulding County, Ohio, the last "bare" county in the country. Initially, 20 of Ohio's 88 counties were at risk of having no Exchange plan next year. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Lawmakers to Return to Session in Two Weeks, Address Budget. Pennsylvania's 2017-18 state budget remains out of balance, but lawmakers will not return to work to address it until September 11. The House will likely return to session on September 11, and the Senate on September 18. At that time, the House must act on the Senate's $2.2 billion revenue plan, supported by Governor Wolf. The Governor said the state's main bank account will "run out of cash" in three weeks — about the time a large Medicaid payment is due — because of a seasonal low-flow period of tax collections and an entrenched post-recession deficit. September holds the potential for another downgrade to

Pennsylvania's battered credit rating and Governor Wolf may need to start freezing cash for state programs or postponing payments to vendors. Read More

DHS Office of Developmental Programs' Proposed Community Living Waiver Available. Pennsylvania's Department of Human Services Office of Developmental Programs (ODP) published for comment a proposed Community Living Waiver. The proposed Community Living Waiver is modeled on ODP's Person/Family Directed Support Waiver, though among the notable differences is there will be a $70,000 per person per fiscal year total limit for all Community Living Waiver services with an exception for supports coordination services. Comments are due within 30 days. Two webinars will also be held to receive comments on September 18 and September 20. The anticipated effective date for the Community Living Waiver is January 1, 2018. Read More

Puerto Rico

Puerto Rico Asks Congress to Fill Medicaid Funding Shortfall Through CHIP Reauthorization Bill. *CQ* reported on August 25, 2017, that Puerto Rico is appealing to Congress to help fill a $600 million Medicaid funding shortfall by tacking funds onto a bill to reauthorize the Children's Health Insurance Program (CHIP). Puerto Rico is likely facing the largest municipal bankruptcy in history and is expected to hit a "Medicaid cliff" in March of 2018 when $6.4 billion in extra funding provided through the Affordable Care Act is exhausted. If Congress agrees to provide extra funding, it will be the second time this year that they have acted to shore up Puerto Rico's Medicaid program. Read More

Texas

Medicaid Proposes Reimbursement Cuts of at least 10 Percent for Several Specialties. *Modern Healthcare* reported on August 25, 2017, that Texas Medicaid has proposed to reduce reimbursement rates by at least 10 percent for several specialties and services, including ear, nose, and throat specialists, radiation oncology, dentists, and ambulance providers. Providers claim the decreased reimbursement rates will negatively impact access to care and that many have not received a reimbursement increase over the past ten years. The newly proposed reimbursement rates would take effect on October 1. Read More

National

Slow Rollout of IMD Reimbursement Changes Congest Emergency Departments. *Modern Healthcare* reported on August 29, 2017, that state Medicaid agencies' slow implementation of a Centers for Medicare & Medicaid Services (CMS) policy that allows Medicaid managed care organizations (MCOs) to pay IMDs is continuing to crowd emergency departments. CMS finalized the policy last year to allow MCOs to pay IMDs for stays lasting 15 or fewer days in a month; however, only 7 states with Medicaid managed care have started reimbursing these psychiatric facilities. The delay in implementation is attributed to questions regarding the development of IMD

rates, recouping costs from MCOs for stays over 15 days, and behavioral health carve-outs, among other reasons. Read More

Hospitals Say Cutting DSH Funding Can Negatively Impact Access for Low-income Patients. *Modern Healthcare* reported on August 28, 2017, that hospitals are warning cuts to Medicaid disproportionate share hospital (DSH) payments will reduce access to care for Medicaid enrollees and eliminate efforts to improve care for these individuals. The Centers for Medicare & Medicaid Services (CMS) will cut $43 billion in DSH payments from fiscal 2018 through 2025. Based on the proposed formula, states with lower uninsured rates will see the largest cuts. Hospitals are calling upon CMS to delay the proposed rule, which is currently set to take effect on October 1. Read More

Ohio, Colorado Governors to Propose Bipartisan Health Care Plan to Congress. *Governing* reported on August 23, 2017, that Ohio Governor John Kasich and Colorado Governor John Hickenlooper are finalizing a proposal for a bipartisan health care plan to replace the Affordable Care Act. The plan, which focuses on stabilizing insurance markets and the employer mandate, could be ready to present to the Senate Health, Education, Labor, and Pensions (HELP) Committee in September. The plan also gives states flexibility to implement their own reforms and reduces federal regulations, but does not address Medicaid expansion. The proposal will be sent to other governors in hopes that they sign on. Read More

ACA Tax Repeal Legislation May be Tied to CHIP Reauthorization. The *Wall Street Journal* reported on August 29, 2017, that members of Congress are considering using the CHIP reauthorization bill as an opportunity to repeal-and-replace certain Affordable Care Act (ACA) taxes, including the medical device tax and Health Insurance Tax (HIT); the move could compromise reauthorization of the popular program. Senate Finance Chair Orrin Hatch (R-UT), who was also the chief sponsor of the 1997 CHIP legislation, is said to be working with lawmakers to ensure the funding is continued. Federal funding for CHIP is currently set to expire September 30. If the program is not reauthorized, three states and Washington, D.C. would exhaust their federal funding by December 2017, and federal funding for an additional 27 states would run out by March 2018. Read More

Industry News

Optum to Acquire The Advisory Board Company's Health Business Line. Optum and The Advisory Board Company announced on August 29, 2017, that The Advisory Board Company's health care business will become part of Optum, a subsidiary of UnitedHealth Group that provides information and technology-enabled health services. The merger is expected to close by the end of this year or early next year, pending approval from stockholders. Read More

Civitas Solutions to Acquire Habilitative Services. Civitas Solutions, Inc. announced on August 23, 2017, that it had signed an agreement to acquire the stock of Habilitative Services, Inc. (HSI), as well as two affiliate companies that provide services to individuals with intellectual and developmental disabilities in Minnesota. The acquisition will include HSI's 86 residential sites, which are located in 22 counties. Read More

Vestar Capital Partners Acquires Wisconsin-based Quest Analytics. Vestar Capital Partners announced on August 22, 2017, that it has acquired Wisconsin-based Quest Analytics, which offers provider network management software and services to health plans. Terms were not disclosed. Quest founders David Hill and John Weiss will remain active in the company and retain a minority ownership. Richard Barasch, former CEO of Universal American and senior adviser to Vestar, will join the Quest board. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
TBD	Delaware	Contract Awards (Optional)	200,000
Timeline to be Revised	Alabama ICN (MLTSS)	RFP Release	25,000
September 1, 2017	New Mexico	RFP Release	700,000
September 1, 2017	Virginia MLTSS	Implementation - Central	23,000
September 8, 2017	Virginia Medallion 4.0	Proposals Due	700,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October 1, 2017	Virginia MLTSS	Implementation - Charlottesville/Western	17,000
October 1, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Contract Awards	85,000
Timeline to be Revised	Alabama ICN (MLTSS)	Proposals Due	25,000
November 1, 2017	Florida Statewide Medicaid Managed Care (SMMC)	Proposals Due	3,100,000
November 1, 2017	Virginia MLTSS	Implementation - Roanoke/Alleghany, Southwest	23,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
November 15, 2017	New Mexico	Proposals Due	700,000
December 1, 2017	Virginia MLTSS	Implementation - Northern/Winchester	26,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Delaware	Implementation (Optional)	200,000
January 1, 2018	Illinois	Implementation	2,700,000
January 1, 2018	Pennsylvania HealthChoices	Implementation (SW, NW Zones)	640,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SW Zone)	100,000
January 1, 2018	Alaska Coordinated Care Demonstration	Implementation	TBD
January 1, 2018	Washington (FIMC - North Central RSA)	Contract Awards	66,000
January 1, 2018	Virginia MLTSS	Implementation - CCC Demo, ABD in Medallion 3.0	105,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
Winter 2018	Massachusetts One Care (Duals Demo)	Contract Awards	TBD
March, 2018	North Carolina	RFP Release	1,500,000
March 1, 2018	Pennsylvania HealthChoices	Implementation (NE Zone)	315,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
March 15, 2018	New Mexico	Contract Awards	700,000
April 16, 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
June, 2018	North Carolina	Proposals Due	1,500,000
July 1, 2018	Pennsylvania HealthChoices	Implementation (SE Zone)	830,000
July 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
July 1, 2018	MississippiCAN	Implementation	500,000
Timeline to be Revised	Alabama ICN (MLTSS)	Implementation	25,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	85,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona Acute Care/CRS	Implementation	1,600,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC)	Implementation	3,100,000
January 1, 2019	Pennsylvania HealthChoices	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2019	New Mexico	Implementation	700,000
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
July 1, 2019	North Carolina	Implementation	1,500,000
September 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
September 1, 2019	Texas STAR, CHIP Statewide	Implementation	3,400,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION IMPLEMENTATION STATUS

Below is a summary table of state dual eligible financial alignment demonstration status.

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (June 2017)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	117,302	33.5%	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore)
Illinois	Capitated	4/1/2014	6/1/2014	136,000	50,064	36.8%	Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	10/1/2013	1/1/2014	97,000	16,809	17.3%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	39,046	39.0%	AmeriHealth Michigan; Coventry (Aetna); Michigan Complete Health (Centene); Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	1/1/2015	4/1/2015	124,000	4,566	3.7%	There are 14 FIDA plans currenting serving the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	561	2.8%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	74,347	65.2%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400	13,717	54.0%	Neighborhood Health Plan of RI
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	7,915	14.8%	Absolute Total Care (Centene); Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	39,919	23.8%	Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	27,194	41.1%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**391,440**	**31.2%**	

Note: Enrollment figures in the above chart are based on state enrollment reporting, where available, and on CMS monthly reporting otherwise.

HMA Welcomes…

Carol Clancy, Principal – San Francisco, California

Carol joins HMA most recently from Maguire Correctional Facility/Maple Street Correctional Center in Redwood City, California, where she served as Clinical Services Manager II. In this role, Carol oversaw all mental health and recovery programs in the jail; made decisions on programming, budget, policies, and procedures in mental health and recovery programs; and collaborated with law enforcement personnel on provision of mental health services in the jail. Additionally, she served as liaison between correctional mental health, community mental health programs, and the courts.

Additional roles Carol held with Maguire Correctional Facility include Interim Clinical Services Manager and Supervising Psychologist/Staff Psychologist. As the Staff Psychologist, she supervised and trained clinical staff and pre-doctoral interns and administered psycho-diagnostic intake assessments and court-ordered psychological evaluations. Carol also provided consultation for the Sheriff's Office Crisis Management Unit.

Carol brings to HMA a wealth of experience in teaching, training, and clinical supervision, as well as individual and group therapy with children, families, and adults. She has served as Adjunct Faculty at Alliant University, Holy Names University, and Argosy University. Additional roles Carol has held include Social Worker at Lucille Packard Children's Hospital, School Psychologist at Jefferson County Public School District, Therapist/Mental Health Evaluator at Presidio Child Placement Agency, Mental Health Evaluator at Lookout Mountain Youth Services Center, Crisis Intervention Specialist at Denver Police Department Victim's Assistance Unit, and many other clinical roles throughout the years.

Carol received her Bachelor of Arts degree in Psychology from the State University of New York at Purchase and Master of Social Work degree from Bryn Mawr College. She earned her Doctorate degree in Clinical Psychology from the University of Denver School of Professional Psychology and is a Licensed Clinical Psychologist in California.

Michelle Rogers, Senior Consultant – Denver, Colorado

Michelle joins HMA most recently from the U.S. Department of Health and Human Services, Administration for Community Living (ACL) in Denver, where she served as the Aging Services Program Specialist for Region 8. In this role, Michelle provided oversight to State Units on Aging for Older American's Act programs and discretionary grants, and served as state liaison to North Dakota, South Dakota, and South Dakota's federally recognized tribes. She worked with high-risk tribal elderly programs to improve health outcomes, including better sanitation of congregate sites, food safety, policy implementation, data integrity, and consumer satisfaction. Additionally, she provided technical assistance to states and tribes for program data and grant reporting, and served as ACL Advisor to the opioid epidemic workgroup, HIV/AIDS national strategy, oral and behavioral health committees, healthy senior housing, and transportation initiatives.

Prior to ACL, Michelle served as Program Administrator of the Longer Term Care Division with Colorado Department of Health Care Policy and Financing

(HCPF), where she provided program oversight for the Home and Community-Based Services-Children with Autism Waiver (HCBS-CWA) and the Consumer Directed Attendant Support Services (CDASS). She was the contract administrator for 20 case management contracts. Additionally, she chaired the CWA and CDASS consumer advisory committees, and participated in various quality improvement projects, including development of a case management monitoring tool and creation of a children's long-term care assessment tool.

Additional roles Michelle has held include Program Coordinator of Aging and Adult Services with the Colorado Department of Human Services and Program Specialist of Colorado Indigent Care Program with HCPF.

Michelle received her Bachelor of Arts degree in Kinesiology and Applied Physiology from the University of Colorado.

Health Management Associates (HMA) is an independent health care research and consulting firm, specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, Health Management Associates has offices in Albany, New York; Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Phoenix, Arizona; Portland, Oregon; Sacramento, San Francisco, and Southern California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.

http://healthmanagement.com/about-us/

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.