HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

October 12, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

Julia Scully
Email

THIS WEEK

IN FOCUS

WASHINGTON 1115 DEMONSTRATION WAIVER APPROVED BY CMS

This week, our *In Focus* section reviews the agreement-in-principle between the State of Washington Health Care Authority (HCA) and the Centers for Medicare & Medicaid Services (CMS) on a new section 1115 demonstration waiver, which will further the state's Healthier Washington initiative across three major dimensions. The agreement will provide up to $1.5 billion in federal funding for delivery system reform incentives, expanded options for long-term services and supports, and supportive housing and employment. HCA and CMS hope to finalize the special terms and conditions of the waiver in the coming months.

Accountable Communities of Health

In 2015 and 2016, nine Accountable Communities of Health (ACHs) were formed across the state, bringing together public health entities, community organizations, and health leaders in each region. ACHs are tasked with addressing the health needs of their region and, through the waiver, will be critical in implementing the Delivery System Reform Incentive Payment (DSRIP) program. The waiver authorizes up to $1.125 billion in funds for the

establishment and implementation of DSRIP projects. Each regional ACH will be able to propose and pursue DSRIP projects around health system capacity building, care delivery redesign, and prevention and health promotion. Where approved, ACHs will coordinate the projects and will be eligible, along with their partners, to receive incentive payments for meeting process milestones and improvements in DSRIP outcomes measures. Additionally, ACHs will serve a significant role in working with Medicaid managed care organizations (MCOs) to expand value-based purchasing (VBP) in MCO contracts, with a target of 90 percent of Medicaid payments being value-based by the end of the five-year waiver.

Expanded LTSS Options

The second major initiative of the waiver address the state's long-term services and supports (LTSS) delivery system. Despite ranking high in LTSS performance and low in LTSS costs, Washington is preparing its LTSS delivery system for what the waiver refers to as the "age wave," in which the number of residents ages 65 or older will more than double in the next 25 years. The waiver includes two new benefit packages and one new eligibility category around LTSS. The two benefits described below provide additional home and community based services (HCBS) options that support individuals and families, with a goal of avoiding or delaying the need for more intensive Medicaid LTSS.

- **Medicaid Alternative Care (MAC).** The MAC benefit will provide support for unpaid family caregivers who support Medicaid beneficiaries not utilizing Medicaid-funded LTSS. The MAC benefit includes training, support groups, respite services, as well as support for housework, errands, and home-delivered meals.
- **Tailored Supports for Older Adults (TSOA).** The TSOA eligibility category of benefit package targets individuals who are not eligible for Medicaid due to financial status and who have been determined to be at risk of future Medicaid LTSS use. The TSOA option provides similar supports and benefits to unpaid family caregivers without forcing individuals or families to spend down to Medicaid eligibility.

It is important to note that Medicaid LTSS is primarily delivered outside of managed care, through fee-for-service, and that nothing in the waiver proposes shifting LTSS into managed care.

Supportive Housing and Employment Services

The third initiative under the waiver seeks to address the impact on health outcomes of lack of stable housing and employment through a package of supporting housing services and supported employment services. Both housing and employment initiatives will be coordinated through exiting behavioral health organizations (BHOs), Medicaid MCOs, and the Department of Social and Health Services, and Area Agencies on Aging.

Supportive Housing Benefits. While CMS has not approved funding for room and board, the waiver instead will provide services to help Medicaid beneficiaries achieve stable housing. The benefits specifically target:

- individuals who are chronically homeless individuals, as defined by the U.S. Department of Housing and Urban Development (HUD);
- individuals with frequent or lengthy institutional care;

- individuals with frequent or lengthy adult residential care or treatment stays;
- individuals with LTSS and frequent turnover of in-home caregivers or providers; and
- individuals at highest levels of risk for expensive care and negative outcomes, defined by a Predictive Risk Intelligence SysteM (PRISM) risk score of 1.5 or higher.

Individuals will be deemed eligible for supportive housing benefits if they fall into one of the above categories and exhibit a medical or functional need for the benefit. The state anticipates an average caseload of around 3,000 individuals receiving supportive housing benefits.

Supported Employment Services. The waiver will also provide job coaching and training, employer relations assistance, and job placement services to individuals on Medicaid with physical, behavioral, or LTSS needs that limit their employment opportunities. The waiver addresses four specific populations with a targeted outcome for each.

- Helping Medicaid members who are older or have a disability, or those with the potential to be enrolled in the Housing and Essential needs program, remain engaged in the labor market.
- Preventing an escalation in behavioral health needs for individuals with severe and persistent mental illness, multiple episodes of inpatient substance abuse treatment, and/or co-occurring mental illness and substance use disorder.
- Supporting individuals with a traumatic brain injury (TBI) or a physical disability and significant LTSS needs.
- Supporting working age youth with a behavioral health diagnosis.

Again, the stated anticipates an average caseload of around 3,000 individuals.

Link to Waiver Approval, More Information

Link to CMS Waiver Approval Letter:
http://www.governor.wa.gov/sites/default/files/Washington_AIP%20Letter%20(2).pdf

Link to More Information:
http://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation

HMA Medicaid Roundup

Alabama

RCO Program Concerns Grow Amid Funding Delays. The *Times Daily* reported on October 9, 2016, that the Medicaid regional care organizations (RCOs) slated to participate in the state's new managed-care model beginning in July 2017 are concerned about long-term funding for the program. The state Legislative Contract Review Committee recently delayed a $1.3 million legal contract with Capell and Howard, the Montgomery-based law firm chosen to help the state's Medicaid agency with the RCO transition. The program was slated to begin this month, but was delayed due to state budget issues. While the federal government has agreed to provide $700 million in funding over the next five years, RCOs are expressing concerns about the number of organizations looking to participate and overhead costs associated with implementation. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Beth Kidder Named as New Medicaid Director. *Politico* reported on October 11, 2016, that Agency for Health Care Administration (AHCA) interim secretary Justin Senior announced on October 6, 2016, that Beth Kidder will become the new Medicaid director. Kidder has worked at AHCA for 15 years and played a large role in the state's first Medicaid managed care procurement. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Lawmakers Consider Medicaid Expansion Alternatives. *Georgia Health News* reported on October 5, 2016, that Georgia lawmakers are continuing to look at alternative models for Medicaid expansion, specifically a variation of the premium assistance model, in which Medicaid funds are used to purchase insurance for Medicaid expansion members through the Exchange. A state Senate legislative panel heard testimony on the subject this week. Georgia has the third-highest uninsured rate in the nation at 13.9 percent, with an estimated 500,000 individuals that fall into the state's coverage gap between Medicaid eligibility and qualifying for subsidies on the Exchange. Read More

Kansas

Medicaid Expansion Discussion Continues. *KCUR.org* reported on October 7, 2016, that the Rural Health Working Group, which was tasked with finding solutions other than Medicaid expansion to improve rural health care in Kansas, has been unable to reach a consensus on a plan. Governor Sam Brownback appointed nine legislators to the group to explore options to address physician shortages and hospital closings other than expanding Medicaid eligibility, which Governor Brownback wants to leave for discussion by the legislature during the 2017 session. However, at least one member of the working group as well as advocacy organizations are still proposing Medicaid expansion as a partial remedy for the state's healthcare issues. The working group is expected to hold two more meetings in November and December before making recommendations at the beginning of the 2017 legislative session. Read More

Louisiana

Vote Extends Medicaid Claims Processing Contract with Molina. *The Associated Press* reported on October 6, 2016, that Louisiana lawmakers voted to extend the state's $46 million contract with Molina Information Systems LLC for Medicaid claims processing through December 31, 2017. State official said they needed the extension to avoid delays in payments to health plans and providers. The state is in the process of seeking other vendors, in part to meet federal guidelines requiring that the work be broken into multiple contracts. Molina has handled claims processing for the state since 1981, and its contract has grown to include other functions. Read More

Massachusetts

MassHealth Suspends Medicaid Payments to Avenue Homecare Services. *The Boston Globe* reported on October 10, 2016, that Massachusetts-based Avenue Homecare Services began transferring approximately 800 patients to other home care agencies in September after MassHealth officials announced that the agency was suspending Medicaid payments to the company. The decision comes after state Attorney General Maria Healey opened an investigation on the company for fraudulent activity in June 2015 and MassHealth officials deemed that suspending payments would not compromise the case. Both the Attorney General's office and MassHealth officials have declined to comment on the ongoing case or suspension of payments. MassHealth suspended payments to another home health company, Compassionate Homecare Inc., recently indicted for allegedly filing false claims and withholding funds from the state. The company also transferred their patients after the state suspended payments. Read More

Mississippi

North Mississippi Health Services Plans to Exit United Healthcare Network. The *Daily Journal* reported on October 8, 2016, that North Mississippi Health Services intends to stop serving United Healthcare members in January 2017 due to a payment dispute. Most Medicaid beneficiaries in Mississippi are required to enroll in managed care through either Centene's Magnolia Health

Plan or United Healthcare. United Healthcare Southeast public relations director Tracey Lempner says the plan is awaiting more information from North Mississippi Health Services so that they can fix the issue. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Bill Introduces New Jersey Public Option. On October 3, 2016, *NJ.com* reported that Assemblyman Reed Gusciora introduced the "New Jersey Public Option Health Act" (A4211), a bill that would require the Department of Health and the Department of Banking and Insurance to create a government-run health plan. With Oscar, Health Republic of New Jersey, and UnitedHealthcare pulling out of the health exchange this November, Assemblyman Gusciora introduced this bill as a means of creating health plans that could compete with the two remaining private carriers—Horizon Blue Cross Blue Shield of New Jersey and AmeriHealth, which currently insure more than 80 percent of enrollees in New Jersey. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Delivery System Reform Incentive Payment (DSRIP) Project Approval and Oversight Panel Hears Concerns. The Project Approval and Oversight Panel (PAOP) tasked with serving as advisors and reviewers of Performing Provider Systems status and project performance during the five-year DSRIP duration met last week to receive a briefing on the mid-point assessment process and PPS progress. New York Medicaid Director Jason Helgerson noted that DSRIP is going well but that it is very much a work in progress. He expressed two concerns, one about funds flow and money going to downstream providers, and one about engagement of community-based organizations. The state has distributed $1.2 billion in DSRIP payments in the first year, yet only 33 percent of the money earned has actually been distributed; most of the funds remain unspent. Of the money that has been expended, over 70 percent went either to the PPS project management office or to hospitals. One of the key goals of DSRIP was to build up the community-based health care infrastructure, particularly in primary care, and to better integrate the health care delivery system with community-based organizations that address social determinants of health. These strategies are essential to reducing avoidable hospital use and its associated cost. Helgerson noted that many of the DSRIP projects are just being implemented but suggested that PPS rationale for holding back funds from downstream PPS partners was becoming more tenuous. A webcast of the meeting is available here.

Governor Cuomo Seeks Zero-Growth Budget. As he has in each of the six years since he took office, Governor Andrew Cuomo is asking state agencies to submit "zero-growth" budget plans for the 2017-18 state fiscal year, which starts April 1. That means agency heads need to keep year-to-year operation expenses flat in budget plans. According to the Albany Times-Union, however, some sizeable exceptions to the zero growth request exist, including Medicaid, which is the largest expenditure in the state budget. The current year's state budget is approximately $145 billion. Read More

Integrated Licensing Program. The October newsletter from the New York Office of Mental Health (OMH) includes an update on a new, integrated licensure process. The state is committed to encouraging integrated care that addresses heath, mental health, and substance use issues in a coordinated fashion. Historically providers interested in offering services from OMH, the Office of Alcohol and Substance Abuse Services (OASAS), and the Department of Health (DOH) had to pursue a license from each agency with jurisdiction, leading to long delays for providers seeking to treat patients with multiple needs. To help remedy this situation, the three agencies worked together for nearly four years to streamline their review and approval processes, coming up with the Integrated Licensing Program. The new regulations cover clinical and physical plant standards, staffing requirements, and a single application and review process. The regulation provides for giving authority to OMH, OASAS, and DOH to establish joint operating, reporting, and survey procedures for primary care and behavioral health services, and for allowing providers to deliver the desired range of cross-agency clinic services at a single site under a single license. Read More

Health Care Disparities in New York's Medicaid Managed Care Program. As part of its ongoing quality assurance activities the Department of Health prepared a report on disparities in quality of care in New York's Medicaid managed care program. The report examines disparities by various demographic characteristics, with the aim of identifying areas where disparities exist and documenting how these disparities may have changed over time. The report looks at disparities across a number of dimensions, including gender, age, race/ethnicity, Medicaid aid category, cash assistance, mental health condition, geographic location, and primary language spoken. The report reviews 59 quality measures that are collected as part of the Quality Assurance Reporting Requirements, which are largely based on measures of quality developed by the NCQA Healthcare Effectiveness Data and Information Set (HEDIS). Some key findings were:

- Blacks had lower rate of performance than Whites for 29 percent of the measures (down from 35 percent in 2012) after adjusting for demographic differences.
- Among the Asian and Hispanic groups, rate of performance was the same or better than Whites for the majority of the 59 measures.
- Income inequality affects quality of care, with lower scores in screening and controlling cholesterol levels, the amount of preventive care for children and adolescents, and the amount of preventive care for women.
- Racial disparities remain in the management of diabetes and cardiovascular conditions.
- For black adults with a serious mental illness, the quality of care was comparable or better for selected measures in preventive care, medication management, care for persons living with HIV, and care related to the management of behavioral health. The quality was lower for several chronic illnesses such as diabetes care, cardiovascular care, and care for respiratory illnesses.
- Across the majority of measures, individuals whose primary language was not English reported the same or better performance than individuals whose primary language was English.

- Regional disparities exist in the majority of reported measures, with New York City performing less well than all other regions of the state. Read More

State Settles with Jail Health Services Provider in Nassau County. New York Attorney General Eric T. Schneiderman announced a settlement with Armor Correctional Health Services, a Florida-based jail health services company responsible for providing comprehensive medical services to Nassau County Correctional Center (NCCC). The agreement resolves a lawsuit filed by the attorney general in July 2016, which alleged that Armor either failed to perform or egregiously underperformed many of its contractual obligations, placing inmates' health in jeopardy. Armor has agreed that for a period of three years it will not bid on or enter into any contract to provide jail health services in New York State and will pay $350,000. Nassau County has also appointed an independent monitor to ensure Armor's compliance with its contractual obligations at NCCC for the duration of its contract. The attorney general's office will retain $100,000 of that payment as penalties, and it will transfer the remaining $250,000 to Nassau County as reimbursement related to Armor's performance of certain contractual obligations. Read More

Delivery System Reform Incentive Payment (DSRIP) Quarterly Reports. New York has recently posted the Performing Provider Systems' DSRIP Year 2, First Quarterly Reports, covering PPS activity from April 1, 2016, to June 30, 2016. The reports provide highly detailed information on each of the DSRIP projects that each PPS is undertaking, a report on funds flow, and updates on operational factors such as workforce development, governance, information technology, cultural competence and health literacy. Read More

Medicaid Blocks Payments for Controlled Substances Exceeding Legal Limits. *The Washington Times/AP* reported on October 7, 2016, that New York officials are making progress blocking Medicaid payments to pharmacies that provide narcotics and controlled substances exceeding legal limits. The effort is in response to a February 2015 audit that uncovered $1.2 million in claims payments exceeded legal limits for controlled substances from 2009 to 2013, including 3,323 managed care claims that exceeded limits. Since the audit, the state has denied $3.3 million in claims through July. It has also instructed managed care organizations to review improper claims and implement controls. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Drug Price Relief Initiative Set for November 2017 Ballot. *Cleveland.com* reported that the Ohio Drug Price Relief Act is officially slated to appear on the state's November 2017 ballot, following certification of the initiative by Ohio Secretary of State Jon Husted. A recent report released by Vorys Health Care Advisors and Health Management Associates stated that the proposal would be difficult, if not impossible, to implement. The initiative now goes to the bipartisan Ohio Ballot Board to draft the ballot language. The board has to do so no later than 75 days before the 2017 election. Read More

Oregon

OHA Announces CCO Rate Increase for 2017. *The Portland Business Journal* reported on October 11, 2016, that the Oregon Health Authority (OHA) announced a 3.2 percent average increase in 2017 monthly capitation rates for the state's Coordinated Care Organizations (CCOs). Increases ranged from 0.6 percent to 11.6 percent for 12 CCOs; another four CCOs received decreases. OHA Director Lynne Saxton noted that Oregon again met its targeted annual Medicaid cost containment growth rate of 3.4 percent. Rates are certified annually by accounting firm Optumas and are impacted by regional costs, risk, and hospital reimbursement rates. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Settlement Proceeds to Support Increased Nursing Home Oversight. On October 4, 2016, Pennsylvania health officials announced plans to leverage $1.2 million in settlement proceeds from a case against a nursing home chain to increase nursing home oversight. Department of Health Secretary Karen Murphy said that DOH plans to hire more employees and write new regulations to implement the recommendations of a task force examining ways to improve care at the more than 700 nursing homes in Pennsylvania. The Department of Aging will play an oversight role through its ombudsman program. DOH plans to focus on:

- Enacting regulations or legislation to implement the task force recommendations.
- Expanding nursing home inspections to focus on quality of life issues.
- Improving surveys to evaluate quality of life at homes.

For more information, visit www.nursinghomes.health.pa.gov. Read More

Appeals Court Supports FTC Request to Stop Hospital Merger. A federal appeals court recently reversed a lower court's decision to deny the Federal Trade Commission's (FTC) request to temporarily pause the hospital merger between Penn State Hersey Medical Center and PinnacleHealth System until an administrative review is conducted. The appeal was granted after the judge determined that the lower court did not properly carry out the test to determine if the merger would create a monopoly. The case began with a 2015 FTC complaint asserting that the combined hospitals would gain control of over 76 percent of the healthcare market in Harrisburg, Pennsylvania, resulting in higher healthcare costs and lower care quality. The next step in the Penn State Hersey Medical Center and PinnacleHealth merger case is a FTC administrative adjudication. Read More

West Virginia

Lawsuit Over Medicaid I/DD Cuts Granted Class Action Status. *The News & Observer* reported on October 7, 2016, that a lawsuit filed against the West Virginia Department of Health and Human Resources on behalf of five Medicaid beneficiaries with intellectual and developmental disabilities (I/DD) has been granted class action status. U.S. District Judge Thomas Johnson's

September 30, 2016, ruling allows individuals with I/DD affected by cuts in services under West Virginia's I/DD waiver to join the suit against the department. The waiver program provides Medicaid beneficiaries with in-home and community-based services. The lawsuit was filed by Mountain State Justice. Read More

Wisconsin

Judge Rules against State in Medicaid Nursing Payments Case. The *Wisconsin State Journal* reported on October 9, 2016, that on September 27 a Waukesha County judge ruled that the Wisconsin Department of Health Services did not have the authority to reclaim Medicaid payments from private duty nurses, which state auditors have been doing since 2012. A group of nurses said that since that time, state auditors collected between $7,000 and $142,000 per nurse due to paperwork mistakes, such as lack of documented doctor's orders, reportedly forcing many nurses to leave their practices. Approximately 2,000 nurses in the state provide in-home care to Medicaid beneficiaries. Circuit Court Judge Kathryn Foster said that requiring such extensive, specific documentation from nurses is outside of the department's authority. Read More

National

Medicaid Expansion Costs Are Higher Than Expected. *The New York Times* reported on October 5, 2016, that the number of individuals signing up for Medicaid expansion has surpassed projections and that expansion members have greater health care needs than expected. These two factors are believed to be driving Medicaid costs higher than was anticipated. States reporting higher-than-expected costs include Arkansas, Kentucky, and Ohio. In response, these states are looking at ways to offset rising costs, for example, by requiring recipients to pay premiums for coverage. Thirty-one states and the District of Columbia have expanded Medicaid. Beginning in January of 2017, states will be required to pay a 5 percent matching rate for expansion members, rising to 10 percent in 2020. Read More

Senators Look to Block Risk Corridor Settlement with Insurers. *CQ Roll Call* reported on October 11, 2016, that four Republican senators hope to block the Obama Administration from settling risk corridor payment lawsuits filed by health insurers that participated in the Exchanges. Exchange plans filed the lawsuits after receiving only about 12.6 percent of federal risk corridor payments promised under the Affordable Care Act. The remaining payments were hamstrung by Republicans in Congress, led by Marco Rubio (R-FL). The Obama Administration indicated it would settle the suits out of the Justice Department's Judgment Fund, a move that Republicans say circumvents Congress. The four senators who hope to introduce the legislation in November are John Barrasso (R-WY), Mike Lee (R-UT), Marco Rubio (R-FL), and Ben Sasse (R-NE).

Industry Research

Medicaid Expansion Leads to Lower Uncompensated Care, Higher Medicaid Revenue for Hospitals, JAMA Report Shows. *The Journal of the American Medical Association* published a report on October 11, 2016, showing how Medicaid expansion has led to large decreases in hospital uncompensated care costs and

increases in overall Medicaid revenues. The report looked at hospitals in 19 states that expanded Medicaid and compared finances with those hospitals in 25 states that had not expanded at that time. Read More

Industry News

Molina Expects 1.5-2 Percent Exchange Margins in 2017. *The Wall Street Journal* reported on October 6, 2016, that Molina expects to post profit margins of 1.5 percent to 2 percent on its Exchange business in 2017. The company attributes its success in the Exchange market to its experience in Medicaid, where it manages a similar population of members with lower incomes and a higher incidence of chronic health conditions. Meanwhile, insurers such as United Healthcare, Aetna, and Humana have posted millions of dollars in losses on the Exchanges and are subsequently limiting their presence in the Exchange market. Read More

Ardent Health Services Agrees to Acquire LHP Hospital Group. *The Tennessean* reported on October 5, 2016, that Ardent Health Services has agreed to acquire LHP Hospital Group, which operates five hospitals in Florida, Idaho, New Jersey, and Texas. The deal is expected to increase Tennessee-based Ardent's revenues by 50% to $3 billion. Ardent currently operates fourteen hospitals in New Mexico, Oklahoma and Texas. Terms were not disclosed, but the deal is expected to close by the end of 2016 or early 2017. Read More

Healthcare REITs Scale Back Skilled Nursing Holdings. *The Wall Street Journal* reported on October 11, 2016, that health care-focused real estate investment trusts (REITs) are scaling back their holdings in skilled nursing facilities (SNFs). SNFs are being impacted by shorter lengths-of-stay and lower payments rates, especially as government-funded programs shift to value-based care. Several healthcare REITs that also invest in hospitals and other medical office buildings have spun-off their SNF holdings, which they say has resulted in improved stability and growth. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
October, 2016	Missouri (Statewide)	Contract Awards	700,000
October, 2016	Nevada	Contract Awards	420,000
October, 2016	Washington, DC	RFP Release	200,000
October, 2016	Massachusetts	RFP Release	860,000
November 1, 2016	Arizona ALTCS (E/PD)	RFP Release	30,000
November 1, 2016	Texas STAR Kids	Implementation	200,000
November, 2016	Oklahoma ABD	RFP Release	177,000
November 9, 2016	Wisconsin Family Care/Partnership (MLTSS)	Proposals Due	14,000
December 1, 2016	Massachusetts MassHealth ACO - Pilot	Implementation	TBD
December 9, 2016	Virginia MLTSS	Contract Awards	212,000
January 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
January 1, 2017	Nebraska	Implementation	239,000
January 1, 2017	Minnesota SNBC	Implementation (Remaining Counties)	45,600
December, 2016	Massachusetts MassHealth ACO - Full	Proposals Due	TBD
January 17, 2017	Wisconsin Family Care/Partnership (MLTSS)	Contract Awards	14,000
January 18, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
January, 2017	Oklahoma ABD	Proposals Due	177,000
February, 2017	Rhode Island	Implementation	231,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
May, 2017	Oklahoma ABD	Contract Awards	177,000
July 1, 2017	Wisconsin Family Care/Partnership (MLTSS)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
August, 2017	Georgia	Implementation	1,300,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October, 2017	Massachusetts MassHealth ACO - Full	Implementation	TBD
October, 2017	Massachusetts	Implementation	860,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
March, 2018	North Carolina	RFP Release	1,500,000
April, 2018	Oklahoma ABD	Contract Awards	177,000
June, 2018	North Carolina	Proposals Due	1,500,000
September, 2018	North Carolina	Contract awards	1,500,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000
July 1, 2019	North Carolina	Implementation	1,500,000

Dual Eligible Financial Alignment Demonstration Implementation Status

Below is a summary table of the progression of states toward implementing a dual eligible financial alignment demonstration.

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (June 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	119,814	34.2%	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	48,218	35.5%	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	13,038	13.4%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	38,767	38.8%	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	124,000	5,480	4.4%	There are 17 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	217	1.1%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	62,009	54.4%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400			Neighborhood INTEGRITY
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	5,419	10.1%	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	42,069	25.0%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	26,975	40.7%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**362,006**	**28.9%**	

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

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