HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

October 19, 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: HIGHLIGHTS FROM KAISER/HMA 50-STATE SURVEY
- FLORIDA AHCA SEEKS TO EXTEND MANAGED CARE 1115 WAIVER
- MISSOURI STATEWIDE MEDICAID MCO AWARDS ANNOUNCED
- TENNESSEE ISSUES INMATE HEALTH SERVICES RFP
- VIRGINIA MEDICAID EXPANSION PUSH CONTINUES AMID BUDGET SHORTFALL
- CHS SELLS MAJORITY INTEREST IN HOME HEALTH BUSINESS TO ALMOST FAMILY, INC.

IN FOCUS

HIGHLIGHTS FROM KAISER/HMA 50-STATE MEDICAID DIRECTOR SURVEY

This week, our *In Focus* section reviews highlights and shares key takeaways from the 16th annual Medicaid Budget Survey conducted by the Kaiser Commission on Medicaid and the Uninsured (KCMU). Survey results were released on October 13, 2016, in three new reports: "***Medicaid Enrollment & Spending Growth: FY 2016 & 2017,***" "***Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017,***" and "***Putting Medicaid in the Larger Budget Context: An In-Depth Look at Four States in FY 2016 and FY 2017.***" The reports were prepared by Vernon K. Smith, Ph.D., Kathleen Gifford, Eileen Ellis, and Barbara Edwards from HMA and by Robin Rudowitz, Elizabeth Hinton, Larisa Antonisse, and Allison Valentine from the Kaiser Family Foundation. HMA's Pat Casanova, Sarah Jagger, and Dennis Roberts also contributed. The survey was conducted in collaboration with the National Association of Medicaid Directors.

This survey reports on trends in Medicaid spending, enrollment, and policy initiatives for FY 2016 and FY 2017, highlighting policy changes implemented in

state Medicaid programs in FY 2016 and those planned for implementation in FY 2017 based on information provided by the nation's state Medicaid Directors.

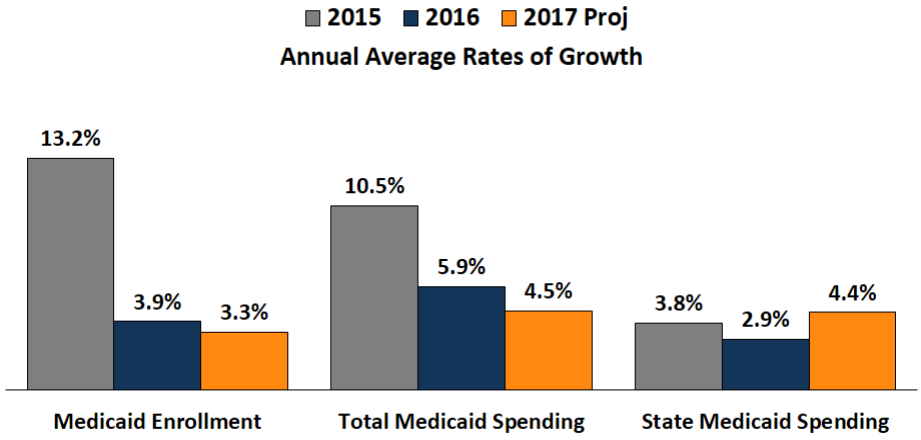
Key Report Highlights

In the following sections, we highlight a few of the major findings from the reports. This is a fraction of what is covered in the 50-state survey reports, which include significant detail and findings on policy changes and initiatives related to eligibility and enrollment, managed care, long-term services and supports (LTSS), provider payment rates, and covered benefits (including prescription drug policies). The reports also look at the key issues and challenges now facing Medicaid programs.

Medicaid Enrollment and Spending Growth

After significant increases in FY 2015 associated with the implementation of the ACA Medicaid expansion, Medicaid spending and enrollment growth slowed significantly in FY 2016 and is projected to further slow in FY 2017. An uptick in the state share of Medicaid spending is projected for FY 2017 primarily reflecting the phase-down in the federal share for the ACA expansion population from 100 percent to 95 percent.

Figure 1 – Medicaid Enrollment and Spending Growth, FY 2015-2016 and FY 2017 (Projected)

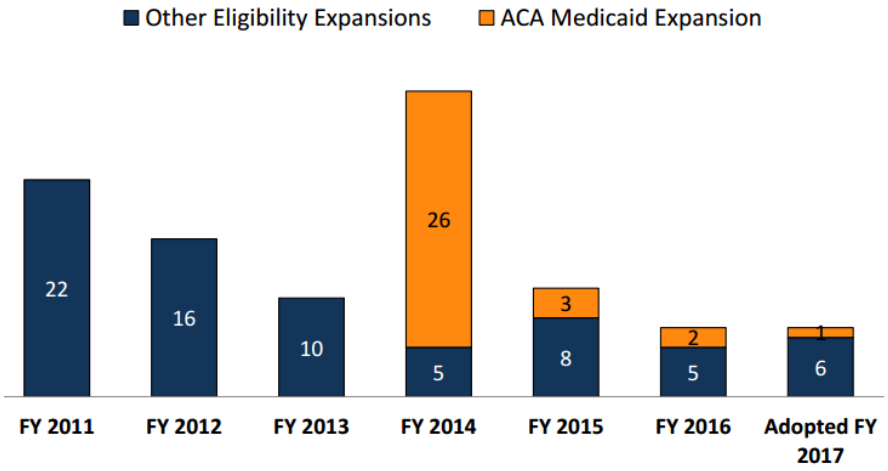


SOURCE: Enrollment growth for FY 2015-2016 is based on KCMU analysis of CMS, Medicaid & CHIP Monthly Applications, Eligibility Determinations, and Enrollment Reports, accessed October 2016. The spending growth rate for FY 2015 is derived from KCMU Analysis of CMS Form 64 Data. All other growth rates are from the KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2016

Medicaid Eligibility Standard Changes

- As of October 2016, 32 states (including DC) have adopted the ACA Medicaid expansion, with two states expanding in FY 2016 (Alaska and Montana) and one state in FY 2017 (Louisiana).
- Some states have approval or are seeking approval to impose premiums or monthly contributions under Medicaid expansion waivers. Many states have initiatives to expand coverage to the criminal justice involved population.

Figure 2 – Number of States with Eligibility Expansions/Enhancements FY 2011-2017

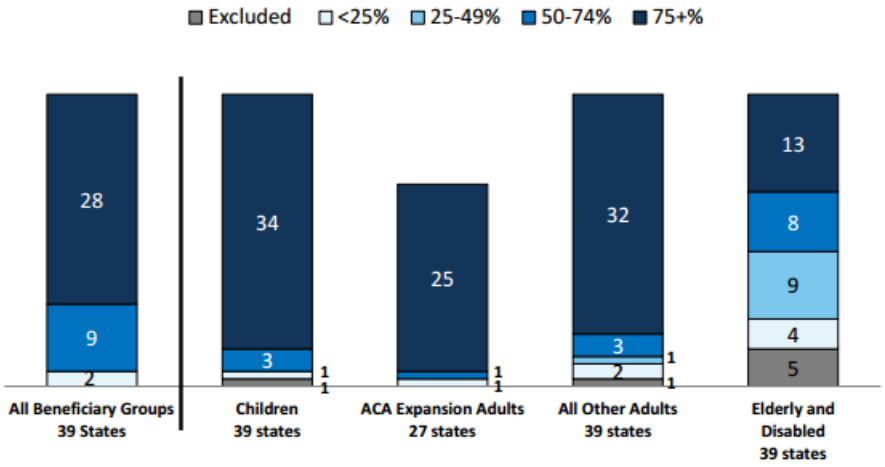


SOURCE: KCMU Survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2011-2016.

Medicaid Managed Care Policy Changes

- A total of 39 states (including DC) contract with risk-based managed care organizations (MCOs) to serve their Medicaid enrollees. As of July 2016, 28 of these 39 states had at least 75 percent of all Medicaid beneficiaries enrolled in MCOs (up from 21 states in July 2015).

Figure 3 – MCO Penetration Rates for Select Groups of Medicaid Beneficiaries, as of July 1, 2016



SOURCE: KCMU Survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2016.

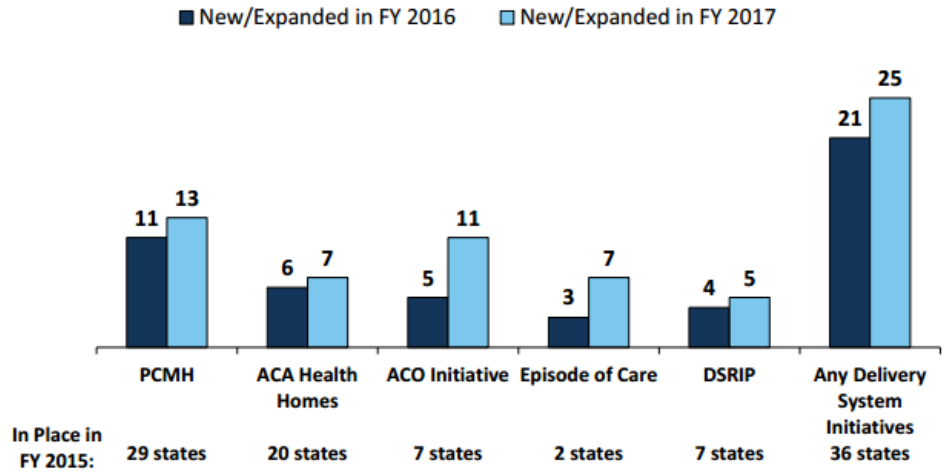
- The trend toward increased use of MCOs continues: three states (Iowa, Rhode Island, and West Virginia) terminated their Primary Care Case Management (PCCM) programs in either FY 2016 or FY 2017 and shifted those populations into risk-based MCOs. Also, Alabama plans to implement a new MCO program in FY 2017 and Missouri plans to expand its MCO program statewide in FY 2017.

- To learn about MCO enrollment of populations with special needs, the survey asked states with MCOs to indicate whether MCO enrollment for certain populations was "always mandatory," "always voluntary," "varies (by geography or other factor)," or is "always excluded." As of July 1, 2016, 28 states indicated that MCO enrollment of pregnant women was always mandatory. Fewer states indicated MCO enrollment was always mandatory for foster children (16 states), individuals with intellectual or development disabilities (I/DD) (10 states), children with special health care needs (16 states), adults with severe mental illness (SMI) (16 states), or adults with physical disabilities (16 states).
- The survey also addressed MCO coverage of behavioral health service and asked states with MCOs to indicate whether behavioral health services were "always carved-in," "always carved-out," or whether MCO coverage "varies (by geography or other factor)."As of July 2016, 20 states always carved-in specialty outpatient mental health, 24 states always carved-in inpatient mental health, 24 states always carved-in outpatient substance use disorder (SUD) services, and 26 states always carved-in inpatient SUD.
- States are using managed care to advance quality and alternative payment models and to help screen for social needs. Seventeen (17) states in both FY 2016 and FY 2017 implemented, or plan to implement, new or expanded quality initiatives. Five states in FY 2016 and 10 states in FY 2017 have identified, or will identify, targets in MCO contracts for the use of alternative provider payment models. Twenty-six (26) states reported requiring or encouraging MCOs to screen for social needs and provide referrals to other services in FY 2016 and four states intend to do so in FY 2017.

Emerging Delivery System and Payment Reform Initiatives

- Twenty-one (21) states in FY 2016 and 25 states in FY 2017 reported adopting or expanding one or more initiatives, including patient-centered medical homes (PCMHs), Health Homes, Accountable Care Organizations (ACOs) as well as other initiatives to better manage the care of persons with multiple chronic conditions.

Figure 4 – Number of States with Delivery System Reform Activity, FYs 2016-2017

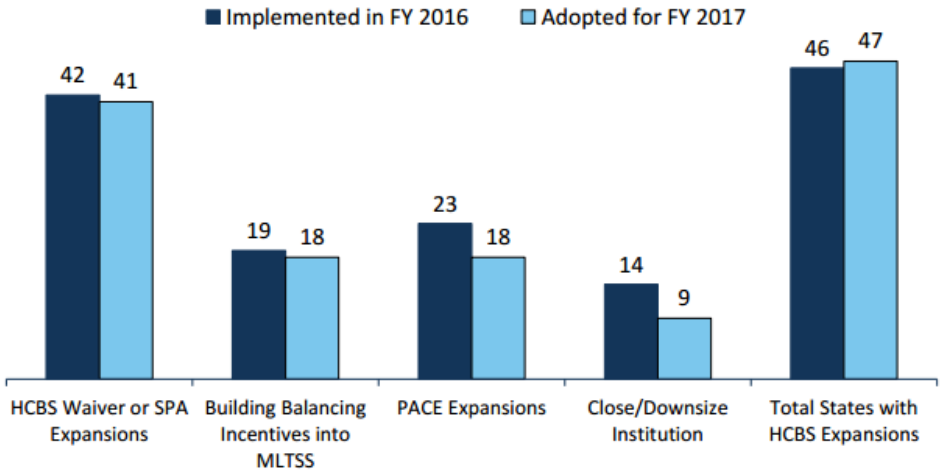


SOURCE: KCMU Survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2016.

Long Term Services and Supports (LTSS)

- Nearly every state reported actions to expand the number of persons served in community settings in both years (46 states in FY 2016 and 47 states in FY 2017).

Figure 5 – State Long-Term Care Actions to Serve More Individuals in Community Settings, FYs 2016-2017



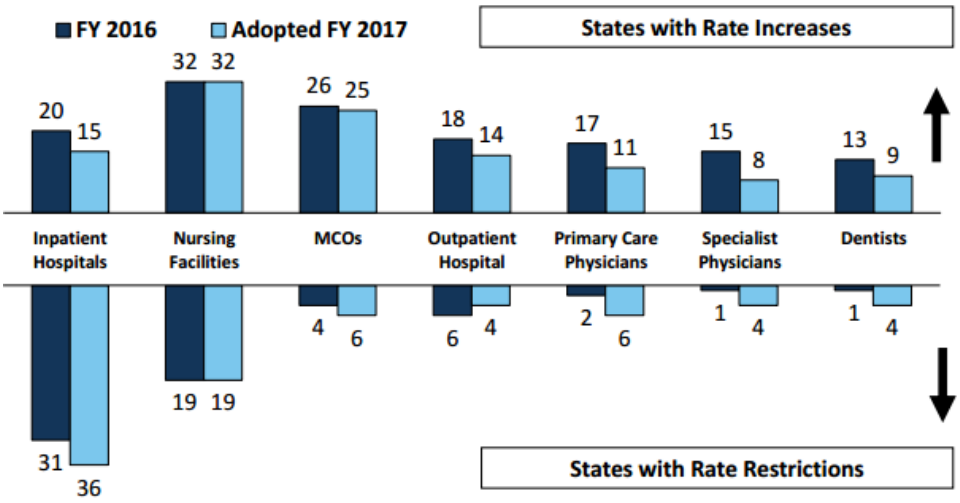
SOURCE: KCMU Survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2016.

- In June 2015, CMS issued an Informational Bulletin to clarify when and how Medicaid reimburses for certain housing-related activities. Sixteen (16) states reported that they have or will implement or expand housing-related services as outlined in the Informational Bulletin in FY 2016 or FY 2017.
- Twenty-three (23) states provided some or all LTSS through a managed care arrangement (MLTSS) as of July 1, 2016; 15 states offered MLTSS on a statewide basis for at least some LTSS populations. Enrollment into the MLTSS program is "always mandatory" statewide for seniors in 13 of the 23 MLTSS states, for individuals with ID/DD in eight states, for non-elderly adults with physical disabilities in 12 states, and for individuals who have full dual eligibility status in nine states.

Provider Rates

- In FY 2016, more states implemented rate increases (45 states) compared to rate restrictions (38 states). For FY 2017, slightly fewer states adopted rate increases (40 states) than rate restrictions (41 states). States were more likely to increase rates for outpatient hospital, primary care physicians, specialist physicians, dentists, MCOs, and nursing facilities and more likely to restrict rates for inpatient hospitals.

Figure 6 – Provider Rate Changes Implemented in FY 2016 and Adopted for FY 2017



SOURCE: KCMU Survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2016.

- For FY 2016, five states added new provider taxes. DC has a new hospital tax, Connecticut added a tax on ambulatory surgery centers, and Utah added a tax on ambulance providers. Both California and Pennsylvania implemented new MCO taxes, replacing prior MCO taxes that did not meet new federal guidelines for Medicaid MCO taxes.
- For FY 2017, four states are adding new taxes. Louisiana and Wyoming are adding hospital taxes, and Louisiana, Michigan, and Vermont are adding taxes on ambulance providers.

Looking Ahead: Perspectives of Medicaid Directors

When asked to identify the top priorities, issues, and challenges for FY 2017 and beyond, Medicaid directors listed the following:

- **Controlling Medicaid Costs.** Regardless of economic trends, Medicaid remains such a significant portion of state budgets that the program is under constant pressure to control spending and achieve greater value. For FY 2017, cost control and cost containment was specifically mentioned as one of the top three priorities by a large share of states surveyed. The major focus of cost control is shifting to delivery system and payment reforms, incentivizing high quality care, better outcomes, and lower costs.
- **Payment and Delivery System Reform Initiatives.** Over half of states mentioned these initiatives as a top priority for FY 2017, including "value-based purchasing" approaches and other strategies, described by one state as "changes to the delivery system to improve efficiency and care outcomes," in other states as "integration of physical and behavioral health," "continuing to transform the system through managed care," and in others as "system transformation, clinical management, and population health." Significantly, a number of the delivery and payment reform initiatives go beyond traditional medical care delivery, addressing goals related to social determinants of health and population health.

- **Medicaid Infrastructure Development.** Several states listed the development and operationalization of new eligibility and MMIS projects as a major priority in FY 2017, either as a priority in themselves or as necessary for the success of other initiatives. Medicaid programs also need the systems capability to implement quality improvement, provider and MCO monitoring, data analytics, and cost control strategies. A major Medicaid issue and priority is the staffing and other resources for systems and IT development, and the infrastructure necessary for Medicaid to implement its major initiatives.

Links to Kaiser/HMA 50-State Survey Reports

Link to "Medicaid Enrollment & Spending Growth: FY 2016 & 2017"

Link to "Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017"

Link to "Putting Medicaid in the Larger Budget Context: An In-Depth Look at Four States in FY 2016 and FY 2017"

HMA Medicaid Roundup

Connecticut

CSEA, SEIU Seek Injunction to Block Group Home Privatization. *The CT Mirror* reported on October 13, 2016, that two labor unions representing Connecticut state employees will file a request for injunction in state court to block the planned privatization of 40 state-run group homes as well as services for people with intellectual or developmental disabilities. CSEA-SEIU Local 2001 (Civil Service Employees Association) and SEIU 1199 (Service Employees International Union) say that resulting layoffs of about 600 state employees, including 500 union members, would violate Connecticut law. The privatization is part of Connecticut Governor Dannel Malloy's plan to shrink the state's workforce. Governor Malloy's plan would impact about 16,742 individuals with intellectual or developmental disabilities. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

AHCA Seeks to Extend Medicaid 1115 Managed Medical Assistance Waiver. The Florida Agency for Health Care Administration (AHCA) released a three-year Waiver Extension Request to extend Florida Medicaid's 1115 Managed Medical Assistance (MMA) Waiver for the period July 1, 2017 through June 30, 2020. The Agency is not proposing any substantive changes in the renewal of the MMA Waiver. The MMA program provides primary care, acute care, dental care, and behavioral health care for Florida Medicaid recipients statewide. Managed care contracts are competitively bid through a procurement process. The Agency is not requesting waiver or expenditure authorities related to the Low Income Pool (LIP) program as CMS advised that LIP could not be not be extended past June 30, 2017. The public notice and public comment period is October 11, 2016 – November 10, 2016. Public meetings will be held October 18 in Tallahassee, October 20 in Tampa and October 21 in Miami. Read More

Massachusetts

Southcoast Health System, Care New England Abandon Merger Discussions. *The Boston Globe* reported on October 17, 2016, that New Bedford, Massachusetts-based Southcoast Health System and Providence, Rhode Island-based Care New England Health System jointly announced they will forgo plans to merge. The deal would have created an eight-hospital system across two states with over $2 billion in annual revenues. Negotiations had been underway for almost a year. Read More

Missouri

Statewide Managed Care Awards Announced. Missouri announced on October 18, 2016, that Centene, UnitedHealthcare and WellCare were selected to participate in the state's newly expanded statewide Medicaid managed care program. Contracts for the program, called HealthNet Managed Care, are for one year beginning May 1, 2017, with four one-year renewal options. Final agreements will be negotiated between the plans and the Missouri Office of Administration, Division of Purchasing. Centene and WellCare are incumbent plans, while United is a new entrant. Aetna was the other incumbent. WellCare had about 117,000 HealthNet members as of June 2016 through its Missouri Care subsidiary; it began serving Missouri's Medicaid population in 1998. Centene has operated in Missouri since 2012 through its Home State Health subsidiary and had nearly 103,000 HealthNet members as of June 2016.

Montana

Hospitals See Declining Operating Margins After Medicaid Expansion. *Great Falls Tribune* reported on October 18, 2016, that according to a report released by the Montana Hospital Association, operating margins across state hospitals deteriorated to negative 2.2 percent following Medicaid expansion. More than 50,000 people enrolled in the state's Medicaid expansion program in the first six months. While uncompensated costs have declined and Medicaid volume is up, these improvements have been offset by lower utilization rates in commercial insurance and self-pay. After becoming the 30th state to expand Medicaid, Montana's uninsured rate fell from 15 percent in 2015 to 7 percent in 2016. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Audit Finds $19 Million in Overpayments to Medicaid Plans in Fiscal 2015. *The Lansing Star* reported on October 14, 2016, that New York overpaid Medicaid managed care plans by nearly $19 million in fiscal 2015 because of a flaw in how premiums are calculated, according to a State Comptroller's audit. The state is also at risk of making an additional $56.8 million in overpayments over the next three years. According to the audit, the New York Department of Health incorrectly accounted for certain taxes and failed to collect $38.6 million in actuarial costs, skewing the premiums calculations. In fiscal year 2015, New York had 7.1 million Medicaid enrollees accounting for around $53 billion in Medicaid claims. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Insurance Department Announces 2017 Affordable Care Act Rates. On October 17, 2016, the Pennsylvania Insurance Department (PID) announced 2017 rates for individual and small group health insurance plans offered under the Affordable Care Act (ACA). Insurance company rates in Pennsylvania will have an average increase of 32.5 percent for individual plans and 7.1 percent for small

group plans. Insurance Commissioner Teresa Miller also announced that PID requested permission to file an amicus brief in support of Highmark, Inc. in its lawsuit to require the federal government to fund risk corridor payments to insurers that incurred higher claims than expected. Highmark filed suit for these payments, which it claims cost the insurer $223 million in 2014. Read More

Penn State-Pinnacle Drop Merger After Appeals Court Loss. On October 14, 2016, Penn State Health Milton S. Hershey Medical Center and PinnacleHealth System announced that they have decided to abandon efforts to merge. The hospitals' decision follows a federal court ruling in late September that sided with the Federal Trade Commission's opposition to the merger. The Pennsylvania Attorney General's office also had opposed the merger. Dr. Craig Hillemeier, Penn State's Senior Vice President for Health Affairs and CEO of the Milton S. Hershey Medical Center, said in an email to staff after Friday's vote that the decision to suspend the merger is based in large part on the expected "time and cost associated with continuing litigation," balanced against the prospect of reversing the Circuit Court's decision. PinnacleHealth President and CEO Michael Young sent a similar email to his staff on Friday, as well. The agreement was opposed by both the Federal Trade Commission and Pennsylvania's Office of the Attorney General, which argued that the proposed combination would create too dominant a player in the South Central Pennsylvania health care market. Read More

Tennessee

State Releases Inmate Health Services RFP. *The Tennessean* reported on October 12, 2016, that Tennessee has released a request for proposal (RFP) for its prison health services business, which serves 20,000 inmates. Proposals are due November 28, 2016. The current contract with Centurion of Tennessee is set to expire in February 2017. The contract is worth $270 million. Read More

Virginia

Medicaid Expansion Push Continues as State Faces Budget Shortfall. *The Washington Post* reported on October 13, 2016, that Virginia Governor Terry McAuliffe hopes to tap into rainy-day funds for Medicaid to address a $1.5 billion budget shortfall, while his administration continues to push for Medicaid expansion. Governor McAuliffe has stated that Medicaid expansion would free up $211 million annually in state funds currently spent on mental health and hospital services for the uninsured. The Republican-led General Assembly has blocked prior attempts to expand Medicaid. Meanwhile, the state is facing a $861 million budget gap for fiscal years 2016 and 2017, and expects a $654 million shortfall in fiscal year 2018. Read More

Washington

Community Health Plan of Washington Names Leanne Berge CEO. Community Health Plan of Washington (CHPW) announced that Leanne Berge will take over as CEO, effective December 1, 2016, after the retirement of Lance Hunsinger. Berge most recently served as Chief Operating Officer for Mount Auburn Cambridge IPA. She has also served in leadership roles at Network

Health, Commonwealth Care Alliance, Harvard Pilgrim Health Care, and the Massachusetts Division of Insurance.

National

Health Care Issues on the Ballot in Several States this November. *CQ Roll Call* reported on October 12, 2016, that a variety of health care referendums and initiatives will be on the ballots in several states this November, with voters deciding on issues including drug pricing, hospital financing, universal health care and finding funds for state health Exchanges. In California, voters will decide on a constitutional amendment to prevent state lawmakers from using certain health care funds for general expenses. In Colorado, residents will vote on ColoradoCare, a universal health care program. In Washington, voters will weigh in on taxing adult standalone dental plans to help fund Washington Healthplanfinder.

CMS May Not Count Most Medicaid Medical Homes as Alternative Payment Models under MACRA Rule. *Modern Healthcare* reported on October 17, 2016, that the final MACRA rule released by the Centers for Medicare & Medicaid Services (CMS) will not count most Medicaid patient-centered medical homes as alternative payment models (APMs). APMs are aimed at improving care for beneficiaries with chronic conditions or serious mental illness. In its proposed rule, CMS said it was considering allowing Medicaid medical homes to count as APMs if they assumed at least 4 percent risk in 2019 and 5 percent in 2020. However, stakeholders have argued that Affordable Care Act never intended for medical homes to assume risk. CMS is still finalizing its proposal regarding minimum risk requirements. Read More

States Rethinking Medicaid Non-Emergency Medical Transportation Benefits. *Inside Health Policy* reported on October 13, 2016, that states are increasingly looking at whether to provide Medicaid beneficiaries with non-emergency medical transportation. While California recently extended Medicaid transportation benefits to include non-emergency medical transportation, other states like Indiana, Iowa, and Kentucky are looking at discontinuing the benefit for Medicaid expansion members. Medicaid Health Plans of America chief executive Jeff Myers says cutting the benefit is likely to prove more costly to states in the long run. Read More

HHS to Pilot Provider Network Comparison Tool for Exchange Plans in Four States. *Kaiser Health News* reported on October 14, 2016, that the U.S. Department of Health and Human Services (HHS) will pilot a tool this fall allowing consumers to compare provider networks for Exchange plans in their area. The goal is to provide consumers shopping on HealthCare.gov information on how narrow a plan's provider network may be and which physicians and hospitals are included. The pilot will be available in four states: Maine, Ohio, Tennessee, and Texas. Read More

Medicaid Opioid Addiction Coverage Remains a Challenge. *The PEW Charitable Trusts* reported on October 14, 2016, that Medicaid coverage of opioid addiction treatment varies widely among states and continues to be a challenge, particularly in many southern and western states. Under the Affordable Care Act, all states are required to pay for addiction treatment for all enrollees. However, many physicians are opting not to treat Medicaid patients because of low reimbursement rates. Additionally, health plans have restrictions on

treatments, including dosage and duration limits. In the fiscal year ending June 30, 2016, Medicaid paid for 7 percent of all buprenorphine prescriptions, compared to 57 percent for commercial insurers. Read More

Industry News

Community Health Systems to Sell Majority Interest in Home Health Division to Almost Family, Inc. Community Health Systems, a Tennessee-based operator of general acute care hospitals in 22 states, announced on October 17, 2016, that it has signed a definitive agreement to sell a majority ownership interest in its home health division to Almost Family, Inc. The deal will increase Almost Family's home health operations to 340 branches across 26 states. The transaction is expected to close in the fourth quarter of 2016. Read More

Addus HomeCare Appoints Two New Board Members. Addus HomeCare announced on October 19, 2016, that it has appointed Susan Weaver, MD, and Darin Gordon to the company's board. Dr. Weaver serves as the chief executive of health care services company C3Healthcare Rx, and was formerly with Blue Cross and Blue Shield of North Carolina. Mr. Gordon most recently headed up the Tennessee Division of Health Care Finance and Administration and also served as the director of TennCare. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
October, 2016	Nevada	Contract Awards	420,000
October, 2016	Washington, DC	RFP Release	200,000
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
December, 2016	Massachusetts	RFP Release	860,000
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.

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 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.