HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

August 16, 2017

THIS WEEK

HMA WEEKLY ROUNDUP

This week, our *In Focus* section is taking a brief summer vacation. Below, we provide our regular HMA Roundups, Industry News, RFP and Duals Calendars, and HMA News sections. We also want to take a moment to remind our readers about the HMA Information Services (HMAIS) Daily Roundup, which includes breaking industry news and state-by-state updates from HMA consultants in the field. The Daily Roundup is available only to HMAIS subscribers and includes advance content from the HMA Weekly Roundup, which continues to be distributed to readers every Wednesday evening. In other words, HMAIS subscribers have a leg up on the competition by getting breaking news and analysis first. For more information about HMAIS and the Daily Roundup please contact Carl Mercurio at cmercurio@healthmanagement.com or 212-575-5929.

HMA Medicaid Roundup

California

Advocacy Groups Sue Medi-Cal for Moving Patients with Complex Medical Conditions to Managed Care. *California Healthline* reported on August 10, 2017, that two consumer health advocacy groups have filed a lawsuit against California's Medi-Cal program for shifting patients with complex medical conditions from fee-for-service Medicaid to managed care. The suit, filed in Los Angeles Superior Court by Neighborhood Legal Services of Los Angeles County and Western Center on Law and Poverty, addresses a decision by the California Department of Health Care Services to overturn a ruling by an administrative law judge. The judge's decision would have allowed patients with complex medical conditions like epilepsy, microcephaly, and mitochondrial disorders, to remain in fee-for-service Medicaid. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Local Government Contribution Poses Obstacle to Accessing $1.5 Billion in LIP Funding for Charity Care. *Health News Florida* reported on August 11, 2017, that Florida hospitals will be unlikely able to access $1.5 billion from the Low Income Pool (LIP) fund for charity care unless local governments can provide $559 million in matching funds. Local governments will have difficulties raising the money necessary as counties no longer receive an incentive for providing matching funds and the legislature decided to cut $521 million from the state's Medicaid program. Read More

US to Appeal Decision in State Children with Disabilities Case. *Health News Florida* reported on August 10, 2017, that the Justice Department and children's health advocates will appeal a recent U.S. District Judge's ruling, which found that Florida is not failing to provide medically necessary treatment to children with disabilities. Judge William Zloch dismissed the five-year-old case, stating that the Florida Agency for Health Care Administration made changes so that children were not in danger of being denied private-duty nursing services or at risk of being institutionalized. The original lawsuit alleged that Florida was violating the Americans with Disabilities Act and other laws by not providing services that would permit children with complex needs to reside in their homes and communities. Read More

Georgia

Medicaid Director, Deputy Director Step Down. *Georgia Health News* reported on August 15, 2017, that Georgia Medicaid Director Linda Wiant and Deputy Medicaid Director Marcey Alter have left their positions. Currently, no interim or permanent Medicaid chief has been named. Read More

Illinois

HFS Announces Medicaid Managed Care Contract Awards. The Illinois Department of Healthcare and Family Services (HFS) announced on August 11, 2017, that Blue Cross Blue Shield of Illinois, Harmony Health Plan (WellCare), IlliniCare Health Plan (Centene), Meridian Health, Molina Healthcare of IL, and Cook County's CountyCare Health Plan were awarded contracts in the state's Medicaid Managed Care Organization procurement. CountyCare will only serve Cook County. Centene's IlliniCare will also serve the Department of Children and Family Services (DCFS) Youth managed care population. The contracts are effective January 1, 2018, for four years, with an option to renew for an additional four years. Incumbent plans Aetna and NextLevel did not win contracts, nor did new entrant Trusted Health Plan (District of Columbia) Inc. Read More

Iowa

Medicaid Managed Care Rate Talks Continue. *The Des Moines Register* reported on August 11, 2017, that negotiations between Iowa and three contracted Medicaid managed care plans are continuing weeks longer than expected. Amerigroup, AmeriHealth Caritas, and United Healthcare have reported heavy losses in the state's Medicaid managed care program and have maintained rates that are not adequate. The state, meanwhile, faces significant budget pressures. Read More

Maine

November Ballot to Include Medicaid Expansion. *The Associated Press* reported on August 12, 2017, that Maine voters will consider a ballot question on November 7, 2017, on whether the state should expand Medicaid. Expansion is projected to cost $54 million annually, with approximately 79,000 individuals eligible for coverage. Maine Governor Paul LePage and Republican lawmakers oppose the expansion ballot question and have pushed for work requirements for Medicaid beneficiaries. The state recently submitted an 1115 Medicaid waiver application to the Centers for Medicare & Medicaid Services that calls for work requirements, premiums, and asset testing. Read More

Michigan

Medicaid Expansion Lowers Uncompensated Care Costs, Study Finds. *Michigan Radio* reported on August 12, 2017, that uncompensated care costs in Michigan fell 56 percent between 2013 and 2015 thanks to the state's Medicaid expansion, according to a study by the Center for Healthcare Research and

Transformation. Uncompensated care costs fell from $903 million in 2013 to $394 million. The state expanded Medicaid in April 2014. Read More

Mississippi

State Medicaid Department Reviewing Medicaid Managed Care Award Protests. *The Clarion-Ledger* reported on August 14, 2017, that the Mississippi Division of Medicaid has seven days to review evidence in a protest over the state's most recent Medicaid managed care contract awards. Hinds Country Chancery Judge William Singletary issued the deadline after denying a request by protesting health plans Amerigroup and Mississippi True to block the contracts from being implemented. The two protesting bidders claim to have evidence of a conflict of interest surrounding the award decision. Read More

Montana

State to End Medicaid Expansion TPA Contract with BCBS. *Modern Healthcare* reported on August 10, 2017, that Montana is ending its Third Party Administrator (TPA) contract with Blue Cross and Blue Shield of Montana for the Montana Health and Economic Livelihood Partnership (HELP), the state's Medicaid expansion program. The state is currently facing a $75 million budget shortfall, while the TPA contract is work approximately $6 million annually. The state plans to submit a waiver amendment request to the Centers for Medicare & Medicaid Services on September 2, following public hearings. The HELP waiver is set to expire at the end of 2020. Read More

Nebraska

DHHS Releases Final Long Term Care Redesign Recommendations. The Nebraska Department of Health and Human Services (DHHS) released on August 9, 2017, its final Long Term Care (LTC) Redesign Plan. Under the plan, the Medicaid MLTSS population will be carved into existing contracts serving the state's managed care program, Heritage Health. The recommendations of the final plan do not significantly differ than those of the draft. Phase 1 populations (older individuals and individuals with physical disabilities) would begin to be carved in on January 1, 2020, with phase 2 populations (individuals with intellectual and/or developmental disabilities (I/DD)) to follow on January 1, 2021. Read More

CMS Approves Changes to Health Insurance Premium Program. *Live Well Nebraska* reported on August 15, 2017, that Nebraska has received federal approval to make cost methodology changes aimed at ensuring the viability of the state's Health Insurance Premium Program (HIPP). The Centers for Medicare & Medicaid Services (CMS) approved the changes in July. HIPP provides assistance with premiums, deductibles, and co-payments to low-income individuals to help pay for insurance when it is cheaper than providing Medicaid coverage. The state determined that changes were needed to cost calculations after the state transitioned to its new Heritage Health Medicaid managed care program. Read More

New Hampshire

Medicaid Expansion Agreement May Be Out of Compliance. *Concord Monitor/Associated Press* reported on August 12, 2017, that the New Hampshire Medicaid expansion program may be out of compliance with federal regulation and that changes are needed, according to the Centers for Medicare & Medicaid Services (CMS). CMS expressed concern because the state relies on voluntary contributions from insurance companies and hospitals to cover some of the state's costs. If lawmakers do not make the changes, federal funding may be withheld. The program currently serves 40,000 individuals. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

First 1,000 Days on Medicaid Initiative Launched. New York has launched a new focus for Medicaid Redesign: The First 1000 Days on Medicaid initiative. This initiative recognized that a child´s first three years are the most crucial years of their development. The initiative is designed to ensure that New York´s Medicaid program is working with health, education and other system stakeholders to maximize outcomes and deliver results for children. The First 1000 Days on Medicaid initiative is envisioned as a collaborative effort, bringing together stakeholders in a series of four work group meetings between August and November. The work group will be charged with developing a ten–point agenda to focus on enhancing access to services and improving outcomes for children on Medicaid in their first 1000 days of life. Read More

Behavioral Health Outreach and Education Initiative Launched. New York has launched a new statewide initiative aimed at educating and encouraging eligible Medicaid members to enroll in Health and Recovery Plans and Health Homes and to make use of newly available Home and Community Based Services. Working together, the New York Association of Psychiatric Rehabilitation Services (NYAPRS) and their partners at the Mental Health Empowerment Project and the Alcoholism and Substance Abuse Providers will provide peer educators to visit program and community settings to engage in an informal and interactive discussion about the new choices enrollees with more extensive behavioral health conditions can make. NYAPRS will hold a Kick-Off Webinar to describe the initiative on August 23 at 3 pm. Link to Webinar

Regulatory Modernization Initiative Announced. 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 is focused on Post-Acute Care Management Models. 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 first meeting is scheduled for Thursday, August 17th from 10:30 am to 3:00 pm in Meeting Room 6 of the Empire State Plaza in Albany.

Value Based Payment Roadmap Requirements Related to Social Determinants of Health and Community Based Organizations. The Department of Health will be hosting a webinar outlining the Value Based Payment (VBP) Roadmap requirements related to Social Determinants of Health (SDH) and Community Based Organizations. The purpose of this webinar is to initiate dialogue and begin collaboration between New York State Department of Health, Office of Health Insurance Programs, plans, providers, and other VBP stakeholders related to developing VBP SDH interventions. The webinar is scheduled for August 25 from 9 – 11 am. The webinar will be recorded and made available on the Department of Health website. Link to Webinar

Delivery System Reform Incentive Payment Program Scorecards. New York has posted Achievement Value Scorecards for each of the 26 Performing Provider Systems for the 4th quarter of DSRIP year 2 performance. The scorecards provide project-specific scores for all the projects that a PPS has undertaken, as well as a total for each PPS. The total earned by PPS through DSRIP Year 2 was $2,529,408,899 out of a possible $2,640,661,329 (95.7 percent). For the 4th quarter, PPSs earned 89.8 percent of possible payment, ranging from OneCity Health (operated by NYC H+H), which earned 95.7 percent of its possible payment, to Central NY Care Collaborative, which earned only 79.8 percent. DSRIP year 3, which began on April 1, shifts more of the payment away from process and more toward outcome measures, and it is probable that payments will drop moving forward. Read More

Value Based Payment Quality Measure Set and Quality Assurance Reporting Requirements. The New York State Department of Health has released draft technical specifications for newly proposed quality measures for both the 2018 Value Based Payment (VBP) Quality Measure Set and the 2018 Quality Assurance Reporting Requirements (QARR). The public comment period will occur for the next 30 days. The state seeks feedback on the proposed new measures seeking specific comments to targeted questions per measure, as well as whether you support, support with modifications, or do not support the use of this quality measure. Comments related to the measure intent and measure feasibility are also encouraged. Comments should be submitted in writing using the Public Comment Submission Form (available on the VBP web page) by September 11, 2017 to vbp@health.ny.gov. Proposed New Measures:

- Continuity of Care from Inpatient Detox to Lower Level of Care
- Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care
- Initiation of Pharmacotherapy upon New Episode of Opioid Dependence
- Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence
- Maintaining/Improving Employment or Higher Education Status
- Maintenance of Stable or Improved Housing Status

- Mental Health Engagement in Care 30 Days
- No or Reduced Criminal Justice Involvement
- Percentage of HARP Enrolled Members Who Received Personalized Recovery Oriented Services (PROS) PROS or Home and Community Based Services (HCBS)
- Potentially Preventable Mental Health Related Readmission Rate 30 Days
- Utilization of Pharmacotherapy for Alcohol Abuse or Dependence
- Utilization of Pharmacotherapy for Opioid Dependence

Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania House Speaker Mike Turzai Taking Heat for Budget Stalemate. On August 10, 2017, the *Pittsburgh Post-Gazette* reported, the Pennsylvania House is in recess until the end of August without a final plan to pay for the budget. The $32 billion budget passed right after the fiscal year started July 1, and since then, the General Assembly has been unable to pass a revenue bill. Pennsylvania House Speaker Mike Turzai called a special session of the GOP caucus on July 22, but sent members home after four hours and announced the House would wait to see what revenue proposals come from the Senate or governor. On July 27, the PA Senate narrowly approved a plan that included a tax on natural gas drilling. House leadership said they would return sometime before the end of August to debate the Senate's package. Representatives were told to prepare for a possible return this month, but a date for that hasn't yet been set. The House is scheduled to return for a regular session September 11. Read More

UPMC Announces Definitive Agreement to Acquire Pinnacle Health. On August 11, 2017, the *Philadelphia Inquirer* reported, UPMC reached an agreement on July 28 to acquire Pinnacle Health System of Harrisburg. Pending regulatory approval, the deal is expected to be completed Sept. 1. The government recently approved Pinnacle Health's acquisition of Carlisle Regional Medical Center, Lancaster Regional Medical Center, Heart of Lancaster Medical Center and Memorial Hospital of York. Pinnacle Health landed with UPMC on the rebound, after the Federal Trade Commission blocked Pinnacle's merger with Penn State Hershey Medical Center over concern that the deal would allow prices to rise in the Harrisburg region. Read More

Texas

House Passes Bill to Delay Medicaid MCO Payments to Fund Teacher Benefits. The *Austin American-Statesman* reported on August 16, 2017, the Texas House has approved a Senate bill to delay payments to Medicaid managed care organizations (MCOs) to fund bonuses for current teachers and reduce health care deductibles for retired teachers. As previously reported, the Texas House had previously passed its own version of the bill that would have

utilized the state's rainy day funds rather than delaying Medicaid MCO payments. The bill will now proceed to the Governor's office. Read More

National

Exchange Plan Rate Increases Vary Widely in 2018, Early Analysis Shows. *Modern Healthcare* reported on August 10, 2017, that preliminary 2018 rate requests submitted by plans on the federal Exchange markets vary from an increase of 49 percent to a decrease of 5 percent across 21 major cities, according to an analysis by the Kaiser Family Foundation. Health Insurers offering plans next year have until August 16 to submit final rates. An average of 4.6 insurers per state are expected to participate in the federal Exchange in 2018, down from 5.1 in 2017 and 6.2 in 2016. Read More

Ending Cost-sharing Subsidies Would Cause Premiums to Rise 20 Percent, CBO Says. The Congressional Budget Office (CBO) on August 15, 2017, reported that ending cost-sharing subsidies for Affordable Care Act Exchange plans would result in a 20 percent increase in silver plan premiums in 2018 and a 25 percent increase by 2020. Loss of the subsidies would also leave five percent of Americans living in areas without coverage and increase the federal deficit by $194 billion over a decade. Read More

Senate Exchange Stabilization Bill Likely to Have Narrow Focus on Subsidies. *CQ News* reported on August 14, 2017, that a potential bipartisan Senate bill aimed at stabilizing the Affordable Care Act Exchanges will likely have a narrow focus on cost-sharing subsidies. A number of bipartisan groups have been working on stabilization bills, focusing on issues like the cost-sharing subsidies, repealing the medical device tax, and amending the employer mandate. Read More

Insurers Enter Bare Exchange Counties to Offer Coverage. *The New York Times* reported on August 15, 2017, that insurers are entering "bare counties" to sell coverage on the Affordable Care Act Exchanges. Although President Donald Trump predicted that the Exchange markets would fail and leave large parts of the country without coverage, insurers, including Centene, have begun to enter these markets. Centene recently announced it would offer insurance in 14 rural counties in Nevada. In 2018, only two counties in Wisconsin and Ohio will be bare. However, if the Trump Administration halts insurer subsidies, it is possible that more insurers may choose to leave the market. Read More

CMS Grants Health Insurers More Time to Plan, Recalculate Premium Rates. *The New York Times* reported on August 13, 2017, that the Centers for Medicare & Medicaid Services (CMS) has granted health insurers a three-week extension until September 5, 2017, to file premium rate requests for 2018 Exchange plans. Insurers participating on the Affordable Care Act Exchanges face an uncertain future, given threats from President Trump's administration to end cost-sharing subsidies. According to the Trump administration, states had allowed plans to account for the potential loss of the subsidies in their rate requests. Read More

Industry News

Meridian Names Jon Cotton Corporate President. *Crain's Detroit Business* reported on August 14, 2017, that Meridian has appointed Jon Cotton as corporate president, effective September 4. Senior vice president of business development Sean Kendall will succeed Cotton as president of MeridianHealth of Michigan. Read More

Anthem to Exit Virginia Exchange, Reduce Off-Exchange Offerings. *Fortune* reported on August 11, 2017, that Anthem is withdrawing from the Virginia health insurance Exchange in 2018 and will also trim it's off-exchange offerings in Washington and Scott counties and in Bristol, Virginia. Read More

Centerbridge Partners to Acquire Majority Stake in Davis Vision. Centerbridge Partners announced on August 9, 2017, that it will acquire a majority stake in Davis Vision, the managed vision unit of Highmark Health. Centerbridge will also buy a minority in Highmark's Visionworks retail subsidiary. Centerbridge intends to merge Davis Vision with Superior Vision, in which it owns a majority stake. Read More

Baptist Healthcare System Acquires Kentucky-based Hardin Memorial Health. *Louisville Business First* reported on August 15, 2017, Baptist Healthcare System signed a letter of intent to acquire Hardin Memorial Health, an independent, county-owned health system in Kentucky. The acquisition includes Hardin Memorial Hospital and more than 45 outpatient facilities in ten counties. The terms of the transaction were not disclosed. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
TBD	Delaware	Contract Awards (Optional)	200,000
August, 2017	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
Summer/Fall 2017	Ohio MLTSS	RFA Release	130,000
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
October, 2017	Alabama ICN (MLTSS)	Proposals Due	25,000
October, 2017	Ohio MLTSS	Contract Awards	130,000
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
July, 2018	Alabama ICN (MLTSS)	Implementation	25,000
July, 2018	Ohio MLTSS	Implementation	130,000
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.

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