HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

September 6, 2017

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

THIS WEEK

- IN FOCUS: NEW MEXICO ISSUES CENTENNIAL CARE 2.0 RFP
- HMA ANNOUNCEMENT: HMA, COMMUNITY CARE OF NORTH CAROLINA FORM STRATEGIC PARTNERSHIP
- OREGON MEDICAID AUDIT FINDS 55,000 INDIVIDUALS INELIGIBLE
- NEW YORK DRUG SPENDING EXCEEDS CAP, TRIGGERING SUPPLEMENTAL REBATE PROVISIONS
- NEW JERSEY APPROPRIATES FUNDING TOWARDS END-OF-LIFE INITIATIVES
- GOVERNORS OFFER BIPARTISAN BLUE PRINT TO STABILIZE EXCHANGE
- FUNDING FOR ACA EXCHANGE ENROLLMENT OUTREACH SIGNIFICANTLY DECREASED
- TENET HEALTHCARE CEO TO STEP DOWN
- CAROLINAS HEALTHCARE SYSTEM AND UNC HEALTH CARE PURSUE JOINT VENTURE

IN FOCUS

NEW MEXICO ISSUES CENTENNIAL CARE 2.0 MEDICAID MANAGED CARE RFP

This week, our *In Focus* section reviews the request for proposals (RFP) released by the New Mexico Human Services Department (HSD) to reprocure contracts for the state's Medicaid managed care program in its second phase, Centennial Care 2.0. Centennial Care provides integrated Medicaid managed care coverage, including long-term services and supports (LTSS) and behavioral health, to nearly 700,000 Medicaid beneficiaries in the state, with annual spending of roughly $4.5 billion.

Covered Population

Centennial Care 2.0 will cover the majority of New Mexico Medicaid beneficiaries, with the exception of:

- Native Americans, not receiving LTSS or who have opted out of managed care;
- Individuals residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID);
- Partial benefit enrollees;
- Members of the Program of All Inclusive Care for the Elderly (PACE);
- Individuals with intellectual and developmental disabilities (I/DD) in a home and community based services (HCBS) waiver; and
- Select other HCBS waiver recipients.

Out of more than 877,000 Medicaid beneficiaries in New Mexico, roughly 88,000 are in fee-for-service (FFS) as full benefit enrollees, with another 117,000 partial benefit enrollees. When fully implemented in 2019, Centennial Care 2.0 anticipates covering roughly 700,000 beneficiaries in total.

Contract Awards, Terms

New Mexico's HSD intends to award between three and five statewide contracts to serve Centennial Care 2.0; the state currently contracts with four MCOs. Contracts are scheduled to run from March, 2018, through December 31, 2022. Based on an implementation date of January 1, 2019, this equates to a four-year contract term, with an option to extend for one additional year, through 2023.

Evaluation Criteria

The majority of points available to bidders are in the technical proposal section, and it should be noted there is a cost component of the bid. Additional points are included in the scoring criteria for finalist oral presentations.

Evaluation Criteria	Points Available
Mandatory Requirements	Pass/Fail
References	300
Technical Proposal	1,390
Cost Proposal	400
Subtotal	***2,090***
Oral Presentations (Finalists Only)	400
Total	**2,490**

RFP Timeline

There is a mandatory acknowledgement of receipt due on September 18, ahead of a mandatory pre-proposal conference on September 19. Proposals are due to HSD on November 3, with finalists to be selected on December 22. Notices of intent to award will be announced on January 8, 2018, with final contracts awarded on March 15, 2018. Implementation is set for January 1, 2018.

RFP Timeline	Date
RFP Released	September 1, 2017
Mandatory Acknowledgement of Receipt Form	September 18, 2017
Mandatory Pre-Proposal Conference	September 19, 2017
Proposals Due	November 3, 2017
Selection of Finalists	December 22, 2017
Notice of Intent to Award	January 8, 2018
Contract Awards	March 15, 2018
Implementation	January 1, 2019

Current Medicaid Managed Care Market

Molina and Presbyterian are the two largest MCOs in the current Centennial Care program, each with roughly one-third of the market.

Centennial Care Plans	August 2017 Enrollment	Market Share
Molina Healthcare	228,785	33.7%
Presbyterian Health Plan	221,897	32.7%
Blue Cross Blue Shield of NM	139,540	20.6%
United Healthcare	87,977	13.0%
Total Managed Care	**678,199**	

Link to RFP

http://www.hsd.state.nm.us/Centennial_Care_RFP.aspx

HMA Announcement

Health Management Associates, Community Care of North Carolina Form Strategic Partnership

Today, Health Management Associates (HMA) and Community Care of North Carolina, Inc. (CCNC) announced the formation of a strategic partnership that will leverage the complementary skills and expertise of both organizations to offer providers and payers innovative solutions for the challenges of today's healthcare landscape.

HMA works with states, health plans, and providers across the country to develop more effective ways to deliver and pay for the healthcare of vulnerable populations. That work includes a breadth of experience developing and implementing strategies for new organizational structures to transform practices and establish clinically integrated systems (including behavioral health integration), creating mutually beneficial connections between delivery systems and managed care organizations, and operationalizing strategies for multiple provider network development.

"For over three decades, HMA has been committed to helping our clients make publicly funded healthcare work better," said Jay Rosen, founder and President of HMA. "CCNC has been living that mission, pioneering innovative new ways to deliver care. We are thrilled to be working together to make a difference for vulnerable populations and communities."

CCNC has extensive experience with the organization and support of high-performing primary care and community-based, physician-led collaborations. The organization has specific expertise developing actionable data analytics, care management of populations with complex needs, integration of pharmacy services into the care team, and programs designed to meet the needs of special populations, such as pregnant women and children in foster care.

"CCNC and HMA bring complementary skills to the table, and we look forward to working with payers and providers to find new and better ways to improve quality, reduce costs and provide greater value," said Allen Dobson, Jr., MD, President and CEO of CCNC.

To further solidify this new affiliation, in October HMA will open its 21st office in Raleigh, N.C. It will be led by Managing Principal Roxane Townsend, MD.

HMA is an independent, national research and consulting firm specializing in publicly funded healthcare including policy, programs, and reform. HMA provides leadership, experience, and technical expertise to government agencies, public and private providers, health systems, health plans, institutional investors, foundations, and associations. For more information, visit https://www.healthmanagement.com/

CCNC is a national leader in transforming health care. CCNC's program joins community-based care managers with local primary care physicians and diverse teams of health professionals to develop whole-person plans of care. Informed by statewide data and predictive analytics, CCNC builds patient centered practice models, connects people to the right local resources and leads collaborations with health systems and public health. This proven population health management approach delivers better health outcomes at lower costs. For more information, visit https://www.communitycarenc.org/

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HMA Medicaid Roundup

California

Medi-Cal Plans Push for End to Printed Provider Directories. The *Los Angeles Times* reported on September 4, 2017, that Medi-Cal managed care plans are requesting that California stop automatically mailing printed provider directories to Medicaid enrollees. Instead, plans recommend the state mail postcards with a link to the online provider directories and an option to receive a printed copy. State officials are currently reviewing the proposal. Read More

Iowa

Medicaid Director Stier Named Deputy Director of State Department of Human Services. *The Des Moines Register* reported on September 5, 2017, that Iowa Medicaid Director Mikki Stier will replace Sally Titus as deputy director of the state's Department of Human Services. Stier will continue to oversee the state's Medicaid program until the position is filled. Read More

Mississippi

Managed Care Award Protest Centers on Medicaid Director Emails. The *Daily Journal* reported on September 1, 2017, that emails between Medicaid Director David Dzielak and an executive at Molina is at the center of Mississippi True's conflict of interest claims. Mississippi True, a managed care plan formed by a group of hospitals in the state, claimed that they have evidence of a conflict of interest surrounding the award. The state refuted these claims, citing the first email chain was a colleague notifying the Dzielak that there was a job opening, and that the second email chain was pertaining to Molina's plans for Mississippi should it be awarded the contract. Read More

Missouri

Decision to Raise In-Home Care Eligibility Requirements Puts Thousands At Risk of Losing Coverage. The *Missourian* reported on September 5, 2017, that approximately 60,000 individuals in Missouri are at risk for losing in-home care after the state Department of Health and Senior Services raised the eligibility threshold. Governor Eric Greitens vetoed a bill that would have allocated $35 million to continue providing services to those who do not meet the new eligibility requirements. Read More

Medicaid Expansion Renewed Through 2020, Funding Problems Loom. *Modern Healthcare* reported on September 5, 2017, the Center for Medicare &

Medicaid Services (CMS) has extended the Missouri Medicaid expansion program, known as Gateway to Better Health, through 2022. However, the program faces uncertainty because of potential CMS changes to disproportionate-share hospital payments. Additionally, CMS will provide Missouri with a set amount of $30 million annually for the program, instead of 95 percent federal match for programs serving adults at 138 percent of the federal poverty level. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Appropriates $5 Million Towards End-Of-Life Initiatives. *NJBiz* reported on August 31, 2017, that New Jersey Senator Paul Sarlo, former Senator Kevin O'Toole, and Holy Name Medical Center CEO and President, Michael Maron, announced a $5 million budget appropriation to fund eight key initiative to develop an end-of-life care model in New Jersey. This funding, which is among the highest amounts budgeted for end-of-life care in the nation, will consist of eight key initiatives. The funding will include developing a model for end-of-life care that will address all aspects of care two years prior and one year after an individual's death; researching ways to compare end-of-life experiences and quality of life; designing education, training and state certification courses for health care professionals; and working with the Medical Society of New Jersey to provide policy recommendations. Read more

New Mexico

Christus St. Vincent, Christus Health Settle Medicaid False Claims Lawsuit. The *Albuquerque Journal* reported on September 1, 2017, Christus St. Vincent Regional Medical Center and its partner, Christus Health, agreed to pay $12 million to settle a whistleblower lawsuit over Medicaid claims. The lawsuit alleged that Christus violated the False Claims Act by providing its own money to fund certain Medicaid services in Sante Fe County between 2001 and 2009, so that the hospital could boost its federal match. These alleged payments are referred to as "non-bona fide donations." Christus said the payments were made to support community health initiatives. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Posts Webinar on Value Based Payment, Social Determinants of Health and Community Based Organizations. The New York Department of Health has posted slides and a webinar that look at the state's Value Based Payment Roadmap and its requirements for addressing social determinants of health (SDH). The webinar, conducted by Medicaid Director Jason Helgerson, noted that New York is a national leader on VBP and social determinants. The VBP Roadmap requires that 80 percent of contracts between MCOs and providers be based on a VBP arrangement. As of January 2018, each VBP contractor (health system, Independent Practice Association, Accountable Care Organization) must implement at least one SDH intervention. The state has developed a SDH Intervention Template that lists social determinants

organized into five categories: Economic Stability (employment, housing, food, transportation); Education (educational disparities, literacy, English proficiency); Social, Family, Community (criminal justice involvement, stigma, trauma); Health and Health Care (lack of access to care; health literacy); Neighborhood and Environment (substandard housing, physical barriers, structural inadequacies). The template lists numerous potential interventions for each SDH, as well as the metric to be used in determining the effectiveness of the intervention. In addition to identifying a SDH intervention, VBP contractors must contract with a Tier 1 CBO (non-profit, non-Medicaid-billing community-based social/human service organization). The state believes that CBOs are essential to plans achieving VBP goals due to their experience in and knowledge of local communities. As contracting is a new form of financing for many CBOs, the state has provided resources (including the CBO Planning Grants, and the Value Based Payment University on-line training and in-person boot camps) to assist them in assessing their business model to understand the types of social determinants they may address, and how they might support VBP arrangements. Helgerson noted that performance requirements are likely to be part of any contracts between a CBO and a plan or a VBP contractor as the VBP contractors will be financially responsible for overall outcomes. CBOs are not required to take on financial risk, but they may choose to have performance standards tied to bonus payments where appropriate. Read More

Value Based Payment Readiness for Behavioral Health Providers. The New York State Office of Mental Health (OMH) and Office for Alcoholism and Substance Abuse Services (OASAS) have established the New York State Behavioral Health (BH) Value Based Payment (VBP) Readiness Program. The program will fund BH providers to come together in Behavioral Health Care Collaboratives (BHCCs) for planning and implementation, to support the development of shared infrastructure. BHCCs will share clinical quality standards, data collection, analytics, and reporting, to improve care quality and enhance their value in VBP arrangements. The state has concluded a review of the submitted Notifications of Interest for the program and has identified potential Lead agencies. They note, however, that New York does not have the resources to fund all potential applicants. The state is encouraging providers to come together in collaborative arrangements, noting that all BHCCs must have a comprehensive network of providers that encompass the full continuum of Mental Health and Substance Use Disorder services. A list of potential lead agencies has been posted on the OMH web site. Eligible Lead Agencies will receive the application submission guidelines on September 15, 2017. Read More

Drug Spending Exceeds Cap, Triggering Supplemental Rebate Provisions. As part of the 2017-18 budget, New York adopted legislation that limits drug spending growth to the 10–year rolling average of the medical component of the Consumer Price Index plus five percent, (less the State share rebate target of $55 million). Should drug spending exceed the cap, Department of Health (DOH) is authorized to negotiate enhanced rebates with drug manufacturers. The law further authorizes the Drug Utilization Review Board (DURB) to request drug development, cost/pricing, and other data to determine appropriate target rebate amount, as well as allowing the Commissioner of Health to require prior authorization, directing Medicaid Managed Care (MMC) plans to remove drug(s) from their formularies, waiving prescriber prevails provisions and accelerating rebate collections. DoH recently

announced that drug spending is projected to exceed the Drug Cap by $119M State share. This is driven by an overall 15 percent year-to-year increase in managed care and FFS State share net pharmacy spend. DoH has alerted drug manufacturers which drugs they intend to refer to the DURB, and have begun negotiating additional rebates, prior to DURB referral. DoH expects that it will forward that list to the DURB later this month, which the DURB will review and make determinations about additional rebates. If after the DURB recommends a target rebate amount, DOH and the manufacturer still have not reached agreement regarding supplemental rebate amounts, the manufacturer will be required to provide DOH with information related to the actual costs of developing, marketing, researching and distributing the drug. A presentation describing the process is available on the MRT website. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Reduced Medicaid Managed Care Reimbursements Threaten Pharmacies, Pharmacists Claim. The *Dayton Daily News* reported on August 31, 2017, that significant decreases in reimbursements from Medicaid managed care organizations (MCOs) are putting local pharmacies at risk of closure, and some pharmacies may stop accepting Medicaid patients in response. Pharmacists claim that MCO reimbursements do not cover the cost of the drug, packaging, dispensing fee, and administrative fee. MCOs argue that reimbursement rates are based on negotiated contract pricing. Read More

Oregon

Medicaid Establishes Eligibility Compliance Office After Audit Finds 55,000 Individuals Ineligible. *The Oregonian* reported on September 1, 2017, the Oregon Health Authority will establish a Medicaid Eligibility Compliance Office after an annual eligibility review found nearly 55,000 people were no longer qualified for Medicaid. Nearly 48 percent of a backlog of 115,000 Medicaid enrollees were found ineligible, which is 20 percentage points higher than the annual average. The state attributed the large backlog to technology problems and increases in enrollment under the Affordable Care Act. Read More

Hearing Held on Ballot Measure to Overturn Health Insurance Premium Tax, Increase in Hospital Tax. *The Oregonian* reported on September 5, 2017, that Oregon held a hearing on a ballot measure that could overturn $550 million in health insurance premium taxes and increased hospital taxes. During the hearing, legislators revealed proposed language to put before voters to determine whether the state should reverse the 1.5 percent tax on health insurance premiums and the increase in taxes on certain hospital revenues. Both opponents and supporters of the measure said the language was unclear. The measure will be included on the January 23 special election ballot. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania's Prescription Drug Monitoring Program Celebrates First Year Achievements. Governor Tom Wolf recognized the achievements of the Commonwealth's Prescription Drug Monitoring Program (PDMP) since its creation in August 2016. The goal of the PDMP is to assist health care providers in prescribing and dispensing medications safely and referring patients to treatment if needed. The PDMP collects Schedule II-V controlled-substance prescription data and stores it in a secure database only available to health care professionals and others as authorized by law. This system also assists prescribers in referring patients with the disease of addiction to an appropriate treatment program. Some of the achievements highlighted included:

- More than 93,000 users registered with the PDMP
- More than 53,000 searches on a weekday
- An 86 percent drop in the number of patients going to five or more prescribers and pharmacists to get prescriptions for opioids or benzodiazepines (known as "doctor shopping")
- A 30 percent decrease in the number of youth who received prescriptions for painkillers
- Sharing data with 11 other states and Washington, DC

Starting in September, the PDMP will integrate with electronic health records and pharmacy management systems of eligible health care entities in Pennsylvania. Read More

As Budget Impasse Persists, Governor Wolf Warns of Dire Consequences. The Pennsylvania budget impasse is about to extend into a third month and Governor Wolf is urging House Republicans to act quickly to balance the budget. In the absence of House action, the Wolf Administration has been relatively quiet what he would cut should the legislature not send him a plan to fund the $32 billion budget it passed two months ago. "No decisions have been made at this time," said J.J. Abbott, spokesman for Wolf. Wolf's warning came as he announced transfers between bank accounts to allow the state to continue to pay its bills for three weeks. But that money will likely run out by September 15, when Medicaid payments are due. The House is scheduled to return to session September 11 — four days before money from this latest transfer runs out. Read More

Wyoming

State Eyes Options for Addressing Medicaid Funding Shortage. *Casper Star Tribune* reported on September 2, 2017, that next month the Wyoming Department of Health will provide state lawmakers with recommendations to address a Medicaid funding shortage of up to $30 million. The state is considering options to hold down costs, including initiatives to stress home and community-based services over long-term care facilities, reducing reimbursement to providers, or shifting funds from other state programs. The shortfall is expected to increase as the state's Medicaid population ages. Read More

National

Study Indicates Link Between Medicaid Eligibility for Parents and Coverage for Children. *Kaiser Health News* reported on September 5, 2017, that children are more likely to be enrolled in Medicaid when Medicaid eligibility is extended to their parents, according to a study published in *Health Affairs*. Analyzing data collected from 2013 to 2015 from the American Community Survey, researchers found that approximately 700,000 kids that were eligible for Medicaid but were not previously enrolled gained coverage as a result of their parents gaining coverage through the Medicaid expansion. The spillover benefits children acquired when their parents' were eligible for Medicaid is referred to as the "welcome-mat" effect. Read More

President Trump to Push for One Last ACA Repeal Effort, Focus on Medicaid Block Grants. *Politico* reported on September 5, 2017, this month President Donald Trump and several Senate Republicans will push one last time to repeal and replace the Affordable Care Act. Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA) are working with White House staff to draft a bill to move Medicaid to a block grant system. The draft bill is expected to be released this week. Read More

Senate HELP Committee Chairman Wants to Pass Bipartisan Bill to Stabilize Exchanges in Coming Weeks. *Politico* reported on September 1, 2017, that Senator Lamar Alexander (R-TN), chairman of the Senate Health, Education, Labor and Pensions (HELP) Committee, hopes to pass a bipartisan bill to stabilize the Affordable Care Act (ACA) health insurance Exchanges within three weeks. The bill is expected to have a narrow focus, providing funding for cost-sharing subsidies for one year and more flexibility for the states concerning key requirements of the ACA. Senator Alexander plans to release a draft bill by the third week of September. Read More

Governors Offer Bipartisan Blue Print to Stabilize Exchange. The Ohio Office of Health Transformation announced on August 31, 2017, that Governor John Kasich (R-OH), along with seven other governors, sent a bipartisan letter to Congress encouraging actions to stabilize Exchange markets and encourage affordability. The letter offers a blue print to immediately stabilize the Exchange markets, preserve coverage, control premium costs, and form partnerships between the federal and state governments through payment innovation.

Funding for ACA Exchange Enrollment Outreach Significantly Decreased. *Politico* reported on August 31, 2017, the federal government will reduce funding for Affordable Care Act Exchange enrollment outreach efforts for the 2018 enrollment season. The advertising budget will be reduced from $100 million to $10 million and funding for navigator organizations from approximately $63 million to $37 million. The decision is expected to result in lower enrollment, especially for states that use the federal Healthcare.gov website. Read More

Industry News

Private Equity Firms Invest Billions in Opioid Treatment Facilities. *The Wall Street Journal* reported on September 2, 2017, that private equity firms have been heavily investing in opioid treatment facilities. Last year, firms spent more than $2.89 billion to acquire or expand clinics that provide detox, residential care, outpatient, and methadone treatment services. Firms are also approaching not-for-profit entities seeking to convert them to for-profit. Read More

Anthem to Exit Exchange in 17 Missouri Counties, Remain in 68. *The New York Times* reported on September 1, 2017, that Anthem, Inc., will no longer offer Exchange plans in 17 counties in Missouri. Anthem will continue to serve 68 counties in the state. Read More

Ensign Group Acquires Two Skilled Nursing Facilities in Arizona. The Ensign Group, Inc. announced on September 5, 2017, the acquisition of two skilled nursing facilities in Arizona effective September 1: Desert Blossom Health and Rehabilitation Center, an 88-bed facility based in Mesa; and Pueblo Springs Rehabilitation Center, a 115-bed facility based in Tucson. Ensign now has 229 facilities across 14 states, including 21 hospice agencies, 18 home health agencies and three home care businesses. Read More

Carolinas HealthCare System and UNC Health Care Pursue Joint Venture. *Modern Healthcare* reported on August 31, 2017, that Carolinas HealthCare System, the largest hospital system in North Carolina, and UNC Health Care, an academic system, have signed a letter of intent to create a joint venture. Together the two health systems have 14 hospitals in North Carolina with combined annual revenues of $14.4 billion. The organizations have initiated negotiations to merge their clinical, medical education, and research resources, and are expecting a finalized agreement by the end of the year. Read More

Tenet Healthcare CEO to Step Down. *Modern Healthcare* reported on August 31, 2017, that Trevor Fetter, CEO of Tenet Healthcare, the third-largest investor-owned hospital system, is stepping down in March 2018, or when a new successor is chosen. Tenet's board is in the process of searching for Fetter's replacement and Ronald Rittenmeyer, the lead director on the board, will become the executive chairman immediately. Tenet posted a $56 million operating loss in the second quarter of this year. Read More

Company Announcements

Josefina Carbonell, SVP of Long Term Care and Nutrition for Independent Living Systems, Receives the Arthur S. Flemming Award. Read More

RFP CALENDAR

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

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION IMPLEMENTATION STATUS

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

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

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

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

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

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