HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

October 4, 2017

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

THIS WEEK

IN FOCUS

HMA AUTHORS REPORT ON DIGITALLY DRIVEN INTEGRATED PRIMARY CARE AND BEHAVIORAL HEALTH

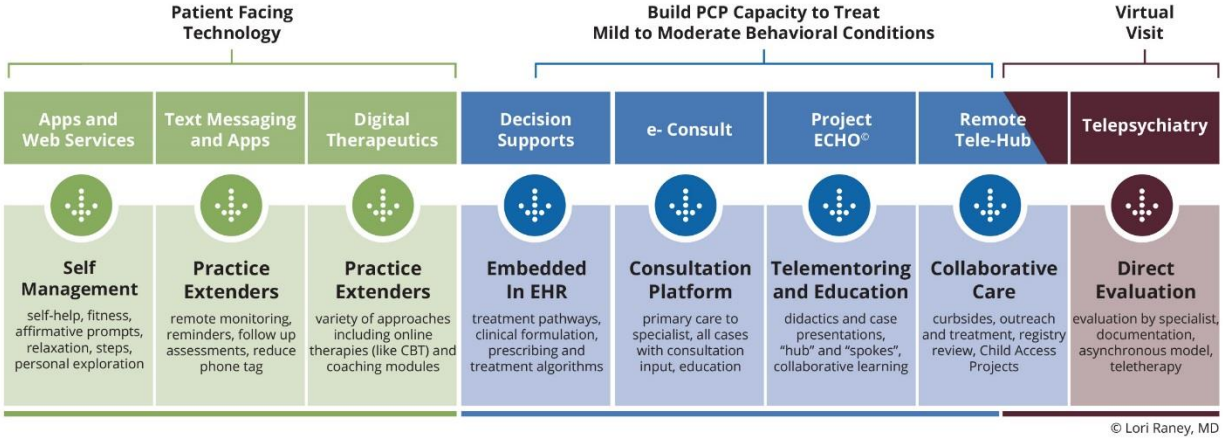
This week, our In Focus section highlights an article, *Digitally Driven Integrated Primary Care and Behavioral Health: How Technology Can Expand Access to Effective Treatment*, published in the Current Psychiatry Report, co-authored by HMA Principals Lori Raney, MD, and David Bergman, MPA, as well as John Torous, MD, and Michael Hasselberg, M.S., Ph.D. Together, they addressed how technology solutions can be utilized for more widespread implementation of effective integrated primary care and behavioral health. The article

deconstructs the four core principals of effective integrated care, team-based care, evidence-based care, measurement-based care, and population-based care, to identify the critical tasks. Several of the tasks related to these core principles are adaptable to technology.

There are many different technologies available including: patient-facing tools, technologies that help to build the knowledge and skills of primary care providers (PCPs), and virtual care. Patient-facing tools allow self-management of symptoms and serve as "practice extenders" for the team. When digital approaches help build the knowledge and skills of PCPs, it can increase their capacity to treat mild to moderate mental illness in the primary care setting. Virtual care can provide telepsychiatry and other behavioral health specialty services remotely.

Building the capacity for PCPs to treat behavioral health conditions in primary care settings is done in many ways. Clinical decision supports enhance health-related decisions using the right channels, like electronic health records. Electronic consultation or eConsults can provide enhanced communications between PCPs and specialists regarding treatment in the referral process. Psychiatric Project ECHO (Extensions of Community Healthcare Outcomes) allows PCPs telementoring and collaborative learning for the treatment of behavioral health conditions. Remote tele-hubs can provide behavioral healthcare for sites that would not otherwise have access due to lack of workforce, patient populations or resources. While virtual visits do not solve the workforce shortage problem, they can help with the geographical maldistribution of behavioral health providers.

TECHNOLOGY ENABLED BEHAVIORAL HEALTH IN PRIMARY CARE



The major obstacles to widespread implementation of traditional integration of primary care and behavioral health models can be attributed to workforce shortages, competencies to deliver evidence-based approaches, and inadequate reimbursement. Digital solutions—alone and in combination—are showing some promise in integrating care, and technology developers will need to understand the current evidence base for effective integration efforts. With this understanding, key tasks that could be adapted with technology can be used to develop new and revised solutions. The use of these technologies is a growing area of research and development that warrants further investigation, particularly as multiple approaches are increasingly being used together. This article explores the evidence base and breaks down the key tasks that along

with human support could help extend behavioral health expertise to larger populations in need.

Link to the *Current Psychiatry* Report
http://rdcu.be/wlmr

HMA Medicaid Roundup

Arkansas

Medicaid Expansion Spending $200 Million More Than Expected. *ArkansasOnline* reported on October 2, 2017, that spending on the Arkansas Medicaid expansion program hit $1.9 billion in fiscal 2017, up 24 percent from the prior year and about $200 million higher than expected. Strong enrollment growth drove the cost increase. Spending on the state's traditional Medicaid program increased by just 4 percent. This news comes as Arkansas Governor Asa Hutchinson has expressed the intention to move about 60,000 people off the expanded Medicaid program and also reduce spending on traditional Medicaid. Read More

Delaware

Medicaid Managed Care Contract Awards Announced. The Delaware Department of Health and Social Services announced on September 29, 2017, that Highmark Health Options Blue Cross Blue Shield and AmeriHealth Caritas have been awarded the state's Medicaid managed care contracts, effective January 1, 2018. Highmark and UnitedHealthcare were the incumbent plans. The Medicaid managed care program serves approximately 200,000 individuals. Read More

Hawaii

State Submits 1115 Medicaid Waiver for Housing Services. *Modern Healthcare* reported on September 29, 2017, that Hawaii submitted an 1115 Medicaid waiver requesting reimbursement for supportive housing services for individuals who are chronically homeless and have a behavioral, physical, or substance use disorder diagnosis. Funding would be used to appoint state employees to help eligible beneficiaries find housing and provide moving assistance. The waiver is currently being reviewed by the Centers for Medicare & Medicaid Services (CMS). Public comment is open through October 17. Read More

Kentucky

Courts Likely to Order State to Release Communications Related to Medicaid Reform Plans. *Murray State's NPR Station* reported on October 4, 2017, courts will likely rule that Kentucky state officials must turn over emails and communications related to the state's plan to reform Medicaid, according to legal experts. An open records request was filed to obtain communications

related to Governor Matt Bevin's controversial plans to amend the state's Medicaid waiver, which would require Medicaid recipients to pay co-pays and premiums. The state Medicaid waiver is expected to be released before the court rules whether state officials must hand over their communications. Read More

Massachusetts

Waiver Proposes Moving Adults Off Medicaid and Limiting Access to LTSS, Drugs. *Modern Healthcare* reported on September 27, 2017, that Massachusetts submitted a request to the Centers for Medicare & Medicaid Services (CMS) to move childless, non-disabled adults above the federal poverty level off Medicaid and into the state's Exchange. Under the waiver request, non-disabled members below the federal poverty level would no longer receive long-term services and supports, and the state would create a narrower prescription drug formulary. The waiver request represents an attempt to curb growing health care costs as the federal government is no longer providing funding for the full cost of expansion. CMS is accepting public comments on the waiver request through October 20. Read More

Michigan

Auto Insurance Reform Bill Shifts Vehicular Accident Health Care Costs to Medicaid. *The Detroit News* reported on October 3, 2017, that the Michigan legislature's bipartisan plan would lower auto insurance premiums by shifting health care costs associated with auto accidents onto Medicaid. If passed, the bill would make Medicaid responsible for paying for chronic nursing home and attendant care costs for injured motorists already on Medicaid or those who have exhausted their benefits through their health insurer, create a fee schedule to limit the amount medical providers can charge auto accident victims, and limit in-home health attendant hours. According to the House Fiscal Agency, the bill would increase Medicaid expenses by $10 million in the first year and $150 million annually over the next ten years. Read More

Montana

Medicaid Expansion Saves State $30 Million. The *Billings Gazette* reported on September 29, 2017, that the Montana Medicaid expansion has saved the state more than $30 million since January 2016, largely because of an improved federal match for certain members. According to the Montana Department of Public Health and Human Services, the state's expansion enrollment is about 84,000. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Division of Developmental Disabilities Incorporates Community Care Waiver into Comprehensive Medicaid Waiver. The New Jersey Division of Developmental Disabilities (DDD) announced on September 25, 2017 that it will incorporate its 1915(c) Community Care Waiver (CCW) into the state's 1115(a) demonstration waiver, better known as the Comprehensive Medicaid

Waiver. The incorporation into Comprehensive Medicaid Waiver is an administrative change and will not affect DDD-funded services. This change will be effective on November 1, 2017. Questions can be submitted to DDD.CCWHelpdesk@dhs.state.nj.us.

Governor Chris Christie Reveals Plan to Fund Opioid Programs. *Politico* reported on October 2, 2017, that Governor Chris Christie outlined his plan to fund his opioid programs, which are expected to cost up to $240 million. His plan includes $90 million from savings on debt service, $70 million from lapsed funds from the Department of Human Services, and $30 million from savings on the State Health Benefits Plans. The remaining $40 million is expected to come from revenue from this fiscal year. Read More

Care Plus Bergen Becomes New Operator of Bergen Regional Medical Center. *NJ.com* reported October 3, 2017, that Care Plus Bergen has assumed operations of Bergen Regional Medical Center, effective October 1. Care Plus Bergen, a coalition consisting of Integrity House, Care Plus NJ and Rutgers Regional Medical Center, was awarded a 19-year contract to be the operator of facility. As part of the contract, Bergen County will invest more than $50 million to make capital improvements and strengthen the hospital's delivery of behavioral health, substance use treatment and long term care services. Under Care Plus Bergen's management, the hospital will be operated as a nonprofit entity and be renamed New Bridge Medical Center. Read More

New Jersey Hospital Association Names Cathleen Bennett as New President and CEO. *NJBiz* reported on September 27, 2017, that Cathleen Bennett, the current Commissioner of the New Jersey Department of Health, will become the next president and CEO of the New Jersey Hospital Association (NJHA). She will be succeeding Betsy Ryan, who will remain at the NJHA until the end of October. Commissioner Bennett will assume her new role on November 9. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Medicaid Managed Care Advisory Review Panel Update. The New York Medicaid Managed Care advisory Review Panel, the legislatively mandated oversight body for New York's Medicaid managed care program, held its quarterly meeting on June 22. Jonathan Bick, Director of the Division of Health Plan Contracting and Oversight for the New York Department of Health, provided a program update. In addition, the panel received an update on behavioral health and health homes, the Residential Redesign Transformation being undertaken by the Office for Alcohol and Substance Abuse Services, and an update on the status of managed long-term care. Slides are available on request.

Program Updates:

- Centene has announced an agreement to acquire Fidelis Care, the state's largest Medicaid managed care plan. Neither Centene nor Fidelis Care have provided the Department of Health with any details about the transaction. It will require review by the Department of Health, who will examine the character and competence of the new entity; an assurance that state laws and policies will be met; and a

review of provider network adequacy. The arrangement will also be reviewed by the Attorney General, as it involves the privatization of charitable assets.

- YourCare is expanding into five additional counties.
- Excellus is expanding into Erie County.
- VNS Choice is expanding its HIV Special Needs Plan into Nassau and Westchester.
- CMS has approved a state plan amendment to include harm reduction services in the state's Medicaid benefit effective January 2018.
- Payment for early elective deliveries has been reduced effective September 1. Payment had been reduced by 50 percent in 2017; it is now reduced 75 percent, in an effort to limit unnecessary and potentially harmful early elective deliveries.
- In an effort to encourage the use of telehealth, the state has developed a new mechanism for Medicaid managed care plans to bill for the services through an "in lieu of" provision. It allows plans to bill for cost-effective services that fall outside the benefit package as long as they can demonstrate cost-savings. In addition, the Department of Health is requiring all plans to submit a Telehealth Innovation Plan describing the role of telehealth in service delivery.

Behavioral Health

- Utilization of home and community based services among Health and Recovery Plan enrollees remains low. (Health and Recovery Plans serve individuals with serious mental illness and/or substance use disorders.) The state is developing a new process for allowing HARP members to access HCBS services that does not include a health home, but instead utilizes a State Designated Entity. Only 32 percent of current HARP enrollees are also enrolled in a health home, creating a major access barrier to obtaining HCBS services.
- To further improve access to services for HARP members, the state has launched a peer education and outreach program, coordinated through the New York Association of Psychiatric Rehabilitation Services.
- The state has launched a VBP Readiness Program for behavioral health providers. Providing $60 million in funding, the state is encouraging groups of providers to come together in collaboratives that are better prepared to enter into VBP arrangements.
- In an effort to reduce reliance on inpatient detoxification, the NY Office for Alcohol and Substance Abuse Services has begun a Residential Redesign Transformation. The intent is to more successfully link people, especially those with opioid addiction, to community-based services. The emphasis is on increasing access to medication-assisted treatment, and integrated models of care delivery, and assuring equal availability of the full array of services and programs, across the state. OASAS believes this effort will greatly expand the number of individuals being served.

Managed Long-Term Care

- NY is considering what integrated care for dual-eligibles will look like when the Fully Integrated Duals Advantage (FIDA) demonstration ends at the end of 2019. While receptivity to FIDA has been limited, the state believes that an integrated approach is the best way to manage care for high-needs populations. They are holding a series of stakeholder meetings across the state to gain input into their thinking.
- The Department of Health received 25 applications from entities seeking to become a Workforce Investment Organization. The Workforce Investment Program is targeted to direct care workers, with the goals of supporting the critical long term healthcare workforce infrastructure through retraining, redeployment, and enhancing skillsets. Managed Long-Term Care Plans will be required to contract with DOH–designated workforce training centers.
- The Division of Finance and Rate-Setting is engaged in talks with CMS regarding creating high-need rate cells. The discussion comes about in recognition that the current managed care rate-setting process does not adequately capture the cost of care for individuals with very high needs. As part of this year's budget, NY committed to engaging CMS in discussion about establishing separate rate cells for specific populations: the nursing home, high-cost/high-need home and personal care, and Health and Recovery Plan populations. No decisions have been made.

New Policy for Addressing Managed Long-Term Care Plan Closures. The New York Department of Health has established a process for addressing the transition of managed long-term care enrollees to a new plan as the result of (a) plan closure, (b) a plan's service area reduction or withdrawal, or (c) merger, acquisition or other arrangement approved by the Department. This comes as several plans have exited the market, largely due to financial challenges. The policy requires that an MLTC formally submit a request to withdraw from the market to the Department, and receive specific approval, prior to any action on the part of the plan. The Department must approve any request to withdraw. Notices must be sent to all members with information on what other plans are available. Members have 60 days to select a new plan, at which point they will be auto-assigned to a new MLTC plan under a methodology that takes steps to preserve enrollee – provider relationships with any necessary auto assignment. The new plan must continue to provide services under the enrollee's existing plan of care, and utilize existing providers, for the earlier of the following: 120 days after enrollment; or until the new plan has conducted an assessment and the enrollee has agreed to the new plan of care. Read More

North Shore LIJ to End MLTC Plan Operations. North Shore LIJ Health Plan Inc. will close its Medicaid managed long term care (MLTC) plan at the end of the year due to mounting losses. The plan, a nonprofit founded in 2013 by Northwell Health, serves 6,000 members. NSLIJ Health Plan has entered into an arrangement with Centers Plan for Healthy Living to transfer its membership effective December 1. Centers Plan, a for-profit plan with 18,700 members, does not currently have a significant presence on Long Island, where the bulk of NSLIJ Health Plan membership reside. Read More

Community Based Organizations and Value Based Purchasing. The New York Department of Health has posted a new video in its Delivery System

Reform Incentive Program whiteboard series. The video is titled "What CBOs Need to Know to Be Successful in VBP." New York State Medicaid Director Jason Helgerson lays out five things that Community Based Organizations (CBOs) need to know in order to be successful in the move to Value Based Payment (VBP):

- Know what type of CBO you are (one billing Medicaid vs. not billing Medicaid – only organizations that do not bill Medicaid fulfil the state's requirement that all VBP providers must contract with a CBO);
- Know your value proposition, and how your organization is key to providers' achieving cost and quality goals;
- Seek VBP arrangements that align with what you already do well;
- Use PPS Innovation Funds as a way to test the effectiveness of your intervention;
- Network and begin building relationships with providers.

VBP University Semester Focuses on Community Based Organizations. The New York Department of Health has launched an on-line learning program they call VBP University. VBP University is an educational resource designed to raise awareness, knowledge and expertise in the move to Value Based Payment (VBP). The program consists of four semesters, and individuals who successfully complete all four semesters will be awarded a certificate of completion. Semester 1 provided background information; Semester 2 focused on specific topic areas in the move to VBP: governance, stakeholder engagement, business strategy, finance, and data. Semester 3 has just been posted. Semester 3 addresses Social Determinants of Health, Community Based Organizations, and VBP Contracting Strategies. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_u/index.htm

Disproportionate Share Hospital Cuts Would Hurt New York. Cuts to the Medicaid Disproportionate Share Hospital (DSH) funding, which were included as part of the Affordable Care Act, would be substantial in New York, especially to the state's public and safety net hospitals. New York stands to lose $329 million in federal payments in the fiscal year that began on October 1, the largest cut, in terms of dollars, for any state. In anticipation of the cuts, Governor Cuomo has not released DSH funding to NYC Health + Hospitals, NYC's public hospital system. The CEO of the system, Stanley Brezenoff, has criticized the state for withholding $380 million in DSH funds due to them for the previous fiscal year, even though the state has released DSH funds to most other hospitals across the state. As reported in Politico, Health + Hospitals has only 18 days cash on hand, and if the money doesn't come soon, the system will have trouble making payroll and paying vendors. Read More

Oklahoma

State Withdraws 1332 State Innovation Waiver. *FOX 23 News* reported on September 30, 2017, that Oklahoma has withdrawn a request for a section 1332 State Innovation Waiver that would have allowed the state to operate its own reinsurance program to help stabilize the individual Exchange market. The state withdrew the request after the Trump Administration failed to approve the waiver before a September 25, 2017, deadline. Officials say that the waiver

would have helped reduce premiums, allowing as many as 30,000 more individuals who could not otherwise afford it buy Exchange plans. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Medical Assistance Advisory Committee September 28 Meeting. *Office of Medical Assistance (OMAP) Update:* The HealthChoices re-procurement is currently in a stay and scheduled for hearing before the full bench of the Commonwealth Court on October 18. Leesa Allen, Deputy Secretary of OMAP said that the department has requested an expedited hearing and hopes to have a decision by the end of the year. In the absence of new HealthChoices contracts, agreements with the currently participating MCOs are being amended and extended through 2018. Allen said the new goals of HealthChoices, such as increased value-based purchasing targets, are being incorporated in the 2018 contract extensions. *Office of Mental Health and Substance Abuse Services (OMHSAS) Update:* Acting Directory of the Bureau of Policy, Planning and Program Development, Ellen DiDomenico, provided an OMHSAS update. Regarding the shift to value-based purchasing, she said that behavioral health was about a year behind physical health and emphasized that determining the best metrics for BH has been challenging. On the 21st Century Cures Grant, DiDomenico provided an update on Pennsylvania Coordinated Medication Assisted Treatment (PACMAT) applications as a hub and spoke model for addiction treatment with specialists, physicians, and prescribers collaborating for medication assisted treatment. She said four models are expected around the state in the first year of application. Read More

Puerto Rico

House Republicans Add $1 Billion in Medicaid Funding for Puerto Rico to CHIP Bill. *The New York Times* reported on October 3, 2017, that House Energy and Commerce Committee Republicans have added $1 billion in Medicaid funding for Puerto Rico under the Children's Health Insurance Program (CHIP) reauthorization bill. The proposal would provide $880 million through 2019 and another $120 million if the committee's financial oversight board certified that Puerto Rico took steps to prevent fraud and abuse and improve efficiency. To pay for the funding, lawmakers are seeking to increase premiums for wealthier Medicare beneficiaries and redirecting some prevention health funding from community-based health centers. Read More

Texas

IDD Managed Care Pilot Cancelled. The Texas Health and Human Services Commission has cancelled its Intellectual and Developmental Disability (IDD) Managed Care Pilot. The cancellation will be addressed at the IDD System Redesign Advisory Committee meeting scheduled for October 3 at 1:30 p.m. Read More

Utah

Advocates Seek to Expand Medicaid through Ballot Initiative. The *Daily Herald* reported on October 3, 2017, that health advocates in Utah have filed paperwork for a ballot initiative to expand Medicaid under the Affordable Care Act. If the initiative makes it onto the November ballot and is approved by voters, the state would expand Medicaid to cover an additional 127,000 residents earning up to 138 percent of the poverty line. Read More

West Virginia

State Files Amendment to Eliminate Upper Payment Limit Program. The West Virginia Department of Health and Human Resources announced on September 27, 2017, that the Bureau for Medical Services has filed a state plan amendment (SPA 17-003) to eliminate the upper payment limit (UPL) program, effective October 1, and replace it with a direct payment program. The UPL program makes supplemental payments up to Medicare rates to hospitals participating in the prospective payment system (PPS). Instead, the money would be paid to hospitals through capitated payments to managed care organizations. Read More

National

White House Considers Possible Replacements for HHS Secretary. *Politico* reported on October 1, 2017, that a dozen names are rumored to be receiving attention as possible replacements for Tom Price as Secretary of Health and Human Services. These include:

- Seema Verma: administrator for the Centers for Medicare & Medicaid Services
- Scott Gottlieb: Food and Drug Administration commissioner
- David Shulkin: Department of Veterans Affairs secretary
- Don Wright: interim Health and Human Services secretary, acting assistant health secretary
- Bobby Jindal: former Louisiana governor
- Rick Santorum: former U.S. Senator
- Ben Carson: secretary of Housing and Urban Development

Read More

House, Senate Committees Move to Advance CHIP Bills. *CQ* reported on October 3, 2017, that the House Energy and Commerce Committee is moving quickly to advance legislation that seeks to extend funding for the Children's Health Insurance Program (CHIP) for five years. Funding for the program expired on September 30. The draft bill includes provisions to offset costs, including targeting Medicaid third-party liability, lottery winning calculations, and Medicare premium adjustments for higher incomes. A Senate CHIP bill does not address offset provisions. Both bills will retain a 23 percent increase in CHIP funding through 2019, followed by a lower rate by 2021. Read More

Trump Administration to Delay Drug Discount Rule to July 2018. *CQ* reported on September 28, 2017, that the Trump Administration is delaying implementation of a federal drug discount rule from March 2018 to July 2018. The rule would set a maximum price on drugs bought through the 340B federal drug discount program. The program allows hospitals who serve a certain number of Medicaid and low-income Medicare patients to purchase drugs from pharmaceutical companies at a discount, usually about 22 percent below the list price. Hospitals are then reimbursed for the drugs at the full price, rewarding the hospitals for providing charitable care. The Trump administration is reportedly weighing changes to the rule. Hospitals oppose the delay. Read More

Residents of Non-Expansion States Have Higher Medical Debt. *KCUR 89.3* reported on October 4, 2017, that adults in states that did not expand Medicaid had higher medical debt than those in states that expanded, according to researchers Aaron Sojourner and Ezra Golbertstein of the University of Minnesota. In non-expansion states, unpaid medical bills dropped from 47 to 40 percent, compared to in expansion states that saw a drop from 43 to 30 percent. However, since efforts to repeal and replace the Affordable Care Act failed, the 19 non-expansion states could potentially still expand Medicaid in 2018. Read Mor

Lower-Cost Hepatitis C Drugs May Help Medicaid Programs Expand Treatment. *Kaiser Health News* reported on October 3, 2017, that lower-cost Hepatitis C drugs, such Mavyret, may allow Medicaid programs to expand treatment to more individuals. Mavyret, which cures all six genetic types of Hepatitis C in about two months, costs $26,400 for a course of treatment, compared to other drugs, like Harvoni (Gilead), with prices ranging from $55,000 to $95,000. When high-priced Hepatitis C drugs first came to market, many states limited access; about a dozen states have no such restrictions. Read More

Industry News

Steward Health System Completes Acquisition of IASIS Healthcare. The *Boston Globe* reported on September 29, 2017, that Steward Health Care System has acquired IASIS Healthcare for $2 billion, making it the largest private for-profit hospital system in the country. Steward, which is backed by Cerberus Capital Management, now has 36 hospitals across ten states with estimated annual revenues of $8 billion. Read More

Civitas Solutions Completes Acquisition of Habilitative Services. *BusinessWire* reported on October 2, 2017, that Civitas Solutions, Inc. has successfully completed its acquisition of Habilitative Services, Inc. (HSI) and two related companies. Civitas agreed to acquire HSI's 86 residential sites, which serve individuals with intellectual and developmental disabilities in Minnesota. Including the acquisition of HSI, Civitas has completed 10 acquisitions during this fiscal year. Read More

Former Molina CEO to Purchase Molina-Owned California Clinics. *Modern Healthcare* reported on September 28, 2017, that former Molina CEO Dr. J. Mario Molina is in the process of purchasing 17 primary care clinics in California that are currently owned by Molina Healthcare. The clinics serve approximately 120,000 patients annually in underserved areas. Dr. Molina hopes to finalize the agreement by January 1. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
Timeline to be Revised	Alabama ICN (MLTSS)	RFP Release	25,000
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	Massachusetts MassHealth ACO - Full	Implementation	TBD
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
November 17, 2017	Texas STAR+PLUS Statewide	RFP Release	530,000
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 10, 2018	Texas STAR+PLUS Statewide	Proposals Due	530,000
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 1, 2018	Massachusetts	Implementation	850,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
March 15, 2018	New Mexico	Contract Awards	700,000
April 1, 2018	New Hampshire	RFP Release	160,000
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
November 1, 2018	New Hampshire	Proposals Due	160,000
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 1, 2019	New Hampshire	Contract Awards	160,000
January, 2019	Texas STAR+PLUS Statewide	Contract Awards	530,000
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
July 1, 2019	North Carolina	Implementation	1,500,000
July 1, 2019	New Hampshire	Implementation	160,000
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/

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.