HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

November 1, 2017

THIS WEEK

IN FOCUS

IOWA ISSUES REQUEST FOR PROPOSALS (RFP) TO ADD MEDICAID MANAGED CARE PLANS

This week, our *In Focus* section reviews the request for proposals (RFP) issued on October 31, 2017, to add one or more Medicaid managed care organizations (MCOs) to the statewide IA Health Link managed care program. It was confirmed this week that one of the three current MCOs, AmeriHealth Caritas Iowa, would be exiting the program. The RFP is seeking to add one or more new MCOs, and current contract holders, Anthem's Amerigroup and UnitedHealthcare, are not required to bid. IA Health Link covers roughly 600,000 members with annual capitation payments of more than $1.5 billion.

RFP Details

Bidders must be a current Medicaid MCO in another state, or must be owned by a parent company with Medicaid MCO experience in another state. Awarded MCOs will provide statewide coverage to nearly all Iowa Medicaid beneficiaries, including those receiving long-term services and supports (LTSS), behavioral health services, and services for individuals with intellectual or developmental disabilities (I/DD). The awarded MCO or MCOs will receive a three year and three month-long contract, extending through the middle of 2021, with an optional two-year contract extension beyond that.

RFP Timeline

There will be two rounds of letters of intent, which are not mandatory to submit a bid, but are required to submit questions to the state. These are due on November 16 and December 11, respectively. Proposals are due on January 5, 2018, with a notice of award expected on February 27, 2018, and final contracts signed March 30, 2018. Any awarded MCOs will begin providing coverage on July 1, 2018.

RFP Milestone	Date
First Letter of Intent Due	Thursday, November 16, 2017
Second Letter of Intent Due	Monday, December 11, 2017
Proposals Due	Friday, January 05, 2018
Notice of Award	Tuesday, February 27, 2018
Implementation	Sunday, July 01, 2018

Current Medicaid MCO Market

As of July 2017, AmeriHealth Caritas was the largest health plan in the state, with more than 213,000 members (37.5 percent of the market). Not included in the table below are roughly 50,000 Hawk-i (CHIP) members.

Health Plan	Enrollment (July 2017)	Market Share
Amerigroup	187,611	33.0%
UnitedHealthcare	167,686	29.5%
AmeriHealth Caritas	213,389	37.5%
Total (excluding Hawk-i CHIP)	**568,686**	

It is also worth noting, given AmeriHealth Caritas' exit from the program, that as of March 2017, AmeriHealth Caritas covered the significant majority of members receiving LTSS. March 2017 state data indicates that AmeriHealth Caritas covered more than 23,400 out of nearly 37,400 members receiving LTSS, while Amerigroup and UnitedHealthcare covered roughly 7,600 and 6,300 members, respectively. As mentioned previously, AmeriHealth Caritas will be exiting the program at the end of November 2017.

HMA MEDICAID ROUNDUP

Arkansas

Eligibility Assessments Begin for Provider-Led Arkansas Shared Savings Entities. The *Courier News* reported on October 28, 2017, that the Arkansas' Department of Human Services began selecting in September the 30,000 individuals with developmental or intellectual disabilities, mental illness, or substance use disorders who will participate in the new Provider-led Arkansas Shared Savings Entities (PASSE) program. Beginning in 2018, each PASSE will be paid a capitated rate, and beginning in 2019, the state will make global payments to each PASSE. The Department is currently calculating the baseline cost of these 30,000 Medicaid members, which will be used in determining the global payments. Read More

Colorado

State Awards Contracts to Five Regional Accountable Entities. The Colorado Department of Health Care Policy & Financing announced its intent to award contracts to five organizations to act as Regional Accountable Entities under the state's Accountable Care Collaborative:

- Region 1: Reunion Health in Partnership with Rocky Mountain Health Plans
- Region 2: Northeast Health Partners, LLC.
- Region 3 and 5: Colorado Access
- Region 4: Health Colorado, Inc.
- Region 6 and 7: Colorado Community Health Alliance Plus, LLC (CCHA)

Connecticut

Governor Vetoes Increased Hospital Provider Tax. The *Hartford Courant* reported on October 31, 2017, that Connecticut Governor Dannel Malloy signed a $41.3 billion biannual state budget; however, the Governor issued a line-item veto of a proposed hospital provider tax increase. The proposal would have increased the hospital provider tax from six percent to eight percent. Read More

Delaware

HMA Awarded Health Care Innovation Contract. Delaware announced on October 26, 2017, that the Health Care Commission has awarded Health Management Associates (HMA) a $1.3 million contract to help the state pursue health innovation. HMA will support the Department of Health and Social Services in integrating behavioral health services into primary care and support the Healthy Neighborhoods initiative to bring individuals and organizations together at the local and community level. HMA will build on the Delaware Center for Health Innovation's foundation to create long-term transformation. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Department of Corrections Seeks $19 Million for Hepatitis C Treatment Following Lawsuit. *Health News Florida* reported on October 26, 2017, that the Florida Department of Corrections (DOC) is requesting $19 million in funding from the state Legislature to provide treatment for 500 inmates with the Hepatitis C virus. The request comes after the state was hit with a lawsuit in May seeking Hepatitis C testing and treatment for all inmates. Read More

Florida Legislature Delays Vote on KidCare Premiums. *Health News Florida* reported on October 27, 2017, that Florida has delayed a vote on whether to waive October and November premiums for 6,338 children disenrolled from the state's KidCare Children's Health Insurance Program (CHIP) in 48 counties impacted by Hurricane Irma. Instead the state will offer to waive October premiums and allow families to re-enroll their children if the problem was affordability. Another option is to use funds from a state "CHIP In" program to cover some of the premiums. Read More

Idaho

Veyo Ends NEMT Contract with Department of Health and Welfare. *The Seattle Times* reported on October 30, 2017, that Veyo, a non-emergency medical transportation (NEMT) company, will be ending its contract with the Idaho Department of Health and Welfare ahead of schedule. Veyo was awarded a $70 million contract to provide NEMT for Medicaid patients in 2016, with the contract set to end on March 5, 2018. The reason for the termination is unknown at this time. Read More

Iowa

CMS Approves Waiver Request to End Retroactive Coverage. *Modern Healthcare* reported on October 31, 2017, that the Centers for Medicare & Medicaid Services (CMS) has approved Iowa's waiver request to eliminate retroactive coverage for newly enrolled Medicaid beneficiaries. The state predicts that ending retroactive coverage would reduce monthly enrollment by 3,300 enrollees and annual Medicaid spending by nearly $37 million. Arkansas, Indiana, Kentucky, and New Hampshire have either been granted permission or have a pending request in to CMS to end retroactive coverage. Read More

Democratic Legislators Call for an End to Medicaid Managed Care and Propose Public Option. The *Des Moines Register* reported on October 27, 2017, that state Senator Matt McCoy and Representative John Forbes are proposing that Iowa put an end to its Medicaid managed care program and create a public option. The two democratic legislators proposed Healthy Iowans for a Public Option (HIPO), which would allow Iowans currently purchasing private insurance to buy Medicaid coverage instead. Currently, it is uncertain how much the Medicaid public option would cost. Read More

Kansas

Kansas Requests Work Requirement Under KanCare 2.0 Waiver. *The Wichita Eagle* reported on October 27, 2017, that Kansas submitted its proposal for KanCare 2.0, the next iteration of its statewide Medicaid managed care waiver program, to the Centers for Medicare & Medicaid Services (CMS). The waiver proposal includes a work requirement, which would affect 12,000 adults out of the 400,000 people currently enrolled in KanCare, according to Governor Sam Brownback's administration. Read More

Kentucky

State Expects Federal Approval of Medicaid Work Requirement. *WUKY* reported on October 27, 2017, that Kentucky expects the Centers for Medicare & Medicaid Services to approve a request to overhaul the state's Medicaid program and to implement a work requirement for many Medicaid beneficiaries. Kentucky Governor Matt Bevin's administration estimates the requirement will result in 95,000 fewer Medicaid members by 2021. Read More

Massachusetts

Lawsuit Filed by Steward Health Care Over Transparency Requirements. The *Boston Globe* reported on October 31, 2017, that Massachusetts has been hit with a lawsuit by Steward Health Care System, claiming the state lacks the authority to require the system to hand over certain financial information. Steward says the financial details reveal sensitive information, adding that the Massachusetts Center for Health Information and Analysis makes the information publicly available. Steward has been fined more than $300,000 for failing to make the information available. Read More

Senate Bill Would Require State to Report Companies with Heavy Users of MassHealth. *The Boston Globe* reported on October 31, 2017, that a new Massachusetts Senate health care bill would require the state to report the top 50 employers with the highest number of employees who receive coverage through MassHealth. The bill would require those companies identified to pay a large portion of a $200 million assessment to cover funding shortfalls in MassHealth, the state's Medicaid program. It is uncertain whether the bill will pass the state legislature. Read More

Mississippi

Governor to Transition Medicaid Eligibility Verification to DHS, Eyes Medicaid Work Requirements. *Clarion Ledger* reported on October 26, 2017, that Mississippi Governor Phil Bryant plans to transition Medicaid eligibility verification responsibilities to the state Department of Human Services (DHS) and is considering work requirements for Medicaid recipients. DHS and the Division of Medicaid will present a plan for the transition on October 27. Read More

New Mexico

Proposal to Require Premiums, Copays for Certain Medicaid Beneficiaries Criticized. The *Albuquerque Journal* reported on October 30, 2017, that New Mexico's proposal to charge premiums to Medicaid beneficiaries with higher incomes, as well as expand the use of copays, was strongly criticized during a public hearing. In response, state officials said they were amenable to changes based on public feedback. Before going into effect, the proposal must be approved by the Centers for Medicare & Medicaid Services (CMS) under the state's section 1115 waiver. Read More

CHIP to Drive $31 Million in Medicaid Cost Increase. *Albuquerque Journal* reported on October 25, 2017, that Medicaid spending will increase by $31 million to maintain coverage under the Children's Health Insurance Program (CHIP) next year, largely because Congress has not reauthorized funding for the program. Overall, Medicaid spending in the state is expected to increase by $82 million, including the impact of growing enrollment, medical cost inflation, and covering a slowly increasing share of Medicaid expansion costs. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Division of Aging Services Releases Latest Program Utilization Data. The New Jersey Department of Human Services, Division of Aging Services (DoAS) released a summary report of program use by county. The report gives enrollment levels for disabled and aged populations for the following programs:

1. Pharmaceutical Assistance to the Aged and Disabled (PAAD)
2. Senior Gold Prescription Discount Plan
3. Specified Low-Income Medicare Beneficiary (SLMB) Qualified Individual 1 (QI-1)
4. Lifeline Utility Assistance Program and Lifeline Tenants Assistance Program (begins November 2017)
5. Universal Service Fund (USF) and Low-income Home Energy Assistance Program (LIHEAP)

PAAD has the largest enrollment with more than 120,000 older adults and individuals with disabilities enrolled. Program use by eligibility category is provided. A copy of the report can be found here.

Division of Mental Health and Addiction Services Issues RFP on Alternative Approaches to Pain Management for Older Adults. The New Jersey Division of Mental Health and Addiction Services (DMHAS) released the RFP on October 13, 2017, for educational programs regarding alternative approaches to pain management in older adults under a grant from the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Targeted Response to the Opioid Crisis program (Opioid STR), authorized under Section 1003 of the 21st Century Cures Act. A total of $275,000 is available with up to five awards of $55,000 each. Proposals are due by 4:00 pm EST on November 13, 2017. Final award announcements will be made on January 2, 2018, with an anticipated contract start date of March 1, 2018. The RFP is available here.

CoverNJ Coalition Leads Statewide Open Enrollment Outreach. The New Jersey Hospital Association (NJHA) reported on October 30, 2017 that a diverse coalition of stakeholders including consumer advocates, healthcare organizations, health plans, social service groups and more have come together to promote access to health insurance during the Affordable Care Act open enrollment season of November 1 – December 15, 2017. CoverNJ Coalition held an outreach event at Robert Wood Johnson University Hospital to kick off its outreach efforts. It is encouraging New Jersey residents to visit www.healthcare.gov to sign up for insurance through the online marketplace. The Coalition aims to counter the recent barriers to obtaining health insurance including funding cuts to the open enrollment marketing budget and health navigators, and plans to close the online website every Sunday. Coalition members are collaborating on many activities to raise awareness and support consumers shopping for insurance, using advertising and social media outreach, town halls and other enrollment events, and a website, www.covernj.org, that helps connect New Jersey residents with enrollment counselors who can answer questions and help them sign up for coverage. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Managed Long Term Care Workforce Investment Program Update. New York has announced awards for its long-term care workforce investment initiative. The program, which requires managed long-term care plans to contract with designated, state-approved training organizations, is intended to better prepare and expand the work force in the long-term care sector. It makes available up to $245 million through March 2020 for initiatives to retrain, recruit and retain healthcare workers in the long–term care sector. The Workforce Investment Program will target direct care workers, with the goals of supporting the critical long-term healthcare workforce infrastructure through retraining, redeployment, and enhancing skillsets. The state has approved 23 organizations for participation in the program. The list can be found on the Department of Health Medicaid Redesign web site. The Department of Health will issue further information pertaining to Plan/Workforce Investment Organization application structure in the coming weeks. Read More

AlphaCare Founders Sue Magellan Health. The founders of AlphaCare, a managed long-term care plan that operates in NYC and Westchester, are suing Magellan Health, which owns a majority share of the plan. As reported in

Crain's HealthPulse, the suit accuses Magellan of trying to force AlphaCare to merge with the New York division of Senior Whole Health, in breach of its fiduciary duties. Magellan announced an acquisition agreement with Senior Whole Health in July. AlphaCare currently has 4,700 enrollees; Senior Whole Health has 9,000 members. The complaint alleges that AlphaCare would effectively cease to exist and be subsumed into a wholly owned subsidiary of Magellan if the transaction is completed, forcing out the minority stockholders. Read More

Ohio

State Review Panel Releases Medicaid Funds. The *Columbus Dispatch* reported on October 30, 2017 that the Republican-led state Controlling Board voted unanimously Monday to continue funding for the Ohio Medicaid Program, releasing $264 million in state funds. Controlling Board oversight of Medicaid funding was inserted in HB 49, Ohio's Operating Budget Bill. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Medical Assistance Advisory Committee held on October 26th. *Office of Medical Assistance Programs (OMAP) Update:* Leesa Allen announced that she will be taking on the role of Acting Executive Deputy Secretary for the Department of Human Services. Allen will stay on as Deputy Secretary of OMAP until someone else is appointed. A hearing on the HealthChoices reprocurement was held in Commonwealth Court on October 18, 2017. DHS requested an expedited process and hopes to have more to report by December. Patricia Allan is the new Children's Health Insurance Program (CHIP) Acting Executive Director. *Office of Mental Health and Substance Abuse Services (OMHSAS) Update:* Ellen DiDominico, acting Deputy Secretary for the Office of Mental Health and Substance Abuse Services (OMHSAS), updated the committee, sharing that OMHSAS has been implementing CCBHCs since July 1 and preliminary data will be available at the end of October. Regarding value-based procurements, DiDominico said OMHSAS is moving away from paying for units of service. She referenced two separate cycles for behavioral health contracts, but said both include language around value-based purchasing and what MCOs are expected to do with capturing alternative payment methods.

DOH Offers Funding to Integrate EHRs with Prescription Drug Monitoring Program. Using $3.8 million in federal grants, the Pennsylvania Department of Health (DOH) is integrating the Prescription Drug Monitoring Program (PDMP) in the health systems' electronic health records (EHRs) and pharmacy systems. Funding will be available through August 2019 for DOH to cover the costs of connecting EHRs and other health IT systems to the PDMP. Interested health care organizations can visit the DOH website to learn more and are encouraged to apply using the Integration Request Form. Read More

Washington

Colorado DHCPF Executive Director Sue Birch to Become HCA Director. Sue Birch, executive director of the Colorado Department of Health Care Policy and Financing, will leave next month to become director of the Washington Health Care Authority. Birch has headed the Colorado department since January 2011. Read More

Wisconsin

Democratic Candidates for Governor Push for Public Option. The *Journal Sentinel* reported on October 27, 2017, that Democratic candidates for governor in Wisconsin are uniting around A449, a bill to create a health insurance "public option." The proposal would allow residents above the federal poverty level and residents who qualify for federal subsidies to buy into BadgerCare, the state's Medicaid program. Supporters of the bill argue that the public option would be able to compete against private insurers and reduce premiums, while opponents of the bill argue that BadgerCare is not sustainable and does not reimburse providers enough to expand the program. Read More

National

CMS Proposed Rule Provides States Flexibility in Defining Essential Health Benefits. *Modern Healthcare* reported on October 27, 2017, that a Centers for Medicare & Medicaid Services (CMS) proposed new rule is intended to lower costs in the individual and small group markets by giving states more flexibility to stabilize the health insurance Exchange and to define "essential health benefits." The proposed rule would also eliminate standardized health plan options for 2019, exempt student health insurance from rate reviews, increase the rate review threshold from 10 to 15 percent, and allow insurers to lower the medical loss ratio (MLR) below 80 percent in the individual market if plans can demonstrate that it would help stabilize the market, among other changes. Read More

Congress Adopts Budget Resolution that Would Cut $1.3 Trillion in Non-Medicare Health Funding by 2027. *Vox.com* reported on October 26, 2017, that the House and Senate adopted a budget resolution that would cut $1.3 trillion in funding for non-Medicare health programs by 2027, including Medicaid, as well as $473 billion in cuts to Medicare. The budget resolution would reduce Medicaid funding more than the Graham-Cassidy bill or the American Health Care Act. The budget resolution will allow Republicans to pass tax cuts with a simple majority. Read More

Murray-Alexander Bill Would Reduce Budget Deficit by $3.8 Billion, CBO Projects. *Modern Healthcare* reported on October 25, 2017, that the Bipartisan Health Care Stabilization Act of 2017 would reduce the federal budget deficit by $3.8 billion between 2018 and 2027, according to the Congressional Budget Office. The bill, sponsored by Senators Lamar Alexander (R-TN) and Patty Murray (D-WA), would reinstate cost sharing subsidies in an effort to stabilize the Exchanges. Because Exchange plans already priced 2018 products assuming the subsidies would end, they would have to refund any excess revenues to the government, thereby reducing the federal deficit. Read More

Exchange Enrollment Numbers Expected to Decline Amid Trump Administration Changes. *ABC News* reported on October 30, 2017, that health policy experts expect enrollment in the Affordable Care Act Exchanges to decline for 2018 amid changes by the Trump administration, including cutting the enrollment period in half, reducing funding for advertisements and navigator programs, and halting cost-sharing reduction (CSR) payments. Polls show widespread consumer confusion. The enrollment period begins on November 1 and closes on December 15. Read More

ACA Exchange Plan Premium Increases Are Attributable to End of CSR Payments, Study Says. The Kaiser Family Foundation reported on October 27, 2017, that Affordable Care Act (ACA) silver plan premium increases, which range from 7 percent to 38 percent for 2018, can be attributed to the end of cost-sharing reduction (CSR) payments. The analysis looked at data from 32 states and Washington DC. When the Trump administration discontinued the payments on October 12, many insurers increased premiums for 2018 silver-level plans and some increased premiums across the board. CSR payments only apply to the silver tier plans and insurers are still required under the ACA to offer reduced cost-sharing silver plans to low-income individuals. Read More

Industry News

CVS Reportedly in Talks to Buy Aetna for $66 Billion. *The Wall Street Journal* reported on October 26, 2017, that CVS is in talks to buy Aetna for $66 billion, or over $200 per share. Aetna shares rose 10 percent after the talks were reported, making its market value $58 billion. Read More

Magellan Health Completes Senior Whole Health Acquisition. Magellan Health announced on October 31, 2017, that it has completed the acquisition of Senior Whole Health Holdings, Inc. (SWH) for $400 million. The terms of the agreement include a contingent consideration payment based on SWH's Medicare plan in Massachusetts achieving at least four stars on the Centers for Medicare & Medicaid Services (CMS) Star Rating in 2018. SWH provides Medicare and Medicaid dual-eligible benefits to more than 22,000 members in Massachusetts and New York. The terms of agreement will be released on Magellan's 3Q17 earnings call scheduled for November 1. Read More

Tenet Implements Cost-Cutting Strategies to Mitigate Financial Losses in 3Q2017. *Modern Healthcare* reported on October 27, 2017, that Tenet Healthcare plans to eliminate 1,300 jobs in its regional management layer to mitigate anticipated losses of $367 million from continuing operations in the third quarter. The losses are attributed to Hurricanes Harvey and Irma decreasing admissions, CMS not approving the Medi-Cal hospital fee program in California, changes in Florida's low-income pool program, unexpected Medicaid cuts in Texas, and general decreases in admissions. Read More

Trinity Health Improves Operating Income and Revenues in 2017. *Modern Healthcare* reported on October 27, 2017, that Trinity Health improved its operating income to $266 million and revenue to $17.6 billion in 2017. Revenues were up 7.9 percent from the previous year. The Catholic-sponsored health system's performance was supported by strong acquisitions, growth in volume, better service mix, improved revenue-cycle management and population health risk-share gains. Read More

Medicaid Plans Positioned to Tackle Social Determinants of Health, Opioid Crisis, Executives Say. *FierceHealthcare* reported on October 31, 2017, that Medicaid managed care executives speaking at a conference this week said that health plans are positioned to tackle social determinants of health and the opioid crisis. Efforts include rewarding members for healthy behaviors, implementing recuperative programs, offering care management services, and using data analytics to identify populations at risk for opioid use. Executives also urged states to develop financially viable reimbursement rates. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
Timeline to be Revised	Alabama ICN (MLTSS)	RFP Release	25,000
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
November, 2017	Kansas KanCare	RFP Release	380,000
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 5, 2018	Iowa	Proposals Due	600,000
January 10, 2018	Texas STAR+PLUS Statewide	Proposals Due	530,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
January, 2018	Kansas KanCare	Proposals Due	380,000
February 27, 2018	Iowa	Contract Awards	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
June, 2018	Kansas KanCare	Contract Awards	380,000
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 1, 2018	Iowa	Implementation	600,000
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
January, 2019	Kansas KanCare	Implementation	380,000
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.

HMA NEWS

HMA Consultants Tapped as Authors for Book About Oregon Health Care Reforms

Health Reform Policy to Practice – Oregon's Path to a Sustainable Health System: A Study in Innovation published by Elsevier Academic Press in August, provides a real-world example of an innovative, successful, and comprehensive Medicaid program redesign conducted by the State of Oregon. HMA colleagues Tina Edlund, Jeanene Smith, Cathy Kaufmann, and Lori Coyner were actively involved in Oregon's health care reform efforts and have authored chapters on the development of Oregon's metrics and incentive program, its patient-centered primary care medical home program, and its comprehensive system of supports for delivery system transformation.

Health Reform Policy to Practice – Oregon's Path to a Sustainable Health System: A Study in Innovation Is available for purchase through Elsevier. To learn more or to purchase the book, visit https://www.elsevier.com/books/health-reform-policy-to-practice/stock/978-0-12-809827-1.