Health Management Associates
HMA Weekly Roundup
Trends in State Health Policy
December 6, 2017

RFP Calendar

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This Week

- In Focus: Texas Issues STAR+PLUS Request for Proposals
- Kansas, Wisconsin Medicaid Directors to Resign
- Illinois Finalizes Contracts with Seven Medicaid Managed Care Plans
- 21 Florida MCOs Submit Bids for Medicaid Managed Care Procurement
- Colorado Expands Access to Hepatitis C Drugs for Medicaid Members
- CVS Health to Acquire Aetna in $77 Billion Deal
- Optum to Acquire DaVita Medical Group for $4.9 Billion.
- Advocate Health Care to Merge with Aurora Health Care

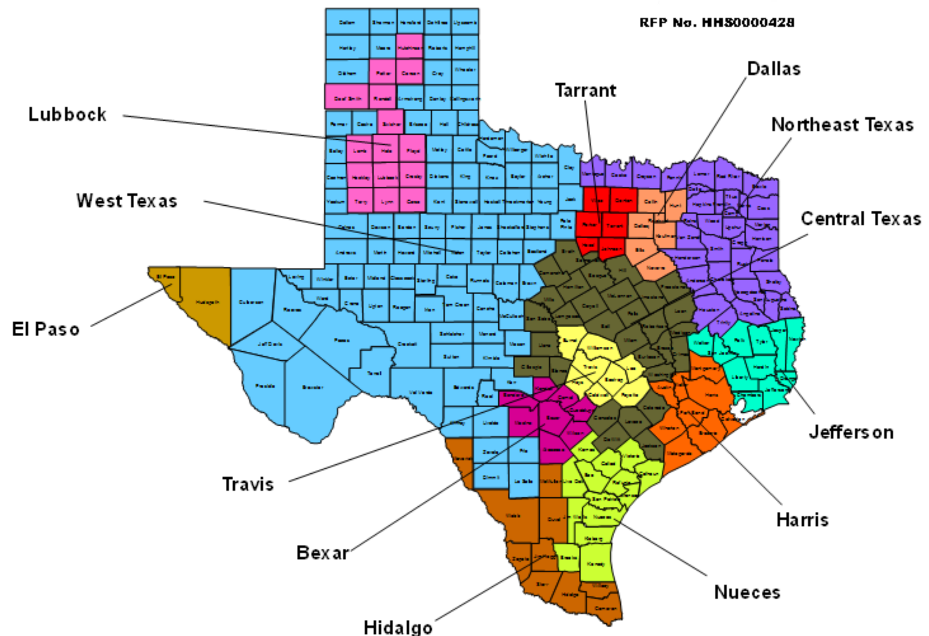
In Focus

Texas Issues STAR+PLUS Request for Proposals

This week, our *In Focus* section reviews the Texas STAR+PLUS request for proposals (RFP) issued on December 4, 2017. The STAR+PLUS Medicaid managed care program covers approximately 519,000 individuals who have disabilities or are aged 65 or older. The program will integrate Acute Care services and Long-Term Services and Supports (LTSS), and cover members including those with intellectual or developmental disabilities (IDD) and dual eligibles. Managed care organizations (MCOs) will also provide access to behavioral health services, such as mental health and substance use disorder counseling and treatment. When fully implemented, Texas expects enrollment to be over 530,000 and annualized spending over $7.5 billion, based on FY 2018 data.

RFP Details

The Texas Health and Human Services Commission (HHSC) will award contracts to at least two MCOs for each Texas Service Area (SA). These are: Bexar, Central Texas, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Northeast Texas, Nueces, Tarrant, Travis, and West Texas.



The contracts are expected to start on January 1, 2020 and continue through August 31, 2022, with possible extension periods not to exceed a total of eight operational years.

Covered Populations and Market Size

The STAR+PLUS program will cover the following populations:

- Supplemental Security Income (SSI) eligibles age 21 and older;
- Individuals age 21 and older who are Medicaid eligible because they are in a Social Security Exclusion Program;
- Individuals who qualify for the STAR+PLUS Home and Community-Based Services (HCBS) program;
- Medicaid eligible residents of licensed nursing facilities;
- Individuals age 21 and older who are eligible for Medicare and Medicaid;
- Individuals eligible for the Medicaid for Breast and Cervical Cancer (MBCC) program, who are age 18 to 65;
- Individuals enrolled in the following § 1915(c) waiver programs receive Acute Care Covered Services from the MCO:
    - Community Living Assistance and Support Services (CLASS);
    - Home and Community-based Services (HCS);

    - Deaf-Blind Multiple Disability waiver (DBMD); and
    - Texas Home Living (TxHmL).

- Residents of community-based intermediate care facilities for individuals with intellectual disabilities or related conditions (ICF/IIDs) receive Acute Care Covered Services from the MCO. In this RFP, the Texas Health and Human Services Commission (HHSC) includes language that MCOs must be prepared under Readiness Review to demonstrate they can provide IDD LTSS services if HHSC determines that IDD LTSS is added to STAR+PLUS. A section has been added to the RFP for respondents to demonstrate their capacity to provide these services.

Texas' federally-recognized tribes (Alabama-Coushatta Tribes of Texas, Kickapoo Traditional Tribes of Texas, and Yselta Del Sur Pueblo of Texas) may be included in the STAR+PLUS Program on a voluntary basis.

Non-emergency medical transportation; mental health rehabilitation and targeted case management for dual eligible; dual eligible participants of 1915(c) waiver programs and residents of community-based ICF/IID; and wrap-around services may be added to STAR+PLUS at any time, at the discretion of HHSC.

Scoring Criteria

Proposals will be scored based on the following criteria:

Criteria	Score
Extent to which the goods and services meet HHSC's needs and the needs of the Members for whom the goods and services are being purchased	48%
Indicators of probable vendor performance	24%
Effect of the acquisition on agency productivity	14%
Delivery terms	14%

RFP Timeline

Contracts will be effective January 1, 2020, through August 31, 2022. Proposals are due March 6, 2018.

RFP Milestone	Date
RFP Release	December 4, 2017
Proposals Due	March 6, 2018
Contract Start	October 2018
Operational State	January 1, 2020

Current Texas Market

Texas currently contracts with five STAR+PLUS plans: Anthem, Cigna, Centene, Molina, and UnitedHealthcare. Enrollment was over 519,000 as of February 2017.

TX STAR+PLUS MCO	Feb-17 Enrollment	Market Share
Anthem	131,953	25.4%
Cigna	50,294	9.7%
Centene	137,840	26.6%
Molina	85,853	16.5%
UnitedHealthcare	113,165	21.8%
Total STAR+PLUS Enrollment	**519,105**	

The current program was procured through three different RFPs: STAR+PLUS Expansion for the Dallas and Tarrant Service Areas; Uniform Managed Care Contract for the Bexar, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, and Travis Service Areas; and the STAR+PLUS Medicaid Rural Service Area (MRSA) for the Central Texas, Northeast Texas, and West Texas Service Areas.

RFP	Service Areas	Optional Extensions Expire
STAR+PLUS Expansion	Dallas, Tarrant	January 31, 2019
Uniform Managed Care Contract	Bexar, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Travis	February 29, 2020
STAR+PLUS Medicaid Rural Service Area (MRSA)	Central Texas, Northeast Texas, West Texas	August 31, 2022

Link to RFP

HMA Medicaid Roundup

Alaska

Alaska Seeks Medicaid Waiver to Move Mental Health Services to Managed Care. *Modern Healthcare* reported on November 29, 2017, that Alaska is seeking a federal waiver to contract with an administrative services organization (ASO) to manage mental health and substance abuse disorder services for Medicaid beneficiaries. The proposal, which would also seek to waive the IMD exclusion, is open for public comment through December 29. Read More

California

Gold Coast Health Plan, Optum Address Concerns Over Pharmacy Payment Rates. *VC Star* reported on December 3, 2017, that Gold Coast Health Plan continues to defer to its pharmacy benefit management vendor on prescription drug payment rates to pharmacies, despite complaints that the rates are too low. Gold Coast contracted with OptumRx last year, resulting in a decline in average payments to between $4 and $5 per prescription, compared to $10 to $11 previously. Read More

WelbeHealth Raises $15 Million, To Partner with Sutter on PACE. *MedCity News* reported on February 8, 2017, that startup WelbeHealth will enter the Program for All-Inclusive Care for the Elderly (PACE) market in Stockton and Modesto, California, after raising $15 million in a round of financing led by F-Prime Capital and .406 Ventures. WelbeHealth will partner with Sutter Health on the PACE initiative. Read More

Medicaid Director Confirms 'Widespread Deficiencies' at SynerMed. The *Los Angeles Times* reported on November 30, 2017, that California Medicaid director Jennifer Kent has confirmed "widespread deficiencies" at physician practice management firm SynerMed, which was accused by a whistleblower of denying care to thousands of Medicaid patients. The state has ordered insurers that work with Synermed to determine how many members might be at risk of delayed or unfulfilled access to services. SynerMed serves more than 1.8 million individuals enrolled in Medicaid, Medicare and commercial insurance. Read More

Connecticut

Connecticut to Delay Cuts to Medicare Savings Program. *The CT Mirror* reported on December 5, 2017, that Connecticut will delay for two months the implementation of eligibility limits for the state's Medicare Savings Program, which allows use of Medicaid dollars to pay for certain medical costs

not covered by Medicare, including premiums, copays, and deductibles. The new limits were set to take effect on January 1, 2018, and are expected to impact 86,000 low-income seniors and residents with disabilities. The state Department of Social Services will use the extra time to review coverage alternatives and assess the impact of the new limits. Read More

Colorado

Colorado Expands Access to Hepatitis C Drugs for Medicaid Members. *The Denver Post* reported on December 1, 2017, that Colorado will lift restrictions that had prevented patients with Hepatitis C from receiving high-cost drugs to cure the disease unless the patient had advanced liver damage. The policy change, which takes effect January 1, 2018, follows both a fall in the price of drugs to treat Hepatitis C as well as class-action litigation filed on behalf of patients. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

21 MCOs Submit Bids for Medicaid Managed Care Procurement. *Health News Florida* reported on December 1, 2017, that 21 insurers submitted bids for the Florida Medicaid Managed Care procurement, worth $90 billion over five years. Awards are expected to be announced in April 2018. There are currently 11 plans in the program, all of which rebid. The program covers 3.1 million individuals out of a total 4 million Medicaid beneficiaries in the state. Another 98,420 are enrolled in managed long-term care. Read More

Simply Healthcare Returns $1.8 Million to Florida Under Medicaid Achieved Savings Rebate Rule. *The Ledger* reported on December 2, 2017, that Simply Healthcare Plan has returned $1.8 million to the Florida Medicaid program under the state's Achieved Savings Rebate rule. Simply Healthcare is the first Medicaid plan to return funds to the state under the rule, which limits Medicaid plans to certain financial thresholds. Read More

Appeals Court Orders Hearings on Hospital Challenges to Medicaid Outpatient Rate Cuts. *Health News Florida* reported on December 1, 2017, that a Florida Court of Appeals has ordered formal administrative hearings on challenges filed by hospitals concerning state Medicaid outpatient rate cuts for fiscal 2017. The court ruled that the Florida Agency for Health Care Administration acted improperly when it dismissed the challenges. Hospitals filed 67 petitions asking for hearings on the matter. Read More

Illinois

Illinois Finalizes Contracts with Seven Medicaid Managed Care Plans. The *Chicago Tribune* reported on November 29, 2017, that Illinois has finalized four-year contracts with seven managed care plans to cover the state's Medicaid population. In February, Illinois Governor Bruce Rauner announced a plan to trim the number of Medicaid plans from 12 to seven and move additional Medicaid members into managed care, which he says will save the state money. Read More

Illinois Voids No-bid Medicaid Consulting Contract. *The State Journal Register* reported on December 5, 2017, that Illinois Chief Procurement Officer Ellen Daley voided a $13 million, no-bid consulting contract with McKinsey & Company aimed at helping the state increase enrollment in Medicaid managed care plans. Daley stated that the state Department of Healthcare and Family Services should have put the business out to competitive bid. Illinois Senator Andy Manar (D-Bunker Hill) said that the voided contract raises other concerns about how the state awarded Medicaid managed care plan contracts in a recent procurement. The state legislature is holding hearings on the awards. Read More

Indiana

Indiana to Implement Tiered Structure for HSA Contributions Made by Expansion Members. *Modern Healthcare* reported on December 5, 2017, that Indiana will switch to a tiered structure for determining how much the state's Medicaid expansion members and other adults are required to contribute to health savings accounts (HSAs). For example, members with incomes between 101 percent and 138 percent of poverty would be required to make a flat $20 monthly contribution. Currently, expansion members are required to contribute 2 percent of their monthly income to an HSA. Read More

Kansas

Secretary of Health to Step Down. *The Kansas City Star* reported on November 30, 2017, that Kansas Secretary of Health and Environment Susan Mosier will step down from the position on January 5. Mosier was appointed secretary in 2014, after working as state Medicaid director. Read More

Michigan

Tenet Plans Layoffs at Detroit Medical Center. *Modern Healthcare* reported on December 4, 2017, that Tenet Healthcare is seeking to lay off 150 employees at the Detroit Medical Center (DMC) as part of a company-wide cost cutting plan. Tenet had also wanted to close several poor-performing DMC units, but the move was postponed. All told, Tenet is targeting 1,300 layoffs nationwide. Read More

Missouri

Mercy Health System Posts 58 Percent Decline in Quarterly Operating Income. *Modern Healthcare* reported on November 29, 2017, that Missouri-based Mercy Health System posted a 58 percent decline in operating income to $12.4 million in the quarter ended September 30, 2017, compared to the same period last year. The company's operating margin fell to 0.8 percent from 2.2 percent. Mercy attributes the drop to rising costs associated with the acquisition of St. Anthony's Medical Center in St. Louis. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Senate to Vote on EHR Bill to Reduce Drug Diversion. *NJ Spotlight* reported on December 5, 2017, that the New Jersey Senate will vote on an electronic health records bill aimed at reducing drug diversion and potential drug abuse. S3592, which was introduced by state Senator Loretta Weinberg, would require electronic health records be able to accept, process, and transmit Schedule II prescriptions and meet all federal standards related to communicating and protecting these prescriptions. Senator Joseph Vitale, chair of the state Senate health committee, is urging lawmakers to move the vote to mid-January to address providers' concerns regarding compliance and telemedicine laws. The vote is scheduled for December 7. Read More

Medicaid Agency Issues Public Notice on Change to PACE Reimbursement Methodology. On November 28, 2017 the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) issued a public notice for comments on a revised methodology for calculating Program for All-Inclusive Care for the Elderly (PACE) reimbursements. While PACE entities have been paid according to an Upper Payment Limit, now referred to as the Amount Would Otherwise Have Paid (AWOP), DMAHS intends to seek approval from the Centers for Medicare and Medicaid Services (CMS) for a state plan amendment that would recalculate the AWOP annually based on applicable payments otherwise made under the Medicaid managed long term services and supports (MLTSS) program. The new PACE capitation rate would be a percentage reduction from the AWOP, revised annually based on anticipated changes in the utilization and cost of PACE services. Comments and inquires may be submitted in writing by mail or fax within 30 days of the notice date. See the full notice and contact information Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York ACA Exchange Enrollment Sees 45,000 New Customers. New York State of Health, the state's health insurance marketplace, announced enrollment details for the first four weeks of the 2018 open enrollment period. More than 45,850 new enrollees already have enrolled in coverage, including 14,500 consumers who have enrolled in a Qualified Health Plan (QHP) and 31,350 who have enrolled in the Essential Plan for lower income New Yorkers. Enrollment is outpacing last year by about 13 percent. New York has seen a corresponding drop in its uninsured rate. According to data released by the Centers for Disease Control and Prevention (CDC) in early November, New York's uninsured rate has reached a new low of 4.7 percent compared to 10 percent in 2013 when NY State of Health opened. Read More

Department of Health to Offer Value Based Payment Bootcamp in New York City. The New York Department of Health recently announced that due to high demand, they will be offering an additional Value Based Payment (VBP) Bootcamp in New York City on January 9, 2018 at the New York Academy of Medicine (1216 5th Ave, New York, NY 10029). VBP Bootcamps are meant to equip VBP contractors and interested parties such as managed care organizations, providers, associations, and community based organizations,

with the knowledge necessary to implement payment reform. Topics for this boot camp include:

- Introduction to VBP Finance
- MCO Adjustments: incentive payments and the risk mitigation strategies
- Contracting Best Practices, Lifecycle, & Checklist
- Community-Based Organizations and VBP Contracting Requirements
- VBP Arrangements and Associated Measure Sets

Further information about the VBP boot camp schedule and courses offered can be found on the Department of Health website. Read More

Medicaid Initiative Focusing on Young Children Introduced in August. In August 2017, the New York Department of Health launched a new focus for Medicaid Redesign: The First 1000 Days on Medicaid initiative. This initiative recognized that a child´s first three years are the most crucial years of their development. The initiative is designed to ensure that New York´s Medicaid program is working with health, education and other system stakeholders to maximize outcomes and deliver results for children. The initiative brought together stakeholders in a series of work groups, culminating in a ten–point agenda that focuses on enhancing access to services and improving outcomes for children on Medicaid in their first 1000 days of life. Jason Helgerson, NY's Medicaid Director, will participate in a Facebook Live conversation with Kate Breslin, President and CEO of the Schuyler Center for Analysis and Advocacy, and co-Vice Chair of the initiative. The event will be held December 13 from 1:15 – 2:15. Registration is not required; the event will take place on the Schuyler Center Facebook page.

New York Medical Society Opposes Proposed CVS Takeover of Aetna. The Medical Society of the State of New York has registered concerns about the proposed CVS takeover of Aetna. They have called upon the U.S. Federal Trade Commission and Department of Justice to make a critical review as to the potential impact of the takeover. They argue that "health care decisions should be the result of discussions between a patient and their doctor, without interference from a behemoth corporation." They raise the possibility of even more burdensome and excessive prior authorization barriers for prescription medications, as well as further marginalization of many community pharmacies and community providers. Read More

Disability Rights New York Sues State. Disability Rights New York, a client assistance program that provides free legal and advocacy services to individuals with disabilities, has filed a suit against the New York State Office for People with Developmental Disabilities, for the "unnecessary institutionalization of adults with disabilities in residential educational programs after they complete their education." The complaint cites 97 cases where individuals have aged out of residential schools and yet remain in the institutional setting, in violation of the Americans with Disabilities Act. They argue that the state needs to begin discharge planning for students at residential schools at age 16, so that they are able to live and receive services in the most integrated setting. Read More

Governor Acts on Health Care Legislation. New York Governor Andrew Cuomo vetoed a bill that would have added topical oxygen wound therapy to the Medicaid benefit, saying that it circumvents the process that NY has established for determining Medicaid coverage. The Medicaid Evidence Based Benefits Review Advisory Committee is meant to develop recommendations

using "sound, evidence-based determinations on the efficacy of treatment," and this bill would preclude such a review. Simultaneously the governor approved a bill that will mandate coverage for three-dimensional mammography, digital breast tomosynthesis, which is already a covered benefit under Medicaid, despite a lack of research demonstrating its long-term efficacy (the U.S. Preventive Services Task Force has declined to issue a recommendation either for or against the use of 3D mammography as a screening procedure for breast cancer). The Health Plan Association opposed the bill, which allows 3-D digital mammography to be used for initial breast cancer screenings in lieu of the traditional and standard mammography, as 3-D digital mammography is significantly more expensive than traditional mammography, and there is no evidence to show that 3-D digital mammography should replace traditional mammography as the frontline screening for breast cancer. In the governor's approval memo he notes that the bill does not eliminate the insurer's ability to apply medical necessity criteria, and so "strikes a proper balance between a [patient's ability to obtain coverage for breast tomosynthesis and an insurer's ability to review the use of the screening procedure for medical necessity." Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Office of Long Term Living Deputy Secretary to Resign. The Pennsylvania Managed Long-Term Services and Supports (MLTSS) Subcommittee of the Pennsylvania Medical Assistance Advisory Committee (MAAC) met on December 5, 2017. The Department of Human Services (DHS) announced that Jen Burnett, Deputy Secretary of the Office of Long Term Living (OLTL), will be leaving DHS as of December 15, 2017. Kevin Hancock, currently the OLTL Chief of Staff, was announced as the new Deputy Secretary of OLTL. Community HealthChoices, the Commonwealth's Managed Long Term Services and Supports program, is still scheduled to go live in the SW Zone on January 1, 2018.

DHS Secretary Visits SUD Treatment Program for Pregnant and Parenting Women. Pennsylvania's Department of Human Services Acting Secretary Teresa Miller and Department of Drug and Alcohol Programs Acting Secretary Jennifer Smith visited Thomas Jefferson University's Maternal Addiction Treatment Education & Research (MATER) Family Center, one of the state's 45 Centers of Excellence (COE). The COEs coordinate care for people with Medicaid, and treatment is team-based and "whole-person" focused, with the explicit goal of integrating behavioral health and primary care. COEs work as a hub-and-spoke network, with the designated center serving as the hub. The spokes may include primary care practices, the criminal justice system, other treatment providers, and other referral sources. Jefferson's MATER Family Center is an outpatient program offering pregnant and parenting women comprehensive and compassionate care for substance use disorder (SUD). All women at Family Center receive comprehensive behavioral and physical health services. Read More

Texas

Texas Releases STAR+PLUS Medicaid Managed Care RFP. As highlighted in this week's *In Focus*, the Texas Department of Health and Human Services released a Request for Proposals (RFP) for its STAR+PLUS Medicaid managed care program for 530,000 aged, blind, and disabled individuals on December 4, 2017. The state intends to award contracts to at least two managed care organizations in each of the 13 service areas. Contracts will run through August 31, 2022 with contract periods not to exceed a total of eight years. The anticipated operational start date is January 1, 2020. RFP documents can be found here.

HHS Headquarters Infested With Rats. *The Texas Tribune* reported on November 29, 2017, that the Austin headquarters of the Texas Health and Human Services Commission is infested with several hundred rats. The state will hire a private exterminator to rid the building of the rat problem. Read More

Texas Sees 10 Percent Drop in Early Intervention Program Enrollment. *Houston Chronicle* reported on November 29, 2017, that Texas has experienced a 10 percent drop in enrollment in the state's Early Intervention Program, which serves children with conditions like autism and Down syndrome, according to a report from not-for-profit Texans Care for Children. The report blamed cuts in funding for the program. Enrollment in the Gulf Coast area fell by 21 percent. Read More

Wisconsin

Wisconsin Seeks to Extend Partial Medicaid Expansion Waiver for 5 More Years. *Wisconsin Public Radio* reported on December 5, 2017, that Wisconsin will submit a waiver request to the Centers for Medicare & Medicaid Services (CMS) to extend its partial Medicaid expansion for an additional five years. The current expansion program is set to expire at the end of 2018. The Wisconsin Department of Health Services will be holding a public hearing on December 7. Read More

Medicaid Director to Resign. The Wisconsin Department of Health Services announced on December 5, 2017, that Michael Heifetz, Medicaid director and administrator of the Division of Medicaid Services (DMS), will resign effective December 13. Deputy Administrator Casey Himebauch will serve as interim administrator of DMS. Read More

National

Senator Collins Requests Additional Funding for ACA Stabilization Bill. *The Hill* reported on December 4, 2017, that Senator Susan Collins (R-ME) is now seeking $10 billion over two years for an Affordable Care Act (ACA) stabilization bill, up from her original $4.5 billion. The bill, which is sponsored by Collins and Senator Bill Nelson (D-FL), would fund reinsurance pools to help lower Exchange plan premiums and offset the impact of the repeal of the individual mandate. Collins said she had received assurances that the ACA stabilization bill would pass in exchange for her support of the Republican tax bill. Read More

HHS Nominee Pledges to Help Lower Drug Prices. The *Chicago Sun Times* reported on November 29, 2017, that the former drug industry executive nominated by President Trump to head the U.S. Health and Human Services has promised to help lower drug prices. Alex Azar said during a Senate committee hearing on his nomination that his priorities would be lowering drug prices, health insurance affordability, opioids, and Medicare efforts to pay for value. Read More

Medicaid Work Requirements May Prevent Access to Care for Individuals Struggling with Opioid Addiction. *Politico* reported on December 3, 2017, that Medicaid work requirements may push people out of treatment who are suffering from opioid addiction. At least eight states, including Kentucky, New Hampshire, Maine, and Indiana, are seeking federal approval for such waivers. Although governors say they will exempt individuals with chronic drug problems or mental illness, critics fear that these individuals would lose benefits, specifically if they go in and out of treatment or have relapsed. State data for Indiana show that just more than a quarter of enrollees with diagnosed problems are getting treated. Kentucky is the first state expected to get its waiver approved. About 95,000 people in the state are expected to lose Medicaid coverage over a five-year period. Read More

States See Medicaid Savings After Addressing Social Determinants of Health, Study Says. *USA Today* reported on December 5, 2017, that some states are seeing significant savings in Medicaid costs among their sickest members by addressing social determinants of health such as housing, hunger, drug abuse, and depression, according to a report by the National Governors Association. The study says that states can save more than $2 for every dollar invested in social services among their sickest members. The findings are based on a national pilot program providing targeted and coordinated health care and social services in Rhode Island, Connecticut, West Virginia, Colorado, Wyoming, Alaska, Michigan, New Mexico, Wisconsin, and Puerto Rico. Read More

Industry News

CVS Health to Acquire Aetna in $77 Billion Deal. CVS Health announced on December 3, 2017, that it will acquire Aetna Inc. in a deal valued at approximately $77 billion, including $69 billion in cash and stock as well as $8 billion in assumed debt. The transaction values Aetna stock at about $207 per share, or $145 per share in cash plus 0.8378 shares of CVS stock. Aetna will operate as a stand-alone business unit within CVS Health. Aetna chairman and chief executive Mark Bertolini will join the CVS board. Aetna shareholders will own about 22 percent of the combined company following the transaction; CVS shareholders will own 78 percent. The deal is expected to be accretive to CVS earnings in the second year and deliver $750 million in near-term synergies. Aetna is one of the nation's leading health insurance companies, serving 44.6 million members, including commercial, Medicare and Medicaid lines. CVS operates 9,700 retail drugstores, 1,100 clinics, and the Caremark pharmacy benefit management operation, with nearly 90 million members, among other services like infusion. The transaction is expected to close in 2018, pending shareholder and regulatory approvals. Read More

Optum to Acquire DaVita Medical Group for $4.9 Billion. UnitedHealth Group's Optum division announced on December 6, 2017, an agreement to acquire DaVita Medical Group (DMG) for $4.9 billion in cash. DMG, which is part of publicly traded DaVita Inc., will become part of OptumCare, which provides primary, specialty, in-home, urgent and surgical care services. The acquisition is expected to close next year, pending regulatory approval.

Advocate Health Care to Merge with Aurora Health Care. *Modern Healthcare* reported on December 4, 2017, that Illinois-based Advocate Health Care announced it will merge with Wisconsin-based Aurora Health Care. The combined organization will have 3,300 employed physicians, 500 outpatient locations, 70,000 employees and 2.7 million patients. The deal is expected to close in mid-2018, pending state and federal approval. Terms of the deal were not disclosed. Advocate chief executive Jim Skogsbergh and Aurora chief executive Nick Turkal, M.D, will serve as co-CEOs. Advocate's previous attempt to merge with NorthShore University HealthSystem was blocked by a U.S. District Court. Read More

For-Profit Hospitals Face Disruptions from Regulatory Changes, Technological Advancements, Fitch Says. *Modern Healthcare* reported on November 30, 2017, that for-profit hospitals face the threat of market disruption from regulatory changes, new competitors like Amazon, and technological advancements, according to Fitch Ratings in its 2018 industry outlook report. Fitch also pointed to the continued market focus on affordability and price transparency that allows consumers to shop around. Fitch said innovation will be among keys to success. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
Timeline to be Revised	Alabama ICN (MLTSS)	RFP Release	25,000
December 2017	Virginia MLTSS	Implementation - Northern/Winchester	26,000
January 1, 2018	Delaware	Implementation	200,000
January 1, 2018	Illinois	Implementation	2,700,000
January 1, 2018	Pennsylvania HealthChoices (Delay Likely)	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 25, 2018	Arizona	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 (Delay Likely)	Implementation (NE Zone)	315,000
March 1, 2018	Massachusetts	Implementation	850,000
March 6, 2018	Texas STAR+PLUS Statewide	Proposals Due	530,000
March 8, 2018	Arizona	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 (Delay Likely)	Implementation (SE Zone)	830,000
July 1, 2018	MississippiCAN	Implementation	500,000
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	Implementation	1,600,000
October 1, 2018	Texas STAR+PLUS Statewide	Contract Start	530,000
November 1, 2018	New Hampshire	Proposals Due	160,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC)	Implementation	3,100,000
January 1, 2019	Pennsylvania HealthChoices (Delay Likely)	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	160,000
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
July 1, 2019	Iowa	Implementation	600,000
September 1, 2019	Texas STAR, CHIP Statewide	Implementation	3,400,000
January 1, 2020	Texas STAR+PLUS Statewide	Operational Start Date	530,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000

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