HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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RFP Calendar

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THIS WEEK

IN FOCUS

PUERTO RICO RELEASES GOVERNMENT HEALTH PLAN RFP

This week's *In Focus* section, written by HMA Principal Juan Montanez, reviews the request for proposals (RFP) issued by Puerto Rico earlier this month to deliver managed care services to the territory's Government Health Plan (GHP) members. The government of Puerto Rico is seeking to contract with between three and six MCOs to provide services to the approximately 1.3 million members of the GHP, the territory's medical assistance and insurance affordability program. Proposals in response to the recently issued RFP are due in early April.

SERVICES AND POPULATIONS COVERED

The GHP provides preventive, primary, acute care, behavioral health, and pharmacy services to pregnant women, newborns, children, parents and childless adults who meet income requirements. The GHP encompasses federal

Medicaid and CHIP funds along with territory general funds. The GHP also has a "buy-in" option, and certain government employees – such as the territory's police – receive health care through the GHP at no cost.

Significant Contract Changes

The most significant changes in this contract from the previous contract (RFP released in 2014) are as follows:

- In keeping with initiatives proposed in the recently released Fiscal Plan, the GHP will transition from a model where a single MCO operates in one of eight geographic regions to an island-wide model where MCOs will, in effect, compete for business across the territory. New enrollees will be auto-assigned to an MCO and, in alignment with federal laws and regulations, have 90 days to change MCOs. Details on the auto-assignment algorithm are not yet available.
- Because of the change in model, MCOs will need the capacity and ability to provide an adequate network and manage services for members who live anywhere in the territory. In a press conference held in early February, the territory's health secretary noted that this change in model is driven in part by concerns regarding the availability of specialists. MCOs are encouraged to propose approaches to meeting this requirement that incorporate "partnerships" with other MCOs and provider-based organizations (health systems, IPAs, etc.). These partnerships could incorporate alternative payment models and various modalities of "value-based care."
- In its RFP announcement, in related public communications and in the aforementioned Fiscal Plan, the government has placed significant emphasis on MCOs addressing the needs of high-cost GHP members – individuals with chronic or high- cost diseases who are also the highest utilizers of GHP-covered services. In response to this, MCOs will be expected to propose innovative approaches to managing and delivering care to these members.
- While historically the government has contracted directly with a PBM, in public communications it has suggested that it may consider allowing or requiring the MCOs to fulfill PBM functions.
- In its Fiscal Plan the government is targeting a five-year reduction of almost 18 percent (in current dollars) in the average per-member cost of the program, from approximately $175 to $144. While this goal is not entirely dependent on MCO requirements - for instance, there are assumptions in the Fiscal Plan regarding standardization of provider fees, MFCU-driven fraud recoveries and PDL controls - it is safe to assume that the government will expect MCOs to manage their provider networks, service utilization and reimbursement such that the government's goal becomes achievable.

Current Medicaid Managed Care Market

At present the 1.3 million GHP members are divided amongst four carriers, each of which operates as the single MCO in two of eight geographic regions:

- Triple-S, the owner of the Blue Cross and Blue Shield licenses in Puerto Rico, and the largest insurance company on the island.

- MMM, the largest issuer of Medicare Advantage products on the island.
- First Medical, a provider-based plan that also has significant government employee and retiree business.
- Molina Healthcare's Puerto Rico subsidiary.

Enrollment in Puerto Rico Medicaid Managed Care by Plan, September 2017	
Plan	Sep-17
Triple-S Salud	379,199
% of total	*31.1%*
Molina Healthcare of PR	305,956
% of total	*25.1%*
First Medical Health Plan Inc.	275,064
% of total	*22.5%*
InnovaCare	260,162
% of total	*21.3%*
Puerto Rico Totals	1,220,381

Source: NAIC, S&P Global Market Intelligence, HMA
Note: Total enrollment differs from the estimate in the *In Focus* text due to differing sources. Exact current Medicaid managed care enrollment in Puerto Rico is difficult to determine due to changes in population after Hurricane Maria.

RFP Timeline

Proposals in response to the recently issued RFP are due in early April. The government expects to announce the winning proposals in June, with resulting contracts planned to go into effect in October.

Puerto Rico Medicaid Managed Care RFP Timeline	
RFP Activity	Date
RFP Released	February 8, 2018
Bidder's Conference	February 23, 2018
Proposals Due	April 6, 2018
Anticipated Award	June
Anticipated Contract Execution	End of June
Anticipated Go-Live	October 2018

Link to RFP/Bidders' Library

The public notice for the RFP can be accessed by clicking here.

HMA Medicaid Roundup

Colorado

State Considers Medicaid Work Requirements. *The Washington Examiner* reported on February 23, 2018, that Colorado Governor John Hickenlooper is open to Medicaid work requirements for able-bodied beneficiaries. Hickenlooper is the second Democratic governor along with Louisiana's John Bel Edwards to consider Medicaid work requirements. Read More

Florida

House Panel Votes for Medicaid Work Requirements. *News4Jax.com* reported on February 21, 2018, that a Florida House panel voted 14-4 on House Bill 751, which calls for Medicaid work requirements. Senator Anitere Flore (R-Miami) said it is unlikely the state Senate would tackle the issue with less than three weeks left in the legislative session. Read More

Low Income Pool Funding Is Lower than Expected. *Health News Florida* reported on February 25, 2018, that Florida will receive $730.6 million in supplemental Medicaid funding for the Low Income Pool (LIP) program for fiscal 2018, almost $60 million less than projected by Medicaid director Beth Kidder last fall. Local funding amounted to $279 million, down from an anticipated $303 million. The federal match was $451.4 million. Governor Rick Scott had predicted last year that LIP funding would total $1.5 billion. Read More

Florida Medicaid Limits Opioid Prescriptions to Seven Days. *PalmBeachPost.com* reported on February 20, 2018, that the Florida Agency for Health Care Administration is limiting Medicaid opioid prescriptions to a maximum seven-day supply, effective February 19. Exemptions are available if deemed medically necessary by a physician. Medicaid will also no longer require prior authorization for certain drugs that help fight opioid addiction. Read More

Idaho

Partial Medicaid Expansion Plan Lacks Republican Support. *Modern Healthcare* reported on February 27, 2018, that a plan by Idaho Governor Butch Otter to partially expand Medicaid to about half the state's gap population was sent back to committee after lack of support from Republican lawmakers. The Governor's bill sought two federal waivers to expand Medicaid coverage for 12

costly conditions and to provide subsidies to certain low-income individuals. Previous efforts to expand Medicaid eligibility have failed. Read More

Republicans at Odds Over Merged 1332-1115 Waiver Proposal. *Modern Healthcare* reported on February 26, 2018, that Republican lawmakers in Idaho are at odds over a Medicaid proposal that would allow individuals at the poverty level to qualify for Exchange subsidies, while Medicaid would act as a high-risk pool for expensive care. The plan is to merge 1115 and 1332 waivers into a combined super-waiver, expanding Medicaid coverage to approximately 35,000 uninsured individuals. The state legislature must approve the proposal before the waiver can be submitted for federal approval. Read More

Iowa

Medicaid Providers Denounce Low Rates, Delayed Payments. *Hawk Eye* reported on February 23, 2018, that health care providers in Iowa complained during a public forum to Medicaid officials about low reimbursement levels and payment delays associated with the state's Medicaid managed care program. Attending the event were Jerry Foxhoven, director of the Iowa Department of Human Services, and Medicaid Director Michael Randol. Read More

Maine

Medicaid Expansion Stalls. *Maine Public News* reported on February 22, 2018 that efforts to expand Medicaid in Maine have stalled, with the administration of Governor Paul LePage stating it won't take steps to implement the voter-approved program unless funding is appropriated first. Legislators say the law requires the LePage administration to take certain steps, including filing a plan with federal regulators. Read More

Maine Medicaid to Outsource Disability Eligibility Determinations. *Maine Public News/Bangor Daily News* reported on February 26, 2018, that Maine will outsource Medicaid disability eligibility determinations effective in June. The no-bid, $5.6 million, 25-month contract will be handled by Commonwealth Medicine, a division of University of Massachusetts Medical School. The Maine Department of Health and Human Services will eliminate 10 positions on its Medical Review Team. Read More

Maryland

Maryland Has Lowest Health Care Costs in Study of Five States. *The Baltimore Sun* reported on February 23, 2018, that health care costs in Maryland were 16 percent lower on average than in Colorado, Utah, Minnesota, and Oregon, according to a report entitled "Healthcare Affordability: Untangling Cost Drivers." The report, by the Network for Regional Healthcare Improvement, attributes the low costs to Maryland's all-payer insurance model as well as the state's efforts to regulate hospital payments. Read More

Michigan

Michigan Receives Bids for Behavioral Health Carve-In. *Crain's Detroit Business* reported on February 22, 2018, that Michigan has received bids from community mental health agencies to participate in three regional pilot projects designed to integrate behavioral health into Medicaid managed care. The plan was first approved by the state last year. Awards are expected by March 9 and implementation is set to begin October 1. A fourth pilot was considered in Kent County but the state could not find a Medicaid plan willing to participate. Read More

Missouri

Lawmakers Consider Medicaid Work Requirements. *The Missourian* reported on February 21, 2018, that Missouri state Senator David Sater (R-Cassville) introduced a bill that that would institute Medicaid work requirements. The measure would require able-bodied Medicaid beneficiaries to spend at least 80 hours a month employed, looking for work, volunteering, or participating in job training. Exemptions are available for individuals with disabilities, substance abuse disorders, and complex medical conditions, as well as for pregnant women, primary caregivers, and low-income residents living in areas with high unemployment. Read More

Montana

Hospitals, Advocates Launch Ballot Initiative to Reauthorize Medicaid Expansion. *Montana Public Radio* reported on February 22, 2018, that the Montana Hospital Association and the American Heart Association launched a ballot initiative in hopes of reauthorizing the state's Medicaid expansion in fiscal 2019. The initiative also proposes an increase in the tobacco tax. The state's Medicaid expansion extends coverage to 90,000 individuals. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey MCOs Expand Service Areas. The following New Jersey managed care organizations (MCOs) have expanded their service areas:

UnitedHealthcare Dual Complete ONE (D-SNP). As of January 1, 2018, United's fully integrated dually eligible special needs plan (FIDE SNP) expanded to serve dually eligible members in Cumberland, Salem and Sussex counties. This brings the total number of counties served in New Jersey to 19 out of 21.

WellCare of New Jersey. The Department of Human Services, Division of Medical Assistance and Health Services approved WellCare's expansion into seven additional counties. WellCare now serves NJ FamilyCare enrollees in 17 out of the state's 21 counties. The seven new counties are Atlantic, Camden, Cumberland, Gloucester, Monmouth, Salem and Warren.

Governor's Budget Address Rescheduled. New Jersey Governor Murphy signed bills that will change the timing for his 2018-19 budget address from the fourth Tuesday in February to March 13, 2018. A2378 and S1248 passed in the Assembly and the Senate, respectively, and were signed by the Governor. Similar extensions have been provided in the past for the first budgets of other Governors.

New Jersey Seeks to Expand Inpatient Capacity for Individuals Who Need Both Mental Health and Substance Use Treatment. *NJ Spotlight* reported on February 26, 2018, that the Department of Health invited providers to submit plans to add up to 53 more inpatient beds in the underserved regions of the state including Hunterdon, Morris and Warren counties. The latest effort responds to national capacity guidelines of 40 beds per 100,000 residents, and follows almost 20 years without state initiatives for expansion. Read More

Attorney General Creates Office to Respond to Opioid Addiction Epidemic. *NJBIZ* reported on February 22, 2018, that New Jersey's Office of the Attorney General created the Office of the New Jersey Coordinator of Addiction Response and Enforcement Strategies, also known as NJ CARES. Sharon Joyce will lead the new office, in addition to her role as acting director of the Consumer Affairs Division and Deputy Director of the Office of Law division. NJ CARES is charged with public education about opioid addiction, identify prevention opportunities and solutions. It will also manage new 24-hour opioid response teams, launch an Interagency Drug Awareness Dashboard and enhance the state's Prescription Monitoring Program. Read More

Governor Murphy Signs Bill to Increase Planned Parenthood Funding. *NorthJersey.com* reported on February 21, 2018, that Governor Murphy signed his first bill, S-120, to give close to $7.5 million in grants through the Department of Health for Planned Parenthood and other family planning providers that lost state funding under the Christie administration. Cecile Richards, outgoing president of Planned Parenthood joined Gov. Murphy for the signing. Gov. Murphy also signed a bill to expand Medicaid coverage for family planning services to ease restrictions for access to long-acting reversible contraceptives. Six family planning clinics closed in 2010, reducing women's access to care. Read More

State Lawmaker Proposes Medicaid Demonstration to Cover Room and Board for Terminally Ill, Community-based Medicaid Enrollees. New Jersey Assembly bill A3299 was introduced by Valerie Huttle (D-Englewood) to establish a three-year Medicaid demonstration project by the Division of Medical Assistance and Health Services (DMAHS). The demonstration would cover room and board services for community-based enrollees under hospice care who would otherwise be eligible for such care in a hospital, nursing home or other institutional setting. In this context room and board is defined as assistance in paying mortgage or rent, food and other expenses, and the provision of services required to remain in the community. The bill seeks to help individuals who have insufficient financial resources to be sustained in the community and to further reduce avoidable reliance on institutional care. The bill was introduced in the last legislative session as A911. It has been referred to the Assembly Health and Senior Services Committee. Read More

New Mexico

New Mexico Judge Denies Injunction in Medicaid Managed Care Awards Dispute. *The New Mexican* reported on February 26, 2018, that a New Mexico judge declined to issue an injunction blocking the state from proceeding with newly awarded Medicaid managed care contracts. In dismissing the lawsuit filed by Molina Healthcare, the judge ruled that the court lacked jurisdiction given pending protests with the state Human Services Department. Molina and three other companies filed protests after the state awarded Medicaid managed contracts to other health plans. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Medicaid Managed Care Advisory Review Panel Holds Quarterly Meeting. 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 February 22. Jonathan Bick, Director of the Division of Health Plan Contracting and Oversight for the NY Department of Health, provided an update on Plan mergers, acquisitions, expansions, and closures.

Two applications for new plans are under review:

• New York Quality Healthcare Corporation, a subsidiary of Centene Corporation has applied to be certified as an Article 44 HMO in NYS. This application is currently under review.

• Partners Health Plan, which operates the plan participating in the duals demonstration program for individuals with intellectual/developmental disabilities (FIDA-IDD) has applied to become a mainstream Medicaid managed care plan. Partners operates in NYC, Long Island, Westchester, and Rockland Counties. The FIDA-IDD plan, which began operations in April 2016, currently has 764 members.

Two plan requests for geographic expansion have been approved:

• Excellus – 1 county expansion for Medicaid, CHP and HARP (Erie County)
• HealthNow – 2 counties (Genesee and Niagara)

Four plan requests for geographic expansion are under review:

• CDPHP – 4-county expansion for Medicaid, CHP and HARP (Essex, Clinton, Franklin and Warren)

• YourCare – 5-county expansion for Medicaid, CHP, and HARP (Orleans, Genesee, Livingston, Wayne and Seneca)

• United Healthcare – 1-county expansion for CHP (Dutchess, Erie, Franklin, Greene, Livingston, Orleans, Saratoga, Schenectady, Wyoming, and Yates)

• VNS Choice – 2-county expansion for MLTC (Nassau and Westchester)

Office of Health Insurance Programs Presents Medicaid Managed Care Plan Financial Status. The Office of Health Insurance Programs presented premium surplus and loss statistics for New York's Medicaid managed care plans to the Medicaid Managed Care Advisory Review Panel. The information was presented for 2015 and 2016, and broke out statistics for mainstream plans, Health and Recovery Plans, the Essential Plan, and HIV Special Needs Plans. Overall profitability decreased between 2015 and 2016, driven by significant declines in the mainstream Medicaid managed care program; all other lines of business showed increases in profitability. In 2015 mainstream Medicaid managed care plans across the state showed plan operating profit of $366 million; in 2016 it was a loss of $390 million. For-profit plans show stronger financial strength as compared with not-for-profit plans; plans located in NYC did slightly better than plans in other regions. Slides are posted on the HMAIS web site, and are available upon request.

Medicaid Managed Care Profitability 2015 – 2016

	Operating Margin	Total	Mainstream	HARP	Essential Plan	HIV SNP
2015						
	All Plans	1.9%	1.7%	3.4%	4.9%	1.4%
	Not-For-Profit	1.0%	1.0%	1.3%	1.8%	
	For-Profit	5.3%	4.7%	13.5%	13.0%	
2016	All Plans	0.8%	-1.8%	5.1%	17.8%	2.3%
	Not-For-Profit	-0.1%	-2.1%	2.3%	13.2%	
	For-Profit	4.5%	-0.8%	19.7%	30.9%	

OPWDD Finalizes Draft Waiver Transition Plan for Individuals with Intellectual and Developmental Disabilities. The New York Office for People with Developmental Disabilities (OPWDD) has finalized its Draft Waiver Transition Plan which lays out their vision for reform of the system serving people with intellectual and developmental disabilities, "People First Care Coordination." The Transition Plan describes the development of Care Coordination Organizations, which will provide Health Home Care Management services. Care Coordination Organizations are being established by groups of OPWDD providers in each region across the state that will provide multi-agency care coordination. OPWDD envisions CCOs affiliating with managed care plans, ultimately shifting to a mandatory Medicaid managed care system, as most of NY's Medicaid program already requires. The shift to a mandatory managed care system will happen gradually, with a five-year transition planned. The draft plan reflects changes made as a result of the public comment period, and will now be submitted to CMS for approval. Read More

Pennsylvania

Governor Joins Other Governors in Push for Health Care Reform. A bipartisan group of five governors, including Pennsylvania Governor Tom Wolf, issued a high-level outline for ways states can reform the nation's health care system. The blueprint was issued by the governors of Alaska, Colorado, Nevada, Ohio, and Pennsylvania and calls on states to implement policies in their state Medicaid programs that would encourage value-based care models,

discourage anti-competitive practices among health networks, and improve patient access and lower costs overall. The plan outlines the following strategies for improving health system performance:

- Reorient the system on value
- Align consumer incentives
- Encourage more competition and innovation
- Reform insurance markets
- Expand proven state Medicaid innovations
- Modernize the state and federal relationship. Read More

South Carolina

State Awards Dental ASO Contract to DentaQuest. South Carolina announced on February 23, 2018, that it had awarded a dental administrative services organization (ASO) contract to DentaQuest. DentaQuest has held the contract with the state for the last several years. The contract will run from March 1, 2018, to March 31, 2025.

Tennessee

Tennessee Requests $252 Million in Uncompensated Care Funding. *Modern Healthcare* reported on February 21, 2018, that Tennessee has submitted a federal waiver request for $252 million annually in uncompensated care funds for hospitals. The state is currently receiving $163 million annually in federal funds for uncompensated care. Tennessee is not a Medicaid expansion state. Read More

Virginia

House Committee Projects Alternative Medicaid Expansion Would Cost $441.5 Million. *The Richmond Times-Dispatch* reported on February 28, 2018, that the Virginia House Appropriations Committee projects that the total cost of a state Senate-proposed limited Medicaid expansion plan would be $441.5 million. The plan would expand Medicaid to nearly 61,000 individuals with mental illness, substance use disorders, or life-threatening, complex medical conditions. The cost would be $186 million for two years if enrollment is capped at 20,000. The program would also cover 2,300 individuals with developmental or intellectual disabilities waiting for waiver services in community settings. The Senate proposal would not utilize enhanced federal funding under the Affordable Care Act. Read More

Wisconsin

State Releases Family Care Partnership RFP for Selected Service Areas. The Wisconsin Department of Health Services on February 27, 2018, released a request for proposal (RFP) for geographic service areas eight and 12 of the state's Family Care Partnership, a Medicaid managed long-term care program for low-income frail, elderly individuals and adults with developmental, intellectual, or physical disabilities. Proposals are due on April 11, 2018, with implementation expected to begin January 2019. Wisconsin began procuring the Family Care contracts in phases in 2016 as part of an effort to make the program available in every county in the state. The RFP and additional documents can be found here.

Legislature Passes Exchange Reinsurance Bill. *Modern Healthcare* reported on February 21, 2018, that the Wisconsin legislature passed a bill to establish a reinsurance fund aimed at stabilizing the state's Exchange plan market. The bill now heads to Governor Scott Walker's desk. The measure, which still requires federal 1332 waiver approval, would cover at least 50 percent of claims between $50,000 and $200,000. Read More

Charges Filed in Death of Milwaukee County Jail Inmate. The *Associated Press/TMJ* reported on February 21, 2018, that Miami-based Armor Correctional Health Services, Inc., faces misdemeanor charges for allegedly falsifying health records in the 2016 death of a Milwaukee County jail inmate. Three jail employees were also charged. Read More

National

Justice Department to Support Local Officials in Lawsuits Against Opioid Distributors. *The New York Times/Associated Press* reported on February 27, 2018, that the U.S. Department of Justice (DOJ) announced it would support local officials in lawsuits against opioid manufacturers and distributors. Hundreds of lawsuits have been filed, with targets including Allergan, Johnson & Johnson, Purdue Pharma, Amerisource Bergen, Cardinal Health, and McKesson. DOJ will file a statement of interest in the multidistrict litigation, saying that the federal government suffered substantial costs from opioid addiction. Read More

FDA to Allow Drugs that Reduce Opioid Cravings. *The New York Times* reported on February 25, 2018, that the Food and Drug Administration (FDA) will allow pharmaceutical companies to sell drugs that help reduce opioid cravings. The new approach, which is designed to expand utilization of Medicaid-Assisted Therapy for opioid abuse, will attempt to "correct a misconception that patients must achieve total abstinence in order for MAT to be considered effective," according to Alex Azar, secretary of the U.S. Department of Health & Human Services. Read More

Industry News

Centene to Acquire MHM Services. Centene announced on February 26, 2018, that it has signed a definitive agreement to acquire MHM Services, including its 49 percent ownership of Centurion, the correctional healthcare services joint venture between Centene and MHM. MHM is a national provider of healthcare and staffing services to correctional systems and other government agencies, serving 330,000 individuals in 300 facilities. The transaction is expected to close in the first quarter of 2018. Read More

Community Health Systems Reports 4Q17 Net Loss. *Modern Healthcare* reported on February 27, 2018, that Community Health Systems posted a $2 billion net loss in the fourth quarter of 2017, largely from a write down of goodwill. In the same period last year, the company reported a net loss of $220 million. Read More

Stepping Stones Group Acquires Cobb Pediatric Therapy Services. The Stepping Stones Group, a portfolio company of Five Arrows Capital Partners, announced on February 22, 2018, that it has acquired Georgia-based Cobb Pediatric Therapy Services. Financial terms were not disclosed. Cobb Pediatric provides a range of therapy services for children in schools throughout the Southeast. With this acquisition, Stepping Stones will expand from 20 states to 25. Read More

Mercy Health, Bon Secours to Be Fifth Largest Catholic System Following Merger. *Modern Healthcare* reported on February 21, 2018, that Mercy Health and Bon Secours Health System have agreed to merge in a deal that would create the nation's fifth largest Catholic health system. The combined system would generate $8 billion in annual revenues and consist of 43 hospitals across Florida, Kentucky, Maryland, New York, Ohio, South Carolina, and Virginia. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2018 (Delayed from 2017)	Alaska Coordinated Care Demonstration	Contract Awards	TBD
2018	Massachusetts One Care (Duals Demo)	RFP Release	TBD
Spring 2018	North Carolina	RFP Release	1,500,000
March 2018	Alabama ICN (MLTSS)	RFP Release	25,000
March 1, 2018	Pennsylvania HealthChoices (Delay Likely)	Implementation (NE Zone)	315,000
March 1, 2018	Massachusetts	Implementation	850,000
March 6, 2018	Iowa	Proposals Due	600,000
March 6, 2018	Texas STAR+PLUS Statewide	Proposals Due	530,000
March 8, 2018	Arizona	Contract Awards	1,600,000
April or May 2018	Alabama ICN (MLTSS)	Contract Award	25,000
April 1, 2018	New Hampshire	RFP Release	160,000
April 6, 2018	Texas STAR and CHIP	RFP Release	3,342,530
April 6, 2018	Puerto Rico	Proposals Due	~1,300,000
April 11, 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Proposals Due	~1,600
April 16, 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
April 24, 2018	Iowa	Contract Awards	600,000
April 27, 2018	Florida Children's Medical Services	Responses Due	50,000
April 12, 2018	Washington FIMC (Remaining Counties)	Proposals Due	~1,600,000
May 2018	Puerto Rico	Contract Awards	~1,300,000
May 22, 2018	Washington FIMC (Remaining Counties)	Contract Awards	~1,600,000
June 2018	North Carolina	Proposals Due	1,500,000
June 2018	Kansas KanCare	Contract Awards	380,000
June 4, 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Contract Award	~1,600
June 26, 2018	Florida Children's Medical Services	Contract Award	50,000
July 2018	Texas STAR and CHIP	Proposals Due	3,342,530
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
September 26, 2018	Texas STAR and CHIP	Evaluation Period Ends	3,342,530
October 2018	Puerto Rico	Implementation	~1,300,000
October 2018	Alabama ICN (MLTSS)	Implementation	25,000
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 2019	Kansas KanCare	Implementation	380,000
January 1, 2019	Wisconsin LTC (Milwaukee and Dane Counties)	Implementation	~1,600
January 1, 2019	Washington FIMC (Remaining Counties)	Implementation for RSAs Opting for 2019 Start	~1,600,000
January 1, 2019	Florida Children's Medical Services	Contract Start	50,000
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 24, 2019	Texas STAR and CHIP	Contract Start	3,400,000
July 1, 2019	North Carolina	Implementation	1,500,000
July 1, 2019	New Hampshire	Implementation	160,000
July 1, 2019	Iowa	Implementation	600,000
January 1, 2020	Texas STAR+PLUS, STAR, and CHIP	Operational Start Date	530,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Washington FIMC (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	TBD

COMPANY ANNOUNCEMENTS

MCG Health Releases 22nd Edition of Evidence-Based Care Guidelines.

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