HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

March 7, 2018

RFP Calendar

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This Week

Save The Date

HMA's 2018 Conference on Trends in Publicly Sponsored Healthcare to Address Community Engagement and Shared Responsibility in Medicaid

October 1-2, 2018
The Palmer House, Chicago, IL

Health Management Associates (HMA) is proud to announce its annual conference on *Trends in Publicly Sponsored Healthcare*, October 1-2, 2018, in Chicago. The theme of this year's event is *Medicaid in an Era of Community Engagement and Shared Responsibility: Opportunities and Pitfalls for Payers, Providers and States* and features some of the nation's most innovative healthcare leaders as keynote speakers.

This is the third conference HMA has presented on trends in publicly sponsored healthcare. Last year's event in Chicago brought together more than 400 executives from health plans, providers, state and federal government agencies, community-based organizations and others serving Medicaid beneficiaries and other vulnerable populations. It was a collaborative, high-level event featuring more than 35 speakers and representing the interests of a broad-based constituency of healthcare leaders.

This year's meeting promises to be even better, with a sharp focus on the challenges and opportunities Medicaid-focused organizations face in an evolving federal and state regulatory environment. Additional details, including a complete agenda, will be available in the weeks ahead. Questions can be directed to Carl Mercurio, cmercurio@healthmanagement.com, (212) 575-5929.

Confirmed Keynote Speakers to Date
(in alphabetical order; others to be announced)

The Next Wave: How Medicaid Plans Are Positioning Themselves for Success

***John Baackes**, CEO, L.A. Care Health Plan*
***Laurie Brubaker**, Head of Aetna Medicaid, Aetna Inc.*
***Patrick Sturdivant**, President, Virginia Medicaid Health Plan, Anthem Inc.*

How States Are Fostering Community Engagement and Innovation in Medicaid

***Mari Cantwell**, Chief Deputy Director, Health Care Programs, California Department of Health Care Services*
***Stephanie Muth,** State Medicaid Director, Medicaid/CHIP Medical and Social Services Division, Texas Health and Human Services Commission*
***Allison Taylor**, Director of Medicaid, Indiana Family and Social Services Administration*

Additional planned sessions to focus on Community Engagement, Long-Term Services and Supports, Social Determinants of Health, Value-Based Payments, Behavioral Integration, Community-based Organizations, Integrated Care, Health Care Convergence, and Managing Chronically Ill Patients.

IN FOCUS

INTERAGENCY, CROSS-SECTOR COLLABORATION TO IMPROVE CARE FOR VULNERABLE CHILDREN: LESSONS FROM SIX STATE INITIATIVES

This week's *In Focus* highlights a recently released report written by Health Management Associates colleagues Sharon Silow-Carroll, Diana Rodin, and Anh Pham, titled "*Interagency, Cross-Sector Collaboration to Improve Care for Vulnerable Children: Lessons from Six State Initiatives.*" Prepared for the Lucile Packard Foundation for Children's Health, the report highlights how programs in Colorado, the District of Columbia, New York, Oregon, and Washington State have implemented collaboration mechanisms focused on fostering communication and coordination across programs for vulnerable children.

There is growing acknowledgement that children and youth with special health care needs (CYSHCN) and other vulnerable populations can best be served through a coordinated approach across the myriad programs and agencies that touch them, including Medicaid, Public Health, Behavioral Health, Education/Early Learning, Human Services and others. However, states face structural, operational, financial, regulatory, and cultural challenges to breaking down traditional silos to achieve interagency, cross-sector collaboration.

Some states have made progress in overcoming these barriers, recognizing opportunities for state-level interagency collaboration and taking steps to address aspects of fragmentation and duplication of services for vulnerable children. Whereas most of the collaboration efforts examined emerge from the health sector and focus specifically on CYSHCN, others are truly cross-sector and take a broader view of vulnerable children – with participants entering the collaboration through the "doors" of education, child welfare, mental health, juvenile justice, or labor and income supports.

This report describes six programs in five states that implemented collaboration mechanisms such as interagency councils and task forces, data sharing agreements, and new departments or dedicated staff focused on fostering communication and coordination across programs for vulnerable children. Their achievements include: better identification of CYSHCN and more children/families with a shared care plan (Colorado care coordination data sharing pilot); "flagging" of CYSHCN for targeted outreach (Washington's CYSHCN cross-agency data system); increased health screening and dental visit form completion in public schools the District of Columbia's data sharing across Education, Medicaid, and Health departments); a common developmental screening metric for health and early learning systems (Oregon's alignment of Health and Early Learning), a new interactive website for families of vulnerable children to navigate services across health, education, and human services (New York's Council on Children and Families), and a cross-sector ten-point plan for improving long term outcomes for young children enrolled in Medicaid (New York's First 1000 Days on Medicaid initiative).

While each state's environment and experiences are unique, common strategies and lessons across the programs studied suggest the following recommendations may help other states promote interagency collaboration:

- Inspire the Governor to launch a collaborative initiative as a statewide priority with cross-agency goals and hold state agencies accountable
- Select and nurture collaboration leaders with a broad view of "health and well-being" and the ability to foster relationships – consider cross-system leadership
- Establish sustainable collaboration structures and resources (e.g., cross-agency council, dedicated staff, and technical advisory committee) through legislation or interagency agreements; tailor tools and resources to the scope of the initiative, as narrowly targeted efforts require less new infrastructure and investment
- When targeting CYSHCN, incorporate the family/youth/child voice on an ongoing basis, in conjunction with advocacy efforts that train and support families for participating in policy and program planning
- Align with other state initiatives and federal grant opportunities; such efforts will leverage funding and be mutually reinforcing and more likely to gain broad support
- Use robust project management techniques stressing transparency, inclusion, and realistic timelines
- Establish common metrics, goals, and incentives across programs and agencies, with legal and technical guidance to facilitate data sharing and overcome obstacles
- Build standards and requirements for collaboration into managed care contracts and other systems, with monitoring and consequences for non-compliance
- Invest in and assist local collaboration activities, where service provision takes place

More broadly, efforts are needed to expand the concept of "health and well-being" to promote greater collaboration across sectors, agencies, and programs, and better coordinated services for CYSHCN and other vulnerable populations and their families.

To access the full report, click here.

To contact Sharon Silow-Carroll, lead author of the report, email ssilowcarroll@healthmanagement.com.

HMA Medicaid Roundup

Arizona

Arizona Awards Medicaid Managed Care Contracts. On March 5, 2018, Arizona awarded the Arizona Health Care Cost Containment System (AHCCCS) Complete Care Integrated Services Medicaid managed care contracts. The seven managed care organizations are: Banner-University Family Care Plan, Care1st Health Plan Arizona (WellCare), Health Choice Arizona (Steward Health Choice Arizona), Health Net Access (Centene), Magellan Complete Care of Arizona, Mercy Care, and UnitedHealthcare Community Plan. Contracts were awarded for the Central, South, and North geographic service areas, and plans are expected to collectively enroll roughly 1.5 million Medicaid members. Contracts are slated to begin October 1, 2018. Read More

Arkansas

CMS Approves Arkansas Medicaid Work Requirements Waiver. *Arkansas Online* reported on March 5, 2018, that the Centers for Medicare & Medicaid Services (CMS) approved Arkansas' Medicaid waiver that implements Medicaid work requirements. The waiver will affect 39,000 non-disabled, childless adults aged 19 to 49. Originally, Arkansas was also seeking to reduce Medicaid eligibility to the poverty level, which would have dropped enrollment by 62,998 individuals. The Arkansas Department of Human Services predicted it would have saved $307 million from reduced eligibility. However, CMS did not approve this. The state expects to save $49.4 million from the work requirements. Read More

California

UC Davis Medical Center Expands Free Genomic Testing for Medi-Cal Members. The *Sacramento Bee* reported on March 1, 2018, that the University of California Davis Medical Center is expanding its free genomic testing program for Medi-Cal families. A two-year, $50,000 grant will help cover the cost of the testing to help diagnose rare genetic disorders. Currently, Medi-Cal provides limited access to genetic testing. Read More

California Individual Market to See Enrollment Fall by 378,000, Study Says. *The Los Angeles Times* reported on March 1, 2018, that repealing the individual mandate is expected to reduce enrollment in the California individual insurance market by 378,000, according to a *Health Affairs* study. Of these, 250,000 have insurance through Covered California, the state's Affordable Care Act Exchange. Premiums are expected to rise 7 percent more than expected. Read More

Florida

Florida Senate Drops Medicaid MCO Rate Cuts from Budget. *News Service Florida* reported on March 1, 2018, that the Florida Senate has removed the Medicaid managed care plan rate cuts from the state's proposed fiscal 2019 budget. The cuts of as much as $230 million were met with opposition from the House. The Senate did keep its proposal to cut $8 million from the Healthy Start Program, which serves 6,600 high-risk pregnant women and infants statewide. The Senate and House conference committee has until March 2 to resolve budget differences. Read More

Hawaii

Hawaii Awards Community Care Services Contract to Ohana Health Plan. Ohana Health Plan, a WellCare company, announced on March 6, 2018, that it has been awarded a contract with Hawaii's Department of Human Services' Med-QUEST Division to provide Community Care Services (CSS). The Community Care Services program offers social services, connecting behavioral health resources, housing, employment and transportation to approximately 5,200 Medicaid-eligible adults in Hawaii with severe mental illnesses. The program is expected to begin on July 1, 2018, under a two-year contract. Ohana has held the contract since 2013. Read More

Illinois

Legislature Approves Bill to Revamp Medicaid Hospital Assessment. The *New Haven Register/Associated Press* reported on February 28, 2018, that the Illinois legislature approved a plan to update the state's hospital assessment program and redistribute Medicaid payments based on where services are provided. The current assessment program ends on June 30, 2018. Governor Bruce Rauner is expected to sign the bill. Read More

Louisiana

House Passes Medicaid Bill That Recommends Work, But Doesn't Require It. *NOLA.com/The Times-Picayune* reported on March 2, 2018, that the Louisiana House passed a bill recommending that able-bodied individuals on Medicaid find work, but adding no one would lose coverage for refusing. The House approved a separate bill that would require the Department of Health to verify Medicaid recipient household incomes if they were 10 percent above the upper income threshold. Read More

Massachusetts

Massachusetts Providers Expect Confusion as State Rolls Out ACO Networks. *The Boston Globe* reported on March 1, 2018, that Massachusetts health care providers expect confusion among Medicaid patients as the state begins to roll out new Accountable Care Organization networks. Members assigned to an ACO have until May 31 to switch before they are locked in for nine months. The changes are expected to impact more than 800,000 Medicaid recipients and are designed to better manage patient care, reimburse providers based on quality, and to address social determinants of health. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Quality Performance Results Published for New Jersey Nursing Facilities. The New Jersey Department of Human Services released the performance metrics for all nursing facilities in 2016 and the first three quarters of 2017 on long-stay residents for the following five measures:

1. Pressure ulcer
2. Physically restrained
3. Falls with major injury
4. Flu vaccine
5. Antipsychotic medication use

These measures are part of the CMS Minimum Data Set 3.0 (MDS 3.0) for clinical assessment of residents in nursing facilities. The report includes the statewide average for each measure and the individual nursing facility performance rates. Read More

New Jersey MLTSS Program Implements Nursing Facility Quality Metrics for 'Any Willing Quality Provider' Initiative. The New Jersey Department of Human Services (DHS) Medicaid Managed Long-Term Services and Supports (MLTSS) Steering Committee's Quality Workgroup is rolling out a multi-year Any Willing Quality Provider (AWQP) initiative that will distribute a "pre-baseline" data set to nursing facilities to inform them about their performance on five quality metrics. DHS will collect and distribute the data bi-annually to help nursing facilities design and implement quality improvement plans. Ultimately, there will be seven performance measures used as the basis for managed care organizations to determine if nursing facility providers are eligible to enter into MLTSS contracts. Nursing facilities must meet at least four out of seven measures to be designated an AWQP. Measurement specifications are available in Appendix A of a letter that was sent to nursing facilities in February 2018, available here.

New Mexico

Governor Signs Bill Outlawing "Step Therapy". The *Tribune New Service/Governing* reported on March 5, 2018, that New Mexico Governor Susana Martinez has signed a bill outlawing the insurance company practice known as "step therapy," which requires patients to use less expensive medication before a more expensive one. The legislation passed without opposition in the state Senate or House. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Consumer Groups Express Concern about Centene Acquisition of Fidelis Care. Four leading statewide consumer advocacy groups – Consumers Union, Health Care for All New York, Medicaid Matters New York, and New Yorkers for Accessible Health Coverage – released a statement expressing concerns about the proposed acquisition of the nonprofit Fidelis Care health plan by Centene Corporation, a national for-profit insurance company. The major concerns are:

1) Fidelis Care's charitable health care assets should be protected for the public's benefit, and remain dedicated to a social mission of expanding health insurance coverage and care for the medically underserved.

2) The state must provide fair, impartial, and comprehensive oversight of any insurance conversions or acquisitions to ensure they are in the public interest.

3) Shortfalls in health care funding for Medicaid and other public health care programs are an urgent public matter. The state needs long-term funding streams for state health care programs rather than relying on one-time conversion assets.

The consumer groups argue that all aspects of the Centene-Fidelis Care transaction need to be clearly understood and spelled out before making any decision as to whether the sale is in the public interest. Read More

New York Health + Hospitals President Outlines Strategy for Addressing Financial Challenges. Dr. Mitchell Katz, the newly appointed President and CEO of the New York Health + Hospitals (H + H), outlined his plans for addressing the system's ongoing financial challenges. H + H, the largest public hospital system in the country, is facing a $1.6 billion deficit in 2019, projected to rise to $1.8 billion in 2020. In a presentation to the City Council, Katz articulated his priorities for the system and identified seven actions the system will take to improve its financial viability. His priorities are to invigorate and expand primary care, to improve access to needed specialty care, and to bring fiscal solvency to H + H. Action steps include the following:

- Reduce administrative expenses by eliminating consultants and decreasing administrative positions
- Bill insurance for insured patients
- Code and document effectively
- Stop sending away paying patients
- Invest resources into hiring positions that are revenue generating
- Provide specialized services that are well reimbursed
- Convert uninsured people who qualify for insurance to be insured

Read More

New York Announces Care Coordination Organizations for People with Intellectual/Developmental Disabilities. The New York Office for People With Developmental Disabilities (OPWDD) is implementing People First Care Coordination, a new approach to coordinating services for people with intellectual and developmental disabilities in New York State. The new care coordination model is called Health Home Care Management. It will span multiple service systems, including the OPWDD system, and incorporate physical health, behavioral health and life support services. Care Coordination Organizations (CCOs), based on a health home model, are being established by groups of OPWDD providers in each region across the state to provide multi-agency care coordination. Six new CCOs have been identified to begin providing care management services July 1, 2018:

- Advance Care Alliance
- Care Design NY
- LIFEPlan
- Person Centered Services
- Prime Care Coordination
- Tri-County Care

The Medicaid Service Coordination (MSC) program which is currently used to coordinate developmental disabilities services will be replaced by this new service. The CCOs will be staffed by care managers, and to ensure the continuity of care, in many cases the new care managers will be current Medicaid service coordinators who will receive additional training for this new role.

OPWDD envisions CCOs affiliating with managed care organizations, ultimately shifting to a mandatory Medicaid managed care system reflecting the structure of most of NY's Medicaid program. They expect the shift to a mandatory managed care system will happen gradually, with a five-year transition planned. Read More

Excellus BlueCross BlueShield Increases Profits. *The Syracuse Post-Standard* reported on February 28, 2018, that Excellus BlueCross BlueShield, an upstate insurance plan that participates in NY's publicly sponsored coverage programs, nearly doubled its profits in 2017. Excellus generated net income, or profit, of $182.3 million last year, up from $99.5 million in 2016, according to a report filed today with the state. The insurer's net income was 3.2 percent of the $5.6 billion it collected in revenue, the highest net income percentage since 2011. Read More

North Carolina

North Carolina Releases Enrollment Broker Services RFP. The North Carolina Department of Health and Human Services released the Medicaid Enrollment Broker Services request for proposals (RFP) on March 2, 2018. North Carolina is seeking to transition its Medicaid program from a fee-for-service model to a managed care model. Most Medicaid and NC Health Choice populations will be mandatorily enrolled in Prepaid Health Plans (PHPs), with the exception of duals, PACE, medically needy, Health Insurance Premium Payment (HIPP) beneficiaries, and beneficiaries only eligible for emergency services. The transition of beneficiaries with a serious mental illness, a serious emotional disturbance, a substance use disorder, or an intellectual/developmental disability (IDD) will be delayed until the launch of Behavioral Health and I/DD Tailored Plans. North Carolina estimates 2.1 million individuals will be eligible for managed care. The enrollment broker will support the state's transformation of Medicaid through choice counseling, call center capabilities, outreach, and other enrollment broker services. Proposals are due April 13, 2018. Contracts will be awarded May 31, 2018.

Atrium Health Drops Merger with UNC Health Care. *Modern Healthcare* reported on March 2, 2018, that Atrium Health, previously known as Carolinas HealthCare System, suspended merger negotiations with UNC Health Care after criticism from state officials over potential price increases. Atrium is the largest hospital chain in North Carolina. Read More

Ohio

Medicaid Work Requirements Proposal Draws Criticism. The *Columbus Dispatch* reported on March 1, 2018, that advocates, providers, and others testified against Ohio Medicaid's proposal to implement work requirements for non-disabled adults enrolled in Medicaid at a public hearing in Columbus. Testimony included complaints the new requirements would create undue burden on county agencies, force many vulnerable individuals to lose Medicaid by creating additional obstacles to accessing care, and jeopardize lives. Read More

Oklahoma

Governor Issues Executive Order for Medicaid Work Requirements. *Fox 25 News* reported on March 6, 2018, that Oklahoma Governor Mary Fallin issued an executive order to develop Medicaid work requirements. The order instructs the Oklahoma Health Care Authority to file the waiver and state plan amendments within the next six months. All Medicaid beneficiaries will be required to work with the exception of individuals who are under the age of 19 or over 64, physically or mentally unfit for employment, pregnant, caretakers, and those in a drug or alcohol addiction treatment and program. Read More

Pennsylvania

Pennsylvania Streamlines Access to MAT for Opioid Use Disorder. Pennsylvania Governor Tom Wolf announced on March 1, 2018, that the state's Medicaid program will no longer require prior authorization to cover medication-assisted treatment (MAT) for opioid use disorder. MAT, a Food and Drug Administration (FDA)-approved treatment, was previously subject to prior authorization rules could delay access during a critical treatment window. The administration will work with Medicaid managed care organizations to fully implement the new policy within 60 days. The announcement comes halfway through a three-month public health emergency declaration, which allows government officials to temporarily suspend some regulations to help fight Pennsylvania's opioid epidemic. Read More

South Carolina

South Carolina Awards Multi-Vendor Integrator Award to Cognosante. South Carolina announced on February 23, 2018, that it has awarded a Multi-Vendor Integrator contract to Cognosante, effective March 6, 2018, through March 5, 2023. Cognosante will perform project management oversight of third-party solutions providers as they design, develop, and implement solutions to replace the state's Medicaid Management Information System with a new Medicaid Enterprise System.

Virginia

Governor Warns House Lawmakers to Fund Medicaid Expansion or He Will Propose Budget Amendment. *The Washington Post* reported on March 2, 2018, that Virginia Governor Ralph Northam told state budget negotiators to include Medicaid expansion in spending plans or he would add the expansion as a budget amendment. Northam, a Democrat, made a campaign promise to expand Medicaid to approximately 400,000 low-income adults in Virginia. He needs to win over two Republicans to pass a budget with expansion. Read More

West Virginia

Medicaid Budget Concerns Arise as Raises Teachers' Pay to End Strike. *The New York Times* reported on March 6, 2018, that Medicaid funding could be at risk after West Virginia Governor James Justice signed a bill increasing state workers' and teachers' pay by 5 percent following a statewide teachers' strike. According to West Virginia Senate Finance Chairman Craig Blair, the pay raises could be funded through cuts to Medicaid, among other areas; however, the Governor stated that the Medicaid budget would not be cut. The strike was in response to low pay and rising health insurance costs. The raises are expected to cost the state treasury approximately $110 million a year. Read More

Wisconsin

Governor Signs Exchange Reinsurance Bill. *The Hill* reported on February 28, 2018, that Wisconsin Governor Scott Walker signed legislation to establish a $200 million reinsurance fund aimed at stabilizing the state's Exchange market. The bill authorizes the state to apply for a federal 1332 waiver to offer the reinsurance program, which would cover up to 80 percent of medical claims costing between $50,000 and $250,000. Read More

National

White House Proposes ACA 'Relief Provisions.' *Politico* reported on March 6, 2018, that the Trump administration has proposed several conservative policy changes to the Affordable Care Act marketplaces in exchange for stabilizing them, according to a leaked document obtained by *Politico*. These include allowing short-term, limited-duration health plans, expanding health savings accounts (HSAs), and modifying age-rating requirements to allow premium variation up to 5:1. The administration will support cost-sharing reduction (CSR) payments after 2018. Read More

HHS Secretary Says Changes Coming to Provider Reimbursements. *CQ News* reported on March 5, 2018, that Health and Human Services (HHS) Secretary Alex Azar announced that the Trump administration will overhaul the way the federal government reimburses providers. In an effort to improve technology and transparency, HHS will make changes to interoperability, price transparency, and care delivery through Medicare and Medicaid, and remove regulations that hinder private innovation. Azar hinted at changes to Medicare's fee-for-service payment schedule and value-based changes through pilot programs from the Center for Medicare and Medicaid Innovation (CMMI). Read More

Federal Judge Annuls CMS Hospital Medicaid Reimbursement Rule. *Chron* reported on March 5, 2018, that U.S. District Judge Emmet Sullivan annulled a new rule from the Centers for Medicare & Medicaid Services (CMS) that allowed CMS to count private insurance payments against hospitals' Medicaid reimbursement amounts, known by hospitals as "double dipping." CMS is expected to appeal the ruling. Texas Children's Hospital was the first hospital to contest the double dipping practice. In 2014, Sullivan granted an injunction in favor of hospitals that were affected, but CMS codified that reimbursement change into a rule and denied funding to hospitals. Read More

Grassley Introduces 340B Drug Discount Transparency Bill. *Modern Healthcare* reported on March 2, 2018, that Senator Chuck Grassley (R-IA) introduced a bill that would require hospitals to report prices paid to manufacturers for drugs in the 340B drug discount program. Meanwhile, the Senate health committee is expected to hold hearings on the 340B program this spring, following hearings later this month by the House Energy & Commerce Committee. Other lawmakers critical of the 340B program have introduced legislation to limit the program. Read More

Public Skeptical of Medicaid Work Requirements, Lifetime Limits, Says Kaiser Survey. *Modern Healthcare* reported on March 1, 2018, that a Kaiser Family Foundation survey found that the public is skeptical of Medicaid work requirements and lifetime limits. Among those polled, 41 percent said the goal of work requirements is to reduce government spending, while 33 percent said it was to reduce poverty. Two thirds said that Medicaid should be available to low-income people as long as they qualify. Overall, 74 percent held favorable views of Medicaid. Read More

Few Medicaid Beneficiaries Are Paying Required Premiums. *Kaiser Health News* reported on March 1, 2018, that Medicaid enrollees are largely opting not to pay Medicaid premiums. In Arkansas, for example, only 20 percent of Medicaid recipients who earn above the poverty level paid the required $13 monthly premium. In Indiana, Iowa, Michigan, and Montana, tens of thousands of individuals are also foregoing payment. Beneficiaries are also failing to meet other conditions, such as voluntary health risk assessments. Read More

Industry News

HCR ManorCare to File for Bankruptcy, Transfer Ownership to Quality Care Properties. *Reuters* reported on March 2, 2018, the real estate investment trust Quality Care Properties will take control of nursing home operator HCR ManorCare, which is filing for Chapter 11 bankruptcy. In exchange for full ownership, Quality Care will forgive back rent owed by ManorCare. Quality Care expects to close the deal in the third quarter of 2018. Read More

Addus HomeCare to Acquire Ambercare. Addus HomeCare reported on February 28, 2018, that it had signed a definitive agreement to acquire New Mexico-based Ambercare Corporation for $40 million. Ambercare provides personal care, hospice, and home health services to 2,600 individuals across New Mexico. The transaction is expected to close in the second quarter of 2018. Read More

Uber Launches Transportation Service for Patients. *Axios* reported on March 1, 2018, that Uber has launched a non-emergency transportation service that allow hospitals, clinics, nursing homes and other health care organizations to help patients schedule rides to appointments up to 30 days in advance. Health care providers would cover the cost of the ride. Hospital systems that have piloted the Uber service include MedStar Health, NYU Langone Health, LifeBridge Health and Renown Health. Read More

Centene to Acquire Community Medical Group. Centene announced on March 5, 2018, that it will acquire Florida-based Community Medical Group, a primary care provider serving more than 70,000 Medicaid, Medicare Advantage, and Exchange members. The transaction is expected to close in the first quarter of 2018. Read More

Partners Healthcare Adds Lifespan to Merger Talks with Care New England. *Modern Healthcare* reported on February 28, 2018, that Partners Healthcare added Lifespan to its merger talks with Care New England as part of a plan to expand into Rhode Island. Lifespan owns three hospitals in the state. Read More

Tenet Discloses Investigation into Detroit Medical Center. *Modern Healthcare* reported on February 28, 2018, that Detroit Medical Center, owned by Tenet Healthcare Corp., is under federal investigation for possible violations of anti-kickback, false claims, and self-referral laws. Tenet said it has hired an outside law firm to review the company's compliance with reporting obligations. Last July, DMC laid off 14 advanced practice nurses and physician assistants, prompting inquiries by the U.S. attorney's office. A *Crain's* article questioned whether the lay-offs were related to potential violations of federal laws that regulate various aspects of hospital billing. Read More

Simplura Acquires SarahCare of Jenkintown. One Equity Partners announced on February 23, 2018, that portfolio company Simplura has acquired SarahCare of Jenkintown, Pennsylvania, an independent home and community health company. SarahCare offers adult day care, companion services, hospice, palliative care and other in-home health services. The financial terms of the transaction were not disclosed. 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
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 22, 2018	Washington FIMC (Remaining Counties)	Contract Awards	~1,600,000
June 2018	Puerto Rico	Contract Awards	~1,300,000
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

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