HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in Health Policy

October 7, 2020

RFP CALENDAR

HMA News

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THIS WEEK

IN FOCUS

OHIO RELEASES MEDICAID MANAGED CARE RFA

This week, our *In Focus* section reviews the Ohio Medicaid Managed Care request for applications (RFA) released by the Ohio Department of Medicaid (ODM) on September 30, 2020. The RFA follows the release of two requests for information (RFIs) in June 2019 and February 2020, soliciting feedback from

individuals, providers, and interested bidders to help design a new Medicaid managed care program. Ohio will award contracts, worth over $11 billion annually, to no more than five managed care organizations (MCOs) in each of the state's three regions (Central/Southeast Region, Northeast Region, and West Region), with implementation beginning January 5, 2022. The procurement will not include the MyCare Ohio dual demonstration.

Ohio Medicaid Managed Care Program

The selected MCOs will be part of a re-imagined Medicaid managed care program that unbundles the current program and will include a new single, statewide prepaid inpatient health plan, the OhioRISE Plan, that will provide behavioral health services to children with serious/complex behavioral health needs that are at risk or in foster care; and a single pharmacy benefit manager (SPBM) responsible for providing and managing pharmacy benefits for all Medicaid eligibles. Together, the MCOs, the OhioRISE Plan, and the SPBM will coordinate and collaborate to achieve a seamless service delivery system for members, providers, and system partners. ODM will also centralize claims submission, prior authorization submission, through a single fiscal intermediary (FI) for non-pharmacy claims and authorization requests, which the FI will triage to the MCOs for adjudication. Additionally, ODM is centralizing provider credentialing and re-credentialing to minimize the provider burden of credentialing with multiple MCOs.

MCOs will provide physical health services to all enrollees and will provide behavioral health services to all enrollees except for behavioral health to children in the OhioRISE Plan. MCOs will be required to use population health management principles to address health inequities and disparities, including removing barriers to care through the use of alternative sites and providers of care, such as telehealth and community-based providers; providing preventive, health promotion, and wellness services; connecting with communities; ensuring health equity in all policies, practices, and operations; and recognizing the significance of behavioral health needs to overall health and wellbeing.

Evaluation

The evaluation process consists of four phases:

- Phase I: Review of Mandatory Qualifications
- Phase II: Review of Responses to Application Questions
- Phase III: Oral Presentation
- Phase IV: Selection

MCOs can achieve a total of 1,100 points. Those with the highest total scores will be recommended for selection.

Phase	Possible Points
Mandatory Qualifications	**Pass/Fail**
Application Questions	**1,000**
Qualifications & Experience	85
Population Health	395
Benefits & Service Delivery	340
Operational Excellence & Accountability	180
Oral Presentation	**100**
Total	**1,100**

Timeline

Proposals are due November 20 with awards expected January 25, 2021. The contracts will run from January 5, 2022, through June 30, 2024, with optional renewals each fiscal year afterwards.

RFP Activity	Date
RFP Issued	September 30, 2020
Proposals Due	November 20, 2020
Awards	January 25, 2021
Implementation	January 5, 2022

Current Market

Current incumbents are Centene/Buckeye Health Plan, CareSource, Molina, Paramount Advantage, and UnitedHealthcare. The market is largely dominated by CareSource, with over half the market share based on covered lives.

Enrollment in Ohio Medicaid by Plan, 2019, August 2020		
Plan	2019	Aug-20
Buckeye/Centene	**288,133**	**349,103**
% of total	*13.9%*	*15.1%*
CareSource	**1,083,694**	**1,184,362**
% of total	*52.3%*	*51.2%*
Molina	**243,271**	**275,820**
% of total	*11.7%*	*11.9%*
Paramount Advantage	**199,258**	**205,249**
% of total	*9.6%*	*8.9%*
UnitedHealthcare	**258,002**	**298,002**
% of total	*12.4%*	*12.9%*
Total Ohio	**2,072,358**	**2,312,536**

Note: Starting in 2020, Ohio changed Medicaid managed care enrollment data sources. The new data now combines ABD and Dual. As a result, these numbers were excluded from plan totals, bringing the total enrollment below the actual 2.45 million.

Source: OH Dept. of Medicaid, HMA

Link to Ohio RFA

HMA Medicaid Roundup

District of Columbia

District of Columbia Implements New Medicaid Contracts, Begins Transition of Individuals With Complex Care Needs to Managed Care. The District of Columbia Department of Health Care Finance (DHCF) announced on October 2, 2020, the implementation of its new Medicaid managed care contracts, which transitions current fee-for-service members with complex care needs to Medicaid managed care. These enrollees will be distributed to the recently awarded health plans: AmeriHealth Caritas, CareFirst BlueCross BlueShield, and MedStar Family Choice. The 90-day transition period began on October 1 and extends through December 31, 2020. Read More

Kansas

Kansas Awards New Contract to Conduent to Handle Medicaid Applications. *The Associated Press/KSN* reported on October 5, 2020, that the Kansas Department of Health and Environment (KDHE) awarded a contract to New Jersey-based Conduent to handle the state's Medicaid applications, replacing Maximus amid years of complaints about backlogs, mishandling of applications, and other problems. Conduent signed a six-year contract, effective 2021, worth nearly $135 million. Read More

Kentucky

Kentucky to Relaunch State Exchange for 2022 Coverage. *Modern Healthcare* reported on October 5, 2020, that Kentucky Governor Andy Beshear announced plans to relaunch the state-based kynect health insurance Exchange, with open enrollment scheduled to begin 2021 and implementation scheduled for January 2022. Individuals will be able to request health coverage and other support, including job training, food assistance, child care, senior care, and substance abuse recovery. Kynect was dismantled by former governor Matt Bevin. Read More

Missouri

Missouri MCOs Form Collaborative Partnership Branded Healthy Blue. Anthem, Inc. subsidiary Missouri Care and Blue Cross Blue Shield of Kansas City, the largest not-for-profit health plan in Missouri, announced on October 1, 2020, their partnership to collaboratively serve Missouri's Medicaid program under the new name Healthy Blue, effective January 1, 2021. The new collaboration will not affect Medicaid coverage for the approximately 263,000 Missouri Care members. Read More

New Hampshire

New Hampshire Hospitals Could See Losses of $300 Million by Year End Due to COVID-19. *InDepthNH.org* reported on September 29, 2020, that New Hampshire hospitals will likely see "staggering and unsustainable" losses of up to $300 million due to the COVID-19 pandemic, according to Steve Ahnen, president of the New Hampshire Hospital Association, in an update to a state Legislative Advisory Board. Since March, hospitals have seen a $516 million reduction in revenue, which has been offset with over $300 million in federal and state help. Read More

New York

HMA Roundup – Cara Henley (Email Cara)

Governor Announces Final Regulations on Mental Health, SUD Parity Compliance. New York Governor Andrew Cuomo released on October 1, 2020, final regulations requiring health insurers to provide comparable coverage for benefits to treat mental health and substance use disorders (SUD). The new regulations were proposed by the New York State Department of Financial Services and Department of Health and were adopted following a 60 day public comment period. The new regulations will require parity compliance programs to locate discrepancies in coverage of services for the treatment of mental health conditions and SUD and ensure appropriate identification and remediation of improper practices. The final regulations will be effective December 29, 2020. Read More

New York Medicaid Pharmacy Benefit Carve-Out Could Cost State $1.5 Billion Over Five Years, Report Finds. *Crain's New York* reported on October 1, 2020, that New York's plan to carve the Medicaid pharmacy benefit out of managed care into fee-for-service could cost the state an estimated $154 million during the first year of implementation and $1.5 billion over five years, according to a report recently released by the New York Health Plan Association and the Coalition of New York State Public Health Plans. The state Department of Health savings projections did not account for key components such as reductions in premium tax receipts and increased state administrative costs, the report claims. Since transitioning to a carve-in model in 2011, net costs per prescription for all New York Medicaid prescriptions decreased by 8.9 percent. Read More

North Carolina

North Carolina Awards Electronic Visit Verification Contract to Sandata Technologies. On October 2, 2020, the North Carolina Department of Health and Human Services (DHHS) announced that it has awarded the electronic visit verification (EVV) contract to Sandata Technologies. Implementation is scheduled for January 2021. DHHS will conduct stakeholder engagement discussions to provide the details of the implementation plan for each of the affected home and community-based service programs subject to the EVV requirements. Read More

Oregon

Oregon Providers, CCO Clash Over Pricing. *The Lund Report* reported on October 3, 2020, that Medicaid coordinated care organization (CCO) Centene/Trillium Community Health Plan was accused by providers of a "bait-and-switch" tactic in order to demonstrate to the Oregon Health Authority (OHA) that it has a network of providers large enough to serve the Portland area. According to an anonymous provider, Trillium offered to negotiate pricing after the provider contracts were signed, but then only offered fee-for-service rates which are markedly lower than those offered by Health Share, the only other insurer in the Portland area. Trillium was one of 15 CCOs awarded a contract in 2019. The state originally awarded Trillium a contract to serve Douglas, Lane, and Linn counties then approved an application for them to expand into the Portland-area counties beginning September 2020. Trillium must submit a corrective action plan addressing Medicaid provider network capacity to state regulators by October 15. Read More

Oregon Awards $160 Million to Medicaid CCOs for Meeting Quality Targets. *The Lund Report* reported on October 4, 2020, that the Oregon Health Authority distributed $160 million to the state's 15 Medicaid coordinated care organizations (CCOs) operating in the state last year for meeting specific quality targets. The best-performing CCO was PrimaryHealth of Josephine County, which failed to win a new Medicaid contract. Oregon plans to increase quality pool distribution rewards to 4.5 percent of total funding for Medicaid insurers and to require them to meet health equity goals in 2021. Read More

Pennsylvania

Pennsylvania Medicaid Enrollment up 7.4 Percent in August. The Pennsylvania Department of Human Services (DHS) released on September 29, 2020, updated Medicaid enrollment data. Medicaid enrollment statewide has increased by 210,576, or 7.4 percent, to 3,042,139 from February to August. Overall, enrollment in Medicaid is growing and DHS continues to anticipate potential surges in applications because of decreased unemployment benefits and impacts from increased housing insecurity. Read More

Pennsylvania Providers Seek Merger Despite FTC Antitrust Lawsuit. *The Philadelphia Inquirer* reported on October 5, 2020, that the Federal Trade Commission (FTC) publicly released federal court testimony from its antitrust lawsuit against Pennsylvania-based Medicaid provider Thomas Jefferson University, which is seeking to acquire Einstein Healthcare Network. The FTC argues that Jefferson will raise prices charged under private health plans after acquiring Einstein, allegations which Jefferson chief executive Stephen K. Klaso disputes. Einstein chief executive Barry Freedman testified that if the FTC blocks the merger it will be much more difficult to find another acquirer due to financial damages from the pandemic. Read More

Texas

Texas Medicaid Expansion Could Cover Nearly 1 Million Individuals, Bring in $5.4 Billion Federal Dollars, Study Finds. *The Houston Chronicle* reported on September 30, 2020, that Medicaid expansion in Texas could result in $5.4 billion additional federal dollars to the state and enroll about 954,000 more individuals, according to a study by Texas A&M University. The study estimates that about 1.2 million individuals would be eligible under traditional expansion, a move that could drive down the state's 18.4 percent uninsured rate as of year-end 2019. Medical leaders and health policy experts support Medicaid expansion, especially during the COVID-19 pandemic, yet Governor Greg Abbott has long opposed it. Read More

National

Trump Ends COVID-19 Relief Talks Until After November Election. *Politico* reported on October 6, 2020, that President Trump announced he is ending negotiations with Democrats on a COVID-19 relief package until after the November election. Read More

CMS Gives Hospitals 14 Weeks to Comply With COVID-19, Influenza Reporting Requirements. *Modern Healthcare* reported on October 6, 2020, that the Centers for Medicare & Medicaid Services (CMS) will issue notices to approximately 6,000 hospitals currently participating in Medicare and Medicaid stating that they have 14 weeks to comply with COVID-19 and influenza reporting requirements or risk losing reimbursements. The White House Coronavirus Task Force notes that about 86 percent of hospitals are submitting the required information daily, and CMS intends to publicly publish how every hospital is complying with the data requirements starting October 21. Read More

HHS to Distribute $20 Billion in New Provider Relief Funds. *Modern Healthcare* reported on October 1, 2020, that the U.S. Department of Health and Human Services (HHS) announced it will begin accepting and processing applications for $20 billion in new provider relief grants from October 5 through November 6. To qualify, providers must supply revenue and financial data with their application. Providers who received previously allocated grants worth 2 percent of their annual revenue may be eligible for an add-on payment. HHS has already distributed $100 billion out of the $175 billion that Congress appropriated for the relief fund. Read More

Medicaid Expansion Beneficiaries Likely to Become Uninsured if ACA Repealed. The Kaiser Family Foundation reported on October 1, 2020, that if the Supreme Court overturned the Affordable Care Act (ACA), those enrolled in the Medicaid expansion eligibility group would lose their federal entitlement to coverage and states would be stripped of their 90 percent federal matching dollars for their Medicaid costs. States that wish to continue to cover this group would need to either seek waivers from the Department of Health and Human Services (HHS) or finance the coverage themselves without enhanced federal matching funds, which would likely not be possible both due to COVID-19 and state budget constraints. The elimination of the ACA would likely result in an increase in the uninsured rate, a decrease in access to care, and weaker economic outcomes for states. Read More

DOJ Healthcare Fraud Takedown Results in $6 Billion of Charges Against 345 Individuals. *Modern Healthcare* reported on September 30, 2020, that the Department of Justice (DOJ) charged 345 individuals, including doctors, nurses, telehealth executives, durable medical equipment owners, and those connected to genetic testing laboratories and pharmacies across 51 judicial districts, with submitting $6 billion in fraudulent claims to federal healthcare programs and private insurers for telehealth consultations and substance abuse treatment. As the largest healthcare fraud takedown in DOJ history, the indictment includes $4.5 billion connected to telehealth, $845 million connected to substance abuse treatment facilities, and $806 million connected to illegal opioid distribution schemes across the country. Read More

Medicaid, CHIP Enrollment Has Grown to 75 Million Through June. *Modern Healthcare* reported on September 30, 2020, that Medicaid and Children's Health Insurance Program (CHIP) enrollment nationwide grew to nearly 75 million in June, a 5.7 percent increase since March. Enrollment increases are associated with states pausing Medicaid eligibility redetermination processes. Read More

House Committee Finds Pharmaceutical Companies Raised Drug Prices to Boost Profits. *Politico* reported on September 30, 2020, that pharmaceutical companies exponentially raised drug prices to boost profits and bonuses, according to a House Oversight and Reform Committee investigation of a dozen companies over an 18-month period. Costs, such as rebates that drugmakers pay to pharmacy benefit managers, did not account for the consistently rising drug prices. Currently, Medicare is prohibited from negotiating directly with drug companies to lower prices. Read More

Senate Passes Legislation to Relax Medicare Provider Relief Loans, Delay Medicaid DSH Cuts. *Modern Healthcare* reported on September 30, 2020, that the Senate passed a stopgap government funding bill that relaxes repayment terms on $100 billion in Medicare Accelerated and Advance Payment Program loans and delays cuts to Medicaid disproportionate-share hospital (DSH) payments until December 11. The legislation would give providers one year after the loans were issued to start repayment. Recoupment rates would also be lowered from its current 100 percent level to 25 percent for the first 11 months of repayment, and 50 percent for the six months afterward. Hospitals would have 29 months to begin paying back funds in full before interest rates, which the bill lowered from 9.6 percent to 4 percent, would apply. The bill awaits the president's signature. Read More

Industry News

Priority Health to Offer Financial Incentives to Providers for Tracking Social Determinants of Health. On October 6, 2020, Michigan-based Priority Health announced plans to offer provider-based incentives for tracking social determinants of health (SDoH) data. The increased reimbursement rates for eligible providers will apply to all Medicare and Medicaid members and begin on January 2021. Read More

Clover Health to Go Public Following Merger with Special Purpose Acquisition Company (SPAC). *Modern Healthcare* reported on October 6, 2020, that Medicare Advantage startup Clover Health is planning to go public following the closure of its merger with Social Capital Hedosophia Holdings Corp. III, a special purpose acquisition company. The deal, which values Clover at $3.7 billion, is expected to deliver up to $1.2 billion of gross proceeds of which Clover will receive up to $728 million. Clover will continue to be led by chief executive Vivek Garipalli and president Andrew Toy, while founder and chief executive of Social Capital Hedosophia Chamath Palihapitiya will act as senior advisor. Clover currently serves more than 57,000 members in 34 counties across seven states, and plans to expand into an additional seven counties and an eighth state in 2021. Read More

Pathways Completes Acquisition of 3 Community Intervention Services Companies. Behavioral and mental health services provider Pathways Health and Community Support, LLC announced on October 6, 2020, that it completed its acquisition of three Community Intervention Services (CIS) companies – Access Family Services (AFS), Family Behavioral Resources (FBR) and Autism Education and Research Institute (AERI) – which will operate as one entity (FBR-AERI). The acquisition will expand Pathway's presence in North Carolina and Pennsylvania and introduce new service lines in South Carolina. Read More

Averhealth Acquires Ohio-Based American Court Services. Substance use monitoring and treatment services provider Averhealth announced on October 6, 2020, its acquisition of Ohio-based American Court Services (ACS). With the financial support of Five Arrows Capital Partners, Averhealth's acquisition will ensure continuity of electronic monitoring services as well as drug and alcohol testing services for the clients of ACS and extend Averhealth's footprint in Ohio and and the Great Lakes region. Read More

Centene to Expand Medicare Advantage Plan Offerings in 2021. Centene announced on October 6, 2020, that it plans to expand its Medicare Advantage plan offerings for 2021 to 1,249 counties across 33 states, a 30 percent increase from 2020. Centene will offer 122 new plan designs across 30 states and introduce Medicare Advantage plans in Rhode Island and Vermont. Centene currently serves nearly 1 million Medicare members across the country. Read More

Behavioral Health Group Acquires RI-based Center for Treatment & Recovery. Behavioral Health Group (BHG) announced on October 2, 2020, that it has acquired Rhode Island-based Center for Treatment & Recovery, which will be renamed BHG Pawtucket Treatment Center. BHG operates a network of outpatient opioid treatment and recovery centers, delivering medical and behavioral therapies for individuals with opioid use disorder. With this latest acquisition, BHG now operates 71 locations in 15 states. Read More

Veritas Capital Closes on $5 Billion Acquisition of DXC Technology, Re-Named Gainwell Technology. *CRN* reported on September 16, 2020, that New-York based private equity firm Veritas Capital closed on its $5 billion acquisition of DXC Technology's state and local health and human services business October 1. The business will be re-named Gainwell Technology. Paul Saleh, DXC Technology's executive vice president and chief financial officer, will become chief executive officer of Gainwell. Read More

Arosa+LivHome Launches Emergency Fund for Caregivers, Office Staff. *Home Health Care News* reported on September 30, 2020, that Arosa+LivHome launched the Arosa Grant Circle program, an emergency fund for caregivers and office staff. Employees facing financial hardship can submit a request for a $500 to $1,000 grant. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
October 2020	North Dakota Expansion	RFP Release	19,500
November 2020	Ohio	Proposals Due	2,450,000
Fall 2020	Oklahoma	RFP Release	800,000
Late 2021	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, Santa Clara, San Francisco, San Joaquin, Stanislaus, and Tulare	RFP Release	1,640,000
Late 2021	California GMC - Sacramento, San Diego	RFP Release	1,091,000
Late 2021	California Imperial	RFP Release	75,000
Late 2021	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	RFP Release	286,000
Late 2021	California San Benito	RFP Release	7,600
January 2021	Nevada	RFP Release	465,000
January 1, 2021	Kentucky Rebid	Implementation	1,200,000
January 1, 2021	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2021	Pennsylvania HealthChoices Physical Health	Implementation	2,260,000
January 1, 2021	Washington Integrated Managed Care (Expanded Access)	Implementation	*NA*
January 25, 2021	Ohio	Awards	2,450,000
April 1, 2021	Indiana Hoosier Care Connect ABD	Implementation	90,000
July 1, 2021	North Carolina - Phase 1 & 2	Implementation	1,500,000
January 5, 2022	Ohio	Implementation	2,450,000
Early 2022 – Mid 2022	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, Santa Clara, San Francisco, San Joaquin, Stanislaus, and Tulare	Awards	1,640,000
Early 2022 – Mid 2022	California GMC - Sacramento, San Diego	Awards	1,091,000
Early 2022 – Mid 2022	California Imperial	Awards	75,000
Early 2022 – Mid 2022	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Awards	286,000
Early 2022 – Mid 2022	California San Benito	Awards	7,600
January 2024	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, Santa Clara, San Francisco, San Joaquin, Stanislaus, and Tulare	Implementation	1,640,000
January 2024	California GMC - Sacramento, San Diego	Implementation	1,091,000
January 2024	California Imperial	Implementation	75,000
January 2024	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Implementation	286,000
January 2024	California San Benito	Implementation	7,600

COMPANY ANNOUNCEMENTS

Telligen Enhances Population Health Solutions with MCG Health Partnership

HMA WELCOMES

Doris Tolliver – Senior Consultant

Doris Tolliver is a strategic thinker specializing in racial and ethnic equity, organizational effectiveness, change management, and business strategy development. She has spent her career working to advance the interests of vulnerable populations, serving in programmatic and leadership roles in both the private and public sectors.

Prior to joining HMA, Doris served as the inaugural managing director of Equitable Impact for the Foster America team, focused on transforming life outcomes for vulnerable children. Dedicated to serving those in need, she served as a child welfare consultant for the Child Welfare Strategy Group (CWSG) at the Annie E. Casey Foundation.

She also spent more than a decade in public service at the Indiana Department of Child Services in various leadership roles, including chief of staff and human resources director. While serving as chief of staff she provided operations and policy leadership and transformed the organizational structure and culture to integrate outcomes, technology, and strategic planning at the organization and program levels.

Her child welfare experience is complemented by her work in community service and with educational and training organizations. Through her work experience she has prioritized diversity, equity, and inclusion while providing executive oversight to various organizations.

Doris is an expert in federal and state regulatory compliance and has a strong track record of organizational restructuring and change management. Her background in child welfare, human resources, and law aid her in partnering with cross-sector stakeholders to improve outcomes for children and families.

She earned her Bachelor of Arts degree from the University of California, Davis and holds a Master of Arts degree in human resources management from Webster University.

Doris is a licensed attorney and earned her Juris Doctor from Indiana University, Robert H. McKinney School of Law.

Linda Krish – Senior Consultant

An accomplished healthcare professional and executive, Linda Krish has extensive revenue cycle operations and financial experience as well as vast technical expertise.

During her career, Linda has worked on projects including re-engineering operations for a multi-million-dollar healthcare provider and hospital, having a direct financial impact on the organization. She prides herself on providing clients with positive, transparent communications and operational management improvement skills.

Before joining HMA, she served as senior director in charge of revenue cycle professional and outreach lab billing for a large healthcare system. In this role she successfully improved operational revenue cycle workflows, processes, and systems efficiencies while achieving reductions in processing times and costs and drastically improving cash collections.

A dynamic technical expert, Linda has also held positions overseeing hospital and professional billing, coding, and accounts receivable management for a wide range of clinics, hospitals and skilled nursing facilities. She has the operational experience needed for assessing workflows for process improvement and educating and training staff, physicians, and colleagues to increase productivity and improve services within existing systems.

She previously served as regional executive director overseeing operations and client management for a technology and pharmaceutical distribution company where she focused on and successfully implemented software and practice management solutions for multiple clients.

Linda earned an associate's degree in management from Lakeshore Technical College and has completed coursework toward her bachelor's degree at Silver Lake College and University of Phoenix.

HMA News

HMA Names Douglas Elwell Chief Executive; Charles Milligan Joins Firm as Chief Operating Officer. Health Management Associates (HMA) announced on October 5, 2020, that chief operating officer Douglas (Doug) L. Elwell will assume the role of chief executive, effective November 1. Elwell has been HMA chief operating officer since February. Previously, Elwell served as the Illinois Medicaid director. Charles J. (Chuck) Milligan will join HMA November 1 as the firm's new chief operating officer. Marilynn Y. Evert, HMA's chief executive for the last 11 years, will continue her 21-year career with the firm as vice chairman and senior advisor.

New this week on HMA Information Services (HMAIS):

Medicaid Data

- Nevada Medicaid Managed Care Enrollment is Up 17.6%, Aug-20 Data
- New Jersey Medicaid Managed Care Enrollment is Up 10.5%, Aug-20 Data
- New York CHIP Managed Care Enrollment is Down 1.2%, Aug-20 Data
- New York Medicaid Managed Care Enrollment is Up 9.8%, Aug-20 Data
- Washington Medicaid Managed Care Enrollment is Up 6.9%, Aug-20 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Georgia Et Al. Third-Party Liability Services RFP, Oct-20
- Maryland Medicaid Dental Benefits Administrator RFP, Contract and Related Documents, 2015-20
- Puerto Rico Government Health Plan Medicaid Contracts, 2019
- Texas D-SNP Contracts, 2020-21
- Washington Partnership Access Lines and Psychiatric Consultation Line Carrier Assessment TPA RFI, Oct-20
- New Hampshire Medicaid Care Management Services RFP, Proposals, Awards, and Scoring/Evaluations, 2018-19

Medicaid Program Reports, Data and Updates:

- Alabama Governor's Proposed Budget, FY 2021
- Alaska Medicaid Demographics, Aug-20
- Arizona AHCCCS 1115 Waiver Documents, 2020
- Arizona AHCCCS External Quality Review Annual Reports, 2019
- Arizona Quarterly Progress Reports for Centers for Medicare and Medicaid Services (CMS), 2019-20
- Georgia Budget Update and Amended FY 2021 and FY 2022 Requests Presentation, Aug-20
- Kentucky Home and Community Based (HCB) and Model II (MIIW) Amended 1915c Waiver Applications, Oct-20
- New Jersey Family Care Enrollment by Age, Eligibility Group, and County, 2016-19, Sep-20
- OhioRISE Procurement Update Presentation, Sep-20
- Tennessee Medicaid Managed Care HEDIS/CAHPS Reports, 2015-20
- Tennessee TennCare Annual Reports, FY 2010-19
- Utah Medical Care Advisory Committee Meeting Materials, Sep-20

- Virginia Commonwealth Coordinated Care Plus Data Books and Capitation Rates, 2016-21
- Virginia Medallion 4.0 Rate Reports, 2019-21
- Virginia Medicaid Member Advisory Committee Meeting Materials, Aug-20

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