2017 Medicaid Managed Care Conference

Innovations in Managing Costs & Delivery System Reform – Strategies for Enrollment, Operations, Population Health, Quality Care and Cost Containment in a New Era of Healthcare

October 2 - 3, 2017
Loews Royal Pacific Resort
Orlando, FL

KEY CONGRESS TAKEAWAYS

- Examining Innovative Programs & Trends in Medicaid Managed Care
- Update from Capitol Hill on Medicaid Managed Care – Examining Reform Proposals and State Budgets
- Population Stratification: Targeting and Engaging High-Need, High-Cost Medicaid Members to Improve Quality and Reduce Cost
- Medicaid Member Outreach: Establishing a Unique Incentive Program to Attract and Retain Members
- Strategies to Enhance Member Centric Managed Care through State Agency and Medicaid Health Plan Partnerships
- Utilizing Managed Care to Ensure High Quality, High Value Care for the Medicaid Population
- Managing the Expectation of Lower Cost & Improved Outcomes in Medicaid Managed Care
- Examining the Dual Eligible Demonstration Projects
- Enhancing Payment Design to Incentivize Performance in Medicaid Managed Care
- Transition to Population Health within Medicaid Managed Care
- Implementing Effective Programs to Impact High Utilizers of Medicaid Services
- Quantifying the Population Level Impact of Healthcare Access on Patient Lives within Medicaid Managed Care
- Designing Behavioral Health Interventions within Medicaid Managed Care to Manage Medical Cost Ratio
- Effectively Implementing Evidence-Based Services into Medicaid Managed Care
- Effective Strategies to Integrate Social Determinants in Medicaid Managed Care

ESTEEMED SPEAKING FACULTY

- **David Dzielak, PhD**
  Executive Director
  MISSISSIPPI DIVISION OF MEDICAID
- **Barrie Baker, MD, MBA**
  Chief Medical Officer
  TUFTS HEALTH PUBLIC PLANS
- **Zane Chrisman**
  Deputy Commissioner,
  Regulatory Health Link Division
  ARKANSAS INSURANCE DEPARTMENT
- **Alison Croke, MHA**
  Vice President, Medicare-Medicaid Integration
  NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND
- **Deb Florio**
  Deputy Director, Medicaid & CHIP
  STATE OF RHODE ISLAND
- **SreyRam Kuy, MD, MHS, FACS**
  Chief Medical Officer, Medicaid
  LOUISIANA DEPARTMENT OF HEALTH
- **Taft Parsons, III, MD**
  Chief Medical Officer
  MOLINA HEALTHCARE OF MICHIGAN
- **Stephanie Bates**
  Assistant Director,
  Division of Program Quality & Outcomes
  KENTUCKY DEPARTMENT FOR MEDICAID SERVICES
- **Frances Martini, RN, BSN, MBA**
  Director, Government Clinical Programs
  BLUECARE TENNESSEE
- **Rick Gordon**
  Associate Vice President, Medicare
  VIRGINIA PREMIER HEALTH PLAN
- **Mike Randol**
  State Medicaid Director
  Director, Division of Healthcare Finance
  KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT
- **Jill Bell**
  Vice President &
  Chief Marketing/Communications Officer
  PASSPORT HEALTH PLAN
- **Patty Byrnes**
  Director, Government Relations – Federal
  AMERIHEALTH CARITAS
- **Preston Cody**
  Assistant Administrator, Behavioral Health
  WASHINGTON STATE HEALTH CARE AUTHORITY
- **Dena Stoner**
  Senior Policy Advisor
  TEXAS DEPARTMENT OF STATE HEALTH SERVICES
- **Rep. Kionne McGhee**
  Representative, District 117
  FLORIDA HOUSE OF REPRESENTATIVES
- **Jay Ludlam**
  Director, MO HealthNet Division
  MISSOURI DEPARTMENT OF SOCIAL SERVICES
- **Jason Silva, JD, PMP**
  Senior Consultant
  HEALTH MANAGEMENT ASSOCIATES
- **Shawn Shuman**
  Director, Clinical Programs
  UPMC HEALTH PLAN

Exhibitor: Mediware

MAIN CONFERENCE WORKSHOP SESSION

Navigating the Medicaid Landscape in Times of Change:
Examining Potential Modifications that Impact States, Health Plans and MCOs
- HEALTH MANAGEMENT ASSOCIATES

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HOW TO REGISTER:

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The state of U.S. healthcare has experienced significant changes during this past year, particularly regarding Medicaid legislation. Medicaid is on its way toward becoming the nation's largest health insurer. More states are turning to Medicaid Managed Care to control costs and promote innovation in healthcare delivery. New policies and the expansion of coverage has led to extraordinary growth in Medicaid enrollments, and the number of Medicaid managed care enrollments is expected to exceed 61 million by 2021.

Global Media Dynamic's **2017 Medicaid Managed Care Conference** will bring together Medicaid leaders from states, health plans and Managed Care Organizations nationwide, as well as government leaders and policy makers to discuss national trends and initiatives being used across the country to optimize growth potential of this important sector. Join us and be an innovator in healthcare delivery system reform. Through comprehensive case studies, you will learn about innovative programs states and health plans are working on to best serve the growing Medicaid population, key strategies to reduce program costs and better manage utilization of health services, improvements in plan performance, healthcare quality and outcomes, insights on new managed care regulations, and much more.

Register today to reserve your seat at the conference and take advantage of early bird discounts. Call **1-800-646-9581** or register online at **www.2017medicaid.com**.

We look forward to seeing you in Orlando!

Sincerely,

GMD Medicaid Managed Care Team

WHO SHOULD ATTEND

From State & Government Agencies:

Directors and Managers of:

- State Medicaid
- Managed Care
- Health Services/ Healthcare Programs
- Human/Social Services
- Medical Assistance
- Strategic Planning
- Policy Analysis
- Compliance
- Quality Assurance
- Quality Improvement
- Healthcare Financing

From Health Plans & Managed Care Organizations:

Chief Executive Officers, Chief Operating Officers, Chief Financial Officers, Chief Medical Officers, Chief Strategy Officers, and Chief Information Officers

Also, Presidents, Vice Presidents, Directors and Managers of:

- Medicaid
- CHIP
- Long-Term Care
- Behavioral Health
- Sales and Marketing
- Network Development
- Compliance
- Government/State-Sponsored Programs
- Clinical Affairs
- Finance
- Operations

This Program is Also Relevant to:

Chief Executive Officers, Presidents, Vice Presidents, Directors and Managers from organizations providing the following programs/services:

- Purchasing Pools
- Care Management Technology
- Radiology Management
- Third Party Recoveries
- Pharmacy Benefit Administrators
- Risk Adjustment
- Behavioral Health Management
- Health Management Solutions
- Care Management for the Elderly
- Non-Emergency Medical Transportation Management
- Reinsurance Services
- Business Development Management
- Healthcare Administrative Management
- Business Process Organizations
- Revenue Enhancement Services
- Healthcare/Medicaid Consulting

DAY ONE • MONDAY, OCTOBER 2, 2017

7:15 *Conference Registration & Morning Breakfast*

8:00 *Chairperson's Opening Remarks*

8:15 Keynote Presentation on Medicaid Managed Care

This session will provide an update on current trends and policies pertaining Medicaid Managed Care. Please stay tuned for an update on speaker information.

9:00 Rhode Island's Coordinated Care Pilot – Utilizing Managed Care to Ensure High Quality, High Value Care for the Medicaid Population

In Washington, policymakers are debating major philosophical and political questions about the future of healthcare in the U.S. Notably absent from this debate is how to address underlying cost drivers of healthcare. State-based initiatives drive innovations to tackle affordability. Medicaid programs are transforming the way healthcare is paid for and delivered to contain costs and improve health outcomes. This transformation is taking place in partnership with consumers, providers, Managed Care Organizations (MCOs) and other payers. Rhode Island has long used Managed Care as its lever to ensure high quality, high value care for all Medicaid populations.

The MCOs serving RI Medicaid members have ranked in the Top 10 nationally for the past eight years as ranked by U.S. News and World Reports. Charged by Governor Gina Raimondo's 2015 Reinventing Medicaid Initiative to advance both delivery system and payment reform opportunities, it established Accountable Care Organizations to work with and through Medicaid Managed Care Organizations. Through this pilot, which the state launched in Spring 2016, the state certified six Accountable Entities that are responsible for providing and coordinating a comprehensive set of services to attributed Medicaid beneficiaries (100,000 lives in the pilot). The state's two managed care plans contracted with the AEs, establishing a total cost of care methodology, how savings will be shared between the AE and the MCOs, and quality performance targets.

Deb Florio
Deputy Director, Medicaid & CHIP
STATE OF RHODE ISLAND

9:45 *Networking & Refreshments Break*

10:15 Quantifying the Population Level Impact of Healthcare Access on Patient Lives within Medicaid Managed Care

Louisiana chose to expand Medicaid, which led to more than 400,000 residents gaining health insurance in just seven months since July 2016. Louisiana Medicaid's quality section developed a set of performance metrics to understand how healthcare access directly impacted the lives of its newest members. The metrics developed found that, within seven months of Medicaid expansion, 57,000 adults received preventive care or new patient services; 5,700 women underwent breast cancer screenings;

and 3,600 adults were diagnosed with, and started receiving treatment for, hypertension. Another 6,300 adults received colon cancer screenings, and polyps were removed from 1,800 of those patients. In Louisiana, 90% of the Medicaid beneficiaries are in a Managed Care Organization.

This methodology is being replicated by other Medicaid states, and can be extrapolated to the non-expansion population as well as non-Medicaid populations, to assess how health care access impacts lives, particularly in a predominately managed care environment.

SreyRam Kuy, MD, MHS, FACS
Chief Medical Officer, Medicaid
LOUISIANA DEPARTMENT OF HEALTH

PANEL DISCUSSION

11:00 Best Practices & Trends in Medicaid Managed Care

Panelists will discuss issues that states are focused on as well as key activities across the country that are likely to develop into national trends; regulations that are likely to impact the Medicaid Managed Care marketplace over the next few years, and how to keep up with these changes; best practices for working with MCOs; and strategies to improve quality, manage cost and drive innovation.

Stephanie Bates
Assistant Director, Division of Program Quality & Outcomes
KENTUCKY DEPARTMENT FOR MEDICAID SERVICES

Mike Randol
State Medicaid Director
Director, Division of Healthcare Finance
KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT

Jill Bell
Vice President & Chief Marketing/Communications Officer
PASSPORT HEALTH PLAN

12:00 Update from Capitol Hill on Medicaid Managed Care – Examining Reform Proposals and State Budgets

This session will provide insights on the ongoing national debate on health care reform, focused primarily on the Medicaid industry. Understanding these reform proposals will also impact states, the session will also discuss implications to state budgets including operations, benefit delivery and what this all means to the members served under the Medicaid program.

Patty Byrnes
Director, Government Relations – Federal
AMERIHEALTH CARITAS

12:45 Luncheon for All Attendees & Speakers

1:45 Sustaining Reform within Medicaid Expansion – Examining the Arkansas Medicaid Expansion Experience

In 2012, Arkansas was the first state to design Medicaid Expansion to meet its own needs. Since then, dozens of other states have followed suit by implementing innovations to better meet the needs of their populations. Arkansas has utilized this time and experience of other states to continue to grow and adapt to an ever-changing arena.

This presentation will look back at the interplay with health insurance regulations as a part of the Arkansas Medicaid Expansion experience, preview potential changes to the health insurance industry, and describe how Medicaid Managed Care companies are uniquely positioned to be successful in these changing markets.

Zane Chrisman
Deputy Commissioner, Regulatory Health Link Division
ARKANSAS INSURANCE DEPARTMENT

2:30 A Look at ACO Implementation: Massachusetts' and a Medicaid MCO's Transition

With extension of its 1115 Waiver and implementation of the CMS Mega Rule, MassHealth rebid its current contracts for member care, which pay the vast majority of providers on a Fee-For-Service (FFS) basis. The new contracts include, among other changes, a choice of three Accountable Care Organization (ACO) models, mandatory up-side and down-side risk for providers, over thirty required Pay-For-Quality metrics and integration of new additional services.

Tufts Health Public Plans, Inc. partnered with five very different health systems, placing one bid with each as a separate ACO, as well as one bid by itself for all other providers. This presentation will review the process of creating six new individual ACOs from a FFS world.

Barrie Baker, MD, MBA
Chief Medical Officer
TUFTS HEALTH PUBLIC PLANS

3:15 Networking & Refreshments Break

3:45 Designing Behavioral Health Interventions within Medicaid Managed Care to Manage Medical Cost Ratio

With the push to integrate behavioral health benefits into managed care, payers have the opportunity to better address high cost populations that traditionally receive poor care. This session will address strategies and interventions that target members with co-morbid medical and behavioral health disorders.

Taft Parsons, III, MD
Chief Medical Officer
MOLINA HEALTHCARE OF MICHIGAN

4:30 Effectively Implementing Evidence-Based Services into Medicaid Managed Care

Texas was one of the first states to integrate Long Term Services and Supports (LTSS) into capitated Medicaid Managed Care. The Texas managed care system has continued to evolve to include new services and populations. Promoting the independence of individuals with multiple physical, mental and cognitive challenges in the community requires innovative, evidence-based approaches. This session will describe Texas' efforts, in partnership with managed care organizations, to develop, test and sustain evidence-based practices which serve managed care members with complex needs using specialized rehabilitative services, health incentives and self-directed models of service.

Dena Stoner
Senior Policy Advisor
TEXAS DEPARTMENT OF STATE HEALTH SERVICES

5:15 End of Day One

DAY TWO • TUESDAY, OCTOBER 3, 2017

7:15 Networking Breakfast

8:00 Chairperson's Recap of Day One

8:15 State District Perspective on Medicaid Managed Care for States, Health Plans and the Medicaid Population

This session will provide a district perspective on Medicaid Managed Care. The speaker will provide a state house perspective on challenges and solutions when it comes to Medicaid, and how to best serve the Medicaid population.

Rep. Kionne McGhee
Representative, District 117
FLORIDA HOUSE OF REPRESENTATIVES

8:55 Paying for Value for the Washington State Medicaid Managed Care Population

Paying for value is a primary Healthier Washington strategy to achieving the triple aim of better health, better care and lower costs. Meeting this goal will require shifting reimbursement strategies away from a system that pays for volume of service to one that rewards quality and outcomes. To that end, Washington will drive 90 percent of state-financed healthcare to value-based payment by 2021. The state will use its purchasing power to lead by example and accelerate the adoption of value-based reimbursement and alternative payment strategies in the commercial market. Washington purchases healthcare coverage for more than 2 million people through Apple Health (Medicaid) and the Public Employee Benefits Board Program.

Through this session you will learn how Washington State has transitioned our vision into action in our Medicaid managed care contracts.

Preston Cody
Assistant Administrator, Behavioral Health
WASHINGTON STATE HEALTH CARE AUTHORITY

9:35 Managing the Expectation of Lower Cost & Improved Outcomes in Medicaid Managed Care – The Mississippi Experience

Managed care made its debut in the Medicaid program in Mississippi in 2011. The state began the program cautiously by limiting enrollment to a maximum of fifteen percent of the beneficiary population. The new enrollees, which included the disabled population, could choose to opt out of the program. Initially only eight percent of the Medicaid population ended up enrolled in the program. The expectation of the legislature was that managed care would reduce cost and improve healthcare outcomes. However, the statutory limit on the number of individuals enrolled and the fact that the enrolled population had some of the most challenging health conditions created a situation where those expectations where challenging at best.

This presentation will review the history of managed care in Mississippi, the challenges faced by the program, and ultimately how the expectation of lower cost and improved outcomes was managed.

David Dzielak, PhD
Executive Director
MISSISSIPPI DIVISION OF MEDICAID

10:15 Networking & Refreshments Break

PANEL DISCUSSION

10:45 Examining the Dual Eligible Demonstration Projects

This panel of health plan leaders will provide an update on the dual eligible demonstration and initiatives, special needs plans and areas for future improvement. Topics to be discussed include:

- The dual eligible population
- Integrating MLTSS into a special needs plan and product offerings
- Early successes and challenges
- Suggestions for engaging providers
- Opportunities/flexibilities that add value for members
- How MMPs can assist states in rebalancing long-term care
- Provider outreach and collaboration
- Continuity of care
- Challenges, lessons learned and recommendations for the future

Alison Croke, MHA
Vice President, Medicare-Medicaid Integration
NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND

Shawn Shuman
Director, Clinical Programs
UPMC HEALTH PLAN

Rick Gordon
Associate Vice President, Medicare
VIRGINIA PREMIER HEALTH PLAN

11:45 Back to the Future: Transition to Population Health within Medicaid Managed Care

In 2011, BlueCare Tennessee moved to a population health approach to manage 600,000 members across the state of Tennessee. It began a journey requiring the health plan to meld its entire division into a better-prepared team focused on understanding how to turn data into action. Now, in 2017, BlueCare has achieved success in improving quality scores, employee/member satisfaction and utilization while maintaining a strong financial position. At the end of the presentation, the attendee will be able to:

- Discuss approaches to preparing for and achieving a culture change
- Recognize the key elements to manage a diverse Medicaid population
- Discuss the efficiencies created by teamwork between the clinical and data management staff

Frances Martini, RN, BSN, MBA
Director, Government Clinical Programs
BLUECARE TENNESSEE

12:25 Shining a Light in the Black Box of Encounters: Monitor/Maintain Quality and Compliance within Medicaid Managed Care

Encounters are a necessary evil for state Medicaid programs, managed care organizations and a growing pool of sub-capitated and alternative payment provider types. Encounters got special attention in CMS's update of the Managed Care "mega-rule" requirements. Yet despite their importance, encounter platforms tend to be under-funded and treated as an afterthought. No more! From both a state Medicaid, as well as from a managed care perspective, learn how encounters can be used to monitor quality, program compliance and by law enforcement while avoiding compliance pitfalls.

Jay Ludlam
Director, MO HealthNet Division
MISSOURI DEPARTMENT OF SOCIAL SERVICES

12:45 Conference Concludes

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MAIN CONFERENCE WORKSHOP SESSION

Monday, October 2, 2017 · 5:30 p.m. – 7:30 p.m.

Navigating the Medicaid Landscape in Times of Change: Examining Potential Modifications that Impact States, Health Plans and MCOs

MCOs and state governments rely on certainty, but certainty in the healthcare industry is in short supply following the 2016 election. Now, with the recent stumble in Congress to repeal and replace the Affordable Care Act, many are trying to understand the future of our current healthcare landscape – specifically, the future of Medicaid. Will Congress and the new President take another shot at legislative changes? If legislative changes are off the table for the foreseeable future, what administrative changes by HHS and CMS can alter the future of Medicaid?

Much uncertainty continues to shroud the future of the Medicaid landscape. While no one has a crystal ball to know how everything will ultimately play out, fully understanding the potential modifications to Medicaid is critical for states, health plans and MCOs moving forward within the new Medicaid landscape.
This workshop will provide attendees with:

- An overview of the current Medicaid landscape
- Insight into some of the more certain administrative changes that are expected for Medicaid from HHS and CMS
- An understanding of some of the less certain legislative changes that might still come from Congress

Whether it's navigating the more certain changes coming from HHS and CMS, or preparing for the less certain changes coming from Congress, MCOs and states will benefit from having a better understanding of the road ahead.

ABOUT THE WORKSHOP LEADER:

Jason Silva, JD, PMP is a *Senior Consultant* at **HEALTH MANAGEMENT ASSOCIATES**. Jason Silva has significant compliance expertise and experience with managed care and dual eligible populations. Prior to joining HMA, Jason was with Health Net, Inc., one of the managed care organizations (MCOs) selected by California to serve as a Medicare-Medicaid Plan (MMP) for the state's dual eligible demonstration (known as Cal MediConnect) in both Los Angeles and San Diego counties. Jason served as Health Net's MMP point person for the federal and state regulators. He primarily worked on Medicare and Medicaid compliance, specifically focusing on dual eligible demonstrations, Dual Eligible Special Needs Plans (D-SNPs), and Managed Long-term Services and Supports (MLTSS). He also served as the lead Health Net dual eligible compliance resource, and was involved with a diverse set of stakeholders, including advocates, regulators, and beneficiaries.

Jason's background includes extensive work in the healthcare, insurance, and investment management industries. He is a Project Management Professional (PMP), and has managed manifold enterprise-wide IT projects. He received his bachelor's degree from the University of California, San Diego and his JD from the University of Wisconsin Law School. Jason is admitted to the State Bar of Wisconsin.

EXHIBITOR

Mediware

Mediware's Harmony software for Health and Human Services organizations has been an innovator and market leader in delivering the most advanced off-the-shelf solutions available today. For more than 15 years, Harmony solutions have led the industry with proven products that are quick and inexpensive to implement. Our integrated end-to-end suite of solutions is purpose-built for managing the ubiquitous delivery of managed care long-term services and supports across the entire consumer spectrum. We effectively empower human services organizations with the visibility and reporting they require to manage their MLTSS services. Our product modules maximize consumer outcomes while increasing service delivery efficiency, ensuring compliance with funding requirements and automating Medicaid waiver processes. The Harmony suite of solutions are unique and enable the administration and delivery of multi-program, client-centric care in both traditional and consumer-directed service models. For more information, call 866-951-2219 or visit our website at www.mediware.com/LTSS.

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Current sponsorship opportunities for the **2017 Medicaid Managed Care Conference** range from speaking to exhibiting at the event. All sponsorship opportunities are on a first come first serve basis. For information on sponsorship and exhibiting opportunities, please contact **Justin Sanders** at 1-800-646-9581 or **jsanders@globalmediadynamics.com**

VENUE

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