RADAR on

Medicare Advantage

Strategies and Analysis for Medicare Advantage, Medicare Part D and Managed Medicaid

April 19, 2018
VOLUME 24 | NUMBER 8

Managing Editor
Lauren Flynn Kelly
lkelly@aishealth.com

Executive Editor
Jill Brown

Court Ruling Elevates UHC's Battle for Pa. Medicaid Contract

UnitedHealth Group this month scored a long-awaited win for its managed Medicaid business when the Commonwealth Court of Pennsylvania ruled that the state inappropriately denied bid protests from the company's UnitedHealthcare of Pennsylvania, Inc. (UHC) unit. The court's decision is just the latest in a string of developments that have taken place since September 2015 — when the Pennsylvania Dept. of Human Services (DHS) first solicited for new Medicaid managed care contracts — and represents a potential setback in Centene Corp.'s recent string of new contract awards and reprocurements.

At stake are three-year contracts that represent $1 billion in annualized revenue for incumbents UnitedHealth and Aetna Inc., which were both excluded from the final selection of participants, according to analysts. Aetna protested the first round of selections after it was chosen to serve only one region and won an injunction to block the state from moving forward with the contracts. DHS issued a rebid and in January 2016 dropped Aetna and UHC altogether, while newcomer Centene was selected to negotiate for three out of five zones *(RMA 1/12/17, p. 8)*.

UHC, which currently operates as an MCO in three regions of the state's mandatory HealthChoices program, has filed multiple bid protests since it was first informed in November 2016 that it was not selected to negotiate for contracts in any region of the managed Medicaid program. According to an April 10 memorandum opinion from the court, DHS rescinded its original selections due to a scoring error, but later informed UHC that it still did not score high enough to be selected for negotiations in any zone.

continued on p. 7

With Latest Provider Buy, Humana Boosts Fla. MA Positioning

Amid speculation that the nation's second-largest Medicare Advantage insurer is seeking to further entwine itself with long-time Medicare Part D partner and retail giant Wal-Mart Stores, Inc., Humana Inc. on April 10 said it had acquired Orlando-based provider Family Physicians Group (FPG). While the acquisition is minor in scope, it sets up Humana for potential MA membership growth in the competitive Florida market and adds to the company's momentum in the primary care space.

This is the second strategic investment unveiled by Humana since its deal to be acquired by Aetna Inc. fell through in February 2017. The insurer in December said it planned to acquire a 40% minority interest in the Kindred at Home division of Kindred Healthcare, Inc. for approximately $800 million in cash *(RMA 12/21/17, p. 1)*. Kindred shareholders recently approved the deal, which is expected to close this summer.

Published by AIS Health, Washington, DC. An independent publication not affiliated with insurers, vendors, manufacturers or associations.

The Kindred transaction temporarily hushed rumors of an imminent Humana sale, but a March 29 W*all Street Journal* report indicated that Humana and Walmart were looking at a "range of options," including a possible acquisition by the latter *(RMA 4/5/18, p. 1)*.

According to Humana's April 10 press release, FPG is one of the largest at-risk providers serving MA and managed Medicaid HMO patients in Greater Orlando with a footprint that includes 22 clinics located in Lake, Orange, Osceola and Seminole counties. The company said FPG currently serves more than 22,000 MA patients, including nearly 4,000 Humana members, in addition to more than 21,000 patients in other lines of business including Medicaid, fee-for-service Medicare and commercial. FPG will continue to operate as a multi-payer provider.

Humana added that acquiring FPG, which is an accredited Patient-Centered Medical Home and has been recognized for its diabetes and heart/stroke clinical programs, advances its strategy of expanding its primary care model with the overall goal of "creating a national footprint of high-performing, senior-focused primary care physicians."

Bruce Broussard, Humana's president and CEO, during a Feb. 7 conference call to discuss fourth-quarter and full-year 2017 earnings highlighted home and primary care as part of an integrated strategy to "create a holistic 360-degree view of the customer and…drive a simplified, personalized experience for members that make it easy for them to achieve their best health." Humana in 2017 launched 15 new clinics in seven markets for a total of 195 clinics across 27 markets serving approximately 260,000 individuals, not counting the addition of FPG.

While the acquisition will have a minor financial impact, it enables Humana to continue building out its provider footprint as it consolidates its primary care clinics in Florida and South Texas under the new payer-agnostic physician brand CONVIVA and grows its reach with home health via the Kindred deal, observed Evercore ISI securities analyst Michael Newshel in an April 10 research note.

"[O]f course, this reinforces the broader theme of vertical integration across the industry," he wrote. "Small provider deals like this make sense in a standalone or a potential [Humana] takeout/partnership scenario."

Humana's decision to expand its current primary care footprint in Southern Florida to include Central Florida enhances the insurer's positioning in a high-growth MA market, added Newshel, referring to recent year-over-year growth of 10% in the four counties that FPG serves vs. an industry rate of 8% from 2017 to 2018.

Humana noted during the February earnings call that it currently serves nearly 30% of its Florida individual MA HMO members and nearly 50% of its Texas individual Medicare HMO members in clinics under CONVIVA. "Our strategy is for CONVIVA to provide local depth and drive both health care service and Medicare Advantage growth opportunities with greater member access and engagement in health over the long term," stated Broussard.

Centene Made Similar Buy in Miami-Dade

Major Medicaid managed care organization Centene Corp. last month unveiled a similar deal in Florida with its planned acquisition of at-risk primary care provider Community Medical Holdings Corp. *(RMA 3/15/18, p. 5)*. Doing business as Community Medical Group, the provider group serves more than 70,000 Medicaid, MA and exchange enrollees in Miami-Dade County and will remain multi-payer after the transaction is complete. In addition to setting up Centene to grow its Medicaid market share in Florida,

Radar on Medicare Advantage (ISSN: 2576-4691) is published 24 times a year by AIS Health, 2101 L Street, NW, Suite 400, Washington, D.C. 20037, 800-521-4323, www.AISHealth.com.

Managing Editor, Lauren Flynn Kelly; Executive Editor, Jill Brown

the deal gives the insurer its first U.S. primary care physician group asset and adds to the home-based clinical services Centene acquired with the 2013 purchase of U.S. Medical Management, observed Newshel in a March 5 note on that transaction.

Financial terms of the Humana-FPG deal were not disclosed. The acquisition is not expected to have a material impact on Humana's 2018 financial guidance, added the insurer.

For more information, visit www.humana.com or contact Newshel at michael.newshel@evercoreisi.com. ✧

As MA Program Grows, Insurers Weigh EGWP Opportunities

Nearly 4.2 million out of 21 million total Medicare Advantage beneficiaries are currently enrolled in an Employer Group Waiver Plan (EGWP), with enrollment in these group retiree options rising by double-digit percentages in the last couple of years. Yet the market continues to be dominated by large, national players and Blue Cross and Blue Shield plans, observes a new executive briefing from HealthScape Advisors LLC (see chart, this page). With millions of baby boomers expected to age in to the Medicare program over the next decade, the Chicago-based consulting firm is advising many of its regional clients to consider tapping this "untapped" EGWP opportunity.

EGWPs offer plan sponsors certain flexibilities that are not available with individual MA coverage, and regional plans are in a prime position to compete with larger carriers because of their local relationships, contends Cary Badger, principal with HealthScape in Seattle and a former Regence Group executive. Under EGWP waivers, plans may customize everything from the open enrollment process to supplemental benefits. "What we've found working with our regional clients is they have the connections with the large regional employers. Even though they may not have a national presence, they do have significant influence over regional and local businesses and in particular, public employers," observes Badger.

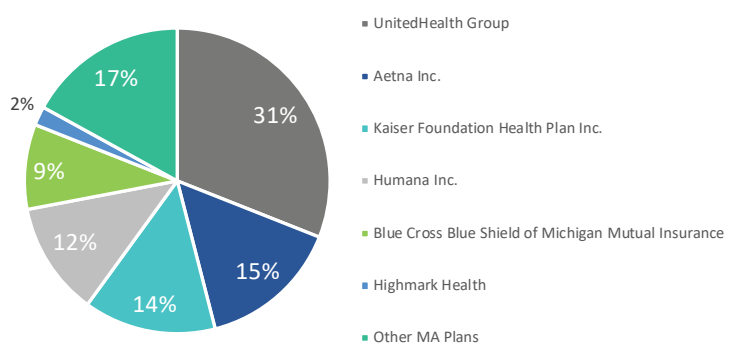
What's often held regional plans back in the past from sponsoring EGWPs is a host of operational considerations and a required set of core competencies that are separate from individual MA. Key operational areas often in need of redesign are marketing (e.g., responding to proposals, sales training for both MA and group commercial field forces) and actuarial (e.g., developing EGWP quotes and accounting for customization rules, enrollment minimums and service area considerations). "Bidding on these retirees is much different from both commercial groups or individual MA, so it's a big leap of faith for commercial account teams to then start selling and administering MA group policies," observes Badger.

To help clients get past such stumbling blocks, HealthScape offers a variety of services to create an "administrative bridge into the group market," Badger explains, and the firm has already completed about 10 projects for its regional clients enabling them to apply and operate as EGWPs.

The value proposition for employers, he adds, is the documented efficiencies that come with managing the cost of the benefits, which cannot be achieved with traditional fee-for-service Medicare. "They reap the savings of the managed care components of the plan…and allow retirees to get better benefits than they can in the open market," he says, referring to enhanced vision, dental and prescription drug coverage options that often come with EGWPs.

When Minnesota not-for-profit insurer UCare launched its group Medicare retiree plans in 1999, the plans were designed to offer richer benefits than what was available through the individual Medicare market and

Top Six EGWP Plans Represent Over 80% of Current Market Share



EGWP=Employer Group Waiver Plans
SOURCE: HealthScape's Medicare Advantage Market Spotlight Tool. Visit https://healthscape.com for more information.

employers were interested in them because they included prescription drug coverage for their retirees, explains Brian Eck, associate vice president of sales for UCare. When the Medicare Part D program was established, EGWPs remained attractive to employers because they enhanced the benefit by providing drug coverage through the so-called donut hole and in UCare's experience, retirees tend to stay enrolled in the plans long-term because of the stronger benefit packages, Eck tells AIS Health.

UCare now serves about 5,080 EGWP enrollees through more than 80 employer groups, including the State of Minnesota, University of Minnesota, Federal Reserve Bank and several counties and school districts. Some higher profile EGWP groups have given UCare more visibility in the marketplace, says Eck. UCare also offers individual MA products, dual-eligible plans and exchange-based coverage.

One of the key differences between administering individual MA plans and EGWPs is that the plan materials can vary by employer and group materials do not need to be approved by CMS, he points out. "Although this makes it easier to get materials off the shelf, it means an entire set of new materials needs to be developed," says Eck. "To make this transition flow better, UCare keeps the group materials in line with the individual plan materials for ease in development and companywide training (i.e., product management, enrollment, billing and member service)."

Customized Plans May Suit Larger Groups

UCare tries to reduce the burden of managing multiple Summary of Benefits and Evidence of Coverage sets by offering a commonly used benefit set when selling to a new group, while customized plans are developed only if a large group has enough retirees and commitment to the retiree market, he explains.

One additional advantage of EGWPs is that insurers know more about the risk profile of the group (in advance) because the employer/union has a better idea of who will be covered than individual plans, adds Badger. "So, you basically have a good underwriting picture of the potential enrollment, which is more difficult with individual plans," he remarks.

Contact Badger at cbadger@healthscape.com or Eck via Wendy Wicks at wwicks@ucare.org. ✧

Sizable Star Ratings Changes May Be Ahead for 2020, Beyond

CMS in the recently posted final Call Letter for Medicare Advantage and Part D plans included several "enhancements" to the Parts C and D star ratings for 2019 but did not make any significant changes or remove "topped out" measures aside from a switch related to audit results *(RMA 4/5/18, p. 1)*. One notable mention, however, signals that more substantive change could be ahead: CMS is convening a panel of stakeholders to provide input on various aspects of the ratings.

Plans to establish a Technical Expert Panel (TEP) this year had been mentioned in the draft Call Letter, and CMS reiterated in the final version that the panel will include representatives across various stakeholder groups to obtain feedback on the star ratings framework, topic areas, methodology and operational measures. The agency contracted with RAND Corp. to set up the panel, analyze the suggestions and relay them to CMS.

"Careful attention should be paid to the work of this TEP as it will likely serve as CMS' sounding board for program changes, which are now long overdue," observed Melissa Smith, vice president of stars and quality innovations at Gorman Health Group, in an April 11 blog post. Smith and other industry experts had expressed surprise that CMS in the draft Call Letter did not propose the removal of measures in support of CMS Administrator Seema Verma's "Patients Over Paperwork" initiative.

For 2020, CMS said in the final Call Letter, it is considering changes in nine categories pertaining to existing measures, including whether to exclude data for participants in the MA Value-Based Insurance Design model when calculating the cut points for relevant measures.

Panel Will Look at Audits in Ratings

The TEP also may provide suggestions regarding the processes used to review and ensure data integrity and how the ratings should relate to audits and enforcement actions, said CMS. For 2019, CMS finalized a plan to retire the current Beneficiary Access and Performance Programs measure — which is based on sanctions, civil money penalties (CMPs) and Compliance Activity Module data — and introduced a new display measure including only CAM data using the same methodology that has been used in the past to calculate the measure deduction for the CAM score.

And while CMS said it will "continue to explore how to highlight performance issues on the Medicare Plan Finder," the agency said it would not at this time move forward with displaying an icon or other type of notice for sponsors that received a CMP. In reviewing comments from stakeholders, CMS observed concerns that the icon "could create confusion among beneficiaries and that it would not accurately

reflect a sponsoring organization's current performance."

On the topic of contract consolidations and quality bonus star ratings, which the Medicare Payment Advisory Commission highlighted in its latest report to Congress *(RMA 4/5/18, p. 4)*, CMS referred to its final rule making policy changes and updates for the MA and Part D programs (83 Fed. Reg. 16440, April 16, 2018). That rule, which was released April 2, finalized the use of "enrollment-weighted means" when determining the star rating of consolidated contracts, starting with consolidations approved on or after Jan. 1, 2019, as authorized in the Bipartisan Budget Act of 2018.

Large national players have in recent years been using the opportunity of consolidating contracts to move enrollees from lower rated contracts that do not qualify for bonus payments to higher rated ones that do (see infographic, this page). The new changes have the potential to "level the playing field" for regional plans and provider-sponsored plans, suggests Cary Badger, principal with HealthScape Advisors LLC in Seattle.

The use of a weighted average "more accurately reflects the quality scores derived in the local health care markets," he explains in an email. "In this way the regional plans and [provider-sponsored plans] will compete with the national plans on these specific scores for Quality ratings and commensurate payments (4+ stars)."

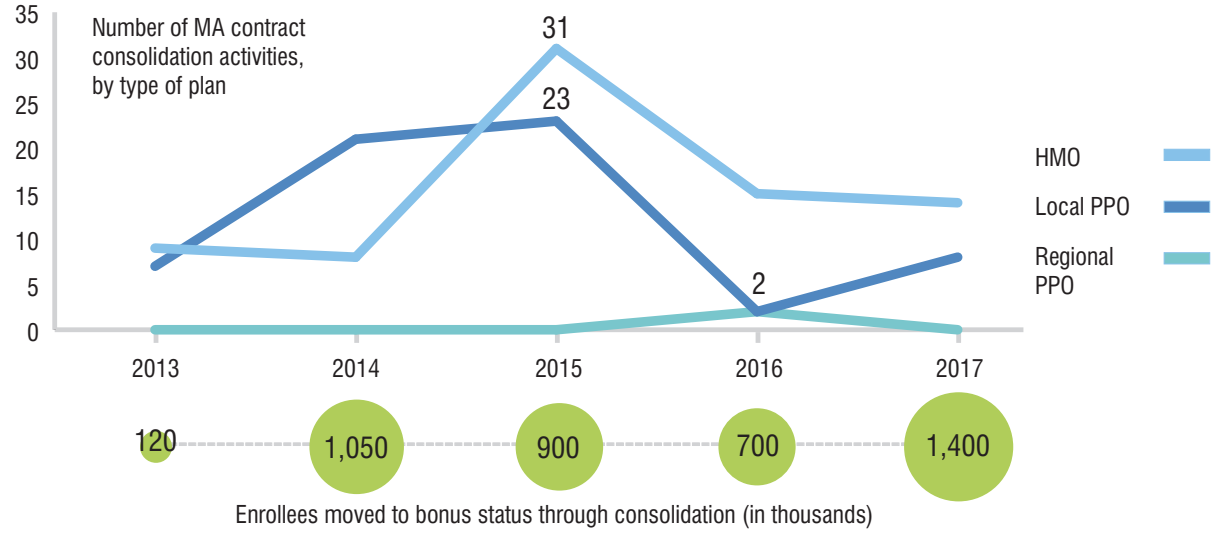
Beneficiaries also may benefit from the new methodology, as it increases the pressure on plans to improve their stars performance "in the delivery system and health plan where the beneficiary receives his/her care," he adds.

Visit https://tinyurl.com/7eg-3hom. Contact Badger at cbadger@healthscape.com. ✧

Contract Consolidation Activity in Medicare Advantage Market

by Jinghong Chen

Over the years, CMS has encouraged companies offering MA plans to consolidate contracts as a way to streamline contract administration for the companies and CMS. Since 2013, more than 4 million beneficiaries have been moved to 4-star plans solely due to the consolidation strategy, which represents over 20% of the enrollment in MA contracts participating in the bonus program and over 30% of the enrollment in contracts at or above 4 stars, according to Medicare Payment Advisory Commission (MedPAC). But MedPAC has argued that these consolidations result in an inaccurate picture of plan quality for beneficiaries and in its March report to Congress made several recommendations aimed at limiting plans' use of contract consolidations for star ratings and quality bonus payment purposes. Below shows an overview of MA contract consolidation activities from 2013 to 2017.



NOTE: Each year's total enrollment figures are rounded. The total for the end of 2014 is greater than previously reported and includes the movement of 700,000 employer group-sponsored Medicare Advantage enrollees to bonus-status contracts. Data exclude cost-reimbursed plans and private fee-for-service plans.

SOURCE: Medicare Payment Advisory Commission analysis of CMS enrollment and cross-walk data. Visit www.medpac.gov.

WellCare Uses Peer Power To Address Social Factors

Connecting low-income and elderly members with available community resources such as food banks and housing programs has become a common part of managed care organizations' overall strategy to address social determinants of health. One alternative approach WellCare Health Plans, Inc. relies on and continues to refine is the deployment of CommUnity Liaisons, call center-based "laypeople" that in some cases draw from personal experience to empathize with members while delivering "informational support."

WellCare in 2014 launched the nationwide, toll-free CommUnity Assistance Line that connects callers with CommUnity Liaisons who provide referrals to a nationwide network of community-based public assistance programs providing free services outside the plan's benefits. The complimentary, toll-free line is available to WellCare's Medicare Advantage and Medicaid enrollees as well as to the general public. The program is one component of WellCare's larger Health*Connections* initiative, which also includes a research team that identifies local community resources and a field-based community relations team.

Study Assessed Utility of Liaisons

Through a new study that was conducted with the University of South Florida and summarized in the March issue of *The American Journal of Accountable Care*, the insurer researched to what extent CommUnity Liaisons supported a single plan's members facing stressful circumstances and provided them with informational and emotional support, both enabled by personal experiences with the social services system. The study did not assess whether this form of social support protects population health or reduces health care spending, but the authors suggested that future research should evaluate the relationship between participants' access to social services and medical spending/health services utilization.

"The results of this study, the first in a series that WellCare is currently conducting, are intended to help identify better ways of delivering improved health outcomes to members who often have challenges in life that go beyond health care," says Pamme Lyons Taylor, vice president, WellCare's Center for CommUnity Impact. Social factors including healthy food, safe housing and financial security account for nearly 70% of all health outcomes, according to WellCare. And CMS recently recognized the potential of addressing such factors to improve outcomes by expanding its definition of health-related supplemental benefits *(RMA 4/5/18, p. 1)*.

Many Call Center Reps Had Disabilities

Researchers conducted in-depth interviews with CommUnity Liaisons and managers of the program in December 2016. Interviews revealed that the liaisons mostly worked part time in the call center and had been recruited through a variety of resources, including the state vocational rehabilitation agency and recruitment firms specializing in employment for people with disabilities. Many of them had disabilities, including deafness and physical limitations.

The call center-based representatives used an extensive software suite to locate more than 160,000 community resources for callers and identify service gaps in the local social services network. They also managed referrals by entering information into a dedicated "social services electronic health record" that can be seen by other MCO employees (e.g., nurse case managers), according to the study report.

Liaisons Drew From Personal Experiences

Interviews with the 13 liaison/manager respondents confirmed that participants called the assistance line in search of "informational support," which the liaisons provided through advice, suggestions and information that participants could use to address their problems. For example, one caller was relieved to learn of a local food pantry that could enable her to save money for paying other expenses like medical and utility bills.

Only seven out of the 13 respondents described providing emotional support, which they indicated was a "precondition of delivering information support" since participants are often notably upset upon calling. Additionally, all respondents reported that callers contacted the assistance line because they experienced adversity, such as losing their job or going through a divorce.

Evidence reinforcing the idea that the liaisons' life experiences better enabled them to provide tailored support was mixed, observed the authors. While some were able to provide targeted information based on their own experience with having a certain disability or illness or using local paratransit services, researchers noted that the program evolved to include fewer liaisons who had received social services and was extended to workers such as students and caregivers who were seeking part-time and/or flexible employment.

"We feel 'lived experiences' are a critical and necessary component to the CommUnity Liaison model," remarks Lyons Taylor. But as WellCare

gathers various data points — such as the feedback from this particular study — to better operationalize its assistance line, it has made certain adjustments. "Through this work, we also expanded our definition of 'lived experience' beyond direct use of social services to include additional peer groups who themselves have had their own personal experiences such as students, caregivers, former military, seniors and more," she tells AIS Health.

Overall, empowering members to access social services can remove barriers to healthy behaviors and generate a return on investment, contends WellCare. The insurer in 2017 alone connected 33,000 individuals to more than 106,000 social service resources. WellCare found that those served were nearly two-and-a-half times more likely to have a better body mass index and five times more likely to schedule and go to their annual primary care visit.

For more information, contact WellCare spokesperson Alissa Lawver at alissa.lawver@wellcare.com. ✧

Court Sides With UHC in Pa. Battle

continued from p. 1

Meanwhile, the deputy secretary for the Office of Medical Assistance Programs (OMAP) and the deputy chief counsel in the department's Office of General Counsel in December 2016 met with two executives from Centene, including Chairman and CEO Michael Neidorff, to discuss concerns about the operational readiness of Centene's Pennsylvania Health & Wellness, Inc. (PHW) unit to serve HealthChoices. Centene at the time had already been selected to coordinate physical and long-term services and supports in all five zones of the state's separate Community HealthChoices initiative, beginning in 2018 *(RMA 9/1/16, p. 1)*. The discussion led to PHW being selected in three regions of the managed Medicaid program, even though its proposals scored high enough to qualify for all five zones.

UHC immediately filed a bid protest asserting that, among other things, the state failed and refused to provide any documents or information to support its evaluation and scoring of the proposals. The insurer filed additional supplemental protests, including one in which it charged that the December 2016 meeting between PHW and DHS violated state procurement code. DHS on June 5, 2017, denied UHC's protests and argued that the meeting was allowed because the reissued RFP from July 2016 included a clause permitting the department to seek oral or written clarifications from a bidder to ensure that they understand and will be responsive to the requirements.

Court Ordered Reversal of State Decision

In response to UHC's appeal, the court deferred to the original RFP — which designated that a single project officer would be the sole point of contact between the department and bidding MCOs — and agreed that the meeting in question was not authorized by the reissued RFP. As a result, the court ordered the reversal of the department's response to UHC's bid protests.

The court also cited legal precedent that such a ruling nullifies the awarded contract, meaning the decision could lead to yet another reprocurement, observed Evercore ISI securities analyst Michael Newshel in an April 11 research note. This would, of course, give Aetna and UHC another shot at maintaining their presence in the managed Medicaid program — "or at least temporary extensions at a minimum while the contracts are resolved," he wrote. While this presents some downside risk for Centene, Evercore doesn't "see anything in the ruling that necessarily changes the odds for a different outcome if there is another reprocurement," added Newshel.

The state has not outlined the next steps and tells AIS Health it is still reviewing the decision and is "committed to providing the highest quality health care available" to the individuals served by its Medicaid program.

Aetna, UHC Are Pleased With Ruling

When contacted by AIS Health, Aetna and UHC both responded that they are pleased with the court's decision. "We look forward to continuing to serve the more than 1 million Pennsylvanians who have entrusted us with their health care needs," added a spokesperson for UHC.

Meanwhile, a PHW spokesperson emailed the following statement: "While we are disappointed with the Commonwealth Court's decision, we are committed to the Commonwealth of Pennsylvania, where we are actively managing the current Community HealthChoices contract in the Southwest and rolling out that program statewide over the next two years. Pennsylvania Health and Wellness is committed to transforming the health of our community one person at a time. We have a solid track record of bringing healthcare innovation and high-quality care through a local approach. The HealthChoices Request for Proposal that we submitted would have brought strong competition while moving the Commonwealth forward toward Value Based Purchasing and increasing better health outcomes."

For more information, call the DHS press office at (717) 425-7606. Contact Newshel at michael.newshel@evercoreisi.com. ✧

News Briefs

✦ ***While men and women generally received the same quality of care in the Medicare Advantage program in 2016, white MA beneficiaries continued to report experiences with care that are either better than or similar to the experiences reported by enrollees in racial and ethnic minority groups,*** according to the latest CMS report detailing racial, ethnic and gender disparities in MA care. The one exception was that compared with white beneficiaries, Asian or Pacific Islander enrollees reported better experiences than white enrollees on one out of the eight patient experience measures assessed, observed CMS and its research partner RAND Corp. The third annual report was released this month in honor of National Minority Health Month and is based on an analysis of two sources of information: the Medicare Consumer Assessment of Healthcare Providers and Systems Survey and the Healthcare Effectiveness Data and Information Set. View the full report at https://tinyurl.com/y73cfd98.

✦ ***Massachusetts' request to implement a closed drug formulary in its MassHealth Medicaid program may be in jeopardy, according to news reports.*** The state in September 2017 submitted an amended Section 1115 Demonstration waiver to CMS that proposed various program modifications, including the use of common commercial tools (e.g., closed formulary, specialty pharmacy network) to obtain lower drug prices and enhanced rebates. But HHS Sec. Alex Azar and CMS officials are likely to reject its request for a closed formulary, partly because of fears that pharmaceutical manufacturers may sue the federal government if CMS approves the waiver, reports *Inside Health Policy*.

✦ ***Medical costs associated with fatal and nonfatal falls among older adults in 2015 amounted to an estimated $50 billion, nearly all of which was attributed to health care for nonfatal falls, according to a new study published in the*** **Journal of the American Geriatrics Society.** By comparison, a 2013 estimate of U.S. health care spending on medical events for certain conditions estimated $38 billion (adjusted to 2015 dollars) in total spending for nonfatal older adult falls, observed researchers. The study found that nonfatal falls cost Medicare approximately $28.9 billion and Medicaid $8.7 billion. Nearly 25% of older adults studied reported falling in the past year; 24% of those individuals fell three or more times. Researchers used population data for adults age 65 and older from the National Vital Statistics System and cost estimates from the Web-based Injury Statistics Query and Reporting System for fatal falls, and quasi-experimental regression analysis of data from the Medicare Current Beneficiaries Survey for nonfatal falls. View the study at https://tinyurl.com/y9888w2w.

✦ ***Through a new partnership with Landmark Health, LLC, Blue Cross and Blue Shield of North Carolina will soon offer home-based medical care to Medicare Advantage members with complex chronic conditions such as diabetes, chronic obstructive pulmonary disease and congestive heart failure.*** Starting June 1, the service will be available at no additional cost to approximately 6,500 customers in the Triangle, Triad, Charlotte and Fayetteville regions of the state. Landmark care teams will deliver home-based medical, behavioral and palliative care and social support services to eligible MA enrollees of the North Carolina Blues plan. Landmark inked a similar deal with Blue Cross Blue Shield of Massachusetts last year *(RMA 4/13/17, p. 3)*. Contact Landmark Senior Director of Brand and Marketing Jessica Diaz at (657) 234-8416.

✦ ***PEOPLE ON THE MOVE: Adam Boehler*** will take over the role of deputy administrator and director of the CMS Innovation Center. He replaces ***Patrick Conway, M.D.,*** who is now the president and CEO of Blue Cross and Blue Shield of North Carolina. Boehler is the founder and CEO of Landmark Health, a company focused on delivering medical services to the most chronically ill patients….***Scott Powers*** was hired as the new president and chief operating officer of Alignment Healthcare, a senior-focused population health company. He was previously the president of health plan operations at Cambia Health Solutions….Fallon Health named ***Linda Weinreb, M.D.,*** medical director of its Medicaid programs and Medicaid accountable care organizations. Weinreb, a family physician, previously served as vice chair and professor in the Dept. of Family Medicine and Community Health at University of Massachusetts Medical School and medical director of the Family Health Center of Worcester's Homeless Families Program.