Advanced Medicaid Training Day 1 May 19th, 2026 9:00 am – 5:00 pm ET	
9:00 – 9:15 am	**Welcome and Introductions**
9:15 – 9:30 am	**Today's Goals and Agenda**
9:30 – 10:45 am	***Managed Care*** • This module will provide a review of the federal guidelines governing Medicaid managed care arrangements including rules under Medicaid waivers as well as a component of a Medicaid State Plan. • The presentation will include critical issues for states including procurement, contracting, rate setting, quality assurance and oversight, and financing. • Discussion will focus on risks and benefits that states experience when using managed care organizations to deliver services; financing issues; and a review on the development of capitation rates are risk sharing arrangements between states and managed care organizations.
10:45 – 11:00 am	**Break**
11:00 am – 12:15 pm	***State Directed Payments*** • State Directed Payments are funding streams that involve the state providing additional funds to MCOs who, in turn, distribute funds to health care providers including hospitals, especially safety net hospitals. • More than forty states have used State Directed Payments (SDPs) and the national spending on SDPs exceeded $100 billion. CMS recently issued new regulations that change the federal guidelines for SPDs. • This module will explain these changes and how states can continue their SDP programs in compliance with the new federal rules
12:15 – 1:45 pm	**Lunch**
1:45 – 2:45 pm	***Waivers and Reporting Requirements*** This module will cover the three main types of Medicaid waivers: 1. 1115 Research and Demonstration Waivers – Key concepts in 1115 waivers including: application process, budget neutrality, and reporting requirements. New CMS rules governing two unique opportunities in 1115 waivers: Delivery System Reform Incentive Payment programs (DSRIP) and Designated State Health Programs (DSHP), with examples of each in various states. 2. 1915(b) Waivers – Two types of waiver options under the statutory provision will be reviewed: 1915(b)(1): Primary Care Case Management (PCCM) which allows states to mandate enrollment in a managed care plan or primary care case management program. And 1915(b)(4) which allows states to limit the number or type of providers who can provide specific Medicaid services (e.g., transportation or disease management).

	3. 1915(c) Waivers – These "Home and Community Based Waivers" are the most common Medicaid waiver. The module will include the federal guidelines and explain how states can use these waivers to address the needs of people who prefer to receive long term care services in their home community rather than in institutions. Considerable time will be allotted to explaining the waiver authority and providing examples from states on different types of clients served and services provided.
2:45 – 3:00 pm	**Break**
3:30 – 4:30 pm	***H.R. 1 Community Engagement*** • As state agencies ramp up to prepare for Medicaid Community Engagement starting in January, 2027, state officials are working on their systems, operations, and staffing plans. Underlying all these plans are the financial issues: how much will these changes cost? What are the state and federal (or local) shares of the total costs? How do we align our policies, systems modifications, and state budgets with federal and state funding? • This module will provide an overview of the financial issues that states will be addressing related to community engagement: how state policies will inform operations and systems, how operations and systems will impact budgets, and how state budgets will be informed by the extent to which state or federal funds are allowable and available. While community engagement is an expansion state requirement, the financial issues to implement could translate to other new requirements for all states (expansion and non-expansion).
4:30 – 5:00 pm	**Wrap Up / Questions**

Advanced Medicaid Training Day 2 May 20th, 2026 9:00 am – 5:00 pm	
9:00 – 9:15 am	**Recap, Reflections, and Questions from Yesterday**
9:15 – 9:30 am	**Today's Agenda and Goals**
9:30 – 10:30 am	***H.R. 1 Rural Health Transformation*** • The Rural Health Transformation (RHT) Program was authorized by H.R. 1 and empowers states to strengthen rural communities across America by improving healthcare access, quality, and outcomes by transforming the healthcare delivery ecosystem. This session will review the initial awards to states and how states are beginning to implement RHT. • In terms of Medicaid, while RHT grants are not Medicaid funds, they are administered by CMS and many states have their Medicaid agencies participating in the planning and operations of the RHT grants. Some states also are thinking about how to coordinate RHT grants with their Medicaid programs, especially in terms of rural hospitals that may experience reductions in Medicaid funding due to HR 1.
10:30 – 10:45 am	**Break**
10:45 am – 12:00 pm	***Rate Based Payments*** • This module will provide participants with an overview as to how Medicaid reimbursement rates for providers are developed and approved by CMS. • The following topics will be covered: a description of federal guidelines including the requirement that rates be sufficient to include enough providers to ensure beneficiaries with access to care; the federal upper limits on provider reimbursement (referred to as Upper Payment Limits) as used in prescription drugs, hospital reimbursement, supplemental payments, etc; fee-for-service rates; Alternative Payment Methodologies (APMs) such as Value Based Payments; and the new federal rules governing situations in which states plan to decrease provider reimbursement rates, although this will be reviewed in detail in the module on New Rule requirements.
12:00 – 1:30 pm	**Lunch**
1:30 – 2:30 pm	***New Rule Requirements and Regulations*** • This module will cover the two major final rules that CMS issues in May 2024 aimed at strengthening access, quality, accountability and equity across Medicaid. • The Ensuring Access to Medicaid Services File Rule (CMS-2442-F) takes a comprehensive, cross-delivery-system approach to improving Medicaid access and care quality across fee-for-service (FFS), managed are, and home- and community-based services (HCBS).

	• The Medicaid & CHIP Managed Care Access, Finance and Quality Final rule, strengthens standards for Medicaid and CHIP managed care. • These regulations cover different issues and have various timelines for implementation and this module will provide participants with "cheat sheets" that summarize the new rules and their respective implementation dates along with any additional (sub-regulatory) guidance on these new regulations.
2:30 – 2:45 pm	**Break**
2:45 – 4:00 pm	**Supplemental Payment Reporting requirement and the Supplemental Payment Validation (SPV) process** • Medicaid supplemental payments have grown to represent a sizable portion of state Medicaid payments to hospitals, as well as physicians and certain other types of providers. • This module will present a snapshot of supplemental payments nationwide to illustrate their importance in the financing of health care providers as well as a review of the federal rules governing these types of payments along with "pain points" that states encounter with supplemental payment programs and provide examples of state supplemental payment programs.
4:00 – 4:30 pm	**Wrap Up / Questions**
4:30 – 5:00 pm	**Evaluations & Farewell**