Co-Chairs’ Welcome and Opening Remarks

Co-Chairs:
Nathan Goldstein, Chief Strategy Officer
CENSEO HEALTH

Kevin Healy, Senior Vice President, Clinical Payer Solutions
OPTUM
Nathan Goldstein
Chief Strategy Officer

Nathan Goldstein is a serial entrepreneur with a passion for reforming health care. As Chief Strategy Officer of CenseoHealth, he is responsible for spearheading efforts to identify and execute new opportunities for the Company to leverage its in-home diagnostic and care expertise to drive improved care for its clients and members.

Before joining CenseoHealth, Goldstein served as CEO of Gorman Health Group where he brought the industry’s leading Medicare consulting firm into the health reform era by developing new practices and software products, doubling the company’s client base. In addition to Goldstein’s focus on Medicare “Star Ratings” and risk adjustment, teams led by Goldstein developed software to improve client’s revenue management, compliance and business strategy, and forecasting. During this time, he was also a founding member of the first full-service risk adjustment management company serving the managed care industry.

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About CenseoHealth

CenseoHealth’s mission is to facilitate meaningful connections between health plans and their members by providing tailored solutions resulting in high-quality, cost-effective health care. The Company’s suite of services is anchored by CareConsult™, a home health consultation conducted by one of the Company’s 10,000 licensed physicians that results in improved member engagement, more accurate diagnoses, and more informed primary care providers. CenseoHealth’s additional services expand the Company’s breadth of support and subsequently assist health plans in their effort to close gaps in care and reduce medication errors.
Kevin M. Healy
Senior Vice President
Optum Clinical Solutions

Kevin is currently the Senior Vice President of Optum's Clinical Solutions focusing on the Payer and ACO markets. Kevin is responsible for solving for the needs of today’s complex requirements as they pertain to data analytics, care and disease management, wellness, prospective and retrospective risk adjustment, STARS, Hedis, quality and complex population management.

Prior to joining Optum Kevin was the Chief Development Officer of INSPIRIS (acquired by Optum in 2011), Senior Vice President of Sales for Warm Health (acquired by Altegra Health), Managing Director of Corporate Development at Social Service Coordinators (acquired by Altegra) and the National Sales Manager for Healthcare Dimensions and the SilverSneakers Fitness Program (acquired by Healthways).

Kevin resides in Scottsdale, Arizona with his wife and daughter.
Opening Keynote Address: The Next Phase for Healthcare Reform

Senator Tom Daschle
FORMER SENATE MAJORITY LEADER and Author of Getting it Done: How Obama and Congress Finally Broke the Stalemate to Make Way for Health Care Reform; Founder and Chairman, THE DASCHLE GROUP, A PUBLIC POLICY ADVISORY OF BAKER DONELSON
Born in Aberdeen, South Dakota, Tom Daschle graduated from South Dakota State University in 1969. Upon graduation, he entered the United States Air Force where he served as an intelligence officer in the Strategic Air Command until mid-1972.

Following completion of his military service, Senator Daschle served on the staff of Senator James Abourezk. In 1978, he was elected to the U.S. House of Representatives where he served for eight years. In 1986, he was elected to the U.S. Senate and eight years later became its Democratic Leader. Senator Daschle is one of the longest serving Senate Democratic Leaders in history and the only one to serve twice as both Majority and Minority Leader. During his tenure, Senator Daschle navigated the Senate through some of its most historic economic and national security challenges including a Presidential impeachment, 9/11, the anthrax attack in his Senate office, and the wars in Iraq and Afghanistan.

In 2003, he chronicled some of these experiences in his book, Like No Other Time: The 107th Congress and the Two Years That Changed America Forever. His most recent book The United States Senate: Fundamentals of Government was published in January, 2013.

Senator Daschle is the Founder and Chairman of The Daschle Group, A Public Policy Advisory of Baker Donelson. The Daschle Group provides strategic advice on key national issues including health care, energy, transportation and the environment. Since leaving the Senate, he has distinguished his expertise in health care through the publications of two books: Critical: What We Can Do About the Health-Care Crisis and Getting It Done, a chronicle of the efforts to enact the Affordable Care Act. He has been published in Health Affairs, The New England
Journal of Medicine, most major daily newspapers as well as many other respected publications.

He is a member of the Health Policy and Management Executive Council at the Harvard School of Public Health in addition to the Global Policy Advisory Council for the Health Worker Migration Initiative.

In 2007, he joined with former Majority Leaders George Mitchell, Bob Dole, and Howard Baker to create the Bipartisan Policy Center (BPC), an organization dedicated to finding common ground on some of the pressing public policy challenges of our time. Senator Daschle has co-chaired several BPC health task forces and issued numerous reports on health related, consensus driven health policy.

Senator Daschle is Chair of the Board of Directors at the Center for American Progress and serves as the Vice Chair of the National Democratic Institute for International Affairs. He is also a member of the Council of Foreign Relations.

In addition, Senator Daschle’s board memberships include the Blum Foundation; the Energy Future Coalition, the Edward M. Kennedy Institute, Sindicatum Sustainable Resources, Accumen, and the Advisory Boards for Accenture and Zoc Docs.

Senator Daschle has been awarded four honorary doctorate degrees from universities in Massachusetts and South Dakota.

He is married to Linda Hall Daschle and has three children and five grandchildren.
CMS Policy Update

Jeff Grant, MPA, Senior Advisor, Payment and Policy and Financial Management Group; Center for Consumer Information and Insurance Oversight*

CENTERS FOR MEDICARE & MEDICAID SERVICES
Jeff Grant has worked on ACA financial programs since July 2010, first in the Office of Consumer Information and Insurance Oversight, and now in CIIIO. He has been a key senior leader in the implementation of health insurance marketplaces and associated financial provisions, advising staff and management on policy development, payment methodology, and operational implementation. As the original marketplace financial team member, Jeff has provided strategic and technical direction for financial programs that impact the individual and small group private insurance markets, including premium tax credits, cost sharing reductions, user fees, reinsurance, risk adjustment, and risk corridors.

Jeff has over 22 years of experience in Federal health insurance programs, previously having led the development of the systems and operations to implement Medicare Advantage risk adjustment and Medicare Part D payment reconciliation. Jeff previously served Senior Vice President for Client Services at Health Risk Partners, LLC, where he supported clients on risk adjustment and enrollment and payment reconciliation. He is a retired Naval Reservist with 22 years of service.
Risk Adjustment and Reinsurance in ACA Markets: 2014 Results, 2015 Outlook

Jeff Grant, MPA
March 21, 2016

Premium Stabilization Programs

• Section 1343 of the Affordable Care Act provides for a permanent risk adjustment (RA) program
  – Applies to non-grandfathered individual and small group plans inside and outside Exchanges
  – Provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions)
  – Transfers funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection
• Section 1341 of the ACA establishes a three-year transitional reinsurance (RI) program that helps defray the costs of the highest cost enrollees
2014 Summary

- CMS implemented RA and RI in 49 states plus DC
  - Massachusetts operated its own RA program
  - Connecticut operated RI program using CMS data
- RA calculated $6.6 billion in total transfers in the ACA-compliant individual and small group markets
  - $4.8 billion individual
  - $1.8 billion small group
- RI calculated $7.9 billion in payments to ACA-compliant individual market issuers (100% coinsurance rate)

RA/RI Operational Landscape -- 2014

- CMS implemented a distributed data collection process consisting of an External Data Gathering Environment (EDGE) located at each of 775 issuers
- Each EDGE server was connected to a central management server operated by CMS in the Amazon cloud
- EDGE servers hold issuer detailed claims and enrollee data
- Data from EDGE is summarized and reported to CMS for RA and RI program calculations and for operational monitoring
- EDGE server deployment commenced September 2013
- Data collection started upon deployment, depending on issuer readiness to submit to their server
Operational Monitoring

• CMS monitored data completeness on each server
  – CMS used enrollment and claims baseline estimates from issuers to evaluate data completeness
  – 90% of enrollment and claims data was the benchmark success metric for the EDGE data “quantity” requirement
• CMS also monitored key data “quality” indicators using an empirical outlier analysis
  – Issuers with outliers either explained the issue as a unique population characteristic or as a data extract/submission problem
  – Data problems had to be corrected or the issuer could receive an RA default charge and/or forego RI payments
  – Most outliers were explainable; all data quality issues were addressed before CMS executed final RA and RI calculations
• In 2014, 772 out of 775 servers met quantity and quality standards at the time CMS executed final RA and RI calculations

General Conclusions for 2014 RA

• Risk adjustment transfers went from issuers with low claims costs to those with high claims costs
• In the individual market, small plans received payments more frequently than large plans; opposite was true in small group
• Small plans tend to vary from the mean more than large, and thus saw a greater percent of premium transferred
• In general, higher actuarial value (AV) plans had higher risk scores
  – The risk transfer formula neutralizes some of the effect of the higher risk scores through higher transfers, on average, to higher AV plans
  – However, within each metal level, there were still transfers from issuers with low-risk enrollment to issuers with high-risk enrollment
Issuers with Relatively High Claims Generally Had High Plan Liability Risk Score (PLRS)

Distribution of issuers by quartile of PLRS and quartile of per enrollee claims, Individual Market

Amounts shown are at the issuer level and weighted by billable MMs of enrollment.

In Individual Market, Small Plans Received Payments More Frequently than Large Plans

Distribution of transfers as % of premium, by issuer size, Individual Market

Amounts shown at issuer level and weighted by billable members months of enrollment.
In Small Group Market, Large Plans Received Payments More Frequently than Smaller Plans

Distribution of transfers as % of premium, by issuer size, Small Group Market

<table>
<thead>
<tr>
<th>Percent of Premium</th>
<th>&lt;12k MMs</th>
<th>12-120k MMs</th>
<th>&gt;120k MMs</th>
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Amounts shown at issuer level and weighted by billable members months of enrollment.

Issuer-level Selection Is Key Driver of Transfer Direction and Magnitude

RA payment by metal level and by transfers as % of issuer revenues, Individual Market

All calculations at the issuer level and weighted by member months.
Issuer-level Selection Is Key Driver of Transfer Direction and Magnitude

RA payment by metal level and by transfers as % of issuer revenues, Small Group Market

All calculations at the issuer level and weighted by member months.

Within Metal Transfers Correlate with Enrollees with HCCs

Percent of enrollees with at least one HCC by RA charges/payments as % of issuer revenues and metal level, Individual Market

At issuer level and weighted by member months. Payments/receipts as a percent of all plans’ premiums.
Within Metal Transfers Correlate with Enrollees with HCCs

Percent of enrollees with at least one HCC by RA charges/payments as % of issuer revenues and metal level, Small Group Market

- Issuers Charges, >10%
- Issuers Charges, 0% to 10%
- Issuers Payments, 0% to 10%
- Issuers Payments, >10%

2016 Outlook: EDGE Operations

- CMS has instituted several operational improvements for 2015 benefit year operations
- EDGE operational leads assigned at each issuer
- Detailed schedule for data submission with interim submission deadlines
- New support structures in place
- Earlier “quantity” and “quality” analysis to identify and resolve issues well before data submission deadline
- New measures for data quality oriented around addressing discrepancies from 2014 RA and RI
2016 Outlook: Reinsurance

- RI collections should top the $6 billion targeted for RI payments for 2015 benefit year
- Total RI funds available for payment for benefit year 2015 will be $7.7 billion
- CMS is in the process of remitting early RI payments at a 25% coinsurance rate
  - These payments are an advance toward final payment
  - CMS will calculate final 2015 RI payments after May 2, 2016 data submission deadline and announced on June 30, 2016

2016 Outlook: Risk Adjustment

- Interim risk transfer results for 2015 benefit year distributed to issuers in 21 states on March 18
  - In states that did not meet the CMS credibility threshold, no issuers received interim transfer results
  - In states that did, only issuers that had 90% of claims and enrollment data on their EDGE servers received results
- CMS will soon release a White Paper discussing potential future changes to the risk adjustment program
- March 31, 2016 CMS is hosting a national conference to discuss the paper and receive initial public feedback
- You may register for conference at www.regtap.info
SPECIAL CMS ADDRESS: EDGE Server Operations in ACA Insurance Markets

Linda Osinski, Senior Advisor, Division of Reinsurance Operations
CENTERS FOR MEDICARE & MEDICAID SERVICES
Linda Osinski is the Acting Director of the Division of Reinsurance Operations at the Centers for Medicare and Medicaid Operations (CMS). She has over twenty years experience in government and private health insurance operations. For the past 4 years has served at CMS’s Senior Technical Lead on the development and implementation of the EDGE server, which collects claims and enrollment data to support the Reinsurance and Risk Adjustment programs established under the Affordable Care Act. Prior to coming to CMS, Linda was the Manager of Operations for Virginia and the District of Columbia at a Medicaid managed care organization, where she was responsible for provider appeals, implementing Medicaid contractual requirements as well as testing and implementing a new claims and benefits system. Linda began her career with a commercial health insurer reviewing and updating provider data, performing fee-for-service and capitated claims analysis and reconciliation, evaluating and implementing provider contracts and developing provider fee schedules.
EDGE Server Operations in ACA Markets: Final 2015 Data Submission

Linda Osinski
RISE Annual Summit – Nashville, TN
March 21, 2016

Agenda

• 2015 Data Submission: The Final 6 Weeks
  – Assess Quantity and Quality
  – Calculate Predicted Results
  – Compare Predicted Results to Actual Results
  – Create an Action Plan
• Blackout and Discrepancy Filing
• New development in 2016 and 2017
2015 Data Submission: The Final 6 Weeks

Where to begin…

• The 2015 CMS Risk Adjustment (RA) and Reinsurance (RI) benefit year final data submission deadline is May 2, 2016
• Issuers should use the next 6 weeks to focus efforts on the accuracy of the data that has been submitted and to evaluate what additional data needs to be submitted to achieve the best possible RA and RI calculations
• CMS recommends the following course of action:
  – Assess if you have met CMS’ minimum submission requirements and establish a timeline if you have not
  – Compare current RA and RI calculations to anticipated final results
  – Create an action plan to achieve the best possible results by May 2
Assess Quantity and Quality

- CMS has established a minimum data submission threshold to ensure risk adjustment calculations are accurate
  - CMS expects all issuers to meet a quantity threshold of 90% of both reported enrollment and claim baseline
    - Over 90% of issuers have achieved this threshold
    - Issuers that have not reached 90/90 should continue submitting data and formulate a rapid recovery plan to meet the threshold
  - After reaching the 90/90 requirement issuers should focus less on data quantity and more on ensuring the data that has been submitted meets predicted calculations
Assess Quality

- CMS quality assessments begin on 3/21 for issuers who have submitted a minimum of 80% of their baseline enrollment and claims
- CMS has published the final quality measures on www.regtap.info
- Issuers identified as quality outliers must either:
  - provide an acceptable justification, if the outlier can be explained
  - update the EDGE server to accurately reflect enrollment and claims data if the outlier was caused by inaccurate data

Issuer Quality Analysis

- CMS has established a process to identify outliers as a key safeguard of program oversight
- CMS does not have the same knowledge that issuers have of their own data and CMS cannot detect data quality anomalies that fall within the normal distribution of data (i.e. data that is not an outlier)
- Issuers are responsible for ensuring the completeness and accuracy of all data submitted
- Issuers should develop processes to assess independently the quality of their EDGE data
Calculate Predicted Results

Validate Independently Calculated RA and RI Values

- Utilize an independent predictive model to perform internal calculations
  - As a starting point, use only the data you believe has been submitted and accepted on the server to evaluate your calculations
  - Validate the predicted internal calculations to EDGE server RA and RI specific reports
    - Reinsurance: RISR and RIDE
    - Risk Adjustment: RARSD, RACSD, and RATEE
- Aligning your predicted calculations and EDGE server calculations will be useful in the evaluation and prioritization of unsubmitted data
Determine Differences in Predicted and Actual Results

- Differences between issuer predicted calculations and EDGE server calculations likely indicate:
  - a problem with the accuracy of the data on the server
    - an incomplete set of diagnosis codes
    - claims accepted but not selectable (orphaned claims)
  - an incomplete set of diagnosis codes
  - claims accepted but not selectable (orphaned claims)
  - a misinterpretation of the calculation methodology
    - How the maximum out of pocket limit is applied for RI
    - How billable member months are calculated for cross year claims for RA
  - a misunderstanding of data eligible for consideration
    - RA excludes specific bill types and service codes

Predicting RA and RI Calculations

Reinsurance
- Proactively identify individual market enrollees
- Aggregate claims to identify enrollees who have met or are approaching the attachment point and enrollees who have exceeded the cap
- Apply the appropriate Maximum Out of Pocket adjustments

Risk Adjustment
- Proactively identify individual and small group market enrollees
- Utilize the 2015 Benefit Year Risk Adjustment: HHS-Developed Risk Adjustment Model Algorithm DIY software and instructions to estimate individual enrollee risk scores
  - NOTE: When using the RA DIY software remember to also include any supplemental diagnosis codes your have or intend to submit
Compare Predicted Calculations to Actual Results and Prioritize

Compare Predicted Calculations with EDGE Server Calculations

- Once predicted and EDGE server calculations align, add all unsubmitted data to the predictive model to determine your anticipated final RA and RI calculations
  - Assuming all data is submitted and accepted by May 2nd, this full data calculation would represent your maximum RA and RI potential
- As data is submitted to the server, return to the aligned model adding only the data that was submitted and accepted by the EDGE server to validate your predicted progress
  - Compare your predictive model to the EDGE server calculations every time data is submitted.
  - Issuers can execute the RA and RI reports independent of CMS
Differences in Predicted and EDGE Server Calculations

- Your final predicted calculations, which includes all potential data, will not match the EDGE server calculations until all data is submitted and accepted.
- While data is being loaded incrementally calculations will not match due to:
  - Records rejected at the time of submission
  - Records yet to be submitted
  - Orphaned claims
- Data can be added and removed from your predictive model to identify which rejected, unsubmitted, or orphaned data, if prioritized, will move you most quickly to achieving your goal.

Prioritize to Achieve Predicted Goal

- Review rejected and unsubmitted data as well as orphaned claims to determine the data submission priority.
- Prioritize and apply resources to fixing data that will maximize your calculations and move you closer to your goal:
  - High dollar claims with multiple diagnoses
  - Claims with unique diagnoses that are not already included in risk score calculations
- Data that can be fixed quickly may not have the greatest impact on your EDGE calculations:
  - Low dollar claims for enrollees that will not meet the attachment point
  - Claims with service codes that are not included in the RA model.
Create an Action Plan

Establish a Schedule

- Establish a schedule of activities including:
  - Creation of a submission schedule
  - Identification of unsubmitted data
  - Prioritization of new, rejected, and orphaned data
  - Execution of report commands
  - Planning for disaster
  - Communicating with CMS

- Creation of a submission schedule
  - If submitting weekly and you want the data to be included in the next batch of summary reports to CMS upload files by 11:59pm on Thursday
Submission Schedule

• Consider the following when planning your submission schedule
  – April 8th - Submit the last full enrollment file
  – April 15th – April 24th Submit the last major batch of claims and supplemental diagnoses
  – April 16th – April 24th – Make corrections to rejected claim and supplemental diagnoses records
  – April 25th – May 2nd – Focus on records that would have a material impact on your RI and RA calculations

Identification of Unsubmitted Data

• Outstanding and Pended Claims
  – Claims that have not been submitted or are pended may have a material impact on calculations
    • Determine if all inpatient facility, and other high dollar/high risk claims, have been submitted by your provider community as well as the number and type of claims pended in the claims department
    • Develop a plan to have claims submitted and/or processed as soon as possible
Identification of Unsubmitted Data

- Additional Diagnoses
  - Issuers are permitted to use medical record and EDI as sources to identify unique diagnosis codes that may contribute to risk score calculations.
  - Identification of additional diagnoses can take a significant amount of time and effort but can have a material impact on risk score calculations.
    - If you did not perform medical record review for 2015 services, evaluate whether this would be a valuable source of data for 2016.
    - Consider evaluating diagnosis codes that were truncated through the EDI process and submit them using the supplemental diagnosis file.

Prioritization of New, Rejected and Orphaned Data

- Know the criteria that makes a claim RA and/or RI eligible to prioritize claims that will have the greatest material impact.
- Prioritize claims that include unique diagnosis codes.
  - If a diagnosis code was previously submitted and the claim is for the individual market, consider the impact on RI to determine prioritization.
- Before making a decision about whether to resolve an orphaned claim, determine if the diagnoses and claim paid amounts will contribute to your overall predicted RA and RI calculations.
Execution of Commands and Preparing for Disaster

- Execute Commands and Program Specific Reports
  - Execute CMS issued commands every Friday morning and verify all reports were produced
  - Review ECD, RIDE, RISR, RARSD, RACSD and RATEE
    - Generate reports using the local command if necessary to confirm submitted and accepted data is being added to your RA and RI calculations

- Prepare for a Disaster
  - Back up your data frequently and save it to an external storage area in the event you need to restore your server or a prior version of your data

Communication

- Communicate with CMS
  - Respond to CMS outreach related to quantity and quality promptly
    - Delayed responses will result in escalation to CEOs
  - Contact EDGE_Server_Data@cms.hhs.gov early and as often as needed for assistance including policy questions, technical support and understanding reports
    - Issuers who fail to contact CMS during the data submission window to report a problem will not be permitted to submit additional data after the May 2nd deadline
Blackout, Discrepancies, and Future Development

- EDGE blackout is scheduled for May 2, 2016, at 5pm ET
  - 2016 data submission to production will begin in July
  - 2016 data submission to test can begin in April after 2016 plan data is uploaded
- The discrepancy filing period is from May 3rd – May 20th
  - Failure to submit data, to make corrections to rejected data or to review and validate RA and RI calculations is not a discrepancy
  - Only a failure of the software to perform accurate calculations based on accepted data is a discrepancy
2016 Data Submission and 2017 Improvements

- CMS will develop a 2016 data submission schedule and requirements during the blackout period
- Tentative development activities for the end of 2016 and the beginning of 2017 include:
  - A third zone for testing code prior to a release
  - Updates to the file processing detail reports
  - Updates to risk adjustment reports
  - An earlier 2017 production data submission window
Co-Chair’s Recap of Day One

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Kevin resides in Scottsdale, Arizona with his wife and daughter.
Featured Session – The Health Exchanges: Enrollment and Impact-to-Date

Anne Filipic, President

ENROLL AMERICA
Anne Filipic serves as President of Enroll America, a non-profit organization dedicated to maximizing the number of Americans who enroll in and retain health coverage made available through the Affordable Care Act. Most recently, Ms. Filipic was the Deputy Director of the White House Office of Public Engagement. Previously, she served as Deputy Director of Intergovernmental Affairs for Health and Human Services Secretary Kathleen Sebelius. Her background includes key positions in a variety of electoral and issue campaigns, including the 2008 Obama for America campaign, where she served as Field Director during the Iowa caucuses and Colorado General Election Director. As an early leader in the Obama for America campaign, Ms. Filipic played a key role in developing and implementing the campaign’s successful organizing model, which has fundamentally altered the nature of grassroots engagement in the electoral and public policy context.

Since joining Enroll America in January 2013, Ms. Filipic has appeared in dozens of media outlets including The New York Times, Washington Post, Los Angeles Times, Bloomberg News, MSNBC’s “All In with Chris Hayes”, CNN’s “CrossFire”, and “The Daily Show with Jon Stewart.” Enroll America is the nation’s leading health care enrollment coalition, which brings together community and health organizations, businesses, volunteers and others to inform consumers about the new health coverage options and how to enroll in them. Representing Enroll America and its coalition, Ms. Filipic has become a leading voice on the consumer experience and best practices around ACA enrollment and engagement. In 2015, Ms. Filipic was recognized as one of the “Top 100 Most Influential People in Healthcare” by Modern Healthcare.

Ms. Filipic is a graduate of Washington University in St. Louis.
FALL 2012: LIMITED AWARENESS OF RECENT HEALTH REFORMS

78% of the uninsured don’t know about the new health insurance exchanges

83% of people who could be eligible for the new Medicaid expansion don’t know about it

FALL 2012: PAST EXPERIENCES SEEKING COVERAGE

Helpless Frustrated Stressed Angry Pessimistic Overwhelmed Worried Confused

Hopeful Distrust Optimistic Alone Scared Confident
USING DATA TO INFORM TARGETED OUTREACH
MEETING CONSUMERS WHERE THEY ARE, WITH TRUSTED MESSENGERS

GetCoveredAmerica.org

The health insurance marketplace opens November 1st. See if you could get covered now.

Sign up to learn more about your health insurance options.

GetCoveredAmerica.org

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EnrollAmerica.org | GetCoveredAmerica.org
3-22-2016

4
ENROLL AMERICA:
OE1 & OE2 ACCOMPLISHMENTS

MORE THAN 6 MILLION CONSUMERS CONTACTED
(APRIL 2014 – FEBRUARY 2015)

LEANING INTO PARTNERSHIPS IN OE3

Harnessing the Power of 6,700 Partnerships
Reaching Key Communities With Targeted or Large-Scale Outreach

HOURLY WORKERS
National Restaurant Workers' Association

PEOPLE OF COLOR
34 states, 11 community-based organizations
Collaboration: California Black Leadership Alliance, UnidosUS, League of Latin American Citizens

YOUNG ADULTS
Columbia Public Health

Source: Enroll America Field Program (2015–2016)
EMPOWERING LOCAL LEADERS & ORGANIZATIONS

Sustaining the Movement: Giving Local Groups the Tools to Enroll Their Communities

Partners Trained in OE3 From All 50 States and D.C.

People Trained in OE3

Over 16,000

Percentage of Get Covered Academy Participants Saying OE3 Was Their Most Effective Year Yet

70%

A SHIFT IN THE UNINSURED – BY COUNTY

2013 Uninsured Model: 16.4% of 18-64 year olds uninsured

2015 Uninsured Model: 10.7% of 18-64 year olds were uninsured
ENROLLMENT – BY THE NUMBERS

Total Enrolled (FFMS + SBMs)

Enrolled in OE1 (10.01.13 - 04.19.14)  Enrolled in OE2 (11.01.14 - 02.22.15)  Enrolled in OE3 (11.01.15 - 01.31.16)

- 8 MILLION
- 11.7 MILLION
- 12.7 MILLION

Source: Health Insurance Marketplace Weekly Open Enrollment Snapshots, CMS

Enrollment in Healthcare.gov States

Of 9.6 million FFM enrollees, there were about 4 million NEW marketplace enrollees during OE3.

OE3 Plan Selections

New Enrollees  Reenrollees

OE2

OE3

40%  42%  58%  60%  63%  37%

New Enrollees Acted Earlier in OE3


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3-22-2016

Source: Health Insurance Marketplace Weekly Open Enrollment Snapshots, CMS
CONSUMERS SIGNING UP EARLIER

Trends in the Timing of Marketplace Plan Selections in the HealthCare.gov States During the 2014, 2015 and 2016 Open Enrollment Periods (OEPs)

The proportion of consumers that selected or were automatically reenrolled in a Marketplace plan during the early part of the OEP was higher during the 2016 OEP (86 percent) when compared to the 2015 OEP (73 percent).

<table>
<thead>
<tr>
<th>OEP</th>
<th>Early Part of the OEP</th>
<th>Middle Part of the OEP</th>
<th>End of the OEP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>63.0%</td>
<td>25.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>2015</td>
<td>73.0%</td>
<td>14.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>2016</td>
<td>86.0%</td>
<td>8.0%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

Note: Data for the Early Part of the OEP corresponds with the Marketplace Enrollment Reports or Snapshots that includes the deadline for coverage beginning on January 1. No data for the end of the OEP includes the weekly OEP that correspond with the surge at the end of the applicable OEP.

Source: ASPE calculations based on Centers for Medicare & Medicaid Services data that have been publicly reported in MarketPlace Enrollment Reports and Marketplace Enrollment Snapshots for the applicable coverage years.

ENROLLMENT IN HEALTHCARE.GOV STATES

Of the 5.6 million OE3 FFM reenrollees, 70% actively shopped for a new plan.

<table>
<thead>
<tr>
<th>OE2 (through 2/22/15)</th>
<th>OE3 (through 2/1/16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>New consumers</td>
<td>4.7 million</td>
</tr>
<tr>
<td>Reenrollees</td>
<td>4.2 million</td>
</tr>
<tr>
<td>Active reenrollees</td>
<td>2.2 million</td>
</tr>
<tr>
<td>Automatic reenrollees</td>
<td>2 million</td>
</tr>
</tbody>
</table>

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ENROLLMENT IN FFM + SBM STATES

During OE3, Americans made nearly 12.7 million plan selections.

New vs. Reenrollees As of 2/1/16
- 36% Active Reenrollees
- 39% New Enrollees
- 22% Auto-reenrollees

4.8 million New Enrollees
4.5 million Actively reenrolled
2.7 million Auto-reenrolled

Proportion with Financial Help As of 2/1/16
- 85%
- $290 Average monthly tax credit
- $106 Average monthly premium after tax credit

Proportion of Youth As of 2/1/16
- 36% Under Age 35
- 8% 18-34 yrs.
- 28% 35-54 yrs.
- 37% <18 yrs.

LESSONS LEARNED IN IMPLEMENTATION
LEADING WITH AFFORDABILITY IS KEY

Actions Taken by the Uninsured to Get Information About Health Insurance

Among the Uninsured Ages 18-64 Percent Who...

- say they have tried to seek out more information about getting or changing health insurance: 43%
- say they have been personally contacted about signing up for health insurance or Medicaid in the past 6 months: 52%
- say they have tried to figure out if they qualify for coverage: 28%
- say they have tried to figure out if they qualify for financial assistance to purchase health insurance: 31%
- say they are aware that January 2016 is the deadline to enroll in health insurance: 3%

Nearly 1 in 4 consumers who used the Get Covered Calculator immediately went on to start the enrollment process

Source: Enroll America OE3 Calculator Usage

DEADLINES MOTIVATE CONSUMERS

Weekly Enrollment Snapshots

Source: Enroll America OE3 Calculator Usage
THE FINE & CONSUMERS

“Sign up by the January 31st deadline or you may face a fine of $695 of 2.5% of your income, whichever is higher!”

FOLLOW-UP IS KEY

Growth in Enrollment Rate by Number of Volunteer Follow-Ups

- After First Follow Up
- After Second Follow Up
- After Third Plus Follow Up

Overall | African-American | Latino | Youth
CONSUMERS WANT IN-PERSON ASSISTANCE

Going into OE3, more than 7 in 10 wanted in-person help

Source: PerryUndem Research (2015)

THE GET COVERED CONNECTOR

Making it easy for people to search for and seamlessly schedule appointments with local assisters for free application help.

Find Local Help

Need help with your health insurance application? Enter your ZIP code below to find appointments with local application assisters.

Enter Your ZIP Code:  
Search Within:  
Language:  

Search For Help

www.getcoveredamerica.org/connector/

Get Covered Connector Locations Offering Appointments Increased

55%

OE2: 3,011
OE3: 4,699
MAKE IT EASY FOR CONSUMERS TO GET HELP ONLINE

New Plans, New Prices are available every year and we encourage consumers to shop and find the plan that best fits their needs and budget.

Paid Media: Digital Advertising

4 IN 5
GOT HELP PAYING FOR THEIR HEALTH INSURANCE.

FINANCIAL HELP IS HERE.

TO GET AFFORDABLE HEALTH INSURANCE.
Earned Media Strategies

WHERE WE'RE GOING
MILLIONS REMAIN UNINSURED

Figure 1: Quarterly Uninsured Rate Estimates for Nonelderly Adults (Ages 18 to 64) Using the Gallup-Healthways Well-Being Index, 2012 to 2016

Source: The Office of the Assistant Secretary for Planning and Evaluation’s (ASPE) analysis of the Gallup-Healthways Well-Being Index survey data through February 22, 2016.

WE NEED TO HELP MILLIONS RENEW

12.7 Million Enrolled in OE3 ➔ We want to help them stay covered
BUILDING A SUSTAINABLE, COMMUNITY-BASED ENROLLMENT INFRASTRUCTURE
THANK YOU
Anne Filipic
AFILIPIC@ENROLLAMERICA.ORG
Special Focus Group: Medicare Advantage Member Journey Snapshot

Susan Semack, Vice President, Healthcare Division
MORPACE
Susan Semack
Vice President Healthcare Practice

Experience
Susan is a seasoned research professional with 25 years of experience in supplier-side marketing research and consulting. Since 2004 she has served as the Morpace Healthcare Practice leader, and is responsible for the management and oversight of healthcare research and divisional operations.

Recent Medicare-focused research includes CAHPS Clinician and Group projects, physician engagement in wellness care, Medicare Advantage plan design, and member purchase decision making.

Susan specializes in ad hoc research design and problem solving and is experienced in all most quantitative and qualitative methodologies. Her particular areas of specialty include customer/member satisfaction, communications testing, branding, and product development. Key responsibilities include research consulting to address business objectives, methodological design, sample design, and questionnaire development, in addition to overseeing data collection, data analysis, and report preparation.

Ms. Semack brings 15 years of qualitative experience to the Healthcare practice and regularly facilitates focus groups for health insurance clients addressing both member and employer audiences. Further, she is experienced with many online qualitative approaches including online focus groups, bulletin boards, and e-communities. From critical sample definition, to creative project execution, to forward-thinking interpretation, Ms. Semack is a value-add partner to Morpace clients.

Ms. Semack has been employed by Morpace for the length of her career, including various management positions beginning in 1990.

Education
B.S., Marketing, Michigan State University

Affiliations
American Marketing Association (AMA)
Alpha Kappa Psi, professional business fraternity
Featured Panel: Attracting, Engaging, Retaining and Educating Your Members – Embracing a New Era of Communication

**Moderator:**
Nathan Goldstein, *Chief Strategy Officer*
CENSEO HEALTH

**Panelists:**
Sharon LaSure-Roy, *Senior Consultant, Social Media and Digital Communications*
FLORIDA BLUE

Neal Sofian, *Director of Member Engagement*
PREMERA BLUE CROSS

Jamey Shiels, *Vice President, Digital Experience*
AURORA HEALTH CARE, INC.

David Murray, *Manager, Social Media*
BLUECROSS BLUE SHIELD OF MICHIGAN
Nathan Goldstein
Chief Strategy Officer

Nathan Goldstein is a serial entrepreneur with a passion for reforming health care. As Chief Strategy Officer of CenseoHealth, he is responsible for spear heading efforts to identify and execute new opportunities for the Company to leverage its in-home diagnostic and care expertise to drive improved care for its clients and members.

Before joining CenseoHealth, Goldstein served as CEO of Gorman Health Group where he brought the industry's leading Medicare consulting firm into the health reform era by developing new practices and software products, doubling the company's client base. In addition to Goldstein's focus on Medicare "Star Ratings" and risk adjustment, teams led by Goldstein developed software to improve client’s revenue management, compliance and business strategy, and forecasting. During this time, he was also a founding member of the first full-service risk adjustment management company serving the managed care industry.

Goldstein is a nationally known speaker and presents at numerous industry events each year on topics including health reform, reimagining the health care service model and innovations in clinical practice.

Before entering health care, Goldstein's communications company had clients including presidential candidates, members of the U.S. Congress, network news anchors, Fortune 500 CEOs and one infamous Gonzo journalist. He specialized in writing on health care related topics, and, on behalf of his clients, his writings have been syndicated in over 100 newspapers nationwide.

About CenseoHealth

CenseoHealth’s mission is to facilitate meaningful connections between health plans and their members by providing tailored solutions resulting in high-quality, cost-effective health care. The Company’s suite of services is anchored by CareConsult™, a home health consultation conducted by one of the Company’s 10,000 licensed physicians that results in improved member engagement, more accurate diagnoses, and more informed primary care providers. CenseoHealth’s additional services expand the Company’s breadth of support and subsequently assist health plans in their effort to close gaps in care and reduce medication errors.
Neal S. Sofian, MSPH

Neal is recognized nationally for over 35 years of innovation in behavior change, population-based and corporate health promotion/management, and care management. He is responsible for developing the first major telephonic coaching programs in the United States during the 1980s-90s and many of the early social networking platforms including the American Cancer Society’s Cancer Survivors Network.

Neal is currently the Director of Member Engagement at Premera Blue Cross where he is responsible for development of new strategies to engage the 2 million members of Premera in reaching their optimal health, one person at a time. He is currently focused on building models and tools using choice architecture to integrate personalized/micro-tailored messaging based on integration of the Vulnerability Index, intrinsic rewards, and intervention choice.

Prior to Premera, Neal was the Director of Behavioral Interventions for Resolution Health after its acquisition of the NewSof Group of which Neal was the co-founder and CEO. The NewSof Group was a consulting and new media development company focused on scalable change, learning, coaching, sharing, and support. Prior to NewSof, Neal was responsible for the launch of Lexant, a population health company.

During his tenure at Group Health Cooperative, Neal served as Director of Innovation, Manager of Worksite and Community Programs, and General Manager of Health At Work, the Northwest’s first worksite health promotion company in 1983. Neal is the commercial founder of Free & Clear (now Quit for Life) smoking cessation, the largest and recognized standard in smoking cessation services. He is also a pretty fair potter and sculpture. Neal holds a master's degree in public health from the University Of Missouri School Of Medicine.
Jamey Shiels
Vice President, Digital Experience
Aurora Health Care

Jamey Shiels is the Vice President of Digital Experience at Aurora Health Care, an integrated health system in Eastern Wisconsin. Jamey has more than 15 years of experience in marketing, digital and social business strategy, developing integrated communications programs for Fortune 500 brands and an international non-profit. Jamey also serves as an instructor for Digital Marketing and Social Media courses for the University of Wisconsin Milwaukee.

Jamey joined Aurora in 2008 where he was asked to build the digital and social media programs. The scope and team grew to encompass marketing technology and he is now responsible for leading a team of specialists, who focus on optimizing digital technology channels to drive consumer engagement. His responsibilities include developing the organizations digital strategy and executing activities for all consumer-facing channels including web, mobile, apps and marketing technology. His team drives all planning, project management, user experience design, content strategy and development for Aurora’s digital properties including the AuroraHealthCare.org, myAurora (electronic health record) and CRM systems.

Jamey holds a BA in Marketing from Michigan State University and will complete an MBA with a focus in Information Technology Innovation and Management in May 2017.
David Murray (@DaveMurr) serves as the Manager of Social Media for Blue Cross Blue Shield of Michigan. In one year with BCBSM David increased the brand's online community by over 1400%, and maintained a content participation average between 25-30%. His strategic direction has also lead to award winning social media recognition.

An advocate for education and best practices in digital and social web communications, David founded the Social Media Club Detroit, and has spoken at BlogWorld, unGeeked, and TEDx events. Murray has also been featured in Wall Street Journal Online, and David Meerman Scott’s book, The New Rules of PR and Marketing.