

# Perspectives

Accelerate through health care's biggest transitions

# Perspectives



Welcome to the Spring 2015 issue of Perspectives.

It's hard to believe that five years have passed since the Affordable Care Act (ACA) was signed into law. In that time, we have seen substantial changes across the industry as health plans, providers and consumers have learned to navigate a more challenging health care landscape.

Optum<sup>™</sup> remains committed to understanding the complexities and bringing together the brightest minds in health care to translate and formulate modern solutions to help health plans accelerate through the transitions of this complex, post reform regulatory environment.

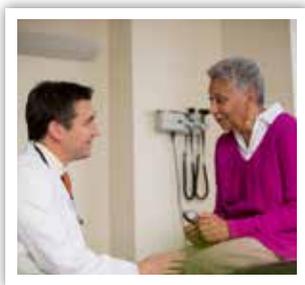
In this issue, we take a closer look at real-world examples and proven strategies health plans are using to implement integrated clinical care models to measure interventions, effectively balance risk adjustment and quality programs, successfully position themselves for growth in the public exchanges, and better utilize operations and technology to achieve this success.

We hope it serves as a valuable resource to you and your colleagues.

Best regards,

A handwritten signature in black ink, appearing to read 'Eric Murphy'.

Eric Murphy  
Executive Vice President and Enterprise Growth Officer, Optum



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Integrated clinical model helps plans measure impact of interventions



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Integrating risk adjustment and quality aligns plan resources, goals



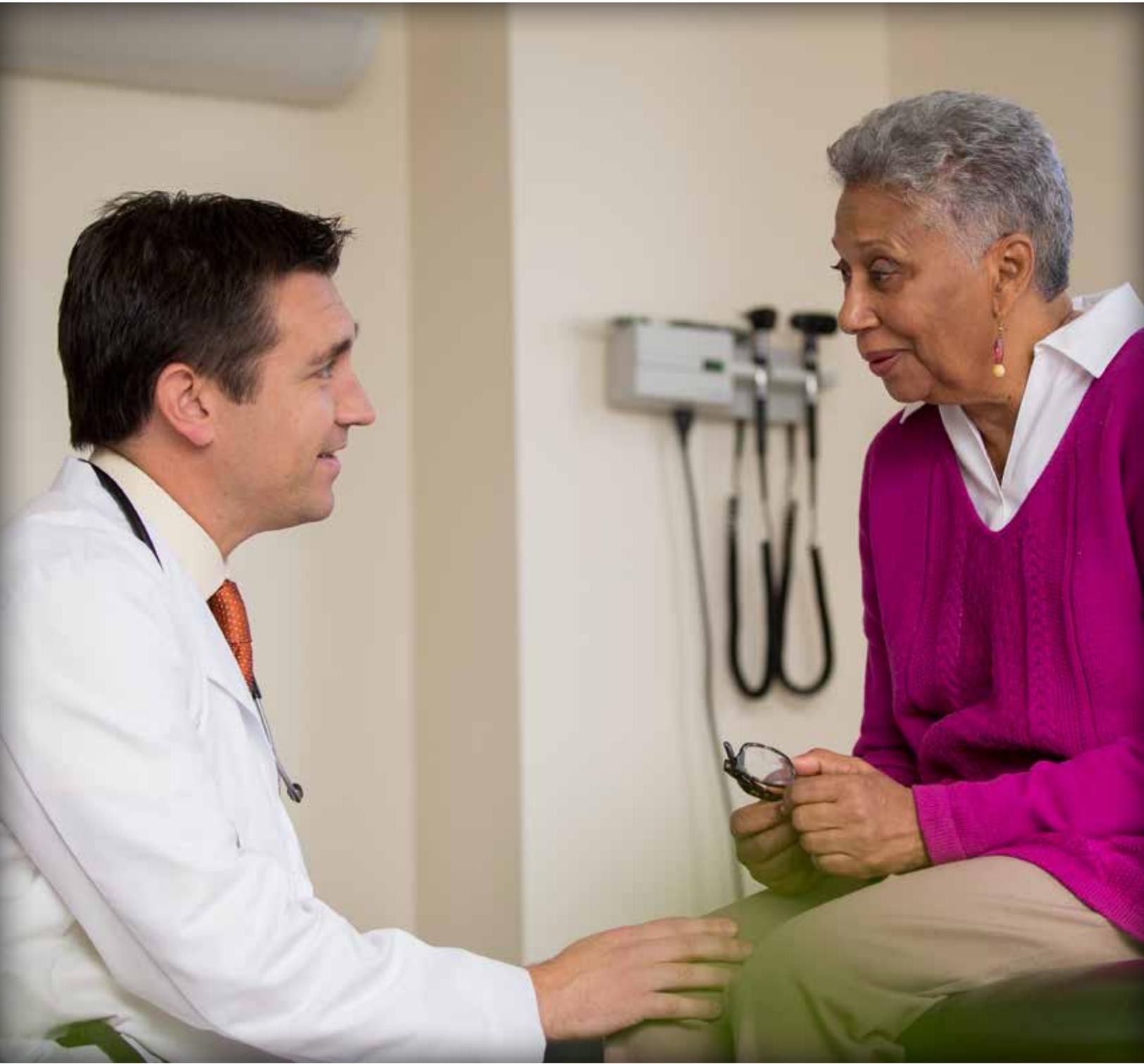
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Integrated clinical model helps plans  
measure impact of interventions

## Expert presenters

**Dr. Scott Howell**, Senior National Medical Director, Optum

**Mark Anderson**, Senior Vice President, Technology and Innovation Risk Solutions Group, Optum

Since the Affordable Care Act (ACA) was signed into law five years ago, health plans have been shifting their business models to accommodate risk sharing with providers and coordinate population health management functions to improve quality of care and lower administrative cost. As this effort continues and risk-sharing and value-based models take shape, plans should consider an integrated clinical model that leverages technology to better answer the questions about which interventions will yield the best results, according to Dr. Scott Howell, senior national medical director, Optum, who spoke at a recent Optum Perspectives webinar, "Accelerating the Progression Toward an Integrated Clinical Model."

In this new model, Howell explained, health plans will need to upgrade their clinical management focus to support a care delivery performance approach that includes:

- Proactive engagement with the right members and providers — with the right intervention programs
- Coordinated processes across departments, including the underlying technology infrastructure to support integration
- Optimized performance-based results for quality, cost reduction and risk-based revenue

### Reducing costs while improving care

Payers, providers and consumers all play a role in the post-ACA paradigm, Howell told webinar attendees. "Payers are talking about operational efficiency due to [medical loss ratio (MLR)] and regulatory requirements, while also improving clinical performance and investing in provider relationships," Howell said. Providers moving to risk-bearing models, such as accountable care organizations (ACOs), are striving to reduce cost, measure performance and improve quality and outcomes, while consumers now require more information to make health care decisions.

Howell added to achieve the "triple aim," plans and providers must work together to improve the experience of care and the health of populations and reduce the per capita costs of health care.

However, the road to that end game is seemingly long. A recent study conducted for the Optum Institute by Harris Interactive showed that only 43 percent of hospitals and 34 percent of physicians believe they are adequately prepared to take greater responsibility for managing patient care, and just 30 percent of hospitals and 16 percent of physicians state that they are adequately prepared to take on greater financial risk for managing patient care. Moreover, Howell explained, five years from now, willingness to accept performance-based risk likely will need to double among both groups.

Figure 1

#### Population health management

##### Adequately Prepared to Take:

###### Greater Responsibility for Managing Patient Care



Physicians



Hospitals

###### Greater Financial Risk for Managing Patient Care



Physicians



Hospitals

“People know that in five years they are going to have to accept some performance-based risk ... so what's the plan for getting there within those five years?”

— Dr. Scott Howell  
Senior National Medical Director, Optum



Physicians lag behind hospitals in their willingness to adopt value-based opportunities, primarily due to concerns about the complexity of these programs, their administrative costs and fear of taking on increased risk without adequate rewards, the Optum study found. However, there is no question that the pathway for all provider entities is headed toward managing risk among stakeholders.

“The whole spectrum — physicians, hospitals and hospital based physician groups — must be focused on better coordination of care, better coordination of outcomes, and the ability to take on some clinical risk and financial risk,” Howell said. “The next step is figuring out how you integrate all that from a technology standpoint, so that all of these different aspects can live in one single format.”

### Integration leads to more evolved solutions

According to Mark Anderson, senior vice president, technology and innovation risk group, Optum, the best way to start is by leveraging Optum insights around value creation, quality and risk-reduction controls. Optum value-based reimbursement frameworks give health plans the ability to leverage core analytics into an integrated workflow, improve provider transparency and align to contractual performance, Anderson told webinar attendees.

“In this integrated clinical model, we have brought those insights into a very enriched service delivery structure that is very cyclical in terms of how we look at the impact on outcomes,” he said, adding that the business value delivered by the Optum analytics platform strategy starts with the data, which are transformed by

*“Optum value-based reimbursement frameworks give health plans the ability to leverage core analytics into an integrated workflow, improve provider transparency and align to contractual performance.”*

— Mark Anderson

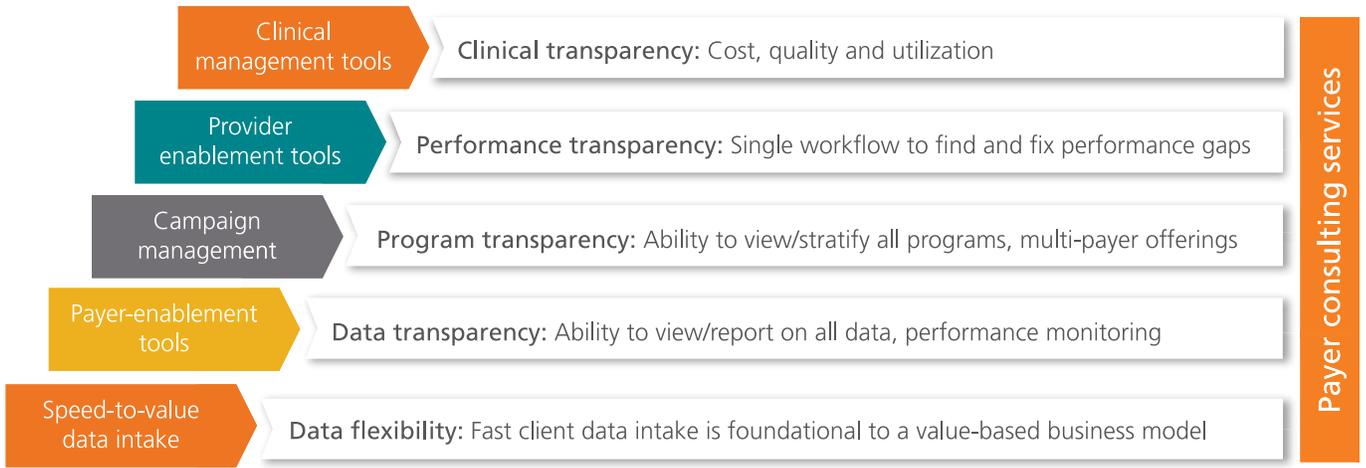
Senior Vice President Technology and Innovation Risk Solutions Group, Optum

Figure 2

Approach: Holistic approach to integrated clinical services



Clinical | Model



Optum analytics, and ends with a holistic approach to integrated clinical services.

“We think about all of this from a clinical care perspective because that’s where we can really start to drive transparency across cost, quality and care utilization metrics,” Anderson continued. “Continuous improvement helps us to look at the impact of the interventions that we are applying across population health both with the provider and at the member level, and [to analyze] how well those interventions are truly driving change and outcomes,” he said.

The differences between a traditional approach and the Optum clinical model are that a traditional model can be unconnected or fragmented, according to Anderson, and the Optum global clinical model is member-centric, focused on value, targeted across all dimensions, and well-orchestrated to manage and prioritize closing gaps. These differences will help “improve the accuracy of our risk premium focus, continually drive quality improvements, reduce utilization, improve satisfaction and provider abrasion, and importantly, drive return on investment,” Anderson asserted.

The Optum integrated clinical model framework “provides the right information at the right time with the right intervention to the right stakeholder that we feel can help drive the change or influence that change from a behavioral management perspective.” This framework integrates six core pillars into its foundation for clinical improvement:

*Continuous improvement helps us to look at the impact of the interventions that we are applying across population health both with the provider and at the member level.*

— Mark Anderson  
Senior Vice President Technology and Innovation Risk Solutions Group, Optum

- Provider network management
- Cost and utilization management
- Integrated quality management
- Capacity and campaign management
- Holistic risk-adjustment solutions
- Value-based enablement

In addition to integrating services, the Optum framework also coordinates workflow, resulting in a patient-driven approach to provider engagement that cycles from risk-adjusted conditions to clinical quality to care excellence, closing gaps along the way and evaluating effectiveness for ongoing model refinement. Specific features of the Optum integrated clinical model include: physician extension/integrated care coordination; CRM desktop support for

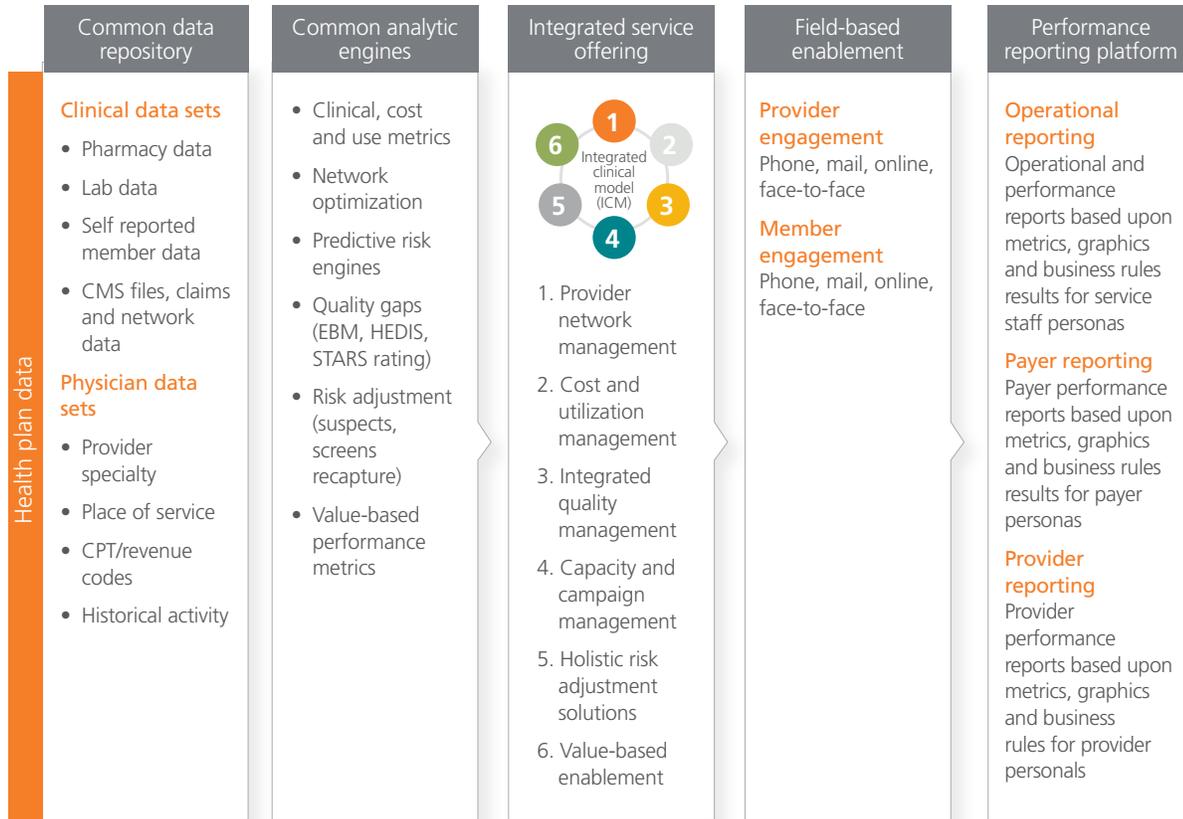
in-market clinical team; gap management provider interface to support clinical improvement; and integrated reporting.

“This strategy delivers by leveraging existing market leading IP, integrating provider and payer engagement, cost and quality, and

leveraging Optum analytics expertise,” he said. “Optum can help plans manage from end to end the quality of care that’s delivered not just at the point of care but also through member populations-based health solutions.”

Figure 3

Optum integrated clinical model framework



### How Optum can help

To meet new market demands, health plans must push toward new business models and capabilities centered on comprehensive care of member populations. In this new model, health plans will need to upgrade their clinical management focus to support care delivery performance, Optum can help with:

- Proactive engagement with the right members and providers—with the right intervention programs
- Coordinating processes across departments, including the underlying technology infrastructure to support integration
- Optimizing performance-based results for quality, cost reduction and risk-based revenue

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Integrating risk adjustment and quality aligns plan resources, goals

## Expert presenters

**Mary Larson**, Risk Adjustment Lead, Network and Population Health Consulting, Optum

**Ryan McKeown**, Quality Lead, Network and Population Health Consulting, Optum

**D**eveloping a framework that balances the need for stepped-up risk adjustment and quality programs may seem like a tall order, but health plans can streamline this process by using best practices as a road map to increase provider engagement, improve member touch points, better align funding and improve program efficiency, and drive better results. Knowing where to start and how to prioritize resources can give plans a jump-start and help them create integrated risk and quality programs that have a significant impact on providers, members and their bottom lines.

“As you step through the framework built for your risk and quality programs, you are thinking first of your organizational structure and your strategy,” said Ryan McKeown, quality lead, network and population health consulting, Optum, at a recent Optum Perspectives webinar, “Evaluating the Effectiveness of Your Organization Against Best Practices for Risk Adjustment and Quality Programs.”

According to McKeown, plans need to assess the status of their organizational structure and strategy, identify opportunities and prioritize areas of focus and return on investment, engage providers and members (as well as internal clinical and operational management teams), and inform and sustain performance using data, analytics and reporting.

## A risk-plus-quality strategy involves multiple moving parts

“When you are thinking about starting or improving your risk and quality integration, an important place to start is making sure that groups that often are siloed in your organization are coming together to have conversations, at least to start with, about what programs each group has going on currently and how those can be better aligned,” Mary Larson, risk adjustment lead, network and population health consulting, Optum, remarked during the webinar.

Larson told attendees that there are five basic components to designing an integrated risk adjustment quality program. These are:

- Analytics — collecting data and building member and provider profiles
- Targeting — determining which programs are the best fit for your specific members and providers, which is “one of the most important and strategic areas”

Figure 1

Comprehensive risk adjustment model





- Intervention — deploying activities that close clinical and coding gaps to improve quality
- Submission — collecting, reporting and submitting data to the Centers for Medicare and Medicaid Services and the Department of Health and Human Services
- Compliance — integrating active compliance surveillance and monitoring throughout the entire program

The compliance component checks that “as you are performing your interventions, such as prospective chart reviews, that you are validating the data that is being collected and looking at how that compares to the claims that you are seeing from the provider,” Larson explained. Optum has broken down the elements of a comprehensive risk adjustment model further, into three sections that each have specific action steps (see Fig. 1).

Creating an integrated approach to risk adjustment and quality can be complicated, so health plans should be aware that there are a number of factors to consider beyond the core elements of analytics, chart review, in-house assessments and in-office assessments, Larson continued. “There are a lot of outside influences that are going to have an impact on the strategy and execution of your programs,” she said, such as the Healthcare Effectiveness Data and Information Set (HEDIS) and Medicare Advantage (MA) Star ratings, the Affordable Care Act (ACA) and others.

*“There are a lot of outside influences that are going to have an impact on the strategy and execution of your programs.”*

*— Mary Larson  
Risk Adjustment Lead,  
Network and Population Health Consulting, Optum*

For example, she noted that health plans might be located in a state that risk-adjusts for Medicaid, or plans may have ACA membership and will have to determine how to apply their risk programs to that population. Another influencer is the implementation of ICD-10, Larson added. “How does the pending implementation of ICD-10 in October influence your programs? Your providers will be going through a lot of training and preparedness for ICD-10 in the last half of the year, and that’s going to take a lot of attention away from risk adjustment education and prospective programs, especially in-office assessment programs,” she said.

This scenario on the provider end “could lead to less complete and accurate documentation and data during this period, so plans may want to increase chart reviews in 2016 against those 2015 dates of service to ensure you are capturing completely everything that they’ve documented in the chart,” she advised.

### Integrating quality for end-to-end results

Because quality is the key to any health plan’s success, they should approach quality management holistically, looking for people, process and technology opportunities across all capabilities (see Fig. 2). As plans “are expanding what is measured and what is monitored, you have to look at the scope of quality in your organization with a holistic lens,” McKeown said. “When plans do that ... [they] have identified clear opportunities to align with risk adjustment to minimize abrasion and realize efficiencies,” he continued.

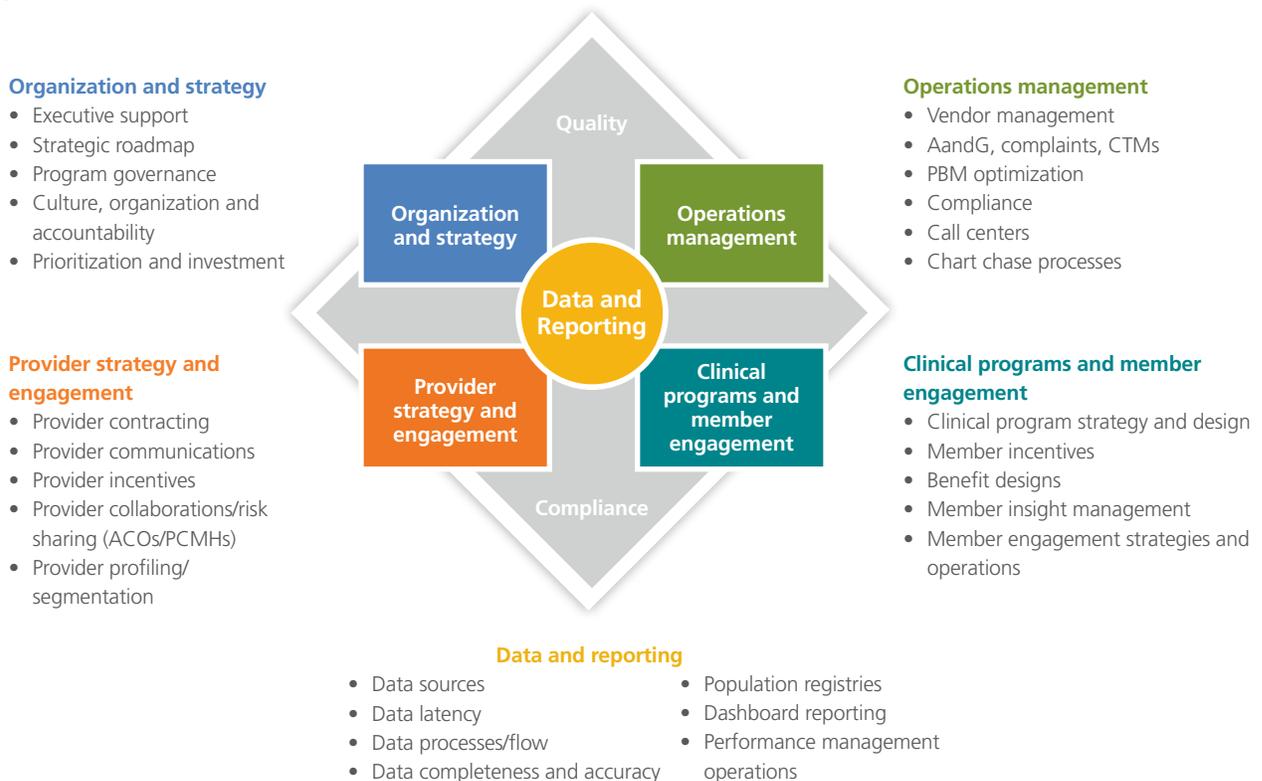
While assessing quality in provider strategy and engagement functions, for example, plans need to consider what the best investment is for their provider network, and what type of reporting or data exchange would benefit that function, McKeown told attendees. And when looking more closely at data and reporting, which touches all quality capabilities, he said, it is imperative that plans understand the “interplay of these mechanisms.”

Integrating risk and quality starts, McKeown said, with aligning structure and governance, includes the following elements:

- Communication and collaboration — Plans need to gather the right people across teams and buildings to address the intersection of quality and risk.
- Need for joint understanding — Plans should determine where to put money to improve the entire enterprise.
- Alignment of goals and financial impacts — Plans need to understand they must both pull the same lever together and understand that there are longer-term goals, such as higher MA star ratings at stake. In other words, plans need to communicate among core functions that “there is a longer-term play for higher benchmarks, and [the governance function] should say ‘can we integrate into your process or you into ours, so we can, nearer term, offset quality programs from a budget perspective using risk-adjustment revenues?’” McKeown asserted.
- Governance structure — Plans must take into account both the team (IT/analytics and medical informatics, finance/risk, quality/clinical for star ratings and HEDIS, member engagement, provider relations and contracting) and the process (regular cadence, documentation and escalation process).

At the intersection of risk and quality, plans will need to “use all of the tools in the toolbox,” McKeown noted, stating that both risk and quality programs are essential to building toward and supporting the comprehensive annual assessment. To be successful, plans must establish relationships with members and providers, offer providers useful data at the point of care, build

Figure 2  
Quality Framework





and continually reset strategies and goals, and provide integrated reporting that uses resources wisely, he said.

Larson also reminded attendees that coordination on the plan side correlates to better results and outcomes on the member side and greater satisfaction on the provider side. “Think about your programs from a member point of view and try to consolidate

them, so that when you have a member on the phone for one purpose ... you can layer in the other pieces you need and you are not calling that member seven times in a year to manage all of your programs,” she concluded. “The same thing holds true with providers — if you are in there focusing on risk adjustment, try to layer in that quality education as well.”

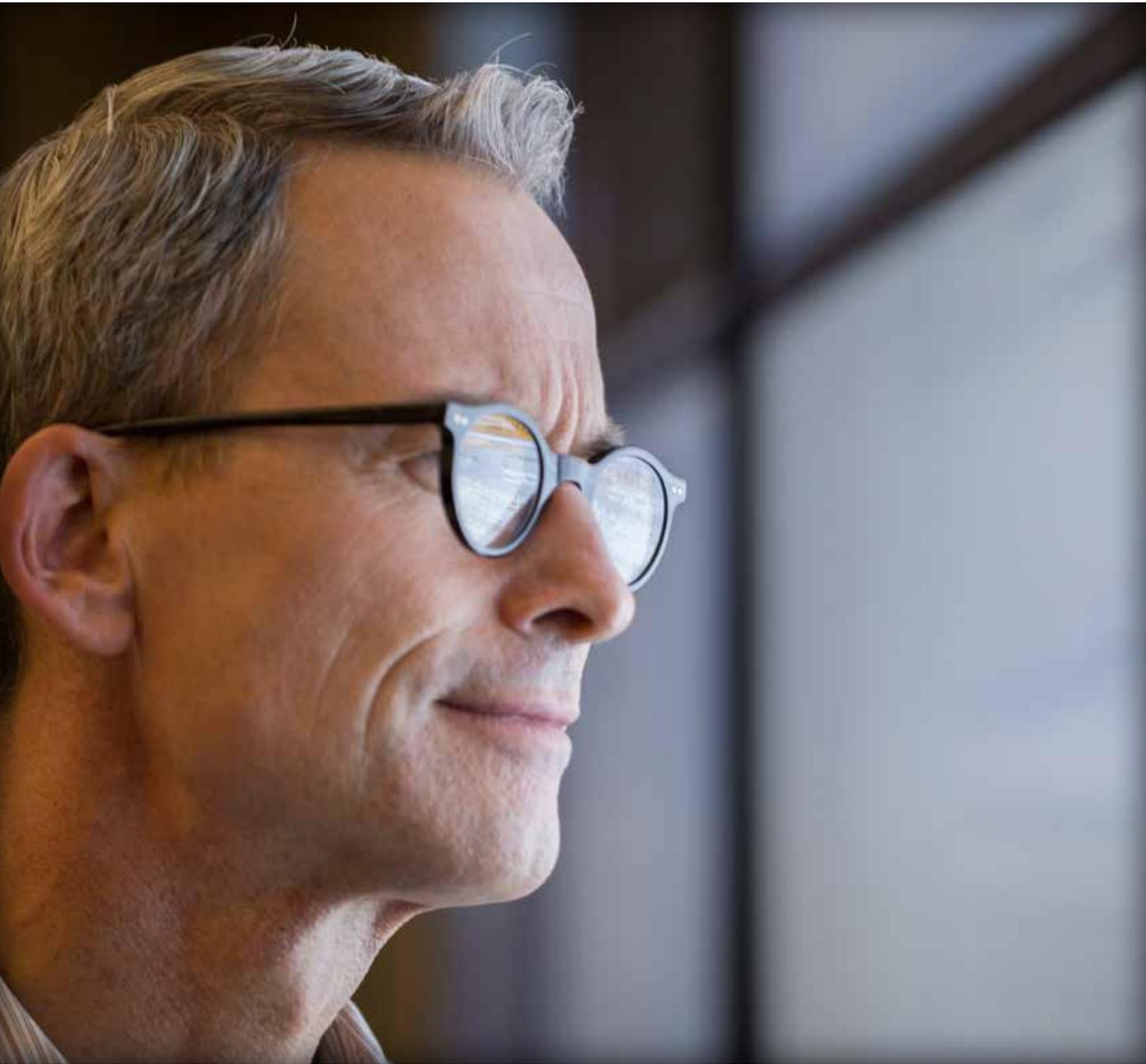
### How Optum can help

As regulations continue to expand in the health care market with risk adjustment programs and requirements related to quality metrics, it is challenging for health plans to determine what operational infrastructure and programs need to be in place and how to evaluate effectiveness of current organizational structures. Optum can help with:

- Optimizing organizational structure for efficient execution
- Getting the right analytic infrastructure in place to help guide decisions
- Integrating the right programs to improve quality results and compliance

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Plans should take full advantage of technology, operations to manage exchange markets

**A**s Affordable Care Act (ACA) exchange markets evolve, health plans managing these markets must face certain realities:

many exchanges have not functioned as anticipated, technology has not always worked as expected, pricing often has been driven by poor data and inadequate risk assessment, and the market has been in a state of flux. During the transition to a more stabilized, post-ACA world, plans that keep the endgame in mind — efficient, compliant, high-quality and price-competitive offerings — are more likely to be successful.

To achieve this success, plans not only must continue to focus on member acquisition and retention and clinical management, they also need to understand the new roles that operations, administration and technology will play in the new paradigm, according to John Lloyd, senior vice president, payer solutions, Optum, who spoke at a recent Optum Perspectives webinar, “Managing Individual Markets in a Post-ACA Environment.”

One of the most significant shifts that plans must navigate in the exchange markets is how to set prices that take into account unknown risks while also remaining competitive. “We realize that it’s always going to be a price-driven market because of the subsidies and the availability of the spreadsheet prices,” Lloyd said. By using operations that are unique to the market, “we are hoping some additional effort will create more consumer stickiness and less churn,” he told attendees. A more rational pricing strategy could come from “decent alignment between the cost to provide service and the market price,” he noted.

Optum believes plans currently should be building strategies to: develop “big data” analytics capabilities for risk-adjusted payment; focus on analytics as the framework for clinically evaluating members, collaborating with providers on cost of care, and modeling the most efficient path to managing and documenting members; and consider new approaches for modeling data, Lloyd stated.

## Expert presenters

### **Vinay Koneru**

Senior Director, Technology Solutions, Global Solutions, Optum

### **John Lloyd**

FSA, MAAA, Senior Vice President, Payer Solutions, Optum

## New environment calls for new approaches

Specifically, what plans are attempting to manage today is the convolution of quality, risk and data communications, according to Lloyd. Assessing members “not only for the purposes of risk transfer and risk adjustment, but also for care management,” is the goal in this new environment.

Vinay Koneru, technology solutions, Optum, explained that there are many uncertainties in the new ACA environment that can have an impact on membership acquisition and retention. “Previously we understood our members and our prospects, and we had enough information about the people we were going after,” Koneru stated. With the exchange, “we have no idea who we are getting.”

*Technology and algorithms can help plans understand the risks behind each member.*

— *Vinay Koneru*  
Senior Director, Technology Solutions, Global Solutions, Optum

Technology and algorithms can help plans understand the risks behind each member, “in spite of the absence of insurance claims data,” he asserted. “Technology solutions ... enable capture of the data and also enable actuarial teams to address and understand the risk” that the payer is assuming, he continued.

*“This process is “a zero-sum game of being in a competitive place and getting enrollment, or not being there, or having a competitive rate and not being able to sustain it economically. Your cost structure may not compute.”*

— John Lloyd

FSA, MAAA, Senior Vice President, Payer Solutions, Optum

The new reality for pricing in a post-ACA context is a sea change away from using an experience base to project the cost of care and set a price, Lloyd explained, and toward multiple-scenario pricing, where plans have to simulate competitive market outcomes, likely enrolled membership and enrollees’ risk mix, while also considering revenue and risk load requirements. In other words, Lloyd stated, pricing now represents an iterative process attempting to align emerging market potential, competitive pricing targets and feasibility within payers’ financial goals.

This process is “a zero-sum game of being in a competitive place and getting enrollment, or not being there, or having a competitive rate and not being able to sustain it economically. Your cost structure may not compute,” Lloyd said. “This is a tough way to price for actuaries, but there is logic to it and it is data driven, and we think that’s the way to conquer the problem that the market poses.”

Bottom line, he said, plans need to figure out “what it’s going to take to be competitive in a market that’s much more price-driven ... where the pivot point for your price may be much more narrowly defined.”

### Operations and technology are important levers

During the transition period, plans need to ask how they can minimize impacts on their exchange business by ramping up the use operations and technology while remaining focused on improving the overall member experience. Factors to consider in this area are continued price dispersion, different consumer types, member movement, and legacy data issues and process workarounds, Koneru suggested.

Figure 1

#### Pricing — Market feasibility as pricing



Although in the past plans could do a member risk assessment by developing a fixed strategy, with the exchange population “we continuously have to do an assessment on a day-to-day basis to determine what is my net risk today, what will my net risk be tomorrow, and what will it look like by the end of the year?” said Koneru.

As plans approach risk management, they need to consider how they can reduce risk and financial impacts. Operations and technology capabilities can help plans better understand membership volume and risk profiles, devise premium stabilization programs and monitor regulatory compliance. This approach should include a focus on strategy, analytics (particularly to understand consumer behaviors and patterns), audits, data quality (this should include accommodating scenarios where minimum data levels are not met or data are unavailable) and cross-functional engagement, Koneru continued.

Lloyd pointed out that in the past, plans could show a member a rate, but could not guarantee that rate because it had to be underwritten. “Now, all that’s gone. ... It’s a much more accelerated timeline and a much different set of contacts ... and the workflow is very different,” he said. “Part of what [Optum] has done is to figure out that data flow, how to validate it, and how to do it on a more real-time basis.”

## A step-wise approach to moving forward

Optum recommends that plans in the exchange markets take the following three steps to be successful:

- **Access data sources.** “We do quite a bit of upfront pricing using a much broader data set,” Lloyd said. This data set should include population health benchmarks, Centers for Medicare and Medicaid Services baseline data, member data and provider data. In analyzing these data sets, plans also should consider a comprehensive view of the member and apply clinical and market expertise to gain insights from the data. “How do we even begin to understand risk from a population perspective? The only way to do it is to broaden [data] as much as we can so it encompasses every possible risk opportunity,” Koneru said.
- **Aggregate and stratify the data.** Koneru posed the question of what it would take to identify the actual risk of the member and not rely primarily on claims information. He advised that clinical data and market insights be analyzed to create actionable care management plans for each member, and that these plans encompass both prospective and retrospective services. Further, plans should be funneling information to providers at the point of care.
- **Model the data.** Critical advances in risk management analytics highlight the value of a significantly more robust statistical logic to plan and manage best possible care, Lloyd remarked. Koneru added that the amount of financial risk involved is forcing plans to examine the entirety of the data set. “Every model needs to be put through each and every scenario, ... forcing us to find new ways of looking at things on a more purely operational basis,” he said. “We can’t look at the data once a quarter anymore. We have to look at it every day, week and month.”

Success in the post-ACA environment will be “heavily dependent on how effectively [organizations] are managing their risk ... and capturing the true risk of their members,” Koneru concluded. “You have to continually be aware of what the overall market risk looks like, as well as what your risk looks like, and enable, through your technology and operations, its management.”

## How Optum can help

Optum assists health plans meet the requirement to regularly submit claims and enrollment information to the Department of Health and Human Services (HHS) through an Edge Server. Optum HIX Edge Server Services offers health plans everything they need to be confident in cost-effective compliance:

- Seamlessly achieve data accuracy targets
- Help comply with all data submission and collection requirements
- Reduce the risk of resource-consuming audits
- Help meet applicable HHS timelines
- Access to robust, actionable reporting
- Data support (DQAR and RA/R) for discrepancy reporting process as outlined by HHS

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## Positioning for continued growth in public exchanges

**W**ith 4 million people enrolled in public health exchanges as of the end of 2014, most payers competing in federally facilitated marketplaces or state-based exchanges are finally beyond the initial stages of implementation. Payer can now envision taking their plans to a new level where they can deliver more consumer-oriented offerings and engagement approaches, supported by efficient operations, sophisticated data analytics and appropriately estimated risk management models.

Although the industry may not be quite there yet, payers should consider the pathway toward, and the benefits of, the next generation of public exchanges, according to Optum Perspectives panel members speaking at a recent webinar, “Public Exchange 2.0: Positioning for Future Growth.” The panel of Optum payer market experts was led by Jeff Lowry, vice president, payer exchange consulting, Optum, and included Mike Nestor, vice president, payer consulting, Optum; Craig Howarth, senior director, payer consulting, Optum; and Kecia Rockoff, director, actuarial consulting, Optum.

Lowry kicked off the panel discussion by sharing that Optum experts, who have been involved with the exchanges since October 2013, have done extensive work across state and federal exchanges in multiple states, serving as general contractors and systems integrators to help plans with enrollment, data centers, payments, financial management and reporting. Excerpts from the panel discussion are highlighted below.

**Lowry: What are the operational impacts or considerations that payers have dealt with in the 2014–15 open enrollment periods?**

**Nestor:** The context I will provide is heavily influenced by work on the federal exchanges and healthcare.gov. In terms of process for payers, this year seemed to be a much more stable experience compared to the prior year. There were major improvements across core elements of the system ... but more important was the consumer experience and the payer experience. Like any very large enterprise, in the first year the program may not be fully evolved, the second year

## Expert presenters

**Craig Howarth**, Senior Director, Payer Consulting, Optum

**Jeff Lowry**, Vice President, Payer Exchange Consulting, Optum

**Mike Nestor**, Vice President, Payer Consulting, Optum

**Kecia Rockoff**, Director, Actuarial Consulting, Optum

it is hitting stabilization, and in the third year, the goal is to have a more mature product. This was our second year, similar to other state-based exchanges, so it was a question of stabilization, making the consumer experience more predictable and also refining existing functionality.

*Although the industry may not be quite there yet, payers should consider the pathway toward, and the benefits of, the next generation of public exchanges.*

— Jeff Lowry  
Vice President, Payer Exchange Consulting, Optum

Unlike the prior year when there were tremendous spikes in enrollment, we had the expected spikes around the key dates at the start and end of open enrollment, so the experience was much more stable and steady. Payers, the marketplace and [the Centers for Medicare and Medicaid Services (CMS)] also focused on data reconciliation. The prior year, everyone was learning, it was all new and there was a lot of new functionality, so there was an opportunity this year to improve the data that was captured during that time period as we collectively learn more. There has been a heavy investment on all sides in improving the quality of the data.



**Lowry: What are the financial impacts or considerations that payers have dealt with in the 2014–15 open enrollment periods?**

**Rockoff:** It's a whole new ballgame for the financial and actuarial areas as well. It's very important to understand how data is coming in and what the challenges are with the data, what the most common errors are and what's getting fixed, so you know how to make estimates for the 3Rs [reinsurance, risk corridors, risk adjustment]. ... We have to anticipate what those are going to be without really having any data. ... As the 2014 experience rating data was coming in, the plans started [analyzing] the data and comparing it to their estimates of the 3Rs to see whether they were close or not, and had to start preparing the data to feed it to their edge servers, which was a big effort. I think most plans have been able to work with CMS and get that data loaded and are getting reports back.

It's very important right now to ensure the data is as accurate as possible, validate the data, see that CMS understands what they've received, and make certain that CMS is using the data that you sent correctly. These are all important for 2015–16. Also, plans are still filing rates with very little data, so you have to keep your finger on all of your estimates and make sure that they're coming in as expected. ...

The focus will continue to be on the consumer experience investment and acceleration of application entry, so we can improve the process and the quality of data. The other main focus is around

minimizing complexity both for consumers and payers. ... We are reaching a point of stability, having learned from the prior years.

**Lowry: What are the operational impacts or considerations that payers should be planning for in upcoming enrollment periods?**

**Howarth:** From a state-based exchange standpoint, there are a lot of challenges around the consumer experience. From working with the states you see there is a flow of information from the states out to the payers, which is a new thing in the industry ... having the state involved at the onset of that flow means there are some challenges and the immaturity of the model leads to unknowns. ... When it comes to consumer experience, how the consumer understands how to enroll and who to call are some of the challenges from both a payer's and the state's perspective.

From a payer standpoint, my answer is two-fold, for those already on state-based exchanges and for payers who may be just starting to get into that world. For those for whom the process is brand new, there is a lack of predictability. Generally, back-end processes are the same, but it's different at the onset of the process. During open enrollment, enrollment is going to increase, so that puts a burden on forecasting and operations to make sure that they are staffed appropriately...

It's very important right now to ensure the data are as accurate as possible, validate the data, see that CMS understands what they've received, and make certain that CMS is using the data that you sent correctly.

— Kacia Rockoff  
Director, Actuarial Consulting, Optum

Also, how can we ensure that the consumer experience — that regular connection with the member — is maximized from an efficiency standpoint? Does the payer have a consistent understanding of how to address general medical questions as well as billing questions? And how does that fit into the overall strategy, given that there are different ways of handling [those encounters]?

States obviously are challenged with how to handle the volume that's coming in, and that has a trickle-down effect to the payers. A payer on multiple state exchanges — which could include up to 26 different states — need to know how each state is affecting its operations. ... A payer we worked with [found that] one state's volume was 50 percent above forecast, which caused [unexpected] expense and tremendous stress on the operations.

Data reconciliation also is an issue right now. Are records at the state consistent with those of the payer? The difference between payer and SBM records could result in a lack of funds going back and forth, so plans have to work with the states to make sure that funds and enrollment are correct. ... And manual processes are [still] going to exist, so payers have to factor that in.

**Lowry: What are the financial impacts or considerations that payers should be planning for in upcoming enrollment periods?**

**Rockoff:** Reconciliation and understanding the manual processes are critical in your planning for 2015, 2016 and 2017. You need to know that the enrollment you think you have matches the enrollment that the state thinks you have, and you need to watch that on a consistent, weekly or monthly basis, depending on what measure you are looking at. ... Right now, plans are filing their rates for 2016, yet they won't know what the results of the 3Rs are until the end of this year.

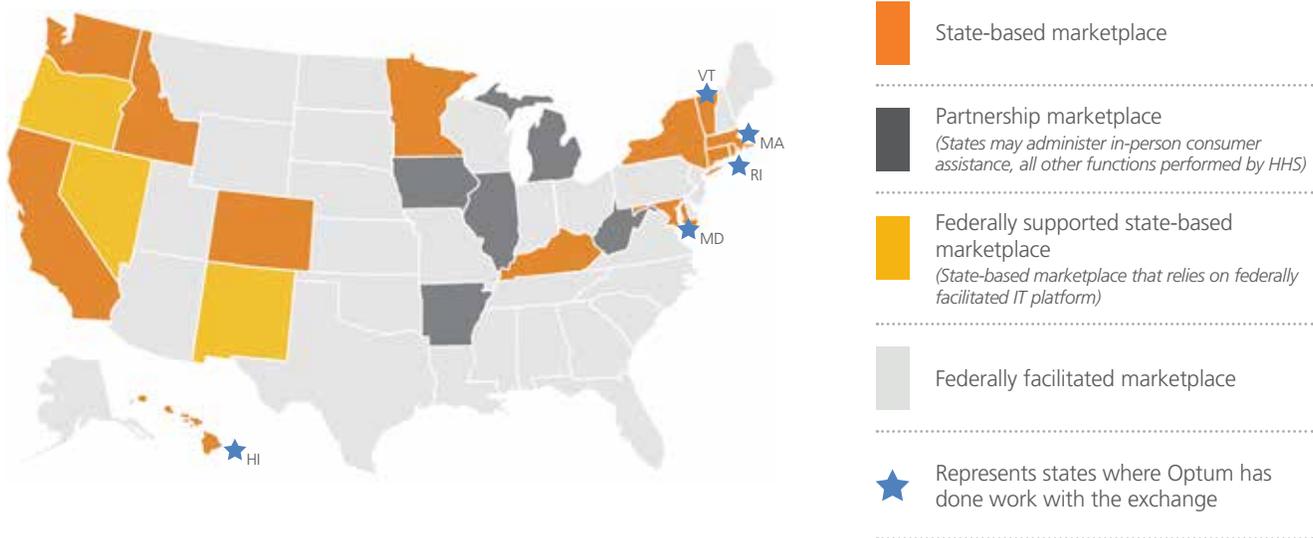
King v. Burwell is a big issue right now and a lot of plans have been asking their states if they can file two sets of rates to account for either outcome in that case. ... Another big change coming up is small group expansion. As of 2016, the small group definition is going to expand up to 100, and there are all kinds of risks associated with that. Some of these 'larger-smaller' groups may decide to self-insure. There's new reinsurance that's available to reinsure small populations like that, which may be an incentive for small groups to leave the market and leave the less healthy in the market, which can increase premiums for everyone. ...

It is important that you understand where you are today as much as you can with your data, so you can be prepared to make estimates and decisions in the future in this continuously changing environment.

**Lowry: What should payers be considering to account for any upcoming CMS policy changes (for example, prepping for audits, operational assessments, advanced analytics?)**

**Nestor:** A couple of things payers should be reminded of for this year and next year, in terms of open enrollment, is that a change in the enrollment date in 2015 — two weeks early — is a significant amount of time and reduces our collective time to prepare for open enrollment, which means any of our operational processes and case management, advertising and consumer engagement functions all need to have earlier steps to support that earlier date.

**Figure 1**  
**Geographic breakdown of exchange marketplaces**



Source: State Health Insurance Marketplace Types, 2015, KFF State Health Facts: <http://kff.org/health-reform/slide/state-decisions-for-creating-health-insurance-exchanges/>



Across the industry, we are also seeing a new focus on consumer retention. So what steps are you taking to ensure retaining your membership, whether through active outreach campaigns or leveraging direct enrollment, where you are keeping a consumer more guided toward your plan and the policies you offer on the exchanges? ... Plans also are looking at enhanced functionality. Exchanges will be migrating to more standard functionality moving forward. ...

The policy-level premium payment also is going to be critical as we move away from what's been in place over the last 12 months around group payments. I am seeing a move to understand the financial aspects of this, to use more sophisticated ways of

analyzing back-end data, to ensure accuracy and to focus on compliance-related activities in our future.

**Howarth:** In regard to the marketing aspect, state-based exchanges' ability to market is somewhat limited, and essentially comes down to brand and price, so we are really looking at retention rather than acquisition where it pertains to marketing. Over the last few years the marketing of health plans has gone from a membership model to a consumerism model. So how can we be more like the Targets of the world when it comes to marketing on a health care exchange? ... The crux of the matter really is this: Are the internal tools and capabilities there to execute on the strategies that are in place?

[When plans engage with members and provide individualized services,] the member may see that brand or that logo and be willing to pay a slightly higher price because the company has many products and services that give the member the experience to support maintaining that relationship.

So does the payer have the expertise and the tools to have a centralized data repository to start analyzing who the new members are, and how it can get risk assessment from both a financial and a marketing standpoint? What conditions are on board? What additional products and services do we as a payer have to offer members? How do we reach out from a one-to-one perspective rather than through mass marketing? Retention becomes even more key than it was previously. We shop based on brand and price instead of based on employer-based enrollment.

## How Optum can help

Optum assists our clients in positioning for success across both state-based and federally facilitated marketplaces whether they are entering an exchange for the first time or looking to expand into additional exchanges. With proven methodologies, customizable tools and experienced professionals, including consultants with over 200,000 hours of work directly supporting exchanges, we provide insights in the following areas:

- Market, financial and operational assessments
- Enrollment and payment reconciliation and remediation
- Interplay between exchange and Medicaid enrollment
- Profitability and segmentation analytics
- Marketing and brand strategy
- Consumer insights and segmentation
- Audits and filings

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# Biographies



**Mark Anderson**, Senior Vice President Technology and Innovation Risk Solutions Group, Optum

Anderson leads the innovation effort around risk solutions group, value-based reimbursement administration and advanced analytics. He holds more than 20 years of experience in executive leadership, strategy, MandA, budgeting, product commercialization, and advanced analytics within health and human capital services. Previously, he's been on the advisory boards for many national organizations and the strategic benefits board for leading Fortune 500 corporations. He was also the recipient of the renowned "Medistar Award" in 2008.



**Craig Howarth**, Senior Director, Payer Consulting, Optum

Howarth brings 15 years of experience in the health care industry, focused on process improvement and customer experience enhancement. He specializes in large scale transformations around operational improvements, data management, segmentation and campaign management. Most recently, Howarth led consulting work on both the Massachusetts and Vermont health insurance exchanges.



**Dr. Scott Howell**, Senior National Medical Director, Optum

Howell is responsible for risk adjustment, quality performance and predictive modeling. Prior to Optum, he was the regional chief medical officer (RCMO) for the Northeast Region of Americhoice, Inc., focusing on the Medicaid and Dual SNPs populations. He also served as the medical director for managed care at the AIDS Healthcare Foundation along with having responsibility for international consulting in Russia, Ukraine, Guatemala, Honduras and Haiti.



**Vinay Koneru**, Senior Director, Technology Solutions, Global Solutions, Optum

Koneru has more than 20 years of experience in the development of technology solutions. He has spent the past 12 years in the U.S. working in a variety of industries, including health care, telecom, education and finance. Since joining Optum, Koneru has designed and built an innovative solution for client reporting that can address current needs with an ROI of an 18 months.



**Mary Larson**, Risk Adjustment Lead, Network and Population Health Consulting, Optum

Larson has more than 10 years of experience improving health plan revenues, with specific focus on Medicare and Medicaid risk adjustment. In her role with Optum, Larson has provided management oversight of prospective risk adjustment business, led the risk adjustment strategy development and tactical planning for a large regional Medicare Advantage (MA) health plan.



**John C. Lloyd, FSA, MAAA**, Senior Vice President, Payer Solutions, Optum

Lloyd has more than 25 years of experience in the group insurance industry, managing the financing and administration of health and life products. His experience includes financial reviews and actuarial appraisals of HMOs, Blue Cross and Blue Shield (BCBS) plans and commercial carriers; capital and surplus management for health entities. Lloyd is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries (AAA).



**Jeffrey K. Lowry, BS, MHA**, Vice President, Payer Exchange Consulting, Optum

Lowry brings 30 years of experience from both the provider and payer arenas to his role at Optum, most recently setting up an exchange health plan (individual products) on the state of New York marketplace. Lowry leads strategy development and consulting delivery implementation for Optum, working across both public and private exchanges.



**Ryan McKeown**, Quality Lead, Network and Population Health Consulting, Optum

McKeown leads the strategy and delivery of consulting offerings to develop, implement and drive successful integrated quality programs in the Medicare Advantage, Medicaid and commercial/ACA space. His specific areas of focus include governance, strategy, financial/ROI, engagement programs, technology, data management and analytics across HEDIS, CAHPS, HOS, pharmacy and operations measures.



**Michael Nestor**, Vice President, Payer Consulting, Optum

A successful executive with almost 20 years' experience, Nestor has led complex enterprise business and technology initiatives to deliver innovative new products and technology solutions that enhance customer satisfaction, drive revenue growth and reduce operational expenses. Since joining Optum, Nestor has held multiple positions with responsibilities for client project delivery, client account management, operational improvement and organizational leadership.



**Kecia Rockoff, FSA, MAAA**, Actuarial Director, Payer Consulting, Optum

Rockoff brings 25 years of experience in the financial aspects of health care management. She specializes in developing predictive solutions to measure the actuarial and financial impact of market changes, such as changes to 3Rs and ICD-10 as a result of the Affordable Care Act (ACA). Most recently, she has participated in a variety of consulting roles on health insurance exchanges, and the Federally Facilitated Marketplace.

# Perspectives

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