
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Engaging Consumers in their Care – Experiences from Care Coordination and Beyond

Health Insurance Marketplace HealthCare.gov

Member Engagement

Anand A Shukla
Senior Vice President
Centene Commercial Solutions

October 5, 2016

Health Insurance Marketplace HealthCare.gov

Centene at-a-glance

CENTENE® Corporation

WHO WE ARE

St. Louis

based company founded in Milwaukee in 1984

28,900 employees

#124

on the Fortune 500 list

#4

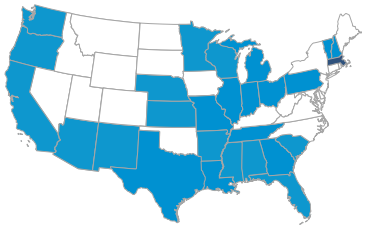
Fortune's Fastest Growing Companies (2015)

$39.4 - $40.0 billion

expected revenue for 2016

$7.5 billion in cash and investments

WHAT WE DO



28 states

with government sponsored healthcare programs

- **Medicaid** (24 states)
- **Exchanges** (14 States)
- **Medicare** (12 States)
- **Correctional** (8 States)

2 international markets

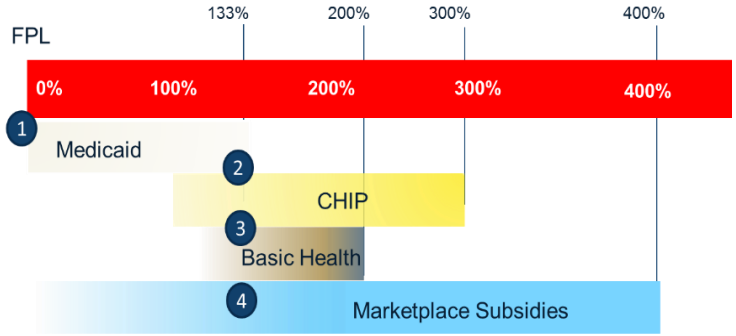
11.4 million members

includes 2.8 million TRICARE eligibles

~290 Product / Market Solutions

Marketplace Footprint

- Providing coverage to the previously **uninsured and underserved** populations
- Specific focus on **lower income, subsidized members** under 400% of the Federal Poverty Level
- Committed to collaborating with CMS and state regulators to deliver **affordable access to quality care** through Marketplace
- **Disciplined approach to pricing** to ensure sustainable position

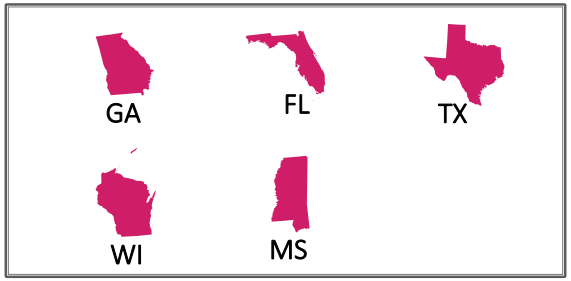


State based Marketplaces, Medicaid Expansion

Medicaid Expansion via Marketplaces

Medicaid Expansion, FFM

Non-Medicaid Expansion, FFM



State based, Active Purchaser, Medicaid Expansion

Brand Pillars

Local

- We live and work in the **same communities**.
- We **partner with local health care providers and community organizations** to provide access to care for our members.

Helpful

- We offer **valued guidance and assistance** to make health insurance accessible.
- We **remove barriers** to make it simple to get well, stay well, and be well.

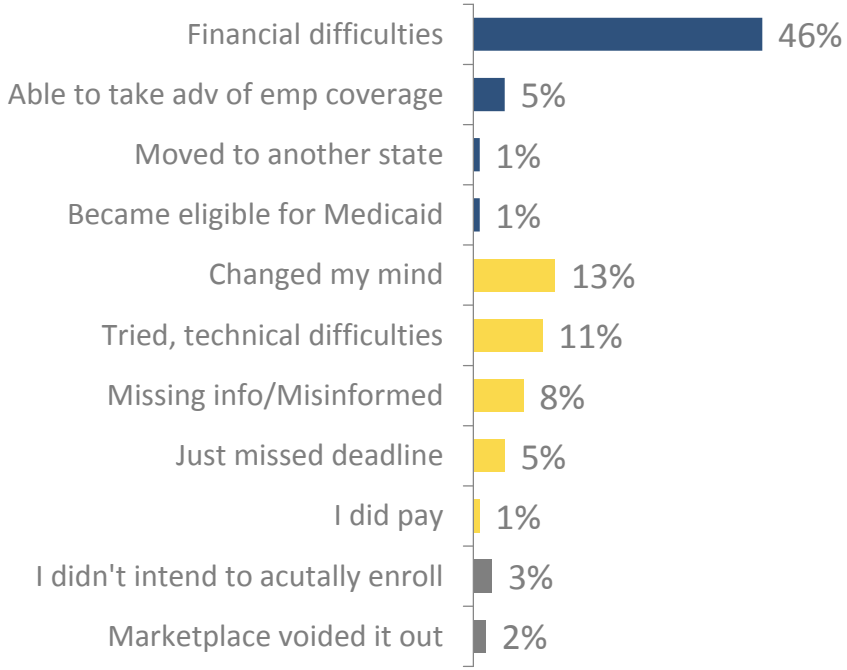
Affordable

- We offer **affordable and reliable** health care insurance coverage.
- We provide **well-rounded services and choices** to help our members achieve their best health.

Taking a Pulse…

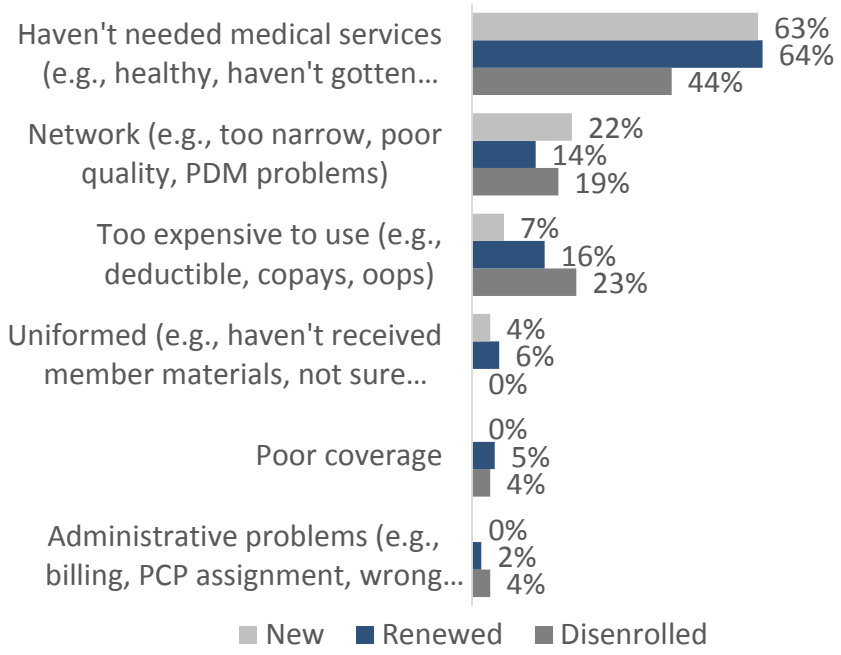
CENTENE® Corporation

Reason for Not making a Binder Payment

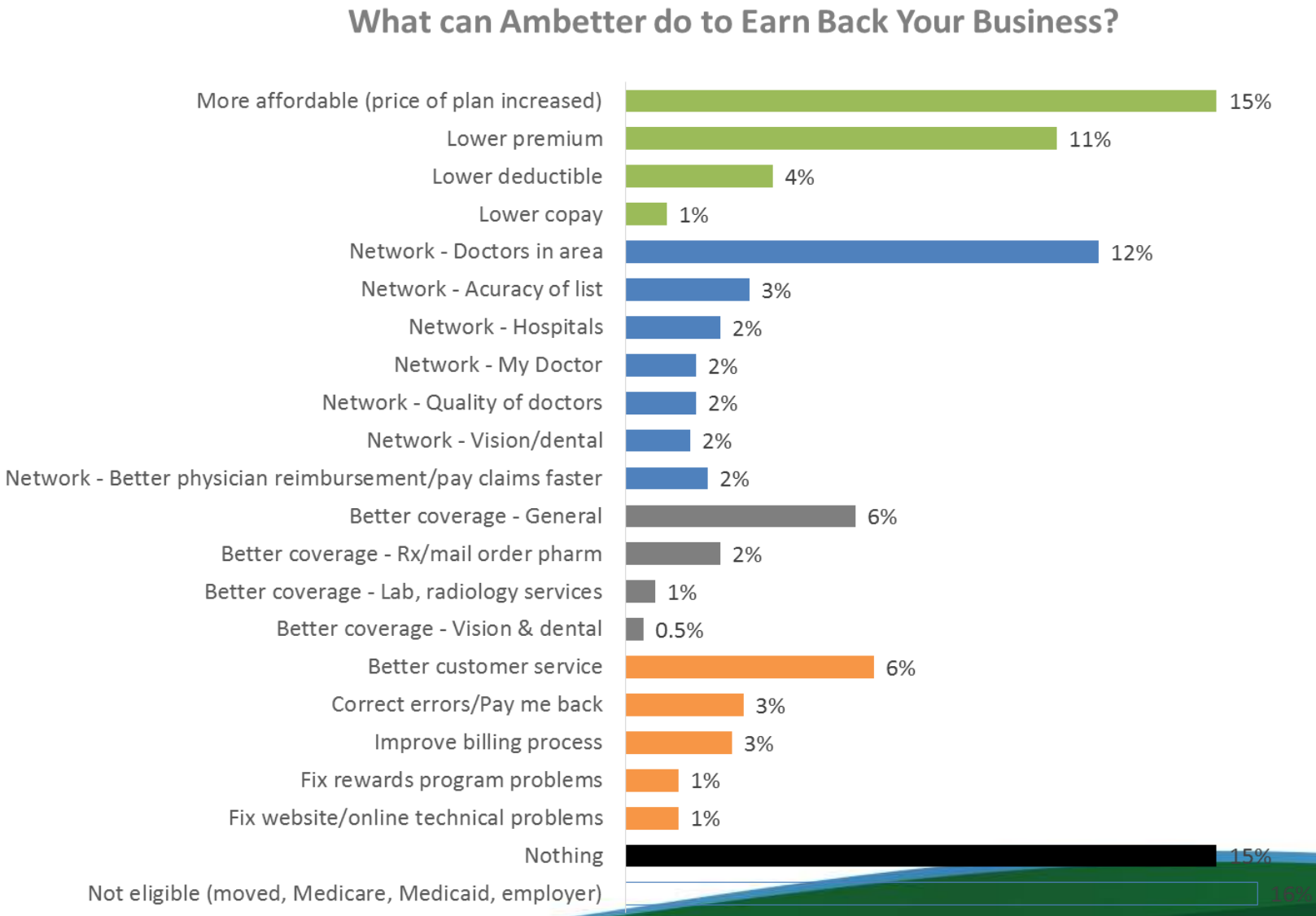


Reasons for Non-use

Base: Those who haven't/didn't use at all

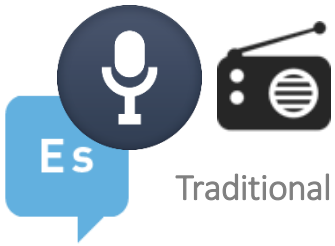


Taking a Pulse…

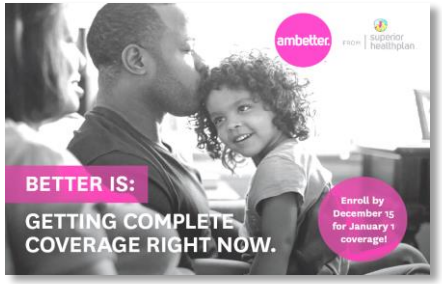


Integrated External Presence

CENTENE® Corporation



Traditional Media



Local Advertising

Community Events

ambetter.

Digital Media

Social Media

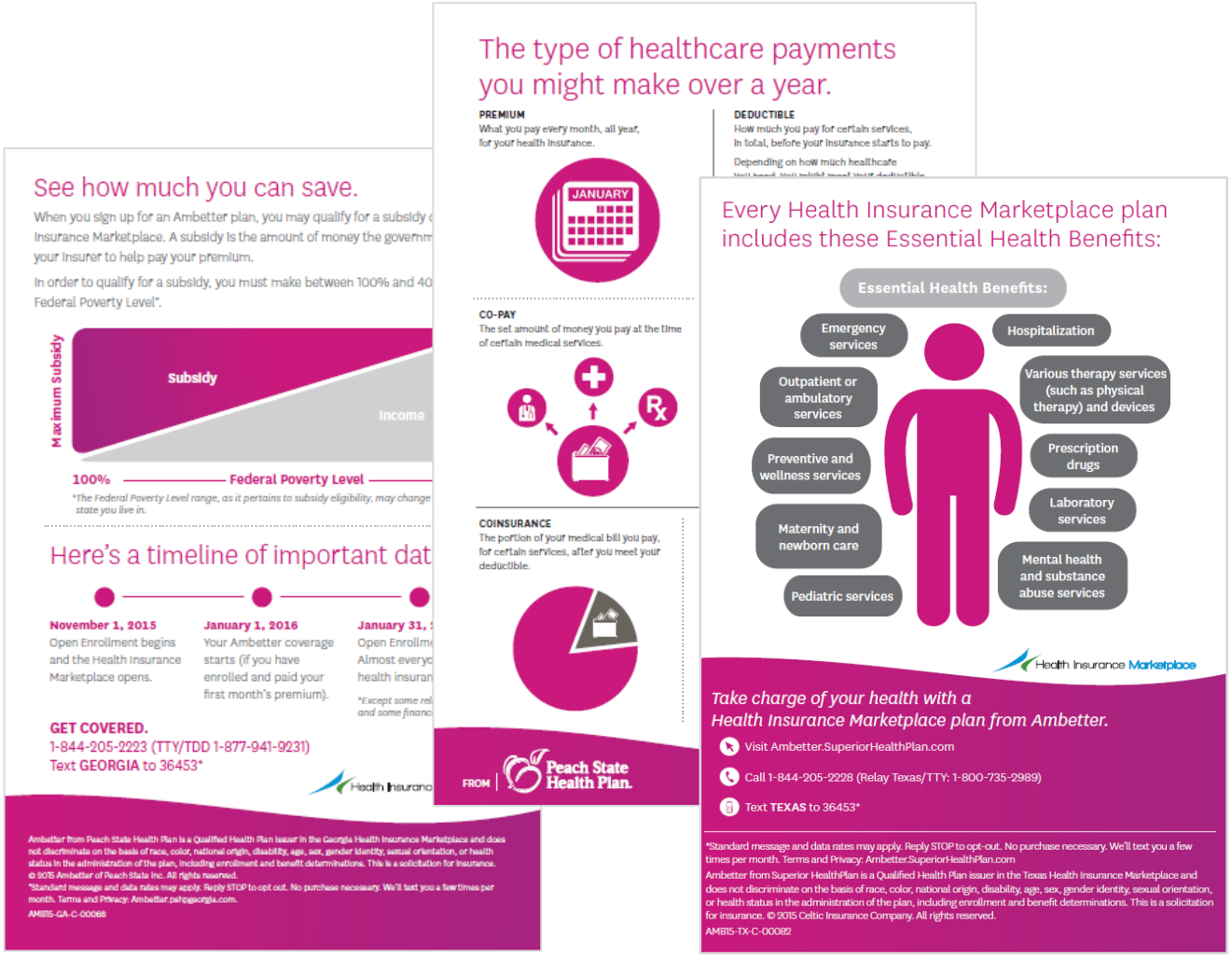
Owned Media

Education: Quick Guide Cards

CENTENE® Corporation

Quick Guide Cards

- Insurance jargon simplified!
- Subsidy education
- Buying a plan on the Health Insurance Marketplace
- Essential Health Benefits
- Important Enrollment Dates
- Importance of making timely payments



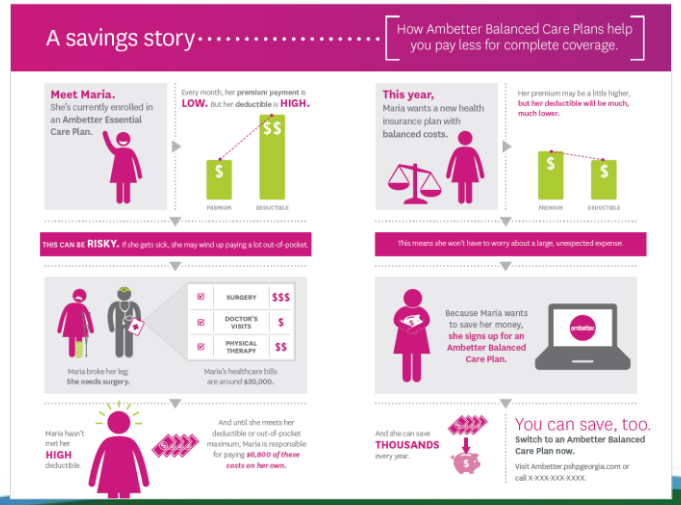
Ongoing Member Engagement

CENTENE® Corporation

Pre Member

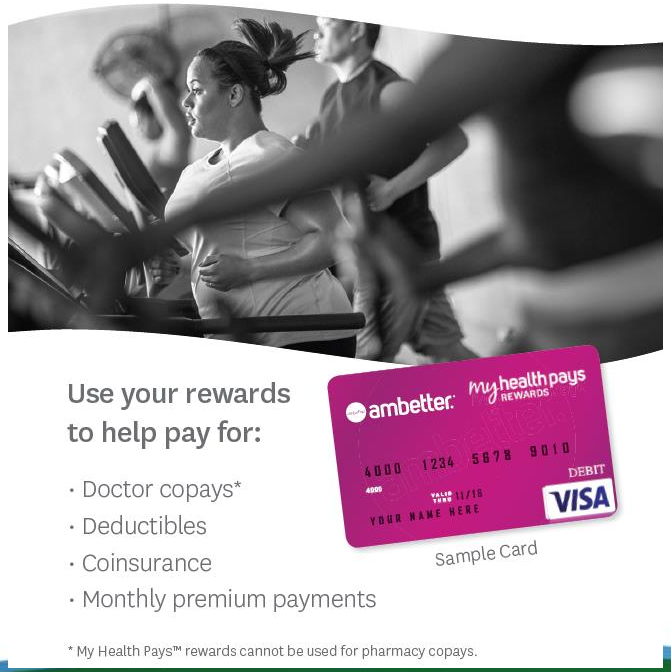
Member Onboarding

Renewal



MyHealth Pays Reward Program

- A unique incentive program that rewards members for healthy behaviors
- Members can earn rewards for **Annual Wellness Visits** ($50), **Flu Shots** ($25), filling out a **Member Welcome Survey** ($50), and going to the **Gym** 8 times per month ($20/month)
- The reward dollars are loaded onto a limited use card that can be used to pay out of pocket costs (copays, deductibles, etc) or monthly premium payments



CMS
Highmark Complex Care Management Model

October 5, 2016

Charles DeShazer, MD
VP & Executive Medical Director
Medical Management & Quality

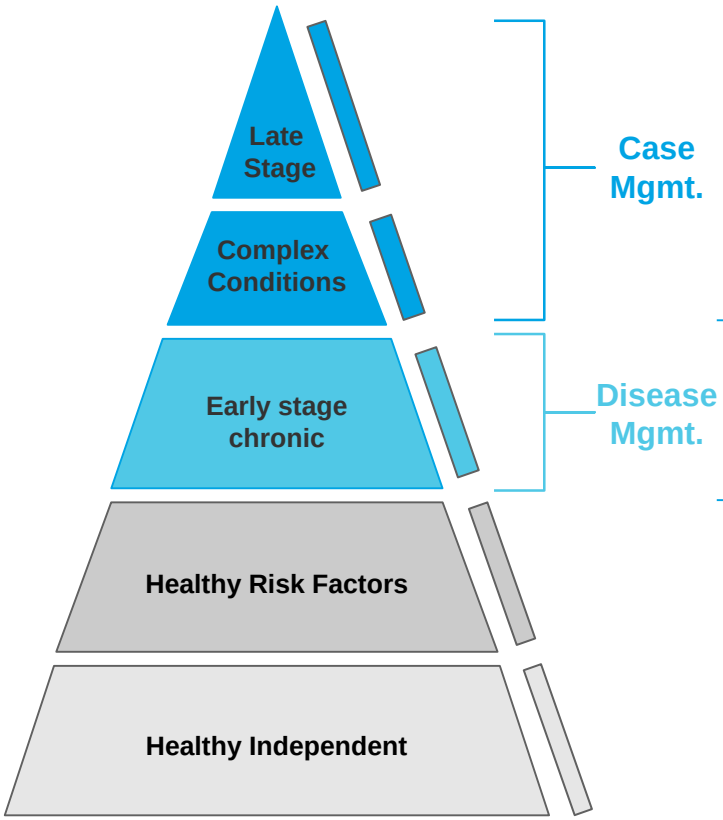
HIGHMARK®

Government Markets Complex Care Model is oriented around 5 key components

1	Target members	Identify members with clinical needs that can be addressed by Highmark care team and that have greatest opportunity for impact
2	Programs and interventions	Align suite of programs and interventions to address unique needs of the target population and to focus on opportunities for greatest impact
3	Staffing model	Create role specialization, engage multidisciplinary care team members to fullest extent and allow clinicians to work at top of license
4	Approach to member management	Assign ownership over geo-based panels to improve coordination and continuity of care with local vendors, providers and community resources
5	Program effectiveness	Shift away from heavy focus on process metrics towards a comprehensive view of both process and outcome based metrics, e.g., clinical, cost, utilization

The Complex Care Model targets high risk members with characteristics that indicate opportunity for impact

Target members from clinical segments



- Case mgmt. targets members with characteristics that indicate an opportunity to improve health and well-being and holistically manage member needs while positively impacting outcomes and the **ability to help member reduce utilization** and spend (e.g., members with ESRD are excluded)
  - Individual ACA members that fall into this population typically have an **avg. annual cost of $27K**
  - Risk score, likelihood of hospitalization and number of care gaps for these members is higher than **90% of all members**
  - Many of these members also have **diagnoses for behavioral health**

- Disease management targets members with **one of 5** chronic conditions, **COPD, CAD, CHF, Diabetes, Asthma**, that have a high enough risk score or care gap index indicating opportunities to improve member's health

While the model does not focus on engaging healthy members, these members are included in the Complex Case Manager's geo panel and will naturally show up on Complex Case Manager's radar if their health deteriorates

The approach to more effective member management through the Complex Care Model is oriented around 3 guiding principles

1. MA and ACA members are managed in geo-based panels to improve coordination and continuity of care with local vendors, providers and community resources

2. Case managers act as ‘quarterbacks’, fully owning their member panel and engaging a multidisciplinary care team to holistically manage member needs

3. The multidisciplinary care team is organized in pods across geos, flexing their role in member management based identified member needs

Care Management: Health Plan Complex Care Model

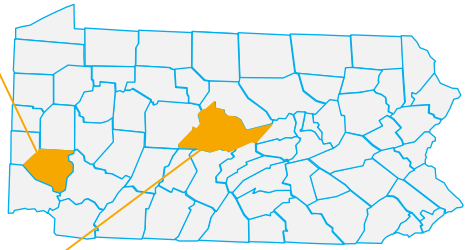
Leveraging the strengths of a multidisciplinary team to meet member needs through a **telephonic** engagement approach

Case Manager

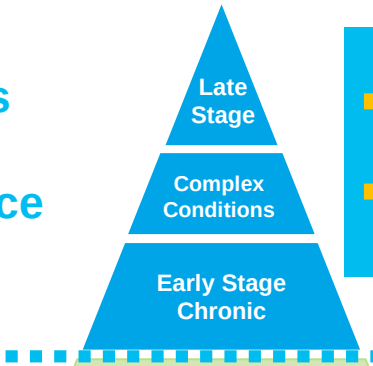
Geographic panels developed for Med Adv and ACA members to strengthen connections with members and providers by creating continuity of case management resources.

Case Manager

Complex Case Managers serve each geography with knowledge of the local community needs and resources



Target members where we can make a difference



Keep healthy members healthy

Manage Medical Costs

Improve Care Coordination

Strengthen Connections

HIGHMARK®

Q&A Session

To engage on social media use the following hashtag: **#issuerinsights**

To submit questions remotely, email us at: **Partnership@cms.hhs.gov**

Health Insurance Marketplace HealthCare.gov

Marketplace Year 3: Issuer Insights & Innovation

Health Insurance Marketplace HealthCare.gov