Sunday, October 23
3:00 pm – 5:00 pm Registration and Information Desk Open

Monday, October 24
6:45 am – 5:45 pm Registration and Information Desk Open
6:45 am – 5:45 pm Registration and Information Desk Open
8:00 am – 8:45 am Sponsored Breakfast Briefings

**What Does the Future of Medicare Enrollees Look Like?**
*Powered by Deloitte*

As Baby Boomers increasingly join the ranks of Medicare eligibles, Medicare Advantage (MA) plans will need to know how to attract and retain this population, as well as what might be some of the cost and affordability implications of this next wave of enrollees. With an older population already on Medicare for several years and the younger half of the generation still more than ten years out, the differences in characteristics could potentially be significant; including use of online services, shopping habits, and other key characteristics. Understanding their decision making processes is critical to the business of MA plans and enrollee buy-in. Attendees will learn how future beneficiaries differ from current ones and whether their preferences, habits, and decision making processes differ. Speakers will share findings from their primary research on consumer attitudes, preferences and priorities that shed light on these strategic questions.

- **Claire Boozer Cruse**, Lead Market Insights, Deloitte Center for Health Solutions, Deloitte Services LP
- **Leslie Read**, Principal, U.S. Health Plans Consumer & Digital Transformation Leader, Deloitte Consulting LLP

**The State of Value-Based Reimbursement in 2016**
*Powered by McKesson Health Solutions*

Value-based insurance design (V-BID) and reimbursement are often cited as potential solutions to questions of cost. Value-based proposals continue to garner interest and bipartisan support from multi-stakeholder groups. During this session, information will be newly released and highlight technologies providers and payers are employing on their journey to value-based reimbursement. Learn how connecting payer systems can help accelerate the value realized from these new, innovative models.

- **Andrei Gonzales, MD**, Director VBR Initiatives, McKesson Health Solutions
Monday, October 24

8:00 am – 8:45 am

Sponsored Breakfast Briefings (continued)

Improving Star Ratings Utilizing Lead Indicators for Operational Metrics
*Powered by Dell Health Plan Innovation & Consulting*

Have you ever wondered what your health plan could do to improve CAHPS and/or HOS measures that are part of the Medicare Advantage Star Ratings? How can a health plan influence responses to the questions on these surveys? This session will explore how to use operational metrics as lead indicators to provide insight to Stars Ratings measures that are based on survey data, as well as using supplemental data sources (e.g. social media) to assist in identifying opportunities for improvement.

- **Suman De**, Principal Healthcare Innovation & Business Development Consultant, Dell Health Plan Innovation & Consulting
- **Deana Rhodes**, Dell Health Plan Innovation & Consulting
- **Karen A. Way, MHA**, Health Plan Innovation Lead, Analytics Solutions Architect, Dell Health Plan Innovation & Consulting

Transforming While Performing in a Rapidly Evolving Industry
*Powered by Cognizant*

Transformative market forces, coupled with rapid advances in digital technologies, are placing consumers at the center of an increasingly virtualized, personalized and delocalized healthcare system. Government health plans are looking for new ways to drive down costs and maintain compliance while shifting from volume to value and creating a personalized experience for their members. Addressing these challenges will require broad new capabilities, from improving administrative efficiencies, through building business models based on quality of outcomes, and implementing digitized processes that address consumer demands for product customization and more control over their care decisions. How will your organization embrace change and succeed in our rapidly evolving healthcare landscape when faced with so many competing priorities? Join us for a discussion of strategies that can help impact your organization’s success today and tomorrow.

- **Becky Erbe**, Vice President, Government Solutions, Cognizant
- **Diana Sonbay-Benli**, Vice President, Government Solutions, Cognizant
Monday, October 24

8:00 am – 8:45 am  Sponsored Breakfast Briefings (continued)

Understanding How Medicare Age-ins Navigate Enrollment
Powered by eHealth, Inc.
This session will highlight the results of a recent qualitative in-home study with 30 current Medicare enrollees, as well as quantitative research with 2,000 current and future Medicare enrollees. You will learn how consumers navigate health insurance options, enrollment, and make health care decisions. The speakers will also discuss how health plans can help Medicare beneficiaries make more informed choices when shopping online.

- Lorrianne Nault, Senior Director, User Experience Design, eHealth, Inc.
- Nate Purpura, Vice President, Communications, eHealth, Inc.
- Jennifer Wheat, Senior Manager, Customer Care, eHealth, Inc.

Network Adequacy Requirements in Medicare and Medicaid: What You Need to Know
Powered by BRG
Health plans are creating new and more complex provider networks in an effort to increase quality and reduce costs. These new networks are receiving increased scrutiny by regulators at both the federal and state level. In addition to the adequacy of the network itself, regulators and consumers are increasingly focused on provider directory accuracy given the complexity of new provider networks and the out-of-pocket costs associated with out-of-network services. Recent regulatory developments underscore the importance of this issue as well as the operational challenges health plans face in meeting these requirements. This session will provide an overview of the efforts to define adequacy and accessibility, including a discussion of recent developments in federal Medicare and Medicaid requirements.

- Jeremy Earl, Partner, McDermott Will & Emery
- Brian E. Hoyt, Managing Director, BRG

Changing Payer-Provider Relationship – Are You Prepared?
Powered by Payspan
This session will provide a snapshot of key changes taking place with new ACO alternative reimbursement models and how they will impact payer-to-provider relationships for reimbursement. These new dynamics will affect payers as providers struggle with performance base reimbursement and new governance requirements. The traditional relationship between payers and providers will change significantly in the coming years. Are you ready to handle these challenges while at the same time providing superior service to your members and meeting consumer expectations? Join this session to take a look ahead and discuss how you can apply solutions now.

- Bill Nordmark, Chief Growth Officer, Payspan
Monday, October 24

8:00 am – 8:45 am  Sponsored Breakfast Briefings (continued)
**Embedding Flexibility in Solutions to help Transform Payer Organizations**
*Powered by ikaSystems*

This session will provide perspectives on current and forward-thinking solutions that help (and will help) payers transform their business so it can effectively compete and thrive in era of accelerated changes. Attendees will learn about real-world challenges related to driving engagement, regulatory compliance, and reducing administrative costs. Attendees will also learn why innovative flexible technology solutions are a must to address these payer challenges.

- **Girish Pathria**, Vice President, Product Management and Marketing, ikaSystems

9:00 am – 9:45 am  Welcome and Opening Keynote
**Priorities and Future Directions for Medicare Advantage and Part D: View from CMS**

- **Sean Cavanaugh**, Deputy Administrator and Director, Center for Medicare, Centers for Medicare & Medicaid Services (CMS)

9:45 am – 10:15 am  General Session
**How Medicare Advantage Plans Improve the Lives of Low Income Beneficiaries**

- **Pat Wang**, Chief Executive Officer, Healthfirst

10:15 am – 10:35 am  Break with Table Tops

10:40 am – 11:25 am  Concurrent Sessions
**Operations: Ongoing Development of the Encounter Data System**

Speakers will discuss the continued development of the Medicare Advantage Encounter Data System (EDS), including efforts to create a more stable data submission and validation process.

- **Eric E. Cahow**, Vice President, Medicare Revenue Management, Anthem, Inc.
- **Mark E. Miller, PhD**, Executive Director, MedPAC
Monday, October 24

10:40 am – 11:25 am

Concurrent Sessions (continued)

Compliance: CMS Provider Directory Monitoring Initiative: Key Findings and Lessons Learned
This session will highlight CMS’ monitoring efforts related to Medicare Advantage provider directories. In addition, best practices for health plans working to improve provider directory accuracy will be shared.

- Christine M. Reinhard, ESQ, MBA, Health Insurance Specialist, Division of Surveillance, Compliance and Marketing, Medicare Drug and Health Plan Contract Group, Centers for Medicare & Medicaid Services (CMS)
- Jeremy Willard, Health Insurance Specialist, Division of Surveillance, Compliance and Marketing, Medicare Drug and Health Plan Contract Group, Centers for Medicare & Medicaid Services (CMS)

Care Management: Are your Quality Strategies Working?
*Powered by Quest Diagnostics*
As healthcare continues to transition to a value-based care model, addressing quality and gaps in care is increasingly critical to positive health outcomes and business success. This session will share insights on how different health plans are improving quality outcomes, from real-time analytics at the point of care to in-home clinical risk assessments. Learn strategies to make the most informed clinical and operational decisions—and improve the health of your members, and your bottom line.

- Patrick James, MD, Chief Medical Director, Quest Diagnostics

Technologies & Business Solutions: Personalization: The Secret to Driving Engagement and Improving Health Outcomes
*Powered by Welltok*
The secret to fully understanding and engaging your senior members – both within and outside of the healthcare system – lies in taking a systematic approach to engagement centered around personalized member experiences. By using a combination of consumer data, applied analytics, incentive design, and multi-channel communications, you can improve the beneficiary experience and improve Stars performance – whether it’s member satisfaction and retention or diabetes care and gaps closure. This session will reveal new insights on seniors, including their increasing use of technology to improve their health and what it means for your engagement initiatives. Speakers will also explore how to leverage data, CMS-compliant incentives and enterprise-level technologies to create a truly personalized and rewarding experience for your Medicare members, that’s also scalable. Your seniors are ready, are you?
Monday, October 24

11:30 am – 12:15 pm

**Concurrent Sessions**

**Operations: Insight to Improve the MA Value-Based Insurance Design Model**

Speakers will discuss the Medicare Advantage Value-Based Insurance Design (MA-VBID) model test that starts on January 1, 2017 and model improvements to promote quality of care and reduce health care costs for Medicare Advantage beneficiaries.

- **Adam Finkelstein**, Health Insurance Specialist, VBID Lead, Seamless Care Models Group, Center for Medicare and Medicaid Innovation (CMMI), Centers for Medicare & Medicaid Services (CMS)
- **Helene Weinraub**, Vice President, Medicare, UPMC Health Plan

**Compliance: MA/Part D Denials, Appeals & Grievances: Best Practices and Common Findings**

Speakers will discuss recent CMS audit findings related to denials, appeals and grievances and provide insight on practical tools and best practices that MA organizations and Part D plan sponsors can implement to improve performance.

- **Beckie Peyton**, Division of Appeals Policy, Medicare Enrollment and Appeals Group, Centers for Medicare & Medicaid Services (CMS)
- **Jennifer M. Smith**, Director, Division of Analysis, Policy & Strategy, Medicare Part C & D Oversight and Enforcement Group, Centers for Medicare & Medicaid Services (CMS)

**Technologies & Business Solutions: Using Analytics to Identify and Strategically Manage Patient Opioid Abuse**

*Powered by Verscend*

Opioid abuse continues to be a chronic health care issue, impacting every community across the country. Health plans managing Medicare and Medicaid populations face ongoing challenges in successfully addressing members with opioid abuse problems, and will benefit from proactive identification and intervention before potential risk turns into full-blown addiction, or worse. This session will explore the use of data analytics to identify potential opioid abuse patterns, including the use of predictive modeling and benchmarking. The session will also provide practical tactics to use data to develop and deploy clinical support to patients at-risk to curb potential long-term abuse.

- **Philip Finocchiaro, MD, FACP**, Senior Medical Director, Quality and Clinical Outcomes, Verscend
- **David Rearick, DO, MBA, CPE**, Chief Medical Officer, Marsh & McLennan Agency, Mid-Atlantic
Monday, October 24

11:30 am – 12:15 pm  Concurrent Sessions (continued)
Care Management: The Importance of Collaboration in Supporting SNP Members 
*Powered by Vital Decisions*
In this interactive session, the speakers will discuss the role that collaboration among providers, health plans and other stakeholders plays in supporting members who are coping with advanced illnesses and approaching end of life. Hear about the strategies one health plan employed to support and meet the special needs of their D-SNP members.

- **Connie Ducaine**, Director, Clinical Account Management, Vital Decisions
- **Mary Mailloux, MD**, Medical Director, Medicare Dual-Eligible Special Needs Plan (D-SNP), Coventry Health Care of Florida

12:35 pm – 1:35 pm  General Luncheon Session
*How the Medicare Advantage Program Enhances Consumer Choice*

1:40 pm – 2:25 pm  Concurrent Sessions
Compliance: Medicare Risk Adjustment Data Validation Audits: What You Need to Know
Experts will discuss recent developments in CMS’s RADV program including the ongoing MAC contracting efforts, the fee-for-service adjuster, and best practices to ensure more effective data submission processes.

- **Thomas E. Hutchinson**, Strategic Advisor, EBG Advisors, Inc.

Care Management: Strategies to Better Understand and Address Health Care Disparities
Speakers will discuss recent CMS data detailing the health care experiences and quality of care received by diverse Medicare Advantage populations. Strategies that plans can implement to reduce health disparities will also be shared.

- **Madeleine A. Shea, PhD**, Deputy Director, Office of Minority Health, Centers for Medicare & Medicaid Services (CMS)
- **Ghita Worcester**, Senior Vice President, Public Affairs and Marketing, UCare
Monday, October 24

1:40 pm – 2:25 pm  Concurrent Sessions

**Operations: Are You Ready for a CMS Audit? Perspectives on What You Need to Know**
*Powered by Cody Consulting*

This session will provide a front row seat to a 2016 Medicare Advantage plan audit by CMS. Attendees will learn about the audit process, a few unexpected audit actions, and some insights on what the speaker wished he had known prior to the audit. The speaker will also provide some recommendations on what, and how plans must prepare – including technology solutions that can support the health plan’s burden of “proof”.

- **Mike Turrell**, CEO, Ultimate Health Plans

**Technologies & Business Solutions: Using Segmentation and Analytics to Optimize Plan Performance and Increase the Star Rating**
*Powered by Novu*

If you are seeking to understand the inner workings of how analytics matched with omni-channel technology can improve your plans’ ability to meet beneficiary needs and increase your Star rating, then this session is designed for you. Join us to learn about the process, tools and technologies required to build a successful reward and incentive program for your health plan.

- **Tom Wicka**, CEO and Co-Founder, Novu

2:30 pm – 2:50 pm  Dessert Break

2:50 pm – 3:30 pm  General Session

**Delivery of Care Models: Plan-Provider Collaborations to Promote the Right Care at the Right Time**

Leaders will discuss innovative programs that take best advantage of health plan and provider capabilities to address the needs of Medicare beneficiaries.

- **Eric Haas, MD**, Senior Medical Director, Medicare Cost & Performance Solutions, Florida Blue
- **Glen R. Stream, MD, MBI**, President and Chair, Family Medicine for America’s Health
- **Ankit Patel**, Vice President, Clover Health

3:30 pm – 3:50 pm  General Session

**Why Medicare Advantage Is Important: How Health Plans Are Shaping the Medicare Program**

- **Marilyn Tavenner**, President & CEO, America’s Health Insurance Plans
Monday, October 24

3:50 pm – 4:05 pm  Break

4:05 pm – 4:45 pm  General Session
  **The Spillover Effect: How MA is Influencing the Fee-for-Service Program**
  This session will highlight new research demonstrating the effects Medicare Advantage plans have on improving care and reducing costs throughout the Medicare program.
  - **Jose F. Figueroa, MD, MPH**, Instructor of Medicine, Harvard Medical School
  - **Austin Frakt, PhD**, Health Economist, Department of Veterans Affairs, Boston University, Harvard University

4:45 pm – 5:45 pm  General Session
  **Implications of the 2016 Election for Public Programs**
  - **Avik S. A. Roy**, Former Senior Fellow, The Manhattan Institute; Opinion Editor, Forbes

5:45 pm – 7:15 pm  Networking Reception

Tuesday, October 25

7:00 am – 6:30 pm  Registration and Information Desk Open

8:00 am – 8:45 am  Sponsored Breakfast Briefings
  **Understanding the Dynamics of Socio-Economic Status and Star Ratings: How to Overcome Barriers to Accurately Measure Medicare Advantage Plan Performance**
  **Powered by Inovalon**
  There is growing awareness in the healthcare industry that the socio-economic status (SES) of a Medicare Advantage health plan’s members can have a big impact on its quality ratings. With quality ratings increasingly linked to reimbursement and member retention, understanding the impact of SES factors on CMS Star Ratings is key. This session will provide an update on current research related to which SES factors most affect quality ratings for specific measures and provide perspective on the current CMS proposals to address SES in Star Ratings. Speakers will explore how research findings can help shape your strategies to effectively engage disadvantaged populations and target those members at greatest risk to improve overall quality and performance scores.
Tuesday, October 25

8:00 am – 8:45 am

Sponsored Breakfast Briefings (continued)

**An Innovative Approach to Supporting Patients with the Greatest Needs**

*Powered by CVS Health*

Patients with multiple chronic conditions require significantly more care and have higher costs than patients with a single chronic condition. This session will explore an innovative approach that delivers personalized pharmacy care for these patients. You will learn how a dedicated pharmacy care team can help support coordination with health plan resources and provide patients with unique pharmacy service.

**Care Models That Work: Moving from Complex to Collaboration**

*Powered by Optum*

What care models are delivering the best quality of care and most value for Medicare and Medicaid populations? Our industry continues to focus on the challenge of escalating medical spend while resources are limited to engage and deliver the spectrum of care required to manage populations at risk. This forces a new collaboration across payers, providers and consumers—with significant financial incentives to reduce costs and improve clinical and quality outcomes. In this session, we will explore care models that derive value by integrating care programs and delivering a person-centric approach.

- **Todd Spaulding**, Vice President, Product Management and General Manager, Medicare and Health Plan Market, Optum

**How Can We Be “Insights Poor” in an Era of Data “Richness”?**

*Powered by LexisNexis® Health Care*

Though HHS has drawn considerable attention to the release of CMS data over the past several years, the promise of big data has yet to be realized across the Medicare and Medicaid programs. Access to data alone does not guarantee improvement in the areas of greatest need. It's where big data, small data and analytics intersect that true intelligence can be achieved and leveraged to make decisions that lead to cost reductions, improved health outcomes and compliance. Join this session to explore the promise of data intelligence when socioeconomic information, public records data and analytics collide with your health programs traditional data sources.

- **Josh Schoeller**, Vice President, Client Engagement, LexisNexis Health Care
Tuesday, October 25

8:00 am – 8:45 am  
Sponsored Breakfast Briefings (continued)  
Digital Transformation for Growth and Success in Government Health Programs  
**Powered by Capgemini**  
This session will provide an overview on developing strategic capabilities in areas directly related to improving performance in Medicare and Medicaid with an emphasis on better addressing the behavioral needs of beneficiaries and improving care for dual eligibles. You will hear insights drawn from academic thought leadership, recent industry trends and compelling case studies in related industries.

- **Aimee Sziklai**, Vice President, Health BU, Capgemini  
- **Scott Whitt**, Vice President, Health Practice, Capgemini

Maximizing your MTM Programs to Drive Improved Health Outcomes  
**Powered by Express Scripts**  
The ever-changing Medicare landscape is requiring plans to adapt their Medication Therapy Management (MTM) programs by employing new strategies, innovative initiatives, and different uses of technology to be able to provide the best in class, holistic care your members need. Session attendees will learn how to strategically up their MTM game through care coordination amongst providers, members, nurse care coordinators and pharmacies to maximize health outcomes. We will also demonstrate how plan sponsors could be using MTM programs to tackle challenging performance measures and major healthcare issues like the opioid epidemic.

- **Kevin Boesen**, PharmD, Chief Executive Officer, SinfoníaRx  
- **Snezana Mahon**, PharmD, Senior Director, Medicare, Express Scripts

To SNP or Not to SNP  
**Powered by Change Healthcare**  
This session will present the regulatory and operational challenges faced by Medicaid and Medicare plans entering the MMP and DSNP markets. We will address audit requirements, operational and service impacts, analytics and reporting, impacts on community based care, claim filing, reporting and clinical staff.

- **Shelley Stevenson**, Director, Government Programs Practice, Change Healthcare
Tuesday, October 25

8:00 am – 8:45 am  
**Sponsored Breakfast Briefings (continued)**  
*Modernize your MA Risk Adjustment Program with a 360 Degree Approach*  
*Powered by Health Fidelity*  
Through the real-world experience of a provider-sponsored health plan, this session will demonstrate how a comprehensive risk adjustment program that fits multiple lines of business while achieving operational economies is a necessity in today’s value-based care landscape. Attendees will discover how to best leverage retrospective risk adjustment approaches in partnership with point of care efforts, explore best practices for implementing new technology, and review analytics for measuring risk adjustment transformation.

- **Mary Beth Jenkins**, Senior Vice President and Chief Operating Officer, UPMC Health Plan  
- **Adele L. Towers, MD, MPH FACP**, Senior Clinical Advisor, UPMC Enterprises

9:00 am – 9:40 am  
**General Session**  
*Future of Delivery System Reform: The Role of Medicare*  

- **Patrick Conway, MD, MSc**, CMS Acting Principal Deputy Administrator, Deputy Administrator for Innovation and Quality, CMS Chief Medical Officer, Centers for Medicare & Medicaid Services (CMS)

9:40 am – 10:10 am  
**General Session**  
*Challenges and Opportunities for Medicare Advantage Health Plans*  

- **Jim Eppel**, President and Chief Executive Officer, UCare

10:10 am – 10:25 am  
**Break**

10:25 am – 11:10 am  
**Concurrent Sessions**  
*Operations: Plan Strategies for Managing Rising Drug Costs*  
This session will highlight ongoing MA and Part D plan efforts to ensure access to breakthrough medications while promoting affordability for beneficiaries and taxpayers.

- **Sarah Marche**, Vice President of Pharmacy Services, Highmark, Inc.
Tuesday, October 25

10:25 am – 11:10 am  Concurrent Sessions (continued)

Compliance: Strategies for Strengthening Your FDR Oversight Program
In this session, MA organizations and Part D plan sponsors will learn about strategies to utilize to ensure effective oversight of first tier, downstream and related entities (FDRs).

- Babette S. Edgar, PharmD, MBA, FAMCP, Principal, BluePeak Advisors

Operations: RAPS to EDS Transition: The Necessary Partnership between Providers, Groups, and Health Plans
Powered by Episource, LLC
In this new risk adjustment world where EDS (Encounter Data System) is quickly replacing RAPS (Risk Adjustment Processing System), it is integral that health plans, providers and other stakeholders work together to address the vast array of new challenges. Under EDS, CMS has significantly increased the complexity of the data necessary for submission for risk adjustment and payment purposes. This session will help health plans, providers and groups navigate this complexity by providing strategies on how to collaborate more effectively with each other. Specifically, the discussion will focus on how to understand and resolve rejected submissions, how to drive value from the MAO-004 reports (i.e. EDS version of accepted diagnosis codes for risk adjustment), and identify additional compliance and related RADV audit risks of potential concern for the industry. Attendees will learn how to prepare for this new EDS world, and what they need to be doing today in order to be successful tomorrow.

- David Myer, Vice President, Healthcare Informatics, SCAN Health Plan
- Tim Spaeath, Senior Vice President, Payer Solutions, Episource

Technologies & Business Solutions: The MACRA Rule and its Technology Implications for Payers with Medicare Lines of Business
Powered by HealthEdge
This session will provide an overview of key imperatives facing health plans with regards to the impending Medicare Access and CHIP Reauthorization Act (MACRA) rule. Attendees will learn about important preparations necessary for health plans with Medicare Lines of Business. This session will explore how technology will play a critical role enabling the agility essential for health plans to quickly and easily adapt to the value-based reimbursements and new provider contracts that MACRA requires. The speakers will share the implications that technology has for effectively dealing with the new dynamics that MACRA is bringing first to Medicare, and also to Medicare Advantage and Medicaid plans.

- Andrew Davis, Vice President and General Manager, Medicare Segment, Medica
- Harry Merkin, Vice President of Product Marketing, HealthEdge
Tuesday, October 25

11:15 am – 12:00 pm  General Session
Improving Care for Medicare Beneficiaries with Chronic Conditions

12:00 pm – 12:30 pm  Closing Session
The Medicare Program in 2017 and Beyond: The View from CMS
  • Andrew Slavitt, Acting Administrator, Centers for Medicare & Medicaid Services (CMS)

12:30 pm  National Conference on Medicare Adjourns

1:45 pm  Dual Eligibles Summit Begins