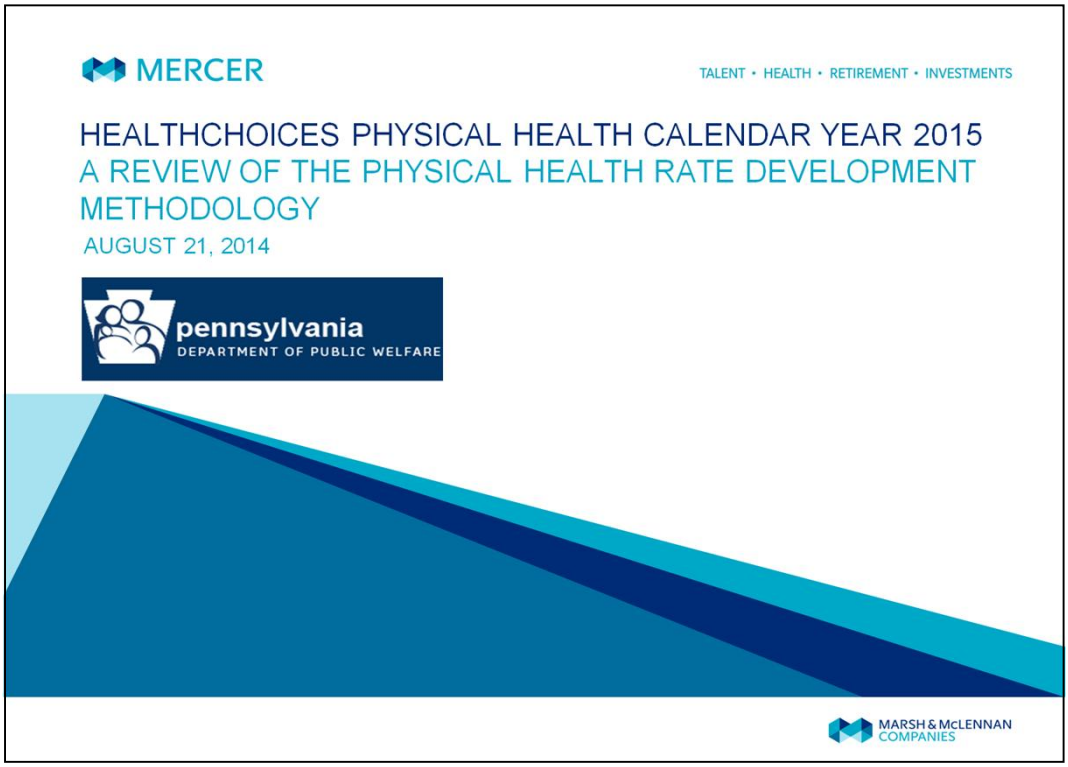
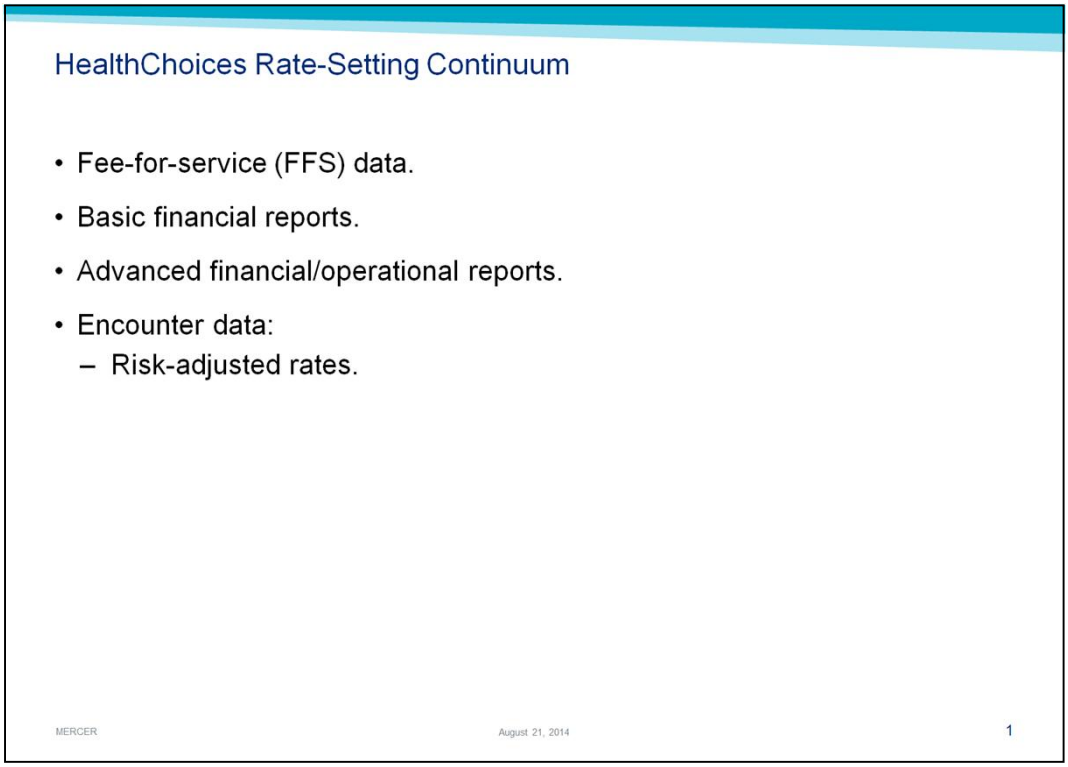
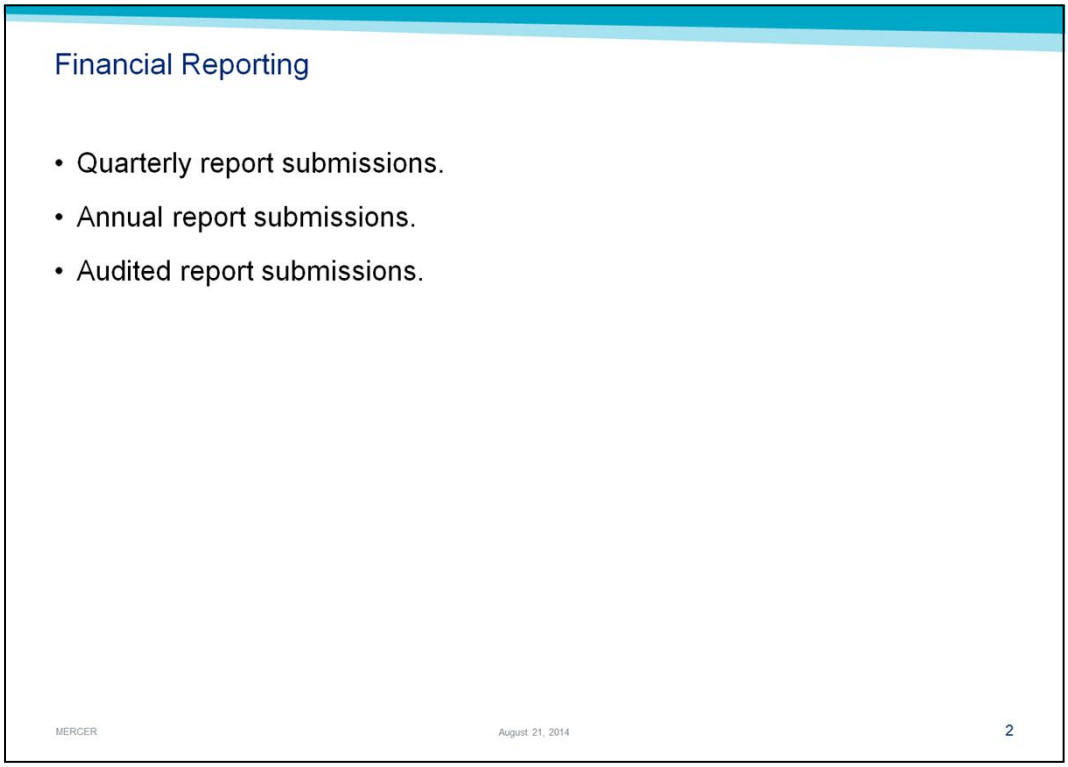


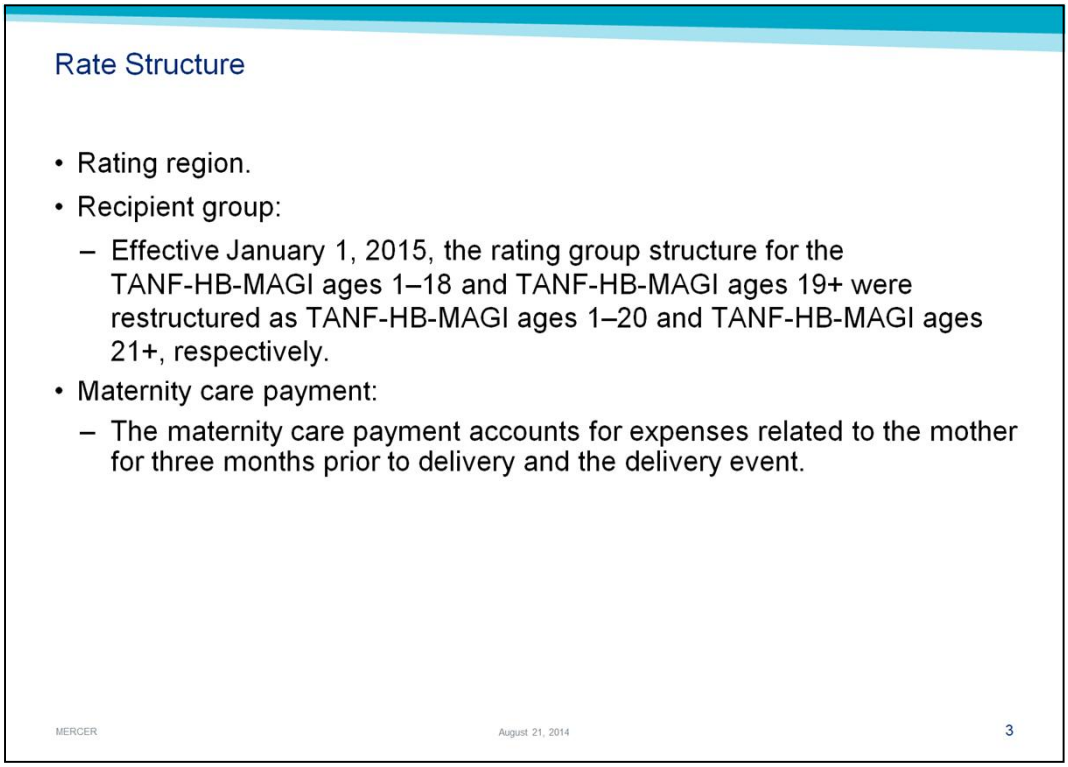
- This presentation provides an overview of the rate-setting methodology applicable to the HealthChoices Southeast (SE), Southwest (SW), and Lehigh/Capital (LC) zones.
- Please note that there are certain aspects of the calendar year (CY) 2015 rate development process that may not uniformly apply to all three HealthChoices zones. This presentation displays such occurrences on each slide, if necessary.



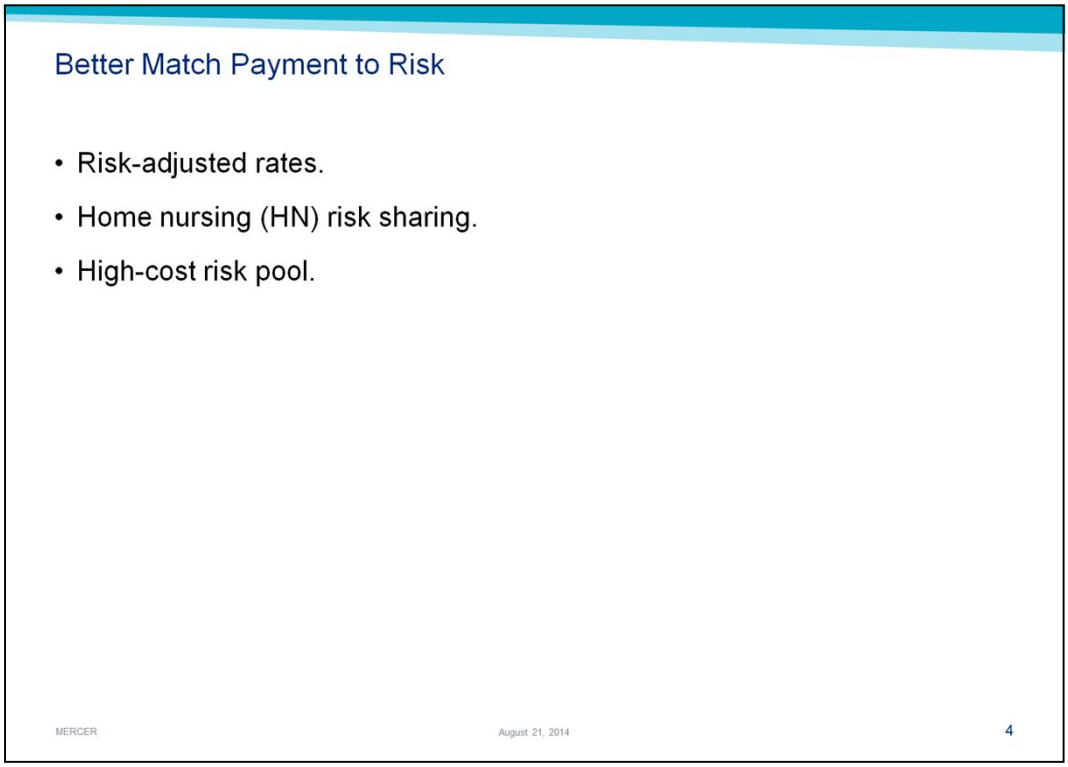
- As each HealthChoices zone matures, the appropriateness of relying on historical fee-for-service (FFS) data diminishes, while relying on actual experience from the participating physical health managed care organizations (PH-MCOs) becomes more important. More specifically, PH-MCO encounter data will continue to take a more predominant role in rate setting.
- Encounter data offers more complete information, less reliance on ad hoc data requests, and provides the ability to make additional comparisons among PH-MCOs (including providing support for risk-adjusted rates).
- Risk-adjusted rates significantly improves the Department of Public Welfare's (DPW) ability to better match payment to risk by incorporating objective means of evaluating acuity/risk differences among the PH-MCOs in the HealthChoices zones.



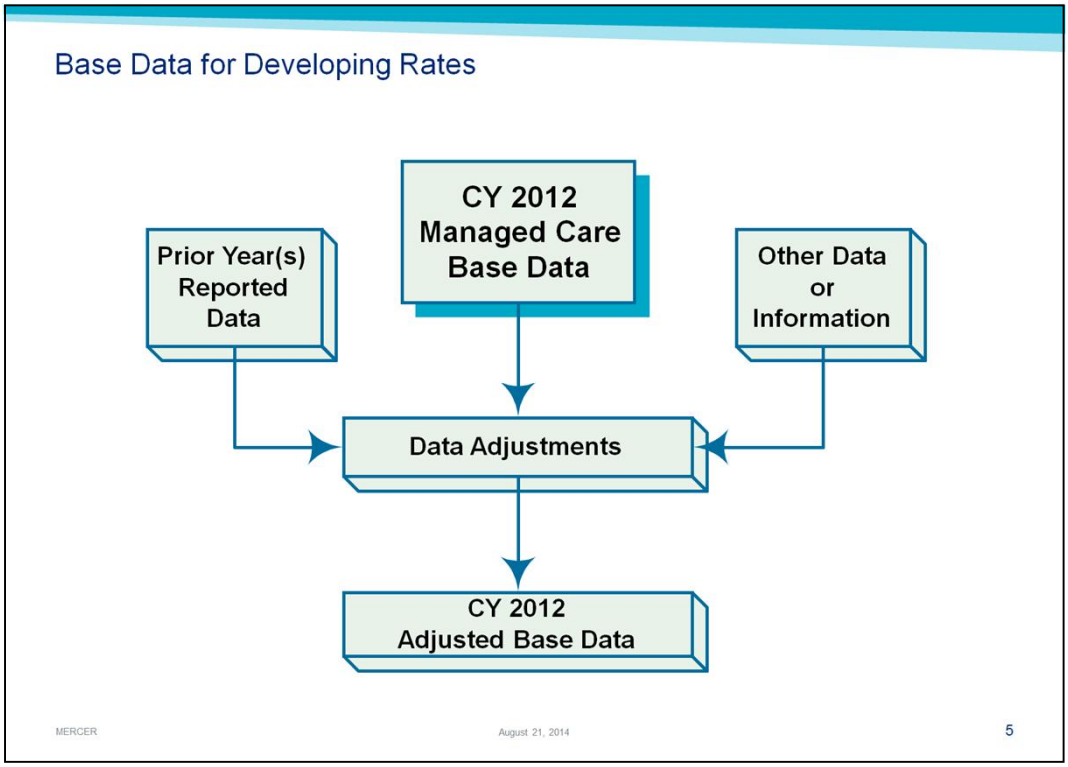
- With input from the PH-MCOs, DPW staff has made a concerted effort to focus the HealthChoices financial reporting requirements (FRRs) on key areas.
- Quarterly reporting supports DPW's efforts to monitor the performance of each PH-MCO and provide regular updates to the accuracy of each report.
- Annual reports reduce the administrative burden on both the PH-MCOs and DPW staff by limiting the completion of the reports to once per year.
- Annual reports provide important data to augment the quarterly reports.
- The HealthChoices capitation rates are developed from the information contained in the audited financial reports and other available information.
- As complete and accurate encounter data becomes available, it will be used to further support rate development.



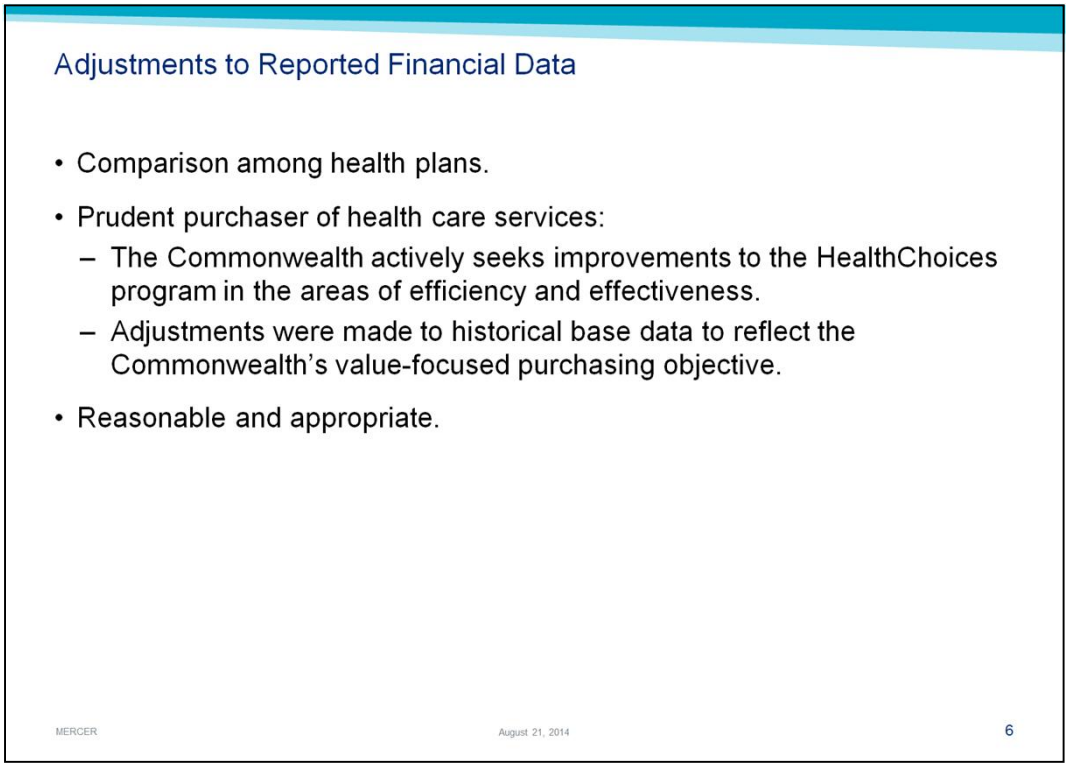
- The HealthChoices capitation rates will be developed for each rating region within a zone.
- There will be six rate cells plus the maternity care payment:
  - TANF-HB-MAGI < 2 Months.
  - TANF-HB-MAGI 2–11.999 Months.
  - TANF-HB-MAGI Ages 1–20.
  - TANF-HB-MAGI Ages 21+.
  - SSI-HH-Other Disabled.
  - Breast and Cervical Cancer.
  - Maternity Care Payment.
- Effective January 1, 2015, the rating group structure for the TANF-HB-MAGI ages 1–18 and TANF-HB-MAGI ages 19+ were restructured as TANF-HB-MAGI ages 1–20 and TANF-HB-MAGI ages 21+, respectively.
- The maternity care payment is intended to be a lump-sum payment to account for the expenses related to the mother for three months prior to delivery and the delivery event. No newborn expense is included in the maternity care payment.



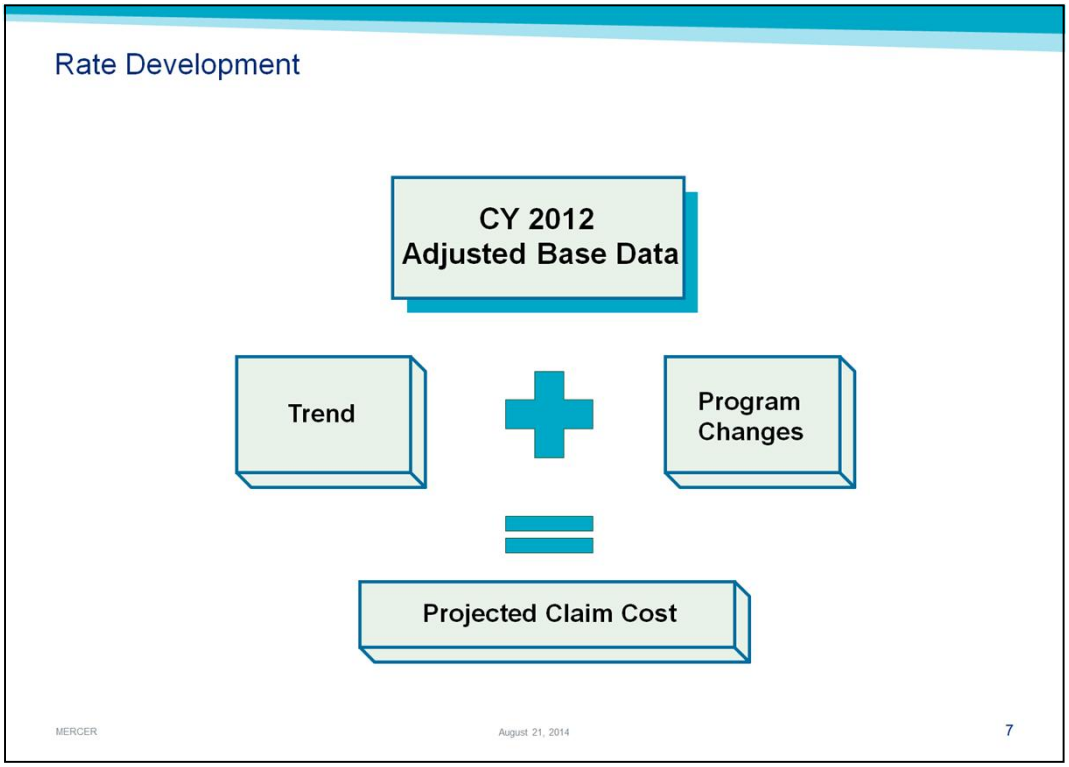
- Risk adjustment better matches payment to risk compared to traditional rate setting by considering acuity/risk selection among the PH-MCOs in each region, respectively. Risk adjustment will not be applied to the maternity care payment or the Breast and Cervical Cancer rating group.
- The HN risk-sharing program addresses the adverse risk of a small number of high-cost users of HN services. More details are provided in later slides. The high-cost risk pool addresses selection concerns by withholding a percentage of the capitation payments, setting the funds aside into a pool, and later distributing that pool among the PH-MCOs. More details are provided in later slides.



- The basis of the HealthChoices capitation rates will be the data reported by the PH-MCOs through the Commonwealth's FRRs. As complete and accurate encounter data becomes available, it will be used to support rate development.
- For the most part, the FRRs mirror the rating structure of the HealthChoices program – separate reports for each recipient group and region. Maternity is combined with non-maternity experience in Report #5, which poses a special challenge to develop rates consistent with HealthChoices policy. This is addressed in subsequent slides.
- Although comprehensive in nature, the FRRs do not always provide sufficient information on certain issues considered in a particular year's rate-setting process. Therefore, Mercer may use information from previous years, DPW's FFS program, other states' data, or other proprietary information to assist in the rate development process.
- The reported experience from each PH-MCO reflects the management and accounting policies/practices thereof. These policies/practices may generate expenses that do not reflect: 1) the risk of an efficient and effective PH-MCO or 2) DPW's participation intentions within the HealthChoices program. Adjustments may therefore be needed.



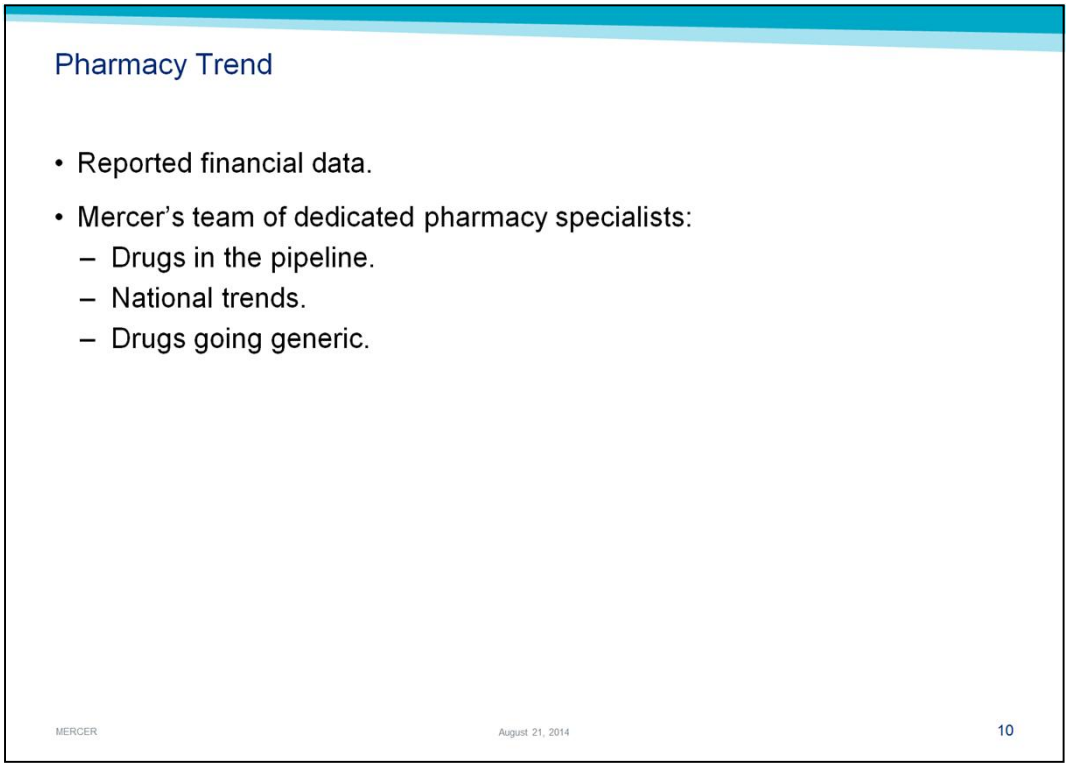
- To ensure that DPW and CMS are appropriately using the public resources available to fund the HealthChoices program, Mercer reviews the base financial data, as reported by the PH-MCOs, to determine if adjustments are needed to ensure that the cost of the HealthChoices program is reasonable and appropriate.
- These adjustments may increase or decrease the base financial data and can be PH-MCO-specific or more global in nature.
- Specific managed care practices can affect reported experience. The following are key issues that Mercer considers for adjustments: incurred-but-not-reported (IBNR) claims liability, pharmacy rebates, medical management, third-party liability/coordination of benefits (TPL/COB), provider contracting, credibility of the data (relational modeling), and non-state plan services. For example, if a particular PH-MCO is not taking advantage of third-party payers, their reported financial experience will be inflated. DPW and CMS, as prudent purchasers of health care, should not support this practice. Thus, an adjustment to the PH-MCO financial experience may be necessary.
- Through targeted and comparative analyses and Mercer's experience in Medicaid managed care programs, Mercer and DPW worked together to identify opportunities for improved managed care effectiveness in areas such as, preventable inpatient acute admissions, preemptible emergency department (ED) visits, and improved pharmacy management. These adjustments were made to the CY 2012 base financial data to better reflect the Commonwealth's value-focused purchasing objectives.



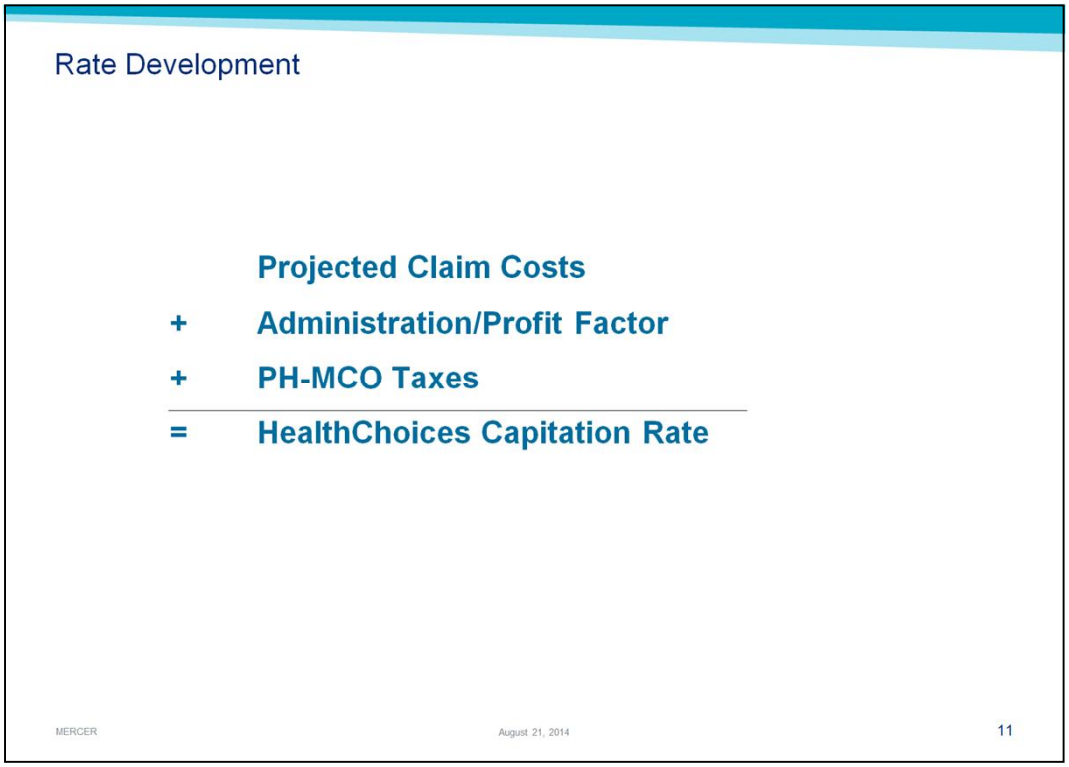
- The main components of the rate-setting process are adjusted base data, trend, and program changes.
- Trend is an estimate of the change in cost/utilization of services, from the base period to the rating period.
- Mercer develops trend estimates for categories of service (COS) and recipient groups by reviewing a variety of data sources. For example, disabled populations (e.g., SSI) may have higher trends than non-disabled (e.g., TANF) populations.
- Many factors can influence trends, including effective medical/care management (i.e., UM/CM/DM), efficient contracting with providers, appropriate provider use (i.e., not sending all members in need of a tonsillectomy to an academic medical center), generic substitution in pharmacy, widespread use of less costly preventive services, and member education.
- Program changes that may materially impact the HealthChoices program, and are not reflected in the base year data, are reviewed and discussed with the Commonwealth regarding their impact on the capitation rate-setting process. These adjustments include, but may not be limited to:
  - Taxes.
  - Adult dental benefit limit.
  - Six prescription limit.
  - Pharmacy rebates.
  - Health insurance providers fee.
  - Enrollment changes:
    - Eligible but not enrolled/latent demand.

- Mercer considers several different sources of information to develop trend estimates specifically for the HealthChoices program.
- Mercer and DPW work together to arrive at trends that are reasonable and appropriate for the services provided, the population covered, the risk incurred, and the medical management practice patterns for the HealthChoices program.
- General and specific health economic indices provide a national perspective on health care trends.
- The PH-MCOs' reported experience provides more HealthChoices-specific trend information. This information reflects the management practices of the HealthChoices program by each PH-MCO. As a result, Mercer will see varying trends in the historical HealthChoices experience.
- Mercer's proprietary information of other state Medicaid programs provides additional perspectives on health care trends.
- As needed, FFS trend information provides a comparison to assess the effectiveness of the managed care program.

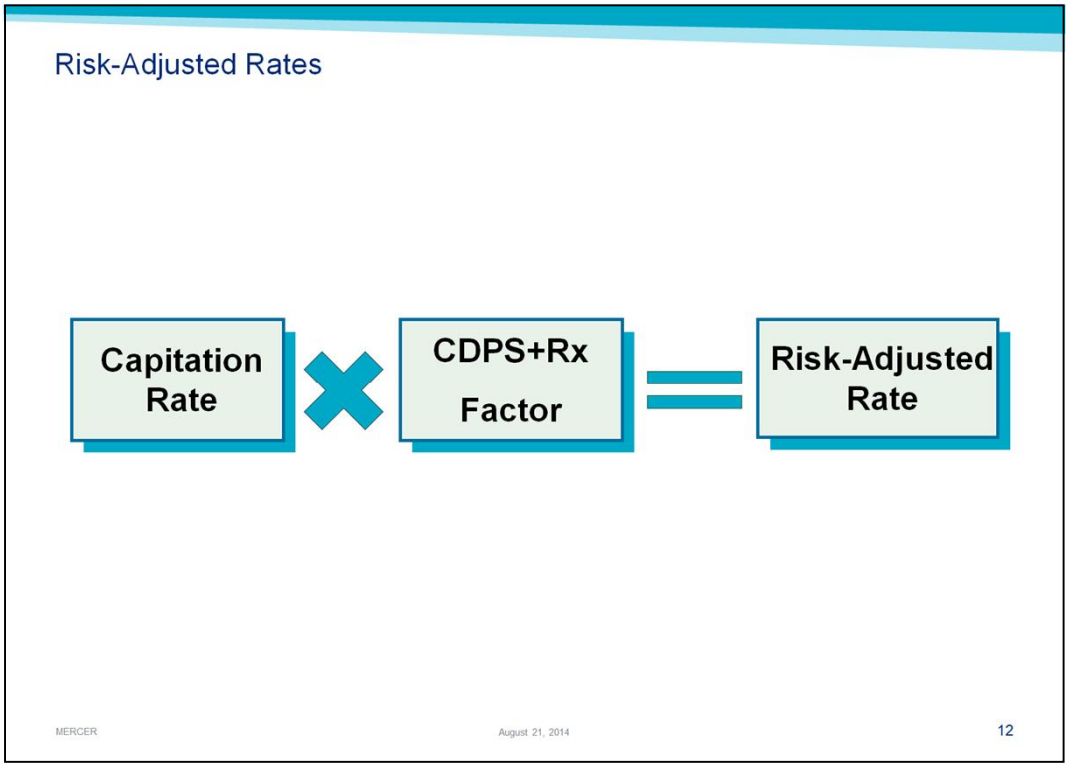
- Hospital trends continue to play a significant role in the cost of delivering health care, whether it is the commercial or public health care arena.
- Every PH-MCO should actively manage the care of its enrolled members through tools such as: appropriate utilization management, discharge planning, network management, member education, and preventive services, to ensure that HealthChoices is efficiently and effectively managed.



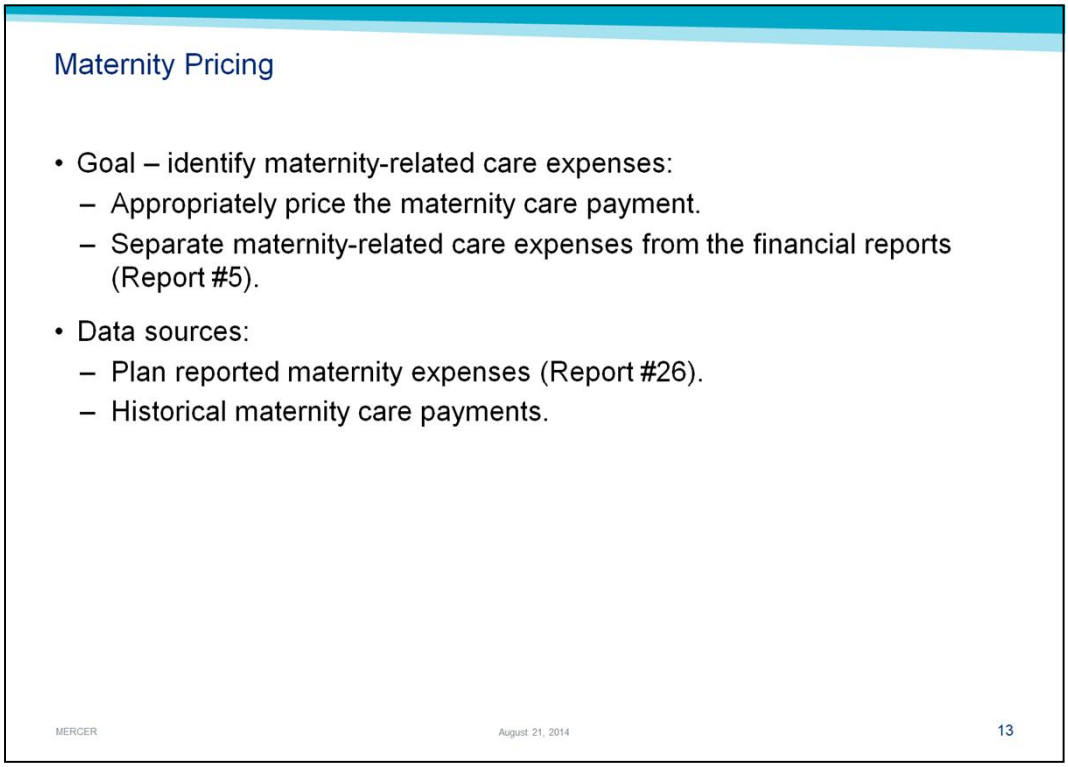
- Pharmacy remains one of the largest concerns of most state Medicaid programs.
- Several states (not necessarily Pennsylvania) are taking aggressive actions to reduce the cost of providing a prescription drug benefit through Medicaid by:
  - Reducing pharmacy reimbursement.
  - Aggressive care management programs.
  - Formularies and prior authorization.
  - Aggressive use of generic substitution.
  - Reducing benefits (prescription drugs are an optional service under Medicaid).
  - Higher rebates from manufacturers.
  - Provider profiling.
  - Member education.
  - Pharmacy 1115 waivers.
- The PH-MCOs' reported experience on the management of the pharmacy benefit provides HealthChoices-specific information related to pharmacy trends.
- Mercer's team of dedicated pharmacy specialists review and analyze national information, including drugs in the FDA approval process and drugs coming off patent protection, to provide information on pharmacy trends.
- Although commercial health care programs can leverage copays to influence the cost of drugs to the sponsor (increasing employees' copay reduces cost to sponsor), Medicaid has restrictions on the value of copayments that beneficiaries are subject to and restrictions on denying service in the case of inability to make a copayment.



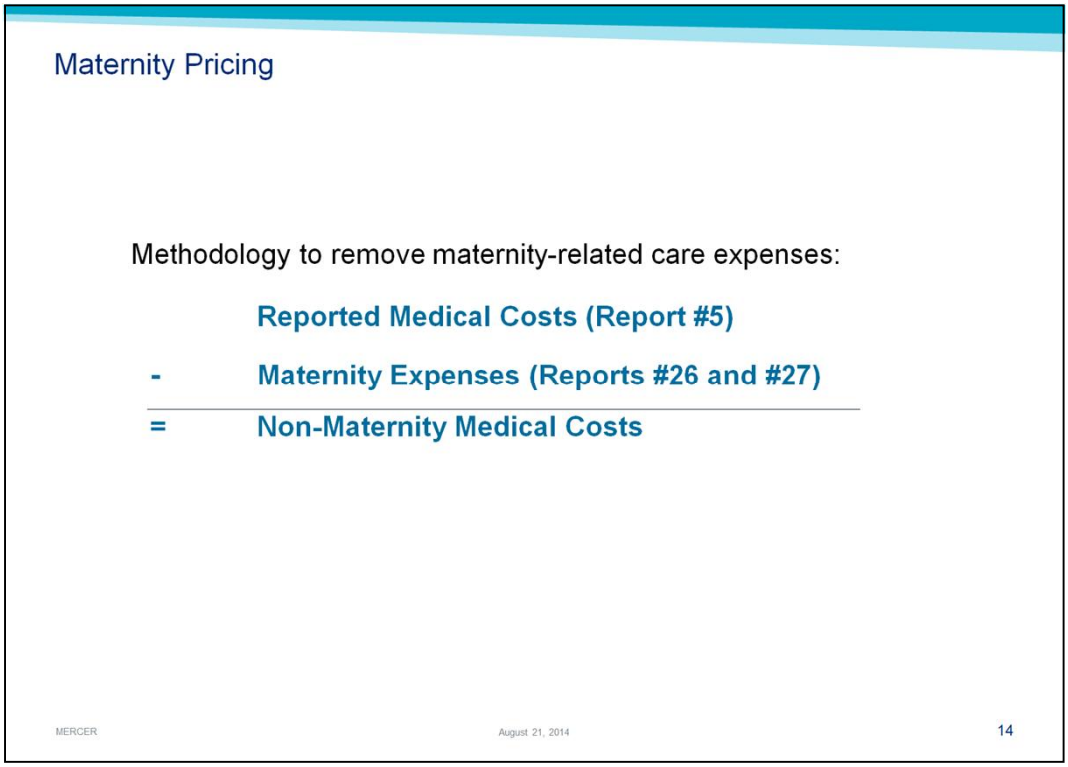
- Projected claim costs are the result of applying trend and program changes to the base data.
- The total capitation rate is composed of both the projected claim costs and an administration/profit factor.
- The administration/profit factor is developed as a percentage of the capitation rate (i.e., “percent of premium”). Historical HealthChoices administrative/profit levels will be reviewed in the development of an appropriate factor.
- Applicable taxes will be added to the applicable rating periods.
- Mercer will certify to CMS that the final base capitation rates were developed using an actuarially sound process, as described in Section 438.6(c) of the Medicaid Managed Care Final Rule. Rates developed by Mercer are actuarial projections of future, contingent events. Actual results will differ from these projections.
- It is CMS’ opinion that PH-MCOs contracting with states on a risk basis must make their own independent judgments of the states’ rates, based on their own costs of doing business and their understanding of the population to be covered.



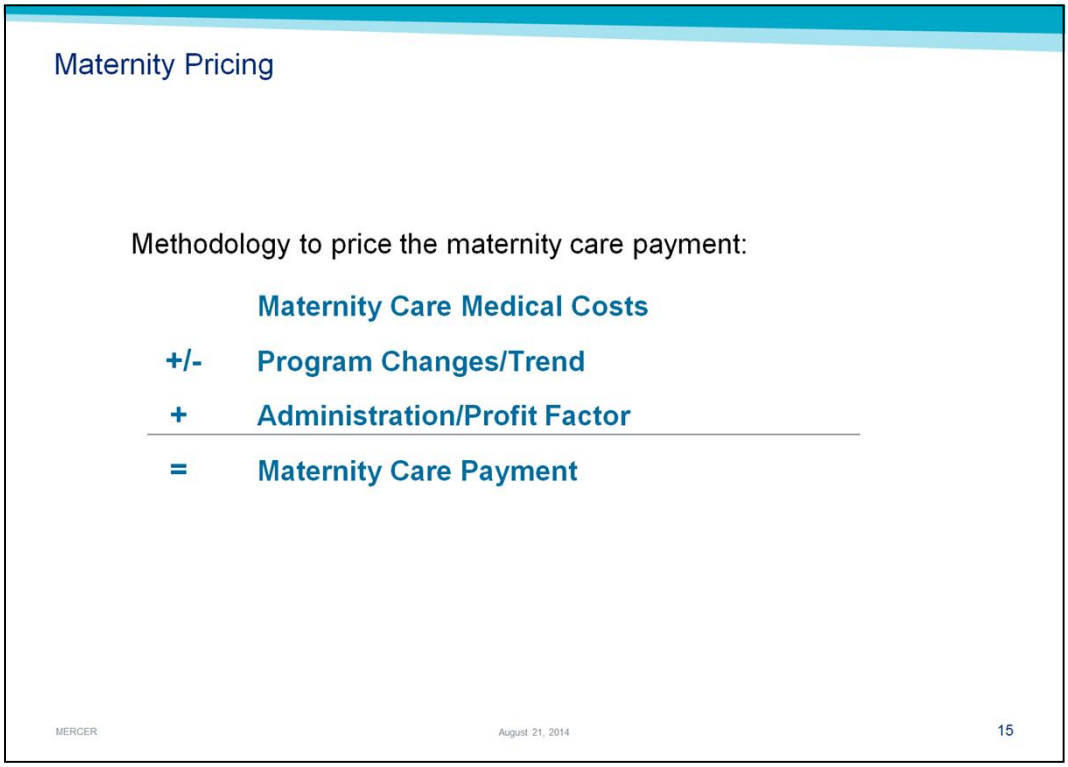
- This is a basic illustration of the risk-adjusted rate process used in all HealthChoices zones.
- Each PH-MCO will receive a set of risk factors for each federal recipient group and region combination (e.g., TANF-HB-MAGI Ages 1–20/Allegheny). The factors will be budget neutral to ensure the risk-adjustment process neither increases nor decreases the total capitation applicable to each HealthChoices zone.
- The risk-adjustment factors are updated at regular intervals.
- Risk adjustment will not be applied to the maternity care payment or the Breast and Cervical Cancer rating group.



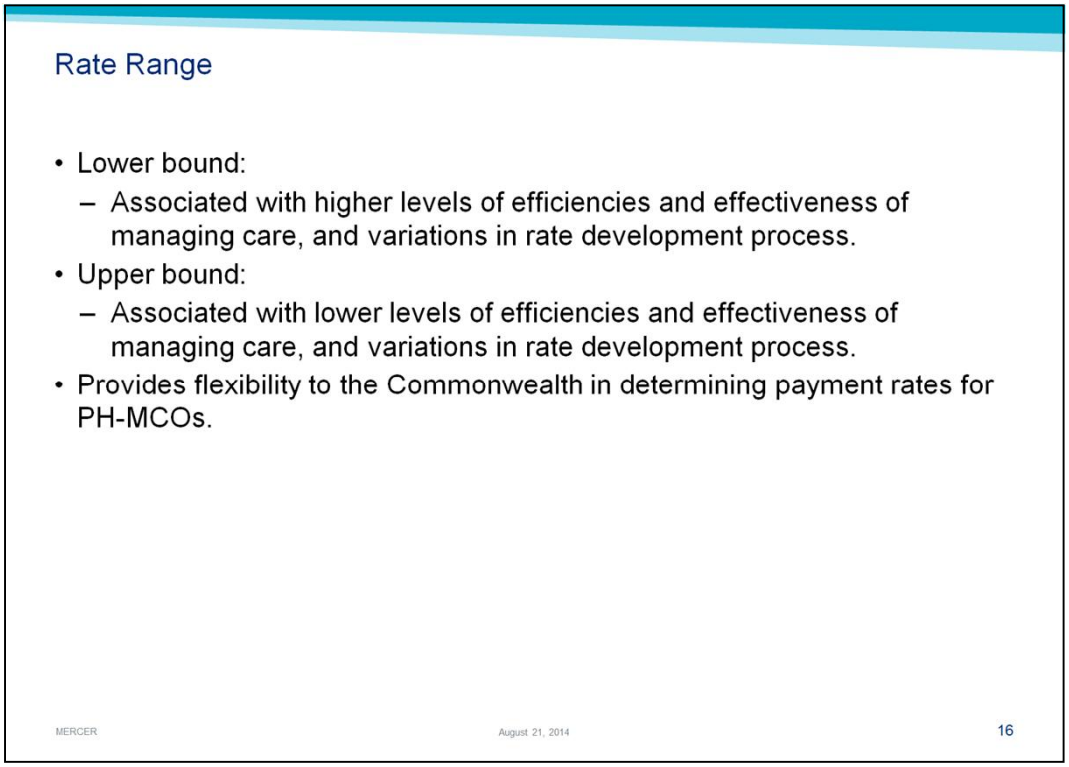
- The maternity care payment is a separate “rate cell” within the HealthChoices rating structure where risk adjustment is not applied.
- The maternity care payment is applicable to all recipient groups and represents a “lump-sum payment” for maternity-related services provided three months prior to delivery and the delivery event. Newborn risk is not included in the maternity care payment.
- DPW makes a maternity care payment to each PH-MCO after receiving documentation of a covered live birth.
- Using information reported by the PH-MCOs, Mercer develops the separate maternity care payment. As needed, Mercer supplements this information with other data.
- Conversely, the monthly capitation rates reflect “non-maternity” risk. Therefore, the maternity-related data inherent in Report #5 must be removed in the rate-setting process; otherwise, DPW will pay twice for maternity services.
- For a pregnant member, the PH-MCO still receives monthly capitation applicable to that person’s recipient group/region. The maternity care payment is a “supplemental” payment.



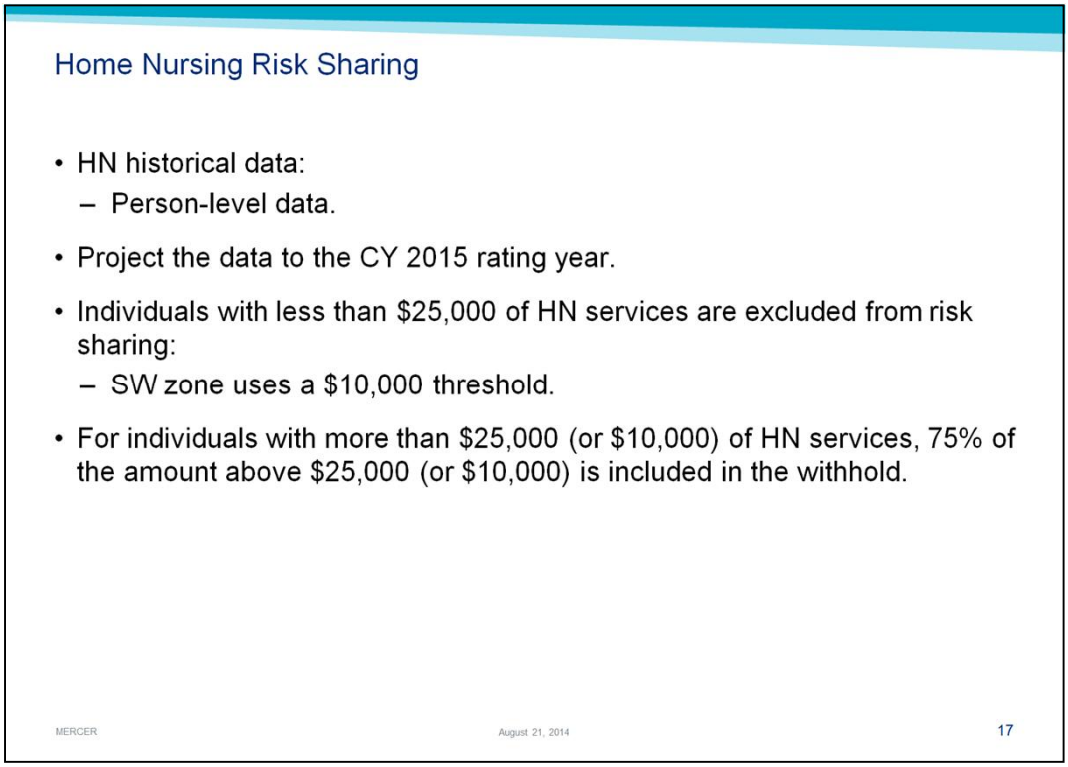
- To match payment to HealthChoices policy, Mercer must remove maternity-related data from Report #5 prior to developing the capitation rates, using information contained in the PH-MCOs' annual reports #26 and #27.
- An average cost per delivery will be derived by dividing the maternity medical expenses on Report #26 by the total number of outcomes presented on Report #27 for the corresponding state fiscal year time period. This calculation will be performed using the C-section and vaginal data, respectively.
- The resulting C-section and vaginal average costs per outcome will be trended forward six months to reflect a CY time period consistent with data in Report #5.
- Since Report #26 provides zone-wide data, an assumption will be made pertaining to the relative risk differential between maternity outcomes in each respective rating region within the SE and SW zones.
- Using the number of outcomes from Report #27, an estimation of the CY maternity-related medical expenses will be derived by multiplying the CY average costs per outcome by the number of CY outcomes for C-section and vaginal, respectively, for each rating region and recipient group. As a result, maternity-related medical expense "reports" will be consistent with Report #5 with respect to time period (i.e., CY) and format (i.e., region/recipient group/service group).
- The final step involves subtracting the respective maternity-related medical expenses from the respective Report #5, resulting in a "non-maternity" set of base data that will be used to develop the monthly capitation rates consistent with the policies of the HealthChoices program.



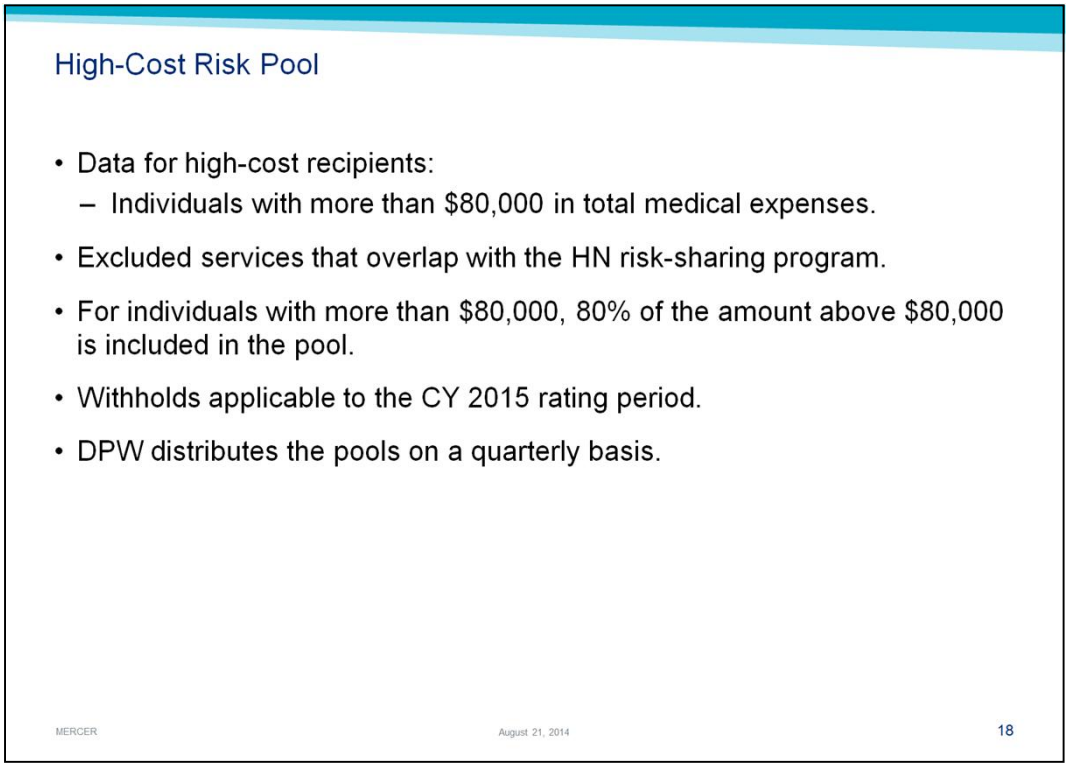
- Similar to the construction of the monthly capitation rates, Mercer uses the maternity data as a base for developing the maternity care payment.
- Again, the maternity base data is projected forward to the rating periods, and any program changes applicable to maternity are considered.
- Trends used in developing the maternity care payment are developed in the same manner as those used in monthly capitation payments, with consideration of actual HealthChoices maternity experience.
- The same administration/profit factor is incorporated and the result is the overall maternity care payment.
- Mercer develops a separate maternity care payment for each rating region, but the same maternity care payment applies to all live deliveries for members in any recipient group.



- The lower-bound and upper-bound of each rate are developed as a function of the overall rate development process. Mercer is cognizant of the assumptions and factors used to develop the rates and considers these issues in developing ranges for use by the Commonwealth.
- In developing the lower-bound and upper-bound, Mercer considers the impact of varying trend factors, the effect of statistical variation present in data sets, the impact of variation in assumptions, and other assumptions regarding levels of efficiencies.
- The width of each rate range may vary. In Mercer's opinion, the width of the rate ranges are reasonable.
- The rates that Mercer may recommend to the Commonwealth may not be the mathematical midpoint of any given rate range.
- Use of the rate ranges is at the Commonwealth's discretion.
- Mercer does not certify individual rates for each PH-MCO.
- Each PH-MCO is responsible for independently reviewing their own data and analyses before making a decision to contract with the Commonwealth.



- HN services have been defined by DPW as a specific set of procedure/revenue codes provided to individuals less than age 21.
- Mercer used information obtained from the PH-MCOs to develop the premiums for CY 2015.
- On a person-level basis, the projected data is compared against the $25,000 deductible (or $10,000 in the SW zone). If an individual has projected HN services expense greater than the deductible, 75% of the amount above the deductible is included in the premium calculation.
- The premium is a per member per month value that is deducted from the capitation rates. The PH-MCOs receive risk-sharing payments based on reporting criteria established by the Commonwealth.
- It is likely that risk-sharing premiums will escalate at a quicker pace than other aspects of rate development due to the currently fixed deductibles. It is Mercer's recommendation to DPW that the deductibles/thresholds be periodically increased or at least reviewed for all risk-sharing/risk pool programs.



- The high-cost risk pool is intended to redistribute a fixed amount of money among the participating PH-MCOs to reflect differences in selection related to high-cost recipients.
- Services that potentially overlap among the risk-sharing/risk pool programs have been recognized, and efforts made to ensure all programs are mutually exclusive:
    - HN services for individuals less than age 21 are excluded from the high-cost risk pool.
- The risk pool withholds are intended to represent 80% of the estimated medical expenses associated with high-cost recipients, beyond the $80,000 attachment point. The remaining 20% of expenses remain in the capitation rates.
- The high-cost risk pool amounts will be withheld from the capitation rates and later distributed to the PH-MCOs based on criteria established by the Commonwealth.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