Commonwealth Care
FY2013 Procurement

Jean Yang
Chief Financial Officer

Jen Flint
Manager of Operations,
Commonwealth Care

Daniel Apicella
Manager of Health Care Finance

Board of Directors Meeting
February 9, 2012

Agenda

- FY2013 Budget
- FY2012 Oversight Initiative Update
- Proposed FY2013 Procurement Plan
- Other FY2013 Initiatives
- Next steps

FY2013 Budget

FY13 State Budget Summary

- Despite an economic recovery, the state continues to experience fiscal challenges in FY2013
- Health care remains the foremost driver of the state's fiscal pressures with spending demands outpacing revenue increases. Health care spending will exceed 40% of the entire state budget for the first time in FY2013

State Health Care Program Successes & Challenges

- Substantial success in "bending the cost curve" while maintaining eligibility was achieved by multiple state health care programs in FY12
  - MassHealth: on track to save $588M through rate restructuring, program integrity enhancements and payment strategies
  - Group Insurance Commission: saving $20~30M through a new incentive program for state employees to enroll in low-cost health plans
  - Medical Security Program Direct Coverage: re-procurement resulted in a new managed care plan, saving $16M
  - Commonwealth Care: an aggressive competitive procurement leveraged MCO innovation and competition to save more than $80M
- The FY13 budget continues to have ambitious cost containment targets

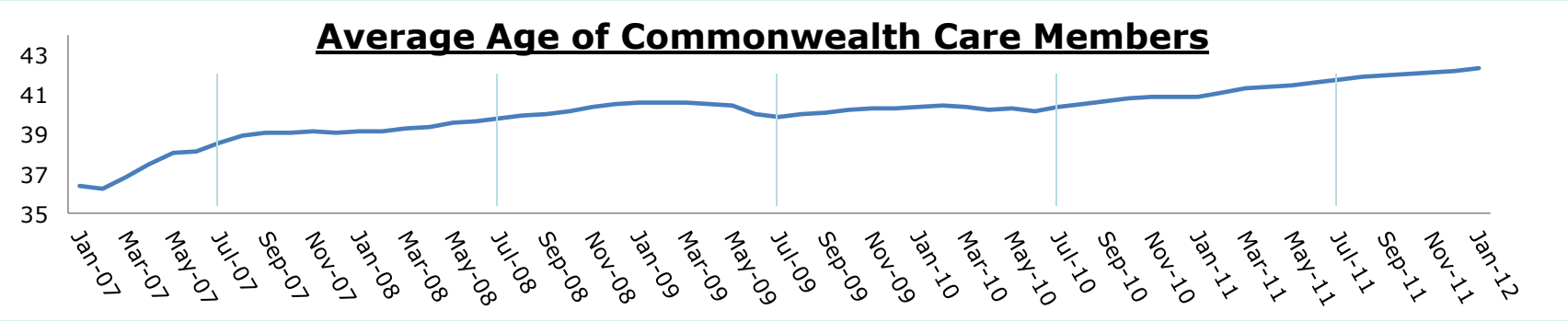
FY13 Commonwealth Care Funding

- Commonwealth Care is funded at $974M for FY13
- Enrollment is expected to increase to nearly 208,000, predominantly attributable to the reintegration of Aliens With Special Status (AWSS)
  - Enrollment growth is also expected from a transition of membership from the Medical Security Program upon the anticipated expiration of federal UI extensions in late FY12
- The FY13 budget can only accommodate the projected enrollment increase if we are able to keep our overall capitation rate ***flat***

FY13 Capitation Challenge

A flat capitation rate would further "raise the bar" from a highly successful MCO procurement in FY12

- FY12 achieved a 5% gross capitation decrease relative to FY11, without benefits or eligibility reduction or net increase in copayments
- A flat capitation rate will require that we overcome medical cost trend, which is in part driven by a progressively aging population



AWSS Reintegration

- Notwithstanding the budget challenge, we are grateful for the extraordinary commitment that the Administration has made to Commonwealth Care with its budget proposal, which includes full funding for AWSS reintegration
  - Approximately 13,000 Bridge members and over 24,000 waitlisted AWSS members will become eligible for Commonwealth Care
  - Reintegration will take place in FY12, with full-year budget impact on FY13

AWSS Reintegration (cont)

- The $974M in FY13 funding includes $156M for covering the AWSS population through Commonwealth Care
  - Relative to the $42M funding for the Bridge program in FY12, this is an increase of $114M in funding that is not eligible for federal matching
  - This serves as an important bridge solution that provides full, equal coverage for AWSS members before a more sustainable mechanism for funding AWSS coverage – namely, federal tax credit subsidies under national health care reform – becomes effective in 2014

AWSS Reintegration (cont)

We have launched a process to reintegrate AWSS members as quickly and responsibly as possible, and in a manner consistent with all applicable Commonwealth Care program rules

Bridge members

- Transition to Commonwealth Care benefit plans effective **March 1, 2012**
- PT1 members will have an opportunity to switch from CeltiCare to Network Health*; PT2 and PT3 members may choose any plan

Waitlisted & new AWSS members

- Access to Commonwealth Care open as of **May 1, 2012**
- Enrollment will be subject to FY12 program rules (i.e., limited choice for PT1 members; full choice and differential premiums for PT2 and PT3 members)

All AWSS members enrolled as of June 1st will have the opportunity to participate in the upcoming open enrollment for FY13 coverage

FY13 program rules, to be determined by the procurement strategy, will apply uniformly to both AWSS members and non-AWSS members

*Subject to the low-cost plans' availability by service area.

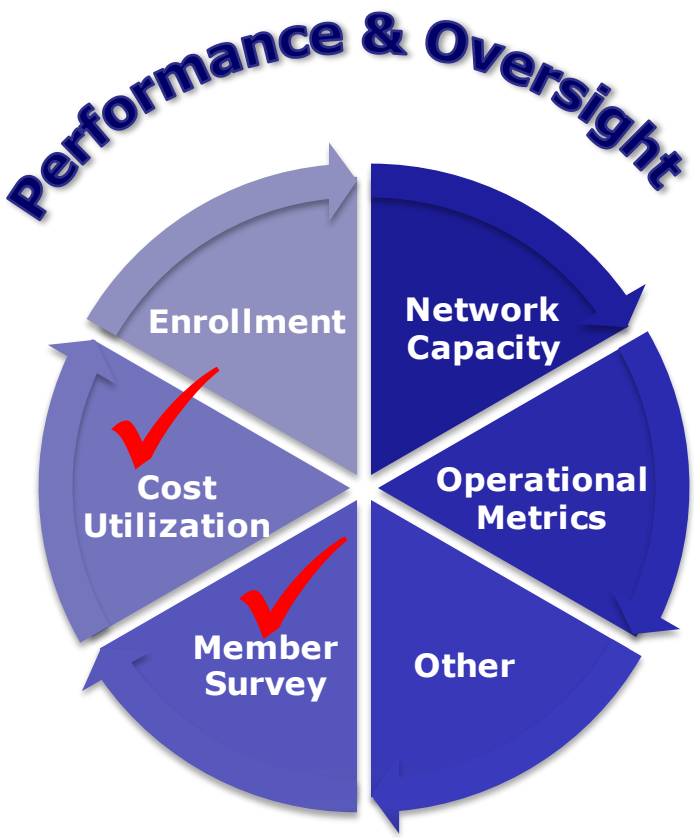
FY13 Procurement Strategy

- We will pursue another aggressive procurement that promotes high quality and dependable coverage at low cost
  - Leverage lessons learned from FY12
  - Continue to harness the power of competition
  - Challenge *all* MCOs to maximize cost-efficiency while ensuring high quality of care
- Our strategy is once again to achieve program savings without restricting enrollment, cutting benefits or increasing copayments
  - Base enrollee premiums for members with income >150% FPL will increase by 1.5% ($1-2 PMPM), consistent with the Health Connector's recommendation for the 2012 Affordability Schedule

FY2012 Oversight Initiative Update

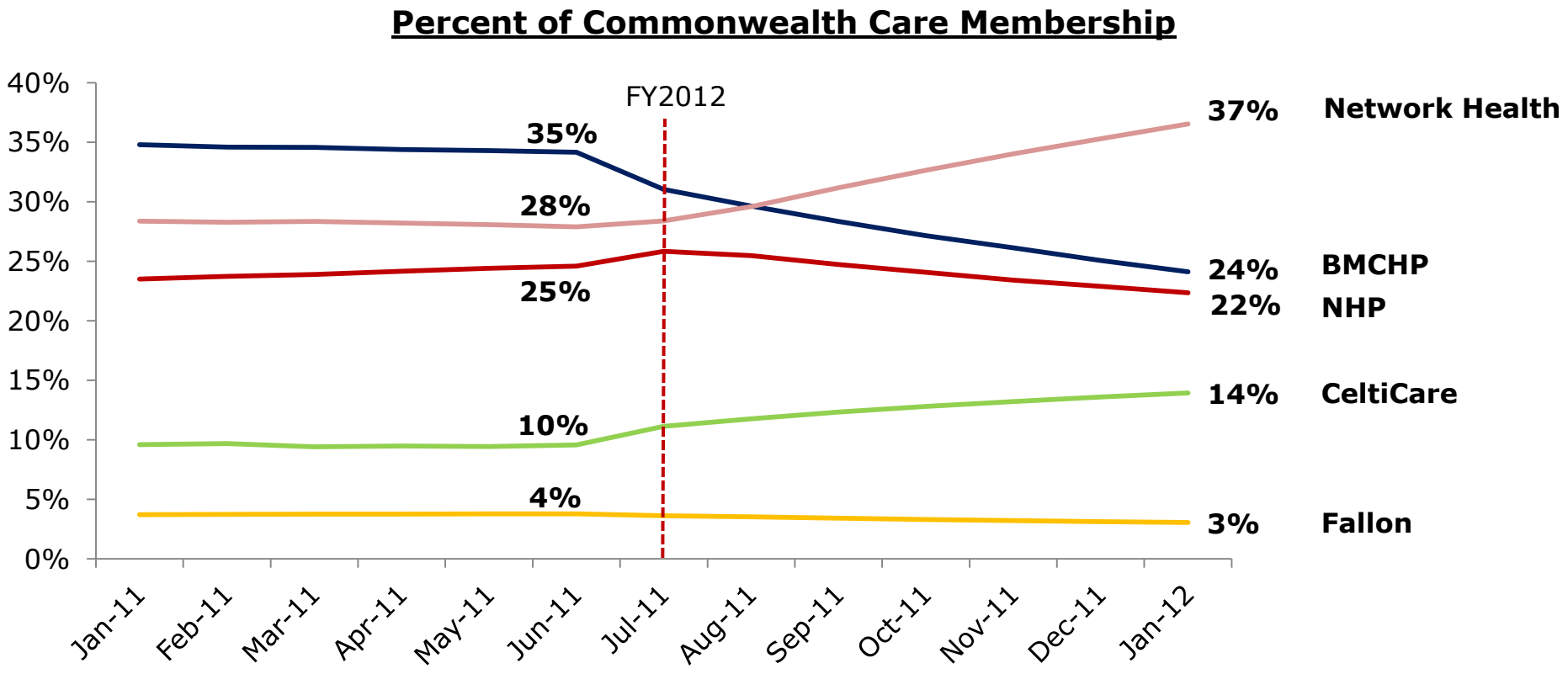
Overview

- We have begun to analyze emerging program performance for early FY12
- In December we provided data on enrollment, network capacity and operational metrics
- The focus of today's update is on cost/utilization and the member experience
- While these preliminary insights are important to study, they are *extremely early* and will be subject to continued monitoring/verification going forward



Enrollment By MCO

A key driver of FY12's aggregate capitation rate decrease is gains in membership by the two lowest-cost MCOs – Network Health and CeltiCare



Financial Performance of Low-Cost MCOs

MCO financial reporting on Q1 FY12 suggests breakeven results by both CeltiCare and Network Health under their new rate structures

	CeltiCare	Network Health
Base Medical Capitation ($PMPM)	$329.39	$329.39
Composite Capitation Adjustment (plan type, region, acuity)	0.9028	0.9957
Actual Medical Revenue ($PMPM)	$297.37	$327.97
Medical Cost w/ IBNR ($PMPM)	$295.89	$328.43
Gain (Loss) on Medical Revenue ($PMPM)	$1.48	($0.46)
	0.5%	*-0.1%*

Source: MCO 4B reports, Q1 FY12

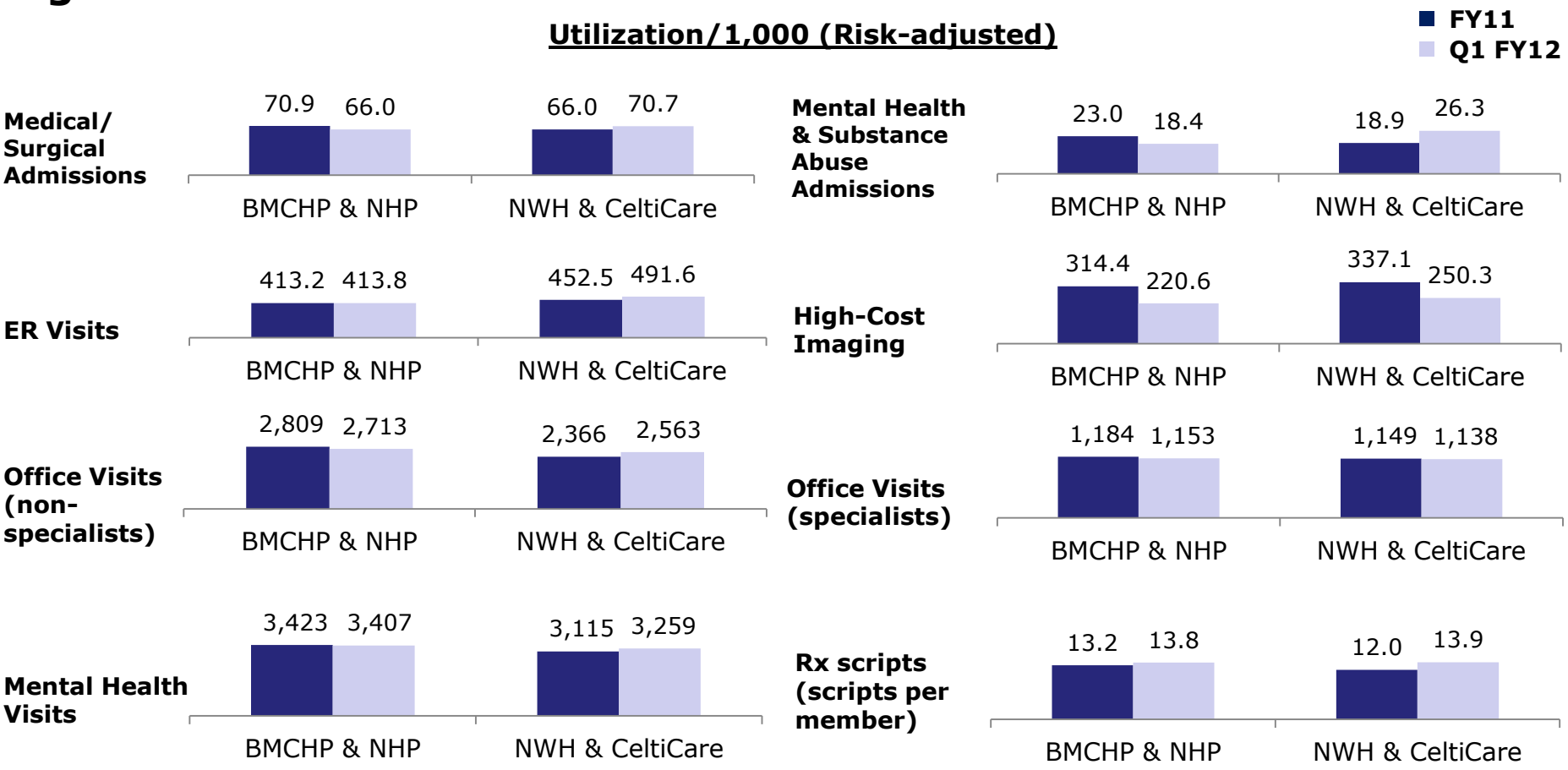
Utilization Analysis

- While it is known that the lowest-cost MCOs' cost advantage is competitive unit cost, a key question is whether the narrower network design imposes inappropriate barriers to access
- We have analyzed utilization of key service categories
  - Comparing the lowest-cost MCOs (CeltiCare and Network Health) and higher-cost MCOs (BMCHP and NHP)
  - Comparing Q1 FY12 relative to FY11
  - Results are risk-adjusted

Utilization Results – Key Services

The lowest cost MCOs' utilization did not notably decrease from FY11 to FY12, and it does not appear to be systematically lower relative to higher-cost MCOs

Utilization/1,000 (Risk-adjusted)



Member Survey

Results from the second member satisfaction survey suggests that access and quality of coverage have NOT been compromised in FY12 notwithstanding the program changes

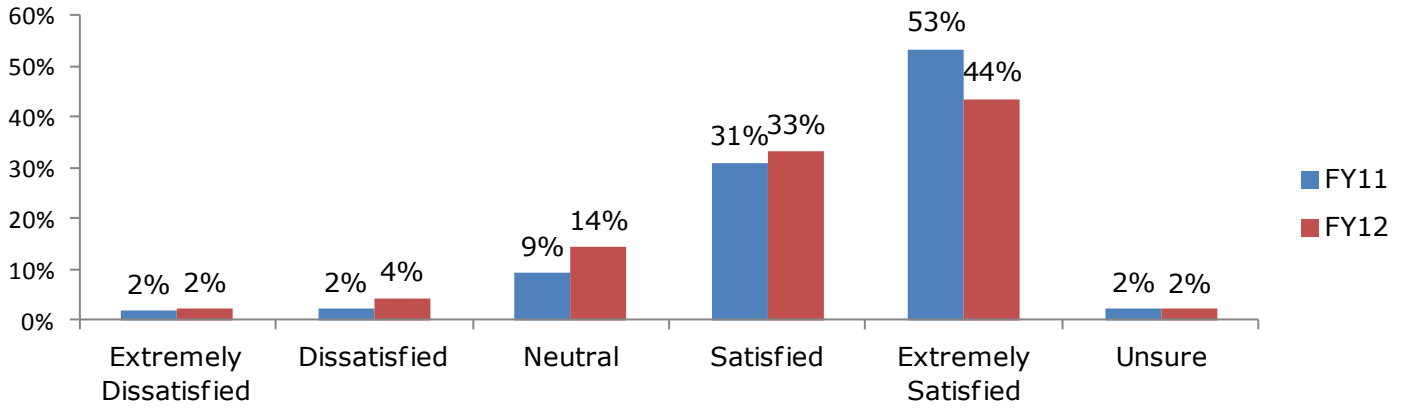
High-level Summary of Survey Findings

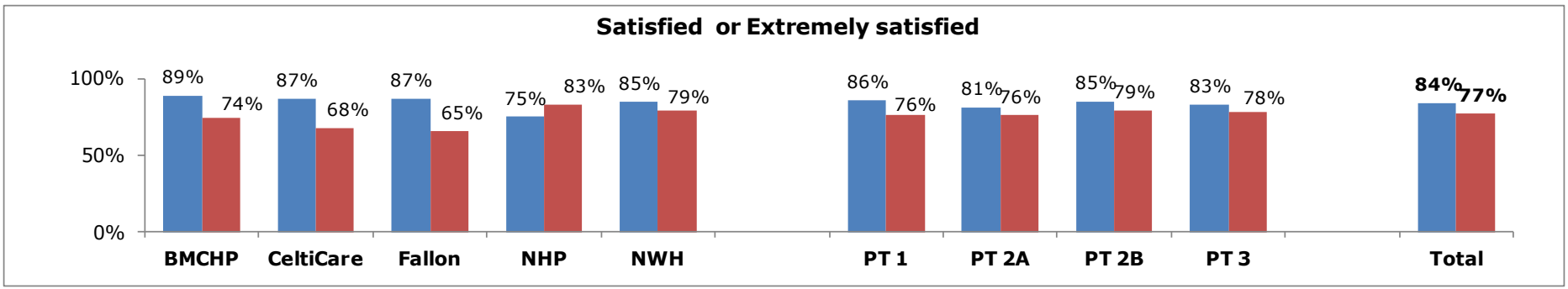
- Commonwealth Care continues to have high member satisfaction, with over three-quarters of our members being satisfied or extremely satisfied with the program
- Overall satisfaction has shown a slight decline relative to FY11. However, it appears that the program changes, including limited choice for certain PT1 members, did not lead to elevated member concerns about access, quality, or provider choice
- At the same time, we have observed a small drop in satisfaction with our servicing, potentially attributable to the more complex program rules and the changes made by MCOs. This suggests that more robust support for members is a potential area of increased focus going forward

Member Survey Results

The vast majority of Commonwealth Care members continue to be satisfied with the program, although there is a moderate decline in "extremely satisfied" members

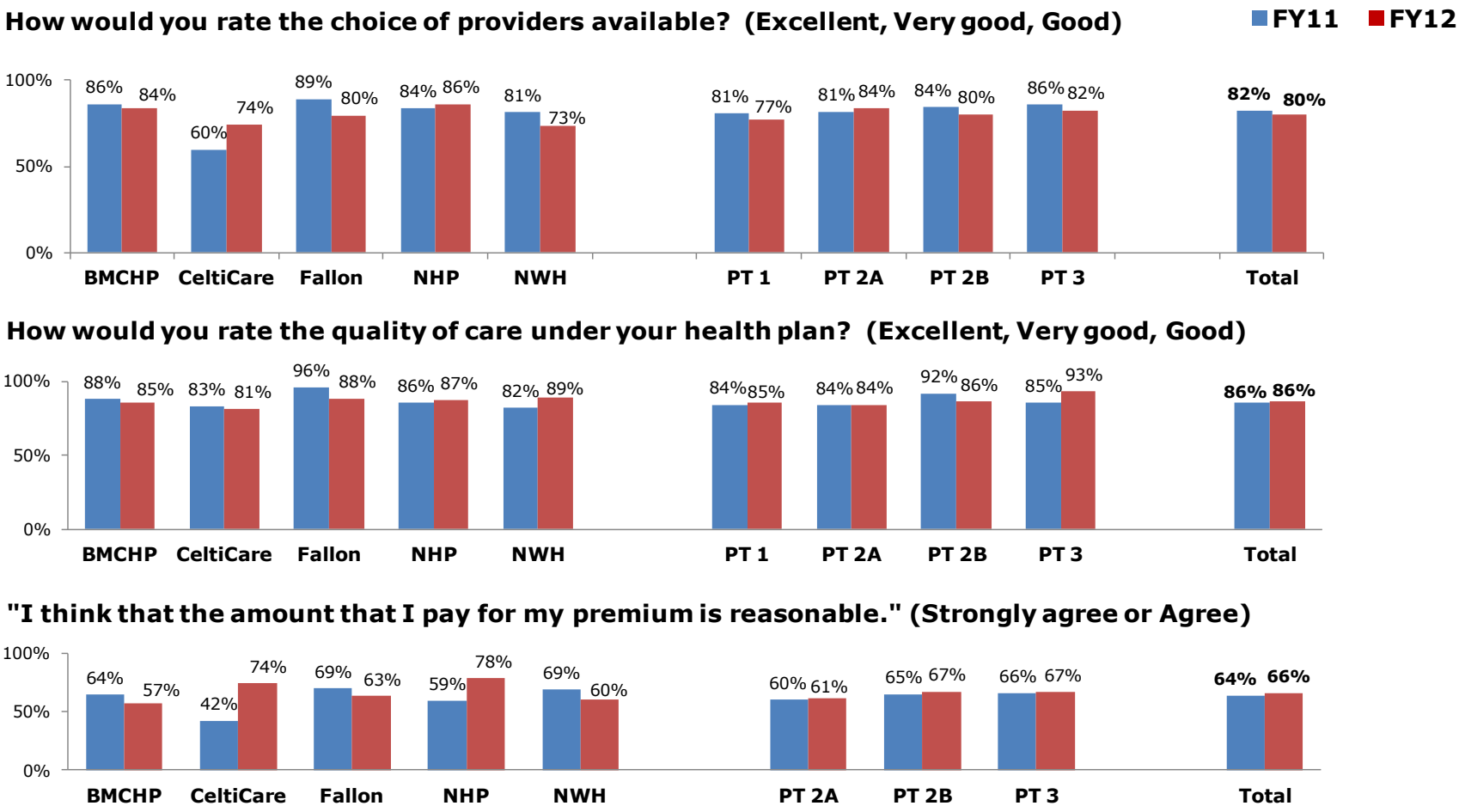
Question: How satisfied are you with the Commonwealth Care program overall?





Member Survey Results (cont)

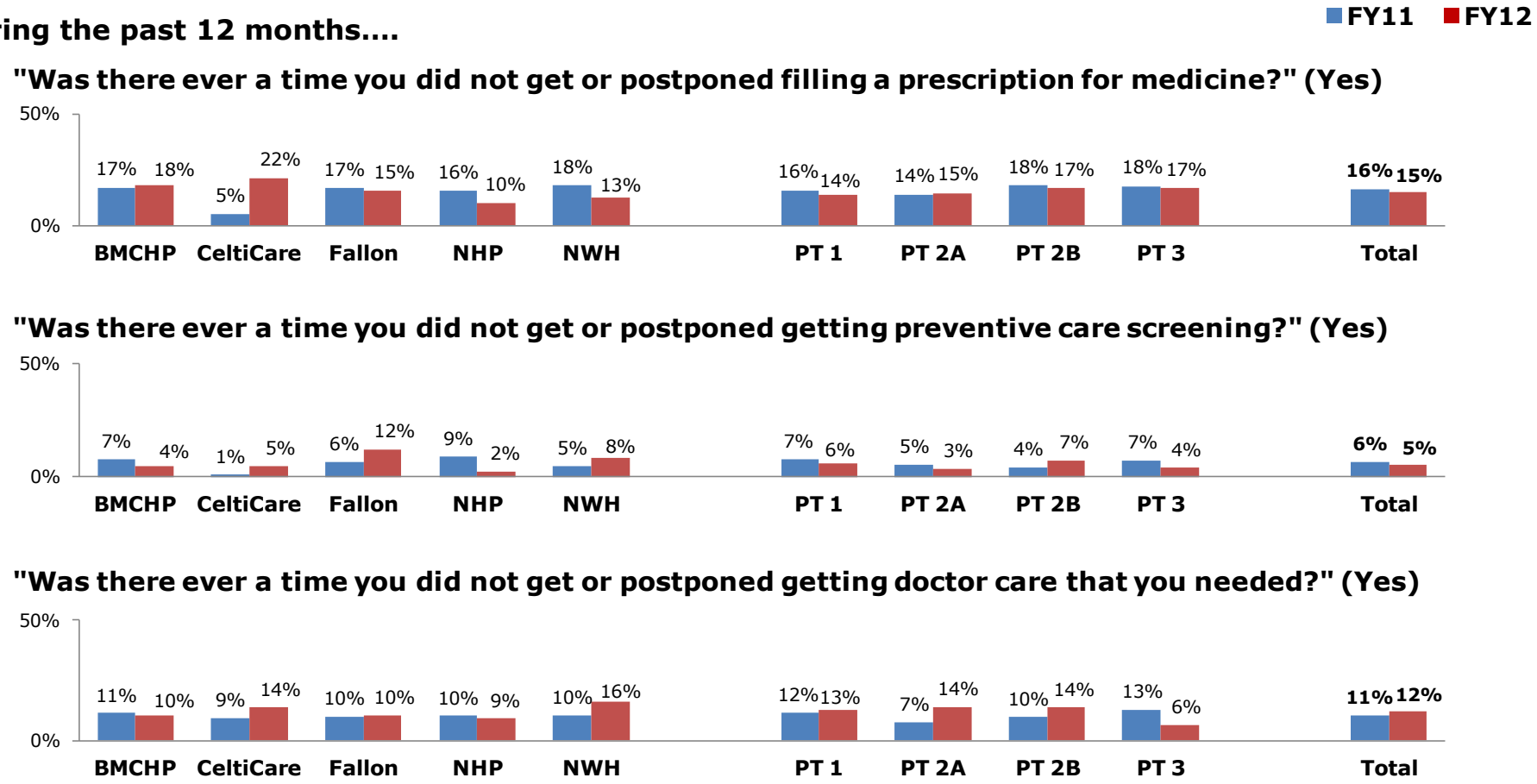
Member feedback on provider choice, quality and affordability appears to be similar to FY11



Member Survey Results (cont)

Overall, member feedback on their ability to access medical and pharmacy care is also similar to FY11

During the past 12 months….



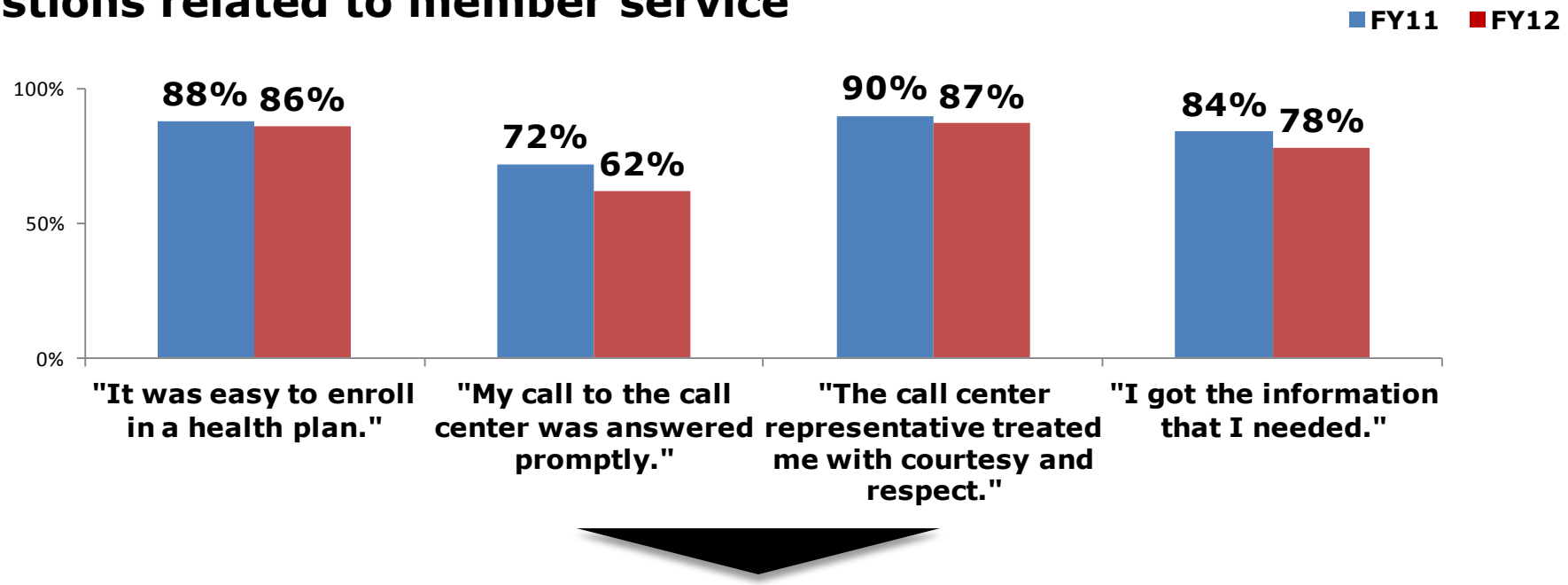
Member Survey Results (cont)

PT1 members who were subject to limited health plan choice did not reflect a compromised experience in their coverage

Survey Questions	FY11	FY12	
	PT1	All PT1	Subject to Limited Choice
Satisfied or Extremely satisfied with the program overall	**86%**	**76%**	**81%**
Rate the choice of providers available as Excellent, Very good, or Good	**81%**	**77%**	**73%**
Rate the quality of care as Excellent, Very good, or Good	**84%**	**85%**	**85%**
Were told by a doctor's office/clinic that they weren't accepting new patients	**28%**	**18%**	**18%**
Had to change to a new doctor's office/clinic because of a change in health plan	**17%**	**17%**	**24%**
During the past 12 months…			
Did not get or postponed filling a prescription for medicine	**16%**	**14%**	**16%**
Did not get or postponed getting preventive care screening	**7%**	**6%**	**7%**
Did not get or postponed getting doctor care needed	**12%**	**13%**	**13%**
Found it Easy to enroll in a health plan	**87%**	**86%**	**89%**
Satisfied or Extremely satisfied with the choice of health plans available	**69%**	**69%**	**66%**

Member Survey Results (cont)

We observed a small decline in positive member feedback in questions related to member service



- Member support was a high priority for our FY12 implementation
- Nevertheless, program changes might have resulted in an increase in member disruption during the process, which further stresses the importance of robust member support

Member Survey Results (cont)

We are studying the survey results to identify areas of clarification and improvement in member services for the coming year

- Average speed of answer remains favorable
  - Survey results indicate a 10% drop in satisfaction with promptness of answering calls while actual speed of answer has remained under 30 seconds on average for the past 12 months

- Several call center quality improvement efforts are under way
  - Monthly after-hours refresher trainings
  - Dedicated program rule training and call calibration sessions
  - One-on-one and large group "soft skills" trainings, focused on tone, empathy and providing efficient, accurate service
  - Improving escalation processes, making it easier for members to reach a supervisor

- Call center preparation and training will continue to be a critical component of open enrollment planning as we move into FY13

AWSS Reintegration Operational Readiness

To ensure a flawless AWSS reintegration process in the coming months, we have taken several steps to be prepared and to deliver excellent customer service

- Call Center Staffing & Training
  - Hired 11 additional staff in February and expect to hire an additional 6 staff in March
  - All existing staff have been trained to assist Bridge/AWSS members in making their enrollment selections

- Specialized Bridge queue
  - A specialized queue went live on 2/3 in the main IVR menu (option #5) to assist Bridge callers
  - Highly seasoned call center representatives will be taking calls to the Bridge queue

- Additional accommodations
  - The call center will remain open on President's Day, 2/20
  - Non-English-speaking members will receive assistance from bi-lingual staff and be able to use the language line

Conclusions of FY12 Analysis

- Analysis on the emerging experience of FY12 is preliminary and subject to continued validation
- However, observations to date are supportive of the strategy that was pursued, which, instead of reducing benefits or making coverage less affordable, leveraged competition and innovation among MCOs
- Analysis of the data suggests that all of our MCOs continue to provide high quality, credible coverage to Commonwealth Care members

Proposed FY2013 Procurement Design

Actuarially Sound Rate Range

- Our independent actuary has provided the preliminary Actuarially Sound Rate Range for FY2013
  - The lower bound of the rate range reflects demonstrated savings of the MCOs with the lowest overall cost structure
  - A downward adjustment for average population risk, which takes into account the impact of AWSS reintegration, is incorporated

FY13 Preliminary Actuarially Sound Rate Range (Provided by Wakely Consulting)		
	Low	High
Total Capitation (Medical & Admin)	**$354.58**	**$480.60**

Proposed Bidding Rules

- Our proposed bidding rules for FY13 reflect the core principles of our approach in FY12, i.e., provide incentives for MCOs to compete, innovate and differentiate on the basis of price and value
- The goal is to leverage competitive bids while maintaining benefits and affordability for members
- In combination, we believe that these proposed bidding rules reflect the approach most likely to deliver a successful outcome

Proposed Bidding Rule #1 – Bid Ceiling

- A capitation bid ceiling is set by the Health Connector, which reflects reasonable, achievable savings targets compared to average experience in FY2011 and best-estimate actuarial assumptions
- MCOs are allowed to bid at or below the following capitation bid ceiling: $415 PMPM (Medical + Admin)
- Only one bid will be submitted for all plan types and regions; actual capitation rates will be subject to program-wide adjustment factors/methodologies (plan type, region, demographics, acuity) defined by the Health Connector

Proposed Bidding Rule #2 – Bid Floor

- MCOs are required to submit actuarially sound capitation rate bids
- A bid that is below the lower bound of the preliminary Actuarially Sound Rate Range may be accepted by the Health Connector, provided that the bidder is able to demonstrate the actuarial soundness of its bid to the satisfaction of the Health Connector's independent actuary
- In the event a bid that is below the lower bound of the preliminary Actuarially Sound Rate Range is determined to be actuarially sound, the preliminary rate range will be amended accordingly before it is certified as the final Actuarially Sound Rate Range

Proposed Bidding Rule #3 – Enrollee Contribution

- Plan Type 2 and Plan Type 3 members who choose the lowest-cost MCO will be subject to the base enrollee contribution
  - The base enrollee contribution will be determined by the CY2012 Affordability Schedule
- For Plan Type 2 and Plan Type 3 members who do not choose the lowest-cost plan, an enrollee premium differential will be charged above the base enrollee contribution
- The enrollee premium differential will continue to be MCO-specific and set based on the difference between each MCO's bid and the lowest bid
  - Progressive according to income

Proposed Bidding Rule #4 – Limited Choice for Certain New PT1 Members

- A same subset of Plan Type 1 members that have limited choice in FY12 (also defined below) will be limited to the choice of *two* MCOs – the lowest-bidding MCO and the second lowest-bidding MCO that offer coverage in the member's service area, provided that the second lowest-cost bid does not exceed $380 PMPM
  - Incoming Commonwealth Care Plan Type 1 members…
  - who were not insured in the past 180 days by a Commonwealth Care MCO other than the lowest bidder or the second lowest bidder in the service area
  - This coverage history in the past 180 days can be through either Commonwealth Care or MassHealth
- Providing the choice of two MCOs instead of one to these incoming PT1 members was a strength of the FY12 procurement outcome. We propose to pursue a comparable level of member choice in FY13

Proposed Bidding Rule #5 – Active Open Enrollment Contingency

- No restrictions applied to open enrollment – all enrolled members are able to choose any MCO for any reason
- *However,* if fewer than two MCOs that currently provide coverage in all five regions bid a capitation rate that is equal to or lower than $380 PMPM, an active open enrollment for Plan Type 1 members will be conducted
  - Plan Type 1 members who do not affirmatively choose an MCO during open enrollment would then be assigned to the lowest-bidding MCO that offers coverage in the member's service area

Risk Adjustment

- We will continue to apply the risk adjustment methodology newly implemented in FY12
- Two refinements in the risk score calculation process will be introduced in FY13
  - In addition to Commonwealth Care encounter data, MassHealth data will also be included in the risk profile analysis, which allows us to capture diagnosis records of members who had prior history with MassHealth
  - Due to claims lag, currently new members are excluded from DxCG adjustment for the first several months of their enrollment, which is a source of potential residual risk selection. In FY13, this issue will be mitigated with a mechanism of retroactive reconciliation
- Similar to FY12, the Health Connector will provide simulation data to support MCOs in their analysis of these changes

Other Key Contract Items

Term of the FY13 MCO Contract

- 12-month contract from July 2012 through June 2013
- Contract extension for the period of July – Dec 2013 will be structured as an option
- The Health Connector will collaborate with MassHealth to identify the appropriate plan to transition to 1/1/2014

Stop Loss

- Maintain existing mechanism
- Claims cost of a single member in excess of $150K in the contract year will be reimbursed by the stop loss pool at 75%

Aggregate Risk Sharing

- Maintain existing mechanism
- An MCO's gain or loss relative to its medical capitation revenue in excess of 4% and up to 50% will be shared 50-50 between the MCO and the Health Connector

Other FY2013 Initiatives

Payment Reform Pilot

- Promoting payment reform is a strategic focus for all state health insurance programs
- We were encouraged by the Secretary of ANF and the Health Connector Board to explore opportunities to incorporate payment reform initiatives in the FY13 Commonwealth Care program
- This is intended as a component of and in coordination with the broader effort to advance market-wide payment reform

Payment Reform Pilot (cont)

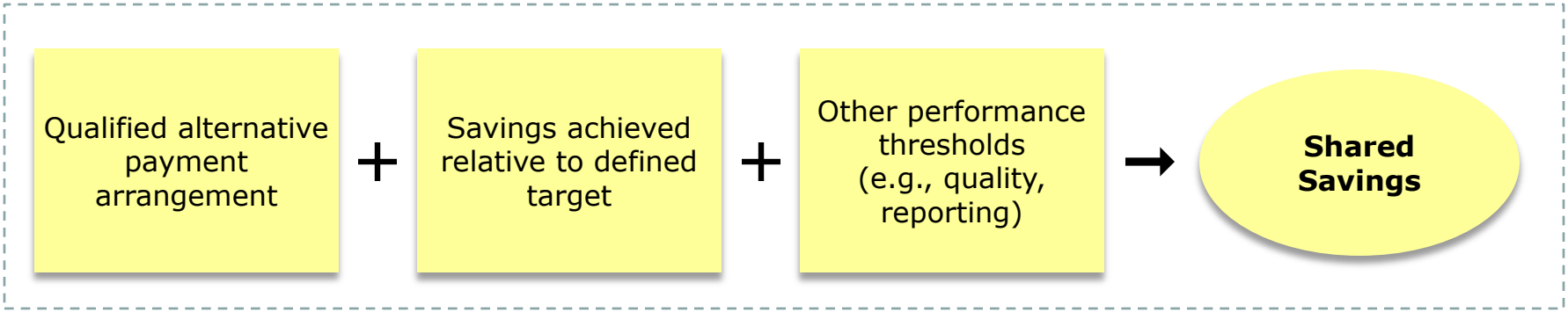
As a step in the planning process, the Health Connector solicited inputs from Commonwealth Care MCOs

MCO Feedback

- MCOs agree that moving away from fee-for-service is the right direction, although they see this as a longer-term transition
- Successful migration towards alternative payment models requires an operational transformation, which is dependent on provider commitment and infrastructure investment. There is also a significant learning curve
- Population size matters. Larger programs have an advantage in engaging MCOs/providers
- Infrastructure support must be combined with meaningful performance accountability in order to change behavior

Payment Reform Pilot (cont)

We have begun to work with MassHealth in a collaborative effort to explore a "shared savings" pilot program



Key objectives:

- Provide incentives for MCOs and providers to accelerate their migration towards alternative contracting models
- Provide an opportunity for the MCOs, providers and the state to learn from the experience, which will inform larger-scale initiatives

Payment Reform Pilot (cont)

Next Steps:

- The Health Connector and MassHealth are working together to develop a detailed plan for the pilot program
  - Under the vision for this initiative, MCOs will be encouraged to enter into shared savings arrangements for their provider contracts on both the MassHealth side and the CommonwealthCare side
- The goal is to launch the joint program in the fall of 2012

Tobacco Cessation Program

- The FY13 budget includes $2M in funding for enhancing the tobacco cessation benefit of Commonwealth Care
- Studies of MassHealth have suggested that tobacco cessation is a cost-effective investment that improves member health and generates savings
- The Health Connector is gathering information from various sources, including the MassHealth program, to develop the specific requirements of the Commonwealth Care Tobacco Cessation program, which will be launched in the beginning of FY13

Closing Message and Next Steps

Summary

- We are proud of Commonwealth Care's success in FY12, especially the fact that cost containment was achieved without compromising the value of the program

- Although our experiment is still ongoing, compared with last year, we have greater confidence that market competition can indeed "jolt the system", spur health plan innovation and uncover solutions to our health care affordability challenges

- The state has made a commitment to cover many more Commonwealth Care members in FY13, and with this procurement plan, our goal is to ensure our coverage remains comprehensive and affordable

- We have once again presented a major challenge to our MCOs; as in FY12, we believe that this can also be turned into a tremendous opportunity

Proposed Next Steps