

HEALTHCHOICES NORTHEAST ZONE, NORTHWEST ZONE, AND BREAST AND CERVICAL CANCER PHYSICAL HEALTH FEE-FOR-SERVICE DATABOOK

COMMONWEALTH OF PENNSYLVANIA

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Introduction

The intent of this databook is to provide interested parties historical fee-for-service (FFS) data on the cost and utilization patterns of HealthChoices-eligible populations in the Northeast and Northwest zones, who were enrolled in the Commonwealth of Pennsylvania's (Commonwealth) ACCESS Plus program or traditional FFS. This databook also provides historical FFS data on the cost and utilization patterns of the breast and cervical cancer (BCC) population in the aforementioned zones, as well as the Southeast, Southwest, and Lehigh/Capital HealthChoices zones, who will be eligible for the Commonwealth's HealthChoices managed care program. Additionally, this databook provides information on adjustments that will be made to the historical FFS data in calculating capitation rate ranges for the prospective rating period. Mercer Government Human Services Consulting (Mercer) produced this databook with input from the Commonwealth.

This databook was prepared to help interested parties understand the basis for the development of capitation rate ranges for the populations and services covered under the HealthChoices program. This databook contains demographic, cost, and utilization data for physical health services that will be the responsibility of the HealthChoices physical health managed care organizations (PH-MCOs).

Please note the following items concerning this FFS databook and the HealthChoices FFS-based capitation rate development process:

- Information in this databook can be found on the internet at the following address:
<http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/index.htm>
- If there are any discrepancies between the information in this databook and the information available on the web site, the information in this databook takes priority.
- This databook contains claims and utilization data for recipients in the FFS program, not the Voluntary or mandatory managed care programs. In this context, the reference to the FFS program includes the Commonwealth's ACCESS Plus and traditional FFS programs. Due to similar eligibility criteria, the vast majority of the historical data in this databook reflects experience for individuals enrolled in ACCESS Plus.
- The FFS cost and utilization data in this databook have been summarized from information contained in the Commonwealth's claims database. The demographic information was taken from the Commonwealth's eligibility files.
- Users are cautioned that direct comparisons between this databook and the Commonwealth's FFS data may not be appropriate (please refer to Section 7 for adjustments reflected in this databook).

- The Department of Public Welfare (DPW) and Mercer will take note of relevant information, advice, suggestions, and input from managed care organizations and their actuaries.

The historical data time periods chosen for the zones and populations summarized in this databook vary due to the different HealthChoices implementation dates and available FFS data. The historical FFS data has been summarized for the following zones and populations by the specified years (based on date of service or date of delivery):

Northeast zone:

- Calendar year (CY) 2011 (January 2011 – December 2011) processed through September 2013.
- CY 2012 (January 2012 – December 2012) processed through September 2013.

Northwest zone:

- State Fiscal Year (SFY) 10–11 (July 2010 – June 2011) processed through September 2013.
- SFY 11–12 (July 2011 – June 2012) processed through September 2013.

BCC Population (all zones):

- SFY 10–11 (July 2010 – June 2011) processed through September 2013.
- SFY 11–12 (July 2011 – June 2012) processed through September 2013.

The respective FFS data has been summarized for the HealthChoices Northeast and Northwest zones, as well as the Southeast, Southwest, and Lehigh/Capital HealthChoices zones included in this databook. The zones include the following counties in the Commonwealth:

Northeast Zone	Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming
Northwest Zone	Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango, Warren
Southeast Zone	Bucks, Chester, Delaware, Montgomery, Philadelphia
Southwest Zone	Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, Westmoreland
Lehigh/Capital Zone	Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntington, Lancaster, Lebanon, Lehigh, Northampton, Perry, York

The user of this databook is cautioned against relying solely on the data contained herein. The Commonwealth and Mercer provide no guarantee, either written or implied, that this databook is 100% accurate or error-free.

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Covered Populations

This databook provides summarized FFS data according to the rate cell structure listed in the subsequent table:

HealthChoices Physical Health Rate Cell Structure
Temporary Assistance for Needy Families-Healthy Beginnings-Modified Adjusted Gross Income (TANF-HB-MAGI) < 2 Months
TANF-HB-MAGI 2–11.999 Months
TANF-HB-MAGI Ages 1–20
TANF-HB-MAGI Ages 21+
Supplemental Security Income-Healthy Horizons (SSI-HH)-Other Disabled
Breast and Cervical Cancer (BCC)
Categorically Needy State-Only (GA-CNO)
Medically Needy State-Only (GA-MNO)
Maternity Care Payment

Refer to Appendix B for the detailed Recipient/Program Coverage Chart

This databook and the resulting rate ranges will not reflect any expenses related to spend-down as a result of established procedures at the county assistance offices that prevent the Commonwealth from paying for medical services during the spend-down period.

Effective July 1, 2012, the Commonwealth re-mapped most Federal GA individuals into other rating groups, most notably SSI-HH. The historical FFS data in this databook reflects the re-mapping of individuals based on the new category of aid and program status codes.

Effective March 1, 2013, the BCC population has been added to the HealthChoices program statewide. The BCC population includes women under age 65 who have been screened and diagnosed with breast or cervical cancer or a pre-cancerous condition of the breast or cervix. The Commonwealth assigns the category of aid/program status code of PH/20 to this population. For purposes of this databook, the historical FFS BCC data are shown separately.

As the Commonwealth transitions in the future to using a MAGI income determination methodology for applicable populations, it is expected that MAGI individuals will be included with TANF-HB-MAGI. To support this change, the rating cell structure has been modified to now

reflect the following age groupings: TANF-HB-MAGI < 2 Months, TANF-HB-MAGI 2–11.999 Months, TANF-HB-MAGI Ages 1–20, and TANF-HB-MAGI Ages 21+.

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Covered Services

The specific services required under the HealthChoices program are detailed in the program’s supporting documentation available from DPW. The FFS claims data for these services have been summarized in Sections 5 through 9 by the following service categories:

FFS Service Categories

Category of Service	General Description/Definition	Unit of Measurement
Pharmacy	All drugs claims except: <ul style="list-style-type: none"> • Family planning. • Drugs provided during an inpatient stay. • Drugs paid as bundled service or global fee. 	Internal Control Number (ICN) Count
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screens	Complete screens as detailed on the EPSDT Periodicity Schedule, excluding vaccines.	Unique Encounters
Lab/Radiology	All laboratory diagnostic services except: <ul style="list-style-type: none"> • Family planning. • Lab services provided during an inpatient stay. • Lab services paid as bundled service or global fee. All radiology diagnostic services except: <ul style="list-style-type: none"> • Family planning. • Radiology services provided during an inpatient stay. • Radiology services paid as bundled service or global fee. 	Allowed Quantity
Vision	All vision services, excluding those that are paid as a bundled service or global fee.	Allowed Quantity

Category of Service	General Description/Definition	Unit of Measurement
Durable Medical Equipment (DME)	<p>All unbundled DME, supplies, and blood products except:</p> <ul style="list-style-type: none"> • DME/medical supplies that are part of an inpatient stay. • DME/medical supplies paid as a bundled service or global fee. 	Allowed Quantity
Home Health and Hospice	<p>Home Health: All medical services provided in the home. This excludes transportation of recipients, providers, and equipment.</p> <p>Hospice: All hospice services.</p>	Allowed Quantity
Long-Term Care	<p>Institutional: First 30 consecutive days of nursing home only, all costs for extended care stays, excluding drugs and professional provider services that are paid separately (included in other respective service categories).</p> <p>HIV/AIDS Waiver: All waiver services for recipients eligible for the HIV/AIDS waiver; services these recipients receive through their Medical Assistance (MA) Health Care Benefits Package are excluded.</p>	Days and Allowed Quantity, Respectively
Family Planning	<p>All family planning drugs and services, excluding family planning provided as part of a complete EPSDT screen.</p>	Allowed Quantity and ICN Count
Therapy/Diagnostic	<p>All specialized therapies (including chemotherapy, radiation therapy, and support components) except those rendered during an inpatient stay.</p> <p>All diagnostic studies (including audiology and sleep studies) except those services rendered during an inpatient stay.</p>	Allowed Quantity
Ambulance/Transportation	<p>Ambulance and transportation services except:</p> <ul style="list-style-type: none"> • Services rendered during an inpatient stay. • Service paid as part of a bundled service or global fee. 	ICN Count

Category of Service	General Description/Definition	Unit of Measurement
Federally Qualified Health Center/Rural Health Clinic (FQHC/RHC)	All services provided to a recipient at an FQHC/RHC except: <ul style="list-style-type: none"> Dental services. Complete EPSDT screens. Professional provider services not billed by the FQHC/RHC. 	Unique Encounters
Emergency Room (ER)	Services provided to recipients in an ER, including trauma response team associated with hospital critical care. If the visit results in a physical health inpatient admission, then the costs are incorporated into the inpatient stay.	Unique Encounters
Dental	Dental services, including dental oral surgery (except for facility services).	Allowed Quantity
Physician	All services from primary care providers and specialty physicians.	Allowed Quantity
Other Practitioners	All services from podiatrists, chiropractors, certified registered nurses, certified nurse midwives, nurses, psychologists, optometrists (non-vision services), nutritionists, Certified Registered Nurse Anesthetists (CRNAs), tobacco cessation providers, renal dialysis centers, birthing centers, independent medical/surgery clinics, and HIV/AIDS case managers. This excludes facility services associated with an inpatient admission and professional provider services that are paid separately.	Allowed Quantity
Facility Non-Inpatient	All services provided from an outpatient facility, ambulatory surgical center, or short procedure unit, including the facility support components (includes observation services) except: <ul style="list-style-type: none"> Professional provider services that are paid separately. ER services. Services that result in a physical health inpatient admission, which are incorporated into the inpatient stay. 	Unique Encounters

Category of Service	General Description/Definition	Unit of Measurement
Inpatient Acute Care	All costs related to acute or sub-acute care hospital stays except: <ul style="list-style-type: none"> Professional provider services that are paid separately. Nursing home care. 	Covered Days
Inpatient Rehabilitation	All costs related to other physical health inpatient stays, except for professional provider services that are paid separately and nursing home care.	Covered Days

Additional costs are not included in the reports in Sections 5 and 6. For additional information please refer to:

- Section 7 – Adjustments Reflected in this Databook.
- Appendix A – Program Changes Chart.

Maternity Care Payment

To facilitate the development of the maternity care payment, maternity-related claims for all recipients have been summarized separately from other claims. This separation of claims allows the Commonwealth to pay the PH-MCOs for each delivery via the maternity care payment. One payment will be made per live delivery, regardless of the number of births. All costs for any delivery, except for cesarean section (C-section), have been included in the vaginal delivery costs. Only live births are included in the birth counts.

Maternity data for the BCC population was reviewed and was determined to be negligible. For this reason, no separate FFS BCC maternity data exhibits are provided in this databook. No adjustment will be made to the Southeast, Southwest, or Lehigh/Capital HealthChoices maternity care payments to include BCC births, but to the extent that a BCC member in these zones gives birth, the respective HealthChoices maternity care payment will apply. However, BCC births in the Northeast and Northwest zones have been included in the corresponding HealthChoices maternity care payments, respectively. It is expected that the Commonwealth will make the applicable maternity care payment for that member, using the normal maternity care payment process in effect for the HealthChoices program, in all respective zones of the Commonwealth.

Deliveries were identified by one of the following codes: (a) Diagnosis Related Group (DRG) codes were used when there was an inpatient facility claim associated with the delivery; (b) procedure codes were used when there was not an inpatient claim associated with a delivery and, instead, professional claims were used.

Maternity Care

Code Identifying a Delivery		Type of Delivery
All Patient Refined (APR)-DRG Codes (facility claims)	0540	C-section
	0541	Vaginal
	0542	Vaginal
	0560	Vaginal
Procedure Codes (professional claims)	59400	Vaginal
	59409	Vaginal
	59410	Vaginal
	59610	Vaginal
	59612	Vaginal
	59614	Vaginal
	59412	Vaginal
	59510	C-section
	59514	C-section
	59515	C-section
	59618	C-section
	59620	C-section
	59622	C-section
	59525	C-section

There were several cases in the data when a single delivery event had conflicting codes that indicated both a C-section and vaginal delivery. In these situations, the assignment of a C-section or vaginal delivery was based on which delivery type the majority of codes supported. If there was no majority (i.e., a tie), the presence of procedure code 01960 or 01967, indicating anesthesia treatment for a vaginal delivery, resulted in a vaginal delivery type classification. In situations where a tie existed, but neither anesthesia procedure code 01960 or 01967 was present, the delivery event was defaulted to a C-section delivery type.

Once a delivery (multiple births are considered one delivery) was identified, all physical health claims (for the mother only) 90 days prior to and including the delivery were extracted and summed into a total maternity cost event and attributed to maternity cost data in the base year (i.e., SFY or CY) that the birth event occurred. All applicable claims for the mother in this 90-day period were allocated to the maternity data.

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Report Descriptions

Non-maternity FFS cost and utilization reports are summarized by SFY or CY, zone, and rate cell in Section 5 of this databook. Additionally, non-maternity FFS cost and utilization reports for the BCC population are summarized by SFY and zone. Each data sheet provides two years of non-maternity data for user convenience. Maternity FFS reports summarized by year of delivery, zone, and type of delivery appear in Section 6. Each data sheet provides two years of maternity data for user convenience. The FFS member months (MMs) and the average number of recipients per month (FFS MMs divided by 12 or number of FFS deliveries) are provided. The Voluntary MCO MMs (i.e., those enrolled in the Voluntary managed care program) and the average number of enrollees per month are also shown at the top of the applicable reports. The MMs were calculated from the Commonwealth's recipient days file.

As stated earlier, the reports contain only the cost and utilization data for recipients in the FFS program (e.g., ACCESS Plus and traditional FFS), not the Voluntary or mandatory managed care programs.

The remaining columns on each page are described below:

- *Category of Service* – defined in Section 3.
- *Annualized Utilization Per 1,000* – for the non-maternity data, this is computed by dividing the utilization by FFS MMs and then multiplying this result by 12,000. In the maternity care data reports, the utilization per 1,000 deliveries was calculated by dividing the utilization by the number of FFS deliveries and then multiplying the result by 1,000.
- *Unit Cost* – average cost of each service line item; paid amount divided by the total number of services delivered (utilization).
- *PMPM/CPD* – per member per month (PMPM) or cost per delivery (CPD) costs based on the historical FFS data; paid amount divided by the FFS MMs or FFS deliveries.

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Non-Maternity Data for SFY 10–11, SFY 11–12, CY 2011, and CY 2012

The following exhibits are available for the Northeast and Northwest zones:

- 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.
- GA-CNO.
- GA-MNO.
- Maternity Care Payment.

The following exhibits are available for the BCC population:

- Northeast Zone.
- Northwest Zone.
- Southeast Zone.
- Southwest Zone.
- Lehigh/Capital Zone.

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Maternity Data for SFY 10–11, SFY 11–12, CY 2011, and CY 2012

The following exhibits are available for the Northeast and Northwest zones:

- Vaginal Delivery.
- C-section Delivery.

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Adjustments Reflected in this Databook

This section lists the adjustments made to reflect a FFS environment equivalent to a managed care risk environment. The following adjustments are reflected in the summaries shown in Sections 5 and 6:

- The two types of reports shown in this databook represent the non-maternity (Section 5) and maternity (Section 6) claims paid by the Commonwealth. These reports are mutually exclusive. With the exception of all pharmacy, ambulance, and ER benefits, the PH-MCOs are not responsible for behavioral health services.
- The Commonwealth has removed all Disproportionate Share Hospital (DSH) payments from the data. DPW will make any applicable payment directly to the provider.
- The Commonwealth has removed all Graduate Medical Education (GME) payments from the data. DPW will make any applicable payment directly to the provider.
- All claims and eligibility data for individuals in the following settings have been removed from the data:
 - State Mental Hospitals.
 - State Mental Retardation (MR) Center.
 - South Mountain Restoration Center.
 - Youth Development Center/Youth Forestry Camp.
 - Long-Term Care Capitated Program.
 - Health Insurance Premium Payment (HIPP) Program.
- For individuals residing in a private, intermediate care facility-mentally retarded, all claims associated with the facility's room and board have been removed from the data.
- After reviewing the PROMISe system processes for gross adjustments, the Commonwealth and Mercer determined that no adjustments were needed to account for gross adjustments.
- Effective July 1, 2010, the Commonwealth made changes in its hospital inpatient reimbursement levels, which included converting to an APR-DRG payment methodology for the ACCESS Plus and FFS programs. Mercer and the Commonwealth discussed the impact that changes in the Commonwealth's APR-DRG fee schedule (since July 1, 2010) would have on the CY 2015 capitation rates, and have agreed that a 0.9090 adjustment factor must be applied to all claims within the base data with dates of discharge prior to July 1, 2011. An additional adjustment factor of 0.9753 must be applied to all claims within the base data with dates of discharge prior to July 1, 2012. These adjustments were applied to the FFS-paid dollars for the Inpatient Acute Care category of service only. Accordingly, the Inpatient Acute Care costs reported in this databook reflect historical utilization levels and contemporary unit cost levels.
- Based on the Commonwealth's policies for managed care coverage of institutionalized persons (e.g., nursing homes or juvenile detention centers (JDC)) and/or Pennsylvania

Department of Aging (PDA) waiver enrollees, the historical FFS data included in this databook were adjusted as follows:

- Only claims and eligibility for the first 30 consecutive days of a nursing home stay were included. After 30 consecutive days in a nursing home, a person will be disenrolled from HealthChoices.
- Only non-PDA waiver service claims for the first 30 consecutive days of PDA waiver enrollment were included. After 30 consecutive days in the PDA waiver, a person will be disenrolled from HealthChoices.
- Only non-JDC facility claims for the first 35 consecutive days in a JDC were included; an adjustment was made to remove FFS claim expenditures provided directly by (i.e., inside) the JDC during this 35-day period. After 35 consecutive days in a JDC, a person will be disenrolled from HealthChoices.
- 1915(c) waiver services (excluding HIV/AIDS), early intervention services, MR targeted case management, school-based access programs, medically fragile foster care, funeral director, family planning Title XX and V, energy assistance and Department of Health services for eligible recipients have also been removed from the data.
- This databook contains only information covering the estimated time period that the HealthChoices PH-MCOs would have been at risk. The HealthChoices PH-MCOs will not be responsible for prior periods of coverage (e.g., prior to application), retroactive eligibility (e.g., period between application and eligibility determination), and managed care enrollment lag (e.g., period between eligibility determination and estimated managed care enrollment). Accordingly, this databook reflects the time period that reasonably equates to the PH-MCO coverage time as follows:
 - Non-BCC population:
 - Since the base data contained in this databook are after implementation of the ACCESS Plus program, and the enrollment policies are similar between the ACCESS Plus program and the HealthChoices program (including disenrollment of adult dual eligibles), the Commonwealth advised Mercer that using the ACCESS Plus enrollment spans would be an accurate methodology to summarize historical FFS cost, utilization, and eligibility data that would reflect the HealthChoices program's risk period.
 - For the small number of population categories that will be eligible for the HealthChoices program, but not ACCESS Plus, the Commonwealth and Mercer agreed to use the HealthChoices behavioral health managed care organization (BH-MCO) enrollment begin date to determine the equivalent HealthChoices risk period. Since HealthChoices behavioral health enrollment was statewide as of July 1, 2007, this was a reasonable solution:
 - For new eligibles, if the BH-MCO begin date was equal to the individual's date of birth, the HealthChoices risk period was assumed to start on the BH-MCO begin date.
 - For new eligibles whose BH-MCO begin date was not equal to the date of birth, the HealthChoices risk period was assumed to start on the BH-MCO begin date, plus 22 days.

- For individuals whose eligibility was reinstated within six months of a previous loss in coverage, the HealthChoices risk period was assumed to start on the BH-MCO begin date applicable to the reinstatement.
 - Accordingly, for these population categories, this databook contains no experience data prior to the assumed HealthChoices risk period.
- BCC population:
 - For the HealthChoices zones, where the BCC population has been enrolled in the ACCESS Plus program, Mercer was able to leverage the ACCESS Plus enrollment spans as described previously.
 - For the HealthChoices zones, where the BCC population has been enrolled in the traditional FFS program, Mercer estimated the PH-MCO coverage period to be the person's first day of MA eligibility, plus 45 days, unless the individual had a prior contiguous eligibility span preceding the BCC span. In these situations, Mercer estimated the PH-MCO coverage period to be concurrent with the first day of BCC eligibility.
- As of January 1, 2006, dual eligibles ages 21 or older were no longer eligible to enroll in the HealthChoices program. Working with the Commonwealth, Mercer developed a methodology to identify and exclude the applicable population group from this databook, based on the data fields available. This exclusion was only applied to the small population who was eligible for the HealthChoices program, but not ACCESS Plus. The presence of Medicare Part D in the eligibility data, along with age, was used to exclude the adult dual eligibles.
- This databook summarizes claims according to the date of service and reflects payments made through September 2013. Claims for SFY 10–11, SFY 11–12, CY 2011, and CY 2012 were not complete due to claims adjustments and lag time for payments, which took longer than the approximate nine months after December 2012. For purposes of developing completion factor adjustments, the individual categories of services were consolidated into five major categories that exhibit similar payment run-out traits, as detailed below, and were analyzed separately for each major population group (e.g., TANF-HB-MAGI, SSI-HH-Other Disabled):

FFS Completion Factor Service Categorization

Category of Service	Consolidated Major Category
Pharmacy	Pharmacy
EPSDT Screens	Physician
Lab/Radiology	Outpatient
Vision	Other
DME	Other
Home Health and Hospice	Other
Long-Term Care	Other
Family Planning	Other
Therapy/Diagnostic	Other

Category of Service	Consolidated Major Category
Ambulance/Transportation	Other
FQHC/RHC	Outpatient
ER	Outpatient
Dental	Other
Physician	Physician
Other Practitioners	Physician
Facility Non-Inpatient	Outpatient
Inpatient Acute Care	Inpatient
Inpatient Rehabilitation	Inpatient

In addition to the usual considerations for developing completion factor adjustments, special consideration was given to the inpatient consolidated major category as a result of the Commonwealth's increased emphasis on claim overpayment recovery, as well as the impact of the large scale re-adjudication of inpatient acute care claims in March 2011, and July and August 2012. These factors had a significant impact on the inpatient category, resulting in material reductions to historically-reported inpatient expenditures. The inpatient completion factor adjustments reflect Mercer's best estimate of how these influences will affect the ultimate inpatient claims levels for the data presented in this databook.

The resulting completion factor adjustments were then applied to the FFS-paid dollars for each respective category of service for each month of service (e.g., paid dollars x completion factor adjustment). Please refer to Appendix C for the monthly completion factor adjustments:

- No adjustment for the Commonwealth's historical FFS pharmacy rebates has been applied to the data contained herein. For purposes of producing this databook, Mercer opted to display the historical FFS pharmacy-paid amount, gross of any federal Medicaid and state supplemental rebates obtained by the Commonwealth. Therefore, users are cautioned about making direct comparisons between the pharmacy data contained in this databook to older databooks:
 - Consideration will be given to the HealthChoices PH-MCOs' ability to obtain pharmacy rebates in the course of developing the managed care capitation rates (please refer to Section 8 for more information on this pending adjustment).
- Due to the statewide expansion of the HealthChoices behavioral health program as of July 1, 2007, there was not a need to adjust the historical FFS non-maternity, non-emergency laboratory/radiology claims data as in previous databooks. It is assumed that the applicable laboratory/radiology services that are the responsibility of the BH-MCOs were covered and paid for by the BH-MCOs in lieu of the FFS program. For the BCC population, no adjustment was made as it was assumed that the laboratory/radiology services related to behavioral health were immaterial.

The historical FFS claims paid amounts are net of the copay requirements (i.e., cost sharing) in use by the Commonwealth during the respective time period. The Commonwealth requires the HealthChoices program to use the same copays as in FFS, so no adjustment was necessary unless there is a change in copays (see Program Changes Chart).

8

Adjustments That will be Made to Calculate Base Capitation Rate Ranges

This section describes the adjustments that Mercer will make to calculate the prospective base capitation rate ranges. Mercer makes several adjustments to the FFS data to match the experience of an actuarially equivalent, non-enrolled population. Mercer will certify that the base capitation rate ranges were developed following an actuarially sound process as required by the Centers for Medicare and Medicaid Services (CMS).

The following list of adjustments has not been reflected in this databook:

- Anomalies may exist in the data; therefore, Mercer will consider the two historical years of FFS data. The two years of historical FFS data will be consolidated to arrive at a blended base data set, upon which subsequent adjustments and trend factors will be applied in the development of the prospective capitation rate ranges.
- Mercer will develop prospective FFS trend factors through a review of the historical FFS data, input from the Commonwealth, Mercer's knowledge of the Pennsylvania marketplace, and Mercer's knowledge of health care trends in other states. The resulting trend factors will be annual factors that Mercer will use to project the base data. The number of months/years that the annual trend factors will be applied will be equivalent to the difference between the midpoint of the blended base data period and the midpoint of the rating period.
- Mercer will adjust the data for the following material program changes:
 - Those that occurred during the base years (SFY 10–11, SFY 11–12, CY 2011, and CY 2012) and are not fully reflected in the data.
 - Those that occurred after SFY 11–12 or CY 2012 and have been approved by the Commonwealth.
 - Please refer to the Program Changes Chart in Appendix A, which summarizes adjustments to be considered based on information available at this time (subject to revision).
- Mercer will make adjustments to each service category. These adjustments will reflect the typical changes that occur when a state shifts from a FFS environment to a managed care program. For example, hospital inpatient utilization tends to decrease, while outpatient services utilization tends to increase. Consideration will be given to the fact that the historical FFS data represents a time period when the Commonwealth's ACCESS Plus program was operational:
 - Since the FFS pharmacy line is gross of any rebates, Mercer will make an additional adjustment to reflect the expected level of rebates that an efficient and effective managed care program can obtain. Consideration will be given to the recent federal health care reform provisions associated with Medicaid rebates.

- For the HealthChoices Northeast and Northwest zone capitation rate ranges, Mercer will adjust the projected managed care claim costs to reflect differences in selection in the FFS data (e.g., primarily the ACCESS Plus program) as compared to the HealthChoices program in the aggregate. These program selection adjustments may vary by rate cell and zone; however, it is expected that no selection adjustment will be applied to the TANF-HB-MAGI < 2 months, TANF-HB-MAGI 2–11.999 months, or Maternity Care Payment rate cells.
- An allowance for the HealthChoices PH-MCOs' administration/profit expenses will be added to the projected managed care claim costs based upon a percentage of the premium.
- As part of the capitation rate development process, Mercer will compare the HealthChoices Northeast zone, Northwest zone, and the BCC population rate ranges, to the rate ranges developed in previous years for the HealthChoices programs.

9

Non-Maternity Data Summary

The following charts summarize the FFS MMs and PMPM costs for the different rate cells for SFY 10–11, SFY 11–12, CY 2011, and CY 2012 in the HealthChoices Northeast and Northwest zones, and the BCC population, respectively:

Non-Maternity Data Summary

Northeast Zone Rate Cell	CY 2011		CY 2012	
	FFS MMs	PMPM	FFS MMs	PMPM
TANF-HB-MAGI < 2 Months	17,188	\$ 1,588.41	17,189	\$ 1,730.10
TANF-HB-MAGI 2–11.999 Months	80,142	\$ 164.23	81,153	\$ 156.23
TANF-HB-MAGI Ages 1–20	1,123,978	\$ 97.58	1,133,242	\$ 98.81
TANF-HB-MAGI Ages 21+	323,969	\$ 206.83	327,903	\$ 201.50
SSI-HH-Other Disabled	570,927	\$ 594.53	592,853	\$ 590.23
GA-CNO	39,153	\$ 371.74	40,603	\$ 388.24
GA-MNO	30,690	\$ 122.79	25,598	\$ 144.07

Non-Maternity Data Summary

Northwest Zone Rate Cell	SFY 10–11		SFY 11–12	
	FFS MMs	PMPM	FFS MMs	PMPM
TANF-HB-MAGI < 2 Months	8,671	\$ 1,743.59	8,133	\$ 1,777.43
TANF-HB-MAGI 2–11.999 Months	38,111	\$ 170.04	36,678	\$ 154.37
TANF-HB-MAGI Ages 1–20	541,935	\$ 102.16	528,168	\$ 102.53
TANF-HB-MAGI Ages 21+	173,346	\$ 230.06	168,806	\$ 211.63
SSI-HH-Other Disabled	315,083	\$ 605.26	318,694	\$ 614.41
GA-CNO	23,874	\$ 377.11	23,229	\$ 344.06
GA-MNO	12,513	\$ 126.37	12,032	\$ 159.58

Non-Maternity Data Summary

BCC Population Zone	SFY 10–11		SFY 11–12	
	FFS MMs	PMPM	FFS MMs	PMPM
Northeast Zone	2,743	\$ 1,608.23	2,932	\$ 1,905.39
Northwest Zone	2,298	\$ 1,038.32	1,938	\$ 1,185.38

BCC Population Zone	SFY 10–11		SFY 11–12	
	FFS MMs	PMPM	FFS MMs	PMPM
Southeast Zone	5,117	\$ 1,044.59	4,871	\$ 1,291.72
Southwest Zone	5,038	\$ 1,112.95	4,976	\$ 1,239.17
Lehigh/Capital Zone	3,181	\$ 1,356.72	3,577	\$ 1,415.18

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Maternity Data Summary

The following charts summarize the FFS deliveries and cost per delivery for the different delivery types in SFY 10–11, SFY 11–12, CY 2011, and CY2012 in the HealthChoices Northeast and Northwest zones, respectively:

Maternity Data Summary

Northeast Zone		CY 2011			CY 2012		
Delivery Type	Deliveries	Percent	Per Delivery	Deliveries	Percent	Per Delivery	
C-Section	1,969	32.2%	\$ 6,456.30	1,990	32.6%	\$ 6,635.91	
Vaginal	4,156	67.9%	\$ 4,507.80	4,114	67.4%	\$ 4,596.84	
Combined	6,125	100.0%	\$ 5,134.18	6,104	100.0%	\$ 5,261.61	

Maternity Data Summary

Northwest Zone		SFY 10–11			SFY 11–12		
Delivery Type	Deliveries	Percent	Per Delivery	Deliveries	Percent	Per Delivery	
C-Section	1,106	34.6%	\$ 6,636.01	977	34.6%	\$ 6,662.99	
Vaginal	2,095	65.5%	\$ 4,521.11	1,851	65.5%	\$ 4,555.04	
Combined	3,201	100.0%	\$ 5,251.84	2,828	100.0%	\$ 5,283.28	

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Eligibility Distribution

The following chart summarizes the total MMs and Voluntary MCO MMs by zone, SFY, and rate cell. The percentage of total MMs that the Voluntary MCOs represent (i.e., managed care penetration) is also provided. The BCC population is excluded from these charts since the BCC population was excluded from the Voluntary managed care program:

Eligibility Distribution

Northeast Zone	CY 2011			CY 2012		
	Rate Cell	Total MMs	MCO MMs MCO Percent	Total MMs	MCO MMs MCO Percent	
TANF-HB-MAGI < 2 Months	19,456	2,268	11.7%	18,990	1,801	9.5%
TANF-HB-MAGI 2–11.999 Months	90,285	10,143	11.2%	89,355	8,202	9.2%
TANF-HB-MAGI Ages 1–20	1,283,085	159,107	12.4%	1,264,962	131,720	10.4%
TANF-HB-MAGI Ages 21+	379,235	55,266	14.6%	375,664	47,761	12.7%
SSI-HH-Other Disabled	631,920	60,993	9.7%	644,548	51,695	8.0%
GA-CNO	45,645	6,492	14.2%	46,327	5,724	12.4%
GA-MNO	36,105	5,415	15.0%	29,837	4,239	14.2%

Eligibility Distribution

Northwest Zone	SFY 10–11			SFY 11–12		
	Rate Cell	Total MMs	MCO MMs MCO Percent	Total MMs	MCO MMs MCO Percent	
TANF-HB-MAGI < 2 Months	11,393	2,722	23.9%	10,884	2,751	25.3%
TANF-HB-MAGI 2–11.999 Months	49,684	11,573	23.3%	49,373	12,695	25.7%
TANF-HB-MAGI Ages 1–20	731,178	189,243	25.9%	720,345	192,177	26.7%
TANF-HB-MAGI Ages 21+	230,444	57,098	24.8%	228,616	59,810	26.2%
SSI-HH-Other Disabled	411,876	96,793	23.5%	422,721	104,027	24.6%
GA-CNO	29,408	5,534	18.8%	29,304	6,075	20.7%
GA-MNO	15,562	3,049	19.6%	15,387	3,355	21.8%

Appendix A

Program Changes Chart (Subject to Revision)

The following table shows the program changes that may be considered in the capitation rate development process. This programmatic changes chart is subject to change (e.g., additions and deletions) as additional information becomes available:

Issue for Consideration	Effective Date
Gross Receipts Tax	Rating Period
Copays – Increase in copay fees	5/15/2012
Hospital APR-DRG Payment Levels – Changes to the Commonwealth’s hospital reimbursement levels	TBD
State-only General Assistance – Changes that may result in a reduction in the number of people	7/1/2012
Pharmacy Reduction – Prescriptions limited to 6 per month, with exceptions	1/1/2012
Dental – Reduction in services for Adults	9/30/2011
Enrollment changes due to Medicaid woodworking	4Q2013
Due to declining population sizes and changes in relative risk, consideration will be given to combining the GA-CNO and GA-MNO into one rate cell	TBD
Healthy PA 1115 Waiver – Impact on the HealthChoices program due to the new Healthy PA 1115 waiver	TBD

Appendix B

Recipient/Program Coverage Chart

Category	Program Status Code	Description	Recipient Group
A	00	SSI Aged	SSI-HH-Other Disabled
A	44	SSI Aged State Supplement for SSI recipients (Known as the sandwich Group)	SSI-HH-Other Disabled
A	45	SSI Aged Nursing Home State Supplement for SSI recipients	SSI-HH-Other Disabled
A	46	SSI Aged Recipients who receive a Mandatory SSP will be SSA	SSI-HH-Other Disabled
A	60	SSI Aged Individual Receiving Dom Care Supplement	SSI-HH-Other Disabled
A	62	SSI Aged Individual Receiving PCBH Supplement	SSI-HH-Other Disabled
A	64	SSI Aged State Supplement for SSI recipients w/FLAC Code B	SSI-HH-Other Disabled
C	00	TANF	TANF-HB-MAGI
C	04	TANF alien (Subject to 5 year bar)	TANF-HB-MAGI
C	06	TANF Timeout	TANF-HB-MAGI
C	07	Extended TANF - Contingency	TANF-HB-MAGI
C	08	Extended TANF	TANF-HB-MAGI
C	09	Extended TANF - DV	TANF-HB-MAGI
C	53	TANF Work Support (Disabled)	TANF-HB-MAGI
C	57	TANF Work Support (Extended TANF)	TANF-HB-MAGI
C	58	TANF Work Support (Extended TANF)	TANF-HB-MAGI
C	59	TANF Work Support (Domestic Violence)	TANF-HB-MAGI
C	71	TANF Transitional Cash Assistance - EMC	TANF-HB-MAGI
C	72	TANF Transitional Cash Assistance - Non-EMC	TANF-HB-MAGI
D	02	GA RRP/RCA (Refugee Cash Assist)	SSI-HH-Other Disabled
D	05	Repatriated National	SSI-HH-Other Disabled
J	00	SSI Disabled	SSI-HH-Other Disabled
J	31	SSI Disabled Federal Foster Care	SSI-HH-Other Disabled
J	32	SSI Disabled Federal Adoption Assist	SSI-HH-Other Disabled
J	33	SSI Disabled State Foster Care	SSI-HH-Other Disabled
J	35	SSI Adoption Foster Care Other State	SSI-HH-Other Disabled
J	36	Out of State Adoption Assistance	SSI-HH-Other Disabled
J	37	SSI SPLC	SSI-HH-Other Disabled
J	44	SSI Disabled State Supplement for SSI Recipients	SSI-HH-Other Disabled

Category	Program Status Code	Description	Recipient Group
J	45	SSI Disabled Nursing Home State Supplement for SSI Recipients	SSI-HH-Other Disabled
J	46	SSI Disabled Recipients who Received a Mandatory SSP will be SSA	SSI-HH-Other Disabled
J	60	SSI Disabled individual Receiving Dom Care Sup	SSI-HH-Other Disabled
J	62	SSI Disabled Individual Receiving PCBH Sup	SSI-HH-Other Disabled
J	64	SSI Disabled State Supplement for SSI Recipients w/FLAC Code B	SSI-HH-Other Disabled
M	00	SSI Blind	SSI-HH-Other Disabled
M	44	SSI Blind State Supplement for SSI Recipients (Known as the sandwich group)	SSI-HH-Other Disabled
M	45	SSI Blind Nursing Home State Supplement for SSI Recipients	SSI-HH-Other Disabled
M	46	SSI Blind Recipients who receive a Mandatory SSP will be SSA	SSI-HH-Other Disabled
M	60	SSI Blind Indv Receiving Dom Care Sup	SSI-HH-Other Disabled
M	62	SSI Blind Indv Receiving PCBH Sup	SSI-HH-Other Disabled
M	64	SSI Blind State Supplement for SSI Recipients w/FLAC Code B	SSI-HH-Other Disabled
MG	00	MAGI Pregnant Woman/Infant/Child/Youth	TANF-HB-MAGI
MG	18	MAGI NMP SMA/Income Ineligible Pregnant Woman/Newborn	TANF-HB-MAGI
MG	19	MAGI Youth (Newly Eligible)	TANF-HB-MAGI
MG	27	MAGI Infant/Child/Youth/Caretaker (Below TANF/NMP Limit)	TANF-HB-MAGI
MG	71	MAGI TMA Infant/Child/Youth/Caretaker	TANF-HB-MAGI
PA	00	NMP Aged	SSI-HH-Other Disabled
PA	22	NMP Aged Spend Down (Ongoing Auth)	SSI-HH-Other Disabled
PA	81	Aged Disabled Adult Child	SSI-HH-Other Disabled
PA	84	"Pickle" Aged	SSI-HH-Other Disabled
PA	85	Disabled Employment Aged	SSI-HH-Other Disabled
PAN	00	Aged Long Term Care (NMP)	SSI-HH-Other Disabled
PAN	66	Aged Long Term Care W/Buy-In (NMP)	SSI-HH-Other Disabled
PAN	80	Aged Long Term Care W/Buy-In (NMP)	SSI-HH-Other Disabled
PAW	00	Aged Waiver Program (NMP)	SSI-HH-Other Disabled
PAW	66	Aged Waiver Program W/Buy-In (NMP)	SSI-HH-Other Disabled
PAW	80	Aged Waiver Program W/Buy-In (NMP)	SSI-HH-Other Disabled
PAW	81	Special SSI Waiver-Aged-DAC	SSI-HH-Other Disabled
PAW	84	Special SSI Waiver-Aged-Pickle	SSI-HH-Other Disabled

Category	Program Status Code	Description	Recipient Group
PAW	85	Special SSI Waiver-Aged-Dis-Emp	SSI-HH-Other Disabled
PC	00	NMP TANF	TANF-HB-MAGI
PC	02	NMP TANF Refugee (RMA)	TANF-HB-MAGI
PC	03	NMP TANF Rep Unaccompanied Minor	TANF-HB-MAGI
PC	22	NMP AFDC Spend-Down (Ongoing Auth)	TANF-HB-MAGI
PC	23	NMP Four Month Extended Benefit	TANF-HB-MAGI
PC	27	NMP TANF For the Family	TANF-HB-MAGI
PC	30	Release from YDC	TANF-HB-MAGI
PC	31	NMP TANF Federal Foster Care	TANF-HB-MAGI
PC	32	NMP TANF Fed Adoption Assistance	TANF-HB-MAGI
PC	33	NMP TANF State Foster Care	TANF-HB-MAGI
PC	34	NMP TANF State Adoption Assistance	TANF-HB-MAGI
PC	35	Adoption Asst Foster Care Other State	TANF-HB-MAGI
PC	36	Out of State Adoption Assistance	TANF-HB-MAGI
PC	37	NMP SPLC (Subsidized Permanent Legal Custodianship)	TANF-HB-MAGI
PC	40	MAGI Former Foster Care	TANF-HB-MAGI
PC	71	EMC Eligible	TANF-HB-MAGI
PCN	02	Refugee Nursing Home	TANF-HB-MAGI
PCN	31	LTC-NMP Fed Foster Care	TANF-HB-MAGI
PCN	32	LTC-Fed Adop Assistance	TANF-HB-MAGI
PCN	33	LTC - NMP State Foster Care	TANF-HB-MAGI
PCN	34	LTC-NMP Sta Adop Assis Recip in Fac	TANF-HB-MAGI
PCN	35	LTC - NMP Out of State Foster Care	TANF-HB-MAGI
PCN	36	LTC - NMP Out of State Adop Assistance	TANF-HB-MAGI
PCN	37	LTC - NMP SPLC Child	TANF-HB-MAGI
PCW	02	Special Groups Waiver Programs	TANF-HB-MAGI
PD	00	NMP GA Chronically Needy Age 0-20	SSI-HH-Other Disabled
PD	22	NMP GA Chron Need Spend-Down (Ongoing) Age 0-20	SSI-HH-Other Disabled
PH	00	Category Needy Healthy Horizon	SSI-HH-Other Disabled
PH	20	Breast & Cervical Cancer	BCC
PH	80	Category Needy Healthy Horizon W/Buy-In	SSI-HH-Other Disabled
PH	95	Category Needy Healthy Horizon Child Special Needs	SSI-HH-Other Disabled
PH	97	SSI Pending/Child W/Special Needs (1yr-18yrs)	SSI-HH-Other Disabled
PI	00	Medically Improved MAWD	SSI-HH-Other Disabled
PI	66	Med Improved MAWD Eligible for SLMB	SSI-HH-Other Disabled
PI	80	Med Improved MAWD Elig for Buy-In	SSI-HH-Other Disabled
PJ	00	NMP Disabled	SSI-HH-Other Disabled

Category	Program Status Code	Description	Recipient Group
PJ	22	NMP Disabled Spend-Down (Ongoing)	SSI-HH-Other Disabled
PJ	81	Disabled Adult Child	SSI-HH-Other Disabled
PJ	83	Disabled Special SSI Group Widows/Widowers Age 50-64	SSI-HH-Other Disabled
PJ	84	Disabled "Pickle" Aged Age 0-64	SSI-HH-Other Disabled
PJ	85	Disabled Employment Aged Age 18-64	SSI-HH-Other Disabled
PJ	98	MA Eligible BBA/SSI Inelig. PRWORA	SSI-HH-Other Disabled
PJN	00	Disabled Long Term Care (NMP)	SSI-HH-Other Disabled
PJN	66	Disabled Long Term Care w/Buy-In (NMP)	SSI-HH-Other Disabled
PJN	80	Disabled Long Term Care w/Buy-In (NMP)	SSI-HH-Other Disabled
PJW	00	Disabled Waiver Program (NMP)	SSI-HH-Other Disabled
PJW	66	Disabled Waiver Program W/Buy-In (NMP)	SSI-HH-Other Disabled
PJW	80	Disabled Waiver Program W/Buy-In (NMP)	SSI-HH-Other Disabled
PJW	81	Special SSI Waiver-Dis-DAC Age 18-64	SSI-HH-Other Disabled
PJW	83	Special SSI Waiver -Disabled widow(er) 50-64	SSI-HH-Other Disabled
PJW	84	Special SSI Waiver - Disabled Pickle Age 18-64	SSI-HH-Other Disabled
PJW	85	Special SSI Waiver Disabled Emp Age 18-64	SSI-HH-Other Disabled
PM	00	NMP Blind	SSI-HH-Other Disabled
PM	22	NMP Blind Spend-Down (Ongoing)	SSI-HH-Other Disabled
PM	81	Blind Disabled Adult Child	SSI-HH-Other Disabled
PM	84	Blind "Pickle" Individual	SSI-HH-Other Disabled
PM	85	Blind Disabled Employment Age 18+	SSI-HH-Other Disabled
PMN	00	Blind Long Term care (NMP)	SSI-HH-Other Disabled
PMN	66	Blind Long Term Care W/Buy-In (NMP)	SSI-HH-Other Disabled
PMN	80	Blind Long Term Care W/Buy-In (NMP)	SSI-HH-Other Disabled
PMW	00	Blind Waiver Program (NMP)	SSI-HH-Other Disabled
PMW	66	Blind Waiver Program w/Buy-In (NMP)	SSI-HH-Other Disabled
PMW	80	Blind Waiver Program W/Buy-In (NMP)	SSI-HH-Other Disabled
PMW	81	Special SSI Waiver-Blind DAC Age 18+	SSI-HH-Other Disabled
PMW	84	Special SSI Waiver-Blind Pickle Age 18+	SSI-HH-Other Disabled
PMW	85	Special SSI Waiver-Blind Employment Age 18+	SSI-HH-Other Disabled
PS	16	NMP SMA Preg Woman and Children	TANF-HB-MAGI
PS	18	NMP SMA Inc Ineligible PregWoman/Newborns	TANF-HB-MAGI
PU	00	NMP TANF/CU	TANF-HB-MAGI
PU	22	NMP TANF/CU Spend-Down (Ongoing)	TANF-HB-MAGI
PU	23	NMP Four Month Extended Benefit	TANF-HB-MAGI
PU	27	NMP TANF/CU for the Family	TANF-HB-MAGI
PU	71	EMS Eligible	TANF-HB-MAGI
PW	00	MAWD	SSI-HH-Other Disabled

Category	Program Status Code	Description	Recipient Group
PW	66	MAWD Elig for SLMB	SSI-HH-Other Disabled
PW	80	MAWD Elig for Medicare Buy-In	SSI-HH-Other Disabled
TA	00	MNO Aged	SSI-HH-Other Disabled
TA	22	SSI MNO Aged Spend Down Age 65+	SSI-HH-Other Disabled
TA	66	Specif Low Inc Med Benef. Buy-In (MNO)	SSI-HH-Other Disabled
TA	80	With Buy-In	SSI-HH-Other Disabled
TAN	00	Aged Long Term Care (MNO)	SSI-HH-Other Disabled
TAN	66	Aged Long Term Care W/Buy-In (MNO)	SSI-HH-Other Disabled
TAN	80	Aged Long Term Care W/Buy-In (MNO)	SSI-HH-Other Disabled
TAW	00	Aged Waiver Program (MNO)	SSI-HH-Other Disabled
TAW	66	Aged Waiver Program W/Buy-In (MNO)	SSI-HH-Other Disabled
TAW	80	Aged Waiver Program W/Buy-In (MNO)	SSI-HH-Other Disabled
TC	00	MNO TANF	TANF-HB-MAGI
TC	22	TANF MNO Abs/Inc Spend down <65	TANF-HB-MAGI
TD	00	MNO GA Chronically Needy Age 0-20	SSI-HH-Other Disabled
TD	22	GA MNO Spend down Age 0-20	SSI-HH-Other Disabled
TJ	00	MNO Disabled	SSI-HH-Other Disabled
TJ	22	SSI MNO Disabled Spend down	SSI-HH-Other Disabled
TJ	66	Specif Low Inc Med Benef. Buy-In (MNO)	SSI-HH-Other Disabled
TJ	80	With Buy-In	SSI-HH-Other Disabled
TJN	00	Disabled Long Term Care (MNO)	SSI-HH-Other Disabled
TJN	66	Disabled Long Term Care w/Buy-In (MNO)	SSI-HH-Other Disabled
TJN	80	Disabled Long Term Care W/Buy-In (MNO)	SSI-HH-Other Disabled
TJW	00	Disabled Waiver Program (MNO)	SSI-HH-Other Disabled
TJW	66	Disabled Waiver Program W/Buy-In (MNO)	SSI-HH-Other Disabled
TJW	80	Disabled Waiver Program W/Buy-In (MNO)	SSI-HH-Other Disabled
TU	00	MNO TANF/CU	TANF-HB-MAGI
TU	22	TANF MNO UPWE Spend down	TANF-HB-MAGI
U	00	TANF/CU	TANF-HB-MAGI
U	04	TANF/U Alien (Subject to 5 Years bar)	TANF-HB-MAGI
U	06	TANF Timeout	TANF-HB-MAGI
U	07	Extended TANF-Contingency	TANF-HB-MAGI
U	08	Extended TANF	TANF-HB-MAGI
U	09	Extended TANF-DV	TANF-HB-MAGI
U	53	TANF Work Support (Disabled)	TANF-HB-MAGI
U	57	TANF Work Support (Extended TANF)	TANF-HB-MAGI
U	58	TANF Work Support (Extended TANF)	TANF-HB-MAGI
U	59	TANF Work Support (Domestic Violence)	TANF-HB-MAGI
U	71	TANF Transitional Cash Assistance - EMC	TANF-HB-MAGI

Category	Program Status Code	Description	Recipient Group
U	72	TANF Transitional Cash Assistance - Non-EMC	TANF-HB-MAGI
PD	00	NMP GA Chronically Needy; age 21+	GA-CNO
PD	22	NMP GA Chronically Needy Spend-Down (Ongoing); age 21+	GA-CNO
TD	00	MNO GA Chronically Needy; age 21+	GA-MNO
TD	22	GA MNO Spend-Down; age 21+	GA-MNO

NOTE: Recipients in the above categories are excluded if they are age 21 and over with Medicare D, or if they are in a facility or setting that precludes managed care enrollment.

Provided by DPW on January 15, 2014

Appendix C

FFS Completion Factor Adjustments

SFY 10–11 Completion Factors by Month of Service

Population Groups	Consolidated Major Category	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11
TANF, Healthy Beginnings, and MAGI	Inpatient	0.9983	0.9995	0.9992	0.9989	0.9986	0.9982	0.9978	0.9976	0.9975	0.9972	0.9970	0.9966
	Physician	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001
	Pharmacy	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
	Outpatient	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003
	Other	1.0016	1.0016	1.0016	1.0017	1.0017	1.0018	1.0018	1.0018	1.0018	1.0018	1.0018	1.0019
SSI and Healthy Horizons	Inpatient	0.9983	0.9995	0.9992	0.9989	0.9986	0.9982	0.9978	0.9976	0.9975	0.9972	0.9970	0.9966
	Physician	1.0002	1.0002	1.0002	1.0002	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0004
	Pharmacy	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
	Outpatient	1.0004	1.0004	1.0004	1.0004	1.0004	1.0004	1.0004	1.0004	1.0005	1.0005	1.0005	1.0005
	Other	1.0004	1.0005	1.0006	1.0007	1.0008	1.0008	1.0009	1.0011	1.0013	1.0014	1.0016	1.0018
GA-CNO and GA-MNO	Inpatient	0.9983	0.9995	0.9992	0.9989	0.9986	0.9982	0.9978	0.9976	0.9975	0.9972	0.9970	0.9966
	Physician	1.0001	1.0001	1.0001	1.0001	1.0001	1.0002	1.0002	1.0003	1.0003	1.0003	1.0004	1.0004
	Pharmacy	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
	Outpatient	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0004	1.0004	1.0004	1.0004	1.0004
	Other	1.0012	1.0013	1.0014	1.0015	1.0016	1.0017	1.0019	1.0022	1.0023	1.0023	1.0025	1.0025

CY 2011 Completion Factors by Month of Service

Population Groups	Consolidated Major Category	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11
TANF, Healthy Beginnings, and MAGI	Inpatient	0.9978	0.9976	0.9975	0.9972	0.9970	0.9966	0.9964	0.9964	0.9963	0.9963	0.9962	0.9960
	Physician	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001	1.0002	1.0002	1.0002	1.0002	1.0002	1.0002
	Pharmacy	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
	Outpatient	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003
	Other	1.0018	1.0018	1.0018	1.0018	1.0019	1.0019	1.0019	1.0019	1.0019	1.0019	1.0020	1.0020
SSI and Healthy Horizons	Inpatient	0.9978	0.9976	0.9975	0.9972	0.9970	0.9966	0.9964	0.9964	0.9963	0.9963	0.9962	0.9960
	Physician	1.0003	1.0003	1.0003	1.0003	1.0003	1.0004	1.0005	1.0005	1.0005	1.0005	1.0006	1.0006
	Pharmacy	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
	Outpatient	1.0004	1.0004	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005
	Other	1.0009	1.0011	1.0013	1.0014	1.0016	1.0018	1.0020	1.0021	1.0022	1.0023	1.0024	1.0025
GA-CNO and GA-MNO	Inpatient	0.9978	0.9976	0.9975	0.9972	0.9970	0.9966	0.9964	0.9964	0.9963	0.9963	0.9962	0.9960
	Physician	1.0002	1.0003	1.0003	1.0003	1.0004	1.0004	1.0004	1.0004	1.0004	1.0005	1.0005	1.0006
	Pharmacy	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0001
	Outpatient	1.0003	1.0004	1.0004	1.0004	1.0004	1.0004	1.0004	1.0004	1.0004	1.0004	1.0004	1.0005
	Other	1.0019	1.0022	1.0023	1.0023	1.0025	1.0025	1.0025	1.0026	1.0026	1.0029	1.0030	1.0030

SFY 11–12 Completion Factors by Month of Service

Population Groups	Consolidated Major Category	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	
TANF, Healthy Beginnings, and MAGI	Inpatient	0.9964	0.9964	0.9963	0.9963	0.9962	0.9960	0.9964	0.9971	0.9975	0.9982	0.9987	0.9994	
	Physician	1.0002	1.0002	1.0002	1.0002	1.0002	1.0002	1.0002	1.0002	1.0002	1.0002	1.0003	1.0003	
	Pharmacy	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	
	Outpatient	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0004	1.0004
	Other	1.0019	1.0019	1.0019	1.0019	1.0020	1.0020	1.0021	1.0021	1.0022	1.0022	1.0023	1.0023	
SSI and Healthy Horizons	Inpatient	0.9964	0.9964	0.9963	0.9963	0.9962	0.9960	0.9964	0.9971	0.9975	0.9982	0.9987	0.9994	
	Physician	1.0005	1.0005	1.0005	1.0005	1.0006	1.0006	1.0006	1.0006	1.0007	1.0007	1.0008	1.0010	
	Pharmacy	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	
	Outpatient	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	1.0006	1.0006	1.0006	
	Other	1.0020	1.0021	1.0022	1.0023	1.0024	1.0025	1.0026	1.0026	1.0030	1.0031	1.0032	1.0033	
GA-CNO and GA-MNO	Inpatient	0.9964	0.9964	0.9963	0.9963	0.9962	0.9960	0.9964	0.9971	0.9975	0.9982	0.9987	0.9994	
	Physician	1.0004	1.0004	1.0004	1.0005	1.0005	1.0006	1.0006	1.0006	1.0007	1.0007	1.0007	1.0007	
	Pharmacy	1.0000	1.0000	1.0000	1.0000	1.0000	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001	
	Outpatient	1.0004	1.0004	1.0004	1.0004	1.0004	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	
	Other	1.0025	1.0026	1.0026	1.0029	1.0030	1.0030	1.0030	1.0030	1.0032	1.0034	1.0035	1.0036	1.0037

CY 2012 Completion Factors by Month of Service

Population Groups	Consolidated Major Category	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
TANF, Healthy Beginnings, and MAGI	Inpatient	0.9964	0.9971	0.9975	0.9982	0.9987	0.9994	1.0015	1.0044	1.0089	1.0160	1.0402	1.0561
	Physician	1.0002	1.0002	1.0002	1.0002	1.0003	1.0003	1.0005	1.0008	1.0009	1.0017	1.0026	1.0038
	Pharmacy	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
	Outpatient	1.0003	1.0003	1.0003	1.0003	1.0004	1.0004	1.0004	1.0005	1.0013	1.0030	1.0046	1.0082
	Other	1.0021	1.0021	1.0022	1.0022	1.0023	1.0023	1.0025	1.0029	1.0031	1.0036	1.0043	1.0053
SSI and Healthy Horizons	Inpatient	0.9964	0.9971	0.9975	0.9982	0.9987	0.9994	1.0015	1.0044	1.0089	1.0160	1.0402	1.0561
	Physician	1.0006	1.0006	1.0007	1.0007	1.0008	1.0010	1.0011	1.0013	1.0016	1.0027	1.0043	1.0062
	Pharmacy	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0001	1.0001	1.0003	1.0004
	Outpatient	1.0005	1.0005	1.0005	1.0006	1.0006	1.0006	1.0007	1.0008	1.0016	1.0034	1.0048	1.0072
	Other	1.0026	1.0026	1.0030	1.0031	1.0032	1.0033	1.0034	1.0039	1.0042	1.0053	1.0074	1.0092
GA-CNO and GA-MNO	Inpatient	0.9964	0.9971	0.9975	0.9982	0.9987	0.9994	1.0015	1.0044	1.0089	1.0160	1.0402	1.0561
	Physician	1.0006	1.0006	1.0007	1.0007	1.0007	1.0007	1.0011	1.0013	1.0016	1.0028	1.0039	1.0061
	Pharmacy	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001	1.0001
	Outpatient	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	1.0006	1.0015	1.0033	1.0051	1.0070
	Other	1.0030	1.0032	1.0034	1.0035	1.0036	1.0037	1.0037	1.0037	1.0045	1.0064	1.0088	1.0105

SFY 10–11 Completion Factors by Month of Service

Population Groups	Consolidated Major Category	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11
BCC	Inpatient	0.9983	0.9995	0.9992	0.9989	0.9986	0.9982	0.9978	0.9976	0.9975	0.9972	0.9970	0.9966
	Physician	1.0002	1.0002	1.0002	1.0002	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0003	1.0004
	Pharmacy	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
	Outpatient	1.0004	1.0004	1.0004	1.0004	1.0004	1.0004	1.0004	1.0004	1.0005	1.0005	1.0005	1.0005
	Other	1.0004	1.0005	1.0006	1.0007	1.0008	1.0008	1.0009	1.0011	1.0013	1.0014	1.0016	1.0018

SFY 11–12 Completion Factors by Month of Service

Population Groups	Consolidated Major Category	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
BCC	Inpatient	0.9964	0.9964	0.9963	0.9963	0.9962	0.9960	0.9964	0.9971	0.9975	0.9982	0.9987	0.9994
	Physician	1.0005	1.0005	1.0005	1.0005	1.0006	1.0006	1.0006	1.0006	1.0007	1.0007	1.0008	1.0010
	Pharmacy	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
	Outpatient	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	1.0005	1.0006	1.0006	1.0006
	Other	1.0020	1.0021	1.0022	1.0023	1.0024	1.0025	1.0026	1.0026	1.0030	1.0031	1.0032	1.0033



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