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CALENDAR YEAR 2021 HEALTHCHOICES

PHYSICAL HEALTH DATABOOK:
SOUTHEAST ZONE
SOUTHWEST ZONE
LEHIGH/CAPITAL ZONE
NORTHEAST ZONE
NORTHWEST ZONE

MARCH 12, 2020

Commonwealth of Pennsylvania

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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INTRODUCTION

The purpose of this databook is to provide the HealthChoices (HC) physical health managed care organizations (PH-MCOs) historical summarized data for the HC program, which will be used in capitation rate setting. The Commonwealth of Pennsylvania's (Commonwealth) HC program operates mandatory Medicaid managed care in five zones: Southeast (SE), Southwest (SW), Lehigh/Capital (LC), Northeast (NE) and Northwest (NW) zones. The databook provided represents the physical health (PH) services, including maternity services, covered in the HC program for calendar year (CY) 2018, which were the responsibility of the participating PH-MCOs for each of the five zones. This CY 2018 databook will serve as the base data for the development of the CY 2021 HC PH capitation rates.

Additionally, this databook provides information on the methodology Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, will use to develop the prospective CY 2021 capitation rates for the HC PH program. Mercer produced this databook with input from the Commonwealth's Department of Human Services (Department).

Historically, audited financial data submitted by the PH-MCOs was used as the base data for the HC PH rate setting. Starting in CY 2019, and in compliance with guidance from the Centers for Medicare & Medicaid Services, Mercer moved to using an encounter base for capitation rate setting. PH-MCO submitted PROMISe™ encounters with incurred dates of January 1, 2018 through December 31, 2018, and with runout through September 30, 2019, are summarized in this databook and will be used as base data for the development of the CY 2021 HC PH capitation rates.

The use of encounter data allows for a greater level of detail of analysis and review during rate development. For CY 2021, the encounter data was validated year-over-year with past encounter data, and against PH-MCO audited financial data and deemed to be appropriate and usable for rate setting. To account for underreporting or completion, encounters will be adjusted using audited financial reports within the rate-setting process. For purposes of this databook, no financial adjustments were applied.

The CY 2018 PH-MCO experience contained in this databook is representative of the rate cell and rating region structure expected to be in place during the CY 2021 rating period.

The following table illustrates the county composition of each rating region. Counties displayed below represent prospective region mappings:

RATING REGION COUNTIES CHART

HC ZONE	RATE REGION 1	RATE REGION 2
SE Zone	Delaware and Philadelphia counties	Bucks, Chester and Montgomery counties
SW Zone	Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Lawrence Washington, and Westmoreland counties	Bedford, Blair, Cambria, Indiana and Somerset counties
LC Zone	Adams, Berks, Cumberland, Lancaster, Lehigh, Northampton and York counties	Dauphin, Franklin, Fulton, Huntingdon, Lebanon and Perry counties
NE Zone	Bradford, Centre, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming counties	Carbon, Columbia, Juniata, Mifflin, Montour, Northumberland, Schuylkill, Snyder and Union counties
NW Zone	Crawford, Erie, Forest, Mercer, Venango and Warren counties	Cameron, Clarion, Clearfield, Elk, Jefferson, McKean and Potter counties

In addition to separate rating regions, the HC program considers the different risk characteristics of the enrolled population by establishing separate rate cells. Members are assigned to prospective rate cells based on their age, gender, category of assistance code and program status code.

In addition to the six prospective rate cells, shown below, within the HC program, there is also a maternity care supplemental payment. The maternity care supplemental payment is made to the PH-MCOs per live birth delivery (C-section or vaginal), regardless of the number of births during the delivery event. The maternity care payment reflects the risk of the mother's PH claims 90 days prior to the birth event and the birth event. Behavioral health (BH) services provided to pregnant women will be paid for by the BH managed care organizations (BH-MCOs), as provided by the respective agreements.

Rate cells may change between rate cycles to address data credibility, populations entering or leaving HC or to meet the needs of HC as it evolves. The rate cells and care payments for CY 2021 rate setting as of the date of this databook are listed below and are subject to change:

- Under Age 1

- TANF-MAGI Ages 1–20

- TANF-MAGI Ages 21+

- Disabled-BCC Ages 1+

- Newly Eligible Ages 19 to 44

- Newly Eligible Ages 45 to 64

- Maternity Care Supplemental Payment

Additionally, this databook reflects the implementation of the Community HealthChoices (CHC) program effective January 1, 2018, for the SW zone, January 1, 2019, for the SE zone and January 1, 2020, for the LC, NE and NW zones. Eligibility in CHC is limited to ages 21+ and a combination of either being dually eligible, nursing facility level of care certifiable, in a nursing home, receiving long-term services and supports (LTSS) or in certain Medicaid waivers. When CHC implements in a zone, some of the members will leave HC and transition into CHC immediately. The majority of these CHC eligible members are enrolled in HC through various waivers and are determined to be a part of the Disabled-BCC Ages 1+ rate cell (examples of these waivers include Attendant Care, Independence, COMMCARE, Aging Waiver and OBRA). A small number of these waiver-eligible members are in the TANF-MAGI Ages 21+ and Newly Eligible rate cells.

To develop a databook that reflects the CHC program and population transition, Mercer excluded individuals' cost and enrollment data in the base experience expected to shift from the HC PH program to the CHC program. The Department's historical eligibility data identified these individuals. For more information regarding the impact of excluding CHC eligible members on the member month (MM) and non-maternity per member per month (PMPM), please refer to the Appendix.

Services the PH-MCOs were responsible for in the CY 2018 time period include, but are not limited to, the following:

COVERED SERVICES	
Pharmaceutical	Medical Diagnostic
Pharmaceutical Non-Drug	Federally Qualified Health Center (FQHC) and Rural Health Clinics (RHC)
Laboratory	Emergency Room
Radiology	Dental
Complete Early and Periodic Screening, Diagnosis and Treatment Screens	Dental/Oral Surgery
Vision	Primary Care Providers
Durable Medical Equipment/Medical Supplies	Specialty Physician
Hospice	Other Practitioners
Home Health Care/HIV-AIDS Waiver	Facility Non-Inpatient (includes SPU/ASC)
Family Planning Services	Other Outpatient
Family Planning — Pharmaceutical	Inpatient Acute Care
Therapy	Inpatient — Rehab
Ambulance/Transportation	Nursing Home

The Department has separate agreements for BH-MCOs providing BH services, as well as CHC-MCOs providing LTSS.

This databook focuses on the historical encounter data from the PH-MCOs participating in HC. Since this is data from the HC PH program, graduate medical education or disproportionate share hospital payments are not included. Furthermore, to the extent any of the PH-MCOs implemented copayments or benefit limitations based on the Department's policies, a portion of the CY 2018 data may include the effects of these programmatic changes (see the chart in Section 4).

The encounter data for CY 2018 was submitted through PROMISe™ by the following PH-MCOs listed by zone below:

SOUTHEAST ZONE
Keystone Family Health Plan (Keystone)
Health Partners Plans, Inc. (Health Partners)
UnitedHealthcare of Pennsylvania, Inc. (United)
Aetna Better Health, Inc. (Aetna)

SOUTHWEST ZONE
UPMC *for You*, Inc. (UPMC)
Gateway Health Plan, Inc. (Gateway)
UnitedHealthcare of Pennsylvania, Inc. (United)
Aetna Better Health, Inc. (Aetna)

LEHIGH/CAPITAL ZONE
AmeriHealth Caritas Health Plan (AmeriHealth)
Gateway Health Plan, Inc. (Gateway)
UnitedHealthcare of Pennsylvania, Inc. (United)
Aetna Better Health, Inc. (Aetna)
UPMC *for You*, Inc. (UPMC)

NORTHEAST ZONE
AmeriHealth Caritas Health Plan (AmeriHealth)
Aetna Better Health, Inc. (Aetna)
Geisinger Health Plan (Geisinger)

NORTHWEST ZONE
AmeriHealth Caritas Health Plan (AmeriHealth)
UPMC *for You*, Inc. (UPMC)
Gateway Health Plan, Inc. (Gateway)
Aetna Better Health, Inc. (Aetna)

To create this databook, Mercer aggregated the PH-MCOs' submitted encounter data for all HC zones, by rate cell and category of service (COS). Thus, this databook can be described as a current review of the cumulative experience of the PH-MCOs that served the HC program in CY 2018.

CAVEATS

The user of this databook is cautioned against relying solely on the data contained herein. The Commonwealth and Mercer provide no guarantee, neither written nor implied that this databook is 100% accurate or error-free. The CY 2018 data presented in this databook was supplied from the Commonwealth's Medicaid Management Information System (MMIS) data warehouse on October 9, 2019. Any resubmissions to MMIS by the PH-MCOs after this date are not reflected in this databook unless otherwise noted.

This document assumes the reader is familiar with the Commonwealth's Medicaid program, Medicaid eligibility rules and actuarial rating techniques. It is intended for the Department and the PH-MCOs and should not be relied upon by other parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these data. This document should only be reviewed in its entirety.

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SUMMARIZED CALENDAR YEAR 2018 ENCOUNTER DATA

This section summarizes and provides additional detail for the encounter data utilized and for the accompanying databook exhibits.

METHODOLOGY

As part of the encounter data review and validation process, Mercer makes several adjustments to ensure the data is appropriate for use in rate setting. The following is a summary of the data criteria and adjustments applied to the CY 2018 encounter data:

• Data reflects voided and adjusted encounters.

• Data only includes PH-MCO encounter records that pass the required PROMISe™ edits. In certain cases, denied encounter records are included if the Commonwealth determines an edit is not working as intended.

• Data are limited to CY 2018 incurred claims based on the first date of service with runout through September 30, 2019.

• Detail paid amounts are used for professional, outpatient and dental encounters and header paid amounts are used for inpatient and pharmacy encounters. Encounters are grouped into these categories based on claim type.

    – M and B claim types are categorized as professional.

    – O and C claim types are categorized as outpatient.

    – D claim types are categorized as dental.

    – I, A and L claim types are categorized as inpatient.

    – P and Q claim types are categorized as pharmacy.

• Pharmacy encounters are gross of all market share and state supplemental rebates.

• Eligibility was attached to the encounter data based on eligibility files received from the Department. Attaching eligibility to the encounter data provided member demographic information, such as rate cell and rating region.

Along with the preceding bullets, Mercer summarized the PH-MCOs' expenses by COS in the financial reports. To align the encounter data to the financial report COS, a service group hierarchy logic was applied to the encounter data based on Appendix A of the Financial Reporting Requirements. This logic is reviewed annually and is subject to change. Appendix A uses criteria including, but not limited to, procedure codes, revenue codes, provider type and provider specialty, diagnoses and bill type, to map encounters into categories of service.

A separate logic is developed to identify all maternity encounter events (C-section and vaginal). This logic uses a combination of MS-DRGs, diagnosis codes, procedure codes and birth certificate data to identify the birth events. Once the events are identified, a 90-day lookback is used to identify all services for members 90 days before the birth event, which aligns with the terms of the supplemental maternity payment.

Several unit types are reported in the encounter data. While encounter units considered in rate-setting vary by service and are selected based on the quality of reporting and nature of the service provided, a uniform approach was taken for this databook. A count of detailed lines is the unit type for all COS except for Inpatient Acute Care, Inpatient Rehab and Nursing Home, which are based on covered days reported in the PH-MCOs' submitted encounter data. Due to data aggregation and difference in service mix, a PH-MCO's experience within any COS may vary from what is in the databook.

EXHIBITS

The utilization per 1,000, unit cost and PMPM data are summarized separately in the exhibits for each rating region by COS, for each rate cell. To calculate the utilization per 1,000 and PMPM metrics within the exhibits, MMs calculated from Department provided eligibility files were utilized.

Maternity data is summarized separately for the PH-MCOs' C-section and vaginal maternity expenses. Since the maternity care payment is made for live births only, the maternity expense data reflects information for only live outcomes. As a result, non-live expense data will not be included in the development of the maternity care payment, but instead will remain in the monthly capitation rates for the applicable rate cell. Note, while the databook displays the maternity data split between C-section and vaginal, only one aggregate supplemental maternity payment is developed in the rate-setting process (accounting for both C-section and vaginal deliveries).

The data exhibits are Microsoft Excel spreadsheets and are provided in a set of worksheets for each rating region that array rate cells and COS and show a single metric to compare across services and rate cells. The following exhibits for each zone and rate region combination are:

- Utilization per 1,000

- Unit Cost

- PMPM and per member per delivery

The PH-MCOs may find the exhibits and additional information on the internet at the following address: https://www.dhs.pa.gov/providers/Providers/Pages/Managed-Care-Information.aspx.

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RATE DEVELOPMENT METHODOLOGY

This section describes the rate-setting methodology Mercer will use for the development of the prospective capitation rates for the HC program. These rates will be developed following an actuarially sound process consistent with applicable federal regulations and professional standards.

BACKGROUND

In the past, Mercer developed capitation rates using the Department's historical fee-for-service (FFS) data. As the HC program has matured, the rate-setting process has transitioned from a methodology relying upon FFS data to a methodology based upon health plan financial, operational and submitted encounter data. The financial, operational and submitted encounter data from the PH-MCOs offer the most recent source of data.

METHODOLOGY

To develop prospective rates, Mercer will consider the financial, encounter and eligibility data each of the PH-MCOs submit to the Department as part of their current contractual requirements. These sources include data on enrollment, expenditures, unit cost and utilization. Supplementary data may also be incorporated into the rate-setting process. The sources of this supplementary data may be the Department, the current PH-MCOs and other sources deemed appropriate by Mercer and the Department. For CY 2021 HC PH rate setting, the submitted PROMISe™ encounter data will be the primary data source used in rate development.

As data accuracy and validity are essential components in developing capitation rate ranges, the Department and Mercer will analyze the submitted data for reasonableness and reliability. The areas that may be reviewed include, but are not limited to, the following:

- The magnitude of reserve estimates relative to incurred claims.

- The consistency of data.

- Side-by-side comparisons of each PH-MCO's data.

- Comparisons of PH-MCO financials to submitted encounters.

To reflect the risk of and the Commonwealth's expectations for the HC program in the prospective rating period, Mercer will adjust the data as necessary. These adjustments may be positive or negative, specific to a PH-MCO or more "global" in nature.

Mercer will use CY 2018 PH-MCO financial data from the HC program to develop an adjustment to align the encounter base with financials. This adjustment serves to address under or over reporting that may exist within the encounter data as well as to apply an incurred claims adjustment.

Adjustments may be made to reflect any programmatic and policy changes to the design of the HC program not reflected in the base data. These adjustments also may be positive, negative or budget neutral. Please refer to the Programmatic Changes section of this narrative to review contemplated programmatic or policy changes. Note, all program changes in this narrative are subject to change before the completion of rates, and subsequent program changes may be included as well.

Mercer will trend the data to the applicable prospective rating period since the submitted encounter data represents a historical period. No single source will be used to develop the prospective managed care trend rates. The trend sources that will be considered include, but are not limited to:

- PH-MCO submitted encounter data

- PH-MCOs' financial reports

- HC market changes

- Indices (such as the Consumer Price Index)

- Benchmarks to neighboring states as appropriate (FFS trends, managed care trends)

An additional component of the prospective rates will be an amount reasonable for administration and underwriting gain. Mercer will develop this non-benefit component, with input from the Department, by analyzing administrative expense reports from the historic health plans and possibly other data sources.

The rate-setting methodology described above will result in capitation rate ranges for each PH-MCO, region and rate cell. Mercer only certifies the contracted rate and not the rate ranges. The Department recommends each PH-MCO independently analyze its projected medical and non-benefit expense and other premium needs for comparison to the Department's rate offers in the aggregate.

RISK MITIGATION ARRANGEMENTS

In addition to the base capitation rates, the Department uses supplemental risk mitigation techniques to better match payment to risk among the PH-MCOs in the HC program. These risk mitigation techniques apply to both the Traditional and Adult Expansion populations and include:

- Risk-adjusted rates

- Home nursing risk sharing

- High-cost risk pool (HCRP)

- Under Age 1 risk sharing

- Cystic fibrosis specialty drug risk sharing

- Home accessibility durable medical equipment (DME) risk sharing

Risk-Adjusted Rates

The Department has risk-adjusted rates in the HC program using the combined Chronic Illness and Disability Payment System and Medicaid Rx risk-adjustment model (CDPS+Rx) developed at the University of California at San Diego. CDPS+Rx quantifies differences in risk between PH-MCOs using age and gender demographics, along with diagnostic and pharmacy usage history. The CDPS+Rx process determines PH-MCO plan factors that adjust the rates the Department pays to each PH-MCO. The development of PH-MCO plan factors includes a budget-neutrality step that causes this process to be revenue neutral for the Department.

Home Nursing Risk Sharing

Additionally, the Department provides risk sharing for home nursing (HN) services provided to children over the age of one. The current terms of the HN risk sharing program require the PH-MCOs to be responsible for claims up to a threshold of $5,000 of incurred qualifying HN services, at which point the Department will then reimburse each PH-MCO for 80% of paid claims eligible for coverage over this threshold. There is no limit to the risk sharing. Since the HN risk sharing program is currently based on a CY accumulation period, Mercer will calculate a premium that represents the Department's risk for the next risk sharing program year.

High-Cost Risk Pool

The Department implemented an HCRP in all zones with varying historical effective dates for high-cost recipients over the age of one. The primary objective of the HCRP is to improve the distribution of available funds among the participating PH-MCOs for high-cost recipients. For these recipients, the PH-MCOs are at risk for the first $80,000 of incurred medical costs and 20% of all incurred medical costs over $80,000. The HCRP is funded by retaining from the capitation rates, 80% of the estimated medical expenses that exceed an annualized threshold of $80,000 for high-cost recipients. These funds are then redistributed among the participating PH-MCOs, based on each PH-MCO's proportion of reported medical expenses (over the threshold) associated with high-cost recipients in the zone.

To help assure provider network pricing differences do not skew the distribution process, the Department may reprice PH-MCO reported inpatient hospital expenses using the Department's Medicaid FFS fee schedule to determine the percentage each PH-MCO receives of the risk pool. Recognizing risk for high-cost recipients can shift between PH-MCOs and the related cash flow concerns of the PH-MCOs, the risk pool is designed to distribute the risk pool funds based on recent

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experience patterns of the PH-MCOs, thereby helping to improve the matching of payment to risk for high-cost recipients. The risk pool is not intended to represent specific risk valuation, and the funding level may not match the ultimate medical expense in any single period.

Under Age 1 Risk Sharing

Effective January 1, 2018, a new Under Age 1 rate cell was created. Given the small population size of the rate cell with volatility in high-cost claims and because this population is not subject to risk adjustment, the Department implemented an Under Age 1 risk sharing arrangement to help mitigate risk for the PH-MCOs. For recipients who are in the Under Age 1 rate cell during the contract year, the PH-MCOs are at risk for the first $25,000 of incurred medical costs and 25% of all incurred medical costs over $25,000 for the rating period. The Under Age 1 risk sharing is funded by retaining from the capitation rates, 75% of the estimated medical expenses exceed an annualized threshold of $25,000 for high-cost members from the Under Age 1 rate cell.

Cystic Fibrosis Specialty Drug Risk Sharing

Effective January 1, 2016, the Department implemented a hepatitis C and cystic fibrosis specialty drug risk sharing (SDRS) arrangement. Effective for CY 2020 rates, hepatitis C drugs were removed from this risk sharing program, but cystic fibrosis drugs remain. The Department will determine and share with PH-MCOs a list of drugs and a price list specific to cystic fibrosis to be covered under this arrangement. The price list will reflect pricing net of potential PH-MCO price discounts and be used in the repricing component of the risk sharing arrangement terms. The Department will reimburse the PH-MCOs 80% of the repriced cost of covered drugs. There is no deductible for this program.

Home Accessibility DME Risk sharing

Effective January 1, 2020, the Department implemented a risk sharing arrangement for Home Accessibility DME claims. The Department will reimburse the PH-MCOs 70% of their costs. There is no deductible for this program.

Additionally, all risk mitigation arrangements are mutually exclusive such that a claim cannot qualify for more than one arrangement (risk adjustment not included.) The terms of each risk mitigation program are subject to change and may vary based on the Department's policies.

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PROGRAMMATIC CHANGES CHART

This exhibit describes the programmatic changes previously considered in the capitation rate range development process. This Programmatic Changes Chart may differ from actual programmatic changes applied during the rate development process.

PROGRAMMATIC CHANGES CHART

ADJUSTMENT	EFFECTIVE DATE	RATE CELL	CATEGORY OF SERVICE
Inpatient Pricing Adjustment — adjustment to inpatient acute care services to reflect reimbursement levels at least equivalent to FFS reimbursement levels.	07/01/2013	All Rate Cells	Inpatient Acute Care
High-Cost Pharmacy Removal — adjustment to reflect the removal of specific high-cost pharmaceuticals from the historical base data for development under a separate methodology (see High-Cost Pharmacy Add-on).	N/A	Excludes Under Age 1	Pharmaceutical
Ambulance Fee Increase and Treat not Transport — increased funding for minimum fee schedule and patient-refused trips.	01/01/2019	All Rate Cells	Ambulance/ Transportation
Adult Dental BLE — adjustment to account for the auto-assignment of Adult Dental Benefit Limit Exceptions for members with applicable diagnostic conditions.	01/01/2020	Excludes Under Age 1 and TANF-MAGI Ages 1-20	Dental
PDL Unit Cost — adjustment to account for the change in the average drug unit costs within the base data period.	01/01/2020	All Rate Cells	Pharmaceutical
Population Adjustments Non-CHC: • Transitional MA • IMD Population Removal • Continuous Enrollment • CHC Impact — Nursing Facility	11/01/2016 01/01/2018 01/01/2019 01/01/2019	Excludes Under Age 1 Rate Cell	Total Capitation Rate

ADJUSTMENT	EFFECTIVE DATE	RATE CELL	CATEGORY OF SERVICE
High-Cost Pharmacy Add-on — capitation rate add-on for covering specific high-cost pharmaceuticals in the prospective rating period. Historical costs associated with these specific high-cost pharmaceuticals will be removed from the base data (see High-Cost Pharmacy Removal).	N/A	Excludes Under Age 1 Rate Cell	Total Capitation Rate
Opioid Use Disorder Centers of Excellence — adjustment for PH costs related to the implementation of new Opioid Use Disorder Centers of Excellence.	10/01/2016	Excludes Under Age 1 Rate Cell	Total Capitation Rate
Opioid Use Disorder Centers of Excellence Care Management — adjustment for care management costs associated with Opioid Use Disorder Centers of Excellence	01/01/2019	Excludes Under Age 1 Rate Cell	Total Capitation Rate
Patient-Centered Medical Homes (PCMH) — adjustment for establishing recently required PCMH arrangements within the HC program.	01/01/2017	All Rate Cells	Total Capitation Rate
Provider Incentive Payments — funding for the Community Based Care Management and Provider Pay for Performance	01/01/2019	All Rate Cells	Total Capitation Rate
DME Home Accessibility — capitation rate add-on for removable ramps and lifts	01/01/2020	Excludes Under Age 1 and TANF-MAGI Ages 1–20 and Newly Eligible ages 19–44	Total Capitation Rate
Appendix 14 (APR/DRG Adjustment) — adjustment to Medicaid payments for inpatient acute care services.	07/01/2010	All Rate Cells	Total Capitation Rate
Appendix 16 (Enhanced Access Payments) — adjustment to Medicaid payments for professional services.	01/01/2016	All Rate Cells	Total Capitation Rate
Appendix 16a — adjustment to Medicaid payments for professional services.	01/01/2016	All Rate Cells	Total Capitation Rate
Appendix 17 — adjustment to Medicaid payments for outpatient services.	01/01/2019	All Rate Cells	Total Capitation Rate

ADJUSTMENT	EFFECTIVE DATE	RATE CELL	CATEGORY OF SERVICE
MCO Assessment — includes a per diem factor of 1.0087 to account for differences between MMs and person counts.	07/01/2016	All Rate Cells	Total Capitation Rate

APPENDIX A
CHC REMOVAL IMPACT

ZONE	IMPACTED RATE CELL	MMs PRE	MMs POST	% Δ	PMPMs PRE	PMPMs POST	% Δ
Southeast	TANF-MAGI Ages 21+	1,056,855	1,051,168	-0.5%	$295.74	$289.54	-2.1%
	Disabled-BCC Ages 1+	1,579,743	1,422,152	-10.0%	$1,042.88	$905.20	-13.2%
	Newly Eligible Ages 19 to 44	2,230,986	2,227,587	-0.2%	$252.57	$250.98	-0.6%
	Newly Eligible Ages 45 to 64	974,934	964,227	-1.1%	$572.95	$566.09	-1.2%
Southwest	TANF-MAGI Ages 21+	629,479	629,479	0.0%	$319.51	$319.51	0.0%
	Disabled-BCC Ages 1+	983,967	983,967	0.0%	$877.44	$877.44	0.0%
	Newly Eligible Ages 19 to 44	1,219,508	1,219,508	0.0%	$292.68	$292.68	0.0%
	Newly Eligible Ages 45 to 64	569,030	569,030	0.0%	$556.51	$556.51	0.0%
Lehigh/Capital	TANF-MAGI Ages 21+	658,912	657,794	-0.2%	$286.87	$283.68	-1.1%
	Disabled-BCC Ages 1+	875,953	850,143	-2.9%	$840.40	$812.05	-3.4%
	Newly Eligible Ages 19 to 44	1,183,778	1,182,209	-0.1%	$248.21	$247.26	-0.4%
	Newly Eligible Ages 45 to 64	516,178	511,228	-1.0%	$561.47	$559.20	-0.4%
Northeast	TANF-MAGI Ages 21+	432,864	432,300	-0.1%	$288.27	$287.16	-0.4%
	Disabled-BCC Ages 1+	559,483	543,318	-2.9%	$853.99	$826.37	-3.2%
	Newly Eligible Ages 19 to 44	815,398	814,535	-0.1%	$242.91	$242.29	-0.3%

ZONE	IMPACTED RATE CELL	MMs PRE	MMs POST	% Δ	PMPMs PRE	PMPMs POST	% Δ
	Newly Eligible Ages 45 to 64	382,857	379,760	-0.8%	$525.35	$523.18	-0.4%
Northwest	TANF-MAGI Ages 21+	212,843	212,288	-0.3%	$282.66	$281.37	-0.5%
	Disabled-BCC Ages 1+	341,570	328,171	-3.9%	$809.32	$772.16	-4.6%
	Newly Eligible Ages 19 to 44	405,255	404,517	-0.2%	$244.03	$243.30	-0.3%
	Newly Eligible Ages 45 to 64	174,643	172,757	-1.1%	$536.83	$532.67	-0.8%

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