

HEALTHCHOICES PHYSICAL HEALTH DATABOOK:

SOUTHEAST ZONE
SOUTHWEST ZONE
LEHIGH/CAPITAL ZONE
NORTHEAST ZONE
NORTHWEST ZONE

COMMONWEALTH OF PENNSYLVANIA

APRIL 8, 2015

GOVERNMENT HUMAN SERVICES CONSULTING



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A

Introduction

The purpose of this databook is to provide physical health managed care organizations (PH-MCOs) historical, summarized financial data on HealthChoices members in the Southeast zone, Southwest zone, Lehigh/Capital zone, Northeast zone, and Northwest zone. These five zones form the Commonwealth of Pennsylvania's (Commonwealth) mandatory Medicaid managed care program, HealthChoices. The data provided represents the physical health (PH) services (including maternity services) covered under HealthChoices for calendar year (CY) 2013 that were the responsibility of the participating PH-MCOs. Additionally, this databook provides information on the methodology that Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, will use to develop the prospective capitation rate ranges for the HealthChoices program. Mercer produced this databook with input from the Commonwealth's Department of Human Services (Department).

The HealthChoices Southeast and Southwest programs are currently composed of two distinct rating regions. The following table illustrates the composition of each rating region:

RATING REGION/COUNTIES CHART

Rating Region	Counties Included
Southeast Zone: Philadelphia	Philadelphia
Southeast Zone: Four Surrounding Counties	Bucks, Chester, Delaware, Montgomery
Southwest Zone: Allegheny	Allegheny
Southwest Zone: Thirteen Surrounding Counties	Armstrong, Beaver, Bedford, Blaire, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, Westmoreland
Lehigh/Capital Zone	Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, York
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

In addition to separate rating regions, the HealthChoices program considers the different risk characteristics of the enrolled population by establishing rating groups (i.e., categories of aid). The following table illustrates the seventeen rating groups:

RATING GROUP/CATEGORY OF AID CHART

Rating Group	Category of Aid
1	TANF-HB-MAGI < 2 Months
2	TANF-HB-MAGI 2–11.999 Months
3	TANF-HB-MAGI Ages 1–20
4	TANF-HB-MAGI Ages 21+
5	SSI-HH-Other Disabled
6	Breast and Cervical Cancer
7	Maternity Care Payment
8	Newly Eligible Women Ages 19 to 20
9	Newly Eligible Women Ages 21 to 34
10	Newly Eligible Women Ages 35 to 44
11	Newly Eligible Women Ages 45 to 54
12	Newly Eligible Women Ages 55 to 64
13	Newly Eligible Men Ages 19 to 20
14	Newly Eligible Men Ages 21 to 34
15	Newly Eligible Men Ages 35 to 44
16	Newly Eligible Men Ages 45 to 54
17	Newly Eligible Men Ages 55 to 64

It is important to note that the CY 2013 PH-MCO experience contained in this databook is representative of the financial rating group structure in place during that reporting year. Due to a change in the HealthChoices program effective January 1, 2006, nearly all of the dual eligibles have been removed from HealthChoices. Only dual eligibles less than age 21 remain in the HealthChoices program, along with the months associated with a person's retroactive Medicare coverage (i.e., disenrollment from HealthChoices occurs prospectively). For prospective rate-setting purposes, the few remaining dual eligibles are combined with the rating group SSI-HH-Other Disabled.

There is a possibility that a few dual-eligible recipients in other categories may exist, but the impact on the rate ranges and eligibility member months (MM) is immaterial. Similarly, 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.

Effective March 1, 2013, the Commonwealth introduced the Breast and Cervical Cancer rating group. Previous to this date, the Breast and Cervical Cancer population was part of the fee-for-service (FFS) program.

Effective January 1, 2015, the Commonwealth has further refined the TANF-HB-MAGI rating group structure to 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+.

The maternity care payment is made for women delivering in all categories of aid. One payment is made per live birth delivery (C-section or vaginal), regardless of the number of births. The maternity care payment has historically been a lump-sum payment intended to reflect the risk of only the mother's PH claims five months prior to the delivery, during the delivery event, and two months after the delivery. Effective July 1, 2011, the maternity care payment was changed to reflect 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 contracts.

Services that the PH-MCOs were responsible for in the CY 2013 time period include, but are not limited to, the following:

Covered Services	
Hospital Inpatient	Laboratory/Radiology
Renal Dialysis Center	EPSDT Screens
Hospice/Home Health Care	EPSDT Services
Ambulatory Surgical Centers	DME/Medical Supplies
ER (including BH-related visits)	Family Planning
Physician (including Specialty Physicians)	Therapy
Chiropractor, Podiatrist	Ambulance
Pharmacy (including BH drugs)	Nursing Home/PDA Waiver (first 30 days)
FQHC/RHC (not including supplemental state payments to these entities)	Dental

There are separate contracts between the Commonwealth and BH-MCOs for the provision of BH services.

The reimbursement provided under the HealthChoices contract is intended for the coverage of medically-necessary services covered under the Commonwealth's State Plan. The PH-MCOs have the ability to utilize this reimbursement to provide medically-necessary services in place of or in addition to the services covered under the State Plan, as well as those services, if any, identified under section 1915(b)(3) of the Centers for Medicare and Medicaid Services (CMS) approved HealthChoices waiver, in order to meet the needs of the individual enrollee in the most efficient manner. However, since the capitation rates cannot include these additional services, an adjustment may be required in the rate development process to incorporate the cost of State Plan services, which would have been provided in the absence of alternative or additional services.

This databook focuses on the historical, summarized financial data from the PH-MCOs that have been participating in HealthChoices. Since this is actual data from the HealthChoices program, no data is included related to graduate medical education (GME) or disproportionate share hospital (DSH) payments. Furthermore, to the extent that any of the PH-MCOs implemented copayments or benefit limitations based on the Commonwealth's policies, a portion of the CY 2013 data may include the effects of these programmatic changes (see Exhibit D on page 11).

The summarized financial data for CY 2013 was based on 2013 year-end audited financial reports as submitted by:

Southeast Zone

Keystone Family Health Plan (Keystone)
Health Partners Plans, Inc. (Health Partners)
UnitedHealthcare of Pennsylvania, Inc. (United)
Aetna Better Health, Inc. (Aetna)
HealthAmerica Pennsylvania, Inc. dba CoventryCares (Coventry)

Southwest Zone

UPMC for You, Inc. (UPMC)
Gateway Health Plan, Inc. (Gateway)
UnitedHealthcare of Pennsylvania, Inc. (United)
HealthAmerica Pennsylvania, Inc. dba CoventryCares (Coventry)

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 Northeast, LLC (AmeriHealth)
HealthAmerica Pennsylvania, Inc. dba CoventryCares (Coventry)
Geisinger Health Plan (Geisinger)

Northwest Zone

AmeriHealth Caritas Health Plan (AmeriHealth)
UPMC for You, Inc. (UPMC)
Gateway Health Plan, Inc. (Gateway)
HealthAmerica Pennsylvania, Inc. dba CoventryCares (Coventry)

To create this databook, Mercer aggregated the PH-MCOs' reported financial data for all HealthChoices zones, by category of aid and category of service. Thus, this databook can be described as a current review of the cumulative experience of the PH-MCOs that served the HealthChoices program in CY 2013.

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 2013 data presented in this databook was downloaded from the Commonwealth's electronic Financial Reporting and Monitoring (e-FRM) web-based system on October 9, 2014. Any resubmissions to e-FRM by the PH-MCOs after this date are not reflected in this databook unless otherwise noted.

B

Rate Range Development Methodology

This section provides a description of the rate-setting methodology that Mercer will use for the development of the prospective capitation rate ranges for the HealthChoices program. These rate ranges will be developed following an actuarially sound process, as described within the federal regulations [i.e., section 438.6(c)] issued by CMS.

Background

In the past, Mercer developed capitation rate ranges using the Commonwealth's historical FFS data. As the HealthChoices 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 encounter data. The financial, operational, and encounter data from the PH-MCOs offer the most recent source of data.

Methodology

To develop prospective rate ranges, Mercer will consider the financial reports that each of the current PH-MCOs submit to the Commonwealth as part of their current contractual requirements. These financial reports 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 Commonwealth, the current PH-MCOs, and/or other sources deemed appropriate by Mercer and the Commonwealth.

Since data accuracy and validity are essential components in developing capitation rate ranges that are appropriate for HealthChoices and useable by the Commonwealth for rate discussions, the Commonwealth 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 among the reports.
- Side-by-side comparisons of each plan's reports.

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

In addition to the aforementioned, adjustments may be made to reflect any programmatic/policy changes to the design of the HealthChoices program that are not reflected in the base data.

These adjustments also may be positive or negative. Please refer to the Programmatic Changes Chart in Section D for a review of some of these contemplated programmatic/policy changes.

Mercer will trend the data to the applicable prospective rating period since the reported financial data represents historical time periods (e.g., CY 2013). 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-MCOs' financial reports.
- HealthChoices market changes.
- Indices (such as CPI).
- Neighboring states (FFS trends, managed care trends).
- Pennsylvania-specific FFS trends.

An additional component of the prospective rate ranges will be an amount that is reasonable for administration and profit. Mercer will develop this rate component, with input from the Department, by analyzing actual administrative expense reports from each of the current health plans and/or other data sources.

As stated in the introduction, the Commonwealth removed most dual eligibles from the HealthChoices program, effective January 1, 2006. Given the small number of dual eligibles remaining in HealthChoices, the SSI & HH with Medicare and SSI & HH without Medicare groups will be consolidated into a single SSI-HH-Other Disabled rate cell.

For the TANF-HB-MAGI < 2 Months, TANF-HB-MAGI 2–11.999 Months, TANF-HB-MAGI Ages 1–20 and TANF-HB-MAGI Ages 21+ rate cells, age relativity factors will be used to separate the TANF and HB financial data into these four rating groups.

The rate-setting methodology described above will result in capitation rate ranges for each of the rating groups. These rate ranges provide the Commonwealth with flexibility for the rate discussion process. However, the Commonwealth does recommend that each PH-MCO independently analyze its own projected medical and administrative expense, and other premium needs, for comparison to the Commonwealth's rate offers in the aggregate.

The Commonwealth also utilizes risk-adjusted rates in the HealthChoices 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/gender demographics, along with diagnostic and pharmacy usage history. The CDPS+Rx process determines PH-MCO plan factors that adjust the rates that the Department pays to each PH-MCO. The development of PH-MCO plan factors includes a budget-neutrality step that causes the risk-adjustment process to be budget neutral for the Commonwealth.

Additionally, the Commonwealth provides risk sharing for home nursing (HN) services provided to children. The current terms of the HN risk-sharing program require the PH-MCOs to be responsible for claims up to a threshold, at which point the Commonwealth will then reimburse each PH-MCO for 75% of paid claims that are eligible for coverage in excess of 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 (i.e., rate withhold) that represents the Commonwealth's risk for the next risk-sharing program year. The terms of the risk-sharing program are subject to change and may vary based on the Department's procurement schedule. Given the risk-sharing program's narrow specificity of risk and high per-recipient cost, risk-sharing costs may fluctuate substantially from year to year. However, over a period of several years, the amount withheld from the rates is expected to be equivalent to the amount paid by the Commonwealth in risk-sharing claims (i.e., budget neutral).

The Commonwealth introduced a high-cost risk pool (HCRP) in HealthChoices. For these high-cost recipients, current terms of the HCRP require the PH-MCOs to be responsible for the first \$80,000 in incurred medical costs. The HCRP is intended to improve the distribution of available funds among the participating PH-MCOs for high-cost recipients. The objective of the HCRP is to withhold from the capitation rates 80% of the estimated expenses that exceed \$80,000 for high-cost recipients and then redistribute this pool of funds among the participating PH-MCOs, based on each PH-MCO's proportion of reported medical expense associated with high-cost recipients. To help assure that the distribution process is not skewed by provider network pricing differences, the Commonwealth intends to re-price PH-MCO reported inpatient hospital expenses using the Commonwealth's Medicaid FFS fee schedule to determine the percentage each PH-MCO receives of the risk pool. The HCRP is not a risk-sharing arrangement. Recognizing that risk for high-cost recipients can shift between PH-MCOs and the related cash flow concerns of the PH-MCOs, the HCRP is designed to distribute the risk pool funds based on recent experience patterns of the PH-MCOs, thereby helping to improve the matching of payment to risk for high-cost recipients.

Accordingly, Mercer will calculate withhold values for the prospective rating period. The terms of the HCRP are subject to change and may vary based on the Department's procurement schedule. The HCRP is not intended to represent specific risk valuation and the funding level may not match ultimate medical expense in any single time period.

C

Summarized Calendar Year 2013 Financial Data

This section represents the year-end financial experience for HealthChoices PH-MCOs for CY 2013. Exhibits labeled “Category of Service/PMPMs” present the PH-MCOs’ CY 2013 medical expense data. For each rating region, aggregate expense data is provided on each category of aid. Please note that because maternity-related expense data is reported/included in the respective category of aid of the mother, there is no separate column for “maternity.”

Exhibits labeled “Maternity Category of Service/Costs per Delivery” presents the PH-MCOs’ C-section and vaginal maternity expense data for state fiscal year (SFY) 2012–2013. 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 rating group.

In addition to the number of MMs and the actual number of deliveries in each category of aid, Mercer summarized the PH-MCOs’ expense data for each of the categories of service that are delineated in the financial reports. The per member per month (PMPM) values represent the combined experience for the PH-MCOs for a particular category of service and category of aid combination. Totals have been provided for each category of service and category of aid.

Please note that no adjustments have been made to the data contained in exhibits; the information included is as reported by the PH-MCOs. The PH-MCOs may find the exhibits and additional information on the internet at the following address:

<http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/>

The data exhibits are Microsoft Excel spreadsheets, and can be found under the following labels:

- Exhibit C-1: Philadelphia County – Category of Service/PMPMs
- Exhibit C-2: Four Surrounding Counties – Category of Service/PMPMs
- Exhibit C-3: Southeast Zone – Maternity Category of Service/Costs per Delivery
- Exhibit C-4: Allegheny County – Category of Service/PMPMs
- Exhibit C-5: Thirteen Surrounding Counties – Category of Service/PMPMs
- Exhibit C-6: Southwest Zone – Maternity Category of Service/Costs per Delivery
- Exhibit C-7: Lehigh/Capital Zone – Category of Service/PMPMs
- Exhibit C-8: Lehigh/Capital Zone – Maternity Category of Service/Costs per Delivery
- Exhibit C-9: Northeast Zone – Category of Service/PMPMs

Exhibit C-10: Northeast Zone – Maternity Category of Service/Costs per Delivery

Exhibit C-11: Northwest Zone – Category of Service/PMPMs

Exhibit C-12: Northwest Zone – Maternity Category of Service/Costs per Delivery

D

Programmatic Changes Chart

Exhibit D describes the programmatic changes that have previously been considered in the capitation rate development process. This Programmatic Changes Chart is subject to change as additional information becomes available.

EXHIBIT D: PROGRAMMATIC CHANGES CHART

HealthChoices Physical Health Programmatic Changes Chart for Prospective Rates			
Issue	Effective Date	Category of Aid	Category of Service
Enhanced Access Payments – Increase Medicaid payments for professional and other medical services in the Southeast zone to improve access to care.	01/01/2009	TANF-HB-MAGI, and SSI-HH-Other Disabled	All Professional and Other Services, excluding Emergency Room, Facility Non-Inpatient, and Other Outpatient
5.90% Gross Receipts Tax.	10/01/2009	All Categories	Total Capitation Rate
APR Adjustment – Adjustment to payment levels for inpatient services to reflect the Commonwealth's policy change of moving to an APR-DRG methodology for hospital inpatient payments.	07/01/2010	All Categories	Inpatient, excluding Rehab and Nursing Home
Dental – Reduction of dental services for adults.	09/30/2011	TANF-HB-MAGI Ages 21+, SSI-HH-Other Disabled, and BCCPT	Dental and Dental / Oral Surgery
Pharmacy Rebates – Change in achievable rebates due to federal policy change. Changes reflect appropriate rebate levels to apply to base data, which is gross of rebates.	03/23/2010	All Categories	Pharmaceutical, Pharmaceutical LTC, Family Planning Pharmaceutical

EXHIBIT D: PROGRAMMATIC CHANGES CHART**HealthChoices Physical Health Programmatic Changes Chart for Prospective Rates**

Issue	Effective Date	Category of Aid	Category of Service
Eligible but not Enrolled/Latent Demand and CHIP – Adjustment made to account for new enrollees, former CHIP enrollees moving to MA, and impacts on acuity.	10/01/2013 & 01/01/2015	TANF-HB-MAGI Ages 1-20, TANF-HB-MAGI Ages 21+, and SSI-HH-Other Disabled	Total Capitation Rate
Health Insurance Providers Fee (HIPF) – Adjustment applied to the final capitation rates to provide funding, in the form of a capitation withhold, for PH-MCOs subject to the HIPF.	01/01/2014	All Categories	Total Capitation Rate
Removal of Medically Needy – Adjustment made to account for the removal of this population segment and impacts on acuity.	01/01/2015	TANF-HB-MAGI 21+, SSI-HH-Other Disabled	Total Capitation Rate

Note: Due to the current budgetary climate within the Commonwealth of Pennsylvania, other programmatic changes may be considered in developing the rate ranges.



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