HEALTH WEALTH CAREER

CALENDAR YEAR 2020 HEALTHCHOICES

PHYSICAL HEALTH DATABOOK:

SOUTHEAST ZONE

SOUTHWEST ZONE

LEHIGH/CAPITAL ZONE

NORTHEAST ZONE

NORTHWEST ZONE

MARCH 29, 2019

Commonwealth of Pennsylvania

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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1
INTRODUCTION

The purpose of this databook is to provide the HealthChoices Physical Health managed care organizations (PH-MCOs) historical summarized data for the HealthChoices program, which will be used in capitation rate setting. The Commonwealth of Pennsylvania's (Commonwealth) HealthChoices 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 HealthChoices program for calendar year (CY) 2017 that were the responsibility of the participating PH-MCOs for each of the five zones. This CY 2017 databook will serve as the base data for development of the CY 2020 HealthChoices PH capitation rates.

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 CY 2020 capitation rates for the HealthChoices 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 HealthChoices 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 purposes of capitation rate setting. PH-MCO submitted PROMISe™ encounters with incurred dates of January 1, 2017 through December 31, 2017, and with runout through September 30, 2018, are summarized in this databook and will be used as base data for development of the CY 2020 HealthChoices PH capitation rates.

Use of encounter data allows for a greater level of detail of analysis and review during rate development. For CY 2020, the encounter data was validated 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 2017 PH-MCO experience contained in this databook is representative of the rate cell and rating region structure that is expected to be in place during the CY 2020 rating period.

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

RATING REGION COUNTIES

HEALTHCHOICES 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, Vanango and Warren counties	Cameron, Clarion, Clearfield, Elk, Jefferson, McKean and Potter counties

In addition to separate rating regions, the HealthChoices 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 one payment that 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 HealthChoices, or to meet the needs of HealthChoices as it evolves. The rate cells/supplemental payments for CY 2020 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 anticipated on 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.

In order to develop a databook that reflects the CHC program and population transition, Mercer excluded individuals' cost and enrollment data in the base experience that would be expected to shift from the HealthChoices PH program to the CHC program. These individuals were identified using Department provided historical eligibility data. 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 that the PH-MCOs were responsible for in the CY 2017 time period include, but are not limited to, the following:

COVERED SERVICES	
Pharmaceutical	Medical Diagnostic
Pharmaceutical Non-Drug	Federally Qualified Health Center (FQHC) & 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

There are separate agreements between the Department and the BH-MCOs for the provision of BH services, as well as separate agreements for the CHC MCOs for the provision of LTSS.

This databook focuses on the historical encounter data from the PH-MCOs that have been participating in HealthChoices. Since this is actual data from the HealthChoices PH program, no data are included related to graduate medical education or disproportionate share hospital payments. Furthermore, to the extent that any of the PH-MCOs implemented copayments or benefit limitations based on the Department's policies, a portion of the CY 2017 data may include the effects of these programmatic changes (see the chart in Section 4).

The encounter data for CY 2017 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 HealthChoices 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 HealthChoices program in CY 2017.

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 2017 data presented in this databook was supplied from the Commonwealth's Medicaid Management Information System (MMIS) data warehouse on October 17, 2018. 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.

2
SUMMARIZED CALENDAR YEAR 2017 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 2017 encounter data:

- Data reflects voided and adjusted encounters.
- Data are limited to CY 2017 incurred claims based on the first date of service with runout through September 30, 2018.
- 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; and P and Q claim types are categorized as pharmacy.
- Pharmacy encounters are gross of all market share rebates that may be achieved by the PH-MCOs. Mercer accounts for these market share rebates as an adjustment in the rate-setting process.
- 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.

In addition to the bullets above, Mercer summarized the PH-MCOs' expense data for each of the 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 COS categories.

A separate logic is developed to identify all maternity encounter events (C-section and vaginal). This logic uses a combination of MS-DRGs, diagnoses 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 the combination of procedures within a COS, there may be variation within a PH-MCO's experience when compared to what is reported in aggregate.

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 and unit cost metrics displayed within the exhibits, the detailed encounter line counts for all categories of service were used, except for the Inpatient Acute Care, Inpatient Rehab and Nursing Home COS, which use covered days as reported in PH-MCO PROMISe™ submitted encounter data. 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: http://www.dhs.pa.gov/provider/healthcaremedicalassistance/managedcareinformation/.

3
RATE DEVELOPMENT METHODOLOGY

This section describes the rate-setting methodology that Mercer will use for the development of the prospective capitation rates for the HealthChoices 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 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 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 that 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 2020 HealthChoices 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 that are appropriate for HealthChoices and useable by the Department for rate discussions, 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 HealthChoices 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 2017 PH-MCO financial data from the HealthChoices program to develop an adjustment to align the encounter base with financials. This adjustment serves to address under or overreporting 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 HealthChoices program that are 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 for a review of some of these contemplated programmatic or policy changes.

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
- HealthChoices 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 that is 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 that 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 HealthChoices 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
- Specialty drug risk mitigation:
  - Hepatitis C and cystic fibrosis specialty drug risk sharing (SDRS)
  - Hepatitis C specialty drug quality risk pool (SDRP)

Risk-Adjusted Rates

The Department has 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 and 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 this process to be zero-sum 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 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 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 in excess of $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 expense (in excess of the threshold) associated with high-cost recipients in the zone.

To help assure that 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 that 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 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 in excess of $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 that exceed an annualized threshold of $25,000 for high-cost members from the Under Age 1 rate cell.

Hepatitis C and Cystic Fibrosis Specialty Drug Risk Sharing

Effective January 1, 2016, the Department implemented a hepatitis C and cystic fibrosis SDRS arrangement. The Department will determine and share with the PH-MCOs, a list of drugs and a price list specific to hepatitis C or cystic fibrosis to be covered under this arrangement. The price list will reflect pricing net of potential PH-MCO price discounts and net of expected rebate levels. The price list will be utilized 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.

Hepatitis C Specialty Drug Quality Risk Pool

In addition to the SDRS, effective January 1, 2016, the Department implemented a hepatitis C SDRP. The SDRP will be distributed to the PH-MCOs based on the number of credits earned. Credits are earned when a PH-MCO submits a notice of a completed sustained virological response (SVR) documenting undetectable hepatitis C ribonucleic acid following completion of therapy, and the PH-MCO paid for all covered drugs for the member. If more than one PH-MCO covered the responsibilities of notice of the SVR and payment for covered drugs, the credit is allocated based on the notification of the SVR and the proportion of repriced drug costs borne by each PH-MCO. The

SDRP will be funded by 10% of the covered drug cost included in the capitation rate ranges. 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 that have previously been 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
Shift Nursing Fee Increase – $5/hour adjustment for Registered Nurses and Licensed Practical Nurses for pediatric shift nursing.	07/01/2016	Excludes TANF-MAGI Ages 21+ and Newly Eligible Ages 45 to 64	Home Health Care/ HIV-AIDS Waiver
Family Planning – Adjustment to account for changes in the medical assistance (MA) fee schedule increasing fees to 125% of Medicare, for select services.	12/01/2016	Excludes Under Age 1	Family Planning Services
Ambulance Fee Increase – Adjustment to reflect minimum fee schedule for select ambulance services	01/01/2019	All Rate Cells	Ambulance/ Transportation

ADJUSTMENT	EFFECTIVE DATE	RATE CELL	CATEGORY OF SERVICE
Population Adjustments Non-CHC: • Transitional MA • 5% Income Disregard • IMD Population Removal • Refugee Cash Assistance • Continuous Enrollment • CHC Impact – Nursing Facility	 11/01/2016 11/01/2016 01/01/2018 01/01/2019 01/01/2019 01/01/2019	Excludes Under Age 1 Rate Cell	Total Capitation Rate
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 HealthChoices program.	01/01/2017	All Rate Cells	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 1.0091 to account for differences between MMs and person counts.	07/01/2016	All Rate Cells	Total Capitation Rate
Health Insurance Providers Fee (HIPF) – Adjustment applied to the final capitation rates to provide funding for PH-MCOs subject to the HIPF.	01/01/2014	All Rate Cells	Total Capitation Rate

APPENDIX

ZONE	IMPACTED RATE CELL	MMs PRE	MMs POST	% Δ	PMPMs PRE	PMPMs POST	% Δ
Southeast	TANF-MAGI Ages 21+	993,980	989,083	-0.5%	$291.78	$285.31	-2.2%
	Disabled-BCC Ages 1+	1,574,394	1,442,567	-8.4%	$1,012.61	$899.72	-11.1%
	Newly Eligible Ages 19 to 44	2,219,293	2,216,411	-0.1%	$240.26	$238.88	-0.6%
	Newly Eligible Ages 45 to 64	968,492	958,478	-1.0%	$563.06	$556.23	-1.2%
Southwest	TANF-MAGI Ages 21+	599,407	598,252	-0.2%	$296.33	$294.42	-0.6%
	Disabled-BCC Ages 1+	1,019,407	985,818	-3.3%	$885.38	$844.05	-4.7%
	Newly Eligible Ages 19 to 44	1,247,273	1,245,853	-0.1%	$262.06	$261.17	-0.3%
	Newly Eligible Ages 45 to 64	569,139	563,826	-0.9%	$532.11	$529.33	-0.5%
Lehigh/Capital	TANF-MAGI Ages 21+	610,802	609,733	-0.2%	$275.17	$273.81	-0.5%
	Disabled-BCC Ages 1+	861,398	838,209	-2.7%	$806.11	$781.34	-3.1%
	Newly Eligible Ages 19 to 44	1,201,338	1,199,601	-0.1%	$228.48	$227.18	-0.6%
	Newly Eligible Ages 45 to 64	511,357	506,169	-1.0%	$550.19	$545.42	-0.9%
Northeast	TANF-MAGI Ages 21+	406,206	405,533	-0.2%	$276.12	$274.68	-0.5%
	Disabled-BCC Ages 1+	555,481	539,349	-2.9%	$817.49	$793.93	-2.9%

ZONE	IMPACTED RATE CELL	MMs PRE	MMs POST	% Δ	PMPMs PRE	PMPMs POST	% Δ
	Newly Eligible Ages 19 to 44	832,036	831,281	-0.1%	$235.57	$235.16	-0.2%
	Newly Eligible Ages 45 to 64	378,778	375,632	-0.8%	$510.49	$507.75	-0.5%
Northwest	TANF-MAGI Ages 21+	202,679	202,229	-0.2%	$279.15	$277.95	-0.4%
	Disabled-BCC Ages 1+	348,459	336,586	-3.4%	$779.68	$743.04	-4.7%
	Newly Eligible Ages 19 to 44	422,995	422,543	-0.1%	$234.37	$233.49	-0.4%
	Newly Eligible Ages 45 to 64	174,617	172,746	-1.1%	$512.52	$508.29	-0.8%

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