Mercer

Government Human Services Consulting

Calendar Year 2025 HealthChoices Physical Health Databook

Southeast, Southwest, Lehigh/Capital, Northeast, and Northwest Zones

Commonwealth of Pennsylvania

May 16, 2024

Contents

Section 1

Introduction

The purpose of this databook is to provide the HealthChoices (HC) physical health (PH) managed care organizations (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 PH services, including maternity services, covered in the HC program for state fiscal year (SFY) 2022–2023, which were the responsibility of the participating PH-MCOs for each of the five zones. This SFY 2022–2023 databook will serve as the base data for the development of the calendar year (CY) 2025 HC PH capitation rates.

Additionally, this databook provides information on the methodology Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, will use to develop the prospective CY 2025 capitation rates for the HC PH program. Mercer produced this databook with input from the Commonwealth's Department of Human Services (Department).

PH-MCO submitted PROMISe™ encounters with incurred dates of July 1, 2022, through June 30, 2023, and with runout through December 31, 2023, are summarized in this databook and will be used as base data for the development of the CY 2025 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 2025, the encounter data was validated year-over-year with past encounter data and against PH-MCO financial data and deemed to be appropriate and usable for rate setting. To account for underreporting or completion, Mercer will adjust encounters using financial reports within the rate-setting process. For purposes of this databook, no financial adjustments were applied.

The SFY 2022–2023 PH-MCO experience contained in this databook is representative of the eligibility category and rating region structure expected to be in place during the CY 2025 rating period.

The following table illustrates the county composition of each rating region. The 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

HC Zone	Rate Region 1	Rate Region 2
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 eligibility categories. Members are assigned to prospective eligibility categories based on their age, gender, category of assistance code, and program status code. Members are assigned to prospective rate cells based on their eligibility category and rating region.

In addition to the six prospective eligibility categories, within the HC program, there is also a maternity care payment. The maternity care payment is made to the PH-MCOs per live birth delivery (caesarean-section [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-MCOs, as provided by the respective agreements.

Eligibility categories 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 eligibility categories and care payments for CY 2025 rate setting as of the date of this databook are listed below and are subject to change:

- Under Age 1
- Temporary Assistance for Needy Families-Modified Adjusted Gross Income (TANF-MAGI) Ages 1-20
- TANF-MAGI Ages 21+
- Disabled-Breast and Cervical Cancer (BCC) Ages 1+
- Newly Eligible Ages 19 to 44
- Newly Eligible Ages 45 to 64

- Maternity care payment

Services the PH-MCOs were responsible for in the SFY 2022–2023 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
Laboratory	Emergency Room
Radiology	Dental
Complete Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screens	Dental/Oral Surgery
Vision	Primary Care Providers
Durable Medical Equipment (DME)/Medical Supplies	Specialty Physician
Hospice	Other Practitioners
Home Health Care/HIV-AIDS Waiver	Facility Non-Inpatient (includes Short Procedure Units/Ambulatory Surgical Centers [SPUs/ASCs])
Family Planning Services	Other Outpatient
Family Planning — Pharmaceutical	Inpatient Acute Care
Therapy	Inpatient — Rehabilitation
Ambulance/Transportation	Nursing Home

Some services are covered through a non-risk arrangement and are excluded from the Databook. See Appendix 18, Appendix 18A, and Appendix 18B of the CY 2024 PH-MCO Agreement for details. If a covered non-risk service moves to at-risk, an adjustment will be made to include it in the rates for the applicable rating period.

The Department has separate agreements for BH-MCOs providing BH services, as well as Community HealthChoices-MCOs providing long-term services and supports.

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. These encounters are also net of collected and reported third-party liability (TPL) and coordination of benefits (COB) amounts as of the runout date on page 1. Furthermore, to the extent any of the PH-MCOs implemented copayments or benefit limitations based on the Department’s policies, a portion of the SFY 2022–2023 data may include the effects of these programmatic changes (see the chart in Section 4).

Effective September 1, 2022, the Commonwealth completed an MCO reprocurement process that resulted in changes to the managed care plan composition in each zone. Consequently, the SFY 2022–2023 data incorporates PH-MCO data from pre- and post-procurement periods. The encounter data for SFY 2022–2023 was submitted through PROMISe by the following PH-MCOs listed by zone below.

SE Zone
Keystone Family Health Plan (Keystone)
Health Partners Plans, Inc. (Health Partners)
UnitedHealthcare of Pennsylvania, Inc. (United)
Geisinger Health Plan (Geisinger)
UPMC *for You*, Inc. (UPMC)
Aetna Better Health, Inc. (Aetna)
SW Zone
UPMC *for You*, Inc. (UPMC)
Highmark Wholecare (Highmark Wholecare)
Geisinger Health Plan (Geisinger)
Health Partners Plans, Inc. (Health Partners)
AmeriHealth Caritas Health Plan (AmeriHealth)
UnitedHealthcare of Pennsylvania, Inc. (United)
Aetna Better Health, Inc. (Aetna)
LC Zone
AmeriHealth Caritas Health Plan (AmeriHealth)
Highmark Wholecare (Highmark Wholecare)
UPMC *for You*, Inc. (UPMC)
Geisinger Health Plan (Geisinger)
Health Partners Plans, Inc. (Health Partners)
UnitedHealthcare of Pennsylvania, Inc. (United)
Aetna Better Health, Inc. (Aetna)
NE Zone
AmeriHealth Caritas Health Plan (AmeriHealth)
Geisinger Health Plan (Geisinger)
Health Partners Plans, Inc. (Health Partners)
UPMC *for You*, Inc. (UPMC)

Aetna Better Health, Inc. (Aetna)
NW Zone
AmeriHealth Caritas Health Plan (AmeriHealth)
UPMC *for You*, Inc. (UPMC)
Geisinger Health Plan (Geisinger)
Health Partners Plans, Inc. (Health Partners)
Highmark Wholecare (Highmark Wholecare)
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 SFY 2022–2023.

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 SFY 2022–2023 data presented in this databook was supplied from the Commonwealth's Medicaid Management Information System (MMIS) data warehouse on January 10, 2024. 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 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.

Section 2

Summarized SFY 2022–2023 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 SFY 2022–2023 encounter data:

- Reflects voided and adjusted encounters.
- 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.
- Limited to SFY 2022–2023 incurred claims based on the first date of service with runout through December 31, 2023.
- Institution for Mental Disease (IMD) beneficiaries with stays longer than 15 days are excluded.
- Coronavirus Disease 2019 (COVID-19) related vaccines and associated vaccine administration costs are excluded (these services will be included in prospective capitation rates).
- 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 claim types and B claim types are categorized as professional.
  - O claim types and C claim types are categorized as outpatient.
  - D claim types are categorized as dental.
  - I claim types, A claim types, and L claim types are categorized as inpatient and/or long-term care.
  - P claim types 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 eligibility category and rating region.

Along with the preceding bullets, Mercer summarized the PH-MCOs' expenses by financial report COS. To align the encounter data to the financial report COS, Mercer applied a service group hierarchy logic 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.

A separate logic is developed to identify all maternity encounter events (C-section and vaginal). This logic uses a combination of Medicare Severity-Diagnosis Related Groups, diagnosis codes, procedure codes, and birth certificate data to identify the birth events. Fee-for-service (FFS) data is also reviewed to identify maternity birth events. Once the birth 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 maternity care 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 Rehabilitation, and Nursing Home, which are based on a length of stay calculated from the PH-MCOs' submitted encounter data. Length of stay is the number of inpatient days between the first date of service and last date of service, plus one day if those dates are the same. Due to data aggregation and differences 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 per member per month (PMPM) data are summarized separately in the exhibits for each rating region by COS for each rate cell. Utilization per 1,000 and PMPM metrics within the exhibits use member months calculated from Department eligibility files.

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 maternity care payment is developed in the rate-setting process (accounting for both C-section and vaginal deliveries).

The data exhibits are for each rating region; they array rate cells and COS to 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 (PMPD)

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.

Section 3

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.

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 2025 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 SFY 2022–2023 PH-MCO financial data from the HC program to develop an adjustment to align the encounter base with financials. This adjustment addresses, but is not limited to, under- or over-reporting within the encounter data, unpaid claims liability reserves, subcapitation, settlements, and alternative payment arrangements.

Adjustments may be made to reflect any HC programmatic and policy changes absent from the base data. These adjustments also may be positive, negative, or budget neutral. Please refer to the Programmatic Changes Chart section of this narrative to review contemplated programmatic or policy changes in prior rate development cycles. 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 base data to the prospective rating period since the submitted encounter data represents a historical period. No single data source will be used to develop the prospective managed care trend rates. The 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 core Consumer Price Index)
- Benchmarks to neighboring states as appropriate (FFS trends, managed care trends)

The prospective rates will include amounts that cover administration, underwriting margin, and tax components. Mercer will develop these non-benefit components with input from the Department by analyzing administrative expense reports from the PH-MCOs and possibly other data sources.

This rate-setting methodology results in capitation rate ranges for each PH-MCO, region, and eligibility category. 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 HC program. These risk-mitigation techniques apply to both the Traditional and Adult Expansion populations and include:

- Risk-adjusted rates
- Home Nursing (HN) Risk-Sharing (HNRS)
- High-Cost Risk Pool (HCRP)
- Under Age 1 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, 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.

HN Risk-Sharing

Additionally, the Department provides risk sharing for HN services provided to children over age 1. 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 12-month accumulation period, Mercer will calculate a premium that represents the Department's risk for the next risk sharing program year.

HCRP

The Department implemented an HCRP in all zones with varying historical effective dates for high-cost recipients over age 1. 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 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 eligibility category was created. Given the small population size of the eligibility category 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 eligibility category 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 exceeding an annualized threshold of $25,000 for high-cost members from the Under Age 1 eligibility category.

Section 4

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	Eligibility Category and Care Payment	COS
Legislative Ambulance Fee — Adjustment to fund legislative minimum fees reimbursed to ambulance providers for select services.	January 1, 2023	Excludes maternity care payment	Ambulance/ Transportation
Pittsburgh Ambulance — Unit cost adjustment up to 105% of the non-Philadelphia area, urban, Medicare fee for select ground ambulance events.	January 1, 2021	Excludes maternity care payment	Ambulance/ Transportation
Philadelphia Ambulance — Unit cost adjustment up to 105% of the Philadelphia area, urban, Medicare fee for select ground ambulance events.	January 1, 2023	Excludes maternity care payment	Ambulance/ Transportation
COVID-19 Testing — An adjustment to the base data to reflect forecasted COVID-19 testing use and costs.	March 1, 2020	All eligibility categories and maternity care payment	Laboratory
COVID-19 Treatment — An adjustment to the base data to reflect forecasted COVID-19 treatment use and costs.	March 1, 2020	All eligibility categories and maternity care payment	All COS
Shift Nursing Fee Increase — $5.00 per hour adjustment for Registered Nurses and	January 1, 2022	Under Age 1, TANF-MAGI Ages 1-20, Disabled-BCC Ages 1+, and Newly	Home Health Care/HIV-AIDS Waiver

Adjustment	Effective Date	Eligibility Category and Care Payment	COS
Licensed Practical Nurses for pediatric shift nursing.		Eligible Ages 19 to 44 eligibility categories	
IMD Population Removal.	January 1, 2018	Excludes Under Age 1 eligibility category and maternity care payment	Total Capitation Rate
Continuous Coverage Unwinding Population Adjustment.	April 1, 2023	Excludes Under Age 1 eligibility category and maternity care payment	Total Capitation Rate
Patient Centered Medical Home Pediatric Nursing Care — Adjustment to account for new case management requirements associated with the Patient Centered Medical Home Pediatric Nursing Care Program.	January 1, 2023	Under Age 1, TANF-MAGI Ages 1-20, and Disabled-BCC Ages 1+ eligibility categories	All COS
Funding for Provider Pay for Performance — Includes $0.20 PMPM for Missed Shift Incentives.	January 1, 2019	All eligibility categories and maternity care payment	Total Capitation Rate
Obesity Treatment Agents — Adjustment for the expected cost and use of these agents beyond what is accounted for in pharmacy trends.	January 1, 2023	Excludes Under Age 1 eligibility category and maternity care payment	Pharmaceutical
MCO Assessment — Includes a per diem factor to account for differences between member months and person counts.	July 1, 2016	All eligibility categories and maternity care payment	Total Capitation Rate

Mercer Health & Benefits LLC
333 South 7th Street, Suite 1400
Minneapolis, MN 55402
www.mercer-government.mercer.com