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# HEALTHCHOICES PHYSICAL HEALTH DATABOOK:

## SOUTHEAST ZONE

## COMMONWEALTH OF PENNSYLVANIA

APRIL 21, 2017

GOVERNMENT HUMAN SERVICES CONSULTING

pennsylvania
DEPARTMENT OF HUMAN SERVICES

MARSH & McLENNAN COMPANIES

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# 1

# 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. This is one of five zones that 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) 2015 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 PH program. Mercer produced this databook with input from the Commonwealth's Department of Human Services (Department).

It is important to note that the CY 2015 PH-MCO experience contained in this databook is representative of the financial rate cell and rating region structure in place during that reporting year. The following tables illustrate the county composition of each region in both the base period and the prospective contract period. Counties displayed in the prospective region/county chart below represent the region mappings after the Southeast region reconfiguration effective January 1, 2016, and the remaining zones' region reconfiguration effective January 1, 2017.

**REGION/COUNTIES CHARTS**

| CY 2015 Base Data Region | Counties Included |
|---|---|
| Southeast Zone: Region 1 | Philadelphia |
| Southeast Zone: Region 2 | Bucks, Chester, Delaware, Montgomery |
| Southwest Zone: Region 1 | Allegheny |
| Southwest Zone: Region 2 | 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 |

## REGION/COUNTIES CHARTS

| CY 2015 Base Data Region | Counties Included |
|---|---|
| Northwest Zone | Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango, Warren |

| Prospective Rating Region | Counties Included |
|---|---|
| Southeast Zone: Rate Region 1 | Delaware, Philadelphia |
| Southeast Zone: Rate Region 2 | Bucks, Chester, Montgomery |
| Southwest Zone: Rate Region 1 | Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Lawrence, Washington, Westmoreland |
| Southwest Zone: Rate Region 2 | Bedford, Blaire, Cambria, Indiana, Somerset |
| Lehigh/Capital Zone: Rate Region 1 | Adams, Berks, Cumberland, Lancaster, Lehigh, Northampton, York |
| Lehigh/Capital Zone: Rate Region 2 | Dauphin, Franklin, Fulton, Huntingdon, Lebanon, Perry |
| Northeast Zone: Rate Region 1 | Bradford, Centre, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, Wyoming |
| Northeast Zone: Rate Region 2 | Carbon, Columbia, Juniata, Mifflin, Montour, Northumberland, Schuylkill, Snyder, Union |
| Northwest Zone: Rate Region 1 | Crawford, Erie, Forest, Mercer, Venango, Warren |
| Northwest Zone: Rate Region 2 | Cameron, Clarion, Clearfield, Elk, Jefferson, McKean, Potter |

In addition to separate rating regions, the HealthChoices program considers the different risk characteristics of the enrolled population by establishing rate cells. The following table illustrates the rate cells for rate-setting as of the date of this databook:

## RATE CELL CHART

| Rate Cell Number | Rate Cell Description |
|---|---|
| 1 | Under Age 1 |
| 2 | TANF-MAGI Ages 1–20 |
| 3 | TANF-MAGI Ages 21+ |
| 4 | Disabled-BCC Ages 1+ |
| 5 | Maternity Care Payment |
| 6 | Newly Eligible Women Ages 19 to 44 |
| 7 | Newly Eligible Women Ages 45 to 64 |

## RATE CELL CHART

| Rate Cell Number | Rate Cell Description |
|---|---|
| 8 | Newly Eligible Men Ages 19 to 44 |
| 9 | Newly Eligible Men Ages 45 to 64 |

It is important to note that the CY 2015 PH-MCO experience contained in this databook is representative of the financial rate cell 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 under age 21 remain in the HealthChoices PH 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 included in the Under Age 1 and Disabled-BCC Ages 1+ rate cells.

There is a possibility that a few dual-eligible recipients in other cells 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 Department introduced the Breast and Cervical Cancer rate cell. Previous to this date, the Breast and Cervical Cancer population was part of the fee-for-service (FFS) program.

Effective January 1, 2018, the former Breast and Cervical Cancer and SSI-HH-Other Disabled rate cells will be combined into the Disabled-BCC Ages 1+ rate cell.

Effective January 1, 2015, the Department further refined the TANF-MAGI rate cell structure to reflect the following age groupings: TANF-MAGI < 2 Months, TANF-MAGI 2–11.999 Months, TANF-MAGI Ages 1–20, and TANF-MAGI Ages 21+.

Effective January 1, 2018, under age one members formally assigned to the TANF-MAGI < 2 Months, TANF-MAGI 2-11.999 Months, and SSI-HH-Other Disabled will form the Under Age 1 rate cell.

The maternity care payment is made for women delivering in all rate cells. 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 agreements.

Services that the PH-MCOs were responsible for in the CY 2015 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 | Dental |

There are separate agreements between the Department and BH-MCOs for the provision of BH services.

The reimbursement provided under the HealthChoices agreement 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) of the Centers for Medicare and Medicaid Services 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 PH program, no data is 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 2015 data may include the effects of these programmatic changes (see the Programmatic Changes Chart in Section 4).

The summarized financial data for CY 2015 was based on 2015 year-end audited financial reports as submitted by:

Keystone Family Health Plan (Keystone)

Health Partners Plans, Inc. (Health Partners)
UnitedHealthcare of Pennsylvania, Inc. (United)
Aetna Better Health, Inc. (Aetna)

To create this databook, Mercer aggregated the PH-MCOs' reported financial data for the Southeast zone, by rate cell 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 2015.

The user of this databook is cautioned against relying solely on the data contained herein. The Department and Mercer provide no guarantee, neither written nor implied, that this databook is 100% accurate or error-free. The CY 2015 data presented in this databook was downloaded from the Department's electronic Financial Reporting and Monitoring (e-FRM) web-based system on December 6, 2016. Any resubmissions to e-FRM by the PH-MCOs after this date are not reflected in this databook unless otherwise noted.

# 2

# 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 consistent with applicable federal regulations and professional standards.

## Background

In the past, Mercer developed capitation rate ranges using the Department'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 Department 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 Department, the current PH-MCOs, and/or other sources deemed appropriate by Mercer and the Department.

Since 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 among the reports
- Side-by-side comparisons of each plan's reports

To reflect the risk of and the Department'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 PH-MCO, or more "global" in nature.

As stated in the introduction, the Department 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 cells

were consolidated into a single SSI-HH-Other Disabled rate cell. Effective January 1, 2018, the Breast and Cervical Cancer rate cell will be combined with SSI-HH-Other Disabled to form the Disabled-BCC rate cell. Additionally effective January 1, 2018, under age one members formally assigned to the TANF-MAGI < 2 Months, TANF-MAGI 2-11.999 Months, and SSI-HH-Other Disabled will form the Under Age 1 rate cell.

For the Under Age 1, TANF-MAGI Ages 1–20, and Disabled-BCC Ages 1+ rate cells, age relativity factors will be used to separate the TANF-MAGI Ages 0–20, SSI & HH With Medicare, SSI & HH Without Medicare – Other Disabled, and Breast and Cervical Cancer financial data into these three rate cells.

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 (see the Programmatic Changes Chart in Section 4) 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 2015). 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
- PROMISe encounter data
- HealthChoices market changes
- Indices (such as CPI)
- Neighboring states (FFS trends, managed care trends)

An additional component of the prospective rate ranges will be an amount that is reasonable for administration and underwriting gain. 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.

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

## Risk Mitigation

### *Risk Adjusted Rates*

The Department 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 Department.

### *Home Nursing Risk Sharing*

Additionally, the Department 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 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.

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, premiums charged to the PH-MCOs are expected to be equivalent to the amount paid by the Department in risk-sharing claims (i.e., budget neutral).

### *High-Cost Risk Mitigation*

The Department will provide a risk mitigation arrangement in the HealthChoices PH program for high-cost members. This arrangement will be mutually exclusive from all other risk mitigation arrangements (i.e. costs for services eligible for the other risk mitigation arrangements are excluded from this arrangement) and may come in the form of either a risk pool or risk sharing. To fund the high-cost member risk arrangement, Mercer will calculate a premium that will be removed from the capitation rates and represents a percentage of the estimated expenses that exceed a per recipient calendar year annual threshold. The PH-MCO will be responsible for paid expenditures up to the established threshold as well as a percentage of the expenditures in excess of the threshold for the high-cost members qualifying for the arrangement.

In the event of a risk sharing arrangement, the Department will reimburse each PH-MCO for a percentage of eligible paid expenditures in excess for the established threshold. Mercer will calculate a premium that represents the Department's risk for the risk-sharing program year. The Department anticipates that a high-cost member risk sharing arrangement will be developed and applicable specifically to the Under Age 1 population in the HealthChoices PH program.

In the event that the high-cost member risk arrangement takes the form of a risk pool and not a risk sharing arrangement, the Department will retain, from the capitation rates, a percentage of the estimated expenditures that exceed an established threshold. This process will create a pool of funds that will be distributed among the participating PH-MCOs based on each PH-

MCO's proportion of reported medical expense associated with qualifying high-cost recipients. To help assure that the distribution process is not skewed by provider network pricing differences, the Department may re-price 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 ultimate medical expense in any single time period.

The terms of arrangement for the HealthChoices PH program are subject to change and may vary based on the Department's procurement schedule.

## *Hepatitis C and 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. 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 rebate levels. The price list will be utilized in the re-pricing component of the risk sharing arrangement. The Department will reimburse the PH-MCOs 80% of the repriced cost of covered drugs. There is no deductible for this program.

Mercer will calculate a premium that represents the Department's risk for the prospective rating period. The terms of this arrangement are subject to change and may vary based on the Department's procurement schedule.

## *Hepatitis C Specialty Drug Risk Pool*

In addition to the SDRS, effective January 1, 2016, the Department implemented a hepatitis C specialty drug risk pool (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 notice of a completed SVR documenting undetectable hepatitis C RNA following completion of therapy, and the PH-MCO paid for all covered drugs for the member. In the event that 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 on the proportion of repriced drug costs borne by each PH-MCO. The SDRP will be will be funded by 10% of the covered drug cost included in the capitation rate ranges. There is no deductible for this program.

Mercer will calculate a premium for the prospective rating period. The terms of this arrangement are subject to change and may vary based on the Department's procurement schedule.

# 3

## Summarized Calendar Year 2015 Financial Data

This section represents the year-end financial experience for HealthChoices PH-MCOs for CY 2015. Exhibits labeled “Category of Service/PMPMs” present the PH-MCOs’ CY 2015 medical expense data. For each rating region, aggregate expense data is provided on each rate cell. Please note that because maternity-related expense data is reported/included in the respective rate cell of the mother, there is no separate column for “maternity.”

Exhibits labeled “Maternity Data” present the PH-MCOs’ C-section and vaginal maternity expense data for state fiscal year (SFY) 2014–2015. 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.

In addition to the number of MMs and the actual number of deliveries in each rate cell, 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 rate cell combination. Totals have been provided for each category of service and rate cell.

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.pa.gov/provider/healthcaremedicalassistance/managedcareinformation/.

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

Exhibit 1: Philadelphia County – Aggregate Data
Exhibit 2: Four Surrounding Counties – Aggregate Data
Exhibit 3: Southeast Zone – Maternity Data

# 4

# Programmatic Changes Chart

The Programmatic Changes Chart below 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.

**PROGRAMMATIC CHANGES CHART**

| HealthChoices Physical Health Programmatic Changes Chart for Prospective Rates | | | |
|---|---|---|---|
| **Issue** | **Effective Date** | **Rate Cells** | **Category of Service** |
| Inpatient Pricing Adjustment – Adjustment to inpatient acute care services to reflect reimbursement levels at least equivalent to FFS reimbursement levels. | 7/1/2013 | All Rate Cells | Inpatient Acute Care |
| QHC/RHC Payment Adjustment to PPS Levels – Adjustment to reflect PPS payment levels for FQHC/RHC services. | 1/1/2016 | All Rate Cells | FQHC and Rural Health Clinics |
| 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). | 1/1/2016 | TANF-MAGI Ages 1-20, TANF-MAGI Ages 21+, & Disabled-BCC | Pharmaceutical |
| Shift Nursing Fee Increase - $5/hr. adjustment for Registered Nurses and Licensed Practical Nurses for pediatric shift nursing. | 7/1/2016 | TANF-MAGI < 2 Months, TANF-MAGI 2 – 11.999 Months, TANF-MAGI Ages 1-20, Disabled-BCC | Home Health Care/ HIV-AIDS Waiver |

## PROGRAMMATIC CHANGES CHART

| HealthChoices Physical Health Programmatic Changes Chart for Prospective Rates | | | |
|---|---|---|---|
| **Issue** | **Effective Date** | **Rate Cells** | **Category of Service** |
| Family Planning – Adjustment to account for changes in the MA fee schedule increasing fees to 125% of Medicare for select services. | 12/1/2016 | TANF-MAGI Ages 1-20, TANF-MAGI Ages 21+, & Disabled-BCC | Family Planning Services |
| Population Adjustment - Adjustment made to account for:<br>• Transitional Medical Assistance<br>• 5% Income Disregard<br>• Express Lane and Fast Track enrollment<br>• Former SSI enrollees moving to Newly Eligible and subsequent impacts on acuity | 1/1/2015 (SSI Population Shift)<br>1/1/2016 (Fast Track)<br>3/12/2016 (SSI Population Shift)<br>11/1/2016 (TMA, 5% Disregard, Express Lane) | TANF-MAGI 2 – 11.999 Months, TANF-MAGI Ages 1-20, TANF-MAGI Ages 21+, & Disabled-BCC | 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 were removed from the base data (see High Cost Pharmacy Removal above). The add-ons also include amounts for additional screenings expected from the Hepatitis C Screening Act passed in 2016. | 1/1/2016 | TANF-MAGI Ages 1-20, TANF-MAGI Ages 21+, & Disabled-BCC | Total Capitation Rate |

## PROGRAMMATIC CHANGES CHART

| HealthChoices Physical Health Programmatic Changes Chart for Prospective Rates | | | |
|---|---|---|---|
| **Issue** | **Effective Date** | **Rate Cells** | **Category of Service** |
| Opioid Use Disorder Centers of Excellence – Adjustment for physical health costs related to the implementation of new Opioid Use Disorder Centers of Excellence. | 10/1/2016 | TANF-MAGI Ages 1-20, TANF-MAGI Ages 21+, and Disabled-BCC | Total Capitation Rate |
| Patient Centered Medical Homes (PCMH) – Adjustment for establishing newly required PCMH arrangements within the HealthChoices program. | 1/1/2017 | All Rate Cells | Total Capitation Rate |
| Appendix 14 – Adjustment to Medicaid payments for inpatient acute care services. | 7/1/2010 | All Rate Cells except Maternity | Total Capitation Rate |
| Appendix 16 (Enhanced Access Payments) – Adjustment to Medicaid payments for professional services. | 1/1/2016 | All Rate Cells except Maternity | Total Capitation Rate |
| Appendix 16a – Adjustment to Medicaid payments for professional services. | 1/1/2016 | All Rate Cells except Maternity | Total Capitation Rate |
| MCO Assessment | 7/1/2016 | 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. | . | All Rate Cells | 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.**


Government Human Services Consulting
Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ  85016
+1 602 522 6500