Office of State Procurement
PROACT Contract Certification of Approval

This certificate serves as confirmation that the Office of State Procurement has reviewed and approved the contract referenced below.

Reference Number: 2000100373 (4)
Vendor: Amerigroup Louisiana inc
Description: Provide healthcare services to Medicaid enrollees
Approved By: Pamela Rice
Approval Date: 1/05/2016

Your amendment that was submitted to OSP has been approved.

Rev 2010/08

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

Amendment #: 4

LaGov #: 2000100373

CFMS #: 733527

DHH #: 060467

(Regional/ Program/ Facility): Medical Vendor Administration

AND

Amerigroup Louisiana, Inc.
Contractor Name

Original Contract Amt: 1,964,731,789

Original Contract Begin Date: 02-01-2015

Original Contract End Date: 01-31-2018

AMENDMENT PROVISIONS

Change Contract From:

Maximum Amount: 1,964,731,789

See Attachment A-4.

Change To:

Maximum Amount: 2,080,312,191

See Attachment A-4.

Justification:

The changes contained in Attachment A-4 are necessary for the integration of specialized behavioral health services and the continued successful operation of the Medicaid managed care program.

This Amendment Becomes Effective: 12-01-2015

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

CONTRACTOR

Amerigroup Louisiana, Inc.

CONTRACTOR SIGNATURE — DATE: 11/30/15

PRINT NAME: Sonya Nelson

CONTRACTOR TITLE: CEO

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Secretary, Department of Health and Hospital or Designee

SIGNATURE — DATE: 12/2/15

NAME: J. Ruth Kennedy

TITLE: Medicaid Director

OFFICE: Bureau of Health Services Financing

PROGRAM SIGNATURE — DATE

NAME

Attachment/ Exhibit Letter or Number	Contract Document Name	Change From:	Change To[1]:	Justification
Attachment D	Rate Certification		Replace with Mercer rate certification dated October 15, 2015.	A rate revision was necessary to address technical changes related to out-of-state hospital payments and kick payments, as well as programmatic changes related to the termination of LaHIPP and the addition of new mandatory populations.
Attachment I	Behavioral Health Rate Certification	New attachment	Add Mercer rate certification dated November 20, 2015.	Specialized behavioral health services are being integrated into Bayou Health and rates for these services were developed by Mercer
Attachment J	Non-Emergency Medical Transportation Rate Certification	New attachment	Add Mercer Rate certification dated November 4, 2015.	All non-emergency transportation services will be provided by the MCOs and rates for these services were developed Mercer.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA		Changes are contained in the redlined version of the RFP.	Specialized behavioral health services are being integrated into Bayou Health.

[1] Additions underlined; deletions struck through

Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA **Appendix O**		Replaced with updated version.-	Changes were made to add requirements related to the assignment of anti-trust rights to the State of Louisiana.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA **Appendix T –** Request for Member Disenrollment		Replaced with updated version.	Changes were made due to the integration of specialized behavioral health services into Bayou Health.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA **Appendix UU** – Behavioral Health Provider Network – Geographic and Capacity Standards		Replaced with updated version.	Changes were made due to the integration of specialized behavioral health services into Bayou Health.

MERCER
MAKE TOMORROW, TODAY

Jaredd Simons, ASA, MAAA
Senior Associate Actuary

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+1 404 442 3358
www.mercer-government.mercer.com

Ms. Jen Steele
Medicaid Deputy Director
Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821

October 15, 2015

Subject: Louisiana Bayou Health Physical Health Services – Full Risk-Bearing Managed Care Organization Rate Range Development and Actuarial Certification update for the Period December 1, 2015 through January 31, 2016

Dear Ms. Steele:

The Louisiana Department of Health and Hospitals (DHH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for the State of Louisiana's Bayou Health program for the period of December 1, 2015 through January 31, 2016. This certification update includes two technical revisions that are retrospectively effective February 1, 2015 and two programmatic changes that will be effective December 1, 2015. For reference, the original capitation rate certification letter for the period July 1, 2015 through January 31, 2016 is included with this document in Appendix E.

This letter provides an overview of the analyses and methodology to support the technical revisions, programmatic changes, and the resulting capitation rate ranges effective December 1, 2015 through January 31, 2016 for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS). This rate development process used Medicaid fee-for-service (FFS) medical and pharmacy claims, Bayou Health Shared Savings claims experience, and Bayou Health Prepaid encounter data. It resulted in the development of a range of actuarially sound rates for each rate cell. The capitation rate ranges are summarized in Appendix A and represent payment in full for the covered services. Appendix B shows the full rate development from the base data as shown in the data book released by the State, dated January 31, 2015 (after excluding LaHIPP claims and including the revised Maternity kick payment deliveries {Table 1-A and 1-B}), and applies all the rate setting adjustments as described in this letter.

Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows,

governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government mandated assessments, fees, and taxes, and the cost of capital. Note: Please see pages 8-9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.

Technical Revisions

Following the implementation of the Bayou Health at-risk capitated program, effective February 1, 2015, Mercer became aware of two issues requiring a technical revision to the previously certified rates. These are the following:

- A misalignment in the Maternity kick payment delivery event count logic between the State's fiscal agent and what was included in rate development.
- A decision made by the First Circuit Court of Appeals altering the reimbursement to out-of-state border hospitals.

These issues and methodology of the technical revisions are described in detail in the following sections.

Technical Revision #1 (Maternity Kick Payment Delivery Event Count Logic)

Mercer worked with DHH and the State's fiscal agent (Molina) to revise and align the Maternity kick payment delivery event count logic underlying the rate development and the logic implemented by Molina for payment to the Bayou Health managed care organizations (MCOs). A full description of the Maternity kick payment logic can be found in Schedule Z of the Bayou Health MCO financial reporting requirements guideline.

The following describes all the changes made to the inpatient physical health services encounters delivery event count logic. All other logic remains unchanged:

- Included all available diagnoses codes on a claim to identify a delivery. Previously, only the primary diagnosis code was used to identify a delivery.
- Included inpatient hospital claims only (claim type = 01 and billing provider type = 60) to identify a delivery. Previously, outpatient claims and all billing provider types were considered to identify a delivery.
- Restricted the age of the enrolled mother to greater than or equal to 10 years of age to identify a delivery. Previously, all ages were considered to identify a delivery.

- Diagnoses code range 640-669 where the 5th digit must be a 1 or 2. Previously, all codes in the range 650-669 were used to identify a delivery and no consideration was made for the 5th digit.
- Stillborn deliveries are identified using the following revenue codes: V271, V273-274, or V276-277. Previously, all V27 (V271-V279) were used to identify a stillborn delivery.

The following describes all the changes made to the professional encounters delivery logic, all other logic remains unchanged:

- Restricted to billing provider types 19, 20, and 90 to identify a delivery. Previously, all billing provider types were considered to identify a delivery.
- Restricted the age of the recipient to greater than or equal to 10 years of age to identify a delivery. Previously, all ages were considered to identify a delivery.

Additionally, after all encounters are identified, a single live-born delivery is identified for a given recipient within a 245-day period, plus or minus. Previously, a 120-day period, plus or minus, was used to identify a single delivery.

The revision to the Maternity kick payment delivery event count logic resulted in a reduction in deliveries of 1.98%, which increased the cost per delivery by 2.02%. Table 1-A shows the regional impact to the Maternity kick payment deliveries and cost per delivery. Table 1-B shows the regional impact to the Full Medicaid Pricing (FMP) cost per delivery.

Table 1-A: Regional impact to deliveries and cost per delivery due to the Maternity kick payment delivery event count logic change

Region Description	CY 2013 Deliveries	Original Cost per Delivery	CY 2013 Revised Deliveries	Revised Cost per Delivery	Deliveries % Change	Cost per Delivery % Change	Cost Per Delivery Impact
Gulf	10,987	$5,758.51	10,706	$5,910.05	-2.56%	2.63%	$151.54
Capital	9,772	$5,100.71	9,480	$5,258.10	-2.99%	3.09%	$157.40
South Central	10,504	$5,063.13	10,352	$5,137.39	-1.45%	1.47%	$74.27
North	8,132	$5,207.82	8,080	$5,241.63	-0.65%	0.65%	$33.82
Statewide	**39,396**	**$5,296.26**	**38,617**	**$5,403.03**	**-1.98%**	**2.02%**	**$106.78**

Table 1-B: Regional impact to FMP cost per delivery due to delivery event count logic change

Region Description	CY 2013 Deliveries	Original FMP Cost per Delivery	Revised Deliveries	Revised FMP Cost per Delivery	FMP Cost per Delivery % Change	FMP Cost Per Delivery Impact
Gulf	10,987	$3,053.19	10,706	$3,133.54	2.63%	$80.35
Capital	9,772	$3,046.41	9,480	$3,140.42	3.09%	$94.01
South Central	10,504	$2,662.95	10,352	$2,702.01	1.47%	$39.06
North	8,132	$2,632.96	8,080	$2,650.06	0.65%	$17.10
Statewide	**39,396**	**$2,860.71**	**38,617**	**$2,918.39**	**2.02%**	**$57.68**

Technical Revision #2 (Out-of-State Border Hospital Reimbursement)

A First Circuit Court of Appeals decision, Vicksburg, LLC v. State ex rel. Dep't of Health and Hospitals, 2010-1248 (La. App. 1st Cir. 3/25/11), 63 So.3d205, determined that a reimbursement methodology promulgated by DHH was unconstitutional in its application to River Region. River Region is a hospital located in Vicksburg, Mississippi, and administered inpatient health care services to Louisiana Medicaid patients. Consequently, DHH altered its reimbursement methodology to Mississippi out-of-state (Mississippi trade area) border hospitals from a per diem basis to a percentage of billed charges. These hospitals will now be reimbursed at 60% and 40% of billed charges for children and adults, respectively.

Mercer re-priced these out-of-state border hospital claims using the base claims experience (calendar year {CY} 2013) and determined the change to be immaterial to all rating categories with the exception of the Maternity kick payment. The South Central and North regions' Maternity kick payments were affected most with a 4.78% and 1.60% increase, respectively, as these are the regions bordering the Mississippi trade area. There was minimal to no impact to the Maternity kick payments of the Capital and Gulf regions. Table 2 shows the regional impact to the Maternity kick payments cost per delivery.

Table 2: Regional impact to cost per delivery due to the out-of-state border hospitals reimbursement methodology change

Region Description	CY 2013 Revised Deliveries	Table 1-A Revised Cost per Delivery	Out of State Inpatient Hospital Adjustment	Revised Cost per Delivery	Cost Per Delivery Impact
Gulf	10,706	$5,910.05	0.00%	$5,909.95	($0.10)
Capital	9,480	$5,258.10	0.04%	$5,260.37	$2.27
South Central	10,352	$5,137.39	4.78%	$5,382.83	$245.44
North	8,080	$5,241.63	1.60%	$5,325.55	$83.91
Statewide	**38,617**	**$5,403.03**	**1.55%**	**$5,486.91**	**$83.88**

Table 3: Total impact of the technical revisions

		Delivery Count Logic Update Impact		OOS IP Hospital Adj. Impact	
	[A]	[B]	[C]	[D]	[E]= [A]+[B]+[C]+[D]
Region Description	Original Total Cost per Delivery[1]	Cost Per Delivery Impact[2]	FMP Cost per Delivery Impact[3]	Cost Per Delivery Impact[4]	Revised Total Cost Per Delivery
Gulf	$8,811.70	$151.54	$80.35	($0.10)	$9,043.49
Capital	$8,147.12	$157.40	$94.01	$2.27	$8,400.79
South Central	$7,726.08	$74.27	$39.06	$245.44	$8,084.84
North	$7,840.78	$33.82	$17.10	$83.91	$7,975.61

Notes:
1: Target cost per delivery certified in the August 11, 2015 letter for the period July 1, 2015 through January 31, 2016.
2: Limited cost per delivery impact shown in Table 1-A.
3: FMP cost per delivery impact shown in Table 1-B.
4: Limited cost per delivery impact shown in Table 2.

Programmatic Changes

Effective December 1, 2015, DHH will implement two program changes to Bayou Health:

- The termination of the Louisiana's Health Insurance Premium Payment (LaHIPP) program.
- The mandatory enrollment of populations who were previously allowed to voluntarily opt-out of Bayou Health.

The details of the methodology used to quantify and reflect the impact of the aforementioned program changes are described in the following sections.

Programmatic Change #1 (LaHIPP Program)
Effective December 1, 2015, DHH will terminate the LaHIPP program. This program pays for some or all of the health insurance premiums for an enrollee if they have insurance available through someone in the family and are enrolled in Medicaid. The program also covers out of pocket expenses incurred by the enrollee (Medicaid is the secondary payer).

LaHIPP is not a category of eligibility and enrollees in this program were eligible under the other categories of aid (COA) in Bayou Health. LaHIPP membership and claims experience were removed from the base claims experience (CY 2013) for purposes of developing the capitation rate range. Appendix C shows the statewide impact by COA from removing LaHIPP enrollees from the base claims experience. The LaHIPP claims are explicitly provided in the data book dated January 31, 2015.

Programmatic Change #2 (Voluntary Opt-Out Populations)
Effective December 1, 2015, populations currently allowed to voluntarily opt-out of Bayou Health will become mandatorily enrolled. These populations are defined in section 3.1 of the contract as the following:

- Children under 19 years of age who are:
  - Eligible for Supplemental Security Income (SSI) under title XVI of the Social Security Act;
  - Eligible under Section 1902(e)(3) of the Social Security Act;
  - In foster care or other out-of-home placement;
  - Receiving foster care or adoption assistance;
  - Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of title V of the Social Security Act, and is defined by the DHH in terms of either program participation or special health care needs; or
  - Enrolled in Family Opportunity Act Medicaid Buy-In Program
- Native Americans who are members of federally recognized tribes, except when the MCO is:
  - The Indian Health Service; or
  - An Indian health program or urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreements or compact with the Indian Health Service.

Mercer used logic provided by DHH to identify SSI and foster care children who have opted-out of Bayou Health; however, there was no clearly defined logic available to Mercer to identify Native Americans. Thus, for base claims experience, Mercer utilized the residual CY 2013 FFS claims incurred by FFS populations who met the criteria for inclusion into Bayou Health and were not identified as a voluntary opt-in population (home- and community-based services {HCBS} Waiver and Chisholm Class Members), as defined in section 3.2 of the contract.

After identifying the appropriate voluntary opt-out populations' CY 2013 FFS membership and claims experience, Mercer created an adjustment to be applied in the rate development to account for the voluntary opt-out experience. When reviewing the opt-out experience to create this adjustment, Mercer accounted for the same rating adjustments as the Shared Savings/FFS population in the capitation rates effective February 1, 2015. These adjustments include:

- Incurred but not reported (IBNR)
- Fee adjustments
- Retroactive eligibility
- Fraud and abuse recoupments
- ACT 312 and pharmacy rebates
- Pediatric Day Health Care adjustments
- Specialized behavioral health mixed services protocol
- Affordable Care Act (ACA) Primary Care Providers (PCP) enhanced payments
- Trend

As the opt-out population has not been previously covered by the Bayou Health program, additional considerations had to be taken for the trend duration for the opt-out experience. The population covered under Bayou Health effective February 1, 2015 has a trending midpoint of August 1, 2015. The rating period for the voluntary opt-out population is December 1, 2015 through January 31, 2015 and therefore has a trending midpoint of January 1, 2015. Mercer accounted for the five month difference in trending midpoint for the opt-out population.

Additionally, Mercer used specific managed care contracting adjustments for the voluntary opt-out population. Considering the short rating period for the voluntary opt-outs, Mercer did not apply contracting adjustments for utilization but did apply a 1.0% to 3.0% increase for unit cost.

The overall adjustment for the inclusion of the voluntary opt-out populations can be found in Appendix D.

Certification of Rate Ranges

In preparing the rate ranges shown in Appendix A, Mercer has used and relied upon enrollment, FFS claims, encounter data, reimbursement level, benefit design, and other information supplied by DHH and its fiscal agent. DHH, its fiscal agent, and the Prepaid plans are responsible for the validity and completeness of the data supplied. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion they are appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that the rates in Appendix A were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the managed care contract. Rate estimates provided are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates and ranges developed by Mercer are actuarial projections of future contingent events. Actual Bayou Health MCO costs will differ from these projections. Mercer has developed these rates on behalf of DHH to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c), and in accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

Bayou Health MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by Bayou Health MCOs for any purpose. Mercer recommends that any Bayou Health MCO considering contracting with DHH should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges before deciding whether to contract with DHH.

This certification letter assumes the reader is familiar with the Bayou Health program, Medicaid eligibility rules, and actuarial rate-setting techniques. It is intended for DHH and CMS, and should not be relied upon by third 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 results.

If you have any questions on any of the information provided, please feel free to call me at +1 404 442 3358.

Sincerely,

Jaredd Simons, ASA, MAAA
Senior Associate Actuary

Appendix A: Bayou Health Physical Health Services Capitation Rate Range

Region Description	COA Description	Rate Cell Description	CY 2013 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
Gulf	SSI	0-2 Months	287	$27,550.49	$28,980.93
Gulf	SSI	3-11 Months	1,728	$5,306.40	$5,598.82
Gulf	SSI	Child 1-18	121,839	$415.04	$442.48
Gulf	SSI	Adult 19+	276,046	$1,017.76	$1,071.30
Gulf	Family & Children	0-2 Months	43,082	$1,762.38	$1,854.57
Gulf	Family & Children	3-11 Months	104,284	$247.57	$264.13
Gulf	Family & Children	Child 1-18	2,050,898	$120.22	$128.10
Gulf	Family & Children	Adult 19+	373,887	$324.28	$342.34
Gulf	BCC	BCC, All Ages	3,695	$2,303.99	$2,450.13
Gulf	LAP	LAP, All Ages	9,457	$154.82	$165.54
Gulf	HCBS	Child 0-18	6,538	$1,550.29	$1,682.92
Gulf	HCBS	Adult 19+	20,790	$615.74	$662.30
Gulf	CCM	CCM, All Ages	15,581	$902.87	$983.44
Gulf	Maternity Kick Payment	Maternity Kick Payment	10,700	$9,017.48	$9,270.19
Gulf	EED Kick Payment	EED Kick Payment	N/A	$5,154.77	$5,241.55
Capital	SSI	0-2 Months	163	$28,413.29	$29,843.73
Capital	SSI	3-11 Months	1,461	$5,394.45	$5,686.88
Capital	SSI	Child 1-18	88,633	$450.26	$482.06
Capital	SSI	Adult 19+	209,421	$1,046.13	$1,107.31
Capital	Family & Children	0-2 Months	38,631	$1,911.98	$2,007.10
Capital	Family & Children	3-11 Months	94,165	$266.72	$285.60
Capital	Family & Children	Child 1-18	1,858,073	$127.17	$135.85
Capital	Family & Children	Adult 19+	268,605	$370.09	$391.17
Capital	BCC	BCC, All Ages	3,946	$2,296.45	$2,442.59
Capital	LAP	LAP, All Ages	10,487	$156.09	$166.80
Capital	HCBS	Child 0-18	6,774	$1,549.11	$1,681.75

Region Description	COA Description	Rate Cell Description	CY 2013 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
Capital	HCBS	Adult 19+	20,494	$615.61	$662.17
Capital	CCM	CCM, All Ages	15,381	$903.89	$984.46
Capital	Maternity Kick Payment	Maternity Kick Payment	9,457	$8,357.75	$8,581.28
Capital	EED Kick Payment	EED Kick Payment	N/A	$5,401.33	$5,498.12
South Central	SSI	0-2 Months	213	$27,684.14	$29,114.58
South Central	SSI	3-11 Months	1,662	$5,304.60	$5,597.03
South Central	SSI	Child 1-18	90,974	$484.83	$516.46
South Central	SSI	Adult 19+	246,315	$967.55	$1,021.90
South Central	Family & Children	0-2 Months	43,407	$2,105.59	$2,205.16
South Central	Family & Children	3-11 Months	104,247	$284.68	$302.96
South Central	Family & Children	Child 1-18	2,034,374	$135.19	$144.12
South Central	Family & Children	Adult 19+	285,291	$341.45	$360.97
South Central	BCC	BCC, All Ages	2,890	$2,311.73	$2,457.87
South Central	LAP	LAP, All Ages	12,222	$156.88	$167.60
South Central	HCBS	Child 0-18	6,213	$1,552.76	$1,685.39
South Central	HCBS	Adult 19+	22,305	$617.28	$663.84
South Central	CCM	CCM, All Ages	16,290	$903.12	$983.69
South Central	Maternity Kick Payment	Maternity Kick Payment	10,347	$8,073.21	$8,303.76
South Central	EED Kick Payment	EED Kick Payment	N/A	$4,915.62	$5,010.65
North	SSI	0-2 Months	239	$27,956.38	$29,386.81
North	SSI	3-11 Months	1,678	$5,304.79	$5,597.21
North	SSI	Child 1-18	99,769	$446.00	$473.76
North	SSI	Adult 19+	211,578	$923.45	$974.40
North	Family & Children	0-2 Months	32,218	$1,994.51	$2,095.51
North	Family & Children	3-11 Months	80,049	$262.11	$279.64
North	Family & Children	Child 1-18	1,586,038	$121.51	$129.34
North	Family & Children	Adult 19+	213,578	$326.14	$344.95
North	BCC	BCC, All Ages	2,395	$2,326.15	$2,472.29

Region Description	COA Description	Rate Cell Description	CY 2013 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
North	LAP	LAP, All Ages	6,545	$156.89	$167.60
North	HCBS	Child 0-18	3,944	$1,553.38	$1,686.01
North	HCBS	Adult 19+	16,992	$617.35	$663.91
North	CCM	CCM, All Ages	16,296	$903.59	$984.16
North	Maternity Kick Payment	Maternity Kick Payment	8,077	$7,945.67	$8,173.23
North	EED Kick Payment	EED Kick Payment	N/A	$4,660.27	$4,746.63

Appendix B: Development of Rate Ranges for December 1, 2015 through January 31, 2016

Rate Development Description

The below portrays the details of the rate development based on the combined Prepaid, Shared Savings, and Legacy Medicaid/FFS (Chisholm and HCBS) data. The rate development exhibit takes the base data that was provided in Attachment 1 of the data book issued on January 31, 2015, (after excluding LaHIPP claims and including the revised Maternity kick payment deliveries {Table 1-A}), and applies the various rate-setting adjustments. The columns in the exhibit are as follows:

Base Data – The base data in these columns includes IBNR.
Member Month (MMs) – MMs for the CY 2013 period.
Per Member Per Month (PMPM) – Computed as the total paid amount divided by the total MMs. Statewide PMPMs were used where appropriate, as indicated in the rate certification letter.

Base Data Adjustments:
Annual Trend – (Low & High) – Annualized trend that is equivalent to the trend factor applied to the base data.
Trend Factor – (Low & High) – Trend factor that is equivalent to the compounded annualized trend applied to the base data.
Base Period Adj. – Overall base period adjustment applied to both the low and high PMPMs. A list of the data source-specific adjustments and the level of detail in which they were applied can be found in the table below:

Base Period Adjustments	
Prepaid	**Shared/FFS**
	Fraud and Abuse Adjustment (statewide adj.)
Fee Schedule Adjustment (hospital specific adj.)	Fee Schedule Adjustment (hospital specific adj.)
ACT 312 Adjustment (statewide adj.)	ACT 312 Adjustment (statewide adj.)
	Rx Rebate Adjustment (statewide adj.)
ACA PCP Adjustment (category of service level adj.)	ACA PCP Adjustment (category of service level adj.)
LBHP Adjustment (category of service level adj.)	LBHP Adjustment (category of service level adj.)
Retro-activity Adjustment (rate cell level adj.)	Retro-activity Adjustment (rate cell level adj.)
NEMT Adjustment (rate cell level adj.)	

Managed Care Adj. Factor – (Low & High) – Low and high managed care savings factors applied to the corresponding low and high PMPMs. A list of the data source-specific adjustments and the level of detail in which they were applied can be found in the table below:

Managed Care Adjustments

Prepaid	Shared/FFS
Managed Care Savings*	Managed Care Savings*
	GDR

* Managed care savings adjustments were applied to previously unmanaged populations utilizing Legacy Medicaid/FFS claims (HCBS and Chisholm), as well as newly added services.

Voluntary Opt-Out Adj. Factor – (Low & High) – Low and high factors applied to the corresponding low and high PMPMs for mandating the voluntary opt-out populations.
Out-of-State Adj. Factor – Factor applied to account for the out-of-state border hospitals reimbursement change. Applies to both Low and High PMPMs.
Outlier Add-on (PMPM) – PMPM added to account for outlier payments. Applies to both Low and High PMPMs.
Claims PMPM – (Low) – Calculated as: N = [B *E * (1+G)*H*J*L] + M.
Claims PMPM – (High) – Calculated as: O = [B * F * (1+G)*I*K*L] + M.
Fixed Admin Load – (Low & High) – A PMPM adjustment added to the corresponding Low and High PMPMs.
Variable Admin Load – (Low & High) – A percentage adjustment applied to the corresponding Low and High PMPMs.
Profit @ 2% – Provision in these rates has been made for a 2% risk margin.
Premium Tax @ 2.25% – Provision in these rates has been made for Louisiana's 2.25% premium tax.
PMPM After Admin – (Low) – Calculated as: V = (N * (1 + Q) + P)/(1 – T – U).
PMPM After Admin – (High) – Calculated as: W = (O * (1 + S) + R)/(1 – T – U).
Full Medicaid Pricing (FMP) Add-On – FMP component of the rate.
Premium tax on FMP – Provision in the FMP component of the rates has been made for Louisiana's 2.25% premium tax.
Final Loaded Rates – (Low) – Calculated as: Z = V + X + Y.
Final Loaded Rates – (High) – Calculated as: AA = W + X + Y.

			Base Data		Base Data Adjustments										Outliers			Capitation Rate Load								Full Medicaid Payment			
			A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA
Region Name	COA Desc	Rate Cell Code	MMs	PMPM	Annual Trend-Low	Annual Trend-High	Trend Factor-Low	Trend Factor-High	Base Period Adj.	Managed Care Adj. Factor-Low	Managed Care Adj. Factor-High	Voluntary Opt-Out Adj. Factor - Low	Voluntary Opt-Out Adj. Factor - High	Out of State Hospital Adj. Factor	Outlier Add-on - PMPM	Claims PMPM-Low	Claims PMPM-High	Fixed Admin Load- Low (PMPM)	Variable Admin Load- Low (%)	Fixed Admin Load- High (PMPM)	Variable Admin Load- High (%)	Profit @ 2%	Premium Tax @ 2.25%	PMPM After Admin- Low	PMPM After Admin- High	FMP Add-On	Premium tax on FMP	Final Loaded Rates-Low	Final Loaded Rates-High
Gulf	SSI	Newborn, 0-2 Months	267	$ 19,659.26	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	0.91	0.92	1.00	$ 945.10	$ 18,120.97	$ 19,413.84	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 20,075.10	$ 21,505.54	$ 7,307.19	$ 168.20	$ 27,550.49	$ 28,980.93
Gulf	SSI	Newborn, 3-11 Months	1,728	$ 4,031.32	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	0.97	0.97	1.00	$ 63.79	$ 3,991.93	$ 4,256.71	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,410.05	$ 4,702.48	$ 876.18	$ 20.17	$ 5,306.40	$ 5,598.82
Gulf	SSI	Child, 1-18 Years	121,839	$ 293.29	2.9%	5.9%	1.06	1.13	-1.4%	0.98	0.99	1.09	1.09	1.00	$ 2.39	$ 330.23	$ 354.60	$ 10.89	4.4%	$ 11.67	4.4%	2.0%	2.25%	$ 371.52	$ 396.97	$ 42.54	$ 0.98	$ 415.04	$ 440.48
Gulf	SSI	Adult, 19+ Years	276,046	$ 682.56	2.9%	5.9%	1.06	1.13	0.4%	0.99	0.99	1.00	1.00	1.00	$ -	$ 717.95	$ 766.17	$ 10.89	4.3%	$ 11.67	4.4%	2.0%	2.25%	$ 793.72	$ 847.25	$ 219.00	$ 5.04	$ 1,017.76	$ 1,071.30
Gulf	Family and Children	Newborn, 0-2 Months	43,082	$ 1,151.97	0.7%	4.1%	1.01	1.09	-7.5%	1.00	1.00	1.03	1.04	1.00	$ 46.33	$ 1,160.18	$ 1,242.84	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,295.55	$ 1,387.74	$ 456.32	$ 10.50	$ 1,762.38	$ 1,854.57
Gulf	Family and Children	Newborn, 3-11 Months	104,284	$ 200.83	2.3%	5.8%	1.05	1.12	-10.6%	0.97	0.97	1.00	1.00	1.00	$ 0.21	$ 182.41	$ 196.72	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 212.01	$ 228.57	$ 34.76	$ 0.80	$ 247.57	$ 264.13
Gulf	Family and Children	Child, 1-18 Years	2,050,898	$ 89.55	3.0%	6.2%	1.06	1.13	-4.9%	0.95	0.96	1.00	1.00	1.00	$ 0.05	$ 86.25	$ 92.69	$ 10.89	4.7%	$ 11.67	4.8%	2.0%	2.25%	$ 105.73	$ 113.60	$ 14.17	$ 0.33	$ 120.22	$ 128.10
Gulf	Family and Children	Adult, 19+ Years	373,887	$ 214.99	2.9%	5.9%	1.06	1.13	1.7%	0.96	0.97	1.01	1.01	1.00	$ -	$ 225.50	$ 241.23	$ 10.89	4.8%	$ 11.67	4.8%	2.0%	2.25%	$ 258.19	$ 276.25	$ 64.60	$ 1.49	$ 324.28	$ 342.34
Gulf	Breast and Cervical Cancer	BCC, All Ages Female	3,695	$ 1,282.45	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	1.08	1.08	1.00	$ -	$ 1,572.30	$ 1,704.28	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,737.63	$ 1,883.77	$ 553.62	$ 12.74	$ 2,303.99	$ 2,450.13
Gulf	LaCHIP Affordable Plan	All Ages	9,457	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	1.00	1.00	1.00	$ -	$ 115.68	$ 124.73	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.73	$ 148.44	$ 16.71	$ 0.38	$ 154.82	$ 165.54
Gulf	HCBS Waiver	18 & Under, Male and Female	6,538	$ 1,368.00	2.0%	4.6%	1.04	1.10	0.5%	0.94	0.97	1.00	1.00	1.00	$ -	$ 1,349.97	$ 1,469.57	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,495.85	$ 1,628.48	$ 53.22	$ 1.23	$ 1,550.29	$ 1,682.92
Gulf	HCBS Waiver	19+ Years, Male and Female	20,790	$ 521.48	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	1.00	1.00	1.00	$ -	$ 480.29	$ 522.01	$ 10.89	4.3%	$ 11.67	4.3%	2.0%	2.25%	$ 534.32	$ 580.88	$ 79.59	$ 1.83	$ 615.74	$ 662.30
Gulf	Chisholm Class Members	Chisholm, All Ages Male & Female	15,581	$ 772.12	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	1.00	1.00	1.00	$ -	$ 749.15	$ 821.56	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 833.39	$ 913.96	$ 67.92	$ 1.56	$ 902.87	$ 983.44
Gulf	Maternity Kickpayment	Maternity Kickpayment, All Ages	10,700	$ 5,258.68	0.0%	2.0%	1.00	1.04	-0.6%	1.00	1.00	1.02	1.02	1.00	$ -	$ 5,311.39	$ 5,540.04	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 5,882.82	$ 6,135.53	$ 3,064.13	$ 70.53	$ 9,017.48	$ 9,270.19
Capital	SSI	Newborn, 0-2 Months	163	$ 19,659.26	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	0.91	0.92	1.00	$ 945.10	$ 18,120.97	$ 19,413.84	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 20,075.10	$ 21,505.54	$ 8,150.58	$ 187.61	$ 28,413.29	$ 29,843.73
Capital	SSI	Newborn, 3-11 Months	1,461	$ 4,031.32	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	0.97	0.97	1.00	$ 63.79	$ 3,991.93	$ 4,256.71	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,410.05	$ 4,702.48	$ 982.25	$ 22.15	$ 5,394.45	$ 5,686.88
Capital	SSI	Child, 1-18 Years	86,633	$ 344.62	3.0%	5.9%	1.06	1.13	1.4%	0.98	0.99	1.05	1.06	1.00	$ 2.39	$ 384.74	$ 413.11	$ 10.89	4.4%	$ 11.67	4.4%	2.0%	2.25%	$ 430.98	$ 462.78	$ 18.84	$ 0.43	$ 450.26	$ 482.06
Capital	SSI	Adult, 19+ Years	209,421	$ 748.67	3.0%	5.9%	1.06	1.13	4.1%	0.99	0.99	1.00	1.00	1.00	$ -	$ 817.86	$ 873.07	$ 10.89	4.3%	$ 11.67	4.4%	2.0%	2.25%	$ 902.61	$ 963.79	$ 140.29	$ 3.23	$ 1,046.13	$ 1,107.31
Capital	Family and Children	Newborn, 0-2 Months	38,631	$ 1,162.14	0.8%	4.0%	1.01	1.09	-6.4%	1.00	1.00	1.04	1.04	1.00	$ 46.33	$ 1,185.54	$ 1,270.85	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,323.48	$ 1,416.60	$ 575.26	$ 13.24	$ 1,911.98	$ 2,007.10
Capital	Family and Children	Newborn, 3-11 Months	94,165	$ 224.82	2.1%	5.6%	1.05	1.12	-7.5%	0.97	0.97	0.99	0.99	1.00	$ 0.21	$ 208.83	$ 225.26	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 241.12	$ 260.00	$ 25.03	$ 0.58	$ 266.72	$ 285.60
Capital	Family and Children	Child, 1-18 Years	1,858,073	$ 96.23	3.2%	6.3%	1.07	1.14	-1.8%	0.94	0.95	1.00	1.00	1.00	$ 0.05	$ 95.19	$ 102.39	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 115.37	$ 124.05	$ 11.54	$ 0.27	$ 127.17	$ 135.85
Capital	Family and Children	Adult, 19+ Years	268,605	$ 249.04	3.0%	5.9%	1.06	1.13	6.0%	0.96	0.97	1.00	1.00	1.00	$ -	$ 269.34	$ 287.85	$ 10.89	4.7%	$ 11.67	4.7%	2.0%	2.25%	$ 306.00	$ 327.08	$ 62.65	$ 1.44	$ 370.09	$ 391.17
Capital	Breast and Cervical Cancer	BCC, All Ages Female	3,946	$ 1,282.45	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	1.08	1.08	1.00	$ -	$ 1,572.30	$ 1,704.28	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,737.63	$ 1,883.77	$ 546.25	$ 12.57	$ 2,296.45	$ 2,442.59
Capital	LaCHIP Affordable Plan	All Ages	10,487	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	1.00	1.00	1.00	$ -	$ 115.68	$ 124.73	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.73	$ 148.44	$ 17.95	$ 0.41	$ 156.09	$ 166.80
Capital	HCBS Waiver	18 & Under, Male and Female	6,774	$ 1,368.00	2.0%	4.6%	1.04	1.10	0.5%	0.94	0.97	1.00	1.00	1.00	$ -	$ 1,349.97	$ 1,469.57	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,495.85	$ 1,628.48	$ 52.07	$ 1.20	$ 1,549.11	$ 1,681.75
Capital	HCBS Waiver	19+ Years, Male and Female	20,494	$ 521.48	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	1.00	1.00	1.00	$ -	$ 480.29	$ 522.01	$ 10.89	4.3%	$ 11.67	4.3%	2.0%	2.25%	$ 534.32	$ 580.88	$ 79.45	$ 1.83	$ 615.61	$ 662.17
Capital	Chisholm Class Members	Chisholm, All Ages Male & Female	15,381	$ 772.12	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	1.00	1.00	1.00	$ -	$ 749.15	$ 821.56	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 833.39	$ 913.96	$ 66.92	$ 1.59	$ 903.89	$ 984.46
Capital	Maternity Kickpayment	Maternity Kickpayment, All Ages	9,457	$ 4,642.97	0.0%	2.0%	1.00	1.04	0.3%	1.00	1.00	1.01	1.01	1.00	$ -	$ 4,707.64	$ 4,909.89	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 5,214.12	$ 5,437.65	$ 3,072.90	$ 70.73	$ 8,357.75	$ 8,581.28
South Central	SSI	Newborn, 0-2 Months	213	$ 19,659.26	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	0.91	0.92	1.00	$ 945.10	$ 18,120.97	$ 19,413.84	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 20,075.10	$ 21,505.54	$ 7,437.83	$ 171.20	$ 27,684.14	$ 29,114.58
South Central	SSI	Newborn, 3-11 Months	1,662	$ 4,031.32	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	0.97	0.97	1.00	$ 63.79	$ 3,991.93	$ 4,256.71	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,410.05	$ 4,702.48	$ 874.42	$ 20.13	$ 5,304.60	$ 5,597.03
South Central	SSI	Child, 1-18 Years	90,974	$ 344.26	3.4%	6.2%	1.07	1.13	0.4%	0.98	0.99	1.09	1.10	1.00	$ 2.39	$ 399.39	$ 427.67	$ 10.89	4.1%	$ 11.67	4.1%	2.0%	2.25%	$ 445.38	$ 477.02	$ 38.56	$ 0.89	$ 484.83	$ 516.46
South Central	SSI	Adult, 19+ Years	246,315	$ 682.00	3.0%	5.9%	1.06	1.13	1.0%	0.99	0.99	1.01	1.01	1.00	$ -	$ 726.58	$ 775.52	$ 10.89	4.4%	$ 11.67	4.4%	2.0%	2.25%	$ 803.41	$ 857.75	$ 160.45	$ 3.69	$ 967.55	$ 1,021.90
South Central	Family and Children	Newborn, 0-2 Months	43,407	$ 1,252.76	0.7%	4.1%	1.01	1.09	-6.8%	1.00	1.00	1.03	1.03	1.00	$ 46.33	$ 1,257.07	$ 1,346.41	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,402.85	$ 1,502.22	$ 687.13	$ 15.82	$ 2,105.59	$ 2,205.16
South Central	Family and Children	Newborn, 3-11 Months	104,247	$ 223.91	2.4%	5.7%	1.05	1.12	-5.3%	0.96	0.97	0.99	0.99	1.00	$ 0.21	$ 206.77	$ 222.66	$ 10.89	5.2%	$ 11.67	5.2%	2.0%	2.25%	$ 236.60	$ 256.88	$ 45.04	$ 1.04	$ 284.68	$ 302.96
South Central	Family and Children	Child, 1-18 Years	2,034,374	$ 102.79	3.3%	6.3%	1.07	1.14	-3.0%	0.94	0.95	1.00	1.00	1.00	$ 0.05	$ 100.85	$ 108.27	$ 10.89	4.5%	$ 11.67	4.5%	2.0%	2.25%	$ 121.45	$ 130.38	$ 13.43	$ 0.31	$ 135.19	$ 144.12
South Central	Family and Children	Adult, 19+ Years	285,291	$ 232.99	2.9%	5.9%	1.06	1.13	2.8%	0.97	0.97	1.01	1.01	1.00	$ -	$ 247.50	$ 264.57	$ 10.89	4.8%	$ 11.67	4.8%	2.0%	2.25%	$ 282.33	$ 301.85	$ 57.79	$ 1.33	$ 341.45	$ 360.97
South Central	Breast and Cervical Cancer	BCC, All Ages Female	2,880	$ 1,282.45	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	1.08	1.08	1.00	$ -	$ 1,572.30	$ 1,704.28	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,737.63	$ 1,883.77	$ 561.19	$ 12.92	$ 2,311.73	$ 2,457.87
South Central	LaCHIP Affordable Plan	All Ages	12,222	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	1.00	1.00	1.00	$ -	$ 115.68	$ 124.73	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.73	$ 148.44	$ 16.72	$ 0.43	$ 156.88	$ 167.60
South Central	HCBS Waiver	18 & Under, Male and Female	6,213	$ 1,368.00	2.0%	4.6%	1.04	1.10	0.5%	0.94	0.97	1.00	1.00	1.00	$ -	$ 1,349.97	$ 1,469.57	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,495.85	$ 1,628.48	$ 55.63	$ 1.28	$ 1,552.76	$ 1,685.39
South Central	HCBS Waiver	19+ Years, Male and Female	22,305	$ 521.48	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	1.00	1.00	1.00	$ -	$ 480.29	$ 522.01	$ 10.89	4.3%	$ 11.67	4.3%	2.0%	2.25%	$ 534.32	$ 580.88	$ 81.09	$ 1.87	$ 617.28	$ 663.84
South Central	Chisholm Class Members	Chisholm, All Ages Male & Female	16,290	$ 772.12	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	1.00	1.00	1.00	$ -	$ 749.15	$ 821.56	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 833.39	$ 913.96	$ 68.16	$ 1.57	$ 903.12	$ 983.69
South Central	Maternity Kickpayment	Maternity Kickpayment, All Ages	10,347	$ 4,429.47	0.0%	2.0%	1.00	1.04	2.5%	1.00	1.00	1.02	1.02	1.05	$ -	$ 4,660.05	$ 5,058.65	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 5,371.85	$ 5,602.40	$ 2,640.58	$ 60.78	$ 8,073.21	$ 8,303.76
North	SSI	Newborn, 0-2 Months	239	$ 19,659.26	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	0.91	0.92	1.00	$ 945.10	$ 18,120.97	$ 19,413.84	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 20,075.10	$ 21,505.54	$ 7,703.95	$ 177.33	$ 27,956.38	$ 29,386.81
North	SSI	Newborn, 3-11 Months	1,678	$ 4,031.32	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	0.97	0.97	1.00	$ 63.79	$ 3,991.93	$ 4,256.71	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,410.05	$ 4,702.48	$ 874.61	$ 20.13	$ 5,304.79	$ 5,597.21
North	SSI	Child, 1-18 Years	99,769	$ 296.46	3.0%	5.8%	1.06	1.12	3.7%	0.98	0.99	1.11	1.11	1.00	$ 2.39	$ 357.88	$ 382.54	$ 10.89	4.4%	$ 11.67	4.5%	2.0%	2.25%	$ 401.76	$ 429.51	$ 43.25	$ 1.00	$ 446.00	$ 473.76
North	SSI	Adult, 19+ Years	211,578	$ 640.82	2.8%	5.8%	1.06	1.12	0.5%	0.99	0.99	1.00	1.00	1.00	$ -	$ 673.41	$ 719.20	$ 10.89	4.5%	$ 11.67	4.5%	2.0%	2.25%	$ 746.28	$ 797.23	$ 173.18	$ 3.99	$ 923.45	$ 974.40
North	Family and Children	Newborn, 0-2 Months	32,218	$ 1,241.60	0.7%	4.1%	1.01	1.09	-4.4%	1.00	1.00	1.01	1.02	1.00	$ 46.33	$ 1,262.23	$ 1,352.97	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,408.49	$ 1,506.50	$ 572.83	$ 13.19	$ 1,994.51	$ 2,095.51
North	Family and Children	Newborn, 3-11 Months	80,049	$ 206.13	2.4%	5.8%	1.05	1.12	-4.9%	0.97	0.97	1.00	1.00	1.00	$ 0.21	$ 196.13	$ 213.33	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 229.23	$ 246.76	$ 32.15	$ 0.74	$ 262.11	$ 279.64
North	Family and Children	Child, 1-18 Years	1,586,038	$ 87.20	3.0%	6.2%	1.06	1.13	-1.1%	0.96	0.96	1.00	1.00	1.00	$ 0.05	$ 88.02	$ 94.43	$ 10.89	4.8%	$ 11.67	4.8%	2.0%	2.25%	$ 107.70	$ 115.53	$ 13.51	$ 0.31	$ 121.51	$ 129.34
North	Family and Children	Adult, 19+ Years	213,578	$ 219.68	2.8%	5.9%	1.06	1.13	2.2%	0.97	0.97	1.01	1.01	1.00	$ -	$ 231.41	$ 247.81	$ 10.89	4.9%	$ 11.67	5.0%	2.0%	2.25%	$ 265.00	$ 283.81	$ 59.76	$ 1.38	$ 326.14	$ 344.95
North	Breast and Cervical Cancer	BCC, All Ages Female	2,395	$ 1,282.45	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	1.08	1.08	1.00	$ -	$ 1,572.30	$ 1,704.28	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,737.63	$ 1,883.77	$ 575.28	$ 13.24	$ 2,326.15	$ 2,472.29
North	LaCHIP Affordable Plan	All Ages	6,545	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	1.00	1.00	1.00	$ -	$ 115.68	$ 124.73	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.73	$ 148.44	$ 16.73	$ 0.43	$ 156.89	$ 167.60
North	HCBS Waiver	18 & Under, Male and Female	3,944	$ 1,368.00	2.0%	4.6%	1.04	1.10	0.5%	0.94	0.97	1.00	1.00	1.00	$ -	$ 1,349.97	$ 1,469.57	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,495.85	$ 1,628.48	$ 56.24	$ 1.29	$ 1,553.38	$ 1,686.01
North	HCBS Waiver	19+ Years, Male and Female	16,992	$ 521.48	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	1.00	1.00	1.00	$ -	$ 480.29	$ 522.01	$ 10.89	4.3%	$ 11.67	4.3%	2.0%	2.25%	$ 534.32	$ 580.88	$ 81.16	$ 1.87	$ 617.35	$ 663.91
North	Chisholm Class Members	Chisholm, All Ages Male & Female	16,296	$ 772.12	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	1.00	1.00	1.00	$ -	$ 749.15	$ 821.56	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 833.39	$ 913.96	$ 68.62	$ 1.58	$ 903.59	$ 984.16
North	Maternity Kickpayment	Maternity Kickpayment, All Ages	8,077	$ 4,646.89	0.0%	2.0%	1.00	1.04	-0.2%	1.00	1.00	1.01	1.02	1.02	$ -	$ 4,780.66	$ 4,986.56	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 5,295.00	$ 5,522.56	$ 2,591.04	$ 59.64	$ 7,945.67	$ 8,173.23

Appendix C: Statewide Impact by COA from Removing the LaHIPP Program

	Base Data		LaHIPP Base Data		Base Data without LaHIPP		
COA Description	CY 2013 MMs or Deliveries	PMPM or Cost per Delivery	CY 2013 MMs or Deliveries	PMPM or Cost per Delivery	CY 2013 MMs or Deliveries	PMPM or Cost per Delivery	PMPM % Change
SSI	1,358,223	$604.69	6,217	$209.79	1,352,006	$606.51	0.30%
Family and Children	9,226,622	$134.62	15,795	$41.30	9,210,827	$134.78	0.12%
Breast and Cervical Cancer	12,936	$1,291.59	10	$173.89	12,926	$1,292.45	0.07%
LaCHIP Affordable Plan	38,711	$120.14	-	$-	38,711	$120.14	0.00%
HCBS Waiver	108,183	$704.37	4,133	$501.96	104,050	$712.42	1.14%
Chisholm Class Members	64,569	$774.94	1,021	$950.64	63,548	$772.12	-0.36%
Maternity Kick Payment	38,617	$4,755.22	36	$2,548.60	38,581	$4,757.30	0.04%
Total	**10,809,244**	**$221.53**	**27,176**	**$187.53**	**10,782,068**	**$221.62**	**0.04%**

Appendix D: Statewide Impact by Rating Category from Mandating the Voluntary Opt-Out Populations

COA Description	Rate Cell Description	MMs	Target PMPM	Voluntary Opt-out Impact	Revised Target PMPM
SSI	Newborn, 0-2 Months	902	$22,649.82	-8.21%	$20,790.32
SSI	Newborn, 3-11 Months	6,529	$4,681.23	-2.67%	$4,556.26
SSI	Child, 1-18 Years	401,215	$390.44	8.50%	$423.64
SSI	Adult, 19+ Years	943,360	$835.78	0.17%	$837.21
Family and Children	Newborn, 0-2 Months	157,338	$1,365.85	2.75%	$1,403.46
Family and Children	Newborn, 3-11 Months	382,745	$239.82	-0.38%	$238.92
Family and Children	Child, 1-18 Years	7,529,383	$116.71	0.20%	$116.94
Family and Children	Adult, 19+ Years	1,141,361	$284.46	0.68%	$286.39
Breast and Cervical Cancer	BCC, All Ages Female	12,926	$1,681.21	7.70%	$1,810.70
LaCHIP Affordable Plan	All Ages	38,711	$142.65	0.31%	$143.08
HCBS Waiver	18 & Under, Male and Female	23,469	$1,562.16	0.00%	$1,562.16
HCBS Waiver	19+ Years, Male and Female	80,581	$557.60	0.00%	$557.60
Chisholm Class Members	Chisholm, All Ages Male & Female	63,548	$873.67	0.00%	$873.67
Maternity Kick Payment	Maternity Kick Payment, All Ages	38,581	$5,489.32	1.58%	$5,575.99
Total		**10,782,068**	**$267.33**	**0.93%**	**$269.81**

Appendix E: Bayou Health Rate Certification Effective July 1, 2015 through January 31, 2016

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MERCER
MAKE TOMORROW, TODAY

Ms. Jen Steele
Medicaid Deputy Director
Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821

August 11, 2015

Subject: Louisiana Bayou Health Program – Full Risk-Bearing Managed Care Organization Rate Development and Actuarial Certification for the Period July 1, 2015 through January 31, 2016

Dear Ms. Steele:

The Louisiana Department of Health and Hospitals (DHH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for the State of Louisiana's Bayou Health program for the period of July 1, 2015 through January 31, 2016. This certification includes the addition of Full Medicaid Pricing (FMP) for ambulance and hospital-based physician services, and replaces the capitation rate ranges certified in the January 31, 2015 letter for the period February 1, 2015 through January 31, 2016.

The Bayou Health program began February 1, 2012, and operated under two separate managed care paradigms for the first three years of the program. The Bayou Health Prepaid program operated under an at-risk capitated arrangement, and the Shared Savings program was an enhanced Primary Care Case Management (ePCCM) program. Effective February 1, 2015, Bayou Health will begin operating as an at-risk capitated program only.

This letter presents an overview of the methodology used in Mercer's managed care rate development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS). This rate development process used Medicaid fee-for-service (FFS) medical and pharmacy claims, Bayou Health Shared Savings claims experience, and Bayou Health Prepaid encounter data. It resulted in the development of a range of actuarially sound rates for each rate cell. The capitation rate ranges are summarized in Appendix A and represent payment in full for the covered services and CMS Consultation guide is included in Appendix N.

Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government mandated assessments, fees, and taxes, and the cost of capital. Note: Please see pages 8-9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.

Rate Methodology

Overview

Capitation rate ranges for the Bayou Health program were developed in accordance with rate-setting guidelines established by CMS. For rate range development for the Bayou Health managed care organizations (MCOs), Mercer used calendar year 2013 (CY13) Medicaid FFS medical and pharmacy claims, Bayou Health Shared Savings claims experience, and Bayou Health Prepaid encounter data. Restrictions were applied to the enrollment and claims data so that it was appropriate for the populations and benefit package defined in the contract.

Mercer reviewed the data provided by DHH and the Prepaid and Shared Savings plans for consistency and reasonableness and determined that the data are appropriate for the purpose of setting capitation rates for the MCO program. The data certification shown in Appendix L has been provided by DHH, and its purpose is to certify the accuracy, completeness, and consistency of the base data.

Adjustments were made to the selected base data to match the covered populations and Bayou Health benefit packages for rating year 2015 (RY15). Additional adjustments were then applied to the base data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data.
- Provision for incurred-but-not-reported (IBNR) claims.
- Financial adjustments to encounter data for under-reporting.
- Trend factors to forecast the expenditures and utilization to the contract period.
- Changes in benefits covered by managed care.
- Addition of new populations to the Bayou Health program.
- Opportunities for managed care efficiencies.
- Administration and underwriting profit/risk/contingency loading.

In addition to these adjustments, DHH takes two additional steps in the matching of payment to risk:

- Application of maternity supplemental (kick) payments.
- Application of risk-adjusted regional rates.

The resulting rate ranges for each individual rate cell were net of Graduate Medical Education (GME) payments to teaching hospitals provided in the Louisiana Medicaid State Plan. Appendix M shows the full rate development from the base data as shown in the data book released by the State, dated January 31, 2015, and applies all the rate setting adjustments as described in this letter.

Bayou Health Populations

Covered Populations

In general, the Bayou Health program includes individuals classified as Supplemental Security Income (SSI), Family & Children, Breast and Cervical Cancer (BCC), and LaCHIP Affordable Plan (LAP) as mandatory or voluntary opt-out populations. Voluntary opt-in populations include Home- and Community-Based Services (HCBS) waiver participants and Chisholm Class Members (CCM).

Chisholm Class Members

Effective February 1, 2015, members of Louisiana's Chisholm class will be permitted to participate in Bayou Health on a voluntary opt-in basis. Previously, membership in the Chisholm class would make a recipient ineligible for Bayou Health.

Chisholm refers to a class action lawsuit (*Chisholm v. Hood*) filed in 1997. CCMs are defined as all current and future recipients of Medicaid in the State of Louisiana, under age 21, who are now or will in the future be placed on the Office of Citizens with Developmental Disabilities' Request for Services Registry.

LaHIPP Population

Effective February 1, 2015, Bayou Health will include individuals covered by the Louisiana's Health Insurance Premium Payment (LaHIPP) Program. This program pays for some or all of the health insurance premiums for an enrollee if they have insurance available through someone in the family and are enrolled in Medicaid. The program also covers out of pocket expenses incurred by the enrollee (Medicaid is the secondary payer).

Premiums will continue to be paid by DHH, but out of pocket expenses incurred by the enrollee will be the responsibility of the MCO. LaHIPP is not a category of eligibility. Enrollees in this program are eligible under the other categories of aid (COA) and their experiences are included in the applicable COA and Rate Cell combination for purposes of developing the capitation rate range.

Excluded Populations

The following individuals are excluded from participation in the Bayou Health program:

- Medicare-Medicaid Dual Eligible Beneficiaries.
- Qualified Medicare Beneficiaries (QMB) (only where State only pays Medicare premiums).
- Specified Low-income Medicare Beneficiaries (SLMB) (where State only pays Medicare premiums).
- Medically Needy Spend-Down Individuals.
- Individuals residing in Long-term Care Facilities (Nursing Home, Intermediate Care Facility/Developmentally Disabled (ICF/DD)).
- Individuals enrolled in the Program for All-inclusive Care for the Elderly (PACE).
- Individuals only eligible for Family Planning services.
- Individuals enrolled in the Greater New Orleans Community Health Connection (GNOCHC) Demonstration waiver.

Appendix B encompasses a comprehensive list of Bayou Health's covered and excluded populations.

Rate Category Groupings

Rates will vary by the major categories of eligibility. Furthermore, where appropriate, the rates within a particular category of eligibility are subdivided into different age bands to reflect differences in risk due to age. In addition, due to the high cost associated with pregnancies, DHH will pay a maternity kick payment to the MCOs for each delivery that takes place. Table 1 shows a list of the different rate cells for each eligibility category including the maternity kick payments.

Table 1: Rate Category Groupings

COA Description	Rate Cell Description
SSI	Newborns, 0-2 Months of Age
	Newborns, 3-11 Months of Age
	Child, 1-18 Years of Age
	Adult, 19+ Years of Age

COA Description	Rate Cell Description
Family & Children	Newborns, 0-2 Months of Age
	Newborns, 3-11 Months of Age
	Child, 1-18 Years of Age
	Adult, 19+ Years of Age
BCC	BCC, All Ages
LAP	LAP, All Ages
HCBS	Child, 0-18 Years of Age
	Adult, 19+ Years of Age
CCM	CCM, All Ages
Maternity Kick Payment	Maternity Kick Payment
Early Elective Delivery Kick Payment	EED Kick Payment

Region Groupings

For rating purposes, Louisiana has been split into four different regions. Table 2 lists the associated parishes for each of the four regions.

Table 2: Region Groupings

Region Description	Associated Parishes (Counties)
Gulf	Assumption, Jefferson, Lafourche, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John, St. Mary, and Terrebonne
Capital	Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, St. Tammany, Tangipahoa, Washington, West Baton Rouge, and West Feliciana
South Central	Acadia, Allen, Avoyelles, Beauregard, Calcasieu, Cameron, Catahoula, Concordia, Evangeline, Grant, Iberia, Jefferson Davis, Lafayette, Lasalle, Rapides, St. Landry, St. Martin, Vermilion, Vernon, and Winn
North	Bienville, Bossier, Caddo, Caldwell, Claiborne, DeSoto, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Natchitoches, Ouachita, Red River, Richland, Sabine, Tensas, Union, Webster, and West Carroll

Bayou Health Services

Covered Services

Appendix C lists the services that the Bayou Health MCOs must provide. The MCOs also have the ability to develop creative and innovative solutions to care for their members (i.e., provide other cost-effective alternative services) as long as the contractually-required Medicaid services are covered. Costs of alternative services are expected to be funded through savings on the contractually-required services for which these services are a cost-effective substitute.

New Services

Effective February 1, 2015, DHH has decided to incorporate services covered historically by FFS in the Bayou Health program. The following services were previously excluded from the Bayou Health program and now are included:

- Hospice services.
- Personal care services for ages 0-20.
- Non-Emergent Medical Transportation (NEMT) services (non-covered services).

Hospice and Personal Care services claims are all captured in Legacy Medicaid/FFS claims. Therefore, the impact of Hospice and Personal Care services can be calculated by referencing Attachment 1 of the Bayou Health Data Book released by the State, dated January 31, 2015.

Additionally, NEMT will be the responsibility of the Bayou Health MCO, even if the recipient is being transported to a Medicaid-covered service that is not a Bayou Health-covered service. Previously, Prepaid enrollee NEMT to Bayou Health excluded services would have been FFS. Mercer has created an adjustment for the Prepaid NEMT Encounters to account for this addition and the impact can be found in Appendix D. This additional service cannot be distinguished for Shared Savings/FFS claims because all NEMT services for these populations were covered under FFS. The impact of the additional services are fully captured for the Shared Savings and FFS populations in the NEMT experience on Attachment 1 of the Bayou Health Data Book released by the State, dated January 31, 2015.

Behavioral Health Mixed Services Protocol

In the Request for Proposals (RFP) issued by the State for the Bayou Health program to be effective February 1, 2015, Behavioral Health services are divided into two levels: basic and specialized. Basic Behavioral Health services will be the responsibility of Bayou Health MCOs. Basic services include:

- General hospital inpatient services, including acute detoxification.

- General hospital emergency room (ER) services, including acute detoxification.
- Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) encounters that do not include any service by a specialized behavioral health professional.
- Professional services, excluding services provided by specialized behavioral health professionals.

Specialized Behavioral Health services will be identified primarily based on provider type. Any service provided by behavioral health specialists, as well as behavioral health facilities are considered Specialized Behavioral Health. Appendix E summarizes the adjustment that was applied to each Basic Behavioral Health service category.

Behavioral health pharmacy costs will remain the responsibility of the Bayou Health plans, regardless of the prescribing doctor's specialty. Therefore, no adjustment to pharmacy costs are required.

Excluded Services

Bayou Health MCOs are not responsible for providing acute care services and other Medicaid services not identified in Appendix C, including the following services:

- Applied Behavioral Analysis.
- Dental services with the exception of Early and Periodic Screening & Diagnostic Treatment (EPSDT) varnishes provided in a primary care setting.
- ICF/DD services.
- Personal Care services for those ages 21 and older.
- Nursing Facility services.
- School-based Individualized Education Plan services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures including school nurses.
- HCBS waiver services.
- Specialized Behavioral Health.
- Targeted Case Management services.
- Services provided through DHH's Early-Steps Program.

Data Adjustments

IBNR Claims

Completion factors were developed to incorporate consideration for any outstanding claims liability. The paid through date for the IBNR factor development is February 28, 2014 (2 months of runout).

To establish the completion factors for the Shared Savings/Legacy Medicaid FFS data, claims were grouped into three COA and seven main completion service categories. All remaining service categories were grouped into the other service category. Completion category mapping is provided in Appendix C. Note that the BCC and CCM populations utilized SSI completion factors and the LAP population utilized Family & Children completion factors, as these populations are expected to exhibit similar completion patterns. Appendix F-1 summarizes the completion factors adjustment that was applied to the Shared Savings/Legacy Medicaid FFS data.

Encounter claim completion factors, developed separately for each Prepaid plan, were compared to completion factors provided by the Prepaid plan actuaries and summarized by completion category of service. Appendix F-2 summarizes the completion factors adjustment that was applied to the Prepaid encounter data. Mercer determined that Prepaid encounter claims categorized as "Prescribed Drugs" for all populations and "Other" for the Family & Children and LAP populations only, is deemed to be complete, thus a 0% IBNR adjustment is applied. All other IBNR adjustments shown as 0.0% in Appendices F-1 and F-2 are due to rounding.

Under-Reporting

Under-reporting adjustments were developed by comparing encounter data from the Medicaid management information system (MMIS) to financial information provided by the Prepaid plans. This adjustment was computed and applied on a plan basis resulting in an overall adjustment of 3.6%. Note this adjustment does not apply to the Shared Savings claims nor Legacy Medicaid/FFS data. This adjustment is included in the data book released by the State, dated January 31, 2015.

Third-Party Liabilities

All claims are reported net of third party liability, therefore no adjustment is required.

Fraud and Abuse Recoveries

DHH provided data related to fraud and abuse recoveries on the Shared Savings and Legacy FFS. The total adjustment applied was -0.1%. Prepaid plans included fraud and abuse recoveries in their financial reports. These recoveries were included in the development of the under-reporting adjustment.

Co-Payments

Co-pays are only applicable to prescription drugs. Pharmacy claims are reported net of any co-payments so no additional adjustment is necessary.

Disproportionate Share Hospital Payments

Disproportionate share hospital (DSH) payments are made outside of the MMIS system and have not been included in the capitation rates.

Fee Schedule Adjustments

Fee Changes

These capitation rates reflect changes made by DHH to the fee schedules used in the FFS program. The first of these changes, effective February 1, 2013, was a 1% cut in fees paid to non-rural, non-state hospitals. This 1% cut also applied to physician services, except for procedure codes affected by Section 1202 of the Affordable Care Act (ACA), when performed by a physician eligible for the enhanced payment rate. Fee changes also include estimation of cost settlements and reflect the most up to date cost settlement percentages for each facility. For most non-rural facilities, the cost settlement percentage is 66.46%; however, some facilities are settled at different amounts. Rural facilities are cost settled at 110%. The Fee Schedule adjustments for Prepaid and Shared Savings/FFS are different primarily because the Shared Savings adjustment includes the impact of removing GME costs. A detailed breakdown of the fee changes by fee type (Inpatient, Outpatient, and Physician) is provided in Tables 3 through 7.

Table 3: Total Inpatient Fee Change Impact

Program	Historical Cost	Adjusted Cost	Difference	% Change
FFS/Shared	$241,618,333	$231,450,795	$(10,167,538)	-4.2%
Encounter	$242,871,303	$245,575,202	$2,703,899	1.1%
Total:	**$484,489,636**	**$477,025,997**	**$(7,463,639)**	**-1.5%**

Table 4: Total Outpatient Fee Change Impact

Program	Historical Cost	Adjusted Cost	Difference	% Change
FFS/Shared	$144,561,703	$145,753,679	$1,191,976	0.8%
Encounter	$163,170,757	$178,679,937	$15,509,181	9.5%
Total:	**$307,732,460**	**$324,433,616**	**$16,701,157**	**5.4%**

Table 5: Total Physician Fee Change Impact (does not reflect reduction of Affordable Care Act {ACA}–enhanced payments)

Program	Historical Cost	Adjusted Cost	Difference	% Change
FFS/Shared	$317,853,687	$317,707,582	$ (146,105)	0.0%
Encounter	$262,096,884	$261,889,654	$ (207,147)	-0.1%

Program	Historical Cost	Adjusted Cost	Difference	% Change
Total:	**$579,950,571**	**$579,597,236**	**$(353,252)**	**-0.1%**

Table 6: Total Fee Change Impact for Other Claims (includes pharmacy, lab/radiology, FQHC/RHC, and other services)

Program	Historical Cost	Adjusted Cost	Difference	% Change
FFS/Shared	$516,113,110	$516,113,110	$(0)	0.0%
Encounter	$472,643,308	$472,643,391	$(0)	0.0%
Total:	**$988,756,418**	**$988,756,501**	**$(0)**	**0.0%**

Table 7: Total Fee Change Impact for All Claims (excluding ACA Primary Care Providers {PCP} Enhanced Payments)

Program	Historical Cost	Adjusted Cost	Difference	% Change
FFS/Shared	$1,220,146,833	$1,211,025,166	$ (9,121,667)	-0.7%
Encounter	$1,140,782,252	$1,158,788,184	$18,005,932	1.6%
Total:	**$2,360,929,085**	**$2,369,813,350**	**$8,884,266**	**0.4%**

Hospital Privatization

During 2013, nine state hospitals were affected by privatization, with seven privatizing and two closing. They are listed below:

Privatizing

- E.A. Conway
- Huey P. Long
- Leonard J. Chabert
- LSU Shreveport
- Medical Center of LA – New Orleans
- University Medical Center Lafayette
- Washington St. Tammany Regional Medical Center

Closing

- W.O. Moss Regional Medical Center
- Earl K. Long

As a result of this privatization, they are no longer paid for services based on the state hospital fee schedule, but rather on the non-state, non-rural fee schedule. Similarly, reimbursement for

cost-based services for these hospitals is now based on the 66.46% cost settlement percentage for non-state, non-rural hospitals, rather than the 90% cost-settlement percentage applicable to state hospitals. The utilization in the facilities that are closing was assumed to be absorbed by other facilities in the regions and claims were adjusted accordingly.

For Shared Savings/FFS inpatient hospital claims, the inpatient settlements received as a state hospital were removed from the rate calculation since they are not paid to non-state hospitals. The claims were then re-priced using the July 1, 2014 per diems provided by DHH. For the two hospitals that are closing, W.O. Moss Regional Medical Center and Earl K. Long, DHH provided Mercer guidance on which hospitals were expected to absorb their utilization. W.O. Moss Regional Medical Center will be absorbed by Lake Charles Memorial and Earl K. Long will be absorbed by Our Lady of the Lake. For Encounter claims, the ratio between historical per diems and current per diems were used for claims re-pricing.

For outpatient hospital claims, the historical claims were adjusted for differences between the state hospital fee schedule and the general hospital fee schedule. Outpatient cost-based services were re-priced based on cost-to-charge ratios (CCRs) provided by DHH, which reflect costs associated with the Prepaid plans claims. The overall claims dollar impact of this adjustment is shown in Tables 8 and 9.

Table 8: Inpatient Impact of LSU Hospital Privatization*

Program	Historical Cost	Adjusted Cost	Difference	% Change
FFS/Shared	$15,196,381	$13,793,540	$ (1,402,840)	-9.2%
Encounter	$22,826,670	$23,165,474	$338,804	1.5%
Total:	**$38,023,050**	**$36,959,014**	**$(1,064,036)**	**-2.8%**

* Change in FFS/Shared includes removal of GME costs.

Table 9: Outpatient Impact of LSU Hospital Privatization

Program	Historical Cost	Adjusted Cost	Difference	% Change
FFS/Shared	$12,910,923	$10,663,597	$ (2,247,325)	-17.4%
Encounter	$25,564,646	$23,390,499	$ (2,174,147)	-8.5%
Total:	**$38,475,568**	**$34,054,096**	**$ (4,421,472)**	**-11.5%**

Table 10 summarizes the overall fee schedule adjustment by COA that was applied to the Prepaid encounter and Shared Savings/FFS claims data.

Table 10: Fee Schedule Adjustment

Prepaid Fee Schedule Adjustment	
COA Description	**Rate Impact**
SSI	1.5%
Family & Children	1.7%
BCC	0.6%
LAP	2.3%
HCBS	0.0%
CCM	0.0%
Maternity Kick Payment	1.7%
Early Elective Delivery (EED) Kick Payment	1.7%
Total	**1.6%**

Shared Savings/FFS Fee Schedule Adjustment	
COA Description	**Rate Impact**
SSI	-1.4%
Family & Children	-0.8%
BCC	-0.3%
LAP	0.8%
HCBS	0.7%
CCM	0.7%
Maternity Kick Payment	-0.6%
EED Kick Payment	-0.6%
Total	**-0.8%**

Full Medicaid Pricing

Beginning in April 2014, DHH implemented a series of program changes to ensure consistent pricing in the Medicaid program for hospital services, including inpatient hospital, outpatient hospital, hospital-based physician, and ambulance services. This change required the use of FMP in the calculation of per member per month (PMPM) payments to MCOs. DHH expects that this rate increase will lead to increased payments to those providers contracting with the MCOs to maintain and increase access to inpatient hospital, outpatient hospital, hospital-based physician, and ambulance services to the enrolled Medicaid populations. Mercer and the State reviewed the aggregate funding levels for these services between the base period and the contract period and determined that an addition to the historical data was necessary in order to ensure the capitation rate ranges reflect adequate statewide pricing levels. Separate adjustments were made to each of the four services to capture the full impact of statewide funding.

FMP adjustments were implemented for inpatient and outpatient services effective April 2014. Physician and ambulance FMP adjustments are effective July 2015.

Inpatient Hospital Services

For the Prepaid encounter and the Shared Savings/FFS data, inpatient service costs were increased by 65.1% and 59.9%, respectively. Mercer relied upon an analysis of Medicare diagnosis related group equivalent pricing of Medicaid services provided by DHH. For the Prepaid encounter, this analysis was done for the population served by the three Prepaid plans in aggregate. A separate analysis was done for the Shared Savings/FFS population. The

analyses relied upon encounter and Shared Savings/FFS data incurred from July 2012 to June 2013 and compared the adjusted Medicare payments to the Medicaid payment on a per discharge basis at each hospital. The Medicare payments were adjusted to reflect the treatment of Medicaid patients and reflected the state fiscal year 2014 (SFY14) reimbursement schedule. The SFY13 Medicaid payments were adjusted to reflect fee changes effective in SFY14 and payments made outside of the claims system (outlier payments). Mercer applied the ratio between the two payments to the base data at a hospital-specific level.

Outpatient Hospital Services

For the Prepaid encounter and the Shared Savings/FFS data, outpatient service costs were increased by 52.7% and 56.3%, respectively. The outpatient increase was developed according to the State Plan using cost to charge ratios, which used reported costs and billed charges by hospital. The cost to charge ratios supplied by DHH were reported on hospital fiscal year bases, which varied by hospital from 2/28/2013 to 12/31/2013. The billed charges originated from the Prepaid encounter and the Shared Savings/FFS base data. Mercer applied the ratio between the base data and cost estimates at a hospital level to develop the outpatient component of the FMP.

Hospital-Based Physician Services

For Prepaid encounter and Shared Savings/FFS experience, hospital-based physician services meeting the State Plan's criteria for FMP were increased by 83.2% and 105.6%, respectively. Mercer performed an analysis of hospital-based physician services provided at participating facilities by participating physicians compared to the average commercial rates for the same services according to the State Plan methodology. The average commercial rates are maintained by DHH and updated periodically. For state-owned or operated entities, average commercial rate factors are updated annually. DHH provided state-owned conversion factors for calendar year 2015. For non-state owned or operated entities, the average commercial rate factors are indexed to Medicare rates and updated every 3 years. DHH provided the latest available non-state factors, which were last updated as recently as April 2013. The scheduled update of these factors is currently underway and expected to be completed by the end of calendar year 2015.

Ambulance Services

For Prepaid encounter and Shared Savings/FFS experience, ambulance services meeting the State Plan's criteria for FMP were increased by 49.2% and 44.4%, respectively. Mercer performed an analysis of ambulance services utilized by Medicaid enrollees according to the State Plan using Medicare fee schedules and average commercial rates as a percentage of Medicare. Ambulance providers were classified as either Large Urban Governmentals (LUG) or non-LUGs. LUGs have historically received 100% of the gap between average commercial rate

and the Medicaid fee schedule while non-LUGs have historically received 17.35% of the gap. Mercer developed increases using these assumed funding levels. Average commercial rates as a percentage of Medicare were provided by DHH and were determined based on SFY12 claims. According to the State Plan, average commercial rates are updated every three years. The next update is anticipated to occur before the end of calendar year 2015.

ACA PCP

Under Section 1202 of the ACA, state Medicaid programs were required to increase payments to PCPs in 2013 and 2014. This requirement expires on December 31, 2014. As a result, 2013 Bayou Health encounter and FFS claims were adjusted to reflect the decrease in PCP payment rates between 2013 and 2015. The reduction, applied at the COA level is based on adjusting the provider fee schedule from the enhanced ACA rate to the Medicaid rate set by DHH. For the Prepaid Encounters, the enhanced payment data was under-reported at the time Mercer requested data as Prepaid health plans were still reprocessing some of the enhanced claims. Discussions were held with each of the existing Prepaid health plans to make sure that Mercer was identifying these claims appropriately. For detail on the adjustment applied to these claims, see Appendices G1-G2.

Table 11 summarizes the overall adjustment by COA that was applied to the Prepaid encounter and Shared Savings/FFS claims data.

Table 11: ACA PCP Adjustment

Prepaid Encounter ACA PCP Carve-Out	
COA Description	**Rate Impact**
SSI	-1.3%
Family & Children	-3.9%
BCC	-0.7%
LAP	-4.3%
HCBS	0.0%
CCM	0.0%
Maternity Kick Payment	0.0%
EED Kick Payment	0.0%
Total	**-2.4%**

Shared Savings/FFS ACA PCP Carve-Out	
COA Description	**Rate Impact**
SSI	-1.4%
Family & Children	-4.7%
BCC	-0.7%
LAP	-5.1%
HCBS	-0.7%
CCM	-0.9%
Maternity Kick Payment	0.0%
EED Kick Payment	0.0%
Total	**-3.1%**

Program Changes

The following adjustments were developed for known program changes as of December 31, 2014.

Act 312

Effective January 1, 2014, Act 312 requires that when medications are restricted for use by an MCO using a step therapy or fail first protocol, the prescribing physician shall be provided with, and have access to, a clear and convenient process to expeditiously request an override of such restrictions from the MCO. The MCO is required to grant the override under certain conditions. Mercer reviewed this new requirement and estimated the impact of this change to be an increase of approximately 3% of pharmacy costs.

EED

Beginning February 2015, facility and delivering physician costs for EEDs will not be covered under the Bayou Health program. MCOs receive an EED Kick Payment for deliveries that occur prior to 39 weeks for reasons that are not medically indicated in the Louisiana Electronic Event Registration System (LEERS) maintained by the Office of Public Health/Vital Records. Deliveries that occur prior to 39 weeks for reasons that are medically indicated in LEERS will receive the Maternity Kick Payment. Mercer identified the average facility and delivering physician costs included in the Maternity Kick Payment by region and removed those costs to create the EED Kick Payment. Table 12 shows the EED adjustment and reduction amount by region in the low and high scenarios. The resulting EED Kick Payment is equal to the Maternity Kick Payment plus the reduction amount in Table 12 and is shown in Appendix A.

Table 12: Early Elective Delivery Rate Reduction

Early Elective Delivery Rate Reduction			
Region Description	**Reduction (%)**	**Reduction – Low Cost per Delivery**	**Reduction – High Cost per Delivery**
Gulf	34.3	$(3,703.28)	$(3,858.92)
Capital	43.3	$(2,832.60)	$(2,951.64)
South Central	41.2	$(2,914.86)	$(3,037.36)
North	38.0	$(3,164.81)	$(3,297.82)
Total	**38.9**	**$(3,167.07)**	**$(3,300.16)**

Retro-Active Eligibility Adjustment

Beginning in February 2015 members granted retro-active eligibility will be capitated retro-actively, based on their eligibility for Bayou Health, for up to 12 months prior to enrollment in an MCO. The MCO selected by these members will then receive one capitation payment per month of retro-active enrollment, and will be liable for all claims incurred during this retro-active

eligibility period. Mercer developed an adjustment factor to apply to the base data in the capitation rate development. Mercer did not apply any savings adjustments to the retro-active period claims in the development of these factors because the MCO will have no ability to manage utilization during the retro-active period.

The retro-active eligibility adjustment was developed as an increase to the capitation rates set for all members, meaning that the capitation payment is higher than otherwise required on non-retro-active member months (MMs). Retro-active enrollment in any given rate cell will generate the same capitation payment per month to the MCO as any other enrollee in that same rate cell. The factors were developed at a rate cell level on a statewide basis (i.e., all regions used the same factors). The calculation relied upon retro-active claims PMPM, unique enrollee counts, and the average duration to develop the expected increase to Bayou Health claims.

Mercer reviewed the average duration of enrollees who were retro-actively enrolled during 2013 using data from July 2012 to December 2013. From August 2012 to May 2013, DHH performed additional enrollment review processes, which caused the average duration of retro-active enrollment to increase significantly over normal levels. After May 2013, DHH returned to normal enrollment review processes and the average duration of enrollment decreased significantly. DHH confirmed that they do not foresee a need for implementing this additional review process in the future and expect the enrollment patterns to be consistent with those observed in the second half of 2013. Mercer relied upon July through December 2013 enrollment lags to develop an average durational assumption by COA and is shown in Appendix H-1.

In some rate cells, the retro-active claims PMPM was below the base data claims PMPM. This generated an adjustment factor less than 1.0. The decision was made to not use a factor less than 1.0 on any rate cell. These implied factors (calculated) and final factors (used) are supplied in Appendix H-2.

Table 13 summarizes the overall adjustment by rate cell for retro-active eligibility.

Table 13: Retro-Active Eligibility Adjustment

Retro-Active Eligibility Adjustment		
COA Description	**Rate Cell Description**	**Adjustment (%)**
SSI	0-2 Months	0.0
SSI	3-11 Months	0.0
SSI	Child 1-18	0.0
SSI	Adult 19+	0.5

Retro-Active Eligibility Adjustment		
Family & Children	0-2 Months	0.0
Family & Children	3-11 Months	0.0
Family & Children	Child 1-18	0.0
Family & Children	Adult 19+	1.7
BCC	BCC, All Ages	7.5
LAP	LAP, All Ages	0.0
HCBS	Child 0-18	0.0
HCBS	Adult 19+	0.0
CCM	CCM, All Ages	0.0
Maternity Kick Payment	Maternity Kick Payment	0.0
EED Kick Payment	EED Kick Payment	0.0
Total		**0.4**[1]

Rating Adjustments

Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the cost of providing health care services in a future period. Mercer studied historical cost and utilization data for each of the three data sources incorporated in the capitation rates: Prepaid encounters, Shared Savings, and FFS. Trends were selected based on Louisiana experience, as well as national trend information.

Due to the relatively short history of managed care in Louisiana, as well as the bifurcated nature of the current Bayou Health program, Mercer's trend studies using Louisiana-specific data were limited in scope. Based on these studies, it was determined that the use of a single trend rate for all three data sources was best. In selecting these trends, there was reliance on national Medicaid trends as well as Louisiana-specific data.

Trends, delineated by utilization, unit cost, PMPM, and by population are shown in Appendices I1-I3.

[1] Revised from 0.7 to 0.4 due to a typographical error in the certification letter dated January 31, 2015.

PDHC Adjustments

The number of PDHC providers has grown throughout the State during 2014. In areas where centers have begun operation, there has been an increase in the total costs of enrollees whom utilize these services indicating that this population may have been historically under served by alternative services.

Due to the uneven distribution of PDHC providers in the State, each regional group has different proportions of members utilizing PDHC services. Mercer developed projected utilization per 1,000 MMs of PDHC-eligible members for each region based on the number of new facilities that will be operating during the rating period in that region. PDHC eligible members were simply defined as any enrollee in a child rate cell (SSI ages 0-18, Family & Children ages 0-18, LA CHIP, HCBS 0-19, and Chisholm). Any enrollees under the age of 21 are eligible for PDHC services, however, the data showed that virtually all users of this service were under the age of 19 and therefore no adjustment to the adult rate cells was warranted. Table 14 shows the summary of PDHC providers and estimated PDHC users by regions. To develop the estimated PDHC service cost, Mercer developed the PDHC cost per PDHC user per month. The estimation is based on the regional experience of PDHC providers during CY13. In the Gulf region, where there is little experience due to a lack of providers, an average statewide cost was used. The summary of estimated PDHC service cost per PDHC user per month and the estimated PDHC service cost due to the increased number of providers are shown in Table 15.

Table 14: Projected Number of PDHC Users

Projected Number of PDHC Users						
Region	**Existing Number of Providers[2]**	**Projected Number of Providers in Operation**	**Total PDHC Eligible MMs**	**Projected PDHC Users Per 1,000 MMs**	**Current Number of PDHC Users**	**Projected PDHC Users**
Gulf	1	2	2,357,462	0.076	5	179
Capital	5	6	2,121,456	0.481	901	1,020
South Central	1	3	2,315,409	0.173	176	401
North	3	5	1,829,787	0.421	228	770

[2] Based on December 2013 Experience.

Table 15: PDHC Adjustment

	PDHC Adjustment					
	PDHC Cost per Month[3]	**Projected Number of PDHC Users**	**Estimated Total PDHC Cost**	**PDHC Expenses in Base Data**	**Total Expenses for Category of Service "Other"**	**Program Change Factors for Category of Service "Other"**
	(A)	**(B)**	**(C)= (A) * (B)**	**(D)**	**(E)**	**(F)= ((C)-(D)) / (E)**
Gulf	$4,260.64	179	$764,123	$12,737	$681,410	110.3%
Capital	$4,559.67	1,020	$4,651,437	$4,249,502	$4,638,594	8.7%
South Central	$3,664.74	401	$1,470,474	$688,524	$2,213,236	35.3%
North	$4,557.50	770	$3,507,473	$1,099,006	$1,578,008	152.6%

Managed Care Adjustments

For those populations and services that had previously been excluded from Bayou Health, Mercer adjusted the capitation rates to reflect areas for managed care efficiency. Managed Care is able to generate savings by:

- Encouraging the use of preventive services so that acute conditions are not exacerbated to the point that requires a visit to the ER or hospitalization.
- Using alternatives to the ER for conditions that are non-emergent in nature.
- Increasing access and providing member education.
- Minimizing duplication of services.
- Hospital discharge planning to ensure a smooth transition from facility-based care to community resources and minimize readmissions.

Statewide managed care savings factors were applied to the HCBS and Chisholm class COAs. Additionally, durable medical equipment (DME) and NEMT costs for Shared Savings enrollees were adjusted as part of this rate setting, as these services were excluded from Bayou Health Shared Savings. Appendices J1-J2 summarizes the managed care savings adjustments that were applied to the Shared Savings/Legacy Medicaid FFS data.

[3] Based on PDHC users' CY13 experience. Gulf region does not have enough experience and the projection is based on the average of the other three regions' projections.

Shared Savings Rx claims

Under the Bayou Health Shared Savings program, plans had limited ability to manage prescription drug costs. In order to use the Shared Savings experience to set capitated rates, adjustments were needed to account for generic dispense rate (GDR) differences between the Prepaid and Shared Savings experience. For the Prepaid program, GDR was approximately 84%, compared to approximately 77% for Shared Savings and FFS. Mercer assumed the change in GDR would be zero the first month the rates are in effect, increasing evenly over the next three months until an 84% GDR is achieved in May 2015. Per section 6.33 of the Bayou Health RFP, MCOs are required to allow members 60 days to transition medications after enrollment in the MCO. The extra 30 days is to allow time for the MCO to identify the member for such a transition. This adjustment is a downward adjustment to the Shared Savings claims data. Mercer's analyzed Shared Savings prescription drug experience and compared it to the spending on similar therapeutic classes of drugs in the Prepaid program. Mercer determined that achieving the same GDR levels would result in savings of 13%-16%. After adjusting for phase-in, the savings for rating year 2015 is 11%-13%. Tables 16 and 17 detail the savings breakdown by COA, both without and with the phase in period.

Table 16: GDR Savings Adjustment – Without Phase In Period

Annualized Savings from Improvement in GDR						
Category of Service Description	**SSI**	**Family & Children***	**BCC**	**LAP**	**HCBS Waiver* (FFS)**	**Total**
	(%)	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**
Low Savings	4.2	21.2	0.0	29.9	6.7	13.3
High Savings	7.2	24.2	2.1	32.9	9.7	16.3

Table 17: GDR Savings Adjustment – With Phase-In Period

Savings from Improvement in GDR (w/Phase-in)						
Category of Service Description	**SSI**	**Family & Children***	**BCC**	**LAP**	**HCBS Waiver* (FFS)**	**Total**
	(%)	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**
Low Savings	3.5	17.7	0.0	24.9	5.6	11.1
High Savings	6.0	20.2	1.8	27.4	8.1	13.6

* In the above two tables, the HCBS waiver aid category is inclusive of CCMs.

Rx Rebates

FFS and Shared Savings claims were reduced 1.5% for Rx rebates collected by the MCO. This factor was developed using Prepaid plans experience as reported in financial statements provided to DHH. Prepaid Encounters were taken as net of drug rebates, so no adjustment was necessary.

Outliers

As part of the State Plan, inpatient hospitals receive an additional payment for high-cost stays for children under six, called outliers. These payments are for inpatient stays with a total cost to the hospital in excess of $150,000, where the cost is determined based on the hospital's Neonatal Intensive Care Unit (NICU) or Pediatric Intensive Care Unit (PICU)-specific cost-to-charge ratio (CCR). DHH makes payments to a maximum of $10 million, annually. As payment of outlier liability is the responsibility of Bayou Health MCOs, this additional $10 million was built into the rates based on the distribution by rate cell observed in SFY11 and SFY12. The most recent outlier information received was for SFY13 payments, which Mercer analyzed and determined the claims payment distribution to be an anomaly compared to SFY11 and SFY12 experience that was more consistently distributed. Thus, Mercer came to the decision that utilizing data from SFY11 and SFY12 would provide a more representative basis for the future claims distribution patterns. Outliers added an average cost of $0.93 PMPM to the base data used in rate setting. Table 18 details the impact of outliers on the rates by rate cell.

Table 18: Outliers Adjustment

Outlier claims to be added into Bayou Health from $10 million pool				
COA Description	**Rate Cell Description**	**CY13 MMs**	**Outlier PMPM**	**Outliers Total Adjustment**
SSI	Newborn, 0-2 Months	915	$945.10	$864,764
SSI	Newborn, 3-11 Months	6,651	$63.79	$424,266
SSI	Child, 1-18 Years	403,901	$2.39	$965,701
Family & Children	Newborn, 0-2 Months	157,724	$46.33	$7,307,552
Family & Children	Newborn, 3-11 Months	383,886	$0.21	$82,083
Family & Children	Child, 1-18 Years	7,542,938	$0.05	$355,635
Total*		**10,809,244**	**$0.93**	**$10,000,000**

* Totals includes MMs for all populations in Bayou Health.

GME

Mercer removed GME amounts in the FFS and Shared Savings data to be consistent with DHH's intention to continue paying GME amounts directly to the teaching hospitals. The

adjustment to remove GME from FFS and Shared Savings is part of the fee adjustment process for hospital claims. It is not explicitly calculated as a separate item. Mercer uses fee schedules that are net of GME in the fee adjustment process. Encounter data does not include GME payments and therefore no adjustment is required.

Data Smoothing

For certain rate cells, there were not enough MMs within each region to produce a statistically credible rate. For rate cells with less than 30,000 MMs per region, Mercer calculated a statewide capitation rate. Affected rate cells include:

- SSI newborns 0-1 years of age
- BCC, All Ages
- LAP, All Ages
- HCBS, All Ages
- CCM, All Ages

Voluntary Opt-In Adjustments

It is unclear at this time if there will be a material difference in the risk profile of the Opt-in population from the historical FFS population. Therefore, Mercer made no adjustments for selection risk in the development of the HCBS and CCM rates.

Non-Medical Expense Load

The actuarially sound capitation rate ranges developed include a provision for MCO administration and other non-medical expenses. Mercer reviewed historical Prepaid plan expense data and relied on its professional experience in working with numerous State Medicaid programs to develop the administrative load. The load for each rate cell was determined using a fixed and variable cost model. Under this model, a fixed administrative expense is attributed to each MM, which reflects program requirements, such as state-mandated staffing. Added to this is a variable administrative amount, based on claims volume. For pharmacy, 2% of claims cost was targeted, while 6.1% was targeted for medical. Maternity kick payment rate cells have only the variable medical administrative load. Previously, a percentage load was applied to all rate cells, with a smaller load being applied to maternity kick payments. This change results in retention loads that vary as a percentage by rate cell. See Appendix K for the percentage of premium allocated to total retention load in the rates. These percentages include all three components of retention: Administrative Costs, Margin, and Premium Tax. This methodology results in a higher allocation of administrative costs on the rate cells with higher utilization, which Mercer believes is more accurate in reflecting the drivers of plan administration requirements.

Mercer reviewed plan financial information provided by the Prepaid plans to develop administrative cost expectations. The development included allocations for increases in expenses including items such as additional case management due to claims volume and increases in staff compensation over time. The administrative development also included an expected increase in salary for the Behavioral Health Medical Director ($200,000), Program Integrity Officer ($100,000), and two Fraud and Abuse Investigators ($65,000 each). Final Administrative cost expectation was $21.78-$23.34 PMPM.

Additionally, provision has been made in these rates for a 2% risk margin calculated before applying any adjustment for FMP. Final rates also include provision for Louisiana's 2.25% premium tax.

Risk Adjustment

Risk adjustment will be applied to the rates in Attachment A to reflect differences in health status of the members served in each MCO using the Adjusted Clinical Groups (ACG) model. The risk adjustment process does not increase nor decrease the overall cost of the program, but can change the distribution across the various Bayou Health MCOs according to the relative risk of their enrolled members.

Federal Health Insurer Fee

Section 9010 of the ACA established a health insurance provider fee (HIPF), which applies to certain for-profit/tax-paying health insurers. For-profit Medicaid health plans are not exempt from the HIPF, which will become a cost of doing business that is appropriate to recognize in actuarially sound capitation rates.

At the time of this certification, many aspects of the calculation and application of this fee are not yet determined and/or finalized. These fees will be calculated and become payable sometime during the third quarter of 2016. As these fees are not yet defined by insurer and by market place, no adjustment has been made in the rate range development for the Bayou Health program. An adjustment and revised certification will be considered when the fee amount and impacted entities applicable to this rate period are announced in 2016.

Certification of Final Rate Ranges

In preparing the rate ranges shown in Attachment A, Mercer has used and relied upon enrollment, FFS claims, encounter data, reimbursement level, benefit design, and other information supplied by DHH and its fiscal agent. DHH, its fiscal agent, and the Prepaid plans are responsible for the validity and completeness of the data supplied. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In

our opinion they are appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that the rates in Attachment A were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the managed care contract. Rate estimates provided are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates and ranges developed by Mercer are actuarial projections of future contingent events. Actual Bayou Health MCO costs will differ from these projections. Mercer has developed these rates on behalf of DHH to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c), and in accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

Bayou Health MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by Bayou Health MCOs for any purpose. Mercer recommends that any Bayou Health MCO considering contracting with DHH should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges before deciding whether to contract with DHH.

This certification letter assumes the reader is familiar with the Bayou Health Program, Medicaid eligibility rules, and actuarial rate-setting techniques. It is intended for DHH and CMS, and should not be relied upon by third 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 results.

If you have any questions on any of the information provided, please feel free to call me at +1 404 442 3358.

Sincerely,

Jaredd Simons, ASA, MAAA
Senior Associate Actuary

Appendix A: Bayou Health Capitation Rate Range

Region Description	COA Description	Rate Cell Description	CY13 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
Gulf	SSI	0-2 Months	291	$29,176.77	$30,649.57
Gulf	SSI	3-11 Months	1,790	$5,329.02	$5,622.79
Gulf	SSI	Child 1-18	122,394	$384.88	$408.98
Gulf	SSI	Adult 19+	276,704	$1,016.63	$1,069.17
Gulf	Family & Children	0-2 Months	43,180	$1,719.26	$1,805.59
Gulf	Family & Children	3-11 Months	104,549	$247.21	$263.69
Gulf	Family & Children	Child 1-18	2,053,265	$120.02	$127.86
Gulf	Family & Children	Adult 19+	374,005	$321.77	$339.30
Gulf	BCC	BCC, All Ages	3,702	$2,180.61	$2,310.26
Gulf	LAP	LAP, All Ages	9,457	$154.51	$164.98
Gulf	HCBS	Child 0-18	6,826	$1,542.22	$1,671.56
Gulf	HCBS	Adult 19+	21,296	$603.34	$648.62
Gulf	CCM	CCM, All Ages	15,710	$907.57	$987.84
Gulf	Maternity Kick Payment	Maternity Kick Payment	10,987	$8,693.19	$8,930.22
Gulf	EED Kick Payment	EED Kick Payment	N/A	$4,989.91	$5,071.30
Capital	SSI	0-2 Months	168	$29,990.86	$31,463.67
Capital	SSI	3-11 Months	1,491	$5,427.68	$5,721.44
Capital	SSI	Child 1-18	89,519	$428.69	$457.43
Capital	SSI	Adult 19+	210,439	$1,041.06	$1,100.97
Capital	Family & Children	0-2 Months	38,789	$1,860.57	$1,949.19
Capital	Family & Children	3-11 Months	94,611	$267.11	$286.00
Capital	Family & Children	Child 1-18	1,863,396	$126.75	$135.38
Capital	Family & Children	Adult 19+	268,984	$369.43	$390.13
Capital	BCC	BCC, All Ages	3,946	$2,174.10	$2,303.74
Capital	LAP	LAP, All Ages	10,487	$155.77	$166.24
Capital	HCBS	Child 0-18	7,164	$1,540.61	$1,669.94

Region Description	COA Description	Rate Cell Description	CY13 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
Capital	HCBS	Adult 19+	21,638	$601.27	$646.55
Capital	CCM	CCM, All Ages	15,831	$908.48	$988.75
Capital	Maternity Kick Payment	Maternity Kick Payment	9,772	$8,042.15	$8,252.09
Capital	EED Kick Payment	EED Kick Payment	N/A	$5,209.55	$5,300.45
South Central	SSI	0-2 Months	217	$29,299.51	$30,772.32
South Central	SSI	3-11 Months	1,692	$5,341.06	$5,634.83
South Central	SSI	Child 1-18	91,728	$447.09	$474.60
South Central	SSI	Adult 19+	247,354	$960.19	$1,013.28
South Central	Family & Children	0-2 Months	43,502	$2,067.98	$2,162.65
South Central	Family & Children	3-11 Months	104,512	$285.49	$303.81
South Central	Family & Children	Child 1-18	2,038,315	$134.79	$143.67
South Central	Family & Children	Adult 19+	285,454	$339.25	$358.20
South Central	BCC	BCC, All Ages	2,893	$2,188.81	$2,318.46
South Central	LAP	LAP, All Ages	12,222	$156.56	$167.04
South Central	HCBS	Child 0-18	6,665	$1,543.77	$1,673.11
South Central	HCBS	Adult 19+	23,110	$604.14	$649.42
South Central	CCM	CCM, All Ages	16,556	$907.77	$988.04
South Central	Maternity Kick Payment	Maternity Kick Payment	10,504	$7,621.88	$7,830.28
South Central	EED Kick Payment	EED Kick Payment	N/A	$4,707.02	$4,792.92
North	SSI	0-2 Months	239	$29,599.93	$31,072.74
North	SSI	3-11 Months	1,678	$5,356.16	$5,649.93
North	SSI	Child 1-18	100,260	$407.65	$431.58
North	SSI	Adult 19+	212,259	$921.58	$971.65
North	Family & Children	0-2 Months	32,253	$1,974.38	$2,071.47
North	Family & Children	3-11 Months	80,214	$262.78	$280.30
North	Family & Children	Child 1-18	1,587,962	$121.17	$128.96
North	Family & Children	Adult 19+	213,631	$324.52	$342.79
North	BCC	BCC, All Ages	2,395	$2,203.79	$2,333.44

Region Description	COA Description	Rate Cell Description	CY13 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
North	LAP	LAP, All Ages	6,545	$156.57	$167.05
North	HCBS	Child 0-18	4,164	$1,544.93	$1,674.26
North	HCBS	Adult 19+	17,320	$605.27	$650.55
North	CCM	CCM, All Ages	16,472	$908.28	$988.54
North	Maternity Kick Payment	Maternity Kick Payment	8,132	$7,733.60	$7,947.96
North	EED Kick Payment	EED Kick Payment	N/A	$4,568.79	$4,650.14

Appendix B: Bayou Health Eligibility Designation

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
SSI (Aged, Blind and Disabled)				
Acute Care Hospitals (LOS > 30 days)	●			
BPL (Walker vs. Bayer)	●			
Disability Medicaid	●			
Disabled Adult Child	●			
Disabled Widow/Widower (DW/W)	●			
Early Widow/Widowers	●			
Family Opportunity Program*	●		●	
Former SSI*	●		●	
Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	●			
PICKLE	●			
Provisional Medicaid	●			
Section 4913 Children	●			
SGA Disabled W/W/DS	●			
SSI (Supplemental Security Income)*	●		●	
SSI Conversion	●			
Tuberculosis (TB)	●			
SSI (OCS Foster Care, IV-E OCS/OYD and OCS/OYD (XIX))				
Foster Care IV-E - Suspended SSI			●	
SSI (Supplemental Security Income)			●	
TANF (Families and Children, LIFC)				
CHAMP Child	●			
CHAMP Pregnant Woman (to 133% of FPIG)	●			
CHAMP Pregnant Woman Expansion (to 185%	●			

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
FPIG)				
Deemed Eligible	●			
ELE - Food Stamps (Express Lane Eligibility-Food Stamps)	●			
Grant Review	●			
LaCHIP Phase 1	●			
LaCHIP Phase 2	●			
LaCHIP Phase 3	●			
LaCHIP Phase IV: Non-Citizen Pregnant Women Expansion	●			
LIFC - Unemployed Parent / CHAMP	●			
LIFC Basic	●			
PAP - Prohibited AFDC Provisions	●			
Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL	●			
Regular MNP (Medically Needy Program)	●			
Transitional Medicaid	●			
FCC (Families and Children)				
Former Foster Care children	●			
Youth Aging Out of Foster Care (Chaffee Option)	●			
FCC (OCS Foster Care, IV-E OCS/OYD and OCS/OYD (XIX))				
CHAMP Child			●	
CHAMP Pregnant Woman (to 133% of FPIG)			●	
IV-E Foster Care			●	
LaCHIP Phase 1			●	
OYD - V Category Child			●	
Regular Foster Care Child			●	

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
YAP (Young Adult Program)			●	
YAP/OYD			●	
BCC (Families and Children)				
Breast and/or Cervical Cancer	●			
LAP (Families and Children)				
LaCHIP Affordable Plan	●			
HCBS Waiver				
ADHC (Adult Day Health Services Waiver)		●		
Children's Waiver - Louisiana Children's Choice		●		
Community Choice Waiver		●		
New Opportunities Waiver - SSI		●		
New Opportunities Waiver Fund		●		
New Opportunities Waiver, non-SSI		●		
Residential Options Waiver - non-SSI		●		
Residential Options Waiver - SSI		●		
SSI Children's Waiver - Louisiana Children's Choice		●		
SSI Community Choice Waiver		●		
SSI New Opportunities Waiver Fund		●		
SSI/ADHC		●		
Supports Waiver		●		
Supports Waiver SSI		●		
CCM				
Chisholm Class Members**		●		
LaHIPP				
Louisiana's Health Insurance Premium Payment Program***	●	●	●	●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
Excluded				
CHAMP Presumptive Eligibility				●
CSOC				●
DD Waiver				●
Denied SSI Prior Period				●
Disabled Adults authorized for special hurricane Katrina assistance				●
EDA Waiver				●
Family Planning, New eligibility / Non-LaMOM				●
Family Planning, Previous LaMOMs eligibility				●
Family Planning/Take Charge Transition				●
Forced Benefits				●
GNOCHC Adult Parent				●
GNOCHC Childless Adult				●
HPE B/CC				●
HPE Children under age 19				●
HPE Family Planning				●
HPE Former Foster Care				●
HPE LaCHIP				●
HPE LaCHIP Unborn				●
HPE Parent/Caretaker Relative				●
HPE Pregnant Woman				●
LBHP - Adult 1915(i)				●
LTC (Long-Term Care)				●
LTC Co-Insurance				●
LTC MNP/Transfer of Resources				●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
LTC Payment Denial/Late Admission Packet				●
LTC Spend-Down MNP				●
LTC Spend-Down MNP (Income > Facility Fee)				●
OCS Child Under Age 18 (State Funded)				●
OYD (Office of Youth Development)				●
PACE SSI				●
PACE SSI-related				●
PCA Waiver				●
Private ICF/DD				●
Private ICF/DD Spend-Down Medically Needy Program				●
Private ICF/DD Spend-Down Medically Needy Program/Income Over Facility Fee				●
Public ICF/DD				●
Public ICF/DD Spend-Down Medically Needy Program				●
QI-1 (Qualified Individual - 1)				●
QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)				●
QMB (Qualified Medicare Beneficiary)				●
SLMB (Specified Low-Income Medicare Beneficiary)				●
Spend-Down Medically Needy Program				●
Spend-Down Denial of Payment/Late Packet				●
SSI Conversion / Refugee Cash Assistance (RCA)/ LIFC Basic				●
SSI DD Waiver				●
SSI Payment Denial/Late Admission				●
SSI PCA Waiver				●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
SSI Transfer of Resource(s)/LTC				●
SSI/EDA Waiver				●
SSI/LTC				●
SSI/Private ICF/DD				●
SSI/Public ICF/DD				●
State Retirees				●
Terminated SSI Prior Period				●
Transfer of Resource(s)/LTC				●

* Children under 19 years of age who are automatically enrolled into Bayou Health, but may voluntarily disenroll.
** Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the OCDD's Request for Services Registry who are *CCMs*.
*** LaHIPP is not a category of eligibility. Eligibility designation for LaHIPP enrollees will vary according to the qualifying category of eligibility.

Appendix C: Bayou Health Covered Services

Medicaid Category of Service	Units of Measurement	Completion Category of Service
Inpatient Hospital	Days	Inpatient
Outpatient Hospital	Claims	Outpatient
Primary Care Physician	Visits	Physician
Specialty Care Physician	Visits	Physician
FQHC/RHC	Visits	Physician
EPSDT	Visits	Physician
Certified Nurse Practitioners/Clinical Nurse	Claims	Physician
Lab/Radiology	Units	Other
Home Health	Visits	Other
Emergency Transportation	Units	Transportation
NEMT	Units	Transportation
Rehabilitation Services (occupational therapy {OT}, physical therapy {PT}, speech therapy {ST})	Visits	Other
DME	Units	Other
Clinic	Claims	Physician
Family Planning	Visits	Physician
Other*	Units	Other
Prescribed Drugs	Scripts	Prescribed Drugs
ER	Visits	Outpatient
Basic Behavioral Health	Claims	Physician
Hospice*	Admits	Inpatient
Personal Care Services (Age 0-20)*	Units	Physician

* Services that were previously excluded from the Bayou Health program and now are included.

Appendix D: NEMT Adjustment

		NEMT Adjustment				
COA Description	**Rate Cell Description**	**Gulf (%)**	**Capital (%)**	**Southwest (%)**	**North (%)**	**Total (%)**
SSI	Newborns, 0-2 Months of Age	0.0	0.0	0.0	0.0	0.0
SSI	Newborns, 3-11 Months of Age	0.0	0.0	0.0	0.0	0.0
SSI	Child, 1-18 Years of Age	183.3	73.1	42.9	9.7	68.7
SSI	Adult, 19+ Years of Age	24.1	25.9	14.5	12.6	20.0
Family & Children	Newborns, 0-2 Months of Age	0.0	0.9	1.0	0.3	0.3
Family & Children	Newborns, 3-11 Months of Age	0.0	0.1	0.1	0.8	0.2
Family & Children	Child, 1-18 Years of Age	73.2	49.9	26.1	13.9	39.7
Family & Children	Adult, 19+ Years of Age	12.1	13.8	6.6	2.4	9.4
BCC	BCC, All Ages	0.0	1.1	1.5	2.5	1.1
LAP	LAP, All Ages	13.4	34.2	0.0	0.0	7.8
HCBS	Child, 0-18 Years of Age	0.0	0.0	0.0	0.0	0.0
HCBS	Adult, 19+ Years of Age	0.0	0.0	0.0	0.0	0.0
CCM	CCM, All Ages	0.0	0.0	0.0	0.0	0.0
Maternity Kick Payment	Maternity Kick Payment	0.0	0.0	0.0	0.0	0.0
Total		**27.4**	**27.7**	**14.8**	**10.3**	**20.9**

Appendix E: Behavioral Health Mixed Services Protocol

PMPM Impact of Behavioral Health Mixed Services Protocol							
COA Description	**Rate Cell Description**	**Inpatient Hospital (%)**	**Outpatient Hospital (%)**	**Primary Care Physician (%)**	**ER (%)**	**FQHC/RHC (%)**	**Total (%)**
SSI	Newborns, 0-2 Months of Age	0.0	0.0	0.0	0.0	0.0	0.0
SSI	Newborns, 3-11 Months of Age	0.0	0.0	0.0	0.0	0.1	0.0
SSI	Child, 1-18 Years of Age	1.1	0.3	4.4	4.8	10.4	2.4
SSI	Adult, 19+ Years of Age	0.6	0.1	1.0	5.0	0.9	1.3
Family & Children	Newborns, 0-2 Months of Age	0.0	0.0	0.0	0.0	0.0	0.0
Family & Children	Newborns, 3-11 Months of Age	0.0	0.0	0.0	0.0	0.0	0.0
Family & Children	Child, 1-18 Years of Age	1.6	0.1	1.2	1.5	3.7	1.5
Family & Children	Adult, 19+ Years of Age	0.6	0.1	0.7	1.9	1.0	1.0
BCC	BCC, All Ages	0.0	0.0	0.1	1.1	0.3	0.1
LAP	LAP, All Ages	1.1	0.0	1.4	1.3	5.5	1.4
HCBS	Child, 0-18 Years of Age	0.4	0.1	2.6	6.4	13.4	1.4
HCBS	Adult, 19+ Years of Age	0.4	0.1	1.3	9.2	3.4	1.5
CCM	CCM, All Ages	1.5	0.3	4.0	4.3	9.4	2.3
Total		**0.5**	**0.1**	**1.0**	**2.5**	**2.8**	**1.1**

Appendix F-1: Shared Savings/FFS IBNR Adjustment

	COA Description						
Category of Service Description	**SSI**	**Family & Children**	**BCC**	**LAP**	**HCBS**	**CCM**	**Maternity Kick Payment**
	(%)	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**
Inpatient Hospital	4.6	6.1	4.6	6.1	2.6	4.6	N/A
Outpatient Hospital	2.9	2.6	2.9	2.6	2.4	2.9	N/A
Primary Care Physician	3.8	2.4	3.8	2.4	3.9	3.8	N/A
Specialty Care Physician	3.8	2.4	3.8	2.4	3.9	3.8	N/A
FQHC/RHC	3.8	2.4	3.8	2.4	3.9	3.8	N/A
EPSDT	3.8	2.5	0.0	2.4	3.9	3.8	N/A
Certified Nurse Practitioners/Clinical Nurse	3.8	2.4	3.8	2.4	3.9	3.8	N/A
Lab/Radiology	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Home Health	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Emergency Transportation	2.4	3.8	2.4	3.8	1.3	2.4	N/A
NEMT	2.4	3.8	2.4	3.8	1.3	2.4	N/A
Rehabilitation Services (OT, PT, ST)	3.3	3.0	0.0	3.0	1.5	3.3	N/A
DME	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Clinic	3.8	2.5	3.8	2.4	3.9	3.8	N/A
Family Planning	3.8	2.4	3.8	2.4	3.9	3.8	N/A
Other	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Prescribed Drugs	0.0	0.0	0.0	0.0	0.0	0.0	N/A
ER	2.9	2.6	2.9	2.6	2.4	2.9	N/A
Basic Behavioral Health	3.8	2.5	3.8	2.4	3.9	3.8	N/A
Hospice	4.6	6.1	4.6	0.0	2.6	4.6	N/A
Personal Care Services	3.8	2.6	0.0	0.0	3.9	3.8	N/A
Total	**2.2**	**2.3**	**2.4**	**1.7**	**1.6**	**2.6**	**4.0**

Appendix F-2: Prepaid IBNR Adjustment

	COA Description						
Category of Service Description	**SSI**	**Family & Children**	**BCC**	**LAP**	**HCBS**	**CCM**	**Maternity Kick Payment**
	(%)	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**
Inpatient Hospital	2.0	6.9	1.7	9.7	N/A	N/A	N/A
Outpatient Hospital	2.4	3.0	2.6	2.6	N/A	N/A	N/A
Primary Care Physician	2.8	3.0	2.8	3.0	N/A	N/A	N/A
Specialty Care Physician	2.8	3.0	2.8	3.0	N/A	N/A	N/A
FQHC/RHC	2.9	3.0	2.9	3.0	N/A	N/A	N/A
EPSDT	2.9	3.0	2.4	3.0	N/A	N/A	N/A
Certified Nurse Practitioners/Clinical Nurse	2.8	3.0	2.8	3.1	N/A	N/A	N/A
Lab/Radiology	1.1	0.0	1.3	0.0	N/A	N/A	N/A
Home Health	1.1	0.0	1.3	0.0	N/A	N/A	N/A
Emergency Transportation	3.1	2.3	3.1	2.3	N/A	N/A	N/A
NEMT	1.3	1.5	1.6	2.4	N/A	N/A	N/A
Rehabilitation Services (OT, PT, ST)	1.1	0.0	0.5	0.0	N/A	N/A	N/A
DME	1.0	0.0	1.1	0.0	N/A	N/A	N/A
Clinic	2.5	3.1	2.7	2.9	N/A	N/A	N/A
Family Planning	2.8	3.0	2.8	2.8	N/A	N/A	N/A
Other	1.3	0.0	1.5	0.0	N/A	N/A	N/A
Prescribed Drugs	0.0	0.0	0.0	0.0	N/A	N/A	N/A
ER	2.3	2.9	2.4	2.6	N/A	N/A	N/A
Basic Behavioral Health	2.9	3.0	2.8	3.0	N/A	N/A	N/A
Hospice	4.6	6.1	4.6	0.0	N/A	N/A	N/A
Personal Care Services	3.8	2.4	0.0	0.0	N/A	N/A	N/A
Total	**1.4**	**2.9**	**1.9**	**2.2**	**N/A**	**N/A**	**2.1**

Appendix G-1: ACA PCP Carve-Out Adjustment – Shared Savings/FFS Claims

COA Description	MMs	Expenses	PMPM	ACA Enhanced Claims	ACA Carve-Out	Enhanced Claims at Medicaid Fee Schedule	ACA Carve-Out PMPM
SSI	534,039	$335,720,231	$628.64	$16,912,081	$ (4,741,489)	$12,170,592	$(8.88)
Family & Children	4,803,890	$687,008,562	$143.01	$119,227,890	$ (31,854,474)	$87,373,415	$(6.63)
BCC	3,894	$5,411,598	$1,389.73	$125,195	$ (36,099)	$89,096	$(9.27)
LAP	24,552	$3,089,875	$125.85	$580,909	$ (159,439)	$421,470	$(6.49)
HCBS	104,050	$74,126,785	$712.42	$1,792,858	$ (546,701)	$1,246,156	$(5.25)
CCM	63,548	$49,066,793	$772.12	$1,830,936	$ (438,595)	$1,392,341	$(6.90)
Maternity Kick Payment	20,227	$93,991,004	$4,646.74	$118,341	$(34,420)	$83,921	$(1.70)
Total	**5,533,973**	**$1,248,414,847**	**$225.59**	**$140,588,209.72**	**$ (37,811,217.78)**	**$102,776,991.94**	**$(6.83)**

Appendix G-2: ACA PCP Carve-Out Adjustment – Prepaid Encounter Claims

COA Description	MMs	Expenses	PMPM	ACA Enhanced Claims	ACA Carve-Out	Enhanced Claims at Medicaid Fee Schedule	ACA Carve-Out PMPM
SSI	817,967	$484,281,922	$592.06	$22,217,143	$(6,355,861)	$15,861,282	$(7.77)
Family & Children	4,406,937	$554,415,102	$125.81	$86,893,087	$(22,109,241)	$64,783,846	$(5.02)
BCC	9,032	$11,294,648	$1,250.51	$277,935	$(75,376)	$202,560	$(8.35)
LAP	14,159	$1,560,869	$110.24	$260,918	$(70,249)	$190,668	$(4.96)
HCBS	-	$-	$-	$-	$-	$-	$-
CCM	-	$-	$-	$-	$-	$-	$-
Maternity Kick Payment	19,132	$89,550,169	$4,680.59	$122,458	$(33,773)	$88,685	$(1.76)
Total	**5,248,095**	**$1,141,102,710**	**$217.43**	**$109,771,540.72**	**$(28,644,499.92)**	**$81,127,040.80**	**$(5.46)**

Appendix H-1: 6-Month Average Duration Calculation

	SSI			Family & Children[4]			BCC[4]		
First Month of Enrollment	**Recipients**	**Member Months**	**Average Duration**	**Recipients**	**Member Months**	**Average Duration**	**Recipients**	**Member Months**	**Average Duration**
Jul-13	1,022	2,073	2.0	5,109	8,174	1.6	24	47	2.0
Aug-13	1,129	2,292	2.0	6,475	10,519	1.6	29	55	1.9
Sept-13	1,178	2,399	2.0	6,123	9,436	1.5	31	57	1.8
Oct-13	1,022	2,219	2.2	5,678	9,096	1.6	15	29	1.9
Nov-13	1,196	2,369	2.0	5,697	10,118	1.8	35	70	2.0
Dec-13	1,089	2,220	2.0	4,720	7,916	1.7	19	37	1.9
6-Month Avg. Duration			**2.0**			**1.6**			**1.9**

[4] Revised due to a typographical error in the certification letter dated January 31, 2015.

Appendix H-2: Statewide Summary by Rating Category

		Retro-Active Period Claims						Total Base Claims			Total Base Claims Including Retro-Active Adjustment				
		(A)	(B)	(C)	(D)	(E) = (C)/(B)	(F) = (A)*(D)*(E)	(G)	(H)	(I) = (H)/(G)	(J) = (A)*(D)+(G)	(K) = (F)+(H)	(L) = (K)/(J)	(M) = (L)/(I)	(N) = MAX(L,1)
Category of Aid	Category of Aid Description	Recipients	Member Months (Capped at 12 months)	Claims	Selected Avg. Duration	Claims PMPM	Modified Claims Total	Member Months	Claims	Claims PMPM	Member Months	Claims	Claims PMPM	Observed Retro Factor	Final Retro Factor
SSI	Newborn, 0-2 Months	-	-	$ -	2.05	$ -	$ -	915	$ 17,215,170	$ 18,814	915	$ 17,215,170	$ 18,814	1.0000	1.0000
SSI	Newborn, 3-11 Months	-	-	$ -	2.05	$ -	$ -	6,651	$ 24,818,296	$ 3,732	6,651	$ 24,818,296	$ 3,732	1.0000	1.0000
SSI	Child, 1-18 Years	1,097	3,528	$ 779,022	2.05	$ 220.81	$ 495,801	403,901	$ 123,004,730	$ 305	406,146	$ 123,500,531	$ 304	0.9985	1.0000
SSI	Adult, 19+ Years	12,278	32,453	$ 26,548,934	2.05	$ 818.07	$ 20,558,886	946,756	$ 639,085,266	$ 675	971,887	$ 659,644,152	$ 679	1.0055	1.0055
Family and Children	Newborn, 0-2 Months	-	-	$ -	1.63	$ -	$ -	157,724	$ 179,711,511	$ 1,139	157,724	$ 179,711,511	$ 1,139	1.0000	1.0000
Family and Children	Newborn, 3-11 Months	-	-	$ -	1.63	$ -	$ -	383,886	$ 79,427,903	$ 207	383,886	$ 79,427,903	$ 207	1.0000	1.0000
Family and Children	Child, 1-18 Years	30,101	73,414	$ 4,988,780	1.63	$ 67.95	$ 3,332,762	7,542,938	$ 696,145,300	$ 92	7,591,982	$ 699,478,063	$ 92	0.9983	1.0000
Family and Children	Adult, 19+ Years	42,338	64,174	$ 18,628,437	1.63	$ 290.28	$ 20,024,218	1,142,074	$ 255,222,939	$ 223	1,211,056	$ 275,247,157	$ 227	1.0170	1.0170
Breast and Cervical Cancer	BCC, All Ages Female	366	822	$ 2,540,941	1.93	$ 3,091.17	$ 2,183,263	12,936	$ 16,384,789	$ 1,267	13,642	$ 18,568,052	$ 1,361	1.0746	1.0746
LaCHIP Affordable Plan	All Ages	-	-	$ -	-	$ -	$ -	38,711	$ 4,566,649	$ 118	38,711	$ 4,566,649	$ 118	1.0000	1.0000
HCBS Waiver	18 & Under, Male and Female	-	-	$ -	-	$ -	$ -	24,819	$ 32,738,606	$ 1,319	24,819	$ 32,738,606	$ 1,319	1.0000	1.0000
HCBS Waiver	19+ Years, Male and Female	-	-	$ -	-	$ -	$ -	83,364	$ 41,966,487	$ 503	83,364	$ 41,966,487	$ 503	1.0000	1.0000
Chisholm Class Members	Chisholm, All Ages Male & Female	-	-	$ -	-	$ -	$ -	64,569	$ 47,801,497	$ 740	64,569	$ 47,801,497	$ 740	1.0000	1.0000
Maternity Kickpayment	Maternity Kickpayment, All Ages	-	-	$ -	-	$ -	$ -	37,572	$ 178,244,133	$ 4,744	37,572	$ 178,244,133	$ 4,744	1.0000	1.0000

Notes:

* The above analysis does not include payments to members who paid out-of-pocket for services before being enrolled in Medicaid.

1. Final retro-adjustment factor was set to a 1.0 factor for those instances where the observed retro-active factor resulted in a negative adjustment.
2. Retro-active period claims not credible as the LAP population entered into Bayou Health effective January 1, 2013. Assumes Family & Children experience for the LAP retro-adjustment factor.
3. HCBS waiver and Chisholm populations are new to the Bayou Health program and no retro-active claims experience is available to determine retro-active period adjustment factor.

Appendix I-1: Annualized Trend Adjustment for SSI/BCC

	Annualized Trend					
	SSI/BCC					
Category of Service Description	**Low Util (%)**	**High Util (%)**	**Low Unit Cost (%)**	**High Unit Cost (%)**	**Low PMPM (%)**	**High PMPM (%)**
Inpatient Hospital	0.0	2.0	0.0	1.0	0.0	3.0
Outpatient Hospital	1.0	4.0	1.0	3.0	2.0	7.1
Primary Care Physician	1.0	5.0	1.0	2.0	2.0	7.1
Specialty Care Physician	1.0	5.0	1.0	2.0	2.0	7.1
FQHC/RHC	2.0	5.0	1.0	2.0	3.0	7.1
EPSDT	1.0	5.0	1.0	2.0	2.0	7.1
Certified Nurse Practitioners/Clinical Nurse	1.0	5.0	1.0	2.0	2.0	7.1
Lab/Radiology	1.0	2.0	1.0	2.0	2.0	4.0
Home Health	1.0	2.0	1.0	2.0	2.0	4.0
Emergency Transportation	1.0	2.0	1.0	2.0	2.0	4.0
NEMT	1.0	2.0	1.0	2.0	2.0	4.0
Rehabilitation Services (OT, PT, ST)	1.0	2.0	1.0	2.0	2.0	4.0
DME	1.0	2.0	1.0	2.0	2.0	4.0
Clinic	1.0	5.0	1.0	2.0	2.0	7.1
Family Planning	1.0	5.0	1.0	2.0	2.0	7.1
Other	1.0	2.0	1.0	2.0	2.0	4.0
Prescribed Drugs	5.4	7.2	0.0	0.0	5.4	7.2
ER	0.0	1.0	1.0	3.0	1.0	4.0
Basic Behavioral Health	1.0	5.0	1.0	2.0	2.0	7.1
Hospice	1.0	2.0	1.0	2.0	2.0	4.0
Personal Care Services	1.0	2.0	1.0	2.0	2.0	4.0
Total	**2.4**	**4.6**	**0.4**	**1.2**	**2.8**	**5.8**

Appendix I-2: Annualized Trend Adjustment for Family & Children/LAP

	Annualized Trend					
	Family & Children/LAP					
Category of Service Description	**Low Util (%)**	**High Util (%)**	**Low Unit Cost (%)**	**High Unit Cost (%)**	**Low PMPM (%)**	**High PMPM (%)**
Inpatient Hospital	0.0	2.0	0.0	1.0	0.0	3.0
Outpatient Hospital	2.0	5.0	1.0	3.0	3.0	8.2
Primary Care Physician	1.0	5.0	1.0	2.0	2.0	7.1
Specialty Care Physician	1.0	5.0	1.0	2.0	2.0	7.1
FQHC/RHC	2.0	5.0	1.0	2.0	3.0	7.1
EPSDT	1.0	5.0	1.0	2.0	2.0	7.1
Certified Nurse Practitioners/Clinical Nurse	1.0	5.0	1.0	2.0	2.0	7.1
Lab/Radiology	1.0	2.0	1.0	2.0	2.0	4.0
Home Health	1.0	2.0	1.0	2.0	2.0	4.0
Emergency Transportation	1.0	2.0	1.0	2.0	2.0	4.0
NEMT	1.0	2.0	1.0	2.0	2.0	4.0
Rehabilitation Services (OT, PT, ST)	1.0	2.0	1.0	2.0	2.0	4.0
DME	1.0	2.0	1.0	2.0	2.0	4.0
Clinic	1.0	5.0	1.0	2.0	2.0	7.1
Family Planning	1.0	5.0	1.0	2.0	2.0	7.1
Other	1.0	2.0	1.0	2.0	2.0	4.0
Prescribed Drugs	5.4	7.2	0.0	0.0	5.4	7.2
ER	0.0	1.0	1.0	2.0	1.0	3.0
Basic Behavioral Health	1.0	5.0	1.0	2.0	2.0	7.1
Hospice	1.0	2.0	1.0	2.0	2.0	4.0
Personal Care Services	1.0	2.0	1.0	2.0	2.0	4.0
Total	**2.1**	**4.5**	**0.5**	**1.3**	**2.7**	**5.8**

Appendix I-3: Annualized Trend Adjustment for HCBS Waiver/CCMs

	HCBS Waiver/Chisholm Class Members					
Category of Service Description	**Low Util (%)**	**High Util (%)**	**Low Unit Cost (%)**	**High Unit Cost (%)**	**Low PMPM (%)**	**High PMPM (%)**
Inpatient Hospital	0.0	2.0	1.0	1.0	1.0	3.0
Outpatient Hospital	1.5	4.5	2.0	4.0	3.5	8.7
Primary Care Physician	1.0	5.0	1.0	1.0	2.0	6.1
Specialty Care Physician	1.0	5.0	1.0	1.0	2.0	6.1
FQHC/RHC	1.0	5.0	2.0	2.0	3.0	7.1
EPSDT	1.0	5.0	1.0	1.0	2.0	6.1
Certified Nurse Practitioners/Clinical Nurse	1.0	5.0	1.0	1.0	2.0	6.1
Lab/Radiology	1.0	3.0	1.0	1.0	2.0	4.0
Home Health	1.0	3.0	1.0	1.0	2.0	4.0
Emergency Transportation	0.0	3.0	1.0	1.0	1.0	4.0
NEMT	0.0	3.0	1.0	1.0	1.0	4.0
Rehabilitation Services (OT, PT, ST)	1.0	3.0	1.0	1.0	2.0	4.0
DME	1.0	3.0	1.0	1.0	2.0	4.0
Clinic	1.0	5.0	1.0	1.0	2.0	6.1
Family Planning	1.0	5.0	1.0	1.0	2.0	6.1
Other	1.0	3.0	1.0	1.0	2.0	4.0
Prescribed Drugs	1.0	2.0	1.0	1.0	2.0	3.0
ER	1.5	4.5	2.0	4.0	3.5	8.7
Basic Behavioral Health	1.0	5.0	1.0	1.0	2.0	6.1
Hospice	1.0	3.0	1.0	1.0	2.0	4.0
Personal Care Services	1.0	5.0	1.0	1.0	2.0	6.1
Total	**0.9**	**3.2**	**1.1**	**1.2**	**2.0**	**4.5**

Appendix J-1: Managed Care Savings Adjustment – HCBS Waiver/CCM

	Managed Care Savings Assumptions					
	HCBS Waiver/CCM[5],[6]					
Category of Service Description	**Low Util (%)**	**High Util (%)**	**Low Unit Cost (%)**	**High Unit Cost (%)**	**Low PMPM (%)**	**High PMPM (%)**
Inpatient Hospital	-12.5	-10.0	1.0	5.0	-11.6	-5.5
Outpatient Hospital	-10.0	-7.5	1.0	3.0	-9.1	-4.7
Primary Care Physician	2.5	5.0	5.0	7.0	7.6	12.4
Specialty Care Physician	-12.5	-10.0	0.0	2.0	-12.5	-8.2
FQHC/RHC	0.0	2.5	0.0	2.0	0.0	4.5
EPSDT	0.0	0.0	5.0	7.0	5.0	7.0
Certified Nurse Practitioners/Clinical Nurse	2.5	5.0	5.0	7.0	7.6	12.4
Lab/Radiology	-10.0	-5.0	0.0	2.0	-10.0	-3.1
Home Health	0.0	0.0	0.0	2.0	0.0	2.0
Emergency Transportation	-5.0	-2.5	0.0	2.0	-5.0	-0.6
NEMT	0.0	2.5	0.0	2.0	0.0	4.5
Rehabilitation Services (OT, PT, ST)	-5.0	-2.5	0.0	2.0	-5.0	-0.6
DME	-10.0	-7.5	0.0	2.0	-10.0	-5.6
Clinic	-10.0	-7.5	0.0	2.0	-10.0	-5.6
Family Planning	0.0	2.5	0.0	2.0	0.0	4.5
Other	0.0	2.5	0.0	2.0	0.0	4.5
Prescribed Drugs	-10.4	-10.4	0.0	0.0	-10.4	-10.4
ER	-12.5	-10.0	5.0	7.0	-8.1	-3.7
Basic Behavioral Health	0.0	0.0	0.0	2.0	0.0	2.0
Hospice	0.0	0.0	0.0	0.0	0.0	0.0
Personal Care Services	-10.0	-5.0	0.0	0.0	-10.0	-5.0
Total	**-7.2**	**-5.9**	**0.9**	**2.2**	**-6.4**	**-3.7**

[5] The HCBS waiver and CCM population are previously unmanaged populations.

[6] Current services for Prepaid, Shared Savings, and LaHIPP populations are managed and Managed Care savings are not applied

Appendix J-2: Managed Care Savings Adjustment – Shared Savings

	Managed Care Savings Assumptions					
	Shared Savings*					
Category of Service Description	**Low Util (%)**	**High Util (%)**	**Low Unit Cost (%)**	**High Unit Cost (%)**	**Low PMPM (%)**	**High PMPM (%)**
Inpatient Hospital						
Outpatient Hospital						
Primary Care Physician						
Specialty Care Physician						
FQHC/RHC						
EPSDT						
Certified Nurse Practitioners/Clinical Nurse						
Lab/Radiology						
Home Health						
Emergency Transportation						
NEMT	0.0	5.0	0.0	2.0	0.0	7.1
Rehabilitation Services (OT, PT, ST)						
DME	-0.2	-15.0	0.0	2.0	-0.2	-13.3
Clinic						
Family Planning						
Other						
Prescribed Drugs	-1.0**	-0.5**	0.0	0.0	-1.0**	-0.5**
ER						
Basic Behavioral Health						
Hospice	0.0	0.0	0.0	0.0	0.0	0.0
Personal Care Services	-10.0	-5.0	0.0	0.0	-10.0	-5.0
Total	**-0.5**	**-0.2**	**0.0**	**0.0**	**-0.5**	**-0.2**

* Covered services previously not covered under the Shared Savings program.

** These Shared Savings managed care savings assumptions are not applied to the BCC COA.

*** Current services for Prepaid, Shared Savings, and LaHIPP populations are managed and Managed Care savings are not applied.

Appendix K: Non-Medical Expense Load

Retention Loads by Rate Cell									
		Lower Bound of Range				Upper Bound of Range			
		Gulf	Capital	South Central	North	Gulf	Capital	South Central	North
COA Description	Rate Cell Description	Retention %	Retention %	Retention %	Retention %	Retention %	Retention %	Retention %	Retention %
SSI	Newborns, 0-2 Months of Age	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7
SSI	Newborns, 3-11 Months of Age	9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5
SSI	Child, 1-18 Years of Age	11.4	10.9	10.5	11.2	11.4	10.9	10.6	11.2
SSI	Adult, 19+ Years of Age	9.5	9.4	9.6	9.8	9.6	9.4	9.6	9.8
Family & Children	Newborns, 0-2 Months of Age	10.5	10.5	10.4	10.4	10.5	10.4	10.4	10.4
Family & Children	Newborns, 3-11 Months of Age	14.0	13.4	13.3	13.6	13.9	13.4	13.3	13.5
Family & Children	Child, 1-18 Years of Age	18.4	17.5	17.0	18.3	18.4	17.5	17.0	18.3
Family & Children	Adult, 19+ Years of Age	12.7	12.0	12.4	12.7	12.7	12.0	12.4	12.7
BCC	BCC, All Ages	9.6	9.6	9.6	9.6	9.6	9.6	9.6	9.6
LAP	LAP, All Ages	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0
HCBS	Child, 0-18 Years of Age	9.8	9.8	9.8	9.8	9.8	9.8	9.8	9.8
HCBS	Adult, 19+ Years of Age	10.1	10.1	10.1	10.1	10.2	10.2	10.2	10.2

Retention Loads by Rate Cell									
		Lower Bound of Range				Upper Bound of Range			
		Gulf	Capital	South Central	North	Gulf	Capital	South Central	North
COA Description	Rate Cell Description	Retention %	Retention %	Retention %	Retention %	Retention %	Retention %	Retention %	Retention %
CCM	CCM, All Ages	10.1	10.1	10.1	10.1	10.1	10.1	10.1	10.1
Maternity Kick Payment	Maternity Kick Payment	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7

Appendix L: Data Reliance Attestation

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

August 27, 2014

Mr. Jaredd Simons, ASA, MAAA
Senior Associate
Mercer Government Human Services
3560 Lenox Road, Suite 2400
Atlanta, GA 30326

Subject: Capitation Rate Range Certification for the Bayou Health Prepaid Program – Implementation Year (February 1, 2015 – January 31, 2016)

Dear Jaredd:

I, Jen Steele, Medicaid Deputy Director and Chief Financial Officer, for the State of Louisiana's Department of Health and Hospitals (DHH), hereby affirm that the data prepared and submitted to Mercer Government Human Services Consulting (Mercer) for the purpose of certifying the February 1, 2015 – January 31, 2016 Prepaid rates were prepared under my direction, and to the best of my knowledge and belief, are accurate, complete, and consistent with the data used to develop the capitation rates. This data includes calendar year (CY) 2013 fee-for-service (FFS) data files, MCO submitted encounter data, and supplemental information on payments made outside of Louisiana's Medicaid Management Information Systems (MMIS).

Mercer relied on DHH and its fiscal agent for the collection and processing of the FFS data, encounter data, and other information used in setting these capitation rates. Mercer did not audit the data, but did assess the data for reasonableness as documented in the rate certification letter.

Jen Steele
Signature

8/27/14
Date

Appendix M: Development of Final Rates for July 1, 2015 through January 31, 2016

Rate Development Description

The below portrays the detail of the rate development based on the combined Prepaid, Shared Savings, and Legacy Medicaid/FFS (Chisholm, HCBS, and LaHIPP) data. The rate development exhibit takes the base data that was provided in Attachment 1 of the data book issued on January 31, 2015, and applies the various rate setting adjustments. The columns in the exhibit are as follows:

Base Data – The base data in these columns includes IBNR.
MMs – MMs for the CY13 period.
PMPM – Computed as the total paid amount divided by the total MMs. Statewide PMPMs were used where appropriate, as indicated in the rate certification letter.

Base Data Adjustments:
Annual Trend - (Low & High) – Annualized trend that is equivalent to the trend factor applied to the base data.
Trend Factor - (Low & High) – Trend factor that is equivalent to the compounded annualized trend applied to the base data.
Base Period Adj. – Overall base period adjustment applied to both the low and high PMPMs. A list of the data source-specific adjustments and the level of detail in which they were applied can be found in the table below:

Base Period Adjustments		
Prepaid	**Shared/FFS**	**LaHIPP**
	Fraud and Abuse Adjustment (statewide adj.)	Fraud and Abuse Adjustment (statewide adj.)
Fee Schedule Adjustment (hospital specific adj.)	Fee Schedule Adjustment (hospital specific adj.)	Fee Schedule Adjustment (hospital specific adj.)
ACT 312 Adjustment (statewide adj.)	ACT 312 Adjustment (statewide adj.)	ACT 312 Adjustment (statewide adj.)
	Rx Rebate Adjustment (statewide adj.)	Rx Rebate Adjustment (statewide adj.)
ACT PCP Adjustment (category of service level adj.)	ACT PCP Adjustment (category of service level adj.)	
LBHP Adjustment (category of service level adj.)	LBHP Adjustment (category of service level adj.)	LBHP Adjustment (category of service level adj.)

Base Period Adjustments		
Prepaid	**Shared/FFS**	**LaHIPP**
Retro-activity Adjustment (rate cell level adj.)	Retro-activity Adjustment (rate cell level adj.)	Retro-activity Adjustment (rate cell level adj.)
NEMT Adjustment (rate cell level adj.)		

Managed Care Adj. Factor (Low & High) – Low and high managed care savings factors applied to the corresponding low and high PMPMs. A list of the data source-specific adjustments and the level of detail in which they were applied can be found in the table below:

Managed Care Adjustments		
Prepaid	**Shared/FFS**	**LaHIPP**
Managed Care Savings*	Managed Care Savings*	None
	GDR	

* Managed care savings adjustments were applied to previously unmanaged populations utilizing Legacy Medicaid/FFS claims (HCBS and Chisholm), as well as newly added services.

Outlier Add-on (PMPM) – PMPM added to account for outlier payments. Applies to both Low and High PMPMs.
Claims PMPM (Low) – Calculated as: K = [B *E * (1+G)*H] + J.
Claims PMPM (High) – Calculated as: L = [B * F * (1+G)*I] + J.
Fixed Admin Load (Low & High) – A PMPM adjustment added to the corresponding Low and High PMPMs.
Variable Admin Load (Low & High) – A percentage adjustment applied to the corresponding Low and High PMPMs.
Profit @ 2% – Provision in these rates has been made for a 2% risk margin.
Premium Tax @ 2.25% – Provision in these rates has been made for Louisiana's 2.25% premium tax.
PMPM After Admin - Low – Calculated as: S = (K * (1 + N) + M)/(1 – Q – R).
PMPM After Admin - High – Calculated as: T = (L * (1 + P) + O)/(1 – Q – R).

			Base Data		Base Data Adjustments							Outliers			Capitation Rate Load								Full Medicaid Pricing			
			A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X
Region Name	COA Desc	Rate Cell Code	MMs	PMPM	Annual Trend-Low	Annual Trend-High	Trend Factor-Low	Trend Factor-High	Base Period Adj.	Managed Care Adj. Factor-Low	Managed Care Adj. Factor-High	Outlier Add-on - PMPM	Claims PMPM-Low	Claims PMPM-High	Fixed Admin Load- Low (PMPM)	Variable Admin Load-Low (%)	Fixed Admin Load-High (PMPM)	Variable Admin Load-High (%)	Profit @ 2%	Premium Tax @ 2.25%	PMPM After Admin-Low	PMPM After Admin- High	FMP Add-On	Premium tax on FMP	Final Loaded Rates-Low	Final Loaded Rates-High
Gulf	SSI	Newborn, 0-2 Months	291	$ 19,478.95	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	$ 945.10	$ 19,605.45	$ 20,936.71	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 21,718.65	$ 23,191.46	$ 7,260.31	$ 167.81	$ 29,176.77	$ 30,649.57
Gulf	SSI	Newborn, 3-11 Months	1,790	$ 3,966.82	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	$ 63.79	$ 4,036.79	$ 4,304.79	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,461.42	$ 4,755.19	$ 848.08	$ 19.52	$ 5,329.02	$ 5,622.79
Gulf	SSI	Child, 1-18 Years	122,394	$ 292.96	2.9%	5.9%	1.06	1.13	-1.4%	0.98	0.99	$ 2.39	$ 302.71	$ 324.02	$ 10.89	4.4%	$ 11.67	4.4%	2.0%	2.25%	$ 341.49	$ 365.80	$ 42.41	$ 0.98	$ 384.88	$ 409.19
Gulf	SSI	Adult, 19+ Years	276,704	$ 681.20	2.9%	5.9%	1.06	1.13	0.4%	0.99	0.99	$ -	$ 717.35	$ 764.64	$ 10.89	4.3%	$ 11.67	4.4%	2.0%	2.25%	$ 783.04	$ 845.58	$ 218.56	$ 5.03	$ 1,016.63	$ 1,069.17
Gulf	Family and Children	Newborn, 0-2 Months	43,180	$ 1,149.57	0.7%	4.1%	1.01	1.09	-7.5%	1.00	1.00	$ 46.33	$ 1,122.09	$ 1,199.45	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,253.38	$ 1,339.71	$ 455.39	$ 10.48	$ 1,719.26	$ 1,805.59
Gulf	Family and Children	Newborn, 3-11 Months	104,549	$ 200.42	2.3%	5.8%	1.05	1.12	-10.6%	0.97	0.97	$ 0.21	$ 182.14	$ 196.37	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 211.71	$ 226.18	$ 34.70	$ 0.80	$ 247.21	$ 263.69
Gulf	Family and Children	Child, 1-18 Years	2,053,265	$ 89.50	3.0%	6.2%	1.06	1.13	-4.9%	0.95	0.96	$ 0.05	$ 86.08	$ 92.48	$ 10.89	4.7%	$ 11.67	4.8%	2.0%	2.25%	$ 105.54	$ 113.37	$ 14.16	$ 0.33	$ 120.02	$ 127.86
Gulf	Family and Children	Adult, 19+ Years	374,005	$ 214.94	2.9%	5.9%	1.06	1.13	1.7%	0.96	0.97	$ -	$ 223.22	$ 238.47	$ 10.89	4.8%	$ 11.67	4.8%	2.0%	2.25%	$ 255.89	$ 273.23	$ 64.56	$ 1.49	$ 321.77	$ 339.10
Gulf	Breast and Cervical Cancer	BCC, All Ages Female	3,702	$ 1,291.59	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	$ -	$ 1,460.86	$ 1,577.84	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,615.27	$ 1,744.92	$ 552.62	$ 12.72	$ 2,180.61	$ 2,310.26
Gulf	LaCHIP Affordable Plan	All Ages	9,457	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	$ -	$ 115.39	$ 124.22	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.41	$ 147.88	$ 16.71	$ 0.38	$ 154.51	$ 164.98
Gulf	HCBS Waiver	18 & Under, Male and Female	6,826	$ 1,357.71	2.0%	4.6%	1.04	1.10	0.5%	0.95	0.97	$ -	$ 1,343.79	$ 1,460.38	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,469.28	$ 1,618.62	$ 51.75	$ 1.19	$ 1,542.22	$ 1,671.56
Gulf	HCBS Waiver	19+ Years, Male and Female	21,296	$ 509.87	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	$ -	$ 470.37	$ 510.93	$ 10.89	4.2%	$ 11.67	4.3%	2.0%	2.25%	$ 523.50	$ 568.78	$ 76.05	$ 1.80	$ 603.34	$ 648.62
Gulf	Chisholm Class Members	Chisholm, All Ages Male & Female	15,710	$ 774.94	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	$ -	$ 753.39	$ 825.52	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 838.14	$ 918.40	$ 67.87	$ 1.56	$ 907.57	$ 987.84
Gulf	Maternity Kickpayment	Maternity Kickpayment, All Ages	10,987	$ 5,122.05	0.0%	2.0%	1.00	1.04	-2.6%	1.00	1.00	$ -	$ 5,092.15	$ 5,305.63	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 5,640.00	$ 5,877.03	$ 2,984.49	$ 68.70	$ 8,693.19	$ 8,930.22
Capital	SSI	Newborn, 0-2 Months	168	$ 19,478.95	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	$ 945.10	$ 19,605.45	$ 20,936.71	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 21,718.65	$ 23,191.46	$ 8,066.08	$ 186.12	$ 29,990.86	$ 31,463.67
Capital	SSI	Newborn, 3-11 Months	1,491	$ 3,966.82	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	$ 63.79	$ 4,036.79	$ 4,304.79	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,461.42	$ 4,755.19	$ 944.51	$ 21.74	$ 5,427.68	$ 5,721.44
Capital	SSI	Child, 1-18 Years	89,519	$ 344.20	3.0%	5.9%	1.06	1.13	1.5%	0.98	0.99	$ 2.39	$ 365.03	$ 390.59	$ 10.89	4.4%	$ 11.67	4.4%	2.0%	2.25%	$ 409.50	$ 438.24	$ 18.76	$ 0.43	$ 428.69	$ 457.43
Capital	SSI	Adult, 19+ Years	210,439	$ 745.67	3.0%	5.9%	1.06	1.13	4.1%	0.99	0.99	$ -	$ 813.72	$ 867.77	$ 10.89	4.3%	$ 11.67	4.4%	2.0%	2.25%	$ 898.08	$ 958.00	$ 139.76	$ 3.22	$ 1,041.06	$ 1,100.97
Capital	Family and Children	Newborn, 0-2 Months	38,789	$ 1,156.11	0.6%	4.0%	1.01	1.09	-6.4%	1.00	1.00	$ 46.33	$ 1,140.87	$ 1,220.31	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,274.05	$ 1,362.67	$ 573.32	$ 13.20	$ 1,860.57	$ 1,949.19
Capital	Family and Children	Newborn, 3-11 Months	94,611	$ 223.96	2.1%	5.6%	1.05	1.12	-7.5%	0.97	0.97	$ 0.21	$ 209.26	$ 225.68	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 241.58	$ 260.47	$ 24.96	$ 0.57	$ 267.11	$ 286.00
Capital	Family and Children	Child, 1-18 Years	1,863,396	$ 96.04	3.2%	6.3%	1.07	1.14	-1.8%	0.94	0.95	$ 0.05	$ 94.83	$ 101.98	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 114.97	$ 123.60	$ 11.52	$ 0.27	$ 126.75	$ 135.38
Capital	Family and Children	Adult, 19+ Years	268,984	$ 248.77	3.0%	5.9%	1.06	1.13	6.0%	0.96	0.97	$ -	$ 268.79	$ 286.95	$ 10.89	4.7%	$ 11.67	4.7%	2.0%	2.25%	$ 305.40	$ 326.10	$ 62.59	$ 1.44	$ 369.43	$ 390.13
Capital	Breast and Cervical Cancer	BCC, All Ages Female	3,946	$ 1,291.59	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	$ -	$ 1,460.86	$ 1,577.84	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,615.27	$ 1,744.92	$ 546.25	$ 12.57	$ 2,174.10	$ 2,303.74
Capital	LaCHIP Affordable Plan	All Ages	10,487	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	$ -	$ 115.39	$ 124.22	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.41	$ 147.88	$ 17.95	$ 0.41	$ 155.77	$ 166.24
Capital	HCBS Waiver	18 & Under, Male and Female	7,164	$ 1,357.71	2.0%	4.6%	1.04	1.10	0.5%	0.95	0.97	$ -	$ 1,343.79	$ 1,460.38	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,469.28	$ 1,618.62	$ 50.17	$ 1.15	$ 1,540.61	$ 1,669.94
Capital	HCBS Waiver	19+ Years, Male and Female	21,638	$ 509.87	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	$ -	$ 470.37	$ 510.93	$ 10.89	4.2%	$ 11.67	4.3%	2.0%	2.25%	$ 523.50	$ 568.78	$ 76.02	$ 1.75	$ 601.27	$ 646.55
Capital	Chisholm Class Members	Chisholm, All Ages Male & Female	15,831	$ 774.94	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	$ -	$ 753.39	$ 825.52	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 838.14	$ 918.40	$ 68.76	$ 1.58	$ 908.48	$ 988.75
Capital	Maternity Kickpayment	Maternity Kickpayment, All Ages	9,772	$ 4,497.81	0.0%	2.0%	1.00	1.04	0.3%	1.00	1.00	$ -	$ 4,510.47	$ 4,700.44	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 4,995.73	$ 5,205.68	$ 2,977.87	$ 68.54	$ 8,042.15	$ 8,252.09
South Central	SSI	Newborn, 0-2 Months	217	$ 19,478.95	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	$ 945.10	$ 19,605.45	$ 20,936.71	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 21,718.65	$ 23,191.46	$ 7,410.29	$ 170.57	$ 29,299.51	$ 30,772.32
South Central	SSI	Newborn, 3-11 Months	1,692	$ 3,966.82	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	$ 63.79	$ 4,036.79	$ 4,304.79	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,461.42	$ 4,755.19	$ 859.85	$ 19.79	$ 5,341.06	$ 5,634.83
South Central	SSI	Child, 1-18 Years	91,726	$ 344.01	3.4%	6.2%	1.07	1.13	0.4%	0.98	0.99	$ 2.39	$ 364.84	$ 389.34	$ 10.89	4.1%	$ 11.67	4.1%	2.0%	2.25%	$ 407.86	$ 436.37	$ 38.35	$ 0.88	$ 447.09	$ 474.60
South Central	SSI	Adult, 19+ Years	247,354	$ 679.80	3.0%	5.9%	1.06	1.13	1.0%	0.99	0.99	$ -	$ 720.34	$ 768.13	$ 10.89	4.4%	$ 11.67	4.4%	2.0%	2.25%	$ 796.60	$ 849.68	$ 159.91	$ 3.68	$ 960.19	$ 1,013.28
South Central	Family and Children	Newborn, 0-2 Months	43,502	$ 1,250.37	0.7%	4.1%	1.01	1.09	-6.8%	1.00	1.00	$ 46.33	$ 1,224.44	$ 1,309.36	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,366.54	$ 1,461.21	$ 665.66	$ 15.78	$ 2,067.98	$ 2,162.65
South Central	Family and Children	Newborn, 3-11 Months	104,512	$ 223.52	2.4%	5.7%	1.05	1.12	-8.3%	0.96	0.97	$ 0.21	$ 207.58	$ 223.51	$ 10.89	5.2%	$ 11.67	5.2%	2.0%	2.25%	$ 239.49	$ 257.81	$ 44.86	$ 1.03	$ 285.49	$ 303.81
South Central	Family and Children	Child, 1-18 Years	2,038,315	$ 102.68	3.3%	6.3%	1.07	1.14	-3.0%	0.94	0.95	$ 0.05	$ 100.49	$ 107.86	$ 10.89	4.5%	$ 11.67	4.5%	2.0%	2.25%	$ 121.06	$ 129.53	$ 13.42	$ 0.31	$ 134.79	$ 143.67
South Central	Family and Children	Adult, 19+ Years	285,454	$ 232.89	2.9%	5.9%	1.06	1.13	2.8%	0.97	0.97	$ -	$ 245.52	$ 262.05	$ 10.89	4.8%	$ 11.67	4.8%	2.0%	2.25%	$ 280.15	$ 299.10	$ 57.77	$ 1.33	$ 339.25	$ 358.20
South Central	Breast and Cervical Cancer	BCC, All Ages Female	2,893	$ 1,291.59	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	$ -	$ 1,460.86	$ 1,577.84	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,615.27	$ 1,744.92	$ 560.64	$ 12.90	$ 2,188.81	$ 2,318.46
South Central	LaCHIP Affordable Plan	All Ages	12,222	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	$ -	$ 115.39	$ 124.22	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.41	$ 147.88	$ 18.72	$ 0.43	$ 156.56	$ 167.04
South Central	HCBS Waiver	18 & Under, Male and Female	6,665	$ 1,357.71	2.0%	4.6%	1.04	1.10	0.5%	0.95	0.97	$ -	$ 1,343.79	$ 1,460.38	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,469.28	$ 1,618.62	$ 53.27	$ 1.23	$ 1,543.77	$ 1,673.11
South Central	HCBS Waiver	19+ Years, Male and Female	23,110	$ 509.87	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	$ -	$ 470.37	$ 510.93	$ 10.89	4.2%	$ 11.67	4.3%	2.0%	2.25%	$ 523.50	$ 568.78	$ 76.83	$ 1.81	$ 604.14	$ 649.42
South Central	Chisholm Class Members	Chisholm, All Ages Male & Female	16,556	$ 774.94	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	$ -	$ 753.39	$ 825.52	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 838.14	$ 918.40	$ 68.07	$ 1.57	$ 907.77	$ 988.04
South Central	Maternity Kickpayment	Maternity Kickpayment, All Ages	10,504	$ 4,368.34	0.0%	2.0%	1.00	1.04	2.5%	1.00	1.00	$ -	$ 4,477.23	$ 4,665.81	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 4,959.93	$ 5,167.33	$ 2,903.03	$ 68.92	$ 7,821.88	$ 7,830.28
North	SSI	Newborn, 0-2 Months	239	$ 19,478.95	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	$ 945.10	$ 19,605.45	$ 20,936.71	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 21,718.65	$ 23,191.46	$ 7,703.95	$ 177.33	$ 29,599.93	$ 31,072.74
North	SSI	Newborn, 3-11 Months	1,678	$ 3,966.82	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	$ 63.79	$ 4,036.79	$ 4,304.79	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,461.42	$ 4,755.19	$ 874.61	$ 20.13	$ 5,356.16	$ 5,649.93
North	SSI	Child, 1-18 Years	100,260	$ 295.72	3.0%	5.8%	1.06	1.12	3.7%	0.98	0.99	$ 2.39	$ 322.88	$ 344.03	$ 10.89	4.4%	$ 11.67	4.5%	2.0%	2.25%	$ 363.57	$ 387.50	$ 43.09	$ 0.99	$ 407.65	$ 431.58
North	SSI	Adult, 19+ Years	212,259	$ 639.16	2.8%	5.8%	1.06	1.12	0.5%	0.99	0.99	$ -	$ 672.15	$ 717.13	$ 10.89	4.5%	$ 11.67	4.5%	2.0%	2.25%	$ 744.90	$ 794.96	$ 172.71	$ 3.98	$ 921.58	$ 971.65
North	Family and Children	Newborn, 0-2 Months	32,253	$ 1,240.40	0.7%	4.1%	1.01	1.09	-4.4%	1.00	1.00	$ 46.33	$ 1,244.56	$ 1,331.66	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,388.93	$ 1,486.03	$ 572.27	$ 13.17	$ 1,974.38	$ 2,071.47
North	Family and Children	Newborn, 3-11 Months	80,214	$ 205.87	2.4%	5.8%	1.05	1.12	-4.9%	0.97	0.97	$ 0.21	$ 198.77	$ 213.95	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 229.93	$ 247.45	$ 32.11	$ 0.74	$ 262.78	$ 280.30
North	Family and Children	Child, 1-18 Years	1,597,962	$ 97.14	3.1%	6.2%	1.06	1.13	-1.1%	0.96	0.96	$ 0.05	$ 97.72	$ 94.08	$ 10.89	4.8%	$ 11.67	4.8%	2.0%	2.25%	$ 107.37	$ 115.15	$ 13.49	$ 0.31	$ 121.17	$ 128.95
North	Family and Children	Adult, 19+ Years	213,631	$ 219.65	2.8%	5.9%	1.06	1.13	2.2%	0.97	0.97	$ -	$ 229.95	$ 245.85	$ 10.89	4.9%	$ 11.67	5.0%	2.0%	2.25%	$ 263.39	$ 281.66	$ 59.76	$ 1.38	$ 324.52	$ 342.79
North	Breast and Cervical Cancer	BCC, All Ages Female	2,365	$ 1,291.59	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	$ -	$ 1,460.86	$ 1,577.84	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,615.27	$ 1,744.92	$ 575.28	$ 13.24	$ 2,203.79	$ 2,333.44
North	LaCHIP Affordable Plan	All Ages	6,545	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	$ -	$ 115.39	$ 124.22	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.41	$ 147.88	$ 18.73	$ 0.43	$ 156.57	$ 167.05
North	HCBS Waiver	18 & Under, Male and Female	4,164	$ 1,357.71	2.0%	4.6%	1.04	1.10	0.5%	0.95	0.97	$ -	$ 1,343.79	$ 1,460.38	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,469.28	$ 1,618.62	$ 54.40	$ 1.25	$ 1,544.93	$ 1,674.26
North	HCBS Waiver	19+ Years, Male and Female	17,320	$ 509.87	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	$ -	$ 470.37	$ 510.93	$ 10.89	4.2%	$ 11.67	4.3%	2.0%	2.25%	$ 523.50	$ 568.78	$ 79.93	$ 1.84	$ 605.27	$ 650.55
North	Chisholm Class Members	Chisholm, All Ages Male & Female	16,472	$ 774.94	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	$ -	$ 753.39	$ 825.52	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 838.14	$ 918.40	$ 68.56	$ 1.58	$ 908.28	$ 988.54
North	Maternity Kickpayment	Maternity Kickpayment, All Ages	8,132	$ 4,615.95	0.0%	2.0%	1.00	1.04	-0.2%	1.00	1.00	$ -	$ 4,605.18	$ 4,799.14	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 5,100.64	$ 5,314.99	$ 2,573.72	$ 59.24	$ 7,733.60	$ 7,947.96

Appendix N: 2015 Managed Care Rate Setting Consultation Guide

Section I. July 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
1. General Information	
A. A letter from the certifying actuary, who meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, that certifies that the final capitation rates or rate ranges meet the standards in 42 CFR §438.6(c).	Please refer to the certification letter dated August 11, 2015. All following page and exhibit references are specific to this certification.
B. The final and certified capitation rates or the final and certified rate ranges for all rate cells and regions, as applicable.	Please refer to Appendix A for a summary of all rate ranges by rate cell and region.
C. Brief descriptions of:	
i. The specific state Medicaid managed care programs covered by the certification.	Please refer to page 1.
ii. The rating periods covered by the certification.	Please refer to page 1.
iii. The Medicaid populations covered through the managed care programs for which the certification applies.	A brief description can be found on pages 3-4. Appendix B encompasses a comprehensive list of Bayou Health's covered and excluded populations.
iv. The services that are required to be provided by the managed care plans.	A brief description can be found on pages 6-7. Appendix C encompasses a comprehensive list of Bayou Health's covered services.
2. Data	
A. A description of the data used to develop capitation rates. This description should include:	
i. The types of data used, which may include (but is not limited to) claims data, encounter data, plan financial data, or other Medicaid program data.	Please refer to page 2.
ii. The age of all data used.	Please refer to page 2.
iii. The sources of all data used.	Please refer to page 2.

Section I. July 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
iv. To the extent that a significant portion of benefits are provided through subcapitated arrangements, a description of the data received from the subcapitated plans or providers.	N/A
v. To the extent that claims or encounter data are not used or not available, an explanation of why that data was not used or was not available.	N/A
B. Information related to the availability and the quality of the data used:	
i. The steps taken by the actuary or by others (which may include but is not limited to the state Medicaid program or the managed care organizations) to validate or improve the quality and accuracy of the data.	Please refer to the base data adjustment section beginning on page 7.
ii. Any concerns that the actuary has over the availability or quality of the data.	The data certification shown in Appendix L has been provided by DHH, and its purpose is to certify the accuracy, completeness, and consistency of the base data.
C. Any information related to changes in data used when compared to the most recent rating period:	
i. Any new data sources used by the actuary since the last certification and any data sources that the actuary has not continued to use since the last certification.	Bayou Health Shared Savings claims experience is used as a new data source. The Bayou Health Prepaid program operated under an at-risk capitated arrangement, and the Shared Savings program was an enhanced Primary Care Case Management (ePCCM) program. Effective February 1, 2015, Bayou Health will begin operating as an at risk capitated program only.
ii. How the data sources used have changed since the last certification.	N/A
D. Any plans or efforts to improve the data sources used for future certifications and any new data sources that are expected to be available and potentially used for future certifications.	N/A
E. Any adjustments that are made to the data.	Please refer to the base data adjustment section beginning on page 7.

Section I. July 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
3. Projected Benefit Costs	
A. Covered services and benefits	
i. Any changes related to the benefits covered by the Medicaid managed care organizations since the last certification, including but not limited to:	
a. More or fewer state plan benefits covered by the Medicaid managed care organization.	Please refer to the new services section on page 6.
b. Requirements deemed necessary by the state to ensure access or proper delivery of covered services, for minimum or maximum levels of payment from managed care organizations to any providers or class of providers.	N/A
c. Requirements or conditions of any applicable waivers.	N/A
ii. For each change related to benefits covered, the estimated impact of the change on amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment.	Please refer to the covered services section beginning on page 6.
B. Projected benefit cost trends	
i. The projected change in benefit costs from the historical period to the rating period, or trend, including but not limited to:	
a. The methodologies used to develop projected benefit costs trends.	Please refer to the trend section beginning on page 17.
b. Any data used or assumptions made in developing projected benefit cost trends.	Please refer to the trend section beginning on page 17.
c. Any applicable comparisons to historical benefit cost trends or other program benefit cost trends.	Please refer to the trend section beginning on page 17.

Section I. July 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
d. The different components of projected benefit cost trends, including but not limited to changes in price (such as provider reimbursement rates) and changes in utilization (such as the volume of services provided).	Please refer to Appendices I1-I3.
e. Any other material adjustments to projected benefit cost trends, and a description of the data, assumptions, and methodologies used to determine those adjustments.	N/A
f. To the extent there are any differences, projected benefit cost trends by:	
i. Service or category of service.	Please refer to Appendices I1-I3.
ii. Rate cell or Medicaid population.	Please refer to Appendices I1-I3.
C. Other adjustments to projected benefit costs:	
i. Any other adjustments made to projected benefit costs excluding those described above, including but not limited to:	
a. The impact of managed care on the utilization on the unit costs of health care services.	Please refer to the managed care adjustments section beginning on page 19 and Appendices J1-J2.
b. Changes to projected benefit costs in the rating period outside of regular changes in utilization or unit cost of services.	Please refer to the program changes section beginning on page 14.
D. Final projected benefit costs by relevant level of detail (for example, by Medicaid population or by rate cell).	Please refer to Appendix M.
4. Projected Non-benefit Costs	
E. Non-benefit costs including but not limited to:	Please refer to the non-medical expense load section beginning on page 22.
i. Administrative costs.	
ii. Care management or coordination costs.	
iii. Provisions for:	
a. Cost of capital.	
b. Risk margin.	
c. Contingency margin.	

Section I. July 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
d. Underwriting gain.	
e. Profit margin.	
iv. Taxes, fees, and assessments.	
v. Any other material non-benefit costs.	N/A
5. Rate Range Development	
A. Any assumptions for which values vary in order to develop rate ranges.	Please refer to the trend and managed care adjustments sections beginning on page 19, the Shared Savings Rx claims section beginning on page 20 and the non-medical expense load section on page 22.
B. The values of each of the assumptions used to develop the minimum, the mid-point (as applicable), and the maximum of the rate ranges.	Please refer to sections related to trend assumptions, managed care adjustments, Shared Savings Rx adjustment, prospective program change adjustments, and non-medical expense load considerations.
C. A description of the data, assumptions, and methodologies that were used to develop the values of the assumptions for the minimum, the mid-point (as applicable), and maximum of the rate ranges.	Please refer to sections related to trend assumptions, managed care adjustments, Shared Savings Rx adjustment, prospective program change adjustments, and non-medical expense load considerations.
6. Risk and Contractual Provisions	
A. Risk adjustment processes.	Please see risk adjustment section on page 23.
B. Risk sharing arrangements, such as risk corridor or large claims pool.	Please see outliers section on page 21.
C. Medical loss ratio requirements, such as a minimum medical loss ratio requirement.	N/A
D. Reinsurance requirements.	N/A
E. Incentives or withhold amounts.	Please see federal health insurer fee section on page 23.

Section I. July 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
7. Other Rate Development Considerations	
A. All adjustments to the capitation rates, or to any portion of the capitation rates, should reflect reasonable, appropriate, and attainable costs in the actuary's opinion and must be included in the rate certification. CMS notes that adjustments that are performed at the end of the rate setting process without adequate justification might not be considered actuarially sound.	N/A
B. The final contracted rates should either match the capitation rates or be within the rate ranges in the actuarial certification. This is required in total and by each rate cell.	N/A. Certification of the rate range.

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November 20, 2015

Subject: Louisiana Bayou Health Program – Specialized Behavioral Health (BH) Actuarial Certification for Capitation Rate Ranges Effective December 1, 2015 through January 31, 2016

Dear Jen:

The State of Louisiana (State) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop actuarially sound capitation rate ranges for use in the State's contracts with the managed care organizations (MCOs) for Medicaid Specialized BH services provided to Medicaid-eligible adults and children in the Bayou Health program. The rate ranges were developed for specialized BH services covered under the managed care program for Medicaid-eligible adults and children for the contract period, effective from December 1, 2015 through January 31, 2016 (rating period).

This letter presents an overview of the analyses and methodology used in Mercer's managed care rate range development for Medicaid services for the purpose of satisfying the requirements of the Centers for Medicare and Medicaid Services (CMS) in a manner consistent with CMS regulations, 42 CFR 438.6(c).

Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government-mandated assessments, fees and taxes, and the cost of capital.

This letter describes the development of the draft rate ranges in Appendix B. The assumptions detailed in the memo illustrate the development of the midpoint rates for each rate cell on a statewide basis. The regional development of the rate ranges is included in the Appendices, which include the individual impacts of the programmatic change adjustments by region and rate cell.

Program Overview

The Louisiana Behavioral Health Partnership (LBHP) began March 1, 2012, and has operated under an at-risk capitation contract for the Adult population since the program inception. The Children's program has been administered on a non-risk basis by the Prepaid Inpatient Health Plan (PIHP). Effective December 1, 2015, the specialized BH services will be covered under the contracts with the Bayou Health MCOs. The initial rating period will be December 1, 2015 through January 31, 2016 to align with the remainder of the current Bayou Health rating period. Effective February 1, 2016, the specialized BH services will be integrated into the overall Bayou Health rating structure.

Separate capitation payments will be made for specialized behavioral health services effective December 1, 2015. The MCOs will continue to receive a payment for prior Bayou Health covered services under the Bayou Health rate cell structure. In addition, a separate payment will be made for eligible individuals for their specialized behavioral services under the current LBHP rate cell structure as outlined later in this letter.

Covered Populations

Bayou Health covers a broad array of Medicaid eligible populations. Specific information on the covered populations is contained in the contract. The following categories of aid (COA) are covered for a BH capitated payment under the contract and considered in rate setting:

- Non-Disabled Adults, Ages 21+
- Disabled Adults, Ages 21+
- Dually Eligibles, All Ages
- Non-Disabled Children, Ages 0-20
- Foster Care and Disabled Children, Ages 0-20

Mercer summarized the specialized behavioral health service utilization and cost data for the Medicaid eligible individuals into the rate cell structure. This structure is based on the prior LBHP rate structure for specialized BH services from Mercer's review of the historical cost and utilization patterns in the available experience.

The historical BH costs vary by age and eligibility category. Separate rate cells were designed for the Child and Adult populations. Non-Disabled populations have significantly lower BH costs compared to Disabled/Foster Care populations. As such, separate rate cells were created for the non-Disabled and Disabled/Foster Care populations. The dually eligible population is eligible for services where Medicare is the primary payer. As the Medicare crossover services will be excluded from the Bayou Health capitated program, a separate rate cell was necessary to address

the cost differences for the dually eligible populations. Due to the small number of dual eligibles under the age of 21, Mercer included all dual eligibles regardless of age into a single rate cell.

Populations that remain fee-for-service (FFS) or part of the non-risk program and are not covered under the capitation payment are as follows:

- Eligible under the Refugee Cash/Medical Assistance program
- Eligible under the Medicare Savings Program (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, Qualified Individuals, and Qualified Disabled Working Individuals)
- Eligible under the Emergency Services Only program (aliens who do not meet Medicaid citizenship/ 5-year residency requirements)
- Eligible under the Long-Term Care Medicare Co-insurance program
- Eligible under the Section 1115 Greater New Orleans Community Health Connection Waiver
- Eligible under the Family Planning Eligibility Option (FPEO) that provides family-planning-services
- Eligible under the Program of All-Inclusive Care for the Elderly (PACE), a community-based alternative to placement in a nursing facility that includes a complete “managed care” type benefit combining medical, social and long-term care services
- Adults residing in Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD)
- Non-Medicaid adult on the eligibility file who is eligible for a Low-Income Subsidy program administered by the Social Security Administration
- Any Medicaid eligible person during a period of incarceration

Covered Services

The Bayou Health program will cover a broad array of specialized mental health and addiction services, including the following services covered under the State Plan:

- Inpatient Psychiatric Hospital services
- Psychiatric Emergency Room services
- Outpatient Psychiatric services
- Crisis Intervention services
- Community Psychiatric Support services
- Addiction services.
- Assertive Community Treatment
- Multi-systemic Treatment
- Medical Physician / Psychiatrist / Nurse Practitioner

- Psychosocial Rehabilitation
- Other BH Professional (Mental Health (MH) Providers and Clinics, Nurses, and Other Licensed Providers)
- Federally Qualified Health Center (FQHC)
- Psychiatric Residential Treatment Facility
- Therapeutic Group Home
- 1915(b)(3) Services - Case Conference

Medicaid eligibles receive Physical Health and other Medicaid-covered services from the Bayou Health MCOs or through the State's fee-for-service (FFS) program. The acute care portion of Bayou Health includes coverage for prescription drugs for both Physical Health and BH medications. As such, prescription drugs are not included in these capitation rate ranges nor any prescription drug considerations discussed in this letter.

Children who are enrolled in the CSoC 1915(c) waiver program or included in the 1915(b)(3) CSoC program will only be in Bayou Health for Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH) and Substance Use Disorder (SUD) Residential services in terms of BH coverage. The other specialized BH services will be managed by Magellan. More information on CSoC considerations is included later in this letter. The State maintains a list of the individuals enrolled in the CSoC program as well as a waiver segment code on the eligibility records. This logic was utilized to exclude the requisite services from the rate development.

For the dually eligible individuals, Medicare crossover claims have been excluded from the base data and rate development. These services are paid directly by the State after coordinating with Medicare and have been excluded from the services covered under the capitation rates.

This actuarial certification is specific to the capitation rates for the Specialized BH portion of the Bayou Health program effective December 1, 2015 through January 31, 2016.

Rate Methodology

Overview

Capitation rate ranges for the Specialized BH services were developed in accordance with rate-setting guidelines established by CMS. One of the key considerations in the development of the rate ranges was the base data. The primary base data used to develop the rate ranges were managed care encounter data provided by the State.

The encounter data are submitted by the PIHP to the State's fiscal agent, Molina. Molina provided an extract of the encounter data to Mercer in March 2014 for use in the preparation of the Data

Book. The encounter data extract included recipient-level claims and utilization detail. The eligibility information used in the encounter data analysis is summarized from the State's eligibility file, which outlines enrollment segments for each member. The contents of the Data Book are consistent with the data summarized for the current LBHP rate period of March 2015 through November 2015 with the exception of additional breakouts by region. The decision was made to utilize the same base data for the December 2015 through January 2016 rate development and prepare updated Data Books for Specialized BH services with the use of 2014 data for the February 2016 rates consistent with the plan for the Bayou Health program.

Mercer reviewed the Specialized BH contract to identify covered services. Then, the following adjustments to the base data were evaluated:

- Trend factors to forecast the expenditures and utilization for the rating period
- Programmatic changes not reflected in the base data
- Managed care adjustments
- Administration and risk margin loading

The various steps in the rate range development are described in the following paragraphs.

Base Data

The base data used to establish the capitation rates are summarized in the Data Book. The Data Book contains demographic, cost, and utilization data related to specialized BH services only. The Data Book is included along with this certification letter.

PIHP Encounter Data

The State provided Mercer with 2012 and CY 2013 encounter data submitted by the PIHP for services delivered to adults (on an at-risk basis) and children (on a non-risk basis). Mercer used this data to support the rate calculations. After review of the data, Mercer determined that actual experience incurred from January 1, 2013 through December 31, 2013, paid through February 2014 was suitable for rate development and as noted consistent with the Data Book utilized in the development of the March 2015 through November 2015 rates. Data prior to this time period reflected lower volume of services as the adult managed care program began in March, 2012.

Mercer performed a review of the PIHP encounter data for the State. This review included:

- Checks for month-to-month consistency of claims and eligibility
- Checks for reasonability of the utilization and unit cost information
- Comparisons to PIHP financial data and historical FFS data

- Analysis of claims lag triangles

Note that Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, and financial data and information supplied by the State and the PIHP. The State and the PIHP are solely responsible for the validity and completeness of these supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion they are appropriate for the intended rate-setting purpose. However, if the data and information are incomplete and/or inaccurate, the values shown in this report may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this report.

Base Data Adjustments

After analysis of historical payment patterns and discussions with the State, Mercer was able to assess the accuracy and completeness of the information and estimate any necessary adjustments. Mercer applied adjustments to the encounter data so that they reflected the populations and services covered under the contract, including the considerations of the new mixed services protocol effective March 2015.

Mercer reviewed the PIHP encounter data to ensure they were appropriate for the populations and services covered. The following items were not included in the encounter data or were already deducted from the paid amounts in the encounter data, and therefore no further adjustment was necessary:

- Third-party liability recoveries are already deducted from the payments used in rate setting. No material amounts were paid outside the claim system.
- Copayments, coinsurance, and deductibles
- Disproportionate Share Hospital payments (AA.3.5)

Mercer understands that payment rates for Graduate Medical Education (GME) hospitals included in the claim data are consistent with applicable State fee schedule rates which do not include the GME portion of Inpatient payments. Because Mercer relied on the payment information included in the dataset submitted by the PIHP, the GME portion of Inpatient payments are not included in the base data and won't be included in the capitation rates. The State will continue to make supplemental payments to hospitals for GME, as applicable.

Completion factors were applied to the encounter data to reflect claims not yet adjudicated (see step AA.3.14 in the CMS Rate-setting Checklist). Financial lags were available separately for

Inpatient and all other services. Mercer compared the results of the encounter completion analysis to the financial lags to evaluate whether an encounter underreporting adjustment was necessary. .

For more information on the adjustments listed above, please refer to Section 4 of the Data Book included in this submission.

Other Base Data Considerations

Excluded Populations and Services

Certain adjustments were not necessary due to exclusions made in the data summarization process. These adjustments include:

- **Excluding non-covered populations** (for example, qualified Medicare beneficiaries, Medically Needy spend-down individuals, etc., see step AA.2.1) — Please see Data Book Section 2 for more information.
- **Excluding non-covered services** (for example, Physical Health services, 1915(c) Waiver services, etc., see step AA.3.1) — Please see Data Book Section 3 for more information.

State Plan Service Considerations

The rate development considers expected costs for State Plan services delivered in a managed care environment. In some cases for the Adult population, the prior PIHP provided an approved service in-lieu-of a State Plan service. In these cases, Mercer has reflected the costs of the State Plan service and applied a managed care discount to arrive at total costs consistent with actual paid expenses. The table below identified the key services priced using this methodology.

2013 Paid Encounter Claims

State Plan	In Lieu Of	Non-Dual	Dual Eligble	Encounter Unit Cost	State Plan Unit Cost	Managed Care Discount
Inpatient	IP IMD (21-64)	$ 13,021,841	N/A	$ 489.45	$ 646.94	-24%
Acute Detox Facilities	SUD Residential	$ 4,163,515	$ 338,654	$ 67.14	$ 145.51	-54%
ER	Crisis	$ 141,408	$ 25,365	$ 81.79	$ 249.12	-67%

The unit costs for the in-lieu-of services was less than the alternative State Plan services, demonstrating the cost-effectiveness of these services.

New Mixed Service Protocol

The State has implemented changes to the services classified as specialized behavioral health services. Previously, Institutional services (Inpatient, Outpatient, and ER) were covered as specialized behavioral health services under LBHP if the claim was identified with a qualifying BH

diagnosis. Effective March 1, 2015, only claims from BH facilities or services provided by BH specialists will be classified as specialized behavioral health services, as described below.

- **Inpatient and Outpatient services —** BH facilities include freestanding psychiatric hospitals, general hospital distinct part psych (DPP) units, MH clinics and rehab facilities, substance use disorder facilities, residential settings, and other BH providers.
- **Professional BH services —** BH specialists include physicians, doctors of osteopathic medicine (DO), and advanced practice registered nurses with specialty in psychiatry, as well as psychologist and licensed MH professionals. Unlicensed BH providers are covered for Rehab services only. Coverage includes services provided by BH specialists regardless of service location, including consults and services provided by a BH specialist in a general Inpatient or ER setting. Servicing provider specialty (as opposed to billing provider) is used to determine classification of specialized behavioral health services. Services billed and provided separately by non-BH specialists (such as general nurse practitioner) where place of service is a BH facility are classified as Acute care services under Bayou Health and not classified as specialized behavioral health services.
- **ER Services —** ER services are not classified as specialized BH, except for professional components billed by BH specialists or when the facility component is billed by a BH facility (for example, a freestanding psychiatric facility or DPP unit billing revenue code 450).
- **Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services —** FQHC and RHC services are covered in full when any service provided during a visit is provided by a BH specialist. All other FQHC and RHC visits are not classified as specialized BH services.

The details of the mixed service protocol are summarized in the Data Book. The net impact of the changes to the mixed service protocol resulted in approximately $13.8 M of historical 2013 encounter data being reclassified as basic BH, which was already accounted for in the Bayou Health February 2015 rates.

Trend

Trend is an estimate of the change in the overall cost of providing health care services over a finite period of time (AA.3.10). Capitation rate ranges are actuarial projections of future contingent events and a trend factor is necessary to estimate the expenses of providing health care services in the future rating period.

To develop the December 1, 2015 through January 31, 2016 rate ranges using the CY 2013 encounter data as a base, Mercer projected costs based on a review of historical experience, emerging trends, and expected costs and utilization during the rating period. The midpoint of the

base data was July 1, 2013. The midpoint of the rating period is January 1, 2016, which necessitated 30 months of total trend to project from the base time period to the rating period.

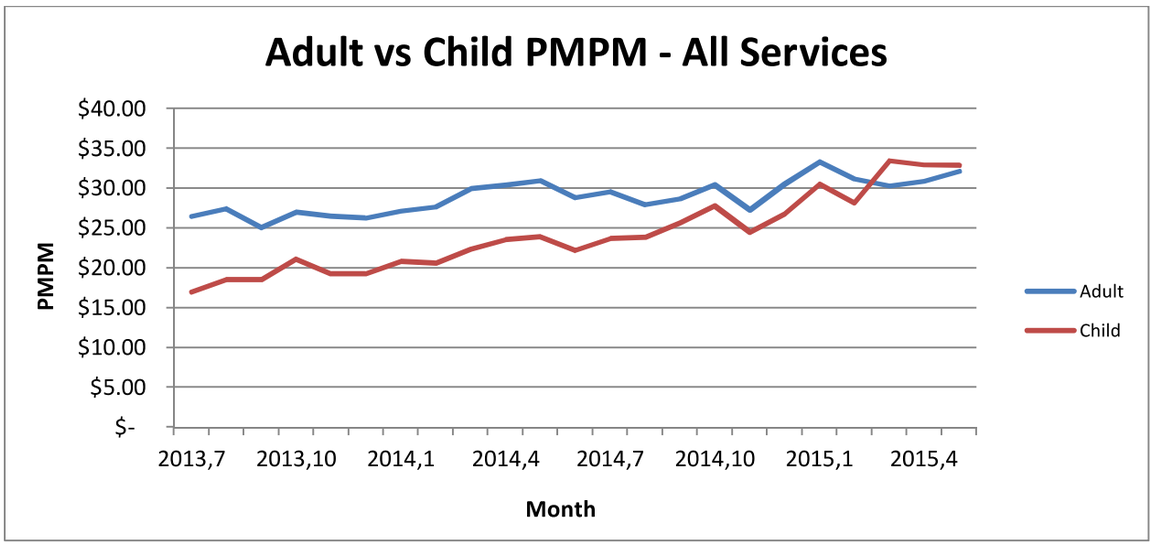
Trend Data Sources

As more recent utilization and cost data has become available for Specialized BH services beyond the 2013 base data period, Mercer focused the trend analysis on the actual trend patterns from the midpoint of the base data period (July 2013) through the most recently available data through May 2015.Mercer created rolling-average Per Member Per Month (PMPM) summaries using the managed care encounter data for various time intervals (three month, six month, nine month and 12 month) by region, rating group, and major service category.

The trend analysis focused on the emerging PMPM trends, which encompassed both the unit cost and utilization components. Each rate cell in the State experience exhibited unique trends reflecting the underlying characteristics of the population and the mix of services received. The CY 2014 and emerging 2015 data indicated significant increases in utilization for many services. The trends for the community psychiatric and psychosocial rehabilitation service categories exhibited significant PMPM growth from the beginning of 2013 through May 2015. Given the limited projection period from the end of the available data (May 2015) through the midpoint of the rate period (January 1, 2016), Mercer assumed prospective trend patterns for the Specialized BH services consistent with the trend levels exhibited in the emerging data through May 2015.

Mercer reviewed trend information in other state's Medicaid programs and national indices as reasonability checks. These sources were reviewed, but the trend observations in the LA specific program experience were determined to be the most credible base for future projections. The significant utilization trends exhibited in the LA program experience are higher than other state programs that have higher established historical utilization levels.

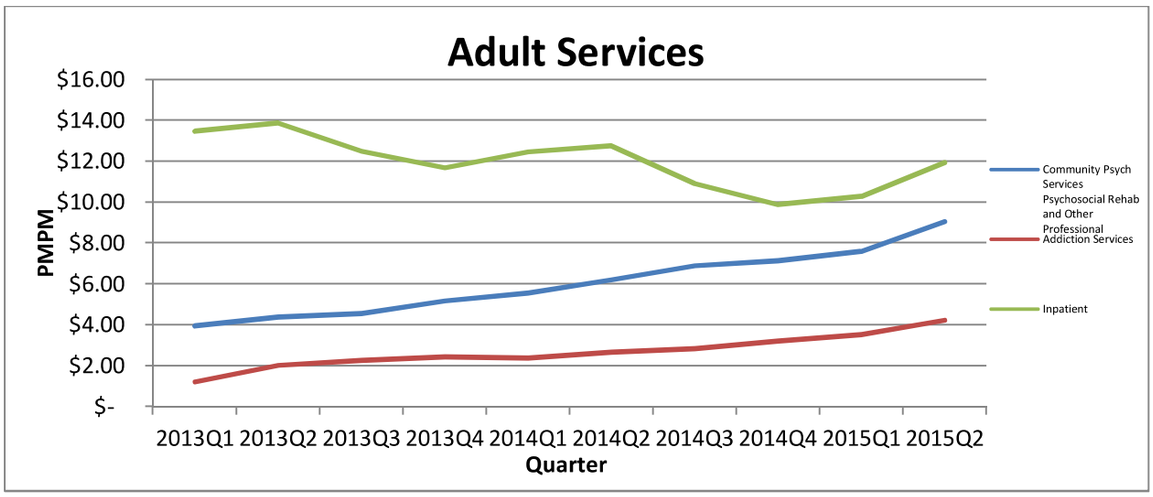
Trends observed in the data through May 2015 indicate significant growth in the overall service utilization for all regions and rate cells, particularly the children's services. The graphs below show quarterly PMPM growth between CY 2013 and May 2015.



The PMPM progression illustrates that, while Adult trends appeared to mitigate during 2014 from the historic growth, trends in the first two quarters of 2015 have re-emerged for certain services. While children's services have historically been low compared to that of adults, recent utilization growth has driven notably high PMPM trends in 2014 and 2015. Mercer developed trend assumptions at the region and category of service level based on the specific trend patterns reflected in the data. Generally, the trend drivers were consistent by region. As such, the trend observations are provided below on a statewide basis specific to each population.

Adult Trend Observations

The adult trends are primarily driven by utilization growth in Community Psych, Psychosocial Rehab and Addiction Services throughout 2013 and into the first two quarters of 2015. There was significant growth of community based services starting in CY 2013 that has continued into 2015. Utilization of addiction treatment services has experienced more significant trends in 2015. The higher trends for community-based services were partially offset in 2014 by decreasing utilization of Inpatient services. The table below shows the trends in the historic quarterly adult PMPMs for these three categories of service.



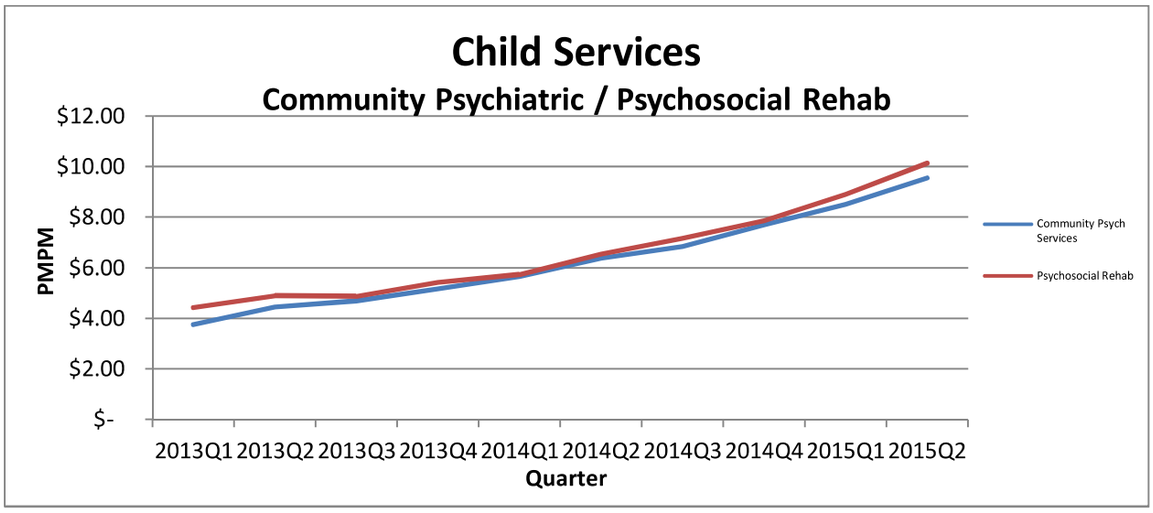
The composite annual PMPM trends for each category of service for adults are listed in the table below. Mercer grouped similar categories of service that had similar trend patterns together to increase credibility for the smaller categories of service. Trends were applied for 30 months from the midpoint of CY 2013 to the midpoint of the December 1, 2015 through January 31, 2016 rating period.

Categories of Service	Annualized PMPM Trend
Inpatient, Inpatient Detox	-3.5%
Emergency Room, Outpatient, Medical Physician/Psychiatrist, Other Professional, FQHC,	18.2%
Community Psychiatric Support, Psychosocial Rehab, ACT	22.7%
Addiction Services	39.5%
Crisis Intervention, MST, and Other Services	31.3%
Total	11.5%

Child Trend Observations

The Child trends are driven by utilization growth in Community Psych and Psychosocial Rehab, and recently Other Professional services. Significant growth in these services was observed throughout the entire period between CY 2013 and the early months of CY 2015. Based on the continued growth into CY 2015, Mercer expects higher trends to continue throughout CY 2015, and into the rating period for children's services. The table below shows the trends in the historic

quarterly child PMPMs for the categories of service that are driving the growth in children's services.



The overall trend projection for each category of service for children is listed in the table below.

Categories of Service	Annualized PMPM Trend
Inpatient, Inpatient Detox	9.0%
Emergency Room, Outpatient, Medical Physician/Psychiatrist, Other Professional, FQHC,	18.6%
Community Psychiatric Support, Psychosocial Rehab, ACT	42.1%
PRTF	16.6%
Crisis Intervention, MST, Addiction Services, Other Services, Therapeutic Group Home	12.6%
Total	29.7%

The overall annualized projected BH service trend assumption is 11.5% for adults, 29.7% for children, or 24.4% overall including increases in both utilization and general cost inflation. Mercer recognizes that prospective trends can vary based, on fluctuations in service utilization and has considered this variability in the development of the trend ranges. To project the final rate ranges, Mercer varied the trend assumptions by varying the annualized trend from an overall annual rate of 21.1% at the Lower Bound to 27.0% at the Upper Bound. The Lower Bound represents lower

rates of growth as initial period trends moderate and the Upper Bound represents continued utilization growth at the higher levels observed during the initial years of the program.

Programmatic Changes

Mercer and the State discussed programmatic changes that may impact the managed care contract. This included a review of changes to the State's hospital fee schedules, adjustments to account for changes in population mix, rate changes for certain providers after the 2013 base data time period, and adjustments for final decisions on program coverage after the development of the base data. The following sections describe the analysis for each program change as well as the statewide impact of the adjustment. Mercer has included Appendix C which details the percentage and PMPM impact of each adjustment by region and rate cell.

Inpatient Hospital Fee Schedules

Inpatient Hospital fee schedules have changed in Medicaid from the levels reported in the base data. Most notably, rates for certain public hospitals changed as a result of the public/private partnership. The changes to the hospital rates represent both increases and decreases depending on the hospital.

Mercer has included an adjustment to the capitation rates to account for the changes to the hospital reimbursement, including the public/private partnership. In order to account for this change, Mercer analyzed the base data by hospital and region separately for adults and children services. For adults, Mercer compared the PIHP fee schedules and per diem costs reported in the encounter data to the new State Medicaid fee schedule. Based on this comparison, Mercer determined no adjustment was needed for the Adult rates as the PIHP fee schedule underlying the encounter data generally aligned with the new State Medicaid fee schedule. For children, however, hospital reimbursement levels in the encounter data generally followed historic State Medicaid fee schedules. As a result, an adjustment was necessary to reflect changes between the historic and the new fee schedule for the children's rates.

Overall, this represents a 0.3% increase to the rate ranges and impacts child rating groups only.

Medication Management Rate Change

Effective January 2013, the prior Medication Management procedure code of 90862 was eliminated and the services were required to be billed under General Evaluation and Management codes 99211-99214, 90863. These codes, as reflected in the base data, were reimbursed at lower rates averaging approximately $47 per unit than the prior medication management services in 2012. The PIHP revised the fee schedule in 2014 to adjust the fees for medication management

services up to prior historical levels. The State indicated it expects providers to continue to be paid at the higher reimbursement level under the Bayou Health program.

Mercer analyzed 2014 encounter data by region and observed an increase in the average reimbursement rate for these services to roughly $73 per unit. Mercer calculated the program change impact based on reported service utilization in each region.

As the Medication Management service costs are captured in both the Medical Physician/Psychiatrist category and the Other Professional category along with other procedures, Mercer calculated a proportionate program change to each category to incorporate the expected impact on the broader service category for this fee increase. Specifically, Mercer applied adjustments to Medical Physician/Psychiatrist and to Other Professional categories of service.

Overall, this represents a 1.4% increase to the rates and impacts all rating groups.

Population Mix Considerations

Disability Medicaid Closure

In 2014, the State eliminated coverage of the Disability Medicaid category identified by Type Case code 125. This group included coverage for approximately 10,000 aged, blind and disabled adults. Although this coverage category was discontinued, approximately 50% of individuals previously eligible are expected to enroll through either provisional Medicaid (Type case 211) or Supplemental Security Income eligibility. Mercer evaluated the historical costs for the Disability Medicaid population identified under Type Case code 125 and compared this group to the remaining population in the Disabled Adult and Dual Eligible Adult rates cells. The Disability Medicaid group had higher-than-average costs in each of the rate cells. Based on the assumption that not all individuals previously covered under Disability Medicaid individuals would reenroll (which is supported by emerging 2014 enrollment), Mercer calculated a downward adjustment to reflect the lower average cost of the remaining population.

LaCHIP – Family and Children

Subsequent to the summarization of the CY 2013 base data, the State informed Mercer of an eligibility group that will be covered under the managed care program for specialized BH services but was not included in the CY 2013 base data. Mercer analyzed historic CY 2013 claim experience for this population group and developed an adjustment factor that reflects the PMPM impact to the existing CY 2013 average PMPM.

The impact of these two population adjustments is a decrease of 0.5% to the rates overall and impacts adult rating groups only.

Retroactive Eligibility Adjustment

The retroactivity considerations for Specialized BH services will mirror the coverage responsibility of the Bayou Health plans for acute care services. As a reminder, beginning in February 2015 members granted retroactive eligibility were capitated retroactively, based on their eligibility for Bayou Health, for up to 12 months prior to enrollment in an MCO. The MCO selected by these members will then receive one capitation payment per month of retroactive enrollment, and will be liable for all claims incurred during this retroactive eligibility period. For Specialized BH services this policy goes into effect on December 1, 2015. Mercer developed an adjustment factor to apply to the base data in the capitation rate development.

The retroactive eligibility adjustment was developed specific to each rate cell as utilization levels for specialized BH services varied between retroactive and non-retroactive enrollees. Retroactive enrollment in any given rate cell will generate the same capitation payment per month to the MCO as any other enrollee in that same rate cell. The factors were developed at a rate cell level on a statewide basis (i.e., all regions used the same factors). The calculation relied upon retroactive claims PMPM, unique enrollee counts, and the average duration to develop the expected increase to Bayou Health claims.

Mercer reviewed the average duration of enrollees who were retroactively enrolled during 2013. The program change was calculated by summarizing the PMPM for the retroactive eligibles and blending it with the respective rate cell PMPM based on enrollment. The program change adjustment reflects the impact on average rate cell PMPMs as a result of adding these retroactive eligibles. The table below summarizes the impact of the Retroactive Eligibility Adjustment.

Population	Adjustment
Non-Disabled Adults	-0.1%
Disabled Adults	0.2%
Non-Disabled Children	-0.2%
Disabled Children	-0.1%
Dually Eligibles	0.0%

Other Populations

The State has outlined recent decisions to further clarity the Bayou Health covered populations for specialized BH services. As these populations represent a change from what was captured in the base data or Data Book, Mercer analyzed the impact on the PMPM for these changes for the final rates. The table below summarized the impact for the following population changes.

- Coverage of Spend-down populations

- Coverage of Medically Needy populations
- Removal of Denied SSI, Forced Benefits and Terminated SSI populations

Population	Adjustment
Non-Disabled Adults	-0.3%
Disabled Adults	-0.0%
Non-Disabled Children	+0.0%
Disabled Children	+0.0%
Dually Eligibles	0.0%

These other population considerations added 23,165 member months (or 0.2%) to the populations included in the Data Book.

Overall, the adjustments for Disability Medicaid Closure, LaCHIP – Family and Child, Retroactive Eligibility and Other Population considerations represent a decrease of 0.6% to the capitation rate ranges on a statewide basis.

Permanent Supportive Housing Provider Rate Increase

Subsequent to CY 2013, the State implemented a 5% rate increase to certain providers delivering community psych services to individuals in the permanent supportive housing (PSH) program. Using the list of PSH providers from the State, Mercer summarized historic cost and utilization data for community psych services for these providers and calculated the impact of the 5% increase. Mercer applied this impact to rating group and region based on historic utilization patterns.

Overall, this represents a 0.1% increase to the rates and impacts all rating groups.

1915(c) CSoC Regional Expansion

As noted earlier in this letter, the CSoC population will be generally excluded from Bayou Health for specialized BH services. Magellan will continue to administer this program. From 2013 through early 2015, the CSoC population has expanded. Mercer evaluated the implications of this expansion on the rate cells for the Bayou Health program.

The State submitted an amendment to the 1915(c) CSoC waiver to increase the number of waiver slots and expand the waiver program statewide starting in 2014. Upon expansion, certain Children previously classified in a disabled or non-disabled rating group shifted to the CSoC program. Mercer calculated the volume of CSoC transitions by comparing the average 2013 CSoC

enrollment to emerging levels as of April, 2015. The growth by region is outlined in the table below:

CSoC Enrollment	Average 2013	As of April, 2015
Gulf	198	449
Capital	214	426
South Central	152	341
North	491	510
Statewide	1,054	1,726

Mercer then analyzed the historic Specialized BH expenses associated with CSoC enrollees and noted that it is materially higher when compared to the PMPM for other child rating groups ($554 PMPM vs $18 PMPM, respectively). Because of this differential, the movement of those higher needs children out of disabled or non-disabled rating groups resulted in a reduction in the average PMPM by region. The transition analysis was performed on a regional basis using the underlying PMPMs for each region as well as CSoC-specific PMPMs for each region.

Overall, this represents a decrease of 1.8% to the rates and impacts child rating groups only.

Bayou Retained Liability for CSoC Specialized BH Services

As individuals change eligibility status between the CSoC program and other Bayou rate cells, the State has implemented policies that warrant program change consideration from the Data Book.

Month One Claim Liability

If individuals transition from a Bayou rate cell to CSoC after the first day of the month, Bayou will retain liability for specialized BH services for the remainder of that month. After the first month of CSoC eligibility, claim liability for specialized BH services will no longer be the responsibility of Bayou. For the capitation rate development, Mercer has assumed full capitation payment for Specialized BH services will be made to the Bayou Health MCOs for the first month for which they are identified for the CSoC waiver, even if the individual is only enrolled in CSoC for a partial month.

To calculate this adjustment, Mercer summarized the initial month of specialized BH services and eligibility for those individuals transitioning to CSoC. Mercer then compared this data to that of non-Disabled and Disabled children to develop an appropriate PMPM adjustment. Because individuals transitioning to CSoC typically have higher utilization levels than that of non-Disabled

or Disabled children, this coverage change results in an upward PMPM adjustment to the costs captured in the Data Book.

SUD Residential/PRTF/TGH Coverage
All SUD Residential, PRTF and TGH services delivered to CSoC individuals will remain with Bayou Health regardless of CSoC eligibility status. Mercer summarized SUD Residential, PRTF and TGH claims for CSoC eligibles and included these expenses in the respective non-Disabled Child or Disabled Child rate cells. This coverage decision results in an upward adjustment to the costs captured in the data book.

The impact of these two considerations is a 0.8% increase to the rates overall and impacts child rating groups only.

Historic Outpatient Cost Settlements
The State has historically implemented fee schedule adjustments for various outpatient services. For outpatient providers, the fee schedule adjustment process includes an estimation of cost settlements that are not captured in the historic base data. Since cost settlements will become the responsibility of the MCOs under managed care, an adjustment to the Bayou Health rates was necessary. Because outpatient services do not constitute a material portion of the service array for Specialized BH, this adjustment was not expected to be material.

To calculate the historic outpatient cost settlement impact, Mercer analyzed provider-level cost settlement information provided by the State. Comparing this information to claim payment data, Mercer calculated the historic cost settlement impact by provider. These cost settlements were included as a program change to the Specialized BH portion of the Bayou Health rates.

Overall, this represents a slight positive impact, rounded to 0.0%, to the rates and impacts all rating groups.

PRTF Per Diem Adjustment
The State informed Mercer of two PRTF providers that have historically been subject to risk sharing arrangements that have had recent per diem changes. The prior risk sharing process resulted in additional payments to the providers as the per diem documented in the cost reports was higher than the interim rates. Mercer has built in consideration of provider specific rates for these providers based on the cost report per diems.

To calculate the impact, the State provided Mercer with the risk sharing calculations that were based on base paid and final targeted per diem rates for these two providers. The final cost

impact was calculated by another firm on behalf of the State. Mercer reviewed these calculations for reasonability but did not audit them. Mercer leveraged the final calculations to determine the net impact to the CY 2013 time period to develop the program change impact. Mercer incorporated the expected cost for the per diem change based on utilization during the 2013 time period and applied an upward adjustment to the PRTF COS.

Overall, this represents an increase 0.2% to the rates on a statewide basis and impacts child rating groups only.

Inpatient Concurrent Review

Based on the contract with the State, Magellan currently authorizes Inpatient stays up to seven day increments, and will be responsible for any current Inpatient authorization period that extends beyond the effective date of December 1, 2105. The Bayou Health MCOs will be responsible for concurrent review of any open authorizations and will assume responsibility for the inpatient stay after the Magellan authorization period ends.

Mercer analyzed the impact of transitioning the responsibility for the concurrent review portion of IP stays that were authorized in the prior month by analyzing 2014 and 2015 claims data. As the Data Book is summarized based on the service begin date for the inpatient stay, this transition of responsibility in the middle of stays that cross-over December 1, 2015 creates an additional liability for the Bayou Health program. This adjustment was applied for one month as only December 2015 will be impacted by the transition from Magellan to Bayou.

Mercer understands that Magellan authorizations are typically seven days. Mercer has assumed any concurrent reviews and continued authorizations by Magellan would occur in seven day increments. As such, Mercer analyzed the average monthly volume of inpatient expenses that start in one month and continue into another month and segmented the stay into a period that concludes Magellan's coverage based on seven day increments with the remainder of the stay transitioning over to Bayou Health. For example, a stay that began on November 14th and continued through December 12th was assumed to be Magellan's responsibility from November 14th through December 5th (first 21 days, 3 7-day increments) with the December 6th through the 12th as the responsibility of the Bayou Health plan.

While this adjustment is only expected to impact the December 2015 coverage month as the average length of stay is approximately 7 days, the adjustment has been scaled to impact half of the rating period of December 2015 and January 2016.

Average monthly expense associated with remainder of stays	$238,000

Average monthly inpatient expense	$5,143,000
Average monthly inpatient impact associated with continuing stays	4.6%
Final impact to the rating period (impact to one of two months only)	2.3%

The table below summarizes the impact by rate cell across all service categories.

Population	Adjustment
Non-Disabled Adults	0.5%
Disabled Adults	1.0%
Non-Disabled Children	0.2%
Disabled Children	0.2%
Dually Eligibles	0.1%

Elimination of the 1915(i) Program Authority and Amendment of the State Plan

In order to accelerate receipt of medically necessary specialized mental health services for adults and make community-based LMHP services available to more individuals, the State intends to transition services currently in the 1915(i) to the Medicaid State Plan. The prior 1915(i) authority limited the availability of certain services to adults requiring acute stabilization or meeting certain functional criteria for a major mental disorder and the seriously mentally ill (SMI). The services covered under the 1915(i) included community psychiatric services including ACT, psychosocial rehab services, and services provided by other licensed mental health professionals. Another aspect of the 1915(i) program was the requirement of an independent assessment to confirm an individual met the population criteria before services could be received.

While the services will be covered under the State Plan, individuals will need to meet medical necessity criteria in order to be authorized for the services. Mercer understands the medical necessity criteria for community psychiatric and psychosocial rehab services will generally align with the diagnosis criteria associated with major mental disorders and SMI. The criteria for other licensed mental health professionals will apply to a broader segment of the covered population and not be specific to major mental disorders or SMI.

Mercer has reviewed the changes to the delivery of these former 1915(i) services with Mercer clinicians and policy consultants and identified two specific rate considerations.

- Elimination of the Independent Assessment will likely result in individuals accessing services more quickly. The State has indicated that individuals have experienced on average a 30-day wait period for services while they await the independent assessment. Mercer analyzed the historical claims data to identify the subset of the 1915(i) users that were new to the program and expected to utilize more services in a 12-month period if the independent assessment was eliminated. Specifically, Mercer evaluated the individuals

who utilized services up through December 2013 and made an assumption about the number of clients who utilized services in December that would have utilized more services had their authorizations started earlier in the year. For example, individuals with 12-months of annual utilization were not impacted by the change, but 87% of the individuals with authorizations starting in December were assumed to use an additional month of service. The summary below shows the program change calculation.

Total 1915(i) recipients in 2013	5,555
Subset of recipients that projected to receive an additional month of service	1,363
Average monthly cost of 1915(i) services	$587
Annualized program change impact	$799,868
Total 2013 1915(i) expenses	$9,753,804

- Expanded access to services provided by other licensed professionals (OLP) will likely result in an increase to the penetration rate over time for other professional services. Individuals will still need to meet medical necessity criteria to access other professional services, but more individuals are expected to meet the criteria than historically when the 1915(i) services were limited to SMI or major mental disorder. To evaluate the potential change in utilization, Mercer reviewed the service utilization and penetration rates for other states where other professional services have been covered in the State Plan. The penetration rates in these other states are higher for adults indicating broader utilization of the services. The penetration rate findings are as follows:

2013 Penetration Rate for OLP Services in Louisiana	2.5% of Adults
Penetration Rate for similar OLP Services in Other States	Up to 10% of Adults

Mercer assumed the utilization of these services would increase over time essentially modeling a two-fold expansion of these services from November 2015 to January 2017. The utilization has been assumed to progressively increase over time as provider capacity may need to be developed to meet the demand as individuals understand the availability of these services.

Projected November 2015 users based on emerging data	3,549
Projected January 2017 users	7,097
Total new users in rating period for December 2015 and January 2016	760
Average monthly cost of services provided by other licensed professionals	$82

Annualized program change impact ($62,455 multiplied by 6)	$374,733
Total 2013 services provided by other licensed professionals	$6,563,731

This issue will continue to be monitored and evaluated as part of future rate-setting exercises as more data becomes available. The overall impact of the adjustment to account for the elimination of the 1915(i) authority and coverage of these services under the State Plan is a 0.6% impact overall and impacts the adult rate cells only.

The overall impact all of all the programmatic changes described above is a 1.3% increase to the rates. Again, the regional and rate cell impacts of these changes are summarized in Appendix C.

1915(b)(3) Services

The historical utilization of Physician Case Consultation services has been minimal in the initial years of the program. As such, the 1915(b)(3) rate for this service is essentially $0.00 on a PMPM basis. The service utilization will continue to be analyzed and the rate adjusted accordingly, as necessary. This is within the requested waiver authority of $0.13 PMPM.

Managed Care Assumptions

Mercer evaluated whether additional adjustments were necessary to address changes to utilization as a result of care management practices. As the adult encounter data are from a period of time when capitated managed care was in operation, Mercer did not incorporate any further adjustment for future changes as a result of managed care. Similarly, Mercer made no adjustment to the Children's capitation rate calculations for additional impact of managed care. While the data from the Children's program are from a non-risk setting, the current PIHP did perform utilization review and care management of the Children's population under the non-risk contract. Also, the two-month rating period of December/January does not provide sufficient time to impact the service utilization patterns.

Administration and Risk Margin Loading

Mercer included an assumption for administrative expenses under a managed care program with particular consideration for the impact of integration with the existing Bayou Health acute care program. The State provided Mercer with anticipated staffing requirements for the upcoming Bayou Health contract period beginning December 1, 2015. Mercer reviewed the behavioral health staffing requirements as they apply to each MCO participating in the Bayou Health program. Each staffing position was evaluated to determine if it would be already fulfilled within the current Bayou health program, and therefore would not need to be considered as part of the behavioral health program. The administrative costs for the required staffing positions were

modeled based on wage and other employee-related expense information from the Bureau of Labor and Statistics. Mercer also included consideration for MCO overhead for these staffing positions. Mercer developed a PMPM cost expectation for these additional staffing needs and converted the PMPM to a percentage based on the final service cost projection underlying the rates.

Based on this review, Mercer included a general administrative allowance of 8.0%, which is similar to the prior administrative assumption under the current adult capitation rates. This is due to the fact that the State is now contracting with multiple MCOs rather than just one. In addition to the general administrative allowance, an underwriting gain/risk margin of 2.0% has been included in the capitation rates. The administration and risk margin load factor (AA.3.2) is expressed as a percentage of the gross capitation rate (that is, premium) before premium tax adjustment, and is consistent with the current Bayou Health rates.

Health Insurer Provider Fee Consideration

The State plans to address the Health Insurer Provider Fee and associated implications of non-deductibility through a retrospective payment once the fees are known for the impacted premium years. As such, no consideration has been made for the fee in these capitation rates. Further discussion between the MCOs and the State will occur as fee notices become available from the IRS for the respective premium year.

Premium Tax Adjustment

Louisiana Statute 22:842 requires businesses issuing life, accident, health or service insurance or other forms of contracts or obligations covering such risks to pay certain premium taxes. The tax for businesses with revenue exceeding $7,000 amounts to 2.25% of gross annual premiums. The State has determined that the PIHP contract for the Medicaid Adult capitated BH program is subject to this taxation. This is a uniform, broad-based fee imposed on all health maintenance organizations and preferred provider organizations and all lines of business.

This premium tax is a legitimate cost of doing business in the State of Louisiana for Medicaid managed care organizations and PIHPs, and reasonable to include in the consideration of actuarially sound capitation rate ranges. Since this is a cost of doing business in the State, Mercer included consideration for this tax in the rate range development.

The premium tax adjustment is expressed as a percentage of the gross capitation rate (that is, premium). Mercer applied a 2.25% upward adjustment to the rate to account for the premium tax.

Rate Ranges

In order to develop the rate ranges, Mercer varied the trend assumptions outlined above to reflect the potential fluctuations in service utilization growth beyond observed experience. The lower bound trend accounts for mitigation of trend from the observed early 2015 levels, whereas the upper bound reflects higher consideration of trends from 2015 Mercer recognizes that prospective trends can vary based, not only on fluctuations in service utilization but also on the achieved degree of care management. Variation in these trend assumptions results in a rate range of approximately 5.9% below the 50th %-ile rate for the Lower Bound and 5.9% above the 50th %-ile rate for the Upper Bound.

The rate ranges can be found on Appendix B.

Rate Development Overview

To provide additional detail on the rate development, Mercer has provided an overview of the adjustments applied to each rate cell in Appendices B and C. The exhibits present the breakdown of the assumptions used to calculate the 50th %-ile rates within the actuarially sound rate ranges for each region.

Rate Certification

In preparing the rate ranges shown in Appendix B for the December 1, 2015 through January 31, 2016 contract period for the Louisiana BH program, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, and financial data and information supplied by the State and the PIHP. The State and the PIHP are solely responsible for the validity and completeness of these supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion they are appropriate for the intended rate-setting purpose. However, if the data and information are incomplete and/or inaccurate, the values shown in this report may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this report.

Because modeling all aspects of a situation or scenario is not possible or practical, Mercer may use summary information, estimates, or simplifications of calculations to facilitate the modeling of future events in an efficient and cost-effective manner. Mercer may also exclude factors or data that are immaterial in our judgment. Use of such simplifying techniques does not, in our judgment, affect the reasonableness, appropriateness, or attainability of the results for the Medicaid program. Actuarial assumptions may also be changed from one certification period to the next because of changes in mandated requirements, program experience, changes in expectations

about the future, and other factors. A change in assumptions is not an indication that prior assumptions were unreasonable, inappropriate, or unattainable when they were made.

Mercer certifies that the rate ranges in Appendix B, were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid-covered populations and services under the managed care contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rate ranges developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time, and are subject to unforeseen and random events. Therefore any projection must be interpreted as having a likely, and potentially wide range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual MCO costs will differ from these projections. Mercer has developed these rate ranges on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by the MCOs for any purpose. Mercer recommends that the MCOs analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges before deciding whether to contract with the State.

The State understands that Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that the State secures the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

This certification letter assumes the reader is familiar with the Louisiana managed care program, Medicaid eligibility rules and actuarial rating techniques. It is intended for the State and CMS, and should not be relied upon by third 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 results. This document should only be reviewed in its entirety. Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

The State agrees to notify Mercer within 30 days of receipt of this report if it disagrees with anything contained in this report or is aware of any information or data that would affect the results of this report that has not been communicated or provided to Mercer or incorporated herein. The report will be deemed final and acceptable to the State if nothing is received by Mercer within such 30-day period.

If you have any questions on any of the information provided, please feel free to call me at 612 642 8940, Brad at 612 642 8756 or Bennett at 612 642 8609.

Sincerely,

Jonathan Marsden, FSA, MAAA
Partner

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Senior Associate

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Senior Associate

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Appendices

Appendix A
Louisiana Behavioral Health Partnership Medicaid Capitation Rates
Effective December 1, 2015 to January 31, 2016
50th Percentile Rates by Rate Cell and Region for Specialized BH Services

MARSH & McLENNAN COMPANIES

50th Percentile Rates by Rate Cell and Region
December 1, 2015 - January 31, 2016

		Contract Period December 1, 2015 - January 31, 2016			
Rate Cell	Age	Gulf Region	Capital Region	South Central Region	North Region
Non-Disabled Adults	21+	$ 29.26	$ 25.76	$ 25.91	$ 28.76
Disabled Adults	21+	$ 104.37	$ 84.66	$ 84.27	$ 75.27
Non-Disabled Children	0-20	$ 28.52	$ 28.14	$ 23.58	$ 40.90
Foster Care and Disabled Children	0-20	$ 170.07	$ 139.10	$ 152.44	$ 246.19
Dually Eligible	Any	$ 18.50	$ 6.78	$ 7.49	$ 8.84

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Appendices

Appendix B
Louisiana Behavioral Health Partnership Medicaid Capitation Rate Development
Effective December 1, 2015 to January 31, 2016
Adult and Child Rate Cells

MARSH & McLENNAN COMPANIES

Rate Development Summary
December 1, 2015 - January 31, 2016

Gulf Region		Base Year		Rate Development Data Adjustments				Rate Development Loads			Contract Period December 1, 2015 - January 31, 2016		
		A	B	C	D	E	F	G	H	I			
Rate Cell	Age	MMs	PMPM	Trend *	Program Changes	Managed Care Adjustment	Target Service Cost	Underwriting Gain **	Administration **	Premium Tax **	50th Percentile Rate ***	Lower Bound Rate	Upper Bound Rate
Non-Disabled Adults	21+	386,912	$ 13.85	25.9%	4.6%	0.0%	$ 25.72	2.0%	8.0%	2.25%	$ 29.26	$ 27.57	$ 30.95
Disabled Adults	21+	305,452	$ 66.79	11.1%	5.8%	0.0%	$ 91.76	2.0%	8.0%	2.25%	$ 104.37	$ 99.78	$ 108.97
Non-Disabled Children	0-20	2,248,412	$ 12.98	30.3%	-0.3%	0.0%	$ 25.02	2.0%	8.0%	2.25%	$ 28.52	$ 26.66	$ 30.38
Foster Care and Disabled Children	0-20	186,151	$ 74.76	32.2%	-0.4%	0.0%	$ 149.20	2.0%	8.0%	2.25%	$ 170.07	$ 159.24	$ 180.91
Dually Eligible	Any	275,235	$ 9.17	22.7%	6.3%	0.0%	$ 16.26	2.0%	8.0%	2.25%	$ 18.50	$ 17.45	$ 19.55
Total		**3,402,162**	**$ 20.88**	**25.3%**	**1.6%**	**0.0%**	**$ 37.18**	**2.0%**	**8.0%**	**2.25%**	**$ 42.35**	**$ 39.84**	**$ 44.86**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

** Admin & Underwriting Gain shown as a % of the total rate before premium tax. Premium Tax is shown as a percent of total premium.

*** Rate Development Formula: 50th Percentile Rate = [B*(1+C)^(30/12)*(1+D)*(1+E)]/(1-G-H)/(1-I)

Rate Development Summary
December 1, 2015 - January 31, 2016

Capital Region		Base Year		Rate Development Data Adjustments				Rate Development Loads			Contract Period December 1, 2015 - January 31, 2016		
		A	B	C	D	E	F	G	H	I			
Rate Cell	Age	MMs	PMPM	Trend *	Program Changes	Managed Care Adjustment	Target Service Cost	Underwriting Gain **	Administration **	Premium Tax **	50th Percentile Rate ***	Lower Bound Rate	Upper Bound Rate
Non-Disabled Adults	21+	282,441	$ 14.29	18.1%	4.6%	0.0%	$ 22.65	2.0%	8.0%	2.25%	$ 25.76	$ 24.56	$ 26.96
Disabled Adults	21+	239,540	$ 60.83	7.7%	1.8%	0.0%	$ 74.44	2.0%	8.0%	2.25%	$ 84.66	$ 81.66	$ 87.66
Non-Disabled Children	0-20	2,028,943	$ 12.18	31.9%	1.8%	0.0%	$ 24.72	2.0%	8.0%	2.25%	$ 28.14	$ 26.36	$ 29.91
Foster Care and Disabled Children	0-20	159,015	$ 60.36	31.2%	2.8%	0.0%	$ 122.25	2.0%	8.0%	2.25%	$ 139.10	$ 130.65	$ 147.55
Dually Eligible	Any	222,400	$ 3.17	26.9%	3.8%	0.0%	$ 5.96	2.0%	8.0%	2.25%	$ 6.78	$ 6.46	$ 7.11
Total		**2,932,339**	**$ 18.29**	**24.7%**	**2.2%**	**0.0%**	**$ 32.45**	**2.0%**	**8.0%**	**2.25%**	**$ 36.92**	**$ 34.85**	**$ 38.99**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

** Admin & Underwriting Gain shown as a % of the total rate before premium tax. Premium Tax is shown as a percent of total premium.

*** Rate Development Formula: 50th Percentile Rate = [B*(1+C)^(30/12)*(1+D)*(1+E)]/(1-G-H)/(1-I)

Rate Development Summary
December 1, 2015 - January 31, 2016

South Central Region		Base Year		Rate Development Data Adjustments				Rate Development Loads			Contract Period December 1, 2015 - January 31, 2016		
		A	B	C	D	E	F	G	H	I			
Rate Cell	Age	MMs	PMPM	Trend *	Program Changes	Managed Care Adjustment	Target Service Cost	Underwriting Gain **	Administration **	Premium Tax **	50th Percentile Rate ***	Lower Bound Rate	Upper Bound Rate
Non-Disabled Adults	21+	295,987	$ 15.38	15.4%	3.7%	0.0%	$ 22.77	2.0%	8.0%	2.25%	$ 25.91	$ 24.53	$ 27.28
Disabled Adults	21+	282,541	$ 67.29	4.2%	-0.5%	0.0%	$ 74.09	2.0%	8.0%	2.25%	$ 84.27	$ 81.00	$ 87.54
Non-Disabled Children	0-20	2,220,847	$ 10.68	32.0%	-2.9%	0.0%	$ 20.69	2.0%	8.0%	2.25%	$ 23.58	$ 22.16	$ 25.01
Foster Care and Disabled Children	0-20	171,952	$ 70.60	29.5%	-0.4%	0.0%	$ 133.69	2.0%	8.0%	2.25%	$ 152.44	$ 142.86	$ 162.03
Dually Eligible	Any	296,258	$ 5.00	11.7%	-0.1%	0.0%	$ 6.59	2.0%	8.0%	2.25%	$ 7.49	$ 7.09	$ 7.89
Total		**3,267,585**	**$ 18.64**	**22.0%**	**-1.3%**	**0.0%**	**$ 30.16**	**2.0%**	**8.0%**	**2.25%**	**$ 34.36**	**$ 32.45**	**$ 36.28**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

** Admin & Underwriting Gain shown as a % of the total rate before premium tax. Premium Tax is shown as a percent of total premium.

*** Rate Development Formula: 50th Percentile Rate = [B*(1+C)^(30/12)*(1+D)*(1+E)]/(1-G-H)/(1-I)

Rate Development Summary
December 1, 2015 - January 31, 2016

North Region		Base Year		Rate Development Data Adjustments				Rate Development Loads			Contract Period December 1, 2015 - January 31, 2016		
		A	B	C	D	E	F	G	H	I			
Rate Cell	Age	MMs	PMPM	Trend *	Program Changes	Managed Care Adjustment	Target Service Cost	Underwriting Gain **	Administration **	Premium Tax **	50th Percentile Rate ***	Lower Bound Rate	Upper Bound Rate
Non-Disabled Adults	21+	223,944	$ 15.62	19.2%	4.4%	0.0%	$ 25.27	2.0%	8.0%	2.25%	$ 28.76	$ 27.15	$ 30.37
Disabled Adults	21+	239,483	$ 47.21	13.2%	2.8%	0.0%	$ 66.16	2.0%	8.0%	2.25%	$ 75.27	$ 71.65	$ 78.89
Non-Disabled Children	0-20	1,731,176	$ 16.87	34.6%	1.4%	0.0%	$ 35.34	2.0%	8.0%	2.25%	$ 40.90	$ 38.08	$ 43.71
Foster Care and Disabled Children	0-20	158,711	$ 134.32	19.3%	3.8%	0.0%	$ 213.36	2.0%	8.0%	2.25%	$ 246.19	$ 230.17	$ 262.21
Dually Eligible	Any	232,802	$ 3.99	27.6%	5.9%	0.0%	$ 7.77	2.0%	8.0%	2.25%	$ 8.84	$ 8.27	$ 9.41
Total		**2,586,116**	**$ 25.62**	**25.6%**	**2.5%**	**0.0%**	**$ 45.76**	**2.0%**	**8.0%**	**2.25%**	**$ 52.74**	**$ 49.35**	**$ 56.14**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

** Admin & Underwriting Gain shown as a % of the total rate before premium tax. Premium Tax is shown as a percent of total premium.

*** Rate Development Formula: 50th Percentile Rate = [B*(1+C)^(30/12)*(1+D)*(1+E)]/(1-G-H)/(1-I)

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Appendices

Appendix C
Program Change Calculations
Effective December 1, 2015 to January 31, 2016

MARSH & McLENNAN COMPANIES

Program Changes - Impact Summary
December 1, 2015 - January 31, 2016

Gulf Region		Individual Program Changes - PMPM Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	$ 24.60	$ 0.10	$ -	$ 0.44	$ (0.10)	$ 0.01	$ -	$ -	$ 0.00	$ -	$ 0.67	$ 1.12
Disabled Adults	21+	$ 86.76	$ 0.73	$ -	$ 1.75	$ 0.34	$ 0.22	$ -	$ -	$ (0.01)	$ -	$ 1.97	$ 5.00
Non-Disabled Children	0-20	$ 25.08	$ 0.04	$ 0.07	$ 0.30	$ (0.09)	$ 0.01	$ (0.69)	$ 0.27	$ 0.00	$ 0.02	$ -	$ (0.06)
Foster Care and Disabled Children	0-20	$ 149.78	$ 0.27	$ 0.30	$ 2.29	$ (0.12)	$ 0.13	$ (5.15)	$ 1.11	$ 0.01	$ 0.58	$ -	$ (0.59)
Dually Eligible	Any	$ 15.30	$ 0.01	$ -	$ 0.01	$ 0.24	$ 0.08	$ -	$ -	$ 0.00	$ -	$ 0.61	$ 0.96
Total		**$ 36.60**	**$ 0.12**	**$ 0.06**	**$ 0.53**	**$ (0.03)**	**$ 0.04**	**$ (0.74)**	**$ 0.24**	**$ 0.00**	**$ 0.04**	**$ 0.30**	**$ 0.58**

		Individual Program Changes - Percent Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	n/a	0.4%	0.0%	1.8%	-0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	2.7%	4.6%
Disabled Adults	21+	n/a	0.8%	0.0%	2.0%	0.4%	0.2%	0.0%	0.0%	0.0%	0.0%	2.3%	5.8%
Non-Disabled Children	0-20	n/a	0.2%	0.3%	1.2%	-0.4%	0.1%	-2.8%	1.1%	0.0%	0.1%	0.0%	-0.3%
Foster Care and Disabled Children	0-20	n/a	0.2%	0.2%	1.5%	-0.1%	0.1%	-3.4%	0.7%	0.0%	0.4%	0.0%	-0.4%
Dually Eligible	Any	n/a	0.1%	0.0%	0.1%	1.6%	0.6%	0.0%	0.0%	0.0%	0.0%	4.0%	6.3%
Total		**n/a**	**0.3%**	**0.2%**	**1.5%**	**-0.1%**	**0.1%**	**-2.0%**	**0.7%**	**0.0%**	**0.1%**	**0.8%**	**1.6%**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

Program Changes - Impact Summary
December 1, 2015 - January 31, 2016

Capital Region		Individual Program Changes - PMPM Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	$ 21.64	$ 0.15	$ -	$ 0.50	$ (0.09)	$ 0.00	$ -	$ -	$ 0.10	$ 0.00	$ 0.35	$ 1.00
Disabled Adults	21+	$ 73.13	$ 0.82	$ -	$ 1.71	$ (2.66)	$ 0.01	$ -	$ 0.00	$ 0.25	$ -	$ 1.20	$ 1.31
Non-Disabled Children	0-20	$ 24.29	$ 0.05	$ 0.40	$ 0.60	$ (0.01)	$ 0.00	$ (0.94)	$ 0.28	$ 0.02	$ 0.04	$ -	$ 0.44
Foster Care and Disabled Children	0-20	$ 118.88	$ 0.30	$ 2.57	$ 2.73	$ (0.09)	$ 0.06	$ (5.96)	$ 2.93	$ 0.09	$ 0.74	$ -	$ 3.37
Dually Eligible	Any	$ 5.74	$ 0.01	$ -	$ 0.04	$ 0.02	$ 0.01	$ -	$ -	$ 0.00	$ -	$ 0.15	$ 0.22
Total		**$ 31.75**	**$ 0.13**	**$ 0.41**	**$ 0.75**	**$ (0.24)**	**$ 0.01**	**$ (0.98)**	**$ 0.35**	**$ 0.05**	**$ 0.07**	**$ 0.14**	**$ 0.71**

		Individual Program Changes - Percent Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	n/a	0.7%	0.0%	2.3%	-0.4%	0.0%	0.0%	0.0%	0.4%	0.0%	1.6%	4.6%
Disabled Adults	21+	n/a	1.1%	0.0%	2.3%	-3.6%	0.0%	0.0%	0.0%	0.3%	0.0%	1.6%	1.8%
Non-Disabled Children	0-20	n/a	0.2%	1.6%	2.5%	0.0%	0.0%	-3.9%	1.1%	0.1%	0.2%	0.0%	1.8%
Foster Care and Disabled Children	0-20	n/a	0.2%	2.2%	2.3%	-0.1%	0.0%	-5.0%	2.5%	0.1%	0.6%	0.0%	2.8%
Dually Eligible	Any	n/a	0.1%	0.0%	0.6%	0.3%	0.1%	0.0%	0.0%	0.1%	0.0%	2.5%	3.8%
Total		**n/a**	**0.4%**	**1.3%**	**2.4%**	**-0.7%**	**0.0%**	**-3.1%**	**1.1%**	**0.2%**	**0.2%**	**0.5%**	**2.2%**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

South Central Region		Individual Program Changes - PMPM Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	$ 21.96	$ 0.14	$ -	$ 0.37	$ (0.09)	$ 0.01	$ -	$ -	$ (0.00)	$ -	$ 0.39	$ 0.82
Disabled Adults	21+	$ 74.47	$ 0.84	$ -	$ 1.14	$ (3.47)	$ 0.08	$ -	$ -	$ (0.00)	$ -	$ 1.04	$ (0.37)
Non-Disabled Children	0-20	$ 21.30	$ 0.04	$ 0.01	$ 0.08	$ (0.08)	$ 0.00	$ (0.76)	$ 0.07	$ 0.00	$ 0.03	$ -	$ (0.61)
Foster Care and Disabled Children	0-20	$ 134.24	$ 0.30	$ (0.07)	$ 0.56	$ (0.11)	$ 0.01	$ (3.70)	$ 1.36	$ 0.00	$ 1.10	$ -	$ (0.55)
Dually Eligible	Any	$ 6.59	$ 0.01	$ -	$ 0.01	$ (0.18)	$ 0.01	$ -	$ -	$ 0.01	$ -	$ 0.13	$ (0.01)
Total		**$ 30.57**	**$ 0.13**	**$ 0.00**	**$ 0.22**	**$ (0.39)**	**$ 0.01**	**$ (0.71)**	**$ 0.12**	**$ 0.00**	**$ 0.08**	**$ 0.14**	**$ (0.40)**

		Individual Program Changes - Percent Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	n/a	0.6%	0.0%	1.7%	-0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	3.7%
Disabled Adults	21+	n/a	1.1%	0.0%	1.5%	-4.7%	0.1%	0.0%	0.0%	0.0%	0.0%	1.4%	-0.5%
Non-Disabled Children	0-20	n/a	0.2%	0.0%	0.4%	-0.4%	0.0%	-3.6%	0.3%	0.0%	0.2%	0.0%	-2.9%
Foster Care and Disabled Children	0-20	n/a	0.2%	-0.1%	0.4%	-0.1%	0.0%	-2.8%	1.0%	0.0%	0.8%	0.0%	-0.4%
Dually Eligible	Any	n/a	0.2%	0.0%	0.1%	-2.7%	0.2%	0.0%	0.0%	0.1%	0.0%	2.0%	-0.1%
Total		**n/a**	**0.4%**	**0.0%**	**0.7%**	**-1.3%**	**0.0%**	**-2.3%**	**0.4%**	**0.0%**	**0.3%**	**0.4%**	**-1.3%**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

North Region		Individual Program Changes - PMPM Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	$ 24.20	$ 0.12	$ -	$ 0.46	$ (0.10)	$ 0.00	$ -	$ -	$ (0.03)	$ -	$ 0.63	$ 1.07
Disabled Adults	21+	$ 64.34	$ 0.55	$ -	$ 1.43	$ (1.40)	$ 0.04	$ -	$ -	$ (0.32)	$ -	$ 1.52	$ 1.82
Non-Disabled Children	0-20	$ 34.86	$ 0.06	$ (0.01)	$ 0.25	$ (0.05)	$ 0.01	$ (0.09)	$ 0.30	$ (0.01)	$ 0.01	$ -	$ 0.48
Foster Care and Disabled Children	0-20	$ 205.64	$ 0.42	$ (0.20)	$ 1.46	$ (0.16)	$ 0.03	$ (0.34)	$ 4.32	$ (0.11)	$ 2.30	$ -	$ 7.71
Dually Eligible	Any	$ 7.33	$ 0.02	$ -	$ 0.03	$ 0.08	$ 0.02	$ -	$ -	$ 0.01	$ -	$ 0.27	$ 0.44
Total		**$ 44.67**	**$ 0.13**	**$ (0.02)**	**$ 0.43**	**$ (0.17)**	**$ 0.02**	**$ (0.08)**	**$ 0.47**	**$ (0.04)**	**$ 0.15**	**$ 0.22**	**$ 1.10**

		Individual Program Changes - Percent Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	n/a	0.5%	0.0%	1.9%	-0.4%	0.0%	0.0%	0.0%	-0.1%	0.0%	2.6%	4.4%
Disabled Adults	21+	n/a	0.9%	0.0%	2.2%	-2.2%	0.1%	0.0%	0.0%	-0.5%	0.0%	2.4%	2.8%
Non-Disabled Children	0-20	n/a	0.2%	0.0%	0.7%	-0.1%	0.0%	-0.3%	0.9%	0.0%	0.0%	0.0%	1.4%
Foster Care and Disabled Children	0-20	n/a	0.2%	-0.1%	0.7%	-0.1%	0.0%	-0.2%	2.1%	-0.1%	1.1%	0.0%	3.8%
Dually Eligible	Any	n/a	0.2%	0.0%	0.5%	1.1%	0.2%	0.0%	0.0%	0.2%	0.0%	3.7%	5.9%
Total		**n/a**	**0.3%**	**0.0%**	**1.0%**	**-0.4%**	**0.0%**	**-0.2%**	**1.0%**	**-0.1%**	**0.3%**	**0.5%**	**2.5%**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

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Appendices

Appendix D
CMS Consultation Guide
Effective December 1, 2015 to January 31, 2016

Section I. December 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
1. General Information	
A. A letter from the certifying actuary, who meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, that certifies that the final capitation rates or rate ranges meet the standards in 42 CFR §438.6(c).	Please refer to the Mercer rate certification letter. All following page and exhibit references are specific to this certification.
B. The final and certified capitation rates or the final and certified rate ranges for all rate cells and regions, as applicable.	Please refer to Appendix B for a summary of all rate ranges by rate cell and region.
C. Brief descriptions of:	
i. The specific state Medicaid managed care programs covered by the certification.	Please refer to pages 1-2.
ii. The rating periods covered by the certification.	Please refer to page 1.
iii. The Medicaid populations covered through the managed care programs for which the certification applies.	A brief description can be found on pages 2-3. Section 2 of the Data Book encompasses a comprehensive list of Bayou Health's covered and excluded populations.
iv. The services that are required to be provided by the managed care plans.	A brief description can be found on pages 3-4. Section 3 of the Data Book encompasses a comprehensive list of Bayou Health's covered services.
2. Data	
A. A description of the data used to develop capitation rates. This description should include:	
i. The types of data used, which may include (but is not limited to) claims data, encounter data, plan financial data, or other Medicaid program data.	Please refer to pages 4-9.
ii. The age of all data used.	Please refer to pages 4-9.
iii. The sources of all data used.	Please refer to pages 4-9.
iv. To the extent that a significant portion of benefits are provided through subcapitated arrangements, a description of the data received from the subcapitated plans or providers.	N/A

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Section I. December 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
v. To the extent that claims or encounter data are not used or not available, an explanation of why that data was not used or was not available.	N/A
B. Information related to the availability and the quality of the data used:	
i. The steps taken by the actuary or by others (which may include but is not limited to the state Medicaid program or the managed care organizations) to validate or improve the quality and accuracy of the data.	Please refer to the base data adjustment section beginning on page 6.
ii. Any concerns that the actuary has over the availability or quality of the data.	N/A
C. Any information related to changes in data used when compared to the most recent rating period:	
i. Any new data sources used by the actuary since the last certification and any data sources that the actuary has not continued to use since the last certification.	The Children's program has been administered on a non-risk basis by the PIHP. This data was not included in the prior LBHP certification for the Adult population at-risk capitation contract.
ii. How the data sources used have changed since the last certification.	Please refer to the base data adjustment section beginning on page 6.
D. Any plans or efforts to improve the data sources used for future certifications and any new data sources that are expected to be available and potentially used for future certifications.	Please refer to the base data adjustment section beginning on page 6.
E. Any adjustments that are made to the data.	Please refer to the base data adjustment section beginning on page 6.
3. Projected Benefit Costs	
A. Covered services and benefits	
i. Any changes related to the benefits covered by the Medicaid managed care organizations since the last certification, including but not limited to:	
a. More or fewer state plan benefits covered by the Medicaid managed care organization.	Please refer to the covered services section on pages 3-4.

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Section I. December 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
b. Requirements deemed necessary by the state to ensure access or proper delivery of covered services, for minimum or maximum levels of payment from managed care organizations to any providers or class of providers.	Please refer to the covered services section on pages 3-4, as well as the base data adjustments section on pages 6-8.
c. Requirements or conditions of any applicable waivers.	N/A
ii. For each change related to benefits covered, the estimated impact of the change on amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment.	Please refer to the covered services section on pages 3-4, as well as the base data adjustments section on pages 6-8. Section 4 of the Data Book outlines adjustments Mercer made to the encounter data and the impacts of each adjustment.
B. Projected benefit cost trends	
i. The projected change in benefit costs from the historical period to the rating period, or trend, including but not limited to:	
a. The methodologies used to develop projected benefit costs trends.	Please refer to the trend section beginning on page 8.
b. Any data used or assumptions made in developing projected benefit cost trends.	Please refer to the trend section beginning on page 8.
c. Any applicable comparisons to historical benefit cost trends or other program benefit cost trends.	Please refer to the trend section beginning on page 8.
d. The different components of projected benefit cost trends, including but not limited to changes in price (such as provider reimbursement rates) and changes in utilization (such as the volume of services provided).	Please refer to the trend section beginning on page 8.
e. Any other material adjustments to projected benefit cost trends, and a description of the data, assumptions, and methodologies used to determine those adjustments.	N/A
f. To the extent there are any differences, projected benefit cost trends by:	
i. Service or category of service.	Please refer to the trend section beginning on page 8.
ii. Rate cell or Medicaid population.	Please refer to the trend section beginning on page 8.

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Section I. December 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
C. Other adjustments to projected benefit costs:	
i. Any other adjustments made to projected benefit costs excluding those described above, including but not limited to:	
a. The impact of managed care on the utilization on the unit costs of health care services.	Please refer to the managed care assumptions section on page 22.
b. Changes to projected benefit costs in the rating period outside of regular changes in utilization or unit cost of services.	Please refer to the program changes section beginning on page 13.
D. Final projected benefit costs by relevant level of detail (for example, by Medicaid population or by rate cell).	Please refer to Appendices A and B.
4. Projected Non-benefit Costs	
E. Non-benefit costs including but not limited to:	
i. Administrative costs.	Please refer to the administration and risk margin loading section beginning on page 22.
ii. Care management or coordination costs.	Included as a component of Administrative costs. Please refer to the administration and risk margin loading section beginning on page 22.
iii. Provisions for:	
a. Cost of capital.	Please refer to the administration and risk margin loading section beginning on page 22.
b. Risk margin.	Considered in the Margin component. Please refer to the administration and risk margin loading section beginning on page 22.
c. Contingency margin.	N/A
d. Underwriting gain.	Included as a component of Administrative costs. Please refer to the administration and risk margin loading section beginning on page 22.
e. Profit margin.	N/A
iv. Taxes, fees, and assessments.	Please refer to the health insurer provider fee consideration and premium tax adjustment sections beginning on page 23.
v. Any other material non-benefit costs.	N/A
5. Rate Range Development	
A. Any assumptions for which values vary in order to develop rate ranges.	Please refer to the trend section beginning on page 8, the administration and risk margin loading section beginning on page 22 and the rate ranges section on page 24.

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Section I. December 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
B. The values of each of the assumptions used to develop the minimum, the mid-point (as applicable), and the maximum of the rate ranges.	Please refer to sections related to trend assumptions, prospective program change adjustments, administration and risk margin loading considerations and rate range assumptions.
C. A description of the data, assumptions, and methodologies that were used to develop the values of the assumptions for the minimum, the mid-point (as applicable), and maximum of the rate ranges.	Please refer to sections related to trend assumptions, prospective program change adjustments, administration and risk margin loading considerations and rate range assumptions.
6. Risk and Contractual Provisions	
A. Risk adjustment processes.	Please refer to the administration and risk margin loading section beginning on page 22.
B. Risk sharing arrangements, such as risk corridor or large claims pool.	N/A
C. Medical loss ratio requirements, such as a minimum medical loss ratio requirement.	N/A
D. Reinsurance requirements.	N/A
E. Incentives or withhold amounts.	N/A
7. Other Rate Development Considerations	
A. All adjustments to the capitation rates, or to any portion of the capitation rates, should reflect reasonable, appropriate, and attainable costs in the actuary's opinion and must be included in the rate certification. CMS notes that adjustments that are performed at the end of the rate setting process without adequate justification might not be considered actuarially sound.	Please see Actuarial soundness definition on page 1, as well as the rate certification section on pages 24-26.
B. The final contracted rates should either match the capitation rates or be within the rate ranges in the actuarial certification. This is required in total and by each rate cell.	This letter certifies the rate range. Rates are being set at the 50th percentile for all rating categories and illustrated on Appendices A and B.

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November 4, 2015

Subject: Louisiana Bayou Health Non-Emergency Medical Transportation (NEMT) Services – Full Risk-Bearing Managed Care Organization (MCO) Rate Range Development and Actuarial Certification for the Period December 1, 2015 through January 31, 2016

Dear Ms. Steele:

The Louisiana Department of Health and Hospitals (DHH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for NEMT services provided under the State of Louisiana's Bayou Health program. NEMT capitation rate ranges were developed for the period December 1, 2015 through January 31, 2016. These rates were developed for individuals that received specialized behavioral health services under the Bayou Health program, but received physical health services under Louisiana fee-for-service (FFS) Medicaid. This population was classified into the following rate cells: Chisholm Class Members (CCM), Home- and Community-Based Services (HCBS) Waiver members, and Other. The Other rate cell is constructed of dually eligible individuals and Long-Term Services and Support (LTSS) recipients who are not in either of the other two NEMT rate cells. This letter provides an overview of the analyses and methodology used in the development of the NEMT rate ranges, as well as a certification to the actuarial soundness of the rate ranges presented.

Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government mandated assessments, fees, and taxes, and the cost of capital. Note: Please see pages 8-9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.

Rate Methodology

Overview

NEMT capitation rate ranges were developed in accordance with rate-setting guidelines established by the Centers for Medicare & Medicaid Services (CMS). Calendar year (CY) 2013 FFS data with runout through March 31, 2015 were used as the base data for December 1, 2015 through January 31, 2016 NEMT rate development.

Mercer applied the following additional adjustments to the base data, which are consistent with the CMS capitated rate-setting checklist:

- Trend factors to forecast expenditures and utilization to the contract period.
- Loading for non-medical expenses.

The various steps used in the development of the rate ranges are described in the following paragraphs.

NEMT Rate Development

Covered Populations

Mercer received eligibility and enrollment data from the State's fiscal agent. The covered populations under the NEMT rate include the Medicaid eligible population excluded from Bayou Health physical health services and the Voluntary Opt-In populations who have not chosen to enroll in Bayou Health physical health services. The excluded populations primarily include dually eligible individuals and nursing facility residents. Mercer assigned rate cells using the following hierarchy:

1. CCM
2. HCBS Waiver Recipients
3. Other

CCM

Chisholm refers to a class action lawsuit (*Chisholm v. Hood*) filed in 1997. CCMs are defined as all current and future recipients of Medicaid in the State of Louisiana, under age 21, who are now or will in the future be placed on the Office of Citizens with Developmental Disabilities' (OCDD) Request for Services Registry.

Members of Louisiana's Chisholm class are permitted to participate in Bayou Health physical health services on a voluntary opt-in basis. The members who choose not to opt into Bayou Health physical health services will have their NEMT services covered under Bayou Health NEMT services.

HCBS Waiver Recipients

HCBS recipients were identified using the eligibility groups shown in Appendix C. HCBS recipients are permitted to participate in Bayou Health physical health services on a voluntary opt-in basis. The members who choose not to opt into Bayou Health physical health services will have their NEMT services covered under Bayou Health NEMT services.

Other

The remaining population covered under the NEMT rate is comprised of dually eligible individuals and LTSS recipients. Some dually eligible individuals are included in either the CCM or HCBS Waiver rate cells as a result of the established hierarchy; however, the majority of dually eligible individuals are included in the Other rate cell. These recipients are excluded from Bayou Health physical health services, but will have their NEMT services covered under Bayou Health NEMT services.

Base Data Development

FFS Data and Base Data Adjustments

Mercer utilized claim line level FFS data incurred from January 1, 2013 through December 31, 2013, paid through March 31, 2015, as the base data. Mercer identified the Bayou Health NEMT services populations and identified their NEMT services to be used as the base data. The NEMT services were identified using the claim category of service field "CLC_Claim_Cat_Serv" with the following codes:

- 23 – Non-Emergency Ambulance Transportation
- 92 – Non-Emergency Non-Ambulance Transportation

Mercer reviewed the FFS data to ensure it appeared reasonable and appropriate but did not audit the data. Specifically, Mercer reviewed the completeness and consistency of incurred claims over time.

Mercer reviewed claim lags and determined the NEMT claims were complete with the given runout and thus no adjustment for incurred but not reported claims was necessary for the FFS data.

The base data used for the NEMT rate development can be found in Appendix A. This appendix includes member months, expenses, units, annualized utilization per 1,000 recipients (util/1,000), unit cost, and base data per member per month (PMPM) rate.

Rating Adjustments

Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the expenses of providing NEMT services in a future period. As part of the rate development, Mercer developed the utilization, unit cost, and PMPM trend rates in the table below and applied them to all rate cells equivalently.

Rate Cell	Low Trend	High Trend
CCM	7.0%	9.0%
HCBS	0.0%	1.0%
Other	15.0%	17.0%
Total	**11.8%**	**13.6%**

The base data were trended 30 months, from the midpoint of the CY 2013 base data to the midpoint of the rating period December 1, 2015 through January 31, 2016. Mercer relied upon FFS experience for these populations in developing trend.

Fraud and Abuse Recoupment

Mercer reviewed fraud and abuse recoupments and determined no adjustment was necessary.

Retroactive Eligibility

Mercer reviewed retroactive eligibility and determined no adjustment was necessary.

Managed Care Contracting and Savings Adjustments

Mercer did not apply an adjustment for managed care contracting because Louisiana Medicaid relied upon a sub-contractor to provide the FFS NEMT services during the base data period. Additionally, due to the limited time period covered by these rates, even if the potential for managed care savings does exist, Mercer does not believe significant managed care savings could be realized during the rating period.

Non-Medical Expense Load

Retention

Retention is expressed as a percentage of the gross capitation rate (i.e., premium). These percentages were developed incorporating the following considerations:

- Administrative requirements specific to the NEMT services section of the Bayou Health physical health services contract.
- Administrative expense benchmarks for other Medicaid NEMT services.

- Underwriting gain of 2.00%.
- Premium tax of 2.25%.

Mercer used a total factor of 12.93% for administration expenses, underwriting gain, and premium tax in the development of the NEMT capitation rates.

Rate Ranges

The final rate ranges represent a "best estimate" of the range of anticipated cost of providing NEMT services during the contract period for the covered populations. The lower end of an actuarially sound rate range attempts to ensure the capitation revenue received provides sufficient margin so that insolvency is not a significant risk for the MCOs participating in Bayou Health. The upper end of an actuarially sound rate range attempts to ensure the capitation revenue is not so large that the State is at risk of paying too much for the provision of NEMT services for eligible recipients. Mercer used CY 2013 annual enrollment to calculate the composite capitation rates.

December 1, 2015 through January 31, 2016 Bayou Health NEMT services rate ranges are displayed in the following table:

Category of Aid (COA)	CY 2013 Member Months	Lower Bound	Upper Bound
CCM	62,148	$7.21	$7.55
HCBS	181,177	$12.74	$13.06
Other	1,029,188	$11.34	$11.84
Composite Total	**1,272,513**	**$11.34**	**$11.80**

Please find additional information related to the Bayou Health NEMT services Rate Development in Appendix B.

Certification

In preparing these actuarially sound capitation rate ranges, Mercer has used and relied upon enrollment, eligibility, FFS claims data, and other various information supplied by the State and its fiscal agent. The State and its fiscal agent are responsible for the validity and completeness of these supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion, they are appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that these rate ranges were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the populations and services covered under the managed care contract. The undersigned actuary is a member of the American Academy of Actuaries and meets its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rate ranges developed by Mercer are actuarial projections of future contingent events. Actual results will differ from these projections. Mercer has developed these rate ranges on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

Providers are advised that the use of these rate ranges may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these rate ranges by providers for any purpose. Mercer recommends that any provider considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to the rates offered by the State before deciding whether to contract with the State.

This certification letter assumes the reader is familiar with the State's Bayou Health program, Medicaid eligibility rules, and actuarial rating techniques. It is intended for the State and CMS, and should not be relied upon by third 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 results. This document should be reviewed only in its entirety.

If you have questions on any of the above, please feel free to contact me at +1 404 442 3358 at your convenience.

Sincerely,

Jaredd Simons, ASA, MAAA
Senior Associate Actuary

Appendix A: NEMT CY 2013 Base Data

COA	CY 2013 Member Months	Total Paid	Units	Annual Util/1,000	Unit Cost	Base PMPM
CCM	62,148	$329,458	4,180	807	$78.82	$5.30
HCBS	181,177	$2,010,030	22,014	1,458	$91.31	$11.09
Other	1,029,188	$7,165,120	104,303	1,216	$68.70	$6.96
Total	**1,272,513**	**$9,504,608**	**130,497**	**1,231**	**$72.83**	**$7.47**

Appendix B: NEMT Rate Development

	Base Data					Rate After Trend			Rate After Retention		
Rate Cell	MMs	Expenses	PMPM	Low Trend	High Trend	Low PMPM	High PMPM	Admin	Low PMPM	High PMPM	Target PMPM
CCM	62,148	$ 329,458	$ 5.30	7.00%	9.00%	$ 6.28	$ 6.58	12.93%	$ 7.21	$ 7.55	$ 7.38
HCBS	181,177	$ 2,010,030	$ 11.09	0.00%	1.00%	$ 11.09	$ 11.37	12.93%	$ 12.74	$ 13.06	$ 12.90
Other	1,029,188	$ 7,165,120	$ 6.96	15.00%	17.00%	$ 9.87	$ 10.31	12.93%	$ 11.34	$ 11.84	$ 11.59
Total	**1,272,513**	**$ 9,504,608**	**$ 7.47**	**11.80%**	**13.62%**	**$ 9.87**	**$ 10.28**	**12.93%**	**$ 11.34**	**$ 11.80**	**$ 11.57**

Appendix C: NEMT Eligibility Designation

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Excluded
SSI (Aged, Blind and Disabled)			
Acute Care Hospitals (LOS > 30 days)			●
BPL (Walker vs. Bayer)			●
Disability Medicaid			●
Disabled Adult Child			●
Disabled Widow/Widower (DW/W)			●
Early Widow/Widowers			●
Family Opportunity Program*			●
Former SSI*			●
Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)			●
PICKLE			●
Provisional Medicaid			●
Section 4913 Children			●
SGA Disabled W/W/DS			●
SSI (Supplemental Security Income)*			●
SSI Conversion			●
Tuberculosis (TB)			●
SSI (OCS Foster Care, IV-E OCS/OYD and OCS/OYD (XIX))			
Foster Care IV-E - Suspended SSI			●
SSI (Supplemental Security Income)			●
TANF (Families and Children, LIFC)			
CHAMP Child			●
CHAMP Pregnant Woman (to 133% of FPIG)			●
CHAMP Pregnant Woman Expansion (to 185% FPIG)			●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Excluded
Deemed Eligible			●
ELE - Food Stamps (Express Lane Eligibility-Food Stamps)			●
Grant Review			●
LaCHIP Phase 1			●
LaCHIP Phase 2			●
LaCHIP Phase 3			●
LaCHIP Phase IV: Non-Citizen Pregnant Women Expansion			●
LIFC - Unemployed Parent / CHAMP			●
LIFC Basic			●
PAP - Prohibited AFDC Provisions			●
Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL			●
Regular MNP (Medically Needy Program)			●
Transitional Medicaid			●
FCC (Families and Children)			
Former Foster Care children			●
Youth Aging Out of Foster Care (Chaffee Option)			●
FCC (OCS Foster Care, IV-E OCS/OYD and OCS/OYD (XIX))			
CHAMP Child			●
CHAMP Pregnant Woman (to 133% of FPIG)			●
IV-E Foster Care			●
LaCHIP Phase 1			●
OYD - V Category Child			●
Regular Foster Care Child			●
YAP (Young Adult Program)			●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Excluded
YAP/OYD			●
BCC (Families and Children)			
Breast and/or Cervical Cancer			●
LAP (Families and Children)			
LaCHIP Affordable Plan			●
HCBS Waiver			
ADHC (Adult Day Health Services Waiver)		●	
Children's Waiver - Louisiana Children's Choice		●	
Community Choice Waiver		●	
New Opportunities Waiver – SSI		●	
New Opportunities Waiver Fund		●	
New Opportunities Waiver, non-SSI		●	
Residential Options Waiver - non-SSI		●	
Residential Options Waiver – SSI		●	
SSI Children's Waiver - Louisiana Children's Choice		●	
SSI Community Choice Waiver		●	
SSI New Opportunities Waiver Fund		●	
SSI/ADHC		●	
Supports Waiver		●	
Supports Waiver SSI		●	
CCM			
Chisholm Class Members**		●	
LaHIPP			
Louisiana's Health Insurance Premium Payment Program***			●
Dually Eligible			
Louisiana's Dually Eligible Population****	●	●	

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Excluded
Excluded from Bayou Health Physical Services			
CHAMP Presumptive Eligibility			●
CSOC			●
DD Waiver			●
Denied SSI Prior Period			●
Disabled Adults authorized for special hurricane Katrina assistance			●
EDA Waiver			●
Family Planning, New eligibility / Non-LaMOM			●
Family Planning, Previous LaMOMs eligibility			●
Family Planning/Take Charge Transition			●
Forced Benefits			●
GNOCHC Adult Parent			●
GNOCHC Childless Adult			●
HPE B/CC			●
HPE Children under age 19			●
HPE Family Planning			●
HPE Former Foster Care			●
HPE LaCHIP			●
HPE LaCHIP Unborn			●
HPE Parent/Caretaker Relative			●
HPE Pregnant Woman			●
LBHP - Adult 1915(i)			●
LTC (Long-Term Care)	●		
LTC Co-Insurance			●
LTC MNP/Transfer of Resources	●		
LTC Payment Denial/Late Admission Packet	●		

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Excluded
LTC Spend-Down MNP	●		
LTC Spend-Down MNP (Income > Facility Fee)			●
OCS Child Under Age 18 (State Funded)			●
OYD (Office of Youth Development)			●
PACE SSI			●
PACE SSI-related			●
PCA Waiver			●
Private ICF/DD	●		
Private ICF/DD Spend-Down Medically Needy Program	●		
Private ICF/DD Spend-Down Medically Needy Program/Income Over Facility Fee			●
Public ICF/DD	●		
Public ICF/DD Spend-Down Medically Needy Program	●		
QI-1 (Qualified Individual - 1)			●
QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)			●
QMB (Qualified Medicare Beneficiary)			●
SLMB (Specified Low-Income Medicare Beneficiary)			●
Spend-Down Medically Needy Program			●
Spend-Down Denial of Payment/Late Packet	●		
SSI Conversion / Refugee Cash Assistance (RCA)/ LIFC Basic			●
SSI DD Waiver			●
SSI Payment Denial/Late Admission	●		
SSI PCA Waiver			●
SSI Transfer of Resource(s)/LTC	●		
SSI/EDA Waiver			●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Excluded
SSI/LTC	●		
SSI/Private ICF/DD	●		
SSI/Public ICF/DD	●		
State Retirees			●
Terminated SSI Prior Period			●
Transfer of Resource(s)/LTC	●		

* Children under 19 years of age who are automatically enrolled into Bayou Health, but may voluntarily disenroll.
** Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the OCDD's Request for Services Registry who are CCMs.
*** LaHIPP is not a category of eligibility. Eligibility designation for LaHIPP enrollees will vary according to the qualifying category of eligibility.
****Dually eligible individuals are identified based on the Medicare Duals Eligibility table supplied by the State's fiscal agent. Dually eligible individuals are represented by Dual Status codes 02, 04, and 08.

Subcontract Requirements Checklist for MCOs

Plan Name:

Subcontractor Name:

Summary of services to be provided:

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	DHH Feedback
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between DHH and the MCO and the department issued guides and either physically incorporating these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.		
2	Include a signature page that contains a MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for renewals as well).		
3	Specify the effective dates of the subcontract agreement.		
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.		
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.		
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.		
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and DHH for any of the reasons described in the contract, the MCO shall immediately make available to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to DHH.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	DHH Feedback
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.		
9	Require that if any requirement in the subcontract is determined by DHH to conflict with the contract between DHH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.		
10	Identify the population covered by the subcontract.		
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to members through the last day that the subcontract is in effect.		
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.		
13	Specify the amount, duration and scope of benefits and services that are provided by the subcontractor.		
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.		
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 CFR §§ 493.1 and 493.3, and any other federal requirements.		
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO members pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between DHH and the MCO). MCO members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by LRS 40:1299.96 and 45 CFR 164.524 as amended and subject to reasonable charges.		
17	Include record retention requirements as specified in the contract between DHH and the MCO.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	DHH Feedback
18	Shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The MCO shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.		
19	Require the subcontractor to submit to the MCO a disclosure of ownership in accordance with RFP Section 15.1.10. **The completed disclosure of ownership must be submitted with the checklist.**		
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or DHH or its designee.		
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by DHH or its designee.		
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by DHH.		
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontractual and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by DHH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.		
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by DHH.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	DHH Feedback
25	Require safeguarding of information about MCO members according to applicable state and federal laws and regulations and as described in contract between DHH and the MCO.		
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.		
27	Provide that the subcontractor comply with DHH's claims processing requirements as outlined in the RFP.		
28	Provide that the subcontractor adhere to DHH's timely filing guidelines as outlined in the RFP.		
29	Provide that, if a subcontractor discovers an error or a conflict with a previously adjudicated encounter claim, MCO shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by DHH or if circumstances exist that prevent contractor from meeting this time frame a specified date shall be approved by DHH.		
30	Provide that the subcontractor, if performing a key internal control, submit to an independent SSAE 16 SOC type 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by DHH, the subcontractor must provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.		
31	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from DHH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	DHH Feedback
32	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between DHH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between DHH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by DHH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by DHH.		
33	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's members and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.		
34	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services.		
35	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.		
36	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.		
37	Include a conflict of interest clause as stated in the contract between DHH and the MCO.		
38	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between DHH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.		
39	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	DHH Feedback
40	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and its implementing regulation at 45 CFR Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.		
41	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.		
42	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.		
43	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.		
44	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Bayou Health. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.		

MCO Request for Member Disenrollment/Change

To: MAXIMUS

MAXIMUS FAX: 1-888-858-3875

From:

HEALTH PLAN FAX:

Print the Name of Member (Last, First, Middle Initial)	Birth Date	Medicaid ID Number or Social Security Number

☐ Member's utilization of services is fraudulent or abusive (e.g. member loans the MCO issued ID card to another person to obtain services). (Attach narrative with additional information including date of referral to Medicaid Program Integrity's Fraud Hotline)

☐ Member is placed in a long-term care nursing facility, ICF/DD facility, or becomes eligible for a Medicaid Home and Community-Based Services Waiver or hospice. Indicate which _____

☐ Member expired Date: _____

☐Member incarcerated Date:_____ Facility:_____

☐ Member has moved out of state. New Address: _____

☐ Other _____

Health Plan Signature:_____**Date:** _____

The Louisiana Department of Health and Hospitals will determine if the MCO has shown a good cause to disenroll the Medicaid/CHIP member. The Enrollment Broker will give written notification to the MCO of the decision. Medicaid/CHIP members have the right to appeal disenrollment decisions and request a state fair hearing with the Division of Administrative Law. All requests will be reviewed on a case-by-case basis and are subject to the sole discretion of DHH or its designee (Enrollment Broker). All decisions are final and not subject to the dispute resolution process by the MCO. (MCO Request for Proposals, 11.11.4)

The MCO shall not discriminate against any Medicaid /CHIP member on the basis of their health status, need for health care services or any other adverse reason with regard to the member's health, race, sex, handicap, age, religion or national origin.

☐**Disenrollment Approved Effective Date: _____** ☐**Disenrollment Denied/Reason:**_____

DHH Signature:_____**Date:** _____

Maximus Signature:_____**Date**: _____

Health Plan notified of decision.

Appendix UU

Behavioral Health Provider Network - Geographic and Capacity standards

			Monitoring
Psychiatrists	**Rural**	**Urban**	**Quarterly GeoAccess Reports, Network Development Plan, Weekly Provider Registry**
Psychiatrists	**30 miles**	**15 miles**	
Behavioral Health Specialists	**30 miles**	**15 miles**	
Advanced Practice Registered Nurse (Behavioral Health Specialty)	The network standard is applied to this category of providers collectively. However, DHH requires reporting and monitoring for each individual specialist type shown here.		
Clinical Nurse Specialist (Behavioral Health Specialty)			
Licensed Addiction Counselor			
Licensed Clinical Social Worker			
Licensed Marriage and Family Therapist			
Licensed Professional Counselor			
Medical Psychologist			
Physician Assistant(Behavioral Health Specialty)			
Psychologist-Clinical			
Psychologist-Counseling			
Psychologist-Developmental			
Psychologist-General (Non-Declared)			
Pychologist-Other			
Psychologist-School			
Psychiatric Residential Treatment Facilities (PRTFs)	**Travel distance to a PRTF shall not exceed 200 miles for 90% of members**		
Psychiatric Residential Treatment Facility			
Psychiatric Residential Treatment Facility Addiction			
Psychiatric Residential Treatment Facility Hospital Based			
Psychiatric Residential Treatment Facility Other Specialization			
Substance Use Residential Treatment Facilities	**Adolescents**	**Adults**	
ASAM Level III.3/5 Clinically Managed High Intensity	**60 miles**	**30 miles**	
ASAM Level III.7 Medically Monitored Intensive	**n/a**	**60 miles**	
ASAM Level III.7D Medically Monitored Re	**n/a**	**60 miles**	
Other Facilities	**n/a**	**n/a**	
Crisis Receiving Center	The network development plan must include an assessment of coverage for access to these services including distance, population density, and provider availability variables. All gaps in coverage must be identified and addressed in the Network Development Plan		
Repite Care Services Agency/Center Based Respite			
Assertive Community Treatment Team			
Mental Health Clinic (Legacy MHC)			
Behavioral Health Rehab Provider Agency			
Mental Health Rehabilitation Agency			
Multi-Systemic Theraphy Agency			
Therapeutic Group Home			
Mental Health Clinic (Legacy MHC)			
Hospital, Distinct Part Psychiatric Unit			
Hospital, Free Standing Psychiatric Unit			
Federally Qualified Health Clinics (with Behavioral Health Specialty)			
Substance Abuse and Alcohol Abuse Center (Outpatient)			