

## Louisiana Calendar 2007 and 2008 Databook

At the request of the State of Louisiana Department of Health and Hospitals (“DHH”), Mercer Government Human Services Consulting (“Mercer”) has developed a databook to summarize enrollment and Medicaid expenditures in an effort to inform interested parties of expenditure and demographic data in different regions of the State. The information is provided for current CommunityCARE enrollees as well as those fee-for-service (“FFS”) members who are yet to enroll into the CommunityCARE program. The State is in the process of evaluating alternatives to improve the delivery system to these individuals. One option is to implement an enhanced PCCM (“ePCCM”) program; which will build upon the current CommunityCARE program.

The databook is only for informational purposes. It is anticipated that the State would pay ePCCM entities an administrative fee under a savings model and that a benchmark per member per month (“PMPM”) rate would be developed; this document is not intended to reflect any rate methodology that the State may adopt. The source data used to develop the databook will also be used to develop the benchmark PMPMs; which will be compared against actual expenditures to determine savings under the ePCCM program (if any). While the source data used to develop the databook is the same as that used to determine the benchmark PMPMs for the ePCCM program, the program design has not been fully developed as the State is still seeking input from various stakeholders on program design. There are also a number of adjustments that will be made to the data, beyond what is already included in the databook, to determine the benchmark PMPMs.

This databook is developed using fee-for-service claims provided by DHH and its fiscal agent for claims incurred in calendar year 2007 (“CY07”) and calendar year 2008 (“CY08”). The data summary is provided by region and also on a statewide basis. A number of restrictions related to covered population and covered services were applied to match the data to the population that would likely transition into the improved care management program. The databook is currently provided for informational purposes only. Once the State finalizes the program design and the reimbursement methodology is finalized, the data may need to be updated. At this point, Mercer would issue any required update to the databook so that interested entities would be able to evaluate the proposed reimbursement methodology in the context of actual historical experience to make an informed decision as to their ability to provide the services requested under a new delivery model and reimbursement methodology. Once benchmark PMPMs are available, the reviewer should be cognizant that there will be differences between the databook and the benchmark PMPM when reviewing the information. As such, the information contained in the databook is not provided as an indicator of any rate methodology or potential rates that will be issued in the future.

## Covered Population

Mercer worked with DHH to determine the populations that would be included and excluded from participation in the new program. Those populations excluded consist of:

- Dual Eligibles
- Medically Needy Spend Down Population
- Children in Foster Care
- Children Special Needs Population (ABD kids <19 Years)
- Recipients residing in a Nursing Home or Long-Term Care facility
- Individuals with Mental Retardation/Developmental Disability
- State Funded Only Populations

Mercer has summarized the covered eligibility groups into four main categories. They are:

- Aged and Disabled
- Children and Families
- LaChip
- Pregnant Women

As noted above, the presentation of the covered population information is for informational purposes only. DHH reserves the right to revise the covered populations that will participate in any new program, but welcome comments from the public regarding which populations would most benefit from enhanced care coordination or management.

## Covered Services

The databook contains historical utilization and cost data for services currently covered under the Medicaid State Plan and which it is expected that an ePCCM program would manage. In general, it is anticipated that vendors participating in the ePCCM program will be expected to coordinate, authorize and provide most services currently covered by Medicaid. Specific services that will be provided separately by Medicaid on a fee-for-service basis, which are envisioned not to be the responsibility of the vendor, consist of:

- Skilled Nursing Home Service
- Intermediate Care Facilities
- Adult Day Care
- Case Management
- Waiver Services
- Community Care PCCM Fees (\$3 PMPM)
- Pace Capitation Payments

## Completion Factor Adjustment (IBNP)

An adjustment to complete the data has already been made within the databook. The same completion factors will also be applied to the benchmark PMPM development process. Completion factors are applied to account for claims that have already been incurred by DHH but are yet to be paid. This is due to the lag time between the rendering of the medical service, the processing of the claim by the provider, and then adjudication by DHH's fiscal agent. The pattern of lag in payment varies from service to service. Prescription drug claims are usually the quickest to complete due to the processing of these claims by electronic means. Inpatient claims typically take the longest to complete. Most Inpatient claims are processed within six months of being incurred, but even then, some claims may even take longer to process. Application of the completion factor reflects the true cost of providing services during the period, otherwise, medical cost would be understated.

The aggregate average completion factor applied by Mercer in CY08 is 9.00%. CY07 claims are considered substantially complete.

## Retroactive Enrollment and Claims

Mercer has excluded retroactive enrollment and claims as well as those during the first month of Medicaid eligibility. The rationale for this is that plans would not be able to manage utilization patterns until Medicaid enrollees were officially enrolled into the plan. Even after eligibility, there is usually a 30-45 day period which are not the responsibility of the plan. The retroactive enrollment and claims, as well that those during the first month of eligibility, are included for newborns because they may be automatically enrolled into the mother's plan.

If you have any questions about the attached databook, please contact An Danh of Mercer at [an.danh@mercer.com](mailto:an.danh@mercer.com), or Roberta Bradford at [roberta.bradford@mercer.com](mailto:roberta.bradford@mercer.com).

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