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: 2000107367 (17)
Vendor: Aetna Better Health, Inc.
Description: Amd 17: Single PDL, rate cert; no change to time or money.
Approved By: Pamela Rice
Approval Date: 8/06/2019

Your amendment that was submitted to OSP has been approved.

Rev 2017-01

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 17

LAGOV#: 2000107367

LDH #: 060466

Medical Vendor Administration

(Regional/ Program/ Facility)

Bureau of Health Services Financing

AND

Aetna Better Health, Inc.

Contractor Name

Original Contract Amount: 1,964,731,789

Original Contract Begin Date: 02-01-2015

Original Contract End Date: 01-31-2018

RFP Number: 305PUR-DHHRFP-BH

AMENDMENT PROVISIONS

Change Contract From: From Maximum Amount: $3,306,823,393.00 Current Contract Term: 2/1/15-12/31/19

See Attachment A17 and Attachment D.

Change Contract To: To Maximum Amount: Changed Contract Term:

See Attachment A17, Attachment D1, Attachment D2.

Justifications for amendment:

These revisions are required for implementation of the single Preferred Drug List (PDL), update provider directory accuracy initiatives, and compliance with state law. Revisions contained in this amendment are within scope and comply with the terms and conditions as set forth in the RFP.

This Amendment Becomes Effective: 04-01-2019

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

Aetna Better Health, Inc.

David Delaney 7/2/19

CONTRACTOR SIGNATURE DATE

PRINT NAME: David Delaney

CONTRACTOR TITLE: Chief Financial Officer

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE Cindy Rives-for DATE

NAME: Jen Steele

TITLE: Medicaid Director

OFFICE: Bureau of Health Services Financing

PROGRAM SIGNATURE DATE

NAME

Contract Amendment #17
Attachment A-17

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
1	Attachment D Rate Certification	Mercer rate certifications; Attachments D1, D2 in amendment 16	Replaced with updated rate certifications; Attachments D1 and D2.	Updated expansion and non-expansion rate certifications, effective 4/1/19 through 12/31/19, reflect changes due to: • Single Preferred Drug List (PDL) • Local Pharmacy adjustments • Rx Copay Limit adjustment • FMP updates • St. Elizabeth/Our Lady of the Lake merger • IMD Short Stays adjustment • Wage Verification Disenrollment adjustment • High Needs rate development
2	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	6.3 Covered Services 6.3.1.1 According to 42 CFR §438.3, the MCO must cover all outpatient drugs where the manufacturer has entered into the Federal rebate agreement and meet the standards in Section 1927 of the Social Security Act. The MCO may manage coverage and utilization of drugs through the formation of a Preferred Drug List (PDL), excluding the Common PDL. Procedures used to manage utilization may include, but are not limited to, prior authorization, utilization edits and clinical edits. Self-administered drugs dispensed by a pharmacy, including specialty pharmacies, shall be covered as a pharmacy benefit unless otherwise approved by LDH Pharmacy staff.	6.3 Covered Services ~~6.3.1.1 According to 42 CFR §438.3, the MCO must cover all outpatient drugs where the manufacturer has entered into the Federal rebate agreement and meet the standards in Section 1927 of the Social Security Act. The MCO may manage coverage and utilization of drugs through the formation of a Preferred Drug List (PDL), excluding the Common PDL. Procedures used to manage utilization may include, but are not limited to, prior authorization, utilization edits and clinical edits. Self-administered drugs dispensed by a pharmacy, including specialty pharmacies, shall be covered as a pharmacy benefit unless otherwise approved by LDH Pharmacy staff.~~	This revision is required for the implementation of the single PDL.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		Physician administered drugs that are not listed on the FFS fee schedule but the manufacturer has signed the federal rebate agreement, should be covered as a pharmacy benefit. Prior authorization and/or other safety edits are allowed on physician administered drugs. 6.3.1.2 The MCO shall provide coverage for all drugs deemed medically necessary for members under the age of twenty-one (21). 6.3.1.3 The MCO is not required to follow the LDH monthly prescription limits. However, it may not enact prescription quantity limits more stringent than the Medicaid State Plan. If prescription limits are adopted, the MCO monthly prescription limits must have Point of Sale (POS) override capabilities when a greater number of prescriptions per month are determined to be medically necessary by the prescriber. MCO monthly prescription limits must have Point of Sale (POS) override capabilities when a greater quantity is determined to be medically necessary by the prescriber and MCO. 6.3.1.4 The "Covered Drug List" is all drugs included in the federal rebate agreement. A subset of the Covered Drug List shall be the "Preferred Drug List (PDL)" listing all preferred agents. The "Common PDL" (list of drugs common to all MCOs	~~Physician administered drugs that are not listed on the FFS fee schedule but the manufacturer has signed the federal rebate agreement, should be covered as a pharmacy benefit. Prior authorization and/or other safety edits are allowed on physician administered drugs.~~ ~~6.3.1.2 The MCO shall provide coverage for all drugs deemed medically necessary for members under the age of twenty-one (21).~~ 6.3.1.~~3~~1 The MCO may follow the FFS limit of four prescriptions per calendar month ~~is not required to follow the LDH monthly prescription limits~~. However, it may not enact prescription ~~quantity~~ limits more stringent than the Medicaid State Plan. If prescription limits are ~~adopted~~ enacted, the MCO shall ~~monthly prescription limits must~~ have Point of Sale (POS) override capabilities when a greater number of prescriptions per calendar month are determined to be medically necessary by the prescriber. 6.3.1.2 Except for the use of approved generic drug substitution of brand drugs, under no circumstances shall the MCO permit the therapeutic substitution of a prescribed drug without a prescriber's authorization. ~~6.3.1.4 The "Covered Drug List" is all drugs included in the federal rebate agreement. A subset of the Covered Drug List shall be the "Preferred Drug List (PDL)" listing all preferred~~	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		without prior authorization) shall be maintained and updated upon LDH request, as well as posted.	~~agents. The "Common PDL" (list of drugs common to all MCOs without prior authorization) shall be maintained and updated upon LDH request, as well as posted.~~	
3	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	6.3.2 Covered Drug List The Covered Drug List shall include all outpatient drugs where the manufacturer has entered into the Federal rebate agreement and met the standards in Section 1927 of the Social Security Act. 6.3.2.1 The MCO shall expand its Covered Drug List, as needed, to include newly FDA-approved drugs subject to Section 1927(d) of the Social Security Act, which are deemed to be appropriate, safe, and efficacious in the medical management of members. 6.3.2.2 The Covered Drug List may only exclude coverage of drugs or drug categories permitted under Section 1927(d) of the Social Security Act. In addition, the MCO may include in its Covered Drug List any FDA approved drugs that may allow for clinical improvement or are clinically advantageous for the management of a disease or condition. 6.3.2.3 Except for the use of approved generic drug substitution of brand drugs, under no circumstances shall the MCO permit the therapeutic substitution of a prescribed drug without a prescriber's authorization.	6.3.2 Covered Drug List ~~The Covered Drug List shall include all outpatient drugs where the manufacturer has entered into the Federal rebate agreement and met the standards in Section 1927 of the Social Security Act.~~ ~~6.3.2.1 The MCO shall expand its Covered Drug List, as needed, to include newly FDA-approved drugs subject to Section 1927(d) of the Social Security Act, which are deemed to be appropriate, safe, and efficacious in the medical management of members.~~ ~~6.3.2.2 The Covered Drug List may only exclude coverage of drugs or drug categories permitted under Section 1927(d) of the Social Security Act. In addition, the MCO may include in its Covered Drug List any FDA approved drugs that may allow for clinical improvement or are clinically advantageous for the management of a disease or condition.~~ ~~6.3.2.3 Except for the use of approved generic drug substitution of brand drugs, under no circumstances shall the MCO permit the therapeutic substitution of a prescribed drug without a prescriber's authorization.~~	This revision is required for the implementation of the single PDL.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		The MCO Covered Drug list should be updated at least weekly from a national drug database.	~~The MCO Covered Drug list should be updated at least weekly from a national drug database.~~ 6.3.2.1 In accordance with 42 CFR §438.3, the MCO shall maintain a Covered Drug List (CDL) which includes all outpatient drugs for which the manufacturer has entered into a Federal rebate agreement and met the standards in Section 1927 of the Social Security Act. The CDL will be provided by LDH to the MCOs as a weekly drug file. 6.3.2.2 The CDL shall include all drugs deemed medically necessary for members under the age of twenty-one (21). 6.3.2.3 The CDL shall exclude only those drugs or drug categories permitted for exclusion under Section 1927(d) of the Social Security Act, with exceptions listed in the Louisiana State Plan. MCOs are allowed to cover vaccines, compounded drugs, diabetic supplies, and rebate eligible OTCs as a regular pharmacy benefit (not value added). MCOs are allowed to cover additional drugs as a value added benefit. 6.3.2.4 The CDL shall be updated at least weekly using a national drug database. 6.3.2.5 When drugs (OTC or legend) are being covered as a pharmacy benefit and offered as a value added benefit, pharmacy encounters shall indicate such in the Character 1:	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			Submission type (Q, F, or V) of the 4-character prefix on the ICN of the Rx encounter. 6.3.2.6 The MCO may apply Point of Sale safety and utilization edits that align with FDA indications for any covered drug. 6.3.2.7 Self-administered drugs dispensed by a pharmacy, including specialty pharmacies, shall be covered as a pharmacy benefit unless otherwise approved by LDH. 6.3.2.8 Physician-administered drugs that are not listed on the FFS fee schedule but for which the manufacturer has signed a federal rebate agreement shall be covered as either a pharmacy benefit or a medical benefit. If the physician administered drug is not on the FFS fee schedule, but the MCO covers as a medical benefit, then reimbursement shall be set as a minimum by the current FFS reimbursement methodology in the state plan.	
4	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	6.3.3 Preferred Drug List 6.3.3.1 The PDL is a subset of drug products on the Covered Drug List, and an up-to-date version shall be available to all providers and members through the MCO web site and electronic prescribing tools. The PDL must be available in electronic format and easily searchable by brand or generic name. The PDL should also be available in a searchable PDF file document listed by therapeutic classes. Any edits on	6.3.3 Preferred Drug List ~~6.3.3.1 The PDL is a subset of drug products on the Covered Drug List, and an up-to-date version shall be available to all providers and members through the MCO web site and electronic prescribing tools. The PDL must be available in electronic format and easily searchable by brand or generic name. The PDL should also be available in a searchable PDF file document listed by therapeutic classes. Any edits on~~	This revision is required for the implementation of the single PDL.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		preferred products such as quantity limits, step therapy, or prior authorization should be noted on the PDF file document. 6.3.3.2 Drugs that are on the Covered Drug List, but not on the PDL must be available to members through a prior authorization process. Pharmacy prior authorizations must be resolved (approved or denied) within 24 hours of the request, seven (7) days a week. The MCO must have an automated process that allows the pharmacy to dispense up to a 72-hour emergency supply of a product or full unbreakable packages without having to obtain a prior authorization. At a minimum two emergency supply fills shall be allowed per prescription. The pharmacy shall be reimbursed for both the ingredient and the dispensing fee for both fills. Emergency fills may be included in a post adjudication audit to identify misuse of the override. The Department may require allowing the emergency override for certain DUR initiatives. The pharmacist shall place an "03" in NCPDP field 418-DI (Level of Service) as noted in NCPDP guidelines. 6.3.3.3 The PDL shall be reviewed by the MCO in its entirety and updated at least annually and upon LDH request but no more frequently than quarterly with 60 days' notice. 6.3.3.4 The MCO shall limit negative changes to the PDL (e.g., remove a drug, impose step therapy, etc.) to four times a year, unless urgent circumstances require more timely action, such	~~preferred products such as quantity limits, step therapy, or prior authorization should be noted on the PDF file document.~~ ~~6.3.3.2 Drugs that are on the Covered Drug List, but not on the PDL must be available to members through a prior authorization process. Pharmacy prior authorizations must be resolved (approved or denied) within 24 hours of the request, seven (7) days a week. The MCO must have an automated process that allows the pharmacy to dispense up to a 72-hour emergency supply of a product or full unbreakable packages without having to obtain a prior authorization. At a minimum two emergency supply fills shall be allowed per prescription. The pharmacy shall be reimbursed for both the ingredient and the dispensing fee for both fills. Emergency fills may be included in a post adjudication audit to identify misuse of the override. The Department may require allowing the emergency override for certain DUR initiatives. The pharmacist shall place an "03" in NCPDP field 418-DI (Level of Service) as noted in NCPDP guidelines.~~ ~~6.3.3.3 The PDL shall be reviewed by the MCO in its entirety and updated at least annually and upon LDH request but no more frequently than quarterly with 60 days' notice.~~ ~~6.3.3.4 The MCO shall limit negative changes to the PDL (e.g., remove a drug, impose step therapy, etc.) to four times a year, unless urgent circumstances require more timely action, such~~	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		as drug manufacturer's removal of a drug from the market due to patient safety concerns. The addition of a newly approved generic and removal of the brand equivalent does not constitute a negative PDL change. 6.3.3.5 The PDL and any revision thereto, shall be reviewed and approved by LDH prior to implementation. Any changes to the PDL, including but not limited to any/all prior authorization, fail first, step therapy requirements or prescription quantity limits, shall be submitted to LDH at least 30 days prior to implementation. The MCO shall not replace an approved preferred drug on the PDL without prior approval of LDH. 6.3.3.6 The selection of drugs included on the PDL shall be sufficient to ensure enough provider choice and include FDA approved drugs to serve the medical needs of all enrollees, including those with special needs. The MCO shall have at least two oral "preferred" drugs in each behavioral health therapeutic class and at least one injectable drug in each class that has an injectable product available without prior authorization.	~~as drug manufacturer's removal of a drug from the market due to patient safety concerns. The addition of a newly approved generic and removal of the brand equivalent does not constitute a negative PDL change.~~ ~~6.3.3.5 The PDL and any revision thereto, shall be reviewed and approved by LDH prior to implementation. Any changes to the PDL, including but not limited to any/all prior authorization, fail first, step therapy requirements or prescription quantity limits, shall be submitted to LDH at least 30 days prior to implementation. The MCO shall not replace an approved preferred drug on the PDL without prior approval of LDH.~~ ~~6.3.3.6 The selection of drugs included on the PDL shall be sufficient to ensure enough provider choice and include FDA approved drugs to serve the medical needs of all enrollees, including those with special needs.~~ ~~The MCO shall have at least two oral "preferred" drugs in each behavioral health therapeutic class and at least one injectable drug in each class that has an injectable product available without prior authorization.~~ <u>6.3.3.1 A subset of the CDL shall be the Preferred Drug List (PDL).</u>	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			6.3.3.2 The PDL shall be established by LDH and indicate the preferred and non-preferred status of covered drugs. 6.3.3.3 The PDL shall be maintained by LDH and made available on the LDH website. The MCO shall make the PDL available to its providers and members through electronic prescribing tools and a static link on the MCO website to the PDL maintained on the LDH website. 6.3.3.4 LDH shall provide the MCO with a list of drugs included on the PDL by NDC number after each FFS P&T meeting and upon the Secretary's approval of P&T committee recommendations. Changes shall be implemented January 1 and July 1 after FFS P&T, unless otherwise directed by LDH. LDH shall provide the MCOs at least 30 days written notice prior to the implementation date of any changes to the list of drugs included on the PDL. 6.3.3.5 LDH shall monitor the rate of MCO compliance with the PDL. Compliance rate shall be defined as the number of preferred prescriptions paid divided by total prescriptions paid for drugs in therapeutic classes listed on the PDL. The MCO shall seek to achieve a 90 percent compliance rate. 6.3.3.6 The MCO shall not enter into agreements with manufacturers to acquire discounts or rebates on drugs.	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			Current MCO manufacturer drug discount or rebate agreements shall be discontinued by 4/30/19. 6.3.3.7 New drugs entering the marketplace in the PDL therapeutic classes shall be added as non-preferred until FFS P&T reviews the drug, unless otherwise directed by LDH. 6.3.3.8 If a branded product is preferred on the PDL, the MCO shall not require the prescriber to indicate in writing that the branded product is medically necessary. The MCO shall reimburse for a brand name drug at a brand reimbursement when the brand drug is preferred. POS denial messaging for the generic entity shall indicate that the brand name is preferred. 6.3.3.9 DXC (formerly Molina) will post weekly drug file data for the MCOs. MCOs shall have 3 business days after receipt of file to download and implement drug PA status. There shall be a mandatory generic substitution for all drugs, when a generic is available, unless the brand is justified with applicable DAW codes or the brand is preferred.	
5	Exhibit 3 305PUR-DHHRFP-BH-	6.3.3.8 Common PDL	~~6.3.3.8 Common PDL~~	This revision is required for the implementation of the single PDL.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
	MCO-2014-MVA	The "Common PDL" (list of drugs common to all MCOs without prior authorization) shall be maintained and updated upon LDH request. A separate "Common PDL" document should be posted with the other PDL documents. The Common PDL should be reviewed at least annually and upon LDH request.	~~The "Common PDL" (list of drugs common to all MCOs without prior authorization) shall be maintained and updated upon LDH request.~~ ~~A separate "Common PDL" document should be posted with the other PDL documents.~~ ~~The Common PDL should be reviewed at least annually and upon LDH request.~~	
6	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	6.3.4 Prior Authorization for Pharmacy Benefits 6.3.4.1 Prior authorization must comply with 42 CFR § 438.3(s)(6) and may be used for drug products only under the following conditions: 6.3.4.1.1 When prescribed drugs included in the federal rebate program have clinical criteria; 6.3.4.1.2 To determine when prescribed drugs are medically necessary; 6.3.4.1.3 When prescribed drugs are inconsistent with FDA-approved labeling, including behavioral health drugs or when prescribed drugs are inconsistent with nationally accepted guidelines; 6.3.4.1.4 When a prescribed brand name medication has an A-rated generic equivalents. The MCO can encourage a	6.3.4 Prior Authorization for Pharmacy Benefits ~~6.3.4.1 Prior authorization must comply with 42 CFR § 438.3(s)(6) and may be used for drug products only under the following conditions:~~ ~~6.3.4.1.1 When prescribed drugs included in the federal rebate program have clinical criteria;~~ ~~6.3.4.1.2 To determine when prescribed drugs are medically necessary;~~ ~~6.3.4.1.3 When prescribed drugs are inconsistent with FDA-approved labeling, including behavioral health drugs or when prescribed drugs are inconsistent with nationally accepted guidelines;~~ ~~6.3.4.1.4 When a prescribed brand name medication has an A-rated generic equivalents. The MCO can encourage a~~	This revision is required for the implementation of the single PDL.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		prescriber to complete the FDA Medwatch form, but this should not be required or considered in the PA approval/denial determination process of a brand drug. If a PA is requested for a narrow therapeutic index (NTI) drug, every effort should be made to verify if the recipient is currently on a specific brand/generic, then the PA shall be approved. NTI drugs: Aminophylline, Carbamazepine, Cyclosporine, Digoxin, Disopyramide, Ethosuximide, Flecainide, L-Thyroxine, Lithium, Phenytoin, Theophylline, Thyroid, Valproic Acid, and Warfarin. (All drugs listed in the Common PDL are exempt from PA requirements); 6.3.4.1.5 To minimize potential drug over-utilization; 6.3.4.1.6 To accommodate exceptions to Medicaid drug utilization review standards related to proper maintenance drug therapy; and/or 6.3.4.1.7 Under other conditions with LDH Pharmacy approval. 6.3.4.1.8 Prior authorization shall not require more than two failures of preferred products. 6.3.4.2 The MCO shall override prior authorization for selected drug products or devices at LDH's discretion. 6.3.4.3 The MCO shall not require prior authorization for a dosage change for any medications (including long-acting	~~prescriber to complete the FDA Medwatch form, but this should not be required or considered in the PA approval/denial determination process of a brand drug. If a PA is requested for a narrow therapeutic index (NTI) drug, every effort should be made to verify if the recipient is currently on a specific brand/generic, then the PA shall be approved. NTI drugs: Aminophylline, Carbamazepine, Cyclosporine, Digoxin, Disopyramide, Ethosuximide, Flecainide, L-Thyroxine, Lithium, Phenytoin, Theophylline, Thyroid, Valproic Acid, and Warfarin. (All drugs listed in the Common PDL are exempt from PA requirements);~~ ~~6.3.4.1.5 To minimize potential drug over-utilization;~~ ~~6.3.4.1.6 To accommodate exceptions to Medicaid drug utilization review standards related to proper maintenance drug therapy; and/or~~ ~~6.3.4.1.7 Under other conditions with LDH Pharmacy approval.~~ ~~6.3.4.1.8 Prior authorization shall not require more than two failures of preferred products.~~ ~~6.3.4.2 The MCO shall override prior authorization for selected drug products or devices at LDH's discretion.~~ ~~6.3.4.3 The MCO shall not require prior authorization for a dosage change for any medications (including long-acting~~	

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		injectable antipsychotics) and other medication assisted treatment (including dosages of buprenorphine or buprenorphine/naloxone) that have been previously authorized and/or approved by the MCO, as long as the newly prescribed dose is within established FDA guidelines for that medication. 6.3.4.4 The MCO must notify the requesting practitioner of the approval or disapproval of the request within 24 hours once relevant medically necessary information is obtained from the prescriber. 6.3.4.5 The MCO must provide access to a toll-free call center for prescribers to call to request prior authorization for non-preferred drugs or drugs that are subject to clinical edits. The MCO must allow prescribers and pharmacies to submit prior authorization requests by phone, fax or automated process. If the MCO or its pharmacy benefit manager operates a separate call center for prior authorization requests, it will be subject to the provider call center standards set forth in Section 12 of this Contract and monetary penalties set forth in Section 20 of this Contract. 6.3.4.6 The MCO shall not penalize the prescriber or member, financially or otherwise, for prior authorization requests or other inquiries regarding prescribed medications.	~~injectable antipsychotics) and other medication assisted treatment (including dosages of buprenorphine or buprenorphine/naloxone) that have been previously authorized and/or approved by the MCO, as long as the newly prescribed dose is within established FDA guidelines for that medication.~~ ~~6.3.4.4 The MCO must notify the requesting practitioner of the approval or disapproval of the request within 24 hours once relevant medically necessary information is obtained from the prescriber.~~ ~~6.3.4.5 The MCO must provide access to a toll-free call center for prescribers to call to request prior authorization for non-preferred drugs or drugs that are subject to clinical edits. The MCO must allow prescribers and pharmacies to submit prior authorization requests by phone, fax or automated process. If the MCO or its pharmacy benefit manager operates a separate call center for prior authorization requests, it will be subject to the provider call center standards set forth in Section 12 of this Contract and monetary penalties set forth in Section 20 of this Contract.~~ ~~6.3.4.6 The MCO shall not penalize the prescriber or member, financially or otherwise, for prior authorization requests or other inquiries regarding prescribed medications.~~	

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		6.3.4.7 Denials of prior authorization requests or offering of an alternative medication shall be provided to the prescriber and member in writing. 6.3.4.8 A member receiving a prescription drug that was on the MCO's PDL and subsequently removed or changed, shall be permitted to continue to receive that prescription drug if determined to be medically necessary for at least sixty (60) days. Medical necessity must be determined in consultation with the prescriber. 6.3.4.9 The MCO must have an automated process that allows the pharmacy to dispense up to a 72-hour supply of a product or full unbreakable packages without having to obtain a prior authorization At a minimum two emergency supply fills shall be allowed per prescription. The pharmacy shall be reimbursed for both the ingredient and the dispensing fee for both fills. Emergency fills may be included in a post adjudication audit to identify misuse of the override. The Department may require allowing the emergency override for certain DUR initiatives. The pharmacist shall place an "03" in NCPDP field 418-DI (Level of Service) as noted in NCPDP guidelines. Pharmacy prior authorization denials may be appealed in accordance with Section 13 of this Contract.	~~6.3.4.7 Denials of prior authorization requests or offering of an alternative medication shall be provided to the prescriber and member in writing.~~ ~~6.3.4.8 A member receiving a prescription drug that was on the MCO's PDL and subsequently removed or changed, shall be permitted to continue to receive that prescription drug if determined to be medically necessary for at least sixty (60) days. Medical necessity must be determined in consultation with the prescriber.~~ ~~6.3.4.9 The MCO must have an automated process that allows the pharmacy to dispense up to a 72-hour supply of a product or full unbreakable packages without having to obtain a prior authorization At a minimum two emergency supply fills shall be allowed per prescription. The pharmacy shall be reimbursed for both the ingredient and the dispensing fee for both fills. Emergency fills may be included in a post adjudication audit to identify misuse of the override. The Department may require allowing the emergency override for certain DUR initiatives. The pharmacist shall place an "03" in NCPDP field 418-DI (Level of Service) as noted in NCPDP guidelines.~~ ~~Pharmacy prior authorization denials may be appealed in accordance with Section 13 of this Contract.~~	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			6.3.4.1 LDH intends to align FFS and MCO prior authorization (PA) criteria for drugs on the single PDL over time through the Drug Utilization Review (DUR) board. The MCOs shall have input on PA criteria development and representation on the DUR board. Prior to alignment, the MCOs shall maintain PA criteria that is not more restrictive than FFS. The MCO shall have a Prior Authorization (PA) process that complies with 42 CFR § 438.3(s)(6) and the following requirements. 6.3.4.1.1 The MCO shall allow prescribers and pharmacies to submit PA requests by phone, fax or automated process; 6.3.4.1.2 The MCO shall provide access to a toll-free call center for prescribers to call to request PA for non-preferred drugs or drugs that are subject to clinical edits. If the MCO or its pharmacy benefit manager operates a separate call center for PA requests, it will be subject to the provider call center standards set forth in Section 12 of this Contract and monetary penalties set forth in Section 20 of this Contract; 6.3.4.1.3 PA requests shall be approved or denied within 24 hours of receipt, seven (7) days a week. The MCO shall notify the requesting practitioner of the approval or disapproval of the request within 24 hours. Denials of prior authorization requests or offering of an alternative medication shall be provided to the prescriber and member in writing. PA denials	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			may be appealed in accordance with Section 13 of this Contract; Consistent with the requirements of Section 1927 of the Social Security Act, LDH will hold MCOs to a 99.5% compliance rate with the 24-hour resolution requirement. If a MCO is reporting less than 99.5% compliance on the RX055 report, an explanation shall be included with the report in the notes section; 6.3.4.1.4 The MCO shall have an automated process that allows the pharmacy to dispense without PA up to a 72-hour emergency supply of a product or full unbreakable package. At a minimum, the MCO shall allow two consecutive emergency supply fills per prescription. The MCO shall reimburse the pharmacy for both the ingredient and the dispensing fee for both fills. Emergency fills may be included in a post payment review to identify misuse; 6.3.4.1.5 The MCO shall prior authorize drugs with a non-preferred status on the PDL; 6.3.4.1.6 The MCO shall not prior authorize drugs with a preferred status on the PDL, except to align with FFS clinical edits;	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			6.3.4.1.7 For self-administered drugs, the MCO shall not prior authorize drugs not on the PDL, except to align with FFS clinical edits or otherwise directed by LDH; 6.3.4.1.8 The MCO may prior authorize drugs when safety and utilization edits are exceeded when approved by LDH, except for drugs used for the treatment and prevention of HIV/AIDS. Drug utilization edits aligned through DUR initiatives shall be adhered to, however, safety and utilization edits outside of DUR initiatives may be aligned with FDA indications; 6.3.4.1.9 MCO prior authorization (PA) criteria and/or step therapy related to the preference of one agent over another agent within a therapeutic class listed on the PDL shall not be more restrictive than FFS. Application of PA and/or step therapy criteria more restrictive than FFS may result in daily monetary penalties of $10,000 starting the day LDH is made aware of the violation and ending when the criteria change is implemented; 6.3.4.1.10 PA and/or step therapy shall not be applied to preferred agents listed on the PDL in a manner that would disadvantage the selection of the preferred agents over other agents within the therapeutic class; 6.3.4.1.11 PA and/or other safety edits are allowed on physician-administered drugs;	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			6.3.4.1.12 If a PA is requested for a narrow therapeutic index (NTI) drug, every effort should be made to verify if the recipient is currently on a specific brand/generic, then the PA shall be approved for the corresponding product. NTI drugs include: Aminophylline, Carbamazepine, Cyclosporine, Digoxin, Disopyramide, Ethosuximide, Flecainide, L-Thyroxine, Lithium, Phenytoin, Theophylline, Thyroid, Valproic Acid, and Warfarin; 6.3.4.1.13 PA shall not require more than two failures of preferred products; 6.3.4.1. 14 The MCO shall override PA for selected drug products or devices at LDH's discretion, including but not limited to certain DUR initiatives; 6.3.4.1.15 The MCO shall not require PA for a dosage change for any medications (including long-acting injectable antipsychotics) and other medication assisted treatment (including dosages of buprenorphine or buprenorphine/naloxone) that have been previously authorized and/or approved by the MCO, as long as the newly prescribed dose is within established FDA guidelines for that medication;	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			6.3.4.1.16 The MCO shall not penalize the prescriber or member, financially or otherwise, for PA requests or other inquiries regarding prescribed medications; 6.3.4.1.17 A member receiving a prescription drug that was on the PDL and was removed from the PDL or changed from preferred to non-preferred status shall be allowed to continue to receive that prescription drug for at least sixty (60) days after notification of such change by MCO. The MCO shall have 30 days after receipt of the NDC list to send out notifications of negative changes to prescribers and members. Brand/generic preference changes of the same drug entity do not constitute a negative PDL change; 6.3.4.1.18 When a prescriber is requesting brand name medication that has a generic equivalent, the MCO can encourage a prescriber to complete the FDA Medwatch form. A Medwatch form shall not be required or considered in the PA approval/denial determination of a brand drug; and 6.3.4.1.19 PA shall not be utilized to prefer a B-rated generic drug over an A-rated generic.	
7	Exhibit 3 305PUR-DHHRFP-BH-	6.3.4.10 Step Therapy and/or Fail First Protocols 6.3.4.10.1 The MCO may implement step therapy or fail first protocols to drive utilization toward the most efficacious, cost-effective and safest drug therapy. These protocols may be	~~6.3.4.10 Step Therapy and/or Fail First Protocols~~ ~~6.3.4.10.1 The MCO may implement step therapy or fail first protocols to drive utilization toward the most efficacious, cost-effective and safest drug therapy. These protocols may be~~	This revision is required for the implementation of the single PDL.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
	MCO-2014-MVA	applied to either individual drugs or classes of drugs. However, the MCO must provide a clear process for a provider to request an override of such restrictions. An override shall meet the requirements of R.S. 46:460.34. 6.3.4.10.2 Step therapy and/or fail first protocols shall not require more than two failures of preferred products. 6.3.4.11 Submission and Publication of the PDL and Common PDL 6.3.4.11.1 The MCO shall publish and make available to members and providers upon request a hard copy of the most current PDL and Common PDL. The documents shall be posted together on the MCO web page. Updates to the PDL shall be made available to the provider and LDH thirty (30) days before the effective date of the change. 6.3.4.11.2 The MCO shall submit an electronic version of its PDL to LDH at least quarterly within 30 days of the P&T meeting and 30 days prior to implementation of any changes. The PDL must be provided in a format approved by LDH.	~~applied to either individual drugs or classes of drugs. However, the MCO must provide a clear process for a provider to request an override of such restrictions. An override shall meet the requirements of R.S. 46:460.34.~~ ~~6.3.4.10.2 Step therapy and/or fail first protocols shall not require more than two failures of preferred products.~~ ~~6.3.4.11 Submission and Publication of the PDL and Common PDL~~ ~~6.3.4.11.1 The MCO shall publish and make available to members and providers upon request a hard copy of the most current PDL and Common PDL. The documents shall be posted together on the MCO web page. Updates to the PDL shall be made available to the provider and LDH thirty (30) days before the effective date of the change.~~ ~~6.3.4.11.2 The MCO shall submit an electronic version of its PDL to LDH at least quarterly within 30 days of the P&T meeting and 30 days prior to implementation of any changes. The PDL must be provided in a format approved by LDH.~~	
8	Exhibit 3 305PUR-DHHRFP-BH-	6.3.5 Pharmaceutical and Therapeutics (P&T) Committee 6.3.5.1 The MCO shall establish a Pharmaceutical and Therapeutics (P&T) Committee, or similar entity, for the development of the PDL. The Committee shall represent the	6.3.5 Pharmaceutical and Therapeutics (P&T) Committee 6.3.5.1 The MCO ~~shall establish~~ <u>may maintain</u> a Pharmaceutical and Therapeutics (P&T) Committee, or similar entity, <u>solely</u> for the development of <u>PA criteria not aligned</u>	This revision is required for the implementation of the single PDL.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
	MCO-2014-MVA	needs of all its members including enrollees with special needs. Louisiana network physicians, pharmacists, and specialists, including but not limited to a behavioral health specialist, shall have the opportunity to participate in the development of prior authorization criteria and clinical drug policies. The P&T Committee shall consist of at least six members including 3 non-employee Louisiana providers (either Physicians or Pharmacists) that are not employees of the MCO or PBM. The MCO Medical Director and MCO Behavioral Health Medical Director should participate in all P&T meetings. Changes to prior authorization criteria, clinical drug policies, or PDL, must be submitted to LDH for approval at least 30 days prior to implementation. LDH will consider and comment on proposed changes. 6.3.5.2 The P&T committee shall meet at least quarterly in Baton Rouge, Louisiana to consider products in categories recommended for consideration for inclusion/exclusion on the MCO's PDL. The P&T Committee shall consider, for each product included in a category of products, the clinical efficacy, safety, cost-effectiveness and any program benefit associated with the product. 6.3.5.3 The MCO shall develop policies governing the conduct of P&T committee meetings, including procedures by which it makes its PDL recommendations. P&T Committee meetings shall be open to the public and shall allow for public comment	with FFS ~~the PDL~~. The Committee shall represent the needs of all its members including enrollees with special needs. Louisiana network physicians, pharmacists, and specialists, including but not limited to a behavioral health specialist, shall have the opportunity to participate in the approval ~~development~~ of prior authorization criteria and clinical drug policies. The P&T Committee shall consist of at least six members including 3 ~~non-employee~~ Louisiana providers (either Physicians or Pharmacists) that are not employees of the MCO or PBM. The MCO Medical Director and MCO Behavioral Health Medical Director ~~should~~ shall participate in all P&T meetings. Changes to prior authorization criteria~~,~~ or clinical drug policies~~, or PDL,~~ ~~must~~ shall be submitted to LDH for approval at least 30 days prior to implementation. LDH will consider and comment on proposed changes. 6.3.5.2 The MCO P&T committee shall meet at least semi-annually ~~quarterly~~ in Baton Rouge, Louisiana. ~~to consider products in categories recommended for consideration for inclusion/exclusion on the MCO's PDL. The P&T Committee shall consider, for each product included in a category of products, the clinical efficacy, safety, cost-effectiveness and any program benefit associated with the product.~~ 6.3.5.3 The MCO shall develop policies governing the conduct of P&T committee meetings, including procedures by which it develops its PA criteria ~~makes its PDL recommendations~~. MCO	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		prior to voting by the committee on any change in the preferred drug list. The MCO must keep written minutes of the P&T committee meetings. The MCO shall not prohibit any member of the public from attending the P&T committee meetings. 6.3.5.4 The MCO shall notify the Department when the P&T committee meeting has been scheduled. Official public notification of the P&T meeting shall be made on the MCO provider website and through other applicable avenues such as provider training and/or newsletters. The committee shall include a nonvoting representative from LDH that is provided all documents received by committee members.	P&T Committee meetings shall be open to the public and shall allow for public comment prior to voting by the committee on any change in PA criteria ~~the preferred drug list~~. The MCO ~~must~~ shall keep written minutes of its ~~the~~ P&T committee meetings. The MCO shall not prohibit any member of the public from attending ~~the~~ MCO P&T committee meetings. 6.3.5.4 The MCO shall notify the Department when ~~the~~ its P&T committee meeting has been scheduled. Official public notification of the MCO P&T meeting shall be made on the MCO provider website and through other applicable avenues such as provider training and/or newsletters. The committee shall include a nonvoting representative from LDH that is provided all documents received by committee members.	
9	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	7.17.1.7 The MCO must educate network providers about how to access their formulary and PDL on their websites. The MCO must also provide provider education on claims processing and payment policies and procedures.	7.17.1.7 The MCO must educate network providers about how to access ~~their formulary and~~ the PDL on their websites. The MCO must also provide provider education on claims processing and payment policies and procedures.	This revision is required for the implementation of the single PDL.
10	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	7.19.1 The MCO shall maintain accurate provider directory data. LDH shall conduct periodic audits to verify the accuracy of the MCO's provider directory data. The MCO shall maintain an accuracy rate of at least 90%.	7.19.1 The MCO shall maintain accurate provider directory data. LDH shall conduct periodic audits to verify the accuracy of the MCO's provider directory data. The MCO shall maintain an accuracy rate of at least ~~90%~~ 75%. The MCO will not be penalized if it can demonstrate a minimum accuracy rate of 50% in conjunction with a two percentage point improvement from the prior audit period.	This revision is necessary to reflect the department's revised approach to determining provider directory adequacy.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
11		8.1.5.1. The MCO shall take steps to require adoption of the clinical practice guidelines by subcontracted specialized behavioral healthcare providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers consistently achieve eighty percent (80%) compliance, based on MCO measurement findings. The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.	~~8.1.5.1. The MCO shall take steps to require adoption of the clinical practice guidelines by subcontracted specialized behavioral healthcare providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers consistently achieve eighty percent (80%) compliance, based on MCO measurement findings. The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.~~	This provision is being removed because the use of clinical practice guidelines is monitored via other means.
12		8.4.5.3. Concurrent utilization review includes: • Provision of Emergency Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric treatment. The individual is in crisis and not currently in a place of safety. If the individual presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent, as the person needs to be seen right away to determine appropriate treatment. The referral from the MCO for an Emergency Inpatient Psychiatric Hospital Screen shall be made immediately. The screen to determine appropriate treatment shall be completed within one hour after request is received by an emergency room for post-stabilization treatment or three hours after receipt of the request in other circumstances. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric	~~8.4.5.3. Concurrent utilization review includes:~~ ~~• Provision of Emergency Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric treatment. The individual is in crisis and not currently in a place of safety. If the individual presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent, as the person needs to be seen right away to determine appropriate treatment. The referral from the MCO for an Emergency Inpatient Psychiatric Hospital Screen shall be made immediately. The screen to determine appropriate treatment shall be completed within one hour after request is received by an emergency room for post-stabilization treatment or three hours after receipt of the request in other circumstances. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric~~	This provision is being removed because it is not an accurate reflection of the process used to move a member from an emergency situation to an inpatient bed.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		hospitalization, the procedures specified below should be utilized. • Provision of an Urgent Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening is initiated if the individual meets one criterion specified on the state approved screening form and is currently in a place of safety. If the member presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent and follow the protocols and timeframes specified above. If the member presents at a hospital with a psychiatric unit or trained psychiatric personnel, and is admitted by the treating physician, then it will be classified as an urgent screen. The referral from the MCO for an Urgent Inpatient Psychiatric Hospital Screen shall be made within 24 hours after the referral and full medical information is received by MCO. The screen to determine appropriate treatment shall be completed within 24 hours of the MCO's referral after the referral and full medical information is received by MCO. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, due to concerns regarding the safety of a child/youth, the procedures specified above should be utilized. • Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, the MCO shall notify the provider and individual requesting the screen of the results in writing within 48 hours	~~hospitalization, the procedures specified below should be utilized.~~ ~~• Provision of an Urgent Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening is initiated if the individual meets one criterion specified on the state approved screening form and is currently in a place of safety. If the member presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent and follow the protocols and timeframes specified above. If the member presents at a hospital with a psychiatric unit or trained psychiatric personnel, and is admitted by the treating physician, then it will be classified as an urgent screen. The referral from the MCO for an Urgent Inpatient Psychiatric Hospital Screen shall be made within 24 hours after the referral and full medical information is received by MCO. The screen to determine appropriate treatment shall be completed within 24 hours of the MCO's referral after the referral and full medical information is received by MCO. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, due to concerns regarding the safety of a child/youth, the procedures specified above should be utilized.~~ ~~• Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, the MCO shall notify the provider and individual requesting the screen of the results in writing within 48 hours of receipt of the request by the MCO. If denied, the MCO shall~~	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		of receipt of the request by the MCO. If denied, the MCO shall notify the individual requesting the screen immediately, and within 48 hours of receipt of the request by the MCO provide written notification of the results to the provider and individual requesting the screen. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal and the process to do so.	~~notify the individual requesting the screen immediately, and within 48 hours of receipt of the request by the MCO provide written notification of the results to the provider and individual requesting the screen. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal and the process to do so.~~	
13	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	17.10.5 Use of a Pharmacy Benefits Manager (PBM) 17.10.5.1 The MCO must identify the proposed PBM and the ownership of the proposed PBM. Before entering into a subcontract with a PBM, the MCO shall obtain LDH approval. If the PBM is owned wholly or in part by a retail pharmacy provider, chain drug store or pharmaceutical manufacturer, the MCO will submit a written description of the assurances and procedures that must be put in place under the proposed PBM subcontract, such as an independent audit, to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. The MCO must provide a plan documenting how it will monitor such Subcontractors. These assurances and procedures must be transmitted to LDH for review and approval prior to the date pharmacy services begin.	17.10.5 Use of a Pharmacy Benefits Manager (PBM) If the MCO utilizes a PBM for pharmacy claims payment, then the following requirements shall apply: 17.10.5.1 The MCO must identify the proposed PBM and the ownership of the proposed PBM. Before entering into a subcontract with a PBM, the MCO shall obtain LDH approval. ~~If the PBM is owned wholly or in part by a retail pharmacy provider, chain drug store or pharmaceutical manufacturer, t~~The MCO will submit a written description of the assurances and procedures that must be put in place under the proposed PBM subcontract, such as an independent audit, to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. The MCO must provide a plan documenting how it will monitor such Subcontractors. These assurances and procedures must	This revision is required to comply with state law.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		17.10.5.2 The MCO must submit a plan for oversight of the PBM's performance prior to the implementation of the MCO's PBM. The plan must be approved by LDH and comply with this contract and all LDH requirements.	be transmitted to LDH for review and approval prior to the date pharmacy services begin. 17.10.5.2 The MCO must submit a plan for oversight of the PBM's performance prior to the implementation of the MCO's PBM. The plan must be approved by LDH and comply with this contract and all LDH requirements. 17.10.5.3 Any contract for pharmacy benefit manager services shall: 17.10.5.3.1 Be limited to a transaction fee, not to exceed $1.25 per processed claim. The transaction fee covers non-claims costs, exclusive of amounts paid to a pharmacy for a prescription, including the ingredient cost, dispensing fee and provider fee; 17.10.5.3.2 Exclude any rebates or discounts, direct or indirect, from any pharmaceutical manufacturer; and, 17.10.5.3.3 Exclude "spread pricing," defined as any amount charged or claimed by a pharmacy benefit manager to a managed care organization that is in excess of the amount paid to the pharmacy for a prescription, including the ingredient cost, provider fee and dispensing fee.	

<table>
<tr><th>Item Number</th><th>Exhibit/ Attachment/ Document</th><th>Change From:</th><th>Change To:</th><th>Justification</th></tr>
<tr><td>14</td><td></td><td>Section 20.3 Table of Monetary Penalties
<table><tr><td>Provider Directory</td><td>Fifty thousand dollars ($50,000.00) per audit conducted by LDH wherein the MCO is found to have not maintained an accuracy rate of at least 90%.

One thousand dollars ($1,000) per calendar day for failure to correct inaccurate provider directory data within 14 days of notification by LDH.</td></tr></table></td><td>Section 20.3 Table of Monetary Penalties</td><td>This provision is being revised to align with the revision in 7.19.1.</td></tr>
</table>

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:			Justification
				Provider Directory	Fifty thousand dollars ($50,000.00) per audit conducted by LDH wherein the MCO is found to have not maintained an accuracy rate of at least ~~90%~~ 75% per audit period and does not demonstrate a minimum accuracy rate of 50% in conjunction with a two percentage point improvement from the prior audit period. One thousand dollars ($1,000) per calendar day for failure to correct inaccurate provider directory data within 14 days of notification by LDH.	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
15	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	**25.66.3** If the Contractor receives the public records' request directly, the Contractor shall forward the request via email to the LDH Section Chief of Program Operations and Compliance within one business day of receipt. Thereafter, the Contractor shall provide all records to LDH that the Department determines, in its sole discretion, are related to the services performed by the Contractor under this contract that are responsive to the request, pursuant to the timeline and in the requested format established by LDH.	**25.66.3** If the Contractor receives the public records' request directly, the Contractor shall forward the request via email to the ~~LDH Section Chief of Program Operations and Compliance~~ Medicaid Public Records Request Coordinator within one business day of receipt. Thereafter, the Contractor shall provide all records to LDH that the Department determines, in its sole discretion, are related to the services performed by the Contractor under this contract that are responsive to the request, pursuant to the timeline and in the requested format established by LDH.	The change is necessary to ensure efficient processing of public records request.

MERCER
MAKE TOMORROW, TODAY

F. Ronald Ogborne III, FSA, CERA, MAAA
Partner

Erik Axelsen, ASA, MAAA
Senior Associate
3560 Lenox Road NE, Suite 2400
Atlanta, GA 30326
+1 404 442 3100
www.mercer-government.mercer.com

Ms. Pam Diez
Deputy Medicaid Director/Chief Financial Officer
Louisiana Department of Health
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821

May 22, 2019

Subject: Healthy Louisiana Program – Full Risk-Bearing Managed Care Organization (MCO) Rate Development and Actuarial Certification for the Period Effective April 1, 2019 through December 31, 2019

Dear Ms. Diez:

The Louisiana Department of Health (LDH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound[1] capitation rate ranges for the State of Louisiana's (State) Healthy Louisiana program for the period of January 1, 2019 through December 31, 2019. This certification amends the previous certification issued February 6, 2019 and applies to the period of April 1, 2019 through December 31, 2019. The amendments include updates for new programmatic changes implemented by LDH after the prior certification was issued.

This letter presents an overview of the analyses and methodology used to support the programmatic changes, and the resulting capitation rate ranges effective April 1, 2019 through December 31, 2019 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, Healthy Louisiana Shared Savings claims experience, Healthy Louisiana Prepaid encounter data, and Louisiana Behavioral Health Partnership claims experience. It resulted in the development of a range of actuarially sound rates for each rate cell. The final capitation rates and rate ranges are summarized in Appendix A and represent payment in full for the covered services.

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[1] Actuarially Sound/Actuarial Soundness — Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.

Reference: http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf

BASE PROGRAM CHANGE ADJUSTMENTS

Program change adjustments recognize the impact of benefit or eligibility changes occurring during and after the base data period. CMS requires the rate setting methodology used to determine actuarially sound rates incorporate the results of any program changes that have taken place, or are anticipated to take place, between the start of the base data and the conclusion of the contract period.

Program changes that occurred during the base data are referred to as Base Program Change Adjustments.

Pharmacy Copays Limit Adjustment

Per 42 CFR 447.56(f), LDH must have in place measures to limit the amount of cost-sharing that members of a Medicaid household may incur each month to five percent of the family income. Per the State Plan, LDH only charges cost sharing on prescription drugs. Thus, only pharmacy service costs need to be adjusted in order to comply with this requirement.

Effective April 1, 2019, LDH implemented a policy whereby individuals with a family income less than or equal to $800 per month will have a zero-dollar copay for all pharmacy claims. In order to estimate the impact of this program change, Mercer utilized information provided by LDH summarizing the total amount of copayments that they expected to shift from the Medicaid recipient's responsibility to the responsibility of the MCOs. The underlying analysis was performed on encounters with dates of service between July 1, 2017 and June 30, 2018 at the family, i.e. household, level. Mercer used the relevant household IDs provided by LDH and the copayments associated with them in our data for the corresponding time period to estimate the impact of this policy change. The table below summarizes the impact of the Pharmacy Copay Limit Adjustment on projected pharmacy costs on each rate cell.

RATE CELL	RX COPAY LIMIT ADJUSTMENT
SSI	0.80%
Family & Children	0.33%
Foster Care Children	0.02%
BCC	0.19%
LAP	0.00%
HCBS	0.06%
CCM	0.00%
Non-Expansion Subtotal	**0.55%**

PROSPECTIVE RATING ADJUSTMENTS

Program change adjustments that occurred after the base data period, but before the conclusion of the rating period are referred to as Prospective Rating Adjustments.

St. Elizabeth and Our Lady of the Lake (OLOL) Hospital Merger

Effective March 1, 2019, St. Elizabeth became an offsite campus of the main OLOL campus. St. Elizabeth's inpatient and outpatient claims are expected to be reimbursed at the OLOL rates shown in the exhibits below.

Inpatient Per Diem			
IP Claim Type	**Pre-Merger**	**Post-Merger**	**Percent Change**
Acute	$1,102.06	$1,978.58	79.53%
Psychiatric	$610.07	$1,113.55	82.53%

Outpatient Cost-to-Charge ratios (CCR)			
OP Claim Type	**Pre-Merger**	**Post-Merger**	**Percent Change**
Therapy	NA	0.368	
Operating Room	NA	0.261	
Clinic	NA	0.619	
Cost-based Services	0.154	0.228	47.66%

To estimate the impact of the St. Elizabeth and OLOL merger on projected inpatient and outpatient costs, Mercer repriced the historical St. Elizabeth encounters at the post-merger reimbursement levels. The revised fee schedule adjustments to the projected medical expenses are summarized in the table below. Please refer to Appendix D for the incremental impact of this program change.

COA	RATE CELL	FEE ADJUSTMENT EFFECTIVE 4/1/2019
SSI	0 - 2 Months	3.73%
SSI	3 - 11 Months	3.18%
SSI	Child 1 - 20 Years	3.41%
SSI	Adult 21+ Years	4.57%

COA	RATE CELL	FEE ADJUSTMENT EFFECTIVE 4/1/2019
Family & Children	0 - 2 Months	3.40%
Family & Children	3 - 11 Months	4.14%
Family & Children	Child 1 - 20 Years	4.35%
Family & Children	Adult 21+ Years	5.32%
Foster Care Children	All Ages Male & Female	4.62%
BCC	BCC, All Ages	2.17%
LAP	LAP, All Ages	4.80%
HCBS	Child 1 - 20 Years	3.98%
HCBS	Adult 21+ Years	3.84%
CCM	CCM, All Ages	5.01%
SBH - CCM	SBH - CCM, All Ages	3.51%
SBH – Duals & LaHIPP	SBH - Dual Eligible & LaHIPP, All Ages	1.44%
SBH - HCBS	Child 1 - 20 Years	3.62%
SBH - HCBS	Adult 21+ Years	6.03%
SBH - Other	SBH - All Ages	12.46%
Maternity Kick Payment	Maternity Kick Payment	8.32%
EED Kick Payment	EED Kick Payment	0.00%
Non-Expansion Subtotal	**4.57%**	

Single Preferred Drug List (PDL)

Effective May 1, 2019, LDH implemented a Single PDL for selected therapeutic classes. LDH selected the therapeutic classes and drugs included, and LDH and the MCO pharmacy directors established the prior authorization criteria applicable to the drugs included in the Single PDL. MCOs are required to follow the Single PDL and only list as preferred those products preferred by LDH. For branded products listed as preferred over available generics, the MCOs are to consider the generic form non-preferred and not require the prescriber to indicate in writing the branded product is medically necessary.

To estimate the impact of the Single PDL on pharmacy costs, Mercer's actuaries and pharmacists reviewed the historical utilization of drugs in the affected classes and developed assumptions regarding the expected changes in utilization from non-preferred to preferred agents, which were reviewed by LDH pharmacists. The estimated impact of the Single PDL program change on projected pharmacy costs on each rate cell are summarized in the table below.

RATE CELL	UNIT COST ADJUSTMENT
SSI	-0.19%
Family & Children	0.34%
Foster Care Children	0.81%
BCC	0.27%
LAP	0.53%
HCBS	-0.18%
CCM	0.08%
Non-Expansion Subtotal	**0.07%**

Additionally, the MCOs are prohibited from entering into rebate agreements with manufacturers of drugs. Any existing drug rebate agreements were discontinued by May 1, 2019. The MCOs are still allowed to collect rebates on non-drug items such as diabetic testing supplies once the Single PDL is implemented. To account for the changes to the pharmacy rebate adjustment as a result of the Single PDL implementation, Mercer blended the pharmacy rebate adjustment developed the pre- and post-Single PDL rebate expectations to arrive an updated pharmacy rebate adjustment. The table below summarizes the updated impacted of pharmacy rebates on projected pharmacy costs on each rate cell.

RATE CELL	RX REBATE ADJUSTMENT		
	Pre-PDL	Post-PDL	Net
SSI	-3.90%	-0.50%	-0.88%
Family & Children	-3.10%	-0.40%	-0.70%
Foster Care Children	-1.90%	-0.20%	-0.39%
BCC	-1.80%	-0.30%	-0.47%

RATE CELL	RX REBATE ADJUSTMENT		
	Pre-PDL	Post-PDL	Net
LAP	-3.80%	-0.30%	-0.69%
HCBS	-2.80%	-0.50%	-0.76%
CCM	-1.80%	-0.20%	-0.38%
Non-Expansion Subtotal	**-3.47%**	**-0.45%**	**-0.78%**

Local Pharmacy Adjustment

Effective May 1, 2019, LDH changed its reimbursement for pharmacies for FFS prescriptions. The ingredient cost portion of the reimbursement shifts from local Average Acquisition Cost (AAC) to National Average Drug Acquisition Cost (NADAC). The dispensing fee portion of the reimbursement also increases; from $10.41 per prescription to $10.99 per prescription.

These changes in FFS pharmacy reimbursement affect the Healthy Louisiana program because the MCO's are required to reimburse local pharmacies, at minimum, at the FFS level. Per §460.36 of Louisiana's register, local pharmacies are defined as satisfying the two following conditions:

1. Contracts with the MCO or the MCO's contractor in its own name or through a pharmacy services administration organization and not under the authority of a group purchasing organization

2. Has fewer than ten retail outlets under its corporate umbrella

Mercer reviewed an analysis by Myers and Stauffer in which they estimated the difference between local AAC and NADAC ingredient costs. Myers and Stauffer performed the pricing analysis on local pharmacy encounter experience incurred on days of service May 11, 2017 through May 10, 2018. The results of this analysis, in conjunction with the historical utilization of local pharmacies in the Healthy Louisiana program, were used to estimate the impact of the local pharmacy pricing changes on projected pharmacy costs. The table below summarizes the updated impact of local pharmacy pricing changes on projected pharmacy costs on each rate cell.

RATE CELL	LOCAL PHARMACY ADJUSTMENT
SSI	0.42%
Family & Children	0.42%
Foster Care Children	0.57%
BCC	0.21%
LAP	0.34%
HCBS	0.46%
CCM	0.41%
Non-Expansion Subtotal	**0.42%**

CERTIFICATION OF FINAL RATE RANGES

This certification assumes items in the Medicaid State Plan or Waiver, as well as the Healthy Louisiana MCO contract, have been approved by CMS.

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 LDH and its fiscal agent. LDH, its fiscal agent and the Healthy Louisiana MCOs 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. However, if the data and information are incomplete/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 the rate ranges in Appendix A, including any risk-sharing mechanisms, were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid

covered populations and services under the Healthy Louisiana MCO 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.

Rates and 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 Healthy Louisiana MCO costs will differ from these projections. Mercer has developed these rates on behalf of LDH to demonstrate compliance with the CMS requirements under 42 CFR 438.4 and accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

Healthy Louisiana 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 Healthy Louisiana MCOs for any purpose. Mercer recommends that any MCO considering contracting with LDH 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 LDH.

LDH 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 LDH secure 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 Healthy Louisiana Program, Medicaid eligibility rules, and actuarial rate-setting techniques. It has been prepared exclusively for LDH 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. Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

LDH 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 LDH if nothing is received by Mercer within such 30 day period.

If you have any questions on any of the above, please feel free to contact Ron Ogborne at +1 602 522 6595 or Erik Axelsen at +1 404 442 3517 at your convenience.

Sincerely,

F. Ronald Ogborne III, FSA, MAAA, CERA
Partner

Erik Axelsen, ASA, MAAA
Senior Associate

Copy:
Amanda Joyner, Deputy Assistant Secretary – OBH/LDH
Marisa Naquin, Managed Care Finance – LDH
Jen Steele, Medicaid Director – LDH
Karen Stubbs, Deputy Assistant Secretary – OBH/LDH

Robert Butler, Principal – Mercer
Christina Coleman, Associate – Mercer
Kodzo Dekpe, ASA, MAAA, Associate – Mercer

APPENDIX A: HEALTHY LOUISIANA CAPITATION RATE RANGE

REGION DESCRIPTION	COA DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Gulf	SSI	0–2 Months	$29,394.51	$29,421.52	$31,210.89
Gulf	SSI	3–11 Months	$5,733.39	$5,738.87	$6,098.29
Gulf	SSI	Child 1–20 Years	$795.66	$796.54	$849.70
Gulf	SSI	Adult 21+ Years	$1,533.10	$1,534.63	$1,631.81
Gulf	F & C	0–2 Months	$3,240.37	$3,242.94	$3,419.14
Gulf	F & C	3–11 Months	$313.60	$313.91	$332.17
Gulf	F & C	Child 1–20 Years	$188.96	$189.17	$202.00
Gulf	F & C	Adult 21+ Years	$401.25	$401.66	$427.93
Gulf	FCC	All Ages Male & Female	$538.76	$539.39	$580.57
Gulf	BCC	BCC, All Ages	$2,303.98	$2,306.39	$2,444.77
Gulf	LAP	LAP, All Ages	$226.88	$227.13	$241.89
Gulf	HCBS	Child 1–20 Years	$1,834.21	$1,836.20	$1,956.80
Gulf	HCBS	Adult 21+ Years	$1,519.20	$1,520.85	$1,627.17
Gulf	CCM	CCM, All Ages	$1,506.74	$1,508.47	$1,588.75
Gulf	SBH - CCM	SBH - CCM, All Ages	$340.86	$340.86	$356.63

REGION DESCRIPTION	COA DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Gulf	SBH - Duals & LaHIPP	SBH - Dual Eligible & LaHIPP, All Ages	$40.22	$40.22	$43.86
Gulf	SBH - HCBS	SBH - Child 1–20 Years	$223.56	$223.56	$229.55
Gulf	SBH - HCBS	SBH - Adult 21+ Years	$68.79	$68.79	$74.51
Gulf	SBH - Other	SBH - All Ages	$177.34	$177.34	$189.31
Gulf	Maternity Kick Payment	Maternity Kick Payment	$15,125.64	$15,125.64	$15,768.21
Gulf	EED Kick Payment	EED Kick Payment	$7,625.61	$7,625.61	$7,752.09
Gulf	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages	$40.22	$40.22	$43.86
Gulf	Medicaid Expansion	SBH - Other	$177.34	$177.34	$189.31
Gulf	Medicaid Expansion	SBH – CCM, All Ages	$340.86	$340.86	$356.63
Gulf	Medicaid Expansion	Maternity Kick Payment	$15,125.64	$15,125.64	$15,768.21
Gulf	Medicaid Expansion	EED Kick Payment	$7,625.61	$7,625.61	$7,752.09
Capital	SSI	0–2 Months	$29,843.86	$29,871.43	$31,702.98
Capital	SSI	3–11 Months	$5,708.81	$5,714.26	$6,071.38

REGION DESCRIPTION	COA DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Capital	SSI	Child 1–20 Years	$840.85	$841.82	$900.23
Capital	SSI	Adult 21+ Years	$1,496.04	$1,497.63	$1,598.68
Capital	F & C	0–2 Months	$2,866.34	$2,869.04	$3,057.04
Capital	F & C	3–11 Months	$288.51	$288.81	$306.78
Capital	F & C	Child 1–20 Years	$192.26	$192.47	$205.90
Capital	F & C	Adult 21+ Years	$431.27	$431.72	$460.51
Capital	FCC	All Ages Male & Female	$541.63	$542.26	$583.75
Capital	BCC	BCC, All Ages	$2,304.61	$2,307.02	$2,445.24
Capital	LAP	LAP, All Ages	$221.48	$221.72	$236.42
Capital	HCBS	Child 1–20 Years	$1,938.45	$1,940.57	$2,065.89
Capital	HCBS	Adult 21+ Years	$1,525.13	$1,526.79	$1,633.67
Capital	CCM	CCM, All Ages	$1,393.27	$1,394.86	$1,475.21
Capital	SBH - CCM	SBH - CCM, All Ages	$266.57	$266.57	$281.44
Capital	SBH - Duals & LaHIPP	SBH - Dual Eligible & LaHIPP, All Ages	$26.92	$26.92	$29.27

REGION DESCRIPTION	COA DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Capital	SBH - HCBS	SBH - Child 1–20 Years	$163.37	$163.37	$168.68
Capital	SBH - HCBS	SBH - Adult 21+ Years	$68.61	$68.61	$74.35
Capital	SBH - Other	SBH - All Ages	$175.19	$175.19	$186.98
Capital	Maternity Kick Payment	Maternity Kick Payment	$11,225.81	$11,225.81	$11,785.08
Capital	EED Kick Payment	EED Kick Payment	$4,697.68	$4,697.68	$4,807.77
Capital	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages	$26.92	$26.92	$29.27
Capital	Medicaid Expansion	SBH - Other	$175.19	$175.19	$186.98
Capital	Medicaid Expansion	SBH – CCM, All Ages	$266.57	$266.57	$281.44
Capital	Medicaid Expansion	Maternity Kick Payment	$11,225.81	$11,225.81	$11,785.08
Capital	Medicaid Expansion	EED Kick Payment	$4,697.68	$4,697.68	$4,807.77
South Central	SSI	0–2 Months	$29,367.53	$29,394.50	$31,181.32
South Central	SSI	3–11 Months	$5,720.82	$5,726.29	$6,084.52
South Central	SSI	Child 1–20 Years	$749.32	$750.18	$801.01

REGION DESCRIPTION	COA DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
South Central	SSI	Adult 21+ Years	$1,340.64	$1,342.05	$1,431.66
South Central	F & C	0–2 Months	$3,094.56	$3,097.46	$3,299.35
South Central	F & C	3–11 Months	$296.45	$296.76	$315.75
South Central	F & C	Child 1–20 Years	$187.17	$187.38	$200.65
South Central	F & C	Adult 21+ Years	$392.35	$392.76	$419.03
South Central	FCC	All Ages Male & Female	$540.41	$541.04	$582.05
South Central	BCC	BCC, All Ages	$2,298.03	$2,300.43	$2,438.31
South Central	LAP	LAP, All Ages	$231.27	$231.52	$246.19
South Central	HCBS	Child 1–20 Years	$1,837.46	$1,839.45	$1,959.42
South Central	HCBS	Adult 21+ Years	$1,513.68	$1,515.33	$1,620.89
South Central	CCM	CCM, All Ages	$1,353.85	$1,355.39	$1,435.34
South Central	SBH - CCM	SBH - CCM, All Ages	$280.70	$280.70	$296.05
South Central	SBH - Duals & LaHIPP	SBH - Dual Eligible & LaHIPP, All Ages	$26.53	$26.53	$28.85
South Central	SBH - HCBS	SBH - Child 1–20 Years	$66.94	$66.94	$71.35

REGION DESCRIPTION	COA DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
South Central	SBH - HCBS	SBH - Adult 21+ Years	$68.61	$68.61	$74.34
South Central	SBH - Other	SBH - All Ages	$177.02	$177.02	$188.96
South Central	Maternity Kick Payment	Maternity Kick Payment	$10,315.44	$10,315.44	$10,859.55
South Central	EED Kick Payment	EED Kick Payment	$3,964.27	$3,964.27	$4,071.37
South Central	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages	$26.53	$26.53	$28.85
South Central	Medicaid Expansion	SBH - Other	$177.02	$177.02	$188.96
South Central	Medicaid Expansion	SBH – CCM, All Ages	$280.70	$280.70	$296.05
South Central	Medicaid Expansion	Maternity Kick Payment	$10,315.44	$10,315.44	$10,859.55
South Central	Medicaid Expansion	EED Kick Payment	$3,964.27	$3,964.27	$4,071.37
North	SSI	0–2 Months	$29,188.50	$29,215.25	$30,985.29
North	SSI	3–11 Months	$5,640.08	$5,645.45	$5,996.11
North	SSI	Child 1–20 Years	$807.88	$808.81	$863.37
North	SSI	Adult 21+ Years	$1,235.86	$1,237.18	$1,321.05

REGION DESCRIPTION	COA DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
North	F & C	0–2 Months	$2,746.36	$2,748.84	$2,918.70
North	F & C	3–11 Months	$280.61	$280.90	$298.19
North	F & C	Child 1–20 Years	$207.12	$207.36	$222.51
North	F & C	Adult 21+ Years	$373.48	$373.88	$399.87
North	FCC	All Ages Male & Female	$567.61	$568.27	$610.62
North	BCC	BCC, All Ages	$2,292.05	$2,294.44	$2,431.76
North	LAP	LAP, All Ages	$219.17	$219.41	$234.03
North	HCBS	Child 1–20 Years	$1,883.56	$1,885.61	$2,005.75
North	HCBS	Adult 21+ Years	$1,529.36	$1,531.03	$1,638.28
North	CCM	CCM, All Ages	$1,380.64	$1,382.22	$1,463.04
North	SBH - CCM	SBH - CCM, All Ages	$281.56	$281.56	$297.37
North	SBH - Duals & LaHIPP	SBH - Dual Eligible & LaHIPP, All Ages	$33.54	$33.54	$36.52
North	SBH - HCBS	SBH - Child 1–20 Years	$123.77	$123.77	$128.87
North	SBH - HCBS	SBH - Adult 21+ Years	$69.82	$69.82	$75.66

REGION DESCRIPTION	COA DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
North	SBH - Other	SBH - All Ages	$176.21	$176.21	$187.88
North	Maternity Kick Payment	Maternity Kick Payment	$11,563.96	$11,563.96	$12,115.12
North	EED Kick Payment	EED Kick Payment	$5,132.43	$5,132.43	$5,240.92
North	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages	$33.54	$33.54	$36.52
North	Medicaid Expansion	SBH - Other	$176.21	$176.21	$187.88
North	Medicaid Expansion	SBH – CCM, All Ages	$281.56	$281.56	$297.37
North	Medicaid Expansion	Maternity Kick Payment	$11,563.96	$11,563.96	$12,115.12
North	Medicaid Expansion	EED Kick Payment	$5,132.43	$5,132.43	$5,240.92

APPENDIX B: SINGLE PDL RATING ADJUSTMENT

Rate Cell	Projected MMs	Base Rx PMPM[1,2]	Single PDL Unit Cost Adjustment [3]		Pharmacy Rebate Adjustment		
			Gross [4]	Net [5]	Pre-PDL	Post-PDL	Net
SSI	1,313,484	$261.80	-0.2%	-0.2%	-3.9%	-0.5%	-0.9%
Family & Children	9,687,183	$32.58	0.4%	0.3%	-3.1%	-0.4%	-0.7%
Foster Care Children	155,493	$66.19	0.9%	0.8%	-1.9%	-0.2%	-0.4%
BCC	5,736	$308.30	0.3%	0.3%	-1.8%	-0.3%	-0.5%
LAP	40,385	$42.21	0.6%	0.5%	-3.8%	-0.3%	-0.7%
HCBS	23,031	$395.98	-0.2%	-0.2%	-2.8%	-0.5%	-0.8%
CCM	34,227	$136.44	0.1%	0.1%	-1.8%	-0.2%	-0.4%
Non-Expansion Subtotal	**11,259,539**	**$61.02**	**0.1%**	**0.1%**	**-3.5%**	**-0.4%**	**-0.8%**

Notes:

1. Base PMPMs reflect adjustments for underreporting and IBNR.
2. Non-Expansion base data consists of the time period 10/1/2015 - 9/30/2017.
3. Single PDL is effective 5/1/19; therefore, the impact has been pro-rated for the 5/1/2019 - 12/31/2019 period.
4. The "Gross" column represents the Single PDL Unit Cost adjustment for a 12 month period.
5. The "Net" column represents the prorated Single PDL unit cost adjustment for the 5/1/2019 - 12/31/2019 effective period.

APPENDIX C: LOCAL PHARMACY ADJUSTMENT

Rate Cell	Projected MMs	Base Rx PMPM [1,2]	Local Pharmacy % of Base	Local Pharmacy Adj. Percentages (Gross) [3]			Rating Adjustments	
				NADAC	Disp. Fee	Total	Gross	Net
SSI	1,313,484	$261.80	31.5%	0.76%	0.75%	1.51%	0.47%	0.42%
Family & Children	9,687,183	$32.58	31.0%	0.76%	0.75%	1.51%	0.47%	0.42%
Foster Care Children	155,493	$66.19	42.5%	0.76%	0.75%	1.51%	0.64%	0.57%
BCC	5,736	$308.30	15.3%	0.76%	0.75%	1.51%	0.23%	0.21%
LAP	40,385	$42.21	25.2%	0.76%	0.75%	1.51%	0.38%	0.34%
HCBS	23,031	$395.98	34.6%	0.76%	0.75%	1.51%	0.52%	0.46%
CCM	34,227	$136.44	30.6%	0.76%	0.75%	1.51%	0.46%	0.41%
Non-Expansion Subtotal	**11,259,539**	**$61.02**	**31.4%**	**0.76%**	**0.75%**	**1.51%**	**0.47%**	**0.42%**

Notes:

1. Base PMPMs reflect adjustments for under-reporting and IBNR.

2. Non-Expansion base data consists of the time period 10/1/2015 - 9/30/2017.

3. Adjustments are based on an analysis performed by Myers and Stauffer dated December 4, 2018.

APPENDIX D: ST. ELIZABETH/OLOL MERGER IMPACT

COA	RATE CELL	FEE ADJUSTMENT EFFECTIVE 1/1/2019	FEE ADJUSTMENT EFFECTIVE 4/1/2019	MERGER IMPACT
SSI	0 - 2 Months	3.73%	3.73%	0.00%
SSI	3 - 11 Months	3.18%	3.18%	0.00%
SSI	Child 1 - 20 Years	3.40%	3.41%	0.01%
SSI	Adult 21+ Years	4.50%	4.57%	0.07%
Family & Children	0 - 2 Months	3.40%	3.40%	0.00%
Family & Children	3 - 11 Months	4.12%	4.14%	0.02%
Family & Children	Child 1 - 20 Years	4.32%	4.35%	0.03%
Family & Children	Adult 21+ Years	5.20%	5.32%	0.12%
Foster Care Children	All Ages Male & Female	4.61%	4.62%	0.01%
BCC	BCC, All Ages	2.11%	2.17%	0.06%
LAP	LAP, All Ages	4.79%	4.80%	0.02%
HCBS	Child 1 - 20 Years	3.98%	3.98%	0.00%
HCBS	Adult 21+ Years	3.78%	3.84%	0.05%
CCM	CCM, All Ages	5.01%	5.01%	0.01%

COA	RATE CELL	FEE ADJUSTMENT EFFECTIVE 1/1/2019	FEE ADJUSTMENT EFFECTIVE 4/1/2019	MERGER IMPACT
SBH – CCM	SBH - CCM, All Ages	3.51%	3.51%	0.00%
SBH – Duals	SBH - Dual Eligible & LaHIPP, All Ages	1.44%	1.44%	0.00%
SBH – HCBS	Child 1 - 20 Years	3.62%	3.62%	0.00%
SBH – HCBS	Adult 21+ Years	6.03%	6.03%	0.00%
SBH – Other	SBH - All Ages	12.46%	12.46%	0.00%
Maternity Kick Payment	Maternity Kick Payment	8.31%	8.32%	0.01%
EED Kick Payment	EED Kick Payment	0.00%	0.00%	0.00%
Non-Expansion Subtotal		**4.52%**	**4.57%**	**0.04%**

Appendix E: Rate Comparison

			1/1/19 Rates			4/1/19 Rates		
Region	Category of Aid	Rate Cell	Lower Bound PMPM or Cost per Delivery	Final PMPM or Cost per Delivery [1]	Upper Bound PMPM or Cost per Delivery	Lower Bound PMPM or Cost per Delivery	Final PMPM or Cost per Delivery [1]	Upper Bound PMPM or Cost per Delivery
Gulf	SSI	Newborn, 0-2 Months	$ 29,393.75	$ 29,420.76	$ 31,210.07	$ 29,394.51	$ 29,421.52	$ 31,210.89
Gulf	SSI	Newborn, 3-11 Months	$ 5,716.22	$ 5,721.68	$ 6,079.72	$ 5,733.39	$ 5,738.87	$ 6,098.29
Gulf	SSI	Child, 1-20 Years	$ 790.28	$ 791.15	$ 843.88	$ 795.66	$ 796.54	$ 849.70
Gulf	SSI	Adult, 21+ Years	$ 1,513.65	$ 1,515.15	$ 1,610.84	$ 1,533.10	$ 1,534.63	$ 1,631.81
Gulf	Family and Children	Newborn, 0-2 Months	$ 3,240.13	$ 3,242.70	$ 3,418.88	$ 3,240.37	$ 3,242.94	$ 3,419.14
Gulf	Family and Children	Newborn, 3-11 Months	$ 312.92	$ 313.22	$ 331.43	$ 313.60	$ 313.91	$ 332.17
Gulf	Family and Children	Child, 1-20 Years	$ 188.09	$ 188.30	$ 201.07	$ 188.96	$ 189.17	$ 202.00
Gulf	Family and Children	Adult, 21+ Years	$ 397.38	$ 397.79	$ 423.76	$ 401.25	$ 401.66	$ 427.93
Gulf	Foster Care Children	Foster Care, All Ages Male & Female	$ 536.30	$ 536.93	$ 577.92	$ 538.76	$ 539.39	$ 580.57
Gulf	Breast and Cervical Cancer	BCC, All Ages Female	$ 2,292.81	$ 2,295.20	$ 2,432.75	$ 2,303.98	$ 2,306.39	$ 2,444.77
Gulf	LaCHIP Affordable Plan	All Ages	$ 225.02	$ 225.27	$ 239.87	$ 226.88	$ 227.13	$ 241.89
Gulf	HCBS Waiver	20 & Under, Male and Female	$ 1,827.28	$ 1,829.26	$ 1,949.32	$ 1,834.21	$ 1,836.20	$ 1,956.80
Gulf	HCBS Waiver	21+ Years, Male and Female	$ 1,505.43	$ 1,507.07	$ 1,612.32	$ 1,519.20	$ 1,520.85	$ 1,627.17
Gulf	Chisholm Class Members	Chisholm, All Ages Male & Female	$ 1,503.51	$ 1,505.24	$ 1,585.26	$ 1,506.74	$ 1,508.47	$ 1,588.75
Gulf	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	$ 340.86	$ 340.86	$ 356.63	$ 340.86	$ 340.86	$ 356.63
Gulf	SBH - Duals & LaHIPP (Duals)	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	$ 40.22	$ 40.22	$ 43.86	$ 40.22	$ 40.22	$ 43.86
Gulf	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	$ 223.56	$ 223.56	$ 229.55	$ 223.56	$ 223.56	$ 229.55
Gulf	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	$ 68.79	$ 68.79	$ 74.51	$ 68.79	$ 68.79	$ 74.51
Gulf	SBH - Other	SBH - Other, All Ages	$ 177.34	$ 177.34	$ 189.31	$ 177.34	$ 177.34	$ 189.31
Gulf	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 15,125.50	$ 15,125.50	$ 15,768.06	$ 15,125.64	$ 15,125.64	$ 15,768.21
Gulf	Maternity Kickpayment - Early Elective Delivery	Early Elective Delivery	$ 7,625.61	$ 7,625.61	$ 7,752.09	$ 7,625.61	$ 7,625.61	$ 7,752.09
Gulf	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	$ 40.22	$ 40.22	$ 43.86	$ 40.22	$ 40.22	$ 43.86
Gulf	Medicaid Expansion	SBH - Other	$ 177.34	$ 177.34	$ 189.31	$ 177.34	$ 177.34	$ 189.31
Gulf	Medicaid Expansion	SBH - CCM, All Ages	$ 340.86	$ 340.86	$ 356.63	$ 340.86	$ 340.86	$ 356.63
Gulf	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	$ 15,125.50	$ 15,125.50	$ 15,768.06	$ 15,125.64	$ 15,125.64	$ 15,768.21
Gulf	Medicaid Expansion - EED Kick Payment	EED Kick Payment	$ 7,625.61	$ 7,625.61	$ 7,752.09	$ 7,625.61	$ 7,625.61	$ 7,752.09
Capital	SSI	Newborn, 0-2 Months	$ 29,843.11	$ 29,870.68	$ 31,702.16	$ 29,843.86	$ 29,871.43	$ 31,702.98
Capital	SSI	Newborn, 3-11 Months	$ 5,691.64	$ 5,697.07	$ 6,052.80	$ 5,708.81	$ 5,714.26	$ 6,071.38
Capital	SSI	Child, 1-20 Years	$ 833.50	$ 834.46	$ 892.29	$ 840.85	$ 841.82	$ 900.23
Capital	SSI	Adult, 21+ Years	$ 1,469.18	$ 1,470.74	$ 1,569.98	$ 1,496.04	$ 1,497.63	$ 1,598.68
Capital	Family and Children	Newborn, 0-2 Months	$ 2,866.06	$ 2,868.76	$ 3,056.74	$ 2,866.34	$ 2,869.04	$ 3,057.04
Capital	Family and Children	Newborn, 3-11 Months	$ 287.53	$ 287.83	$ 305.74	$ 288.51	$ 288.81	$ 306.78
Capital	Family and Children	Child, 1-20 Years	$ 191.06	$ 191.27	$ 204.60	$ 192.26	$ 192.47	$ 205.90
Capital	Family and Children	Adult, 21+ Years	$ 425.16	$ 425.60	$ 453.94	$ 431.27	$ 431.72	$ 460.51
Capital	Foster Care Children	Foster Care, All Ages Male & Female	$ 539.17	$ 539.80	$ 581.10	$ 541.63	$ 542.26	$ 583.75
Capital	Breast and Cervical Cancer	BCC, All Ages Female	$ 2,293.44	$ 2,295.84	$ 2,433.22	$ 2,304.61	$ 2,307.02	$ 2,445.24
Capital	LaCHIP Affordable Plan	All Ages	$ 219.62	$ 219.86	$ 234.40	$ 221.48	$ 221.72	$ 236.42
Capital	HCBS Waiver	20 & Under, Male and Female	$ 1,931.53	$ 1,933.64	$ 2,058.41	$ 1,938.45	$ 1,940.57	$ 2,065.89
Capital	HCBS Waiver	21+ Years, Male and Female	$ 1,511.36	$ 1,513.01	$ 1,618.83	$ 1,525.13	$ 1,526.79	$ 1,633.67
Capital	Chisholm Class Members	Chisholm, All Ages Male & Female	$ 1,390.04	$ 1,391.63	$ 1,471.72	$ 1,393.27	$ 1,394.86	$ 1,475.21
Capital	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	$ 266.57	$ 266.57	$ 281.44	$ 266.57	$ 266.57	$ 281.44
Capital	SBH - Duals & LaHIPP (Duals)	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	$ 26.92	$ 26.92	$ 29.27	$ 26.92	$ 26.92	$ 29.27
Capital	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	$ 163.37	$ 163.37	$ 168.68	$ 163.37	$ 163.37	$ 168.68
Capital	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	$ 68.61	$ 68.61	$ 74.35	$ 68.61	$ 68.61	$ 74.35
Capital	SBH - Other	SBH - Other, All Ages	$ 175.19	$ 175.19	$ 186.98	$ 175.19	$ 175.19	$ 186.98
Capital	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 11,221.64	$ 11,221.64	$ 11,780.75	$ 11,225.81	$ 11,225.81	$ 11,785.08
Capital	Maternity Kickpayment - Early Elective Delivery	Early Elective Delivery	$ 4,695.48	$ 4,695.48	$ 4,805.53	$ 4,697.68	$ 4,697.68	$ 4,807.77
Capital	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	$ 26.92	$ 26.92	$ 29.27	$ 26.92	$ 26.92	$ 29.27
Capital	Medicaid Expansion	SBH - Other	$ 175.19	$ 175.19	$ 186.98	$ 175.19	$ 175.19	$ 186.98
Capital	Medicaid Expansion	SBH - CCM, All Ages	$ 266.57	$ 266.57	$ 281.44	$ 266.57	$ 266.57	$ 281.44
Capital	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	$ 11,221.64	$ 11,221.64	$ 11,780.75	$ 11,225.81	$ 11,225.81	$ 11,785.08
Capital	Medicaid Expansion - EED Kick Payment	EED Kick Payment	$ 4,695.48	$ 4,695.48	$ 4,805.53	$ 4,697.68	$ 4,697.68	$ 4,807.77

Appendix E: Rate Comparison

			1/1/19 Rates			4/1/19 Rates		
Region	Category of Aid	Rate Cell	Lower Bound PMPM or Cost per Delivery	Final PMPM or Cost per Delivery [1]	Upper Bound PMPM or Cost per Delivery	Lower Bound PMPM or Cost per Delivery	Final PMPM or Cost per Delivery [1]	Upper Bound PMPM or Cost per Delivery
South Central	SSI	Newborn, 0-2 Months	$ 29,366.78	$ 29,393.75	$ 31,180.49	$ 29,367.53	$ 29,394.50	$ 31,181.32
South Central	SSI	Newborn, 3-11 Months	$ 5,703.64	$ 5,709.09	$ 6,065.94	$ 5,720.82	$ 5,726.29	$ 6,084.52
South Central	SSI	Child, 1-20 Years	$ 742.56	$ 743.41	$ 793.71	$ 749.32	$ 750.18	$ 801.01
South Central	SSI	Adult, 21+ Years	$ 1,323.26	$ 1,324.65	$ 1,412.89	$ 1,340.64	$ 1,342.05	$ 1,431.66
South Central	Family and Children	Newborn, 0-2 Months	$ 3,094.31	$ 3,097.21	$ 3,299.08	$ 3,094.56	$ 3,097.46	$ 3,299.35
South Central	Family and Children	Newborn, 3-11 Months	$ 295.78	$ 296.09	$ 315.03	$ 296.45	$ 296.76	$ 315.75
South Central	Family and Children	Child, 1-20 Years	$ 185.94	$ 186.15	$ 199.31	$ 187.17	$ 187.38	$ 200.65
South Central	Family and Children	Adult, 21+ Years	$ 388.68	$ 389.09	$ 415.06	$ 392.35	$ 392.76	$ 419.03
South Central	Foster Care Children	Foster Care, All Ages Male & Female	$ 537.95	$ 538.58	$ 579.40	$ 540.41	$ 541.04	$ 582.05
South Central	Breast and Cervical Cancer	BCC, All Ages Female	$ 2,286.85	$ 2,289.24	$ 2,426.29	$ 2,298.03	$ 2,300.43	$ 2,438.31
South Central	LaCHIP Affordable Plan	All Ages	$ 229.40	$ 229.65	$ 244.17	$ 231.27	$ 231.52	$ 246.19
South Central	HCBS Waiver	20 & Under, Male and Female	$ 1,830.53	$ 1,832.51	$ 1,951.94	$ 1,837.46	$ 1,839.45	$ 1,959.42
South Central	HCBS Waiver	21+ Years, Male and Female	$ 1,499.92	$ 1,501.55	$ 1,606.04	$ 1,513.68	$ 1,515.33	$ 1,620.89
South Central	Chisholm Class Members	Chisholm, All Ages Male & Female	$ 1,350.62	$ 1,352.16	$ 1,431.85	$ 1,353.85	$ 1,355.39	$ 1,435.34
South Central	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	$ 280.70	$ 280.70	$ 296.05	$ 280.70	$ 280.70	$ 296.05
South Central	SBH - Duals & LaHIPP (Duals)	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	$ 26.53	$ 26.53	$ 28.85	$ 26.53	$ 26.53	$ 28.85
South Central	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	$ 66.94	$ 66.94	$ 71.35	$ 66.94	$ 66.94	$ 71.35
South Central	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	$ 68.61	$ 68.61	$ 74.34	$ 68.61	$ 68.61	$ 74.34
South Central	SBH - Other	SBH - Other, All Ages	$ 177.02	$ 177.02	$ 188.96	$ 177.02	$ 177.02	$ 188.96
South Central	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 10,315.38	$ 10,315.38	$ 10,859.48	$ 10,315.44	$ 10,315.44	$ 10,859.55
South Central	Maternity Kickpayment - Early Elective Delivery	Early Elective Delivery	$ 3,964.27	$ 3,964.27	$ 4,071.37	$ 3,964.27	$ 3,964.27	$ 4,071.37
South Central	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	$ 26.53	$ 26.53	$ 28.85	$ 26.53	$ 26.53	$ 28.85
South Central	Medicaid Expansion	SBH - Other	$ 177.02	$ 177.02	$ 188.96	$ 177.02	$ 177.02	$ 188.96
South Central	Medicaid Expansion	SBH - CCM, All Ages	$ 280.70	$ 280.70	$ 296.05	$ 280.70	$ 280.70	$ 296.05
South Central	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	$ 10,315.38	$ 10,315.38	$ 10,859.48	$ 10,315.44	$ 10,315.44	$ 10,859.55
South Central	Medicaid Expansion - EED Kick Payment	EED Kick Payment	$ 3,964.27	$ 3,964.27	$ 4,071.37	$ 3,964.27	$ 3,964.27	$ 4,071.37
North	SSI	Newborn, 0-2 Months	$ 29,187.75	$ 29,214.50	$ 30,984.47	$ 29,188.50	$ 29,215.25	$ 30,985.29
North	SSI	Newborn, 3-11 Months	$ 5,622.90	$ 5,628.24	$ 5,977.53	$ 5,640.08	$ 5,645.45	$ 5,996.11
North	SSI	Child, 1-20 Years	$ 803.50	$ 804.42	$ 858.63	$ 807.88	$ 808.81	$ 863.37
North	SSI	Adult, 21+ Years	$ 1,221.52	$ 1,222.82	$ 1,305.56	$ 1,235.86	$ 1,237.18	$ 1,321.05
North	Family and Children	Newborn, 0-2 Months	$ 2,746.16	$ 2,748.64	$ 2,918.49	$ 2,746.36	$ 2,748.84	$ 2,918.70
North	Family and Children	Newborn, 3-11 Months	$ 279.30	$ 279.59	$ 296.83	$ 280.61	$ 280.90	$ 298.19
North	Family and Children	Child, 1-20 Years	$ 206.33	$ 206.57	$ 221.66	$ 207.12	$ 207.36	$ 222.51
North	Family and Children	Adult, 21+ Years	$ 370.43	$ 370.83	$ 396.58	$ 373.48	$ 373.88	$ 399.87
North	Foster Care Children	Foster Care, All Ages Male & Female	$ 565.15	$ 565.81	$ 607.97	$ 567.61	$ 568.27	$ 610.62
North	Breast and Cervical Cancer	BCC, All Ages Female	$ 2,280.88	$ 2,283.26	$ 2,419.74	$ 2,292.05	$ 2,294.44	$ 2,431.76
North	LaCHIP Affordable Plan	All Ages	$ 217.30	$ 217.54	$ 232.01	$ 219.17	$ 219.41	$ 234.03
North	HCBS Waiver	20 & Under, Male and Female	$ 1,876.63	$ 1,878.67	$ 1,998.27	$ 1,883.56	$ 1,885.61	$ 2,005.75
North	HCBS Waiver	21+ Years, Male and Female	$ 1,515.60	$ 1,517.25	$ 1,623.43	$ 1,529.36	$ 1,531.03	$ 1,638.28
North	Chisholm Class Members	Chisholm, All Ages Male & Female	$ 1,377.41	$ 1,378.98	$ 1,459.55	$ 1,380.64	$ 1,382.22	$ 1,463.04
North	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	$ 281.56	$ 281.56	$ 297.37	$ 281.56	$ 281.56	$ 297.37
North	SBH - Duals & LaHIPP (Duals)	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	$ 33.54	$ 33.54	$ 36.52	$ 33.54	$ 33.54	$ 36.52
North	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	$ 123.77	$ 123.77	$ 128.87	$ 123.77	$ 123.77	$ 128.87
North	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	$ 69.82	$ 69.82	$ 75.66	$ 69.82	$ 69.82	$ 75.66
North	SBH - Other	SBH - Other, All Ages	$ 176.21	$ 176.21	$ 187.88	$ 176.21	$ 176.21	$ 187.88
North	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 11,563.95	$ 11,563.95	$ 12,115.11	$ 11,563.96	$ 11,563.96	$ 12,115.12
North	Maternity Kickpayment - Early Elective Delivery	Early Elective Delivery	$ 5,132.43	$ 5,132.43	$ 5,240.92	$ 5,132.43	$ 5,132.43	$ 5,240.92
North	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	$ 33.54	$ 33.54	$ 36.52	$ 33.54	$ 33.54	$ 36.52
North	Medicaid Expansion	SBH - Other	$ 176.21	$ 176.21	$ 187.88	$ 176.21	$ 176.21	$ 187.88
North	Medicaid Expansion	SBH - CCM, All Ages	$ 281.56	$ 281.56	$ 297.37	$ 281.56	$ 281.56	$ 297.37
North	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	$ 11,563.95	$ 11,563.95	$ 12,115.11	$ 11,563.96	$ 11,563.96	$ 12,115.12
North	Medicaid Expansion - EED Kick Payment	EED Kick Payment	$ 5,132.43	$ 5,132.43	$ 5,240.92	$ 5,132.43	$ 5,132.43	$ 5,240.92

Notes:

1. Where applicable, final rates have been adjusted to account for the portion of contractual withholds that Mercer has determined to not be reasonably attainable.

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MAKE TOMORROW, TODAY

F. Ronald Ogborne III, FSA, CERA, MAAA
Partner

Erik Axelsen, ASA, MAAA
Senior Associate

3560 Lenox Road, Suite 2400
Atlanta, GA 30326
www.mercer-government.mercer.com

Ms. Pam Diez
Deputy Medicaid Director/Chief Financial Officer
Louisiana Department of Health
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821

May 24, 2019

Subject: Healthy Louisiana Expansion Program – Full Risk Bearing Managed Care Organization (MCO) Rate Development and Actuarial Certification for the Period April 1, 2019 through December 31, 2019

Dear Ms. Diez:

The Louisiana Department of Health (LDH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound[1] capitation rates for the State of Louisiana's (State) Healthy Louisiana Expansion program for the period of April 1, 2019 through December 31, 2019. This certification addresses the development of the Expansion Age 19–64 and Expansion High Needs capitation rates. The Expansion Special Behavioral Health (SBH) Dual Eligible, Expansion SBH Chisolm, Expansion SBH Other and the Expansion Maternity Kick Payment rate development is addressed in a separate certification.

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 relied on Healthy Louisiana Encounter data. It resulted in the development of a range of actuarially sound rates for each rate cell. The final capitation rates and rate ranges are summarized in Appendix A and represent payment in full for the covered services.

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[1] Actuarially Sound/Actuarial Soundness — Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.

Reference: http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf.

The remainder of this letter is structured as follows:

Section 1: New Adult Group Capitation Rates

- Part A: General Information
- Part B: Base Data Development
- Part C: Expansion Capitation Rate Development
  - *Subpart C.1: Projected Benefit Costs*
  - *Subpart C.2: Special Contract Provisions*
  - *Subpart C.3: Projected Non-Benefits Costs*
  - *Subpart C.4: Risk Mitigation*

Section 2: Certification of Final Rates

SECTION 1: NEW ADULT GROUP CAPITATION RATES

Part A: General Information

Capitation rates for the Healthy Louisiana Expansion program were developed in accordance with rate-setting guidelines established by CMS. For rate development for the Healthy Louisiana Expansion program, Mercer used data from April 1, 2017 through March 31, 2018. Healthy Louisiana Encounter data was used to develop the rates. All data was reported on an incurred basis and included payment dates through September 30, 2018. Restrictions were applied to the enrollment and claims data so that it was appropriate for the populations and benefit package defined in the Healthy Louisiana managed care organization (MCO) contract.

Mercer reviewed the data provided by LDH and the Healthy Louisiana MCOs for consistency and reasonableness and determined the data was appropriate for the purpose of setting actuarially sound new adult group capitation rates. The data reliance attestation shown in Appendix B has been provided by LDH, and its purpose is to certify the accuracy, completeness and consistency of the base data.

Adjustments were made to the selected base data to align with the covered populations and Healthy Louisiana benefit packages for the April 1, 2019 through December 31, 2019 rating period. Additional adjustments were then applied to the base data to incorporate:

- Provision for incurred but not reported (IBNR) claims.
- Adjustments to encounter data for under-reporting.
- Prospective and retrospective program changes not fully reflected in the base data.
- Trend factors to forecast the expenditures and utilization to the contract period.
- Changes in benefits covered by managed care.
- Changes in LDH's Medicaid eligibility policies.
- Administration and underwriting profit/risk/contingency loading.

In addition to these adjustments, LDH takes an additional step in the matching of payment to risk:

- Application of risk-adjusted regional rate.

The final rates for all rate cells were developed net of Graduate Medical Education (GME) payments to teaching hospitals provided in the Louisiana Medicaid State Plan. Appendix M details the development of rates for the Expansion Age 19–64 and Expansion High Needs populations.

Healthy Louisiana Expansion Rate Cell Structure

Historical claim costs vary by age, gender and eligibility category, and separate rate cells were developed in order to reflect differences in risk. Five distinct rate cells were established within this rating category based on Mercer's review of experience in working with Medicaid Expansion populations in other states. In addition, a Maternity Kick Payment will be paid to the MCOs for each qualifying delivery event that takes place.

TABLE 1:

MEDICAID EXPANSION RATE CELL STRUCTURE
Medicaid Expansion
Age 19–64, Male & Female
Medicaid Expansion – High Needs
Age 19–64, Male & Female
Medicaid Expansion – Dual Eligible
Age 19–64, Male & Female

MEDICAID EXPANSION RATE CELL STRUCTURE
Medicaid Expansion – SBH-CCM
Age 19–64, Male & Female
Medicaid Expansion – SBH-Other
Age 19–64, Male & Female
Maternity Kick Payment
Maternity Kick Payment
Early Elective Delivery (EED) Kick Payment

As previously discussed, this certification covers two of LDH's seven Medicaid Expansion rate cells: Expansion Age 19–64 and Expansion High Needs. For a description of the rate development of the Expansion SBH Dual Eligible, Expansion SBH Chisolm, Expansion SBH Other and the Expansion Maternity Kick Payment, please refer to the Healthy Louisiana rate certification dated February 7, 2019 for rates effective January 1, 2019 through December 31, 2019.

HEALTHY LOUISIANA BENEFIT PACKAGE

Covered Services

Appendix C lists the services the Healthy Louisiana MCOs must provide to the members in the Healthy Louisiana Expansion program. 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 January 1, 2019, Healthy Louisiana MCOs will be responsible for the coverage of Continuous Glucose Monitors (CGM) for all eligible recipients that meet the following criteria:

- Diagnosis of type 1 diabetes with recurrent, unexplained, severe hypoglycemia (glucose levels <50 mg/dl).

- Impaired hypoglycemia awareness that puts the recipient at risk or Pregnant recipient with poorly controlled type 1 diabetes evident by recurrent, unexplained hypoglycemic episodes, hypoglycemic unawareness, postprandial hyperglycemia or recurrent diabetic ketoacidosis.

Excluded Services

Healthy Louisiana MCOs are not responsible for providing physical health (PH) services and other Medicaid services not identified in Appendix C, including the following services:

- Dental services, with the exception of Early and Periodic Screening and Diagnosis Treatment varnishes provided in a Primary Care setting.
- Intermediate care facilities for the developmentally disabled services.
- Personal Care services 21 and older.
- Institutional Long-Term Care (LTC) Facility/Nursing Home services.
- School-based Individualized services.
- 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.
- Home- Community-Based Services (HCBS) waiver services.
- Targeted Case Management services.
- Services provided through LDH's Early-Steps program.
- Coordinated System of Care (CSoC) services previously covered under 1915(c) or 1915(b)(3) waiver authority.
- Medicare Crossover services.
- Services covered under a non-CSoC 1915(c) waiver.

For more specific information on covered services, please refer to the Healthy Louisiana Behavioral Health Integration Amendment issued by LDH.

HEALTHY LOUISIANA SERVICES ELIGIBLE FOR DIFFERENT FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)

There are two groups of services for which LDH receives a different FMAP than the regular state FMAP:

- Family Planning services.
- A list of specified preventive services and adult vaccines established under ACA section 4106.

Mercer has analyzed the component of the rates associated with each group of services so that LDH may claim the enhanced FMAP on these services. Since Family Planning services are reimbursed at the level of 90% FMAP and Expansion is reimbursed at the 93% level for CY 2019, there was no need for Mercer to

calculate the Family Planning component of the Expansion rates. Specific details on codes used to identify the preventive services can be found in Appendix D, which contains the per member per months (PMPMs) that are eligible for the enhanced match rate.

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 (East Bank), Jefferson (West Bank), Lafourche, New Orleans (Algiers), New Orleans (Downtown), New Orleans (Gentilly), New Orleans (Uptown), 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, Alexandria, 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, Monroe, Morehouse, Natchitoches, Ouachita, Red River, Richland, Sabine, Shreveport, Tensas, Union, Webster and West Carroll

PART B: BASE DATA DEVELOPMENT

For rate development for the Healthy Louisiana program, Mercer used data that spans the period of April 1, 2017 through March 31, 2018 from the following sources:

- Louisiana Medicaid eligibility and enrollment data.
- Encounter data reported from the State's Healthy Louisiana Prepaid program.

All data was reported on an incurred basis and included payment dates through September 30, 2018. 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 LDH and the Healthy Louisiana MCOs for consistency and reasonableness and determined the data was appropriate for the purpose of setting capitation rates for the

MCO program. The data reliance attestation shown in Appendix B has been provided by LDH, and its purpose is to certify the accuracy, completeness and consistency of the base data.

Effective February 1, 2015, members were granted retroactive eligibility, based on their eligibility for Healthy Louisiana, 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. Retroactive eligibility and claims are excluded from the base data and handled as a separate adjustment. This adjustment will be discussed later in this letter.

Incurred but Not Reported

Capitation rate ranges were developed using claims data for services incurred in the base period of April 1, 2017 through March 31, 2018 and reflects payments processed through September 30, 2018. Mercer developed IBNR factors for the base period encounter data in order to reflect considerations for any unpaid claims liability. IBNR category mappings are provided in Appendix C. Table 3 summarizes the IBNR factors that were applied to the April 2017 through March 2018 encounter data.

TABLE 3:

IBNR CATEGORY OF SERVICE	EXPANSION AGE 19–64	HIGH NEEDS
Inpatient	1.0241	1.0210
Outpatient	1.0373	1.0474
Physician and Other	1.0173	1.0216
Transportation and SBH	1.0250	1.0287
Prescribed Drugs	1.0000	1.0000
Total	**1.0195**	**1.0215**

Under-Reporting Adjustments

Under-reporting adjustments were developed by comparing encounter data from the Medicaid Management Information System (MMIS) to financial information provided by the MCOs. This adjustment was computed and applied on an MCO basis. Table 4 summarizes the overall aggregate increases applied to the base period expenses.

TABLE 4:

CATEGORY OF SERVICE	EXPANSION AGE 19–64	HIGH NEEDS
Prescribed Drugs	1.0979	1.1091
Non-Rx	1.0740	1.0791

Third-Party Liabilities

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

Copayments

Copayments are only applicable to prescription drugs. Pharmacy claims are reported net of any copayments so no additional adjustment is necessary.

Disproportionate Share Hospital Payments

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

BASE PROGRAM CHANGE ADJUSTMENTS

Program change adjustments recognize the impact of benefit or eligibility changes occurring during and after the base data period. CMS requires that the rate setting methodology used to determine actuarially sound rates incorporate the results of any program changes that have taken place, or are anticipated to take place, between the start of the base data period and the conclusion of the contract period.

Program changes that occurred during the base data period are referred to as Base Program Change Adjustments.

Pharmacy Copays Limit Adjustment

Per 42 CFR 447.56(f), LDH must have in place measures to limit the amount of cost-sharing that members of a Medicaid household may incur each month to 5% of the family income. Per the State Plan, LDH only charges cost sharing on prescription drugs. Thus, only pharmacy service costs need to be adjusted in order to comply with this requirement.

Effective April 1, 2019, LDH implemented a policy whereby individuals with a family income less than or equal to $800 per month will have a zero-dollar copay for all pharmacy claims. In order to estimate the impact of this program change, Mercer utilized information provided by LDH that summarized the total amount of copayments that they expected to shift from the Medicaid recipient's responsibility to the responsibility of the MCOs. The underlying analysis was performed on encounters with dates of service between July 1, 2017 and June 30, 2018 at the family, i.e., household, level. Mercer used the relevant household IDs provided by LDH and the copayments associated with them in our data for the corresponding time period to estimate the impact of this policy change. The estimated impact of the Pharmacy Copay Limit Adjustment was an increase of 0.5% to projected pharmacy costs for the Expansion Age 19–64 rate cell and an increase of 0.5% to projected pharmacy costs for the Expansion High Needs rate cell

DATA SMOOTHING

In reviewing the base data for the Expansion High Needs rate, Mercer determined that it was not sufficiently credible at the regional level. In order to ensure sufficient credibility to develop actuarially sound capitation rates Mercer combined the regional data and calculated a single statewide capitation rate.

PROSPECTIVE RATING ADJUSTMENTS

Program change adjustments that occurred after the base data period, but before the conclusion of the rating period are referred to as Prospective Rating Adjustments.

Fee Schedule Changes

The capitation rates reflect changes in covered services' fee schedules and unit costs, between the base period and the contract period.

Beginning in April 2014, LDH 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 Full Medicaid Pricing (FMP) in the calculation of PMPM payments to MCOs. LDH expects 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 LDH 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 were implemented effective July 2015.

For the non-FMP fee schedule changes discussed in this section, the fee schedule changes are expected to impact MCO costs as MCOs usually contract with providers at rates that are proportional to the Medicaid fee schedule for these services.

Inpatient Services

Inpatient claims were adjusted to reflect changes in the inpatient per diem rates between the base period and the contract period, using the fee schedules published on LDH's website.[2]

The April 1, 2019 rates reflect the estimated impact of the Fee Schedule changes that have been in effect since July 1, 2018.The non-GME part of the per diems were used in this fee adjustment process to be consistent with LDH's intention to continue paying GME amounts directly to the teaching hospitals.

Mercer relied upon an analysis of Medicare Diagnosis Related Group (DRG) equivalent pricing of Medicaid services provided by LDH for the FMP adjustment. Encounter data from January 2017 through December 2017 was analyzed 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 reimbursement level applicable to the rate period. The Medicaid payments were also trended to the rate period and the ratio between the projected Medicare and Medicaid

[2] https://www.lamedicaid.com/provweb1/fee_schedules/feescheduleindex.htm

payments was calculated. Mercer applied the ratio between the two payments to the base data at a hospital specific level.

Also, effective March 1, 2019, St. Elizabeth became an offsite campus of the main Our Lady of the Lake (OLOL) campus. St. Elizabeth's inpatient claims were adjusted to reflect the change in reimbursement rates resulting from the merger. The total impact of the inpatient fee changes is summarized below in Table 5 below:

TABLE 5:

RATE CELL	HISTORICAL COST	FEE CHANGE IMPACT	ADJUSTED COST	FMP IMPACT	IMPACT AS % OF ADJUSTED COST
Expansion Age 19–64	$264,707,245	$22,074,762	$286,782,007	$179,652,112	62.6%
Expansion High Needs	$264,051	$29,315	$293,366	$98,233	33.5%

Outpatient Services

Outpatient claims were adjusted to reflect the most recent cost−to−charge ratios (CCRs) available. The CCRs were reported on hospital fiscal year bases, which varied by hospital from June 30, 2015 to December 31, 2017. The adjustment also included estimation of cost settlements and reflected the most up-to-date cost settlement percentages for each facility.

Effective January 1, 2019 House Concurrent Resolution (HCR) six adjusted reimbursement rates for outpatient services for all hospitals except rural hospitals, state-owned hospitals, and OLOL. The rates for the effected facilities increased by 11.56% except for Children's Hospital where reimbursement for outpatient services increased by 5.26%. Additionally, cost settlement percentages for most non−rural, non-state facilities were increased to 83.18% effective January 1, 2019. Rural facilities are cost settled at 110%.

The outpatient FMP was developed according to the State Plan using the CCRs and the billed charges from the base data. The calculation was completed at a hospital level.

Also, effective March 1, 2019, St. Elizabeth became an offsite campus of the main OLOL campus. St. Elizabeth's outpatient claims were adjusted to reflect the change in reimbursement rates resulting from the merger. The total impact of the outpatient fee changes is summarized in Table 6 below:

TABLE 6:

RATE CELL	HISTORICAL COST	FEE CHANGE IMPACT	ADJUSTED COST	FMP IMPACT	IMPACT AS % OF ADJUSTED COST
Expansion Age 19–64	$365,894,928	$55,742,174	$421,637,101	$94,899,116	22.5%
Expansion High Needs	$192,682	$23,473	$216,155	$52,587	24.3%

Physician-Administered Drugs Fee Schedule Change

Effective July 1, 2018, LDH made changes to the physician-administered drugs (PAD) reimbursement rates.[3] Mercer identified the affected services and estimated the impact of the fee schedule changes to develop adjustments to the capitation rates. The total impact of the PAD fee changes is summarized in Table 7 below:

TABLE 7:

RATE CELL	HISTORICAL COST	FEE CHANGE IMPACT	IMPACT AS % OF HISTORICAL COST
Expansion Age 19–64	$2,207,924	$214,749	9.7%
Expansion High Needs	$812	$48	5.9%

Hospital-Based Physician Services

Mercer calculated the FMP payments for hospital-based physician services provided at participating facilities by participating physicians according to the State Plan methodology. This methodology is designed to bring the payments for the physician services up to the community rate level. The community rate is defined as the rates paid by commercial payers for the same service. For state-owned or operated entities, Mercer calculated the FMP payments according to the State plan using the billed charges from the base data and the commercial charges-to-paid conversion factors provided by LDH. For non-state owned or operated entities, Mercer calculated the FMP payments according to the State plan using the units of service from the base data, the most currently available Medicare fees and the Medicare-to-commercial conversion factors provided by LDH. The conversion factors are maintained by LDH and updated

[3] https://ldh.la.gov/index.cfm/page/3297

periodically. For state-owned or operated entities, the conversion factors are updated annually. For non-state owned or operated entities, the factors are updated every three years.

LDH provided the latest available factors, which were last updated as of October 2018. Table 8 below shows the impact of FMP on the adjusted base cost of hospital-based physician services meeting the State Plan's criteria for FMP.

TABLE 8:

RATE CELL	HISTORICAL COST	ADJUSTED COST	FMP IMPACT	IMPACT AS % OF ADJUSTED COST
Expansion Age 19–64	$81,932,860	$81,932,860	$128,630,001	157.0%
Expansion High Needs	$40,977	$40,977	$54,006	131.8%

Ambulance Services
Mercer calculated the ambulance FMP payments 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 Governmental (LUG) or non-LUGs. LUGs have historically received 100.0% 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 LDH for rate year 2019. According to the State Plan, average commercial rates are updated every three years. Table 9 below shows the impact of FMP on the adjusted base cost of ambulance services meeting the State Plan's criteria for FMP.

TABLE 9:

RATE CELL	HISTORICAL COST	ADJUSTED COST	FMP IMPACT	IMPACT AS % OF ADJUSTED COST
Expansion Age 19–64	$19,430,163	$19,430,163	$13,610,048	70.0%
Expansion High Needs	$14,378	$14,378	$13,805	96.0%

Aggregate Fee Schedule Adjustments
Overall, as shown in Table 10, the combined effect of all the prospective fee adjustments to the Expansion Age 19–64 and Expansion High Needs rate cells was a 51.3% and 38.6% increase in the base data, respectively.

TABLE 10:

RATE CELL	HISTORICAL COST	FEE CHANGE IMPACT	ADJUSTED COST	FMP IMPACT	IMPACT AS % OF ADJUSTED COST
Expansion Age 19–64	$734,173,120	$78,031,685	$812,204,806	$416,791,277	51.3%
Expansion High Needs	$512,900	$52,836	$565,735	$218,632	38.6%

Positron Emission Tomography Scans

Effective February 1, 2018, Healthy Louisiana will cover Positron Emission Tomography (PET) scans for cancer-related purposes. This is a new State Plan service and is considered a PH service.

Mercer developed a projection of the Healthy Louisiana PET scan costs using fee schedule information provided by LDH and an estimate of expected PET scan utilization. As PET scans are a new State Plan service and encounter data is limited, the projected utilization was developed based on experience in Louisiana for a Commercial population (Blue Cross Blue Shield of Louisiana – Individual line of business), emerging utilization experience in the data and PET scan utilization in other Medicaid managed care programs covering similar populations and services in other states. The overall impact on the Expansion rates due to the addition of the PET scan benefit was $0.37 PMPM and $2.92 PMPM for the Expansion Age 19–64 and Expansion High Needs rate cells, respectively. Please see Appendix E for more details.

Managed Care Linkage for Long-Term Care Users

Effective August 1, 2018, the State implemented changes that impact the managed care enrollment date for Healthy Louisiana enrollees who become eligible for LTC services. Specifically, the effective date of B-linkage (i.e., Behavioral Health Only coverage) enrollment status when a member enrolled in managed care with a P-linkage (i.e., Acute and Behavioral Health coverage), is certified as eligible for LTC services, will be the first day of the month following the member's LTC certification. Prior to August 1, 2018, the member was enrolled with a B-linkage effective the first day of the month that member was admitted to LTC. Disenrollment from the P-linkage will continue to happen on the last day of the month the member is admitted to LTC.

During the transitional month where a member is both enrolled with a P-linkage and certified for LTC, the MCO will have additional responsibility for services covered under the managed care contract that are not the responsibility of the nursing facility.

Mercer identified individuals within the base data whose eligibility would be impacted by this change, as well as the cost of the additional services that will become the responsibility of the MCO. This data was utilized to develop adjustments for each region and rate cell. The overall impact of this program change is a 0.14% increase and 0.03% decrease to the Expansion Age 19–64 and Expansion High Needs rate cells, respectively. The table below shows the impact on the base PMPM for the Expansion rates.

TABLE 11:

RATE CELL	HISTORICAL HLA MMS	HISTORICAL HLA ENCOUNTERS	ADJUSTED MMS	ADJUSTMENT DOLLAR IMPACT	HISTORICAL HLA ENCOUNTERS
Expansion Age 19–64	5,196,640	$1,572,114,075	381	$2,416,686	0.2%
Expansion High Needs	1,091	$1,027,495	2	$2,030	0.0%

Continuous Glucose Monitoring Adjustment

Effective January 1, 2019, Healthy Louisiana MCOs will be responsible for the coverage of continuous glucose monitors for all eligible recipients that meet the following criteria:

- Diagnosis of type 1 diabetes with recurrent, unexplained, severe hypoglycemia (glucose levels <50 mg/dl).

- Impaired hypoglycemia awareness that puts the recipient at risk or Pregnant recipient with poorly controlled type 1 diabetes evident by recurrent, unexplained hypoglycemic episodes, hypoglycemic unawareness or postprandial hyperglycemia, or recurrent diabetic ketoacidosis.

Mercer developed a projection of the Healthy Louisiana CGM costs using fee schedule information provided by LDH and an estimate of expected CGM utilization based on clinical expertise. As CGMs are a new State Plan service, the projected utilization was developed based on the SFY17 Expansion Age 19–64 prevalence of recipients with Type I diabetes and insulin dependence. The overall impact on the Expansion rates due to the addition of the CGM benefit was an increase of $0.48 PMPM and $0.49 PMPM for the Expansion Age 19–64 and Expansion High Needs rate cells, respectively. Please see Appendix F for more details.

Federally Qualified Health Center/Rural Health Clinic

Long-acting reversible contraceptive

Effective January 1, 2019, and with the date of service forward, Louisiana Department of Health will reimburse for long-acting reversible contraceptive (LARC) devices and diagnosis separate from the prospective payment system (PPS) rate to Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) providers. The Actual Acquisition Cost (AAC) to the FQHC will determine the reimbursement for LARC devices.

Same Day Billing

Effective for dates of service on or after April 1, 2019, the Medicaid program shall establish an alternative payment methodology for behavioral health services provided in FQHCs and RHCs by one of the following practitioners:

- Physicians with a psychiatric specialty.

- Nurse practitioners or clinical nurse specialist with a psychiatric specialty.
- Licensed clinical social workers.
- Clinical psychologist.

The reimbursement for behavioral health services will equal the all-inclusive encounter PPS rate on file for fee for service on the date of service. This reimbursement will be in addition to any all-inclusive PPS rate on the same date for a medical visit.

Mercer developed the projection of these two changes by using updated fee schedules and supplemental information provided by LDH in conjunction with historical Healthy Louisiana data. Table 12 below summarizes the projected impact to the rates related to these FQHC/RHC reimbursement methodology changes.

TABLE 12:

RATE CELL	RY19 PROJECTED MMS	LARC PMPM	SAME DAY BILLING PMPM	TOTAL FQHC/RHC PMPM
Expansion Age 19–64	6,687,382	$0.00	$0.23	$0.23
Expansion High Needs	1,218	$0.00	$0.51	$0.51

Single Preferred Drug List

Effective May 1, 2019, LDH implemented a Single preferred drug list (PDL) for selected therapeutic classes. LDH selected the therapeutic classes and drugs included, and LDH and the MCO pharmacy directors established the prior authorization criteria applicable to the drugs included in the Single PDL. MCOs are required to follow the Single PDL and only list as preferred those products preferred by LDH. For branded products listed as preferred over available generics, the MCOs are to consider the generic form non-preferred and not require the prescriber to indicate in writing the branded product is medically necessary.

To estimate the impact of the Single PDL on pharmacy costs, Mercer's actuaries and pharmacists reviewed the historical utilization of drugs in the affected classes and developed assumptions regarding the expected changes in utilization from non-preferred to preferred agents, which were reviewed by LDH pharmacists. The estimated impact of the Single PDL program change on projected pharmacy costs on each rate cell are summarized in the table below.

TABLE 13:

RATE CELL	UNIT COST ADJUSTMENT
Expansion Age 19–64	0.6%
Expansion High Needs	0.6%

Additionally, the MCOs are prohibited from entering into rebate agreements with manufacturers of drugs. Any existing drug rebate agreements were discontinued by May 1, 2019. The MCOs are still allowed to collect rebates on non-drug items such as diabetic testing supplies once the Single PDL is implemented. To account for the changes to the pharmacy rebate adjustment as a result of the Single PDL implementation, Mercer blended the pharmacy rebate adjustment developed the pre- and post-Single PDL rebate expectations to arrive an updated pharmacy rebate adjustment. The table below summarizes the updated impacted of pharmacy rebates on projected pharmacy costs on each rate cell.

TABLE 14:

RATE CELL	RX REBATE ADJUSTMENT		
	PRE-PDL	POST-PDL	NET
Expansion Age 19–64	-4.6%	-0.5%	-1.0%
Expansion High Needs	-4.6%	-0.5%	-1.0%

Local Pharmacy Adjustment

Effective May 1, 2019, LDH will reimburse pharmacies for fee-for-service (FFS) prescriptions at a different level. The ingredient cost portion of the reimbursement shifts from local AAC to National Average Drug Acquisition Cost (NADAC). The dispensing fee portion of the reimbursement also increases; from $10.41 per prescription to $10.99 per prescription.

These changes in FFS pharmacy reimbursement affect Healthy Louisiana because the MCO's are required to reimburse local pharmacies at the FFS level. Per §460.36 of Louisiana's register, local pharmacies are defined as satisfying the two following conditions:

1. Contracts with MCO or the manager care organization's contractor in its own name or through a pharmacy services administration organization and not under the authority of a group purchasing organization.

2. Has fewer than ten retail outlets under its corporate umbrella.

Mercer reviewed an analysis by Myers and Stauffer in which they estimated difference between local AAC and NADAC ingredient costs. Myers and Stauffer performed the pricing analysis on local pharmacy encounter experience incurred on dates of service between May 11, 2017 through May 10, 2018. The results of this analysis, in conjunction with the historical utilization of local pharmacies in the Healthy Louisiana program, were used to estimate the impact of the local pharmacy pricing changes on projected pharmacy costs. The expected impact of this program change on projected pharmacy costs was an increase of 0.1% for the Expansion Age 19–64 rate cell and an increase of 0.4% for the Expansion High Needs rate cell.

Wage Verification Disenrollment Adjustment

Effective April 1, 2019, LDH implemented a new process whereby Medicaid enrollees' income data is reviewed periodically and the Medicaid eligibility of certain individuals is reevaluated. Once each quarter, LDH will cross reference income data collected by other State agencies with Medicaid eligibility guidelines to identify individuals who may no longer be eligible for Medicaid. Individuals who are identified through this process are sent verification-of-wage requests. Any individuals who are unable to demonstrate that their household income level is within Medicaid eligibility limits or who do not respond are disenrolled from the program at the end of the quarter. Individuals who do not respond to the wage-verification request can reapply for Medicaid at any point after they are deemed ineligible. Their application will be handled according to LDH's standard process.

In order to estimate the impact of this policy change on the overall acuity of the Expansion Age 19–64 rate cell, LDH provided Mercer with a list of individuals who were identified as ineligible in the 2019 Q1 wage verification run and were subsequently disenrolled. Mercer estimated the relative cost of the disenrolled individuals versus the residual Expansion Age 19–64 population based on historical Healthy Louisiana encounter data. These cost relativities, in conjunction with January 1, 2019 through March 31, 2019 Expansion Age 19–64 enrollment data, were used to develop a baseline acuity adjustment.

Additionally, LDH has observed a material number of individuals who were initially disenrolled due to the 2019 Q1 wage-verification review re-enrolling during 2019 Q2. LDH provided Mercer with six weeks of re-enrollment data which was used to adjust the enrollment projections used in this analysis. Based on this information, Mercer and LDH assumed that approximately 1.7% of the individuals who were disenrolled due to the 2019 Q1 wage-verification reviews would be re-enrolled in Medicaid. The table below summarizes the estimated net impact of the 2019 Q1 wage-verification disenrollments on the overall acuity of the Expansion Age 19–64 rate cell by region.

TABLE 15:

REGION	RATING ADJUSTMENT
Gulf	2.0%
Capital	1.3%
South Central	1.9%
North	1.6%
Statewide	1.7%

Finally, since LDH will be performing these wage-verification reviews quarterly, Mercer and LDH will continue to monitor the impact of future wage-verification review cycles on the overall acuity of the Expansion Age 19–64 rate cell to determine if further modification of this rating adjustment is necessary.

PART C: EXPANSION CAPITATION RATE DEVELOPMENT

Mercer followed rate development standards related to base data and described in Part B of this letter to develop an adjusted base data. To obtain the final projected benefit costs, the base data was further adjusted to account for trends and other contract provisions.

SUBPART C.1: PROJECTED BENEFIT COSTS

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 two data sources incorporated in the capitation rates: Healthy Louisiana encounters and Healthy Louisiana MCO financial reports. Trends were selected based on Louisiana experience, as well as national trend information.

Prospective trends were applied to the base data. The trend factors by category of service (COS) are shown in the table below and are applicable for both the Expansion Age 19–64 and Expansion High Needs rate cells.

TABLE 16:

TREND CLASS	4.1.19 ANNUALIZED LOW TREND
Inpatient Class	1.5%
Outpatient Class	1.2%
Physician Class	8.0%
Other Class	6.2%

TREND CLASS	4.1.19 ANNUALIZED LOW TREND
Transportation Class	-0.4%
Rx Class	6.7%
SBH Inpatient Class	4.4%
SBH Other Class	9.0%
Total	**4.7%**

IN-LIEU OF SERVICES

The costs in the base data reflect costs for State Plan services delivered in a managed care environment. In some cases, for the adult population, the MCOs provided an approved service in lieu of a State plan service. The utilization and unit costs of the in-lieu-of services were taken into account in developing the projected benefit costs of the covered services (as opposed to utilization and unit costs of the State plan services or settings) with the exception of the Inpatient Psychiatric Institutions for Mental Diseases (IMD) stays for which utilization was repriced at the cost of the same services through providers included under the state plan. Additional detail regarding the repricing of the Inpatient Psychiatric IMD stays is described in more detail in the section below. Please refer to Appendix J for a summary of these costs and the percentage of cost that the in-lieu-of services represent in each COS.

INSTITUTIONS FOR MENTAL DISEASES

On May 6, 2016, CMS published the Medicaid and CHIP Programs Final Rule. Provision §438.6(e) states the following, "…the State may make a monthly capitation payment to an MCO or PIHP for adults receiving inpatient treatment in an IMD, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder (SUD) crisis residential services, and length of stay in the IMD is for a short-term stay of no more than 15 days during the period of the monthly capitation payment." This requirement was effective as of July 6, 2016.

No adjustments were made in rate development to IMD SUD services as they were approved as covered services via Louisiana's 1115 Waiver effective February 1, 2018.

For Inpatient Psychiatric IMD stays, Mercer received a list of IMD facilities that existed during the base data period (April 2017 through March 2018). Using this list of IMD facilities, Mercer identified all individuals within the base data who had an overnight stay in an IMD and sorted them into short stays (15 cumulative days or less in a given month) versus long stays (16 or more cumulative days in a given month). Table 17 below shows user-month counts and costs within the base associated with IMD users for the Expansion Age 19–64 and Expansion High Needs rate cells.

Please note that to the extent there were IMDs in the base period that were not included on the IMD facilities list utilized by Mercer for this analysis and/or that there were overnight IMD stays paid for an entity other than Medicaid, the methodology described in this section would not have been able to identify them.

If new or better data becomes available, it may be necessary to refine the IMD adjustments described below accordingly.

For Inpatient Psychiatric IMD long stays, adjustment factors were developed by region, rate cell and year to remove all costs and user months incurred during the IMD long-stay. This includes the member months and costs for the IMD itself as well as non-IMD services incurred during the days in which the individual was in the IMD during the month of the IMD long stay. In aggregate, the impact of these adjustments on the base were a 0.1% reduction to the April 2017 through March 2018 Expansion Age 19–64 and Expansion High Needs PMPM.

Another component of §438.6(e) requires that States "must price utilization at the cost of the same services through providers included under the State Plan." Mercer evaluated the average cost per diem of IMD stays and compared this to the average cost per diem of Inpatient Psychiatric stays in non-IMD hospitals. Repricing the short stay Inpatient Psychiatric IMD utilization at the non-IMD per diem resulted in an increase to SBH inpatient services of 6.4% for both the Expansion Age 19–64 and Expansion High Needs rate cells.

TABLE 17:

		IP PSYCH OVERNIGHT STAY		NON-IP PSYCH SERVICES		ALL SERVICES	
Stay Type	**User Months**	**Cost**	**Cost Per User Month**	**Cost**	**Cost Per User Month**	**Cost**	**Cost Per User Month**
Long Stay	166	$1,475,301	$8,887.35	$242,585	$1,461.35	$1,717,886	$10,348.71
Short Stay	9,403	$26,909,007	$2,861.75	$5,877,773	$625.10	$32,786,779	$3,486.84

The applicable rate development guide (RDG) (July 2018–June 2019) requests certain metrics regarding IMD usage. As stated above, SUD services are considered covered due to the approved 1115 waiver. Therefore, we only reviewed mental health overnight services in IMDs. Further, these mental health (MH) overnight stays were reviewed on a monthly basis, per the Final Rule. Therefore, the maximum stay that occurs in our summarized data (in a month) is 31 days. The two tables below display the metrics requested by the RDG for both the Expansion Age 19–64 and Expansion High Needs rate cells.

TABLE 18:

MONTH STATISTICS FOR ENROLLEES WHO RECEIVED MH OVERNIGHT SERVICES IN AN IMD					
Time Period	**Unique Enrollees**	**Minimum**	**Maximum**	**Mean**	**Median**
4/1/201–3/31/2018	6,400	1	11	1	1

TABLE 19:

LENGTH OF STAY STATISTICS BY MONTH FOR MH OVERNIGHT SERVICES IN AN IMD					
Time Period	**Unique Enrollees**	**Minimum**	**Maximum**	**Mean**	**Median**
4/1/2017–3/31/2018	6,400	1	31	6	6

RETROACTIVE ELIGIBILITY ADJUSTMENT

MCOs are liable for all claims incurred during a retroactive eligibility period. Eligible members are granted retroactive eligibility, based on their eligibility for Healthy Louisiana, for up to 12 months prior to enrollment in an MCO. The MCO selected by these members receive one capitation payment per month of retroactive enrollment.

Mercer reviewed the retroactive eligibility and claims experience data and developed adjustment factors that were applied to the projected benefit costs. Expansion Age 19–64 rates were increased by 2.67% in consideration of the observed cost relativities. Additional detail related to this adjustment is presented in Appendix K.

Subpart C.2: Special Contract Provisions

Incentive Arrangement

The CMS RDG defines incentive arrangements as "any payment mechanism under which a health plan may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract."

Effective February 1, 2018, MCOs may earn incentive payments up to 5%, in total, above the approved capitation payment attributable to the enrollees or services covered by the incentive arrangements implemented by LDH. These incentive payments will support the activities, targets, performance measures, or quality-based outcomes specified in LDH's quality strategy. Mercer will work with LDH to ensure the incentive arrangement is consistently administered such that it complies with the regulations at 42 CFR 438.6(b)(2).

Withhold Arrangement

Effective February 1, 2018, a withhold of the monthly capitated payment shall be applied to incentivize quality, health outcomes and value-based payments. The withhold amount will be equal to 2% of the monthly capitated payment for physical and basic behavioral health for all MCO members, exclusive of maternity kick payments and the FMP component of the monthly capitated payment. Quality and health outcomes, along with value-based payments will each account for 1% (half of the withhold) and are intended to incentivize the MCOs to meet all requirements.

Based on recent Healthy Louisiana MCO performance, Mercer determined that two of the 16 quality or health outcome measures were deemed not reasonably attainable. These two measures are ED visits per

1,000 and Controlling High Blood Pressure. All other measures for quality and health outcomes were deemed reasonably attainable. All value-based payments were deemed reasonably attainable.

Due to two quality and health outcomes being deemed not reasonably attainable, there will be an adjustment to the actuarially sound lower bound. For those rate cells impacted by the withhold, a factor of 1.00125 (1% * 2/16 = 0.125%) will be applied to all impacted rate cells prior to the application of the FMP adjustment in order to comply with the relevant actuarial standards of practice.

SUBPART C.3: PROJECTED NON-BENEFIT COSTS

Non-Medical Expense Load

Administrative Expense Load

The actuarially sound capitation rates developed include a provision for MCO administration and other non-medical expenses. Mercer reviewed line item detail of each MCO's administrative expenses, which tied back to the MCO financial reports as well as relied on its professional experience in working with numerous State Medicaid programs to develop the administrative load. This process included consideration for increases in expenses including items such as additional case management due to claims volume, increases in staff compensation over time, and consideration for enrollment growth. Administrative Expense Load assumptions are summarized by program in Table 20.

TABLE 20:

ADMIN PMPM BY PROGRAM		
Program	**Lower Bound**	**Upper Bound**
Expansion	$34.17	$37.01

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 rate cell, which reflects program requirements, such as state-mandated staffing, and other indirect operational expenses. Added to this is a variable administrative amount, based on claims volume. This methodology results in administrative expense loads that vary as a percentage by rate cell. The resulting variance in administrative expense determined using this methodology results in a higher allocation of administrative expenses on the rate cells with higher utilization, which Mercer believes is more accurate in reflecting the drivers of plan administration requirements.

Underwriting Gain Load

A provision was made in the final rates for underwriting gain. The lower bound reflects an assumption of 1.50% and the upper bound reflects an assumption of 2.50%; the underwriting gain load is calculated prior to the application of FMP adjustments.

Premium-based Taxes

Final rates also include a provision for Louisiana's 5.50% premium tax.

Federal Health Insurance Provider Fee

Section 9010 of the Affordable Care Act 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 remain uncertain. The HIPF fees associated with calendar year 2019 experience will be calculated and become payable sometime during the third quarter of 2020. As these fees are not yet defined by insurer and by marketplace, no adjustment has been made in the rate range development for the Healthy Louisiana program. An adjustment and revised certification will be considered when the fee amount and impacted entities applicable to this rate period are announced.

SUBPART C.4: RISK MITIGATION

Risk Adjustment

Risk adjustment will be applied to the rates in Appendix A to reflect differences in health status of the members served in each MCO using the Adjusted Clinical Groups (ACG) model. The ACG model uses diagnostic information along with member demographics (age and sex categories) to classify members into mutually exclusive ACG categories, which are indicative of health care resource usage in terms of cost consumption. The State typically updates risk scores semi-annually, but the update timing and frequency may change to account for key program changes and data availability.

The application of the ACG model was tailored to the Healthy Louisiana program by using Louisiana cost experience to determine the relative costs associated with each ACG category. This step produces Louisiana-specific cost weights which assign a risk score to each member with sufficient experience (six or more months of enrollment with a MCO). An age/gender risk assumption is made for members without an ACG assignment. These member-level risk scores will be aggregated by MCO, producing MCO risk scores, which are adjusted for budget neutrality. The risk adjustment process does not increase nor decrease the overall cost of the program, but can change the distribution across the various Healthy Louisiana MCOs according to the relative risk of their enrolled members. This is consistent with the budget neutrality requirements outlined in 42 CFR 438.5(g). The FMP component of the rates will not be risk adjusted. The FMP component is added to the risk adjusted rate to produce the final rate.

The risk scores applied to the Expansion Age 19-64 rate cell vary by region.

For more detail regarding the risk adjustment process, please reference the separate risk-adjustment methodology letter that corresponds with each risk adjustment update.

SECTION 2: CERTIFICATION OF FINAL RATES

This certification assumes items in the Medicaid State Plan or Waiver, as well as the Healthy Louisiana MCO contract, have been approved by CMS.

In preparing the rates shown in Appendix A, Mercer has used and relied upon enrollment, encounter data, reimbursement level, benefit design, and other information supplied by LDH and its fiscal agent. LDH, its

fiscal agent, and the Healthy Louisiana MCOs 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. However, if the data and information are incomplete/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 the rates in Appendix A, including any risk-sharing mechanisms, were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the Healthy Louisiana MCO 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.

Rates and 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 Healthy Louisiana MCO costs will differ from these projections. Mercer has developed these rates on behalf of LDH to demonstrate compliance with the CMS requirements under 42 CFR 438.4 and accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

Healthy Louisiana MCOs are advised that the use of these rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rates by Healthy Louisiana MCOs for any purpose. Mercer recommends that any MCO considering contracting with LDH 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 LDH.

LDH 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 LDH secure 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 Healthy Louisiana Program, Medicaid eligibility rules, and actuarial rate-setting techniques. It has been prepared exclusively for LDH 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. Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

LDH 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 LDH if nothing is received by Mercer within such 30-day period.

If you have any questions on any of the above, please feel free to contact Ron Ogborne at +1 602 522 6595 or Erik Axelsen at +1 404 442 3517 at your convenience.

Sincerely,

F. Ronald Ogborne III, FSA, CERA, MAAA
Partner

Erik Axelsen, ASA, MAAA
Senior Associate

Copy:
Amanda Joyner, Deputy Assistant Secretary – OBH/LDH
Marisa Naquin, Managed Care Finance – LDH
Jen Steele, Medicaid Director – LDH
Karen Stubbs, Deputy Assistant Secretary – OBH/LDH
Robert Butler, Principal – Mercer
Christina Coleman, Associate – Mercer
Kodzo Dekpe, ASA, MAAA, Associate – Mercer

APPENDIX A: HEALTHY LOUISIANA CAPITATION RATE RANGES

Region	Category of Aid	Rate Cell	Projected Member Months/Deliveries	Lower Bound PMPM or Cost per Delivery	Final PMPM or Cost per Delivery [1]	Upper Bound PMPM or Cost per Delivery
Gulf	Medicaid Expansion	Age 19 - 64	2,118,672	$ 561.40	$ 561.96	$ 598.39
Gulf	Medicaid Expansion	High Needs	300	$ 1,096.62	$ 1,096.62	$ 1,174.76
Capital	Medicaid Expansion	Age 19 - 64	1,519,852	$ 642.34	$ 643.00	$ 685.68
Capital	Medicaid Expansion	High Needs	493	$ 1,568.65	$ 1,568.65	$ 1,672.06
South Central	Medicaid Expansion	Age 19 - 64	1,683,575	$ 567.51	$ 568.09	$ 605.49
South Central	Medicaid Expansion	High Needs	231	$ 2,665.68	$ 2,665.68	$ 2,848.02
North	Medicaid Expansion	Age 19 - 64	1,365,283	$ 512.80	$ 513.34	$ 548.16
North	Medicaid Expansion	High Needs	194	$ 1,401.63	$ 1,401.63	$ 1,502.89

Notes:
1. Where applicable, final rates have been adjusted to account for the portion of contractual withholds that Mercer has determined to not be reasonably attainable.

APPENDIX B: DATA RELIANCE LETTER

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Department of Health
Bureau of Health Services Financing

Mr. Ron Ogborne, FSA, CERA, MAAA
Partner
Mercer Government Human Services
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016

April 25, 2019

Subject: Capitation Rate Certification for the Healthy Louisiana Expansion Program – Implementation Year (April 1, 2019 through December 31, 2019)

Dear Ron:

I, Pam Diez, Medicaid Deputy Director, for the Louisiana Department of Health (LDH), hereby affirm that the data prepared and submitted to Mercer Government Human Services Consulting (Mercer) for the purpose of certifying the April 1, 2019 through December 31, 2019 Healthy Louisiana Expansion 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 managed care organization submitted encounter data and supplemental information on payments made outside of Louisiana's Medicaid Management Information Systems for the period of April 1, 2017 through March 31, 2018.

Mercer relied on LDH and its fiscal agent for the collection and processing of the 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.

Signature

4/24/19
Date

Copy:
Erik Axelsen, ASA, MAAA, Senior Associate
Robert Butler, Principal
Christina Coleman, Associate
Kodzo Dekpe, ASA, MAAA, Associate

APPENDIX C: HEALTHY LOUISIANA COVERED SERVICES

Table 1: PH and Expansion Programs

Medicaid Category of Service	Units of Measurement	IBNR Category Mapping
Inpatient Hospital	Days	Inpatient
Outpatient Hospital	Claims	Outpatient
Primary Care Physician	Visits	Physician and Other
Specialty Care Physician	Visits	Physician and Other
Federally Qualified Health Center/Rural Health Clinic	Visits	Physician and Other
EPSDT	Visits	Physician and Other
Certified Nurse Practitioners/Clinical Nurse	Claims	Physician and Other
Lab/Radiology	Units	Physician and Other
Home Health	Visits	Physician and Other
Emergency Transportation	Units	Transportation and SBH
NEMT	Units	Transportation and SBH
Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech Therapy)	Visits	Physician and Other
DME	Units	Physician and Other
Clinic	Claims	Physician and Other
Family Planning	Visits	Physician and Other
Other	Units	Physician and Other
Prescribed Drugs	Scripts	Prescribed Drugs
Emergency Room	Visits	Outpatient
Basic Behavioral Health	Claims	Physician and Other
Hospice*	Admits	Inpatient
Personal Care Services (Age 0–20)	Units	Physician and Other
Inpatient Services — Mental Health	Days	Transportation and SBH
Emergency Room — Mental Health	Visits	Transportation and SBH
Professional/Other — Mental Health	Units	Transportation and SBH

Table 2: SBH Program

Medicaid Category of Service	Units of Measurement	IBNR Category Mapping
Inpatient Services — Mental Health	Days	Transportation and SBH
Emergency Room — Mental Health	Visits	Transportation and SBH
Professional/Other — Mental Health	Units	Transportation and SBH
NEMT	Units	Transportation and SBH

APPENDIX D: PREVENTIVE SERVICES ADDENDUM

Attachment A: Preventive Services Logic

Attachment B: Preventive Services Rate Summary

MERCER
MAKE TOMORROW, TODAY

APPENDIX D: PREVENTIVE SERVICES ADDENDUM

The Louisiana Department of Health (LDH) has contracted with Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, to develop actuarially sound capitation rate ranges for the State of Louisiana's Healthy Louisiana Expansion program for the period of April 1, 2019 through December 31, 2019. As part of this work, Mercer was asked to develop the preventive services component of the capitation rates using the same data that was used to develop the capitation rates. Authorized by Section 4106 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-152), clinical preventive services recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF) and adult immunizations recommended by the Advisory Committee on Immunization Practices will receive a one percentage point increase in their Federal Medical Assistance Percentage (FMAP) for those services. This Appendix presents an overview of the analyses and methodology used in Mercer's preventive services rate development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS), in order for LDH to receive the +1.0% Federal match for eligible preventive services. This addendum should be read in conjunction with the rate certification letter.

BASE DATA

The capitation rates were developed using the medical expenses incurred during April 1, 2017 through March 31, 2018 with runout through September 2018, as reported through the Medicaid Management Information Systems (MMIS). All preventive services were assigned to the appropriate rate cells. Please see the rate certification letter for more details.

METHODOLOGY FOR IDENTIFYING PREVENTIVE SERVICES

Using data from the State's MMIS, a multi-step process was followed to measure the amount of preventive services for the calendar year, region and rate tier. Each of these steps is described below.

1. **Grades A and B Preventive Services Identification**

   Preventive services can be identified through the list of recommended services by the USPSTF. Mercer and LDH cooperated in identifying corresponding criteria for each service listed by the USPSTF. Attachment A contains the list of these services and agreed upon criteria that were used to identify preventive services based on a procedure code, diagnosis code, age, and gender criteria match basis.

2. **Adult Immunization Preventive Services Identification**

   According to the USPSTF, immunizations for adults (aged 19 and above) and the administration of those immunizations are eligible for the additional 1.0% Federal match. In identifying eligible

preventive services claims from the data, Mercer identified procedure codes related to immunizations listed by the USPSTF. Table 1 shows the procedure codes determined by Mercer's clinical team to identify those immunizations eligible for the enhanced federal match rate.

The administration costs of the immunizations are not directly linked to the procedure codes in Table 1. Therefore, the administration costs were estimated using the units administered, Louisiana's Medicaid Fee schedule, and the weighted average of the administration procedure codes utilized for people aged 19 and above. Administration procedure codes used include the following: 90471, 90472, 90473 and 90474.

TABLE 1: PROCEDURE CODES IDENTIFYING ELIGIBLE IMMUNIZATIONS

CPT/HCPCS CODES FOR ELIGIBLE IMMUNIZATIONS				
90645	90748	90661	90688	90718
90646	90649	90662	90707	90716
90647	90650	90663	90620	90736
90648	90651	90664	90621	
90632	90630	90666	90733	
90739	90653	90667	90734	
90740	90654	90668	90670	
90746	90656	90672	90732	
90747	90658	90673	90714	
90636	90660	90686	90715	

Process of Developing Preventive Services Portion of Rate

At a high level, the methodology used to develop the percentage of the capitation rates attributable to preventive services consisted of the following steps:

- Pull encounter data for each preventive service separately by region, category of aid (COA), rate cell (RC), and category of service (COS) based on logic detailed in the above section.
- Using these dollars, summarize the per member per month (PMPM) values for all preventive services in aggregate at the region, COA, RC and COS level.
- Develop projected preventive services PMPMs by applying appropriate program change adjustments and trend factors to the preventive services base data PMPMs.

- Develop projected preventive services Full Medicaid Pricing (FMP) PMPM add-on by calculating a base FMP PMPM add-on and applying appropriate program change adjustments and trend factors.
- Summarize total projected preventive services PMPMs by adding together the claims cost and FMP add-on PMPMs at the region, COA and RC level.
- Calculate the percentage of the capitation rates attributable to preventive services by dividing the preventive services projected PMPM by the capitation rate PMPMs at the region, COA and RC level.

Base Data

As stated earlier, Mercer used expense data incurred from April 1, 2017 through March 31, 2018 processed through September 2018. The data selected for the preventive service PMPM calculations satisfied the criteria detailed in the above section.

Since the additional 1.0% FMAP does not apply to Title XXI enrollees, Mercer removed preventive services expenses associated with these members from our preventive services base data.

Consistent with April 1, 2019 Healthy Louisiana Expansion rate development, the following adjustments are reflected in the base data:

- Provision for incurred but not reported claims
- Financial adjustments to encounter data for under-reporting

Program Changes

Program change adjustments recognize the impact of benefit or eligibility changes occurring during and after the base data period. Centers for Medicare & Medicaid Services (CMS) requires the rate development methodology used to determine actuarially sound rates incorporates the results of any programmatic changes that have taken place, or are anticipated to take place, between the start of the base period and the conclusion of the contract period. Mercer reviewed the program change adjustments applied in April 1, 2019 Healthy Louisiana Expansion rate development and determined the following adjustments applied to the preventive services base:

- Inpatient Hospital fee schedule changes
- Outpatient Hospital fee schedule changes

These adjustments were applied to be consistent with the adjustments applied in April 1, 2019 Healthy Louisiana Expansion rate development. For a complete discussion of these program change adjustments, please refer to the Healthy Louisiana April 1, 2019 Expansion rate certification letter.

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 services in a future period. Using

historical plan experience, industry trends, and consideration for commercial health care trends, Mercer developed trend ranges to project the base data to the April 1, 2019 through December 31, 2019 time period. The trends applied in the development of preventive services PMPMs are consistent with those that were applied to the populations in April 1, 2019 Healthy Louisiana Expansion rate development.

The annual PMPM trend for the preventive services was 4.3%.

Mercer reviewed the population and benefit packages and determined that no adjustments outside of those mentioned above were required for preventive services.

FMP

Mercer calculated FMP add-on for eligible Inpatient hospital, Outpatient hospital and Physician services that satisfy the preventive service logic. We then applied provisions for incurred but not reported (IBNR) claims and financial adjustments to encounter data for under-reporting. We trended these dollars to the April 1, 2019 through December 31, 2019 time period using the trends applied in the April 1, 2019 Healthy Louisiana Expansion rate development. For full detail on the FMP calculation, please refer to the April 1, 2019 Healthy Louisiana Expansion rate certification.

Development of the Percentage of the Capitation Rates Attributable to Preventive Services

The projected preventive services claims cost and FMP add-on PMPMs were added together to generate the total preventive services PMPM LDH could claim at the enhanced rate. This total projected preventive services PMPM was divided by the April 1, 2019 capitation rate to determine the percentage of the capitation rate attributable to preventive services. The calculation was performed at the region, COA and RC level.

Attachment B within this addendum displays the percentage of the capitation rates that are attributable to preventive services. These percentages should be applied directly to capitation rates to determine the preventive services amount. The resulting amount does not include load for premium tax, administration or underwriting gain.

Limitations and Considerations

In preparing these calculations, Mercer has used and relied upon enrollment, encounter data and other information supplied by LDH and its fiscal intermediary. LDH and its fiscal intermediary 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 it. In our opinion, it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in the attached exhibits may need to be revised accordingly. Use of this information for any purposes beyond that stated may not be appropriate.

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B	65 to 75 years	Male	76700 76705 76770 76775 G0389	Z87.891 F17.200 F17.201 F17.210 F17.211 F17.220 F17.221 F17.290 F17.291	V15.82 305.1	Include
Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B	18 years or older	Male or Female	99401 - 99404 99411 - 99412 99408 99409 G0442 G0443 G0396 G0397	Z71.41 Z71.42 Z71.51 Z71.52 Z71.6	V65.42	Include for procedure codes 99401-99404 and 99411-99412; Exclude for procedure codes 99408 - 99409 and G-codes
Anemia Screening: Pregnant Women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.	B	No restrictions	Female	85004 85007 85008 85009 85013 85014 85018 85025 85027 85032 85041 82728 G0306 G0307	Z34.00 - Z34.93 O09.**** O10.011 - O16.9 O20.0 - O29.93	V22.x - V23.9	Include
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	No restrictions	Female	81007 87077 87086 87181 87088	Z34.00 - Z34.93 O09.**** O10.011 - O16.9 O20.0 - O29.93	V22.x - V23.9	Include
High Blood Pressure Screening in Adults	The USPSTF recommends screening for high blood pressure in adults age 18 years and older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A	18 years or older	Male or Female	99201 - 99205 99211 - 99215	Z13.6	V81.1 V81.2	Include
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.	B	No restrictions	Female	81211 81212 81213 81214 81215 81216 81217 81162 96040 G0452 S0265	Z80.3 Z80.41 Z15.01 Z15.02	V16.3 V16.41 V84.01 V84.02	Include

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Breast cancer screening	The USPSTF recommends biennial screening mammography for women aged 50 to 74 years.	B	50 to 74 years	Female	77052 77055 77056 77057 77063 77065 77066 77067 G0202			Exclude
Breastfeeding: Primary Care Intervention	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.	B	No restrictions	Female	99201 - 99215 S9443	Z39.1 O92.3 O91.011 - O91.23 O92.011 - O92.79 Q83.0 - Q83.9 P92.1 P92.2 P92.3 P92.4 P92.5 P92.8 P92.9 R63.3	V24.1 676.4 675.xx 676.xx 684 757.6 779.31 783.3	Include for procedure codes 99201-99215; Exclude for procedure code S9443
Cervical Cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years	A	21 to 65 years	Female	G0101 G0123 G0124 G0141 G0143 G0144 G0145 G0147 G0148 P3000 P3001 Q0091 87623 87624 87625 88141 88142 88143 88147 88148 88150 88152 88153 88154 88155 88164 88165 88166 88167 88174 88175			Exclude

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	No restrictions	Female	86631 86632 87081 87110 87205 87270 87320 87490 87491 87492 87810			Exclude
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders	A	35 years or older	Male	80061 82465 83718 83719 83721 84478			Exclude
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men ages 20 to 34 years for lipid disorders if they are at increased risk for coronary heart disease.	B	20 to 34 years	Male	80061 82465 83718 83719 83721 84478	Z13.6	V81.0 V81.1 V81.2	Include
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease	A	45 years or older	Female	80061 82465 83718 83719 83721 84478	Z13.6	V81.0 V81.1 V81.2	Include
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women ages 20 to 44 years for lipid disorders if they are at increased risk for coronary heart disease.	B	20 to 44 years	Female	80061 82465 83718 83719 83721 84478	Z13.6	V81.0 V81.1 V81.2	Include

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	A	50 to 75 years	Male or Female	G0104 G0105 G0106 G0120 G0121 G0122 G0328 44389 44390 44391 44392 44393 44394 44397 44401 44402 45330 45331 45332 45333 45334 45338 45339 45346 45378 45379 45380 45381 45382 45383 45384 45385 45386 45387 45388 45389 45391 45392 74263 82270 82274 99152 99153	Z12.12 Z12.11	V76.41 V76.51	Include for Barium Enema G-codes (G0106, G0120, G0122); Exclude for all other procedure codes
Dental Caries in Children from Birth Through Age 5 Years: Screening	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.	B	6 months to 5 years	Male or Female	D1206 99188			Exclude
Depression Screening: Adult	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	18 years or older	Male or Female	G0444 99201 - 99215 99420 96160 96161	Z13.89	V79.0	Include

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Depression Screening: Adolescents	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 17 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	12 to 17 years	Male or Female	99201 - 99215 99420 96160 96161	Z23.89	V79.0	Include
Diabetes screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	B	40 to 70 years	Male or Female	82947 82948 82950 82951 82952 83036	E66.01 - E66.9 Z68.25 - Z68.29 Z68.30 - Z68.39 Z68.41 - Z68.45 R73.01 - R73.9	278.00 - 278.03 V85.2x V85.3x V85.4x 790.21 - 790.29	Include
Falls Prevention in Older Adults: Counseling and Preventive Medication	The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.	B	65 years or older	Male or Female	97001 97002 97110 97112 97113 97116 97161 - 97164 97750 97530 97799 G0159 G8990 G9131	Z91.81	V15.88	Include
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.	B	No restrictions	Female	82950 82951 82952	Z34.00 - Z34.93 O09.**** O10.011 - O16.9 O20.0 - O29.93	V22.x - V23.9	Include
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	No restriction	Female	87590 87591 87592 87801 87850			Exclude

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.	B	18 years or older	Male or Female	97802 97803 97804 99401 - 99404 99411 99412 G0270 G0271 S9470 G0446 G0447 G0473	E10.10 E10.11 E10.21 E10.311 E10.319 E10.36 E10.39 E10.40 E10.51 E10.65 E10.69 E10.8 E11.00 E11.01 E11.21 E11.311 E11.319 E11.36 E11.39 E11.40 E11.51 E11.65 E11.69 E11.8 E13.10 E66.09 E66.1 E66.8 E66.9 E66.01 E78.4 E78.5 F17.200 F17.201 F17.210 F17.211 F17.220 F17.221 F17.290 F17.291 F43.0 F78.2 I10 I21.9 I21.A I21.A9 I27.2 I27.20 I27.21 I27.22 I27.23 I27.24 I27.29 Z13.6 Z71.3 Z71.82 Z82.49 Z82.41	250.xx (5th digit is 2&3) 272.2 272.4 278.00 278.01 305.1 308.0 - 308.3 401.0 V17.3 V17.41 V17.49 V65.3 V81.2	Include

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Hearing Loss Screening: Newborns	The USPSTF recommends screening for hearing loss in all newborn infants.	B	(Newborn) 0 to 59 days	Male or Female	92551 92552 92558 92567 92586 V5008			Exclude
Hepatitis B screening: non-pregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.	B	No restrictions	Male or Female	86704 86705 86706 87340 87341 87350 87515 87516 87517 G0499	F11.10 - F11.99 F13.10 - F13.99 F14.10 - F14.99 F15.10 - F15.99 R74.0 Z20.2 Z20.5 Z20.6 Z21 Z22.4 Z22.50 - Z22.59 Z51.11 Z72.51 - Z72.53 Z94.0 - Z94.9 Z99.2	292.0 - 292.2 292.81 292.84 292.85 292.89 292.9 304.00 - 304.03 304.10 - 304.13 304.20 - 304.23 304.40 - 304.43 305.40 - 305.43 305.50 - 305.53 305.60 - 305.63 307.70 - 305.73 790.4 V01.6 V01.79 V02.7 V02.8 V02.60 - V02.9 V06 V42.0 - V42.9 V45.11 V58.11 V69.2	Include
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A	No restrictions	Female	86704 86705 86706 87340 87341 87350 87380	Z34.00 - Z34.93 O09.**** O10.011 - O16.9 O20.0 - O29.93	V22.x - V23.9	Include
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	B	No restrictions	Male or Female	86803 86804 87520 87521 87522 G0472	B20 B97.35 D65 - D69.9 F11.10 - F11.99 F13.10 - F13.99 F14.10 - F14.99 F15.10 - F15.99 T80.61X* Z20.5 Z22.50 - Z22.59 Z94.0 - Z94.9 Z99.2	042 079.53 286.0 - 287.9 289.81 - 289.82 292.0 - 292.9 304.00 - 304.03 304.10 - 304.13 304.20 - 304.23 305.40 - 305.43 305.50 - 305.53 305.60 - 305.63 305.70 - 305.73 999.51 V01.79 V42.0 - V42.7 V45.11	Include

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
HIV screening: adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	A	15 to 65 years	Male or Female	86689 86701 86702 86703 87389 87390 87391 87534 87535 87536 87537 87538 87539 87806 G0432 G0433 G0435 G0475 S3645			Exclude
Hypothyroidism Screening: Newborns	Note: USPSTF defers to the HRSA Advisory Committee on Heritable Disorders in Newborns and Children, which recommends the uniform screening panel for core conditions.	A	(Newborn) 0 to 59 days	Male or Female	84436 84437 84439 84443			Exclude
Intimate Partner Violence Screening: Women of Childbearing Age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs for symptoms of abuse.	B	Childbearing Age: 12 to 55 years	Female	99201 - 99205 99211 - 99215	T74.91XA T76.91XA T74.11XA T76.11XA T74.31XA T76.31XA T74.21XA T76.21XA T74.01XA T76.01XA T74.91XA T76.91XA	995.80 995.81 995.82 995.83 995.84 995.85	Include
Latent Tuberculosis Infection: Screening	The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.	B	No restrictions	Male or Female	86480 86481 86580 87116 87555 87556	Z59.0 Z59.3 Z11.1 Z20.1	V60.0 V60.6 V74.1 V01.1	Include
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B	55 to 80 years	Male or Female	S8032 G0296 G0297 71250 71260 71270 71275	F17.200 F17.201 F17.210 F17.211 F17.220 F17.221 F17.290 F17.291 Z87.891 Z12.2	305.1 V15.82 V76.0	Include

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Obesity in Adults: Screening and Management	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m2 or higher to intensive, multicomponent, behavioral interventions.	B	18 years or older	Male or Female	G0446 G0447 96150 96151 96152 96153 96154 96155 97802 97803 97804 99401 - 99404	Z13.89 E66.01 - E66.9 Z68.30 - Z68.39 Z68.41 - Z68.45	V77.8 278.00 - 278.03 V85.3x V85.4x	Include for all other procedure codes; Exclude for G-codes
Obesity Screening and Counseling: Children	The USPSTF recommends that clinicians screen children ages 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	B	6 to 17 years	Male or Female	99401 - 99404 96150 96151 96152 96153 96154 96155 97802 97803 97804	Z13.89 E66.01 - E66.9 Z68.54	V77.8 278.00 - 278.03 V85.54	Include
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	B	No restrictions	Female	76977 77078 77080 77081 77082 77085 77086 78350 78351 G0130			Exclude
Phenylketonuria Screening: Newborns	The USPSTF recommends screening for phenylketonuria in newborns.	B	(Newborn) 0 to 59 days	Male or Female	84030			Exclude
Rh(D) incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	No restrictions	Female	86900 86901	Z34.00 - Z34.93 O09.**** O10.011 - O16.9 O20.0 - O29.93	V22.x - V23.9	Include
Rh(D) incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B			Captured in above criteria	Captured in above criteria	Captured in above criteria	Captured in above criteria
Sexually Transmitted Infections Counseling	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) in all sexually active adolescents and for adults at increased risk for STIs.	B	No restrictions	Male or Female	99401 - 99404 99411 - 99412	Z72.89 Z11.3	V65.45 V69.8 V74.5	Include
Sickle Cell Disease (Hemoglobinopathies) in Newborns: Screening	Note: USPSTF defers to the HRSA Advisory Committee on Heritable Disorders in Newborns and Children, which recommends the uniform screening panel for core conditions.	A	(Newborn) 0 to 59 days	Male or Female	83020 83021 83030 83033 83051			Exclude
Syphilis screening: non-pregnant adults and adolescents	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A	No restrictions	Male or Female	86592 86593 87164 87166 87285			Exclude

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco. The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.	A	No restrictions	Male or Female	99078 99401 - 99404 99411 - 99412 99406 99407 96150 - 96155 G0436 G0437 S9453	Z87.891 F17.200 F17.201 F17.210 F17.211 F17.220 F17.221 F17.290 F17.291	V15.82 305.1	Include for procedure codes 99401-99404, 99411 - 99412, 96150-96155 and 99078; Exclude for procedure codes 99406, 99407, S9453, G0436, and G0437
Tobacco Use Interventions: children and adolescents	The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B	5 to 17 years	Male or Female	Captured in above criteria	Captured in above criteria	Captured in above criteria	Captured in above criteria
Visual acuity screening in children	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.	B	3 to 5 years	Male or Female	99172 99173 99174			Exclude

Region Description	Category of Aid Description	Rate Cell Description	Preventive Services %
Gulf	Medicaid Expansion	Age 19 - 64	1.20%
Gulf	Medicaid Expansion	High Needs	1.41%
Capital	Medicaid Expansion	Age 19 - 64	1.05%
Capital	Medicaid Expansion	High Needs	1.03%
South Central	Medicaid Expansion	Age 19 - 64	0.96%
South Central	Medicaid Expansion	High Needs	0.35%
North	Medicaid Expansion	Age 19 - 64	1.14%
North	Medicaid Expansion	High Needs	1.01%

APPENDIX E: PETSCANS ADJUSTMENT

Exhibit 1: PET Scan Procedure Codes and Fee Schedule

CPT/HCPCS CODE	DESCRIPTION	Technical Component	Physician Component	Total
78811	PET LIMITED AREA	$ 910.40	$ 364.16	$ 1,274.56
78812	PET SKULL-MID THIGH	$ 922.79	$ 369.12	$ 1,291.91
78813	PET WHOLE BODY	$ 925.94	$ 370.38	$ 1,296.32
78814	PET/CT LIMITED AREA	$ 933.54	$ 373.42	$ 1,306.96
78815	PET/CT SKULL-MID THIGH	$ 941.97	$ 376.79	$ 1,318.76
78816	PET/CT WHOLE BODY	$ 942.87	$ 377.15	$ 1,320.02
78608	PET BRAIN IMAGING	$ 906.30	$ 362.52	$ 1,268.82
78609	PET BRAIN IMAGING	$ 905.96	$ 362.38	$ 1,268.34
A9552	FLUORODEOXYGLUCOSE (Tracer for scan)	$ 162.74	$ -	$ 162.74
High-Cost Code Average		**$ 939.46**	**$ 375.79**	**$ 1,315.25**
Total Average Cost (High-Cost Avg + Tracer cost)		**$ 1,102.20**	**$ 375.79**	**$ 1,477.99**

Notes:

1. Unit costs are sourced from Louisiana's fee schedule website effective 2/1/2018.

Exhibit 2: Estimated Cancer Patients

[A][1]	[B]	] = [A]/([B]/(1,000*1	[D]	[E] = [C]*[D]/(1,000*12)
Cancer Patient ID Count	**MMs**	**Cancer Ptnt/1000 Enrollee**	**RY19 Projected MMs**	**RY19 Projected Cancer Patients**
9,334	5,196,640	21.55	6,687,382	12,012

Notes:

1. Cancer patients were identified using diagnosis codes for cancers that commonly use PET scan imaging. The count is a unique count of eligibility IDs over the time period specified.
2. Figures above include experience for the Medicaid Expansion Age 19 - 64 rate cell between 4/1/2017 - 3/31/2018.

Exhibit 3: Estimated Utilization and Final Costs

[A][1]	Selected Util/1000	3.00
[B]	RY19 Projected XP Age 19-64 MMs	6,687,382
[C] = [A]*([B]/(1,000*12))	Total PET Scan XP Age 19 - 64 Units	1,672

Population	RY19 Projected MMs	RY19 Est. Cancer Patient Count	Cancer Patient Count Dist.	Est. RY19 PET Scan Units	Unit Cost	PET Scan Cost	PET Scan PMPM
Expansion Age 19 - 64	6,687,382	12,012	100.0%	1,672	$ 1,477.99	$ 2,470,965	$ 0.37
Expansion High Needs	1,218	N/A	N/A	N/A	N/A	N/A	$ 2.92

Notes:

1. Util/1000 was selected based on various sources.
2. Expansion High Needs is using SSI Adult PMPM adjustment.

APPENDIX F: CONTINUOUS GLUCOSE MONITORS ADJUSTMENT

Table 1: Continuous Glucose Monitors Fees			
CPT Code	**Description**	**Fee**	**Annualized Cost**
A9276	Sensor; invasive (e.g. subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day supply. The above description is abbreviated. (Sensor 4pkg with 7 day life)	$ 300	$ 3,600
A9277	Transmitter; external, for use with interstitial continuous glucose monitoring system	$ 519	$ 519
A9278	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system	$ 488	$ 488
Annual Cost Projection			**$ 4,607**

Table 2: Continuous Glucose Monitors Adjustment				
Population	**Projected Users [1]**	**Penetration Rate**	**Annualized Fee**	**Total Annualized Projected Cost**
Expansion Age 19 - 64	2,318	30.0%	$4,607	$3,203,471

Notes:

1. Projected users were calculated using SFY17 data and restricted to recipients with Type I diabetes with insulin dependence.

APPENDIX G: SINGLE PDL ADJUSTMENT

4.1.19 Expansion Single PDL and Pharmacy Rebates								
Category of Aid	Rate Cell	Projected MMs	Base Rx PMPM	Single PDL Unit Cost Adj.		Pharmacy Rebate Adjustment		
				Gross [4]	Net [5]	Pre-PDL	Post-PDL	Net
Medicaid Expansion	Age 19 - 64	6,687,382	$ 93.78	0.71%	0.63%	-4.60%	-0.50%	-0.96%
Medicaid Expansion	High Needs	1,218	$ 330.78	0.71%	0.63%	-4.60%	-0.50%	-0.96%

Notes:

1. Base PMPMs reflect adjustments for under-reporting and IBNR.
2. Expansion base data consists of the time period 4/1/2017 - 3/31/2018.
3. Single PDL is effective 5/1/2019; therefore, the impact has been pro-rated for the 5/1/2019 - 12/31/2019 period.
4. The "Gross" column represents the Single PDL Unit Cost adjustment for a 12 month period.
5. The "Net" column represents the prorated Single PDL unit cost adjustment for the 5/1/2019-12/31/2019 effective period.

APPENDIX H: LOCAL PHARMACY ADJUSTMENT

4.1.19 Expansion Cost of Dispensing and AAC to NADAC Adjustments									
Category of Aid	Rate Cell	Projected MMs	Base Rx PMPM [1]	Local Pharmacy % of Base	Local Pharmacy Adj. Percentages (Gross) [3]			Rating Adjustments	
					NADAC	Disp. Fee	Total	Gross	Net
Medicaid Expansion	Age 19 - 64	6,687,382	$ 93.78	24.64%	0.76%	0.75%	1.51%	0.37%	0.33%
Medicaid Expansion	High Needs	1,218	$ 330.78	35.63%	0.76%	0.75%	1.51%	0.51%	0.45%

Notes:

1. Base PMPMs reflect adjustments for underreporting and IBNR.
2. Expansion base data consists of the time period 4/1/2017 - 3/31/2018.
3. Adjustments are based on an analysis performed by Myers and Stauffer dated December 4, 2018.

APPENDIX I: WAGE VERIFICATION DISENROLLMENT ADJUSTMENT

APPENDIX I: WAGE VERIFICATION DISENROLLMENT ADJUSTMENT

Enrollment Detail

	CY19 Expansion Enrollment Projections [1]												4/1/19 - 12/31/19 MMs Projections		
Region	January	February	March	April	May	June	July	August	September	October	November	December	Original	Revised	% Chg
Gulf	152,466	152,204	152,555	142,711	142,711	142,711	142,711	142,711	142,711	142,711	142,711	142,711	1,372,995	1,284,400	-6.5%
Capital	115,199	115,463	116,249	109,787	109,787	109,787	109,787	109,787	109,787	109,787	109,787	109,787	1,046,241	988,082	-5.6%
South Central	126,127	126,473	127,013	120,162	120,162	120,162	120,162	120,162	120,162	120,162	120,162	120,162	1,143,117	1,081,460	-5.4%
North	101,118	101,285	101,568	95,884	95,884	95,884	95,884	95,884	95,884	95,884	95,884	95,884	914,112	862,952	-5.6%
Statewide	**494,910**	**495,425**	**497,385**	**468,544**	**468,544**	**468,544**	**468,544**	**468,544**	**468,544**	**468,544**	**468,544**	**468,544**	**4,476,465**	**4,216,894**	**-5.8%**

Re-enrollment Lag Estimates										
Percent Re-enrolled:	1.7% [2]	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

	Re-enrollments by Month									
Disenrolled Members [4]	April	May	June	July	August	September	October	November	December	Re-enrolled MMs
10,014	170	0	0	0	0	0	0	0	0	1,532
6,574	112	0	0	0	0	0	0	0	0	1,006
6,969	118	0	0	0	0	0	0	0	0	1,066
5,783	98	0	0	0	0	0	0	0	0	885
29,340	**499**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4,489**

Adjustment Development

	Continuously Enrolled		Disenrolled (Total)		Re-enrolled		Preliminary 4/1/19		Wage Verification Disenrollment Adj.		
Region	MMs	PMPM [5]	MMs	PMPM [5]	MMs	PMPM [5]	MMs	PMPM [5]	MMs	PMPM [5]	% Chg
Gulf	1,282,868	$ 295.55	90,127	$ 207.55	1,532	$ 207.55	1,372,995	$ 289.77	1,284,400	$ 295.45	2.0%
Capital	987,076	$ 347.99	59,165	$ 266.11	1,006	$ 266.11	1,046,241	$ 343.36	988,082	$ 347.91	1.3%
South Central	1,080,393	$ 300.77	62,724	$ 197.80	1,066	$ 197.80	1,143,117	$ 295.12	1,081,460	$ 300.66	1.9%
North	862,068	$ 280.76	52,044	$ 201.88	885	$ 201.88	914,112	$ 276.27	862,952	$ 280.68	1.6%
Statewide	**4,212,405**	**$ 306.15**	**264,060**	**$ 217.24**	**4,489**	**$ 217.24**	**4,476,465**	**$ 300.90**	**4,216,894**	**$ 306.05**	**1.7%**

Notes:

1. The member months displayed for January - March 2019 are actual enrollment. Member months for April - December are assumed to be constant after accounting for any terminations and re-enrollments in April.
2. The re-enrollment percentage is based on weekly reports provided by LDH through May 19, 2019.
3. The values above only apply to the Expansion, age 19 - 64 rate cell.
4. The disenrolled member counts are based on information provided by LDH on April 11, 2019 that was collected as-of April 3, 2019.
5. The PMPMs displayed are based on encounters incurred 4/1/2017 - 3/31/2018 with runout through 9/30/2018 and do not contain any rate development adjustments (such as Under-reporting, IBNR, Trend, etc.).

Attachment D2

MERCER

APPENDIX J: IN LIEU OF SERVICES

Table 1a: Base Year Expense

		Categories of Covered Services that Contain In-Lieu-of Services/Settings			
		Inpatient	Outpatient	Physician	Specialized Behavioral Health
In-lieu-of Services/Settings	Covered Services Provided in Skilled Nursing Facilities	$ 2,419,590	$ 291	$ 194	$ 588,205
	Crisis Stabilization Units for All Medicaid Eligible Adults				$ -
	Inpatient Treatment Provided to Adults age 21 to 64 in an IMD for a short term stay of no more than 15 days				$ 26,929,020
	Psychiatric Intensive Outpatient Program		$ -		
	In-lieu-of Services/Settings Subtotal	**$ 2,419,590**	**$ 291**	**$ 194**	**$ 27,517,225**
	State Plan Services/Settings	**$ 203,399,137**	**$ 407,380,899**	**$ 227,619,063**	**$ 143,866,855**
	All Services/Settings	**$ 205,818,728**	**$ 407,381,190**	**$ 227,619,257**	**$ 171,384,080**

Table 1b: Percentage of Cost that In-lieu-of Services Represent in each Category of Service

	[A]	[B]	[C] = [B]/[A]
Category of Service	COS Total	In-Lieu-Of Services Total	In-Lieu-Of Services Percentage
Inpatient	$ 205,818,728	$ 2,419,590	1.2%
Outpatient	$ 407,381,190	$ 291	0.0%
Physician	$ 227,619,257	$ 194	0.0%
Specialized Behavioral Health	$ 171,384,080	$ 27,517,225	16.1%

Attachment D2

APPENDIX K: RETROACTIVE ELIGIBILTY ADJUSTMENT

	Base Data (Raw)			Base Data (Completed & Underreporting)			Retro Claims			Final Retro Factors
MOS	MMs	Expenses	PMPM	MMs	Expenses	PMPM	MMs	Expenses	PMPM	Retro/Raw Base
Q3 2016	825,004	$ 189,384,853	$ 229.56	825,004	$ 189,384,853	$ 229.56	78,423	$ 25,483,842	$ 324.95	1.0361
Q4 2016	987,498	$ 244,899,569	$ 248.00	987,498	$ 244,899,569	$ 248.00	74,715	$ 27,986,850	$ 374.58	1.0359
Q1 2017	1,162,533	$ 326,299,960	$ 280.68	1,162,533	$ 327,167,516	$ 281.43	42,694	$ 17,978,888	$ 421.11	1.0177
Q2 2017	1,244,491	$ 362,603,621	$ 291.37	1,244,491	$ 394,064,983	$ 316.65	24,591	$ 16,974,376	$ 690.27	1.0265
Q3 2017	1,266,889	$ 380,245,174	$ 300.14	1,266,889	$ 415,057,350	$ 327.62	31,130	$ 24,783,071	$ 796.12	1.0396
Q4 2017	1,327,651	$ 405,739,950	$ 305.61	1,327,651	$ 447,625,875	$ 337.16	19,774	$ 10,575,139	$ 534.80	1.0110
Q1 2018	1,357,609	$ 423,525,331	$ 311.96	1,357,609	$ 475,308,698	$ 350.11	34,191	$ 23,771,121	$ 695.24	1.0302
Q2 2018	1,386,097	$ 457,552,113	$ 330.10	1,386,097	$ 491,123,135	$ 354.32	29,556	$ 21,769,588	$ 736.55	1.0257
Base Year	**5,196,640**	**$ 1,572,114,075**	**$ 302.53**	**5,196,640**	**$ 1,732,056,906**	**$ 333.30**	**109,686**	**$ 76,103,707**	**$ 693.83**	**1.0267**

Notes:

1. Base Year includes experience between 4/1/2017–3/31/2018.
2. The figures above represent Medicaid Expansion Age 19–64.

APPENDIX L: RATE COMPARISON

			1/1/19 Rates			4/1/19 Rates		
Region	Category of Aid	Rate Cell	Lower Bound PMPM or Cost per Delivery	Final PMPM or Cost per Delivery [1]	Upper Bound PMPM or Cost per Delivery	Lower Bound PMPM or Cost per Delivery	Final PMPM or Cost per Delivery [1]	Upper Bound PMPM or Cost per Delivery
Gulf	Medicaid Expansion	Age 19–64	$ 531.05	$ 531.59	$ 570.18	$ 561.40	$ 561.96	$ 598.39
Gulf	Medicaid Expansion	High Needs	$ 1,569.15	$ 1,569.15	$ 1,745.34	$ 1,096.62	$ 1,096.62	$ 1,174.76
Capital	Medicaid Expansion	Age 19–64	$ 561.50	$ 562.09	$ 603.63	$ 642.34	$ 643.00	$ 685.68
Capital	Medicaid Expansion	High Needs	$ 1,682.94	$ 1,682.94	$ 1,875.27	$ 1,568.65	$ 1,568.65	$ 1,672.06
South Central	Medicaid Expansion	Age 19–64	$ 512.27	$ 512.81	$ 551.18	$ 567.51	$ 568.09	$ 605.49
South Central	Medicaid Expansion	High Needs	$ 1,529.05	$ 1,529.05	$ 1,706.23	$ 2,665.68	$ 2,665.68	$ 2,848.02
North	Medicaid Expansion	Age 19–64	$ 483.65	$ 484.16	$ 520.26	$ 512.80	$ 513.34	$ 548.16
North	Medicaid Expansion	High Needs	$ 1,451.92	$ 1,451.92	$ 1,619.75	$ 1,401.63	$ 1,401.63	$ 1,502.89

Notes:

1. Where applicable, final rates have been adjusted to account for the portion of contractual withholds that Mercer has determined to not be reasonably attainable.

APPENDIX M: RATE DEVELOPMENT PACKAGE

Region:	Gulf
Rate Cell:	Medicaid Expansion Age 19 - 64
Member Months:	1,659,407
Base Period:	April 1, 2017 through March 31, 2018

	Raw Base Data					Base Adjustments		Final Base Data		
Category of Service	Dollars	Units	Util/1000	Unit Cost	PMPM	UR	IBNR	Util/1000	Unit Cost	PMPM
Inpatient Hospital	$ 57,473,488	45,655	330	$ 1,258.87	$ 34.63	7.17%	2.35%	362	$ 1,258.87	$ 37.99
Outpatient Hospital	$ 61,019,965	800,914	5,792	$ 76.19	$ 36.77	7.00%	3.75%	6,429	$ 76.19	$ 40.82
Primary Care	$ 30,333,264	400,823	2,899	$ 75.68	$ 18.28	7.22%	1.75%	3,162	$ 75.68	$ 19.94
Specialty Care	$ 29,564,489	194,864	1,409	$ 151.72	$ 17.82	7.11%	1.68%	1,535	$ 151.72	$ 19.40
FQHC/RHC	$ 2,007,851	27,091	196	$ 74.12	$ 1.21	8.23%	1.27%	215	$ 74.12	$ 1.33
EPSDT	$ 469,603	5,524	40	$ 85.01	$ 0.28	7.33%	1.73%	44	$ 85.01	$ 0.31
Certified Nurse Practitioners/Clinical Nurse	$ 2,181,693	17,945	130	$ 121.58	$ 1.31	7.14%	1.68%	141	$ 121.58	$ 1.43
Lab/Radiology	$ 20,203,869	947,937	6,855	$ 21.31	$ 12.18	7.18%	1.73%	7,474	$ 21.31	$ 13.28
Home Health	$ 849,266	6,219	45	$ 136.56	$ 0.51	6.39%	1.69%	49	$ 136.56	$ 0.55
Emergency Transportation	$ 2,313,347	14,634	106	$ 158.08	$ 1.39	8.78%	2.45%	118	$ 158.08	$ 1.55
Non-Emergency Transportation	$ 5,511,403	111,648	807	$ 49.36	$ 3.32	6.69%	2.41%	882	$ 49.36	$ 3.63
Rehabilitation Services (OT, PT, ST)	$ 159,656	1,116	8	$ 143.06	$ 0.10	5.73%	1.84%	9	$ 143.06	$ 0.10
DME	$ 4,960,706	517,778	3,744	$ 9.58	$ 2.99	6.75%	1.81%	4,070	$ 9.58	$ 3.25
Clinic	$ 1,447,104	7,210	52	$ 200.71	$ 0.87	6.97%	1.76%	57	$ 200.71	$ 0.95
Family Planning	$ 1,568,998	8,915	64	$ 176.00	$ 0.95	7.41%	1.72%	70	$ 176.00	$ 1.03
Other	$ 332,737	11,572	84	$ 28.75	$ 0.20	5.95%	1.33%	90	$ 28.75	$ 0.22
Prescribed Drugs	$ 151,716,245	2,233,893	16,154	$ 67.92	$ 91.43	9.15%	0.00%	17,633	$ 67.92	$ 99.80
Emergency Room	$ 61,232,416	288,850	2,089	$ 211.99	$ 36.90	7.26%	3.77%	2,325	$ 211.99	$ 41.07
Basic Behavioral Health	$ 2,199,520	35,799	259	$ 61.44	$ 1.33	7.27%	1.62%	282	$ 61.44	$ 1.44
Hospice	$ 567,959	55	0	$ 10,326.53	$ 0.34	7.32%	2.40%	0	$ 10,326.53	$ 0.38
Personal Care Services	$ 230	16	0	$ 14.37	$ 0.00	5.54%	0.51%	0	$ 14.37	$ 0.00
Inpatient Services -- Mental Health	$ 18,141,981	32,696	236	$ 554.87	$ 10.93	6.99%	2.57%	259	$ 554.87	$ 12.00
Emergency Room -- Mental Health	$ 113,688	244	2	$ 465.94	$ 0.07	6.95%	2.04%	2	$ 465.94	$ 0.07
Professional/Other -- Mental Health	$ 30,718,128	1,035,290	7,487	$ 29.67	$ 18.51	7.08%	2.48%	8,216	$ 29.67	$ 20.31
Gross Medical Total	**$ 485,087,607**	**6,746,688**			**$ 292.33**	**7.76%**	**1.86%**			**$ 320.86**

Notes:

1. Base Period on this sheet represents experience having occurred from April 1, 2017 to March 31, 2018.
2. In some cases totals may not equal the sum of their respective column components due to rounding.

Attachment D2

Region:	Capital
Rate Cell:	Medicaid Expansion Age 19 - 64
Member Months:	1,161,317
Base Period:	April 1, 2017 through March 31, 2018

	Raw Base Data					Base Adjustments		Final Base Data		
Category of Service	Dollars	Units	Util/1000	Unit Cost	PMPM	UR	IBNR	Util/1000	Unit Cost	PMPM
Inpatient Hospital	$ 57,021,626	41,127	425	$ 1,386.48	$ 49.10	7.17%	2.43%	467	$ 1,386.48	$ 53.90
Outpatient Hospital	$ 52,015,330	694,004	7,171	$ 74.95	$ 44.79	7.24%	3.73%	7,978	$ 74.95	$ 49.83
Primary Care	$ 22,270,883	313,248	3,237	$ 71.10	$ 19.18	7.37%	1.74%	3,536	$ 71.10	$ 20.95
Specialty Care	$ 23,066,760	168,021	1,736	$ 137.28	$ 19.86	7.38%	1.73%	1,897	$ 137.28	$ 21.70
FQHC/RHC	$ 927,377	12,408	128	$ 74.74	$ 0.80	7.95%	1.13%	140	$ 74.74	$ 0.87
EPSDT	$ 440,046	4,426	46	$ 99.42	$ 0.38	7.91%	1.72%	50	$ 99.42	$ 0.42
Certified Nurse Practitioners/Clinical Nurse	$ 1,760,587	14,314	148	$ 123.00	$ 1.52	7.28%	1.67%	161	$ 123.00	$ 1.65
Lab/Radiology	$ 14,329,302	623,566	6,443	$ 22.98	$ 12.34	7.39%	1.79%	7,043	$ 22.98	$ 13.49
Home Health	$ 962,325	3,929	41	$ 244.93	$ 0.83	6.06%	1.32%	44	$ 244.93	$ 0.89
Emergency Transportation	$ 2,200,438	16,577	171	$ 132.74	$ 1.89	8.70%	2.36%	191	$ 132.74	$ 2.11
Non-Emergency Transportation	$ 6,124,431	96,890	1,001	$ 63.21	$ 5.27	6.84%	2.36%	1,095	$ 63.21	$ 5.77
Rehabilitation Services (OT, PT, ST)	$ 340,397	5,226	54	$ 65.14	$ 0.29	5.71%	1.98%	58	$ 65.14	$ 0.32
DME	$ 4,036,938	670,338	6,927	$ 6.02	$ 3.48	7.12%	1.85%	7,557	$ 6.02	$ 3.79
Clinic	$ 994,569	4,239	44	$ 234.62	$ 0.86	7.30%	1.90%	48	$ 234.62	$ 0.94
Family Planning	$ 1,202,845	6,508	67	$ 184.83	$ 1.04	7.57%	1.71%	74	$ 184.83	$ 1.13
Other	$ 402,713	20,138	208	$ 20.00	$ 0.35	6.02%	1.39%	224	$ 20.00	$ 0.37
Prescribed Drugs	$ 115,712,840	1,848,327	19,099	$ 62.60	$ 99.64	9.70%	0.00%	20,952	$ 62.60	$ 109.30
Emergency Room	$ 51,963,677	214,046	2,212	$ 242.77	$ 44.75	7.33%	3.69%	2,462	$ 242.77	$ 49.80
Basic Behavioral Health	$ 1,654,132	28,448	294	$ 58.15	$ 1.42	7.42%	1.66%	321	$ 58.15	$ 1.56
Hospice	$ 595,456	48	0	$ 12,405.34	$ 0.51	7.11%	2.38%	1	$ 12,405.34	$ 0.56
Personal Care Services	$ -	-	-	$ -	$ -	0.00%	0.00%	-	$ -	$ -
Inpatient Services -- Mental Health	$ 16,765,666	28,789	297	$ 582.36	$ 14.44	7.06%	2.48%	326	$ 582.36	$ 15.84
Emergency Room -- Mental Health	$ 150,907	404	4	$ 373.53	$ 0.13	7.11%	2.11%	5	$ 373.53	$ 0.14
Professional/Other -- Mental Health	$ 25,919,263	772,656	7,984	$ 33.55	$ 22.32	7.16%	2.50%	8,769	$ 33.55	$ 24.51
Gross Medical Total	**$ 400,858,507**	**5,587,677**			**$ 345.18**	**7.95%**	**1.94%**			**$ 379.84**

Notes:

1. Base Period on this sheet represents experience having occurred from April 1, 2017 to March 31, 2018.
2. In some cases totals may not equal the sum of their respective column components due to rounding.

Attachment D2

MERCER

Region:	South Central
Rate Cell:	Medicaid Expansion Age 19 - 64
Member Months:	1,311,351
Base Period:	April 1, 2017 through March 31, 2018

	Raw Base Data					Base Adjustments		Final Base Data		
Category of Service	Dollars	Units	Util/1000	Unit Cost	PMPM	UR	IBNR	Util/1000	Unit Cost	PMPM
Inpatient Hospital	$ 47,982,669	42,010	384	$ 1,142.17	$ 36.59	7.99%	2.38%	425	$ 1,142.17	$ 40.46
Outpatient Hospital	$ 49,262,340	713,049	6,525	$ 69.09	$ 37.57	7.72%	3.75%	7,292	$ 69.09	$ 41.98
Primary Care	$ 25,651,335	346,034	3,167	$ 74.13	$ 19.56	7.95%	1.76%	3,479	$ 74.13	$ 21.49
Specialty Care	$ 23,538,704	154,821	1,417	$ 152.04	$ 17.95	7.83%	1.71%	1,554	$ 152.04	$ 19.69
FQHC/RHC	$ 1,581,084	18,492	169	$ 85.50	$ 1.21	7.63%	1.09%	184	$ 85.50	$ 1.31
EPSDT	$ 393,448	4,384	40	$ 89.75	$ 0.30	8.11%	1.66%	44	$ 89.75	$ 0.33
Certified Nurse Practitioners/Clinical Nurse	$ 1,765,270	15,377	141	$ 114.80	$ 1.35	7.79%	1.66%	154	$ 114.80	$ 1.48
Lab/Radiology	$ 14,368,351	667,079	6,104	$ 21.54	$ 10.96	7.83%	1.80%	6,700	$ 21.54	$ 12.03
Home Health	$ 511,617	8,567	78	$ 59.72	$ 0.39	7.37%	1.78%	86	$ 59.72	$ 0.43
Emergency Transportation	$ 3,337,329	25,006	229	$ 133.46	$ 2.54	9.30%	2.32%	256	$ 133.46	$ 2.85
Non-Emergency Transportation	$ 7,783,617	104,070	952	$ 74.79	$ 5.94	7.21%	2.38%	1,045	$ 74.79	$ 6.51
Rehabilitation Services (OT, PT, ST)	$ 65,006	324	3	$ 200.64	$ 0.05	5.97%	2.09%	3	$ 200.64	$ 0.05
DME	$ 4,532,142	571,431	5,229	$ 7.93	$ 3.46	8.04%	1.83%	5,752	$ 7.93	$ 3.80
Clinic	$ 891,204	4,258	39	$ 209.30	$ 0.68	8.08%	1.80%	43	$ 209.30	$ 0.75
Family Planning	$ 995,633	11,481	105	$ 86.72	$ 0.76	8.12%	1.71%	116	$ 86.72	$ 0.83
Other	$ 370,117	20,599	188	$ 17.97	$ 0.28	6.34%	1.70%	204	$ 17.97	$ 0.31
Prescribed Drugs	$ 102,834,258	2,158,556	19,753	$ 47.64	$ 78.42	10.73%	0.00%	21,873	$ 47.64	$ 86.84
Emergency Room	$ 55,917,735	294,293	2,693	$ 190.01	$ 42.64	7.87%	3.69%	3,012	$ 190.01	$ 47.70
Basic Behavioral Health	$ 2,986,241	52,612	481	$ 56.76	$ 2.28	7.99%	1.67%	529	$ 56.76	$ 2.50
Hospice	$ 833,580	53	0	$ 15,727.92	$ 0.64	7.83%	2.40%	1	$ 15,727.92	$ 0.70
Personal Care Services	$ 8,217	3,248	30	$ 2.53	$ 0.01	11.12%	1.82%	34	$ 2.53	$ 0.01
Inpatient Services -- Mental Health	$ 17,767,820	32,247	295	$ 550.99	$ 13.55	7.52%	2.61%	326	$ 550.99	$ 14.95
Emergency Room -- Mental Health	$ 156,057	608	6	$ 256.67	$ 0.12	5.67%	0.95%	6	$ 256.67	$ 0.13
Professional/Other -- Mental Health	$ 26,517,890	743,035	6,799	$ 35.69	$ 20.22	7.63%	2.54%	7,504	$ 35.69	$ 22.32
Gross Medical Total	**$ 390,051,662**	**5,991,634**			**$ 297.44**	**8.57%**	**2.01%**			**$ 329.42**

Notes:

1. Base Period on this sheet represents experience having occurred from April 1, 2017 to March 31, 2018.
2. In some cases totals may not equal the sum of their respective column components due to rounding.

Attachment D2

Region:	North
Rate Cell:	Medicaid Expansion Age 19 - 64
Member Months:	1,064,565
Base Period:	April 1, 2017 through March 31, 2018

	Raw Base Data					Base Adjustments		Final Base Data		
Category of Service	Dollars	Units	Util/1000	Unit Cost	PMPM	UR	IBNR	Util/1000	Unit Cost	PMPM
Inpatient Hospital	$ 40,830,006	35,746	403	$ 1,142.23	$ 38.35	7.63%	2.47%	444	$ 1,142.23	$ 42.30
Outpatient Hospital	$ 37,071,384	636,252	7,172	$ 58.27	$ 34.82	7.41%	3.72%	7,990	$ 58.27	$ 38.79
Primary Care	$ 24,385,644	315,469	3,556	$ 77.30	$ 22.91	7.63%	1.75%	3,895	$ 77.30	$ 25.09
Specialty Care	$ 15,998,946	110,417	1,245	$ 144.90	$ 15.03	7.42%	1.70%	1,360	$ 144.90	$ 16.42
FQHC/RHC	$ 2,481,883	30,734	346	$ 80.75	$ 2.33	8.04%	1.34%	379	$ 80.75	$ 2.55
EPSDT	$ 308,274	3,395	38	$ 90.80	$ 0.29	7.58%	1.73%	42	$ 90.80	$ 0.32
Certified Nurse Practitioners/Clinical Nurse	$ 1,181,879	9,433	106	$ 125.29	$ 1.11	7.50%	1.64%	116	$ 125.29	$ 1.21
Lab/Radiology	$ 13,044,709	613,392	6,914	$ 21.27	$ 12.25	7.30%	1.77%	7,550	$ 21.27	$ 13.38
Home Health	$ 299,365	3,536	40	$ 84.66	$ 0.28	6.95%	1.92%	43	$ 84.66	$ 0.31
Emergency Transportation	$ 1,694,579	9,105	103	$ 186.12	$ 1.59	8.81%	2.43%	114	$ 186.12	$ 1.77
Non-Emergency Transportation	$ 4,642,399	84,120	948	$ 55.19	$ 4.36	6.98%	2.38%	1,039	$ 55.19	$ 4.78
Rehabilitation Services (OT, PT, ST)	$ 82,470	163	2	$ 505.95	$ 0.08	6.06%	2.01%	2	$ 505.95	$ 0.08
DME	$ 3,851,826	900,907	10,155	$ 4.28	$ 3.62	7.28%	1.86%	11,097	$ 4.28	$ 3.95
Clinic	$ 597,582	2,480	28	$ 240.96	$ 0.56	7.22%	2.02%	31	$ 240.96	$ 0.61
Family Planning	$ 952,883	10,593	119	$ 89.95	$ 0.90	7.34%	1.69%	130	$ 89.95	$ 0.98
Other	$ 265,471	17,471	197	$ 15.19	$ 0.25	6.14%	1.61%	212	$ 15.19	$ 0.27
Prescribed Drugs	$ 73,352,704	1,586,440	17,883	$ 46.24	$ 68.90	9.91%	0.00%	19,654	$ 46.24	$ 75.73
Emergency Room	$ 38,686,377	191,745	2,161	$ 201.76	$ 36.34	7.40%	3.73%	2,408	$ 201.76	$ 40.48
Basic Behavioral Health	$ 1,745,141	25,563	288	$ 68.27	$ 1.64	7.64%	1.62%	315	$ 68.27	$ 1.79
Hospice	$ 372,595	47	1	$ 7,927.55	$ 0.35	7.21%	2.55%	1	$ 7,927.55	$ 0.38
Personal Care Services	$ -	-	-	$ -	$ -	0.00%	0.00%	-	$ -	$ -
Inpatient Services -- Mental Health	$ 8,763,415	16,249	183	$ 539.32	$ 8.23	7.18%	2.66%	202	$ 539.32	$ 9.06
Emergency Room -- Mental Health	$ 89,939	338	4	$ 266.09	$ 0.08	7.26%	1.96%	4	$ 266.09	$ 0.09
Professional/Other -- Mental Health	$ 25,416,828	998,731	11,258	$ 25.45	$ 23.88	7.36%	2.51%	12,391	$ 25.45	$ 26.28
Gross Medical Total	**$ 296,116,299**	**5,602,326**			**$ 278.16**	**8.05%**	**2.02%**			**$ 306.63**

Notes:

1. Base Period on this sheet represents experience having occurred from April 1, 2017 to March 31, 2018.
2. In some cases totals may not equal the sum of their respective column components due to rounding.

Attachment D2

Region:	Statewide
Rate Cell:	Medicaid Expansion Age 19 - 64
Member Months:	5,196,640
Base Period:	April 1, 2017 through March 31, 2018

	Raw Base Data					Base Adjustments		Final Base Data		
Category of Service	Dollars	Units	Util/1000	Unit Cost	PMPM	UR	IBNR	Util/1000	Unit Cost	PMPM
Inpatient Hospital	$ 203,307,789	164,538	380	$ 1,235.63	$ 39.12	7.46%	2.41%	418	$ 1,235.36	$ 43.05
Outpatient Hospital	$ 199,369,019	2,844,219	6,568	$ 70.10	$ 38.36	7.31%	3.74%	7,313	$ 70.09	$ 42.71
Primary Care	$ 102,641,126	1,375,574	3,176	$ 74.62	$ 19.75	7.53%	1.75%	3,476	$ 74.62	$ 21.61
Specialty Care	$ 92,168,898	628,123	1,450	$ 146.74	$ 17.74	7.42%	1.71%	1,585	$ 146.74	$ 19.38
FQHC/RHC	$ 6,998,195	88,725	205	$ 78.88	$ 1.35	7.99%	1.23%	224	$ 78.87	$ 1.47
EPSDT	$ 1,611,372	17,729	41	$ 90.89	$ 0.31	7.73%	1.71%	45	$ 90.90	$ 0.34
Certified Nurse Practitioners/Clinical Nurse	$ 6,889,429	57,069	132	$ 120.72	$ 1.33	7.41%	1.67%	144	$ 120.71	$ 1.45
Lab/Radiology	$ 61,946,230	2,851,974	6,586	$ 21.72	$ 11.92	7.40%	1.77%	7,198	$ 21.72	$ 13.03
Home Health	$ 2,622,573	22,251	51	$ 117.86	$ 0.50	6.52%	1.60%	56	$ 117.45	$ 0.55
Emergency Transportation	$ 9,545,691	65,322	151	$ 146.13	$ 1.84	8.95%	2.38%	168	$ 146.12	$ 2.05
Non-Emergency Transportation	$ 24,061,850	396,728	916	$ 60.65	$ 4.63	6.95%	2.38%	1,003	$ 60.67	$ 5.07
Rehabilitation Services (OT, PT, ST)	$ 647,529	6,829	16	$ 94.82	$ 0.12	5.79%	1.96%	17	$ 94.86	$ 0.13
DME	$ 17,381,612	2,660,454	6,143	$ 6.53	$ 3.34	7.29%	1.84%	6,713	$ 6.53	$ 3.65
Clinic	$ 3,930,459	18,187	42	$ 216.11	$ 0.76	7.35%	1.84%	46	$ 216.13	$ 0.83
Family Planning	$ 4,720,360	37,497	87	$ 125.89	$ 0.91	7.59%	1.71%	95	$ 125.83	$ 0.99
Other	$ 1,371,038	69,780	161	$ 19.65	$ 0.26	6.11%	1.50%	174	$ 19.64	$ 0.28
Prescribed Drugs	$ 443,616,047	7,827,216	18,074	$ 56.68	$ 85.37	9.79%	0.00%	19,859	$ 56.63	$ 93.72
Emergency Room	$ 207,800,204	988,934	2,284	$ 210.13	$ 39.99	7.47%	3.72%	2,546	$ 210.09	$ 44.57
Basic Behavioral Health	$ 8,585,034	142,422	329	$ 60.28	$ 1.65	7.62%	1.65%	360	$ 60.27	$ 1.81
Hospice	$ 2,369,590	203	0	$ 11,672.86	$ 0.46	7.43%	2.42%	1	$ 11,677.17	$ 0.50
Personal Care Services	$ 8,447	3,264	8	$ 2.59	$ 0.00	10.97%	1.78%	9	$ 2.58	$ 0.00
Inpatient Services -- Mental Health	$ 61,438,882	109,981	254	$ 558.63	$ 11.82	7.19%	2.57%	279	$ 558.61	$ 13.00
Emergency Room -- Mental Health	$ 510,591	1,594	4	$ 320.32	$ 0.10	6.67%	1.71%	4	$ 320.88	$ 0.11
Professional/Other -- Mental Health	$ 108,572,109	3,549,712	8,197	$ 30.59	$ 20.89	7.30%	2.51%	9,015	$ 30.59	$ 22.98
Gross Medical Total	**$ 1,572,114,075**	**23,928,325**			**$ 302.53**	**8.06%**	**1.95%**			**$ 333.29**

Notes:

1. Base Period on this sheet represents experience having occurred from April 1, 2017 to March 31, 2018.
2. In some cases totals may not equal the sum of their respective column components due to rounding.

Attachment D2

RY 2019 Projected Member Months
Medicaid Expansion Age 19 - 64
2,118,672

	Base Midpoint	Contract Midpoint
	October 1, 2017	August 15, 2019
Contract Period	April 1, 2019 to December 31, 2019	
Trend Months	22.5	

Gulf	Final Base Data			Base Program Changes	Annual Medical Trends	Prospective Rating Adjustments	Projected Medical Expenses		
Category of Service	Util/1000	Unit Cost	PMPM	PMPM Percentage	PMPM Percentage	PMPM Percentage	Util/1000	Unit Cost	PMPM
Inpatient Hospital	362	$ 1,258.87	$ 37.99	0.00%	1.53%	9.12%	367	$ 1,393.32	$ 42.65
Outpatient Hospital	6,429	$ 76.19	$ 40.82	0.00%	1.18%	33.51%	6,500	$ 102.84	$ 55.71
Primary Care	3,162	$ 75.68	$ 19.94	0.00%	7.96%	4.87%	3,398	$ 85.27	$ 24.14
Specialty Care	1,535	$ 151.72	$ 19.40	-0.01%	7.96%	5.01%	1,649	$ 171.17	$ 23.52
FQHC/RHC	215	$ 74.12	$ 1.33	0.00%	7.96%	4.69%	231	$ 83.37	$ 1.60
EPSDT	44	$ 85.01	$ 0.31	0.00%	7.96%	5.13%	47	$ 96.03	$ 0.38
Certified Nurse Practitioners/Clinical Nurse	141	$ 121.58	$ 1.43	0.00%	7.96%	4.75%	152	$ 136.84	$ 1.73
Lab/Radiology	7,474	$ 21.31	$ 13.28	0.00%	6.17%	4.72%	7,906	$ 23.61	$ 15.55
Home Health	49	$ 136.56	$ 0.55	0.00%	6.17%	4.68%	51	$ 151.21	$ 0.65
Emergency Transportation	118	$ 158.08	$ 1.55	-0.03%	-0.36%	5.14%	118	$ 165.59	$ 1.62
Non-Emergency Transportation	882	$ 49.36	$ 3.63	-0.32%	-0.36%	4.89%	879	$ 51.44	$ 3.77
Rehabilitation Services (OT, PT, ST)	9	$ 143.06	$ 0.10	0.00%	6.17%	5.79%	9	$ 160.10	$ 0.12
DME	4,070	$ 9.58	$ 3.25	0.00%	6.17%	4.80%	4,305	$ 10.62	$ 3.81
Clinic	57	$ 200.71	$ 0.95	0.00%	7.96%	4.68%	61	$ 225.74	$ 1.15
Family Planning	70	$ 176.00	$ 1.03	0.00%	7.96%	10.43%	76	$ 208.82	$ 1.32
Other	90	$ 28.75	$ 0.22	0.00%	6.17%	4.68%	95	$ 31.84	$ 0.25
Prescribed Drugs	17,633	$ 67.92	$ 99.80	0.43%	6.72%	4.59%	17,989	$ 78.99	$ 118.42
Emergency Room	2,325	$ 211.99	$ 41.07	-0.03%	1.18%	8.54%	2,351	$ 232.56	$ 45.56
Basic Behavioral Health	282	$ 61.44	$ 1.44	-0.12%	7.96%	4.70%	303	$ 69.03	$ 1.74
Hospice	0	$ 10,326.53	$ 0.38	0.00%	1.53%	7.32%	0	$ 11,240.80	$ 0.42
Personal Care Services	0	$ 14.37	$ 0.00	0.00%	6.17%	4.68%	0	$ 15.91	$ 0.00
Inpatient Services -- Mental Health	259	$ 554.87	$ 12.00	3.80%	4.44%	20.77%	279	$ 702.11	$ 16.32
Emergency Room -- Mental Health	2	$ 465.94	$ 0.07	-0.54%	8.98%	6.09%	2	$ 532.91	$ 0.09
Professional/Other -- Mental Health	8,216	$ 29.67	$ 20.31	-0.08%	8.98%	4.73%	8,906	$ 33.66	$ 24.98
Gross Medical Total			**$ 320.86**	**0.26%**	**4.82%**	**9.72%**			**$ 385.50**

Notes:

1. Final Base Data on this sheet represents experience having occurred from April 1, 2017 to March 31, 2018.
2. Trend Period on this sheet represents experience time period from October 1, 2017 to August 15, 2019.
3. Contract Period on this sheet represents experience time period from April 1, 2019 to December 31, 2019.
4. In some cases totals may not equal the sum of their respective column components due to rounding.
5. Statewide rollups are based on RY 2019 Projected Member Months.

Credibility Adjustment PMPM	**$ -**
% Credibility Adjustment	0.00%
PET Scans Adjustment	**$ 0.37**
% of Final Projected Medical	0.10%
FQHC/RHC Adjustment	**$ 0.34**
% of Final Projected Medical	0.09%
CGM Adjustment	**$ 0.48**
% of Final Projected Medical	0.12%
Final Projected Medical	**$ 386.70**
Administrative Expenses PMPM	**$ 32.73**
% of Final Projected Medical	8.46%
Underwriting Gain PMPM	**$ 6.76**
% of Limited Premium	1.50%
Lower Bound Limited Capitation Rate	**$ 426.19**
Premium Based Taxes	5.50%
Final Lower Bound Limited Capitation Rate	**$ 450.99**

Attachment D2

MERCER

RY 2019 Projected Member Months
Medicaid Expansion High Needs
300

	Base Midpoint	Contract Midpoint
	October 1, 2017	August 15, 2019
Contract Period	April 1, 2019 to December 31, 2019	
Trend Months	22.5	

Gulf	Final Base Data			Base Program Changes	Annual Medical Trends	Prospective Rating Adjustments	Projected Medical Expenses		
Category of Service	Util/1000	Unit Cost	PMPM	PMPM Percentage	PMPM Percentage	PMPM Percentage	Util/1000	Unit Cost	PMPM
Inpatient Hospital	45	$ 1,137.35	$ 4.23	0.00%	1.53%	0.00%	45	$ 1,153.62	$ 4.35
Outpatient Hospital	13,117	$ 136.92	$ 149.67	0.00%	1.18%	7.48%	13,262	$ 148.80	$ 164.45
Primary Care	3,721	$ 73.27	$ 22.72	0.00%	7.96%	-0.01%	3,999	$ 78.71	$ 26.23
Specialty Care	1,446	$ 157.49	$ 18.97	0.00%	7.96%	0.00%	1,553	$ 169.22	$ 21.90
FQHC/RHC	180	$ 69.23	$ 1.04	0.00%	7.96%	0.00%	193	$ 74.39	$ 1.20
EPSDT	-	$ -	$ -	0.00%	7.96%	0.00%	-	$ -	$ -
Certified Nurse Practitioners/Clinical Nurse	273	$ 145.41	$ 3.30	0.00%	7.96%	0.00%	293	$ 156.24	$ 3.81
Lab/Radiology	7,945	$ 21.93	$ 14.52	0.00%	6.17%	0.00%	8,404	$ 23.20	$ 16.25
Home Health	-	$ -	$ -	0.00%	6.17%	0.00%	-	$ -	$ -
Emergency Transportation	236	$ 143.36	$ 2.82	0.00%	-0.36%	0.00%	235	$ 142.88	$ 2.80
Non-Emergency Transportation	3,028	$ 39.86	$ 10.06	0.00%	-0.36%	0.00%	3,018	$ 39.73	$ 9.99
Rehabilitation Services (OT, PT, ST)	-	$ -	$ -	0.00%	6.17%	0.00%	-	$ -	$ -
DME	454	$ 66.16	$ 2.50	0.00%	6.17%	0.00%	480	$ 69.99	$ 2.80
Clinic	-	$ -	$ -	0.00%	7.96%	0.00%	-	$ -	$ -
Family Planning	90	$ 23.56	$ 0.18	0.00%	7.96%	9.79%	96	$ 27.79	$ 0.22
Other	-	$ -	$ -	0.00%	6.17%	0.00%	-	$ -	$ -
Prescribed Drugs	26,792	$ 141.66	$ 316.29	0.36%	6.72%	-0.25%	27,333	$ 157.03	$ 357.67
Emergency Room	3,890	$ 197.20	$ 63.92	0.00%	1.18%	3.75%	3,933	$ 206.86	$ 67.80
Basic Behavioral Health	227	$ 117.45	$ 2.23	0.00%	7.96%	0.00%	244	$ 126.19	$ 2.57
Hospice	-	$ -	$ -	0.00%	1.53%	0.00%	-	$ -	$ -
Personal Care Services	-	$ -	$ -	0.00%	6.17%	0.00%	-	$ -	$ -
Inpatient Services -- Mental Health	1,673	$ 530.13	$ 73.90	6.42%	4.44%	19.43%	1,798	$ 680.07	$ 101.89
Emergency Room -- Mental Health	-	$ -	$ -	0.00%	8.98%	0.00%	-	$ -	$ -
Professional/Other -- Mental Health	19,658	$ 27.48	$ 45.02	0.00%	8.98%	0.00%	21,309	$ 29.79	$ 52.90
Gross Medical Total			**$ 731.38**	**0.80%**	**4.96%**	**3.67%**			**$ 836.84**

Notes:

1. Final Base Data on this sheet represents experience having occurred from April 1, 2017 to March 31, 2018.
2. Trend Period on this sheet represents experience time period from October 1, 2017 to August 15, 2019.
3. Contract Period on this sheet represents experience time period from April 1, 2019 to December 31, 2019.
4. In some cases totals may not equal the sum of their respective column components due to rounding.
5. Statewide rollups are based on RY 2019 Projected Member Months.

Credibility Adjustment PMPM	**$ -**
% Credibility Adjustment	0.00%
PET Scans Adjustment	**$ 2.92**
% of Final Projected Medical	0.35%
FQHC/RHC Adjustment	**$ 0.41**
% of Final Projected Medical	0.05%
CGM Adjustment	**$ 0.48**
% of Final Projected Medical	0.06%
Final Projected Medical	**$ 840.65**
Administrative Expenses PMPM	**$ 50.38**
% of Final Projected Medical	5.99%
Underwriting Gain PMPM	**$ 14.37**
% of Limited Premium	1.50%
Lower Bound Limited Capitation Rate	**$ 905.41**
Premium Based Taxes	5.50%
Final Lower Bound Limited Capitation Rate	**$ 958.10**

Attachment D2

MERCER

RY 2019 Projected Member Months
Medicaid Expansion Age 19 - 64
1,519,852

	Base Midpoint	Contract Midpoint
	October 1, 2017	August 15, 2019
Contract Period	April 1, 2019 to December 31, 2019	
Trend Months	22.5	

Capital	Final Base Data			Base Program Changes	Annual Medical Trends	Prospective Rating Adjustments	Projected Medical Expenses		
Category of Service	Util/1000	Unit Cost	PMPM	PMPM Percentage	PMPM Percentage	PMPM Percentage	Util/1000	Unit Cost	PMPM
Inpatient Hospital	467	$ 1,386.48	$ 53.90	0.00%	1.53%	12.46%	473	$ 1,581.54	$ 62.36
Outpatient Hospital	7,978	$ 74.95	$ 49.83	0.00%	1.18%	30.26%	8,066	$ 98.71	$ 66.35
Primary Care	3,536	$ 71.10	$ 20.95	-0.01%	7.96%	4.42%	3,799	$ 79.76	$ 25.25
Specialty Care	1,897	$ 137.28	$ 21.70	-0.02%	7.96%	4.43%	2,038	$ 154.01	$ 26.16
FQHC/RHC	140	$ 74.74	$ 0.87	0.00%	7.96%	4.02%	150	$ 83.54	$ 1.05
EPSDT	50	$ 99.42	$ 0.42	0.00%	7.96%	5.36%	54	$ 112.55	$ 0.51
Certified Nurse Practitioners/Clinical Nurse	161	$ 123.00	$ 1.65	0.00%	7.96%	4.25%	173	$ 137.77	$ 1.99
Lab/Radiology	7,043	$ 22.98	$ 13.49	0.00%	6.17%	4.13%	7,450	$ 25.31	$ 15.72
Home Health	44	$ 244.93	$ 0.89	0.00%	6.17%	4.03%	46	$ 269.54	$ 1.04
Emergency Transportation	191	$ 132.74	$ 2.11	-0.04%	-0.36%	4.53%	190	$ 138.23	$ 2.19
Non-Emergency Transportation	1,095	$ 63.21	$ 5.77	-0.29%	-0.36%	4.19%	1,091	$ 65.45	$ 5.95
Rehabilitation Services (OT, PT, ST)	58	$ 65.14	$ 0.32	0.00%	6.17%	4.11%	62	$ 71.73	$ 0.37
DME	7,557	$ 6.02	$ 3.79	0.00%	6.17%	4.05%	7,993	$ 6.63	$ 4.42
Clinic	48	$ 234.62	$ 0.94	0.00%	7.96%	4.06%	51	$ 262.33	$ 1.12
Family Planning	74	$ 184.83	$ 1.13	0.00%	7.96%	9.74%	79	$ 217.93	$ 1.44
Other	224	$ 20.00	$ 0.37	0.00%	6.17%	4.07%	237	$ 22.01	$ 0.43
Prescribed Drugs	20,952	$ 62.60	$ 109.30	0.49%	6.72%	4.06%	21,374	$ 72.49	$ 129.12
Emergency Room	2,462	$ 242.77	$ 49.80	-0.04%	1.18%	6.84%	2,489	$ 262.13	$ 54.37
Basic Behavioral Health	321	$ 58.15	$ 1.56	-0.12%	7.96%	4.08%	345	$ 64.94	$ 1.87
Hospice	1	$ 12,405.34	$ 0.56	0.00%	1.53%	7.30%	1	$ 13,501.32	$ 0.62
Personal Care Services	-	$ -	$ -	0.00%	6.17%	4.03%	-	$ -	$ -
Inpatient Services -- Mental Health	326	$ 582.36	$ 15.84	3.96%	4.44%	19.51%	351	$ 730.30	$ 21.35
Emergency Room -- Mental Health	5	$ 373.53	$ 0.14	-0.75%	8.98%	3.87%	5	$ 417.42	$ 0.17
Professional/Other -- Mental Health	8,769	$ 33.55	$ 24.51	-0.08%	8.98%	4.09%	9,506	$ 37.82	$ 29.96
Gross Medical Total			**$ 379.84**	**0.29%**	**4.60%**	**9.49%**			**$ 453.78**

Notes:

1. Final Base Data on this sheet represents experience having occurred from April 1, 2017 to March 31, 2018.
2. Trend Period on this sheet represents experience time period from October 1, 2017 to August 15, 2019.
3. Contract Period on this sheet represents experience time period from April 1, 2019 to December 31, 2019.
4. In some cases totals may not equal the sum of their respective column components due to rounding.
5. Statewide rollups are based on RY 2019 Projected Member Months.

Credibility Adjustment PMPM	**$ -**
% Credibility Adjustment	0.00%
PET Scans Adjustment	**$ 0.37**
% of Final Projected Medical	0.08%
FQHC/RHC Adjustment	**$ 0.19**
% of Final Projected Medical	0.04%
CGM Adjustment	**$ 0.54**
% of Final Projected Medical	0.12%
Final Projected Medical	**$ 454.89**
Administrative Expenses PMPM	**$ 36.33**
% of Final Projected Medical	7.99%
Underwriting Gain PMPM	**$ 7.92**
% of Limited Premium	1.50%
Lower Bound Limited Capitation Rate	**$ 499.14**
Premium Based Taxes	5.50%
Final Lower Bound Limited Capitation Rate	**$ 528.19**

Attachment D2

RY 2019 Projected Member Months
Medicaid Expansion High Needs
493

	Base Midpoint	Contract Midpoint
	October 1, 2017	August 15, 2019
Contract Period	April 1, 2019 to December 31, 2019	
Trend Months	22.5	

Capital	Final Base Data			Base Program Changes	Annual Medical Trends	Prospective Rating Adjustments	Projected Medical Expenses		
Category of Service	Util/1000	Unit Cost	PMPM	PMPM Percentage	PMPM Percentage	PMPM Percentage	Util/1000	Unit Cost	PMPM
Inpatient Hospital	984	$ 1,459.15	$ 119.70	0.26%	1.53%	9.40%	998	$ 1,623.42	$ 135.08
Outpatient Hospital	23,222	$ 62.74	$ 121.41	0.26%	1.18%	36.74%	23,479	$ 86.96	$ 170.15
Primary Care	6,212	$ 79.77	$ 41.29	-0.62%	7.96%	0.00%	6,674	$ 85.18	$ 47.38
Specialty Care	4,048	$ 135.66	$ 45.76	0.26%	7.96%	0.00%	4,349	$ 146.14	$ 52.96
FQHC/RHC	212	$ 77.24	$ 1.36	0.26%	7.96%	0.00%	228	$ 83.20	$ 1.58
EPSDT	-	$ -	$ -	0.00%	7.96%	0.00%	-	$ -	$ -
Certified Nurse Practitioners/Clinical Nurse	307	$ 128.03	$ 3.28	0.26%	7.96%	0.00%	330	$ 137.92	$ 3.80
Lab/Radiology	16,676	$ 22.27	$ 30.95	0.26%	6.17%	0.00%	17,639	$ 23.62	$ 34.72
Home Health	-	$ -	$ -	0.00%	6.17%	0.00%	-	$ -	$ -
Emergency Transportation	1,087	$ 109.81	$ 9.95	0.26%	-0.36%	0.00%	1,083	$ 109.73	$ 9.90
Non-Emergency Transportation	6,682	$ 36.36	$ 20.25	-20.26%	-0.36%	0.00%	6,660	$ 28.90	$ 16.04
Rehabilitation Services (OT, PT, ST)	-	$ -	$ -	0.00%	6.17%	0.00%	-	$ -	$ -
DME	815	$ 60.11	$ 4.08	0.26%	6.17%	0.00%	862	$ 63.75	$ 4.58
Clinic	-	$ -	$ -	0.00%	7.96%	0.00%	-	$ -	$ -
Family Planning	67	$ 454.56	$ 2.54	0.26%	7.96%	5.26%	72	$ 515.43	$ 3.09
Other	202	$ 36.33	$ 0.61	0.26%	6.17%	0.00%	214	$ 38.53	$ 0.69
Prescribed Drugs	35,003	$ 86.20	$ 251.45	0.86%	6.72%	-0.20%	35,709	$ 96.09	$ 285.93
Emergency Room	4,394	$ 324.72	$ 118.91	0.26%	1.18%	5.51%	4,443	$ 347.30	$ 128.59
Basic Behavioral Health	695	$ 70.55	$ 4.08	0.26%	7.96%	0.00%	746	$ 76.00	$ 4.73
Hospice	-	$ -	$ -	0.00%	1.53%	0.00%	-	$ -	$ -
Personal Care Services	-	$ -	$ -	0.00%	6.17%	0.00%	-	$ -	$ -
Inpatient Services -- Mental Health	1,904	$ 519.51	$ 82.44	-33.80%	4.44%	26.40%	2,047	$ 438.82	$ 74.84
Emergency Room -- Mental Health	137	$ 116.20	$ 1.32	0.26%	8.98%	0.00%	148	$ 126.29	$ 1.56
Professional/Other -- Mental Health	34,687	$ 36.99	$ 106.91	0.26%	8.98%	0.00%	37,601	$ 40.20	$ 125.96
Gross Medical Total			**$ 966.30**	**-2.96%**	**4.71%**	**7.75%**			**$ 1,101.57**

Notes:

1. Final Base Data on this sheet represents experience having occurred from April 1, 2017 to March 31, 2018.
2. Trend Period on this sheet represents experience time period from October 1, 2017 to August 15, 2019.
3. Contract Period on this sheet represents experience time period from April 1, 2019 to December 31, 2019.
4. In some cases totals may not equal the sum of their respective column components due to rounding.
5. Statewide rollups are based on RY 2019 Projected Member Months.

Credibility Adjustment PMPM	**$ -**
% Credibility Adjustment	0.00%
PET Scans Adjustment	**$ 2.92**
% of Final Projected Medical	0.26%
FQHC/RHC Adjustment	**$ 0.75**
% of Final Projected Medical	0.07%
CGM Adjustment	**$ 0.54**
% of Final Projected Medical	0.05%
Final Projected Medical	**$ 1,105.78**
Administrative Expenses PMPM	**$ 70.36**
% of Final Projected Medical	6.36%
Underwriting Gain PMPM	**$ 18.97**
% of Limited Premium	1.50%
Lower Bound Limited Capitation Rate	**$ 1,195.11**
Premium Based Taxes	5.50%
Final Lower Bound Limited Capitation Rate	**$ 1,264.66**

Attachment D2

RY 2019 Projected Member Months
Medicaid Expansion Age 19 - 64
1,683,575

	Base Midpoint	Contract Midpoint
	October 1, 2017	August 15, 2019
Contract Period	April 1, 2019 to December 31, 2019	
Trend Months	22.5	

South Central	Final Base Data			Base Program Changes	Annual Medical Trends	Prospective Rating Adjustments	Projected Medical Expenses		
Category of Service	Util/1000	Unit Cost	PMPM	PMPM Percentage	PMPM Percentage	PMPM Percentage	Util/1000	Unit Cost	PMPM
Inpatient Hospital	425	$ 1,142.17	$ 40.46	0.00%	1.53%	13.01%	431	$ 1,309.25	$ 47.04
Outpatient Hospital	7,292	$ 69.09	$ 41.98	0.00%	1.18%	30.13%	7,373	$ 90.90	$ 55.85
Primary Care	3,479	$ 74.13	$ 21.49	-0.01%	7.96%	4.69%	3,737	$ 83.38	$ 25.97
Specialty Care	1,554	$ 152.04	$ 19.69	-0.01%	7.96%	4.79%	1,669	$ 171.16	$ 23.81
FQHC/RHC	184	$ 85.50	$ 1.31	0.00%	7.96%	4.52%	198	$ 96.02	$ 1.58
EPSDT	44	$ 89.75	$ 0.33	0.00%	7.96%	4.91%	47	$ 101.17	$ 0.40
Certified Nurse Practitioners/Clinical Nurse	154	$ 114.80	$ 1.48	0.00%	7.96%	4.69%	166	$ 129.13	$ 1.78
Lab/Radiology	6,700	$ 21.54	$ 12.03	0.00%	6.17%	4.66%	7,088	$ 23.85	$ 14.08
Home Health	86	$ 59.72	$ 0.43	0.00%	6.17%	4.61%	91	$ 66.09	$ 0.50
Emergency Transportation	256	$ 133.46	$ 2.85	-0.18%	-0.36%	5.44%	255	$ 140.00	$ 2.98
Non-Emergency Transportation	1,045	$ 74.79	$ 6.51	-0.28%	-0.36%	4.68%	1,042	$ 77.81	$ 6.76
Rehabilitation Services (OT, PT, ST)	3	$ 200.64	$ 0.05	0.00%	6.17%	5.01%	3	$ 222.87	$ 0.06
DME	5,752	$ 7.93	$ 3.80	0.00%	6.17%	4.60%	6,085	$ 8.78	$ 4.45
Clinic	43	$ 209.30	$ 0.75	0.00%	7.96%	4.60%	46	$ 235.23	$ 0.90
Family Planning	116	$ 86.72	$ 0.83	0.00%	7.96%	10.16%	124	$ 102.65	$ 1.06
Other	204	$ 17.97	$ 0.31	-0.03%	6.17%	4.60%	216	$ 19.87	$ 0.36
Prescribed Drugs	21,873	$ 47.64	$ 86.84	0.63%	6.72%	4.77%	22,314	$ 55.62	$ 103.43
Emergency Room	3,012	$ 190.01	$ 47.70	-0.03%	1.18%	5.67%	3,046	$ 202.95	$ 51.51
Basic Behavioral Health	529	$ 56.76	$ 2.50	-0.04%	7.96%	4.63%	568	$ 63.78	$ 3.02
Hospice	1	$ 15,727.92	$ 0.70	0.00%	1.53%	8.23%	1	$ 17,266.08	$ 0.78
Personal Care Services	34	$ 2.53	$ 0.01	0.00%	6.17%	4.60%	36	$ 2.80	$ 0.01
Inpatient Services -- Mental Health	326	$ 550.99	$ 14.95	4.18%	4.44%	21.92%	350	$ 706.43	$ 20.60
Emergency Room -- Mental Health	6	$ 256.67	$ 0.13	-0.14%	8.98%	11.22%	6	$ 309.00	$ 0.17
Professional/Other -- Mental Health	7,504	$ 35.69	$ 22.32	-0.07%	8.98%	4.70%	8,134	$ 40.48	$ 27.44
Gross Medical Total			**$ 329.42**	**0.34%**	**4.61%**	**9.69%**			**$ 394.53**

Notes:

1. Final Base Data on this sheet represents experience having occurred from April 1, 2017 to March 31, 2018.
2. Trend Period on this sheet represents experience time period from October 1, 2017 to August 15, 2019.
3. Contract Period on this sheet represents experience time period from April 1, 2019 to December 31, 2019.
4. In some cases totals may not equal the sum of their respective column components due to rounding.
5. Statewide rollups are based on RY 2019 Projected Member Months.

Credibility Adjustment PMPM	**$ -**
% Credibility Adjustment	0.00%
PET Scans Adjustment	**$ 0.37**
% of Final Projected Medical	0.09%
FQHC/RHC Adjustment	**$ 0.22**
% of Final Projected Medical	0.06%
CGM Adjustment	**$ 0.41**
% of Final Projected Medical	0.10%
Final Projected Medical	**$ 395.53**
Administrative Expenses PMPM	**$ 34.53**
% of Final Projected Medical	8.73%
Underwriting Gain PMPM	**$ 6.94**
% of Limited Premium	1.50%
Lower Bound Limited Capitation Rate	**$ 437.00**
Premium Based Taxes	5.50%
Final Lower Bound Limited Capitation Rate	**$ 462.44**

Attachment D2

RY 2019 Projected Member Months
Medicaid Expansion High Needs
231

	Base Midpoint	Contract Midpoint
	October 1, 2017	August 15, 2019
Contract Period	April 1, 2019 to December 31, 2019	
Trend Months	22.5	

South Central	Final Base Data			Base Program Changes	Annual Medical Trends	Prospective Rating Adjustments	Projected Medical Expenses		
Category of Service	Util/1000	Unit Cost	PMPM	PMPM Percentage	PMPM Percentage	PMPM Percentage	Util/1000	Unit Cost	PMPM
Inpatient Hospital	3,279	$ 1,758.39	$ 480.54	0.00%	1.53%	8.89%	3,326	$ 1,942.09	$ 538.33
Outpatient Hospital	9,483	$ 51.33	$ 40.56	0.00%	1.18%	17.20%	9,588	$ 60.82	$ 48.60
Primary Care	7,222	$ 66.33	$ 39.92	0.00%	7.96%	-0.47%	7,759	$ 70.93	$ 45.86
Specialty Care	3,201	$ 146.94	$ 39.19	0.00%	7.96%	-0.47%	3,439	$ 157.13	$ 45.03
FQHC/RHC	889	$ 89.72	$ 6.64	0.00%	7.96%	-1.70%	955	$ 94.76	$ 7.54
EPSDT	-	$ -	$ -	0.00%	7.96%	0.00%	-	$ -	$ -
Certified Nurse Practitioners/Clinical Nurse	194	$ 89.14	$ 1.44	0.00%	7.96%	-0.47%	208	$ 95.33	$ 1.65
Lab/Radiology	18,529	$ 20.93	$ 32.32	0.00%	6.17%	-0.22%	19,600	$ 22.09	$ 36.08
Home Health	-	$ -	$ -	0.00%	6.17%	0.00%	-	$ -	$ -
Emergency Transportation	1,857	$ 137.03	$ 21.20	0.00%	-0.36%	-0.47%	1,850	$ 135.93	$ 20.96
Non-Emergency Transportation	3,736	$ 66.35	$ 20.66	0.00%	-0.36%	-0.47%	3,724	$ 65.82	$ 20.43
Rehabilitation Services (OT, PT, ST)	-	$ -	$ -	0.00%	6.17%	0.00%	-	$ -	$ -
DME	-	$ -	$ -	0.00%	6.17%	0.00%	-	$ -	$ -
Clinic	-	$ -	$ -	0.00%	7.96%	0.00%	-	$ -	$ -
Family Planning	-	$ -	$ -	0.00%	7.96%	0.00%	-	$ -	$ -
Other	-	$ -	$ -	0.00%	6.17%	0.00%	-	$ -	$ -
Prescribed Drugs	38,435	$ 138.74	$ 444.37	0.34%	6.72%	1.56%	39,211	$ 156.55	$ 511.54
Emergency Room	5,199	$ 253.21	$ 109.70	0.00%	1.18%	-2.13%	5,256	$ 250.56	$ 109.76
Basic Behavioral Health	1,212	$ 68.98	$ 6.97	0.00%	7.96%	-0.47%	1,302	$ 73.77	$ 8.01
Hospice	-	$ -	$ -	0.00%	1.53%	0.00%	-	$ -	$ -
Personal Care Services	-	$ -	$ -	0.00%	6.17%	0.00%	-	$ -	$ -
Inpatient Services -- Mental Health	6,440	$ 684.34	$ 367.28	6.42%	4.44%	5.64%	6,922	$ 776.58	$ 447.94
Emergency Room -- Mental Health	62	$ 108.39	$ 0.56	0.00%	8.98%	-0.47%	67	$ 116.94	$ 0.66
Professional/Other -- Mental Health	17,366	$ 69.88	$ 101.13	0.00%	8.98%	-0.47%	18,825	$ 75.39	$ 118.27
Gross Medical Total			**$ 1,712.48**	**1.46%**	**4.34%**	**4.20%**			**$ 1,960.65**

Notes:

1. Final Base Data on this sheet represents experience having occurred from April 1, 2017 to March 31, 2018.
2. Trend Period on this sheet represents experience time period from October 1, 2017 to August 15, 2019.
3. Contract Period on this sheet represents experience time period from April 1, 2019 to December 31, 2019.
4. In some cases totals may not equal the sum of their respective column components due to rounding.
5. Statewide rollups are based on RY 2019 Projected Member Months.

Credibility Adjustment PMPM	**$ -**
% Credibility Adjustment	0.00%
PET Scans Adjustment	**$ 2.92**
% of Final Projected Medical	0.15%
FQHC/RHC Adjustment	**$ 0.39**
% of Final Projected Medical	0.02%
CGM Adjustment	**$ 0.41**
% of Final Projected Medical	0.02%
Final Projected Medical	**$ 1,964.36**
Administrative Expenses PMPM	**$ 107.23**
% of Final Projected Medical	5.46%
Underwriting Gain PMPM	**$ 33.41**
% of Limited Premium	1.50%
Lower Bound Limited Capitation Rate	**$ 2,105.01**
Premium Based Taxes	5.50%
Final Lower Bound Limited Capitation Rate	**$ 2,227.52**

Attachment D2

RY 2019 Projected Member Months
Medicaid Expansion Age 19 - 64
1,365,283

	Base Midpoint	Contract Midpoint
	October 1, 2017	August 15, 2019
Contract Period	April 1, 2019 to December 31, 2019	
Trend Months	22.5	

North	Final Base Data			Base Program Changes	Annual Medical Trends	Prospective Rating Adjustments	Projected Medical Expenses		
Category of Service	Util/1000	Unit Cost	PMPM	PMPM Percentage	PMPM Percentage	PMPM Percentage	Util/1000	Unit Cost	PMPM
Inpatient Hospital	444	$ 1,142.23	$ 42.30	0.00%	1.53%	11.67%	451	$ 1,293.80	$ 48.60
Outpatient Hospital	7,990	$ 58.27	$ 38.79	0.00%	1.18%	27.87%	8,078	$ 75.33	$ 50.71
Primary Care	3,895	$ 77.30	$ 25.09	0.00%	7.96%	4.32%	4,185	$ 86.65	$ 30.21
Specialty Care	1,360	$ 144.90	$ 16.42	-0.01%	7.96%	4.09%	1,461	$ 162.03	$ 19.73
FQHC/RHC	379	$ 80.75	$ 2.55	-0.01%	7.96%	4.18%	408	$ 90.39	$ 3.07
EPSDT	42	$ 90.80	$ 0.32	0.00%	7.96%	4.50%	45	$ 101.96	$ 0.38
Certified Nurse Practitioners/Clinical Nurse	116	$ 125.29	$ 1.21	0.00%	7.96%	4.38%	125	$ 140.52	$ 1.46
Lab/Radiology	7,550	$ 21.27	$ 13.38	0.00%	6.17%	4.39%	7,986	$ 23.48	$ 15.63
Home Health	43	$ 84.66	$ 0.31	0.00%	6.17%	4.31%	46	$ 93.41	$ 0.36
Emergency Transportation	114	$ 186.12	$ 1.77	-0.10%	-0.36%	4.71%	114	$ 194.04	$ 1.84
Non-Emergency Transportation	1,039	$ 55.19	$ 4.78	-0.23%	-0.36%	4.53%	1,035	$ 57.36	$ 4.95
Rehabilitation Services (OT, PT, ST)	2	$ 505.95	$ 0.08	0.00%	6.17%	4.31%	2	$ 558.23	$ 0.10
DME	11,097	$ 4.28	$ 3.95	0.00%	6.17%	4.31%	11,739	$ 4.72	$ 4.61
Clinic	31	$ 240.96	$ 0.61	0.00%	7.96%	4.56%	33	$ 270.70	$ 0.74
Family Planning	130	$ 89.95	$ 0.98	0.00%	7.96%	9.67%	140	$ 106.00	$ 1.24
Other	212	$ 15.19	$ 0.27	0.00%	6.17%	4.31%	225	$ 16.77	$ 0.31
Prescribed Drugs	19,654	$ 46.24	$ 75.73	0.54%	6.72%	4.43%	20,051	$ 53.76	$ 89.83
Emergency Room	2,408	$ 201.76	$ 40.48	-0.01%	1.18%	7.43%	2,434	$ 219.13	$ 44.45
Basic Behavioral Health	315	$ 68.27	$ 1.79	-0.10%	7.96%	4.43%	339	$ 76.52	$ 2.16
Hospice	1	$ 7,927.55	$ 0.38	0.00%	1.53%	5.24%	1	$ 8,462.25	$ 0.42
Personal Care Services	-	$ -	$ -	0.00%	6.17%	4.31%	-	$ -	$ -
Inpatient Services -- Mental Health	202	$ 539.32	$ 9.06	3.53%	4.44%	24.36%	217	$ 700.87	$ 12.65
Emergency Room -- Mental Health	4	$ 266.09	$ 0.09	0.00%	8.98%	4.50%	5	$ 301.44	$ 0.11
Professional/Other -- Mental Health	12,391	$ 25.45	$ 26.28	-0.03%	8.98%	4.34%	13,431	$ 28.78	$ 32.21
Gross Medical Total			**$ 306.63**	**0.23%**	**4.75%**	**9.10%**			**$ 365.78**

Notes:

1. Final Base Data on this sheet represents experience having occurred from April 1, 2017 to March 31, 2018.
2. Trend Period on this sheet represents experience time period from October 1, 2017 to August 15, 2019.
3. Contract Period on this sheet represents experience time period from April 1, 2019 to December 31, 2019.
4. In some cases totals may not equal the sum of their respective column components due to rounding.
5. Statewide rollups are based on RY 2019 Projected Member Months.

Credibility Adjustment PMPM	**$ -**
% Credibility Adjustment	0.00%
PET Scans Adjustment	**$ 0.37**
% of Final Projected Medical	0.10%
FQHC/RHC Adjustment	**$ 0.12**
% of Final Projected Medical	0.03%
CGM Adjustment	**$ 0.48**
% of Final Projected Medical	0.13%
Final Projected Medical	**$ 366.75**
Administrative Expenses PMPM	**$ 33.54**
% of Final Projected Medical	9.15%
Underwriting Gain PMPM	**$ 6.46**
% of Limited Premium	1.50%
Lower Bound Limited Capitation Rate	**$ 406.75**
Premium Based Taxes	5.50%
Final Lower Bound Limited Capitation Rate	**$ 430.42**

Attachment D2

MERCER

RY 2019 Projected Member Months
Medicaid Expansion High Needs
194

	Base Midpoint	Contract Midpoint
	October 1, 2017	August 15, 2019
Contract Period	April 1, 2019 to December 31, 2019	
Trend Months	22.5	

North	Final Base Data			Base Program Changes	Annual Medical Trends	Prospective Rating Adjustments	Projected Medical Expenses		
Category of Service	Util/1000	Unit Cost	PMPM	PMPM Percentage	PMPM Percentage	PMPM Percentage	Util/1000	Unit Cost	PMPM
Inpatient Hospital	497	$ 1,027.34	$ 42.58	0.00%	1.53%	8.90%	504	$ 1,134.74	$ 47.70
Outpatient Hospital	20,362	$ 101.38	$ 172.03	0.00%	1.18%	2.51%	20,587	$ 105.08	$ 180.27
Primary Care	4,396	$ 72.89	$ 26.70	0.00%	7.96%	-0.48%	4,724	$ 77.94	$ 30.68
Specialty Care	1,307	$ 157.32	$ 17.14	0.00%	7.96%	17.85%	1,404	$ 199.21	$ 23.31
FQHC/RHC	129	$ 92.15	$ 0.99	0.00%	7.96%	-0.48%	139	$ 98.54	$ 1.14
EPSDT	-	$ -	$ -	0.00%	7.96%	0.00%	-	$ -	$ -
Certified Nurse Practitioners/Clinical Nurse	185	$ 134.32	$ 2.08	0.00%	7.96%	-0.48%	199	$ 143.63	$ 2.39
Lab/Radiology	16,080	$ 22.99	$ 30.80	0.00%	6.17%	-0.48%	17,009	$ 24.20	$ 34.30
Home Health	-	$ -	$ -	0.00%	6.17%	0.00%	-	$ -	$ -
Emergency Transportation	260	$ 140.14	$ 3.04	0.00%	-0.36%	-0.48%	259	$ 139.00	$ 3.00
Non-Emergency Transportation	7,836	$ 81.60	$ 53.29	0.00%	-0.36%	-0.48%	7,810	$ 80.94	$ 52.68
Rehabilitation Services (OT, PT, ST)	-	$ -	$ -	0.00%	6.17%	0.00%	-	$ -	$ -
DME	65	$ 65.86	$ 0.35	0.00%	6.17%	-0.48%	68	$ 69.33	$ 0.39
Clinic	-	$ -	$ -	0.00%	7.96%	0.00%	-	$ -	$ -
Family Planning	-	$ -	$ -	0.00%	7.96%	0.00%	-	$ -	$ -
Other	64	$ 19.88	$ 0.11	0.00%	6.17%	-0.48%	68	$ 20.93	$ 0.12
Prescribed Drugs	31,230	$ 161.29	$ 419.75	0.94%	6.72%	0.25%	31,860	$ 180.72	$ 479.82
Emergency Room	5,025	$ 187.00	$ 78.30	0.00%	1.18%	2.49%	5,080	$ 193.77	$ 82.03
Basic Behavioral Health	391	$ 75.35	$ 2.45	0.00%	7.96%	-0.48%	420	$ 80.58	$ 2.82
Hospice	-	$ -	$ -	0.00%	1.53%	0.00%	-	$ -	$ -
Personal Care Services	-	$ -	$ -	0.00%	6.17%	0.00%	-	$ -	$ -
Inpatient Services -- Mental Health	716	$ 567.67	$ 33.89	6.42%	4.44%	6.96%	770	$ 652.17	$ 41.84
Emergency Room -- Mental Health	-	$ -	$ -	0.00%	8.98%	0.00%	-	$ -	$ -
Professional/Other -- Mental Health	7,985	$ 119.76	$ 79.69	0.00%	8.98%	-0.48%	8,656	$ 129.19	$ 93.19
Gross Medical Total			**$ 963.19**	**0.64%**	**4.83%**	**1.57%**			**$ 1,075.69**

Notes:

1. Final Base Data on this sheet represents experience having occurred from April 1, 2017 to March 31, 2018.
2. Trend Period on this sheet represents experience time period from October 1, 2017 to August 15, 2019.
3. Contract Period on this sheet represents experience time period from April 1, 2019 to December 31, 2019.
4. In some cases totals may not equal the sum of their respective column components due to rounding.
5. Statewide rollups are based on RY 2019 Projected Member Months.

Credibility Adjustment PMPM	**$ -**
% Credibility Adjustment	0.00%
PET Scans Adjustment	**$ 2.92**
% of Final Projected Medical	0.27%
FQHC/RHC Adjustment	**$ 0.18**
% of Final Projected Medical	0.02%
CGM Adjustment	**$ 0.48**
% of Final Projected Medical	0.04%
Final Projected Medical	**$ 1,079.27**
Administrative Expenses PMPM	**$ 72.72**
% of Final Projected Medical	6.74%
Underwriting Gain PMPM	**$ 18.58**
% of Limited Premium	1.50%
Lower Bound Limited Capitation Rate	**$ 1,170.58**
Premium Based Taxes	5.50%
Final Lower Bound Limited Capitation Rate	**$ 1,238.70**

Attachment D2

MERCER

RY 2019 Projected Member Months
Medicaid Expansion Age 19 - 64
6,687,382

	Base Midpoint	Contract Midpoint
	October 1, 2017	August 15, 2019
Contract Period	April 1, 2019 to December 31, 2019	
Trend Months	22.5	

Statewide	Final Base Data			Base Program Changes	Annual Medical Trends	Prospective Rating Adjustments	Projected Medical Expenses		
Category of Service	Util/1000	Unit Cost	PMPM	PMPM Percentage	PMPM Percentage	PMPM Percentage	Util/1000	Unit Cost	PMPM
Inpatient Hospital	418	$ 1,236.07	$ 43.11	0.00%	1.53%	11.50%	424	$ 1,397.93	$ 49.45
Outpatient Hospital	7,317	$ 70.10	$ 42.75	0.00%	1.18%	30.77%	7,398	$ 92.69	$ 57.14
Primary Care	3,476	$ 74.60	$ 21.61	0.00%	7.96%	4.60%	3,735	$ 83.84	$ 26.09
Specialty Care	1,586	$ 146.68	$ 19.39	-0.01%	7.96%	4.65%	1,704	$ 164.91	$ 23.42
FQHC/RHC	224	$ 78.86	$ 1.47	0.00%	7.96%	4.38%	240	$ 88.45	$ 1.77
EPSDT	45	$ 90.95	$ 0.34	0.00%	7.96%	5.02%	48	$ 102.63	$ 0.41
Certified Nurse Practitioners/Clinical Nurse	144	$ 120.72	$ 1.45	0.00%	7.96%	4.54%	155	$ 135.60	$ 1.75
Lab/Radiology	7,197	$ 21.73	$ 13.03	0.00%	6.17%	4.50%	7,613	$ 24.02	$ 15.24
Home Health	56	$ 117.85	$ 0.55	0.00%	6.17%	4.38%	59	$ 130.13	$ 0.64
Emergency Transportation	168	$ 146.04	$ 2.05	-0.10%	-0.36%	5.03%	168	$ 152.71	$ 2.14
Non-Emergency Transportation	1,003	$ 60.70	$ 5.08	-0.28%	-0.36%	4.57%	1,000	$ 63.08	$ 5.26
Rehabilitation Services (OT, PT, ST)	17	$ 94.38	$ 0.14	0.00%	6.17%	4.63%	18	$ 104.46	$ 0.16
DME	6,721	$ 6.53	$ 3.66	0.00%	6.17%	4.46%	7,109	$ 7.21	$ 4.27
Clinic	46	$ 216.24	$ 0.83	0.00%	7.96%	4.48%	49	$ 242.77	$ 1.00
Family Planning	95	$ 125.98	$ 0.99	0.00%	7.96%	10.04%	102	$ 148.95	$ 1.26
Other	174	$ 19.63	$ 0.28	-0.01%	6.17%	4.41%	184	$ 21.68	$ 0.33
Prescribed Drugs	19,867	$ 56.64	$ 93.78	0.51%	6.72%	4.47%	20,268	$ 65.86	$ 111.24
Emergency Room	2,546	$ 210.23	$ 44.60	-0.03%	1.18%	7.13%	2,574	$ 227.65	$ 48.83
Basic Behavioral Health	360	$ 60.26	$ 1.81	-0.09%	7.96%	4.50%	387	$ 67.60	$ 2.18
Hospice	1	$ 11,683.42	$ 0.50	0.00%	1.53%	7.31%	1	$ 12,716.80	$ 0.55
Personal Care Services	9	$ 2.58	$ 0.00	0.00%	6.17%	4.60%	9	$ 2.86	$ 0.00
Inpatient Services -- Mental Health	279	$ 558.74	$ 13.01	3.92%	4.44%	21.26%	300	$ 710.68	$ 17.79
Emergency Room -- Mental Health	4	$ 321.03	$ 0.11	-0.39%	8.98%	6.68%	4	$ 369.78	$ 0.13
Professional/Other -- Mental Health	9,015	$ 30.60	$ 22.99	-0.07%	8.98%	4.48%	9,772	$ 34.64	$ 28.21
Gross Medical Total			**$ 333.52**	**0.28%**	**4.70%**	**9.53%**			**$ 399.27**

Notes:

1. Final Base Data on this sheet represents experience having occurred from April 1, 2017 to March 31, 2018.
2. Trend Period on this sheet represents experience time period from October 1, 2017 to August 15, 2019.
3. Contract Period on this sheet represents experience time period from April 1, 2019 to December 31, 2019.
4. In some cases totals may not equal the sum of their respective column components due to rounding.
5. Statewide rollups are based on RY 2019 Projected Member Months.

Credibility Adjustment PMPM	**$ -**
% Credibility Adjustment	0.00%
PET Scans Adjustment	**$ 0.37**
% of Final Projected Medical	0.09%
FQHC/RHC Adjustment	**$ 0.23**
% of Final Projected Medical	0.06%
CGM Adjustment	**$ 0.48**
% of Final Projected Medical	0.12%
Final Projected Medical	**$ 400.35**
Administrative Expenses PMPM	**$ 34.17**
% of Final Projected Medical	8.53%
Underwriting Gain PMPM	**$ 7.01**
% of Limited Premium	1.50%
Lower Bound Limited Capitation Rate	**$ 441.52**
Premium Based Taxes	5.50%
Final Lower Bound Limited Capitation Rate	**$ 467.22**

Attachment D2

MERCER

RY 2019 Projected Member Months
Medicaid Expansion High Needs
1,218

	Base Midpoint	Contract Midpoint
	October 1, 2017	August 15, 2019
Contract Period	April 1, 2019 to December 31, 2019	
Trend Months	22.5	

Statewide	Final Base Data			Base Program Changes	Annual Medical Trends	Prospective Rating Adjustments	Projected Medical Expenses		
Category of Service	Util/1000	Unit Cost	PMPM	PMPM Percentage	PMPM Percentage	PMPM Percentage	Util/1000	Unit Cost	PMPM
Inpatient Hospital	1,110	$ 1,592.81	$ 147.39	0.09%	1.53%	9.00%	1,126	$ 1,762.45	$ 165.41
Outpatient Hospital	17,670	$ 82.24	$ 121.10	0.11%	1.18%	18.87%	17,865	$ 98.94	$ 147.30
Primary Care	5,500	$ 74.46	$ 34.13	-0.30%	7.96%	-0.17%	5,910	$ 79.63	$ 39.22
Specialty Care	2,810	$ 142.47	$ 33.36	0.14%	7.96%	1.35%	3,019	$ 155.37	$ 39.08
FQHC/RHC	319	$ 83.67	$ 2.23	0.06%	7.96%	-1.00%	343	$ 89.07	$ 2.55
EPSDT	-	$ -	$ -	0.00%	0.00%	0.00%	-	$ -	$ -
Certified Nurse Practitioners/Clinical Nurse	258	$ 127.75	$ 2.75	0.13%	7.96%	-0.10%	277	$ 137.29	$ 3.17
Lab/Radiology	14,779	$ 22.03	$ 27.13	0.12%	6.17%	-0.14%	15,633	$ 23.30	$ 30.36
Home Health	-	$ -	$ -	0.00%	0.00%	0.00%	-	$ -	$ -
Emergency Transportation	891	$ 124.16	$ 9.22	0.11%	-0.36%	-0.23%	888	$ 123.60	$ 9.15
Non-Emergency Transportation	5,406	$ 51.20	$ 23.06	-7.20%	-0.36%	-0.28%	5,388	$ 47.23	$ 21.20
Rehabilitation Services (OT, PT, ST)	-	$ -	$ -	0.00%	0.00%	0.00%	-	$ -	$ -
DME	452	$ 61.74	$ 2.33	0.19%	6.17%	-0.01%	478	$ 65.42	$ 2.61
Clinic	-	$ -	$ -	0.00%	0.00%	0.00%	-	$ -	$ -
Family Planning	49	$ 260.95	$ 1.07	0.25%	7.96%	5.44%	53	$ 296.38	$ 1.31
Other	92	$ 34.50	$ 0.26	0.24%	6.17%	-0.03%	97	$ 36.58	$ 0.30
Prescribed Drugs	33,029	$ 120.18	$ 330.78	0.62%	6.72%	0.33%	33,695	$ 134.34	$ 377.23
Emergency Room	4,523	$ 257.76	$ 97.15	0.13%	1.18%	3.20%	4,573	$ 269.31	$ 102.62
Basic Behavioral Health	629	$ 74.63	$ 3.91	0.11%	7.96%	-0.21%	676	$ 80.11	$ 4.51
Hospice	-	$ -	$ -	0.00%	0.00%	0.00%	-	$ -	$ -
Personal Care Services	-	$ -	$ -	0.00%	0.00%	0.00%	-	$ -	$ -
Inpatient Services -- Mental Health	2,519	$ 603.36	$ 126.63	-4.18%	4.44%	11.69%	2,707	$ 651.78	$ 147.02
Emergency Room -- Mental Health	67	$ 114.83	$ 0.64	0.22%	8.98%	-0.08%	73	$ 124.64	$ 0.76
Professional/Other -- Mental Health	23,451	$ 44.12	$ 86.22	0.13%	8.98%	-0.18%	25,421	$ 47.81	$ 101.27
Gross Medical Total			**$ 1,049.36**	**-0.42%**	**4.66%**	**5.01%**			**$ 1,195.07**

Notes:

1. Final Base Data on this sheet represents experience having occurred from April 1, 2017 to March 31, 2018.
2. Trend Period on this sheet represents experience time period from October 1, 2017 to August 15, 2019.
3. Contract Period on this sheet represents experience time period from April 1, 2019 to December 31, 2019.
4. In some cases totals may not equal the sum of their respective column components due to rounding.
5. Statewide rollups are based on RY 2019 Projected Member Months.

Credibility Adjustment PMPM	**$ -**
% Credibility Adjustment	0.00%
PET Scans Adjustment	**$ 2.92**
% of Final Projected Medical	0.24%
FQHC/RHC Adjustment	**$ 0.51**
% of Final Projected Medical	0.04%
CGM Adjustment	**$ 0.49**
% of Final Projected Medical	0.04%
Final Projected Medical	**$ 1,198.99**
Administrative Expenses PMPM	**$ 72.80**
% of Final Projected Medical	6.07%
Underwriting Gain PMPM	**$ 20.51**
% of Limited Premium	1.50%
Lower Bound Limited Capitation Rate	**$ 1,292.30**
Premium Based Taxes	5.50%
Final Lower Bound Limited Capitation Rate	**$ 1,367.51**

Attachment D2

MERCER

RY 19 Projected Member Months
Medicaid Expansion Age 19 - 64
2,118,672

Gulf				
Category of Service	IMD Long Stays	IMD Short Stays	Copay	Total
Inpatient Hospital	0.00%	0.00%	0.00%	0.00%
Outpatient Hospital	0.00%	0.00%	0.00%	0.00%
Primary Care	0.00%	0.00%	0.00%	0.00%
Specialty Care	-0.01%	0.00%	0.00%	-0.01%
FQHC/RHC	0.00%	0.00%	0.00%	0.00%
EPSDT	0.00%	0.00%	0.00%	0.00%
Certified Nurse Practitioners/Clinical Nurse	0.00%	0.00%	0.00%	0.00%
Lab/Radiology	0.00%	0.00%	0.00%	0.00%
Home Health	0.00%	0.00%	0.00%	0.00%
Emergency Transportation	-0.03%	0.00%	0.00%	-0.03%
Non-Emergency Transportation	-0.32%	0.00%	0.00%	-0.32%
Rehabilitation Services (OT, PT, ST)	0.00%	0.00%	0.00%	0.00%
DME	0.00%	0.00%	0.00%	0.00%
Clinic	0.00%	0.00%	0.00%	0.00%
Family Planning	0.00%	0.00%	0.00%	0.00%
Other	0.00%	0.00%	0.00%	0.00%
Prescribed Drugs	0.00%	0.00%	0.43%	0.43%
Emergency Room	-0.03%	0.00%	0.00%	-0.03%
Basic Behavioral Health	-0.12%	0.00%	0.00%	-0.12%
Hospice	0.00%	0.00%	0.00%	0.00%
Personal Care Services	0.00%	0.00%	0.00%	0.00%
Inpatient Services -- Mental Health	-2.46%	6.42%	0.00%	3.80%
Emergency Room -- Mental Health	-0.54%	0.00%	0.00%	-0.54%
Professional/Other -- Mental Health	-0.08%	0.00%	0.00%	-0.08%
Gross Medical Total	**-0.10%**	**0.23%**	**0.13%**	**0.26%**

RY 19 Projected Member Months
Medicaid Expansion High Needs
300

Gulf				
Category of Service	IMD Long Stays	IMD Short Stays	Copay	Total
Inpatient Hospital	0.00%	0.00%	0.00%	0.00%
Outpatient Hospital	0.00%	0.00%	0.00%	0.00%
Primary Care	0.00%	0.00%	0.00%	0.00%
Specialty Care	0.00%	0.00%	0.00%	0.00%
FQHC/RHC	0.00%	0.00%	0.00%	0.00%
EPSDT	0.00%	0.00%	0.00%	0.00%
Certified Nurse Practitioners/Clinical Nurse	0.00%	0.00%	0.00%	0.00%
Lab/Radiology	0.00%	0.00%	0.00%	0.00%
Home Health	0.00%	0.00%	0.00%	0.00%
Emergency Transportation	0.00%	0.00%	0.00%	0.00%
Non-Emergency Transportation	0.00%	0.00%	0.00%	0.00%
Rehabilitation Services (OT, PT, ST)	0.00%	0.00%	0.00%	0.00%
DME	0.00%	0.00%	0.00%	0.00%
Clinic	0.00%	0.00%	0.00%	0.00%
Family Planning	0.00%	0.00%	0.00%	0.00%
Other	0.00%	0.00%	0.00%	0.00%
Prescribed Drugs	0.00%	0.00%	0.36%	0.36%
Emergency Room	0.00%	0.00%	0.00%	0.00%
Basic Behavioral Health	0.00%	0.00%	0.00%	0.00%
Hospice	0.00%	0.00%	0.00%	0.00%
Personal Care Services	0.00%	0.00%	0.00%	0.00%
Inpatient Services -- Mental Health	0.00%	6.42%	0.00%	6.42%
Emergency Room -- Mental Health	0.00%	0.00%	0.00%	0.00%
Professional/Other -- Mental Health	0.00%	0.00%	0.00%	0.00%
Gross Medical Total	**0.00%**	**0.65%**	**0.15%**	**0.80%**

RY 19 Projected Member Months
Medicaid Expansion Age 19 - 64
1,519,852

Capital				
Category of Service	IMD Long Stays	IMD Short Stays	Copay	Total
Inpatient Hospital	0.00%	0.00%	0.00%	0.00%
Outpatient Hospital	0.00%	0.00%	0.00%	0.00%
Primary Care	-0.01%	0.00%	0.00%	-0.01%
Specialty Care	-0.02%	0.00%	0.00%	-0.02%
FQHC/RHC	0.00%	0.00%	0.00%	0.00%
EPSDT	0.00%	0.00%	0.00%	0.00%
Certified Nurse Practitioners/Clinical Nurse	0.00%	0.00%	0.00%	0.00%
Lab/Radiology	0.00%	0.00%	0.00%	0.00%
Home Health	0.00%	0.00%	0.00%	0.00%
Emergency Transportation	-0.04%	0.00%	0.00%	-0.04%
Non-Emergency Transportation	-0.29%	0.00%	0.00%	-0.29%
Rehabilitation Services (OT, PT, ST)	0.00%	0.00%	0.00%	0.00%
DME	0.00%	0.00%	0.00%	0.00%
Clinic	0.00%	0.00%	0.00%	0.00%
Family Planning	0.00%	0.00%	0.00%	0.00%
Other	0.00%	0.00%	0.00%	0.00%
Prescribed Drugs	0.00%	0.00%	0.48%	0.49%
Emergency Room	-0.04%	0.00%	0.00%	-0.04%
Basic Behavioral Health	-0.12%	0.00%	0.00%	-0.12%
Hospice	0.00%	0.00%	0.00%	0.00%
Personal Care Services	0.00%	0.00%	0.00%	0.00%
Inpatient Services -- Mental Health	-2.31%	6.42%	0.00%	3.96%
Emergency Room -- Mental Health	-0.75%	0.00%	0.00%	-0.75%
Professional/Other -- Mental Health	-0.08%	0.00%	0.00%	-0.08%
Gross Medical Total	**-0.11%**	**0.26%**	**0.14%**	**0.29%**

RY 19 Projected Member Months
Medicaid Expansion High Needs
493

Capital				
Category of Service	IMD Long Stays	IMD Short Stays	Copay	Total
Inpatient Hospital	0.26%	0.00%	0.00%	0.26%
Outpatient Hospital	0.26%	0.00%	0.00%	0.26%
Primary Care	-0.62%	0.00%	0.00%	-0.62%
Specialty Care	0.26%	0.00%	0.00%	0.26%
FQHC/RHC	0.26%	0.00%	0.00%	0.26%
EPSDT	0.00%	0.00%	0.00%	0.00%
Certified Nurse Practitioners/Clinical Nurse	0.26%	0.00%	0.00%	0.26%
Lab/Radiology	0.26%	0.00%	0.00%	0.26%
Home Health	0.00%	0.00%	0.00%	0.00%
Emergency Transportation	0.26%	0.00%	0.00%	0.26%
Non-Emergency Transportation	-20.26%	0.00%	0.00%	-20.26%
Rehabilitation Services (OT, PT, ST)	0.00%	0.00%	0.00%	0.00%
DME	0.26%	0.00%	0.00%	0.26%
Clinic	0.00%	0.00%	0.00%	0.00%
Family Planning	0.26%	0.00%	0.00%	0.26%
Other	0.26%	0.00%	0.00%	0.26%
Prescribed Drugs	0.26%	0.00%	0.60%	0.86%
Emergency Room	0.26%	0.00%	0.00%	0.26%
Basic Behavioral Health	0.26%	0.00%	0.00%	0.26%
Hospice	0.00%	0.00%	0.00%	0.00%
Personal Care Services	0.00%	0.00%	0.00%	0.00%
Inpatient Services -- Mental Health	-37.79%	6.42%	0.00%	-33.80%
Emergency Room -- Mental Health	0.26%	0.00%	0.00%	0.26%
Professional/Other -- Mental Health	0.26%	0.00%	0.00%	0.26%
Gross Medical Total	**-3.45%**	**0.35%**	**0.16%**	**-2.96%**

RY 19 Projected Member Months
Medicaid Expansion Age 19 - 64
1,683,575

South Central				
Category of Service	IMD Long Stays	IMD Short Stays	Copay	Total
Inpatient Hospital	0.00%	0.00%	0.00%	0.00%
Outpatient Hospital	0.00%	0.00%	0.00%	0.00%
Primary Care	-0.01%	0.00%	0.00%	-0.01%
Specialty Care	-0.01%	0.00%	0.00%	-0.01%
FQHC/RHC	0.00%	0.00%	0.00%	0.00%
EPSDT	0.00%	0.00%	0.00%	0.00%
Certified Nurse Practitioners/Clinical Nurse	0.00%	0.00%	0.00%	0.00%
Lab/Radiology	0.00%	0.00%	0.00%	0.00%
Home Health	0.00%	0.00%	0.00%	0.00%
Emergency Transportation	-0.18%	0.00%	0.00%	-0.18%
Non-Emergency Transportation	-0.28%	0.00%	0.00%	-0.28%
Rehabilitation Services (OT, PT, ST)	0.00%	0.00%	0.00%	0.00%
DME	0.00%	0.00%	0.00%	0.00%
Clinic	0.00%	0.00%	0.00%	0.00%
Family Planning	0.00%	0.00%	0.00%	0.00%
Other	-0.03%	0.00%	0.00%	-0.03%
Prescribed Drugs	0.00%	0.00%	0.63%	0.63%
Emergency Room	-0.03%	0.00%	0.00%	-0.03%
Basic Behavioral Health	-0.04%	0.00%	0.00%	-0.04%
Hospice	0.00%	0.00%	0.00%	0.00%
Personal Care Services	0.00%	0.00%	0.00%	0.00%
Inpatient Services -- Mental Health	-2.10%	6.42%	0.00%	4.18%
Emergency Room -- Mental Health	-0.14%	0.00%	0.00%	-0.14%
Professional/Other -- Mental Health	-0.07%	0.00%	0.00%	-0.07%
Gross Medical Total	**-0.11%**	**0.29%**	**0.17%**	**0.34%**

RY 19 Projected Member Months
Medicaid Expansion High Needs
231

South Central				
Category of Service	IMD Long Stays	IMD Short Stays	Copay	Total
Inpatient Hospital	0.00%	0.00%	0.00%	0.00%
Outpatient Hospital	0.00%	0.00%	0.00%	0.00%
Primary Care	0.00%	0.00%	0.00%	0.00%
Specialty Care	0.00%	0.00%	0.00%	0.00%
FQHC/RHC	0.00%	0.00%	0.00%	0.00%
EPSDT	0.00%	0.00%	0.00%	0.00%
Certified Nurse Practitioners/Clinical Nurse	0.00%	0.00%	0.00%	0.00%
Lab/Radiology	0.00%	0.00%	0.00%	0.00%
Home Health	0.00%	0.00%	0.00%	0.00%
Emergency Transportation	0.00%	0.00%	0.00%	0.00%
Non-Emergency Transportation	0.00%	0.00%	0.00%	0.00%
Rehabilitation Services (OT, PT, ST)	0.00%	0.00%	0.00%	0.00%
DME	0.00%	0.00%	0.00%	0.00%
Clinic	0.00%	0.00%	0.00%	0.00%
Family Planning	0.00%	0.00%	0.00%	0.00%
Other	0.00%	0.00%	0.00%	0.00%
Prescribed Drugs	0.00%	0.00%	0.34%	0.34%
Emergency Room	0.00%	0.00%	0.00%	0.00%
Basic Behavioral Health	0.00%	0.00%	0.00%	0.00%
Hospice	0.00%	0.00%	0.00%	0.00%
Personal Care Services	0.00%	0.00%	0.00%	0.00%
Inpatient Services -- Mental Health	0.00%	6.42%	0.00%	6.42%
Emergency Room -- Mental Health	0.00%	0.00%	0.00%	0.00%
Professional/Other -- Mental Health	0.00%	0.00%	0.00%	0.00%
Gross Medical Total	**0.00%**	**1.38%**	**0.09%**	**1.46%**

RY 19 Projected Member Months
Medicaid Expansion Age 19 - 64
1,365,283

North				
Category of Service	IMD Long Stays	IMD Short Stays	Copay	Total
Inpatient Hospital	0.00%	0.00%	0.00%	0.00%
Outpatient Hospital	0.00%	0.00%	0.00%	0.00%
Primary Care	0.00%	0.00%	0.00%	0.00%
Specialty Care	-0.01%	0.00%	0.00%	-0.01%
FQHC/RHC	-0.01%	0.00%	0.00%	-0.01%
EPSDT	0.00%	0.00%	0.00%	0.00%
Certified Nurse Practitioners/Clinical Nurse	0.00%	0.00%	0.00%	0.00%
Lab/Radiology	0.00%	0.00%	0.00%	0.00%
Home Health	0.00%	0.00%	0.00%	0.00%
Emergency Transportation	-0.10%	0.00%	0.00%	-0.10%
Non-Emergency Transportation	-0.23%	0.00%	0.00%	-0.23%
Rehabilitation Services (OT, PT, ST)	0.00%	0.00%	0.00%	0.00%
DME	0.00%	0.00%	0.00%	0.00%
Clinic	0.00%	0.00%	0.00%	0.00%
Family Planning	0.00%	0.00%	0.00%	0.00%
Other	0.00%	0.00%	0.00%	0.00%
Prescribed Drugs	0.00%	0.00%	0.54%	0.54%
Emergency Room	-0.01%	0.00%	0.00%	-0.01%
Basic Behavioral Health	-0.10%	0.00%	0.00%	-0.10%
Hospice	0.00%	0.00%	0.00%	0.00%
Personal Care Services	0.00%	0.00%	0.00%	0.00%
Inpatient Services -- Mental Health	-2.71%	6.42%	0.00%	3.53%
Emergency Room -- Mental Health	0.00%	0.00%	0.00%	0.00%
Professional/Other -- Mental Health	-0.03%	0.00%	0.00%	-0.03%
Gross Medical Total	**-0.09%**	**0.18%**	**0.13%**	**0.23%**

RY 19 Projected Member Months
Medicaid Expansion High Needs
194

North				
Category of Service	IMD Long Stays	IMD Short Stays	Copay	Total
Inpatient Hospital	0.00%	0.00%	0.00%	0.00%
Outpatient Hospital	0.00%	0.00%	0.00%	0.00%
Primary Care	0.00%	0.00%	0.00%	0.00%
Specialty Care	0.00%	0.00%	0.00%	0.00%
FQHC/RHC	0.00%	0.00%	0.00%	0.00%
EPSDT	0.00%	0.00%	0.00%	0.00%
Certified Nurse Practitioners/Clinical Nurse	0.00%	0.00%	0.00%	0.00%
Lab/Radiology	0.00%	0.00%	0.00%	0.00%
Home Health	0.00%	0.00%	0.00%	0.00%
Emergency Transportation	0.00%	0.00%	0.00%	0.00%
Non-Emergency Transportation	0.00%	0.00%	0.00%	0.00%
Rehabilitation Services (OT, PT, ST)	0.00%	0.00%	0.00%	0.00%
DME	0.00%	0.00%	0.00%	0.00%
Clinic	0.00%	0.00%	0.00%	0.00%
Family Planning	0.00%	0.00%	0.00%	0.00%
Other	0.00%	0.00%	0.00%	0.00%
Prescribed Drugs	0.00%	0.00%	0.94%	0.94%
Emergency Room	0.00%	0.00%	0.00%	0.00%
Basic Behavioral Health	0.00%	0.00%	0.00%	0.00%
Hospice	0.00%	0.00%	0.00%	0.00%
Personal Care Services	0.00%	0.00%	0.00%	0.00%
Inpatient Services -- Mental Health	0.00%	6.42%	0.00%	6.42%
Emergency Room -- Mental Health	0.00%	0.00%	0.00%	0.00%
Professional/Other -- Mental Health	0.00%	0.00%	0.00%	0.00%
Gross Medical Total	**0.00%**	**0.23%**	**0.41%**	**0.64%**

RY 19 Projected Member Months
Medicaid Expansion Age 19 - 64
6,687,382

Statewide				
Category of Service	IMD Long Stays	IMD Short Stays	Copay	Total
Inpatient Hospital	0.00%	0.00%	0.00%	0.00%
Outpatient Hospital	0.00%	0.00%	0.00%	0.00%
Primary Care	0.00%	0.00%	0.00%	0.00%
Specialty Care	-0.01%	0.00%	0.00%	-0.01%
FQHC/RHC	0.00%	0.00%	0.00%	0.00%
EPSDT	0.00%	0.00%	0.00%	0.00%
Certified Nurse Practitioners/Clinical Nurse	0.00%	0.00%	0.00%	0.00%
Lab/Radiology	0.00%	0.00%	0.00%	0.00%
Home Health	0.00%	0.00%	0.00%	0.00%
Emergency Transportation	-0.10%	0.00%	0.00%	-0.10%
Non-Emergency Transportation	-0.28%	0.00%	0.00%	-0.28%
Rehabilitation Services (OT, PT, ST)	0.00%	0.00%	0.00%	0.00%
DME	0.00%	0.00%	0.00%	0.00%
Clinic	0.00%	0.00%	0.00%	0.00%
Family Planning	0.00%	0.00%	0.00%	0.00%
Other	-0.01%	0.00%	0.00%	-0.01%
Prescribed Drugs	0.00%	0.00%	0.51%	0.51%
Emergency Room	-0.03%	0.00%	0.00%	-0.03%
Basic Behavioral Health	-0.09%	0.00%	0.00%	-0.09%
Hospice	0.00%	0.00%	0.00%	0.00%
Personal Care Services	0.00%	0.00%	0.00%	0.00%
Inpatient Services -- Mental Health	-2.35%	6.42%	0.00%	3.92%
Emergency Room -- Mental Health	-0.39%	0.00%	0.00%	-0.39%
Professional/Other -- Mental Health	-0.07%	0.00%	0.00%	-0.07%
Gross Medical Total	**-0.11%**	**0.24%**	**0.14%**	**0.28%**

RY 19 Projected Member Months
Medicaid Expansion High Needs
1,218

Statewide				
Category of Service	IMD Long Stays	IMD Short Stays	Copay	Total
Inpatient Hospital	0.09%	0.00%	0.00%	0.09%
Outpatient Hospital	0.11%	0.00%	0.00%	0.11%
Primary Care	-0.30%	0.00%	0.00%	-0.30%
Specialty Care	0.14%	0.00%	0.00%	0.14%
FQHC/RHC	0.06%	0.00%	0.00%	0.06%
EPSDT	0.00%	0.00%	0.00%	0.00%
Certified Nurse Practitioners/Clinical Nurse	0.13%	0.00%	0.00%	0.13%
Lab/Radiology	0.12%	0.00%	0.00%	0.12%
Home Health	0.00%	0.00%	0.00%	0.00%
Emergency Transportation	0.11%	0.00%	0.00%	0.11%
Non-Emergency Transportation	-7.20%	0.00%	0.00%	-7.20%
Rehabilitation Services (OT, PT, ST)	0.00%	0.00%	0.00%	0.00%
DME	0.19%	0.00%	0.00%	0.19%
Clinic	0.00%	0.00%	0.00%	0.00%
Family Planning	0.25%	0.00%	0.00%	0.25%
Other	0.24%	0.00%	0.00%	0.24%
Prescribed Drugs	0.08%	0.00%	0.54%	0.62%
Emergency Room	0.13%	0.00%	0.00%	0.13%
Basic Behavioral Health	0.11%	0.00%	0.00%	0.11%
Hospice	0.00%	0.00%	0.00%	0.00%
Personal Care Services	0.00%	0.00%	0.00%	0.00%
Inpatient Services -- Mental Health	-9.96%	6.42%	0.00%	-4.18%
Emergency Room -- Mental Health	0.22%	0.00%	0.00%	0.22%
Professional/Other -- Mental Health	0.13%	0.00%	0.00%	0.13%
Gross Medical Total	**-1.29%**	**0.71%**	**0.17%**	**-0.42%**

RY 19 Projected Member Months
Medicaid Expansion Age 19 - 64
2,118,672

Gulf								
Category of Service	Prospective Fee Adjustment	P-Linkage	Single PDL	Retro Adjustment	Rx Rebates	COD/NADAC	Wage Verification Adjustment	Total
Inpatient Hospital	3.46%	0.75%	0.00%	2.67%	0.00%	0.00%	1.96%	9.12%
Outpatient Hospital	27.50%	0.02%	0.00%	2.67%	0.00%	0.00%	1.96%	33.51%
Primary Care	0.12%	0.06%	0.00%	2.67%	0.00%	0.00%	1.96%	4.87%
Specialty Care	0.18%	0.14%	0.00%	2.67%	0.00%	0.00%	1.96%	5.01%
FQHC/RHC	0.00%	0.01%	0.00%	2.67%	0.00%	0.00%	1.96%	4.69%
EPSDT	0.43%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.96%	5.13%
Certified Nurse Practitioners/Clinical Nurse	0.00%	0.06%	0.00%	2.67%	0.00%	0.00%	1.96%	4.75%
Lab/Radiology	0.00%	0.03%	0.00%	2.67%	0.00%	0.00%	1.96%	4.72%
Home Health	0.00%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.96%	4.68%
Emergency Transportation	0.00%	0.43%	0.00%	2.67%	0.00%	0.00%	1.96%	5.14%
Non-Emergency Transportation	0.00%	0.20%	0.00%	2.67%	0.00%	0.00%	1.96%	4.89%
Rehabilitation Services (OT, PT, ST)	0.00%	1.06%	0.00%	2.67%	0.00%	0.00%	1.96%	5.79%
DME	0.00%	0.11%	0.00%	2.67%	0.00%	0.00%	1.96%	4.80%
Clinic	0.00%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.96%	4.68%
Family Planning	5.49%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.96%	10.43%
Other	0.00%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.96%	4.68%
Prescribed Drugs	0.00%	0.03%	0.63%	2.67%	-0.96%	0.22%	1.96%	4.59%
Emergency Room	3.66%	0.02%	0.00%	2.67%	0.00%	0.00%	1.96%	8.54%
Basic Behavioral Health	0.02%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.96%	4.70%
Hospice	0.00%	2.51%	0.00%	2.67%	0.00%	0.00%	1.96%	7.32%
Personal Care Services	0.00%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.96%	4.68%
Inpatient Services -- Mental Health	15.34%	0.03%	0.00%	2.67%	0.00%	0.00%	1.96%	20.77%
Emergency Room -- Mental Health	1.35%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.96%	6.09%
Professional/Other -- Mental Health	0.02%	0.03%	0.00%	2.67%	0.00%	0.00%	1.96%	4.73%
Gross Medical Total	**4.72%**	**0.12%**	**0.19%**	**2.67%**	**-0.30%**	**0.07%**	**1.96%**	**9.72%**

RY 19 Projected Member Months
Medicaid Expansion High Needs
300

Gulf								
Category of Service	Prospective Fee Adjustment	P-Linkage	Single PDL	Retro Adjustment	Rx Rebates	COD/NADAC	Wage Verification Adjustment	Total
Inpatient Hospital	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Outpatient Hospital	7.48%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.48%
Primary Care	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.01%
Specialty Care	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FQHC/RHC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
EPSDT	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Certified Nurse Practitioners/Clinical Nurse	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Lab/Radiology	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Home Health	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Emergency Transportation	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Non-Emergency Transportation	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Rehabilitation Services (OT, PT, ST)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DME	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Clinic	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Family Planning	9.79%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.79%
Other	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Prescribed Drugs	0.00%	0.00%	0.63%	0.00%	-0.96%	0.08%	0.00%	-0.25%
Emergency Room	3.75%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.75%
Basic Behavioral Health	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Hospice	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Personal Care Services	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Inpatient Services -- Mental Health	19.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	19.43%
Emergency Room -- Mental Health	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Professional/Other -- Mental Health	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Gross Medical Total	**3.78%**	**0.00%**	**0.27%**	**0.00%**	**-0.41%**	**0.03%**	**0.00%**	**3.67%**

RY 19 Projected Member Months
Medicaid Expansion Age 19 - 64
1,519,852

Capital								
Category of Service	Prospective Fee Adjustment	P-Linkage	Single PDL	Retro Adjustment	Rx Rebates	COD/NADAC	Wage Verification Adjustment	Total
Inpatient Hospital	7.34%	0.71%	0.00%	2.67%	0.00%	0.00%	1.32%	12.46%
Outpatient Hospital	25.16%	0.05%	0.00%	2.67%	0.00%	0.00%	1.32%	30.26%
Primary Care	0.22%	0.15%	0.00%	2.67%	0.00%	0.00%	1.32%	4.42%
Specialty Care	0.20%	0.18%	0.00%	2.67%	0.00%	0.00%	1.32%	4.43%
FQHC/RHC	0.00%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.32%	4.02%
EPSDT	1.28%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.32%	5.36%
Certified Nurse Practitioners/Clinical Nurse	0.01%	0.19%	0.00%	2.67%	0.00%	0.00%	1.32%	4.25%
Lab/Radiology	0.00%	0.10%	0.00%	2.67%	0.00%	0.00%	1.32%	4.13%
Home Health	0.01%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.32%	4.03%
Emergency Transportation	0.00%	0.48%	0.00%	2.67%	0.00%	0.00%	1.32%	4.53%
Non-Emergency Transportation	0.00%	0.15%	0.00%	2.67%	0.00%	0.00%	1.32%	4.19%
Rehabilitation Services (OT, PT, ST)	0.00%	0.07%	0.00%	2.67%	0.00%	0.00%	1.32%	4.11%
DME	0.00%	0.01%	0.00%	2.67%	0.00%	0.00%	1.32%	4.05%
Clinic	0.00%	0.02%	0.00%	2.67%	0.00%	0.00%	1.32%	4.06%
Family Planning	5.49%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.32%	9.74%
Other	0.04%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.32%	4.07%
Prescribed Drugs	0.00%	0.05%	0.63%	2.67%	-0.96%	0.30%	1.32%	4.06%
Emergency Room	2.63%	0.07%	0.00%	2.67%	0.00%	0.00%	1.32%	6.84%
Basic Behavioral Health	0.05%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.32%	4.08%
Hospice	0.22%	2.91%	0.00%	2.67%	0.00%	0.00%	1.32%	7.30%
Personal Care Services	0.00%	0.00%	0.00%	2.67%	0.00%	0.00%	1.32%	4.03%
Inpatient Services -- Mental Health	14.83%	0.04%	0.00%	2.67%	0.00%	0.00%	1.32%	19.51%
Emergency Room -- Mental Health	-0.15%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.32%	3.87%
Professional/Other -- Mental Health	0.04%	0.02%	0.00%	2.67%	0.00%	0.00%	1.32%	4.09%
Gross Medical Total	**5.08%**	**0.16%**	**0.18%**	**2.67%**	**-0.27%**	**0.09%**	**1.32%**	**9.49%**

RY 19 Projected Member Months
Medicaid Expansion High Needs
493

Capital								
Category of Service	Prospective Fee Adjustment	P-Linkage	Single PDL	Retro Adjustment	Rx Rebates	COD/NADAC	Wage Verification Adjustment	Total
Inpatient Hospital	9.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.40%
Outpatient Hospital	36.74%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	36.74%
Primary Care	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Specialty Care	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FQHC/RHC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
EPSDT	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Certified Nurse Practitioners/Clinical Nurse	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Lab/Radiology	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Home Health	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Emergency Transportation	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Non-Emergency Transportation	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Rehabilitation Services (OT, PT, ST)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DME	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Clinic	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Family Planning	5.26%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.26%
Other	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Prescribed Drugs	0.00%	0.00%	0.63%	0.00%	-0.96%	0.13%	0.00%	-0.20%
Emergency Room	5.51%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.51%
Basic Behavioral Health	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Hospice	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Personal Care Services	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Inpatient Services -- Mental Health	26.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	26.40%
Emergency Room -- Mental Health	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Professional/Other -- Mental Health	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Gross Medical Total	**7.81%**	**0.00%**	**0.16%**	**0.00%**	**-0.25%**	**0.04%**	**0.00%**	**7.75%**

RY 19 Projected Member Months
Medicaid Expansion Age 19 - 64
1,683,575

South Central								
Category of Service	Prospective Fee Adjustment	P-Linkage	Single PDL	Retro Adjustment	Rx Rebates	COD/NADAC	Wage Verification Adjustment	Total
Inpatient Hospital	7.22%	0.76%	0.00%	2.67%	0.00%	0.00%	1.88%	13.01%
Outpatient Hospital	24.38%	0.02%	0.00%	2.67%	0.00%	0.00%	1.88%	30.13%
Primary Care	0.01%	0.07%	0.00%	2.67%	0.00%	0.00%	1.88%	4.69%
Specialty Care	0.04%	0.15%	0.00%	2.67%	0.00%	0.00%	1.88%	4.79%
FQHC/RHC	-0.07%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.88%	4.52%
EPSDT	0.30%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.88%	4.91%
Certified Nurse Practitioners/Clinical Nurse	0.00%	0.08%	0.00%	2.67%	0.00%	0.00%	1.88%	4.69%
Lab/Radiology	0.00%	0.05%	0.00%	2.67%	0.00%	0.00%	1.88%	4.66%
Home Health	0.01%	0.00%	0.00%	2.67%	0.00%	0.00%	1.88%	4.61%
Emergency Transportation	0.00%	0.80%	0.00%	2.67%	0.00%	0.00%	1.88%	5.44%
Non-Emergency Transportation	0.00%	0.08%	0.00%	2.67%	0.00%	0.00%	1.88%	4.68%
Rehabilitation Services (OT, PT, ST)	0.00%	0.39%	0.00%	2.67%	0.00%	0.00%	1.88%	5.01%
DME	0.00%	0.00%	0.00%	2.67%	0.00%	0.00%	1.88%	4.60%
Clinic	0.00%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.88%	4.60%
Family Planning	5.32%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.88%	10.16%
Other	0.00%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.88%	4.60%
Prescribed Drugs	0.00%	0.03%	0.63%	2.67%	-0.96%	0.46%	1.88%	4.77%
Emergency Room	1.00%	0.02%	0.00%	2.67%	0.00%	0.00%	1.88%	5.67%
Basic Behavioral Health	0.02%	0.01%	0.00%	2.67%	0.00%	0.00%	1.88%	4.63%
Hospice	0.00%	3.46%	0.00%	2.67%	0.00%	0.00%	1.88%	8.23%
Personal Care Services	0.00%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.88%	4.60%
Inpatient Services -- Mental Health	16.44%	0.10%	0.00%	2.67%	0.00%	0.00%	1.88%	21.92%
Emergency Room -- Mental Health	6.33%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.88%	11.22%
Professional/Other -- Mental Health	0.09%	0.00%	0.00%	2.67%	0.00%	0.00%	1.88%	4.70%
Gross Medical Total	**4.68%**	**0.14%**	**0.16%**	**2.67%**	**-0.25%**	**0.12%**	**1.88%**	**9.69%**

RY 19 Projected Member Months
Medicaid Expansion High Needs
231

South Central								
Category of Service	Prospective Fee Adjustment	P-Linkage	Single PDL	Retro Adjustment	Rx Rebates	COD/NADAC	Wage Verification Adjustment	Total
Inpatient Hospital	9.41%	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	8.89%
Outpatient Hospital	17.75%	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	17.20%
Primary Care	0.00%	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.47%
Specialty Care	0.00%	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.47%
FQHC/RHC	-1.23%	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.70%
EPSDT	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Certified Nurse Practitioners/Clinical Nurse	0.00%	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.47%
Lab/Radiology	0.00%	-0.22%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.22%
Home Health	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Emergency Transportation	0.00%	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.47%
Non-Emergency Transportation	0.00%	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.47%
Rehabilitation Services (OT, PT, ST)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DME	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Clinic	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Family Planning	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Prescribed Drugs	0.00%	1.11%	0.63%	0.00%	-0.96%	0.78%	0.00%	1.56%
Emergency Room	-1.66%	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.13%
Basic Behavioral Health	0.00%	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.47%
Hospice	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Personal Care Services	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Inpatient Services -- Mental Health	6.15%	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	5.64%
Emergency Room -- Mental Health	0.00%	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.47%
Professional/Other -- Mental Health	0.00%	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.47%
Gross Medical Total	**4.14%**	**-0.06%**	**0.16%**	**0.00%**	**-0.25%**	**0.20%**	**0.00%**	**4.20%**

RY 19 Projected Member Months
Medicaid Expansion Age 19 - 64
1,365,283

North								
Category of Service	Prospective Fee Adjustment	P-Linkage	Single PDL	Retro Adjustment	Rx Rebates	COD/NADAC	Wage Verification Adjustment	Total
Inpatient Hospital	6.37%	0.65%	0.00%	2.67%	0.00%	0.00%	1.60%	11.67%
Outpatient Hospital	22.52%	0.06%	0.00%	2.67%	0.00%	0.00%	1.60%	27.87%
Primary Care	-0.06%	0.07%	0.00%	2.67%	0.00%	0.00%	1.60%	4.32%
Specialty Care	-0.46%	0.24%	0.00%	2.67%	0.00%	0.00%	1.60%	4.09%
FQHC/RHC	-0.13%	0.01%	0.00%	2.67%	0.00%	0.00%	1.60%	4.18%
EPSDT	0.19%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.60%	4.50%
Certified Nurse Practitioners/Clinical Nurse	0.00%	0.06%	0.00%	2.67%	0.00%	0.00%	1.60%	4.38%
Lab/Radiology	0.00%	0.08%	0.00%	2.67%	0.00%	0.00%	1.60%	4.39%
Home Health	0.00%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.60%	4.31%
Emergency Transportation	0.00%	0.38%	0.00%	2.67%	0.00%	0.00%	1.60%	4.71%
Non-Emergency Transportation	0.07%	0.14%	0.00%	2.67%	0.00%	0.00%	1.60%	4.53%
Rehabilitation Services (OT, PT, ST)	0.00%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.60%	4.31%
DME	0.00%	0.00%	0.00%	2.67%	0.00%	0.00%	1.60%	4.31%
Clinic	0.00%	0.23%	0.00%	2.67%	0.00%	0.00%	1.60%	4.56%
Family Planning	5.14%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.60%	9.67%
Other	0.01%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.60%	4.31%
Prescribed Drugs	0.00%	0.04%	0.63%	2.67%	-0.96%	0.41%	1.60%	4.43%
Emergency Room	2.93%	0.06%	0.00%	2.67%	0.00%	0.00%	1.60%	7.43%
Basic Behavioral Health	0.01%	0.10%	0.00%	2.67%	0.00%	0.00%	1.60%	4.43%
Hospice	0.00%	0.89%	0.00%	2.67%	0.00%	0.00%	1.60%	5.24%
Personal Care Services	0.00%	0.00%	0.00%	2.67%	0.00%	0.00%	1.60%	4.31%
Inpatient Services -- Mental Health	18.91%	0.25%	0.00%	2.67%	0.00%	0.00%	1.60%	24.36%
Emergency Room -- Mental Health	0.19%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.60%	4.50%
Professional/Other -- Mental Health	0.01%	0.02%	0.00%	2.67%	0.00%	0.00%	1.60%	4.34%
Gross Medical Total	**4.41%**	**0.15%**	**0.15%**	**2.67%**	**-0.24%**	**0.10%**	**1.60%**	**9.10%**

RY 19 Projected Member Months
Medicaid Expansion High Needs
194

North								
Category of Service	Prospective Fee Adjustment	P-Linkage	Single PDL	Retro Adjustment	Rx Rebates	COD/NADAC	Wage Verification Adjustment	Total
Inpatient Hospital	9.42%	-0.48%	0.00%	0.00%	0.00%	0.00%	0.00%	8.90%
Outpatient Hospital	3.00%	-0.48%	0.00%	0.00%	0.00%	0.00%	0.00%	2.51%
Primary Care	0.00%	-0.48%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.48%
Specialty Care	0.00%	17.85%	0.00%	0.00%	0.00%	0.00%	0.00%	17.85%
FQHC/RHC	0.00%	-0.48%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.48%
EPSDT	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Certified Nurse Practitioners/Clinical Nurse	0.00%	-0.48%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.48%
Lab/Radiology	0.00%	-0.48%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.48%
Home Health	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Emergency Transportation	0.00%	-0.48%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.48%
Non-Emergency Transportation	0.00%	-0.48%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.48%
Rehabilitation Services (OT, PT, ST)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DME	0.00%	-0.48%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.48%
Clinic	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Family Planning	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other	0.00%	-0.48%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.48%
Prescribed Drugs	0.00%	-0.36%	0.63%	0.00%	-0.96%	0.95%	0.00%	0.25%
Emergency Room	2.98%	-0.48%	0.00%	0.00%	0.00%	0.00%	0.00%	2.49%
Basic Behavioral Health	0.00%	-0.48%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.48%
Hospice	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Personal Care Services	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Inpatient Services -- Mental Health	7.47%	-0.48%	0.00%	0.00%	0.00%	0.00%	0.00%	6.96%
Emergency Room -- Mental Health	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Professional/Other -- Mental Health	0.00%	-0.48%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.48%
Gross Medical Total	**1.39%**	**-0.09%**	**0.28%**	**0.00%**	**-0.43%**	**0.42%**	**0.00%**	**1.57%**

RY 19 Projected Member Months
Medicaid Expansion Age 19 - 64
6,687,382

Statewide								
Category of Service	Prospective Fee Adjustment	P-Linkage	Single PDL	Retro Adjustment	Rx Rebates	COD/NADAC	Wage Verification Adjustment	Total
Inpatient Hospital	6.03%	0.72%	0.00%	2.67%	0.00%	0.00%	1.68%	11.50%
Outpatient Hospital	25.18%	0.03%	0.00%	2.67%	0.00%	0.00%	1.71%	30.77%
Primary Care	0.07%	0.08%	0.00%	2.67%	0.00%	0.00%	1.71%	4.60%
Specialty Care	0.04%	0.17%	0.00%	2.67%	0.00%	0.00%	1.71%	4.65%
FQHC/RHC	-0.06%	0.00%	0.00%	2.67%	0.00%	0.00%	1.73%	4.38%
EPSDT	0.59%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.69%	5.02%
Certified Nurse Practitioners/Clinical Nurse	0.00%	0.10%	0.00%	2.67%	0.00%	0.00%	1.71%	4.54%
Lab/Radiology	0.00%	0.06%	0.00%	2.67%	0.00%	0.00%	1.71%	4.50%
Home Health	0.01%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.67%	4.38%
Emergency Transportation	0.00%	0.56%	0.00%	2.67%	0.00%	0.00%	1.72%	5.03%
Non-Emergency Transportation	0.01%	0.13%	0.00%	2.67%	0.00%	0.00%	1.70%	4.57%
Rehabilitation Services (OT, PT, ST)	0.00%	0.33%	0.00%	2.67%	0.00%	0.00%	1.57%	4.63%
DME	0.00%	0.03%	0.00%	2.67%	0.00%	0.00%	1.71%	4.46%
Clinic	0.00%	0.04%	0.00%	2.67%	0.00%	0.00%	1.72%	4.48%
Family Planning	5.39%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.70%	10.04%
Other	0.02%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.68%	4.41%
Prescribed Drugs	0.00%	0.04%	0.63%	2.67%	-0.96%	0.33%	1.71%	4.47%
Emergency Room	2.55%	0.04%	0.00%	2.67%	0.00%	0.00%	1.71%	7.13%
Basic Behavioral Health	0.02%	0.02%	0.00%	2.67%	0.00%	0.00%	1.73%	4.50%
Hospice	0.06%	2.70%	0.00%	2.67%	0.00%	0.00%	1.71%	7.31%
Personal Care Services	0.00%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.88%	4.60%
Inpatient Services -- Mental Health	16.02%	0.08%	0.00%	2.67%	0.00%	0.00%	1.71%	21.26%
Emergency Room -- Mental Health	2.19%	-0.01%	0.00%	2.67%	0.00%	0.00%	1.68%	6.68%
Professional/Other -- Mental Health	0.04%	0.02%	0.00%	2.67%	0.00%	0.00%	1.70%	4.48%
Gross Medical Total	**4.74%**	**0.14%**	**0.18%**	**2.67%**	**-0.27%**	**0.09%**	**1.71%**	**9.53%**

RY 19 Projected Member Months
Medicaid Expansion High Needs
1,218

Statewide								
Category of Service	Prospective Fee Adjustment	P-Linkage	Single PDL	Retro Adjustment	Rx Rebates	COD/NADAC	Wage Verification Adjustment	Total
Inpatient Hospital	9.34%	-0.31%	0.00%	0.00%	0.00%	0.00%	0.00%	9.00%
Outpatient Hospital	19.02%	-0.12%	0.00%	0.00%	0.00%	0.00%	0.00%	18.87%
Primary Care	0.00%	-0.17%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.17%
Specialty Care	0.00%	1.35%	0.00%	0.00%	0.00%	0.00%	0.00%	1.35%
FQHC/RHC	-0.70%	-0.30%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.00%
EPSDT	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Certified Nurse Practitioners/Clinical Nurse	0.00%	-0.10%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.10%
Lab/Radiology	0.00%	-0.14%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.14%
Home Health	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Emergency Transportation	0.00%	-0.23%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.23%
Non-Emergency Transportation	0.00%	-0.28%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.28%
Rehabilitation Services (OT, PT, ST)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DME	0.00%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.01%
Clinic	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Family Planning	5.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.44%
Other	0.00%	-0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.03%
Prescribed Drugs	0.00%	0.21%	0.63%	0.00%	-0.96%	0.45%	0.00%	0.33%
Emergency Room	3.37%	-0.16%	0.00%	0.00%	0.00%	0.00%	0.00%	3.20%
Basic Behavioral Health	0.00%	-0.21%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.21%
Hospice	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Personal Care Services	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Inpatient Services -- Mental Health	12.02%	-0.30%	0.00%	0.00%	0.00%	0.00%	0.00%	11.69%
Emergency Room -- Mental Health	0.00%	-0.08%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.08%
Professional/Other -- Mental Health	0.00%	-0.18%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.18%
Gross Medical Total	**5.01%**	**-0.03%**	**0.20%**	**0.00%**	**-0.30%**	**0.14%**	**0.00%**	**5.01%**

			Below the Line Adjustment PMPM Impacts					
Region	Category of Aid	Rate Cell	CGM Adjustment	PET Scan Adjustment	FQHC/RHC Adjustment	Lower Bound Fixed Admin	Lower Bound Variable Admin	Total
Gulf	Medicaid Expansion	Age 19 - 64	$ 0.48	$ 0.37	$ 0.34	$ 17.07	$ 15.66	$ 33.92
Gulf	Medicaid Expansion	High Needs	$ 0.48	$ 2.92	$ 0.41	$ 17.07	$ 33.31	$ 54.19
Capital	Medicaid Expansion	Age 19 - 64	$ 0.54	$ 0.37	$ 0.19	$ 17.07	$ 19.26	$ 37.43
Capital	Medicaid Expansion	High Needs	$ 0.54	$ 2.92	$ 0.75	$ 17.07	$ 53.29	$ 74.57
South Central	Medicaid Expansion	Age 19 - 64	$ 0.41	$ 0.37	$ 0.22	$ 17.07	$ 17.46	$ 35.54
South Central	Medicaid Expansion	High Needs	$ 0.41	$ 2.92	$ 0.39	$ 17.07	$ 90.16	$ 110.95
North	Medicaid Expansion	Age 19 - 64	$ 0.48	$ 0.37	$ 0.12	$ 17.07	$ 16.47	$ 34.52
North	Medicaid Expansion	High Needs	$ 0.48	$ 2.92	$ 0.18	$ 17.07	$ 55.65	$ 76.30
Statewide	Medicaid Expansion	Age 19 - 64	$ 0.48	$ 0.37	$ 0.23	$ 17.07	$ 17.10	$ 35.25
Statewide	Medicaid Expansion	High Needs	$ 0.49	$ 2.92	$ 0.51	$ 17.07	$ 55.73	$ 76.72

			Below the Line Projected Claims Impact					
Region	Category of Aid	Rate Cell	PMPM Before BTL Add Ons	PMPM After CGM Adjustment	PMPM After PET Scan Adjustment	PMPM After FQHC/RHC Adjustment	PMPM After Lower Bound Fixed Admin	PMPM After Lower Bound Variable Admin
Gulf	Medicaid Expansion	Age 19 - 64	$ 385.50	$ 385.99	$ 386.36	$ 386.70	$ 403.77	$ 419.42
Gulf	Medicaid Expansion	High Needs	$ 836.84	$ 837.33	$ 840.24	$ 840.65	$ 857.72	$ 891.04
Capital	Medicaid Expansion	Age 19 - 64	$ 453.78	$ 454.32	$ 454.69	$ 454.89	$ 471.96	$ 491.21
Capital	Medicaid Expansion	High Needs	$ 1,101.57	$ 1,102.11	$ 1,105.03	$ 1,105.78	$ 1,122.85	$ 1,176.14
South Central	Medicaid Expansion	Age 19 - 64	$ 394.53	$ 394.94	$ 395.31	$ 395.53	$ 412.60	$ 430.06
South Central	Medicaid Expansion	High Needs	$ 1,960.65	$ 1,961.06	$ 1,963.98	$ 1,964.36	$ 1,981.43	$ 2,071.60
North	Medicaid Expansion	Age 19 - 64	$ 365.78	$ 366.26	$ 366.63	$ 366.75	$ 383.82	$ 400.29
North	Medicaid Expansion	High Needs	$ 1,075.69	$ 1,076.18	$ 1,079.09	$ 1,079.27	$ 1,096.34	$ 1,152.00
Statewide	Medicaid Expansion	Age 19 - 64	$ 399.27	$ 399.74	$ 400.11	$ 400.35	$ 417.42	$ 434.51
Statewide	Medicaid Expansion	High Needs	$ 1,195.07	$ 1,195.57	$ 1,198.48	$ 1,198.99	$ 1,216.06	$ 1,271.79