Office of State Procurement
PROACT Contract Certification of Approval

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

Reference Number: 2000100373 (10)
Vendor: Community Care Health Plan of Louisiana, Inc. DBA Healthy Blue
Description: Amd 10 update contract verbiage & selected docs due to legis. changes
Approved By: Pamela Rice
Approval Date: 1/29/2018

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 #: 10

LAGOV#: 2000100373

LDH #: 060467

(Regional/ Program/ Facility): Medical Vendor Administration

Bureau of Health Services Financing

AND

Community Care Health Plan of Louisiana, Inc. DBA Healthy Blue
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: $2,818,893,535.00 Current Contract Term: 2/1/2015-1/31/2018

See Attachment A10, Attachment D, Attachment E, Appendix J

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

See Attachment A10, Attachment D, Attachment E, Appendix J

Justifications for amendment:

Revisions contained in this amendment are necessary for the continued successful operation of the Medicaid managed care program.

This Amendment Becomes Effective: 10-01-2017

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

Community Care Health Plan of Louisiana, Inc. DBA Healthy

CONTRACTOR SIGNATURE — DATE: 1-10-18

PRINT NAME: Aaron Lambert

CONTRACTOR TITLE: CEO

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE — DATE: 1/18/17

NAME: Jen Steele

TITLE: Medicaid Director

OFFICE: Bureau of Health Services Financing

PROGRAM SIGNATURE — DATE

NAME

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Attachment D	Rate Certification	Mercer rate certification dated March 13, 2017	Replace with Mercer rate certifications dated January 8, 2018	A new rate certification is required due to the mental health rehabilitation budget reductions.
Attachment E	Incentive-Based Performance Measures Targets for Improvement	Changes contained in the attached document.	Changes contained in the attached document.	This revision will provide for MCO reporting of data in 2018 for incentive-based performance measures to be measured in 2019.
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	2.3.9. Mental Health Parity 2.3.9.1. The MCO shall comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (45 CFR 146 and 147), which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan.	2.3.9. Mental Health Parity 2.3.9.1. The MCO shall comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ~~(45 CFR 146 and 147)~~, which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan. <u>The MCO shall comply with all 42 CFR 438 Subpart K,</u>	Revisions were needed to clarify the responsibility of the MCOs related to mental health parity. Reference to appropriate federal regulations have been added also.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		2.3.9.2. The MCO shall develop and maintain internal controls to ensure mental health parity. The health plan's prior authorization policy, procedures, and practices shall comply with The Wellstone – Domenici Mental Health Parity and Addiction Equality Act of 2008 and 45 CFR Parts 146 and 147. 2.3.9.3. The MCO shall require that all providers and all subcontractors take such actions as are necessary to permit the MCO to comply with mental health parity requirements listed in this contract. To the extent that the MCO delegates oversight responsibilities to a third party, the MCO shall require that such third party complies with provisions of this contract relating to mental health parity. The MCO agrees to require, via contract, that such providers comply with regulations and any enforcement actions, including but not limited	specifically, 438.900, 905, 910, and 915 for all Medicaid managed care enrollees. 2.3.9.1.1. The MCO must comply with parity requirements for aggregate lifetime or annual dollar limits including for prescription drugs as specified in 42 CFR 438.905. 2.3.9.1.2. All financial requirements or treatment limitations, including NQTL, to mental health or substance use disorder benefits shall not be more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits as per 42 CFR 438.910. Financial requirements cannot accumulate separately for medical surgical and mental health/SUD. 2.3.9.2. The MCO shall develop and maintain internal controls to ensure mental health parity. The	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		to termination and restitution. The MCO shall require mental health parity disclosure on provider enrollment forms as mandated by DHH. 2.3.9.4. The MCO shall provide DHH and its designees, which may include auditors and inspectors, with access to MCO service locations, facilities, or installations, including any and all records and files produced, electronic and hardcopy. Access described in this section shall be for the purpose of examining, auditing, or investigating mental health parity. 2.3.9.5. The MCO shall comply with all other applicable state and federal laws and regulations relating to mental health parity and DHH established policies and procedures.	health plan's utilization practices such as prior authorization, standards for medical necessity determination, and network policy, procedures, and practices shall comply with the federal regulations referenced in 2.3.9.1, above. ~~The Wellstone – Domenici Mental Health Parity and Addiction Equality Act of 2008 and 45 CFR Parts 146 and 147~~. 2.3.9.2.1. For the purposes of parity, the state shall define the benefit classifications for parity analysis and provide which covered benefits fall within each benefit classification. If an enrollee is provided mental health or substance use disorder benefits in any classification of benefits, mental health and substance use disorder benefits must be provided to the MCO enrollee in every classification in which medical/surgical benefits are provided.	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			2.3.9.2.2. The MCO may cover, in addition to state plan required services, any service necessary for compliance with the requirements for parity in mental health and substance use disorder benefits based on parity analysis. The State may, based on initial parity analysis to be completed October 2, 2017, and ongoing parity review, require the MCO to cover or change services necessary for compliance including type and amount, duration and scope of services and change policy or operational procedures in order to achieve and maintain compliance with parity requirements. 2.3.9.2.3 The MCO shall ensure enrollees receive a notice of adverse benefit determination per 42 CFR 438.915(b) and other sections of this contract which extend notice requirements beyond denials. The MCO shall make available in hard copy upon	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			request at no cost to the requestor and available on the MCO website, the criteria for medical necessity determinations for mental health and substance use disorder benefits to any enrollee, potential enrollee or provider per 42 CFR 438.915 and 438.236. 2.3.9.3. The MCO shall require that all providers and all subcontractors take such actions as are necessary to permit the MCO to comply with mental health parity requirements listed in this contract. To the extent that the MCO delegates oversight responsibilities to a third party, the MCO shall require that such third party complies with provisions of this contract relating to mental health parity. The MCO agrees to require, via contract, that such providers comply with regulations and any enforcement actions, including but not limited to termination and restitution. The MCO shall require mental health	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			parity disclosure on provider enrollment forms as mandated by DHH. 2.3.9.3.1. If at any time the State moves to a single delivery system and any remaining benefits from FFS are completely provided through managed care, it will be the responsibility of the MCO to review mental health and substance user disorder and medical/surgical benefits and conduct the complete parity analysis to ensure the full scope of services available to all enrollees of the MCO complies with the requirements in 42 CFR 438 Subpart K. The MCO will be required to provide documentation to the State and public. 2.3.9.4. The MCO shall provide DHH and its designees, which may include auditors and inspectors, with access to MCO service locations, facilities, or installations,	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			including any and all records and files produced, electronic and hardcopy. Access described in this section shall be for the purpose of examining, auditing, or investigating mental health parity.	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	6.3.2.3. The Formulary shall be reviewed in its entirety and updated at least semi-annually and upon DHH request.	~~6.3.2.3. The Formulary shall be reviewed in its entirety and updated at least semi-annually and upon DHH request.~~	This provision should not have been included this section, as it is not applicable.
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	6.3.3.7. The MCO shall have at least two "preferred" oral behavioral health drugs in each therapeutic class available at a retail pharmacy without prior authorization.	~~6.3.3.7. The MCO shall have at least two "preferred" oral behavioral health drugs in each therapeutic class available at a retail pharmacy without prior authorization.~~	This provision is duplicative of another provision.
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	6.3.3.8. The MCO shall have at least two "preferred" drugs in each therapeutic class and at least one injectable drug in each class that has an injectable product for behavioral health drugs.	6.3.3.8. The MCO shall have at least two <u>oral</u> "preferred" drugs in each <u>behavioral health</u> therapeutic class and at least one injectable drug in each class that has an injectable product ~~for behavioral health~~	This revision clarifies the MCO's responsibility in reference to preferred drugs in each behavioral health therapeutic class.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			~~drugs~~ available without prior authorization.	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	6.3.4.12. Submission and Publication of the Covered Drug List, PDL~~,~~ and Common PDL 6.3.4.12.1. The MCO shall publish and make available to members and providers upon request a hard copy of the most current Covered Drug List~~,~~ PDL and Common PDL. All of the above documents shall be posted together on the MCO web page. Updates to the PDL shall be made available to the provider and DHH thirty (30) days before the effective date of the change.	6.3.4.12. Submission and Publication of the ~~Covered Drug List,~~ PDL~~,~~ and Common PDL 6.3.4.12.1. The MCO shall publish and make available to members and providers upon request a hard copy of the most current ~~Covered Drug List,~~ PDL and Common PDL. ~~All of t~~The ~~above~~ documents shall be posted together on the MCO web page. Updates to the PDL shall be made available to the provider and DHH thirty (30) days before the effective date of the change.	This revision is necessary to remove references to a Covered Drug List.
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	6.3.7.1. The MCO shall include review of Mental Health/Substance Abuse (MH/SA) drugs in its prospective, retrospective and educational DUR program.	6.3.7.1. The MCO shall include review of Mental Health~~/Substance Abuse (MH/SA)~~ drugs in its prospective, retrospective and educational DUR program.	This revision is necessary to clarify requirements related to substance abuse drugs.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	7.17.2. Local Pharmacy Claims Dispute Management The provisions of this section shall apply to dates of service on or after December 1, 2015. 7.17.2.1. Internal Claims Dispute Process 7.17.2.1.1. The MCO shall develop an internal claims dispute process to permit local pharmacies to dispute the reimbursement paid for any claim made for the dispensing of a drug.	7.17.2. Local Pharmacy Claims Dispute Management The provisions of this section shall apply to dates of service on or after ~~December 1, 2015~~October 1, 2017. 7.17.2.1. Internal Claims Dispute Process 7.17.2.1.1. The MCO shall ~~develop~~ maintain an internal claims dispute process to permit local pharmacies to dispute the reimbursement paid for any claim made for the dispensing of a drug. Reimbursement should be no less than the FFS rate on the date of service as required by Act 301 of the 2017 Louisiana Regular Session. Rates should be updated within 7 calendar days of MCO receipt of the Average Acquisition Cost (AAC) from LDH or its designee. MCOs shall be penalized $1,000 per calendar day for each rate that is not updated	The revisions are necessary to ensure compliance with Act 301 of the 2017 Louisiana Regular Legislative Session.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			within the 7 calendar day timeframe.	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	7.17.2.2. External Claims Dispute Process 7.17.2.2.1. The Department shall develop an external claims dispute process to permit local pharmacies to dispute the outcome of the internal claims dispute process. 7.17.2.2.2. The external claims dispute process shall serve as the final authority on local pharmacy claims disputes. 7.17.2.2.3. The Department shall define a reasonable reimbursement level to be used in the external claims dispute process. The Department may amend this definition unilaterally with sixty (60) calendar days' written notice to the MCO. Such notice shall include the revised definition and either an attestation that capitation rates	~~7.17.2.2. External Claims Dispute Process~~ ~~7.17.2.2.1. The Department shall develop an external claims dispute process to permit local pharmacies to dispute the outcome of the internal claims dispute process.~~ ~~7.17.2.2.2. The external claims dispute process shall serve as the final authority on local pharmacy claims disputes.~~ ~~7.17.2.2.3. The Department shall define a reasonable reimbursement level to be used in the external claims dispute process. The Department may amend this definition unilaterally with sixty (60) calendar days' written notice to the MCO. Such notice shall include the revised definition and either an~~	The removal of this provision is necessary to ensure compliance with Act 301 of the 2017 Louisiana Regular Legislative Session.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		remain actuarially sound or that actuarially sound capitation rates will be paid concurrent with implementation of the revised definition. 7.17.2.2.4. As specified in 7.15.1.8, MCOs shall reimburse pharmacies for any state imposed provider fees for pharmacy services. However, for purposes of the external claims dispute process, such fees shall be excluded from the definition of reasonable reimbursement. 7.17.2.2.5. The Department may require pharmacies to submit disputes of the outcome of the internal claims dispute process within fourteen (14) business days of the date of the written notification from the MCO of the outcome of the internal claims dispute process. 7.17.2.2.6. The Department shall provide written notification of the	~~attestation that capitation rates remain actuarially sound or that actuarially sound capitation rates will be paid concurrent with implementation of the revised definition.~~ ~~7.17.2.2.4. As specified in 7.15.1.8, MCOs shall reimburse pharmacies for any state imposed provider fees for pharmacy services. However, for purposes of the external claims dispute process, such fees shall be excluded from the definition of reasonable reimbursement.~~ ~~7.17.2.2.5. The Department may require pharmacies to submit disputes of the outcome of the internal claims dispute process within fourteen (14) business days of the date of the written notification from the MCO of the outcome of the internal claims dispute process.~~	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		outcome of the external claims dispute process to the pharmacy and the MCO within seven (7) business days of the Department receipt. 7.17.2.2.7. If the Department determines that the disputed reimbursement was not reasonable, it shall require the MCO to provide the pharmacy an increased reimbursement to the Fee for Service Medicaid rate and shall require the MCO to update its payable price on file to reflect the increase. The price update shall be completed within seven (7) business days of written notification of the outcome of the external claims dispute process to the MCO. All disputes that are submitted between the fill date of the original overturned dispute and the subsequent payable price file update shall be adjusted to the increased reimbursement.	~~7.17.2.2.6. The Department shall provide written notification of the outcome of the external claims dispute process to the pharmacy and the MCO within seven (7) business days of the Department receipt.~~ ~~7.17.2.2.7. If the Department determines that the disputed reimbursement was not reasonable, it shall require the MCO to provide the pharmacy an increased reimbursement to the Fee for Service Medicaid rate and shall require the MCO to update its payable price on file to reflect the increase. The price update shall be completed within seven (7) business days of written notification of the outcome of the external claims dispute process to the MCO. All disputes that are submitted between the fill date of the original overturned dispute and the subsequent payable price~~	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			~~file update shall be adjusted to the increased reimbursement.~~	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	8.5.1.1 The MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.	8.5.1.1 The MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination, with the exception of authorizations for CPST and PSR services for which the standard for determination is within five (5) calendar days of obtaining appropriate medical information. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.	This revision provides additional time for review of standard service authorization requests for CPST and PSR services to ensure appropriate utilization of services and delivery of services in a clinically appropriate manner.
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	8.12.3. The MCO shall submit individual PCP and specialized behavioral health provider profile reports to DHH quarterly. MCO provider profiling activities shall	~~8.12.3. The MCO shall submit individual PCP and specialized behavioral health provider profile reports to DHH quarterly. MCO provider profiling activities shall~~	LDH removed this requirement previously, so the contract is being revised to align with that change.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		include, but are not limited to, the following: 8.12.3.1. Utilization of out-of-network providers – The MCO shall maintain a procedure to identify and evaluate member out-of-network provider referral utilization by its PCP panel; 8.12.3.2. Specialist referrals – The MCO shall maintain a procedure to identify and evaluate member specialty provider referral utilization by its PCP panel; 8.12.3.3. Emergency department utilization – The MCO shall maintain a procedure to identify and evaluate member emergency department referral utilization by its provider panel; 8.12.3.4. Hospital admits, lab services, medications, and radiology services – The MCO shall maintain a procedure to identify and evaluate member's utilization; and	~~include, but are not limited to, the following:~~ ~~8.12.3.1. Utilization of out-of-network providers – The MCO shall maintain a procedure to identify and evaluate member out-of-network provider referral utilization by its PCP panel;~~ ~~8.12.3.2. Specialist referrals – The MCO shall maintain a procedure to identify and evaluate member specialty provider referral utilization by its PCP panel;~~ ~~8.12.3.3. Emergency department utilization – The MCO shall maintain a procedure to identify and evaluate member emergency department referral utilization by its provider panel;~~ ~~8.12.3.4. Hospital admits, lab services, medications, and radiology services – The MCO shall maintain a procedure to identify and evaluate member's utilization; and~~	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		8.12.3.5. Individual provider clinical quality performance measures as indicated in Appendix J.	~~8.12.3.5. Individual provider clinical quality performance measures as indicated in Appendix J.~~	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	8.13. PCP and Behavioral Health Provider Utilization & Quality Profile Reporting Requirements The MCO shall submit profile reports quarterly with an Annual Summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.	~~8.13. PCP and Behavioral Health Provider Utilization & Quality Profile Reporting Requirements~~ ~~The MCO shall submit profile reports quarterly with an Annual Summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.~~ *Subsequent provisions will be renumbered accordingly.*	LDH removed this requirement previously, so the contract is being revised to align with that change.
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	Add new subsection	10.6.8 The MCO shall not prohibit, discourage, intimidate, or in any other way take retaliatory action against a provider that reports any complaint to LDH.	This provision is being added to ensure that the ability of providers to escalate complaints to LDH is not impaired.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	14.2.5.11.4 The MCO shall report on performance measures in accordance with the current specifications developed by the measure steward and/or approved by DHH.	14.2.5.1 The MCO shall report on performance measures in accordance with the current specifications developed by the measure steward and/or approved by DHH. The measures will be updated if a HEDIS measure is retired.	This revision clarifies the MCO's responsibility for retired HEDIS measures.
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	17.6.5 The MCO shall resolve all disputed claims, no later than twenty-four (24) months from the date of service.	~~17.6.5 The MCO shall resolve all disputed claims, no later than twenty-four (24) months from the date of service.~~	This provision is being removed because it is an outdated requirement that is inconsistent with other requirements in this contract.
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	Add new subsection	17.6.5 Providers shall have the right to an independent review of claims that are the subject of an adverse determination by the MCO. The review shall be provided and conducted in accordance with R.S. 46:460.31 through 460.89	The addition of this provision is necessary to ensure compliance with Act 349 of the 2017 Louisiana Regular Legislative Session.
Appendix J	Performance Measure Reporting	Changes contained in the attached document.	Changes contained in the attached document.	This revision modifies reporting requirements for incentive-based performance measures.

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

Erik Axelsen, ASA, MAAA
Senior Associate

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MERCER
MAKE TOMORROW, TODAY

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

January 8, 2018

Subject: Healthy Louisiana Program – Full Risk-Bearing Managed Care Organization (MCO) Rate Development and Actuarial Certification for the Period October 1, 2017 through January 31, 2018

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 Healthy Louisiana program for the period of February 1, 2017 through January 31, 2018. This certification amends the previous certification issued March 13, 2017 for rates effective February 1, 2017 through January 31, 2018; and applies to the period of October 1, 2017 through January 31, 2018. The amendment to reflect the impact of an operational change related to the management of Mental Health Rehabilitation (MHR) services implemented by LDH effective October 1, 2017.

This letter presents an overview of the analysis and methodology used to support the change, and the resulting capitation rate ranges effective October 1, 2017 through January 31, 2018 for

[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 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 capitation rate ranges are summarized in Appendix A and represent payment in full for the covered services.

Operational Changes for Mental Health Rehabilitation Services

Effective October 1, 2017, LDH implemented an initiative with the MCOs to improve utilization management of Community Psychiatric Support (CPST) and Psychosocial Rehabilitation (PSR) services for child and adult recipients. LDH worked directly with each of the Healthy Louisiana MCOs to revise their approach to the management of these services by including utilization management protocols. LDH expects this initiative to reduce CPST and PSR utilization by approximately 3.75%.

Mercer reviewed the utilization management plans for all Healthy Louisiana MCOs, as well as LDH's estimated utilization impacts for this initiative and determined they are reasonable and attainable. Accordingly, Mercer applied a utilization reduction of 3.75%. Appendix B summarizes the CPST and PSR services' Non-Expansion rating adjustment. Furthermore, because Expansion rates are based on the Family & Children Adult experience, Mercer determined that a small adjustment to the Expansion rates was also necessary. These adjustments are illustrated in Appendix C. The overall impact to the Non-Expansion and Expansion rates due to the reduction in CPST and PSR services is -0.25% and -0.03%, respectively.

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	Upper Bound PMPM or Cost Per Delivery
Gulf	SSI	0 - 2 Months	$27,236.66	$28,997.75
Gulf	SSI	3 - 11 Months	$7,421.96	$7,900.92
Gulf	SSI	Child 1 - 20 Years	$784.22	$848.88
Gulf	SSI	Adult 21+ Years	$1,304.99	$1,385.29
Gulf	Family & Children	0 - 2 Months	$1,647.96	$1,764.97
Gulf	Family & Children	3 - 11 Months	$272.13	$288.99
Gulf	Family & Children	Child 1 - 20 Years	$168.21	$181.10
Gulf	Family & Children	Adult 21+ Years	$339.95	$359.06
Gulf	Foster Care Children	All Ages Male & Female	$613.52	$675.29
Gulf	BCC	BCC, All Ages	$2,322.40	$2,451.23
Gulf	LAP	LAP, All Ages	$197.95	$212.54
Gulf	HCBS	Child 1 - 20 Years	$2,486.48	$2,719.46
Gulf	HCBS	Adult 21+ Years	$1,072.08	$1,148.96
Gulf	CCM	CCM, All Ages	$1,288.05	$1,418.34
Gulf	SBH - CCM	SBH - CCM, All Ages	$197.88	$222.06
Gulf	SBH – Duals & LaHIPP	SBH - Dual Eligible & LaHIPP, All Ages	$25.74	$27.31
Gulf	SBH - HCBS	SBH - Child 1 - 20 Years	$91.34	$101.58
Gulf	SBH - HCBS	SBH - Adult 21+ Years	$79.86	$84.38
Gulf	SBH - Other	SBH - All Ages	$193.52	$203.38
Gulf	Maternity Kick Payment	Maternity Kick Payment	$11,368.59	$11,595.14
Gulf	EED Kick Payment	EED Kick Payment	$6,630.01	$6,694.80
Gulf	Medicaid Expansion	Female Age 19 - Age 24	$315.51	$343.20
Gulf	Medicaid Expansion	Male Age 19 - Age 24	$276.78	$299.37
Gulf	Medicaid Expansion	Female Age 25 - Age 39	$416.66	$457.66
Gulf	Medicaid Expansion	Male Age 25 - Age 39	$381.69	$418.08
Gulf	Medicaid Expansion	Female Age 40 - Age 49	$589.74	$653.52
Gulf	Medicaid Expansion	Male Age 40 - Age 49	$580.06	$642.56
Gulf	Medicaid Expansion	Female Age 50 - Age 64	$684.70	$760.97
Gulf	Medicaid Expansion	Male Age 50 - Age 64	$768.46	$855.76
Gulf	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages	$25.74	$27.31
Gulf	Medicaid Expansion	SBH - Other, All Ages	$193.52	$203.38

Region Description	COA Description	Rate Cell Description	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost Per Delivery
Gulf	Medicaid Expansion	SBH - Chisholm, All Ages	$197.88	$222.06
Gulf	Medicaid Expansion	High Needs	$1,330.42	$1,473.17
Gulf	Medicaid Expansion	Maternity Kick Payment	$11,368.59	$11,595.14
Gulf	Medicaid Expansion	EED Kick Payment	$6,630.01	$6,694.80
Capital	SSI	0 - 2 Months	$27,236.66	$28,997.75
Capital	SSI	3 - 11 Months	$7,421.96	$7,900.92
Capital	SSI	Child 1 - 20 Years	$798.05	$865.75
Capital	SSI	Adult 21+ Years	$1,354.86	$1,443.99
Capital	Family & Children	0 - 2 Months	$1,718.94	$1,842.46
Capital	Family & Children	3 - 11 Months	$265.45	$282.20
Capital	Family & Children	Child 1 - 20 Years	$176.01	$189.59
Capital	Family & Children	Adult 21+ Years	$396.56	$418.94
Capital	Foster Care Children	All Ages Male & Female	$613.52	$675.29
Capital	BCC	BCC, All Ages	$2,322.40	$2,451.23
Capital	LAP	LAP, All Ages	$197.95	$212.54
Capital	HCBS	Child 1 - 20 Years	$2,486.48	$2,719.46
Capital	HCBS	Adult 21+ Years	$1,072.08	$1,148.96
Capital	CCM	CCM, All Ages	$1,288.05	$1,418.34
Capital	SBH - CCM	SBH - CCM, All Ages	$197.88	$222.06
Capital	SBH – Duals & LaHIPP	SBH - Dual Eligible & LaHIPP, All Ages	$20.86	$22.13
Capital	SBH - HCBS	SBH - Child 1 - 20 Years	$91.34	$101.58
Capital	SBH - HCBS	SBH - Adult 21+ Years	$79.86	$84.38
Capital	SBH - Other	SBH - All Ages	$193.52	$203.38
Capital	Maternity Kick Payment	Maternity Kick Payment	$9,215.36	$9,415.41
Capital	EED Kick Payment	EED Kick Payment	$5,028.99	$5,086.20
Capital	Medicaid Expansion	Female Age 19 - Age 24	$358.87	$392.08
Capital	Medicaid Expansion	Male Age 19 - Age 24	$312.36	$339.46
Capital	Medicaid Expansion	Female Age 25 - Age 39	$480.36	$529.54
Capital	Medicaid Expansion	Male Age 25 - Age 39	$438.35	$482.01
Capital	Medicaid Expansion	Female Age 40 - Age 49	$688.23	$764.72
Capital	Medicaid Expansion	Male Age 40 - Age 49	$676.60	$751.57
Capital	Medicaid Expansion	Female Age 50 - Age 64	$802.28	$893.76
Capital	Medicaid Expansion	Male Age 50 - Age 64	$902.88	$1,007.58
Capital	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All	$20.86	$22.13

Region Description	COA Description	Rate Cell Description	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost Per Delivery
		Ages		
Capital	Medicaid Expansion	SBH - Other, All Ages	$193.52	$203.38
Capital	Medicaid Expansion	SBH - Chisholm, All Ages	$197.88	$222.06
Capital	Medicaid Expansion	High Needs	$1,550.80	$1,721.93
Capital	Medicaid Expansion	Maternity Kick Payment	$9,215.36	$9,415.41
Capital	Medicaid Expansion	EED Kick Payment	$5,028.99	$5,086.20
South Central	SSI	0 - 2 Months	$27,236.66	$28,997.75
South Central	SSI	3 - 11 Months	$7,421.96	$7,900.92
South Central	SSI	Child 1 - 20 Years	$758.29	$822.49
South Central	SSI	Adult 21+ Years	$1,208.54	$1,283.70
South Central	Family & Children	0 - 2 Months	$2,089.31	$2,219.67
South Central	Family & Children	3 - 11 Months	$282.30	$299.43
South Central	Family & Children	Child 1 - 20 Years	$170.47	$183.10
South Central	Family & Children	Adult 21+ Years	$366.13	$386.62
South Central	Foster Care Children	All Ages Male & Female	$613.52	$675.29
South Central	BCC	BCC, All Ages	$2,322.40	$2,451.23
South Central	LAP	LAP, All Ages	$197.95	$212.54
South Central	HCBS	Child 1 - 20 Years	$2,486.48	$2,719.46
South Central	HCBS	Adult 21+ Years	$1,072.08	$1,148.96
South Central	CCM	CCM, All Ages	$1,288.05	$1,418.34
South Central	SBH - CCM	SBH - CCM, All Ages	$197.88	$222.06
South Central	SBH – Duals & LaHIPP	SBH - Dual Eligible & LaHIPP, All Ages	$17.81	$18.89
South Central	SBH - HCBS	SBH - Child 1 - 20 Years	$91.34	$101.58
South Central	SBH - HCBS	SBH - Adult 21+ Years	$79.86	$84.38
South Central	SBH - Other	SBH - All Ages	$193.52	$203.38
South Central	Maternity Kick Payment	Maternity Kick Payment	$9,109.94	$9,315.27
South Central	EED Kick Payment	EED Kick Payment	$4,812.50	$4,871.23
South Central	Medicaid Expansion	Female Age 19 - Age 24	$336.09	$366.50
South Central	Medicaid Expansion	Male Age 19 - Age 24	$293.43	$318.24
South Central	Medicaid Expansion	Female Age 25 - Age 39	$447.53	$492.55
South Central	Medicaid Expansion	Male Age 25 - Age 39	$409.00	$448.96
South Central	Medicaid Expansion	Female Age 40 - Age 49	$638.19	$708.23
South Central	Medicaid Expansion	Male Age 40 - Age 49	$627.53	$696.16

Region Description	COA Description	Rate Cell Description	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost Per Delivery
South Central	Medicaid Expansion	Female Age 50 - Age 64	$742.81	$826.56
South Central	Medicaid Expansion	Male Age 50 - Age 64	$835.08	$930.94
South Central	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages	$17.81	$18.89
South Central	Medicaid Expansion	SBH - Other, All Ages	$193.52	$203.38
South Central	Medicaid Expansion	SBH - Chisholm, All Ages	$197.88	$222.06
South Central	Medicaid Expansion	High Needs	$1,437.90	$1,594.58
South Central	Medicaid Expansion	Maternity Kick Payment	$9,109.94	$9,315.27
South Central	Medicaid Expansion	EED Kick Payment	$4,812.50	$4,871.23
North	SSI	0 - 2 Months	$27,236.66	$28,997.75
North	SSI	3 - 11 Months	$7,421.96	$7,900.92
North	SSI	Child 1 - 20 Years	$841.90	$917.03
North	SSI	Adult 21+ Years	$1,117.47	$1,186.43
North	Family & Children	0 - 2 Months	$2,032.44	$2,161.95
North	Family & Children	3 - 11 Months	$279.89	$297.22
North	Family & Children	Child 1 - 20 Years	$173.58	$187.82
North	Family & Children	Adult 21+ Years	$336.12	$355.46
North	Foster Care Children	All Ages Male & Female	$613.52	$675.29
North	BCC	BCC, All Ages	$2,322.40	$2,451.23
North	LAP	LAP, All Ages	$197.95	$212.54
North	HCBS	Child 1 - 20 Years	$2,486.48	$2,719.46
North	HCBS	Adult 21+ Years	$1,072.08	$1,148.96
North	CCM	CCM, All Ages	$1,288.05	$1,418.34
North	SBH - CCM	SBH - CCM, All Ages	$197.88	$222.06
North	SBH – Duals & LaHIPP	SBH - Dual Eligible & LaHIPP, All Ages	$19.90	$21.11
North	SBH - HCBS	SBH - Child 1 - 20 Years	$91.34	$101.58
North	SBH - HCBS	SBH - Adult 21+ Years	$79.86	$84.38
North	SBH - Other	SBH - All Ages	$193.52	$203.38
North	Maternity Kick Payment	Maternity Kick Payment	$10,063.87	$10,264.05
North	EED Kick Payment	EED Kick Payment	$5,872.28	$5,929.53
North	Medicaid Expansion	Female Age 19 - Age 24	$310.98	$339.44
North	Medicaid Expansion	Male Age 19 - Age 24	$271.39	$294.61
North	Medicaid Expansion	Female Age 25 - Age 39	$414.39	$456.54
North	Medicaid Expansion	Male Age 25 - Age 39	$378.63	$416.05

Region Description	COA Description	Rate Cell Description	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost Per Delivery
North	Medicaid Expansion	Female Age 40 - Age 49	$591.33	$656.89
North	Medicaid Expansion	Male Age 40 - Age 49	$581.43	$645.68
North	Medicaid Expansion	Female Age 50 - Age 64	$688.41	$766.81
North	Medicaid Expansion	Male Age 50 - Age 64	$774.03	$863.77
North	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages	$19.90	$21.11
North	Medicaid Expansion	SBH - Other, All Ages	$193.52	$203.38
North	Medicaid Expansion	SBH - Chisholm, All Ages	$197.88	$222.06
North	Medicaid Expansion	High Needs	$1,328.66	$1,475.38
North	Medicaid Expansion	Maternity Kick Payment	$10,063.87	$10,264.05
North	Medicaid Expansion	EED Kick Payment	$5,872.28	$5,929.53

Appendix B: Non-Expansion CPST and PSR Services Adjustment

			Feb 2017 - Jan 2018 Rates						
			A	B	C	D	E = A + B + C + D	F	G = E + F
COA Description	Rate Cell Description	CY2014 MMs	Claims PMPM	Total Admin PMPM	UW Gain PMPM	Prem Tax PMPM	Limited Rate PMPM	FMP Add On PMPM	Full Rate PMPM
SSI	Newborn, 0-2 Months	1,777	$ 17,896.96	$ 966.71	$ 407.86	$ 1,121.62	$ 20,393.15	$ 6,843.58	$ 27,236.73
SSI	Newborn, 3-11 Months	7,473	$ 4,802.04	$ 251.62	$ 109.27	$ 300.49	$ 5,463.41	$ 1,958.67	$ 7,422.08
SSI	Child, 1-20 Years	438,102	$ 622.49	$ 41.28	$ 14.35	$ 39.47	$ 717.58	$ 83.76	$ 801.34
SSI	Adult, 21+ Years	908,893	$ 907.31	$ 50.77	$ 20.72	$ 56.97	$ 1,035.75	$ 212.19	$ 1,247.95
Family and Children	Newborn, 0-2 Months	181,298	$ 1,165.24	$ 75.17	$ 26.82	$ 73.75	$ 1,340.98	$ 519.13	$ 1,860.11
Family and Children	Newborn, 3-11 Months	408,855	$ 191.51	$ 22.48	$ 4.63	$ 12.72	$ 231.34	$ 43.57	$ 274.90
Family and Children	Child, 1-20 Years	8,163,747	$ 127.12	$ 19.13	$ 3.16	$ 8.70	$ 158.12	$ 14.73	$ 172.85
Family and Children	Adult, 21+ Years	1,405,973	$ 258.33	$ 24.80	$ 6.12	$ 16.83	$ 306.08	$ 53.40	$ 359.48
Foster Care Children	Foster Care, All Ages M & F	145,854	$ 514.08	$ 38.35	$ 11.94	$ 32.85	$ 597.22	$ 20.15	$ 617.38
Breast and Cervical Cancer	BCC, All Ages Female	11,167	$ 1,585.59	$ 86.67	$ 36.16	$ 99.43	$ 1,807.85	$ 514.58	$ 2,322.44
LaCHIP Affordable Plan	All Ages	32,566	$ 149.30	$ 19.87	$ 3.66	$ 10.06	$ 182.88	$ 15.51	$ 198.39
HCBS Waiver	20 & Under, M & F	4,275	$ 2,079.78	$ 115.34	$ 47.46	$ 130.52	$ 2,373.10	$ 114.87	$ 2,487.97
HCBS Waiver	21+ Years, M & F	12,346	$ 809.53	$ 44.71	$ 18.47	$ 50.79	$ 923.50	$ 148.97	$ 1,072.47
Chisholm Class Members	Chisholm, All Ages M & F	20,773	$ 1,035.92	$ 71.71	$ 23.95	$ 65.86	$ 1,197.44	$ 93.73	$ 1,291.17
SBH - Chisholm Class Members	SBH - Chisholm, All Ages M & F	54,449	$ 175.51	$ 10.32	$ 4.02	$ 11.05	$ 200.90	$ -	$ 200.90
SBH - Dual Eligible	SBH - Dual Eligible, All Ages	1,240,232	$ 16.92	$ 2.31	$ 0.42	$ 1.14	$ 20.79	$ 0.48	$ 21.27
SBH - HCBS Waiver	SBH - 20 & Under, M & F	23,926	$ 76.08	$ 5.30	$ 1.76	$ 4.84	$ 87.98	$ 4.79	$ 92.77
SBH - HCBS Waiver	SBH - 21+ Years, M & F	47,163	$ 62.29	$ 4.60	$ 1.45	$ 3.98	$ 72.32	$ 7.90	$ 80.22
SBH -Other	SBH - Other, All Ages	37,833	$ 137.18	$ 8.38	$ 3.15	$ 8.66	$ 157.37	$ 36.21	$ 193.57
Maternity Kickpayment	Maternity Kickpayment, All Ages	76,325	$ 5,405.85	$ 286.50	$ 123.08	$ 338.46	$ 6,153.90	$ 3,909.03	$ 10,062.93
	Aggregate	**13,146,701**	**$ 262.17**	**$ 24.14**	**$ 6.19**	**$ 17.02**	**$ 309.53**	**$ 66.78**	**$ 376.31**

		Oct 2017 - Jan 2018 Rates							
		H	I = A + H	J	K	L	M = I + J + K + L	N	O = M + N
COA Description	Rate Cell Description	Reduction in CPST & PSR Services	Resulting Claims PMPM	Total Admin PMPM	UW Gain PMPM	Prem Tax PMPM	Limited Rate PMPM	FMP Add On PMPM	Full Rate PMPM
SSI	Newborn, 0-2 Months	$ (0.07)	$ 17,896.89	$ 966.71	$ 407.86	$ 1,121.62	$ 20,393.08	$ 6,843.58	$ 27,236.66
SSI	Newborn, 3-11 Months	$ (0.12)	$ 4,801.92	$ 251.62	$ 109.27	$ 300.48	$ 5,463.28	$ 1,958.67	$ 7,421.95
SSI	Child, 1-20 Years	$ (4.58)	$ 617.91	$ 41.28	$ 14.25	$ 39.19	$ 712.63	$ 83.76	$ 796.39
SSI	Adult, 21+ Years	$ (0.71)	$ 906.60	$ 50.77	$ 20.70	$ 56.92	$ 1,034.99	$ 212.19	$ 1,247.18
Family and Children	Newborn, 0-2 Months	$ (0.02)	$ 1,165.21	$ 75.17	$ 26.82	$ 73.75	$ 1,340.95	$ 519.13	$ 1,860.08
Family and Children	Newborn, 3-11 Months	$ (0.01)	$ 191.50	$ 22.48	$ 4.63	$ 12.72	$ 231.33	$ 43.57	$ 274.89
Family and Children	Child, 1-20 Years	$ (0.93)	$ 126.20	$ 19.13	$ 3.14	$ 8.64	$ 157.12	$ 14.73	$ 171.85
Family and Children	Adult, 21+ Years	$ (0.12)	$ 258.22	$ 24.80	$ 6.12	$ 16.83	$ 305.96	$ 53.40	$ 359.36
Foster Care Children	Foster Care, All Ages M & F	$ (3.57)	$ 510.52	$ 38.35	$ 11.87	$ 32.64	$ 593.37	$ 20.15	$ 613.52
Breast and Cervical Cancer	BCC, All Ages Female	$ (0.05)	$ 1,585.54	$ 86.67	$ 36.16	$ 99.43	$ 1,807.80	$ 514.58	$ 2,322.38
LaCHIP Affordable Plan	All Ages	$ (0.42)	$ 148.88	$ 19.87	$ 3.65	$ 10.03	$ 182.43	$ 15.51	$ 197.93
HCBS Waiver	20 & Under, M & F	$ (1.36)	$ 2,078.41	$ 115.34	$ 47.43	$ 130.44	$ 2,371.62	$ 114.87	$ 2,486.49
HCBS Waiver	21+ Years, M & F	$ (0.36)	$ 809.17	$ 44.71	$ 18.46	$ 50.77	$ 923.11	$ 148.97	$ 1,072.09
Chisholm Class Members	Chisholm, All Ages M & F	$ (2.89)	$ 1,033.03	$ 71.71	$ 23.89	$ 65.69	$ 1,194.31	$ 93.73	$ 1,288.05
SBH - Chisholm Class Members	SBH - Chisholm, All Ages M & F	$ (2.79)	$ 172.71	$ 10.32	$ 3.96	$ 10.88	$ 197.88	$ -	$ 197.88
SBH - Dual Eligible	SBH - Dual Eligible, All Ages	$ (0.17)	$ 16.75	$ 2.31	$ 0.41	$ 1.13	$ 20.60	$ 0.48	$ 21.08
SBH - HCBS Waiver	SBH - 20 & Under, M & F	$ (1.32)	$ 74.77	$ 5.30	$ 1.73	$ 4.76	$ 86.56	$ 4.79	$ 91.34
SBH - HCBS Waiver	SBH - 21+ Years, M & F	$ (0.34)	$ 61.95	$ 4.60	$ 1.44	$ 3.96	$ 71.95	$ 7.90	$ 79.85
SBH -Other	SBH - Other, All Ages	$ (0.05)	$ 137.12	$ 8.38	$ 3.15	$ 8.65	$ 157.31	$ 36.21	$ 193.51
Maternity Kickpayment	Maternity Kickpayment, All Ages	$ -	$ 5,405.85	$ 286.50	$ 123.08	$ 338.46	$ 6,153.90	$ 3,909.03	$ 10,062.93
	Aggregate	**$ (0.87)**	**$ 261.30**	**$ 24.14**	**$ 6.17**	**$ 16.97**	**$ 308.59**	**$ 66.78**	**$ 375.37**
	Difference	$ (0.87)	$ -	$ (0.02)	$ (0.05)	$ (0.94)	$ -	$ (0.94)	

Appendix C: Expansion CPST and PSR Services Adjustment

			Feb 2017 - Jan 2018 Rates						
			A	B	C	D	E = A + B + C + D	F	G = E + F
COA Description	Rate Cell Description	Projected MMs	Claims PMPM	Total Admin PMPM	UW Gain PMPM	Prem Tax PMPM	Limited Rate PMPM	FMP Add On PMPM	Full Rate PMPM
Expansion	Aggregate	4,771,283	$ 371.00	$ 26.49	$ 8.59	$ 23.63	$ 429.72	$ 74.61	$ 504.32

		Oct 2017 - Jan 2018 Rates							
		H	I = A + H	J	K	L	M = I + J + K + L	N	O = M + N
COA Description	Rate Cell Description	Reduction in CPST & PSR Services	Resulting Claims PMPM	Total Admin PMPM	UW Gain PMPM	Prem Tax PMPM	Limited Rate PMPM	FMP Add On PMPM	Full Rate PMPM
Expansion	Aggregate	$ (0.15)	$ 370.85	$ 26.49	$ 8.59	$ 23.63	$ 429.55	$ 74.61	$ 504.16
Difference		$ (0.15)	$ -	$ (0.00)	$ (0.01)	$ (0.17)	$ -	$ (0.17)	

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2017 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE

Louisiana — February 1, 2017 through January 31, 2018

Documentation Reference

The 2016 Medicaid Managed Care Rate Development Guide below documents 2 rate certifications for the period February 1, 2017 through January 31, 2018. Due to the rate revision, the previously issued certification (certification #1) may need to be referenced for the requested documentation. Below is a list of certifications applicable to the time period of February 1, 2017 through January 31, 2018. Items not marked in Certification #2 are not altered by the revision.

- Certification #1- Rate Certification dated March 13, 2017 for effective period February 1, 2017 through January 31, 2018. This certification was revised by certification #2 for the period October 1, 2017 through January 31, 2018.
- Certification #2- Rate Certification dated December 1, 2017 for effective period October 1, 2017 through January 31, 2018.

Section I. Medicaid Managed Care Rates	Documentation Reference	
	Certification #1	Certification #2
1. General Information		

MARSH & McLENNAN COMPANIES

Section I. Medicaid Managed Care Rates	Documentation Reference	
	Certification #1	Certification #2
1. General Information		
A. Rate certifications must be done on a 12-month rating period.[1] CMS will consider a time period other than 12-months to address unusual circumstances. For example, CMS will approve a time period other than 12 months for the following reasons: i. When the state is trying to align program rating periods, which may require a rating period longer than one year (but less than two years); or ii. When the state needs to make an amendment to the contract and the rates for an already approved rating period need to be adjusted accordingly.	• N/A	•

[1] As required by 42 CFR §438.2, the definition of a rating period is a period of 12 months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification.

Section I. Medicaid Managed Care Rates	Documentation Reference	
	Certification #1	Certification #2
1. General Information		
B. States and their actuaries must document all the elements described within their rate certifications to provide adequate detail that CMS is able to determine whether the regulatory standards are met. In evaluating the certification, CMS will look to the reasonableness of the information contained in the certification for the purposes of rate development and may require additional information or documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented: i. Data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources. ii. Assumptions made, including any basis or justification for the assumption; and iii. Methods for analyzing data and developing assumptions and adjustments.	• Mercer Rate Certification • Data Book	•
C. The rate certification must include an index that documents the page number or the section number for the items described within this guidance. In cases where not all sections of this guidance are relevant for a particular rate certification (i.e., an amended certification that adds a new benefit for part of the year), inapplicable sections of the guidance should be included and marked as "Not Applicable" in the index.		

Section I. Medicaid Managed Care Rates	Documentation Reference	
	Certification #1	Certification #2
1. General Information		
D. An acceptable rate certification submission, as supported by the assurances from the state, must include the following items and information:		
i. A letter from the certifying actuary, who meets the requirements for an actuary in 42 CFR 438.2, who certifies that the final capitation rates or rate ranges meet the standards in 42 CFR 438.3(c), 438.3(e), 438.4(a), 438.4(b)(1), 438.4(b)(2), 438.4(b)(5), 438.4(b)(6), 438.5(a), 438.5(g), 438.6(a), 438.6(b)(1), 438.6(b)(2), and 438.6(e);	• Mercer Rate Certification ○ Part E: Certification of Final Rate Ranges, pages 41-42	• Mercer Rate Certification • Certification Final Rate Ranges, pages 2-4
ii. The final and certified capitation rates or the final and certified rate ranges for all rate cells and regions;	• Mercer Rate Certification ○ Appendix A	• Mercer Rate Certification • Appendix A, pages 5-9

iii. If rate ranges are certified, assurances that the capitation rate for each rate cell is within the certified rate range; and	• Mercer Rate Certification
	  ○ Introduction, page 1
	  ○ Part E: Certification of Final Rate Ranges, pages 41-42
		• Mercer Rate Certification
		• Introduction, pages 1-2
		• Certification of Final Rate Ranges, pages 2-4

iv. Brief descriptions of the following information (to show that the actuary developing and/or certifying the rates has an appropriate understanding of the program for which he or she is setting rates):		

Section I. Medicaid Managed Care Rates	Documentation Reference	
	Certification #1	Certification #2
1. General Information		
a. A summary of the specific state Medicaid managed care programs covered by the certification. This would include, but not be limited to, the types and numbers of managed care plans included in the rate development (e.g., type should include the program type, such as managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans; and the general types of benefits offered, such as medical or physical health, behavioral or mental health, dental health, and long-term services and supports), the areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.	• Mercer Rate Certification ○ Introduction, pages 1-2	• Mercer Rate Certification • Introduction, pages 1-2
b. The rating periods covered by the certification.	• Mercer Rate Certification ○ Introduction, page 1	• Mercer Rate Certification • Introduction, pages 1-2

c. The Medicaid population(s) covered through the managed care programs for which the certification applies.	• Mercer Rate Certification
	  ○ Introduction, pages 1-2
	  ○ Healthy Louisiana Populations, pages 3-9
	  ○ Appendix B
		•

Section I. Medicaid Managed Care Rates	Documentation Reference	
	Certification #1	Certification #2
1. General Information		

d. Any eligibility or enrollment criteria that could have a significant influence on the specific population to be covered within the managed care program (e.g., the definition of medically frail, or if enrollment in managed care plans is voluntary or mandatory).	• Mercer Rate Certification
	  ○ Healthy Louisiana Populations, pages 3-9
	  ○ Appendix B
		•

e. A general description or list of the benefits that are required to be provided by the managed care plan or plans (e.g., types of medical services, behavioral health or mental health services, long-term care services, etc.), particularly noting any benefits that are carved out of the managed care program or that are new to the managed care program in that rating period covered.	• Mercer Rate Certification
	  ○ Healthy Louisiana Services, pages 9-11
	  ○ Appendix C
		•

Section I. Medicaid Managed Care Rates	Documentation Reference	
2. Data	**Certification #1**	**Certification #2**
A. The rate certification, as supported by the assurances from the State, must thoroughly describe the data used to develop the capitation rates including:		
i. A description of the data, including:		
a. The types of data used, which may include, but is not limited to: fee-for-service claims data; managed care encounter data; health plan financial data; information from program integrity audits; or other Medicaid program data.	• Mercer Rate Certification ○ Part A: Base Data Development, pages 2-3	• Mercer Rate Certification • Intro, page 2
b. The age or time periods of all data used.	• Mercer Rate Certification ○ Part A: Base Data Development, pages 2-3	•
c. The sources of all data used (e.g., State Medicaid Agency; other state agencies; health plans; or other third parties).	• Mercer Rate Certification ○ Part A: Base Data Development, pages 2-3	•
d. If a significant portion of the benefits under the contract with the managed care entity are provided through arrangements with subcontractors that are also paid on a capitated basis (or subcapitated arrangements), a description of the data received from the subcapitated plans or providers; or, if data is not received from the subcapitated plans or providers, a description of how the historical costs related to subcapitated arrangements were developed or verified.	• N/A	•
ii. Information related to the availability and the quality of the data used for rate development, including:		

Section I. Medicaid Managed Care Rates	Documentation Reference	
2. Data	**Certification #1**	**Certification #2**
a. The steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including: (i) Completeness of the data; (ii) Accuracy of the data; and (iii) Consistency of the data across data sources.	• Mercer Rate Certification ○ Part A: Base Data Development, pages 2-3 ○ Base Data Adjustments, pages 12-13	•
b. A summary of the actuary's assessment of the data.	• Mercer Rate Certification ○ Part A: Base Data Development, pages 2-3 ○ Part E: Certification of Final Rate Ranges, pages 40-41	•
c. Any other concerns that the actuary has over the availability or quality of the data.	• N/A	•
iii. If fee-for-service claims or managed care encounter data are not used (or are not available), an explanation of why that data was not used (or was not available) and why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.	• N/A	•
iv. If managed care encounter data was not used in the rate development, an explanation of why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data.	• N/A	•
v. If there is any reliance or use of a data book in the rate development, the details of the template and relevant instructions used in the data book.	• N/A	•

Section I. Medicaid Managed Care Rates	Documentation Reference	
2. Data	**Certification #1**	**Certification #2**
B. The rate certification, as supported by the assurances from the State, must thoroughly describe any significant adjustments, and the basis for the adjustments, that are made to the data, including but not limited to adjustments for:		

i. The credibility of the data;	• Mercer Rate Certification
	  ○ Part A: Base Data Development, pages 2-3
	  ○ Base Data Adjustments, pages 12-13
		•

ii. Completion factors;	• Mercer Rate Certification
	  ○ Part A: Base Data Development, pages 2-3
	  ○ Base Data Adjustments, pages 12-13
		•

iii. Errors found in the data;	• Mercer Rate Certification ○ Assertive Community Treatment (ACT) Services Payment Adjustment, pages 12-13	•

iv. Changes in the program between the time period from which the data is obtained and the rating period (e.g., changes in the population covered; changes in benefits or services; changes to payment models or reimbursement rates to providers; or changes to the structure of the managed care program); and	• Mercer Rate Certification
	  ○ Part B, Subpart B-1, Section 1, Subsection 1.a, pages 14-23
	  ○ Part B, Subpart B-1, Section 1, Subsection 1.a, pages 23-28
		• Mercer Rate Certification
		• Operational Changes, page 2

Section I. Medicaid Managed Care Rates	Documentation Reference	
2. Data	**Certification #1**	**Certification #2**
v. Exclusions of certain payments or services from the data.	• Mercer Rate Certification ○ Healthy Louisiana Services, pages 9-11	•

Section I. Medicaid Managed Care Rates	Documentation Reference	
3. Projected Benefit Costs and Trends	**Certification #1**	**Certification #2**
A. Final capitation rates must comply with 42 CFR 438.4(b)(6) and must be based only upon services described in 42 CFR 438.3(c)(1)(ii) and 438.3(e).		
B. Variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.		
C. The rate certification and supporting documentation must describe the development of the projected benefit costs included in the capitation rates, including:		
i. A description of the data, assumptions, and methodologies used to develop the projected benefit costs and, in particular, all significant and material items in developing the projected benefit costs.	• Mercer Rate Certification ○ Part B, Subpart B-1, Section 1, pages 14-33	• Mercer Rate Certification • Operational Changes, page 2
ii. Any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last certification must be described.	• Mercer Rate Certification ○ Part B, Subpart B-1, Section 1, pages 14-33	• Mercer Rate Certification • Operational Changes, page 2
D. The rate certification and supporting documentation must include a section on projected benefit cost trends (i.e., an estimate the projected change in benefit costs from the historical base data period(s) to the rating period of the rate certification).		
i. This section must include:		
a. Any data used or assumptions made in developing projected benefit cost trends, including a description of the sources of those data and assumptions. The descriptions of data and assumptions should include citations whenever possible.	• Mercer Rate Certification ○ PH Trend, page 18 ○ Historical Trend, page 26 ○ SBH Trend, page 27	•
b. The methodologies used to develop projected benefit trends.	• Mercer Rate Certification ○ PH Trend, page 18 ○ Historical Trend, page 26 ○ SBH Trend, page 28	•

Section I. Medicaid Managed Care Rates	Documentation Reference	
3. Projected Benefit Costs and Trends	**Certification #1**	**Certification #2**
c. Any comparisons to historical benefit cost trends, or other program benefit cost trends, that were analyzed as part of the development of the trend for the rating period of the rate certification.	• Mercer Rate Certification ○ PH Trend, page 18 ○ Historical Trend, page 26 ○ SBH Trend, page 28	•
ii. This section must include the projected benefit cost trends separated into components, specifically:		
a. The projected benefit cost trends should be separated into: (i) Changes in price (i.e., pricing differences due to different provider reimbursement rates or payment models); a-nd (ii) Changes in utilization (i.e., differences in the amount, duration, or mix of benefits or services provided).	• Mercer Rate Certification ○ Appendix E	•
b. If the actuary did not develop the projected benefit cost trends using price and utilization components, the actuary should describe and justify the method(s) used to develop projected benefit cost trends.	• Mercer Rate Certification ○ PH Trend, page 18 ○ SBH Trend, page 28	•
c. The projected benefit cost trends may include other components as applicable and used by the actuary in developing rates (e.g., changes in location of service delivery; the effect of utilization or care management on projected benefit cost trends; regional differences or variations).	• N/A	•
iii. Variations in the projected benefit cost trends must be explained. Projected benefit cost trends may vary by: a. Medicaid populations. b. Rate cells; or c. Subsets of benefits within a category of services (e.g., specialty vs. non-specialty drugs).	• Mercer Rate Certification ○ PH Trend, page 18 ○ Historical Trend, page 26 ○ SBH Trend, page 28	•

Section I. Medicaid Managed Care Rates	Documentation Reference	
3. Projected Benefit Costs and Trends	**Certification #1**	**Certification #2**
iv. Any other material adjustments to projected benefit cost trends, including a description of the data, assumptions, and methodologies used to determine those adjustments must be included.	• N/A	•
v. Any other adjustments to projected benefit costs trends must be described, including: a. The impact of managed care on the utilization and the unit costs of health care services; or b. Changes to projected benefit costs trend in the rating period outside of regular changes in utilization or unit cost of services.	• Mercer Rate Certification ○ PH Efficiency and Managed Care Savings Adjustments, pages 19-22 ○ Appendix F	•
E. If the projected benefit costs include additional services deemed by the State to be necessary to comply with the parity standards of the Mental Health Parity and Addiction Equity Act as required by 42 CFR §438.3(c)(ii), the following must be described: i. The categories of service that contain these services; ii. The percentage of cost that these services represent in each category of service; and iii. How these services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service.	• N/A	•

Section I. Medicaid Managed Care Rates	Documentation Reference	
3. Projected Benefit Costs and Trends	**Certification #1**	**Certification #2**
F. If the projected benefit costs include costs for in-lieu-of services defined at 42 CFR §438.3(e)(2) (i.e., substitutes for State Plan services or settings), the utilization and unit costs of the in-lieu-of services must be taken into account in developing the projected benefit costs of the relevant State plan services (as opposed to utilization and unit costs of the State plan services), unless a statute or regulation explicitly requires otherwise. The following documentation must be described: i. The categories of service that contain in lieu of services; ii. The percentage of cost that in-lieu-of services represent in each category of service; and iii. How the in-lieu-of services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service.	• Mercer Rate Certification ○ State Plan Service Considerations, page 10	•

Section I. Medicaid Managed Care Rates	Documentation Reference	
3. Projected Benefit Costs and Trends	**Certification #1**	**Certification #2**
G. States may make a monthly capitation payment to an MCO or PIHP (in a "risk contract" as defined in 42 CFR 438.2) for an enrollee age 21 to 64 receiving inpatient treatment in an Institution for Mental Diseases (IMD) (as defined in 42 CFR 435.1010) for a short-term stay of no more than 15 days during the period of the monthly capitation payment in accordance with 42 CFR 438.6(e). In these cases, when developing the projected benefit costs for these services, the actuary must use the unit costs of providers delivering the same services included in the State plan. The actuary may use the utilization of the services provided to an enrollee in an IMD in developing the projected benefit costs. The data used for developing the projected benefit costs for these services must not include: i. Costs associated with an IMD stay of more than 15 days; ii. Any other managed care plan costs for services delivered in a month when an enrollee has an IMD stay of more than 15 days; and iii. A member month for any month when an enrollee has an IMD stay of more than 15 days The data and assumptions should be described in the certification.	• Mercer Rate Certification ○ IMD, page 28	•

Section I. Medicaid Managed Care Rates	Documentation Reference	
3. Projected Benefit Costs and Trends	**Certification #1**	**Certification #2**
H. The rate certification must describe how retrospective eligibility periods are accounted for in rate development, including but not limited to: i. The managed care plan's responsibility to pay for claims incurred during the retroactive eligibility period; ii. How the claims information are included in the base data; iii. How the enrollment or exposure information is included in the base data; and iv. How the capitation rates are adjusted to reflect the retroactive eligibility period, and the assumptions and methodologies used to develop those adjustments.	• Mercer Rate Certification ○ Retroactive Eligibility Adjustment, pages 28-29 ○ Appendix H • Databook ○ Contents of this Data Book, page 4	•
I. The rate certification must clearly document the final projected benefit costs by relevant level of detail (e.g., rate cell, or aligned with how the State makes payments to the plans).	• Mercer Rate Certification ○ Appendix L ▪ Table 1: Final Projected Claims PMPM Development	•
J. The rate certification must clearly document the impact on projected costs for all material changes to covered benefits or services since the last rate certification, including but not limited to: i. More or fewer state plan benefits covered by Medicaid managed care; ii. Requirements related to payments from health plans to any providers or class of providers; iii. Requirements or conditions of any applicable waivers; or iv. Requirements or conditions of any litigation to which the state is subjected.	• Mercer Rate Certification ○ Introduction, pages 1-2 ○ Part B, Subpart B-1, Section 1, pages 14-33	• Mercer Rate Certification • Operational Changes, page 2

Section I. Medicaid Managed Care Rates	Documentation Reference	
3. Projected Benefit Costs and Trends	**Certification #1**	**Certification #2**
K. For each change related to covered benefits or services, the rate certification must include an estimated impact of the change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment. Any change not determined by the actuary to be material can be grouped with other non-material changes and described within the rate certification. If this is done, the actuary must give a description of why the changes were not considered material and how they were aggregated into a single adjustment.	• N/A	• Mercer Rate Certification • Operational Changes, page 2 • Appendix B, page 10

Section I. Medicaid Managed Care Rates	Documentation Reference	
4. Pass-Through Payments		
	Certification #1	**Certification #2**
A. A pass-through payment is any amount required by the State to be added to the contracted payment rates between MCOs, PIHPs, or PAHPs and hospitals, physicians, or nursing facilities that is not for one of the following purposes: i. A specific service or benefit provided to a specific enrollee covered under the contract; ii. A provider payment methodology permitted under 42 CFR 438.6(c)(1)(i) through (iii) for services and enrollees covered under the contract;[2] iii. A subcapitated payment arrangement for a specific set of services and enrollees covered under the contract; iv. Graduate Medical Education (GME) payments; or v. Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) wrap around payments.		
B. The rate certification and supporting documentation must describe all existing pass-through payments included in the rates for this rating period, including: i. A description of the pass-through payment; ii. The amount of the pass-through payments, both in total and on a per member per month basis (if applicable); iii. The providers receiving the pass-through payments; iv. The financing mechanism for the pass-through payment; and v. The amount of pass-through payments made to providers in previous years. In general, this should include the same years of historical claims data and financial data used to develop the rates.	• N/A	•

[2] Please note that States must be in compliance with 42 CFR 438.6(c) by the rating period for managed care contracts beginning on or after July 1, 2017.

Section I. Medicaid Managed Care Rates	Documentation Reference	
4. Pass-Through Payments		
	Certification #1	**Certification #2**
C. A common practice in fee-for-service methodologies in Medicaid is to pay providers a supplemental amount beyond the reimbursement rate for the service (e.g., upper payment limit (UPL) payments and disproportionate share hospital (DSH) payments). If states are using a supplemental payment methodology in fee-for-service, it may cause the fee-for-service fee schedule to be lower than a managed care plans' expected negotiated rate. Hence, it may be reasonable to assume higher reimbursements on a per-service basis when looking at the projected benefit costs under managed care in order to ensure that the plan has sufficient capitation rates to cover the expected costs of the enrollees. When transitioning from fee-for-service to managed care, and therefore incorporating a fee-for-service supplemental payment into managed care rates, the actuary must describe: i. A description of the supplemental payment; ii. The total amount of the supplemental payments; iii. The providers who received the supplemental payments under fee-for-service; iv. The methodology that the actuary used to incorporate the supplemental payment into the capitation rates; and v. Any payment mechanisms associated with incorporating the supplemental payment into the capitation rates.	• Mercer Rate Certification ○ PH Historical Adjustments ▪ Inpatient Services, page 14-15 ○ Full Medicaid Pricing (FMP), pages 30-33	•

Section I. Medicaid Managed Care Rates	Documentation Reference	
5. Projected Non-Benefit Costs		
	Certification #1	**Certification #2**
A. Variations in the assumptions used to develop the projected non-benefit costs for covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.		
B. The rate certification and supporting documentation must describe the development of the projected non-benefit costs included in the capitation rates, including: i. A description of the data, assumptions, and methodologies used to develop the projected non-benefit costs, and in particular, all significant and material items in developing the projected non-benefit costs. ii. Any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last rate certification.	• Mercer Rate Certification ○ Non-Medical Expense Load, pages 38-39	•
C. States and actuaries must estimate the projected non-benefit costs for each of the following categories of costs: i. Administrative costs; ii. Care coordination and care management; iii. Provision for margin (which may include profit margin, operating margin, risk margin, contingency margin, cost of capital, or underwriting gain); iv. Taxes, fees, and assessments; and v. Other material non-benefit costs.	• Mercer Rate Certification ○ Non-Medical Expense Load, pages 38-39	•
D. Non-benefit costs may be developed as per member per month (PMPM) costs or as a percentage of projected benefit costs or capitation rates, and different approaches can be taken for different categories of costs. For non-benefit costs that may be difficult to allocate to specific enrollees or groups of enrollees, or for taxes and fees that are assessed as a percentage of premiums, it may be reasonable to calculate those non-benefit costs as a percentage of benefit costs or capitation rates.	• Mercer Rate Certification ○ Non-Medical Expense Load, pages 38-39	•

Section I. Medicaid Managed Care Rates	Documentation Reference	
5. Projected Non-Benefit Costs		
	Certification #1	**Certification #2**
E. Regarding the Health Insurance Providers Fee (HIPF), CMS issued guidance in October 2014 (Medicaid and CHIP FAQs: Health Insurance Providers Fee for Medicaid Managed Care Plans, http://medicaid.gov/federal-policy-guidance/downloads/faq-10-06-2014.pdf). The rate certification and supporting documentation must: i. Specifically address how this fee is incorporated into capitation rates. ii. If the fee is incorporated into the rates in the initial rate certification, an explanation of whether the amount included in the rates is based on the data year or fee year during the rating period of the rate certification. iii. A description of how the amount of the fee was determined, and whether or not any adjustments would be made to the rates once the actual amount of the fee is known. iv. If the fee is not incorporated into the rates in the rate certification because the rates will be adjusted to account for the fee subsequently, an explicit statement that the fee is not included, and a description of when and how the rates will ultimately be adjusted to account for the fee. v. If the capitation rates include benefits as described in 26 CFR §57.2(h)(2)(ix) (e.g., long-term care, nursing home care, home health care, or community-based care), CMS recommends that the per member per month cost associated with those benefits be explicitly reported as a separate amount in the rate certification in order to more accurately account for the appropriate revenue on which the plans will be assessed.	• Mercer Rate Certification ○ Federal Health Insurer Fee, pages 39-40	•

Section I. Medicaid Managed Care Rates	Documentation Reference	
5. Projected Non-Benefit Costs		
	Certification #1	**Certification #2**
F. Due to the health insurance provider fee moratorium established by the Consolidated Appropriations Act of 2016, CMS does not expect any health insurance provider fees to be collected in calendar year 2017. Therefore, no amounts should be included in Medicaid managed care capitation rates for fees that would have been paid by plans to the IRS in 2017 (which would have been assessed off of 2016 net premiums). More information can be found here: https://www.irs.gov/Businesses/Corporations/Affordable-Care-Act-Provision-9010		

Section I. Medicaid Managed Care Rates	Documentation Reference	
6. Rate Range Development		
	Certification #1	**Certification #2**
A. In cases when the actuary develops and certifies rate ranges on behalf of a state, the rate certification and supporting documentation must describe how the rate ranges were developed, including: i. Any assumptions for which values vary in order to develop rate ranges; ii. The values of each of the assumptions used to develop the minimum, the mid-point or best estimate (as applicable), and the maximum of the rate ranges; and iii. A description of the data, assumptions, and methodologies that were used to develop the values of the assumptions for the minimum, the mid-point or best estimate (as applicable), and the maximum of the rate ranges.	• Mercer Rate Certification ○ PH Trend, page 18 ○ Managed Care Savings Adjustment, page 22 ○ SBH Trend, page 28 ○ Appendix E ○ Appendix F	•
B. The information related to rate range development must be included in either the relevant sections of the rate certification or in a separate section related specifically to the rate range development. For example, a description of how certain assumptions related to projected benefit costs vary to develop the rate ranges may be included with the description of other information related to projected benefit costs, or may be included in a section that describes all of the assumptions that were varied to develop the rates. The certification index, described in Section I, Item 1.C, must note where these are described.	• See section A above for more detail.	•

Section I. Medicaid Managed Care Rates	Documentation Reference	
7. Risk Mitigation, Incentives and Related Contractual Provisions		
	Certification #1	**Certification #2**
A. The rate certification and supporting documentation must describe any risk mitigation, incentives, or similar contractual provisions that may affect the rates, rate ranges, or the final net payments to the health plans under the applicable contract.	• Mercer Rate Certification ○ Risk Adjustment, page 40	•
B. The rate certification and supporting documentation must specifically address: i. The risk adjustment model(s) being used to calculate risk scores; ii. The specific data, including the source(s) of the data, being used by the risk adjustment model(s), including any adjustments made to the data; iii. Any changes that are made to risk adjustment model (e.g. conditions for excluding enrollees or data from the risk adjustment model, changes in how the risk scores are determined); iv. How frequently the risk scores are calculated; v. How the risk scores are being used to adjust the capitation rates; and vi. An attestation that the risk adjustment model is cost neutral. (42 CFR §438.5(g).)	• Mercer Rate Certification ○ Risk Adjustment, page 40	•

Section I. Medicaid Managed Care Rates	Documentation Reference	
7. Risk Mitigation, Incentives and Related Contractual Provisions		
	Certification #1	**Certification #2**
C. The rate certification and supporting documentation must indicate if a risk-sharing model is being used to account for the health status of the population in a manner that is not cost neutral (i.e., in a manner that may cause the total projected costs to increase or decrease based on the actual health status of the population). These types of risk-sharing models should only be used prospectively as part of the rate development process and not to adjust the final capitation rates or payments to managed care plans (e.g., estimating how projected changes in the risk of the Medicaid population may affect projected benefit costs). CMS may also consider these as a risk mitigation strategy when there is unusual and significant uncertainty about the health status of the population (e.g., covering a new population in Medicaid). CMS characterizes this type of adjustment as an "Acuity Adjustment." If an acuity adjustment is being used, the rate certification should include: i. The reason that there is significant uncertainty about the health status of the population and the need for an acuity adjustment; ii. The risk adjustment or acuity adjustment model(s) being used to calculate acuity adjustment scores; iii. The specific data, including the source(s) of the data, being used by the risk adjustment or acuity adjustment model(s); iv. The relationship and potential interactions between the acuity adjustment and the risk adjustment; v. How frequently the acuity adjustment scores are calculated; vi. A description of how the acuity adjustment scores are being used to adjust the capitation rates; and vii. An attestation that the acuity adjustment mechanism has been developed in accordance with generally accepted actuarial principles and practices.	• N/A	•

Section I. Medicaid Managed Care Rates	Documentation Reference	
7. Risk Mitigation, Incentives and Related Contractual Provisions		
	Certification #1	**Certification #2**
D. The rate certification and supporting documentation must detail any other risk-sharing arrangements, such as a risk corridor or a large claims pool. This includes: i. A rationale for the use of the risk sharing arrangement; ii. A detailed description of how the risk-sharing arrangement is implemented; iii. A description of any effect that the risk-sharing arrangements have on the development of the capitation rates; and iv. An attestation that the risk-sharing mechanism has been developed in accordance with generally accepted actuarial principles and practices.	• N/A	•
E. If the contract has a medical loss ratio requirements, such as a minimum medical loss ratio requirement, the rate certification and supporting documentation must include: i. A detailed description of, or citation for, the methodology used to calculate the medical loss ratio; and ii. A description of the consequences for having a medical loss ratio below the minimum requirements (e.g., financial recovery; contractual penalties).	• N/A	•
F. The rate certification and supporting documentation must provide a detailed description of any reinsurance requirements under the contract associated with the rate certification, including a description of any effect that the reinsurance requirements have on the development of the capitation rates. The rate certification must also include an attestation that the reinsurance mechanism has been developed in accordance with generally accepted actuarial principles and practices.	• N/A	•

Section I. Medicaid Managed Care Rates	Documentation Reference	
7. Risk Mitigation, Incentives and Related Contractual Provisions		
	Certification #1	**Certification #2**
G. The rate certification must include an attestation that the incentive arrangement will not exceed 105% of the approved capitation payments under the contract that are attributable to the enrollees or services covered by the incentive arrangement as required in 42 CFR §438.6(b)(2);	• N/A	•
H. The rate certification and supporting documentation must describe any incentives or withhold amounts in the contract between the state and the health plans. The rate certification must include: i. A description of the percentage of the certified capitation rates being withheld through withhold arrangements; ii. An estimate of the percentage of the withheld amount through a withhold arrangement that is expected to be returned and the basis for that determination; and iii. A description of any effect that the incentive or withhold arrangements have on the development of the capitation rates.	• N/A	•

Section I. Medicaid Managed Care Rates	Documentation Reference
8. Other Rate Development Considerations	
A. There are services, populations, or programs for which the state receives a different federal medical assistance percentage (FMAP) than the regular state FMAP. In those cases, the portions or amounts of the costs subject to the different FMAP should be shown as part of the rate certification to the extent possible.	
B. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.	
C. The effective dates of changes to the Medicaid managed care program (including eligibility, benefits, payment rate requirements, incentive programs, and program initiatives) should be consistent with the assumptions used to develop the capitation rates.	
D. In determining whether the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider the following: i. All adjustments to the capitation rates, or to any portion of the capitation rates, must reflect reasonable, appropriate, and attainable costs in the actuary's judgment and must be included in the rate certification. ii. Adjustments to the rates or rate ranges that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4. Therefore, the rates or rate ranges will not be considered actuarially sound if adjustments are made outside of the rate setting process described in the rate certification. iii. The final contracted rates in each rate cell must either match the capitation rates or be within the rate ranges in the rate certification. This is required in total and for each and every rate cell.	

Section I. Medicaid Managed Care Rates	Documentation Reference
9. Procedures for Rate Certifications for Rate and Contract Amendments	
A. CMS requires that the State will submit a new rate certification when the rates or rate ranges change.	
B. For contract amendments that do not affect the rates or rate ranges, CMS does not require a new rate certification from the State.	
C. There are several circumstances when CMS would not require a new rate certification: i. A state changes the capitation rates paid to the plans, but the capitation rates still fall within the certified rate ranges for that rating period and contract. ii. A state applies risk scores to the capitation rates paid to the plans under a risk adjustment methodology described in the certification for that rating period and contract.	
D. Any time a rate changes for any reason other than application of a risk adjustment methodology which was included in the initial managed care contract, the state must submit a contract amendment to CMS, even if the rate change does not need a new rate certification.	

Section II. Medicaid Managed Care Rates with Long-Term Services and Supports	Documentation Reference	
1. Managed Long-Term Services and Supports		
	Certification #1	**Certification #2**
A. For managed long-term services and supports (MLTSS) programs, or for programs that include MLTSS as part of the covered benefits, the guidance above in Section I about the required content of the actuarial rate certification is also applicable for rates for provision of MLTSS.		B.
C. The rate certification and supporting documentation for MLTSS programs, or for programs that include MLTSS as part of the covered benefits must also specifically address the following considerations:		
i. The structure of the capitation rates and rate cells or rating categories. States may take different approaches for rate setting for MLTSS. The two most common approaches are to structure the rate cells: a. By health care status and the level of need of the beneficiaries ("blended"); or b. By the long-term care setting that the beneficiary uses ("non-blended").	• N/A	•
ii. The structure of the rates and the rate cells, and the data, assumptions, and methodology used to develop the rates in light of the overall rate setting approach. States that are currently using a structure that differentiates rates by long-term care setting will need to describe why a blended rate structure is not feasible at this time and CMS will work with the state to move to a blended rate structure in the coming rating periods in order to align with the 2013 guidance around MLTSS programs found here. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf	• N/A	•

Section II. Medicaid Managed Care Rates with Long-Term Services and Supports	Documentation Reference	
1. Managed Long-Term Services and Supports		
	Certification #1	**Certification #2**
C. The rate certification must describe the expected effect that managing LTSS has on the utilization and unit costs of services. The certification must describe any effect that the management of this care is expected to have within each care setting and any effect in managing the level of care that the beneficiary receives (e.g., in-home care, community long-term care, nursing facility care).	• N/A	•
D. The projected non-benefit costs, such as administrative costs and care coordination costs, may differ for populations receiving MLTSS from other managed care programs, and the rate certification should describe how the projected non-benefit costs were developed for populations receiving these services.	• N/A	•
E. The rate certification should provide information on historical experience, analysis, and other sources (e.g., studies or research) used to develop the assumptions used for rate setting.	• N/A	•

Section III. New Adult Group Capitation Rates	Documentation Reference	
1. Data		
	Certification #1	**Certification #2**
A. In addition to the expectations for all Medicaid managed care rate certifications, as supported by assurances from the State, described in Section I, the rate certification must describe any data used to develop new adult group rates.	• Mercer Rate Certification ○ Section 2: Expansion Population, page 33-34 ○ Expansion Data Adjustments, page 34-35	•
B. For states that have covered the new adult group in Medicaid managed care plans in 2014, 2015 and/or 2016, CMS expects the rate certification, as supported by assurances from the State, to describe:		
i. Any new data that is available for use in 2017 rate setting;	• N/A	•
ii. How the state and the actuary followed through on any plans to monitor costs and experience for newly eligible adults;	• N/A	•
iii. How actual experience and costs in 2014, 2015 and/or 2016 have differed from assumptions and expectations in previous rate certifications; and	• N/A	•
iv. How differences between projected and actual experience in 2014, 2015 and/or 2016 have been used to adjust the 2017 rates.	• N/A	•

Section III. New Adult Group Capitation Rates	Documentation Reference	
2. Projected Benefit Costs		
	Certification #1	**Certification #2**
A. In addition to the guidance for all Medicaid managed care rate certifications described in Section I, states should include in the rate certification submission and supporting documentation a description of the following issues related to the projected benefit costs for the new adult group:		
i. For states that covered the new adult group in 2014, 2015 and/or 2016:		
a. Any data and experience specific to newly eligible adults covered in 2014, 2015 and/or 2016 that was used to develop projected benefits costs for capitation rates.	• N/A	•
b. Any changes in data sources, assumptions, or methodologies used to develop projected benefits costs for capitation rates since the last certification.	• N/A	•

Section III. New Adult Group Capitation Rates	Documentation Reference	
2. Projected Benefit Costs		
	Certification #1	**Certification #2**
c. How assumptions changed from the 2014, 2015 and/or 2016 rate certification(s) on the following issues: i. Acuity or health status adjustments (in most cases comparing the new adult group enrollees to other Medicaid adult enrollees); ii. Adjustments for pent-up demand; iii. Adjustments for adverse selection; iv. Adjustments for the demographics of newly eligible adults; v. Differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for newly eligible adult rates and other Medicaid population rates; and a. Variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations. vi. Other material adjustments to newly eligible adults projected benefit costs.	• Mercer Rate Certification ○ Additional Rate Adjustments, pages 35-38 ○ Appendix P	•

Section III. New Adult Group Capitation Rates	Documentation Reference	
2. Projected Benefit Costs		
	Certification #1	**Certification #2**
B. For any state that is covering the new adult group, regardless if they have been covered in 2014, 2015 and/or 2016, the following key assumptions related to the new adult group must be included in the rate certification and supporting documentation: i. Acuity or health status adjustments (in most cases comparing new adult group enrollees to other Medicaid adult enrollees); ii. Adjustments for pent-up demand; iii. Adjustments for adverse selection; iv. Adjustments for the demographics of the new adult group; v. Differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for the new adult group rates and other Medicaid population rates; and vi. Other material adjustments to the new adult group projected benefit costs.	• Mercer Rate Certification ○ Rate Cell Structure, page 34 ○ Additional Rate Adjustments, pages 35-38 ○ Appendix P	•
C. The rate certification and supporting documentation must describe any changes to the benefit plan offered to the new adult group.	• N/A	•
D. The rate certification and supporting documentation must describe any other material changes or adjustments to projected benefit costs.	• Mercer Rate Certification ○ Removed and Revised Data Adjustments, page 34-35 ○ Expansion FMP Development, page 38	• Mercer Rate Certification • Operational Changes, page 2 • Appendix C, page 10

Section III. New Adult Group Capitation Rates	Documentation Reference	
3. Projected Non-Benefit Costs		
	Certification #1	**Certification #2**
A. In addition to the guidance all Medicaid managed care rate certifications described in Section I, states must include in the rate certification submission and supporting documentation a description of the following issues related to the projected non-benefit costs for the new adult group:		
i. For states that covered the new adult group in Medicaid managed care plans in 2014, 2015 and/or 2016, any changes in data sources, assumptions, or methodologies used to develop projected non-benefit costs since the last rate certification.	• Mercer Rate Certification ○ Non-Medical Expense Load, pages 38-39 ○ Appendix P	•
ii. How assumptions changed from the 2014, 2015 and/or 2016 rate certification(s) on the following issues: a. Administrative costs; b. Care coordination and care management; c. Provision for operating or profit margin; d. Taxes, fees, and assessments; and e. Other material non-benefit costs.	• Mercer Rate Certification ○ Non-Medical Expense Load, pages 38-39 ○ Appendix P	•
B. The rate certification and supporting documentation must include information on key assumptions related to the new adult group and any differences between the assumptions for this population and the assumptions used to develop projected non-benefit costs for other Medicaid populations for the following issues: a. Administrative costs; b. Care coordination and care management; c. Provision for operating or profit margin; d. Taxes, fees, and assessments; and e. Other material non-benefit costs.		

Section III. New Adult Group Capitation Rates	Documentation Reference	
4. Final Certified Rates or Rate Ranges		
	Certification #1	**Certification #2**
A. In addition to the expectations for all Medicaid managed care rate certifications described in Section I, CMS requests under §438.7(d)[3] that states that covered the new adult group in Medicaid managed care plans in 2014, 2015 and/or 2016 provide:		
i. A comparison to the final certified rates or rate ranges in the previous rate certification; and	• Mercer Rate Certification ○ Appendix Q	• Mercer Rate Certification • Appendix C, page 11
ii. A description of any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.		

[3] The regulation provides: (d) *Provision of additional information*. The State must, upon CMS' request, provide additional information, whether part of the rate certification or additional supplemental materials, if CMS determines that information is pertinent to the approval of the certification under this part. The State must identify whether the information provided in addition to the rate certification is proffered by the State, the actuary, or another party.

Section III. New Adult Group Capitation Rates	Documentation Reference	
5. Risk Mitigation Strategies		
	Certification #1	**Certification #2**
A. CMS requests under §438.7(d) that states describe the risk mitigation strategy specific to the new adult group rates.	• Mercer Rate Certification ○ Medicaid Expansion Minimum/Maximum Medical Loss Ratio (MLR), page 40-41	•
B. For states that covered the new adult group in Medicaid managed care plans in 2014, 2015 and/or 2016, CMS requests the following information: i. Any changes in the risk mitigation strategy from those used during 2014, 2015 and/or 2016; ii. The rationale for making the change in the risk mitigation strategy or removing the risk mitigation strategy used during 2014, 2015 and/or 2016; and iii. Any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during 2014, 2015 and/or 2016.		

Incentive-Based Performance Measures
Targets for Improvement

Identifier	Measure	Measure Description	Target Population	Condition	Target for Improvement
PTB $$	Initiation of Injectable Progesterone Therapy in Women with Previous Pre-Term Births	The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 21st week of gestation.	Children's and Maternal Health	Perinatal and Reproductive Health	**MCOs must only report data related to the measure in ~~2017~~2018. Performance will be measured beginning in ~~2018~~2019.**
NQF #0471 (CSEC) $$	Cesarean Rate for Low-Risk First Birth Women	The percentage of cesareans in live births at or beyond 37.0 weeks gestation to women that are having their first delivery and are singleton (no twins or beyond) and are vertex presentation (no breech or transverse positions).	Children's and Maternal Health	Perinatal and Reproductive Health	**26.47**
(AWC) $$	Adolescent Well Care Visit	The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement Year	Children's Health	Utilization	**40.69**
NQF # 0108 $$	Follow-up Care for Children Prescribed ADHD Medication	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of	Children's Health	Behavioral Health	**MCOs must only report data related to the measure in ~~2017~~2018. Performance will be measured beginning in ~~2018~~2019.**

Incentive-Based Performance Measures
Targets for Improvement

		which was within 30 days of when the first ADHD medication was dispensed.			
NQF #2082 (HIV) $$	HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200	Chronic Disease	HIV	**MCOs must only report data related to the measure in ~~2017~~2018. Performance will be measured beginning in ~~2018~~2019.**
NQF #0272 (PQI 1) $$	Diabetes Short Term Complications Rate	Number of discharges for diabetes short term complications per 100,000 Medicaid enrollees age 18 and older.	Chronic Disease	Diabetes	**17.15**
NQF # 1517 (PPC) $$	Postpartum Care (PPC Submeasure)	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	Maternal Health	Perinatal and Reproductive Health	**63.12**
(AMB) $$	Ambulatory Care-ED Visits	Utilization of ambulatory care. Outpatient and ED Visits per 1000 member months	Population Health	Utilization	**ED Visits 68.37**
#09 (FUH) $$	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization	NCQA	CHIPRA	Behavioral Health	**MCOs must only report data related to the measure in ~~2017~~2018. Performance will be measured beginning in ~~2018~~2019.**

Incentive-Based Performance Measures
Targets for Improvement

	with a mental health practitioner. Two rates are reported: - The percentage of discharges for which the member received follow-up within 30 days of discharge. - The percentage of discharges for which the member received follow-up within 7 days of discharge.				

Effective 10/1/2017

Appendix J – Performance Measure Reporting

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
HEDIS Measures							
#09 (PPC)	Timeliness of Prenatal Care (PPC – Numerator 1)	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization.	NCQA	CHIPRA	Children's and, Maternal Health	Perinatal and Reproductive Health	HEDIS
#10 (CIS)	Childhood Immunization Status	Percentage of children that turned 2 years old during the measurement year and had specific vaccines by their second birthday. MCOs will report all combinations.	NCQA	CHIPRA, MU2	Children's Health	Prevention	HEDIS
#11 (HPV)	Human Papillomavirus (HPV) Vaccine for Female Adolescents	Percentage of female adolescents that turned 13 years old during the measurement year and had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.	NCQA	CHIPRA	Children's Health	Prevention	HEDIS
#12 (IMA)	Immunization Status for Adolescents	Percentage of adolescents that turned 13 years old during the measurement year and had specific vaccines by their 13th birthday.	NCQA	CHIPRA	Children's Health	Prevention	HEDIS
#13 (WCC)	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/ Adolescents	Percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index percentile for age and gender. The percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner, with evidence	NCQA	CHIPRA, MU2	Children's Health	Prevention	HEDIS
#14 (W15)	Well-Child Visits in the First Fifteen Months of Life	Percentage of patients who turned 15 months old during the measurement year and who had the following number of well- child visits with a PCP during their first 15 months of life. Seven rates are reported.	NCQA	CHIPRA	Children's Health	Utilization	HEDIS

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
#15 (W34)	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Percentage of patients 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	NCQA	CHIPRA	Children's Health	Utilization	HEDIS
#16 (HA1C)	Comprehensive Diabetes Care: Hemoglobin A1c testing	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	NCQA	MEDICAID ADULT	Chronic Disease	Diabetes	HEDIS
#17 (SAA)	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	The measure calculates the percentage of individuals 19 years of age or greater as of the beginning of the measurement year with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement year (12 consecutive months).	NCQA	MEDICAID ADULT	Population Health	Behavioral Health	HEDIS
#18 (MPM)	Annual Monitoring for Patients on Persistent Medications	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the four rates separately and as a total rate.	NCQA	MEDICAID ADULT	Chronic Disease	Prevention	HEDIS
#19 (CBP)	Controlling High Blood Pressure	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year based on the following criteria: Members 18-59 whose BP was < 140/90 Members 60-85 with diagnosis of diabetes whose BP was 150/90 Members 60-85 without a diagnosis of diabetes whose BP was 150/90	NCQA	MEDICAID ADULT, MU2, CMS HEALTH HOMES	Chronic Disease	Cardiovascular Care	HEDIS

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
#20 (ABA)	Adult BMI Assessment	The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement or the year prior to the measurement year.	NCQA	MEDICAID ADULT, CMS HEALTH HOMES	Population Health	Prevention	HEDIS
#21 (AMM)	Antidepressant Medication Management	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.	NCQA	MEDICAID ADULT, MU2	Population Health	Behavioral Health	HEDIS
#22 (CCS)	Cervical Cancer Screening	Percentage of women 21–64 years of age who were screened for cervical cancer: • Women 21-64 who had cervical cytology performed every 3 years • Women 30-64 who had cervical cytology/HPV co-testing performed every 5 years	NCQA	MEDICAID ADULT, MU2	Population Health	Prevention	HEDIS
#23 #1800 (AMR)	Asthma Medication Ratio	The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	NCQA	Medicaid	Population Health	Pulmonary/ Critical Care	HEDIS
#24 (FVA)	Flu Vaccinations for Adults Ages 18 to 64	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period.	NCQA	MEDICAID ADULT	Population Health	Prevention	HEDIS/ CAHPS

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
#25 (MSC)	Medical Assistance With Smoking and Tobacco Use Cessation	Assesses different facets of providing medical assistance with smoking and tobacco use cessation. MCOs will report three components (questions): • Advising Smokers and Tobacco Users to Quit • Discussing Cessation Medications • Discussing Cessation Strategies	NCQA	MEDICAID ADULT	Population Health	Prevention	HEDIS/ CAHPS
#26 (MMA)	Medication Management for People with Asthma	The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported.	NCQA	CHIPRA	Population Health	Pulmonary/ Critical Care	HEDIS
~~#27 (CAT)~~	~~Call Answer Timeliness~~ Retired by NCQA	~~Percentage of calls received by the organization's Member Services call centers (during operating hours) during the performance measurement year that were answered by a live voice within 30 seconds.~~	~~NCQA~~	~~None~~	~~Population Health~~	~~Access/ Availability of Care~~	~~HEDIS~~
#28 (CHL)	Chlamydia Screening in Women	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.	NCQA	CHIPRA, MEDICAID ADULT	Population Health, Maternal Health	Perinatal and Reproductive Health, Sexually Transmitted Infectious Diseases	HEDIS
#29 (BCS)	Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	NCQA	MEDICAID ADULT, MU2	Senior Care	Prevention	HEDIS

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
#30 (CAP)	Child and Adolescents' Access to Primary Care Practitioners	Percentage of children ages 12 months – 19 years who had a visit with a PCP. The MCO reports four separate percentages: • Children 12-24 months and 25 months – 6 years who had a visit with a PCP in the measurement year • Children 7-11 years and adolescents 12-19 years who had a visit with a PCP in the measurement year or the year prior to the measurement year.	NCQA	CHIPRA	Children's Health	Access/ Availability of Care	HEDIS
~~#31 (FPC)~~	~~Frequency of Ongoing Prenatal Care~~ Retired by NCQA	~~Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following percentages of expected prenatal visits: <21, 21-40, 41-60, 61-80, > or = 80.~~	~~NCQA~~	~~CHIPRA~~	~~Children's and Maternal Health~~	~~Perinatal and Reproductive Health~~	~~HEDIS~~
PQI Measures							
#32 (PQI05)	COPD and Asthma in Older Adults Admission Rate	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population. The number of discharges for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months for Medicaid enrollees age 40 and older.	AHRQ	MEDICAID ADULT	Population Health	Pulmonary/ Critical Care	Section V
#33 (PQI08)	Heart Failure Admission Rate	Percent of population with an admissions for heart failure (reported by Recipient Parish). The number of discharges for heart failure per 100,000 member months for Medicaid enrollees age 18 and older (reported by Recipient Parish).	AHRQ	MEDICAID ADULT	Chronic Disease	Cardiovascular Care	Section V

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
#34 (PQI15)	Asthma in Younger Adults Admission Rate	Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions. Number of discharges for asthma per 100,000 member months for Medicaid enrollees ages 18 to 39.	AHRQ	MEDICAID ADULT	Population Health	Pulmonary/ Critical Care	Section V
Vital Record Measures							
#35 NQF #1382 (LBW)	Percentage of low birth weight births	Percentage of live births that weighted less than 2,500 grams in the state during the reporting period.	CDC	CHIPRA, HRSA	Children's and Maternal Health	Perinatal and Reproductive Health	Section V
#36 NQF (PC-01)	Elective Delivery	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed	TJC	MEDICAID ADULT, MU2	Maternal Health	Perinatal and Reproductive Health	Section V
CMS Measure							
~~#37 (CDF)~~	~~Screening for Clinical Depression and Follow-Up Plan~~ Retired by LDH	~~Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented. The percentage of patients aged 18 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.~~	~~CMS~~	~~MEDICAID ADULT, MU2, CMS HEALTH HOMES~~	~~Population Health~~	~~Prevention~~	~~Section V~~