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 (1)
Vendor: Amerigroup Louisiana Inc
Description: Provide heatlhcare services to Medicaid enrollees
Approved By: Pamela Rice
Approval Date: 8/25/2015

Your amendment that was submitted to OSP has been approved.

Rev 2010/08

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

Medical Vendor Administration

(Regional/ Program/ Facility)

AND

Amerigroup Louisiana, Inc.

Contractor Name

Amendment #: 1

CFMS #: 733527

734395

DOA #: 305-500675

305-500683

DHH #: 060467

Original Contract Amt 1,964,731,789

Original Contract Begin Date 02-01-2015

Original Contract End Date 01-31-2018

AMENDMENT PROVISIONS

Change Contract From: Maximum Amount: 1,964,731,789

See Attachment A-1.

Change To: Maximum Amount: 1,964,731,789

See Attachment A-1.

Justification:

The changes contained in Attachment A-1 are necessary for the continued successful operation of the Medicaid managed care program.

This Amendment Becomes Effective: 02-01-2015

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

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

CONTRACTOR

Amerigroup Louisiana, Inc.

CONTRACTOR SIGNATURE [signature] DATE 5/19/15

PRINT NAME Sonya Nelson

CONTRACTOR TITLE CEO

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Secretary, Department of Health and Hospital or Designee

SIGNATURE [signature] DATE 7/16/15

NAME J. Ruth Kennedy

TITLE Medicaid Director

OFFICE Bureau of Health Services Financing

PROGRAM SIGNATURE DATE

NAME

Attachment/ Exhibit Letter or Number	Contract Document Name	Change From:	Change To[1]:	Justification
Attachment B	Statement of Work, Page 4	18) Claims & Encounters ➢ Submit denied claims report weekly.	18) Claims & Encounters ➢ Submit denied claims report ~~weekly~~ <u>monthly</u>.	Correcting a typographical error.
Attachment D	Rate certification	Mercer Rate Certification dated August 29, 2014	Replace with Mercer Rate Certification dated January 31, 2015	A revision to the rate certification was needed to incorporate programmatic and operational changes related to the Full Medicaid Payment methodology, the PDHC program, and the mixed services protocol for behavioral health.
Attachment E	Incentive-Based Performance Measures	Target for Improvement column: Initiation 42.07 C&M 48.49	Initiation 42.07 C&M 48.49 <u>MCOs must only report data related to the measure in 2016. Performance will be measured beginning in 2017.</u>	A revision was needed to align the contract with NCQA and AHRQ guidelines for reporting.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**3.4.5.2** Extended Medicaid Programs - Certain individuals who lose SSI eligibility because of a Social Security cost of living adjustment (COLA) or in some	**3.4.5.2** Extended Medicaid Programs - Certain individuals who lose SSI eligibility because of a Social Security cost of living adjustment (COLA) or in some	Correcting a typographical error.

[1] Additions underlined; deletions struck through

		cases entitlement to or an increase in Retirement, Survivors, Disability Insurance (RSDI) benefits, i.e., Social Security benefits. SSI income standards are used in combination with budgeting rules which allow the exclusion of cost of living adjustments and/or certain benefits. Extended Medicaid consists of the following programs: • Disabled Adult Children - Individuals over 19 who become blind or disabled before age twenty-two 22 and lost SSI eligibility on or before after July 1, 1987, as a result of entitlement to or increase in RSDI Child Insurance Benefits;	cases entitlement to or an increase in Retirement, Survivors, Disability Insurance (RSDI) benefits, i.e., Social Security benefits. SSI income standards are used in combination with budgeting rules which allow the exclusion of cost of living adjustments and/or certain benefits. Extended Medicaid consists of the following programs: • Disabled Adult Children - Individuals over 19 who become blind or disabled before age twenty-two 22 and lost SSI eligibility on or ~~before~~ after July 1, 1987, as a result of entitlement to or increase in RSDI Child Insurance Benefits;	
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**4.2.1** Staffing Requirements Add new subsection	**4.2.1.7** Exception to Staffing Requirements Requests for exceptions to mandatory staffing requirements as a result of prevailing best interests must be submitted in writing to DHH for prior approval. The MCO should address the reason for the request, the organization's ability to furnish	A revision was needed to provide an avenue for addressing circumstances when the MCO may need DHH- approved flexibility for meeting staffing requirements.

			services as contractually required with the exception in place, and duration of exception period requested.	
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**4.6 Staff Training and Meeting Attendance** Add new subsection	**4.6.6** DHH reserves the right to assign mandatory training for key staff, staff members, and subcontractors. Failure to comply places DHH at risk of receiving audit findings and/or financial penalties from state and federal auditing agencies.	A revision was needed to clarify that there are circumstances where DHH may formally mandate training.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	Addition of new section	**5.11.1.7** MCO must verify and add Medicaid recipient insurance updates for their members to their system within five business days of receipt. If a member is unable to access services or treatment until an update is made, update requests for that member must be verified and added within four business hours. These updates must be submitted to the DHH fiscal intermediary on the daily file load on the day the update is made.	A revision was needed to clarify the responsibility of the MCOs to process insurance updates within prescribed timeframes.

Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**5.11.5.4** The MCO shall report members with third party coverage to DHH on a weekly basis reporting additions and updates of TPL information in a format and medium specified by DHH.	~~**5.11.5.4** The MCO shall report members with third party coverage to DHH on a weekly basis reporting additions and updates of TPL information in a format and medium specified by DHH.~~	The provision was deleted because of the addition of Section 5.11.1.7.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**6.38 Case Management Reporting Requirements**	**6.3~~8~~9 Case Management Reporting Requirements**	Correcting a numbering error. All subsequent sections to be re-numbered.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**6.39.4.8.** Conduct and report the evaluation of clinical, humanistic and economic outcomes; **6.39.4.9.** Address co-morbidities through a whole-person approach; **6.39.4.10.** Identify members who require in-person case management services and a plan to meet this need; **6.39.4.11.** Coordinate CCMP activities for members also identified in the Case Management Program; and **6.39.4.12.** Include Program Evaluation requirements.	~~**6.39.4.8.** Conduct and report the evaluation of clinical, humanistic and economic outcomes;~~ **6.39.4.8.** Address co-morbidities through a whole-person approach; **6.39.4.9.** Identify members who require in-person case management services and a plan to meet this need; **6.39.4.10.** Coordinate CCMP activities for members also identified in the Case Management Program; and **6.39.4.11.** Include Program Evaluation requirements.	Removal of inapplicable provision and renumbering of subsequent sections

Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**6.42 LaHIPP** Louisiana Health Insurance Premium Payment (LaHIPP) is a Louisiana Medicaid program that pays all or part of the health insurance premium for an employee and their family if: (a) health insurance is available from their job (i.e. Employer Sponsored Insurance); (b) someone in the family has Medicaid; and (c) it is determined it that it would cost less for Louisiana Medicaid to pay the health insurance premium for the person who receives Medicaid than it would be for Louisiana Medicaid to pay the cost of the same person's medical expenses without the insurance. The goal of LaHIPP is to reduce the number of the uninsured and lower Medicaid spending by establishing a third party resource as the primary payer of the Medicaid enrollee's medical expenses. DHH is responsible for determining if an individual qualifies for LaHIPP participation. LaHIPP participants are eligible for enrollment in Bayou Health based on eligibility criteria defined in	**Delete section.**	A revision was needed because there will no longer be a distinction between LaHIPP and other TPL coverage, so reference to LaHIPP is unnecessary.

		Section 3.2. LaHIPP is not an eligibility category. LaHIPP participants are identified in the TPL file. 6.42.3 DHH is responsible for issuing payment for all or part of a LaHIPP participant's health insurance premium. MCO is responsible for payment of a LaHIPP participant's co-payments and deductibles if the participant uses provider that accepts the insurance as the primary payer and)Medicaid as secondary payer. If the provider does not accept this payment arrangement, the participant will be responsible for the co-payments and deductibles. MCO (Medicaid) pays only after a third party has met the legal obligation to pay. MCO (Medicaid) is always the payer of last resort.		

Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**7.9.5.9** Ensure that provider calls are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from DHH). If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.	**7.9.5.9** Ensure that provider ~~calls~~ complaints are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from DHH). If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.	Correcting a typographical error.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**9.1. Minimum Reimbursement to In-Network Providers** **9.1.1.** The MCO shall provide reimbursement for defined core benefits and services provided by an in-network provider. The MCO rate of reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on the date of service or its equivalent (such as a DRG case rate), unless mutually agreed to by both the plan and the provider in the provider contract. **Note:** For providers who receive cost based reimbursement for Medicaid services, the published Medicaid fee-for-service rate shall be the rate that would be	**9.1. Minimum Reimbursement to In-Network Providers** **9.1.1.** The MCO shall provide reimbursement for defined core benefits and services provided by an in-network provider. The MCO rate of reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on the date of service or its equivalent (such as a DRG case rate), unless mutually agreed to by both the plan and the provider in the provider contract. **Note:** For providers who receive cost-based reimbursement (cost settlement and outliers) for Medicaid services, the published Medicaid fee-for-service rate shall	A revision was needed to clarify the responsibilities of the MCOs.

		received in the fee-for-service Medicaid program. Hereafter in this Section, unless otherwise specified, the above reimbursement arrangement is referred to as the "Medicaid rate." DHH will notify MCOs of updates to the Medicaid fee schedule and payment rates.	be the rate that would be received in the fee-for-service Medicaid program. Hereafter in this Section, unless otherwise specified, the above reimbursement arrangement is referred to as the "Medicaid rate." DHH will notify MCOs of updates to the Medicaid fee schedule and payment rates.	
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**13.4.1.1** Acknowledge receipt of each grievance and appeal in writing; . . .	**13.4.1.1** Acknowledge receipt of each grievance and appeal in writing except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the monthly grievance log; . . .	A revision was needed to clarify the responsibility of the MCOs related to written confirmation of grievances.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**14.2.8.2** The MCO shall perform a minimum of two (2) DHH-approved PIPs in the each Contract year, the required three-year PIP, listed in Section 1 of Appendix DD – Performance Improvement Projects, as well as the one-year PIP associated with the contract year, listed in Section 2 of Appendix DD. MCOs may select and DHH may require an additional project each year to	**14.2.8.2** The MCO shall perform ~~a minimum of~~ two (2) DHH-approved PIPs listed in Appendix DD – Performance Improvement Projects ~~in the each Contract year~~ for the initial three-year term of the contract.~~, the required three-year PIP, listed in Section 1 of Appendix DD – Performance Improvement Projects, as well as the one-year PIP associated with the contract year, listed in Section~~	A revision was needed to update the PIP requirements to match departmental priorities.

		reach a maximum of four (4) projects.	~~2 of Appendix DD. MCOs may select and~~ DHH may require up to two (2) additional projects for a maximum of four (4) projects. ~~an additional project each year to reach a maximum of four (4) projects.~~	
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**15.1.8** The MCO will report to DHH, within three (3) business days, when it is discovered that any MCO employee(s), network provider, contractor, or contractor's employee(s) have been excluded, suspended, or debarred from any state or federal healthcare benefit program through the following url: http://new.dhh.louisiana.gov/index.cfm/page/219.	**15.1.8** The MCO will report to DHH, within three (3) business days, when it is discovered that any MCO employee(s), network provider, contractor, or contractor's employee(s) have been excluded, suspended, or debarred from any state or federal healthcare benefit program through the following url: http://new.dhh.louisiana.gov/index.cfm/page/219 or DHH prior approved method.	A revision was needed to clarify that there are circumstances where DHH may formally approve a different notification process than the use of the URL.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**16.12 Off Site Storage and Remote Back-up** Addition of new provision.	**16.12 Off Site Storage and Remote Back-up** **. . .** **16.12.2.6** A list of all back-up files to be stored at remote locations and the frequency with which these files are updated.	The addition of this provision reflects the decision that maintaining this list by the MCOs on an on-going basis is more appropriate than requiring the submission of the information via a report on an annual basis.
Exhibit 3	305PUR-DHHRFP-BH-	**16.12.3** DHH shall be provided with a list of all back-up files to be stored at remote locations and	~~**16.12.3** DHH shall be provided with a list of all back-up files to be stored at remote locations and the~~	The provision was deleted to conform to the change in Section 16.12.2.6.

	MCO-2014-MVA	the frequency with which these files are updated.	~~frequency with which these files are updated.~~	
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**17.12 LAHIPP** MCO is responsible for payment of a LaHIPP participant's co-payments and deductibles if the participant uses provider that accepts the insurance as the primary payer as secondary payer. If the provider does not accept this payment arrangement, the participant will be responsible for the co-payments and deductibles. MCO (Medicaid) pays only after a third party has met the legal obligation to pay. MCO (Medicaid) is always the payer of last resort.	Remove section.	There will no longer be a distinction between LaHIPP and other TPL coverage, so reference to LaHIPP is unnecessary.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**17.2.2 Rejected Claims** 17.2.2.1 The MCO may reject claims because of missing or incomplete information. The original claim must be returned to the provider accompanied by a reject letter.	**17.2.2 Rejected Claims** 17.2.2.1 The MCO may reject claims because of missing or incomplete information. <u>Paper claims that are received by the MCO that are screened and rejected prior to scanning must be returned to the provider with a</u>	A revision was required to clarify that the submission of original claims rejected by the MCOs is not required in every instance and to further clarify the information to be contained in a rejected claim.

		17.2.2.2 A rejected claim should not appear on the Remittance Advice (RA) because it will not have entered the claims processing system. 17.2.2.3 The rejection letter shall indicate why the claim is being returned, including all defects or reasons known at the time the determination is made. As required by La. R.S. 46:460.71, the letter shall contain: • The patient or member name; • The MCO claim number; • The date of each service; • The patient account number assigned by the provider; • Total billed charges; • CPT codes for each procedure, including the amount allowed and any modifiers and units; • The amount due from the member that includes but is not limited to copayments and coinsurance or deductibles; • Identification of the MCO on whose behalf the payment would be made, .i.e., the MCO's name;	letter notifying them of the rejection. Paper claims received by the MCO that are scanned prior to screening and then rejected, are not required to accompany the rejection letter. ~~The original claim must be returned to the provider accompanied by a reject letter.~~ 17.2.2.2 A rejected claim should not appear on the Remittance Advice (RA) because it will not have entered the claims processing system. 17.2.2.3 The rejection letter shall indicate why the claim is being returned, including all defects or reasons known at the time the determination is made~~.~~ ~~As required by La. R.S. 46:460.71, the letter shall contain:~~ and at a minimum, must include the following: • The date the letter was generated; • The patient or member name; • Provider identification, if available, such as provider ID number, TIN or NPI; • ~~The MCO claim number;~~	

		• If the MCO is a secondary payer, then the MCO shall also send acknowledgement of payment as a secondary payer, the primary payer's COB information, and the third-party liability carrier code; • The date the letter was generated; and • Defects or reasons for rejection.	• The date of each service; • The patient account number assigned by the provider; • The ~~T~~total billed charges; • The date the claim was received; and • The reasons for rejection. ~~• CPT codes for each procedure, including the amount allowed and any modifiers and units;~~ ~~• The amount due from the member that includes but is not limited to copayments and coinsurance or deductibles;~~ ~~• Identification of the MCO on whose behalf the payment would be made, .i.e., the MCO's name;~~ ~~• If the MCO is a secondary payer, then the MCO shall also send acknowledgement of payment as a secondary payer, the primary payer's COB information, and the third-party liability carrier code;~~ ~~• The date the letter was generated; and~~ ~~• Defects or reasons for rejection.~~	

Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**17.4 Remittance Advices** In conjunction with its payment cycles, the MCO shall provide: 17.4.1 Each remittance advice generated by the MCO to a provider shall clearly identify for each claim, the following information: • The name of the member; • Unique member identification number; • Patient claim number or patient account number; • Date of service; • Total provider charges; • Member liability, specifying any co-insurance, deductible, co-payment, or non-covered amount; • Amount paid by the MCO; and/or the	**17.4 Remittance Advices** In conjunction with its payment cycles, the MCO shall provide: 17.4.1 Each remittance advice generated by the MCO to a provider shall <u>comply with the provisions of LA-R.S. 46:460.71.</u> ~~clearly identify for each claim, the following information:~~ ~~• The name of the member;~~ ~~• Unique member identification number;~~ ~~• Patient claim number or patient account number;~~ ~~• Date of service;~~ ~~• Total provider charges;~~ ~~• Member liability, specifying any co-insurance, deductible, co-payment, or non-covered amount;~~ ~~• Amount paid by the MCO; and/or the~~	A revision was needed to incorporate a reference to the applicable Louisiana statute.

		• Amount denied and the HIPAA compliant reasons for denial; and • An attachment to the RA if denied due to Third Party Liability (TPL) to include, but not be limited to, TPL Carrier information such as the carrier code, policy number, and mailing address. 17.4.2 Adjustments and Voids shall appear on the RA under "Adjusted or Voided claims" either as Approved or Denied. 17.4.3 In accordance with 42 CFR §455.18 and §455.19, the following statement shall be included on each remittance advice sent to providers: " I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."	~~• Amount denied and the HIPAA compliant reasons for denial; and~~ ~~• An attachment to the RA if denied due to Third Party Liability (TPL) to include, but not be limited to, TPL Carrier information such as the carrier code, policy number, and mailing address.~~ 17.4.2 Adjustments and Voids shall appear on the RA under "Adjusted or Voided claims" either as Approved or Denied. 17.4.3 In accordance with 42 CFR §455.18 and §455.19, the following statement shall be included on each remittance advice sent to providers: "I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."	

Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	17.6.5 The MCO shall adjudicate all claims, including disputed claims, within twenty-four (24) months from the date of service.	17.6.5 The MCO shall ~~adjudicate~~ resolve all ~~claims, including~~ disputed claims~~, within~~ no later than twenty-four (24) months from the date of service.	Correcting a typographical error.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	17.10.3.1 The MCO shall submit a weekly claim-level detail file of pharmacy encounters to DHH which includes individual claim-level detail information on each pharmacy claim dispensed to a Medicaid patient, including but not limited to the total number of metric units, dosage form, strength and package size, National Drug Code of each covered outpatient drug dispensed to Medicaid enrollees. This weekly submission must comply with Section 17.5.6 requirements. See the MCO Systems Companion Guide for a complete listing of claim fields required.	17.10.3.1 The MCO shall submit a weekly claim-level detail file of pharmacy encounters to DHH which includes individual claim-level detail information on each pharmacy claim dispensed to a Medicaid patient, including but not limited to the total number of metric units, dosage form, strength and package size, National Drug Code of each covered outpatient drug dispensed to Medicaid enrollees. This weekly submission must comply with Section ~~17.5.6~~ 17.8 requirements. See the MCO Systems Companion Guide for a complete listing of claim fields required	Correcting a typographical error.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	17.2.5.2 The MCO shall not deny provider claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which	17.2.5.2 The MCO shall not deny provider claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which case the	A revision was needed to clarify the timely filing requirement involving third party liability.

		case the provider is pursuing payment from a third party. In situations of third party benefits, the timeframes for filing a claim shall begin on the date that the third party completes resolution of the claim.	provider is pursuing payment from a third party~~. In situations of third party benefits, the timeframes for filing a claim shall begin on the date that the third party completes resolution of the claim.~~ Claims involving third party liability shall be submitted within the lesser of 180 days of resolution by the third party or 365 days from the date of service.	
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**20.3.2** Other Reporting and/or Deliverable Requirements **Member Call Center** • Operate a member call center 24/7 • Answer 90% of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than 5% **Provider Call Center** • Answer 90% of calls within 30 seconds	**20.3.2** Other Reporting and/or Deliverable Requirements **Member Call Center** • Operate a member call center 24/7 • Answer 9~~0~~5% of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than 5% • No more than 1% of incoming calls receive a busy signal	A revision was necessary to align this section of the RFP with the current performance standard already correctly outlined in section 12.16.14.1.

		• Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than 5%	**Provider Call Center** • <u>Operate a provider call center 24/7</u> • Answer 9~~0~~<u>5</u>% of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than 5% • <u>No more than 1% of incoming calls receive a busy signal</u>	
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**25.63 Termination for Failure to Accept Revised Monthly Capitation Rate**	**25.6~~3~~<u>365</u> Termination for Failure to Accept Revised Monthly Capitation Rate** Should the MCO refuse to accept a revised monthly capitation rate as provided in Section 25.~~40~~<u>42</u> of the RFP, it may request DHH in writing to permit the Contract to be terminated effective at least sixty (60) calendar days from the date of DHH's receipt of the written request. DHH shall have sole discretion to approve or deny the	Correcting an error in numbering and reference to another section in the RFP.

			request for termination and to impose such conditions on the granting of an approval as it may deem appropriate, but it shall not unreasonably withhold its approval.	
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	Addition of Two New Terms in Glossary	**Cost settlement** – Mechanism utilized within a cost based reimbursement system. The Medicaid claims are paid in the interim at a rate that approximates the actual cost of the claim. The actual final reimbursement is determined from the filed cost report and based on the cost reimbursement rules that are contained within the Medicaid State Plan. **Outlier** - Additional payment that is made for catastrophic costs associated with services provided to 1)children under the age of six who received inpatient services in a disproportionate share hospital setting, and 2)infants who have not attained the age of one year who received inpatient services in any acute care setting.	The addition of two terms was necessary to explain changes to Section 9.1.

Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	Appendix J – Performance Measure Reporting	Replace with updated document.	The appendix was updated to align with NCQA and AHRQ guidelines for reporting.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	Appendix O – MCO Subcontract Requirements	Replace with updated document.	The checklist was updated to reflect requirements contained in the RFP.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	Appendix DD - Performance Improvement Projects	Replace with updated document.	The checklist was updated so that the PIP requirements match departmental priorities.

Statement of Work

Goal/Purpose

Contractor will function as a risk-bearing managed care organization (MCO) that provides core benefits and services to eligible Louisiana Medicaid enrollees as defined in the contract, Louisiana Medicaid State Plan, administrative rules and Medicaid Policy and Procedure manuals.

Entire Contract

The contract shall consist of the Form DHH-CF-1, together with all attachments and exhibits listed on the DHH-CF-1.

Deliverables

The Contractor shall provide all deliverables required in the Request for Proposals issued July 28, 2014, RFP305PUR-DHHRFP-BH-MCO-2014-MVA, which includes all Appendices, Addenda, and responses to written comments.

Performance Measures

The contractor will provide to DHH, or maintain on file, all items that document the completion of deliverables outlined in the contract, including but not limited to:

1) Staffing Requirements
   - Develop and maintain written policies, procedures and job descriptions for each functional area.
   - Provide upon request a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed as required by law.
   - Provide a list of marketing training dates at least fourteen calendar days prior to the date of training.

2) Medical Loss Ratio
   - Provide an annual Medical Loss Ratio (MLR) report following the end of the MLR reporting year, which shall be a calendar year.

3) Expanded Services/Benefits
   - The MCO shall provide a description of the expanded services/benefits to be offered by the MCO for approval. Additions, deletions or modifications to expanded services/benefits made during the contract period must be submitted to DHH, for approval.

4) Pharmacy Services
   - Submit pharmacy claims information at frequency established by DHH.
   - Submit reporting specific to the pharmacy program, including, but not limited to:
     - Pharmacy help desk performance
     - Prior authorization performance
     - Prior Authorization request turnaround time
     - Number of claims submitted as a 72-hour emergency supply
     - Denials (name of drug, number of requests, number of denials)
     - Pharmacy network access
     - Grievance and appeals
     - Medication therapy management initiatives

5) Provider Network
   - Develop and maintain a provider network development and management plan that must be submitted to DHH at least annually.
   - Maintain written agreements that document the existence of a provider network that is sufficient to provide adequate access to all required services.
   - Submit quarterly GeoAccess reports documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type

listed in Appendix TT. The attestation included with this report shall provide narrative identifying any gaps in coverage and the corrective measures that will address them.

- Provide written provider credentialing and re-credentialing policies that are compliant with NCQA Health Plan Accreditation standards and all applicable state laws within 30 days of the signing of the contract.
- Develop and implement network development and management policies.
- Maintain a Provider Directory.
- Maintain and issue a provider handbook within thirty days of the date the contract is signed.
- Conduct provider satisfaction surveys annually.

6) Provider Complaint System
   - Develop and implement a provider dispute and appeal process for sanctions, suspensions, and terminations imposed by the MCO against network provider/contractor(s). This process must be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.
   - Provide the names, phone numbers and e-mail addresses of executives with the authority to require corrective actions to DHH within one week of contract approval, and within 2 business days of any changes.

7) Utilization Management
   - Develop and maintain policies and procedures with defined structures and processes for a Utilization Management program that incorporates Utilization Review and Service Authorization.

8) Quality Assessment and Performance Improvement (QAPI) Plans
   - Form a QAPI Committee.
   - Develop a QAPI Work Plan and submit it to DHH thirty (30) days after the effective date of the contract, and annually thereafter.
   - Submit QAPI reports annually.

9) Clinical and Administrative Performance Measures
   - Report to DHH on administrative measures contained in Appendix J of the RFP on a quarterly basis.
   - Report to DHH on clinical measures contained in Appendix J of the RFP on an annual basis 12 months after services begin.
   - Report to DHH all clinical measures monthly based on HEDIS specifications, ignoring all continuous eligibility requirements for HEDIS in this monthly reporting.
   - Publically report on HEDIS 2016 to NCQA.

10) Performance Improvement Projects (PIPs)
   - Submit a description of each PIP to DHH for approval within three months of the execution of the contract and at the beginning of each contract year thereafter.
   - Perform a minimum of two DHH-approved PIPs in each contract year, including the required three-year PIP and the one-year PIP associated with the contract year
   - Submit project data analysis to DHH monthly.
   - Report to DHH on PIP outcomes on an annual basis.

11) Member and Provider Call Centers
   - Establish and maintain a member call center.
   - Develop and submit to DHH for approval a script to be used during the welcome call.
   - Develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards and emergencies including but not limited to hurricane-related evacuations. The MCO shall submit these telephone help line policies and procedures, including performance standards, to DHH for written approval prior to implementation of any policies.
   - Develop call center quality criteria and protocols to measure and monitor the accuracy of responses and phone etiquette and submit to DHH for review and approval annually.

- Establish and maintain a provider call center.
- Submit draft training materials for telephone agents.
- Develop a contingency plan for hiring call center staff to address overflow calls and emails.
- Submit telephone and internet activity reports monthly.

12) Member Services

- Develop and maintain a member handbook that adheres to federal requirements in required formats.
- Maintain grievance and appeals logs and submit to DHH monthly.
- Conduct Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys annually.
- Develop and implement a Member Advisory Council Plan.

13) Enrollment

- Maintain a record of total PCP linkages of Medicaid members and provide this information quarterly to DHH.

14) Marketing and Member Education Materials

- Submit a plan detailing marketing and member education activities within 30 days of contract signature.
- Develop and maintain a welcome newsletter that adheres to federal requirements.
- Submit to DHH for approval all member materials.
- Maintain copies of all member materials including obsolete versions.
- Maintain documentation that reading level software was utilized, including indicator used and reading level of the item.

15) Enrollment Website

- Submit website screenshots to DHH for approval.
- Maintain documentation that reading level software was utilized, including indicator used and reading level of the item.
- Maintain provider directories.

16) Fraud, Waste, and Abuse Compliance

- Submit plan to DHH within 30 days from the date the contract is signed and annually thereafter.
- Submit fraud and abuse activity report quarterly with an annual summary of activity.
- Attest monthly that a search of websites referenced in Section 15.3.3 of the RFP has been completed.

17) Systems

- Maintain records documenting the exchange all required files with the Medicaid fiscal intermediary.
- Submit encounter data to DHH or its contractor as required.
- Submit refresh plan for review and approval annually.
- Develop, prepare, print, maintain, produce, and distribute to DHH distinct Systems design and management manuals, user manuals and quick reference Guides, and any updates.
- Develop a contingency plan to protect the availability, integrity, and security of data during unexpected failures or disasters, (either natural or man-made) to continue essential application or system functions during or immediately following failures or disasters.
- Enroll at least 75% of all contracted hospitals with an emergency department into the Louisiana Health Information Exchange by December 31, 2015.

18) Claims & Encounters

- Submit weekly encounters to Medicaid fiscal intermediary. Encounters must be submitted within 25 days of payment.
- Submit encounter data on the 25th calendar day of the month to the Medicaid fiscal intermediary.
- Submit claims payment accuracy report monthly.

- Submit claims processing interest payments on weekly encounter file.
- Submit denied claims report ~~weekly~~ **monthly**.
- Submit weekly transaction records on all prior authorization requests.
- Develop an internal claims dispute process for those claims or group of claims that have been denied or underpaid. The process must be submitted to DHH for approval within thirty (30) days of the date the Contract is signed by the MCO.

19) Financial Reporting
    - Submit audited financial statements annually.
    - Submit unaudited financial statements monthly.

20) TPL Reporting
    - Report members with third party coverage to DHH on a weekly basis.
    - Submit TPL collections on an annual basis.

21) Emergency Management Plan
    - Submit annually.

Monitoring
Contract monitoring will be at the direction of the Medicaid Deputy Director for managed care or their designee.

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Monitoring activities include:

1) Thorough review and analysis of required work plans and monthly, quarterly and annual reports, as well as review and monitoring of corrective action plans if required of the contractor by DHH;
2) Minimum of weekly status calls between Contractor and DHH Contract Monitor and/or designated Medicaid staff;
3) Face-to-face meetings between Contractor and DHH Contract Monitor and/or designated Medicaid staff as warranted;
4) Solicitation of feedback on Contractor's performance from the Medicaid fiscal intermediary;
5) Annual evaluation through an independent external quality review contractor;
6) Real-time monitoring of member services hotline calls;
7) Investigation of all complaints regarding the Contractor;
8) Monitoring grievances and appeals to determine appropriate resolution;
9) Periodic navigation of contractor website to determine performance;
10) Spot checking to determine that provider listings on contractor website accurately reflects information provided by the providers;
11) Unannounced and scheduled visits to contractor's Louisiana administrative office; and
12) "Secret shopper" calls to Member Services and Provider Services call centers.

Payment: Fixed Rate
See Attachment C for details.

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January 31, 2015

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

Dear Ms. Johnson:

The Louisiana Department of Health and Hospitals (DHH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for the State of Louisiana's Bayou Health program for the period of February 1, 2015 through January 31, 2016. This certification includes the addition of Pediatric Day Health Care (PDHC) services, Full Medicaid Pricing (FMP), Behavioral Health pharmacy costs due to the mixed services protocol and replaces the capitation rate ranges certified in the August 29, 2014 letter for the period February 1, 2015 through January 31, 2016.

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

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

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

Rate Methodology

Overview

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

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

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

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

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

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

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

Bayou Health Populations

Covered Populations

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

CCM

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

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

LaHIPP Population

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

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

Excluded Populations

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

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

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

Rate Category Groupings

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

Table 1: Rate Category Groupings

COA Description	Rate Cell Description
SSI	Newborns, 0-2 Months of Age
	Newborns, 3-11 Months of Age
	Child, 1-18 Years of Age
	Adult, 19+ Years of Age
Family & Children	Newborns, 0-2 Months of Age
	Newborns, 3-11 Months of Age
	Child, 1-18 Years of Age
	Adult, 19+ Years of Age
Breast and Cervical Cancer (BCC)	BCC, All Ages
LAP	LAP, All Ages
HCBS	Child, 0-18 Years of Age
	Adult, 19+ Years of Age
CCM	CCM, All Ages
Maternity Kickpayment	Maternity Kickpayment
Early Elective Delivery Kickpayment	EED Kickpayment

Region Groupings

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

Table 2: Region Groupings

Region Description	Associated Parishes (Counties)
Gulf	Assumption, Jefferson, Lafourche, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John, St. Mary, and Terrebonne
Capital	Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, St. Tammany, Tangipahoa, Washington, West Baton Rouge, and West Feliciana

Region Description	Associated Parishes (Counties)
South Central	Acadia, Allen, Avoyelles, Beauregard, Calcasieu, Cameron, Catahoula, Concordia, Evangeline, Grant, Iberia, Jefferson Davis, Lafayette, Lasalle, Rapides, St. Landry, St. Martin, Vermilion, Vernon, and Winn
North	Bienville, Bossier, Caddo, Caldwell, Claiborne, DeSoto, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Natchitoches, Ouachita, Red River, Richland, Sabine, Tensas, Union, Webster, and West Carroll

Bayou Health Services

Covered Services

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

New Services

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

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

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

Additionally, non-emergency medical transportation (NEMT) will be the responsibility of the Bayou Health MCO, even if the recipient is being transported to a Medicaid-covered service that is not a Bayou Health-covered service. Previously, a Prepaid enrollee's NEMT to Bayou Health excluded services would have been captured in FFS. Mercer has created an adjustment for the Prepaid NEMT Encounters to account for this addition and the impact can be found in Appendix D. This additional service cannot be distinguished for Shared Savings/FFS claims because all NEMT services for these populations were covered under FFS. The impact

of the additional services are fully captured for the Shared Savings and FFS populations in the NEMT experience on Attachment 1 of the Bayou Health Data Book released by the State, dated January 31, 2015.

Behavioral Health Mixed Services Protocol

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

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

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

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

Excluded Services

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

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

- HCBS Waiver services
- Specialized Behavioral Health
- Targeted Case Management services
- Services provided through DHH's Early-Steps Program

Data Adjustments

IBNR Claims

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

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

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

Under-reporting

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

Third-Party Liabilities

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

Fraud and Abuse Recoveries

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

Co-payments

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

Disproportionate Share Hospital Payments

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

Fee Schedule Adjustments

Fee Changes

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

Table 3: Total Inpatient Fee Change Impact

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

Table 4: Total Outpatient Fee Change Impact

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

Table 5: Total Physician Fee Change Impact (does not reflect reduction of ACA−Enhanced Payments)

Program	Historical Cost	Adjusted Cost	Difference	% Change
FFS/Shared	$317,853,687	$317,707,582	$(146,105)	0.0%
Encounter	$262,096,884	$261,889,654	$(207,147)	-0.1%
Total:	**$579,950,571**	**$579,597,236**	**$(353,252)**	**-0.1%**

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

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

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

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

Hospital Privatization

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

Privatizing

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

Closing

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

As a result of this privatization, they are no longer paid for services based on the state hospital fee schedule, but rather on the non-state, non-rural fee schedule. Similarly, reimbursement for cost-based services for these hospitals is now based on the 66.46% cost settlement percentage for non-state, non-rural hospitals, rather than the 90% cost-settlement percentage applicable to state hospitals. The utilization in the facilities that are closing was assumed to be absorbed by other facilities in the regions, and claims were adjusted accordingly.

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

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

Table 8: Inpatient Impact of LSU Hospital Privatization*

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

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

Table 9: Outpatient Impact of LSU Hospital Privatization

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

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

Table 10: Fee Schedule Adjustment

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

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

Full Medicaid Pricing

Effective April 1, 2014, DHH implemented a program change to ensure consistent pricing in the Medicaid program for hospital services. This change required the use of Full Medicaid Pricing (FMP) in the calculation of per member per month (PMPM) payments to MCOs. DHH expects that this rate increase will lead to increased payments to those hospitals contracting with the MCOs to maintain and increase access to inpatient and outpatient hospital services to the enrolled Medicaid populations. Mercer and the State reviewed the aggregate funding levels for hospital services between the base period and the contract period and determined that an addition to the historical data was necessary in order to ensure that the capitation rate ranges reflect adequate statewide pricing levels. Separate adjustments were made to inpatient and outpatient services to capture the full impact of statewide hospital funding.

For the Prepaid encounter and the Shared Savings/FFS, inpatient service costs were increased by 65.1% and 59.9%, respectively. Mercer relied upon an analysis of Medicare diagnosis related group equivalent pricing of Medicaid services provided by DHH. For the Prepaid encounter, this analysis was done for the population served by the three Prepaid plans, in aggregate. A separate analysis was done for the Shared Savings/FFS population. The analyses relied upon encounter and Shared Savings/FFS data incurred from July 2012 to June 2013 and compared the adjusted Medicare payments to the Medicaid payment on a per discharge basis at each hospital. The Medicare payments were adjusted to reflect the treatment of Medicaid patients and reflected the state fiscal year (SFY)14 reimbursement schedule. The SFY13 Medicaid payments were adjusted to reflect fee changes effective in SFY14 and payments made outside of the claims system (outlier payments). Mercer applied the ratio between the two payments to the base data at a hospital-specific level.

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

ACA PCP

Under Section 1202 of the ACA, state Medicaid programs were required to increase payments to PCPs in 2013 and 2014. This requirement expires on December 31, 2014. As a result, 2013 Bayou Health encounter and FFS claims were adjusted to reflect the decrease in PCP payment rates between 2013 and 2015. The reduction, applied at the COA level, is based on adjusting the provider fee schedule from the enhanced ACA rate to the Medicaid rate set by DHH. For the

Prepaid Encounters, the enhanced payment data was under-reported at the time Mercer requested data as Prepaid health plans were still reprocessing some of the enhanced claims. Discussions were held with each of the existing Prepaid health plans to make sure Mercer was identifying these claims appropriately. For detail on the adjustment applied to these claims, see Appendices G1-G2.

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

Table 11: ACA PCP Adjustment

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

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

Program Changes

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

Act 312

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

EED

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

Table 12: EED Rate Reduction

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

Retroactive Eligibility Adjustment

Beginning in February 2015 members granted retroactive eligibility will be capitated retroactively, based on their eligibility for Bayou Health, for up to 12 months prior to enrollment in an MCO. The MCO selected by these members will then receive one capitation payment per month of retroactive enrollment, and will be liable for all claims incurred during this retroactive eligibility period. Mercer developed an adjustment factor to apply to the base data in the capitation rate development. Mercer did not apply any savings adjustments to the retroactive period claims in the development of these factors because the MCO will have no ability to manage utilization during the retroactive period.

The retroactive eligibility adjustment was developed as an increase to the capitation rates set for all members, meaning that the capitation payment is higher than otherwise required on non-retroactive member months. Retroactive enrollment in any given rate cell will generate the same capitation payment per month to the MCO as any other enrollee in that same rate cell. The factors were developed at a rate cell level on a statewide basis (i.e., all regions used the

same factors). The calculation relied upon retroactive claims PMPM, unique enrollee counts, and the average duration to develop the expected increase to Bayou Health claims.

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

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

Table 13 summarizes the overall adjustment by rate cell for retroactive eligibility.

Table 13: Retroactive Eligibility Adjustment

Retroactive Eligibility Adjustment		
COA Description	**Rate Cell Description**	**Adjustment (%)**
SSI	0-2 Months	0.0
SSI	3-11 Months	0.0
SSI	Child 1-18	0.0
SSI	Adult 19+	0.5
Family & Children	0-2 Months	0.0
Family & Children	3-11 Months	0.0
Family & Children	Child 1-18	0.0
Family & Children	Adult 19+	1.7
BCC	BCC, All Ages	7.5
LAP	LAP, All Ages	0.0
HCBS	Child 0-18	0.0
HCBS	Adult 19+	0.0

Retroactive Eligibility Adjustment		
COA Description	**Rate Cell Description**	**Adjustment (%)**
CCM	CCM, All Ages	0.0
Maternity Kickpayment	Maternity Kickpayment	0.0
EED Kickpayment	EED Kickpayment	0.0
Total		**0.7**

Rating Adjustments

Trend

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

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

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

PDHC Adjustments

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

Due to the uneven distribution of PDHC providers in the State, each regional group has different proportions of members utilizing PDHC services. Mercer developed projected utilization per 1,000 Member Months (MM) of PDHC Eligible members for each region based on the number of new facilities that will be operating during the rating period in that region. PDHC eligible members were simply defined as any enrollee in a child rate cell (SSI ages 0-18, Family & Children ages 0-18, LA Chip, HCBS 0-19, and Chisholm). Any enrollees under the age of 21 are

eligible for PDHC services; however, the data showed that virtually all users of this service were under the age of 19 and therefore no adjustment to the adult rate cells was warranted. Table 14 shows the summary of PDHC providers and Estimated PDHC users by regions.

Table 14: Projected Number of PDHC Users

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

* Based on December 2013 experience. Not all providers operated in all of 2013.

To develop the estimated PDHC service cost, Mercer developed the PDHC cost per PDHC user per month. The estimation is based on the regional experience of PDHC providers during CY13. In the Gulf region where there is little experience due to a lack of providers, an average statewide cost was used. The summary of estimated PDHC service cost per PDHC user per month and the estimated PDHC service cost due to the increased number of providers are shown in Table 15.

Table 15: PDHC Adjustment

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

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

Managed Care Adjustments

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

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

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

Shared Savings Rx claims

Under the Bayou Health Shared Savings program, plans had limited ability to manage prescription drug costs. In order to use the Shared Savings experience to set capitated rates, adjustments were needed to account for generic dispense rate (GDR) differences between the Prepaid and Shared Savings experience. For the Prepaid program, GDR was approximately 84%, compared to approximately 77% for Shared Savings and FFS. Mercer assumed the change in GDR would be zero the first month the rates are in effect, increasing evenly over the next 3 months until an 84% GDR is achieved in May 2015. Per section 6.33 of the Bayou Health RFP, MCOs are required to allow members 60 days to transition medications after enrollment in the MCO. The extra 30 days is to allow time for the MCO to identify the member for such a transition. This adjustment is a downward adjustment to the Shared Savings claims data. Mercer analyzed the Shared Savings prescription drug experience and compared it to the spending on similar therapeutic classes of drugs in the Prepaid program. Mercer determined that achieving the same GDR levels would result in savings of 13% to 16%. After adjusting for phase-in, the savings for rating year 2015 is 11% to 13%. Tables 16 and 17 detail the savings breakdown by COA, both without and with the phase in period.

Table 16: GDR Savings Adjustment – Without Phase In Period

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

Table 17: GDR Savings Adjustment – With Phase In Period

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

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

Rx Rebates

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

Outliers

As part of the State Plan, inpatient hospitals receive an additional payment for high cost stays for children under age 6, called outliers. These payments are for inpatient stays with a total cost to the hospital in excess of $150,000, where the cost is determined based on the hospital's Neonatal Intensive Care Unit (NICU) or Pediatric Intensive Care Unit (PICU)-specific CCR. DHH makes payments to a maximum of $10 million, annually. As payment of outlier liability is the responsibility of Bayou Health MCOs, this additional $10 million was built into the rates based on the distribution by rate cell observed in SFY11 and SFY12. The most recent outlier information received was for SFY13 payments, which Mercer analyzed and determined the claims payment distribution to be an anomaly compared to SFY11 and SFY12 experience that was more consistently distributed. Thus, Mercer came to the decision that utilizing distribution patterns from SFY11 and SFY12 would provide a more representative basis for the future claims distribution patterns. Outliers added an average cost of $0.93 PMPM to the base data used in rate setting. Table 18 details the impact of outliers on the rates by rate cell.

Table 18: Outliers Adjustment

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

*Totals includes member months for all populations in Bayou Health.

GME

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

Data Smoothing

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

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

Voluntary Opt-In Adjustments

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

Non-Medical Expense Load

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

cells with higher utilization, which Mercer believes is more accurate in reflecting the drivers of plan administration requirements.

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

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

Risk Adjustment

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

Federal Health Insurer Fee

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

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

Certification of Final Rate Ranges

In preparing the rate ranges shown in Attachment A, Mercer has used and relied upon enrollment, FFS claims, encounter data, reimbursement level, benefit design, and other

information supplied by DHH and its fiscal agent. DHH, its fiscal agent, and the Prepaid plans are responsible for the validity and completeness of the data supplied. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion they are appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

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

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

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

This certification letter assumes the reader is familiar with the Bayou Health Program, Medicaid eligibility rules, and actuarial rate-setting techniques. It is intended for DHH and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

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

Sincerely,

Jaredd Simons, ASA, MAAA
Senior Associate Actuary

Appendix A: Bayou Health Capitation Rate Range

Region Description	COA Description	Rate Cell Description	CY13 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
Gulf	SSI	0-2 Months	291	$29,018.84	$30,491.64
Gulf	SSI	3-11 Months	1,790	$5,286.42	$5,580.19
Gulf	SSI	Child 1-18	122,394	$380.69	$404.80
Gulf	SSI	Adult 19+	276,704	$1,000.11	$1,052.64
Gulf	Family & Children	0-2 Months	43,180	$1,704.84	$1,791.17
Gulf	Family & Children	3-11 Months	104,549	$243.86	$260.33
Gulf	Family & Children	Child 1-18	2,053,265	$118.28	$126.12
Gulf	Family & Children	Adult 19+	374,005	$314.92	$332.46
Gulf	BCC	BCC, All Ages	3,702	$2,158.88	$2,288.53
Gulf	LAP	LAP, All Ages	9,457	$153.68	$164.15
Gulf	HCBS	Child 0-18	6,826	$1,535.18	$1,664.52
Gulf	HCBS	Adult 19+	21,296	$594.57	$639.84
Gulf	CCM	CCM, All Ages	15,710	$901.88	$982.14
Gulf	Maternity Kickpayment	Maternity Kickpayment	10,987	$8,568.30	$8,805.32
Gulf	EED Kickpayment	EED Kickpayment	N/A	$4,865.02	$4,946.41
Capital	SSI	0-2 Months	168	$29,930.42	$31,403.23
Capital	SSI	3-11 Months	1,491	$5,369.15	$5,662.92
Capital	SSI	Child 1-18	89,519	$423.53	$452.27
Capital	SSI	Adult 19+	210,439	$1,017.92	$1,077.83
Capital	Family & Children	0-2 Months	38,789	$1,847.28	$1,935.91
Capital	Family & Children	3-11 Months	94,611	$262.04	$280.92
Capital	Family & Children	Child 1-18	1,863,396	$123.93	$132.56
Capital	Family & Children	Adult 19+	268,984	$356.78	$377.47
Capital	BCC	BCC, All Ages	3,946	$2,155.05	$2,284.70

Region Description	COA Description	Rate Cell Description	CY13 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
Capital	LAP	LAP, All Ages	10,487	$153.58	$164.05
Capital	HCBS	Child 0-18	7,164	$1,534.74	$1,664.08
Capital	HCBS	Adult 19+	21,638	$592.63	$637.91
Capital	CCM	CCM, All Ages	15,831	$901.76	$982.03
Capital	Maternity Kickpayment	Maternity Kickpayment	9,772	$7,647.11	$7,857.06
Capital	EED Kickpayment	EED Kickpayment	N/A	$4,814.51	$4,905.42
South Central	SSI	0-2 Months	217	$29,280.03	$30,752.84
South Central	SSI	3-11 Months	1,692	$5,311.27	$5,605.04
South Central	SSI	Child 1-18	91,728	$440.52	$468.03
South Central	SSI	Adult 19+	247,354	$938.14	$991.23
South Central	Family & Children	0-2 Months	43,502	$2,056.15	$2,150.83
South Central	Family & Children	3-11 Months	104,512	$278.08	$296.40
South Central	Family & Children	Child 1-18	2,038,315	$131.32	$140.19
South Central	Family & Children	Adult 19+	285,454	$326.28	$345.23
South Central	BCC	BCC, All Ages	2,893	$2,160.65	$2,290.30
South Central	LAP	LAP, All Ages	12,222	$153.87	$164.34
South Central	HCBS	Child 0-18	6,665	$1,534.26	$1,663.60
South Central	HCBS	Adult 19+	23,110	$593.83	$639.11
South Central	CCM	CCM, All Ages	16,556	$901.83	$982.10
South Central	Maternity Kickpayment	Maternity Kickpayment	10,504	$7,519.83	$7,728.23
South Central	EED Kickpayment	EED Kickpayment	N/A	$4,604.97	$4,690.87
North	SSI	0-2 Months	239	$29,430.50	$30,903.30
North	SSI	3-11 Months	1,678	$5,329.80	$5,623.57
North	SSI	Child 1-18	100,260	$402.65	$426.58
North	SSI	Adult 19+	212,259	$899.87	$949.93
North	Family & Children	0-2 Months	32,253	$1,958.67	$2,055.77

Region Description	COA Description	Rate Cell Description	CY13 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
North	Family & Children	3-11 Months	80,214	$258.30	$275.83
North	Family & Children	Child 1-18	1,587,962	$118.97	$126.76
North	Family & Children	Adult 19+	213,631	$314.03	$332.30
North	BCC	BCC, All Ages	2,395	$2,162.19	$2,291.84
North	LAP	LAP, All Ages	6,545	$154.04	$164.51
North	HCBS	Child 0-18	4,164	$1,534.80	$1,664.14
North	HCBS	Adult 19+	17,320	$594.89	$640.17
North	CCM	CCM, All Ages	16,472	$901.86	$982.13
North	Maternity Kickpayment	Maternity Kickpayment	8,132	$7,586.19	$7,800.55
North	EED Kickpayment	EED Kickpayment	N/A	$4,421.38	$4,502.73

Appendix B: Bayou Health Eligibility Designation

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

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

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

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

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

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

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

Appendix C: Bayou Health Covered Services

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

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

Appendix D: NEMT Adjustment

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

		NEMT Adjustment				
COA Description	**Rate Cell Description**	**Gulf (%)**	**Capital (%)**	**Southwest (%)**	**North (%)**	**Total (%)**
CCM	CCM, All Ages	0.0	0.0	0.0	0.0	**0.0**
Maternity Kickpayment	Maternity Kickpayment	0.0	0.0	0.0	0.0	**0.0**
Total		**27.4**	**27.7**	**14.8**	**10.3**	**20.9**

Appendix E: Behavioral Health Mixed Services Protocol

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

Appendix F-1: Shared Savings/FFS IBNR Adjustment

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

Appendix F-2: Prepaid IBNR Adjustment

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

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

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

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

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

Appendix H-1: 6-Month Average Duration Calculation

	SSI			Family & Children			BCC		
First Month of Enrollment	**Recipients**	**MMs**	**Average Duration**	**Recipients**	**MMs**	**Average Duration**	**Recipients**	**MMs**	**Average Duration**
Jul-13	1,022	2,073	2.0	5,084	8,109	1.6	25	65	2.6
Aug-13	1,129	2,292	2.0	6,453	10,455	1.6	22	64	2.9
Sept-13	1,178	2,399	2.0	6,105	9,363	1.5	18	73	4.1
Oct-13	1,022	2,219	2.2	5,650	8,944	1.6	28	152	5.4
Nov-13	1,196	2,369	2.0	5,661	10,012	1.8	36	106	2.9
Dec-13	1,089	2,220	2.0	4,699	7,830	1.7	21	86	4.1
6-Month Avg. Duration			**2.0**			**1.6**			**3.9**

Appendix H-2: Statewide Summary by Rating Category

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

Notes:

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

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

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

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

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

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

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

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

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

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

* The HCBS waiver and CCM population are previously unmanaged populations and thus Mercer has utilized Legacy Medicaid/FFS claims for this analysis
** Current services for Prepaid, Shared Savings, and LaHIPP populations are managed and managed care savings are not applied

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

	Managed Care Savings Assumptions					
	Shared Savings*					
Category of Service Description	**Low Util (%)**	**High Util (%)**	**Low Unit Cost (%)**	**High Unit Cost (%)**	**Low PMPM (%)**	**High PMPM (%)**
Inpatient Hospital						
Outpatient Hospital						
Primary Care Physician						
Specialty Care Physician						
FQHC/RHC						
EPSDT						
Certified Nurse Practitioners/Clinical Nurse						
Lab/Radiology						
Home Health						
Emergency Transportation						
Non-Emergency Transportation	0.0	5.0	0.0	2.0	0.0	7.1
Rehabilitation Services (OT, PT, ST)						
DME	-20.0	-15.0	0.0	2.0	-20.0	-13.3
Clinic						
Family Planning						
Other						
Prescribed Drugs	-1.0**	-0.5**	0.0	0.0	-1.0**	-0.5**
ER						
Basic Behavioral Health						
Hospice	0.0	0.0	0.0	0.0	0.0	0.0
Personal Care Services	-10.0	-5.0	0.0	0.0	-10.0	-5.0
Total	**-0.5**	**-0.2**	**0.0**	**0.0**	**-0.5**	**-0.2**

*Covered services previously not covered under the Shared Savings program

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

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

Appendix K: Non-Medical Expense Load

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

Retention Loads by Rate Cell									
		Lower Bound of Range				Upper Bound of Range			
		Gulf	Capital	South Central	North	Gulf	Capital	South Central	North
COA Description	Rate Cell Description	Retention %	Retention %	Retention %	Retention %	Retention %	Retention %	Retention %	Retention %
HCBS	Adult, 19+ Years of Age	10.1	10.1	10.1	10.1	10.2	10.2	10.2	10.2
CCM	CCM, All Ages	10.1	10.1	10.1	10.1	10.1	10.1	10.1	10.1
Maternity Kickpayment	Maternity Kickpayment	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7

Appendix L: Data Reliance Attestation

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

August 27, 2014

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

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

Dear Jaredd:

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

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

Jen Steele
Signature

8/27/14
Date

Bienville Building •628 North 4th Street • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
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Appendix M: Development of Final Rates for February 1, 2015 through January 31, 2016

Rate Development Description

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

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

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

Base Period Adjustments		
Prepaid	**Shared Savings/FFS**	**LaHIPP**
	Fraud and Abuse Adjustment (statewide adj.)	Fraud and Abuse Adjustment (statewide adj.)
Fee Schedule Adjustment (hospital specific adj.)	Fee Schedule Adjustment (hospital specific adj.)	Fee Schedule Adjustment (hospital specific adj.)
ACT 312 Adjustment (statewide adj.)	ACT 312 Adjustment (statewide adj.)	ACT 312 Adjustment (statewide adj.)
PDHC Adjustment (Region and COS level adj.)	PDHC Adjustment (Region and COS level adj.)	PDHC Adjustment (Region and COS level adj.)
	RX Rebate Adjustment (statewide adj.)	RX Rebate Adjustment (statewide adj.)
ACA PCP Adjustment (Category of Service level adj.)	ACA PCP Adjustment (Category of Service level adj.)	
Behavioral Health Mixed	Behavioral Health Mixed	Behavioral Health Mixed

Base Period Adjustments		
Prepaid	**Shared Savings/FFS**	**LaHIPP**
Services Protocol Adjustment (Category of Service level adj.)	Services Protocol Adjustment (Category of Service level adj.)	Services Protocol Adjustment (Category of Service level adj.)
Retroactivity Adjustment (rate cell level adj.)	Retroactivity Adjustment (rate cell level adj.)	Retroactivity Adjustment (rate cell level adj.)
NEMT Adjustment (rate cell level adj.)		

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

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

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

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

			Base Data		Base Data Adjustments							Outliers			Capitation Rate Load								Full Medicaid Pricing			
			A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X
Region Name	COA Desc	Rate Cell Code	MMs	PMPM	Annual Trend-Low	Annual Trend-High	Trend Factor-Low	Trend Factor-High	Base Period Adj.	Managed Care Adj. Factor-Low	Managed Care Adj. Factor-High	Outlier Add-on PMPM	Claims PMPM-Low	Claims PMPM-High	Fixed Admin Load-Low (PMPM)	Variable Admin Load-Low (%)	Fixed Admin Load-High (PMPM)	Variable Admin Load-High (%)	Profit @ 2%	Premium Tax @ 2.25%	PMPM After Admin-Low	PMPM After Admin-High	FMP Add-On	Premium tax on FMP	Final Loaded Rates-Low	Final Loaded Rates-High
Gulf	SSI	Newborn, 0-2 Months	291	$ 19,478.95	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	$ 945.10	$ 19,605.45	$ 20,936.71	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 21,718.65	$ 23,191.46	$ 7,135.93	$ 164.25	$ 29,018.84	$ 30,491.64
Gulf	SSI	Newborn, 3-11 Months	1,790	$ 3,966.82	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	$ 63.79	$ 4,038.79	$ 4,304.79	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,461.42	$ 4,755.19	$ 806.43	$ 18.56	$ 5,286.42	$ 5,580.19
Gulf	SSI	Child, 1-18 Years	122,394	$ 292.96	2.9%	5.9%	1.06	1.13	-1.4%	0.98	0.99	$ 2.39	$ 302.71	$ 324.02	$ 10.89	4.4%	$ 11.67	4.4%	2.0%	2.25%	$ 341.49	$ 365.60	$ 38.31	$ 0.88	$ 380.69	$ 404.80
Gulf	SSI	Adult, 19+ Years	276,704	$ 681.20	2.9%	5.9%	1.06	1.13	0.4%	0.99	0.99	$ -	$ 717.35	$ 764.64	$ 10.89	4.3%	$ 11.67	4.4%	2.0%	2.25%	$ 793.04	$ 845.58	$ 202.41	$ 4.66	$ 1,000.11	$ 1,052.64
Gulf	Family and Children	Newborn, 0-2 Months	43,180	$ 1,149.57	0.7%	4.1%	1.01	1.09	-7.5%	1.00	1.00	$ 46.33	$ 1,122.09	$ 1,199.45	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,253.38	$ 1,339.71	$ 441.30	$ 10.16	$ 1,704.84	$ 1,791.17
Gulf	Family and Children	Newborn, 3-11 Months	104,549	$ 200.42	2.3%	5.8%	1.05	1.12	-10.6%	0.97	0.97	$ 0.21	$ 182.14	$ 196.37	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 211.71	$ 228.18	$ 31.43	$ 0.72	$ 243.86	$ 260.33
Gulf	Family and Children	Child, 1-18 Years	2,053,265	$ 89.50	3.0%	6.2%	1.06	1.13	-4.9%	0.95	0.96	$ 0.05	$ 86.08	$ 92.48	$ 10.89	4.7%	$ 11.67	4.8%	2.0%	2.25%	$ 105.54	$ 113.37	$ 12.46	$ 0.29	$ 118.28	$ 126.12
Gulf	Family and Children	Adult, 19+ Years	374,005	$ 214.94	2.9%	5.9%	1.06	1.13	1.7%	0.96	0.97	$ -	$ 223.22	$ 238.47	$ 10.89	4.8%	$ 11.67	4.8%	2.0%	2.25%	$ 255.69	$ 273.23	$ 57.90	$ 1.33	$ 314.92	$ 332.46
Gulf	Breast and Cervical Cancer	BCC, All Ages Female	3,702	$ 1,291.59	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	$ -	$ 1,460.86	$ 1,577.84	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,615.27	$ 1,744.92	$ 531.38	$ 12.23	$ 2,158.88	$ 2,288.53
Gulf	LaCHIP Affordable Plan	All Ages	9,457	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	$ -	$ 115.39	$ 124.22	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.41	$ 147.88	$ 15.90	$ 0.37	$ 153.68	$ 164.15
Gulf	HCBS Waiver	18 & Under, Male and Female	6,826	$ 1,357.71	2.0%	4.6%	1.04	1.10	0.5%	0.95	0.97	$ -	$ 1,343.79	$ 1,460.38	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,489.28	$ 1,618.62	$ 44.87	$ 1.03	$ 1,535.18	$ 1,664.52
Gulf	HCBS Waiver	19+ Years, Male and Female	21,296	$ 509.87	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	$ -	$ 470.37	$ 510.93	$ 10.89	4.2%	$ 11.67	4.3%	2.0%	2.25%	$ 523.50	$ 568.78	$ 69.47	$ 1.60	$ 594.57	$ 639.84
Gulf	Chisholm Class Members	Chisholm, All Ages Male & Female	15,710	$ 774.94	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	$ -	$ 753.39	$ 825.52	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 838.14	$ 918.40	$ 62.31	$ 1.43	$ 901.88	$ 982.14
Gulf	Maternity Kickpayment	Maternity Kickpayment, All Ages	10,987	$ 5,122.05	0.0%	2.0%	1.00	1.04	-0.6%	1.00	1.00	$ -	$ 5,092.15	$ 5,306.63	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 5,640.00	$ 5,877.03	$ 2,862.41	$ 65.89	$ 8,568.30	$ 8,805.32
Capital	SSI	Newborn, 0-2 Months	168	$ 19,478.95	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	$ 945.10	$ 19,605.45	$ 20,936.71	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 21,718.65	$ 23,191.46	$ 8,027.00	$ 184.76	$ 29,930.42	$ 31,403.23
Capital	SSI	Newborn, 3-11 Months	1,491	$ 3,966.82	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	$ 63.79	$ 4,038.79	$ 4,304.79	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,461.42	$ 4,755.19	$ 887.31	$ 20.42	$ 5,369.15	$ 5,662.92
Capital	SSI	Child, 1-18 Years	89,519	$ 344.20	3.0%	5.9%	1.06	1.13	1.5%	0.98	0.99	$ 2.39	$ 365.03	$ 390.59	$ 10.89	4.4%	$ 11.67	4.4%	2.0%	2.25%	$ 409.50	$ 438.24	$ 13.71	$ 0.32	$ 423.53	$ 452.27
Capital	SSI	Adult, 19+ Years	210,439	$ 745.67	3.0%	5.9%	1.06	1.13	4.1%	0.99	0.99	$ -	$ 813.72	$ 867.77	$ 10.89	4.3%	$ 11.67	4.4%	2.0%	2.25%	$ 898.08	$ 958.00	$ 117.14	$ 2.70	$ 1,017.92	$ 1,077.83
Capital	Family and Children	Newborn, 0-2 Months	38,789	$ 1,158.11	0.6%	4.0%	1.01	1.09	-6.4%	1.00	1.00	$ 46.33	$ 1,140.87	$ 1,220.31	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,274.05	$ 1,362.67	$ 560.34	$ 12.90	$ 1,847.28	$ 1,935.91
Capital	Family and Children	Newborn, 3-11 Months	94,611	$ 223.96	2.1%	5.6%	1.05	1.12	-7.5%	0.97	0.97	$ 0.21	$ 209.26	$ 225.68	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 241.58	$ 260.47	$ 19.99	$ 0.46	$ 262.04	$ 280.92
Capital	Family and Children	Child, 1-18 Years	1,863,396	$ 96.04	3.2%	6.3%	1.07	1.14	-1.8%	0.94	0.95	$ 0.05	$ 94.83	$ 101.98	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 114.97	$ 123.60	$ 8.76	$ 0.20	$ 123.93	$ 132.56
Capital	Family and Children	Adult, 19+ Years	268,984	$ 248.77	3.0%	5.9%	1.06	1.13	6.0%	0.96	0.97	$ -	$ 268.79	$ 286.95	$ 10.89	4.7%	$ 11.67	4.7%	2.0%	2.25%	$ 305.40	$ 326.10	$ 50.22	$ 1.16	$ 356.78	$ 377.47
Capital	Breast and Cervical Cancer	BCC, All Ages Female	3,946	$ 1,291.59	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	$ -	$ 1,460.86	$ 1,577.84	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,615.27	$ 1,744.92	$ 527.64	$ 12.15	$ 2,155.05	$ 2,284.70
Capital	LaCHIP Affordable Plan	All Ages	10,487	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	$ -	$ 115.39	$ 124.22	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.41	$ 147.88	$ 15.80	$ 0.36	$ 153.58	$ 164.05
Capital	HCBS Waiver	18 & Under, Male and Female	7,164	$ 1,357.71	2.0%	4.6%	1.04	1.10	0.5%	0.95	0.97	$ -	$ 1,343.79	$ 1,460.38	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,489.28	$ 1,618.62	$ 44.44	$ 1.02	$ 1,534.74	$ 1,664.08
Capital	HCBS Waiver	19+ Years, Male and Female	21,638	$ 509.87	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	$ -	$ 470.37	$ 510.93	$ 10.89	4.2%	$ 11.67	4.3%	2.0%	2.25%	$ 523.50	$ 568.78	$ 67.58	$ 1.56	$ 592.63	$ 637.91
Capital	Chisholm Class Members	Chisholm, All Ages Male & Female	15,831	$ 774.94	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	$ -	$ 753.39	$ 825.52	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 838.14	$ 918.40	$ 62.20	$ 1.43	$ 901.76	$ 982.03
Capital	Maternity Kickpayment	Maternity Kickpayment, All Ages	9,772	$ 4,497.81	0.0%	2.0%	1.00	1.04	0.3%	1.00	1.00	$ -	$ 4,510.47	$ 4,700.44	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 4,995.73	$ 5,205.68	$ 2,591.72	$ 59.66	$ 7,647.11	$ 7,857.06
South Central	SSI	Newborn, 0-2 Months	217	$ 19,478.95	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	$ 945.10	$ 19,605.45	$ 20,936.71	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 21,718.65	$ 23,191.46	$ 7,391.25	$ 170.13	$ 29,280.03	$ 30,752.84
South Central	SSI	Newborn, 3-11 Months	1,692	$ 3,966.82	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	$ 63.79	$ 4,038.79	$ 4,304.79	$ 10.89	5.5%	$ 11.67	5.5%	2.0%	2.25%	$ 4,461.42	$ 4,755.19	$ 830.73	$ 19.12	$ 5,311.27	$ 5,605.04
South Central	SSI	Child, 1-18 Years	91,728	$ 344.01	3.4%	6.2%	1.07	1.13	0.4%	0.98	0.99	$ 2.39	$ 364.84	$ 389.34	$ 10.89	4.1%	$ 11.67	4.1%	2.0%	2.25%	$ 407.86	$ 435.37	$ 31.92	$ 0.73	$ 440.52	$ 468.03
South Central	SSI	Adult, 19+ Years	247,354	$ 679.80	3.0%	5.9%	1.06	1.13	1.0%	0.99	0.99	$ -	$ 720.34	$ 768.13	$ 10.89	4.4%	$ 11.67	4.4%	2.0%	2.25%	$ 796.60	$ 849.68	$ 138.36	$ 3.18	$ 938.14	$ 991.23
South Central	Family and Children	Newborn, 0-2 Months	43,502	$ 1,250.37	0.7%	4.1%	1.01	1.09	-6.8%	1.00	1.00	$ 46.33	$ 1,224.44	$ 1,309.36	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,366.54	$ 1,461.21	$ 674.10	$ 15.52	$ 2,056.15	$ 2,150.83
South Central	Family and Children	Newborn, 3-11 Months	104,512	$ 223.52	2.4%	5.7%	1.05	1.12	-8.3%	0.96	0.97	$ 0.21	$ 207.58	$ 223.51	$ 10.89	5.2%	$ 11.67	5.2%	2.0%	2.25%	$ 239.49	$ 257.81	$ 37.72	$ 0.87	$ 278.08	$ 296.40
South Central	Family and Children	Child, 1-18 Years	2,038,315	$ 102.68	3.3%	6.3%	1.07	1.14	-3.0%	0.94	0.95	$ 0.05	$ 100.49	$ 107.86	$ 10.89	4.5%	$ 11.67	4.5%	2.0%	2.25%	$ 121.06	$ 129.93	$ 10.02	$ 0.23	$ 131.32	$ 140.19
South Central	Family and Children	Adult, 19+ Years	285,454	$ 232.89	2.9%	5.9%	1.06	1.13	2.8%	0.97	0.97	$ -	$ 245.52	$ 262.06	$ 10.89	4.8%	$ 11.67	4.8%	2.0%	2.25%	$ 280.15	$ 299.10	$ 45.09	$ 1.04	$ 326.28	$ 345.23
South Central	Breast and Cervical Cancer	BCC, All Ages Female	2,893	$ 1,291.59	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	$ -	$ 1,460.86	$ 1,577.84	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,615.27	$ 1,744.92	$ 533.11	$ 12.27	$ 2,160.65	$ 2,290.30
South Central	LaCHIP Affordable Plan	All Ages	12,222	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	$ -	$ 115.39	$ 124.22	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.41	$ 147.88	$ 16.09	$ 0.37	$ 153.87	$ 164.34
South Central	HCBS Waiver	18 & Under, Male and Female	6,665	$ 1,357.71	2.0%	4.6%	1.04	1.10	0.5%	0.95	0.97	$ -	$ 1,343.79	$ 1,460.38	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,489.28	$ 1,618.62	$ 43.97	$ 1.01	$ 1,534.26	$ 1,663.60
South Central	HCBS Waiver	19+ Years, Male and Female	23,110	$ 509.87	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	$ -	$ 470.37	$ 510.93	$ 10.89	4.2%	$ 11.67	4.3%	2.0%	2.25%	$ 523.50	$ 568.78	$ 68.75	$ 1.58	$ 593.83	$ 639.11
South Central	Chisholm Class Members	Chisholm, All Ages Male & Female	16,556	$ 774.94	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	$ -	$ 753.39	$ 825.52	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 838.14	$ 918.40	$ 62.26	$ 1.43	$ 901.83	$ 982.10
South Central	Maternity Kickpayment	Maternity Kickpayment, All Ages	10,504	$ 4,366.34	0.0%	2.0%	1.00	1.04	2.5%	1.00	1.00	$ -	$ 4,477.23	$ 4,665.81	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 4,958.93	$ 5,167.33	$ 2,503.28	$ 57.62	$ 7,519.83	$ 7,728.23
North	SSI	Newborn, 0-2 Months	239	$ 19,478.95	0.4%	3.8%	1.01	1.08	-5.0%	1.00	1.00	$ 945.10	$ 19,605.45	$ 20,936.71	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 21,718.65	$ 23,191.46	$ 7,538.33	$ 173.52	$ 29,430.50	$ 30,903.30
North	SSI	Newborn, 3-11 Months	1,678	$ 3,966.82	1.2%	4.3%	1.03	1.09	-1.7%	0.99	1.00	$ 63.79	$ 4,038.79	$ 4,304.79	$ 10.89	5.5%	$ 11.67	5.9%	2.0%	2.25%	$ 4,461.42	$ 4,755.19	$ 848.84	$ 19.54	$ 5,329.80	$ 5,623.57
North	SSI	Child, 1-18 Years	100,260	$ 295.72	3.0%	5.8%	1.06	1.12	3.7%	0.98	0.99	$ 2.39	$ 322.88	$ 344.03	$ 10.89	4.4%	$ 11.67	4.5%	2.0%	2.25%	$ 363.57	$ 387.50	$ 38.20	$ 0.88	$ 402.65	$ 426.58
North	SSI	Adult, 19+ Years	212,259	$ 639.16	2.8%	5.8%	1.06	1.12	0.5%	0.99	0.99	$ -	$ 672.15	$ 717.13	$ 10.89	4.5%	$ 11.67	4.5%	2.0%	2.25%	$ 744.90	$ 794.96	$ 151.48	$ 3.49	$ 899.87	$ 949.93
North	Family and Children	Newborn, 0-2 Months	32,253	$ 1,240.40	0.7%	4.1%	1.01	1.09	-4.4%	1.00	1.00	$ 46.33	$ 1,244.56	$ 1,331.66	$ 10.89	6.0%	$ 11.67	6.0%	2.0%	2.25%	$ 1,388.93	$ 1,486.03	$ 556.92	$ 12.82	$ 1,958.67	$ 2,055.77
North	Family and Children	Newborn, 3-11 Months	80,214	$ 205.87	2.4%	5.8%	1.05	1.12	-4.9%	0.97	0.97	$ 0.21	$ 198.77	$ 213.96	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 229.93	$ 247.45	$ 27.73	$ 0.64	$ 258.30	$ 275.83
North	Family and Children	Child, 1-18 Years	1,587,962	$ 87.14	3.1%	6.2%	1.06	1.13	-1.1%	0.96	0.96	$ 0.05	$ 87.72	$ 94.08	$ 10.89	4.8%	$ 11.67	4.8%	2.0%	2.25%	$ 107.37	$ 115.15	$ 11.35	$ 0.26	$ 118.97	$ 126.76
North	Family and Children	Adult, 19+ Years	213,631	$ 219.65	2.8%	5.9%	1.06	1.13	2.2%	0.97	0.97	$ -	$ 229.95	$ 245.85	$ 10.89	4.9%	$ 11.67	5.0%	2.0%	2.25%	$ 263.39	$ 281.66	$ 49.50	$ 1.14	$ 314.03	$ 332.30
North	Breast and Cervical Cancer	BCC, All Ages Female	2,395	$ 1,291.59	2.5%	6.3%	1.05	1.14	7.6%	1.00	1.00	$ -	$ 1,460.86	$ 1,577.84	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 1,615.27	$ 1,744.92	$ 534.62	$ 12.31	$ 2,162.19	$ 2,291.84
North	LaCHIP Affordable Plan	All Ages	6,545	$ 120.14	3.3%	6.5%	1.07	1.14	-2.4%	0.92	0.93	$ -	$ 115.39	$ 124.22	$ 10.89	4.6%	$ 11.67	4.6%	2.0%	2.25%	$ 137.41	$ 147.88	$ 16.25	$ 0.37	$ 154.04	$ 164.51
North	HCBS Waiver	18 & Under, Male and Female	4,164	$ 1,357.71	2.0%	4.6%	1.04	1.10	0.5%	0.95	0.97	$ -	$ 1,343.79	$ 1,460.38	$ 10.89	5.3%	$ 11.67	5.3%	2.0%	2.25%	$ 1,489.28	$ 1,618.62	$ 44.50	$ 1.02	$ 1,534.80	$ 1,664.14
North	HCBS Waiver	19+ Years, Male and Female	17,320	$ 509.87	2.0%	4.0%	1.04	1.09	0.9%	0.88	0.91	$ -	$ 470.37	$ 510.93	$ 10.89	4.2%	$ 11.67	4.3%	2.0%	2.25%	$ 523.50	$ 568.78	$ 69.78	$ 1.61	$ 594.89	$ 640.17
North	Chisholm Class Members	Chisholm, All Ages Male & Female	16,472	$ 774.94	2.1%	4.8%	1.04	1.10	0.8%	0.92	0.96	$ -	$ 753.39	$ 825.52	$ 10.89	5.1%	$ 11.67	5.1%	2.0%	2.25%	$ 838.14	$ 918.40	$ 62.29	$ 1.43	$ 901.86	$ 982.13
North	Maternity Kickpayment	Maternity Kickpayment, All Ages	8,132	$ 4,615.95	0.0%	2.0%	1.00	1.04	-0.2%	1.00	1.00	$ -	$ 4,605.18	$ 4,799.14	$ -	6.1%	$ -	6.0%	2.0%	2.25%	$ 5,100.64	$ 5,314.99	$ 2,429.63	$ 55.92	$ 7,586.19	$ 7,800.55

Appendix N: 2015 Managed Care Rate Setting Consultation Guide

Section I. February 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
1. General Information	
A. A letter from the certifying actuary, who meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, that certifies that the final capitation rates or rate ranges meet the standards in 42 CFR §438.6(c).	Please refer to the certification letter dated January 31, 2015. All following page and exhibit references are specific to this certification.
B. The final and certified capitation rates or the final and certified rate ranges for all rate cells and regions, as applicable.	Please refer to Appendix A for a summary of all rate ranges by rate cell and region.
C. Brief descriptions of:	
i. The specific state Medicaid managed care programs covered by the certification.	Please refer to page 1.
ii. The rating periods covered by the certification.	Please refer to page 1.
iii. The Medicaid populations covered through the managed care programs for which the certification applies.	A brief description can be found on pages 3-4. Appendix B encompasses a comprehensive list of Bayou Health's covered and excluded populations.
iv. The services that are required to be provided by the managed care plans.	A brief description can be found on pages 6-8. Appendix C encompasses a comprehensive list of Bayou Health's covered services.
2. Data	
A. A description of the data used to develop capitation rates. This description should include:	
i. The types of data used, which may include (but is not limited to) claims data, encounter data, plan financial data, or other Medicaid program data.	Please refer to page 2.
ii. The age of all data used.	Please refer to page 2.
iii. The sources of all data used.	Please refer to page 2.

Section I. February 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
iv. To the extent that a significant portion of benefits are provided through subcapitated arrangements, a description of the data received from the subcapitated plans or providers.	N/A
v. To the extent that claims or encounter data are not used or not available, an explanation of why that data was not used or was not available.	N/A
B. Information related to the availability and the quality of the data used:	
i. The steps taken by the actuary or by others (which may include but is not limited to the state Medicaid program or the managed care organizations) to validate or improve the quality and accuracy of the data.	Please refer to the base data adjustment section beginning on page 8.
ii. Any concerns that the actuary has over the availability or quality of the data.	The data certification shown in Appendix L has been provided by DHH, and its purpose is to certify the accuracy, completeness, and consistency of the base data.
C. Any information related to changes in data used when compared to the most recent rating period:	
i. Any new data sources used by the actuary since the last certification and any data sources that the actuary has not continued to use since the last certification.	Bayou Health Shared Savings claims experience is used as a new data source. The Bayou Health Prepaid program operated under an at risk capitated arrangement, and the Shared Savings program was an ePCCM program. Effective February 1, 2015, Bayou Health will begin operating as an at risk capitated program only.
ii. How the data sources used have changed since the last certification.	N/A
D. Any plans or efforts to improve the data sources used for future certifications and any new data sources that are expected to be available and potentially used for future certifications.	N/A
E. Any adjustments that are made to the data.	Please refer to the base data adjustment section beginning on page 8.

Section I. February 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
3. Projected Benefit Costs	
A. Covered services and benefits	
i. Any changes related to the benefits covered by the Medicaid managed care organizations since the last certification, including but not limited to:	
a. More or fewer state plan benefits covered by the Medicaid managed care organization.	Please refer to the new services section on page 6.
b. Requirements deemed necessary by the state to ensure access or proper delivery of covered services, for minimum or maximum levels of payment from managed care organizations to any providers or class of providers.	Please refer to the full Medicaid pricing section on page 13.
c. Requirements or conditions of any applicable waivers.	N/A
ii. For each change related to benefits covered, the estimated impact of the change on amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment.	Please refer to the covered services section beginning on page 6.
B. Projected benefit cost trends	
i. The projected change in benefit costs from the historical period to the rating period, or trend, including but not limited to:	
a. The methodologies used to develop projected benefit costs trends.	Please refer to the trend section beginning on page 17.
b. Any data used or assumptions made in developing projected benefit cost trends.	Please refer to the trend section beginning on page 17.
c. Any applicable comparisons to historical benefit cost trends or other program benefit cost trends.	Please refer to the trend section beginning on page 17.

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d. The different components of projected benefit cost trends, including but not limited to changes in price (such as provider reimbursement rates) and changes in utilization (such as the volume of services provided).	Please refer to the trend section beginning on page 17 and Appendices I1-I3.
e. Any other material adjustments to projected benefit cost trends, and a description of the data, assumptions, and methodologies used to determine those adjustments.	N/A
f. To the extent there are any differences, projected benefit cost trends by:	
i. Service or category of service.	Please refer to Appendices I1-I3.
ii. Rate cell or Medicaid population.	Please refer to Appendices I1-I3.
C. Other adjustments to projected benefit costs:	
i. Any other adjustments made to projected benefit costs excluding those described above, including but not limited to:	
a. The impact of managed care on the utilization on the unit costs of health care services.	Please refer to the managed care adjustments section beginning on page 19 and Appendices J1-J2.
b. Changes to projected benefit costs in the rating period outside of regular changes in utilization or unit cost of services.	Please refer to the program changes section beginning on page 14.
D. Final projected benefit costs by relevant level of detail (for example, by Medicaid population or by rate cell).	Please refer to Appendix M.
4. Projected Non-benefit Costs	
E. Non-benefit costs including but not limited to:	Please refer to the non-medical expense load section beginning on page 22.
i. Administrative costs.	Please refer to the non-medical expense load section beginning on page 22.
ii. Care management or coordination costs.	Included as a component of Administrative costs. Please refer to the non-medical expense load section beginning on page 22.
iii. Provisions for:	

Section I. February 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
a. Cost of capital.	Considered in the Margin component. Please refer to the non-medical expense load section beginning on page 22.
b. Risk margin.	Considered in the Margin component. Please refer to the non-medical expense load section beginning on page 22.
c. Contingency margin.	N/A
d. Underwriting gain.	N/A
e. Profit margin.	N/A
iv. Taxes, fees, and assessments.	Please refer to the non-medical expense load and federal health insurer fee section sections on pages 22 and 23, respectively.
v. Any other material non-benefit costs.	N/A
5. Rate Range Development	
A. Any assumptions for which values vary in order to develop rate ranges.	Please refer to the trend and managed care adjustments sections beginning on page 17, the Shared Savings Rx claims section beginning on page 19 and the non-medical expense load section on page 22.
B. The values of each of the assumptions used to develop the minimum, the mid-point (as applicable), and the maximum of the rate ranges.	Please refer to sections related to trend assumptions, managed care adjustments, Shared Savings Rx adjustment, prospective program change adjustments, and non-medical expense load considerations.
C. A description of the data, assumptions, and methodologies that were used to develop the values of the assumptions for the minimum, the mid-point (as applicable), and maximum of the rate ranges.	Please refer to sections related to trend assumptions, managed care adjustments, Shared Savings Rx adjustment, prospective program change adjustments, and non-medical expense load considerations.
6. Risk and Contractual Provisions	
A. Risk adjustment processes.	Please see risk adjustment section on page 23.
B. Risk sharing arrangements, such as risk corridor or large claims pool.	Please see outliers section on page 21.
C. Medical loss ratio requirements, such as a minimum medical loss ratio requirement.	N/A
D. Reinsurance requirements.	N/A
E. Incentives or withhold amounts.	N/A

Section I. February 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
7. Other Rate Development Considerations	
A. All adjustments to the capitation rates, or to any portion of the capitation rates, should reflect reasonable, appropriate, and attainable costs in the actuary's opinion and must be included in the rate certification. CMS notes that adjustments that are performed at the end of the rate setting process without adequate justification might not be considered actuarially sound.	Please see Actuarial soundness definition on page 2.
B. The final contracted rates should either match the capitation rates or be within the rate ranges in the actuarial certification. This is required in total and by each rate cell.	This letter certifies the rate range. Rates are being set at the 50th percentile for all rating categories.

Incentive-Based Performance Measures
Targets for Improvement

Identifier	Measure	Measure Description	Target Population	Condition	Target for Improvement
PTB $$	Initiation of Injectable Progesterone Therapy in Women with Previous Pre-Term Births	The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 21st week of gestation.	Children's and Maternal Health	Perinatal and Reproductive Health	**20.00**
NQF #0471 (CSEC) $$	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 which was within 30 days of when the first ADHD medication was dispensed.	Children's Health	Behavioral Health	**Initiation 42.07** **C&M 48.49** **MCOs must only report data related to the measure in 2016. Performance will be measured beginning in 2017.**
NQF #2082 (HIV) $$	HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200	Chronic Disease	HIV	**54.34**
NQF #0272 (PQI 1) $$	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	Utilization of ambulatory care. Outpatient and ED	Population Health	Utilization	**ED Visits 68.37**

Incentive-Based Performance Measures
Targets for Improvement

		Visits per 1000 member months			

Appendix J - Performance Measure Reporting

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Data
TBD $$	Antenatal Progesterone	TBD	DHH/ULM	None	Children's and Maternal Health	Perinatal and Reproductive Health	HP
NQF #0471 (CSEC) $$	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).	TJC	CHIPRA	Children's and Maternal Health	Perinatal and Reproductive Health	HP
(BHRA)	Behavioral Health Risk Assessment (for Pregnant Women)	Percentage of women, regardless of age, that gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: depression, alcohol use, tobacco use, drug use, and intimate partner violence.	AMA-PCPI	CHIPRA	Children's and Maternal Health	Perinatal and Reproductive Health	State
NQF #1391 (FPC)	Frequency of Ongoing Prenatal Care	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	HP
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	OPH
NQF #1517 (PPC)	Timeliness of Prenatal Care	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	HP
(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	NCQA	CHIPRA	Children's Health	Utilization	HP
(CAP)	Child and Adolescents' Access to Primary Care Practitioners	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 members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line. • Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year. • Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.	NCQA	CHIPRA	Children's Health	Access/Availability of Care	HP
NQF #0038 (CIS)	Childhood Immunization Status	Percentage of children that turned 2 years old during the measurement year and had specific vaccines by their second birthday.	NCQA	CHIPRA, MU2	Children's Health	Prevention	HP

NQF #1448 (DEV)	Developmental Screening in the First Three Years of Life	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.	NCQA	CHIPRA	Children's Health	Prevention	State
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 which was within 30 days of when the first ADHD medication was dispensed.	NCQA	CHIPRA, MU2	Children's Health	Behavioral Health	HP
NQF #1959 (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	HP
NQF #1407 (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	HP
NQF #0024 (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 of : • BMI percentile documentation • Counseling for nutrition • Counseling for physical activity	NCQA	CHIPRA, MU2	Children's Health	Prevention	HP
NQF #1392 (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	HP
NQF #1516 (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	HP
NQF #0021 (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	HP
NQF #0057 (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	HP
NQF #0018 (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.	NCQA	MEDICAID ADULT, MU2, CMS HEALTH HOMES	Chronic Disease	Cardiovascular Care	HP

NQF #0277 (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	State
NQF #2082 (HIV) $$	HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200	HRSA HIV/AIDS Bureau	MEDICAID ADULT	Chronic Disease	HIV	HP
NQF #0272 (PQI 1) $$	Diabetes Short Term Complications Rate	Number of discharges for diabetes short term complications per 100,000 Medicaid enrollees age 18 and older.	AHRQ	MEDICAID ADULT	Chronic Disease	Diabetes	State
NQF #0476 (PC-03)	Antenatal Steriods	This measure assesses patients at risk of preterm delivery at >=24 and <32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns.	TJC	MEDICAID ADULT	Maternal Health	Perinatal and Reproductive Health	HP
NQF #0469 (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	HP
NQF # 1517 (PPC) $$	Postpartum Care (PPC Submeasure)	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	NCQA	MEDICAID ADULT	Maternal Health	Perinatal and Reproductive Health	HP
NQF #1879 (SAA)	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	The measure calculates the percentage of individuals 18 years of age or greater as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months). The measure calculates the percentage of individuals 19 years of age or greater as of the beginning of the measurement year with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement year (12 consecutive months).	CMS	MEDICAID ADULT	Population Health	Behavioral Health	HP
(ABA)	Adult BMI Assessment	The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement or the year prior to the measurement year.	NCQA	MEDICAID ADULT, CMS HEALTH HOMES	Population Health	Prevention	HP
(AMB) $$	Ambulatory Care	Utilization of ambulatory care. Outpatient and ED Visits per 1000 member months	NCQA	CHIPRA	Population Health	Utilization	State
NQF #0105 (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	HP

NQF #0283 (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	State
NQF #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	None - recommended by IPRO	Population Health	Pulmonary/Critical Care	HP
NQF #0648 (CTR)	Care Transition - Transition Record Transmitted to Health Care Professional	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	AMA-PCPI	MEDICAID ADULT, CMS HEALTH HOMES	Population Health	Care Coordination	HP
NQF #0032 (CCS)	Cervical Cancer Screening	Percentage of women 21–64 years of age who were screened for cervical cancer	NCQA	MEDICAID ADULT, MU2	Population Health	Prevention	HP
NQF #0275 (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	State
NQF #0039 (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	HP Survey
NQF #0576 (FUH)	Follow up After Hospitalization for Mental Illness	The percentage of discharges for patients 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 with a mental health practitioner. Two rates are reported	NCQA	CHIPRA, MEDICAID ADULT, CMS HEALTH HOMES	Population Health	Behavioral Health	HP
NQF #0004 (IET)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. Initiation of AOD Treatment. Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.	NCQA	MEDICAID ADULT, MU2, CMS HEALTH HOMES	Population Health	Behavioral Health	HP
NQF #0027 (MSC)	Medical Assistance With Smoking and Tobacco Use Cessation	Assesses different facets of providing medical assistance with smoking and tobacco use cessation	NCQA	MEDICAID ADULT	Population Health	Prevention	HP Survey

NQF #1799 (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	HP
(PCR)	Plan All-Cause Readmission Rate	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probaility ofan acute readmission.	NCQA	MEDICAID ADULT, CMS HEALTH HOMES	Population Health	Utilization	HP
NQF #0418 (CDF)	Screening for Clinical Depression and Follow-Up Plan	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	State
(CAT)	Call Answer Timeliness	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	HP
(ACCA)	Ambulatory Care-Sensitive Condition Admission	This measure is used to assess the age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital per 100,000 population under age 75 years.	CIHI	CMS HEALTH HOMES	Population Health	Access/Availability of Care	HP
NQF #0033 (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	HP
NQF #0031 (BCS)	Breast Cancer Screening	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer. Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	NCQA	MEDICAID ADULT, MU2	Senior Care	Prevention	HP

Administrative Measures

Measure	Minimal Performance Standard
% of PCP Practices that provide verified 24/7 phone access with ability to speak with a PCP Practice clinician (MD, DO, NP, PA, RN, LPN) within 30 minutes of member contact.	≥95%
% of regular and expedited service authorization request processed in timeframes in the contract.	≥95%
Rejected claims returned to provider with reason code within 15 days of receipt of claims submission.	≥99%
% of Call Center calls answered within 30 seconds.	≥95%
Call Center average speed of answer.	30 Seconds
Call Center call abandonment rate.	≤5%
% of grievances and request for appeals received by the MCO including grievances received via telephone and resolved within the timeframe of the contract.	≥95%
% of clean claims paid for each provider type with 15 business days.	≥90%
% of clean claims paid for each provider type within 30 calendar days.	≥99%

Subcontract Requirements Checklist for MCOs

Plan Name:

Subcontractor Name:

Summary of services to be provided:

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

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

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

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

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

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	DHH Feedback
40	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and its implementing regulation at 45 CFR Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.		
41	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.		
42	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.		
43	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.		

Performance Improvement Projects

PIP Focus	Target for Improvement
Prematurity - Reduce premature births to Medicaid-eligible women.	*Reduce prematurity statewide by 15% by the end of the three-year contract period
Attention Deficit and Hyperactivity Disorder (ADHD) – Increase appropriate ADHD diagnosis and drug utilization.	*Reduce by 20% prescriptions among populations who are shown to have a high incidence of prescribing with a focus on the 0-6 population by the end of the three-year contract period