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: 2000441824 (2)
Vendor: Aetna Better Health, Inc.
Description: MCO amd 2; no change to time or money.
Approved By: Pamela Rice
Approval Date: 9/17/2020

Your amendment that was submitted to OSP has been approved.

Rev 2017-01

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 2

LAGOV#: 2000441824

LDH #:

Medical Vendor Administration

(Regional/ Program/ Facility) Bureau of Health Services Financing

AND

Aetna Better Health, Inc.

Contractor Name

Original Contract Amount: 773,109,537

Original Contract Begin Date: 01-01-2020

Original Contract End Date: 12-31-2020

RFP Number: N/A

AMENDMENT PROVISIONS

Change Contract From: From Maximum Amount: $773,109,537.00 Current Contract Term: 01/01/20-12/31/20

See attachments:
B - Statement of Work
D - Rate Certification

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

See attachments:
B2 - Statement of Work
D - Rate Certification

Justifications for amendment:

Revisions contained in this amendment are within scope and comply with the terms and conditions as set forth in the RFP.

This Amendment Becomes Effective: 07-01-2020

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

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

CONTRACTOR

Aetna Better Health, Inc.

CONTRACTOR SIGNATURE David Delaney DATE 8-14-2020

PRINT NAME: David Delaney

CONTRACTOR TITLE: Chief Financial Officer

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE DATE 8/17/20

NAME: Ruth Johnson

TITLE: Medicaid Director

OFFICE: Louisiana Department of Health

PROGRAM SIGNATURE DATE

NAME

Contract Amendment #2
Attachment B2

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
1	Attachment D Rate Certification	Mercer rate certification; Attachment D.	New rate certification effective 7/1/2020.	These revised certifications support the implementation of: • COVID-19 lab testing fee schedule changes • COVID-19 risk corridor
2	Attachment B Statement of Work	5.5.6 For enrollees dis-enrolled due to the invalidation of a duplicate Medicaid ID, the Contractor shall not recover claim payments under the retroactively dis-enrolled enrollee's ID if the remaining valid ID is linked to another MCO or FFS. The MCO shall subrogate to the MCO that is responsible for the claim(s) for the dates of service.	5.5.6 For enrollees dis-enrolled due to the invalidation of a duplicate Medicaid ID, the Contractor shall not recover claim payments under the retroactively dis-enrolled enrollee's ID if the remaining valid ID is linked to another MCO ~~or FFS~~. The MCO shall subrogate the amount of the paid claim(s) to the MCO that is responsible for the claim(s) for the dates of service.	Inclusion of FFS is not applicable in this instance. Duplicate member IDs are for members enrolled with the same MCO or another MCO.
3	Attachment B Statement of Work	[end of section]	5.6.5 Due to potential utilization variances caused by the COVID-19 pandemic, LDH will maintain a risk corridor for all non-Hepatitis C-related medical expenses retroactive to January 1, 2020. The parameters of this risk corridor and process for reconciliation and payments will be specified in the Financial Reporting Guide. LDH may terminate the risk corridor described in this section at its sole discretion. 5.6.5.1 LDH will be fully at risk for actual MCO non-Hepatitis C-related medical expenses that are less than or equal to 2% above the benchmark.	Establishes a risk corridor to address uncertainty around expenditures during the COVID-19 event.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			5.6.5.2 LDH will fully retain any savings for actual MCO non-Hepatitis C-related medical expenses that are less than or equal to 2% below the benchmark. 5.6.5.3 LDH and the MCOs will equally share the risk and any savings for actual MCO non-Hepatitis C-related medical expenses that are between 2% and 5% above or below the benchmark. 5.6.5.4 LDH will be fully at risk for actual MCO non-Hepatitis C-related medical expenses that are greater than or equal to 5% above the benchmark. 5.6.5.5 LDH will fully retain any savings for actual MCO non-Hepatitis C-related medical expenses that are greater than or equal to 5% below the benchmark. 5.6.5.6 The MCO is prohibited from increasing reimbursement rates for in-network and out-of-network providers to such an extent that would generate material losses to LDH, unless the increase was for the purpose of meeting network adequacy standards or otherwise approved by LDH. LDH may assess monetary penalties if it, or its actuary, determines that the rate increase materially impacted the risk corridor and the MCO does not provide sufficient evidence to meet the aforementioned exceptions.	
4	Attachment B Statement of Work	6.1.16. The MCO shall comply with the terms of the Louisiana Department of Justice (DOJ) Agreement (Case 3:18-cv-00608, Middle District of Louisiana) as directed by LDH.	6.1.16. The MCO shall comply with the terms of the Louisiana Department of Justice (DOJ) Agreement (Case 3:18-cv-00608, Middle District of Louisiana), subsequent implementation plans, and other activities required in order to implement this agreement	Provides further instruction for compliance with DOJ Agreement.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			in accordance with the DOJ Agreement Compliance Guide or as directed by LDH. LDH reserves the right to assess monetary penalties for failure to meet this requirement.	
5	Attachment B Statement of Work	6.3.1.1. The MCO may follow the FFS limit of four prescriptions per calendar month. However, it may not enact prescription limits more stringent than the Medicaid State Plan. If prescription limits are enacted, the MCO shall have Point of Sale (POS) override capabilities when a greater number of prescriptions per calendar month are determined to be medically necessary by the prescriber.	6.3.1.1. The MCO shall notify LDH prior to implementing or changing any prescription limits. The MCO may follow the FFS limit of four prescriptions per calendar month. However, it may not enact prescription limits more stringent than the Medicaid State Plan. If prescription limits are enacted, the MCO shall have Point of Sale (POS) override capabilities when a greater number of prescriptions per calendar month are determined to be medically necessary by the prescriber.	Requires notification of prescription limits for LDH awareness.
6	Attachment B Statement of Work	6.3.3.5 LDH shall monitor the rate of MCO compliance with the PDL. Compliance rate shall be defined as the number of preferred prescriptions paid divided by total prescriptions paid for drugs in therapeutic classes listed on the PDL. The MCO shall seek to achieve a 90 percent compliance rate.	6.3.3.5 LDH shall monitor the rate of MCO compliance with the PDL. Compliance rate shall be defined as the number of preferred prescriptions paid (drugs classified with PA Indicators 1 & 3) divided by total prescriptions paid for drugs in therapeutic classes listed on the PDL (drugs classified with PA Indicators 1-4). The MCO shall ~~seek to~~ achieve at least a 92%~~0 percent~~ compliance rate. PDL compliance less than 92% may result in monetary penalties of up to $100,000 per quarter.	Increases PDL compliance rate.
7	Attachment B Statement of Work	6.3.4.1 LDH intends to align FFS and MCO prior authorization (PA) criteria for drugs on the single PDL over time through the Drug Utilization Review (DUR) board. The MCOs shall have input on PA criteria development and representation on the DUR board. Prior to alignment, the MCOs shall maintain PA criteria that is not more restrictive than FFS. The MCO shall have a Prior Authorization (PA) process that complies with 42 CFR § 438.3(s)(6) and the following requirements.	6.3.4.1 MCO prior authorization (PA) criteria shall align with FFS for drugs on the Single PDL that were filled in an outpatient pharmacy setting. LDH intends to align FFS and MCO ~~prior authorization (~~PA~~)~~ criteria for drugs not on the single PDL over time through the Drug Utilization Review (DUR) board. The MCOs shall have input on PA criteria development and representation on the DUR board. Prior to alignment, the MCOs shall maintain PA criteria that is not more restrictive than FFS. The MCO shall have a Prior Authorization (PA)	Aligns contract verbiage with current practice.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			process that complies with 42 CFR § 438.3(s)(6) and the following requirements.	
8	Attachment B Statement of Work	6.3.4.2 As of January 1, 2019, the statewide universal prior authorization form shall be posted and utilized as specified in Act 423 of the 2018 Louisiana Regular Session. In order to obtain necessary information for prior authorization processing, the following therapeutic drug classes shall be considered specialty for prior authorization purposes only: Hepatitis C Direct Acting Antiviral Agents, Synagis, Respiratory monoclonal antibody agents (benralizumab (Fasenra®), dupilumab (Dupixent®), mepolizumab (Nucala®), omalizumab (Xolair®), and reslizumab (Cinqair®), Growth Hormones, Multiple Sclerosis drugs, and Hemophilia agents.	6.3.4.2 As of January 1, 2019, the statewide universal prior authorization form shall be posted and utilized as specified in Act 423 of the 2018 Louisiana Regular Session. In order to obtain necessary information for prior authorization processing, the following therapeutic drug classes shall be considered specialty for prior authorization purposes only: Hepatitis C Direct Acting Antiviral Agents (as directed by LDH) Spinraza and~~,~~ Synagis, ~~Respiratory monoclonal antibody agents (benralizumab (Fasenra®), dupilumab (Dupixent®), mepolizumab (Nucala®), omalizumab (Xolair®), and reslizumab (Cinqair®), Growth Hormones, Multiple Sclerosis drugs, and Hemophilia agents~~. MCOs shall utilize the LDH form and criteria for these specialty classes filled in an outpatient pharmacy setting.	Aligns PA criteria and forms for provider simplification.
9	Attachment B Statement of Work	6.3.7.3 The MCO shall provide for a DUR program that contains the following components: • Prospective DUR program • Retrospective DUR program • Educational DUR program	6.3.7.3 The MCO shall provide for a DUR program that contains the following components: • Prospective DUR program • Retrospective DUR program • Educational DUR program DUR initiatives directed by LDH shall be implemented as directed or with written LDH approval of alternative programming reaching the same outcomes. DUR initiatives not or incorrectly implemented may result in monetary penalties of $250 per claim until identified, then $5,000 daily until programming is corrected and implemented.	Establishes a monetary penalty for DUR initiatives.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
10	Attachment B Statement of Work	**6.3.7.3.1 Prospective DUR Program** 6.3.7.3.1.1 The MCO shall provide for a review of drug therapy at Point of Sale (POS) before each prescription is given to the recipient. Screening should be performed for potential drug problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, duration of therapy, and clinical misuse. The following parameters should be screened at POS. Inappropriate therapy should trigger edits and each edit should have its own separate denial code and description including, but not limited to: early refill, duration of therapy, therapeutic duplication, pregnancy precaution, quantity limit (excluding opioids), quantity limit for long-acting opioids, quantity limit for short-acting opioids, diagnosis code required on selected agents, drug interactions, age limit, and dose limits. Reporting capabilities shall exist for these denial codes. The MCOs will need to report data on edits to the Department on a semi-annual basis prior to the submission date requirement of the DUR Annual Report. 6.3.7.3.1.2 Pharmacy claims processing shall be capable of capturing diagnosis codes at the POS and utilizing codes in the adjudication process at POS. Denial of pharmacy claims could be triggered by an inappropriate diagnosis code or the absence of a diagnosis code.	**6.3.7.3.1 Prospective DUR Program** 6.3.7.3.1.1 The MCO shall provide for a review of drug therapy at Point of Sale (POS) before each prescription is given to the recipient. Screening should be performed for potential drug problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, duration of therapy, and clinical misuse. The following parameters should be screened at POS. Inappropriate therapy should trigger edits and each edit should have its own separate denial code and description including, but not limited to: early refill, duration of therapy, therapeutic duplication, pregnancy precaution, quantity limit (excluding opioids), quantity limit for long-acting opioids, quantity limit for short-acting opioids, diagnosis code required on selected agents, drug interactions, age limit, and dose limits. Reporting capabilities shall exist for these denial codes. ~~The MCOs will need to report data on edits to the Department on a semi-annual basis prior to the submission date requirement of the DUR Annual Report.~~ The MCOs shall align their coding of NCPDP compliant POS edits and overrides with LDH. Prior authorization is not an acceptable method to override certain POS edits. 6.3.7.3.1.2 Pharmacy claims processing shall be capable of capturing diagnosis codes at the POS and utilizing codes in the adjudication process at POS. Denial of pharmacy claims could be triggered by an inappropriate diagnosis code or the absence of a diagnosis code. The MCO shall allow pharmacist overrides on selected POS denials as instructed by LDH. Pharmacist overrides shall utilize NCPDP established standards.	Aligns contract verbiage with current practice.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
11	Attachment B Statement of Work	6.3.7.3.2.2 Claims review must be assessed against predetermined standards while monitoring for therapeutic appropriateness. Prescribers and pharmacists should be contacted via an electronic portal or other electronic means if possible. Facsimile and mail will suffice in some instances. At a minimum, the MCO shall incorporate all of LDH's DUR retrospective initiatives. Retrospective DUR initiatives shall be implemented monthly as directed by LDH pharmacy.	6.3.7.3.2.2 Claims review must be assessed against predetermined standards while monitoring for therapeutic appropriateness. Prescribers and pharmacists should be contacted via an electronic portal or other electronic means if possible. Facsimile and mail will suffice in some instances. Each MCO shall follow retrospective criteria approved at the DUR Board meeting. Retrospective DUR initiatives shall be implemented monthly as directed by LDH pharmacy. LDH approved enrollee profiles shall be sent to providers with the retrospective letters. Additional retrospective DUR initiatives may be implemented by the MCO when previously approved by LDH. ~~At a minimum, the MCO shall incorporate all of LDH's DUR retrospective initiatives. Retrospective DUR initiatives shall be implemented monthly as directed by LDH pharmacy.~~	Aligns contract verbiage with current practice.
12	Attachment B Statement of Work	6.3.7.4 LDH shall review and approve the MCO's DUR policy and procedures, DUR utilization review process/procedure and the standards included therein, and any revisions. At a minimum, the DUR program must include all LDH DUR initiatives and submit new initiatives to LDH for prior approval at least forty-five (45) days in advance of the proposed effective date.	6.3.7.4 LDH shall review and approve the MCO's DUR policy and procedures, ~~DUR utilization review process/procedure and~~ the standards included therein, and any revisions. At a minimum, the DUR program must include all LDH DUR initiatives and submit new initiatives to LDH for prior approval at least forty-five (45) days in advance of the proposed effective date.	Aligns contract verbiage with current practice.
13	Attachment B Statement of Work	6.4.11. Coordinated System of Care (CSoC) Implementation Plan Development In anticipation of the potential for inclusion of CSoC services within Medicaid Managed Care, the MCO shall develop a plan of implementation to be submitted to LDH no later than July 1, 2016. Elements to be addressed in the plan include but are not limited to: 6.4.11.1. Demonstration of the MCOs knowledge on System of Care values and Wraparound Process;	~~6.4.11. Coordinated System of Care (CSoC) Implementation Plan Development~~ ~~In anticipation of the potential for inclusion of CSoC services within Medicaid Managed Care, the MCO shall develop a plan of implementation to be submitted to LDH no later than July 1, 2016. Elements to be addressed in the plan include but are not limited to:~~ ~~6.4.11.1. Demonstration of the MCOs knowledge on System of Care values and Wraparound Process;~~	Removes outdated information that is no longer applicable.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		6.4.11.2. Processes and protocols for screening and referral; 6.4.11.3. Network Development for services and supports; 6.4.11.4. Technical assistance and training for the CSoC providers inclusive of the WAAs, the Family Support Organization (FSO) and other contracted providers; 6.4.11.5. Coordination and communications with key agencies, i.e. OJJ, DCFS, OBH, etc.; 6.4.11.6. Transition and coordination of care out of CSoC level of care. 6.4.11.7. Program monitoring and quality improvement; and 6.4.11.8. Timelines required for implementation.	~~6.4.11.2. Processes and protocols for screening and referral;~~ ~~6.4.11.3. Network Development for services and supports;~~ ~~6.4.11.4. Technical assistance and training for the CSoC providers inclusive of the WAAs, the Family Support Organization (FSO) and other contracted providers;~~ ~~6.4.11.5. Coordination and communications with key agencies, i.e. OJJ, DCFS, OBH, etc.;~~ ~~6.4.11.6. Transition and coordination of care out of CSoC level of care.~~ ~~6.4.11.7. Program monitoring and quality improvement; and~~ ~~6.4.11.8. Timelines required for implementation.~~	
14	Attachment B Statement of Work	6.6.5. The MCO shall accurately report, via encounter data submissions all EPSDT and well-child services, blood lead screening access to preventive services, and any other services as required for LDH to comply with federally mandated CMS 416 reporting requirements. Instructions on how to complete the CMS 416 report may be found on CMS's website at: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html. See **MCO Systems Companion Guide** for format and timetable for reporting of EPSDT data.	6.6.5. The MCO shall accurately report, via encounter data submissions all EPSDT and well-child services, blood lead screening access to preventive services, and any other services as required for LDH to comply with federally mandated CMS 416 reporting requirements. ~~Instructions on how to complete the CMS 416 report may be found on CMS's website at: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.~~ ~~See **MCO Systems Companion Guide** for format and timetable for reporting of EPSDT data.~~	MCOs are not required to submit the CMS 416 report; however, they are required to report accurately the data referenced in this provision for LDH to complete the CMS 416 report.
15	Attachment B Statement of Work	6.19.1.6. Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination;	6.19.1.6. Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination and members of the DOJ Agreement Target	Expands the special health care needs population to include members of the DOJ Agreement Target Population and those at high risk of entering that population.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		6.19.1.7. Adults, 18 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed and have declined to enter or are transitioning out of the CSoC program; 6.19.1.8. Individuals with 2 or more inpatient or 4 or more ED visits within the past 12 months; 6.19.1.9. Individuals with co-occurring behavioral health and developmental disabilities; 6.19.1.10. Individuals diagnosed with Autism Spectrum Disorder (ASD) or at risk of an ASD diagnosis; 6.19.1.11. Newly diagnosed adolescents and young adults, 15-30 years of age, who experience first signs of symptom onset for serious mental illness, such as schizophrenia, bipolar disorder, and/or major depression; and 6.19.1.12. Persons living with HIV/AIDS and who are in need of mental health or substance use early intervention, treatment, or prevention services.	Population who meet the diversion definition set forth by the Department; 6.19.1.7. Adults, 18 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed and have declined to enter or are transitioning out of the CSoC program; 6.19.1.8. Individuals with 2 or more inpatient or 4 or more ED visits within the past 12 months; 6.19.1.9. Individuals with co-occurring behavioral health and developmental disabilities; 6.19.1.10. Individuals diagnosed with Autism Spectrum Disorder (ASD) or at risk of an ASD diagnosis; 6.19.1.11. Newly diagnosed adolescents and young adults, 15-30 years of age, who experience first signs of symptom onset for serious mental illness, such as schizophrenia, bipolar disorder, and/or major depression; ~~and~~ 6.19.1.12. Persons living with HIV/AIDS and who are in need of mental health or substance use early intervention, treatment, or prevention services~~.~~; and 6.19.1.13. Persons with serious mental illness who have complex needs such as multiple chronic conditions, co-morbidities, and co-existing functional impairments and who are at high risk of inpatient admission or Emergency Department visits, including	

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			enrollees transitioning across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting.	
16	Attachment B Statement of Work	6.39.6. Case Management for Members Receiving Nursing Facility Care	6.39.6. Case Management for Members Receiving Nursing Facility Care or otherwise within the DOJ Agreement Target Population	Extends the requirement to those within the DOJ Agreement Target Population.
17	Attachment B Statement of Work	7.9.5.9 Ensure that provider 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 LDH). 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 complaints are acknowledged within three (3) business days of receipt; resolve and/or state the result communicated to the provider within thirty (30) business days of receipt (this includes referrals from LDH). ~~If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.~~	Provider complaints are to be resolved within 30 days.
18	Attachment B Statement of Work	7.13.8. Notification of amendments or changes to any provider agreement which, in accordance with Section 7.11 of this Contract, materially affects this Contract, shall be provided to LDH prior to the execution of the amendment in accordance with Section 23.1 of this Contract.	7.13.8. Notification of amendments or changes to any provider agreement which, in accordance with Section 7.11 of this Contract, materially affects this Contract, shall be provided to LDH prior to the execution of the amendment ~~in accordance with Section 23.1 of this Contract~~.	Removes an incorrect reference.
19	Attachment B Statement of Work	7.17.1.8. The MCO may negotiate the ingredient cost reimbursement in its contracts with providers. However, the MCO shall: • Reimburse the FFS (legacy) to all "local pharmacies" as defined in Act 301 of the 2017 Regular Session of the Louisiana Legislature; • Add any state imposed provider fees for pharmacy services, on top of the minimum dispensing fee required by LDH;	7.17.1.8. The MCO may negotiate the ingredient cost reimbursement in its contracts with providers. However, the MCO shall: • Reimburse the FFS (legacy) to all "local pharmacies" as defined in Act 301 of the 2017 Regular Session of the Louisiana Legislature; • Add any state imposed provider fees for pharmacy services, on top of the ~~minimum~~ professional dispensing fee and ingredient cost reimbursement ~~required by LDH~~;	Clarifies that the provider fee should be an additional reimbursement to ingredient cost and the professional dispensing fee.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		• Update the ingredient costs of medications at least weekly and within three (3) business days of new rates being posted from the source of choice; • Base Maximum Allowable Cost (MAC) price lists on generic drugs with a FDA rating beginning with an "A"; • Make drug pricing list available to pharmacies for review; and • Afford individual pharmacies a chance to appeal inadequate reimbursement	• Update the ingredient costs of medications at least weekly and within three (3) business days of new rates being posted from the source of choice; • Base Maximum Allowable Cost (MAC) price lists on generic drugs with a FDA rating beginning with an "A"; • Make drug pricing list available to pharmacies for review; and • Afford individual pharmacies a chance to appeal inadequate reimbursement	
20	Attachment B Statement of Work	7.17.4.1.1 A specialty drug is defined as a prescription drug which meets all of the following criteria:	7.17.4.1.1 A specialty drug is defined as a prescription drug which meets two or more ~~all~~ of the following criteria:	Aligns contract verbiage with current practice.
21	Attachment B Statement of Work	9.7.7. In addition to the specific Web site requirements outlined above, the MCOs Web site shall be functionally equivalent to the Web site maintained by the LDH FI.	~~9.7.7. In addition to the specific Web site requirements outlined above, the MCOs Web site shall be functionally equivalent to the Web site maintained by the LDH FI.~~	Removes ambiguous requirement.
22	Attachment B Statement of Work	14.2.5.9 The MCO shall submit audited HEDIS results to NCQA according to NCQA's HEDIS data submission timeline for health plans to submit final Medicaid HEDIS results (typically June 15 of each calendar year).	14.2.5.9 The MCO shall submit audited HEDIS results to NCQA according to NCQA's HEDIS data submission timeline for health plans to submit final Medicaid HEDIS results (typically June 15 of each calendar year). 14.2.5.9.1. LDH has the sole discretion to determine whether the MCOs will be granted an exception from obtaining a HEDIS audit and/or from submitting the results of the HEDIS audit to NCQA for either some or all of the quality and health outcome measurements. If such an exception is granted, the MCO shall comply with all instructions and deadlines provided by LDH.	Allows MCOs to submit supplemental results after the NCQA deadline, at LDH's discretion.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
23	Attachment B Statement of Work	17.3.4 The MCO shall pay pharmacy providers no less than the LDH specified dispensing fee. In addition, any state imposed provider fees for pharmacy services, shall be added on top of the minimum dispensing fee required by LDH.	~~17.3.4 The MCO shall pay pharmacy providers no less than the LDH specified dispensing fee. In addition, any state imposed provider fees for pharmacy services, shall be added on top of the minimum dispensing fee required by LDH.~~	The contents of this provision are covered in another section.
24	Attachment B Statement of Work	17.7.1.1.2 Date of birth of Medicaid identification number;	17.7.1.1.2 Date of birth ~~of~~ and Medicaid identification number;	Corrects a grammatical error.
25	Attachment B Statement of Work	17.9.3.2 Due in accordance with the encounter reconciliation schedule published by LDH or its contracted review organization, including encounters reflecting a zero dollar amount ($0.00) and encounters in which the MCO or its subcontractor has a capitation arrangement with a provider. If the MCO fails to submit complete encounter data, including encounters processed by subcontracted vendors (e.g., pharmacy, non-emergency transportation, vision) as measured by a comparison of encounters to cash disbursements within a five (5) percent error threshold (at least ninety-five (95) percent complete), the plan may be penalized as outlined in Section 20 of the Contract.	17.9.3.2 Due in accordance with the encounter reconciliation schedule published by LDH or its contracted review organization, including encounters reflecting a zero dollar amount ($0.00) and encounters in which the MCO or its subcontractor has a capitation arrangement with a provider. ~~If the MCO fails to submit complete encounter data, including encounters processed by subcontracted vendors (e.g., pharmacy, non-emergency transportation, vision) as measured by a comparison of encounters to cash disbursements within a five (5) percent error threshold (at least ninety-five (95) percent complete), the plan may be penalized as outlined in Section 20 of the Contract.~~ If the MCO or its subcontracted vendor(s), individually or in aggregate, fails to submit complete encounter data as measured by a comparison of encounters to cash disbursements within a three percent (3%) error threshold (i.e., encounters are at least ninety-seven percent (97%) but no greater than one hundred percent (100%) of cash disbursements), LDH may impose monetary penalties as outlined in Section 20 of the Contract. LDH, at its sole discretion, may waive the penalty if encounters processed by subcontracted vendors	Clarifies that the completion percentage applies to encounters processed by the MCO and its subcontracted vendors, separately or in aggregate. Allows for a grace period during transition periods.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			(e.g., pharmacy, non-emergency transportation, vision) fall below the completion threshold during the transition to a new vendor; however, this grace period shall not exceed 90 calendar days for encounters processed by either the exiting vendor or the new vendor.	
26	Attachment B Statement of Work	**LIST OF MCO COMPANION GUIDES** **…** **10. Wells Compliance Guide**	**LIST OF MCO COMPANION GUIDES** **…** **10. Wells Compliance Guide** **11. DOJ Agreement Compliance Guide**	Incorporates compliance guide specific to the DOJ Agreement.

20.3.3 Table of Monetary Penalties

		Justification
Risk Corridor (COVID-19)	The total value of the increase: (1) over the previously contracted rate for existing providers, or (2) over the FFS rate for new providers, plus the difference in the losses that would have been realized if the increase had not been in effect for each occurrence that the MCO increased provider reimbursement rates to such an extent that materially impacted the risk corridor without meeting a specified exception as determined by LDH at its sole discretion.	Establishes a monetary penalty corresponding to the COVID-19 risk corridor requirements.
Preferred Drug List (PDL)	One hundred thousand dollars ($100,000.00) per quarter in which the PDL compliance rate is less than 92%.	Establishes monetary penalties corresponding to revisions for PDL compliance rate and DUR initiatives.
Drug Utilization Review (DUR) Program	Two hundred fifty dollars ($250.00) per claim upon identification of DUR initiatives not or incorrectly implemented, plus five thousand dollars ($5,000.00) per day until programming is corrected and implemented.	Establishes monetary penalties corresponding to revisions for PDL compliance rate and DUR initiatives.
Encounter Data	Ten thousand dollars ($10,000.00) per calendar day for each day after the due date that the monthly encounter data has not been received in the format and per specifications outlined in the Contract. ~~Ten thousand dollars ($10,000.00) per calendar day for each day encounter data is received after the due date, for failure to correct and resubmit encounter data that was originally returned to the MCO for correction because submission data was in excess of the five (5) percent error rate threshold, until acceptance of the data by the fiscal intermediary.~~ ~~Ten thousand dollars ($10,000.00) per return by the fiscal intermediary of re-submission of encounter data that was returned to the MCO, as submission data was in excess of the five (5) percent error rate threshold, for correction and was rejected for the second time.~~ Fifty thousand dollars ($50,000) per occurrence in each bimonthly reconciliation in which LDH or its designee determines that the MCO or its subcontracted vendor(s), individually or in aggregate, failed to submit complete encounter data within a three percent (3%) error threshold. Ten thousand dollars ($10,000.00) per occurrence of medical record review by LDH or its designee where the MCO or its provider(s) denotes provision of services which were not submitted in the encounter data regardless of whether or not the provider was paid for the service that was documented.	Clarifies when the monetary penalty will be assessed when the completion threshold is not met. Updates the completion threshold percentage and reduces the amount of the monetary penalty for each instance of non-compliance.

	Penalties specified above shall not apply for encounter data for the first three months after direct services to MCO members have begun to permit time for development and implementation of a system for exchanging data and training of staff and health care providers.	

Attachment C – Performance Measures

From:

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
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 two rates separately and as a total rate.	NCQA	MEDICAID ADULT	Chronic Disease	Prevention	HEDIS

To:

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
~~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 two rates separately and as a total rate.~~	~~NCQA~~	~~MEDICAID ADULT~~	~~Chronic Disease~~	~~Prevention~~	~~HEDIS~~

Justification:

NCQA has retired Annual Monitoring for Patients on Persistent Medications (MPM) measure for HEDIS 2020.

MERCER

HEALTHY LOUISIANA RATE CERTIFICATION ADDENDUM

EFFECTIVE JULY 1, 2020 – DECEMBER 31, 2020

Louisiana Department of Health
August 7, 2020

Mercer Government
Ready for next. Together.

Mr. Daniel Cocran
Chief Financial Officer
Louisiana Department of Health
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821

Subject: Healthy Louisiana Program – Full Risk Bearing Managed Care Organization (MCO) Rate Development and Actuarial Certification for the Period July 1, 2020 through December 31, 2020

August 7, 2020

Dear Mr. Cocran:

The Louisiana Department of Health (LDH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound[1] capitation rates for the State of Louisiana's (State) Healthy Louisiana program for the period of January 1, 2020 through December 31, 2020, or Rate Year 2020 (RY20). This certification amends the previous RY20 certification issued on December 23, 2019.

The previous certification letter presents a detailed 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 certification includes the impact of program change and fee schedule updates effective July 1, 2020, as well as an additional risk mitigation component effective retroactively to January 1, 2020, to address the uncertainty of the global Coronavirus Disease of 2019 (COVID-19) pandemic. At the time of this certification, there is still significant uncertainty regarding how COVID-19 will affect the MCO costs during the RY20 period. Although the original RY20 capitation rates were developed without explicit adjustments for pandemic-related effects, the risk corridor approach ensures LDH and the MCOs share the heightened pricing risk due to the pandemic. The final capitation rates are summarized in Appendix A and represent payment in full for the covered services. The comparison between the January 1, 2020, effective rates and the July 1, 2020, effective rates can be seen in Appendix B.

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

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1

Projected Benefit Costs and Trend

Prospective Rating Adjustments

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

Wage Verification Disenrollment Adjustment

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

Due to the COVID-19 Emergency Declaration, CMS has required states to delay redeterminations for medical coverage effective March 1, 2020, as a condition of the enhanced Federal Medical Assistance Percentage. CMS has authorized this delay to continue until the Emergency Declaration has ended. Wage verification, as a part of the redetermination process, is subject to the same regulation and has been delayed until the end of the Emergency Declaration.

Please see the previous rate certification, dated December 23, 2019, for more detail regarding the impact of this policy change and the original adjustment reflected in the RY20 capitation rates. This addendum reflects the revised adjustment for disenrollments as a result of the suspension after disenrollments through February 2020.Table 1 shows the acuity factors that would be applied for all of RY20 due to the suspension of disenrollments.

Table 1

Region	Rating Adjustment
Gulf	0.88%
Capital	0.78%
South Central	0.80%
North	0.83%

In order to capture the entire impact to acuity back to March 1, 2020, the rates effective July 1, 2020, were further adjusted to account for the impact on the January 1, 2020, through June 30, 2020, period. Table 2 displays the acuity factors by region for July 1, 2020 through December 31, 2020.

Table 2

Region	Rating Adjustment
Gulf	-2.2%
Capital	-1.9%
South Central	-2.0%
North	-2.1%

At the time of this certification, there is no confirmed end date to the COVID-19 Emergency Declaration, nor a restart date for the wage verification process. Therefore, Mercer and LDH will continue to monitor the impact of potential future wage verification review cycles on the overall acuity of the Medicaid Expansion rate cell to determine if further modification of this rating adjustment is necessary.

Inpatient Fee Schedule Changes

Effective July 1, 2020, LDH released an updated Inpatient fee schedule, which can be located on its website.[2] The revised Inpatient fee schedule adjustments are summarized in Table 3. The full Medicaid payment (FMP) was also adjusted because of this fee schedule.

Table 3

	Inpatient Fee Change Impact				FMP Impact as % of
Time Period	Historical Cost	Fee Change Impact	Adjusted Cost	FMP Impact	Adjusted Cost
FFY 2017	$610,583,531	$82,989,545	$693,573,076	$153,497,301	22.13%
FFY 2018	$944,606,107	$72,866,185	$1,017,472,293	$330,454,623	32.48%
Total	$1,555,189,638	$155,855,731	$1,711,045,369	$483,951,924	28.28%

[2] https://www.lamedicaid.com/Provweb1/fee_schedules/feeschedulesindex.htm

Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) Fee Schedule Changes

Effective July 1, 2020, LDH released updated FQHC and RHC fee schedules, which can be located on its website[3]. The updates are sourced from the annual refresh due to any changes to the Medicare Economic Index, which increased 2.2% for all FQHCs and 1.9% for all RHCs (except those that receive a rate based on the alternative payment methodology). The revised fee schedule adjustments, as a percent of projected medical expenses, are summarized in Table 4.

Table 4

FQHC and RHC Fee Change Impact			Impact as % of	
Time Period	Historical Cost	Fee Change Impact	Historical Cost	All Services Cost
FFY 2017	$110,507,044	$9,424,927	8.53%	0.32%
FFY 2018	$188,977,368	$11,758,250	6.22%	0.25%
Total	$299,484,411	$21,183,178	7.07%	0.27%

Non-Emergent Medical Transportation (NEMT) Fee Schedule Changes

Effective July 1, 2020, LDH released an updated Non-Emergent Medical Transportation (NEMT) fee schedule. The update reflects an increase to the ambulatory and wheelchair rates for NEMT providers. The fee schedule adjustment is shown in Table 5.

Table 5

NEMT Fee Change Impact			Impact as % of	
Time Period	Historical Cost	Fee Change Impact	Historical Cost	All Services Cost
FFY 2017	$18,363,079	$666,682	3.63%	0.02%
FFY 2018	$36,061,094	$1,309,219	3.63%	0.03%
Total	$54,424,173	$1,975,901	3.63%	0.03%

COVID-19

At the time of this certification, there is still significant uncertainty regarding how the COVID-19 pandemic will affect MCO costs during RY20. There are uncertain potential changes to the service delivery environment that may have material upward or downward effects on MCO costs, such as, but not limited to, approved treatments/vaccines and additional suspensions of non-emergent procedures or other future governmental and/or local actions.

[3] https://www.lamedicaid.com/Provweb1/fee_schedules/feeschedulesindex.htm

The high level of uncertainty at this time regarding whether the pandemic effects during RY20 would have a net downward or upward effect has led Mercer and LDH to incorporate a program-wide risk corridor to provide financial protection for significant deviation from target rating expectations in either direction. The target capitation rates were developed without explicit adjustments for pandemic-related effects. With this approach, LDH and the MCOs share in the heightened pricing risk due to the pandemic. Section 2 of this certification provides additional information on the program-wide risk corridor. Mercer and LDH will continue to monitor the ongoing effects of the pandemic on the service delivery environment.

2

Special Contract Provisions Related to Payment

Risk Corridor

To address the significant financial uncertainty caused by the pandemic, and to ensure the previously certified capitation rates remain actuarially sound, LDH is implementing a program-wide risk corridor covering the RY20 rating period.

Retroactively effective January 1, 2020, the program-wide risk corridor will include all medical expenditures except for Hepatitis C virus (HCV) direct acting antivirals (DAAs) and related pharmacy, physician and laboratory costs. All Hepatitis C related costs will continue to follow the parameters of the Hepatitis C risk corridor outlined in the RY20 certification dated December 23, 2019. The program-wide risk corridor benchmarks will be developed and reconciled on a regional and rate cell level. The parameters of the risk corridor are shown in Table 6.

Table 6

Risk Band	MCO Responsibility	LDH Responsibility
Outside of +5% of Benchmark	0%	100%
+2% to +5% of Benchmark	50%	50%
0% to ±2% of Benchmark	0%	100%
-2% to -5% of Benchmark	50%	50%
Outside of -5% of Benchmark	0%	100%

3

Certification of Final Rates

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

In preparing the rates shown in Appendix A, Mercer has used and relied upon enrollment, FFS claims, encounter data, reimbursement level, benefit design, and other information supplied by LDH and its fiscal agent. LDH, its fiscal agent, and the Healthy Louisiana MCOs are responsible for the validity and completeness of the data supplied. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion they are appropriate for the intended purposes. The data reliance attestation shown in Appendix C has been provided by LDH, and its purpose is to certify the accuracy, completeness, and consistency of the base data. However, if the data and information are incomplete/inaccurate, the values shown in this certification may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this certification.

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

Mercer certifies the rates in Appendix A, including any risk-sharing mechanisms, were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the Healthy Louisiana MCO contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates and ranges developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially wide, range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual Healthy Louisiana MCO costs will differ from these projections. Mercer has developed these rates on behalf of LDH to demonstrate compliance with the CMS requirements under 42 CFR 438.4 and accordance with

applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

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

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

This certification letter assumes the reader is familiar with the Healthy Louisiana Program, Medicaid eligibility rules, and actuarial rate-setting techniques. It has been prepared exclusively for LDH and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results. Mercer is not responsible for, and expressly disclaims liability for, any reliance on this certification by third parties.

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

If you have any questions on any of the above, please feel free to contact Adam Sery at +1 612 642 8606 or Erik Axelsen at +1 404 442 3517 at your convenience.

Sincerely,

Adam Sery FSA, MAAA
Principal

Erik Axelsen, ASA, MAAA
Senior Associate

Copy: Pam Diez, Deputy Undersecretary – LDH
Amanda Joyner, Deputy Assistant Secretary – OBH/LDH
Marisa Naquin, Managed Care Finance – LDH
Ruth Johnson, Medicaid Executive Director – LDH
Karen Stubbs, Deputy Assistant Secretary – OBH/LDH
F. Ronald Ogborne III, FSA, CERA, MAAA, Partner – Mercer

State of Louisiana

Appendix A: Healthy Louisiana Capitation Rate Range

Region Description	Category of Aid Description	Rate Cell Description	Projected Member Months/Deliveries	Lower Bound PMPM or Cost per Delivery	Final PMPM or Cost per Delivery [1]	Upper Bound PMPM or Cost per Delivery
Gulf	SSI	Newborn, 0-2 Months	129	$ 44,107.15	$ 44,129.82	$ 46,520.03
Gulf	SSI	Newborn, 3-11 Months	1,367	$ 6,421.27	$ 6,424.49	$ 6,843.98
Gulf	SSI	Child, 1-20 Years	127,377	$ 798.93	$ 799.38	$ 854.32
Gulf	SSI	Adult, 21+ Years	276,624	$ 1,710.80	$ 1,711.69	$ 1,826.32
Gulf	Family and Children	Newborn, 0-2 Months	32,751	$ 2,890.93	$ 2,892.29	$ 3,094.67
Gulf	Family and Children	Newborn, 3-11 Months	108,196	$ 333.85	$ 334.02	$ 354.31
Gulf	Family and Children	Child, 1-20 Years	2,086,551	$ 179.35	$ 179.45	$ 191.14
Gulf	Family and Children	Adult, 21+ Years	343,099	$ 431.83	$ 432.06	$ 461.20
Gulf	Foster Care Children	Foster Care, All Ages Male & Female	28,114	$ 476.10	$ 476.38	$ 515.16
Gulf	Breast and Cervical Cancer	BCC, All Ages Female	987	$ 2,571.92	$ 2,573.32	$ 2,836.45
Gulf	LaCHIP Affordable Plan	All Ages	7,182	$ 228.47	$ 228.60	$ 244.64
Gulf	HCBS Waiver	20 & Under, Male and Female	2,091	$ 2,138.25	$ 2,139.46	$ 2,287.87
Gulf	HCBS Waiver	21+ Years, Male and Female	5,256	$ 1,535.69	$ 1,536.57	$ 1,693.41
Gulf	Chisholm Class Members	Chisholm, All Ages Male & Female	11,148	$ 1,430.46	$ 1,431.29	$ 1,517.95
Gulf	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	8,667	$ 232.88	$ 232.88	$ 241.24
Gulf	SBH - Duals & LaHIPP (Duals)	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	423,546	$ 34.41	$ 34.41	$ 36.66
Gulf	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	6,068	$ 138.70	$ 138.70	$ 142.16
Gulf	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	10,053	$ 66.48	$ 66.48	$ 70.07
Gulf	SBH - Other	SBH - Other, All Ages	7,519	$ 182.47	$ 182.47	$ 190.22
Gulf	Maternity Kick Payment	Maternity Kick Payment	6,537	$ 13,924.74	$ 13,924.74	$ 14,581.35
Gulf	Maternity Kick Payment - EED Kick Payment	EED Kick Payment	1	$ 5,618.98	$ 5,618.98	$ 5,732.54
Gulf	Medicaid Expansion	Age 19 - 64	1,783,899	$ 598.08	$ 598.38	$ 637.49
Gulf	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	6,701	$ 34.41	$ 34.41	$ 36.66
Gulf	Medicaid Expansion	SBH - Other	245	$ 182.47	$ 182.47	$ 190.22
Gulf	Medicaid Expansion	SBH - CCM, All Ages	186	$ 232.88	$ 232.88	$ 241.24
Gulf	Medicaid Expansion	High Needs	597	$ 1,742.36	$ 1,742.36	$ 1,864.07
Gulf	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,285	$ 13,924.74	$ 13,924.74	$ 14,581.35
Gulf	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 5,618.98	$ 5,618.98	$ 5,732.54
Capital	SSI	Newborn, 0-2 Months	116	$ 44,593.35	$ 44,616.32	$ 47,011.52
Capital	SSI	Newborn, 3-11 Months	1,547	$ 6,412.17	$ 6,415.39	$ 6,834.78
Capital	SSI	Child, 1-20 Years	96,661	$ 846.73	$ 847.22	$ 908.24
Capital	SSI	Adult, 21+ Years	190,550	$ 1,676.86	$ 1,677.81	$ 1,800.10
Capital	Family and Children	Newborn, 0-2 Months	28,051	$ 2,963.60	$ 2,965.06	$ 3,184.53
Capital	Family and Children	Newborn, 3-11 Months	98,576	$ 297.26	$ 297.42	$ 316.91
Capital	Family and Children	Child, 1-20 Years	1,849,511	$ 191.61	$ 191.72	$ 204.83
Capital	Family and Children	Adult, 21+ Years	286,778	$ 463.72	$ 463.97	$ 496.00
Capital	Foster Care Children	Foster Care, All Ages Male & Female	45,152	$ 478.69	$ 478.97	$ 517.78
Capital	Breast and Cervical Cancer	BCC, All Ages Female	1,503	$ 2,543.86	$ 2,545.24	$ 2,808.09
Capital	LaCHIP Affordable Plan	All Ages	12,010	$ 218.29	$ 218.41	$ 234.35
Capital	HCBS Waiver	20 & Under, Male and Female	2,215	$ 2,162.39	$ 2,163.62	$ 2,312.27
Capital	HCBS Waiver	21+ Years, Male and Female	4,664	$ 1,542.29	$ 1,543.17	$ 1,700.08
Capital	Chisholm Class Members	Chisholm, All Ages Male & Female	7,981	$ 1,422.75	$ 1,423.58	$ 1,510.15
Capital	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	9,510	$ 219.59	$ 219.59	$ 227.81
Capital	SBH - Duals & LaHIPP (Duals)	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	331,681	$ 27.00	$ 27.00	$ 28.67
Capital	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	6,698	$ 114.90	$ 114.90	$ 118.10
Capital	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	9,436	$ 68.06	$ 68.06	$ 71.66
Capital	SBH - Other	SBH - Other, All Ages	10,313	$ 172.32	$ 172.32	$ 179.97
Capital	Maternity Kick Payment	Maternity Kick Payment	5,897	$ 11,044.47	$ 11,044.47	$ 11,593.01
Capital	Maternity Kick Payment - EED Kick Payment	EED Kick Payment	1	$ 4,105.67	$ 4,105.67	$ 4,200.54
Capital	Medicaid Expansion	Age 19 - 64	1,333,310	$ 653.22	$ 653.57	$ 699.14
Capital	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	4,281	$ 27.00	$ 27.00	$ 28.67
Capital	Medicaid Expansion	SBH - Other	528	$ 172.32	$ 172.32	$ 179.97
Capital	Medicaid Expansion	SBH - CCM, All Ages	180	$ 219.59	$ 219.59	$ 227.81
Capital	Medicaid Expansion	High Needs	759	$ 1,872.42	$ 1,872.42	$ 2,004.33
Capital	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	2,596	$ 11,044.47	$ 11,044.47	$ 11,593.01
Capital	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 4,105.67	$ 4,105.67	$ 4,200.54

State of Louisiana

Appendix A: Healthy Louisiana Capitation Rate Range

Region Description	Category of Aid Description	Rate Cell Description	Projected Member Months/Deliveries	Lower Bound PMPM or Cost per Delivery	Final PMPM or Cost per Delivery [1]	Upper Bound PMPM or Cost per Delivery
South Central	SSI	Newborn, 0-2 Months	103	$ 44,240.51	$ 44,263.26	$ 46,654.84
South Central	SSI	Newborn, 3-11 Months	1,496	$ 6,567.73	$ 6,571.05	$ 6,992.04
South Central	SSI	Child, 1-20 Years	106,874	$ 755.46	$ 755.90	$ 809.67
South Central	SSI	Adult, 21+ Years	243,819	$ 1,438.03	$ 1,438.84	$ 1,543.31
South Central	Family and Children	Newborn, 0-2 Months	32,093	$ 2,923.10	$ 2,924.69	$ 3,164.11
South Central	Family and Children	Newborn, 3-11 Months	107,942	$ 304.10	$ 304.27	$ 325.45
South Central	Family and Children	Child, 1-20 Years	2,022,019	$ 184.83	$ 184.94	$ 198.06
South Central	Family and Children	Adult, 21+ Years	316,953	$ 413.88	$ 414.11	$ 443.44
South Central	Foster Care Children	Foster Care, All Ages Male & Female	52,134	$ 475.35	$ 475.63	$ 514.40
South Central	Breast and Cervical Cancer	BCC, All Ages Female	889	$ 2,535.43	$ 2,536.81	$ 2,799.57
South Central	LaCHIP Affordable Plan	All Ages	10,405	$ 213.68	$ 213.80	$ 229.69
South Central	HCBS Waiver	20 & Under, Male and Female	2,339	$ 2,073.32	$ 2,074.49	$ 2,222.23
South Central	HCBS Waiver	21+ Years, Male and Female	6,191	$ 1,541.83	$ 1,542.71	$ 1,699.62
South Central	Chisholm Class Members	Chisholm, All Ages Male & Female	10,150	$ 1,287.61	$ 1,288.36	$ 1,373.54
South Central	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	8,913	$ 201.45	$ 201.45	$ 209.48
South Central	SBH - Duals & LaHIPP (Duals)	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	412,860	$ 26.91	$ 26.91	$ 28.59
South Central	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	6,286	$ 67.26	$ 67.26	$ 69.94
South Central	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	10,889	$ 67.39	$ 67.39	$ 70.99
South Central	SBH - Other	SBH - Other, All Ages	10,633	$ 187.53	$ 187.53	$ 195.35
South Central	Maternity Kick Payment	Maternity Kick Payment	6,304	$ 9,158.62	$ 9,158.62	$ 9,695.65
South Central	Maternity Kick Payment - EED Kick Payment	EED Kick Payment	1	$ 2,360.86	$ 2,360.86	$ 2,453.74
South Central	Medicaid Expansion	Age 19 - 64	1,473,191	$ 570.02	$ 570.33	$ 610.39
South Central	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	5,687	$ 26.91	$ 26.91	$ 28.59
South Central	Medicaid Expansion	SBH - Other	321	$ 187.53	$ 187.53	$ 195.35
South Central	Medicaid Expansion	SBH - CCM, All Ages	143	$ 201.45	$ 201.45	$ 209.48
South Central	Medicaid Expansion	High Needs	333	$ 2,381.10	$ 2,381.10	$ 2,579.98
South Central	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,236	$ 9,158.62	$ 9,158.62	$ 9,695.65
South Central	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 2,360.86	$ 2,360.86	$ 2,453.74
North	SSI	Newborn, 0-2 Months	13	$ 43,128.00	$ 43,150.06	$ 45,530.24
North	SSI	Newborn, 3-11 Months	1,251	$ 6,333.85	$ 6,337.02	$ 6,755.62
North	SSI	Child, 1-20 Years	119,859	$ 765.76	$ 766.20	$ 815.96
North	SSI	Adult, 21+ Years	225,959	$ 1,366.69	$ 1,367.46	$ 1,465.62
North	Family and Children	Newborn, 0-2 Months	23,108	$ 2,507.92	$ 2,509.19	$ 2,697.56
North	Family and Children	Newborn, 3-11 Months	74,544	$ 312.69	$ 312.86	$ 333.64
North	Family and Children	Child, 1-20 Years	1,523,585	$ 201.62	$ 201.74	$ 216.21
North	Family and Children	Adult, 21+ Years	228,817	$ 410.16	$ 410.39	$ 440.88
North	Foster Care Children	Foster Care, All Ages Male & Female	33,839	$ 502.76	$ 503.05	$ 542.11
North	Breast and Cervical Cancer	BCC, All Ages Female	1,097	$ 2,501.38	$ 2,502.74	$ 2,765.15
North	LaCHIP Affordable Plan	All Ages	8,836	$ 215.23	$ 215.35	$ 231.26
North	HCBS Waiver	20 & Under, Male and Female	1,568	$ 2,061.02	$ 2,062.18	$ 2,209.80
North	HCBS Waiver	21+ Years, Male and Female	4,967	$ 1,545.99	$ 1,546.87	$ 1,703.83
North	Chisholm Class Members	Chisholm, All Ages Male & Female	7,681	$ 1,353.77	$ 1,354.56	$ 1,440.42
North	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	7,519	$ 197.03	$ 197.03	$ 205.00
North	SBH - Duals & LaHIPP (Duals)	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	335,470	$ 33.29	$ 33.29	$ 35.43
North	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	3,792	$ 87.15	$ 87.15	$ 90.05
North	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	7,598	$ 70.56	$ 70.56	$ 74.19
North	SBH - Other	SBH - Other, All Ages	9,476	$ 174.84	$ 174.84	$ 182.52
North	Maternity Kick Payment	Maternity Kick Payment	4,560	$ 11,089.61	$ 11,089.61	$ 11,679.01
North	Maternity Kick Payment - EED Kick Payment	EED Kick Payment	1	$ 3,622.01	$ 3,622.01	$ 3,723.95
North	Medicaid Expansion	Age 19 - 64	1,182,206	$ 532.90	$ 533.19	$ 570.73
North	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	3,047	$ 33.29	$ 33.29	$ 35.43
North	Medicaid Expansion	SBH - Other	220	$ 174.84	$ 174.84	$ 182.52
North	Medicaid Expansion	SBH - CCM, All Ages	126	$ 197.03	$ 197.03	$ 205.00
North	Medicaid Expansion	High Needs	362	$ 1,307.94	$ 1,307.94	$ 1,405.14
North	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	2,586	$ 11,089.61	$ 11,089.61	$ 11,679.01
North	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 3,622.01	$ 3,622.01	$ 3,723.95

Note:
1. Where applicable, final rates have been adjusted to account for the portion of contractual withholds that Mercer has determined to be reasonably attainable.

Appendix B: Rate Comparison			1/1/20 Rates				7/1/20 Rates			
Region Description	Category of Aid Description	Rate Cell Description	Projected Member Months/Deliveries	Lower Bound PMPM or Cost per Delivery	Final PMPM or Cost per Delivery [1]	Upper Bound PMPM or Cost per Delivery	Projected Member Months/Deliveries	Lower Bound PMPM or Cost per Delivery	Final PMPM or Cost per Delivery [1]	Upper Bound PMPM or Cost per Delivery
Gulf	SSI	Newborn, 0-2 Months	129	$ 44,140.78	$ 44,163.45	$ 46,553.39	129	$ 44,107.15	$ 44,129.82	$ 46,520.03
Gulf	SSI	Newborn, 3-11 Months	1,367	$ 6,424.79	$ 6,428.01	$ 6,846.96	1,367	$ 6,421.27	$ 6,424.49	$ 6,843.98
Gulf	SSI	Child, 1-20 Years	127,377	$ 798.76	$ 799.21	$ 854.12	127,377	$ 798.93	$ 799.38	$ 854.32
Gulf	SSI	Adult, 21+ Years	276,624	$ 1,710.18	$ 1,711.07	$ 1,825.58	276,624	$ 1,710.80	$ 1,711.69	$ 1,826.32
Gulf	Family and Children	Newborn, 0-2 Months	32,751	$ 2,893.58	$ 2,894.94	$ 3,097.26	32,751	$ 2,890.93	$ 2,892.29	$ 3,094.67
Gulf	Family and Children	Newborn, 3-11 Months	108,196	$ 333.70	$ 333.87	$ 354.12	108,196	$ 333.85	$ 334.02	$ 354.31
Gulf	Family and Children	Child, 1-20 Years	2,086,551	$ 179.24	$ 179.34	$ 191.01	2,086,551	$ 179.35	$ 179.45	$ 191.14
Gulf	Family and Children	Adult, 21+ Years	343,099	$ 431.50	$ 431.73	$ 460.83	343,099	$ 431.83	$ 432.06	$ 461.20
Gulf	Foster Care Children	Foster Care, All Ages Male & Female	28,114	$ 475.52	$ 475.80	$ 514.50	28,114	$ 476.10	$ 476.38	$ 515.16
Gulf	Breast and Cervical Cancer	BCC, All Ages Female	987	$ 2,571.21	$ 2,572.61	$ 2,834.90	987	$ 2,571.92	$ 2,573.32	$ 2,836.45
Gulf	LaCHIP Affordable Plan	All Ages	7,182	$ 228.22	$ 228.35	$ 244.35	7,182	$ 228.47	$ 228.60	$ 244.64
Gulf	HCBS Waiver	20 & Under, Male and Female	2,091	$ 2,138.20	$ 2,139.41	$ 2,287.59	2,091	$ 2,138.25	$ 2,139.46	$ 2,287.87
Gulf	HCBS Waiver	21+ Years, Male and Female	5,256	$ 1,534.27	$ 1,535.14	$ 1,691.41	5,256	$ 1,535.69	$ 1,536.57	$ 1,693.41
Gulf	Chisholm Class Members	Chisholm, All Ages Male & Female	11,148	$ 1,429.88	$ 1,430.71	$ 1,517.25	11,148	$ 1,430.46	$ 1,431.29	$ 1,517.95
Gulf	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	8,667	$ 232.51	$ 232.51	$ 240.87	8,667	$ 232.88	$ 232.88	$ 241.24
Gulf	SBH - Duals & LaHIPP (Duals)	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	423,546	$ 34.10	$ 34.10	$ 36.34	423,546	$ 34.41	$ 34.41	$ 36.66
Gulf	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	6,068	$ 138.47	$ 138.47	$ 141.93	6,068	$ 138.70	$ 138.70	$ 142.16
Gulf	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	10,053	$ 66.22	$ 66.22	$ 69.80	10,053	$ 66.48	$ 66.48	$ 70.07
Gulf	SBH - Other	SBH - Other, All Ages	7,519	$ 181.78	$ 181.78	$ 189.52	7,519	$ 182.47	$ 182.47	$ 190.22
Gulf	Maternity Kick Payment	Maternity Kick Payment	6,537	$ 13,934.18	$ 13,934.18	$ 14,590.37	6,537	$ 13,924.74	$ 13,924.74	$ 14,581.35
Gulf	Maternity Kick Payment - EED Kick Payment	EED Kick Payment	1	$ 5,633.51	$ 5,633.51	$ 5,747.00	1	$ 5,618.98	$ 5,618.98	$ 5,732.54
Gulf	Medicaid Expansion	Age 19 - 64	1,783,899	$ 622.85	$ 623.16	$ 663.96	1,783,899	$ 598.08	$ 598.38	$ 637.49
Gulf	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	6,701	$ 34.10	$ 34.10	$ 36.34	6,701	$ 34.41	$ 34.41	$ 36.66
Gulf	Medicaid Expansion	SBH - Other	245	$ 181.78	$ 181.78	$ 189.52	245	$ 182.47	$ 182.47	$ 190.22
Gulf	Medicaid Expansion	SBH - CCM, All Ages	186	$ 232.51	$ 232.51	$ 240.87	186	$ 232.88	$ 232.88	$ 241.24
Gulf	Medicaid Expansion	High Needs	597	$ 1,741.92	$ 1,741.92	$ 1,863.57	597	$ 1,742.36	$ 1,742.36	$ 1,864.07
Gulf	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,285	$ 13,934.18	$ 13,934.18	$ 14,590.37	3,285	$ 13,924.74	$ 13,924.74	$ 14,581.35
Gulf	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 5,633.51	$ 5,633.51	$ 5,747.00	1	$ 5,618.98	$ 5,618.98	$ 5,732.54
Capital	SSI	Newborn, 0-2 Months	116	$ 44,626.98	$ 44,649.95	$ 47,044.87	116	$ 44,593.35	$ 44,616.32	$ 47,011.52
Capital	SSI	Newborn, 3-11 Months	1,547	$ 6,415.83	$ 6,419.05	$ 6,837.90	1,547	$ 6,412.17	$ 6,415.39	$ 6,834.78
Capital	SSI	Child, 1-20 Years	96,661	$ 846.03	$ 846.52	$ 907.36	96,661	$ 846.73	$ 847.22	$ 908.24
Capital	SSI	Adult, 21+ Years	190,550	$ 1,674.24	$ 1,675.18	$ 1,796.78	190,550	$ 1,676.86	$ 1,677.81	$ 1,800.10
Capital	Family and Children	Newborn, 0-2 Months	28,051	$ 2,966.23	$ 2,967.69	$ 3,186.91	28,051	$ 2,963.60	$ 2,965.06	$ 3,184.53
Capital	Family and Children	Newborn, 3-11 Months	98,576	$ 297.15	$ 297.31	$ 316.68	98,576	$ 297.26	$ 297.42	$ 316.91
Capital	Family and Children	Child, 1-20 Years	1,849,511	$ 191.42	$ 191.53	$ 204.60	1,849,511	$ 191.61	$ 191.72	$ 204.83
Capital	Family and Children	Adult, 21+ Years	286,778	$ 463.30	$ 463.55	$ 495.42	286,778	$ 463.72	$ 463.97	$ 496.00
Capital	Foster Care Children	Foster Care, All Ages Male & Female	45,152	$ 478.11	$ 478.39	$ 517.12	45,152	$ 478.69	$ 478.97	$ 517.78
Capital	Breast and Cervical Cancer	BCC, All Ages Female	1,503	$ 2,542.80	$ 2,544.18	$ 2,806.18	1,503	$ 2,543.86	$ 2,545.24	$ 2,808.09
Capital	LaCHIP Affordable Plan	All Ages	12,010	$ 218.04	$ 218.16	$ 234.06	12,010	$ 218.29	$ 218.41	$ 234.35
Capital	HCBS Waiver	20 & Under, Male and Female	2,215	$ 2,162.42	$ 2,163.65	$ 2,312.08	2,215	$ 2,162.39	$ 2,163.62	$ 2,312.27
Capital	HCBS Waiver	21+ Years, Male and Female	4,664	$ 1,540.60	$ 1,541.48	$ 1,697.81	4,664	$ 1,542.29	$ 1,543.17	$ 1,700.08
Capital	Chisholm Class Members	Chisholm, All Ages Male & Female	7,981	$ 1,422.05	$ 1,422.88	$ 1,509.33	7,981	$ 1,422.75	$ 1,423.58	$ 1,510.15
Capital	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	9,510	$ 219.20	$ 219.20	$ 227.41	9,510	$ 219.59	$ 219.59	$ 227.81
Capital	SBH - Duals & LaHIPP (Duals)	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	331,681	$ 26.52	$ 26.52	$ 28.19	331,681	$ 27.00	$ 27.00	$ 28.67
Capital	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	6,698	$ 114.79	$ 114.79	$ 117.99	6,698	$ 114.90	$ 114.90	$ 118.10
Capital	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	9,436	$ 67.71	$ 67.71	$ 71.31	9,436	$ 68.06	$ 68.06	$ 71.66
Capital	SBH - Other	SBH - Other, All Ages	10,313	$ 171.67	$ 171.67	$ 179.29	10,313	$ 172.32	$ 172.32	$ 179.97
Capital	Maternity Kick Payment	Maternity Kick Payment	5,897	$ 11,049.35	$ 11,049.35	$ 11,597.61	5,897	$ 11,044.47	$ 11,044.47	$ 11,593.01
Capital	Maternity Kick Payment - EED Kick Payment	EED Kick Payment	1	$ 4,113.99	$ 4,113.99	$ 4,208.81	1	$ 4,105.67	$ 4,105.67	$ 4,200.54
Capital	Medicaid Expansion	Age 19 - 64	1,333,310	$ 676.84	$ 677.20	$ 724.31	1,333,310	$ 653.22	$ 653.57	$ 699.14
Capital	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	4,281	$ 26.52	$ 26.52	$ 28.19	4,281	$ 27.00	$ 27.00	$ 28.67
Capital	Medicaid Expansion	SBH - Other	528	$ 171.67	$ 171.67	$ 179.29	528	$ 172.32	$ 172.32	$ 179.97
Capital	Medicaid Expansion	SBH - CCM, All Ages	180	$ 219.20	$ 219.20	$ 227.41	180	$ 219.59	$ 219.59	$ 227.81
Capital	Medicaid Expansion	High Needs	759	$ 1,871.99	$ 1,871.99	$ 2,003.84	759	$ 1,872.42	$ 1,872.42	$ 2,004.33
Capital	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	2,596	$ 11,049.35	$ 11,049.35	$ 11,597.61	2,596	$ 11,044.47	$ 11,044.47	$ 11,593.01
Capital	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 4,113.99	$ 4,113.99	$ 4,208.81	1	$ 4,105.67	$ 4,105.67	$ 4,200.54

Appendix B: Rate Comparison			1/1/20 Rates				7/1/20 Rates			
Region Description	Category of Aid Description	Rate Cell Description	Projected Member Months/Deliveries	Lower Bound PMPM or Cost per Delivery	Final PMPM or Cost per Delivery [1]	Upper Bound PMPM or Cost per Delivery	Projected Member Months/Deliveries	Lower Bound PMPM or Cost per Delivery	Final PMPM or Cost per Delivery [1]	Upper Bound PMPM or Cost per Delivery
South Central	SSI	Newborn, 0-2 Months	103	$ 44,274.15	$ 44,296.90	$ 46,688.20	103	$ 44,240.51	$ 44,263.26	$ 46,654.84
South Central	SSI	Newborn, 3-11 Months	1,496	$ 6,570.57	$ 6,573.88	$ 6,994.33	1,496	$ 6,567.73	$ 6,571.05	$ 6,992.04
South Central	SSI	Child, 1-20 Years	106,874	$ 754.67	$ 755.11	$ 808.79	106,874	$ 755.46	$ 755.90	$ 809.67
South Central	SSI	Adult, 21+ Years	243,819	$ 1,435.78	$ 1,436.59	$ 1,540.83	243,819	$ 1,438.03	$ 1,438.84	$ 1,543.31
South Central	Family and Children	Newborn, 0-2 Months	32,093	$ 2,923.78	$ 2,925.37	$ 3,164.65	32,093	$ 2,923.10	$ 2,924.69	$ 3,164.11
South Central	Family and Children	Newborn, 3-11 Months	107,942	$ 303.44	$ 303.61	$ 324.72	107,942	$ 304.10	$ 304.27	$ 325.45
South Central	Family and Children	Child, 1-20 Years	2,022,019	$ 184.40	$ 184.51	$ 197.59	2,022,019	$ 184.83	$ 184.94	$ 198.06
South Central	Family and Children	Adult, 21+ Years	316,953	$ 413.05	$ 413.28	$ 442.53	316,953	$ 413.88	$ 414.11	$ 443.44
South Central	Foster Care Children	Foster Care, All Ages Male & Female	52,134	$ 474.77	$ 475.05	$ 513.74	52,134	$ 475.35	$ 475.63	$ 514.40
South Central	Breast and Cervical Cancer	BCC, All Ages Female	889	$ 2,534.08	$ 2,535.45	$ 2,797.36	889	$ 2,535.43	$ 2,536.81	$ 2,799.57
South Central	LaCHIP Affordable Plan	All Ages	10,405	$ 213.42	$ 213.54	$ 229.39	10,405	$ 213.68	$ 213.80	$ 229.69
South Central	HCBS Waiver	20 & Under, Male and Female	2,339	$ 2,073.11	$ 2,074.28	$ 2,221.80	2,339	$ 2,073.32	$ 2,074.49	$ 2,222.23
South Central	HCBS Waiver	21+ Years, Male and Female	6,191	$ 1,540.20	$ 1,541.08	$ 1,697.41	6,191	$ 1,541.83	$ 1,542.71	$ 1,699.62
South Central	Chisholm Class Members	Chisholm, All Ages Male & Female	10,150	$ 1,286.69	$ 1,287.43	$ 1,372.50	10,150	$ 1,287.61	$ 1,288.36	$ 1,373.54
South Central	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	8,913	$ 200.89	$ 200.89	$ 208.91	8,913	$ 201.45	$ 201.45	$ 209.48
South Central	SBH - Duals & LaHIPP (Duals)	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	412,860	$ 26.42	$ 26.42	$ 28.08	412,860	$ 26.91	$ 26.91	$ 28.59
South Central	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	6,286	$ 67.08	$ 67.08	$ 69.76	6,286	$ 67.26	$ 67.26	$ 69.94
South Central	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	10,889	$ 66.98	$ 66.98	$ 70.58	10,889	$ 67.39	$ 67.39	$ 70.99
South Central	SBH - Other	SBH - Other, All Ages	10,633	$ 186.95	$ 186.95	$ 194.74	10,633	$ 187.53	$ 187.53	$ 195.35
South Central	Maternity Kick Payment	Maternity Kick Payment	6,304	$ 9,153.57	$ 9,153.57	$ 9,689.29	6,304	$ 9,158.62	$ 9,158.62	$ 9,695.65
South Central	Maternity Kick Payment - EED Kick Payment	EED Kick Payment	1	$ 2,371.84	$ 2,371.84	$ 2,464.49	1	$ 2,360.86	$ 2,360.86	$ 2,453.74
South Central	Medicaid Expansion	Age 19 - 64	1,473,191	$ 590.93	$ 591.25	$ 632.84	1,473,191	$ 570.02	$ 570.33	$ 610.39
South Central	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	5,687	$ 26.42	$ 26.42	$ 28.08	5,687	$ 26.91	$ 26.91	$ 28.59
South Central	Medicaid Expansion	SBH - Other	321	$ 186.95	$ 186.95	$ 194.74	321	$ 187.53	$ 187.53	$ 195.35
South Central	Medicaid Expansion	SBH - CCM, All Ages	143	$ 200.89	$ 200.89	$ 208.91	143	$ 201.45	$ 201.45	$ 209.48
South Central	Medicaid Expansion	High Needs	333	$ 2,372.79	$ 2,372.79	$ 2,570.12	333	$ 2,381.10	$ 2,381.10	$ 2,579.98
South Central	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,236	$ 9,153.57	$ 9,153.57	$ 9,689.29	3,236	$ 9,158.62	$ 9,158.62	$ 9,695.65
South Central	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 2,371.84	$ 2,371.84	$ 2,464.49	1	$ 2,360.86	$ 2,360.86	$ 2,453.74
North	SSI	Newborn, 0-2 Months	13	$ 43,161.63	$ 43,183.68	$ 45,563.60	13	$ 43,128.00	$ 43,150.06	$ 45,530.24
North	SSI	Newborn, 3-11 Months	1,251	$ 6,335.62	$ 6,338.79	$ 6,756.82	1,251	$ 6,333.85	$ 6,337.02	$ 6,755.62
North	SSI	Child, 1-20 Years	119,859	$ 765.14	$ 765.58	$ 815.27	119,859	$ 765.76	$ 766.20	$ 815.96
North	SSI	Adult, 21+ Years	225,959	$ 1,365.34	$ 1,366.11	$ 1,464.12	225,959	$ 1,366.69	$ 1,367.46	$ 1,465.62
North	Family and Children	Newborn, 0-2 Months	23,108	$ 2,508.16	$ 2,509.43	$ 2,697.81	23,108	$ 2,507.92	$ 2,509.19	$ 2,697.56
North	Family and Children	Newborn, 3-11 Months	74,544	$ 311.47	$ 311.64	$ 332.28	74,544	$ 312.69	$ 312.86	$ 333.64
North	Family and Children	Child, 1-20 Years	1,523,585	$ 201.06	$ 201.17	$ 215.59	1,523,585	$ 201.62	$ 201.74	$ 216.21
North	Family and Children	Adult, 21+ Years	228,817	$ 409.46	$ 409.69	$ 440.10	228,817	$ 410.16	$ 410.39	$ 440.88
North	Foster Care Children	Foster Care, All Ages Male & Female	33,839	$ 502.16	$ 502.45	$ 541.43	33,839	$ 502.76	$ 503.05	$ 542.11
North	Breast and Cervical Cancer	BCC, All Ages Female	1,097	$ 2,500.25	$ 2,501.60	$ 2,763.17	1,097	$ 2,501.38	$ 2,502.74	$ 2,765.15
North	LaCHIP Affordable Plan	All Ages	8,836	$ 214.97	$ 215.09	$ 230.96	8,836	$ 215.23	$ 215.35	$ 231.26
North	HCBS Waiver	20 & Under, Male and Female	1,568	$ 2,060.59	$ 2,061.75	$ 2,209.14	1,568	$ 2,061.02	$ 2,062.18	$ 2,209.80
North	HCBS Waiver	21+ Years, Male and Female	4,967	$ 1,544.11	$ 1,544.99	$ 1,701.36	4,967	$ 1,545.99	$ 1,546.87	$ 1,703.83
North	Chisholm Class Members	Chisholm, All Ages Male & Female	7,681	$ 1,352.68	$ 1,353.47	$ 1,439.21	7,681	$ 1,353.77	$ 1,354.56	$ 1,440.42
North	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	7,519	$ 196.56	$ 196.56	$ 204.52	7,519	$ 197.03	$ 197.03	$ 205.00
North	SBH - Duals & LaHIPP (Duals)	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	335,470	$ 32.76	$ 32.76	$ 34.90	335,470	$ 33.29	$ 33.29	$ 35.43
North	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	3,792	$ 86.94	$ 86.94	$ 89.83	3,792	$ 87.15	$ 87.15	$ 90.05
North	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	7,598	$ 70.04	$ 70.04	$ 73.67	7,598	$ 70.56	$ 70.56	$ 74.19
North	SBH - Other	SBH - Other, All Ages	9,476	$ 174.25	$ 174.25	$ 181.90	9,476	$ 174.84	$ 174.84	$ 182.52
North	Maternity Kick Payment	Maternity Kick Payment	4,560	$ 11,091.18	$ 11,091.18	$ 11,679.49	4,560	$ 11,089.61	$ 11,089.61	$ 11,679.01
North	Maternity Kick Payment - EED Kick Payment	EED Kick Payment	1	$ 3,636.87	$ 3,636.87	$ 3,738.62	1	$ 3,622.01	$ 3,622.01	$ 3,723.95
North	Medicaid Expansion	Age 19 - 64	1,182,206	$ 553.56	$ 553.86	$ 592.93	1,182,206	$ 532.90	$ 533.19	$ 570.73
North	Medicaid Expansion	SBH - Dual Eligible & LaHIPP, All Ages (Duals)	3,047	$ 32.76	$ 32.76	$ 34.90	3,047	$ 33.29	$ 33.29	$ 35.43
North	Medicaid Expansion	SBH - Other	220	$ 174.25	$ 174.25	$ 181.90	220	$ 174.84	$ 174.84	$ 182.52
North	Medicaid Expansion	SBH - CCM, All Ages	126	$ 196.56	$ 196.56	$ 204.52	126	$ 197.03	$ 197.03	$ 205.00
North	Medicaid Expansion	High Needs	362	$ 1,305.98	$ 1,305.98	$ 1,403.10	362	$ 1,307.94	$ 1,307.94	$ 1,405.14
North	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	2,586	$ 11,091.18	$ 11,091.18	$ 11,679.49	2,586	$ 11,089.61	$ 11,089.61	$ 11,679.01
North	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 3,636.87	$ 3,636.87	$ 3,738.62	1	$ 3,622.01	$ 3,622.01	$ 3,723.95

Note:
1. Where applicable, final rates have been adjusted to account for the portion of contractual withholds that Mercer has determined to be reasonably attainable.

MERCER

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

Mr. Adam Sery, FSA, MAAA
Principal
Mercer Government Human Services
333 S 7th Street, Suite 1400
Minneapolis MN 55402

October 3, 2019

Subject: Capitation Rate Certification for the Healthy Louisiana Program – Implementation Year (January 1, 2020 through December 31, 2020)

Dear Adam:

I, Daniel Cocran, Medicaid Deputy Director, for the Louisiana Department of Health (LDH), hereby affirm that the data prepared and submitted to Mercer Government Human Services Consulting (Mercer) for the purpose of certifying the January 1, 2020 through December 31, 2020 Healthy Louisiana Rates were prepared under my direction, and to the best of my knowledge and belief, are accurate, complete, and consistent with the data used to develop the capitation rates. This data includes managed care organization submitted encounter data and supplemental information on payments made outside of Louisiana's Medicaid Management Information Systems for the period of October 1, 2016 through September 30, 2018.

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

Signature

10. 30. 19
Date

Copy:
Erik Axelsen, ASA, MAAA, Senior Associate
Ron Ogborne, FSA, CERA, MAAA, Partner

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