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: 2000123594 (6)
Vendor: MCNA Insurance Company
Description: Amd 6 to meet new rule requirements and federal regs.
Approved By: Sue Ellen Hopper
Approval Date: 6/25/2018

Your amendment that was submitted to OSP has been approved.

Rev 2017-01

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 6

LAGOV#: 2000123594

LDH #: 06060

(Regional/ Program/ Facility) Medical Vendor Administration

Original Contract Amt 484,300,137

AND

Original Contract Begin Date 07-01-2014

MCNA Insurance Company d/b/a MCNA Dental Plans
Contractor Name

Original Contract End Date 06-30-2017

RFP Number: 305PUR-DHHRFP-DEN

AMENDMENT PROVISIONS

Change Contract From: From Maximum Amount: 844,522,063 Current Contract Term: 7/1/2014-6/30/2019

See Attachment A6 and Attachment E.

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

See Attachment A6 and Attachment E.

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 revision is necessary to meet the new federal managed care regulatory requirements.

This Amendment Becomes Effective: 07-01-2018

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

MCNA Insurance Company d/b/a MCNA Dental Plans

CONTRACTOR SIGNATURE DATE 6/14/18

PRINT NAME Carlos Lacasa

CONTRACTOR TITLE Senior Vice President and General Counsel

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE DATE 6/19/18

NAME Jen Steele

TITLE Medicaid Director

OFFICE Medical Vendor Administration

PROGRAM SIGNATURE DATE

NAME

MCNA Contract Amendment #6
Attachment A-6
Effective Date 7/1/2018

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
1	Attachment E Rate Certification Letter	Mercer rate certification dated March 31, 2017.	Replace with Mercer rate certification dated May 11, 2018.	This is the required annual rate certification.	
2	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Add to Glossary	Cultural Competency - a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance of and respect for cultural differences and similarities within, among and between groups and the sensitivity to how these differences influence relationships with enrollees. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse enrollee needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.	Added to glossary for clarification as outlined in the Medicaid and Children's Health Insurance Program Managed Care Final Rule	
3	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Add to Glossary	Indian - means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR § 136.12. This means the individual: • Is a member of a Federally recognized Indian tribe; • Resides in an urban center and meets one or more of the four criteria: • Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since	Added to glossary for clarification as outlined in the Medicaid and Children's Health Insurance Program Managed Care Final Rule	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
			1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member; • Is an Eskimo or Aleut or other Alaska Native; • Is considered by the Secretary of the Interior to be an Indian for any purpose; or • Is determined to be an Indian under regulations issued by the Secretary; • Is considered by the Secretary of the Interior to be an Indian for any purpose; or • Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native. Indian health care provider - (IHCP) has the meaning assigned to it in 42 CFR §438.14. and means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). Indian managed care entity - (IMCE) means a MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health		

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
			Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.		
4	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Add new section.	III. Scope of Work B. Deliverables 1. General Requirements F. The DBPM shall submit documentation as specified by the state, but no less frequently than the following: 1) at the time it enters into a contract with the state; 2) on an annual basis; 3) at any time there has been a significant change (as defined by the state) in the DBPM's operations that would affect the adequacy of capacity and services, including changes in DBPM services, benefits, geographic service area, composition of or payments to its provider network, or at the enrollment of a new population in the DBPM. [42 CFR 438.207(b) - (c).	New Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	
5	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Add new section.	III. Scope of Work B. Deliverables 2. Programmatic Requirements C. Primary Dental Provider 5. Enrollees who qualify under the rural resident exception (under which a state may limit a rural area resident to a single PDP), the limitation on the enrollee's freedom to change between primary dental providers (PDP) can only be as restrictive as	New Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	

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			the limitations on disenrollment from the DBPM as requested by the enrollee in accordance with 42 CFR 438.56(c). Disenrollment from the DBPM would be permissible only if the state were to contract with two or more DBPMs.		
6	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work B. Deliverables 2. Programmatic Requirements D. Core Dental Benefits and Services General Provisions 3. Although the DBPM shall provide the full range of required core dental benefits and services listed below, it may choose to provide services over and above those specified when it is cost effective to do so. The DBPM may offer additional benefits that are outside the scope of core dental benefits and services to individual members on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the member and/or member's family, the potential for improved health status of the member, and functional necessity.	III. Scope of Work B. Deliverables 2. Programmatic Requirements D. Core Dental Benefits and Services General Provisions 3. Although the DBPM shall provide the full range of required core dental benefits and services listed below, it may voluntarily choose to provide services over and above those specified when it is cost effective to do so. The DBPM may offer additional benefits that are outside the scope of core dental benefits and services to individual members on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the member and/or member's family, the potential for improved health status of the member, and functional necessity. The DBPM may provide alternative services or deliver services in alternative settings in accordance with 42 CFR §§438.3(e).	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	
7	Exhibit 3	III. Scope of Work B. Deliverables 2. Programmatic Requirements	III. Scope of Work B. Deliverables 2. Programmatic Requirements	States must adopt an EPSDT dental periodicity schedule that is in line with reasonable standards	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	D. Core Dental Benefits and Services EPSDT Services In accordance with 42 CFR §441.56(b)(1)(vi) and periodicity charts posted on Louisiana Medicaid's website at www.lamedicaid.com, the DBPM shall provide dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age.	D. Core Dental Benefits and Services EPSDT Services In accordance with 42 CFR §441.56(b)(1)(vi) and periodicity charts posted on Louisiana Medicaid's website at www.lamedicaid.com, the DBPM shall provide dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age at the eruption of the first tooth and no later than 12 months and within 90 days of the effective date of enrollment for all other enrollees.	of dental practice for the Medicaid and CHIP populations. This aligns with the American Academy of Pediatric Dentistry recommendations.	
8	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work B. Deliverables 2. Programmatic Requirements D. Core Dental Benefits and Services Expanded Services/Benefits 1. As permitted under 42 CFR §438.6(e),the DBPM may offer expanded services and benefits to enrolled Medicaid DBPM members in addition to those core dental benefits and services specified in this RFP.	III. Scope of Work B. Deliverables 2. Programmatic Requirements D. Core Dental Benefits and Services Expanded Services/Benefits 1. As permitted under 42 CFR §438.~~6~~3(e),the DBPM may offer expanded services and benefits to enrolled Medicaid DBPM members in addition to those core dental benefits and services specified in this RFP.	Updating Code of Federal Regulations (CFR) reference	
9	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 10. Provider Network Requirements	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 10. Provider Network Requirements	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
		a) General Provider Network Requirements i. The DBPM must maintain a network of qualified dental providers in sufficient numbers and locations to provide required access to covered services. The DBPM is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network shall be designed to reflect the needs and service requirements of the DBPM's member population. The DBPM shall design its dental provider network to maximize the availability of primary dental services and specialty dental services.	a) General Provider Network Requirements i. The DBPM must maintain a network of qualified dental providers in sufficient number, ~~s~~mix and geographic distribution ~~locations~~ to provide ~~required~~ adequate access to all services covered ~~services~~under the contract for all enrollees in the service area, including those with limited English proficiency or physical or mental disabilities. The DBPM is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network shall be designed to reflect the needs and service requirements of the DBPM's member population. The DBPM shall design its dental provider network to maximize the availability of primary dental services and specialty dental services.		
10		III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 10. Provider Network Requirements a) General Provider Network Requirements iii. All providers shall be in compliance with Americans with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 10. Provider Network Requirements a) General Provider Network Requirements iii. All providers shall be in compliance with 42 CFR 438.206(c)(3) and Americans with Disabilities Act (ADA) requirements and provide physical access to	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
			reasonable accommodations and accessible equipment for Medicaid members with disabilities.		
11	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 10. Provider Network Requirements d) Assurance of Adequate Primary Care Dentist Access and Capacity i. The primary care dentist may practice in a solo or group practice or may practice in a clinic (i.e. Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or outpatient clinic. The DBPM shall provide at least one (1) full time equivalent (FTE) primary care dentist per three thousand (3,000) DBP members. DHH defines a full time primary care dentist as a provider that provides dental care services for a minimum of thirty-two (32) hours per week of practice time. The DBPM shall require that each individual primary care dentist shall not exceed a total of three thousand (3,000) Medicaid linkages in all DBPM's in which the primary care dentist may be a network provider.	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 10. Provider Network Requirements d) Assurance of Adequate Primary Care Dentist Access and Capacity i. The primary care dentist may practice in a solo or group practice or may practice in a clinic (i.e. Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or outpatient clinic. The DBPM shall provide at least one (1) full time equivalent (FTE) primary care dentist per ~~three~~ five thousand (~~3~~5,000) DBP members. DHH defines a full time primary care dentist as a provider that provides dental care services for a minimum of thirty-two (32) hours per week of practice time. The DBPM shall require that each individual primary care dentist shall not exceed a total of ~~three~~ five thousand (~~3~~5,000) Medicaid linkages in all DBPM's in which the primary care dentist may be a network provider.	Changing requirements to align with the Health Resources and Services Administration (HRSA) definition of a Dental Health Professional Shortage Area (HPSA).	

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12	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 10. Provider Network Requirements h) Provider Network Development Management Plan x. The DBPM shall monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English.	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 10. Provider Network Requirements h) Provider Network Development Management Plan x. The DBPM shall monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English, or with physical or mental disabilities.	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	
13	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 10. Provider Network Requirements j) Coordination with Other Service Providers The DBPM shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 10. Provider Network Requirements j) Coordination with Other Service Providers The DBPM shall ~~encourage~~ implement procedures for network providers and subcontractors to cooperate and communicate with other service	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
		members in the coordination and delivery of health care services. Such other service providers may include: Bayou Health Prepaid Health Plans; Bayou Heath Shared Savings Plans; Magellan; Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; FQHCs and RHCs; dental schools; dental hygiene programs; and parish school systems. Such cooperation may involve sharing of information (with the consent of the member).	providers who serve Medicaid members to ensure that each enrollee has an ongoing source of care appropriate to their needs. ~~in the coordination and delivery of health care services.~~ Such other service providers may include: Bayou Health Prepaid Health Plans; Bayou Heath Shared Savings Plans; Magellan; Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; FQHCs and RHCs; dental schools; dental hygiene programs; and parish school systems. Such cooperation may involve sharing of information (with the consent of the member). The DBPM shall formally designate a person or entity as primarily responsible for coordinating services accessed by the members. The DBPM shall provide the member information on how to contact their designated person or entity.		
14	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 10. Provider Network Requirements k) Subcontract Requirements viii. The DBPM shall provide written notification to DHH of its intent to terminate any provider	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 10. Provider Network Requirements k) Subcontract Requirements viii. All subcontracts must provide for termination of the subcontract, or specify other remedies, when	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
		subcontract that may materially impact the DBPM's provider network and/or operations, as soon as possible, but no later than seven (7) calendar days prior to the effective date of termination. In the event of termination of a provider subcontract for cause, the DBPM shall provide immediate written notice to the provider.	the DHH or DBPM determines that the subcontractor has not performed satisfactorily. The DBPM shall provide written notification to DHH of its intent to terminate any provider subcontract that may materially impact the DBPM's provider network and/or operations, as soon as possible, but no later than seven (7) calendar days prior to the effective date of termination. In the event of termination of a provider subcontract for cause, the DBPM shall provide immediate written notice to the provider.		
15	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Add new section.	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 10. Provider Network Requirements m) Indians, Indian Healthcare Providers Network and coverage requirements. (1) The DBPM shall demonstrate that there are sufficient IHCPs participating in the provider network of the Plan to ensure timely access to services available under the Contract from such providers for Indian enrollees who are eligible to receive services. (2) The DBPM shall pay IHCPs, whether participating or not, for covered services provided to Indian enrollees who are eligible to receive services from such providers as follows:	New Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	

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			(i) At a rate negotiated between the DBPM and the IHCP, or (ii) In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the DBPM would make for the services to a participating provider which is not an IHCP; and (iii) Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 C.F.R. § 447.45 and § 447.46. (3) The DBPM shall permit any Indian who is enrolled in the Plan that is not an IMCE and eligible to receive services from a IHCP primary care provider participating as a network provider, to choose that IHCP as his or her primary care provider, as long as that provider has capacity to provide the services. (4) The Plan shall permit Indian enrollees to obtain services covered under the Contract from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services. (5) If timely access to covered services cannot be ensured due to few or no IHCPs, the Plan shall be considered to have met the requirement in paragraph 1.3.1.6.3.1(1) of this section if-- (i) Indian enrollees are permitted by the Plan to access out of-State IHCPs; or (ii) If this circumstance is deemed to be good cause for disenrollment from both the Plan and the State's managed care program in accordance with § 438.56(c).		

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
			(6) The Plan shall permit an out-of-network IHCP to refer an Indian enrollee to a network provider. Enrollment in IMCEs. An IMCE may restrict its enrollment to Indians in the same manner as Indian Health Programs, as defined in 25 U.S.C. § 1603(12), may restrict the delivery of services to Indians, without being in violation of the requirements in 42 C.F.R. § 438.3(d).		
16	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements g) Provider Payments viii. Provider Incentive Plans • Provider Incentive Plans (PIPs) must comply with requirements for physician incentive plans in 42 CFR 417.479, 422.208, 422.210, and 438.6(h). Specific payment cannot be made directly or indirectly under a Provider Incentive Plan to a dentist or dentist group as an inducement to reduce or limit medically necessary services furnished to an individual.	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements g) Provider Payments viii. Provider Incentive Plans • Provider Incentive Plans (PIPs) must comply with requirements for physician incentive plans in 42 CFR 417.479, 422.208, 422.210, 438.3(i) and 438.6(h). Specific payment cannot be made directly or indirectly under a Provider Incentive Plan to a dentist or dentist group as an inducement to reduce or limit medically necessary services furnished to an individual.	Addition of new regulatory reference	
17	Exhibit 3 RFP305PUR-DHHRFP-	Add a new section.	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement	To align with departmental priorities.	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
	DENTAL-PAHP-MVA		11. Utilization Requirements g) Provider Payments <u>x. Dental Full Medicaid Payment (FMP)</u> • <u>The MCO shall ensure that any amounts designated in the PMPM for Dental FMP are used for payment to dentists pursuant to a network contract and for a specific service or benefit provided to a specific enrollee covered under the contract, or any other payment mechanism that is allowed pursuant to 42 CFR 438.6.</u>		
18	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements i) Enrollment and Disenrollment ii. Enrollment Procedures • Effective Date of Enrollment DBPM enrollment for members in a given month will be effective at 12:01AM on the first (1st) calendar day of the month of Medicaid eligibility.	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements i) Enrollment and Disenrollment ii. Enrollment Procedures • Effective Date of Enrollment DBPM enrollment for members in a given month will be effective at 12:01AM on the first (1st) calendar day of the month of Medicaid eligibility. <u>DBPM must accept all individuals assigned to the DBPM by the fiscal intermediary in the order in which</u>	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	

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			they are assigned without restriction. (438.3(d).		
19	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements j) Member Education i. General Guidelines • All member education materials and activities shall comply with the requirements in 42 CFR §438.10 and the DHH requirements set forth in this RFP and the Dental Benefit Program Companion Guide. o In accordance with 42 CFR §438.10(b)(1), DHH shall provide the DBPM the prevalent non-English language spoken by enrollees in the state. Prevalent is defined as five percent of the population statewide. o The DBPM, as required in 42 CFR §438.10(c)(3), shall be responsible for	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements j) Member Education i. General Guidelines • All member education materials and activities shall comply with the requirements in 42 CFR §438.10 and the DHH requirements set forth in this RFP and the Dental Benefit Program Companion Guide. o In accordance with 42 CFR §438.10(b)(1), DHH shall provide the DBPM the prevalent non-English language spoken by enrollees in the state. Prevalent is defined as five percent of the population statewide. o The DBPM, as required in 42 CFR §438.10(c)(3), shall be responsible for	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
		providing to enrollees and potential enrollees written information in the prevalent non-English language in the DBPM's particular service area. o In accordance with 42 CFR §438.10(c)(4)-(5) the DBPM shall provide enrollees oral interpretation services available free of charge, to all non-English languages rather than to only those DHH identifies as prevalent. The DBPM is responsible for providing all written materials in alternative formats and in a manner that considers the special needs of those who, for example, are visually limited or have limited reading proficiency.	providing to enrollees and potential enrollees written information in the prevalent non-English language in the DBPM's particular service area. o In accordance with 42 CFR §438.10(c)(4)-(5) the DBPM shall provide enrollees oral interpretation services available free of charge, to all non-English languages rather than to only those DHH identifies as prevalent. The DBPM is responsible for providing all written materials in alternative formats, available through auxillary aids and services and in a manner that considers the special needs of those who, for example, are visually limited or have limited reading proficiency.		
20	Exhibit 3 RFP305PUR-DHHRFP-	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
	DENTAL-PAHP-MVA	j) Member Education i. General Guidelines • The DBPM shall participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members and comply with the Office of Minority Health, Department of Health and Human Services at the following URL: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 and participate in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees.	j) Member Education i. General Guidelines • The DBPM shall participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members and comply with the Office of Minority Health, Department of Health and Human Services' "National Culturally and Linguistically Appropriate Services Standards (National CLAS Standards)" at the following URL: https://www.thinkculturalhealth.hhs.gov/clas/standards ~~http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15~~ and participate in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees. • The Dental Contractor must have a comprehensive written Cultural Competency Plan describing how the Dental Contractor will ensure culturally competent services, and provide Linguistic Access and Disability-related Access. The plan must be developed in adherence to the National CLAS Standards.		

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21	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements j) Member Education vi. Provider Directory for Members • The DBPM shall develop and maintain a Provider Directory in two (2) formats: o Web-based, searchable online directory for members and the public; and o A hard copy directory for members upon request only; • DHH or its designee shall provide the file layout for the electronic directory to the DBPM after approval of the Contract. The DBPM shall submit templates of its provider directory to DHH within thirty (30) days from the date the Contract is signed, but no later than prior to Readiness Review. • The hard copy directory for members shall be reprinted with updates at least monthly for new members and to fulfill only requests. The web-based online version shall be updated in real time, however no less than weekly.	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements j) Member Education vi. Provider Directory for Members • The DBPM shall develop and maintain a Provider Directory in two (2) formats: o Web-based, <u>in a searchable machine readable file</u>, online directory for members and the public; and o A hard copy directory for members upon request only; • DHH or its designee shall provide the file layout for the electronic directory to the DBPM after approval of the Contract. The DBPM shall submit templates of its provider directory to DHH within thirty (30) days from the date the Contract is signed, but no later than prior to Readiness Review. • The hard copy directory for members shall be reprinted with updates at least monthly for new members and to fulfill only requests. The web-based online version shall be updated in real time, however no less than weekly.	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	

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		• In accordance with 42 CFR §438.10(f) (6), the provider directory shall include, but not be limited to: o Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Medicaid enrollee's service including identification of providers, primary care dentists, specialists, and providers that are not accepting new patients at a minimum; o Identification of primary care dentists, specialists, and dental groups in the service area; o Identification of any restrictions on the enrollee's freedom choice among network providers; and o Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).	• In accordance with 42 CFR §438.10(f) (6), the provider directory shall include, but not be limited to: o Names, as well as any group affiliations, locations, telephone numbers of, website URLs, as appropriate and non-English languages spoken by current contracted providers or skilled interpreter at the provider's office in the Medicaid enrollee's service area and whether the provider has completed cultural competence training, including identification of providers, primary care dentists, specialists, and providers that are not accepting new patients at a minimum; o Identification of primary care dentists, specialists, and dental groups in the service area; o Whether network providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment;		

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			o Identification of any restrictions on the enrollee's freedom choice among network providers; and o Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).		
22	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements j) Member Education xiii. Oral and Written Interpretation Services • The DBPM must make real-time oral interpretation services _available free of charge to each potential member and member. This applies to all non-English languages not just those that Louisiana specifically requires (Spanish and Vietnamese). The member is not to be charged for interpretation services. The DBPM must notify its members that oral interpretation is available for any language and written information is available in Spanish and Vietnamese and how to access	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements j) Member Education xiii. Oral and Written Interpretation Services • The DBPM must make~~ real-time oral~~ interpretation services,<u> including oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language (ASL),</u> available free of charge to each potential member and member. <u>Oral interpretation services shall be available in</u>~~This applies to~~ all non-English languages not just those that Louisiana specifically requires (Spanish and Vietnamese). The member is not to be charged for interpretation services. The DBPM must	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
		those services. On materials where this information is provided, the notation should be written in both Spanish and Vietnamese.	notify its members that oral interpretation is available for any language and written information is available in Spanish and Vietnamese and how to access those services. On materials where this information is provided, the notation should be written in both Spanish and Vietnamese.		
23	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Add new section.	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements j) Member Education xv. Member and State Fair Hearing Procedures • <u>The DBPM shall take no punitive action against a provider who either requests an expedited resolution or supports an enrollee's appeal. [42 CFR 438.410(b)]</u>	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	
24	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements j) Member Education xix. Handling Grievances and Appeals	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements j) Member Education xix. Handling Grievances and Appeals	Center for Medicare & Medicaid Services (CMS) federal mandate	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
		• Special Requirements for Appeals The process for appeals must: o Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal), and must be confirmed in writing unless the member or the provider requests expedited resolution. The member, member's authorized representative or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing; however if filed orally the requestor must follow up in writing. No additional member follow-up is required. o Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The DBPM must inform the member of the limited time available for this in the case of expedited resolution). o Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including dental records, and any other documents and records considered during the appeals process. o Include, as parties to the appeal: ▪ The member and his or her representative; or	• Special Requirements for Appeals The process for appeals must: o Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal), and must be confirmed in writing unless the member or the provider requests expedited resolution. The member, member's authorized representative or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing; however if filed orally the requestor must follow up in writing. ~~No additional member follow-up is required.~~ • Once an oral appeal is received: o MCO will notify the enrollee verbally that a written confirmation is required for the appeal process to continue. MCO should inform the enrollee they will be receiving a notice for written confirmation of the appeal. o The DPMB will send a notice to the enrollee acknowledging the oral appeal request was received and written		

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
		▪ The legal representative of a deceased member's estate.	confirmation is required. This notice must contain the timeframe for receipt of the written confirmation and future actions. o The DBPM will provide a form for the enrollee to sign and send back, as well as the options available for receipt of written confirmation (fax, email, regular postal mail). o The enrollee has 15 days from the date of the notice to send their written confirmation. • If written confirmation is not received within the 15 day timeframe: o The DBPM will close the appeal as incomplete for non-receipt of written confirmation. o The DBPM will send a notification to the enrollee of the appeal closure. This notice must consist of the reason for the incomplete appeal and inform the enrollee that they may submit a new appeal if they are within the original 60 days of the adverse action.		

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
			[Note: This closure does not escalate the appeal to a State Fair Hearing since the initial appeal process was not been completed]. o Once a request for an oral appeal has been closed for non-receipt of a written confirmation, a new appeal date can be established with an oral or written appeal request if it is within the original 60 days of the adverse action. o Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The DBPM must inform the member of the limited time available for this in the case of expedited resolution). o Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including dental records, and any other documents and records considered during the appeals process. o Include, as parties to the appeal: ▪ The member and his or her representative; or ▪ The legal representative of a deceased member's estate.		

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
25	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements j) Member Education xxiii. Continuation of Benefits • Information to Providers and Contractors The DBPM must provide the information specified at 42 CFR §438.10(g)(1) about the grievance system to all providers and contractors at the time they enter into a contract.	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements j) Member Education xxiii. Continuation of Benefits • Information to Providers and Contractors The DBPM must provide the information specified <u>in federal regulations</u> ~~at 42 CFR §438.10(g)(1)~~ about the grievance system to all providers and contractors at the time they enter into a contract.	This revisions is necessary to ensure that contractor adheres to all applicable regulations.	
26	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements k) Quality Management i. Quality Assessment and Performance Improvement Program (QAPI) • The DBPM shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as described in 42 CFR 438.240(a)(1), to:	III. Scope of Work B. Deliverables 3. Operations Requirements B. DBPM Reimbursement 11. Utilization Requirements k) Quality Management i. Quality Assessment and Performance Improvement Program (QAPI) • The DBPM shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as described in 42 CFR 438.~~240(a)(1)~~330(a)1; (a)2, to:	Updating CFR Reference and federal regulation verbiage Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
		o Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities; o Incorporate improvement strategies that include, but are not limited to: ▪ performance improvement projects; ▪ dental record audits; ▪ performance measures; and ▪ surveys o Detect underutilization and overutilization of services Assess the quality and appropriateness of dental care furnished to enrollees with special healthcare needs.	o Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities; o Incorporate improvement strategies that include, but are not limited to: ▪ performance improvement projects; ▪ dental record audits; ▪ performance measures; and ▪ <u>provider and member</u> surveys o Detect underutilization and overutilization of services o Assess the quality and appropriateness of dental		

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
			care furnished to enrollees with special healthcare needs.		
27	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work D. Fraud and Abuse 1. General Requirements C. The DBPM shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, the United States Department of Health and Human Services HHS, the United States and/or Louisiana's Legislative Auditor's Office, the United States and/or Louisiana's Office of the Attorney General, the United States, General Accountability Office (GAO), Comptroller General of the United States, DHH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of six (6) years from the expiration date of the Contract (including any extensions to the Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules. D. The DBPM and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of	III. Scope of Work D. Fraud and Abuse 1. General Requirements C. The DBPM shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, the United States Department of Health and Human Services HHS, the United States and/or Louisiana's Legislative Auditor's Office, the United States and/or Louisiana's Office of the Attorney General, the United States, General Accountability Office (GAO), Comptroller General of the United States, DHH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of <u>ten 10 years from the completion of an audit or the contract expiration, whichever is later</u> ~~six (6) years~~ from the expiration date of the Contract (including any extensions to the Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules.	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
		the above. Each federal and state agency 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 DBPM 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 DBPM 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.	D. The DBPM and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above. Each federal and state agency shall have timely and unrestricted ~~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 DBPM 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 DBPM 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.		
28	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Add a new section	III. Scope of Work E. Technical Requirements 19. Claims Management E. Adherence to Key Claims Management Standards 2. Claims Dispute Management f) Providers shall have the right to an independent review of claims that are the subject of an adverse determination by the DBPM. The review shall be provided and conducted in accordance with R.S. 46:460.82 through 460.89.	Required by Act 284 of the 2018 Regular Louisiana Legislative Session.	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
29	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work F. Subcontracting The contractor shall not contract with any other party for furnishing any of the work and professional services required by the contract without the express prior written approval of the Department. The contractor shall not substitute any subcontractor without the prior written approval of the Department. For subcontractor(s), before commencing work, the contractor will provide letters of agreement, contracts or other forms of commitment which demonstrate that all requirements pertaining to the contractor will be satisfied by all subcontractors through the following: • The subcontractor(s) will provide a written commitment to accept all contract provisions. • The subcontractor(s) will provide a written commitment to adhere to an established system of accounting and financial controls adequate to permit the effective administration of the contract.	III. Scope of Work F. Subcontracting The contractor shall not contract with any other party for furnishing any of the work and professional services required by the contract without the express prior written approval of the Department. The contractor shall not substitute any subcontractor without the prior written approval of the Department. <u>The contractor maintains the ultimate responsibility for complying with all the terms and conditions of its contract with the state.</u> For subcontractor(s), before commencing work, the contractor will provide letters of agreement, contracts or other forms of commitment which demonstrate that all requirements pertaining to the contractor will be satisfied by all subcontractors through the following: • The subcontractor(s) will provide a written commitment to accept all contract provisions. • The subcontractor(s) will provide a written commitment to adhere to an established system of accounting and financial controls adequate to permit the effective administration of the contract.	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement. This change aligns with federal regulation verbiage.	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
30	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work K. Administrative Actions, Corrective Action Plans, Monetary Penalties, and Sanctions 3. Monetary Penalties and Sanctions J. Intermediate Sanctions 1. DHH shall notify the DBPM and CMS in writing of its intent to impose sanctions for violating the terms and conditions of the Contract or violation of federal Medicaid rules and regulations and will explain the process for the DBPM to employ the dispute resolution process as described in this RFP. The following are non-exhaustive grounds for which intermediate sanctions may be imposed when the DBPM acts or fails to act. The DBPM: c) Acts to discriminate among members on the basis of their health status or need for healthcare services; this includes termination of enrollment or refusal to reenroll a member or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future dental services.	III. Scope of Work K. Administrative Actions, Corrective Action Plans, Monetary Penalties, and Sanctions 3. Monetary Penalties and Sanctions J. Intermediate Sanctions 1. DHH shall notify the DBPM and CMS in writing of its intent to impose sanctions for violating the terms and conditions of the Contract or violation of federal Medicaid rules and regulations and will explain the process for the DBPM to employ the dispute resolution process as described in this RFP. The following are non-exhaustive grounds for which intermediate sanctions may be imposed when the DBPM acts or fails to act. The DBPM: c) ~~Acts to~~ Shall not discriminate among members on the basis of their health status~~, or~~ need for healthcare services; race, color, national origin, sex, sexual orientation, gender identity, or disability. ~~t~~This includes termination of enrollment or refusal to reenroll a member or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future dental services.	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement.	

Item Number	Exhibit/ Attachment & Document	Change From:	Change To:	Justification	Feedback
31	Exhibit 3 RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III. Scope of Work L. Additional Terms and Conditions 45. Non-Discrimination In accordance with 42 CFR 438.6 (d) (3) and (4), the DBPM shall not discriminate in the enrollment of Medicaid individuals into the DBPM. The DBPM agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin, or basis of health status or need for healthcare services shall be excluded from participation in, or be denied benefits of the DBPM's program or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the DBPM. The DBPM shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts.	III. Scope of Work L. Additional Terms and Conditions 45. Non-Discrimination In accordance with 42 CFR 438.6 (d) (3) and (4), the DBPM shall not discriminate in the enrollment of Medicaid individuals into the DBPM. The DBPM agrees that no person, on the grounds of handicap, age, race, color, religion, sex, <u>sexual orientation, gender identity,</u> national origin, or basis of health status or need for healthcare services shall be excluded from participation in, or be denied benefits of the DBPM's program or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the DBPM. The DBPM shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts.	Medicaid and Children's Health Insurance Program Managed Care Final Rule requirement.	

Amendment 6
Attachment E
LaGov# 2000123594

MERCER
MAKE TOMORROW, TODAY

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May 11, 2018

Subject: Louisiana Medicaid Dental Benefit Program Capitation Rate Certification for the Period July 1, 2018 through June 30, 2019

Dear Ms. Diez:

In partnership with the State of Louisiana (State), Mercer Government Human Services Consulting (Mercer) has developed statewide actuarially sound[1] capitation rates for the Louisiana Medicaid Dental Benefit Program (DBP). These rates are applicable for the contract period July 1, 2018 through June 30, 2019.

This document presents an overview of the rate development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS). This rate development process was based on managed care encounter data and financial data provided by Managed Care of North America (MCNA) Dental, the current DBP contractor.

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

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

DENTAL CAPITATION RATES

The proposed actuarially sound rates for the DBP are shown in Table 1.

Table 1: Dental Capitation Rates

JULY 1, 2018 TO JUNE 30, 2019	
Rate Cell Description	Monthly Capitation Rate Per Eligible
LaCHIP Affordable Plan	$ 20.38
Medicaid Child/CHIP	$ 16.68
Medicaid Adult	$ 1.30
Medicaid Expansion Child	$ 15.38
Medicaid Expansion Adult	$ 1.28

MANAGED CARE RATE DEVELOPMENT METHODOLOGY

Overview

Effective July 1, 2014, Louisiana implemented a managed DBP for Louisiana Children's Health Insurance Program (LaCHIP) Affordable Plan, Medicaid Children (including the primary LaCHIP program), and Medicaid Adult populations. The State's DBP has been in place since the 1990s providing dental services to Medicaid members in a fee-for-service (FFS) environment. The DBP covers preventive dental services for eligible members younger than age 21 and adult denture benefits for eligible members at age 21 and above. The managed DBP is expected to efficiently manage service costs and utilization, improve access to essential specialty dental services, and increase outreach and education to promote healthy dental behavior.

The capitation rates provided above have been developed consistent with guidance provided in the CMS Medicaid Managed Care Rate Development Guide. These actuarially sound dental capitation rates are based upon the State Plan-covered services only. Base period dental claims data were analyzed, completed, and trended. Adjustments were applied, as appropriate, to reflect programmatic changes to the State Plan that affect the base period data and the contract period. A Prepaid Ambulatory Health Plan (PAHP) administrative load assumption was developed and included. Each of these rating elements is discussed in detail below.

Base Period Data and Enrollment

For the period of July 1, 2018 through June 30, 2019 rate setting, Mercer relied on managed care encounter data from state fiscal years (SFYs) 2016 and 2017. Louisiana's SFY runs from July 1 of a given year through June 30 of the following year.

Mercer combined SFYs 2016 and 2017 data to form the base data for the Medicaid Non-Expansion population. For the Medicaid Expansion population, Mercer used data from the only full year of experience available (i.e., SFY 2017, as base data).

Mercer reviewed the data provided by the State for consistency and reasonableness and determined the data is appropriate for the purpose of setting capitation rates for the DBP. Mercer confirmed the services included in this historical experience are State Plan-covered services only.

Covered Populations

In general, the DBP covers most Medicaid eligible, LaCHIP, and the LaCHIP Affordable Plan populations including full dual eligibles. The LaCHIP population was included in the Medicaid Children category for the dental capitation rates.

Effective July 1, 2016, Louisiana expanded Medicaid coverage under the Affordable Care Act (ACA). The Expansion population was also included in the DBP covered populations.

The DBP non-covered populations are shown in Appendix A.

Rate Cell Structure

For the period of July 1, 2018 through June 30, 2019 rate setting, Mercer established five distinct rate cells for the DBP program.

Table 2: Rate Cell Structure

RATE CELL	PROGRAM	AGE RANGE
LaCHIP Affordable Plan	Non-Expansion	0–20
Medicaid Child/CHIP	Non-Expansion	0–20
Medicaid Adult	Non-Expansion	21 and above
Medicaid Expansion Child	Expansion	19–20
Medicaid Expansion Adult	Expansion	21–64

Retroactive Eligibility

Per the State, membership and claims incurred for covered services rendered prior to enrollment and during any retroactive period up to 12 months of eligibility are covered in the DBP.

Institution of Mental Diseases

The base data was adjusted to remove member months and dental claims associated with enrollees ages 21 to 64 who stayed in an IMD for more than 15 days. The adjustment reduced the adult base member months from 3,914,929 to 3,914,417 for SFY 2016 and from 7,847,757 to 7,847,442 for SFY 2017.

The base data had no dental claims associated with enrollees ages 21 to 64 who stayed in an IMD for more than 15 days.

Data Smoothing

As part of rate development process for the Expansion population, Mercer used SFY 2017 base data with the goal of obtaining a set of base data that had sufficient credibility and reasonableness to develop actuarially sound capitation rates. Mercer determined that July 2016 and August 2016 data for the Medicaid Expansion Child and Medicaid Expansion Adult rate cells were not reasonable for rate setting purposes. Mercer applied the average of September 2016 through June 2017 data to replace July 2016 and August 2016 data, respectively.

Under-Reporting Adjustment

The under-reporting adjustment was developed by comparing encounter data from the Medicaid Management Information System (MMIS) to financial information provided by MCNA. The adjustment was based on detailed quarterly reported financial data provided by MCNA. The year-end financial report is reviewed by the managed care organization's (MCO's) auditors using agreed upon procedures. The audit report accounts for any changes or recommendations recommended by the auditor. Additionally, the financial data is compared to the MCO's annual statutory filing using standards from the National Association of Insurance Commissioners, commonly known as the "Orange Blank," to check for accuracy and completeness.

The adjustment was developed and applied by Child versus Adult. The Child grouping combines Medicaid Child/CHIP, Medicaid Expansion Child and LaCHIP Affordable Plan. The Adult grouping combines Medicaid Adult and Medicaid Expansion Adult. For SFY 2016, the adjustment resulted in an increase of the base per member per month (PMPM) by 5.01% and 13.26% for Child and Adult, respectively, totaling a 5.24% increase of the overall SFY 2016 base PMPM. For SFY 2017, the adjustment resulted in an increase of the base PMPM by 3.21% and 10.33% for Child and Adult, respectively, totaling a 3.61% increase of the overall SFY 2017 base PMPM.

Completion Factors

The encounter data include claims for dates of service from July 1, 2015 to June 30, 2017, and reflect payments through December 31, 2017. Mercer estimated and adjusted for the remaining liability associated with incurred but not reported claims for SFY 2017. The overall adjustment using paid claims data through December 31, 2017 was 0.14% for SFY 2017 claims. The SFY 2016 claims were deemed complete as they reflect 18 months of runout.

Fraud and Abuse Adjustment

Fraud and abuse recoveries were included in the financial reports. These recoveries were included in the development of the under-reporting adjustment.

Trend Adjustments

Trend adjustments were based on analysis of Louisiana dental claims experience and review of dental trend benchmarks in other state Medicaid programs and commercial dental managed care programs. Mercer evaluated trend patterns to examine and project utilization and unit cost trends for the rate period. Total PMPM trend applied to Medicaid Child/CHIP, Medicaid Adult and LaCHIP Affordable Plan is 1.13%. Total PMPM trend applied to Medicaid Expansion Child and Medicaid Expansion Adult is 0.89%.

Co-Payments and Third Party Liability

An adjustment for co-payments was not necessary for this analysis because both the Legacy Medicaid program and the DBP are not subject to co-payments. Recoveries associated with third party liability and subrogation have been removed from claims by selecting only MCO paid amounts.

Programmatic Changes

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

Mercer discussed changes made by Louisiana to its Medicaid program between the base and contract periods and determined that none of the programmatic changes that were identified were expected to impact the DBP.

Administrative Load

The proposed capitation rates shown above include provision for dental (PAHP) administration and profit. Mercer relied upon its professional experience in working with numerous commercial managed dental plans and state Medicaid programs in determining appropriate non-medical expenses. The loads for non-medical expenses and underwriting gain are calculated as percentages of the capitation rate net of premium tax. The load for premium tax is calculated as a percentage of the final capitation rate. The proposed capitation rate, as developed, assumes a 9.25% load for non-medical expenses, 2.00% underwriting gain, and 2.25% premium tax for this rate period. In total, the overall load applied to the rates for administration and profit/contingencies was 13.25%.

Federal Health Insurance Provider 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. This fee is calculated on an annual basis. The fee will be calculated and become payable during the third quarter of 2019. As this fee is not yet defined by insurer and by marketplace, no adjustment has been made in the rate development for the DBP. An adjustment and supplemental certification will be issued, if necessary, when the fee amount and impacted entities applicable to this rate period are announced in 2019.

CERTIFICATION OF FINAL RATES

This certification assumes items in the Medicaid State Plan, as well as the Dental Benefit Program MCO contract, have been approved by CMS.

In preparing the capitation rate for the contract period July 1, 2018 through June 30, 2019 , Mercer used and relied upon enrollment, eligibility and encounter data, fee schedule, and benefit design information supplied by the State. The State is responsible for the validity and completeness of this supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. If the data and information is incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

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 were developed in accordance with generally accepted actuarial practices and principles, and is appropriate for the Medicaid and LaCHIP covered populations and services under the managed care 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.

Capitation rates 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 DBP contractor costs will differ from these projections. Mercer has developed these rates on behalf of the State to demonstrate compliance with the CMS

requirements under 42 CFR 438.4 and accordance with applicable law and regulations. Use of these rates for any purpose beyond that stated may not be appropriate.

The DBP contractor is advised that the use of the rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of the rates by the DBP contractor for any purpose. Mercer recommends that any health plan considering contracting with the State should analyze its own projected dental expense, administrative expense, and any other premium needs for comparison to the rates before deciding whether to contract with the State.

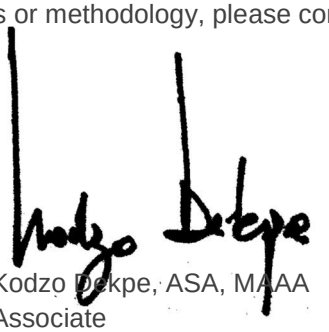
This certification letter assumes the reader is familiar with the Louisiana DBP, DBP eligibility rules, and actuarial rating techniques. It has been prepared exclusively for the State and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified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

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

If you have any questions or comments on the assumptions or methodology, please contact Erik Axelsen at +1 404 442 3517 or Kodzo Dekpe at +1 404 442 3296.

Sincerely,

Erik Axelsen, ASA, MAAA
Senior Associate



Kodzo Dekpe, ASA, MAAA
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APPENDIX A

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	11	Hurricane Evacuees	Yes
002	Deemed Eligible	11	Hurricane Evacuees	Yes
005	SSI/LTC	11	Hurricane Evacuees	Yes
007	LACHIP Phase 1	11	Hurricane Evacuees	Yes
008	PAP - Prohibited AFDC Provisions	11	Hurricane Evacuees	Yes
009	LIFC - Unemployed Parent / CHAMP	11	Hurricane Evacuees	Yes
013	CHAMP Pregnant Woman (to 133% of FPIG)	11	Hurricane Evacuees	Yes
014	CHAMP Child	11	Hurricane Evacuees	Yes
015	LACHIP Phase 2	11	Hurricane Evacuees	Yes
020	Regular MNP (Medically Needy Program)	11	Hurricane Evacuees	Yes
021	Spend-Down MNP	11	Hurricane Evacuees	Yes
025	LTC Spend-Down MNP	11	Hurricane Evacuees	Yes
027	EDA Waiver	11	Hurricane Evacuees	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
028	Tuberculosis (TB)	20	TB	Yes
040	SLMB (Specified Low-Income Medicare Beneficiary)	01	Aged	Yes
040	SLMB (Specified Low-Income Medicare Beneficiary)	02	Blind	Yes
040	SLMB (Specified Low-Income Medicare Beneficiary)	04	Disabled	Yes
047	Illegal/Ineligible Aliens Emergency Services	01	Aged	Yes
047	Illegal/Ineligible Aliens Emergency Services	03	Families and Children	Yes
047	Illegal/Ineligible Aliens Emergency Services	04	Disabled	Yes
047	Illegal/Ineligible Aliens Emergency Services	11	Hurricane Evacuees	Yes
048	QI-1 (Qualified Individual - 1)	01	Aged	Yes
048	QI-1 (Qualified Individual - 1)	02	Blind	Yes
048	QI-1 (Qualified Individual - 1)	04	Disabled	Yes
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	01	Aged	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	04	Disabled	Yes
050	PICKLE	11	Hurricane Evacuees	Yes
053	CHAMP Pregnant Woman Expansion (to 185% FPIG)	11	Hurricane Evacuees	Yes
055	LACHIP Phase 3	11	Hurricane Evacuees	Yes
059	Disabled Adult Child	11	Hurricane Evacuees	Yes
062	SSI/Public ICF/DD	01	Aged	Yes
062	SSI/Public ICF/DD	02	Blind	Yes
062	SSI/Public ICF/DD	04	Disabled	Yes
062	SSI/Public ICF/DD	06	OCS Foster Care	Yes
062	SSI/Public ICF/DD	08	IV-E OCS/OYD	Yes
062	SSI/Public ICF/DD	22	OCS/OYD (XIX)	Yes
063	LTC Co-Insurance	01	Aged	Yes
063	LTC Co-Insurance	02	Blind	Yes
063	LTC Co-Insurance	04	Disabled	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
063	LTC Co-Insurance	11	Hurricane Evacuees	Yes
064	SSI/Private ICF/DD	01	Aged	Yes
064	SSI/Private ICF/DD	02	Blind	Yes
064	SSI/Private ICF/DD	04	Disabled	Yes
064	SSI/Private ICF/DD	06	OCS Foster Care	Yes
064	SSI/Private ICF/DD	08	IV-E OCS/OYD	Yes
064	SSI/Private ICF/DD	22	OCS/OYD (XIX)	Yes
065	Private ICF/DD	01	Aged	Yes
065	Private ICF/DD	02	Blind	Yes
065	Private ICF/DD	04	Disabled	Yes
065	Private ICF/DD	06	OCS Foster Care	Yes
065	Private ICF/DD	08	IV-E OCS/OYD	Yes
065	Private ICF/DD	22	OCS/OYD (XIX)	Yes
083	Acute Care Hospitals (LOS > 30 days)	11	Hurricane Evacuees	Yes
088	Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	11	Hurricane Evacuees	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
090	LTC (Long-Term Care)	11	Hurricane Evacuees	Yes
094	QDWI	04	Disabled	Yes
095	QMB (Qualified Medicare Beneficiary)	17	QMB	Yes
099	Public ICF/DD	01	Aged	Yes
099	Public ICF/DD	02	Blind	Yes
099	Public ICF/DD	03	Families and Children	Yes
099	Public ICF/DD	04	Disabled	Yes
099	Public ICF/DD	06	OCS Foster Care	Yes
099	Public ICF/DD	08	IV-E OCS/OYD	Yes
099	Public ICF/DD	22	OCS/OYD (XIX)	Yes
100	PACE SSI	01	Aged	Yes
100	PACE SSI	02	Blind	Yes
100	PACE SSI	04	Disabled	Yes
101	PACE SSI-related	02	Blind	Yes
101	PACE SSI-related	01	Aged	Yes
101	PACE SSI-related	04	Disabled	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
102	GNOCHC Adult Parent	30	Non Traditional	Yes
103	GNOCHC Childless Adult	30	Non Traditional	Yes
104	Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL	11	Hurricane Evacuees	Yes
115	Family Planning, Previous LAMOMS eligibility	40	Family Planning	Yes
115	HPE Family Planning	16	Presumptive Eligible	Yes
116	Family Planning, New eligibility / Non LA MOM	40	Family Planning	Yes
116	HPE Family Planning	16	Presumptive Eligible	Yes
132	Spend-Down Denial of Payment/Late Packet	01	Aged	Yes
132	Spend-Down Denial of Payment/Late Packet	02	Blind	Yes
132	Spend-Down Denial of Payment/Late Packet	04	Disabled	Yes
136	Private ICF/DD Spend-Down Medically Needy Program	01	Aged	Yes
136	Private ICF/DD Spend-Down Medically Needy Program	02	Blind	Yes
136	Private ICF/DD Spend-Down Medically Needy Program	04	Disabled	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
137	Public ICF/DD Spend-Down MNP	01	Aged	Yes
137	Public ICF/DD Spend-Down Medically Needy Program	02	Blind	Yes
137	Public ICF/DD Spend-Down Medically Needy Program	04	Disabled	Yes
138	Private ICF/DD Spend-Down MNP/Income Over Facility Fee	02	Blind	Yes
138	Private ICF/DD Spend-Down MNP/Income Over Facility Fee	04	Disabled	Yes
139	Public ICF/DD Spend-Down MNP/Income Over Facility Fee	02	Blind	Yes
139	Public ICF/DD Spend-Down MNP/Income Over Facility Fee	04	Disabled	Yes
140	SSI Private ICF/DD Transfer of Resources	02	Blind	Yes
140	SSI Private ICF/DD Transfer of Resources	04	Disabled	Yes
141	Private ICF/DD Transfer of Resources	02	Blind	Yes
141	Private ICF/DD Transfer of Resources	04	Disabled	Yes
142	SSI Public ICF/DD Transfer of Resources	02	Blind	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
142	SSI Public ICF/DD Transfer of Resources	04	Disabled	Yes
143	Public ICF/DD Transfer of Resources	02	Blind	Yes
143	Public ICF/DD Transfer of Resources	04	Disabled	Yes
144	Public ICF/DD MNP Transfer of Resources	02	Blind	Yes
144	Public ICF/DD MNP Transfer of Resources	04	Disabled	Yes
145	Private ICF/DD MNP Transfer of Resources	02	Blind	Yes
145	Private ICF/DD MNP Transfer of Resources	04	Disabled	Yes
178	Disabled Adults authorized for special hurricane Katrina assistance	11	Hurricane Evacuees	Yes
201	1915(i) Behavioral Health only - adults	40	Non Traditional	Yes
201	LBHP - Adult 1915(i)	01	LBHP	Yes
201	LBHP - Adult 1915(i)	02	LBHP	Yes
201	LBHP - Adult 1915(i)	03	LBHP	Yes
201	LBHP - Adult 1915(i)	04	LBHP	Yes
205	LBHP - Adult 1915(i)	01	LBHP	Yes
205	LBHP - Adult 1915(i)	02	LBHP	Yes

TYPE CASE	TYPE CASE DESCRIPTION	AID CATEGORY	AID CATEGORY DESCRIPTION	EXCLUDED NON-EXPANSION POPULATIONS?
205	LBHP - Adult 1915(i)	03	LBHP	Yes
205	LBHP - Adult 1915(i)	04	LBHP	Yes
212	Family Planning/Take Charge Transition	03	Family Planning	Yes
212	HPE Family Planning Elig Options	16	Presumptive Eligible	Yes

APPENDIX B

Table 1a

			Base Data Adjustments		
	[A]	[B]	[C]	[D]	[E]
Rate Cell Description	SFY 2016 MMs	SFY 2016 PMPM	Under-reporting	IBNR	Adjusted Base PMPM
LaCHIP Affordable Plan	34,800	$ 15.82	5.01%	0.00%	$ 16.62
Medicaid Child/CHIP	9,530,068	$ 13.28	5.01%	0.00%	$ 13.94
Medicaid Adult	3,914,417	$ 0.91	13.26%	0.00%	$ 1.04
Medicaid Expansion Child					
Medicaid Expansion Adult					
Total	13,479,285	$ 9.69	5.24%	0.00%	$ 10.20

Table 1b

			Base Data Adjustments		
	[A]	[B]	[C]	[D]	[E]
Rate Cell Description	SFY 2017 MMs	SFY 2017 PMPM	Under-reporting	IBNR	Adjusted Base PMPM
LaCHIP Affordable Plan	36,168	$ 17.16	3.21%	0.17%	$ 17.74
Medicaid Child/CHIP	9,377,679	$ 13.75	3.21%	0.11%	$ 14.20
Medicaid Adult	3,673,064	$ 1.04	10.33%	0.67%	$ 1.15
Medicaid Expansion Child	373,019	$ 12.69	3.21%	0.11%	$ 13.11
Medicaid Expansion Adult	4,174,378	$ 0.99	10.33%	0.67%	$ 1.10
Total	17,634,308	$ 8.06	3.61%	0.14%	$ 8.37

Notes:
[E] = [B] x (1 + [C]) x (1 + [D])

Table 2

	Projected Benefit			
	[A]	[B]	[C]	[D]
Rate Cell Description	Combined PMPM	Annual Trend	Trend Months	Trended PMPM
LaCHIP Affordable Plan	$ 17.19	1.13%	30	$ 17.68
Medicaid Child/CHIP	$ 14.07	1.13%	30	$ 14.47
Medicaid Adult	$ 1.09	1.13%	30	$ 1.12
Medicaid Expansion Child	$ 13.11	0.89%	24	$ 13.35
Medicaid Expansion Adult	$ 1.10	0.89%	24	$ 1.11

	Retention Load				
	[E]	[F]	[G]	[H]	[I]
Rate Cell Description	Admin %	Underwriting Gain	Premium Tax	Total	Final Loaded Rate Low
LaCHIP Affordable Plan	9.25%	2.00%	2.25%	13.25%	$ 20.38
Medicaid Child/CHIP	9.25%	2.00%	2.25%	13.25%	$ 16.68
Medicaid Adult	9.25%	2.00%	2.25%	13.25%	$ 1.30
Medicaid Expansion Child	9.25%	2.00%	2.25%	13.25%	$ 15.38
Medicaid Expansion Adult	9.25%	2.00%	2.25%	13.25%	$ 1.28
					$ 9.13

Notes:
[A]= (Table 1a [A] x Table 1a [E] + Table 1b [A] x Table 1b [E]) / (Table 1a [A] + Table 1b [A])
[D] = [A] x (1 + [B])^([C] / 12)
[H] = 1 - (1 - ([E] + [F])) x (1 - [G])
[I] = [D] / (1 - [H])

APPENDIX C

Premium Group	Jul 2017 - Jun 2018 Rates [A]	Jul 2018 - Jun 2019 Rates [B]	% Change [C] = [B]/[A] - 1
LaCHIP Affordable Plan	$ 19.59	$ 20.38	4.0%
Medicaid Child/CHIP	$ 16.10	$ 16.68	3.6%
Medicaid Adult	$ 1.27	$ 1.30	2.4%
Medicaid Expansion Child[1]	$ 16.10	$ 15.38	-4.5%
Medicaid Expansion Adult[2]	$ 1.27	$ 1.28	0.8%

1. Ratecell was combined with Medicaid Child/CHIP for SFY18
2. Ratecell was combined with Medicaid Adult for SFY18

MERCER
MAKE TOMORROW, TODAY

JULY 2018–JUNE 2019 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE

Louisiana — July 1, 2018 – June 30, 2019

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

A. Rate Development Standards

i. Rate certifications must be done on a 12-month rating period.[3] CMS will consider a time period other than 12 months to address unusual circumstance. For example, CMS would approve a time period other than 12 months for the following reasons:

   a. when the state is trying to align program rating periods, which may require rating period longer than one year (but less than two years); or

   b. when the state needs to make an amendment to the contract and the rates for an already approved rating period need to be adjusted accordingly.

ii. In accordance with 42 CFR §438.4, 438.5, 438.6, and 438.7, an acceptable rate certification submission, as supported by the assurances from the state, includes the following items and information:

   a. a letter from the certifying actuary, who meets the requirements for an actuary in 42 CFR §438.2, who certifies that the final capitation rates meet the standards in 42 CFR §438.3(c), 438.3(e), 438.4 (excluding paragraphs (b)(9)), 438.5, 438.6, and 438.7.

   b. the final and certified capitation rates for all rate cells in accordance with 42 CFR §438.4(b)(4), and all regions (as applicable). [4] Additionally, the contract must specify the final capitation rate(s) in accordance with 42 CFR §438.3(c)(1)(i).

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[3] Per 42 CFR §438.2, "rating period" means a period of 12 months selected by the state for which the actuarially sound capitation rates are developed and documented in the rate certification.

[4] Beginning with rate periods on or after July 1, 2018, actuaries must certify specific rates for each rate cell in accordance with 42 CFR §438.4(b)(4) and 438.7(c), and it is no longer permissible to certify rate ranges. However, 42 CFR §438.7(c)(3) allows states to increase or decrease the capitation rate per rate cell up to 1.5 percent without submitting a revised rate certification.

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

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

i. a summary of the specific state Medicaid managed care programs covered by the rate certification, including, but not limited to:

A. the types and numbers of managed care plans included in the rate development (e.g., type should include the program type, such as managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans).

B. a general description or list of the benefits that are required to be provided by the managed care plan or plans (e.g., types of medical services, behavioral health or mental health services, long-term care services, etc.), particularly noting any benefits that are carved out of the managed care program or that are new to the managed care program in that rating period covered.

C. the areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.

ii. the rating period covered by the rate certification.

iii. the Medicaid population(s) covered through the managed care programs to which the rate certification applies.

iv. any eligibility or enrollment criteria that could have a significant influence on the specific population to be covered within the managed care program (e.g., the definition of medically frail, or if enrollment in managed care plans is voluntary or mandatory).

v. a summary of the special contract provisions related to payment that, per 42 CFR §438.6, are included within rate development (e.g. risk-sharing mechanisms, incentive arrangements, withhold arrangements, state-directed delivery system reform and provider payment initiatives,[5] pass-through payments, and payments to MCOs and PIHPs for enrollees that are a patient in an Institution of Mental Disease (IMD)).

vi. if the state determines that a retroactive adjustment to the capitation rates is necessary, these retroactive adjustments must be certified by an actuary in a revised rate certification and submitted as a contract amendment in accordance with 42 CFR §438.7(c)(2). The rate certification must:

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[5] State direction of managed care plan expenditures under the contract (e.g., value-based purchasing arrangements, multi-player initiatives, quality/performance incentive programs, and all fee schedules) must meet the requirements in 42 CFR 438.6(c) and receive prior approval before implementation. In order to ensure that States can have these directed payment arrangements reviewed and approved prior to developing rates, CMS has a separate process for submitting payment arrangements under 42 CFR 438.6(c).

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

A. describe the rationale for the adjustment; and

B. the data, assumptions and methodologies used to develop the magnitude of the adjustment.

iii. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

iv. Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments from any other rate cell.

v. The effective dates of changes to the Medicaid managed care program (including eligibility, benefits, payment rate requirements, incentive programs, and program initiatives) should be consistent with the assumptions used to develop the capitation rates.

vi. As part of CMS's determination of whether or not the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider whether the submission demonstrates the following:

a. all adjustments to the capitation rates, or to any portion of the capitation rates, must reflect reasonable, appropriate, and attainable costs in the actuary's judgment and must be included in the rate certification.

b. adjustments to the rates that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4. Therefore, the rates will not be considered actuarially sound if adjustments are made outside of the rate setting process described in the rate certification.

c. consistent with 42 CFR §438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell.

vii. Rates must be certified for all time periods in which they are effective, and a certification must be provided for rates for all time periods. Rates from a previous rating period cannot be used for a future time period without an actuarial certification of the rates for the new rating period.

viii. Procedures for rate certifications for rate and contract amendments, include:

a. CMS requires that the state submit a new rate certification when the rates change, except for changes permitted in 42 CFR §438.7(c)(3).

b. for contract amendments that do not affect the rates (except for changes permitted in 42 CFR §438.7(c)(3)), CMS does not require a new rate certification from the state. However, if the contract amendment revises the covered populations, services furnished under the contract

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

or other changes that could reasonably change the rate development and rates, the state and its actuary must provide supporting documentation indicating the rationale as to why the rates continue to be actuarially sound in accordance with 42 CFR §438.4.

c. there are several circumstances when CMS would not require a new rate certification:

   i. the state may increase or decrease capitation rate per rate cell up to 1.5 percent range, in accordance with 42 CFR §438.7(c)(3).

   ii. a state applies risk scores to the capitation rates paid to the plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR §438.7(b)(5)(iii).

d. any time a rate changes for any reason other than application of an approved payment term (e.g., risk adjustment methodology), which was included in the initial managed care contract, the state must submit a contract amendment to CMS, even if the rate change does not need a new rate certification.

SECTION I. MEDICAID MANAGED CARE RATES	
1. General Information	
B. Appropriate Documentation	**Documentation Reference**
i. States and their actuaries must document all the elements described within their rate certifications to provide adequate detail that CMS is able to determine whether or not the regulatory standards are met. In evaluating the rate certification, CMS will look to the reasonableness of the information contained in the rate certification for the purposes of rate development and may require additional information or documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented: a. data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources. b. assumptions made, including any basis or justification for the assumption. c. methods for analyzing data and developing assumptions and adjustments.	● Mercer Rate Certification
ii. The rate certification must include an index that documents the page number or the section number for the items described within this guidance. In cases where not all sections of this guidance are relevant for a particular rate certification (i.e., an amended certification that adds a new benefit for part of the year), inapplicable sections of the guidance should be included and marked as "Not Applicable" in the index.	
iii. There are services, populations, or programs for which the state receives a different federal medical assistance percentage (FMAP)	● Mercer Rate Certification ○ Dental Capitation Rates, page 2

SECTION I. MEDICAID MANAGED CARE RATES	
1. General Information	
than the regular state FMAP. In those cases, the portions or amounts of the costs subject to the different FMAP should be shown as part of the rate certification to the extent possible.	
iv. CMS requests that states that operated the managed care program or programs covered by the rate certification in previous rating periods provide: a. A comparison to the final certified rates or rate ranges in the previous rate certification. For the first rate certification for a rating period, this should be a comparison to the prior rating period's rates or rate ranges. For rate certifications that revise or amend rates in a rating period, this should be a comparison to the latest certified rates for the rating period. b. A description of any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.	● Mercer Rate Certification, Appendix C

SECTION I. MEDICAID MANAGED CARE RATES
2. Data
A. Rate Development Standards
i. In accordance with 42 CFR §438.5(c), states and actuaries must follow rate development standards related to base data, including: a. states must provide all the validated encounter data and/or fee-for-service (FFS) data (as appropriate) and audited financial reports (as defined in see §438.3(m)) that demonstrates experience for the populations to be served by the health plan to the state's actuary developing the capitation rates for at least the three most recent and complete years prior to the rating period.

SECTION I. MEDICAID MANAGED CARE RATES	
2. Data	
b. states and their actuaries must use the most appropriate base data, from the three most recent and complete years prior to the rating period, for developing capitation rates. c. base data must be derived from the Medicaid population, or, if data on the Medicaid population is not available, derived from a similar population and adjusted to make the utilization and price data comparable to data from the Medicaid population. d. states that are unable to develop rates using data that is no older than from the three most recent and complete years prior to the rating period may request approval for an exception as follows: i. this request should be submitted by the state as soon as the actuary starts developing the rate certification and makes a determination that encounter data will not comply with 42 CFR §438.5(c)(1)-(2). ii. the request must describe why an exception is necessary and describe the actions the state intends to take to come into compliance with those requirements. iii. the request must also describe the state's proposed corrective action plan outlining how the state will come into compliance with the base data standards per 42 CFR §438.5(c) no later than two years from the rating period for which the deficiency is identified.	
B. Appropriate Documentation	**Documentation Reference**
i. In accordance with 42 CFR §438.7(b)(1), the rate certification must include: a. a description of base data requested by the actuary for the rate setting process, including: i. a summary of the base data that was requested by the actuary. ii. a summary of the base data that was provided by the state. iii. an explanation of why any base data requested was not provided by the state.	● Mercer Rate Certification ○ Introduction, page 1
ii. The rate certification, as supported by the assurances from the	

SECTION I. MEDICAID MANAGED CARE RATES	
2. Data	
state, must thoroughly describe the data used to develop the capitation rates, including: a. a description of the data, including:	
i. the types of data used, which may include, but is not limited to: fee-for-service claims data; managed care encounter data; health plan financial data; information from program integrity audits; or other Medicaid program data.	● Mercer Rate Certification ○ Introduction, page 1 ○ Base Period Data and Enrollment, pages 2-3
ii. the age or time periods of all data used.	● Mercer Rate Certification ○ Base Period Data and Enrollment, pages 2-3
iii. the sources of all data used (e.g., State Medicaid Agency; other state agencies; health plans; or other third parties).	● Mercer Rate Certification ○ Introduction, page 1 ○ Base Period Data and Enrollment, pages 2-3
iv. if a significant portion of the benefits under the contract with the managed care entity are provided through arrangements with subcontractors that are also paid on a capitated basis (or subcapitated arrangements), a description of the data received from the subcapitated plans or providers; or, if data is not received from the subcapitated plans or providers, a description of how the historical costs related to subcapitated arrangements were developed or verified.	N/A
b. information related to the availability and the quality of the data used for rate development, including:	

SECTION I. MEDICAID MANAGED CARE RATES	
2. Data	
i. the steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including: A. completeness of the data. B. accuracy of the data. C. consistency of the data across data sources.	● Mercer Rate Certification ○ Base Period Data and Enrollment, pages 2-3 ○ Under-reporting, page 4 ○ Completion factors, page 4
ii. a summary of the actuary's assessment of the data.	● Mercer Rate Certification ○ Base Period Data and Enrollment, pages 2-3 ○ Certification of Final Rates, pages 6-7
iii. any other concerns that the actuary has over the availability or quality of the data.	N/A
c. a description of how the actuary determined what data was appropriate to use for the rating period, including:	
i. if fee-for-service claims or managed care encounter data are not used (or are not available), this description should include an explanation of why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.	N/A
ii. if managed care encounter data was not used in the rate development, this description should include an explanation of why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data.	N/A

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2. Data	
d. if there is any reliance or use of a data book in the rate development, the details of the template and relevant instructions used in the data book.	N/A
iii. The rate certification, as supported by the assurances from the state, must thoroughly describe any significant adjustments, and the basis for the adjustments, that are made to the data, including but not limited to adjustments for:	
a. the credibility of the data.	● Mercer Rate Certification ○ Base Period Data and Enrollment, pages 2-3 ○ Certification of Final Rates, pages 6-7
b. completion factors.	● Mercer Rate Certification ○ Completion factors, page 4
c. errors found in the data.	N/A
d. changes in the program between the time period from which the data is obtained and the rating period (e.g., changes in the population covered; changes in benefits or services; changes to payment models or reimbursement rates to providers; or changes to the structure of the managed care program).	N/A
e. exclusions of certain payments or services from the data.	● Mercer Rate Certification ○ Base Period Data and Enrollment, pages 2-3

SECTION I. MEDICAID MANAGED CARE RATES

3. Projected Benefit Costs and Trends

A. Rate Development Standards

i. Final capitation rates must be based only upon the services allowed in 42 CFR §438.3(c)(1)(ii) and 438.3(e).

ii. Variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

iii. In accordance with 42 CFR §438.5(d), each projected benefit cost trend assumption must be reasonable and developed in accordance with generally accepted actuarial principles and practices. Trend assumptions must be developed primarily from actual experience of the Medicaid population or from a similar population, and including consideration of other factors that may affect projected benefit cost trends through the rating period.

iv. If the projected benefit costs include costs for in-lieu-of services defined at 42 CFR §438.3(e)(2) (i.e., substitutes for State Plan services or settings), the utilization and unit costs of the in-lieu-of services must be taken into account in developing the projected benefit costs of the covered services (as opposed to utilization and unit costs of the State plan services or settings), unless a statute or regulation explicitly requires otherwise. The costs of an IMD as an in-lieu-of-service must not be used in rate development. See Section I, item 3.A.v.

v. States may make a monthly capitation payment to an MCO or PIHP (in a “risk contract” as defined in 42 CFR §438.2) for an enrollee age 21 to 64 receiving inpatient treatment in an Institution for Mental Diseases (IMD) (as defined in 42 CFR §435.1010) for a short-term stay of no more than 15 days during the period of the monthly capitation payment in accordance with 42 CFR §438.6(e). In this case, when developing the projected benefit costs for these services, the actuary must use the unit costs of providers delivering the same services included in the State Plan, as opposed to the unit costs of the IMD services. The actuary may use the utilization of the services provided to an enrollee in an IMD in developing the utilization component of projected benefit costs. The data used for developing the projected benefit costs for these services must not include:

   a. costs associated with an IMD stay of more than 15 days.

   b. any other costs for any services delivered during the time an enrollee is in an IMD for more than 15 days.

vi. In connection with section 12002 of the 21st Century Cures Act (P.L. 114-255), CMS requests the following information be provided in the certification for programs that allow IMDs to be used an in lieu of service provider. For purposes of this section, an enrollee means an individual, ages 21 to 64, who received treatment in an IMD:

SECTION I. MEDICAID MANAGED CARE RATES	
3. Projected Benefit Costs and Trends	
a. the number of unique enrollees ages 21 to 64 who received treatment in an IMD through a managed care plan during any point in the base data period; b. the range of and the average number of months and of length of stay during those months that enrollees received care in an IMD; i. CMS requests that the certification provide: the minimum, maximum, mean and median number of months enrollees who received care in an IMD for each base data year; ii. CMS requests that the certification provide: the minimum, maximum, mean and median length of stay in an IMD (which could include multiple stays per month, or stays that extend across 2 or more months) in each base data year. c. the impact that providing treatment through IMDs has had on the capitation rates. i. CMS requests that the certification provide the amount of the capitation rates for IMD services; additionally, the rate certification may include the estimated net impact of using IMD as an in lieu of service on the capitation rates (which would include the costs of IMD services and any reductions in costs of other services).	
B. Appropriate Documentation	**Documentation Reference**
i. The rate certification must clearly document the final projected benefit costs by relevant level of detail (e.g., rate cell, or aligned with how the state makes payments to the plans).	● Mercer Rate Certification ○ Dental Capitation Rates, page 2
ii. The rate certification and supporting documentation must describe the development of the projected benefit costs included in the capitation rates, including:	
a. a description of the data, assumptions, and methodologies used to develop the projected benefit costs and, in particular, all significant and material items in developing the projected benefit costs.	● Mercer Rate Certification, pages 2-5
b. any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since	● Mercer Rate Certification, pages 2-5

SECTION I. MEDICAID MANAGED CARE RATES	
3. Projected Benefit Costs and Trends	
the last rate certification must be described.	
iii. The rate certification and supporting documentation must include a section on projected benefit cost trends (i.e. an estimate the projected change in benefit costs from the historical base data period(s) to the rating period of the rate certification) in accordance with 42 CFR §438.7(b)(2). a. this section must include:	
i. any data used or assumptions made in developing projected benefit cost trends, including a description of the sources of those data and assumptions. A. the descriptions of data and assumptions should include citations whenever possible. B. the description should state whether the trend is developed primarily with actual experience from the Medicaid population or provide rationale for the experience from a similar population that is utilized, and consideration of other factors expected to impact trend.	● Mercer Rate Certification ○ Trend Adjustments, page 5
ii. the methodologies used to develop projected benefit trends.	● Mercer Rate Certification ○ Trend Adjustments, page 5
iii. any comparisons to historical benefit cost trends, or other program benefit cost trends, that were analyzed as part of the development of the trend for the rating period of the rate certification.	● Mercer Rate Certification ○ Trend Adjustments, page 5

SECTION I. MEDICAID MANAGED CARE RATES	
3. Projected Benefit Costs and Trends	
b. this section must include the projected benefit cost trends separated into components, specifically:	
i. the projected benefit cost trends should be separated into: A. changes in price (i.e., pricing differences due to different provider reimbursement rates or payment models); and B. changes in utilization (i.e., differences in the amount, duration, or mix of benefits or services provided).	N/A
ii. if the actuary did not develop the projected benefit cost trends using price and utilization components, the actuary should describe and justify the method(s)used to develop projected benefit cost trends.	● Mercer Rate Certification ○ Trend Adjustments, page 5
iii. the projected benefit cost trends may include other components as applicable and used by the actuary in developing rates (e.g., changes in location of service delivery; the effect of utilization or care management on projected benefit cost trends; regional differences or variations).	N/A
c. variations in the projected benefit cost trends must be explained. Projected benefit cost trends may vary by: i. Medicaid populations. ii. rate cells. iii. subsets of benefits within a category of services (e.g.,	N/A

SECTION I. MEDICAID MANAGED CARE RATES	
3. Projected Benefit Costs and Trends	
specialty vs. non-specialty drugs).	
d. any other material adjustments to projected benefit cost trends must be described in accordance with 42 CFR §438.7(b)(4), including: i. a description of the data, assumptions, and methodologies used to determine each adjustment. ii. the cost impact of each material adjustment. iii. where in the rate setting process the material adjustment was applied.	N/A
e. any other adjustments to projected benefit costs trends must be listed. CMS also requests the following detail about non-material adjustments: i. the impact of managed care on the utilization and the unit costs of health care services. ii. changes to projected benefit costs trend in the rating period outside of regular changes in utilization or unit cost of services.	N/A
iv. If the projected benefit costs include additional services deemed by the state to be necessary to comply with the parity standards of the Mental Health Parity and Addiction Equity Act as required by 42 CFR §438.3(c)(1)(ii), the following must be described: a. the categories of service that contain these additional services necessary for parity. b. the percentage of cost that these services represent in each	N/A

SECTION I. MEDICAID MANAGED CARE RATES	
3. Projected Benefit Costs and Trends	
category of service. c. how these services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service.	
v. For in-lieu-of services defined at 42 CFR §438.3(e)(2) (i.e., substitutes for State Plan services), the following information must be provided and documented: a. the categories of covered service that contain in-lieu-of-services. b. the percentage of cost that in-lieu-of services represent in each category of service. c. how the in-lieu-of services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service. d. for inpatient psychiatric or substance use disorder services provided in an IMD setting, rate development must comply with the requirements of 42 CFR §438.6(e) and the data and assumptions utilized should be described in the rate certification.	N/A
vi. The rate certification must describe how retrospective eligibility periods are accounted for in rate development, including but not limited to: a. the managed care plan's responsibility to pay for claims	● Mercer Rate Certification ○ Retroactive Eligibility, page 3

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3. Projected Benefit Costs and Trends	
incurred during the retroactive eligibility period. b. how the claims information are included in the base data. c. how the enrollment or exposure information is included in the base data. d. how the capitation rates are adjusted to reflect the retroactive eligibility period, and the assumptions and methodologies used to develop those adjustments.	
vii. The rate certification must clearly document the impact on projected costs for all material changes to covered benefits or services since the last rate certification, including, but not limited to: a. more or fewer state plan benefits covered by Medicaid managed care. b. any recoveries of overpayments made to providers by health plans in accordance with 42 CFR §438.608(d). c. requirements related to payments from health plans to any providers or class of providers. d. requirements or conditions of any applicable waivers. e. requirements or conditions of any litigation to which the state is subjected.	N/A
viii. For each change related to covered benefits or services, the rate certification must include an estimated impact of the change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment.	N/A

SECTION I. MEDICAID MANAGED CARE RATES	
3. Projected Benefit Costs and Trends	
a. any change determined by the actuary to be non-material can be grouped with other non-material changes and described within the rate certification, provided that: i. the rate certification includes a list of all non-material adjustments used in the rate development process. ii. the actuary must give a description of why the changes were not considered material and how they were aggregated into a single adjustment. iii. the rate certification provides a description of where in the rate setting process the adjustments were applied. iv. The rate certification documents the aggregate cost impact of all non-material adjustments.	N/A

SECTION I. MEDICAID MANAGED CARE RATES
4. Special Contract Provisions Related to Payment
A. Incentive Arrangements
i. Rate Development Standards a. the rate certification and supporting documentation must describe any incentives included in the contract between the state and the health plans. An incentive arrangement, as defined in 42 CFR §438.6(a), is any payment mechanism under which a health plan may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract. i. the rate certification must include documentation that the incentive arrangement will not exceed 105% of the approved capitation payments under the contract that are attributable to the enrollees or services covered by the incentive arrangements as required in 42 CFR §438.6(b)(2).

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4. Special Contract Provisions Related to Payment	
ii. Appropriate Documentation	**Documentation Reference**
a. the rate certification must include a description of the incentive arrangement. An adequate description includes at least: i. time period of the arrangement, if different than the rating period. ii. enrollees, services, and providers covered by the incentive program. iii. the purpose of the incentive arrangement (e.g. specified activities, targets, performance measures, or quality-based outcomes, etc.). iv. a description of any effect that each incentive arrangement has on the development of the capitation rates.	N/A
B. Withhold Arrangements	
i. Rate Development Standards	
a. the rate certification and supporting documentation must describe any withhold arrangements in the contract between the state and the health plans. As defined in 42 CFR §438.6(a), a withhold arrangement is any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract. i. the targets for a withhold arrangement are distinct from general operational requirements under the contract. ii. arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement. b. in accordance with 42 CFR §438.6(b)(3), the capitation payment(s) minus any portion of the withhold that is not reasonably achievable must be actuarially sound.	

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4. Special Contract Provisions Related to Payment	
ii. Appropriate Documentation	**Documentation Reference**
a. the rate certification must include a description of the withhold arrangement. An adequate description includes at least the following: i. the time period of the arrangement, if different than the rating period and the purpose of the arrangement (e.g. specified activities, targets, performance measures, or quality-based outcomes, etc.). ii. a description of the total percentage of the certified capitation rates being withheld through withhold arrangements. iii. an estimate of the percentage of the withheld amount in a withhold arrangement that is not reasonably achievable and the basis for that determination, including the data, assumptions, and methodologies used to make this determination. iv. a description of how the total withhold arrangement, achievable or not, is reasonable and takes into consideration the health plan's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the health plan's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves. v. a description of any effect that the withhold arrangements have on the development of the capitation rates.	N/A

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4. Special Contract Provisions Related to Payment

C. Risk-Sharing Mechanisms

i. Rate Development Standards

a. in accordance with 42 CFR §438.6(b), if the state utilizes risk-sharing mechanisms with its health plan(s), such as reinsurance, risk corridors, or stop-loss limits, these arrangements must be described in the contract(s) and must be developed in accordance with §438.4, the rate development standards in §438.5, and generally accepted actuarial principles and practices.

b. the rate certification and supporting documentation must describe any risk mitigation that may affect the rates or the final net payments to the health plan(s) under the applicable contract.

ii. Appropriate Documentation	**Documentation Reference**
a. the rate certification and supporting documentation must include a description of any other risk-sharing arrangements, such as a risk corridor or a large claims pool. An adequate description of these includes at least the following: i. a rationale for the use of the risk sharing arrangement. ii. a detailed description of how the risk-sharing arrangement is implemented. iii. a description of any effect that the risk-sharing arrangements have on the development of the capitation rates. iv. documentation demonstrating that the risk-sharing mechanism has been developed in accordance with generally accepted actuarial principles and practices.	N/A
b. if the contract includes a remittance/payment requirement for being below/above a specified medical loss ratio (MLR), the	N/A

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4. Special Contract Provisions Related to Payment	
rate certification and supporting documentation must include a description of this MLR arrangement. An adequate description includes at least the following: i. the methodology used to calculate the medical loss ratio. ii. the formula for calculating a remittance/payment for having a medical loss ratio below/above the minimum requirements. iii. any other consequences for a remittance/payment for a medical loss ratio below/above the minimum requirements.	
c. if the contract has reinsurance requirements, the rate certification and supporting document must include a description of the reinsurance requirements. An adequate description includes at least the following: i. a detailed description of any reinsurance requirements under the contract associated with the rate certification, including the reinsurance premiums and any relevant historical reinsurance experience. ii. identification of any effect that the reinsurance requirements have on the development of the capitation rates. iii. documentation that the reinsurance mechanism has been developed in accordance with generally accepted actuarial principles and practices. iv. if the actuary develops the reinsurance premiums, a description of how the reinsurance premiums were	N/A

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4. Special Contract Provisions Related to Payment	
developed, including the data, assumptions and methodology used.	
D. Delivery System and Provider Payment Initiatives	
i. Rate Development Standards a. consistent with 42 CFR §438.6(c), states may utilize delivery system and provider payment initiatives, including requiring managed care plans to: i. implement value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services. ii. participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative. iii. adopt a minimum fee schedule for network providers that provide a particular service under the contract. iv. provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. v. adopt a maximum fee schedule for network providers that provide a particular service under the contract, so long as the health plan retains the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.	
ii. Appropriate Documentation	**Documentation Reference**
a. the rate certification and supporting documentation must include a description of any delivery system and provider payment initiatives. An adequate description includes at least the following: i. a brief description of the delivery system and provider payment initiatives included in the rates for this rating period. ii. the amount of these payments within the rate development, both in total and on a per member per month basis (if applicable).	N/A

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

iii. the providers receiving these payments.

iv. a description of any effect the delivery system or provider payment initiative has on the development of capitation rates, including the data, assumptions and methodologies used to make this determination.

v. a description of how the payments are included in the capitation rates consistent with the 438.6(c) preprint submitted to CMS.

E. Pass-Through Payments

i. Rate Development Standards

a. a pass-through payment is any amount required by the state to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between MCOs, PIHPs, or PAHPs and hospitals, physicians, or nursing facilities that is not for one of the following purposes: [6]

i. a specific service or benefit provided to a specific enrollee covered under the contract;

ii. a provider payment methodology permitted under 42 CFR §438.6(c)(1)(i) through (iii) for services and enrollees covered under the contract;

iii. a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract;

iv. graduate Medical Education (GME) payments; or

v. Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) wrap around payments.

b. pass-through payments to hospitals must comply with the requirements of 42 CFR §438.6(d). In accordance with 42 CFR §438.6(d)(3), the aggregate pass-through payments to hospitals may not exceed the lesser of: (1) 90 percent of the base amount; or (2) the total dollar

[6] States may not require health plans to make pass-through payments other than those permitted to network providers that are hospitals, physicians, and nursing facilities in accordance with 42 CFR 438.6(d)(1).

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amount of pass-through payments to hospitals identified in the managed care contract(s) and rate certification(s) used to meet the requirement of 42 CFR §438.6(d)(1)(i).

c. the base amount is determined as the sum of (i) and (ii) below:

   i. for inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period and that were provided to the eligible populations under MCO, PIHP, or PAHP contracts two years prior to the rating period, the state must determine reasonable estimates of the aggregate difference between:

      A. the amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under the MCO, PIHP, or PAHP contracts for the 12-month period immediately two years prior to the rating period that will include pass-through payments; and

      B. the amount the MCOs, PIHPs, or PAHPs paid (not including pass-through payments) for those inpatient and outpatient hospital services utilized by the eligible populations under MCO, PIHP, or PAHP contracts for the 12-month period immediately 2 years prior to the rating period.

   ii. for inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period and that were provided to the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period, the state must determine reasonable estimates of the aggregate difference between:

      A. the amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments; and

      B. the amount the state paid under Medicaid FFS (not including pass-through payments) for those inpatient and outpatient hospital services utilized by the eligible populations for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments.

d. the base amount should be the actual amount calculated in the Section I, Item 4.E.i.c of the guide and should not be trended forward.

e. states may calculate reasonable estimates of the aggregate differences in paragraph (c) in accordance with the upper payment limit requirements in 42 CFR part 447.

f. capitation rates may only include pass-through payments to hospitals, physicians and nursing facilities in accordance with 42 CFR 438.6(d); states may not include pass-through payments to providers other than hospitals, physicians, and nursing facilities in the

SECTION I. MEDICAID MANAGED CARE RATES	
4. Special Contract Provisions Related to Payment	
capitation rates.	
ii. Appropriate Documentation	**Documentation Reference**
a. the rate certification and supporting documentation must include a description of all existing pass-through payments incorporated into the rates for this rating period. An adequate description includes at least the following: i. a description of the pass-through payment. ii. the amount of the pass-through payments, both in total and on a per member per month basis (if applicable). iii. the providers receiving the pass-through payments. iv. the financing mechanism for the pass-through payment. v. the amount of pass-through payments incorporated into capitation rates in the previous rating period. vi. the amount of pass-through payments incorporated into capitation rates for the rating period in effect on July 5, 2016.	N/A
b. the certification must document the following information about the base amount for hospital pass-through payments: i. the data, methodologies, and assumptions used to calculate the base amount. ii. the aggregate amounts calculated for Section I, Item 4.E.i.c.i.A, Section I, Item 4.E.i.c.i.B, Section I, Item 4.E.i.c.ii.A, and Section I, Item 4.E.i.c.ii.B.	N/A

SECTION I. MEDICAID MANAGED CARE RATES

5. Projected Non-Benefit Costs

A. Rate Development Standards

i. In accordance with 42 CFR §438.5(e), the development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO, PIHP or PAHP administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital. In addition, the non-benefit component must include other operational costs associated with the provision of services under the contract, including those to comply with the parity standards of the Mental Health Parity and Addiction Equity Act, as required by 42 CFR §438.3(c)(1)(ii).

ii. Non-benefit costs may be developed as per member per month (PMPM) costs or as a percentage of projected benefit costs or capitation rates, and different approaches can be taken for different categories of costs. For non-benefit costs that may be difficult to allocate to specific enrollees or groups of enrollees, or for taxes and fees that are assessed as a percentage of premiums, it may be reasonable to calculate those non-benefit costs as a percentage of benefit costs or capitation rates.

iii. Variations in the assumptions used to develop the projected non-benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

iv. Section 9010 of the Patient Protection and Affordable Care Act imposes a Health Insurance Providers Fee on each covered entity engaged in the business of providing health insurance for United States health risk. CMS policy regarding how this fee may be considered in Medicaid managed care rate development is outlined in CMS's "Medicaid and CHIP FAQs: Health Insurance Providers Fee for Medicaid Managed Care Plans," dated October 2014.[7] States have the flexibility to account for the Health Insurance Providers Fee on a prospective or retrospective basis into rate development for either the data year or fee year. Any payment for the fee must be incorporated in the health plan capitation rates.

   a. due to the health insurance provider fee moratorium established by the Consolidated Appropriations Act of 2016, CMS does not expect any health insurance provider fees to be paid for calendar year 2017 by managed care plans that are subject to that fee. Therefore, no amounts should be included in Medicaid managed care capitation rates for fees that would have been paid by plans to the IRS for 2017 (which

[7] https://www.medicaid.gov/federal-policy-guidance/downloads/faq-10-06-2014.pdf

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5. Projected Non-Benefit Costs	
would have been assessed off of 2016 net premiums).[8] This fee remains in effect for calendar year 2018 and beyond.	
B. Appropriate Documentation	**Documentation Reference**
i. The rate certification and supporting documentation must describe the development of the projected non-benefit costs included in the capitation rates in enough detail so CMS or an actuary applying generally accepted actuarial principles and practices can identify each type of non-benefit expense that is included in the rate and evaluate the reasonableness of the cost assumptions underlying each expense in accordance with 42 CFR §438.7(b)(3). To meet this standard, the documentation must include: a. a description of the data, assumptions, and methodologies used to develop the projected non-benefit costs, and in particular, all significant and material items in developing the projected non-benefit costs. b. any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last rate certification. c. any other material adjustments must be described in accordance with 42 CFR §438.7(b)(4), including: i. a description of data, assumptions, and methodologies used to determine each adjustment. ii. where in the rating setting process each adjustment was applied.	● Mercer Rate Certification ○ Administrative Load, page 5

[8] More information on this issue can be found at: https://www.irs.gov/Businesses/Corporations/Affordable-CareAct-Provision-9010

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5. Projected Non-Benefit Costs	
iii. the cost impact of each material adjustment.	
ii. States and actuaries should estimate the projected non-benefit costs for each of the following categories of costs: a. administrative costs. b. taxes, licensing and regulatory fees, and other assessments and fees. c. contribution to reserves, risk margin, and cost of capital. d. other material non-benefit costs.	● Mercer Rate Certification ○ Administrative Load, pages 5-6
iii. Regarding the Health Insurance Providers Fee, the rate certification and supporting documentation must: a. specifically address how this fee is incorporated into capitation rates if the managed care plan is required to pay the fee for 2018 or 2019. b. if the fee is incorporated into the rates in the initial rate certification, an explanation of whether the amount included in the rates is based on the data year or fee year during the rating period of the rate certification. c. a description of how the amount of the fee was determined, and whether or not any adjustments would be made to the rates once the actual amount of the fee is known. d. if the fee is not incorporated into the rates in the rate certification because the rates will be adjusted to account for the fee subsequently, an explicit statement that the fee is not	● Mercer Rate Certification ○ Federal Health Insurance Provider Fee, pages 5-6

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5. Projected Non-Benefit Costs

included, and a description of when and how the rates will ultimately be adjusted to account for the fee.

e. if the capitation rates include benefits as described in 26 CFR §57.2(h)(2)(ix)(e.g., long-term care, nursing home care, home health care, or community-based care), CMS recommends that the per member per month cost associated with those benefits be explicitly reported as a separate amount in the rate certification in order to more accurately account for the appropriate revenue on which the plans will be assessed.

f. for managed care plans that were required to pay the fee in 2014, 2015, and 2016, a description as to whether or not the fee has been included in the capitation rates for those years (either prospectively in the rates or through amendments to the initially certified rates).

SECTION I. MEDICAID MANAGED CARE RATES

6. Risk Adjustment and Acuity Adjustments

A. Rate Development Standards

i. Risk adjustment is a methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of MCOs, PIHPs, or PAHPs contracted with the state.

ii. As required by 42 CFR §438.5(g), if risk adjustment is applied prospectively or retrospectively, states and their actuaries must select a risk adjustment methodology that uses generally accepted models and must apply it in a budget neutral manner, consistent with generally accepted actuarial principles and practices, across all MCOs, PIHPs or PAHPs in the program to calculate adjustments to the payments as necessary.

SECTION I. MEDICAID MANAGED CARE RATES

6. Risk Adjustment and Acuity Adjustments

iii. An adjustment applied to the total payments across all managed care plans to account for significant uncertainty about the health status or risk of a population is considered an acuity adjustment, which is a permissible adjustment under 42 CFR §438.5(f). (81 FR 27595)

a. acuity adjustments may be used prospectively or retrospectively.

b. while retrospective acuity adjustments may be permissible, they are intended solely as a mechanism to account for differences between assumed and actual health status when there is significant uncertainty about the health status or risk of a population, such as: (1) new populations coming into the Medicaid program; or (2) a Medicaid population that is moving from FFS to managed care when enrollment is voluntary and there may be concerns about adverse selection. In the latter case, there may be significant uncertainty about the health status of which individuals would remain in FFS versus move to managed care; although this uncertainty is expected to decrease as the program matures.

c. CMS may also consider acuity adjustments as a risk mitigation strategy when there is unusual and significant uncertainty about the health status of the population (e.g., covering a new population in Medicaid).

B. Appropriate Documentation	Documentation Reference
i. In accordance with 42 CFR §438.7(b)(5)(i), the rate certification must describe all prospective risk adjustment methodologies, including: a. the data, and any adjustments to that data, to be used to calculate the adjustment. b. the model, and any adjustments to that model, to be used to calculate the adjustment. c. the method for calculating the relative risk factors and the reasonableness and appropriateness of the method in measuring the risk factors of the respective populations. d. the magnitude of the adjustment on the capitation rate per MCO, PIHP, or PAHP. e. an assessment of the predictive value of the methodology	N/A

SECTION I. MEDICAID MANAGED CARE RATES	
6. Risk Adjustment and Acuity Adjustments	
compared to prior rating periods. f. any concerns the actuary has with the risk adjustment process.	
ii. In accordance with 42 CFR §438.7(b)(5)(ii), the rate certification must describe all retrospective risk adjustment methodologies, including: a. the party calculating the risk adjustment. b. the data, and any adjustments to that data, to be used to calculate the adjustment. c. the model, and any adjustments to that model, to be used to calculate the adjustment. d. the timing and frequency of the application of the risk adjustment. e. any concerns the actuary has with the risk adjustment process.	N/A
iii. The rate certification and supporting documentation must also specifically include: a. any changes that are made to risk adjustment models since the last rating period. b. documentation that the risk adjustment model is budget neutral in accordance with 42 CFR §438.5(g).	N/A
iv. If an acuity adjustment is being used, the rate certification must include a description of the acuity adjustment and its basis that is adequate to evaluate its reasonableness and whether it is	N/A

SECTION I. MEDICAID MANAGED CARE RATES

6. Risk Adjustment and Acuity Adjustments

consistent with generally accepted actuarial principles and practices. Such a description includes at least:

a. the reason that there is significant uncertainty about the health status of the population and the need for an acuity adjustment.

b. the acuity adjustment model(s) being used to calculate acuity adjustment scores.

c. the specific data, including the source(s) of the data, being used by the acuity adjustment model(s).

d. the relationship and potential interactions between the acuity adjustment.

e. how frequently the acuity adjustment scores are calculated.

f. a description of how the acuity adjustment scores are being used to adjust the capitation rates.

g. documentation that the acuity adjustment mechanism has been developed in accordance with generally accepted actuarial principles and practices.

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS

1. Managed Long-Term Services and Supports

A. For managed long-term services and supports (MLTSS) programs, or for programs that include MLTSS as part of the covered benefits, the guidance above in Section I regarding the required standards for rate development and CMS's expectations for appropriate documentation required in the rate certification is also applicable for rates for provision of MLTSS.

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS

1. Managed Long-Term Services and Supports

B. Rate Development Standards

i. States may take different approaches for rate setting for MLTSS. The two most common approaches are to structure the rate cells:
   a. by health care status and the level of need of the beneficiaries ("blended"); or
   b. by the long-term care setting that the beneficiary uses ("non-blended").

C. Appropriate Documentation	Documentation Reference
i. The rate certification and supporting documentation for MLTSS programs, or for programs that include MLTSS as part of the covered benefits must also specifically address the following considerations: a. the structure of the capitation rates and rate cells or rating categories (e.g. blended, non-blended, etc.). b. the structure of the rates and the rate cells, and the data, assumptions, and methodology used to develop the rates in light of the overall rate setting approach. c. any other payment structures, incentives, or disincentives used to pay the MCOs, PIHPs or PAHPs (for example, states may provide additional payments to plans that transition beneficiaries from institutional long-term care settings into other settings, or may pay adjusted rates during time periods of setting transitions). d. the expected effect that managing LTSS has on the utilization and unit costs of services. e. any effect that the management of this care is expected to have within each care setting and any effect in managing the	N/A

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS	
1. Managed Long-Term Services and Supports	
level of care that the beneficiary receives (e.g., in-home care, community long-term care, nursing facility care).	
ii. The projected non-benefit costs, such as administrative costs and care coordination costs, may differ for populations receiving MLTSS from other managed care programs, and the rate certification should describe how the projected non-benefit costs were developed for populations receiving these services.	N/A
iii. The rate certification should provide information on historical experience, analysis, and other sources (e.g., studies or research) used to develop the assumptions used for rate setting.	N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
1. Data	
A. In addition to the expectations for all Medicaid managed care rate certifications, as supported by assurances from the State, described in Section I, the rate certification must describe any data used to develop new adult group rates.	● Mercer Rate Certification ○ Base Period Data and Enrollment, pages 2-3
B. For states that have covered the new adult group in Medicaid managed care plans in previous rating periods (i.e. starting in 2014, 2015, 2016, and/or January through June 2017), CMS expects the rate certification, as supported by assurances from the State, to describe:	● Mercer Rate Certification ○ Base Period Data and Enrollment, pages 2-3

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
1. Data	
i. Any new data that is available for use in this rate setting. ii. How the state and the actuary followed through on any plans to monitor costs and experience for newly eligible adults. iii. How actual experience and costs in previous rating periods have differed from assumptions and expectations in previous rate certifications. iv. How differences between projected and actual experience in previous rating periods have been used to adjust these rates.	

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
2. Projected Benefit Costs	
A. In addition to the guidance for all Medicaid managed care rate certifications described in Section I, states should include in the rate certification submission and supporting documentation a description of the following issues related to the projected benefit costs for the new adult group: i. For states that covered the new adult group in previous rating periods:	
a. any data and experience specific to newly eligible adults covered in previous rating periods that was used to develop projected benefits costs for capitation rates.	● Mercer Rate Certification ○ Base Period Data and Enrollment, pages 2-3

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
2. Projected Benefit Costs	
b. any changes in data sources, assumptions, or methodologies used to develop projected benefits costs for capitation rates since the last certification.	● Mercer Rate Certification ○ Base Period Data and Enrollment, pages 2-3
c. how assumptions changed from rate certification(s) for previous rating periods on the following issues: i. acuity or health status adjustments (in most cases comparing the new adult group enrollees to other Medicaid adult enrollees). ii. adjustments for pent-up demand. iii. adjustments for adverse selection. iv. adjustments for the demographics of newly eligible adults. v. differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for newly eligible adult rates and other Medicaid population rates. A. variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations. vi. other material adjustments to newly eligible adults projected benefit costs.	● Mercer Rate Certification ○ Data Smoothing, page 4
B. For any state that is covering the new adult group, regardless if they have been covered in previous rating periods, the following key	● Mercer Rate Certification

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
2. Projected Benefit Costs	
assumptions related to the new adult group must be included in the rate certification and supporting documentation: i. Acuity or health status adjustments (in most cases comparing new adult group enrollees to other Medicaid adult enrollees). ii. Adjustments for pent-up demand. iii. Adjustments for adverse selection. iv. Adjustments for the demographics of the new adult group. v. Differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for the new adult group rates and other Medicaid population rates. vi. Other material adjustments to the new adult group projected benefit costs.	○ Data Smoothing, page 4
C. The rate certification and supporting documentation must describe any changes to the benefit plan offered to the new adult group.	N/A
D. The rate certification and supporting documentation must describe any other material changes or adjustments to projected benefit costs.	N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
3. Projected Non-Benefit Costs	
A. In addition to the guidance all Medicaid managed care rate	N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
3. Projected Non-Benefit Costs	
certifications described in Section I, states must include in the rate certification submission and supporting documentation a description of the following issues related to the projected non-benefit costs for the new adult group: i. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, any changes in data sources, assumptions, or methodologies used to develop projected non-benefit costs since the last rate certification. ii. How assumptions changed from the rate certification(s) for previous rating periods on the following issues: a. administrative costs. b. care coordination and care management. c. provision for operating or profit margin. d. taxes, fees, and assessments. e. other material non-benefit costs.	
B. The rate certification and supporting documentation must include information on key assumptions related to the new adult group and any differences between the assumptions for this population and the assumptions used to develop projected non-benefit costs for other Medicaid populations for the following issues: i. Administrative costs. ii. Care coordination and care management. iii. Provision for operating or profit margin. iv. Taxes, fees, and assessments.	N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
3. Projected Non-Benefit Costs	
v. Other material non-benefit costs.	

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
4. Final Certified Rates	
A. In addition to the expectations for all Medicaid managed care rate certifications described in Section I, CMS requests under 42 CFR §438.7(d) [9] that states that covered the new adult group in Medicaid managed care plans in previous rating periods provide: i. A comparison to the final certified rates or rate ranges in the previous rate certification. ii. A description of any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.	● Mercer Rate Certification, Appendix C

[9] The regulation provides: (d) *Provision of additional information.* The State must, upon CMS' request, provide additional information, whether part of the rate certification or additional supplemental materials, if CMS determines that information is pertinent to the approval of the certification under this part. The State must identify whether or not the information provided in addition to the rate certification is proffered by the State, the actuary, or another party.

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
5. Risk Mitigation Strategies	
A. CMS requests under 42 CFR §438.7(d) that states describe the risk mitigation strategy specific to the new adult group rates.	N/A
B. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, CMS requests the following information: i. Any changes in the risk mitigation strategy from those used during previous rating periods. ii. The rationale for making the change in the risk mitigation strategy or removing the risk mitigation strategy used during previous rating periods. iii. Any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during previous rating periods.	N/A