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 (1)
Vendor: MCNA Insurance Company
Description: Contractor provides managed dental care services to Medicaid enrollees
Approved By: Pamela Rice
Approval Date: 11/10/2015

Your amendment that was submitted to OSP has been approved.

Rev 2010/08

LAGOV PO# 2000123594

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

Amendment #: 1

CFMS #: 728797

DOA #: 305-500664

DHH #: 060160

MVA

(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

AMENDMENT PROVISIONS

Change Contract From: Maximum Amount: 484,300,137

See Attachments A and B.

Change To: Maximum Amount: 484,300,137

See Attachments A and B.

Justification:

The changes contained in Attachments A and B are necessary for the continued successful operation of the Medicaid dental program.

This Amendment Becomes Effective: 07-01-2014

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 8/24/15

PRINT NAME: Carlos A. Lacasa

CONTRACTOR TITLE: Senior Vice President and General Counsel

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Secretary, Department of Health and Hospital or Designee

SIGNATURE DATE 8/27/15

NAME: J. Ruth Kennedy

TITLE: Medicaid Director

OFFICE: Bureau of Health Services Financing

PROGRAM SIGNATURE DATE

NAME

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Attachment E	Rate Certification	Dental Rate Certification dated April 16, 2014	Replace with Revised Dental Rate Certification dated December 3, 2014.	A rate revision was necessary to reflect changes in the covered populations.
Attachment F	Louisiana Dental Plan Administrative Performance Measurement Set	Replace with attached version	Replace with attached version	A replacement was needed to correct the administrative performance measures.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Insert new section	III.B.3.B.12 – Health Insurance Provider Fee (HIPF) Reimbursement See Attachment B	This revision was necessary to comply with federal law.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.B.3.B.11.d Service Authorization i. Service authorization includes, but is not limited to, prior authorization. ii. The DBPM UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR 438.210 and state laws and regulations for initial and continuing	III.B.3.B.11.d Service Authorization i. Service authorization includes, but is not limited to, prior authorization. ii. The DBPM UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR 438.210 and state laws and regulations and the court-ordered requirements of Chisholm v. Kliebert and	A clarification was needed to ensure compliance with court-ordered requirements.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		authorization of services that include, but are not limited to, the following: • Written policies and procedures for processing requests for initial and continuing authorizations of services, where a provider does not request a service in a timely manner or refuses a service;	Wells v. Kliebert for initial and continuing authorization of services that include, but are not limited to, the following: • Written policies and procedures for processing requests for initial and continuing authorizations of services, where ~~a provider does not~~ a member requests a service authorization because ~~in a timely manner or~~ provider refuses a service or does not request a service in a timely manner;	
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.B.3.B.11.e.ii Expedited Service Authorization • In the event a provider indicates, or the DBPM determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the DBPM shall make an expedited authorization decision and provide notice as	III.B.3.B.11.e.ii Expedited Service Authorization • In the event a provider indicates, or the DBPM determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the DBPM shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than	Moved bullet to the correct section

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.	seventy-two (72) hours after receipt of the request for service. • <u>The DBPM may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the DBPM justifies to DHH a need for additional information and how the extension is in the member's best interest.</u>	
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.B.3.B.11.e.iii Post Authorization • The DBPM may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the DBPM justifies to DHH a need for additional information and how the extension is in the member's best interest. • The DBPM shall make retrospective review determinations within thirty (30) calendar days of obtaining the results of any appropriate dental or medical information that may be required, but in no instance later than one	III.B.3.B.11.e.iii Post Authorization • ~~The DBPM may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the DBPM justifies to DHH a need for additional information and how the extension is in the member's best interest.~~ • The DBPM shall make retrospective review determinations within thirty (30) calendar days of obtaining the results of any appropriate dental or medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.	Moved bullet to the correct section

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		hundred, eighty (180) days from the date of service. • The DBPM shall not subsequently retracts its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.	• The DBPM shall not subsequently retracts its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.B.3.B.11.e.iv Timing of Notice . . . Adverse Action ○ The DBPM shall notify the member, in writing using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.10(c) and (d), 42 CFR §438.404(c), and 42 CFR §438.210(b)(c)(d) and in this RFP for member written materials. ○ The DBPM shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an	III.B.3.B.11.e.iv Timing of Notice . . . Adverse Action ○ The DBPM shall notify the member, in writing using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.10(c) and (d), 42 CFR §438.404(c), and 42 CFR §438.210(b)(c)(d) and in this RFP for member written materials. ○ The DBPM shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested. <u>The MCO shall notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as</u>	A revision was made to ensure consistency in the language of notices.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		amount, duration, or scope that is less than requested.	the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.B.3.B.11.j.viii. Member Call Center Performance Standards • Answer ninety-five (95) percent of calls within thirty (30) seconds by a live person or direct the call to an automatic call pickup system with IVR options	III.B.3.B.11.j.viii. Member Call Center Performance Standards • Answer ninety ~~-five~~ (90) percent of calls within thirty (30) seconds by a live person or direct the call to an automatic call pickup system with IVR options;	A revision was made to correct the performance standard in order to ensure consistency with other managed care programs.
Exhibit 3	RFP305PUR-DHHRFP-	III.B.3.B.11.j.xix.	III.B.3.B.11.j.xix. • Special Requirements for Appeals	A revision was made in order to ensure consistency in the

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
	DENTAL-PAHP-MVA	• 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), unless the member or the provider requests expedited resolution. The member 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).	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,	appeals process with other managed care programs.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		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.	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.	
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Addition of new section	III.B.5.A.7. Court-Ordered Reporting The MCO shall comply with all court-ordered reporting requirements currently including but not limited to the Wells v. Kliebert and Chisholm v. Kliebert cases in the manner determined by DHH.	This requirement was added to ensure compliance with court-ordered requirements.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.B.5.C. Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR 455.100-455.104). Form CMS 1513,	III.B.5.C. Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR 455.100-455.104~~4~~6). The Medicaid Ownership and Disclosure Form	The form referenced in the original RFP is obsolete.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		Ownership and Control Interest Statement, is to be submitted to DHH with the proposal; then resubmitted prior to implementation for each Contract period or when any change in the DBPM's management, ownership or control occurs. The DBPM shall report any changes in ownership and disclosure information to DHH within thirty (30) calendar days prior to the effective date of the change.	~~Form CMS 1513, Ownership and Control Interest Statement,~~ is to be submitted to DHH with the proposal; then resubmitted prior to implementation for each Contract period or when any change in the DBPM's management, ownership or control occurs. The DBPM shall report any changes in ownership and disclosure information to DHH within thirty (30) calendar days prior to the effective date of the change.	
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Report Submissions Table	Deleted New Member Contact Report	The report referenced in the original RFP is obsolete.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Report Submissions Table	~~Form CMS 1513, Ownership and Control Interest Statement~~ Medicaid Ownership Disclosure Information Form	The form referenced in the original RFP is obsolete.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	E.19.E.3.e.xi For encounter data submissions, the DBPM shall submit ninety-five (9five%) of its encounter data at least monthly due no later than	III.E.19.E.3.e.xi For encounter data submissions, the DBPM shall submit ninety-five (~~9five~~ 95 %) of its encounter data at least monthly due no later than the twenty-fifth	Correction of typographical error.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		the twenty-fifth (25th) calendar day of the month following the month in which they were processed and approved/paid, including encounters reflecting a zero dollar amount ($0.00) and encounters in which the DBPM has a capitation arrangement with a provider. The DBPM CEO or CFO shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.	(25th) calendar day of the month following the month in which they were processed and approved/paid, including encounters reflecting a zero dollar amount ($0.00) and encounters in which the DBPM has a capitation arrangement with a provider. The DBPM CEO or CFO shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.	
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Addition of new section	III.E.19.E.3.e.xvii. <u>MCO must make an adjustment to encounter claims when the DBP discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed except as noted otherwise. If DHH or its subcontractors discover errors or a conflict with a previously adjudicated encounter claim, the DBPM shall be required to adjust or void the encounter claim within (14) calendar days of notification by DHH or if circumstances exist that prevent contractor from meeting this time frame a specified date shall be approved by DHH.</u>	A revision was made in order to ensure the validity of information received for rate setting and plan evaluation purposes.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Addition of new section	III.E.19.E.3.e.xviii. <u>The DBPM shall provide DHH with weekly data on all prior authorization requests. The data shall be reported electronically to DHH in a mutually agreeable format as specified in the Systems Companion Guide. The DBPM Contractor shall report prior authorization requests on all services which require prior authorization.</u>	This requirement was added ensure compliance with court-ordered reporting requirements.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Monetary Penalties Table Provider Call Center • Answer ninety-five percent of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than five percent	Monetary Penalties Table Provider Call Center • Answer ninety~~-five~~ percent of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than five percent	A revision was made to correct the performance standard in order to ensure consistency with other managed care programs.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Monetary Penalties Table - Access Standards and Guidelines, Timeliness One thousand dollars ($1,000) per occurrence the DBPM is not in compliance with Sections 7.3 through 7.5 of this RFP.	Monetary Penalties Table - Access Standards and Guidelines, Timeliness One thousand dollars ($1,000) per occurrence the DBPM is not in compliance with ~~Sections 7.3 through 7.5~~ <u>Sections III.B.3.B.10.b.– c.</u>	Correction

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.D. 3.A An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The DBPM shall comply with all applicable provisions of 42 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. The DBPM shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal healthcare programs. To help make this determination, the DBPM shall search the following websites: • Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)	III.D. 3.A An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The DBPM shall comply with all applicable provisions of 42 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. The DBPM shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal healthcare programs. To help make this determination, the DBPM shall search the following websites: • Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) http://exclusions.oig.hhs.gov/~~search.aspx~~ . . .	A revision was made to correct the website reference.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		http://exclusions.oig.hhs.gov/search.aspx . . .		
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Appendix L – Dental Benefit Plan Manager PMPM Payment Schedule	Replace with attached version	A replacement was needed to provide a payment schedule for the duration of the contract.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Appendix X – EPSDT Reporting	Replace with attached version	A replacement was needed to incorporate new federal reporting requirements or to ensure compliance with federal reporting requirements.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.B.3.11.1.i. l) Performance Measures i. The DBPM shall report clinical and administrative performance measure (PM) data on at least an annual basis, as specified by DHH.	III.B.3.11.1.i. l) Performance Measures i. The DBPM shall report clinical and administrative performance measure (PM) data on at least an annual basis, as specified by DHH.	A revision was needed as Appendix N was replaced by Attachment F in the original contract.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		• The DBPM shall report on PMs listed in Appendix N which include, but are not limited to, Agency for Healthcare Research and Quality Review (AHRQ), Dental Quality Alliance (DQA), , and/or other measures as determined by DHH. . . .	• The DBPM shall report on PMs listed in ~~Appendix N~~ Attachment F which include, but are not limited to, Agency for Healthcare Research and Quality Review (AHRQ), Dental Quality Alliance (DQA), , and/or other measures as determined by DHH. . . .	
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.B.3.11.l.iii. Performance Measure Goals • The Department shall establish benchmarks for Performance Measures utilizing statewide data of the Medicaid Fee for Service population from 2013 with the expectation that performance improves by a certain percentage toward the benchmarks. • The Performance Measure Goals are contained in Appendix N. • At the department's discretion after the initial contract year, a maximum of 2.5% (0.5% for each of 5 specific performance measures) of the total monthly capitation payment may	III.B.3.11.l.iii. Performance Measure Goals • The Department shall establish benchmarks for Performance Measures utilizing statewide data of the Medicaid Fee for Service population from 2013 with the expectation that performance improves by a certain percentage toward the benchmarks. • The Performance Measure Goals ~~are contained in Appendix N~~ will be provided by DHH. • At the department's discretion after the initial contract year, a maximum of ~~2.5~~ 1% (0.5% for each of the ~~5~~ 2 ~~specific~~ clinical performance measures) of the total monthly capitation payment may be deducted from	A revision was needed to specify performance measures that are subject to the listed penalties and to clarify that DHH will provide the measurement goals.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		be deducted from the total capitation payment to be made in the month of October following the measurement CY if specified performance measures fall below DHH's established benchmarks for improvement.	the total capitation payment to be made in the month of ~~October~~ May following the measurement ~~CY~~ year if ~~specified~~ clinical performance measures fall below DHH's established benchmarks for improvement.	
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.B.3.11.1.iv. Performance Indicator Reporting Systems • The DBPM shall utilize DHH-approved systems, operations, and performance monitoring tools and/or automated methods for monitoring. Access to such systems and tools shall be granted to DHH as needed for oversight. • The monitoring tools and reports shall be flexible and adaptable to changes in the quality measurements required by DHH. • The DBPM shall have processes in place to monitor and self-report performance measures included by not limited to measures listed in Appendix F.	III.B.3.11.1.iv. Performance Indicator Reporting Systems • The DBPM shall utilize DHH-approved systems, operations, and performance monitoring tools and/or automated methods for monitoring. Access to such systems and tools shall be granted to DHH as needed for oversight. • The monitoring tools and reports shall be flexible and adaptable to changes in the quality measurements required by DHH. • The DBPM shall have processes in place to monitor and self-report performance measures included by not limited to measures listed in ~~Appendix F~~ Attachment F. • The DBPM shall provide individual primary care dentist clinical quality profile reports	A revision was needed to replace Appendix F with Attachment F of the contract.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		• The DBPM shall provide individual primary care dentist clinical quality profile reports.		

Attachment E

Jaredd Simons, ASA, MAAA
Senior Associate Actuary

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December 3, 2014

Subject: Revised Louisiana Medicaid Dental Benefit Program Capitation Rate Certification

Dear Ms. Johnson:

In partnership with the State of Louisiana (State), Mercer Government Human Services Consulting (Mercer) has developed statewide actuarially sound capitation rates for the Louisiana Medicaid Dental Benefit Program (DBP). These rates are applicable for the contract period July 1, 2014 through June 30, 2015. The revised certification replaces the certification dated April 16, 2014. This revision occurs to reflect changes made to the covered populations by the State, namely:

- the addition of type cases 127, 210, and 211
- the addition of aid category 16 (Presumptive Eligible)
- the removal of type cases 100 and 101 (Program for All-Inclusive Care for the Elderly {PACE})

Overall, these changes have no impact on the rates certified in the letter dated April 16, 2014.

This document presents an overview of the rate development, as well as a certification of its actuarial soundness, for the purpose of seeking rate approval from the Centers for Medicare & Medicaid Services (CMS) under 42 CFR 438.6(c). This rate development process was based on Medicaid fee-for-service (FFS) dental claims. It resulted in the development of a range of actuarially sound rates for each rate cell. Mercer then worked with DHH to develop a single proposed set of actuarially sound rates for each rate cell, which are included and certified within this letter.

Medicaid benefit plan premium rates are “actuarially sound” if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing, and administrative expenses, any government mandated assessments, fees, and taxes, and the cost

of capital. Note: Please see pages 8 and 9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.

Dental Capitation Rates

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

Table 1: Actuarially Sound Dental Capitation Rates

July 1, 2014 to June 30, 2015	
Rate Cell Description	**Monthly Capitation Rate Per Eligible**
LaCHIP Affordable Plan	$11.85
Medicaid Children	$15.48
Medicaid Adult	$1.26

Managed Care Rate Development Methodology

Overview (AA.1.0, AA.2.4)

Louisiana intends to provide a managed DBP to LaCHIP Affordable Plan, Medicaid Children (including regular LaCHIP children), and Medicaid Adult populations effective July 1, 2014. The State DBP has been in place since the 1990s providing dental services to Medicaid members in a FFS environment. The fee schedule increases in 2007 helped increase access to and participation of dental providers in the network. The coordinated care DBP covers dental preventive services for eligible members younger than age 21 and adult denture benefits for eligible members at age 21 and above and is expected to provide savings and better dental outcomes over the Legacy Medicaid program, improve access to essential specialty dental services, and increase outreach and education to promote healthy dental behavior.

The proposed capitation rates provided above have been developed consistent with guidance provided in the CMS Rate-setting Checklist. 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. Finally, managed care savings and Prepaid Ambulatory Health Plan (PAHP) administrative load assumptions were developed and included. Each of these rating elements is discussed in detail below.

Base Period Data and Enrollment (AA.2.0)

For the period of July 1, 2014 through June 30, 2015 rate setting, Mercer relied on historical Medicaid FFS data from State Fiscal Year (SFY) 2012 and SFY 2013. Louisiana's SFY runs from July 1 of a given year through June 30 of the following year.

Mercer has applied credibility weighting as appropriate to blend data from the two fiscal years focusing on the most recent year of data. The data was blended by placing 80% credibility on SFY 2013 and 20% on SFY 2012 data trended to SFY 2013 for the LaCHIP Affordable Plan population as the LaCHIP Affordable Plan dental benefits started in February 2012; 67% credibility was applied to SFY 2013 and 33% to SFY 2012 data trended to SFY 2013 for the Medicaid Children and Adult populations .The goal of the blending process is to obtain a set of base data that has sufficient credibility and reasonableness to develop actuarially sound capitation rates.

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

Non-Covered Populations (AA.2.1, AA2.2)

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

Retroactive Eligibility (AA.3.4)

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

Completion Factors (AA.3.14)

The FFS data includes claims for dates of service from July 1, 2011 to June 30, 2013, and reflects payments through June 30, 2013. Mercer estimated and adjusted for the remaining liability associated with incurred-but-not-reported claims for SFY 2012 and SFY 2013. The overall adjustments for SFY 2012 and SFY 2013, using paid claims data through June 30, 2013 were -0.14% and 6.75%, respectively.

Fraud and Abuse Adjustment

Adjustment was made for controlling fraud and abuse under managed care. Mercer estimated this adjustment to be -1.67% based on an analysis of historical claims.

Trend Adjustments (AA.3.10)

Trend projections 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 in the FFS data to examine and project utilization trends for the rate period.

The overall annualized per member per month (PMPM) trend assumption is 0.45%.

Data Smoothing (AA.5.0)

Mercer determined that blending the base period provided adequate results and no additional smoothing was required to produce appropriate relationships among ages and services used.

Co-Payments (AA.3.7) and Third Party Liability (AA.3.6)

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

Program Changes (AA.3.1)

Mercer used the fee schedule for DBP services effective July 1, 2013 to calculate prospective fee reduction adjustments applied to SFY 2012 and SFY 2013 as shown in Table 2 below.

Table 2: Fee Reduction Adjustment Assumptions

Rate Cell Description	SFY 2012	SFY 2013
LaCHIP Affordable Plan	-2.0%	0.0%
Medicaid Children	-1.9%	0.0%
Medicaid Adult	-0.2%	0.0%

Overall, the fee schedule changes reduced the SFY 2012 cost by 1.9%. The impact of fee schedule changes to the SFY 2013 cost was minimal.

The State has established benchmarks for performance measures with the expectation that performance improves by a certain percentage toward the benchmarks. The performance measure goals are contained in Appendix N of the DBP's request for proposal. Mercer reviewed the State's numbers in the appendix for reasonableness, but did not audit them. The State's expectation is to increase the percentage of Early and Periodic Screening & Diagnosis Treatment (EPSDT) members (enrolled for at least 90 consecutive days), age 1-20 years, receiving one

annual dental preventive service and the percentage of EPSDT members (enrolled for at least 90 consecutive days), age 6-9 years, receiving one or more sealants on permanent molar teeth, by 5% and 2%, respectively. Mercer has estimated the prospective program change adjustment needed to allow these increases. The overall adjustments applied to SFY 2012 and SFY 2013 base data by rate cell are shown in Table 3.

Table 3: Program Change Adjustment Assumptions

Rate Cell Description	SFY 2012	SFY 2013
LaCHIP Affordable Plan	1.2%	1.4%
Medicaid Children	1.2%	1.4%
Medicaid Adult	0.0%	0.0%

The overall increases to the SFY 2012 and SFY 2013 costs were 1.15% and 1.33%, respectively.

Managed Care Adjustment

Managed care assumptions were based on savings options provided by the State that were analyzed to quantify potential savings in utilization. Table 3 shows a summary of the utilization reduction expected to be achieved by the managed care program.

Table 3: Managed Care Adjustment Assumptions

Rate Cell Description	Utilization	Unit Cost	PMPM
LaCHIP Affordable Plan	-13.9%	0.0%	-13.9%
Medicaid Children	-13.9%	0.0%	-13.9%
Medicaid Adult	-7.2%	0.0%	-7.2%

The overall impact of the managed care assumption was a reduction of 13.9%.

Administrative Load (AA.3.2)

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 load for administration and underwriting profit/risk/contingency is calculated as a percentage of the final capitation rate. The proposed capitation rate, as developed, assumes a 9% load for non-medical expenses, 2% profit/risk/contingency, 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%.

Federal Health Insurance Provider Fee

Section 9010 of the Affordable Care Act imposes a new annual fee on the health insurance premiums, effective January 1, 2014. The tax collected in 2014 will be based on 2013 revenue for applicable health insurers. The actual fee amount will not be determined until August 2014. As the actual amount of the fee is not known at this time, no adjustment was made to the capitation rates. An adjustment and updated certification will be considered when the fee amount and impacted entities are announced in the second half of 2014.

Actuarial Certification

In preparing the capitation rate for the July 1, 2014 through June 30, 2015, Mercer has used and relied upon enrollment, eligibility, FFS 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.

Mercer certifies that the rate was 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 actuary is a member of the American Academy of Actuaries and meets 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. Actual dental claims costs will differ from these projections. Mercer has developed this rate on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and in accordance with applicable law and regulations. Use of the rates for any purpose beyond that stated may not be appropriate.

The health plans are 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 health plans 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, Medicaid eligibility rules, and actuarial rating techniques. It is intended 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. This document should only be reviewed in its entirety.

If you have any questions or comments on the assumptions or methodology, please contact me at +1 404 442 3358.

Sincerely,

Jaredd Simons, ASA, MAAA
Senior Associate Actuary

Attachment A

Type Case	Type Case Description	Aid Category	Aid Category Description	Included in the covered populations?
&0		UN		No
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	11	Hurricane Evacuees	No
002	Deemed Eligible	11	Hurricane Evacuees	No
005	SSI/LTC	11	Hurricane Evacuees	No
007	LACHIP Phase 1	11	Hurricane Evacuees	No
008	PAP - Prohibited AFDC Provisions	11	Hurricane Evacuees	No
009	LIFC - Unemployed Parent / CHAMP	11	Hurricane Evacuees	No
013	CHAMP Pregnant Woman (to 133% of FPIG)	11	Hurricane Evacuees	No
014	CHAMP Child	11	Hurricane Evacuees	No
015	LACHIP Phase 2	11	Hurricane Evacuees	No
020	Regular MNP (Medically Needy Program)	11	Hurricane Evacuees	No
021	Spend-Down MNP	11	Hurricane Evacuees	No
025	LTC Spend-Down MNP	11	Hurricane Evacuees	No
027	EDA Waiver	11	Hurricane Evacuees	No
028	Tuberculosis (TB)	20	TB	No
040	SLMB (Specified Low-Income Medicare Beneficiary)	01	Aged	No
040	SLMB (Specified Low-Income Medicare Beneficiary)	02	Blind	No
040	SLMB (Specified Low-Income Medicare Beneficiary)	04	Disabled	No

Type Case	Type Case Description	Aid Category	Aid Category Description	Included in the covered populations?
047	Illegal/Ineligible Aliens Emergency Services	01	Aged	No
047	Illegal/Ineligible Aliens Emergency Services	03	Families and Children	No
047	Illegal/Ineligible Aliens Emergency Services	04	Disabled	No
047	Illegal/Ineligible Aliens Emergency Services	11	Hurricane Evacuees	No
048	QI-1 (Qualified Individual - 1)	01	Aged	No
048	QI-1 (Qualified Individual - 1)	02	Blind	No
048	QI-1 (Qualified Individual - 1)	04	Disabled	No
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	01	Aged	No
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	04	Disabled	No
050	PICKLE	11	Hurricane Evacuees	No
053	CHAMP Pregnant Woman Expansion (to 185% FPIG)	11	Hurricane Evacuees	No
055	LACHIP Phase 3	11	Hurricane Evacuees	No
059	Disabled Adult Child	11	Hurricane Evacuees	No
062	SSI/Public ICF/DD	01	Aged	No
062	SSI/Public ICF/DD	02	Blind	No
062	SSI/Public ICF/DD	04	Disabled	No
062	SSI/Public ICF/DD	06	OCS Foster Care	No
062	SSI/Public ICF/DD	08	IV-E OCS/OYD	No
062	SSI/Public ICF/DD	22	OCS/OYD (XIX)	No
063	LTC Co-Insurance	01	Aged	No
063	LTC Co-Insurance	02	Blind	No
063	LTC Co-Insurance	04	Disabled	No
063	LTC Co-Insurance	11	Hurricane Evacuees	No
064	SSI/Private ICF/DD	01	Aged	No
064	SSI/Private ICF/DD	02	Blind	No
064	SSI/Private ICF/DD	04	Disabled	No
064	SSI/Private ICF/DD	06	OCS Foster Care	No

Type Case	Type Case Description	Aid Category	Aid Category Description	Included in the covered populations?
064	SSI/Private ICF/DD	08	IV-E OCS/OYD	No
064	SSI/Private ICF/DD	22	OCS/OYD (XIX)	No
065	Private ICF/DD	01	Aged	No
065	Private ICF/DD	02	Blind	No
065	Private ICF/DD	04	Disabled	No
065	Private ICF/DD	06	OCS Foster Care	No
065	Private ICF/DD	08	IV-E OCS/OYD	No
065	Private ICF/DD	22	OCS/OYD (XIX)	No
083	Acute Care Hospitals (LOS > 30 days)	11	Hurricane Evacuees	No
088	Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	11	Hurricane Evacuees	No
090	LTC (Long Term Care)	11	Hurricane Evacuees	No
095	QMB (Qualified Medicare Beneficiary)	17	QMB	No
099	Public ICF/DD	01	Aged	No
099	Public ICF/DD	02	Blind	No
099	Public ICF/DD	04	Disabled	No
099	Public ICF/DD	06	OCS Foster Care	No
099	Public ICF/DD	08	IV-E OCS/OYD	No
100	PACE SSI	01	Aged	No
100	PACE SSI	02	Blind	No
100	PACE SSI	04	Disabled	No
101	PACE SSI-related	01	Aged	No
101	PACE SSI-related	04	Disabled	No
102	GNOCHC Adult Parent	30	Non Traditional	No
103	GNOCHC Childless Adult	30	Non Traditional	No
104	Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL	11	Hurricane Evacuees	No
115	Family Planning, Previous LAMOMS eligibility	40	Family Planning	No
116	Family Planning, New eligibility / Non LaMOM	40	Family Planning	No

Type Case	Type Case Description	Aid Category	Aid Category Description	Included in the covered populations?
132	Spendown Denial of Payment/Late Packet	01	Aged	No
132	Spendown Denial of Payment/Late Packet	04	Disabled	No
136	Private ICF/DD Spendown Medically Needy Program	01	Aged	No
136	Private ICF/DD Spendown Medically Needy Program	04	Disabled	No
137	Public ICF/DD Spendown Medically Needy Program	02	Blind	No
137	Public ICF/DD Spendown Medically Needy Program	04	Disabled	No
138	Private ICF/DD Spendown MNP/Income Over Facility Fee	04	Disabled	No
178	Disabled Adults authorized for special hurricane Katrina assistance	11	Hurricane Evacuees	No
201	1915(i) Behavioral Health only -adults	40	Non Traditional	No
205	LBHP - Adult 1915(i)	01	LBHP	No
205	LBHP - Adult 1915(i)	02	LBHP	No
205	LBHP - Adult 1915(i)	03	LBHP	No
205	LBHP - Adult 1915(i)	04	LBHP	No
212	Family Planning/Take Charge Transition	03	Family Planning	No
212	HPE Family Planning Elig Options	16	Presumptive Eligible	No
UN		UN		No

Louisiana Dental Plan Administrative Performance Measurement Set

Measure	Minimal Performance Standard
Percent of standard service authorizations processed within 2 business days	≥80%
Percent of standard service authorizations processed with 14 calendar days or as extended within allowable timeframes	100%
Percent of expedited service authorizations processed with 72 hours.	100%
% of Call Center calls answered by a live person within 30 seconds of selection	≥90%
Call Center call average hold time for live person	3 minutes
Call Center call abandonment rate	≤5%
% of Member Appeals received by the Health Plan and resolved within 30 days	≥98%
% of Member State Fair Hearings requests received and resolved within 90 days	≥98%
% of clean claims paid for each provider type within 15 business days	≥90%
% of clean claims paid for each provider type within 30 calendar days	≥99%
Rejected Denied claims returned to provider with reason code within 15 days of receipt of claims submission	≥99%

Dental Benefit Plan Clinical Performance Measurement Set

AHRQ Performance Domain	Measure
Use of Service	Percentage of EPSDT enrollees (enrolled for at least 90 consecutive days), ages 1-20, receiving one annual dental preventive service.
Access/Process	Percentage of EPSDT enrollees (enrolled for at least 90 consecutive days), age 6-9 years, receiving one or more sealants on permanent molar teeth.

9. Health Insurance Provider Fee (HIPF) Reimbursement
If the dental benefit plan (DBP) is identified by the Internal Revenue Service (IRS) as a covered entity and thereby subject to an assessed fee ("Annual Fee") whose final calculation includes an applicable portion of the DBP's net premiums written from DHH's Medicaid/CHIP lines of business, DHH shall, upon the DBP satisfying completion of the requirements below, make an annual payment to the DBP in each calendar year payment is due to the IRS (the "Fee Year"). This annual payment will be calculated by DHH (and its contracted actuary) as an adjustment to each DBP's capitation rates for the full amount of the Annual Fee allocable to Louisiana Medicaid/CHIP with respect to premiums paid to the DBP for the preceding calendar year (the "Data Year.") The adjustment will be to the capitation rates in effect during the Data Year.

a) The DBP shall, at a minimum, be responsible for adhering to the following criteria and reporting requirements:
   i. Provide DHH with a copy of the final Form 8963 submitted to the IRS by the deadline listed in the table at the end of this section. The DBP shall provide DHH with any adjusted Form 8963 filings to the IRS within 5 business days of any amended filing.
   ii. Provide DHH Louisiana-specific Medicaid and CHIP-specific premiums included in the premiums reported on Form 8963 (including any adjusted filings) by the deadline listed in the table at the end of this section (for the initial Form 8963 filing) of the Fee Year and within 5 business days of any amended filing.
   iii. If the DBP's Louisiana-specific Medicaid/CHIP premium revenue is not delineated on its Form 8963, provide with its Form 8963 a supplemental delineation of Louisiana-specific Medicaid/CHIP premium revenue that was listed on the DBP's Form 8963 and a methodological description of how its Louisiana-specific Medicaid/CHIP premium revenue (payments to the DBP pursuant to this Contract) was determined. The DBP will indicate for DHH the portion of the Louisiana-specific Medicaid/CHIP premiums that were excluded from the Form 8963 premiums by the DBP as Medicaid long-term care, if applicable, beginning with Data Year 2014.
      - The DBP shall also submit a certification regarding the supplemental delineation consistent with 42 CFR 438.604 and 42 CFR 438.606.
      - If a portion of the Louisiana-specific Medicaid/CHIP premiums were excluded from the Form 8963 premiums

by the DBP as Medicaid long-term care, the DBP shall submit the calculations and methodology for the amount excluded.

iv. Provide DHH with the preliminary calculation of the Annual Fee as determined by the IRS by the deadline listed in the table at the end of this section.

v. Provide DHH with the final calculation of the Annual Fee as determined by the IRS by the deadline listed in the table at the end of this section.

vi. Provide DHH with the applicable federal and state income tax rates by the deadlines listed in the table at the end of this section and include a certification regarding such income tax rates consistent with 42 CFR 438.604 and 42 CFR 438.606

b) For covered entities subject to the HIPF, DHH will perform the following steps to evaluate and calculate the HIPF percentage based on the Contractor's notification of final fee calculation (i.e., HIPF liability) and all premiums for the Contractor subject to Section 9010, as reported on the Contractor's Form 8963, and agreed reasonable by DHH.

i. Review each submitted document and notify the Contractor of any questions.

ii. DHH will check the reasonableness of the DBP's Louisiana-specific Medicaid/CHIP premium revenue included on the DBP's Form 8963/supplemental delineation. This reasonableness check will include, but may not be limited to comparing the DBP's reported Louisiana-specific Medicaid/CHIP premium revenue to DHH's capitation payment records.

iii. DHH and its actuary will calculate revised Data Year capitation rates and rate ranges to account for the Louisiana portion (specific to this contract) of the Contractor's HIPF obligation per the IRS HIPF final fee calculation notice (as noted in 9(a)(v). above). To calculate the capitation payment adjustment, the DHH will:

- Calculate the HIPF obligation as a percentage of the total data year premiums subject to the HIPF (this total will include all of the first $25 million and 50% of the next $25 million of premium deducted by the IRS). This is the "HIPF%", which is unique to each DBP that is subject to the HIPF.
- Calculate Figure A. Figure A is the total premium revenue for coverage in the Data Year from item 9(a)(ii) above. The Figure A amount has no provision for the HIPF obligation.
- Calculate Figure B. Figure B is the portion of Figure A that is for services subject to the HIPF. Capitation revenue for

services that are excludable under Section 9010 of the Patient Protection and Affordable Care Act of 2010, such as long-term care services, will not be included in Figure B. The Figure B amount has no provision for the HIPF obligation.

- Calculate Figure C. Figure C is the calculation of total revenue that incorporates provision for the HIPF and applicable taxes. DHH will use the following formula to calculate Figure C. If the Contractor has not provided satisfactory documentation of federal income tax obligations under section 9(a)(v), then the Average Federal Income Tax Rate (AvgFIT%) in the formula will be zero. If the Contractor has not provided satisfactory documentation of net income tax obligations under section 9(a)(vi). or if state income taxes are not applicable, then the Average State Income Tax Rate (AvgSIT%) in the formula will be zero. The Louisiana Department of Insurance has determined that state premium tax is not applicable to the HIPF payment; as such, no consideration for premium tax will be made. If in the future, however, the applicability of premium tax to the HIPF payments changes, the formula will be modified accordingly.

$$\text{Figure B} = \frac{}{1 - (\text{HIPF\%} / (1 - \text{AvgSIT\%} - \text{AvgFIT\%} \times (1 - \text{AvgSIT\%})))}$$

- Calculate Figure D. DHH will calculate Figure D by subtracting Figure B from Figure C. This is the final HIPF adjustment amount that will serve as the basis for DHH payment to the impacted contractors.
- DHH will compare Figure D with Figure B to calculate the percentage adjustment to the Data Year capitation rates and rate ranges for submission to CMS for approval.

c) DHH (and its contract actuary) will compute the change in capitation revenue that is due to the higher capitation rates by multiplying the adjusted capitation rates by the known member months to determine the total supplemental HIPF payment amount for the DBP.

d) In accordance with the schedule provided in the table at the end of this section, DHH will make a payment to the DBP that is based on the final Annual Fee amount provided by the IRS and calculated by DHH (and its contracted actuary) as an adjustment to the capitation rates in effect during the Data Year. This payment will only be made to the Contactor if DHH determines that the reporting requirements under this section have been satisfied.

e) The DBP shall advise DHH if payment of the final fee payment is less than the amount invoiced by the IRS.
f) The DBP shall reimburse DHH for any amount applicable to Louisiana Medicaid/CHIP premiums that are not paid towards the fee and/or are reimbursed back to the DBP, at any time and for any reason, by the IRS.
g) DHH reserves the right to update the calculation and method of payment for the Annual Fee based upon any new or revised requirements established by CMS in regards to this fee.
h) Payment by DHH is intended to put the DBP in the same position as the DBP would have been in had the DBP's health insurance providers fee tax rate (the final Annual Fee as a portion of the covered entity's premiums filed on Form 8963) and applicable federal and state tax rates been known in advance and used in the determination of the Data Year capitation rates.
i) Table of Deliverables/Deadlines

Plan Deliverables	**Contract Reference(s)**	**2014 Data Year / 2015 Fee Year**	**2015 Data Year / 2016 Fee Year**	**2016 Data Year/2017 Fee Year**	**2017 Data Year/2018 Fee Year**
Form 8963	9(a)(i)	May 1, 2015	May 1, 2016	May 1, 2017	May 1, 2018
Louisiana-specific premium revenue reported on Form 8963	9(a)(ii)	May 1, 2015	May 1, 2016	May 1, 2017	May 1, 2018
Supplemental Delineation of Louisiana-specific premium revenue, if not provided on Form 8963 – *must also include certification and list of exclusion*	9(a)(iii)	May 1, 2015	May 1, 2016	May 1, 2017	May 1, 2018
Applicable Federal and State Income Tax Rate for IRS Preliminary Calculation – *must include certification*	9(a)(vi)	May 1, 2015	May 1, 2016	May 1, 2017	May 1, 2018
Preliminary Calculation of	9(a)(iv)	July 15, 2015	July 15, 2016	July 15,	July 15,

Annual Fee as determined by IRS				2017	2018
Final Calculation of Annual Fee as determined by IRS	9(a)(v)	Within 5 business days of receipt (expected from IRS by August 31st)	Within 5 business days of receipt (expected from IRS by August 31st)	Within 5 business days of receipt (expected from IRS by August 31st)	Within 5 business days of receipt (expected from IRS by August 31st)
Applicable Federal and State Income Tax Rate for IRS Final Calculation – *must include certification*	9(a)(vi)	Within 5 business days of August 31st	Within 5 business days of August 31st	Within 5 business days of August 31st	Within 5 business days of August 31st

DHH Payment Schedule	**Contract Reference(s)**	**2014 Data Year / 2015 Fee Year**	**2015 Data Year / 2016 Fee Year**	**2016 Data Year/2017 Fee Year**	**2017 Data Year/2018 Fee Year**
HIPF Reimbursement from DHH	9(d)	November 15, 2015	November 15, 2016	November 15, 2017	November 15, 2018

j) This section shall survive the termination of the contract.