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 (4)
Vendor: MCNA Insurance Company, d/b/a MCNA Dental Plans
Description: Add funds for Medicaid Expansion and make clarifications.
Approved By: Pamela Rice
Approval Date: 7/21/2016

Your amendment that was submitted to OSP has been approved.

Rev 2016/02

AMENDMENT TO
AGREEMENT BETWEEN STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Amendment #: 4

LAGOV#: 2000123594

DHH #: 060160

MVA

(Regional/ Program/ Facility): Medical Vendor Administration

AND

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

Original Contract Amt: 484,300,137

Original Contract Begin Date: 07-01-2014

Original Contract End Date: 06-30-2017

RFP Number: 305-DHHRFP-DENTAL-F

AMENDMENT PROVISIONS

Change Contract From: From Maximum Amount: 484,300,137 Current Contract Term: 7/01/2014 - 6/30/2017

See Attachment A-4.

See Attachment C.

Change Contract To: To Maximum Amount: 495,042,713 Changed Contract Term:

See Attachment A-4.

See Attachment C.

Justifications for amendment:

The purpose of the amendment is to add funds for Medicaid Expansion as required by Executive Order No. JBE 16-01and to make clarifications regarding operational requirements.

This Amendment Becomes Effective: 07-01-2016

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 6/16/16 DATE

PRINT NAME: Carlos Lacasa

CONTRACTOR TITLE: Senior Vice President and General Counsel

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Secretary, Department of Health and Hospitals or Designee

SIGNATURE 6/17/16 DATE

NAME: Jen Steele

TITLE: Medicaid Director

OFFICE: Medical Vendor Administration

PROGRAM SIGNATURE DATE

NAME

MCNA Contract Amendment #4
Attachment A-4
Effective Date 7/1/2016

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Attachment D	Rate Certification		Replace with updated rate certification letter.	The required annual rate certification has been added.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.B.3.B.10.h.xiv The DBPM shall ensure that provider calls are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 calendar days of receipt (this does not include inquiries from DHH). If not resolved in 30 days the DBPM must document why the issue goes unresolved; however, the issue must be resolved within 90 calendar days.	III.B.3.B.10.h.xiv The DBPM shall ensure that provider ~~calls~~ complaints are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 calendar days of receipt (this does not include inquiries from DHH). If not resolved in 30 days the DBPM must document why the issue goes unresolved; however, the issue must be resolved within 90 calendar days.	A revision was made to correct a typographical error
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.B.3.B.11.g.v Claims Processing Requirements . . . • The DBPM shall process all appealed claims to a paid or denied status within (30) business days of receipt of the appealed claim. • The DBPM shall finalize all claims, including appealed claims, within twenty-four (24) months of the date of service. . . .	III.B.3.B.11.g.v Claims Processing Requirements . . . ~~• The DBPM shall process all appealed claims to a paid or denied status within (30) business days of receipt of the appealed claim.~~ ~~• The DBPM shall finalize all claims, including appealed claims, within twenty-four (24) months of the date of service.~~ . . .	The content of this section is now addressed in Section III.E.19.E.2.d.-e.
Exhibit 3	RFP305PUR-DHHRFP-	III.B.3.B.11.h.iii	III.B.3.B.11.h.iii	A revision was made to correct a typographical error

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
	DENTAL-PAHP-MVA	. . . • The DBPM provider website shall include general and up-to-date information about the DBPM as it relates to the Louisiana Medicaid FFS, Bayou DBPMs. This shall include, but is not limited to: ○ DBPM provider manual; ○ DBPM-relevant DHH bulletins; ○ Information on upcoming provider trainings; ○ A copy of the provider training manual; ○ Information on the provider grievance system; ○ Information on obtaining prior authorization and referrals; and ○ Information on how to contact the DBPM Provider Relations.	. . . • The DBPM provider website shall include general and up-to-date information about the DBPM as it relates to the Louisiana ~~Medicaid FFS, Bayou DBPMs~~ program. This shall include, but is not limited to: ○ DBPM provider manual; ○ DBPM-relevant DHH bulletins; ○ Information on upcoming provider trainings; ○ A copy of the provider training manual; ○ Information on the provider complaint and dispute ~~grievance~~ system; ○ Information on obtaining prior authorization and referrals; and ○ Information on how to contact the DBPM Provider Relations.	
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.B.3.B.11.h.vi Provider Complaint System • The DBPM shall establish a Provider Complaint System for in-network and out-of-network providers to dispute the DBPM's policies, procedures, or any	III.B.3.B.11.h.vi Provider Complaint System • The DBPM shall establish a Provider Complaint System for in-network and out-of-network providers to dispute the DBPM's policies, procedures, or any aspect of the	A revision was made to provide definitions and further clarify the requirements of the Provider Complaint System.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		aspect of the DBPM's administrative functions. . . . • The DBPM shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. The DBPM shall submit its Provider Complaint System policies and procedures to DHH for review and approval within thirty (30) Calendar Days of the date the Contract with DHH is signed, or not later than prior to the Readiness Review. The policies and procedures shall include, at a minimum: . . .	DBPM's administrative functions. • Applicable Definitions ○ **Provider Complaint** - for the purposes of this subsection, a provider complaint (also referred to as provider grievance) is any verbal or written expression, originating from a provider and delivered to any employee of the DBPM, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by the DBPM, excluding request of reconsideration or appeal for specific individual claims. It does include general complaints about claim payment policies. Note that member grievances and appeals filed by providers on behalf of a member should be documented and processed in accordance with member grievance and appeals policies. ○ **Action** - For purposes of this subsection an action is defined as:	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			▪ The denial or limited authorization of a requested service, including the type or level of service; or ▪ The reduction, suspension, or termination of a previously authorized service; or ▪ The failure to provide services in a timely manner, as defined by this RFP; or ▪ The failure of the DBPM to act within the timeframes provided in this RFP. • The DBPM shall establish a Provider Complaint System with which to track the receipt and resolution of provider complaints from in-network and out-of-network providers. • This system must be capable of identifying and tracking complaints received by phone, in writing, or in person, on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the DBPM. . . .	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			• The DBPM shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. The DBPM shall submit its Provider Complaint System policies and procedures to DHH for review and approval within thirty (30) Calendar Days of the date the Contract with DHH is signed, or not later than prior to the Readiness Review. Provider complaints must be acknowledged within three business days. Provider complaints must resolved as soon as feasible, but within no more than thirty calendar days unless both the provider and DHH have been notified of the outstanding issue, and provided a timeline of resolution and reason for the extension of time. All complaints should be resolved in no more than ninety days. The policies and procedures shall include, at a minimum: . . .	
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA		Add a new subsection – III.B.3.B.11.j.i. All member materials must be in a style and reading level that will accommodate the reading skills of	A revision was made to define the reading level of member materials and to provide the acceptable readability indices that produce grade level.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			enrollees. In general the writing should be at no higher than a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy: • Flesch – Kincaid; • Fry Readability Index; • PROSE The Readability Analyst (software developed by Educational Activities, Inc.); • Gunning FOG Index; • McLaughlin SMOG Index; or • Other computer generated readability indices accepted by DHH	

Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Add new section	III.B.3.B.11.p.ii • The DBMP shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. "Completely process" shall mean that the DBPM shall: o Review, approve, and load approved applicants to its provider files in its claims processing system; and o Submit on the weekly electronic Provider Directory to DHH or DHH's designee; or o Deny the application and assure that the provider is not used by the DBPM. All subsequent provisions will be renumbered.	The addition of this section was made to ensure the timely processing of credentialing applications.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.B.3.B.12 Health Insurance Provider Fee (HIPF) Reimbursement	III.B.3.B.12 Health Insurance Provider Fee (HIPF) Reimbursement See Attachment A-4, Appendix I for revisions.	The revisions were made to clarify that the source of the HIPF calculation methodology and the applicable timelines will be the DBPM Financial Reporting Guide.
Exhibit 3	RFP305PUR-DHHRFP-	III.D.1.A.	III.D.1.A.	A revision was made to clarify the requirement of DBPM subcontractors regarding potential fraud,

	DENTAL-PAHP-MVA	The DBPM shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.812 and La. R.S. 46:437.1-437.14; and LAC 50.I.4101-4235.	The DBPM and its subcontractors shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.812 and La. R.S. 46:437.1-437.14; and LAC 50.I.4101-4235.	abuse, and waste.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.D.1.F. The DBPM shall provide access to DHH and/or its designee to all information related to grievances and appeals filed by its members. DHH shall monitor enrollment and termination practices and ensure proper implementation of the DBPM's grievance procedures, in compliance with 42 CFR §§ 438.226-438.228.	III.D.1.F. The DBPM and its subcontractors shall provide access to DHH and/or its designee to all information related to grievances and appeals filed by its members. DHH shall monitor enrollment and termination practices and ensure proper implementation of the DBPM's grievance procedures, in compliance with 42 CFR §§ 438.226-438.228.	A revision was made to clarify the requirements of DBPM subcontractors related to grievances and appeals.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.D.1.M. This prohibition described above in Section III.D.1.L shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. The DBPM shall confer with DHH before initiating any recoupment or withhold of any program integrity related funds. (See Section III.D.5.D.) to ensure that the recovery recoupment or withhold is permissible. In the event that the DBPM obtains funds in cases where recovery recoupment or	III.D.1.M. This prohibition described above in Section III.D.1.L shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. ~~The DBPM shall confer with DHH before initiating any recoupment or withhold of any program integrity related funds. (See Section III.D.5.D.) to ensure that the recovery recoupment or withhold is permissible.~~ In the event that the DBPM obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, the DBPM will return	A revision was made to allow plans to manage network providers under investigation by the DBPM, including reducing potential financial exposure by pursuing recovery and issuing full or partial withholds, without delay caused by seeking DHH and MFCU approval.

		withhold is prohibited under this Section, the DBPM will return the funds to DHH.	the funds to DHH.	
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.D.1.O.2 The DBPM shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, §455.21).	III.D.1.O.2 The DBPM shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, §455.21) <u>both internally and for its subcontractors</u>.	A revision was made to clarify the requirement of the DBPM and its subcontractors related to suspected fraud cases.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.B.11.m. Annual Member Satisfaction Survey i. The DBPM shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members each contract year. ii. Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey. iii. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the DBPM at the time of the survey. iv. The surveys shall provide valid and reliable data for results statewide and by parish.	III.B.11.m. Annual Member Satisfaction Survey i. The DBPM shall conduct annual <u>DHH-approved member satisfaction surveys comparable to the</u> Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members each contract year. ii. Survey results and a description of the survey process shall be reported to DHH ~~separately for each required CAHPS survey~~. iii. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the DBPM at the time of the survey. iv. The surveys shall provide valid and reliable data for results statewide ~~and by parish~~. v. Analyses shall provide statistical analysis for	A revision was made to remove the requirement of an annual CAHPS Dental Plan surveys and to replace it with a survey comparable to the CAHPS Dental Plan surveys because the current CAHPS Dental Plan surveys are not appropriate for this program.

		v. Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards. vi. The most current CAHPS DBPM Survey (currently 4.0) for Medicaid Enrollees shall be used and include: • Getting Needed Care • Getting Care Quickly • How Well Doctors Communicate • DBPM Customer Service • Global Ratings • Member Satisfaction Survey Reports are due 120 calendar days after the end of the contract year.	targeting improvement efforts and comparison to national and state benchmark standards. vi. ~~The most current CAHPS DBPM Survey (currently 4.0) for Medicaid Enrollees shall be used and include~~: • ~~Getting Needed Care~~ • ~~Getting Care Quickly~~ • ~~How Well Doctors Communicate~~ • ~~Health Plan Customer Service~~ • ~~Global Ratings~~ • Member Satisfaction Survey Reports are due 120 calendar days after the end of the contract year.	
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	III.E.19.A.2 2. To the extent that the DBPM compensates providers on a FFS or other basis requiring the submission of claims as a condition of payment, the DBPM shall process the provider's claims for covered services provided to members, consistent with applicable DBPM policies and procedures and the terms of the Contract and the Systems Companion Guide, including, but	III.E.19.A.2 2. To the extent that the DBPM compensates providers on a FFS or other basis requiring the submission of claims as a condition of payment, the DBPM shall process the provider's claims for covered services provided to members, consistent with applicable DBPM policies and procedures and the terms of the Contract and the Systems Companion Guide, including, but not limited to, timely filing	A revision was made to clarify timely filing requirements.

		not limited to, timely filing, and compliance with all applicable state and federal laws, rules and regulations.	guidelines, and compliance with all applicable state and federal laws, rules and regulations. Timely filing guidelines are: a) Medicaid-only claims must be filed within three hundred sixty five (365) days from the date of service. b) Claims involving third party liability shall be submitted within 365 days from the date of service. Medicare claims shall be submitted within six (6) months of Medicare adjudication. c) The DBPM must deny any claim not initially submitted to the DBPM by the three hundred and sixty-fifth (365) calendar day from the date of service, unless DHH, the DBPM or its subcontractors created the error. The DBPM shall not deny claims solely for failure to meet timely filing guidelines due to error by DHH, the DBPM, or its subcontractors. d) For purposes of DBP reporting on payment to providers, an adjustment to a paid claim shall not be counted as a claim and electronic claims shall be treated as identical to paper based claims. e) The DBPM shall not deny claims submitted in cases of retroactive eligibility for failure to meet timely filing guidelines if the claims are submitted within one hundred and eighty (180) days from the member's enrollment in the DBPM.	

Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Add a new section	III.E.19.E.2.d. - e. . . . d) The DBPM shall adjudicate all disputed claims to a paid or denied status within (30) business days of receipt of the disputed claim. e) The DBPM shall resolve all claims, including disputed claims, no later than twenty-four (24) months of the date of service.	A revision was made to provide processing times for disputed claims.

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~~ the DBP's capitation rates, in accordance with the DBP Financial Reporting Guide, 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~~ to be identified by DHH each year. 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 to be identified by DHH each year ~~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 identified by DHH each year ~~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 identified by DHH each year ~~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~~ identified by DHH each year 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 in accordance with the steps outlined in the DBP Financial Reporting Guide 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.~~

~~Figure B~~

~~1 – (HIPF% / (1 – AvgSIT% – AvgFIT% x (1 – 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 DBP Financial Reporting Guide ~~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. . In the event the calculation methodology or method of timing of payment for the Annual Fee as set forth in the DBP Financial Reporting Guide requires modification, DHH will obtain DBP input regarding the required modification(s) prior to the implementation of the modification.

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 Annual Fee as determined by IRS	9(a)(iv)	July 15, 2015	July 15, 2016	July 15, 2017	July 15, 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.

Statement of Work

Goal/Purpose

Contractor will function as a risk-bearing, Prepaid Ambulatory Health Plan health care delivery system responsible for providing specified core dental benefits and services for eligible Louisiana Medicaid enrollees as defined in the Louisiana Medicaid State Plan, administrative rules and Medicaid Policy and Procedure manuals.

Entire Contract

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

Deliverables

The contractor will provide all deliverables outlined in Exhibits 5-7 related to:

1) Quality Assessment and Performance Improvement Program (QAPI)
    - Form a QAPI Committee
        - The QAPI Committee shall meet on a quarterly basis; and
        - A summary of the meeting minutes shall be submitted to DHH with other quarterly reports.
    - Develop a QAPI Work Plan
    - Submit QAPI reports annually
2) Clinical and Administrative Performance Measures
3) Performance Improvement Projects
4) Systems Components
5) Provider Network
6) Call Center
7) Member Services
8) Financial Reporting
9) Non-Financial Reporting
10) Member Materials and Marketing Activities
11) Enrollment Website
12) Emergency Management Plan
13) Fraud and Abuse Plan

Performance Measures

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

1) Quality Assessment and Performance Improvement Plans
    - Form a QAPI Committee
        - The QAPI Committee shall meet on a quarterly basis; and
        - A summary of the meeting minutes shall be submitted to DHH with other quarterly reports.
    - Develop a QAPI Work Plan and submit it to DHH within 30 calendar days from the date the contract is signed, but no later than prior to the readiness review, and annually thereafter.
    - Submit QAPI reports annually

2) Clinical and Administrative Performance Measure
    - Report to DHH on administrative measures contained in Attachment F on a quarterly basis.
    - Report to DHH on clinical measures contained in Attachment F on an annual basis 12 months after services begin.

3) Performance Improvement Projects (PIPs)
    - Perform a minimum of two DHH-approved PIPs.
    - Report to DHH on PIP outcomes on an annual basis.

4) Systems Performance
    - Exchange all required files with the Medicaid fiscal intermediary
    - Submit encounter data as required
    - Process all claims in a timely manner
        - Submit claims payment accuracy report monthly
        - Submit claims processing interest payments monthly
        - Submit denied claims report weekly
    - Submit refresh plan for review and approval annually

5) Provider Network
   - Maintain adequate provider network
   - Maintain Provider Directory
   - Maintain Provider Manual
   - Conduct Provider Satisfaction Surveys annually

6) Call Center
   - Establish and maintain member call center
   - Establish and maintain provider call center
   - Submit draft training materials for telephone agents
   - Submit telephone and internet activity reports monthly

7) Member Services
   - Maintain grievance and appeals logs and submit to DHH monthly
   - Conduct Member Satisfaction Surveys annually

8) Financial Reporting
   - Submit audited financial statements annually
   - Submit unaudited financial statements monthly
   - Submit TPL collections annually

9) Non-Financial Reporting
   - Submit draft technical reports for DHH review and approval
   - Submit completed checklist of required reports
   - Maintain logs of submission of all contractually required reports

10) Member Education Materials
   - Submit to DHH for approval all member materials
   - Maintain copies of all member materials including obsolete versions
   - Maintain documentation that reading level software was utilized, including indicator used and reading level of the item

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

12) Emergency Management Plan
   - Submit annually

13) Fraud and Abuse Plan
   - Submit for DHH for review and approval
   - Submit fraud and abuse activity report quarterly with an annual summary of activity

Monitoring

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

Mary Johnson
Department of Health and Hospitals
Bureau of Health Services Financing
Bayou Health Program
628 North 4th St.
Baton Rouge, LA 70821
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Monitoring activities include:

1) Thorough review and analysis of required work plans and monthly, quarterly and annual reports, as well as review and monitoring of corrective action plans if required of the contractor by DHH;
2) Minimum of weekly status calls between Contractor and DHH Contract Monitor and/or designated Medicaid staff;
3) Face-to-face meetings between Contractor and DHH Contract Monitor and/or designated Medicaid staff as warranted;
4) Solicitation of feedback on Contractor's performance from the Medicaid fiscal intermediary;
5) Annual evaluation through an independent external quality review contractor;
6) Real-time monitoring of member services hotline calls;

7) Investigation of all complaints regarding the Contractor;
8) Monitoring grievances and appeals to determine appropriate resolution;
9) Periodic navigation of contractor website to determine performance;
10) Spot checking to determine that provider listings on contractor website accurately reflects information provided by the providers;
11) Unannounced and scheduled visits to contractor's Louisiana administrative office; and
12) "Secret shopper" calls to Member Services and Provider Services call centers.

Payment: Fixed Rate
See attachment C for details.

Contract Maximum Amounts and Terms of Payment

Maximum Contract Amounts:

The maximum contract amounts outlined below are based on projected enrollment into the DBP times projected Per Member Per Month capitation rate for each contract year. DBPM payments shall be made for actual enrollment in accordance with the monthly capitated rates specified in contract Attachment E – Mercer Certification, Rate Development Methodology and Rates.

Contract year 1 July 1, 2014 to June 30, 2015			
Rate Cell Description	**Projected Member Months**	**Projected Per Member Per Month Capitation Rate**	**Maximum Contract Amount**
LaCHIP Affordable Plan	38,192	$11.85	$452,575
Medicaid Children	7,903,166	$15.48	$122,341,011
CHIP	1,418,385	$15.48	$21,956,596
Medicaid Adult	3,614,180	$1.26	$4,553,866
		Year 1 Total	$149,304,048

Contract year 2 July 1, 2015 to June 30, 2016			
Rate Cell Description	**Projected Member Months**	**Projected Per Member Per Month Capitation Rate**	**Maximum Contract Amount**
LaCHIP Affordable Plan	40,674	$18.28	$563,320
Medicaid Children	8,416,872	$15.48	$131,170,146
CHIP	1,510,580	$15.48	$24,575,981
Medicaid Adult	3,849,101	$1.96	$4,983,508
HIPF			**$2,327,089**
		Year 2 Total	~~$161,964,719~~ **$163,620,044**

~~Contract year 3~~ ~~July 1, 2016 to June 30, 2017~~			
~~**Rate Cell Description**~~	~~**Projected Member Months**~~	~~**Projected Per Member Per Month Capitation Rate**~~	~~**Maximum Contract Amount**~~
~~LaCHIP Affordable Plan~~	~~43,318~~	~~$18.28~~	~~$614,616~~
~~Medicaid Children~~	~~8,998,783~~	~~$15.48~~	~~$139,040,351~~
~~CHIP~~	~~1,608,767~~	~~$15.48~~	~~$26,050,542~~
~~Medicaid Adult~~	~~4,099,293~~	~~$1.96~~	~~$5,309,783~~
		~~**Year 3 Total**~~	~~$173,031,360~~

	~~**3 year Maximum Contract Amount**~~	~~$484,300,137~~

Contract year 3 July 1, 2016 to June 30, 2017			
Rate Cell Description	**Projected Member Months**	**Projected Per Member Per Month Capitation Rate**	**Maximum Contract Amount**
LaCHIP Affordable Plan	**37,631**	**$19.86**	**$747,352**
Medicaid Children	**8,552,387**	**$15.92**	**$136,154,001**
CHIP	**1,558,205**	**$15.92**	**$24,806,624**
Medicaid Adult	**4,074,138**	**$1.27**	**$5,174,155**
Medicaid Expansion – Child	**343,922**	**$15.92**	**$5,475,238**
Medicaid Expansion - Adult	**3,949,943**	**$1.27**	**$5,016,428**
HIPF			**$3,904,023**

	Year 3 Total	**$181,277,821**

	3 year Maximum Contract Amount	**$495,042,713**

DHH reserves the right to re-negotiate the PMPM rates:

a. If the rate floor is removed;

b. If a result of federal or state budget reductions or increases;

c. If due to the inclusion or removal of a Medicaid covered dental service(s) not incorporated in the monthly capitation rates; or

d. In order to comply with federal requirements.

Terms of Payment:

1. DHH shall make monthly capitated payments for each member enrolled into the DBPM in accordance with the capitation rates specified in contract Attachment E – Mercer Certification, Rate Development Methodology and Rates. Capitation rates will be developed in accordance with 42 CFR 438.6 and will include claims for retroactive coverage.

2. DBPM agrees to accept payment in full and shall not seek additional payment from a member for any unpaid costs, including costs incurred during the retroactive period of eligibility.

3. DHH reserves the right to defer remittance of the PMPM payment for June until the first Medicaid Management Information System (MMIS) payment cycle in July to comply with state fiscal policies and procedures.

4. The monthly capitated payment shall be based on Medicaid recipients eligible for DBPM participation during the month, as specified in III.B.3.B.11. i) ii. (p. 57, 2nd to last bullet), and paid in accordance with a schedule to be provided by DHH.

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.

Withhold of Capitation Rate

1. A withhold of the aggregate capitation rate payment shall be applied to provide an incentive for DBPM compliance with the requirements of this contract.
2. The withhold amount will be equivalent to two percent (2%) of the monthly capitation rate payment for all DBPM enrollees.
3. If DHH has not identified any DBPM deficiencies, DHH will pay to the DBPM the withhold of the DBPM's payments withheld in the month subsequent to the withhold.
4. If DHH has determined the DBPM is not in compliance with a requirement of this Contract in any given month, DHH may issue a written notice of non-compliance and DHH may retain the amount withheld for the month prior to DHH identifying the compliance deficiencies.
5. Monthly retention of the withhold amount may continue for each subsequent month so long as the identified deficiencies have not been corrected. If the same or similar deficiency(s) continues beyond timeframes specified for correction as determined by DHH and documented in a written notice of action to the DBPM. DHH may permanently retain the amount withheld for the period of non-compliance

consistent with the administrative actions, monetary penalties, sanctions and liquidated damages provisions of this Contract. The timeframe specified in the written notice of action shall be considered the cure period not less than 30 days unless the deficiency reasonably requires resolution in a shorter time frame after which amounts retained may be permanently withheld.

6. Amounts withheld for failure to achieve established performance measurement goals, as defined in Section III.B.3.B.11.l.iii., may be permanently retained at DHH's discretion.
7. No interest shall be due to the DBPM on any sums withheld or retained under this Section.
8. The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this Contract.

Attachment D

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MERCER
MAKE TOMORROW, TODAY

Ms. Amanda Joyner
Medicaid Deputy Director
Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
628 North 4th Street
P.O. Box 90230
Baton Rouge, LA 70821-0629

May 19, 2016

Subject: Louisiana Medicaid Dental Benefit Program Capitation Rate Certification

Dear Ms. Joyner:

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, 2016 through June 30, 2017.

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 managed care encounter data from State Fiscal Year (SFY) 2015. It resulted in the development of a range of actuarially sound rates for each rate cell. Mercer then worked with the Department of Health and Hospitals (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 page 2 of Actuarial Standard of Practice Number 49, Medicaid Managed Care Capitation Rate Development and Certification, issued March 2015 by the Actuarial Standards Board, 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, 2016 to June 30, 2017	
Rate Cell Description	**Monthly Capitation Rate Per Eligible**
LaCHIP Affordable Plan	$19.86
Medicaid Children	$15.92
Medicaid Adult	$1.27

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 regular LaCHIP children), and Medicaid Adult populations. The state DBP has been in place since the 1990s providing dental services to Medicaid members in a fee-for-service (FFS) environment. 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. The managed DBP 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 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. 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, 2016 through June 30, 2017 rate setting, Mercer relied on managed care encounter data from SFY 2015. Louisiana's SFY runs from July 1 of a given year through June 30 of the following year. The SFY 2015 period was selected because this period reflects the most recent and reliable full year of data that aligns with the PAHP contract year.

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.

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

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.

Completion Factors

The encounter data includes claims for dates of service from July 1, 2014 to June 30, 2015, and reflects payments through December 31, 2015. Mercer estimated and adjusted for the remaining liability associated with incurred-but-not-reported claims for SFY 2015. The overall adjustment using paid claims data through December 31, 2015 was 0.12%.

Under-Reporting Adjustment

Under-reporting adjustment was developed by comparing encounter data from the Medicaid Management Information System (MMIS) to financial information provided by Managed Care of North America (MCNA), the DBP managed care organization (MCO). The adjustment resulted in a 7.14% increase of the base per member per month (PMPM).

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 trends for the rate period.

The overall annualized PMPM trend assumption is 0.72%.

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

Medicaid Expansion

The State has decided to expand Medicaid coverage under the Affordable Care Act (ACA). This expansion will make more than 300,000 people over the age of 18 eligible for the program, effective July 1, 2016. Mercer evaluated the impact of the program change and assumed the following based on a review of the current adult covered population's experience:

- *Expected lag between first month of enrollment and first month of service*: Mercer assumed a 1- to 2-month lag, given the time it would take the new enrollees to familiarize themselves with the DBP, in general, and to obtain some services such as extractions and fillings (not covered by the DBP), which are prerequisite for using the covered removable prosthodontics services in certain cases.
- *Expected penetration/pent-up demand factor*: Mercer assumed a 5.00% to 10.00% higher utilization per 1,000 for the expansion population, compared to the current DBP adult population.

The resulting prospective program change adjustments applied to the projected PMPMs are shown in Table 2 below.

Table 2: Medicaid Expansion Impact Assumptions

Rate Cell Description	PMPM Adjustment
LaCHIP Affordable Plan	0.00%
Medicaid Children	0.00%
Medicaid Adult	-5.00%

No adjustment was applied to the child rate cells as the child subgroup of the Medicaid expansion is small compared to the current DBP child population. Moreover, most of the Medicaid expansion child population has likely been eligible for Medicaid or CHIP and is simply aging out into the adult expansion group.

The programmatic change decreased the overall PMPM by 0.32%.

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 9.00% 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 13.00%.

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. These fees are calculated on an annual basis. The Consolidated Appropriations Act of 2016, Title II, Section 201 suspended the fee for calendar year 2016. Barring any new legislation to the contrary, the fee is scheduled to resume in 2017. It will be calculated and become payable during the third quarter of 2018. As these fees are 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 2018.

Actuarial Certification

In preparing the capitation rate for the contract period July 1, 2016 through June 30, 2017 , Mercer used and relied upon enrollment, eligibility, FFS 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.

Mercer certifies 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, DBP 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 Erik Axelsen at +1 404 442 3517 or Jaredd Simons at +1 404 442 3358.

Sincerely,

Erik Axelsen

Erik Axelsen, ASA, MAAA
Senior Associate

Jaredd Simons, ASA, MAAA
Principal

Attachment A

Type Case	Type Case Description	Aid Category	Aid Category Description	Included in the covered populations?
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

Type Case	Type Case Description	Aid Category	Aid Category Description	Included in the covered populations?
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
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
094	QDWI	04	Disabled	No
095	QMB (Qualified Medicare Beneficiary)	17	QMB	No

Type Case	Type Case Description	Aid Category	Aid Category Description	Included in the covered populations?
099	Public ICF/DD	01	Aged	No
099	Public ICF/DD	02	Blind	No
099	Public ICF/DD	03	Families and Children	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
099	Public ICF/DD	22	OCS/OYD (XIX)	No
100	PACE SSI	01	Aged	No
100	PACE SSI	02	Blind	No
100	PACE SSI	04	Disabled	No
101	PACE SSI-related	02	Blind	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
115	HPE Family Planning	16	Presumptive Eligible	No
116	Family Planning, New eligibility / Non LA MOM	40	Family Planning	No

Type Case	Type Case Description	Aid Category	Aid Category Description	Included in the covered populations?
116	HPE Family Planning	16	Presumptive Eligible	No
132	Spenddown Denial of Payment/Late Packet	01	Aged	No
132	Spenddown Denial of Payment/Late Packet	02	Blind	No
132	Spenddown Denial of Payment/Late Packet	04	Disabled	No
136	Private ICF/DD Spenddown Medically Needy Program	01	Aged	No
136	Private ICF/DD Spenddown Medically Needy Program	02	Blind	No
136	Private ICF/DD Spenddown Medically Needy Program	04	Disabled	No
137	Public ICF/DD Spend-Down MNP	01	Aged	No
137	Public ICF/DD Spenddown Medically Needy Program	02	Blind	No
137	Public ICF/DD Spenddown Medically Needy Program	04	Disabled	No
138	Private ICF/DD Spenddown MNP/Income Over Facility Fee	02	Blind	No
138	Private ICF/DD Spenddown MNP/Income Over Facility Fee	04	Disabled	No
139	Public ICF/DD Spenddown MNP/Income Over Facility Fee	02	Blind	No
139	Public ICF/DD Spenddown MNP/Income Over Facility Fee	04	Disabled	No
140	SSI Private ICF/DD Transfer of Resources	02	Blind	No
140	SSI Private ICF/DD Transfer of Resources	04	Disabled	No
141	Private ICF/DD Transfer of Resources	02	Blind	No
141	Private ICF/DD Transfer of Resources	04	Disabled	No
142	SSI Public ICF/DD Transfer of Resources	02	Blind	No
142	SSI Public ICF/DD Transfer of Resources	04	Disabled	No

Type Case	Type Case Description	Aid Category	Aid Category Description	Included in the covered populations?
143	Public ICF/DD Transfer of Resources	02	Blind	No
143	Public ICF/DD Transfer of Resources	04	Disabled	No
144	Public ICF/DD MNP Transfer of Resources	02	Blind	No
144	Public ICF/DD MNP Transfer of Resources	04	Disabled	No
145	Private ICF/DD MNP Transfer of Resources	02	Blind	No
145	Private ICF/DD MNP Transfer of Resources	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
201	LBHP - Adult 1915(i)	01	LBHP	No
201	LBHP - Adult 1915(i)	02	LBHP	No
201	LBHP - Adult 1915(i)	03	LBHP	No
201	LBHP - Adult 1915(i)	04	LBHP	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