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Ms. Mary Johnson
BAYOU HEALTH Program Director
Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821

December 23, 2013

Subject: Louisiana BAYOU HEALTH Program — Overview of methodology for developing the physician fee increase adjustments for the prepaid rates effective January 1 through June 30, 2014

Dear Ms. Johnson:

This letter outlines the methodology that Mercer Government Human Services Consulting (Mercer) used in developing the Affordable Care Act (ACA) Section 1202 physician fee increase adjustments for the State of Louisiana's BAYOU HEALTH Prepaid program rates for the period January 1 through June 30, 2014 (Calendar Year (CY) 14A).

This letter presents an overview of the methodology used in Mercer's managed care rate development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS). This rate development process resulted in the development of a range of actuarially sound rates for each rate cell. We then worked with DHH to develop a single proposed set of statewide actuarially sound rates for each category of aid, which are attached to 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 8-9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.

Rate Methodology

Overview

The capitation rate ranges for the BAYOU HEALTH managed care program were developed in accordance with rate-setting guidelines established by the Centers for Medicare & Medicaid Services (CMS) and reflect a "Model 2" approach as described in the CMS "Technical Guidance and Rate Setting Practices" checklist for Section 1202. The analyses described herein are intended to address changes necessary based on implementation of the primary care physician (PCP) fee increase included in ACA Section 1202, effective January 1, 2013.

Base Data

There have been no changes made to the base data in the development of the rate ranges. For more details related to the development of the base data, please refer to Mercer's December 19, 2013 certification letter and supporting documents.

Administration/Profit Loading

With respect to the per member per month (PMPM) add-ons developed to address the PCP fee increase (described in more detail below), Mercer added an appropriate administration/profit load specific to those PMPM add-ons. Based on an analysis of fixed and variable administrative costs for consideration of these additional services, Mercer utilized half of the administration/profit load applied in the CY 14A rate development. The overall administration/profit load factor used in the development of the PCP PMPM add-ons was 6.58%. For more detail related to the development of the original administration/profit load, please refer to Mercer's December 19, 2013 certification letter and supporting documents.

Other Elements

There have been no changes made to the trends, prior program changes analyses, the rate range modeling approach, or any of the other rate development components. For more details related to these elements of the certification, please refer to Mercer's December 19, 2013 certification letter and supporting documents.

Physician Fee Increase for Primary Care Services Under ACA Section 1202

CMS completed their review and approved the Louisiana Department of Health and Hospitals (DHH) State Plan Amendment (SPA) LA-13-12 on June 6, 2013, which authorized increased payments to physicians in accordance with Section 1202 of the ACA. Additionally, CMS approved Louisiana's managed care methodology for implementation of the PCP fee increase on July 11, 2013. Consistent with the approved SPA and managed care methodology, the following sections describe the approach Mercer used to calculate the applicable adjustment to the CY 14A

capitation rates, including components critical to DHH's ability to claim the portion of the capitation rates eligible for the enhanced 100% federal financial participation (FFP) associated with the PCP increase.

Summary of Methodology

In accordance with the approved managed care methodology, DHH has opted to utilize the prospective capitation risk model with a retrospective reconciliation (Model 2). Under this approach, the higher costs associated with complying with the PCP increase rule are reflected in the capitation rates via a PMPM add-on specific to the PCP increase. Combining the rate ranges prior to the PCP PMPM increase with the PCP PMPM increase produces the revised CY 14A certified rate ranges. The PCP PMPM add-ons for each category of aid are displayed in Attachment A.

DHH will pay capitation rates to the contracted managed care organizations (MCOs) prospectively that are inclusive of the enhanced PCP fees and expected utilization. DHH will reconcile with the MCOs based on actual utilization, retrospectively. Thus, the capitation rates paid will be inclusive of the enhanced PCP fees and expected utilization, with actual data being used to reconcile the expected utilization with actual utilization. Based on the difference in utilization actually experienced, DHH will reimburse/recoup from the MCOs the unit cost differential between the original CY 14A unit costs and the updated (reflective of Medicare fees) CY 14A aggregate unit costs, multiplied by the differing utilization. All calculations will be performed separately for evaluation and management codes versus vaccine administration codes.

Data Sources

Capitated managed care under the BAYOU HEALTH Prepaid program did not exist until February 2012 and was not fully phased in until July 2012. Therefore, as a primary data source, Mercer utilized historical State Fiscal Year (SFY) 2011 and seven months of 2012 fee for service (FFS) base data (the same data source used in the CY 14A rate development) to determine the portion of the capitation rates attributed to qualifying PCP services. As a supplemental data source, Mercer utilized CY 2012 plan-submitted eligible physician claim data for the PCP increase. The data sources utilized represents the best and most reliable data available to Mercer and DHH.

Please note that the increased payment is not applicable to services provided by a physician delivering services under any other benefit under Section 1905(a) of the Act, such as, but not limited to, the federally qualified health center (FQHC) or rural health clinic (RHC) benefits because, in those instances, payment is made on a facility basis and is not specific to the physician's services. Payments to FQHCs and RHCs were not included in the data used to quantify the PCP increase. In addition, Mercer excluded any claim related to recipients deemed as

non-eligible under BAYOU HEALTH from the FFS data used to quantify the PCP increase. Mercer relied on an attested physician provider list supplied by DHH to further restrict the FFS data to eligible providers who would receive the PCP physician increase.

Calculation of the CY 14A Rate Unit Costs

To calculate the portion of the capitation rate attributed to qualifying PCP services in CY 14A, Mercer analyzed the FFS and plan-submitted data and calculated by individual procedure code, SFY 2011 and 2012 FFS and CY 2012 plan-submitted unit costs associated with the applicable services eligible for the PCP increase. The SFY 2011 and 2012 FFS unit costs include base cost adjustments (incurred but not reported (IBNR) and other) applied to each year separately, utilizing the same factors as the CY 14A rate development. Please refer to the CY 14A rate certification dated December 19, 2013, for further details regarding the base cost adjustments discussed above. Once the adjusted SFY 2011 and 2012 FFS and CY 2012 plan-submitted data unit costs were calculated, Mercer utilized actual professional and immunization services fee schedules provided by DHH to calculate a one-time fee adjustment factor to account for any fee cuts made between the base data time period and the rate effective period. The resulting adjusted SFY 2011 and 2012 FFS unit costs were then blended at a 60/40 rate, respectively, consistent with CY 14A rate development methodology. The adjusted, blended FFS unit cost was then blended with the adjusted CY 2012 plan-submitted unit costs consistent with CY 14A rate development methodology. Please refer to the CY 14A rate certification dated December 19, 2013 for further details regarding the data blending factors discussed above. Aggregate unit costs were then developed by multiplying unit costs at procedure code level by expected CY 14A utilization and dividing by total CY 14A expected utilization, respectively. These calculations were completed by category of aid, and separately for evaluation and management codes versus vaccine administration codes. The resulting unit costs are displayed in Attachment A, identified with the labels {Adjusted Unit Cost (FFS)} and {Adjusted Blended Unit Cost (FFS and Encounter)}.

2013 Medicare Fee Schedule Rates

At the time of this letter, the 2014 Medicare conversion factor and relative value units are not available. Therefore, Mercer developed the ACA PCP fee increase for the CY 14A period using the 2009 conversion factor and 2013 relative value units. When the 2014 conversion factor and relative value units are available, Mercer will revise the ACA PCP fee increase for the CY 14A period accordingly.

The 2013 Medicare fee schedule rates are those used in the FFS program using the methodology approved in the SPA based on the 2009 conversion factor and 2013 relative value units, consistent with the geographic practice cost index (GPCI) schedule published by CMS in January 2013. The 2013 Medicare rates utilized will conform to the approach Louisiana's FFS program

utilizes for each of the specified evaluation and management and vaccine billing codes. The rates are statewide and reflect the mean value among all counties (parishes) for each code and were developed using the following formula (per attachment 4.19-B in the SPA): mean over all parishes/counties per code = (4/64 x GPCIs for Region 01) + (60/64 x GPCIs for Region 99), in which Region 01 and Region 99 represents New Orleans and the rest of Louisiana, respectively.

For vaccine administration codes, Louisiana is utilizing the computed 2013 Medicare rate utilized in the FFS program as approved in the SPA. The 2013 100% of Medicare benchmark unit costs are displayed in Attachment A, identified with the label {Medicare CY 2013 Unit Cost (CMS)}.

Calculation of the CY 14A Rate Unit Costs Attributed to Qualifying PCP Services

To account for utilization for payment levels already above 100% of Medicare, Mercer only considered into its PCP increase calculations, base utilization for codes paid below the 2013 Medicare fee schedule. For the codes paying above 100% of Medicare, the current payment levels were maintained in the calculation.

The unit cost levels inherent in the CY 14A rates were compared to the adjusted 2013 Medicare fee schedule rates. The differential between the adjusted 2013 Medicare fee schedule rates and the CY 14A unit costs by individual procedure code determines the unit cost rate adjustment needed to bring the overall capitation rate to a level that compensates MCOs with an appropriate amount to be able to pay at least the 2013 Medicare fee schedule benchmark (in other words, the amount attributed to the qualifying PCP services in the updated rates). By utilizing the adjusted 2013 Medicare benchmarks for this calculation, Mercer has accounted for payment levels made above 100% of Medicare to ensure those costs do not artificially reduce the amount needed to bring payment levels up to 100% of Medicare. Also, Mercer separated physician and advanced practice registered nurse and physician assistant claim data to account for these providers being reimbursed at 80% of physician fees. The CY 14A unit cost differentials were calculated by category of aid for the evaluation and management codes, separately from vaccine administration codes, and are displayed in Attachment A, identified with the label {Difference in Unit Cost}. This amount will also be used in the calculation of the rate differential eligible for enhanced 100% federal match as described in the Federal Claiming section of this letter.

CY 14A PCP Utilization

As the unit costs and differentials described above were evaluated at procedure code level for evaluation and management codes, separately from vaccine administration codes, expected utilization was also calculated at individual procedure code level (in other words, the unit cost differential for evaluation and management codes and vaccine administration codes will be paid for all applicable code utilization).

To calculate the estimated CY 14A PCP utilization, Mercer analyzed SFY 2011 and 2012 FFS data and CY 2012 plan-submitted data. SFY 2011 and 2012 FFS and CY 2012 plan-submitted utilization associated with the eligible providers for the PCP increase were calculated by individual procedure code. The SFY 2011 and 2012 FFS utilizations include base period adjustments (IBNR and other) applied to each year separately. Both the SFY 2011 and 2012 FFS and CY 2012 utilization were trended forward to the midpoint of the rating effective period from each respective base period. Mercer utilized base adjustments and utilization trends consistent with the physician services trends in the CY 14A rate development. Please refer to the CY 14A rate certification dated December 19, 2013 for further details regarding the base adjustments and utilization trends discussed above. The resulting adjusted SFY 2011 and 2012 FFS utilization were then blended at a 60/40 rate, respectively, in order to be consistent with CY 14A rate development methodology. The adjusted blended FFS utilization was then blended with the adjusted CY 2012 plan-submitted utilization, consistent with CY 14A rate development methodology. Please refer to the CY 14A rate certification dated December 19, 2013 for further details regarding the data blending factors discussed above. Also, Mercer applied a one-time induced utilization factor to capture the expected additional utilization created by higher reimbursement rates. The overall, aggregate induced utilization factor was set at a 1.1% increase.

These calculations were completed by category of aid and separately for evaluation and management codes versus vaccine administration codes. The expected utilization for CY 14A is displayed in Attachment A, identified with the labels {Adjusted Trended Utilization/1000 (FFS)} and {Adjusted Trended Utilization/1000 (FFS and Encounter)}.

CY 14A PCP Procedure Fee Differential PMPM

For purposes of prospective capitation payments under the Model 2 methodology, Mercer calculated the PMPM add-ons associated with the increased costs of implementing the ACA Section 1202 PCP fee increase separately for evaluation and management codes and vaccine administration codes. The vaccine administration fee differential was calculated using an aggregate weighted average of 2013 vaccines for children Medicare rates by age group across the SFY 2011 and 2012 utilization data. The resulting weighted average vaccine administration Medicare rates were utilized as the benchmark for comparison to the unit costs inherent in the CY 14A capitation rates. The CY 14A procedure fee differential PMPMs, excluding administration/profit loading and premium tax, are displayed in Attachment A, identified with the label {Projected ACA PCP PMPM – Total Claims Increase}. The CY 14A procedure fee differential PMPMs, including administration/profit loading and premium tax, are displayed in Attachment A, identified with the label {Projected ACA PCP PMPM – Total Rate Increase}.

Reconciliation Process

In accordance with the approved managed care methodology, DHH will reconcile payments made to the MCOs through the prospective capitation rates with actual utilization reported by the MCOs at the 2013 Medicare computed FFS fee schedule also utilized by the Medicaid FFS program. DHH is requiring each MCO to submit detailed, semi-annual files with claims data on each applicable code for eligible providers, documenting the paid amount made to the providers. Since the various reconciliation components described in this letter were calculated at a category of aid level and not at specific age categories, the reconciliation process will be completed at the same level to ensure consistency. Once DHH receives the semi-annual files documenting the appropriate payments by code to the eligible PCPs, DHH will reconcile with the MCOs and CMS any overpayment or underpayment. The MCOs will be reimbursed (or funds recouped) through the reconciliation process for the amount of unit cost rate differential (the aggregate unit cost differential established in the process of the capitation rate adjustment defined above and not based on the individual current payment amounts) based on actual utilization relative to the utilization level utilized in the capitation rate development. This step will include detailed instructions to the MCOs on how to document to DHH utilization and unit cost rate paid for PCPs. *Note: this reconciliation will be performed separately for evaluation and management codes versus vaccine administration codes.*

Certification of Revised Rate Ranges

In preparing the rate ranges underlying the rates shown in Attachment A, Mercer has used and relied upon enrollment, FFS claims, reimbursement level, benefit design and other information supplied by DHH and its fiscal agent. DHH and its fiscal agent are responsible for the validity and completeness of the data supplied. Also, Mercer has used and relied upon plan-submitted eligible physician claim data and these plans are responsible for the validity and completeness of the data supplied. Mercer has reviewed the data and information for internal consistency and reasonableness, but did not audit them. In our opinion they are appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

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

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

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

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

Rate-Setting Documentation for Federal Claiming

In addition to DHH's approved managed care methodology and the CY 14A capitation rates described in the December 19, 2013 certification letter and supporting documentation, the following section provides the additional rate-setting documentation required in Section 6 of the CMS "Technical Guidance and Rate Setting Practices" checklist for Section 1202. For DHH's use in claiming the portion of the capitation rates eligible for enhanced 100% FFP associated with the PCP increase, Mercer calculated the aggregate 2009 base rate and the differential between the aggregate Medicare rate and the aggregate 2009 base rate to determine the amount eligible for 100% federal match. The following sections describe each component.

Calculation of the 2009 Base Rate Unit Costs

To calculate the 2009 base rate unit costs (for federal claiming purposes), Mercer utilized the July 2009 Medicaid fee schedule, as there was no capitated managed care in Louisiana in 2009. The aggregate 2009 base rate was developed by multiplying July 2009 unit costs at procedure code level by expected CY 14A utilization and dividing by total expected CY 14A utilization. This put the 2009 unit costs on a comparable basis with the CY 14A unit costs. For any procedure code with expected utilization in CY 14A, in which there was no unit cost rate assumed in the 2009 Medicaid fee schedule rate, the unit cost and associated CY 14A utilization included in the calculations

described above were excluded from the aggregate calculation (this exclusion had an immaterial impact on the final aggregate unit costs). This is the same CY 14A utilization that was applied in the calculation of the 2013 Medicare fee schedule rates to establish a comparable aggregate unit cost level. The calculated aggregate 2009 base rate unit costs are displayed in Attachment B, identified with the label {July 2009 "Base Rate" Unit Cost}.

Calculation of the PMPM Differential that Qualifies for 100% FFP

As DHH is using Risk Model 2, the portion of the CY 14A PCP capitation payment that is eligible for 100% FFP is determined by calculating the difference between the base 2009 aggregate weighted average unit cost calculation and the aggregate weighted average unit cost in the 2013 Medicare rate. Also, any additional payments (or recoupment) made through annual utilization reconciliation of the unit cost differential only are eligible for 100% FFP. Using the projected utilization assumed in the CY 14A capitation rates, the differential was put on a total dollar basis by multiplying the unit cost differential by the expected CY 14A utilization. This calculation was performed separately for evaluation and management codes versus vaccine administration codes, and by category of aid. The calculated unit cost differentials, total dollar and PMPM amounts (excluding administration/profit and premium tax) are displayed in Attachment B, identified with the labels {Difference in Unit Cost (Medicare 2013 – July 2009)}, {100% FFP Total Amount}, and {100% FFP Total PMPM (Medicare CY2013 – July 2009)}.

Calculation of the PMPM Differential that Qualifies for Regular State Federal Medical Assistance Percentage

As the capitation rates paid at the time of this submission include unit costs below the 2009 unit cost levels, DHH will claim only the regular State federal medical assistance percentage (FMAP) for capitation payments or additional payments representing unit costs up to the 2009 levels. The portion of the CY 14A PCP capitation payment that is eligible for regular State FMAP is determined by calculating the difference between the CY 14A base aggregate weighted average unit cost calculation and the aggregate weighted average unit costs in the 2009 rate. Using the projected utilization assumed in the CY 14A capitation rates, the differential was put on a total dollar basis by multiplying the unit cost differential by the expected CY 14A utilization. This calculation was performed separately for evaluation and management codes versus vaccine administration codes, and by category of aid. The calculated unit cost differentials, total dollar and PMPM amounts (excluding administration/profit and premium tax) are displayed in Attachment B, identified with the labels {Difference in Unit Cost (July 2009 – Base)}, {Regular State FMAP Total Amount}, and {Regular State FMAP PMPM (July 2009 – Base)}.

All amounts for MCO administration and underwriting gain, including taxes and fees, will be claimed at the State's regular FMAP rate, as they are not eligible for 100% federal match

according to CMS requirements. This calculation was performed separately for evaluation and management codes versus vaccine administration codes, and by category of aid. The calculated PMPM amounts are displayed in Attachment B, identified with the label {Regular State FMAP PMPM (Administration and Profit Load)}. The federal share of any MCO recoupment resulting from the reconciliation with the MCOs will also be returned to CMS in accordance with regular CMS 64 claiming rules at the applicable match rate.

If you have any questions on any of the information provided, please feel free to call me at 404 442 3249.

Sincerely,

Sudha Shenoy

Sudha Shenoy, FSA, MAAA, CERA
Principal

MERCER

Attachment A

BAYOU HEALTH ACA 1202
Jan 2014 – Jun 2014 (CY 14A)

ACA PCP PMPM Rate Increase

	ACA PCP Change to Utilization				ACA PCP Change to Unit Cost			Increase from ACA PCP Changes				Projected ACA PCP PMPM			
Procedure Code Set	Trended & Adjusted Utilization/1000 (FFS)	Adjusted Blended Utilization/1000 (FFS & Encounter)	Induced Utilization*	Adjusted Trended Utilization/1000 (FFS & Encounter)	Adjusted Unit Cost (FFS)	Adjusted Blended Unit Cost (FFS & Encounter)	Medicare CY2013 Unit Cost (CMS)	Difference in Unit Cost	Total ACA PCP Dollars	Attestation Factor	Attestation Adj. ACA PCP Dollars	CY 14A MMs	Total Claims Increase	Total Admin and Profit Load Increase	Total Rate Increase
All Vaccines															
SSI	296	220	1.1%	222	$ 11.63	$ 12.17	$ 17.75	$ 5.58	$ 42,828	100%	$ 42,828	414,270	$ 0.10	$ 0.01	$ 0.11
TANF	1,272	1,051	1.1%	1,063	$ 11.08	$ 11.67	$ 16.42	$ 4.75	$ 918,476	100%	$ 918,476	2,185,206	$ 0.42	$ 0.04	$ 0.46
FCC	1,074	876	1.1%	886	$ 11.38	$ 11.95	$ 17.10	$ 5.15	$ 8,670	100%	$ 8,670	22,812	$ 0.38	$ 0.04	$ 0.42
BCC	22	29	1.1%	30	$ 14.00	$ 14.13	$ 24.87	$ 10.74	$ 126	100%	$ 126	4,764	$ 0.03	$ 0.00	$ 0.03
Total	1,114	917	1.1%	927	$ 11.10	$ 11.69	$ 16.48	$ 4.78	$ 970,100	100%	$ 970,100	2,627,052	$ 0.37	$ 0.04	$ 0.40
Primary Medical															
SSI	3,066	2,709	1.1%	2,738	$ 69.22	$ 67.86	$ 98.68	$ 30.82	$ 2,912,663	100%	$ 2,912,663	414,270	$ 7.03	$ 0.67	$ 7.70
TANF	2,327	2,380	1.1%	2,405	$ 59.75	$ 61.00	$ 87.90	$ 26.90	$ 11,782,662	100%	$ 11,782,662	2,185,206	$ 5.39	$ 0.51	$ 5.90
FCC	2,648	2,638	1.1%	2,666	$ 55.75	$ 58.12	$ 84.07	$ 25.95	$ 131,531	100%	$ 131,531	22,812	$ 5.77	$ 0.55	$ 6.31
BCC	3,390	3,692	1.1%	3,731	$ 55.00	$ 56.52	$ 80.49	$ 23.97	$ 35,510	100%	$ 35,510	4,764	$ 7.45	$ 0.71	$ 8.16
Total	2,449	2,437	1.1%	2,462	$ 61.57	$ 62.16	$ 89.73	$ 27.57	$ 14,862,365	100%	$ 14,862,365	2,627,052	$ 5.66	$ 0.54	$ 6.19
Grand Total															
SSI	3,362	2,928	1.1%	2,960	$ 64.14	$ 63.68	$ 92.60	$ 28.92	$ 2,955,590	100%	$ 2,955,590	414,270	$ 7.13	$ 0.68	$ 7.81
TANF	3,600	3,432	1.1%	3,468	$ 42.55	$ 45.89	$ 66.01	$ 20.12	$ 12,702,655	100%	$ 12,702,655	2,185,206	$ 5.81	$ 0.55	$ 6.36
FCC	3,723	3,514	1.1%	3,552	$ 42.94	$ 46.61	$ 67.38	$ 20.77	$ 140,217	100%	$ 140,217	22,812	$ 6.15	$ 0.58	$ 6.73
BCC	3,413	3,721	1.1%	3,761	$ 54.73	$ 56.19	$ 80.06	$ 23.87	$ 35,636	100%	$ 35,636	4,764	$ 7.48	$ 0.71	$ 8.19
Grand Total	3,563	3,353	1.1%	3,389	$ 45.78	$ 48.37	$ 69.71	$ 21.34	$ 15,834,098	100%	$ 15,834,098	2,627,052	$ 6.03	$ 0.57	$ 6.60

* Induced Utilization is a one time increase to utilization to capture the utilization incentive created by higher reimbursement rates.

Notes:

- Figures include only procedure codes included in the Louisiana SPA.
- Utilization and Unit Cost figures are based off of procedure codes by rate tier where the Medicare CY2013 CMS rates exceeds the FFS rates.

MARSH & McLENNAN COMPANIES

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Attachment B

BAYOU HEALTH ACA 1202
Jan 2014 – Jun 2014 (CY 14A)

ACA PCP PMPM Funding Exhibit

		ACA PCP Change to Unit Cost			Increase from ACA PCP Changes				Projected ACA PCP PMPM				
Procedure Code Set	Adjusted Blended Utilization/1000 (FFS &Encounter)	Adjusted Blended Base Unit Cost (FFS & Encounter)	July 2009 "Base Rate" Unit Cost	Medicare CY2013 Unit Cost (CMS)	Difference in Unit Cost (July 2009 - Base)	Regular State FMAP Total Amount (July 2009 - Base)	Difference in Unit Cost (Medicare CY2013 - July 2009)	100% FFP Total Amount (Medicare CY2013 - July 2009)	CY 14A MMs	Regular State FMAP PMPM (July 2009 - Base)	100% FFP Total PMPM (Medicare CY2013 - July 2009)	Regular State FMAP PMPM (Administration and Profit Load)	Total Rate Increase
All Vaccines													
SSI	222	$ 12.17	$ 12.68	$ 17.75	$ 0.51	$ 3,943	$ 5.07	$ 38,885	414,270	$ 0.01	$ 0.09	$ 0.01	$ 0.11
TANF	1,063	$ 11.67	$ 12.02	$ 16.42	$ 0.34	$ 66,755	$ 4.40	$ 851,721	2,185,206	$ 0.03	$ 0.39	$ 0.04	$ 0.46
FCC	886	$ 11.95	$ 12.28	$ 17.10	$ 0.33	$ 563	$ 4.82	$ 8,106	22,812	$ 0.02	$ 0.36	$ 0.04	$ 0.42
BCC	30	$ 14.13	$ 15.22	$ 24.87	$ 1.09	$ 13	$ 9.65	$ 113	4,764	$ 0.00	$ 0.02	$ 0.00	$ 0.03
Total	927	$ 11.69	$ 12.05	$ 16.48	$ 0.35	$ 71,274	$ 4.43	$ 898,826	2,627,052	$ 0.03	$ 0.34	$ 0.04	$ 0.40
Primary Medical													
SSI	2,738	$ 67.86	$ 78.00	$ 98.68	$ 10.15	$ 958,915	$ 20.67	$ 1,953,748	414,270	$ 2.31	$ 4.72	$ 0.67	$ 7.70
TANF	2,405	$ 61.00	$ 65.49	$ 87.90	$ 4.49	$ 1,964,648	$ 22.42	$ 9,818,014	2,185,206	$ 0.90	$ 4.49	$ 0.51	$ 5.90
FCC	2,666	$ 58.12	$ 62.03	$ 84.07	$ 3.91	$ 19,824	$ 22.04	$ 111,707	22,812	$ 0.87	$ 4.90	$ 0.55	$ 6.31
BCC	3,731	$ 56.52	$ 67.90	$ 80.49	$ 11.38	$ 16,856	$ 12.59	$ 18,654	4,764	$ 3.54	$ 3.92	$ 0.71	$ 8.16
Total	2,462	$ 62.16	$ 67.65	$ 89.73	$ 5.49	$ 2,960,243	$ 22.08	$ 11,902,122	2,627,052	$ 1.13	$ 4.53	$ 0.54	$ 6.19
Grand Total													
SSI	2,960	$ 63.68	$ 73.10	$ 92.60	$ 9.42	$ 962,896	$ 19.50	$ 1,992,695	414,270	$ 2.32	$ 4.81	$ 0.68	$ 7.81
TANF	3,468	$ 45.89	$ 49.11	$ 66.01	$ 3.22	$ 2,031,683	$ 16.90	$ 10,670,972	2,185,206	$ 0.93	$ 4.88	$ 0.55	$ 6.37
FCC	3,552	$ 46.61	$ 49.63	$ 67.38	$ 3.02	$ 20,390	$ 17.75	$ 119,826	22,812	$ 0.89	$ 5.25	$ 0.58	$ 6.73
BCC	3,761	$ 56.19	$ 67.49	$ 80.06	$ 11.30	$ 16,869	$ 12.57	$ 18,767	4,764	$ 3.54	$ 3.94	$ 0.71	$ 8.19
Grand Total	3,389	$ 48.37	$ 52.45	$ 69.71	$ 4.09	$ 3,031,838	$ 17.26	$ 12,802,260	2,627,052	$ 1.15	$ 4.87	$ 0.57	$ 6.60

Notes:
- Figures include only procedure codes included in the Louisiana SPA.
- Utilization and Unit Cost figures are based off of procedure codes by rate tier where the Medicare CY2013 CMS rates exceeds the FFS rates.

MARSH & McLENNAN COMPANIES