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Ms. Pam Diez
Deputy Medicaid Director/Chief Financial Officer
Louisiana Department of Health
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821

January 28, 2019

Subject: Healthy Louisiana Expansion Program – Full Risk-Bearing Managed Care Organization (MCO) Rate Development and Actuarial Certification for the Period Effective January 1, 2019 through March 31, 2019

Dear Ms. Diez:

The Louisiana Department of Health (LDH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound[1] capitation rates for the State of Louisiana's (State) Healthy Louisiana Expansion program for the period of January 1, 2019 through March 31, 2019. This certification amends and extends the previous certification originally issued March 5, 2018 and amended on June 19, 2018, August 24, 2018 and December 18, 2018; it applies to the period of January 1, 2019 through March 31, 2019. The extension includes updates for new programmatic changes implemented by the State effective January 1, 2019 and updates to certain rating assumptions to reflect more recent data. The Healthy Louisiana Expansion rates covering the period of April 1, 2019 through December 31, 2019 will be addressed in a subsequent certification.

This letter presents an overview of the analyses and methodology used to support the revised rating adjustments, and the resulting capitation rates effective January 1, 2019 through March 31, 2019 for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS). This rate development process used Medicaid fee-for-service (FFS) medical and pharmacy claims, Healthy

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

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

Louisiana Shared Savings claims experience, Healthy Louisiana Prepaid encounter data, and Louisiana Behavioral Health Partnership claims experience. It resulted in the development of a range of actuarially sound rates for each rate cell. The final capitation rates and rate ranges are summarized in Appendix A and represent payment in full for the covered services.

BASE DATA DEVELOPMENT

Unless otherwise noted, the base data used for rates developed for the January 1, 2019 through March 31, 2019 period was unchanged from prior certifications.

Pharmacy Rebates

More so than most services covered in the Healthy Louisiana program, the pharmacy benefit is subject to frequent, rapid evolution. Furthermore, LDH expects that Healthy Louisiana MCOs will negotiate and maintain competitive purchasing agreements with pharmaceutical manufacturers, which includes maintaining competitive market share/supplemental rebate agreements. Accordingly, Mercer determined that it was appropriate to review and adjust the pharmacy rebate adjustment made to the base data in prior rate certifications.

In order to determine an appropriate pharmacy rebate adjustment, Mercer analyzed historical Expansion utilization patterns, as reported in the encounter data for the Expansion population, by therapeutic class. The historical experience was projected to the rating period and rebate adjustments were developed in consideration of Healthy Louisiana MCO generic dispensing rates and current rebate levels within each therapeutic class. The resulting revised pharmacy rebate adjustment was a decrease of 4.6%.

PROSPECTIVE RATING ADJUSTMENTS

Unless otherwise noted, the prospective rating adjustments used for rates developed for the January 1, 2019 through March 31, 2019 period were unchanged from prior certifications.

Fee Schedule Changes

Effective January 1, 2019, LDH made changes to its FFS inpatient fee schedule, which can be found on LDH's fee schedules website[2]. Outpatient claims were adjusted to reflect the most recent cost-to-charge ratios (CCRs) available. The CCRs were reported on hospital fiscal year bases, which varied by hospital from June 30, 2015 to December 31, 2017. The adjustment also included estimation of cost settlements and reflected the most up-to-date cost settlement percentages for each facility.

Effective January 1, 2019 House Concurrent Resolution 6 adjusted reimbursement rates for outpatient services for all hospitals except rural hospitals, state-owned hospitals and Our Lady of the Lake. The rates

[2] http://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex2.htm

for the effected facilities increased by 11.56% except for Children's Hospital where reimbursement for outpatient services increased by 5.26%. Additionally, cost settlement percentages for most non-rural, non-state facilities were increased to 83.18% effective January 1, 2019. Rural facilities are cost settled at 110%.

Although MCOs are not required to change their reimbursement to providers based on changes in the Medicaid fee schedules, the fee schedule changes will still affect reimbursement for hospital services as MCOs usually contract with providers at rates that are proportional to the Medicaid fee schedule. In accordance with actuarial standards of practice, the capitation rates have been adjusted to reflect the percentage change in the Medicaid fee schedules. Tables 1 and 2 show the impacts of the fee schedule change. The tables include the impacts on both Limited Medicaid Pricing and Full Medicaid Pricing (FMP) of the hospital services.

Table 1: Inpatient Fee Change Impact				Impact as % of	
Time Period	Historical Cost	Fee Change Impact	FMP Impact	Historical Cost	All Services Cost
CY16	$263,934,947	$1,690,154	$(1,690,154)	0.64%	0.11%

Table 2: Outpatient Fee Change Impact				Impact as % of	
Time Period	Historical Cost	Fee Change Impact	FMP Impact	Historical Cost	All Services Cost
CY16	$228,223,525	$11,077,701	$(11,736,256)	4.85%	0.72%

Physician Full Medicaid Pricing

The list of qualified providers with available average community rates (ACRs) as well as the ACRs for existing providers on the list was updated effective January 1, 2019. Mercer also updated the Medicare physician fee schedule used in the FMP calculation. Mercer evaluated the impact of these updates and adjusted the capitation rates accordingly.

The table below shows the impact on the FMP base gap cost of physician services meeting the State Plan's criteria for FMP.

Table 3: Physician FMP Adjustment	
Time Period	**CY 2016 Adjusted Base Cost Underlying Full Rate**
Effective 7/1/2018 [1]	$341,895,713
Effective 1/1/2019	$349,978,661
Percent Change	2.4%

Note:
1. From table on page 3 of the July 2018–January 2019 certification letter dated December 18, 2018.

Ambulance Services Full Medicaid Pricing

The list of qualified providers with available ACRs as well as the ACRs for existing providers on the list was updated effective January 1, 2019. Mercer also updated the Medicare fee schedule used in the FMP calculation. Mercer evaluated the impact of these updates and adjusted the capitation rates accordingly.

The table below shows the impact on the FMP base gap cost of ambulance services meeting the State Plan's criteria for FMP.

Table 4: Ambulance FMP Adjustment	
Time Period	**CY 2016 Adjusted Base Cost Underlying Full Rate**
Effective 7/1/2018 [1]	$51,526,674
Effective 1/1/2019	$56,006,760
Percent Change	8.7%

Note:
1. From Table 9 of the February 2018–January 2019 certification letter dated March 5, 2018.

Continuous Glucose Monitors

Effective January 1, 2019, Healthy Louisiana MCOs will be responsible for the coverage of Continuous Glucose Monitors (CGM) for all eligible recipients that meet the following criteria:

- Diagnosis of type 1 diabetes with recurrent, unexplained, severe hypoglycemia (glucose levels <50 mg/dl).

- Impaired hypoglycemia awareness that puts the recipient at risk or Pregnant recipient with poorly controlled type 1 diabetes evident by recurrent, unexplained hypoglycemic episodes, hypoglycemic unawareness, postprandial hyperglycemia or recurrent diabetic ketoacidosis.

Mercer developed a projection of the Healthy Louisiana CGM costs using fee schedule information provided by LDH and estimated CGM utilization. As CGMs are a new State Plan service, the projected

utilization was developed based on the SFY17 utilization of recipients with type 1 diabetes and insulin dependence. The overall impact on the Expansion rates due to the addition of the CGM benefit was an increase of $0.47 per member per month (PMPM). Please see Appendix C for additional details.

Federally Qualified Health Center/Rural Health Clinics

Long-acting reversible contraceptive Effective January 1, 2019, LDH will reimburse for long-acting reversible contraceptive (LARC) devices separate from the prospective payment system rate to FQHC and Rural Health Clinics (RHC) providers. The Actual Acquisition Cost to the FQHC will determine the reimbursement for LARC devices. Mercer has reviewed the projected costs associated with this service and estimated an increase of 0.02% to the FQHC/RHC PMPM.

Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the cost of providing health care services in a future period. Mercer studied historical cost and utilization data for each of the three data sources incorporated in the capitation rates: Healthy Louisiana encounters, Healthy Louisiana financial reports and FFS. Trends were selected based on Louisiana experience, as well as national trend information.

The trend factors reflected in the prior rate certifications were updated to reflect emerging Expansion experience as reported in the Healthy Louisiana MCO financial reports and, for the first time, Expansion population encounter data. Specifically, eligibility and encounter data for dates of service through December 31, 2017 with paid runout through June 30, 2018 were summarized and analyzed by Mercer. Based on these analyses, as well as more recent national trend information, updated annualized trend factors were selected. The updated trends were applied to the blended base data. The trend factors are shown in Appendix D.

Non-Medical Expense Load

Administrative Expense Load

The actuarially sound capitation rates developed include a provision for MCO administration and other non-medical expenses. Mercer reviewed line item detail of each MCO's administrative expenses, which tied back to the Healthy Louisiana financial reports as well as relied on its professional experience in working with numerous State Medicaid programs to develop the administrative load. The development included consideration for increases in expenses including items such as additional case management due to claims volume, increases in staff compensation over time, and consideration for enrollment growth. The administrative expense load assumptions reflected in prior rate certifications were updated to reflect additional Expansion experience as reported in the Health Louisiana MCO financial reports.

The administrative expense load for each Healthy Louisiana rate cell was determined using a fixed and variable cost model. Under this model, a fixed administrative expense is attributed to each rate cell, which

reflects program requirements, such as state-mandated staffing, and other indirect operational expenses. Added to this is a variable administrative amount, based on projected claims cost. This methodology results in administrative expense loads that vary by rate cell. The resulting variance in administrative expense determined using this methodology results in a higher allocation of administrative expenses on the rate cells with higher utilization, which Mercer believes is more accurate in reflecting the drivers of plan administration requirements. The final administrative expense load PMPM increased by 7.2% from prior certifications.

Underwriting Gain Load

Additionally, the provision for underwriting gain has been updated relative to the prior rate certifications. The revised adjustment ranges from 1.5% at the lower bound to 2.5% at the upper bound, prior to the application of FMP adjustments. This was done to ensure consistency with January 1, 2019 through December 31, 2019 Healthily Louisiana Non-Expansion rates, which will be addressed in a separate certification.

Risk Adjustment

Risk adjustment will be applied to the rates in Appendix A to reflect differences in health status of the members served in each MCO using the Adjusted Clinical Groups (ACG) model. The ACG model uses diagnostic information along with member demographics (age and sex categories) to classify members into mutually exclusive ACG categories, which are indicative of health care resource usage in terms of cost consumption. The State typically updates risk scores semi-annually, but the update timing and frequency may change to account for key program changes and data availability.

The application of the ACG model was tailored to the Healthy Louisiana program by using Louisiana cost experience to determine the relative costs associated with each ACG category. This step produces Louisiana-specific cost weights which assign a risk score to each member with sufficient experience (six or more months of enrollment with a MCO). An age/gender risk assumption is made for members without an ACG assignment. These member-level risk scores will be aggregated by MCO, producing MCO risk scores, which are adjusted for budget neutrality. The risk adjustment process does not increase nor decrease the overall cost of the program, but can change the distribution across the various Healthy Louisiana MCOs according to the relative risk of their enrolled members. This is consistent with the budget neutrality requirements outlined in 42 CFR 438.5(g). The FMP component of the rates will not be risk adjusted. The FMP component is added to the risk adjusted rate to produce the final rate.

The risk scores applied to the Medicaid Expansion, All Ages, Male & Female rate cell vary by region.

For more detail regarding the risk adjustment process, please reference the separate risk-adjustment methodology letter that corresponds with each risk adjustment update.

CERTIFICATION OF FINAL RATE RANGES

This certification assumes items in the Medicaid State Plan or Waiver, as well as the Healthy Louisiana MCO contract, have been approved by CMS. In preparing the rate ranges shown in Appendix A, Mercer has used and relied upon enrollment, FFS claims, encounter data, reimbursement level, benefit design, and other information supplied by LDH and its fiscal agent. LDH, its fiscal agent, and the Healthy Louisiana MCOs are responsible for the validity and completeness of the data supplied. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion they are appropriate for the intended purposes. However, if the data and information are incomplete/inaccurate, the values shown in this report may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this report.

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

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

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

Healthy Louisiana MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by Healthy Louisiana MCOs for any purpose. Mercer recommends that any MCO considering contracting with LDH

should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges before deciding whether to contract with LDH.

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

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

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

If you have any questions on any of the above, please feel free to contact Ron Ogborne at +1 602 522 6595 or Erik Axelsen at +1 404 442 3517, at your convenience.

Sincerely,

F. Ronald Ogborne III, FSA, CERA, MAAA
Partner

Erik Axelsen, ASA, MAAA
Senior Associate

Copy:
Amanda Joyner, Deputy Assistant Secretary – OBH/LDH
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APPENDIX A: HEALTHY LOUISIANA CAPITATION RATES AND RATE RANGES

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	FINAL PMPM OR COST PER DELIVERY[1]	UPPER BOUND PMPM OR COST PER DELIVERY
Gulf	Medicaid Expansion	Age 19 - 64	$531.05	$531.59	$570.18
Gulf	Medicaid Expansion	High Needs	$1,569.15	$1,569.15	$1,745.34
Capital	Medicaid Expansion	Age 19 - 64	$561.50	$562.09	$603.63
Capital	Medicaid Expansion	High Needs	$1,682.94	$1,682.94	$1,875.27
South Central	Medicaid Expansion	Age 19 - 64	$512.27	$512.81	$551.18
South Central	Medicaid Expansion	High Needs	$1,529.05	$1,529.05	$1,706.23
North	Medicaid Expansion	Age 19 - 64	$483.65	$484.16	$520.26
North	Medicaid Expansion	High Needs	$1,451.92	$1,451.92	$1,619.75

Note:

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

APPENDIX B

Healthy Louisiana Expansion Rates effective January 1, 2019 through March 31, 2019 Incremental Rate Impacts - Expansion @ 0th percentile

			Jul 2018 - Dec 2018 Rates						
			A	B	C	D	E = A + B + C + D	F	G = E + F
COA Description	Rate Cell Description	Proj MMs	Claims PMPM	Total Admin PMPM	Prem Tax PMPM	UW Gain PMPM	Limited Rate PMPM	FMP Add On PMPM	Full Rate PMPM
Medicaid Expansion	Male & Female, Age 19-64	1,671,845	$ 355.50	$ 27.74	$ 22.79	$ 8.29	$ 414.32	$ 87.13	$ 501.45
Medicaid Expansion	High Needs, All Ages, Male & Female	304	$ 1,099.71	$ 56.24	$ 68.73	$ 24.99	$ 1,249.67	$ 262.82	$ 1,512.50
	Aggregate	**1,672,150**	**$ 355.64**	**$ 27.75**	**$ 22.80**	**$ 8.29**	**$ 414.47**	**$ 87.16**	**$ 501.63**

			Jan 2019 - Mar 2019 Rates											
			H	I	J	K	L	M = A+H+I+J+K+L	N	O	P	Q = M + N + O + P	R	S = Q + R
COA Description	Rate Cell Description	Proj MMs	Rx Rebates Impact	IP/OP Fee Adj Impact	FQHC/RHC Impact	CGM Impact	Trend Impact	Resulting Claims PMPM	Total Admin PMPM	Prem Tax PMPM	UW Gain PMPM	Limited Rate PMPM	FMP Add On PMPM	Full Rate PMPM
Medicaid Expansion	Male & Female, Age 19-64	1,671,845	$ (1.26)	$ 4.03	$ 0.00	$ 0.47	$ 17.96	$ 376.70	$ 29.74	$ 24.04	$ 6.56	$ 437.04	$ 86.51	$ 523.56
Medicaid Expansion	High Needs, All Ages, Male & Female	304	$ (3.93)	$ 10.48	$ -	$ -	$ 58.09	$ 1,164.35	$ 60.30	$ 72.43	$ 19.75	$ 1,316.83	$ 272.14	$ 1,588.97
	Aggregate	**1,672,150**	**$ (1.26)**	**$ 4.03**	**$ 0.00**	**$ 0.47**	**$ 17.97**	**$ 376.85**	**$ 29.75**	**$ 24.05**	**$ 6.56**	**$ 437.20**	**$ 86.55**	**$ 523.75**
							Difference	**$ 21.21**	**$ 2.00**	**$ 1.25**	**$ (1.73)**	**$ 22.73**	**$ (0.61)**	**$ 22.12**

APPENDIX C: CONTINUOUS GLUCOSE MONITORS ADJUSTMENT

CPT CODE	DESCRIPTION	FEE	ANNUALIZED COST
A9276	Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = one-day supply. The above description is abbreviated. (Sensor four pkg with seven day life)	$300.00	$3,600.00
A9277	Transmitter; external, for use with interstitial continuous glucose monitoring system.	$518.66	$518.66
A9278	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system.	$488.00	$488.00
Total Cost			**$4,606.66**

POPULATION	POTENTIAL USERS[1]	PENETRATION RATE	ANNUALIZED FEE	TOTAL ANNUALIZED PROJECTED COST
Expansion	2,318	30%	$4,606.66	$3,203,471

Note:
1. Projected users were calculated using SFY2017 data and restricted to recipients with type 1 diabetes with insulin dependence.

APPENDIX D: PROSPECTIVE TRENDS

Annualized RY19 Expansion Trends by Major COS								
Rate Cell	PH		Rx		SBH		All Services	
	Low	High	Low	High	Low	High	Low	High
Medicaid Expansion								
Male & Female Age 19 – 64	2.1%	3.3%	9.0%	10.2%	6.0%	7.2%	4.5%	5.7%
High Needs	1.4%	4.4%	8.1%	11.1%	5.6%	8.6%	3.8%	6.8%
SBH - Dual Eligible, All Ages	3.5%	5.5%	0.0%	0.0%	6.3%	8.3%	5.2%	7.2%
SBH - Other, All Ages	3.5%	6.0%	0.0%	0.0%	2.9%	5.4%	3.1%	5.6%
SBH - Chisholm, All Ages	2.5%	5.0%	0.0%	0.0%	3.0%	5.5%	3.0%	5.5%
Expansion Kick Payment	-0.3%	2.7%	0.0%	0.0%	0.0%	0.0%	-0.3%	2.7%

APPENDIX E: EXPANSION ASSUMPTIONS COMPARISON

1.1.19 Expansion Assumptions Comparison – Lower Bound			
	July 1, 2018	January 1, 2019	% Change
Acuity Adjustment	1.199	1.199	0.0%
Administrative Expense Load (PMPM)	$27.75	$29.75	7.2%

APPENDIX F: EXPANSION RATE COMPARISON

			JULY 1, 2018–DECEMBER 31, 2018		JANUARY 1, 2019–MARCH 31, 2019	
Region Description	**Category of Aid Description**	**Rate Cell Description**	**Projected Member Months**	**Final PMPM [1]**	**Projected Member Months**	**Final PMPM [1]**
Gulf	Medicaid Expansion	Age 19 - 64	1,996,445	$509.14	2,118,672	$531.59
Gulf	Medicaid Expansion	High Needs	1,804	$1,485.34	300	$1,569.15
Capital	Medicaid Expansion	Age 19 - 64	1,250,853	$533.32	1,519,852	$562.09
Capital	Medicaid Expansion	High Needs	1,572	$1,613.87	493	$1,682.94
South Central	Medicaid Expansion	Age 19 - 64	1,478,958	$482.93	1,683,575	$512.81
South Central	Medicaid Expansion	High Needs	1,943	$1,453.81	231	$1,529.05
North	Medicaid Expansion	Age 19 - 64	1,259,716	$466.62	1,365,283	$484.16
North	Medicaid Expansion	High Needs	1,604	$1,409.13	194	$1,451.92

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

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JULY 2017–JUNE 2018 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE

Louisiana — February 1, 2018– January 31, 2019

Documentation Reference

The Medicaid Managed Care Rate Development Guide below documents 5 rate certifications for the period February 1, 2018 through January 31, 2019. Due to the rate revision, the previously issued certification (certification #1) may need to be referenced for the requested documentation. Below is a list of certifications applicable to the time period of February 1, 2018 through January 31, 2019. Items not marked in Certifications #2, #3, #4, and #5 are not altered by the revision. Please note Certification #5 revises the Healthy Louisiana Expansion rates only.

- Certification #1 – Rate Certification dated March 5, 2018 for effective period February 1, 2018 through January 31, 2019. This certification was revised by certification #2 for the entire period of February 1, 2018 through January 31, 2019.
- Certification #2 – Rate Certification dated April 30, 2018 for effective period February 1, 2018 through January 31, 2019.
- Certification #3 – Rate Certification dated June 19, 2018 for effective period May 1, 2018 through January 31, 2019.
- Certification #4 – Rate Certification dated, December 18, 2018 for effective period July 1, 2018 through January 31, 2019.
- Certification #5 – Rate Certification dated, January 28, 2018 for effective period January 1, 2019 through March 31, 2019.

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE				
	Certification Issued 3/5/2018	Certification Issued 4/30/2018	Certification Issued 6/19/2018	Certification Issued 12/18/2018	Certification Issued 1/28/2019
1. Data					
A. In addition to the expectations for all Medicaid managed care rate certifications, as supported by assurances from the State, described in Section I, the rate certification must describe any data used to develop new adult group rates.	• Mercer Rate Certification – Section 2: Expansion Capitation Rate Development, pages 26–29				
B. For states that have covered the new adult group in Medicaid managed care plans in previous rating periods (i.e. starting in 2014, 2015, 2016, and/or January through June 2017), CMS expects the rate certification, as supported by assurances from the State, to describe: i. Any new data that is available for use in this rate setting.	• Mercer Rate Certification – Section 2: Expansion Capitation Rate Development, pages 26–29				

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE				
	Certification Issued 3/5/2018	Certification Issued 4/30/2018	Certification Issued 6/19/2018	Certification Issued 12/18/2018	Certification Issued 1/28/2019
1. Data					
ii. How the state and the actuary followed through on any plans to monitor costs and experience for newly eligible adults.					
iii. How actual experience and costs in previous rating periods have differed from assumptions and expectations in previous rate certifications.					
iv. How differences between projected and actual experience in previous rating periods have been used to adjust these rates.					

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE				
	Certification Issued 3/5/2018	Certification Issued 4/30/2018	Certification Issued 6/19/2018	Certification Issued 12/18/2018	Certification Issued 1/28/2019
2. Projected Benefit Costs					
A. In addition to the guidance for all Medicaid managed care rate certifications described in Section I, states should include in the rate					

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE				
	Certification Issued 3/5/2018	Certification Issued 4/30/2018	Certification Issued 6/19/2018	Certification Issued 12/18/2018	Certification Issued 1/28/2019
2. Projected Benefit Costs					
certification submission and supporting documentation a description of the following issues related to the projected benefit costs for the new adult group: i. For states that covered the new adult group in previous rating periods:					
a. any data and experience specific to newly eligible adults covered in previous rating periods that was used to develop projected benefits costs for capitation rates.	• Mercer Rate Certification – Section 2: Expansion Capitation Rate Development, pages 26–29				• Mercer Rate Certification – Prospective Rating Adjustments, pages 2–5
b. any changes in data sources, assumptions, or methodologies used to develop projected benefits costs for	• Mercer Rate Certification				• Mercer Rate Certification

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE				
	Certification Issued 3/5/2018	Certification Issued 4/30/2018	Certification Issued 6/19/2018	Certification Issued 12/18/2018	Certification Issued 1/28/2019
2. Projected Benefit Costs					
capitation rates since the last certification.	– Section 2: Expansion Capitation Rate Development, pages 26–29				– Prospective Rating Adjustments, pages 2–5
c. how assumptions changed from rate certification(s) for previous rating periods on the following issues: i. acuity or health status adjustments (in most cases comparing the new adult group enrollees to other Medicaid adult enrollees). ii. adjustments for pent-up demand. iii. adjustments for adverse selection. iv. adjustments for the demographics of newly eligible adults.	• Mercer Rate Certification – Section 2: Expansion Capitation Rate Development, pages 26–29				

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE				
	Certification Issued 3/5/2018	Certification Issued 4/30/2018	Certification Issued 6/19/2018	Certification Issued 12/18/2018	Certification Issued 1/28/2019
2. Projected Benefit Costs					
v. differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for newly eligible adult rates and other Medicaid population rates. A. variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations. vi. other material adjustments to newly eligible adults projected benefit costs.	– Appendix R				
B. For any state that is covering the new adult group, regardless if they have been covered in previous rating periods, the following key assumptions related to the new adult group	• Mercer Rate Certification – Section 2:				

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE				
	Certification Issued 3/5/2018	Certification Issued 4/30/2018	Certification Issued 6/19/2018	Certification Issued 12/18/2018	Certification Issued 1/28/2019
2. Projected Benefit Costs					
must be included in the rate certification and supporting documentation: i. Acuity or health status adjustments (in most cases comparing new adult group enrollees to other Medicaid adult enrollees). ii. Adjustments for pent-up demand. iii. Adjustments for adverse selection. iv. Adjustments for the demographics of the new adult group. v. Differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for the new adult group rates and other Medicaid population rates. vi. Other material adjustments to the new adult group projected benefit costs.	Expansion Capitation Rate Development, pages 26–29				
C. The rate certification and supporting documentation must describe any changes to the benefit plan offered to the new adult group.	• Mercer Rate Certification – Rate Cell Structure, pages				• Mercer Rate Certification – Prospective Rating

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE				
	Certification Issued 3/5/2018	Certification Issued 4/30/2018	Certification Issued 6/19/2018	Certification Issued 12/18/2018	Certification Issued 1/28/2019
2. Projected Benefit Costs					
	26 and 27 – Additional Rate Adjustments, page 27 – Appendix R				Adjustments, pages 2–5
D. The rate certification and supporting documentation must describe any other material changes or adjustments to projected benefit costs.	• N/A	• Mercer Rate Certification – Technical Changes for ABA services, page 2 and Appendix C	• Mercer Rate Certification – Technical Revisions, pages 2 and 3 and Appendix C	• Mercer Rate Certification – Programmatic Changes, pages 2 and 3 Appendix C	• Mercer Rate Certification – Prospective Rating Adjustments, pages 2–5 – Appendix B

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE				
	Certification Issued 3/5/2018	Certification Issued 4/30/2018	Certification Issued 6/19/2018	Certification Issued 12/18/2018	Certification Issued 1/28/2019
3. Projected Non-Benefit Costs					
A. In addition to the guidance all Medicaid managed care rate certifications described in Section I, states must include in the rate certification submission and supporting documentation a description of the following issues related to the projected non-benefit costs for the new adult group: i. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, any changes in data sources, assumptions, or methodologies used to develop projected non-benefit costs since the last rate certification. ii. How assumptions changed from the rate certification(s) for	• Mercer Rate Certification – Non-Medical Expense Load, pages 28 and 29 – Appendix W				• Mercer Rate Certification – Non-Medical Expense Load, page 5 – Appendix E

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE				
	Certification Issued 3/5/2018	Certification Issued 4/30/2018	Certification Issued 6/19/2018	Certification Issued 12/18/2018	Certification Issued 1/28/2019
3. Projected Non-Benefit Costs					
previous rating periods on the following issues: a. administrative costs. b. care coordination and care management. c. provision for operating or profit margin. d. taxes, fees, and assessments. e. other material non-benefit costs.					
B. The rate certification and supporting documentation must include information on key assumptions related to the new adult group and any differences between the assumptions for this population and the assumptions used to develop projected non-benefit costs	• Mercer Rate Certification – Non-Medical Expense Load, pages 28 and 29 – Appendix W				• Mercer Rate Certification – Non-Medical Expense Load, page 5 – Appendix E

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE				
	Certification Issued 3/5/2018	Certification Issued 4/30/2018	Certification Issued 6/19/2018	Certification Issued 12/18/2018	Certification Issued 1/28/2019
3. Projected Non-Benefit Costs					
for other Medicaid populations for the following issues: i. Administrative costs. ii. Care coordination and care management. iii. Provision for operating or profit margin. iv. Taxes, fees, and assessments. v. Other material non-benefit costs.					

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE				
	Certification Issued 3/5/2018	Certification Issued 4/30/2018	Certification Issued 6/19/2018	Certification Issued 12/18/2018	Certification Issued 1/28/2018
4. Final Certified Rates or Rate Ranges					
A. In addition to the expectations for all Medicaid managed care rate certifications described in	• Mercer Rate Certification – Appendix Q	• Mercer Rate Certification – Technical Changes for	• Mercer Rate Certification – Technical Revisions,	• Mercer Rate Certification – Programmatic Changes,	• Mercer Rate Certification – Prospective Rating

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE				
	Certification Issued 3/5/2018	Certification Issued 4/30/2018	Certification Issued 6/19/2018	Certification Issued 12/18/2018	Certification Issued 1/28/2018
Section I, CMS requests under 42 CFR §438.7(d)[4] that states that covered the new adult group in Medicaid managed care plans in previous rating periods provide: i. A comparison to the final certified rates or rate ranges in the previous rate certification. ii. A description of any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.		ABA services, page 2 and Appendix C	pages 2 and 3 and Appendix C	pages 2 and 3 and Appendix C	Adjustments, pages 2–5 – Appendix B – Appendix F

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

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE				
	Certification Issued 3/5/2018	Certification Issued 4/30/2018	Certification Issued 6/19/2018	Certification Issued 12/18/2018	Certification Issued 1/28/2019
5. Risk Mitigation Strategies					
A. CMS requests under 42 CFR §438.7(d) that states describe the risk mitigation strategy specific to the new adult group rates.	• Mercer Rate Certification – Part C: Risk Mitigation Strategies, page 29			• Mercer Rate Certification – Risk Adjusted Expansion Rates, page 4	• Mercer Rate Certification – Risk Adjustment, page 6
B. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, CMS requests the following information: i. Any changes in the risk mitigation strategy from those used during previous rating periods. ii. The rationale for making the change in the risk mitigation strategy or removing the risk mitigation strategy used during previous rating periods.	• Mercer Rate Certification – Part C: Risk Mitigation Strategies, page 29			• Mercer Rate Certification – Risk Adjusted Expansion Rates, page 4	• Mercer Rate Certification • Risk Adjustment, page 6

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE				
	Certification Issued 3/5/2018	Certification Issued 4/30/2018	Certification Issued 6/19/2018	Certification Issued 12/18/2018	Certification Issued 1/28/2019
iii. Any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during previous rating periods.					