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LOUISIANA BEHAVIORAL HEALTH PARTNERSHIP (LBHP) CAPITATION RATE DEVELOPMENT ASSUMPTIONS

This document provides a brief description of the methodology used by Mercer Government Human Services Consulting (Mercer) in calculation of the capitation rate ranges effective March 1, 2015 through December 31, 2015 for the State of Louisiana's (State) initial contract period under the new procurement for the prepaid inpatient health plan (PIHP) for Behavioral Health (BH) services provided to Medicaid-eligible individuals under the LBHP. For this rate-setting exercise, Mercer performed a complete rebase of the rates based on new underlying encounter data. This is an approved approach to rate setting per the federal Centers for Medicare and Medicaid Services (CMS).

The LBHP program began March 1, 2012, and has operated under an at-risk capitation contract for the Adult population since the program inception. The Children's program has been administered on a non-risk basis by the PIHP. The State is planning to operate both programs under at-risk contracts, effective March 2015. The key steps in the development of the capitation rate ranges are described below. Appendices A and B at the end of this document provide detail on the build-up of the capitation rates for the Child and Adult populations, respectively. Appendix C provides more detail on the build-up of the capitation rate for a separate Adult population referred to as the 1915(i)-only Adults.

Mercer developed actuarially sound rate ranges for each rate cell based on the methodology described in this memo. The State selected rates within the actuarially sound rate range for each rate cell. The exhibits in the appendices illustrate the development of the selected contract rates.

Develop Base Year Data

The first step in the development of the rates was to establish the base year data. Mercer summarized demographic, cost, and utilization data related to BH services only. The development of the base data included data from the following sources:

- The encounter data are submitted by the PIHP to the State's fiscal agent, Molina. Molina provided an extract of the encounter data to Mercer in March 2014.
- The pharmacy data include both Medicaid fee-for-service (FFS) pharmacy data and Managed Care Organization pharmacy data submitted by the MCOs under contract for the Bayou Health Medicaid managed care Physical Health program.
- The eligibility information used in the encounter data analysis is summarized from the State's eligibility file provided by Molina, which outlines the PIHP enrollment segments for each member.

The encounter and pharmacy data were summarized for Calendar Year (CY) 2013, incurred from January 1, 2013 through December 31, 2013, paid through February 2014. The data for the early

months of the program in 2012 reflected lower volume of services due to program start-up. As such, the CY 2013 time period was selected for use in rate development.

Mercer applied adjustments to the encounter data so that they reflected the populations and services covered under the contract. Additionally, completion factors were applied to reflect claims not yet adjudicated. Please refer to the Behavioral Health Data Book issued with the request for proposal (RFP) for more detail.

In the development of the base data, Mercer summarized the populations according to the following rate cells, which serve as the basis of the capitation rates:

- LBHP Child rate cells:
  - non-Disabled Children, Ages 0–20.
  - Foster Care and Disabled Children, Ages 0–20.
  - Dually Eligible Children, Ages 0–20.
  - Coordinated System of Care (CSoC) Children.
- LBHP Adult rate cells:
  - non-Disabled Adults, Ages 21+.
  - Disabled Adults, Ages 21+.
  - Dually Eligible Adults, Ages 21+.
  - 1915(i)-only Adults, Ages 19+.

The LBHP Child rate cells represent newly capitated groups, effective March 1, 2015. Previously, this group was covered on a non-risk basis by the PIHP. The CSoC Children have a distinct rate cell as they are eligible for additional services under the 1915(c) or 1915(b)(3) waiver authorities. The capitation rates have been constructed under the assumption that any month a child is enrolled in the CSoC program a full capitation payment will be made. As such, for partial months of enrollment in CSoC, utilization of State Plan services prior to or after the CSoC enrollment period are considered in the development of the CSoC capitation rate.

The LBHP Adult rate cells represent a change from the current rate cell structure, which includes a separate rate cell for all individuals age 65+. LBHP will cover Medicare and Medicaid dually eligible individuals under a separate rate cell effective March 1, 2015, which is the start of the next contract period. This decision is based on the exclusion of the Medicare crossover claims from the capitation rate, which results in a much lower expected cost under the LBHP program compared to the other rate cells. As a result of this change, a separate rate cell for individuals age 65+ is no longer necessary for the Non-Dually Eligible Adults. Remaining non-dually eligible members from this rate cell are now included in the non-Disabled Adults 21+ rate cell.

Calculation of Contract Period Rates and Ranges

Trend

Capitation rate ranges are actuarial projections of future contingent events. To develop the March 1, 2015 through December 31, 2015 rate ranges using the CY 2013 encounter data as a

base, Mercer projected costs based on a review of historical experience, emerging trends, and expected costs and utilization during the contract period. Mercer reviewed reported financial and encounter experience data. Mercer also considered similar states' experience and the external marketplace, including CPI and the Medicare Economic Index.

Children and Adults exhibited unique trends in the historical encounter data reflecting the underlying characteristics of the populations and the mix of services received. Final assumptions were set at the per member per month (PMPM) level for each service category and rating group. The trends are primarily driven by utilization growth in community-based services throughout 2013 and into 2014. Observed trends in utilization of hospital services were much lower. As hospital services are more heavily utilized by the Adult population historically, this accounts for the primary difference in expected trends between Children and Adults. For the contract rates selected by the State within the modeled rate ranges, the overall annual projected BH service (non-pharmacy) trend is 6.4% for Adults and 9.7% for Children, which considers both increases in utilization and general cost inflation.

Pharmacy trend assumptions differ significantly from the other service categories. Pharmacy utilization for BH populations is driven by four primary therapeutic classes: Mental/Neurological Disorders (including antipsychotics), Attention Disorders (primarily stimulants for ADHD), Chemical Dependence Agents (i.e. Suboxone, Subutex) and Depression. Atypical antipsychotics have historically been the largest driver of spend for this population. Notable changes in this category include the generic launch of Abilify, which is expected in April of 2015. The generic launch of this product is the primary driver of the low trend projected for the Mental/Neurological Disorders class, and for the LBHP populations overall. For the contract rates selected by the State within the modeled rate ranges, the total annualized projected pharmacy trend assumption is 0.5% for Children and -3.8% for Adults.

The final overall annual trend assumption including BH services and prescription drugs prescribed by BH specialists was 2.9% for Adults and 8.4% for Children.

Programmatic Changes

Mercer and the State discussed programmatic changes that may impact the managed care contract. This included a review of changes to the State's hospital fee schedules, the implementation of new chronic care management for the population, changes to fees for medication management procedure codes, and other rate issues such as Parent Support/Youth Support fee changes.

Inpatient Hospital Fee Schedules

Inpatient Hospital fee schedules have changed in Medicaid from the levels reported in the base data. Most notably, rates for certain public hospitals changed as a result of the public/private partnership. The changes to the hospital rates represent both increases and decreases depending on the hospital.

The State has decided to adjust the capitation rates to account for the changes to the hospital reimbursement, including the public/private partnership. In order to account for this change Mercer analyzed the base data and calculated an adjustment to the rates. Mercer summarized the bed days by hospital for the Children's and Adult populations separately. Mercer compared the PIHP fee schedules and per diem costs reported in the encounter data to the new State Medicaid fee schedule. Based on this comparison, Mercer determined no adjustment was needed for the Adult rates. However, for the Children's population, based on the per diem changes and relative utilization, this warranted a 5.5% upward adjustment to the Inpatient Hospital costs in the Children's rates. Overall, this represents a 0.6% increase to the Child rates.

Chronic Care Management

To increase the quality of care and actively engage the chronic needs population, the PIHP is implementing new chronic care management practices for the Adult population. Specifically, the PIHP has contracted with a Community-based Care Manager to serve as the independent conflict-free Licensed Mental Health Professional who will assess member needs, develop an effective plan of care with the active engagement of the member and their supports, and coordinate the overall treatment of members. Mercer has evaluated the expected increase in costs due to this new initiative and applied an adjustment to the Adult rates. Overall, this represents a 1.0% increase to the Adult rates, which accounts for expected ramp-up of additional utilization throughout 2015.

Medication Management Rate Change

For the Adult program, the PIHP instituted a fee schedule change for Medication Management related services. Effective January 2013, the prior medication management procedure code of 90862 was eliminated and the services were required to be billed under general evaluation and management codes 99211-99214, 90863. The new codes, as reflected in the base data, were reimbursed at lower rates averaging approximately $31 per unit. Based on feedback from the State and the PIHP, Mercer incorporated an upward adjustment into the rates to reflect costs consistent with the prior historical levels and in line with future expected service rates. This results in approximately a 49% increase to the Medication Management services. Mercer assumed this increase would also impact the Children's program under capitated managed care.

As the Medication Management service costs are captured in both the Medical Physician/ Psychiatrist category and the Other Professional category along with other procedures, Mercer calculated a proportionate program change to each category to incorporate the expected impact on the broader service category for this fee increase. Specifically, Mercer applied the following adjustments to the rates:

- Adults:
  - Medical Physician/Psychiatrist: 8.4%.
  - Other Professional: 11.8%.

- Children:
  - Medical Physician/Psychiatrist: 27.1%.
  - Other Professional: 7.7%.

Overall, this represents a 1.1% increase to the Adult rates and a 1.0% increase to the Child rates.

Parent Support/Youth Support Fee Change

The State submitted a 1915(c) waiver amendment to increase the FFS rate for Parent Support and Youth Support services (individual, per 15 minutes) from $10.00 to $12.91. The group service rate also went up accordingly. Overall, this represents a 29.1% increase to the Parent and Youth Support service categories, which increases the overall Child rates by 0.1%.

Coverage of LaCHIP IV Population Under at-risk Managed Care

LaCHIP IV covers non-citizen pregnant women. These individuals are eligible for a specific Medicaid benefit package and have been historically excluded from the LBHP at-risk capitation rate. Mercer evaluated the historical FFS costs for the LaCHIP IV population identified under Type Case code 127. As the population attains Medicaid coverage as a direct result of their pregnancy, the utilization of BH services is low and the PMPM for this population of approximately 20,000 member months is approximately $0.14. Mercer calculated an adjustment to incorporate this population into the non-Disabled Adult rate cell. As their average costs were lower than the general population in this rate cell, this resulted in a downward adjustment of approximately 1.6% to the non-Disabled Adult rate cell. A small portion of these individuals would be covered under the non-Disabled Children's rate cell rather than the non-Disabled Adult rate cell. Mercer evaluated the expected size and costs of this group in the Children's populations and determined no adjustment was warranted. Overall, this represents a decrease of 0.3% to the Adult rates.

Disability Medicaid Closure

The State eliminated coverage of the Disability Medicaid category identified by Type Case code 125. This group included coverage for approximately 10,000 aged, blind and disabled adults. Although this coverage category was discontinued, approximately 50% of individuals previously eligible are expected to enroll through either through provisional Medicaid (Type case 211) or SSI eligibility. Mercer evaluated the historical costs for the Disability Medicaid population identified under Type Case code 125 and compared this group to the remaining population in the Disabled Adult and Dual Eligible Adult rates cells. The Disability Medicaid group had higher than average costs in each of the rate cells. Based on the assumption that not all individuals previously covered under Disability Medicaid individuals would reenroll (which is supported by emerging 2014 enrollment), Mercer calculated a downward adjustment to reflect to lower average cost of the remaining population. This represented a -0.6% adjustment to the Disabled Adult rate cell and a -1.0% adjustment to the Dual Eligible Adult rate cell. Overall, this represents a decrease of 0.5% to the Adult rates.

1915(c) CSoC Regional Expansion

The State submitted an amendment to the 1915(c) CSoC waiver to increase the number of waiver slots and expand the waiver program statewide. When the waiver expands, certain Children with historical utilization of services will move into the CSoC rate cells and out of the other rate cells. The CSoC regions comprise approximately 60% of historical enrollment. In regions where CSoC has operated, the Children in CSoC had higher PMPM costs for State Plan services. The PMPM costs for State Plan services $19.86 excluding CSoC Children compared to $21.10 including the CSoC Children's State Plan service costs. For the historical CSoC regions, the movement of higher needs Children into the CSoC rate cell resulted in approximately a 5% reduction in the PMPM for the other rate cells.

As the rate structure is statewide, the assumed impact on the non-Disabled and Disabled Children rate cells is mitigated as the data reflect the impact for 60% of the State. As such, the ultimate impact is assumed to be approximately a 2% reduction to the PMPM (40% of the enrollment reduced by approximately 5%). Assuming the CSoC statewide expansion will ramp-up throughout the initial contract year, Mercer phased in 50% of the adjustment for a final adjustment of -1% to the non-Disabled and Disabled Children rate cells. Overall, this represents a 0.9% decrease to the average Child rates. However, the net impact is an increase in capitation as more children enroll in the CSoC rate cell.

The overall impact all of all the programmatic changes is a 1.3% increase to the Adult rates and a 0.8% increase to the Child rates.

1915(b)(3) Services

The historical utilization of Physician Case Consultation services has been minimal in the initial years of the program. As such, the 1915(b)(3) rate for this service is essentially $0.00 on a PMPM basis. The service utilization will continue to be analyzed and the rate adjusted accordingly as necessary. This is within the requested waiver authority of $0.13 PMPM.

A segment of the CSoC Children meet the eligibility criteria to receive the enhanced services (Parent and Youth Support, Crisis Stabilization, Respite, and Independent Living Skills) through 1915(b)(3) authority. The 1915(b)(3) services underlying the CSoC rate amount to $117.39 of the $890.36 service PMPM for this rate cell.

Managed Care Assumptions

Mercer evaluated whether additional adjustments were necessary to address changes to utilization as a result of care management practices. As the Adult encounter data are from a period of time when capitated managed care was in operation, Mercer did not incorporate any further adjustment for future changes as a result of managed care. Similarly, Mercer made no adjustment to the Children's capitation rate calculations for additional impact of managed care. While the data from the Children's program are from a non-risk setting, the current PIHP did perform utilization review and care management of the Children's population under the non-risk

contract. Coupled with the level of historical utilization of Inpatient services in the data, Mercer did not expect significant changes in utilization as a result of managed care practices.

CSoC WrapAround Agency (WAA) Fees

The CSoC population is eligible for an enhanced service package under 1915(c) and 1915(b)(3) waiver authorities. The additional services are included below:

- Wraparound Facilitation.
- Crisis Stabilization.
- Parent Support and Training.
- Youth Support and Training.
- Independent Living/Skills Building.
- Short Term Respite Care.

A key component of that package is the wraparound facilitation, which includes an integrated system of care planning and management across multiple levels. These services are currently provided as an administrative function outside the claims payment data. Historical WAA fees were paid based on actual daily enrollment in CSoC. For the initial and final month of CSoC enrollment, the WAA would receive only a portion of the monthly payment rate. Mercer reviewed the experience and determined that the historical data did not reflect new and terminating CSoC eligibility to be uniform throughout the month. As a result, a greater proportion of partial months are reflected in the historical experience than would be expected if enrollment was more uniform.

For the capitation rate development, Mercer has assumed full capitation payment will be made to the PIHP for CSoC individuals in a month, even if the individual is only CSoC enrolled for a partial month. As such, Mercer has incorporated the expected average monthly cost into the capitation rate. Based on the expectation that new and terminating CSoC enrollment will be more uniform throughout each month than the historical experience, Mercer adjusted the average historical monthly WAA fee, and the final amount in the capitation rates for a statewide CSoC program is $942.65 PMPM.

This amount is based on a blended average of the current region estimate (“Mature Program”) and the new CSoC region estimate (“Initial Year”). The Mature Program amount is based on monthly enrollment levels for the current CSoC region during 2013, while the Initial Year amount is based on monthly enrollment levels from the current CSoC region during 2012. Additional detail on the calculation of this final amount is provided in the table below.

The final rate assumes the PIHP will pay the WAA a rate of $1035 per individual for full monthly enrollment and continue the State’s practice of daily reconciliation for partial month enrollment.

Historical WAA Administrative Fees		***Notes:***
A. Total 2013 WAA Fees	$10,866,074	*Partial months receive pro-rated fee. Total includes retroactive adjustments.*
B. Full Month WAA Fee PMPM	$1,035.00	*Contract rate for a recipient participating the full month.*
C. 2013 Unique WAA User Months	12,757	*Recipients participating for partial months are fully counted.*
D. Average Monthly WAA Fee PMPM	$851.77	*D = A / C, Actual Historical Experience, new and terminating CSoC eligibility is NOT uniform throughout the month.*

Average Monthly WAA Fee PMPM		*Assumes new and terminating CSoC eligibility is uniform throughout the month.*
Mature Program (Current CSoC Region)	$951.88	*Relative Factor = 1.117 x D; Historical Experience, adjusted for uniform monthly enrollment.*
Initial Year (New CSoC Region)	$919.90	*Relative Factor = 1.080 x D; Lower due to more partial months as a result of growing enrollment.*
Combined Program	$942.65	*Relative Factor = 1.107 x D; Capitation Rate assumption, accounts for partial month enrollments.*

Full Month WAA Fee PMPM	$1,035.00	*Assumed contract rate PIHP pays to WAA for a full month of enrollment.*

Administration and Profit

Mercer included an assumption for administrative expenses under a managed care program. Mercer evaluated historical administrative costs incurred under the LBHP based on reported financial experience for both the Adult capitated program and the Children capitated program. Mercer also evaluated the expected costs to administer BH Pharmacy benefit, newly covered under LBHP. Mercer reviewed the requirements of the RFP and specifically analyzed the responsibilities of the PIHP in terms of care management and outreach to individuals in the permanent supportive housing program. The specific responsibilities of the PIHP as they pertain to plan of care development, care and utilization management, and outreach were considered in the development of the administrative component of the Adult rates. Based on a review of the prior costs associated with the PIHP administrative responsibilities for the permanent supportive housing program, Mercer incorporate approximately $400,000 or 0.5% admin for the PIHP responsibilities for these functions as they pertain to Medicaid eligible.

Based on this review, Mercer included a general administrative allowance of 7.5%. The incorporation of the additional Pharmacy costs into the capitation rate coupled with the

expectation that the administration of the Pharmacy costs generally requires a lower percentage of administration resulted in the final administrative assumption of 7.5%. In addition to the general administrative allowance, a profit/risk margin of 2.0% has been included in the capitation rates. The administration and risk margin load factor is expressed as a percentage of the gross capitation rate (e.g., premium) before premium tax adjustment and is consistent with the current rates.

Premium Tax Adjustment

Louisiana Statute 22:842 requires businesses issuing life, accident, health, or service insurance or other forms of contracts or obligations covering such risks to pay certain premium taxes. The tax for businesses with revenue exceeding $7,000 amounts to 2.25% of gross annual premiums. The State has determined that the PIHP contract for the Medicaid Adult capitated BH program is subject to this taxation. This is a uniform, broad-based fee imposed on all health maintenance organizations and preferred provider organizations and all lines of business.

The premium tax adjustment is expressed as a percentage of the gross capitation rate (i.e., premium). Mercer applied a 2.25% upward adjustment to the rate to account for the premium tax.

Health Insurer Provider Fee Consideration

The State plans to address the Health Insurer Provider Fee and associated implications of non-deductibility through a retrospective payment once the fees are known for the impacted premium years. As such, no consideration has been made for the fee in these capitation rates. Further discussion between the PIHP and the State will occur as fee notices become available from the IRS for the respective premium year.

1915(i) Rate Development

Through the 1915(i) State Plan Home and Community-based Services (HCBS) federal authority, there are two populations being served. The first population is the existing Medicaid eligible population who meet the needs criteria for the current Mental Health (MH) Clinic option (called the Medicaid 1915(i) population). Individuals in this group receive all Medicaid services as well as State Plan HCBS services. The Medicaid 1915(i) are 21 or over in an eligibility group otherwise covered under the State's Medicaid State Plan and have income that does not exceed 150% of the Federal Poverty Level (FPL). This group is already accounted for in the Medicaid Adult capitation rate cells described in the rate-setting methodology above.

The second population is an eligible group of individuals that the State is expanding Medicaid eligibility for Adults in need of BH services (called the 1915(i)-only population). These individuals only receive State Plan HCBS services and any Medicaid services specifically outlined in the HCBS State Plan. These individuals must be over 18, not otherwise be covered by Medicaid, determined to be medically needy using institutional rules, and have income that does not exceed 150% of the FPL.

The 1915(i)-only population was historically served by the Office of Behavioral Health (OBH) through State-funded clinics. The services covered for the 1915(i)-only population are limited to the following outpatient modalities:

- Treatment by a licensed MH practitioner.
- Community Psychiatric Support and Treatment.
- Psychosocial Rehabilitation.
- Crisis Intervention.
- Psychiatrist services.

Base Year Data

The experience reported by the PIHP for the 1915(i)-only population is limited (181 member months in CY 2013) and not a credible data source for capitation rate development. In order to develop capitation rates for this population, Mercer used a rate update methodology. Under this methodology, the current capitation rate ranges are used as the starting point and adjustments are applied to account for additional trend and programmatic changes effective for the rates in the new contract period.

For reference, the prior 1915(i)-only capitation rate was developed based on historical FFS costs as described below. The array of services included in the 1915(i) is generally consistent with the historical MH Clinic, MH Rehabilitation, and Psychiatrist services covered by Medicaid under the FFS program. As such, Mercer and the State modeled the historical expenses for the 1915(i) population using cost per client served and penetration rates within the Medicaid population. Since the PMPM capitation payment will be based on users meeting income criteria and a documented need for services, the population base is essentially a population of service users. As such, the user's rates are presented as a proportion of the current Medicaid Adult MH Clinic and Rehabilitation service population accessing the various service categories. All data is provided for the time period of July 1, 2009 to June 30, 2010 (Fiscal Year [FY] 2011).

FY 2011 Base Year Cost Proxy

	(A)	(B)	(C)
Category of Service	**Base Year Cost**	**User Rate**	**Base Year Per User Per Month**
MH Clinic	$1,111.56	87.5%	$81.05
Psychiatrist	$251.85	38.0%	$7.98
MH Rehabilitation	$3,537.00	14.0%	$41.26
Subtotal*	$1,563.50		$130.29

*The Base Year Cost Subtotal is the combined total after the user rates are applied.

- Base Year Cost — This column represents the cost per client served statistic for Medicaid users in FY 2011. The MH Clinic line includes consideration for differences in MH Clinic utilization informed by average utilization provided by OBH.

- User Rate — This represents the proportion of the universe of MH Clinic or MH Rehabilitation users that utilized a particular service. For example, with respect to the Medicaid clients meeting the criteria for the 1915(i), approximately 87.5% of those clients received MH Clinic services in FY 2011.
- Base Year Per User Per Month — This represents the baseline for the PMPM calculations and is calculated by multiplying Column (A) by Column (B) and dividing by 12 months under the assumption that clients will remain in the 1915(i) program for at least 12 months.

Calculation of Contract Period 1915(i) Rates and Ranges

Trend

For the 1915(i)-only rates, Mercer developed rates using a rate methodology that started with the medical costs underlying the current capitation rates and trended the costs forward from the midpoint of the current contract rates to the midpoint of the new contract period. Trends were based on trends used in setting the Adult BH capitation rates. Those trends were adjusted based on the fact that they are being applied to a population of users, which minimizes the impact of utilization component of trends.

Program Changes

Based on discussions with the State, it should be noted that none of the program changes mentioned above impacted the historical FFS data used in the 1915(i)-only rate redevelopment.

Managed Care Assumptions

As we were dealing strictly with Outpatient services and a particular cohort of service users, Mercer did not incorporate any downward adjustments for the impact of managed care.

Administration

Mercer included an assumption for administrative expenses under a managed care program. Consistent with the administrative assumption for the Medicaid Adult rates, Mercer will incorporate a general administrative allowance of 7.5% consistent with the assumption underlying the Medicaid Adult rates. In addition to the general administrative allowance, a profit/risk margin of 2.0% will also be included in the capitation rates as well as consideration for the 2.25% premium tax.

Appendix C provides more detail on the build-up of the capitation rate for the 1915(i)-only Adults.

Final Rate Ranges

In order to develop the rate ranges, Mercer varied the trend assumptions underlying the calculations described above. The overall trends assumed for the lower bound represent a mitigation of trends from the recent trends observed in the encounter data, whereas the trends used to develop the upper bound assume higher trends continue into the next contract period. Based on the contract rates selected by the State, we have provided exhibits with the actual trend assumptions utilized. These values are within the range of assumptions used to establish the actuarially sound rate ranges.

The specific adjustments made for program changes and administration were consistent with the figures noted above.

Mercer has prepared these rate ranges in accordance with generally accepted actuarial practices and principles specific to the Medicaid covered populations and services under the managed care contract. Rate ranges developed by Mercer are actuarial projections of future contingent events. Actual costs will differ from these projections. Mercer has developed these rate ranges on behalf of the State to demonstrate compliance with CMS requirements under 42 CFR 438.6(c) and accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

These rate ranges have been prepared by the actuaries noted below, who 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.

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Appendix A
Louisiana Behavioral Health Partnership Medicaid Capitation Rate Development
Effective March 1, 2015 to December 31, 2015
Children Rate Cells

		Base Year		Rate Development Data Adjustments				Capitation Rate Loads				Contract Period March 1, 2015 - December 31, 2015
		A	B	C	D	E	F	G	H	I	J	
Rate Cell	Age	MMs	PMPM	Trend *	Program Changes	Managed Care Adjustment	Projected Medical PMPM	WAA Fee PMPM	Profit**	Administration **	Premium Tax **	RFP Rate PMPM ***
Non-Disabled Children	0-20	8,231,871	$ 14.82	8.0%	0.7%	0.0%	$ 17.52	$ -	2.0%	7.5%	2.25%	$19.81
Foster Care / Disabled Children	0-20	677,357	$ 103.02	8.7%	0.3%	0.0%	$ 123.00	$ -	2.0%	7.5%	2.25%	$139.04
CSoC Children	0-21	12,757	$ 724.98	10.9%	4.4%	0.0%	$ 938.22	$ 942.65	2.0%	7.5%	2.25%	$2,126.15
Duals	0-20	4,383	$ 23.09	8.7%	0.4%	0.0%	$ 27.60	$ -	2.0%	7.5%	2.25%	$31.20
Total		**8,926,368**	**$ 22.53**	**8.4%**	**0.8%**	**0.0%**	**$ 26.85**	**$ 1.35**	**2.0%**	**7.5%**	**2.25%**	**$31.87**

* The trend shown is annualized from the 25 month period (July 1, 2013 - August 1, 2015)

** Admin & Profit shown as a % of the total rate before premium tax. Premium Tax is shown as a percent of total premium.

*** Rate Development Formula: RFP Rate = ([B*(1+C)^(25/12)*(1+D)*(1+E)]+G)/(1-H-I)/(1-J)

Historical WAA Administrative Fees		*Notes:*
A. Total 2013 WAA Fees	$10,866,074	*Partial months receive pro-rated fee. Total includes retroactive adjustments.*
B. Full Month WAA Fee PMPM	$1,035.00	*Contract rate for a recipient participating the full month*
C. 2013 Unique WAA User Months	12,757	*Recipients participating for partial months are fully counted*
D. Average Monthly WAA Fee PMPM	$851.77	*D = A / C, Actual Historical Experience, new and terminating CSoC eligibility is NOT uniform throughout the month.*

Average Monthly WAA Fee PMPM		*Assumes new and terminating CSoC eligibility is uniform throughout the month.*
Mature Program (Current CSoC Region)	$951.88	*Relative Factor = 1.117 x D; Historical Experience, adjusted for uniform monthly enrollment.*
Initial Year (New CSoC Region)	$919.90	*Relative Factor = 1.080 x D; Lower due to more partial months as a result of growing enrollment.*
Combined Program	$942.65	*Relative Factor = 1.107 x D; Capitation Rate assumption, accounts for partial month enrollments.*

Full Month WAA Fee PMPM	$1,035.00	*Assumed contract rate PIHP pays to WAA for a full month of enrollment.*

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Appendix B
Louisiana Behavioral Health Partnership Medicaid Capitation Rate Development
Effective March 1, 2015 to December 31, 2015
Adult Rate Cells

		Base Year		Rate Development Data Adjustments						Contract Period March 1, 2015 - December 31, 2015
		A	B	C	D	E	F	G	H	
Rate Cell	Age	MMs	PMPM	Trend *	Program Changes	Managed Care Adjustment	Profit**	Administration **	Premium Tax **	RFP Rates PMPM***
Non-Disabled Adults, Non-Dual	21+	1,119,612	$ 22.40	6.1%	1.5%	0.0%	2.0%	7.5%	2.25%	$29.08
Disabled Adults, Non-Dual	21+	1,019,345	$ 101.49	1.7%	1.3%	0.0%	2.0%	7.5%	2.25%	$120.47
Dual Eligible Adults	21+	1,122,454	$ 5.61	9.0%	-0.2%	0.0%	2.0%	7.5%	2.25%	$7.58
Total		**3,261,411**	**$ 41.34**	**2.9%**	**1.3%**	**0.0%**	**2.0%**	**7.5%**	**2.25%**	**$50.24**

* The trend shown is annualized from the 25 month period (July 1, 2013 - August 1, 2015)

** Admin & Profit shown as a % of the total rate before premium tax. Premium Tax is shown as a percent of total premium.

*** Rate Development Formula: RFP Rate = [B*(1+C)^(25/12)*(1+D)*(1+E)]/(1-F-G)/(1-H)

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Appendix C
Louisiana Behavioral Health Partnership Medicaid Capitation Rate Development
Effective March 1, 2015 to December 31, 2015
1915(i)-only Adult Rate Cell

	Base Year Data (3/2014 - 4/2015)		Rate Development Data Adjustments						Contract Period March 1, 2015 - December 31, 2015
	A	B	C	D	E	F	G	H	
Category of Service	Base Capitation Rate[1]	Expected Medical Costs	Trend[2]	Program Changes	Managed Care Assumption	Profit[3]	Admin[3]	Premium Tax[3]	RFP Rate PMPM[4]
Clinic[5]	$96.79	$85.15	2.0%	0.0%	0.0%	2%	7.5%	2.25%	$98.36
Psychiatrist	$9.52	$8.38	2.0%	0.0%	0.0%	2%	7.5%	2.25%	$9.68
Psychosocial Rehabilitation	$48.47	$42.64	2.0%	0.0%	0.0%	2%	7.5%	2.25%	$49.25
Subtotal	**$154.78**	**$136.17**	**2.0%**	**0.0%**	**0.0%**	**2.0%**	**7.5%**	**2.25%**	**$157.29**

Notes

1. Base capitation reflects rate selected within the prior modeled rate range and not the actual current contract rate.
2. The trend shown is annualized from the 11 month period (September 1, 2014 - August 1, 2015)
3. Admin & Profit shown as a % of the total rate before premium tax. Premium Tax is shown as a percent of total premium.
4. Rate Development Formula: RFP Rate = [B*(1+C)^(11/12)*(1+D)*(1+E)]/(1-F-G)/(1-H)
5. Clinic services include CPST, Crisis, and Other Licensed Practitioner services.