ADDENDUM #21
Replaces Addendum #19
Response to Q&A – Rate Certification
BAYOU HEALTH – MANAGED CARE ORGANIZATIONS
RFP # 305PUR-DHHRFP-BH-MCO-2014-MVA

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
1.	Rate Book	N/A	N/A	N/A	Are rate development exhibits (in Excel), similar to those provided in prior rate book releases, available to bidders? This information is critical in helping the MCO's understand how Mercer arrived at proposed rate levels by cell.	See Addendum #20 Exhibit 1 in the supplemental exhibits memo, dated September 15, 2014.
2.	Rate Book	N/A	N/A	N/A	When will ACTUAL proposed base rates (as opposed to ranges) be available for review? Given this is not a Bidded RFP, we would need the final proposed rates in order to properly evaluate the expected financial viability of Bayou Health Program.	See Addendum # 20 Exhibit 14 in the supplemental exhibits memo, dated September 15, 2014.
3.	Rate Book	N/A	N/A	N/A	Was any adjustment made for Rx Rebates? There was a specific adjustment made to the SFY14 rates but none in this new rate book.	Fee-for-service (FFS) and Shared Savings claims were reduced 1.5% for Rx rebates collected by the MCO. This factor was developed using Prepaid plans experience as reported in financial statements provided to DHH. Prepaid Encounters were taken as net of drug rebates, so no adjustment was necessary.

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4.	Rate Book	N/A	N/A	N/A	When will risk adjusters for 2/15 and forward be calculated and communicated?	DHH anticipates initial risk scoring at 3 and 6 months post-implementation, followed by semi-annual updates. Each time risk scores are updated, the corresponding methodology and results will be communicated to the health plans.
5.	Rate Book	N/A	N/A	N/A	Does the state have an assumption for the volume of Opt In members expected? If yes, what is the basis for this assumption?	DHH assumes a 20% take-up rate among the voluntary opt in eligible population by February 2015. Actual take up in the first two months of implementation (July and August 2014) has been approximately 4%.
6.	Rate Book	N/A	N/A	N/A	Did the state consider the potential for Opt In members selecting against the Prepaid plans? If yes, was the decision to make no adjustment driven by a lack of credible information or was it determined that there is no expected selection potential?	The decision not to adjust for potential adverse selection was driven by a lack of available experience. Mercer recognizes that there is also potential for favorable selection with these populations as higher utilizers within the population may choose to remain in FFS.
7.	Rate Book	N/A	N/A	Page 3	Regarding the LaHIPP population, please clarify the following statement found on Page 3 of the rate book: "The program also covers out of pocket expenses incurred by the enrollee…..but out of pocket expenses incurred by the enrollee will be responsibility of the MCO". What, if any, member liability was absorbed by the state in prior years under the FFS	According to data provided to Mercer, the State absorbed $328,000 in member liability for member out of pocket expenses. In total, the $328,000 would have added less than $0.03 per member per month (PMPM) to the rate; however, an unknown portion of this amount was paid for populations and services excluded from Bayou Health. Given data limitations, Mercer was unable to determine

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					program?	what portions of these costs were for people and services that would be covered in Bayou Health, but would expect the amount to be less than $0.02 PMPM. Mercer believes that these costs are adequately covered by trend and do not require an explicit adjustment in the base data.
8.	Rate Book	N/A	N/A	Page 6	Do Emergency Services for Undocumented Immigrants continue to be considered NOT COVERED by the MCO's? This was listed as a specific exclusion in prior rate books but appears to be missing from the document released on 8/29/14.	DHH removed all references to undocumented immigrants from all RFP documents as the MCO covered services are based on aid category/type case rather than determined by citizenship status. The type case that would include emergency services for undocumented immigrants is excluded from Bayou Health and therefore excluded from the rate book.
9.	Rate Book	N/A	N/A	N/A	Please explain the decision to reduce the number of rate category groupings? How does the state propose to compensate those plans receiving a greater distribution of higher cost age/gender members under the proposed structure. Is it expected that the risk adjuster process will limit "subsidization"?	Mercer recommended consolidating the rating categories because the risk adjustment process accounts for the age and gender variation. Mercer evaluated the impact of reducing the number of rating category groupings. The results of this analysis showed that the risk-adjustment process appropriately accounts for the risk differences by age and gender. The two approaches were compared and the results showed a minimal revenue

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						impact to each of the Prepaid health plans. Reducing the number of rating categories also removes the need for the inherent rate risk adjustment, which adjusted the risk score to avoid double counting any risk variation among the plans that were already being addressed through the rates that varied by age and gender. Consolidation of the rate cells increased the credibility of most rate cells so that less than 1% of the population has a statewide rate. Previously, more than 6% of the population was statewide rated.
10.	Rate Book	N/A	N/A	Page 11	Please provide additional detail for the rationale behind the creation of the EED kick payment? Does a delivery prior to 39 weeks due to early labor or complications (i.e. NOT elective) receive the higher kick or the EED rate? If it's the latter, please provide justification as to why this makes sense.	The creation of an Early Elective Delivery kick payment is intended to support the Department's goal of reducing the number of unnecessary and costly NICU admissions. MCOs receive an Early Elective Delivery kick payment for deliveries that occur prior to 39 weeks for reasons that are not medically indicated in the Louisiana Electronic Event Registration System (LEERS) maintained by the Office of Public Health/Vital Records. Deliveries that occur prior to 39 weeks for reasons that are medically indicated in LEERS will receive the Maternity kick payment. Please refer to the Notice of Intent published in May 2014 edition of the Louisiana Register

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						for additional information.
11.	Rate Book	N/A	N/A	N/A	Please describe the rationale for reducing the number of rating areas from 9 to 4. What criteria were considered in determining the Parishes included in each region?	Mercer conducted an analysis detailing where billed claims for services rendered at hospitals in each parish were delivered. This analysis was done at both a hospital and parish level. Mercer was able to denote parishes for which services rendered at hospitals were primarily delivered in other parishes outside their designated rating areas (regions). Following discussions with the State, it was decided that no rating area (region) would be split up for the purpose of the regrouping. The previous rating areas (regions) were then grouped based on this hospital claim distribution. For example, Mercer found that the majority of hospital claims for the Thibodaux (Region 3) were for hospital services delivered in New Orleans (Region 1), due to their proximity. Thus, these two regions are now grouped together as the Gulf Region. The decided-upon regroupings also represents more even membership distribution across the four regions.
12.	Rate Book	N/A	N/A	Page 6	What is the estimated impact to the overall average rate of the new services described on page 6?	The impact of Hospice and Personal Care services can be calculated by referencing Attachment 1 (page 21) of the Bayou Health Data Book released by the State, dated

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						July 29, 2014. Non-emergent medical transportation (NEMT) to a non-covered service is now the responsibility of the Bayou Health MCO. Since this is a new covered service, it does not show up in the Prepaid Encounters, but is instead a FFS claim. Mercer has created an adjustment for the Prepaid Encounters to account for this addition and the impact can be found in Exhibit 2 of the supplemental exhibits memo, dated September 15, 2014. This additional service cannot be distinguished for Shared Savings/FFS claims because all NEMT services for these populations were covered under FFS. The impact of the additional services are fully captured for the Shared Savings and FFS populations in the NEMT experience on Attachment 1 (page 21) of the Bayou Health Data Book released by the State, dated July 29, 2014.
13.	Rate Book	N/A	Appendix D-2	Page 28	What is the paid through dates for the IBNR factor development? For some service categories, the IBNR factors are for some populations while non-0 for others. For example, lab and home health, Family Children and LAP has an IBNR factor of 0.0 while SSI and BCC have	The paid through date for the incurred but not reported (IBNR) factor development is February 28, 2014. Mercer determined that Prepaid claims categorized as "Prescribed Drugs" for all populations and "Other" for the Family & Children and LaCHIP Affordable Plan (LAP) populations only is deemed to be

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					factors of 1.1 and 1.3 respectively. Is the 0 IBNR factor due to lack of data or does the Mercer study show that they are complete. Please provide additional detail.	complete, thus a 0% IBNR adjustment is applied (Shown in Appendix D-2 of the rate certification). All other IBNR adjustments shown as 0.0% in Appendices D-1 and D-2 are due to rounding.
14.	Rate Book	N/A	N/A	N/A	What, if any, of the base experience adjustments have been reflected in the data book information released by the state? Again, a detailed buildup of the proposed rates would allow plans to get comfortable with the appropriateness of both the factors themselves and the manner in which they were applied in the calculation.	Refer to section 5 (page 11) of the Bayou Health Data Book released by the State, dated July 29, 2014. The data book can be found on the Bayou Health 2014 RFP Procurement Library webpage at http://new.dhh.louisiana.gov/index.cfm/page/1906.
15.	Rate Book	N/A	ACA PCP	Page 10	Please provide more detail for the calculation of the ACA PCP Adjustments described in Table 4.	The claims subject to the enhanced payment were re-priced using the ratio of the ACA-enhanced fee schedule to the traditional Medicaid fee schedule. For the Prepaid Encounters, the enhanced payment data was underreported at the time Mercer requested data as Prepaid health plans were still reprocessing some of the enhanced claims. Discussions were held with each of the existing Prepaid health plans to make sure that Mercer was identifying these claims appropriately.

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						For detail on the adjustment applied to these claims, see Addendum # 20 Exhibit 3 in the supplemental exhibits memo, dated September 15, 2014.
16.	Rate Book	N/A	Program Changes	Page 10	Please provide more detail for the calculation of the Act 312 Program Change described Page 10 of the Rate Book.	Mercer developed the adjustment factor based on information provided by the health plans and a DHH fiscal impact analysis that estimated the legislative mandate could result in a transition of up to 10% of non-covered/non-preferred claims from preferred. The DHH estimate is certainly conservative and assumes the highest impact. Mercer based its analysis on data provided by the health plans including, but not limited to the number of total claims, cost of total claims, percentage of non-covered/non-preferred claims, number of prior authorizations, cost of prior authorizations. None of the health plans provided their estimated increase in cost, claims, etc. resulting from Act 312, so Mercer was not able to evaluate the 10% referenced in the DHH fiscal impact. Mercer estimated the impact to be a 3% increase based on the 10% increase in non-covered drugs resulting in higher claim cost and additional costs for prior authorization.

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17.	Rate Book	N/A	EED	Page 11	Please clarify the EED Reduction % shown in Table 5. The stated percentages are inconsistent with the actual reductions taken against the standard kick payment. Seems like the reduction %'s are, in fact, the complement of the values shown?	The reduction amount showed in Table 5 is equal to: (1 + Reduction (%) in Table 5) * maternity kickpayment. The Early Elective Delivery (EED) kickpayment rate is equal to the maternity kickpayment plus the reduction amount showed in the Table 5. The maternity kickpayment and EED kickpayment are displayed in Appendix A of the Rate Certification letter provided by the State, dated August 29, 2014.
18.	Rate Book	N/A	Retro-Active Eligibility Adjustment	Page 11	Please provide additional support for the Retro-active Eligibility Adjustments shown in Table 6 of the Rate Book. At a minimum, it would be helpful to see the member months and claims dollars (by rate cell) associated with all retroactivity contained in the base experience. Ideally we would like to see the Loss Ratio the members would have run, assuming the Prepaid reimbursement rates in place for each month of retroactivity. Is this something Mercer looked at as part of their adjustment factor development?	Retroactive claims and corresponding member months were not included in the data book. The retroactive eligibility adjustment was developed as an increase to the capitation rates set for all members, meaning that the capitation payment is higher than otherwise required on non-retroactive member months. Retroactive enrollment in any given rate cell will generate the same capitation payment per month to the MCO as any other enrollee in that same rate cell. The factors were developed at a rate cell level on a statewide basis (i.e., all regions used the same factors). These factors are supplied in Exhibit 4-3 of the supplemental exhibits memo, dated September 15, 2014. The calculation relied

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						upon retroactive claims PMPM, unique enrollee counts, and the average duration assumptions to develop the expected increase to Bayou Health claims. To develop the average duration assumptions, Mercer reviewed the average duration of enrollees who were retroactively enrolled during 2013 using data from July 2012 – December 2013. From August 2012 to May 2013, DHH performed additional enrollment review processes, which caused the average duration of retroactive enrollment to increase significantly over normal levels. After May 2013, DHH returned to normal enrollment review processes and the average duration of enrollment decreased significantly. DHH confirmed that they do not foresee a need for implementing this additional review process in the future and expect the enrollment patterns to be consistent with those observed in the second half of 2013. Mercer relied upon July – December 2013 enrollment lags to develop an average durational assumption by category of aid (COA). The supplemental security income (SSI) population lag triangle is provided as an example in Exhibit 4-1 of the supplemental exhibits memo, dated September 15, 2014. The average duration used for each COA is provided in Exhibit 4-2

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						of the supplemental exhibits memo, dated September 15, 2014 In some rate cells, the retroactive claims PMPM was below the base data claims PMPM. This generated an adjustment factor less than 1.0. The decision was made to not use a factor less than 1.0 on any rate cell. These implied factors (calculated) and final factors (used) are both included in Exhibit 4-3 of the supplemental exhibits memo, dated September 15, 2014.
19.	Rate Book	N/A	Shared Savings Rx Claims	Page 13	Please explain the rationale for the 3 month GDR "ramp up" assumption made for Shared Savings Rx. This seems somewhat aggressive. Did Mercer determine the impact to claims under alternate scenarios and, if so, what were they?	Per section 6.33 of the Bayou Health RFP, MCOs are required to allow members 60 days to transition medications after enrollment in the MCO. The extra 30 days is to allow time for the MCO to identify the member for such a transition. Additionally, consideration was given to month-by-month improvements in Generic Dispense Rate (GDR) achieved by the current MCOs when prescription drugs were added to the Prepaid program in November 2012. In that case, almost all of the gains were achieved within three months.

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20.	Rate Book	N/A	Non-Medical Expense Load	Page 14	In previous rate developments, the variable expense assumption was the same for both medial and pharmacy claims. What is the rationale for the dramatic reduction in this assumption for Rx going forward?	Retention loads to the rates include three components: Administration, Margin, and Premium Tax. The margin load of 2% of premium was applied to all rate cells, including maternity kickpayments. Likewise, premium tax was applied at 2.25% of premium to all rate cells, including maternity kickpayments. Mercer developed administrative costs and applied using a mixture of fixed and variable allocations. This is a change from how administrative loads were applied to the Bayou Health Prepaid rates. Previously, a percentage load was applied to all rate cells, with a smaller load being applied to maternity kickpayments. This changes results in retention loads that vary as a percentage by rate cell. See Exhibit 12 in the supplemental exhibits memo, dated September 15, 2014, for the percentage of premium allocated to total retention load in the rates. These percentages include all three components of retention: Administrative Costs, Margin, and Premium Tax. Mercer reviewed plan financial information provided by the Prepaid plans to develop administrative cost expectations. The development included allocations for increases in expenses including items like

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						additional case management due to claims volume and increases in staff compensation over time. The administrative development also included an expected increase in salary for the Behavioral Health Medical Director ($200,000), Program Integrity Officer ($100,000), and 2 Fraud and Abuse Investigators ($65,000 each). Final Administrative cost expectation was $21.48 - $23.02 PMPM. By comparison, using the same administrative loads used in Bayou Health Prepaid rates, administrative loads (8.9% capitation, 4.45% kickpayments) the resulting 2/1/15 administrative PMPM would have ranged from $20.77 to $22.23. To apply the administrative expense, 50% of the administrative cost was applied to all capitation rate cells ($10.74 - $11.51). This is the fixed portion of administrative expenses. The fixed amount was not applied to maternity kickpayments. The remaining portion of administrative expenses is allocated on a variable basis to all rate cells including kickpayments. The variable portion on any given rate cell is equal to 2.0% of pharmacy claims plus 6.1% of all other claims. Maternity kickpayments do not include any costs for pharmacy, so only the 6.1% medical claim percentage applies to kickpayments. This methodology results in a higher

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						allocation of administrative costs on the rate cells with higher utilization, which Mercer believes is more accurate in reflecting the drivers of plan administration requirements.
21.	Rate Book	N/A	Non-Medical Expense Load	Page 14	Has the state calculated the weighted average total admin load (including margin) for the Prepaid plan as a whole? If so, how does this % compare with what was built into the SFY14 Prepaid rates?	See response to question #20.
22.	Rate Book	N/A	Appendix D-1 and D-2	Page 27	Please confirm that the Totals found at the bottom of Appendix D-1 and D-2 are accurate. All seem somewhat low given the magnitude of some of the larger Category of Service values.	The Totals by Category of Aid (COA) found at the bottom of Appendices D-1 and D-2 are correct.
23.	Rate Book	N/A	N/A	N/A	Please provide the fee schedule adjustments (fee change and hospital privatization impact separately) by rate cell/region and by Prepaid, Shared Savings and LaHIPP.	See Addendum #20 Exhibits 5 and 6 in the supplemental exhibits memo, dated September 15, 2014.
24.	Rate Book	N/A	N/A	N/A	Mercer mentioned that they studied historical cost and utilization data for each of the three data sources. But appendix E: Trend did not show the trends separately by the three data sources. Does this mean the same trend	Due to the relatively short history of managed care in Louisiana, as well as the bifurcated nature of the current Bayou Health program, Mercer's trend studies using Louisiana-specific data were limited in scope. Based on these studies, it was determined that

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					was applied to all the three data sources? Did Mercer's trend studies support that all three data sources have same trends?	the use of a single trend rate for all three data sources was best. In selecting these trends, there was reliance on national Medicaid trends as well as Louisiana-specific data.
25.	Rate Book	N/A	Data Smoothing	Page 14	Please describe the credibility criteria, including member thresholds, referenced in the Data Smoothing section of the Rate Book.	A statewide capitation rate was calculated for all the rate cells with member months (MMs) less than 30,000 per region.
26.	Rate Book	N/A	Outliers	Page 13	Mercer mentioned that the outlier payments were built into the rates based on the distribution by rate cell observed in SFY11 and 12. Since the base data for the rates are CY2013, please explain why CY2013 distribution was not used.	Mercer receives outlier payment information on a State Fiscal Year (SFY) basis. The most recent outlier information received was for SFY 2013 payments, which Mercer analyzed and determined the claims payment distribution to be an anomaly compared to SFY 2011 and SFY 2012 experience that was more consistently distributed. Thus, Mercer came to the decision that utilizing data from SFY 2011 and SFY 2012 would provide a more representative basis for the future claims distribution patterns.
27.	Rate Book	N/A	N/A	N/A	It looks like trend and managed care savings are the only drivers for the rate ranges. Please verify.	The factors that drive the rate range include trend, managed care savings, GDR, and retention load.
28.	Rate Book	N/A	N/A	N/A	For the HCBS/CCM waiver, could Mercer split the PMPM managed care savings into utilization and cost?	See Addendum #20 Exhibit 7 in the supplemental exhibits memo, dated September 15, 2014.

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29.	Rate Book	N/A	N/A	N/A	For the trend development, could Mercer split the PMPM trend into utilization and cost?	See Addendum #20 Exhibit 8 in the supplemental exhibits memo, dated September 15, 2014.
30.	Data Book	N/A	N/A	Page 7	In the data book narrative, page 7, "Effective February 1, 2015, the new mixed services protocol delineates coverage responsibility based on provider type and specialty or facility type. Basic behavior health will continue include services provided in a primary care setting, but also includes all inpatient hospital services provided in a general hospital setting regardless of diagnosis." What is the impact of this change to the rates?	See Addendum #20 Exhibit 9 in the supplemental exhibits memo, dated September 15, 2014.
31.	RFP	2.2.4	Scope of Work	Page 8	Please quantify the expected cost of each benefit management program as they are being priced in the capitation rates	Section 2.2.4. briefly describes the benefit management and administrative services that MCOs are expected to perform as part of their participation in the Bayou Health program. These services are not individually quantified as part of the rate development process; rather, the capitation rate ranges include a non-medical expense load for MCO administration and other non-medical expenses based on historical expense data

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						and Mercer's professional experience in working with state Medicaid programs. (See page 14 of the August 29, 2014 certification letter.)
32.	RFP	2.5	Scope of Work	Page 10	Please quantify the expected cost of each insurance coverage (including reinsurance) as they are being priced in the capitation rates.	Net reinsurance costs (premiums less recoveries) are reflected in each plan's audited financial statements. MCO Encounter data is then adjusted to match these financial statements, such that the actual net cost of reinsurance is reflected in the base data. No adjustment was made to Shared Savings/FFS claims as reinsurance agreements do not exist.
33.	RFP	3.0	Eligibility	Page 14	Please identify any significant changes in eligibility categories where members may have shifted from one category to another from year to year.	There were no significant changes in eligibility categories. Refer to Attachment 1 (page 21) of the Bayou Health Data Book released by the state, dated July 29, 2014, for a detailed analysis of how members are distributed amongst the eligibility categories.
34.	RFP	5.1.3	MCO Reimbursement	Page 31	Please confirm that the state will pay different maternity kick payment rates for births before 39 weeks (as opposed to full-term births). Is this different than the early elective abortion rates?	There are two kick payment rates (see in Appendix A: Bayou Health Capitation Rate Range (pages 17-19) in the Rate Certification letter provided by the State, dated August 29, 2014).

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						The Early Elective Delivery Kick Payment applies to deliveries before 39 weeks with no medical indication in LEERS. The Maternity Kick Payment applies to all other births regardless of gestation, including premature births and stillbirths. There is no early elective abortion rate.
35.	RFP	5.1.3	MCO Reimbursement	Page 31	If the separate maternity kick payments for births before 39 weeks are different than the early elective abortion rates, please provide these rates.	See response to question #34.
36.	RFP	5.1.3	MCO Reimbursement	Page 31	If the state will pay separate maternity kick payments for births before 39 weeks, will there be a single rate for all premature births, or will reimbursements be higher for earlier births or low birth weight babies (if so, please provide details)?	See response to question #34.
37.	RFP	5.1.3	MCO Reimbursement	Page 31	If the state will pay separate maternity kick payments for births before 39 weeks, will this rate be paid for still births as well as live births?	See response to question #34.
38.	RFP	5.6.2	MCO Reimbursement	Page 33	Please provide the data book data broken out by data source (FFS, MCO encounter, etc.).	Refer to Attachment 1 (page 21) of the Bayou Health Data Book released by the state, dated July 29, 2014, for a detailed analysis by data source.

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39.	RFP	5.6.2	MCO Reimbursement	Page 33	Are there any significant known issues regarding existing health plan data?	For Prepaid Encounter data, there were some timing issues with the ACA-enhanced PCP claims. At the time Mercer collected the data, with two months of run-out (paid through February 28, 2014), the MCOs were still re-processing the enhanced claims. To resolve this issue, Mercer held discussions with the Prepaid plans to ensure that the adjustments being made to their Encounter data were reflective of the enhanced payments reported at the time Mercer requested the Encounter data set. No other significant issues with the data are known.
40.	RFP	6.18.1	Core Benefits and Services	Page 60	Please explicitly list out, by rate cell, services the State will continue to pay for on a FFS basis.	Refer to section 3 (page 8) of the Bayou Health Data Book released by the state, dated July 29, 2014, for a detailed list of excluded services.
41.	RFP	5.6.2.1, 5.6.2.2	MCO Reimbursement	Page 33	Please provide trend estimates broken out by components of trend, as listed in the RFP (utilization and unit cost).	See response to question #29.
42.	RFP	5.6.2.2	MCO Reimbursement	Page 33	Does the unit cost trend include adjustments for mix/intensity of services as well as charge trend? If so, please provide an explicit breakout of the components of unit cost trend used in the	Mercer developed unit cost trend based on historical experience in Louisiana, and recent trend developments in other managed Medicaid programs. The unit cost trend was developed as a single estimate, and did not

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					construction of the rates.	delineate between charge trend versus intensity/mix of services. Both charge trend and intensity/mix of services are reflected in the selected unit cost trends, as they are present in the periods underlying Mercer's trend study.
43.	RFP	5.6.3	MCO Reimbursement	Page 34	Are there any services provided to these members through other departments or programs that have been cut this year or expect to be cut in the near future causing the services to be pushed into this program? If so, how has the base experience data been adjusted to take into account these changes in services since the base period?	No, there have been no service reductions in the current year nor are there any anticipated service reductions in other agencies/programs that would impact the new Bayou Health contract.
44.	RFP	5.6.2	MCO Reimbursement	Page 33	For the purposes of developing trends and determining if the historical periods in the data book may be abnormally low or high, please provide rolling 12 month changes in utilization/1,000 and PMPMs going back to earlier years. Or, at a minimum, please provide a summary of additional experience periods from available data sources (for example, fee for service data).	See response to question #24.
45.	RFP	6.0	Core Benefits and Services	Page 42	Are specialty drugs (i.e., J-Codes) the responsibility of the MCO?	Yes. Refer to section 6.3.1 Covered Services in the RFP, released by the state dated July 28, 2014.

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46.	RFP	6.1.4	Core Benefits and Services	Page 44	What are the current types of covered transportation vehicles (e.g. taxi, bus, other)?	The NEMT program covers public and private, non-profit and for-profit transportation vehicles. Medicaid is required by federal law to provide transportation to covered medical services at the least available cost.
47.	RFP	6.1.4	Core Benefits and Services	Page 44	Are members on bus routes required to use public transportation?	No, members are not required to use public transportation.
48.	RFP	6.1.4	Core Benefits and Services	Page 44	Are covered non-emergent transportation trips limited per month or plan year?	There are no limits on NEMT services.
49.	Rate Development (Appendix G) /Addendum 5	N/A /Question 112	New Services/ Question Responses	Page 6/47	Please explain the seemingly contradictory statements made in the rate development narrative and the first round of question responses regarding transportation services. The rate development states that non-emergent medical transportation will be the responsibility of the MCO, even if the service that the recipient is being transported to is not a Bayou Health covered service. The State's response to question 112 of the first round of questions (Addendum 5) indicates that "No, NEMT transportation is only	The State's response indicated that NEMT is provided only to Medicaid-covered services, while the Mercer rate letter indicates that NEMT costs will be the responsibility of the MCO even if transport is being provided to a service not covered by Bayou Health. For example, a Bayou Health MCO might have to cover non-emergent transportation for an enrollee to get to an LBHP-covered service, or some other Medicaid-covered service that is not included in Bayou Health.

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					provided to Medicaid covered services. However if an MCO has contractually agreed to provide additional services or is providing services in lieu of state plan covered services, the MCO must cover the transportation to these services."	
50.OI	Rate Development (Appendix G)	N/A	Fee Schedule Adjustments	Page 8	What is the relationship between the base period claims in the data book and the Medicaid fee schedule? If an MCO reimbursed providers at a higher level than the fee schedule, were these claims adjusted to the Medicaid fee schedule reimbursement level?	Mercer assumed that Prepaid plans contracted at a level above the Medicaid fee schedule but did not quantify the relative relationship between the Prepaid plan data and the Medicaid fee schedule. Mercer also assumed that this relationship would continue in the future and adjust accordingly as the Medicaid fee schedule changes. To preserve this relationship inherent in the Encounter claims, Mercer adjusted Prepaid claims by the percentage change in the Medicaid fee schedule instead of directly re-pricing the claims data. For Shared Savings/FFS, all claims were paid at the Medicaid fee schedule (except for ACA PCP claims), and were adjusted based on changes in the Medicaid fee schedule. ACA PCP claims were paid at the ACA-enhanced rate and then re-priced to the Medicaid fee schedule for use in February 2015 rates.

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
51.	RFP	5.6.2.2	MCO Reimbursement	Page 33	How are Medicaid fee schedule increases developed for hospital, physician, emergency room and pharmacy rates?	Rate increases are developed in accordance with approved policy changes and/or the financial resources appropriated to the affected program.
52.	RFP	5.6.2.2	MCO Reimbursement	Page 33	How often are the Medicaid fee schedules updated?	Fee schedules are updated as required upon approval of state- or federally-initiated policy changes (e.g. ACA mandates, state plan amendments, budget reduction, etc.). The fee scheduled posted online at http://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm is refreshed monthly.
53.	Rate Development (Appendix G)	N/A	Fee Schedule Adjustments	Page 8	What have the historical Medicaid fee schedules increases been in recent years, other than those specified in the rate development document?	Refer to Mercer's prior period rate certification documents for further information regarding historical fee schedule changes published to the State's website located under the resources section: http://new.dhh.louisiana.gov/index.cfm/page/1906 Fee schedules are available at http://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm.
54.	RFP	5.6.2.2	MCO Reimbursement	Page 33	What are the expected future Medicaid fee schedule increases in the next few years?	Medicaid fee schedule increases are not expected in the next few years.

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
55.	RFP	5.6.2.2	MCO Reimbursement	Page 33	What is the State's definition of the Medicaid fee schedule? If it differs by provider type, please provide separate definitions. If it varies by inpatient, outpatient, physician and ancillary services, please provide separate definitions.	Fee schedule definitions are found on the same page as the fee schedules. See the fee schedule link on www.lamedicaid.com.
56.	Rate Development	N/A	Fee Schedule Adjustments	Page 8	Do the adjustments for fee schedule changes represent the differential between the old and new fee schedules, or a repricing of base period claims to the new fee schedule? Said differently, are the assumed reimbursement levels in the rate development for 2015 equivalent to the most recent Medicaid fee schedule.	See response to question #50.
57.	RFP	9.10	MCO Reimbursement	Page 123	Are there other payments/settlements made outside of the claims system that will be the responsibility of the plans? If so, will these be built into the rates? Are any of them fixed dollar pass-through amounts or are they all variable based on utilization?	The Medicaid fee-for-service rate, as that term is used in Section 9.1, may include payments to providers that are not tied to individual claims, depending upon the provider type. For example, Medicaid FFS hospital outlier payments are included in the "Medicaid rate" that is the responsibility of the Bayou Health MCO. Historical non-claims based payments that have been built into the capitation rates include amounts resulting from cost-settlements, "high Medicaid" payments to hospitals, and hospital outlier payments. Where MCOs are responsible for paying the Medicaid FFS rate to providers, as that term is used in Section 9.1, this amount is

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
						variable based on utilization.
58.	RFP	9.10	MCO Reimbursement	Page 123	Are there any fixed dollar supplemental payments (to hospitals or other providers) that the health plans will need to pay and thus include in the rates?	See response to question #57.
59.	RFP	9.10	MCO Reimbursement	Page 123	Are there any variable dollar supplemental payments (for example, varying by utilization) that the MCOs must pay and thus must be included in the rates?	See response to question #57.
60.	RFP	5.6	MCO Reimbursement	Page 33	Will the actuarially sound rates be submitted to CMS for approval?	Yes.
61.	RFP	5.6	MCO Reimbursement	Page 33	Please provide a listing of all Medicaid capitation rates effective during the last three years, by MCO.	Rate certification letters for the current Bayou Health program are available in the RFP procurement library: http://new.dhh.louisiana.gov/index.cfm/page/1906. Risk-adjusted rates specific to each MCO will not be provided.
62.	RFP	5.7.1.1	MCO Reimbursement	Page 34	Please provide a list of the age, gender, and condition groupings for which risk groups will be assigned, including definitions and grouping methodology.	DHH will use the adjusted clinical groups (ACG) model to measure the health risk for each plan. The ACG model uses diagnostic information along with member demographics (age and sex categories) to classify people into mutually exclusive ACGs that are indicative of the expected health care

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
						resource in terms of cost consumption. The risk for each plan will be calculated for the following risk adjustment rating categories: SSI Child, SSI Adult, Family & Children Child, and Family & Children Adult. For a list of all the ACG categories utilized, see Exhibit 13 in the supplemental exhibits memo, dated September 15, 2014.
63.	RFP	5.7.2	MCO Reimbursement	Page 35	Please clarify to what level risk scores will be calibrated to. At the region and category of aid level? At the region and rate cell level?	Risk scores will be calibrated at the regional grouping (effective 2/1/15) and risk adjustment rating category level.
64.	RFP	5.7.2	MCO Reimbursement	Page 35	Will the Average MCO risk score be updated monthly or semi-annually?	See response to question #4.
65.	RFP	5.7.1	MCO Reimbursement	Page 34	Please provide additional detail on how members who have enough months of enrollment to be scored, but who have no claim experience will be included in the risk adjustment process.	The ACG model classifies members who have enough months of enrollment to be scored, but no claims experience into "ACG 5200 – Non Users" category (see question 62 for more details on the ACG groupings). The members are given a low relative cost and are included in the risk score calculation. Generally, these members make up approximately 5% - 9% of the total scored recipients.

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
66.	RFP	5.7.1	MCO Reimbursement	Page 34	Will pharmacy data be used in the risk adjustment process?	At this time, the version of the ACG model used is a diagnostic-based model and does not use pharmacy data to classify individuals into an ACG group. However, the relative costs associated with each ACG category, used to determine the risk scores, include the pharmacy costs.
67.	RFP	5.7.1	MCO Reimbursement	Page 34	Risk Adjustment is designed to be budget neutral to the state. Will the budget neutrality be on a statewide basis, or on a more granular level (ex. by region)?	The budget neutrality is done at the regional grouping (effective 2/1/15) and risk adjustment rating category level (as described in questions #62 and #63).
68.	RFP	5.7.1	MCO Reimbursement	Page 34	Will MCOs be allowed to submit supplemental diagnosis code information for the purpose of risk adjustment?	At this time, plans will not be allowed to submit supplemental diagnosis code information outside of the encounter data for the purposes of risk adjustment.
69.	RFP	9.4	Provider Reimbursement	Page 119	Please provide a breakout of claims and member months incurred under retroactive eligibility that were used in the development of the capitation rates.	See response to question #18.
70.	RFP	9.4	Provider Reimbursement	Page 119	Will the state consider adding a risk sharing arrangement, or pass-through arrangement for claims incurred under retroactive eligibility?	The Department will not consider such an arrangement at this time.

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
71.	RFP	9.4	Provider Reimbursement	Page 119	Please provide detail and summary information on aging of the retroactive membership by rate cell.	See response to question #18.
72.	Data Book	N/A	N/A	N/A	Please provide a breakout of maternity costs by region and rate cell (as opposed to by region only).	Maternity Kick Payment costs are available regionally only and are not delineated by rate cell or COA.
73.	Rate Development (Appendix G)	General Question	N/A	N/A	Please provide a detailed numerical calculation of all rates starting from the base period claims expenses and incorporating all adjustments and add-ons to arrive at the final rates.	See response to question #1.
74.	Rate Development (Appendix G)	N/A	Bayou Health Capitation Rate Range	Page 17	Which rates are the state proposing to actually pay the MCOs in the prepaid program? Because the State has only provided a range for each rate cell, it is difficult to determine the feasibility.	See response to question #2.
75.	Rate Development (Appendix G)	N/A	New services	Page 6	Were prepaid plans and shared savings plans required to provide the same package of services in the base period experience? If there was a differential, please quantify the PMPM expenditures assumed for each service.	Refer to section 3 (page 7) of the Bayou Health Data Book released by the State, dated July 29, 2014, for a list of previously excluded services from the Shared Savings program now included in the base period experience. The PMPM differential can be quantified utilizing the exhibits provided in Excel format shown in Attachment 1 of the Data Book, for each of the newly added services. Refer to the footnotes in the exhibits for details regarding which services were added to the Shared Savings experience.

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
76.	Rate Development (Appendix G)	N/A	Retro-Active Eligibility Adjustment	Page 11	Please provide more detail on how the retro-active eligibility adjustments were determined, including the numerical calculations that lead to these percentage assumptions.	See response to question #18.
77.	Rate Development (Appendix G)	N/A	Retro-Active Eligibility Adjustment	Page 11	Please confirm that retro-active claims and membership were included in the base period claims experience used in the calculation of the rates.	See response to question #18.
78.	Rate Development (Appendix G)	N/A	Retro-Active Eligibility Adjustment	Page 11	Please provide more detail on what the retro-active eligibility adjustment represents, including any numerical calculations used to develop the factors. If retro-active claims and member months were included in the base period claims experience (as stated in the response to question 178 in addendum 5), what was the purpose of this adjustment?	See response to question #18.
79.	Rate Development (Appendix G)	N/A	New services	Page 6	Please quantify the PMPM impact of new services on the developed rates, including hospice services, personal care services, the expansion of non-emergency transportation to non-Bayou Health covered services and any other coverage expansions not mentioned.	See response to question #12.

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
80.	Rate Development (Appendix G)	N/A	Excluded Services	Page 6	Please confirm that the base period experience in the data book reflects the package of covered services that the MCO will be responsible for in the contract period and that excluded services do not have to be carved out.	Confirmed. With the exception of the behavioral health-mixed services protocol, as mentioned in question 97 and on page 6 of the rate certification dated August 29, 2014, no excluded services were included in the data book. Refer to Appendix A (page 15) of the Bayou Health Data Book released by the State, dated July 29, 2014, for a list of covered services that are the MCOs' responsibility.
81.	Rate Development (Appendix G)	N/A	Data Adjustments	Page 7	Please confirm that the claims information in the data book is already adjusted for IBNR and underreporting.	Confirmed. Refer to Section 5 (page 11) of the Bayou Health Data Book released by the state, dated July 29, 2014, for a full list of adjustments applied in the data book.
82.	Rate Development (Appendix G)	N/A	Data Adjustments	Page 7	Is the claims information in the data book already adjusted for fraud and abuse recoveries (including for FFS claims), or were adjustments made alter in the rate development process?	The claims information in the data book has not been adjusted for fraud and abuse recoveries, this adjustment was made in the rate-setting process. An adjustment for fraud and abuse recoveries are shown in the Data Adjustments section (page 8) in the Rate Certification letter provided by the state, dated August 29, 2014.
83.	Rate Development (Appendix G)	N/A	Fee Changes	Page 9	Please provide more detail on the development of the fee change adjustment factors, including any numerical calculations used to develop them. Please specify what adjustments were made to each service category	A full description of the fee changes is provided on pages 8 and 9 of the Rate Certification letter provided by the State, dated August 29, 2014. For a numerical breakdown, see Exhibits 5 and 6 in the supplemental exhibits memo, dated

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
					within each rate cell.	September 15, 2014.
84.	Rate Development (Appendix G)	N/A	ACA PCP	Page 9	Please provide more detail on the development of the ACA PCP adjustment factors, including any numerical calculations used to develop them.	See response to question #15.
85.	Rate Development (Appendix G)	N/A	Act 312	Page 9	Please provide more detail on the development of the Act 312 adjustment factor, including any numerical calculations used to develop it.	See response to question #16.
86.	Rate Development (Appendix G)	N/A	Trend	Page 12	Please provide more detail on the development of the trend factors, including any numerical calculations used to develop them.	See response to question #29.
87.	Rate Development (Appendix G)	N/A	Trend	Pages 12 and 29	Are the trend factors listed in the appendix annual factors, or total trend factors representing the adjustment from the base period to the projection period?	The trend factors listed in Appendix E (page 29) in the Rate Certification letter provided by the state, dated August 29, 2014, are annual factors.
88.	Rate Development (Appendix G)	N/A	Managed Care Adjustments	Page 12	Please provide more detail on the development of the managed care adjustment factors, including any numerical calculations or benchmarking analyses used to develop them.	See response to question #28.
89.	Rate Development (Appendix G)	N/A	Managed Care Adjustments	Pages 12 and 30	Are the managed care adjustment factors listed in the appendix annual factors, or total trend factors representing the	The Managed Care Savings factors listed in Appendix F (page 30) in the Rate Certification letter provided by the state, dated

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
					adjustment from the base period to the projection period?	August 29, 2014, are total factors.
90.	Rate Development (Appendix G)	N/A	Shared Savings Rx Claims	Page 13	Please provide more detail on the development of the Shared Savings Rx adjustment of 11-13%, including any numerical calculations used to develop them and the actual impact on the rates by region and rate cell.	This adjustment is a downward adjustment to the Shared Savings claims data. Mercer's Pharmacy Team analyzed Shared Savings prescription drug experience and compared it to the spending on similar therapeutic classes of drugs in the Prepaid program. Mercer determined that achieving the same GDR levels would result in savings of 13% - 16%. After adjusting for phase-in, the savings for rating year 2015 is 11% - 13%. See Exhibit 10 in the supplemental exhibits memo, dated September 15, 2014, for a detailed savings breakdown by COA.
91.	Rate Development (Appendix G)	N/A	Outliers	Page 13	Please provide more detail on the development of the Outlier Impact of $0.93, including any numerical calculations used to develop them and the actual impact on the rates by region and rate cell.	Historical payment information was used as the basis for determining outlier payments. This additional cost was built into the rates based on the statewide distribution by rate cells observed in SFY 2011 and SFY 2012. Outliers added an average cost of $0.93 PMPM to the base data used in rate setting. See Exhibit 11 in the supplemental exhibits memo, dated September 15, 2014, for details regarding the impact of outliers on the rates by rate cell.

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
92.	Rate Development (Appendix G)	N/A	Non-Medical Expense Load	Page 14	Please provide more detail on the development of the non-medical expense load, including any numerical calculations used to develop the loads (a simplified summary of the fixed and variable cost model would be helpful) and the actual impact on the rates by region and rate cell.	See response to question #20.
93.	General Question	N/A	N/A	N/A	Given that the State will not be providing responses to these questions until September 15th, will the state consider extending the RFP deadline to provide the health plans with a reasonable amount of time to determine whether the proposed rates are feasible once all questions are answered?	No. The RFP deadline will not be extended.
94.	Rate Development (Appendix G)	N/A	Early Elective Deliveries	Page 11	No estimates as to the split of normal maternity kick payments and early elective delivery kick payments were provided. Please provide an estimate for the projected percentage of maternity kick payments that will receive this reduced payment relative to the data provided in the data book.	Analysis of SFY13 LEERS data found 242 deliveries prior to 39 weeks without medical indication. However, LEERS has not been used for payment purposes to date, and DHH anticipates that deliveries prior to 39 weeks without medical indication in LEERS will be largely eliminated within a year's time due to the alignment of clinical practice with Early Elective Delivery payment policy and the alignment of LEERS data entry with medical records.

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
95.	Rate Development (Appendix G)	N/A	Graduate Medical Education	Page 13	Please confirm that the data book provided in early August does not include these costs. If the data book does include these costs, please provide a PMPM estimate for these costs. Please also confirm whether these payments were being made by DHH for incumbent MCOs (That is, that these payments were being made by DHH for all current prepaid MCOs).	The data book does not include any costs related to Graduate Medical Education (GME). DHH has made payments for GME outside of capitation since the inception of Bayou Health in 2012.
96.	RFP Appendix G	N/A	N/A	3	Please detail the GME amounts removed by rate cell and region for the FFS and Shared Savings data.	The adjustment to remove GME from FFS and Shared Savings is part of the fee adjustment process for hospital claims. It is not explicitly calculated as a separate item. Mercer uses fee schedules that are net of GME in the fee adjustment process.
97.	RFP Appendix G	N/A	Behavioral Health Mixed Services Protocol	6	What are the services provided by specialized behavioral health specialists that are excluded from Bayou Health? Do you have a list of service codes that should be excluded? How will we identify specialized behavioral health specialists?	All services provided by behavioral health specialists are excluded from Bayou Health. Mercer does not have specific service codes that should be excluded. All services are excluded based on the provider type. All services that are provided by behavioral health specialists are excluded, regardless of the service rendered. Refer to the section 6.4.1.2 of the RFP for the list of behavioral health specialists.

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
98.	RFP Appendix G	N/A	Under-reporting	7	Does the under-reporting adjustment increase encounter data by 3.7% so that it equals Prepaid plans' reported financial data? If not, please clarify what this adjustment does and what the difference is between encounter data, financial data, and the data used in rate development.	Yes. The underreporting factor was applied on a plan basis and resulted in an overall adjustment of 3.7% to true up Encounter data to the Prepaid plans' reported financial data.
99.	RFP Appendix G	N/A	Hospital Privatization	8	What is the overall rate impact (by rate cell and region) of the hospital privatization and closing?	See Addendum #20 Exhibit 6 in the supplemental exhibits memo, dated September 15, 2014.
100.	RFP Appendix G	N/A	Program Changes	10	Under what conditions must an MCO grant an override to step therapy or fail first protocol? How was the 3% adjustment calculated?	Mercer's Pharmacy Team did not perform a legal review of the bill. Mercer interpreted the language to mean that MCOs cannot require a trial on a Step Therapy or Fail First regimen that is longer than the duration of action of the preferred product. See response to question #16.
101.	RFP Appendix G	N/A	Early Elective Deliveries (EED)	11	Assuming only medically necessary care is covered for Bayou Health, why are early elective deliveries covered? What is the percentage of births that	See response to questions #10 and #94. Effective with dates of service beginning September 1, 2014, the Department's Fiscal Intermediary (Molina) will deny hospital and physician fee-for-service claims for the

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
					were EEDs?	delivery of a baby prior to 39 weeks that is not medically indicated in LEERS; claims for the anesthesia related to the delivery will not be impacted by this policy, however. The reduced kick payment to MCOs for early elective deliveries reflects this same policy.
102.	RFP Appendix G	N/A	Retro-active Eligibility Adjustment	11	Please explain why a member would be granted retroactive eligibility for up to 12 months. It appears that this is applicable to SSI adults, F&C Adults and BCC. While the costs for this retro period are the responsibility of the MCO, and an adjustment is built into the capitation rates, how will Actuarial Soundness be achieved? If one MCO is allocated more high cost retroactive members, how will the rates be adequate for this selection bias?	See response to question #18.
103.	RFP Appendix G	N/A	Rating Adjustments	12	Given the LA has the highest Hepatitis C population per capita, how has Sovaldi and the expected release of new Hep C drugs been factored into the rates? We have seen double digit pharmacy trends due to Sovaldi in 2014, and recent information indicates that costs will potentially triple in 2015.	Trend ranges for pharmacy were set by Mercer's Actuarial Team, with input from Mercer's Medicaid Pharmacy Team. The impact of new drugs coming to market, including Sovaldi and other Hepatitis C treatments, is included in these trends. The Department is currently evaluating

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
					Will Bayou Health consider a Hep C drug kick payment for future reimbursement given the utilization uncertainty with these new pipeline drugs?	Hepatitis C drug costs for incumbent MCOs and may consider a kick payment in the future, if analysis indicates it is warranted. However, no Hepatitis C kick payment is being developed for the new Bayou Health program at this time.
104.	RFP Appendix G	N/A	Outliers	13	Will there be an adjustment if the additional payment for high cost stays exceeds the $10 million built into the rates? Has this been adjusted for changes in Hospital charge master schedules and their corresponding impact on CCRs?	No. Mercer has accounted for the historical outlier payments in rate development for this risk-based contract. See Addendum #20 Exhibit 11 in the supplemental exhibits memo, dated September 15, 2014, for additional information.
105.	RFP Appendix G	N/A	Risk Adjustment	14	How will risk adjustment be performed for LA HIPP and members that are new to Medicaid? How will an MCO that is a new entrant to Bayou Health receive a risk score for its members? Given the auto assignment provisions, members with a prior MCO will be assigned to the prior MCO, which would leave members new to Medicaid to be disproportionately allocated to a new MCO. How will this be taken into account in the	Risk scores are calculated based on a historical risk adjustment study period. If the member has more than six months of eligibility in Medicaid (health plan or FFS) during that risk adjustment study period, they will get a risk score. Members and their corresponding risk scores will then be assigned to a health plan, regional grouping, and risk adjustment rating category based on a recent enrollment snapshot. Risk scores for members who are new to Medicaid, including Louisiana's Health Insurance Premium Payment (LaHIPP) members, will be given an unscored assumption that will be based on averages from the scored population. DHH

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
					risk adjustment process?	and Mercer are still in the process of finalizing the unscored assumption for new contract. No MCO will be limited to members that are new to Medicaid. Auto assignment will ensure that new MCOs receive sufficient enrollment for financial viability as determined by DHH. As Medicaid enrollment has increased little in recent years, auto assignees are likely to be existing Medicaid members and receive a risk score.
106.	Appendix A: Bayou Health Capitation Rate Range (of RFP Appendix G)	N/A	Appendix A: Bayou Health Capitation Rate Range	17	Appendix A has the upper and lower bounds for the capitation rates. When will we receive the rates for the Bayou Health program?	See response to question #2.
107.	Appendix F: Managed Care Savings of RFP Appendix G	N/A	Appendix F: Managed Care Savings	30	Was there a ramp up assumption used in the calculation of the managed care savings? If so, what was this? How has this been adjusted if membership comes in gradually, as it would for a new MCO?	The managed care savings are exclusive of any ramp up effect.
108.	RFP Appendix G	N/A	Fee Schedule Adjustments	8	What was the fee schedule percentage adjustment for the cost settlements (66.46% and 110%)?	In general, the cost settlement percentages used were either 66.46% or 110% depending on hospital type. Refer to the State Plan for specific details.

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
109.	RFP Appendix G	N/A	Rate Methodology Overview	2	Mercer used the Prepaid and Shared Savings (managed) data to establish the Bayou Health Capitation rates. However, for a new MCO, the majority of its members will be new to Medicaid since if a member had a prior MCO, he will be auto assigned to that prior MCO. This means that the majority of a new MCO's members would be unmanaged, while the majority of an existing MCO's membership would be managed. The capitation rates would be adequate for the existing MCOs; however would be insufficient for a new MCO. How will this disparity be addressed in the rates? Will there be consideration for an adjustment to a new MCO's rates given this difference in managed vs. unmanaged composition? Note, risk scores cannot be used since these new members will not have any historical experience.	See response to question #105.
110.	RFP Appendix G	N/A	Rate Category Groupings	4	Claims detail files were provided to us but we could not identify any fields to designate members' region or rate cell. Can you please indicate what fields should be used?	Fields for region/rate cell were not included in the data provided by Molina, as the claims detail file was focused on services provided rather than demographic information about individual members.

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
111.	RFP Appendix G	N/A	Data Adjustments	7	When summing the "Medicaid Payment" field in the claim detail files, we get a very different total from the databook summary that was provided. What criteria need to be used for those numbers to tie?	Claims detail/encounter data provided by Molina will not correspond to the summaries included in the databook, as the former is simply an excerpt of historical data provided from MMIS while the latter, developed by Mercer, has been adjusted based on included and excluded populations and covered and excluded services as planned for the new Bayou Health contract.
112.	Appendix G Rate Letter	General	General	NA	Will appendices be provided that includes detailed base period data and all adjustments applied to that data such that a reviewing actuary can assess the reasonableness of the resulting rates?	See response to question #1.
113.	Appendix G Rate Letter	General	General Population	3	Mercer has indicated that no rate adjustments will be made for the inclusion of the CCM and HCBS opt-in populations. Due to the uncertainty around the cost profile of the opt-in members, will DHH use Mercer to retrospectively review the experience for these individuals and potentially retrospectively adjust the capitation rates if appropriate?	The Department will not retrospectively adjust capitation rates due to this uncertainty, as this is an at-risk contract.
114.	Appendix G Rate Letter	General	Rate Category Groupings	4	The proposed rate category groupings represent significantly less granularity than has historically existed in the Bayou Health program. For example, the prior Family & Children categories for children 1-5, 6-13, 14-18 male, and 14-18 female	See response to question #9.

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
					will be consolidated into a single "Child 1-18 years of age" category. While risk adjustment generally captures high-level risk differences across a population, it is our experience that risk adjustment combined with the more granular rate categories will more accurately reflect cost differentials between the various types of members, and reduce mix-based bias that may exist at the MCO. Is there additional detail in support of the changes to these less granular categories that can be provided?	
115.	Appendix G Rate Letter	General	Retro-Active Eligibility	11 / 12	The proposed process puts participating MCOs at risk for retroactively eligible members. Previously, these individuals' costs were covered by FFS. Mercer has indicated that adjustments were made to account for the MCOs' inability to manage these retroactive claimants, but has not supplied any information regarding the methodology used in arriving at these adjustments. Will Mercer provide additional detail regarding the development of these factors and whether risk differentials were considered in the development of these factors? Will Mercer specifically address why retro-active adjustments were not considered for the majority of the rate cells (e.g. all child categories) per Table 6	See response to question #18.

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					which reflects Retro-Active Eligibility Adjustments by Rate Cell?	
116.	Appendix G Rate Letter	General	Retro-active Eligibility Adjustment	11-12	The proposed retroactive coverage process will result in considerable uncertainty to reporting financial results. At any point in time a plan is responsible for retroactive claims for members that they are not aware of yet. If these are members with medical cost significantly in excess of retroactive revenue this could result in significant restatement of financial results for this period. These significant retroactive claims will result in more volatile claim payment patterns that will lead to more difficult claim liability estimations in general. This process will also complicate medical loss ratio rebate calculations, reinsurance submissions and these members may not be appropriately reflected in risk adjustment process. Will DHH consider these issues and reconsider this approach?	DHH recognizes the additional accounting and reporting burden of processing retroactive revenue and retroactive claims. DHH expects the respondents to follow GAAP guidelines for revenue and expense recognition. Material restatements will be addressed as needed for reporting purposes and for medical loss ratio (MLR) rebate calculation purposes, but the respondents should expect to appropriately adjust reports if there are significant restatements due to retroactive enrollment. Volatility in claim payment patterns, claim liability estimates, and risk adjustment calculations are accounted for in the rate-setting process.
117.	Appendix G Rate Letter	General	Non-Medical	14	The rating documentation indicates that administrative allowances for each rate cell include both fixed PMPM and percentage based components. Will Mercer provide the separate PMPM and percentage components for each rate	See response to question #20.

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
					category grouping?	
118.	Appendix G Rate Letter	General	RX	13	The rating document contains no mention of the Hepatitis C drugs Sovaldi and Olysio. These drugs represent a significant improvement in the treatment of Hepatitis C, but are extremely expensive, and are highly utilized among Medicaid populations. Because these therapies were approved at the end of 2013, their costs would not be present in the CY 2013 base data. Will Mercer provide the amount (on a PMPM basis), if any, by which capitation rates have been adjusted to reflect these new therapies?	See response to question #103.
119.	Appendix G Rate Letter	General	Fee Schedule Adj	9	Table 3 in the report summarizes the fee schedule adjustments that were made to the prepaid and shared savings/FFS base data. Based on the included information it appears that the majority of the listed adjustments are due to changes in cost settlements resulting from hospital privatization. Based on the supplied information it is difficult to determine the reasonability of these adjustments. Will Mercer provide clarification as to why the Fee Schedule adjustments reflected on Table 3 are so varied between the Prepaid and Shared/FFS plans: + .7% for	A detailed breakdown of the fee changes by fee type (Inpatient, Outpatient, and Physician) is provided in Exhibit 5 of the supplemental exhibits memo, dated September 15, 2014. The Fee Schedule adjustments for Prepaid and Shared Savings/FFS are different primarily because the Shared Savings adjustment includes the impact of removing GME costs.

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
					Prepaid plans and -1.5% for Shared Plans/FFS? Will additional quantitative information regarding the development of these factors be made available including, but not limited to, additional schedules which reflect the adjustments for fee schedule and hospital privatization impacts separately?	
120.	Appendix G Rate Letter	General	Shared Savings RX	13	Mercer has applied an assumption that the Generic Dispensing Rate (GDR) from base data of shared savings plans will increase. The current 77% GDR is assumed to increase uniformly to the prepaid MCO average of 84% over a period of three months. What information was considered in developing this three month assumption?	See response to question #19.
121.	Appendix G Rate Letter	General	Hospital Privatization	8	This section references the fact that "two additional state hospitals are closing." What adjustments or exclusions to cost settlement estimates has been made to rates that either account for or remove additional administrative legacy costs resulting from public/private partnership transition/closures? Will Mercer communicate the average PMPM included in the rates for expected cost settlements?	DHH identified for Mercer those hospitals likely to absorb the patients from the two LSU hospitals that are closing/have closed. The claims originating in those hospitals were then re-priced using the fee schedule and cost-to-charge ratios prevailing at the non-LSU hospital expected to absorb those patients.

Question #	Document Reference *(e.g. RFP, RFP Companion Guide, Etc.)*	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
122.	Appendix G Rate Letter	General	Non-Medical Expense Load	14	Will Mercer communicate the average administrative load % on the average revenue expected for the mid-point rates? The 2% on pharmacy reference and 6.1% on medical appears to not be consistent with the average PMPMs of $21.33 and $22.86 communicated. Will Mercer also confirm that these PMPM amounts exclude premium tax and profit/contingency?	See response to question #20.
123.	Appendix G	N/A	New Services	6	Mercer identified three new services effective 2/1/15: 1) Hospice services 2) Personal care services for ages 0-20 3) Non-emergency medical transportation will be the responsibility of the MCO even if the recipient is being transported for non-covered services Can Mercer please identify the amount built into the rates to allow for each of these adjustments?	See response to question #12.
124.	Appendix G	N/A	Shared Savings Rx Claims	13	Mercer expects the Shared Savings' population's pharmacy generic dispensing rate to climb from 77% to 84% over the first 3 months of the program. Will MCOs be permitted to transition medications within the first 3	See response to question #19. From RFP: MCO must ensure that members can continue treatment of maintenance medications for at least 60 days after launch

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					months? The prepaid plans could not transition within the first 3 months of their pharmacy carve-in.	of pharmacy services or enrollment into the MCO's plan. Additionally, an enrollee that is, at the time of enrollment, in the MCO receiving a prescription drug that is not on the MCO's Formulary or PDL shall be permitted to continue to receive that prescription drug if medically necessary for at least 60 days.
125.	Appendix G	N/A	Bayou Health Populations	3	How many members from the LaHIPP population are accounted for in the rate development?	Refer to Attachment 1 (page 21) of the Bayou Health Data Book released by the state, dated July 29, 2014, for a detailed analysis by data source, including the Louisiana's Health Insurance Premium Payment (LaHIPP) population.
126.	Appendix G	N/A	Bayou Health Populations	3	What PMPM cost is assumed for the LaHIPP population within the rate development?	Refer to Attachment 1 (page 21) of the Bayou Health Data Book released by the state, dated July 29, 2014, for a detailed analysis by data source, including the LaHIPP population.
127.	Appendix G	N/A	Rating Adjustments	12	What rating adjustments were made to allow for Sections 6.3.1 – 6.3.5.3 of the RFP, which restricts the MCOs to use a common formulary within 6 months?	No adjustments were made, as the common formulary has not yet been developed.
128.	Appendix G	N/A	Under-reporting	7	Does the under-reporting adjustment of 3.7% true up the encounters to the Prepaid plans' reported experience?	See response to question #98.

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129.	Appendix G	N/A	Table 6: Retro-Active Eligibility Adjustment	12	What rating adjustments were made to allow for Breakthrough Therapy Designation drugs, including Sovaldi?	See response to question #103.
130.	Appendix G	N/A	Data Adjustments	7	Have the Prepaid plans' sub-capitation payments been added to the encounters?	All sub-capitation payments for covered services are included in the data book. Sub-capitation payments for enhanced benefits are excluded from the data book.
131.	Appendix G	N/A	Early Elective Deliveries (EED)	11	Mercer stated that the reduction for early elective deliveries is 38.9%. However, the actual rates show a 60% reduction. Please clarify the appropriate reduction.	See response to question #17.
132.	Appendix G	N/A	N/A	1	Can Mercer provide a full build-up to the rates, similar to the one to the prepaid plans dated 8/8/2015?	See response to question #1.
133.	Appendix G	N/A	Retro-active Eligibility Adjustment	11	How many members with retroactive eligibility are accounted for in the rate development?	See response to question #18.
134.	Appendix G	N/A	Retro-active Eligibility Adjustment	11	How is the incremental cost associated with retroactive members derived? Does Mercer completely reverse their managed care assumptions?	See response to question #18.
135.	Appendix G	N/A	Federal Health Insurer Fee	15	Will there be a Health Insurer Provider Fee payment made to the MCOs in 2015?	The actual Health Insurance Provider Fee (HIPF) for 2015 will become known in 2016 and will be paid at that time. Refer to the Rating Adjustments section (page 15) in the Rate Certification letter provided by the state,

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						dated August 29, 2014, for additional information.
136.	Appendix G	N/A	Appendix E: Trend	29	Please confirm that these trends are annual.	The trend factors listed in Appendix E (page 29) in the Rate Certification letter provided by the state, dated August 29, 2014, are annual factors.
137.	Appendix G	N/A	Appendix E: Trend	29	Did Mercer account for the shift in mix from PCPs to FQHCs?	No. Mercer made no explicit adjustments for shifts in mix of service between federally qualified health centers (FQHCs) and PCPs.
138.	Appendix G	N/A	Fee Schedule Adjustments	8	How did Mercer adjust the rates to account for the privatization of the LSU hospitals?	For Shared Savings/FFS inpatient hospital claims, the inpatient settlements received as a state hospital were removed from the rate calculation since they are not paid to non-state hospitals. The claims were then re-priced using the most recent inpatient per diems provided by DHH. For the two hospitals that are closing, W.O. Moss Regional Medical Center and Earl K. Long, DHH provided Mercer guidance on which hospitals were expected to absorb their utilization. For Encounter claims, the ratio between historical per diems and current per diems were used for claims re-pricing. For outpatient hospital claims, the historical claims were adjusted for differences between

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						the state hospital fee schedule and the general hospital fee schedule. Outpatient cost-based services were re-priced based on cost-to-charge ratios provided by DHH, which reflect costs associated with the Prepaid plans claims. The overall claims dollar impact of this adjustment is shown in Exhibit 6 of the supplemental exhibits memo, dated September 15, 2014.
139.	LouisianaActuarialCertification.pdf		Rate Methodology Overview	P.2	What is the weight or credibility % for each data source (Shared Savings data, Prepaid plans encounter data, FFS data) used in the rate range setting?	The weight is the total membership in the base period (Calendar Year {CY} 2013) of the data source compared to all other data sources. For total membership, refer to Attachment 1 in the Bayou Health Data Book released by the state, dated July 29, 2014.
140.	LouisianaActuarialCertification.pdf		LaHIPP Population	P.3	How was the data for LaHIPP from the databook used in the rate setting?	LaHIPP is not a category of eligibility. Enrollees in this program are eligible under other COAs and their experience will be included in the applicable COA and rate cell combination during rate development.
141.	LouisianaActuarialCertification.pdf		IBNR	P.7	Please confirm that the completion factors applied in the data book have not changed	Confirmed. Refer to Appendix E (page 27-28) in the Rate Certification letter provided by the state, dated August 29, 2014, for final completion factors.

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142.	LouisianaActuarialCertification.pdf		Fee Schedule Adjustments /Fee Changes	P.8	Please provide more details behind the fee changes adjustment? Can we see the cost settlement by facility?	The dollar impact of fee changes by program and provider type (Inpatient, Outpatient, and Physician) are shown in Exhibit 5 of the supplemental exhibits memo, dated September 15, 2014.
143.	LouisianaActuarialCertification.pdf		Fee Schedule Adjustments /Hospital Privatization	P.8-9	What 9 hospitals have been privatized? What two hospitals are closing? Can we see the fee schedule adjustment on the facility level?	The reference to nine hospitals privatizing should be clarified. Nine LSU hospitals were affected by the privatization, with six privatizing and three closing. They are listed below: **Privatizing** EA Conway Leonard J. Chabert LSU Shreveport Medical Center of LA - New Orleans University Medical Center Lafayette Washington St Tammany Regional Medical Center **Closing** W.O. Moss Regional Medical Center Earl K. Long Huey P. Long See Exhibit 6 in the supplemental exhibits memo, dated September 15, 2014, for the overall impact to base period claims costs.

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144.	LouisianaActuarialCertification.pdf		Data Adjustments /Under-Reporting	P.7	Encounter data adjustment is 3.7%. Is it in alignment with the financial data provided by the health plans?	See response to question #98.
145.	LouisianaActuarialCertification.pdf		ACA PCP	P.9	Please provide more details behind the calculation and removal of PCP adjustment	See response to question #15.
146.	LouisianaActuarialCertification.pdf		Program Changes/Act 312	P.10	Please describe the process of evaluating the Rx adjustment due to the Act 312.	See response to question #16.
147.	LouisianaActuarialCertification.pdf		Program Changes/ EED	P.11	Reduction of the kick payment due to early elective deliveries. Based on Table 5 of the rate setting document, does it mean that physician costs associated with maternity payment were reduced by 38.9% due to early elective deliveries?	See response to question #17.
148.	LouisianaActuarialCertification.pdf		Retro Activity Eligibility Adjustment	P.11	Retro-activity eligibility (MCO is responsible for up to 12 months prior to enrollment). Overall adjustment is 0.7%. The only rate cells impacted are Family & Children Adult 19+, BCC, and SSI Adult 19+. Why are other rate cells not impacted? What % of total members does Mercer assume for the retroactivity?	See response to question #18.

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149.	LouisianaActuarialCertification.pdf		Rating Adjustments /Trend	P.12	Mercer indicates that there data sources were considered in trend studies: Prepaid encounters, Shared Savings, and FFS. Did any of these data sources show overall trend lower than 2%-3% that Mercer uses for a lower bound?	Observed trends varied widely by category of service including some major category trends that were negative.
150.	LouisianaActuarialCertification.pdf		Appendix F	P.30	Do managed care assumptions vary between regions?	Managed care assumptions were applied statewide. See Exhibit 7 in the supplemental exhibits memo, dated September 15, 2014, for additional information.
151.	LouisianaActuarialCertification.pdf		Shared Savings Rx Claims	P.13	Mercer rate document refers to 11% to 13% savings in prescription drugs due to generic dispense rate differences between the Prepaid and Shared Savings experience. However, the Appendix F (managed care assumptions) does not include this adjustment for Shared Savings data for prescription drugs. Where can we see this adjustment? Please confirm that it was applied to Shared Savings data as a downward adjustment?	See response to question #90.
152.	LouisianaActuarialCertification.pdf		Risk adjustment	P.14	When should the MCOs expect to receive the risk adjusted rates?	See response to question #4.

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153.	LouisianaActuarialCertification.pdf		Fee Schedule Adjustments /Hospital Privatization	P.8-9	Mercer mentions in the data book narrative that the data book doesn't include an adjustment for hospital reimbursement at the full Medicaid payment level. Does the fee change adjustment described on pages 8-9 of the rate document reflect it?	No, Full Medicaid Payments (FMP) adjustments are not reflected in the rate-setting process.
154.	LouisianaActuarialCertification.pdf		Program changes	P. 10	The RFP documentation (6.33.1) indicates that "The MCO shall continue any treatment of antidepressants and antipsychotics for at least 60 days after enrollment into the MCO's plan". Did Mercer assume an adjustment for this requirement?	The adjustments Mercer applied to the Shared Savings and FFS data reflect our estimate that it will take three months for the MCOs to transition new members to the most efficient pharmaceutical treatments. Per section 6.33.1 of the Bayou Health RFP, MCOs are required to allow members 60 days to continue antidepressant and antipsychotics after enrollment in the MCO's plan. The extra 30 days is to allow time for the MCO to identify the member for such a transition. Additionally, consideration was given to month-by-month improvements in GDR achieved by the current MCOs when prescription drugs were added to the Prepaid program in November 2012. In that case, almost all of the gains were achieved within three months.

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155.	LouisianaActuarialCertification.pdf		Program changes	P.10	Hepatitis C drugs: Did Mercer assume any adjustment for increasing pharmacy costs due to the introduction of Sovaldi and Olysio in early 2014? These are very costly drugs that have had a significant impact on pharmacy trends, and are not accounted for in the base data because they were not yet available in 2013.	See response to question #103.
156.	LouisianaActuarialCertification.pdf		Non-Medical Expense Load	P.14	Please confirm that the case management was included under admin and not under medical in Mercer assumptions.	Case management is included in the administrative expenses in the retention load.
157.	LouisianaActuarialCertification.pdf		Rate Methodology Overview	P.2	Was managed care data normalized for the risk scores?	No, the overall risk score for the entire managed care population is a 1.0.
158.	LouisianaActuarialCertification.pdf		Graduate Medical Education	P.13	Please quantify the impact of removing Graduate Medical Education payments from each of the data sources. How did Mercer apply this adjustment?	In the Prepaid data analysis, GME was not included in our data, since DHH has always paid GME directly outside of capitation. For the Shared Savings and FFS data, the removal of GME costs was part of the fee adjustment process, but was not explicitly quantified.
159.	LouisianaActuarialCertification.pdf		Behavioral Health Mixed Services Protocol	P.6	Was an adjustment made to account for the changes in behavioral health services provided by MCOs? If so, please quantify the adjustment made.	Yes. See Addendum # 20 Exhibit 9 in the supplemental exhibits memo, dated September 15, 2014.