Office of State Procurement
PROACT Contract Certification of Approval

This certificate serves as confirmation that the Office of State Procurement has reviewed and approved the contract referenced below.

Reference Number: 2000107180 (12)
Vendor: United Healthcare of LA, Inc. dba United Healthcare Community Plan
Description: Amd 12
Approved By: Sue Ellen Hopper
Approval Date: 6/18/2018

Your amendment that was submitted to OSP has been approved.

Rev 2017-01

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 12

LAGOV#: 2000107180

LDH #: 060470

Medical Vendor Administration

(Regional/ Program/ Facility) Bureau of Health Services Financing

AND

United Healthcare of LA, Inc. dba United Healthcare Community Plan

Contractor Name

Original Contract Amount: 1,964,731,789

Original Contract Begin Date: 02-01-2015

Original Contract End Date: 01-31-2018

RFP Number: 305PUR-DHHRFP-BH

AMENDMENT PROVISIONS

Change Contract From: From Maximum Amount: $9,633,862,031.00 Current Contract Term: 2/1/15-12/31/19

See Attachment A12, Attachment D, Attachment E, and Attachment L.

Change Contract To: To Maximum Amount: Changed Contract Term:

See Attachment A12, Attachment D, Attachment E, and Attachment L.

Justifications for amendment:

Revisions contained in this amendment are within scope and comply with the terms and conditions as set forth in the RFP. Revisions clarify operational details and are necessary for the continued successful operation of the Medicaid managed care program. Attachment A12 outlines revisions contained in this amendment.

This Amendment Becomes Effective: 02-01-2018

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

CONTRACTOR

United Healthcare of LA, Inc. dba United Healthcare Commu

CONTRACTOR SIGNATURE DATE 5-25-2018

PRINT NAME: Allison Young

CONTRACTOR TITLE: CEO

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE DATE 6/5/18

NAME: Jen Steele

TITLE: Medicaid Director

OFFICE: Bureau of Health Services Financing

PROGRAM SIGNATURE DATE

NAME

Contract Amendment #12
Attachment A-12

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
1	Attachment D Rate certification	Mercer rate certification dated January 22, 2018.	Replace with Mercer rate certification dated April 30, 2018.	The rate certification submitted with Amendment #11 was the interim certification. The attached version contains a technical update related to Applied Behavior Analysis.
2	Attachment E Performance Measures		Changes are contained in the revised document.	The document has been revised to add a measure erroneously omitted from the version contained in Amendment #11. It is not a new measure.
3	Attachment L APM Strategic Plan Requirements and Report		Replace Attachment L with the attached document.	This revision is necessary to align Attachment L with contract changes and changes made in preparation for the VBP baseline report, consistent with discussions with MCOs and previously released VBP FAQs.
4	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	4.4.16. Fraud, Waste, and Abuse Investigators (at a rate of one per fifty thousand and fraction thereof (1:50,000) members, subject to the provisions in Section 15.1.23.	4.4.16. Fraud, Waste, and Abuse Investigators (at a rate of one per fifty thousand and fraction thereof (1:50,000) members, subject to the provisions in Section 15.1.~~23~~14.	This revision will correct a reference to a section of the contract.
5	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	5.4.2.2.3.1. By February 15, 2018, submit to LDH a baseline report on its FY2017 APM use as specified in Attachment L. The calculated rate of baseline APM use shall be reviewed by LDH. If the MCO APM report is complete and consistent with specifications as determined by LDH, LDH will reduce the amount of the	5.4.2.2.3.1. By February ~~15~~28, 2018, submit to LDH a baseline report on its ~~FY~~CY2017 ~~APM~~VBP use as specified in Attachment L. The calculated rate of baseline ~~APM~~ VBP use shall be reviewed by LDH. If the MCO ~~APM~~ VBP report is complete and consistent with specifications as determined by LDH, LDH will reduce the	This revision is necessary to realign the reporting period and due date for the February 2018 VBP baseline report, consistent with discussions with MCOs and previously released VBP FAQs, and to ensure consistent terminology throughout the section.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		VBP withhold for the remainder of CY2018 to 0.80% of the monthly capitation rate. The withhold shall not be reduced for late submissions.	amount of the VBP withhold for the remainder of CY2018 to 0.80% of the monthly capitation rate. The withhold shall not be reduced for late submissions.	
6	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	Add new subsection.	5.4.2.2.3.1.1. MCO has the option to report its CY2017 VBP baseline by a "date of payment" approach (cash basis) or a "date of service" approach (incurred basis).	This revision is necessary to allow for an additional option for MCOs to report VBP use, consistent with discussions with MCOs and previously released VBP FAQs.
7	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	Add new subsection.	5.4.2.2.3.1.2. If the MCO chooses to report its VBP baseline by a "date of service" approach, it must submit a refreshed CY2017 VBP baseline report to LDH by April 15, 2018 and may be subject to longer LDH withholding of VBP funds.	This revision is necessary to allow for an additional option for MCOs to report VBP use, consistent with discussions with MCOs and previously released VBP FAQs.
8	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	5.4.2.2.3.2. By August 15, 2018, submit to LDH for approval, in accordance with Attachment L, a strategic plan to increase its APM use above its FY2017 baseline, including specific strategies, milestones, targets, and deliverables. If the MCO strategic plan is complete and consistent with specifications as determined by LDH, LDH will reduce the VBP withhold for the remainder of CY2018 to 0.40% of the monthly capitation rate and refund any amounts withheld for VBP through July 2018.	5.4.2.2.3.2. By August 15, 2018, submit to LDH for approval, in accordance with Attachment L, a strategic plan to increase its ~~APM~~ VBP use above its ~~FY~~CY2017 baseline, including specific strategies, milestones, targets, and deliverables. If the MCO strategic plan is complete and consistent with specifications as determined by LDH, LDH will reduce the VBP withhold for the remainder of CY2018 to 0.40% of the monthly capitation rate and refund any amounts withheld for	This revision is necessary to ensure consistent terminology throughout the section.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		The withhold shall not be reduced or refunded for late submissions.	VBP through July 2018. The withhold shall not be reduced or refunded for late submissions.	
9	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	5.4.2.2.4.1. By August 15, 2019, submit to LDH a report on its FY2019 APM use as specified in Attachment L. The calculated rate of APM use shall be reviewed by LDH. If the MCO APM report is complete and consistent with specifications as determined by LDH, LDH will reduce the VBP withhold for the remainder of CY2019 to 0.50% of the monthly capitation rate and refund any amounts withheld for VBP through July 2019. The withhold shall not be reduced or refunded for late submissions.	5.4.2.2.4.1. By August ~~15~~30, 2019, submit to LDH a report on its SFY2019 ~~APM~~VBP use as specified in Attachment L. The calculated rate of ~~APM~~VBP use shall be reviewed by LDH. If the MCO ~~APM~~VBP report is complete and consistent with specifications as determined by LDH, LDH will reduce the VBP withhold for the remainder of CY2019 to 0.50% of the monthly capitation rate and refund any amounts withheld for VBP through July 2019. The withhold shall not be reduced or refunded for late submissions.	This revision is necessary to realign the reporting period and due date for the August 2019 VBP use report, consistent with discussions with MCOs and previously released VBP FAQs, and to ensure consistent terminology throughout the section.
10	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	Add new subsection.	5.4.2.2.4.1.1. MCO must report its SFY2019 VBP use using the same method as reported for its CY2017 baseline report (“date of payment” or “date of service” approach).	This revision is necessary to allow for an additional option for MCOs to report VBP use, consistent with discussions with MCOs and previously released VBP FAQs.
11	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	Add new subsection.	5.4.2.2.4.1.2. If the MCO chooses to report its SFY2019 VBP use using a “date of service” approach, it must submit a refreshed SFY2019 VBP use report by October 15, 2019 and may be subject to longer LDH withholding of VBP funds.	This revision is necessary to allow for an additional option for MCOs to report VBP use, consistent with discussions with MCOs and previously released VBP FAQs.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
12	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	5.4.2.2.4.2. By December 1, 2019, submit to LDH a written update on the implementation and status of its APM strategic plan that demonstrates that the MCO met its specific strategies, milestones, targets, and deliverables for FY2019 identified in the MCO's APM strategic plan as approved by LDH. If the MCO did not meet criteria established in the strategic plan, the MCO shall describe why the criteria were not met.	5.4.2.2.4.2. By December 1, 2019, submit to LDH a written update on the implementation and status of its ~~APM~~VBP strategic plan that demonstrates that the MCO met its specific strategies, milestones, targets, and deliverables for SFY2019 identified in the MCO's ~~APM~~VBP strategic plan as approved by LDH. If the MCO did not meet criteria established in the strategic plan, the MCO shall describe why the criteria were not met.	This revision is necessary to ensure consistent terminology throughout the section.
13	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	5.4.2.2.4.3. If the MCO FY2019 APM strategic plan update is deemed by LDH to meet the milestones, targets, and deliverables for FY2019 as identified in the MCO's APM strategic plan as approved by LDH, LDH will refund any amounts withheld for VBP during CY2019.	5.4.2.2.4.3. If the MCO SFY2019 ~~APM~~VBP strategic plan update is deemed by LDH to meet the milestones, targets, and deliverables for SFY2019 as identified in the MCO's ~~APM~~VBP strategic plan as approved by LDH, LDH will refund any amounts withheld for VBP during CY2019.	This revision is necessary to ensure consistent terminology throughout the section.
14	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	Insert a new section after 5.5.5. Subsequent provisions will be renumbered accordingly.	5.5.6. For members dis-enrolled due to the invalidation of a duplicate Medicaid ID, the MCO shall not recover claim payments under the retroactively dis-enrolled member's ID if the remaining valid ID is linked to another MCO or FFS. The MCO shall subrogate to the MCO that paid the claim(s) for the dates of service.	The addition of this subsection is necessary to establish the parameters for subrogation.
15	Exhibit 3 305PUR-DHHRFP-BH-	5.13.2.3. TPL Payment Calculation Scenario 5 Outpatient Pharmacy Claim *(see table)**	5.13.2.3. TPL Payment Calculation Scenario 5 Outpatient Pharmacy Claim *(see updated table)**	This revision is necessary to clarify how to calculate the Medicaid Maximum Allowable amount and how it applies to TPL claims and to clarify what edits should apply. This is necessary to specify that the BIN and PCN should be the same as the primary processor. These changes are

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
	MCO-2014-MVA	If third party liability (TPL) is involved, the MCO as the secondary payer may not deny the claim for a high dollar amount billed for claims less than $1,500. If the TPL pays $0.00 or denies the claim, then the pharmacy claims should be treated as a straight Medicaid pharmacy claim. When there is other third party liability (TPL) payment greater than $0.00, the MCO should electronically bypass prior authorization requirements and Point of Sale edits that would not be necessary as the secondary payer.	If third party liability (TPL) is involved, the MCO as the secondary payer may not deny the claim for a high dollar amount billed for claims less than $1,500. If the TPL pays $0.00 or denies the claim, then the pharmacy claims should be treated as a straight Medicaid pharmacy claim. Taxes on the primary claim should be subtracted before calculating the Medicaid Maximum Allowable. Maximum Medicaid allowable is defined as professional dispensing fee plus ingredient cost (quantity * price per unit) or usual and customary, whichever is less. The pricing calculation is ingredient cost (quantity * price per unit) + Dispensing Fee – TPL amount paid – copayment = Medicaid payment. If U&C is less than the Medicaid allowable, then the calculation is U&C – TPL amount paid – copayment = Medicaid payment. When there is other third party liability (TPL) payment greater than $0.00, the MCO should electronically bypass prior authorization requirements and Point of Sale edits that would not be necessary as the secondary payer. Safety edits should still apply. TPL claims should process with the same PCN and BIN number as primary claims.	required to encourage providers to bill the other third party first and to make claims processing easier as a secondary payor. **Table updates can be found at the end of this document.*
16	Exhibit 3 305PUR-DHHRFP-BH-	6.3.3.2. Drugs that are on the Covered Drug List, but not on the PDL must be available to members through a prior authorization process. Pharmacy prior authorizations must be resolved (approved or denied) within 24 hours of the request, seven (7) days a week. A 72 hour supply of	6.3.3.2. Drugs that are on the Covered Drug List, but not on the PDL must be available to members through a prior authorization process. Pharmacy prior authorizations must be resolved (approved or denied) within 24 hours of the request, seven (7) days a week. ~~A 72 hour supply of~~	This revision is necessary to ensure enrollees have access to necessary medications and that the claims are processed appropriately and consistently.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
	MCO-2014-MVA	the requested medication must be available to recipients in emergency situations.	~~the requested medication must be available to recipients in emergency situations.~~ The MCO must have an automated process that allows the pharmacy to dispense up to a 72-hour emergency supply of a product or full unbreakable packages without having to obtain a prior authorization. At a minimum two emergency supply fills shall be allowed per prescription. The pharmacy shall be reimbursed for both the ingredient and the dispensing fee for both fills. Emergency fills may be included in a post adjudication audit to identify misuse of the override. The Department may require allowing the emergency override for certain DUR initiatives. The pharmacist shall place an "03" in NCPDP field 418-DI (Level of Service) as noted in NCPDP guidelines.	
17	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	6.3.4.1.4. When prescribed brand name medications has an A-rated generic equivalents. The MCO can encourage a prescriber to complete the FDA Medwatch form, but this should not be required or considered in the approval/denial determination process. If the drug has a narrow therapeutic index and the prior authorization for the brand drug is denied, then DHH pharmacy staff must be notified within 24 hours or the next working day of the denial. All details of the claim and prior authorization must be included. (All drugs listed in the Common PDL are exempt from PA requirements);	6.3.4.1.4. When a prescribed brand name medications~~s~~ has an A-rated generic equivalent~~s~~. The MCO can encourage a prescriber to complete the FDA Medwatch form, but this should not be required or considered in the PA approval/denial determination process of a brand drug. If a PA is requested for ~~the drug has~~ a narrow therapeutic index (NTI) drug, every effort should be made to verify if the recipient is currently on a specific brand/generic,~~-~~then the PA shall be approved. NTI drugs: Aminophylline, Carbamazepine, Cyclosporine, Digoxin, Disopyramide, Ethosuximide, Flecainide, L-Thyroxine, Lithium, Phenytoin, Theophylline, Thyroid, Valproic Acid, and Warfarin. ~~and the prior authorization for the brand drug is denied, then DHH pharmacy staff must be notified within 24 hours or the next working day of the denial. All details of the claim and prior authorization must be~~	This revision is necessary to make sure NTI drug therapy is continued if the recipient has established blood levels. This will ensure established blood levels are maintained on NTI drugs by approval of prior authorizations.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			~~included.~~ (All drugs listed in the Common PDL are exempt from PA requirements);	
18	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	6.3.4.9. If a pharmacy prior authorization is under review, the MCO must have an automated process that allows the pharmacy to dispense up to a 72-hour supply of a product or full unbreakable packages without having to obtain an override. The pharmacy may fill consecutive 72-hour supplies if the prescriber remains unavailable but the MCO are only required to pay one dispensing fee. The MCO must reimburse the pharmacy for dispensing the temporary supply of medication.	6.3.4.9. ~~If a pharmacy prior authorization is under review, t~~The MCO must have an automated process that allows the pharmacy to dispense up to a 72-hour supply of a product or full unbreakable packages without having to obtain a prior authorization ~~an override~~. ~~The pharmacy may fill consecutive 72-hour supplies if the prescriber remains unavailable. The MCO must reimburse the ingredient cost for each 72-hour fill, but is only required to pay one dispensing fee. The MCO must reimburse the ingredient cost for each 72-hour fill. but the MCO is only required to pay one dispensing fee~~. ~~The MCO must reimburse the pharmacy for dispensing the temporary supply of medication.~~ At a minimum two emergency supply fills shall be allowed per prescription. The pharmacy shall be reimbursed for both the ingredient and the dispensing fee for both fills. Emergency fills may be included in a post adjudication audit to identify misuse of the override. The Department may require allowing the emergency override for certain DUR initiatives. The pharmacist shall place an "03" in NCPDP field 418-DI (Level of Service) as noted in NCPDP guidelines.	This revision is necessary to ensure recipients have access to necessary medications and that the claims are processed appropriately and consistently.
19	Exhibit 3 305PUR-DHHRFP-BH-	6.3.6.6. Prescription Monitoring Program. The MCO shall require network prescribers to utilize and conduct patient specific queries in the Prescription Monitoring Program (PMP) for behavioral health patients upon writing the first prescription for a controlled substance, then annually. The physician shall print the PMP query and file it as part	~~6.3.6.6. Prescription Monitoring Program. The MCO shall require network prescribers to utilize and conduct patient specific queries in the Prescription Monitoring Program (PMP) for behavioral health patients upon writing the first prescription for a controlled substance, then annually. The physician shall print the PMP query and file it as part~~	This provision is removed as the obligations of prescribers with respect to the Prescription Monitoring Program is outlined in state law.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
	MCO-2014-MVA	of the recipient's record. The MCO shall conduct sample audits to verify compliance. Additional PMP queries should be encouraged to be conducted at the prescriber's discretion.	~~of the recipient's record. The MCO shall conduct sample audits to verify compliance. Additional PMP queries should be encouraged to be conducted at the prescriber's discretion.~~	
20	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	6.24.1.4. Nursing Facility Services, with the exception of post-acute rehabilitative care provided at the discretion of the MCO as a cost effective alternative service to continued inpatient care as per section 6.37.;	6.24.1.4. Nursing Facility Services, with the exception of post-acute rehabilitative care provided at the discretion of the MCO as a cost effective alternative service to continued inpatient care as per section 6.~~37~~27.;	This revision will correct a reference to a section of the contract.
21	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	6.31.3. The MCO shall collect and report the information associated with tobacco cessation and/or problem gaming screening, treatment and referral information as appropriate and as specified in the Behavioral Health Companion Guide.	6.31.3. The MCO shall collect and report the information associated with tobacco cessation and/or problem gaming screening, treatment and referral information as appropriate and as specified in the LDH-issued reporting template ~~Behavioral Health Companion Guide~~.	The Behavioral Health Companion Guide is no longer in use. All requirements are outlined in the contract or reporting templates.
22	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	6.39.5.8. The MCO shall notify OBH as per the Behavioral Health Companion Guide of any problems or issues with the PASRR process.	6.39.5.8. The MCO shall notify OBH as outlined in the LDH-issued reporting template ~~per the Behavioral Health Companion Guide~~ of any problems or issues with the PASRR process.	The Behavioral Health Companion Guide is no longer in use. All requirements are outlined in the contract or reporting templates.
23	Exhibit 3 305PUR-DHHRFP-BH-	6.39.7.1 The MCO shall utilize the Behavioral Health Companion Guide to report utilization of the PASRR process.	6.39.7.1 The MCO shall utilize the LDH-issued reporting template ~~Behavioral Health Companion Guide~~ to report utilization of the PASRR process.	The Behavioral Health Companion Guide is no longer in use. All requirements are outlined in the contract or reporting templates.

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	MCO-2014-MVA			
24	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	Add new subsection.	7.5.4. Provider Monitoring Plan 7.5.4.1. The MCO shall develop and implement a plan for monitoring providers and facilities across all levels of care, which incorporates onsite reviews, administrative desk audits, and member interviews. The MCO's provider monitoring plan shall be inclusive of the following requirements at a minimum: 7.5.4.1.1. Review criteria for each applicable provider type and level of care; 7.5.4.1.2. Sampling approach including number and percent of onsite audits by provider type and number and percent of administrative desk audits; 7.5.4.1.3. Member interview criteria; 7.5.4.1.4. Random audit selection criteria; 7.5.4.1.5. Monitoring tools to be used; 7.5.4.1.6. Frequency of review, including schedule of reviews by provider type; 7.5.4.1.7. Corrective actions to be imposed based on the degree of provider non-compliance with review criteria elements on both an individual and systemic basis;	Provisions were added to ensure that providers meet minimum provider qualifications and requirements beyond just clinical and service considerations.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			7.5.4.1.8. Plan for ensuring corrective actions are implemented appropriately and timely by providers; and 7.5.4.1.9. Inter-rater reliability testing methods. 7.5.4.2. At a minimum, the MCO's annual sampling approach shall result in a statistically significant representative sample with a confidence interval of 95% + or – 5 for each level of care. The sample shall be random and include providers who have served at least one member during the review period. Levels of care shall include outpatient, residential and inpatient. 7.5.4.3. The MCO's provider review criteria shall address the following areas at a minimum: 7.5.4.3.1. Adherence to minimum provider qualifications and requirements at the organizational level and the individual staff level as established by Louisiana law, rules, regulations, SPA, waivers and Medicaid provider policy manuals. This shall include but not be limited to requirements associated with licensure, accreditation, educational and professional experience, and training inclusive of utilization of LDH approved training curriculum in the delivery of services, if applicable, as established by Medicaid provider policy manuals. Verification shall include review of provider and staff personnel records and other administrative records; 7.5.4.3.2. Adherence to appointment availability standards as established by this contract and as	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			evidenced by provider's scheduling system and wait times for appointments and admission; 7.5.4.3.3. Accuracy of provider demographics associated with service location addresses, telephone numbers, languages spoken, current staff rosters and status of accepting new Medicaid referrals, as compared against MCO credentialing files and the MCO provider directory listings; 7.5.4.3.4. Providers shall be reviewed based on the services for which they have received reimbursement. 7.5.4.4. The MCO shall ensure that an appropriate corrective action is taken when a provider or staff fails to meet minimum provider qualifications or requirements, appointment availability standards, or is determined to be out of compliance with provisions of contract requirements, federal and state regulations, law, rules, SPA, waivers, or Medicaid provider policy manuals. The MCO shall monitor and evaluate corrective actions taken to ensure that appropriate changes have been made in a timely manner. 7.5.4.5. The MCO shall make any collected information, monitoring reviews and findings, corrective action plans and follow-up available to LDH upon request in a LDH approved format. 7.5.4.6. LDH reserves the right to require the MCO to modify its provider-monitoring plan inclusive of	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			monitoring tools, frequency and type of monitoring reviews and plans for corrective action.	
25	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	Insert a new section after 7.6.3.2. Subsequent provisions will be renumbered accordingly.	7.6.3.3. The MCO shall require unlicensed staff of provider organizations rendering and receiving reimbursement for Mental Health Rehabilitation (MHR) services to obtain and submit National Provider Identifier (NPI) numbers to the MCO, as well as documentation verifying the unlicensed staff meets all qualifications and requirements for providing mental health rehabilitation (MHR) services established by law, rules, regulations and the Medicaid Behavioral Health Service Provider Manual, inclusive of Evidence-Based Practice (EBP) MHR services, prior to reimbursing agencies for services provided by these staff. Claims submitted for MHR services shall include rendering provider NPIs and other MCO required identifiers regardless of whether the rendering staff is licensed or unlicensed. The MCO shall configure systems to deny claims for services when rendering providers and NPIs are denoted on claims for service that have not been credentialed and approved by the MCO. The MCO shall submit their policies, procedures and work plan associated with this requirement to LDH for approval within 30 days of contract execution. The MCO's work plan shall include timelines associated with systems configuration, systems testing phases, education and outreach to providers, communication notices to providers, and the effective date the MCO's unlicensed staff NPI requirement will go-live.	This new subsection mandates that the MCOs require unlicensed staff of mental health rehabilitation to obtain and submit NPI numbers to ensure appropriate payment.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
26	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	7.6.3.4. …If termination is related to the MCO's operations, the notification shall include the MCO's plan for how it will ensure that will be no stoppage or interruption of services to members.	7.6.3.4. …If termination is related to the MCO's operations, the notification shall include the MCO's plan for how it will ensure that there will be no stoppage or interruption of services to members.	This revision corrects a grammatical error.
27	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	7.8.14.2. The MCO shall ensure its provider network offers covered range of preventive and specialized behavioral health services as reflected in the LDH Behavioral Health Provider Manual and meets the network adequacy standards defined in this contract. …	7.8.14.2. The MCO shall ensure its provider network offers ~~covered~~ a range of preventive and specialized behavioral health services as reflected in the LDH Behavioral Health Provider Manual and meets the network adequacy standards defined in this contract. …	This revision corrects a grammatical error.
28	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	8.6.9. If a prescription for a medication is not filled when the prescription is presented to the pharmacy due to a prior authorization requirement, the MCO must have an automated process that allows the pharmacy to dispense up to a 72-hour supply of a product or full unbreakable packages without having to obtain an override. The pharmacy may fill consecutive 72-hour supplies if the prescriber remains unavailable but the MCO is only required to pay one dispensing fee. The MCO must reimburse the pharmacy for dispensing the temporary supply of medication.	8.6.9. ~~If a prescription for a medication is not filled when the prescription is presented to the pharmacy due to a prior authorization requirement, the~~ The MCO must have an automated process that allows the pharmacy to dispense up to a 72-hour supply of a product or full unbreakable packages without having to obtain a prior authorization ~~an override. The pharmacy may fill consecutive 72-hour supplies if the prescriber remains unavailable but the MCO is only required to pay one dispensing fee. The MCO must reimburse the pharmacy for dispensing the temporary supply of medication. Only~~At a minimum two emergency supply fills shall be allowed per prescription. The pharmacy shall be reimbursed for both the ingredient and the dispensing fee for both fills. Emergency fills may be included in a post adjudication audit to identify misuse of the override. The	To assure recipients have access to necessary medications and that the claims are processed appropriately and consistently.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			Department may require allowing the emergency override for certain DUR initiatives. The pharmacist shall place an "03" in NCPDP field 418-DI (Level of Service) as noted in NCPDP guidelines.	
29	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	14.8.3. The MCO shall submit reports to LDH concerning quality of care concerns and adverse incidents as documented in the Behavioral Health Companion Guide.	14.8.3. The MCO shall submit reports to LDH concerning quality of care concerns and adverse incidents ~~as documented in the Behavioral Health Companion Guide~~.	The Behavioral Health Companion Guide is no longer in use. All requirements are outlined in the contract or reporting templates.
30	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	15.1.18.4.1. All tips (regarding any potential billing or claims issue identified through either complaints or internal review received within the previous two (2) weeks) shall be reported to LDH Program Integrity monthly;	15.1.18.4.1. All tips (regarding any potential billing or claims issue identified through either complaints or internal review received within the previous month ~~two (2) weeks~~) shall be reported to LDH Program Integrity monthly;	This revision corrects an error in consistency and clarifies the timeframe in this provision.
31	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	15.3.7. The MCO, through its Contract Compliance Officer, shall attest monthly to LDH that a search of the websites reference in Section 15.3.4 has been completed to capture all exclusions.	15.3.7. The MCO, through its Contract Compliance Officer, shall attest monthly to LDH that a search of the websites referenced in Section 15.3.~~4~~ 5 has been completed to capture all exclusions.	This revision will correct a reference to a section of the contract.
32	Exhibit 3 305PUR-DHHRFP-BH-	17.2.4.1 If the MCO or LDH or its subcontractors discover errors made by the MCO when a claim was adjudicated, the MCO shall make corrections and reprocess the claim within 30 calendar days of discovery, or if circumstances	17.2.4.1 If the MCO or LDH or its subcontractors discover errors made by the MCO when a claim was adjudicated, the MCO shall make corrections and reprocess the claim within 30 calendar days of discovery, or if circumstances	This revision will ensure that all impacted claims are recycled appropriately.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
	MCO-2014-MVA	exist that prevent the MCO from meeting this time frame, a specified date shall be approved by LDH. The MCO shall automatically recycle the impacted claims and shall not require the providers to resubmit the impacted claims.	exist that prevent the MCO from meeting this time frame, a specified date shall be approved by LDH. The MCO shall automatically recycle ~~the~~ all impacted claims for all providers and shall not require the providers to resubmit the impacted claims.	
33	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	Insert a new section after 17.6.4. Subsequent provisions will be renumbered accordingly.	17.6.5. The provider shall have one hundred and eighty (180) days from the date of denial to dispute the denied claim.	This revision ensures that providers have sufficient time to dispute a denied claim.
34	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	Insert a new section after 17.6.5. Subsequent provisions will be renumbered accordingly.	17.6.6. Payment Recoupments 17.6.6.1. The MCO shall provide written prior notification to a provider of its intent to recoup any payment. 17.6.6.1.1. The notification shall include: 17.6.6.1.1.1. The name of the patient; 17.6.6.1.1.2. Date of birth or Medicaid identification number; 17.6.6.1.1.3. The date or dates of healthcare services rendered; 17.6.6.1.1.4. A complete listing of the specific claims and amounts subject to the recoupment;	The addition of this subsection is necessary to establish the parameters for recoupment of payments from providers by MCOs.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			17.6.6.1.1.5. The specific reasons for making the recoupment for each of the claims subject to the recoupment; 17.6.6.1.1.6. The date the recoupment is proposed to be executed; 17.6.6.1.1.7. The mailing address or electronic mail address where a provider may submit a written response; 17.6.6.1.1.8. The date LDH notified the MCO of the member disenrollment via the ASC X12N 834 Benefit Enrollment and Maintenance Transaction, when applicable; and 17.6.6.1.1.9. Effective date of disenrollment. 17.6.6.2. Before the recoupment is executed, the provider shall have forty-five (45) days from receipt of written notification of recoupment to submit a written response as to why the recoupment should not be put into effect on the date specified in the notice. If the provider fails to submit a written response within the time period provided, the MCO may execute the recoupment on the date specified in the notice. 17.6.6.3. Upon receipt by the MCO of a written response as to why the recoupment should not be put into effect, the MCO shall within thirty (30) days from the date the written response is received, consider the statement,	

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			including any pertinent additional information submitted by the provider, together with any other material bearing upon the matter, and determine whether the facts justify recoupment. The MCO shall provide a written notice of determination to each written response that includes the rationale for the determination. 17.6.6.4. If a recoupment is valid, the provider shall remit the amount to the MCO or permit the MCO to deduct the amount from future payments due to the provider. 17.6.6.5. LDH reserves the right to review and prohibit any recoupment. 17.6.7. For members disenrolled due to the invalidation of a duplicate Medicaid ID, the MCO shall not recover claim payments under the retroactively dis-enrolled member's ID if the remaining, valid ID is also linked to the same MCO for the retroactive disenrollment period. The MCOs shall identify these duplicate Medicaid IDs for a single member and resolve the duplication so that histories of the duplicate records are linked or merged.	
35	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	18.13.1. The MCO shall report to LDH indicators relative to individual evaluations on a monthly basis with information available by region, type of placements, results of recommendations, location of individuals and referral sources as outlined in the Behavioral Health Companion Guide.	18.13.1. The MCO shall report to LDH indicators relative to individual evaluations on a monthly basis with information available by region, type of placements, results of recommendations, location of individuals and referral sources as outlined in the ~~Behavioral Health Companion Guide~~ LDH-issued reporting template.	The Behavioral Health Companion Guide is no longer in use. All requirements are outlined in the contract or reporting templates.

Item Number	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
36	Exhibit 3 305PUR-DHHRFP-BH-MCO-2014-MVA	18.15.1. The MCO may be required to provide LDH-OBH reliable and valid data to meet federal reporting requirements for the SAMHSA-funded SABG and MHBG Block Grants for populations and services covered in this contract as detailed in the Behavioral Health Companion Guide.	18.15.1. The MCO may be required to provide LDH-OBH reliable and valid data to meet federal reporting requirements for the SAMHSA-funded SABG and MHBG Block Grants for populations and services covered in this contract ~~as detailed in the Behavioral Health Companion Guide~~.	The Behavioral Health Companion Guide is no longer in use. All requirements are outlined in the contract or reporting templates.

Item Number 14

5.13.2.3

Change from:

Amount Billed	TPL Paid Amount	Medicaid Maximum Allowable	Patient Responsibility Amount from Primary	Medicaid Pharmacy Co-Pay	Medicaid Payment
55.00	10.00	24.10	26.00 (Ded)	1.00	13.10
30.00	0.00	11.37	28.20 (Ded)	1.00	10.37
85.00	0.00	35.47	64.20 (Ded)	2.00	33.47

Change to:

Amount Billed	TPL Paid Amount	Medicaid Maximum Allowable	Patient Responsibility Amount from Primary	Medicaid Pharmacy Co-Pay	Medicaid Payment
~~55.00~~38.55	~~10.00~~28.55	~~24.10~~31.36	~~26.00 (Ded)~~10.00 (Copay)	~~1.00~~0.50	~~13.10~~2.31
~~30.00~~613.00	~~0.00~~60.00	~~11.37~~40.73	~~28.20~~553.00 (Ded)	~~1.00~~0.00	~~10.37~~0.00
~~85.00~~177.97	~~0.00~~5.22	~~35.47~~14.39	~~64.20~~172.75 (Ded)	~~2.00~~0.50	~~33.47~~8.67

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MAKE TOMORROW, TODAY

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

April 30, 2018

Subject: Healthy Louisiana Program Program – Full Risk-Bearing Managed Care Organization (MCO) Rate Development and Actuarial Certification for the Period Effective February 1, 2018 through January 31, 2019

Dear Ms. Diez:

The Louisiana Department of Health (LDH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound[1] capitation rate ranges for the State of Louisiana's Healthy Louisiana program for the period of February 1, 2018 through January 31, 2019. This certification amends the previous certification issued March 5, 2018 for rates effective February 1, 2018 through January 31, 2019; and applies to the entire period of February 1, 2018 through January 31, 2019. The amendment reflects the impact of a technical change related to the inclusion of Applied Behavioral Analysis (ABA) services for the Specialized Behavioral Health (SBH) and Non-Emergency Medical Transportation (NEMT) Only populations implemented by LDH effective February 1, 2018.

This letter presents an overview of the analysis and methodology used to support the change, and the resulting capitation rate ranges effective February 1, 2018 through January 31, 2019 for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS). This rate development process used Medicaid fee-for-service (FFS) medical and pharmacy claims, Healthy Louisiana Shared Savings claims experience, Healthy Louisiana Prepaid encounter data, and Louisiana

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

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

Behavioral Health Partnership claims experience. It resulted in the development of a range of actuarially sound rates for each rate cell. The capitation rate ranges are summarized in Appendix A and represent payment in full for the covered services.

TECHNICAL CHANGES FOR ABA SERVICES

Effective February 1, 2018, Healthy Louisiana will provide ABA services for all Healthy Louisiana populations. In the previous certification, ABA services were classified as part of the physical health services in the Healthy Louisiana benefit package; therefore, the SBH/NEMT Only populations were not eligible to receive these services through Healthy Louisiana.

The same source data (calendar year 2015 and 2016 ABA FFS claims) and information was used to develop an adjustment for the SBH/NEMT Only populations and the methodology described in the March 5, 2018 letter was unchanged. The inclusion of ABA services for the SBH/NEMT Only populations added $0.62 to the Non-Expansion rates and $0.02 to the Expansion rates. These adjustments are illustrated in Appendices B and C, respectively.

CERTIFICATION OF FINAL RATE RANGES

This certification assumes items in the Medicaid State Plan or Waiver, as well as the Healthy Louisiana MCO contract, have been approved by CMS.

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

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

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

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

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

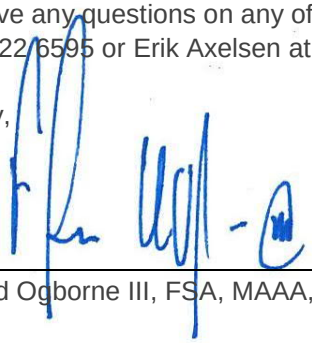
LDH understands that Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends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

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

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

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

Sincerely,



F. Ronald Ogborne III, FSA, MAAA, CERA

Partner

Erik Axelsen, ASA, MAAA

Senior Associate

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Amanda Joyner, Deputy Assistant Secretary - OBH/LDH
Marisa Naquin, Managed Care Finance - LDH
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Karen Stubbs, Deputy Assistant Secretary - OBH/LDH

Robert Butler, Principal - Mercer
Christina Coleman, Associate - Mercer
Kodzo Dekpe, ASA, MAAA, Associate - Mercer

APPENDIX A: HEALTHY LOUISIANA CAPITATION RATE RANGE

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Gulf	SSI	0 - 2 Months	$34,606.48	$34,635.79	$36,479.56
Gulf	SSI	3 - 11 Months	$5,814.84	$5,819.96	$6,153.41
Gulf	SSI	Child 1 - 20 Years	$767.15	$767.95	$815.20
Gulf	SSI	Adult 21+ Years	$1,447.58	$1,449.00	$1,538.68
Gulf	Family & Children	0 - 2 Months	$3,148.47	$3,150.92	$3,328.07
Gulf	Family & Children	3 - 11 Months	$311.62	$311.92	$331.07
Gulf	Family & Children	Child 1 - 20 Years	$180.72	$180.92	$192.79
Gulf	Family & Children	Adult 21+ Years	$372.71	$373.09	$394.79
Gulf	Foster Care Children	All Ages Male & Female	$474.80	$475.36	$510.44
Gulf	BCC	BCC, All Ages	$2,204.92	$2,207.10	$2,325.48
Gulf	LAP	LAP, All Ages	$206.68	$206.91	$220.03
Gulf	HCBS	Child 1 - 20 Years	$1,836.31	$1,838.27	$1,961.99

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Gulf	HCBS	Adult 21+ Years	$1,514.62	$1,516.22	$1,624.13
Gulf	CCM	CCM, All Ages	$1,356.30	$1,357.79	$1,435.28
Gulf	SBH – CCM	SBH – CCM, All Ages	$252.74	$252.74	$258.79
Gulf	SBH – Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	$33.09	$33.09	$34.20
Gulf	SBH – HCBS	SBH – Child 1 - 20 Years	$141.69	$141.69	$143.83
Gulf	SBH – HCBS	SBH – Adult 21+ Years	$66.07	$66.07	$68.95
Gulf	SBH – Other	SBH – All Ages	$188.53	$188.53	$196.12
Gulf	Maternity Kick Payment	Maternity Kick Payment	$13,550.33	$13,550.33	$14,039.00
Gulf	EED Kick Payment	EED Kick Payment	$7,316.96	$7,316.96	$7,425.94
Gulf	Medicaid Expansion	Female Age 19 - Age 24	$280.92	$281.21	$300.85
Gulf	Medicaid Expansion	Male Age 19 - Age 24	$225.48	$225.71	$241.29
Gulf	Medicaid Expansion	Female Age 25 - Age 39	$396.19	$396.60	$424.66
Gulf	Medicaid Expansion	Male Age 25 - Age 39	$397.10	$397.51	$425.65

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Gulf	Medicaid Expansion	Female Age 40 - Age 49	$612.35	$612.98	$656.86
Gulf	Medicaid Expansion	Male Age 40 - Age 49	$597.60	$598.21	$641.01
Gulf	Medicaid Expansion	Female Age 50 - Age 64	$748.31	$749.07	$802.90
Gulf	Medicaid Expansion	Male Age 50 - Age 64	$796.83	$797.64	$855.03
Gulf	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	$33.09	$33.09	$34.20
Gulf	Medicaid Expansion	SBH – Other, All Ages	$188.53	$188.53	$196.12
Gulf	Medicaid Expansion	SBH – Chisholm, All Ages	$252.74	$252.74	$258.79
Gulf	Medicaid Expansion	High Needs	$1,448.74	$1,448.74	$1,580.86
Gulf	Medicaid Expansion	Maternity Kick Payment	$13,550.33	$13,550.33	$14,039.00
Gulf	Medicaid Expansion	EED Kick Payment	$7,316.96	$7,316.96	$7,425.94
Capital	SSI	0 - 2 Months	$34,606.48	$34,635.79	$36,479.56
Capital	SSI	3 - 11 Months	$5,814.84	$5,819.96	$6,153.41
Capital	SSI	Child 1 - 20 Years	$767.57	$768.44	$819.91
Capital	SSI	Adult 21+ Years	$1,396.98	$1,398.48	$1,493.05

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Capital	Family & Children	0 - 2 Months	$2,918.71	$2,921.18	$3,099.62
Capital	Family & Children	3 - 11 Months	$287.97	$288.26	$307.05
Capital	Family & Children	Child 1 - 20 Years	$182.39	$182.60	$195.16
Capital	Family & Children	Adult 21+ Years	$392.53	$392.95	$416.90
Capital	Foster Care Children	All Ages Male & Female	$474.80	$475.36	$510.44
Capital	BCC	BCC, All Ages	$2,204.92	$2,207.10	$2,325.48
Capital	LAP	LAP, All Ages	$206.68	$206.91	$220.03
Capital	HCBS	Child 1 - 20 Years	$1,836.31	$1,838.27	$1,961.99
Capital	HCBS	Adult 21+ Years	$1,514.62	$1,516.22	$1,624.13
Capital	CCM	CCM, All Ages	$1,356.30	$1,357.79	$1,435.28
Capital	SBH - CCM	SBH – CCM, All Ages	$252.74	$252.74	$258.79
Capital	SBH – Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	$23.57	$23.57	$24.29
Capital	SBH – HCBS	SBH – Child 1 - 20 Years	$141.69	$141.69	$143.83
Capital	SBH – HCBS	SBH – Adult 21+ Years	$66.07	$66.07	$68.95

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Capital	SBH – Other	SBH – All Ages	$188.53	$188.53	$196.12
Capital	Maternity Kick Payment	Maternity Kick Payment	$10,887.25	$10,887.25	$11,316.04
Capital	EED Kick Payment	EED Kick Payment	$5,382.73	$5,382.73	$5,478.35
Capital	Medicaid Expansion	Female Age 19 - Age 24	$295.67	$295.99	$317.67
Capital	Medicaid Expansion	Male Age 19 - Age 24	$237.19	$237.44	$254.65
Capital	Medicaid Expansion	Female Age 25 - Age 39	$417.22	$417.67	$448.66
Capital	Medicaid Expansion	Male Age 25 - Age 39	$418.20	$418.65	$449.72
Capital	Medicaid Expansion	Female Age 40 - Age 49	$645.16	$645.85	$694.30
Capital	Medicaid Expansion	Male Age 40 - Age 49	$629.64	$630.31	$677.55
Capital	Medicaid Expansion	Female Age 50 - Age 64	$788.48	$789.32	$848.73
Capital	Medicaid Expansion	Male Age 50 - Age 64	$839.67	$840.56	$903.91
Capital	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	$23.57	$23.57	$24.29
Capital	Medicaid Expansion	SBH – Other, All Ages	$188.53	$188.53	$196.12

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Capital	Medicaid Expansion	SBH – Chisholm, All Ages	$252.74	$252.74	$258.79
Capital	Medicaid Expansion	High Needs	$1,526.30	$1,526.30	$1,672.03
Capital	Medicaid Expansion	Maternity Kick Payment	$10,887.25	$10,887.25	$11,316.04
Capital	Medicaid Expansion	EED Kick Payment	$5,382.73	$5,382.73	$5,478.35
South Central	SSI	0 - 2 Months	$34,606.48	$34,635.79	$36,479.56
South Central	SSI	3 - 11 Months	$5,814.84	$5,819.96	$6,153.41
South Central	SSI	Child 1 - 20 Years	$737.25	$738.08	$785.11
South Central	SSI	Adult 21+ Years	$1,277.84	$1,279.16	$1,361.83
South Central	Family & Children	0 - 2 Months	$3,276.05	$3,278.83	$3,480.54
South Central	Family & Children	3 - 11 Months	$286.62	$286.91	$305.68
South Central	Family & Children	Child 1 - 20 Years	$182.20	$182.41	$194.93
South Central	Family & Children	Adult 21+ Years	$365.42	$365.81	$387.73
South Central	Foster Care Children	All Ages Male & Female	$474.80	$475.36	$510.44
South Central	BCC	BCC, All Ages	$2,204.92	$2,207.10	$2,325.48

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
South Central	LAP	LAP, All Ages	$206.68	$206.91	$220.03
South Central	HCBS	Child 1 - 20 Years	$1,836.31	$1,838.27	$1,961.99
South Central	HCBS	Adult 21+ Years	$1,514.62	$1,516.22	$1,624.13
South Central	CCM	CCM, All Ages	$1,356.30	$1,357.79	$1,435.28
South Central	SBH – CCM	SBH – CCM, All Ages	$252.74	$252.74	$258.79
South Central	SBH – Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	$23.43	$23.43	$24.15
South Central	SBH – HCBS	SBH – Child 1 - 20 Years	$141.69	$141.69	$143.83
South Central	SBH – HCBS	SBH – Adult 21+ Years	$66.07	$66.07	$68.95
South Central	SBH – Other	SBH – All Ages	$188.53	$188.53	$196.12
South Central	Maternity Kick Payment	Maternity Kick Payment	$9,692.36	$9,692.36	$10,119.96
South Central	EED Kick Payment	EED Kick Payment	$4,202.37	$4,202.37	$4,297.72
South Central	Medicaid Expansion	Female Age 19 - Age 24	$275.28	$275.57	$295.39
South Central	Medicaid Expansion	Male Age 19 - Age 24	$221.01	$221.24	$236.97

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
South Central	Medicaid Expansion	Female Age 25 - Age 39	$388.10	$388.51	$416.83
South Central	Medicaid Expansion	Male Age 25 - Age 39	$389.00	$389.41	$417.81
South Central	Medicaid Expansion	Female Age 40 - Age 49	$599.66	$600.29	$644.57
South Central	Medicaid Expansion	Male Age 40 - Age 49	$585.24	$585.86	$629.04
South Central	Medicaid Expansion	Female Age 50 - Age 64	$732.70	$733.47	$787.79
South Central	Medicaid Expansion	Male Age 50 - Age 64	$780.20	$781.02	$838.93
South Central	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	$23.43	$23.43	$24.15
South Central	Medicaid Expansion	SBH – Other, All Ages	$188.53	$188.53	$196.12
South Central	Medicaid Expansion	SBH – Chisholm, All Ages	$252.74	$252.74	$258.79
South Central	Medicaid Expansion	High Needs	$1,417.96	$1,417.96	$1,551.28
South Central	Medicaid Expansion	Maternity Kick Payment	$9,692.36	$9,692.36	$10,119.96
South Central	Medicaid Expansion	EED Kick Payment	$4,202.37	$4,202.37	$4,297.72
North	SSI	0 - 2 Months	$34,606.48	$34,635.79	$36,479.56
North	SSI	3 - 11 Months	$5,814.84	$5,819.96	$6,153.41

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
North	SSI	Child 1 - 20 Years	$753.29	$754.13	$802.44
North	SSI	Adult 21+ Years	$1,193.27	$1,194.49	$1,270.86
North	Family & Children	0 - 2 Months	$2,983.72	$2,986.08	$3,156.24
North	Family & Children	3 - 11 Months	$281.10	$281.38	$299.13
North	Family & Children	Child 1 - 20 Years	$198.05	$198.27	$211.79
North	Family & Children	Adult 21+ Years	$353.95	$354.32	$375.02
North	Foster Care Children	All Ages Male & Female	$474.80	$475.36	$510.44
North	BCC	BCC, All Ages	$2,204.92	$2,207.10	$2,325.48
North	LAP	LAP, All Ages	$206.68	$206.91	$220.03
North	HCBS	Child 1 - 20 Years	$1,836.31	$1,838.27	$1,961.99
North	HCBS	Adult 21+ Years	$1,514.62	$1,516.22	$1,624.13
North	CCM	CCM, All Ages	$1,356.30	$1,357.79	$1,435.28
North	SBH – CCM	SBH - CCM, All Ages	$252.74	$252.74	$258.79
North	SBH – Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	$28.26	$28.26	$29.18

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
North	SBH – HCBS	SBH – Child 1 - 20 Years	$141.69	$141.69	$143.83
North	SBH – HCBS	SBH – Adult 21+ Years	$66.07	$66.07	$68.95
North	SBH – Other	SBH – All Ages	$188.53	$188.53	$196.12
North	Maternity Kick Payment	Maternity Kick Payment	$10,688.83	$10,688.83	$11,117.89
North	EED Kick Payment	EED Kick Payment	$5,181.05	$5,181.05	$5,276.73
North	Medicaid Expansion	Female Age 19 - Age 24	$266.63	$266.91	$285.60
North	Medicaid Expansion	Male Age 19 - Age 24	$214.14	$214.36	$229.19
North	Medicaid Expansion	Female Age 25 - Age 39	$375.77	$376.16	$402.88
North	Medicaid Expansion	Male Age 25 - Age 39	$376.63	$377.02	$403.81
North	Medicaid Expansion	Female Age 40 - Age 49	$580.44	$581.04	$622.82
North	Medicaid Expansion	Male Age 40 - Age 49	$566.47	$567.05	$607.80
North	Medicaid Expansion	Female Age 50 - Age 64	$709.19	$709.92	$761.18
North	Medicaid Expansion	Male Age 50 - Age 64	$755.13	$755.91	$810.54

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
North	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	$28.26	$28.26	$29.18
North	Medicaid Expansion	SBH – Other, All Ages	$188.53	$188.53	$196.12
North	Medicaid Expansion	SBH – Chisholm, All Ages	$252.74	$252.74	$258.79
North	Medicaid Expansion	High Needs	$1,372.53	$1,372.53	$1,498.40
North	Medicaid Expansion	Maternity Kick Payment	$10,688.83	$10,688.83	$11,117.89
North	Medicaid Expansion	EED Kick Payment	$5,181.05	$5,181.05	$5,276.73

APPENDIX B: NON-EXPANSION ABA SERVICES ADJUSTMENT

			Feb 2018 - Jan 2019 Rates (Original)						
			A	B	C	D	E = A + B + C + D	F	G = E + F
COA Description	Rate Cell Description	Projected MMs	Claims PMPM	Total Admin PMPM	Prem Tax PMPM	UW Gain PMPM	Limited Rate PMPM	FMP Add On PMPM	Full Rate PMPM
SSI	Newborn, 0-2 Months	963	$ 20,723.07	$ 965.11	$ 1,289.57	$ 468.93	$ 23,446.68	11,159.80	$ 34,606.48
SSI	Newborn, 3-11 Months	6,983	$ 3,621.59	$ 169.32	$ 225.41	$ 81.97	$ 4,098.28	$ 1,716.57	$ 5,814.84
SSI	Child, 1-20 Years	456,675	$ 579.27	$ 35.48	$ 36.55	$ 13.29	$ 664.59	$ 92.04	$ 756.64
SSI	Adult, 21+ Years	938,794	$ 958.58	$ 50.07	$ 59.97	$ 21.81	$ 1,090.43	$ 242.81	$ 1,333.24
Family and Children	Newborn, 0-2 Months	113,728	$ 1,775.28	$ 92.62	$ 111.06	$ 40.39	$ 2,019.35	$ 1,075.87	$ 3,095.22
Family and Children	Newborn, 3-11 Months	395,749	$ 194.74	$ 22.31	$ 12.91	$ 4.69	$ 234.65	$ 58.56	$ 293.21
Family and Children	Child, 1-20 Years	7,939,771	$ 135.01	$ 18.79	$ 9.14	$ 3.33	$ 166.27	$ 18.87	$ 185.14
Family and Children	Adult, 21+ Years	1,271,721	$ 263.82	$ 23.58	$ 17.09	$ 6.21	$ 310.70	$ 61.04	$ 371.74
Foster Care Children	Foster Care, All Ages M & F	153,036	$ 384.18	$ 29.64	$ 24.61	$ 8.95	$ 447.37	$ 27.42	$ 474.80
Breast and Cervical Cancer	BCC, All Ages Female	7,224	$ 1,535.08	$ 75.08	$ 95.74	$ 34.81	$ 1,740.71	$ 464.20	$ 2,204.92
LaCHIP Affordable Plan	All Ages	39,300	$ 151.02	$ 19.35	$ 10.13	$ 3.68	$ 184.18	$ 22.49	$ 206.68
HCBS Waiver	20 & Under, M & F	4,736	$ 1,378.14	$ 70.26	$ 86.12	$ 31.32	$ 1,565.84	$ 270.48	$ 1,836.31
HCBS Waiver	21+ Years, M & F	15,616	$ 1,130.29	$ 53.63	$ 70.40	$ 25.60	$ 1,279.91	$ 234.71	$ 1,514.62
Chisholm Class Members	Chisholm, All Ages M & F	39,194	$ 1,035.67	$ 68.00	$ 65.62	$ 23.86	$ 1,193.16	$ 163.14	$ 1,356.30
SBH - Chisholm Class Members	SBH - Chisholm, All Ages M & F	47,217	$ 104.57	$ 11.95	$ 6.93	$ 2.52	$ 125.97	$ 0.23	$ 126.20
SBH - Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	1,232,026	$ 20.19	$ 4.88	$ 1.49	$ 0.54	$ 27.10	$ 0.09	$ 27.19
SBH - HCBS Waiver	SBH - 20 & Under, M & F	20,210	$ 36.93	$ 5.89	$ 2.55	$ 0.93	$ 46.30	$ 0.86	$ 47.16
SBH - HCBS Waiver	SBH - 21+ Years, M & F	42,977	$ 51.62	$ 7.21	$ 3.50	$ 1.27	$ 63.60	$ 2.47	$ 66.07
SBH -Other	SBH - Other, All Ages	55,122	$ 134.70	$ 14.65	$ 8.88	$ 3.23	$ 161.46	$ 26.76	$ 188.22
Maternity Kickpayment	Maternity Kickpayment, All Ages	33,044	$ 6,449.69	$ 340.18	$ 403.72	$ 146.81	$ 7,340.40	$ 3,914.13	$ 11,254.53
	Aggregate	**12,781,043**	**$ 257.41**	**$ 22.89**	**$ 16.67**	**$ 6.06**	**$ 303.03**	**$ 63.89**	**$ 366.92**

			Feb 2018 - Jan 2019 Rates (Revised)						
		H	I = A + H	J	K	L	M = I + J + K + L	N	O = M + N
COA Description	Rate Cell Description	Change in ABA Services	Resulting Claims PMPM	Total Admin PMPM	Prem Tax PMPM	UW Gain PMPM	Limited Rate PMPM	FMP Add On PMPM	Full Rate PMPM
SSI	Newborn, 0-2 Months	$ -	$ 20,723.07	$ 965.11	$ 1,289.57	$ 468.93	$ 23,446.68	$ 11,159.80	$ 34,606.48
SSI	Newborn, 3-11 Months	$ -	$ 3,621.59	$ 169.32	$ 225.41	$ 81.97	$ 4,098.28	$ 1,716.57	$ 5,814.84
SSI	Child, 1-20 Years	$ -	$ 579.27	$ 35.48	$ 36.55	$ 13.29	$ 664.59	$ 92.04	$ 756.64
SSI	Adult, 21+ Years	$ -	$ 958.58	$ 50.07	$ 59.97	$ 21.81	$ 1,090.43	$ 242.81	$ 1,333.24
Family and Children	Newborn, 0-2 Months	$ -	$ 1,775.28	$ 92.62	$ 111.06	$ 40.39	$ 2,019.35	$ 1,075.87	$ 3,095.22
Family and Children	Newborn, 3-11 Months	$ -	$ 194.74	$ 22.31	$ 12.91	$ 4.69	$ 234.65	$ 58.56	$ 293.21
Family and Children	Child, 1-20 Years	$ -	$ 135.01	$ 18.79	$ 9.14	$ 3.33	$ 166.27	$ 18.87	$ 185.14
Family and Children	Adult, 21+ Years	$ -	$ 263.82	$ 23.58	$ 17.09	$ 6.21	$ 310.70	$ 61.04	$ 371.74
Foster Care Children	Foster Care, All Ages M & F	$ -	$ 384.18	$ 29.64	$ 24.61	$ 8.95	$ 447.37	$ 27.42	$ 474.80
Breast and Cervical Cancer	BCC, All Ages Female	$ -	$ 1,535.08	$ 75.08	$ 95.74	$ 34.81	$ 1,740.71	$ 464.20	$ 2,204.92
LaCHIP Affordable Plan	All Ages	$ -	$ 151.02	$ 19.35	$ 10.13	$ 3.68	$ 184.18	$ 22.49	$ 206.68
HCBS Waiver	20 & Under, M & F	$ -	$ 1,378.14	$ 70.26	$ 86.12	$ 31.32	$ 1,565.84	$ 270.48	$ 1,836.31
HCBS Waiver	21+ Years, M & F	$ -	$ 1,130.29	$ 53.63	$ 70.40	$ 25.60	$ 1,279.91	$ 234.71	$ 1,514.62
Chisholm Class Members	Chisholm, All Ages M & F	$ -	$ 1,035.67	$ 68.00	$ 65.62	$ 23.86	$ 1,193.16	$ 163.14	$ 1,356.30
SBH - Chisholm Class Members	SBH - Chisholm, All Ages M & F	$ 117.05	$ 221.62	$ 11.95	$ 13.89	$ 5.05	$ 252.51	$ 0.23	$ 252.74
SBH - Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	$ -	$ 20.19	$ 4.88	$ 1.49	$ 0.54	$ 27.10	$ 0.09	$ 27.19
SBH - HCBS Waiver	SBH - 20 & Under, M & F	$ 87.44	$ 124.38	$ 5.89	$ 7.75	$ 2.82	$ 140.83	$ 0.86	$ 141.69
SBH - HCBS Waiver	SBH - 21+ Years, M & F	$ -	$ 51.62	$ 7.21	$ 3.50	$ 1.27	$ 63.60	$ 2.47	$ 66.07
SBH -Other	SBH - Other, All Ages	$ 0.29	$ 134.99	$ 14.65	$ 8.90	$ 3.24	$ 161.77	$ 26.76	$ 188.53
Maternity Kickpayment	Maternity Kickpayment, All Ages	$ -	$ 6,449.69	$ 340.18	$ 403.72	$ 146.81	$ 7,340.40	$ 3,914.13	$ 11,254.53
	Aggregate	**$ 0.57**	**$ 257.99**	**$ 22.89**	**$ 16.70**	**$ 6.07**	**$ 303.65**	**$ 63.89**	**$ 367.54**
	Difference	$ 0.57	$ -	$ -	$ 0.03	$ 0.01	$ 0.62	$ -	$ 0.62

APPENDIX C: EXPANSION ABA SERVICES ADJUSTMENT

			Feb 2018 - Jan 2019 Rates (Original)						
			A	B	C	D	E = A + B + C + D	F	G = E + F
COA Description	Rate Cell Description	Projected MMs	Claims PMPM	Total Admin PMPM	Prem Tax PMPM	UW Gain PMPM	Limited Rate PMPM	FMP Add On PMPM	Full Rate PMPM
Expansion	Aggregate	6,015,546	$ 379.26	$ 29.50	$ 24.31	$ 8.84	$ 441.91	$ 102.11	$ 544.02

		Feb 2018 - Jan 2019 Rates (Revised)							
		H	I = A + H	J	K	L	M = I + J + K + L	N	O = M + N
COA Description	Rate Cell Description	Change in ABA Services	Resulting Claims PMPM	Total Admin PMPM	Prem Tax PMPM	UW Gain PMPM	Limited Rate PMPM	FMP Add On PMPM	Full Rate PMPM
Expansion	Aggregate	$ 0.02	$ 379.28	$ 29.50	$ 24.31	$ 8.84	$ 441.93	$ 102.11	$ 544.04
	Difference	$ 0.02	$ -	$ 0.00	$ 0.00	$ 0.02	$ -	$ 0.02	

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JULY 2017–JUNE 2018 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE

Louisiana — February 1, 2018– January 31, 2019

Documentation Reference

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

- Certification #1 – Rate Certification dated March 5, 2018 for effective period February 1, 2018 through January 31, 2019. This certification was revised by certification #2 for the entire period of February 1, 2018 through January 31, 2019.
- Certification #2 – Rate Certification dated April 30, 2018 for effective period February 1, 2018 through January 31, 2019.

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

A. Rate Development Standards

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

i. Rate certifications must be done on a 12-month rating period.[4] CMS will consider a time period other than 12 months to address unusual circumstance. For example, CMS would approve a time period other than 12 months for the following reasons:

   a. when the state is trying to align program rating periods, which may require rating period longer than one year (but less than two years); or

ii. when the state needs to make an amendment to the contract and the rates for an already approved rating period need to be adjusted accordingly.

iii. In accordance with 42 CFR §438.4, 438.5, 438.6, and 438.7, an acceptable rate certification submission, as supported by the assurances from the state, includes the following items and information:

   a. a letter from the certifying actuary, who meets the requirements for an actuary in 42 CFR §438.2, who certifies that the final capitation rates or rate ranges meet the standards in 42 CFR §438.3(c), 438.3(e), 438.4 (excluding paragraphs (b)(3), (b)(4) and (b)(9)), 438.5, 438.6, and 438.7 (excluding paragraph (c)(3)).

   b. the final and certified capitation rates or the final and certified rate ranges for all rate cells and all regions (as applicable).[5] Additionally, the contract must specify the final capitation rate(s) in accordance with 42 CFR §438.3(c)(1)(i).

   c. if rate ranges are certified, assurances that rates at any point within the rate range would be actuarially sound and that the capitation rate for each rate cell is within the certified rate range.

   d. brief descriptions of the following information (to show that the actuary developing and/or certifying the rates has an appropriate

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[4] Per 42 CFR §438.2, “rating period” means a period of 12 months selected by the state for which the actuarially sound capitation rates are developed and documented in the rate certification.

[5] Beginning with rate periods on or after July 1, 2018, actuaries must certify specific rates for each rate cell in accordance with 42 CFR §438.4(b)(4) and 438.7(c), and it will no longer be permissible to certify rate ranges. However, 42 CFR §438.7(c)(3) will be for rate periods on or after July 1, 2018 which allows states to increase or decrease the capitation rate per rate cell up to 1.5 percent without submitting a revised rate certification. If states or their actuaries have questions on this upcoming regulatory change, please feel free to reach out to your CMS Regional Office to schedule a technical assistance call.

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

understanding of the program for which he or she is developing rates):

i. a summary of the specific state Medicaid managed care programs covered by the rate certification, including, but not limited to:
   A. the types and numbers of managed care plans included in the rate development (e.g., type should include the program type, such as managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans).
   B. a general description or list of the benefits that are required to be provided by the managed care plan or plans (e.g., types of medical services, behavioral health or mental health services, long-term care services, etc.), particularly noting any benefits that are carved out of the managed care program or that are new to the managed care program in that rating period covered.
   C. the areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.

ii. the rating period covered by the rate certification.

iii. the Medicaid population(s) covered through the managed care programs to which the rate certification applies.

iv. any eligibility or enrollment criteria that could have a significant influence on the specific population to be covered within the managed care program (e.g., the definition of medically frail, or if enrollment in managed care plans is voluntary or mandatory).

v. a summary of the special contract provisions related to payment that, per 42 CFR §438.6, are included within rate development (e.g. risk-sharing mechanisms, incentive arrangements, withhold arrangements, state-directed delivery system reform and provider payment initiatives,[6] pass-through payments, and payments to MCOs and PIHPs for enrollees that are a patient in an Institution of Mental Disease (IMD)).

vi. if the state determines that a retroactive adjustment to the capitation rates is necessary, these retroactive adjustments must be certified by an actuary in a revised rate certification and submitted as a contract amendment in accordance with 42 CFR §438.7(c)(2). The rate

[6] State direction of managed care plan expenditures under the contract (e.g., value-based purchasing arrangements, multi-payer initiatives, quality/performance incentive programs, and all fee schedules) must meet the requirements in 42 CFR 438.6(c) and receive prior approval before implementation. In order to ensure that States can have these directed payment arrangements reviewed and approved prior to developing rates, CMS has a separate process for submitting payment arrangements under 42 CR 438.6(c).

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

certification must:

A. describe the rationale for the adjustment; and

iv. the data, assumptions and methodologies used to develop the magnitude of the adjustment.

v. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

vi. Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments from any other rate cell.

vii. The effective dates of changes to the Medicaid managed care program (including eligibility, benefits, payment rate requirements, incentive programs, and program initiatives) should be consistent with the assumptions used to develop the capitation rates.

viii. As part of CMS's determination of whether or not the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider whether the submission demonstrates the following:

a. all adjustments to the capitation rates, or to any portion of the capitation rates, must reflect reasonable, appropriate, and attainable costs in the actuary's judgment and must be included in the rate certification.

b. adjustments to the rates or rate ranges that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4. Therefore, the rates or rate ranges will not be considered actuarially sound if adjustments are made outside of the rate setting process described in the rate certification.

ix. consistent with 42 CFR §438.7(c), the final contracted rates in each cell must either match the capitation rates or be within the rate ranges in the rate certification. This is required in total and for each and every rate cell.

x. Rates must be certified for all time periods in which they are effective, and a certification must be provided for rates for all time periods. Rates from a previous rating period cannot be used for a future time period without an actuarial certification of the rates for the new rating period.

xi. Procedures for rate certifications for rate and contract amendments, include:

a. CMS requires that the state submit a new rate certification when the rates or rate ranges change, except for changes permitted in 42 CFR

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

§438.7(c)(3).

b. for contract amendments that do not affect the rates or rate range, CMS does not require a new rate certification from the state. However, if the contract amendment revises the covered populations, services furnished under the contract or other changes that could reasonably change the rate development and rates, the state and its actuary must provide supporting documentation indicating the rationale as to why the rates continue to be actuarially sound in accordance with 42 CFR §438.4.

c. there are several circumstances when CMS would not require a new rate certification:

i. a state changes the capitation rates paid to the plans, but the capitation rates still fall within the certified rate ranges for that rating period and of the contract.

ii. a state applies risk scores to the capitation rates paid to the plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR §438.7(b)(5)(iii).

xii. any time a rate changes for any reason other than application of an approved payment term (e.g., risk adjustment methodology), which was included in the initial managed care contract, the state must submit a contract amendment to CMS, even if the rate change does not need a new rate certification.

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

B. Appropriate Documentation	Documentation Reference	
	Certification #1	**Certification #2**
i. States and their actuaries must document all the elements described within their rate certifications to provide adequate detail that CMS is able to determine whether or not the regulatory standards are met. In evaluating the rate certification, CMS will look to the reasonableness of the information contained in the rate certification for the purposes of rate development and may require additional information or documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented: a. data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources. b. assumptions made, including any basis or justification for the assumption. c. methods for analyzing data and	– Mercer Rate Certification › Part A: General Information, pages 2-9 – Data Book	–

SECTION I. MEDICAID MANAGED CARE RATES		
1. General Information		
developing assumptions and adjustments.		
ii. The rate certification must include an index that documents the page number or the section number for the items described within this guidance. In cases where not all sections of this guidance are relevant for a particular rate certification (i.e., an amended certification that adds a new benefit for part of the year), inapplicable sections of the guidance should be included and marked as “Not Applicable” in the index.	– Mercer Rate Certification – CMS RDG attached at end of document, pages 105 - 147	– Mercer Rate Certification – CMS RDG attached at end of document, pages 18-60
iii. There are services, populations, or programs for which the state receives a different federal medical assistance percentage (FMAP) than the regular state FMAP. In those cases, the portions or amounts of the costs subject to the different FMAP should be shown as part of the rate certification to the extent possible.	– Mercer Rate Certification › Healthy Louisiana Services Eligible for Different Federal Medical Assistance Percentage (FMAP) page 8	–
iv. In cases when the actuary develops and certifies rate ranges on behalf of a state, the rate certification and supporting	• Mercer Rate Certification o Subpart C.1: Projected Benefit Costs, Trend, page 21 o Appendix G	•

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

documentation must describe how the rate ranges were developed, including: a. any assumptions for which values are varied in order to develop rate ranges. b. the values of each of the assumptions used to develop the minimum, the mid-point or best estimate (as applicable), and the maximum of the rate ranges. c. a description of the data, assumptions, and methodologies that were used to develop the values of the assumptions for the minimum, the mid-point or best estimate (as applicable), and the maximum of the rate ranges.		
v. The information related to rate range development must be included in either the relevant sections of the rate certification or in a separate section related to specifically to the rate range development. For example, a description of how certain assumptions related to projected benefit costs vary to develop the rate ranges may be included with the	• See section A above for more detail.	•

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

	description of other information related to projected benefit costs, or may be included in a section that describes all of the assumptions that were varied to develop the rates. The rate certification index (described in Section I, Item 1.B.ii) must identify where these are described.		

SECTION I. MEDICAID MANAGED CARE RATES

2. Data

A. Rate Development Standards

i. In accordance with 42 CFR §438.5(c), states and actuaries must follow rate development standards related to base data, including:

a. states must provide all the validated encounter data and/or fee-for-service (FFS) data (as appropriate) and audited financial reports (as defined in see §438.3(m)) that demonstrates experience for the populations to be served by the health plan to the state's actuary developing the capitation rates for at least the three most recent and complete years prior to the rating period.

b. states and their actuaries must use the most appropriate base data, from the three most recent and complete years prior to the rating period, for developing capitation rates.

c. base data must be derived from the Medicaid population, or, if data on the Medicaid population is not available, derived from a similar population and adjusted to make the utilization and price data comparable to data from the Medicaid population.

d. states that are unable to develop rates using data that is no older than from the three most recent and complete years prior to the rating period may request approval for an exception as follows:

i. this request should be submitted by the state as soon as the actuary starts developing the rate certification and makes a determination that encounter data will not comply with 42 CFR §438.5(c)(1)-(2).

SECTION I. MEDICAID MANAGED CARE RATES

2. Data

ii. the request must describe why an exception is necessary and describe the actions the state intends to take to come into compliance with those requirements.

ii. the request must also describe the state's proposed corrective action plan outlining how the state will come into compliance with the base data standards per 42 CFR §438.5(c) no later than two years from the rating period for which the deficiency is identified.

B. Appropriate Documentation	Documentation Reference	
	Certification #1	**Certification #2**
i. In accordance with 42 CFR §438.7(b)(1), the rate certification must include: a. a description of base data requested by the actuary for the rate setting process, including: i. a summary of the base data that was requested by the actuary. ii. a summary of the base data that was provided by the state. iii. an explanation of why any base data requested was not provided by the state.	• Data Book • Mercer Rate Certification o Section 1: Medicaid Managed Care Rates ▪ Part B: Base Data Development, page 9	•
ii. The rate certification, as supported by the assurances from the state, must thoroughly describe the data used to develop the capitation rates, including: a. a description of the data, including:		

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2. Data		
i. the types of data used, which may include, but is not limited to: fee-for-service claims data; managed care encounter data; health plan financial data; information from program integrity audits; or other Medicaid program data.	• Mercer Rate Certification o o Section 1: Medicaid Managed Care Rates ▪ Part A: General Information, pages 2-3 ▪ Part B: Base Data Development, page 9	•
ii. the age or time periods of all data used.	• Mercer Rate Certification o Section 1: Medicaid Managed Care Rates ▪ Part A: General Information, pages 2-3 ▪ Part B: Base Data Development, page 9	•
iii. the sources of all data used (e.g., State Medicaid Agency; other state agencies; health plans; or other third parties).	• Mercer Rate Certification o Section 1: Medicaid Managed Care Rates ▪ Part A: General Information, pages 2-3 ▪ Part B: Base Data Development, page 9	•
iv. if a significant portion of the	• N/A	•

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2. Data		
benefits under the contract with the managed care entity are provided through arrangements with subcontractors that are also paid on a capitated basis (or subcapitated arrangements), a description of the data received from the subcapitated plans or providers; or, if data is not received from the subcapitated plans or providers, a description of how the historical costs related to subcapitated arrangements were developed or verified.		
b. information related to the availability and the quality of the data used for rate development, including:		
i. the steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including: A. completeness of the data. B. accuracy of the data.	• Mercer Rate Certification o o Section 1: Medicaid Managed Care Rates ▪ Part B: Base Data Development, pages 9-10	•

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2. Data		
C. consistency of the data across data sources.		
ii. a summary of the actuary's assessment of the data.	• Mercer Rate Certification o Part B: Base Data Development, pages 9-10 o Section 3: Certification of Final Rate Ranges, pages 29-30	•
iii. any other concerns that the actuary has over the availability or quality of the data.	• N/A	•
c. a description of how the actuary determined what data was appropriate to use for the rating period, including:		
i. if fee-for-service claims or managed care encounter data are not used (or are not available), this description should include an explanation of why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.	• N/A	•

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2. Data		
ii. if managed care encounter data was not used in the rate development, this description should include an explanation of why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data.	• N/A	•
d. if there is any reliance or use of a data book in the rate development, the details of the template and relevant instructions used in the data book.	• Mercer Rate Certification o Section 1: Medicaid Managed Care Rates ▪ Part A: General Information, pages 2-3 ▪ Appendix Y ▪ Part B: Base Data Development, pages 8-9	•
iii. The rate certification, as supported by the assurances from the state, must thoroughly describe any significant adjustments, and the basis for the adjustments, that are made to the data, including but not limited to adjustments		

SECTION I. MEDICAID MANAGED CARE RATES		
2. Data		
for:		
a. the credibility of the data.	• Mercer Rate Certification o Part B: Base Data Development, pages 8-9 o Base Data Adjustments, page 13	•
b. completion factors.	• Mercer Rate Certification o Part B: Base Data Development, pages 8-9 o IBNR, page 10 Under-reporting Adjustment, page 10	•
c. errors found in the data.	• N/A	•
d. changes in the program between the time period from which the data is obtained and the rating period (e.g., changes in the population covered; changes in benefits or services; changes to payment models or reimbursement rates to providers; or changes to the structure of the managed care program).	• Mercer Rate Certification o Prospective Rating Adjustments, pages 14-21	• Mercer Rate Certification o Technical Changes for ABA services, page 2
e. exclusions of certain payments or services from the data.	• Mercer Rate Certification o Excluded services, pages 7-8	•

SECTION I. MEDICAID MANAGED CARE RATES

3. Projected Benefit Costs and Trends

A. Rate Development Standards

i. Final capitation rates must be based only upon the services allowed in 42 CFR §438.3(c)(1)(ii) and 438.3(e).

ii. Variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

iii. In accordance with 42 CFR §438.5(d), each projected benefit cost trend assumption must be reasonable and developed in accordance with generally accepted actuarial principles and practices. Trend assumptions must be developed primarily from actual experience of the Medicaid population or from a similar population, and including consideration of other factors that may affect projected benefit cost trends through the rating period.

iv. If the projected benefit costs include costs for in-lieu-of services defined at 42 CFR §438.3(e)(2) (i.e., substitutes for State Plan services or settings), the utilization and unit costs of the in-lieu-of services must be taken into account in developing the projected benefit costs of the covered services (as opposed to utilization and unit costs of the State plan services or settings), unless a statute or regulation explicitly requires otherwise. The costs of an IMD as an in-lieu-of-service must not be used in rate development. See Section I, item 3.A.v.

v. States may make a monthly capitation payment to an MCO or PIHP (in a “risk contract” as defined in 42 CFR §438.2) for an enrollee age 21 to 64 receiving inpatient treatment in an Institution for Mental Diseases (IMD) (as defined in 42 CFR §435.1010) for a short-term stay of no more than 15 days during the period of the monthly capitation payment in accordance with 42 CFR §438.6(e). In this case, when developing the projected benefit costs for these services, the actuary must use the unit costs of providers delivering the same services included in the State Plan, as opposed to the unit costs of the IMD services. The actuary may use the utilization of the services provided to an enrollee in an IMD in developing the utilization component of projected benefit costs. The data used for developing the projected benefit costs for these services must not include:

   a. costs associated with an IMD stay of more than 15 days.

vi. any other costs for any services delivered during the time an enrollee is in an IMD for more than 15 days.

SECTION I. MEDICAID MANAGED CARE RATES

3. Projected Benefit Costs and Trends

vii. In connection with section 12002 of the 21st Century Cures Act (P.L. 114-255), CMS requests the following information be provided in the certification for programs that allow IMDs to be used an in lieu of service provider:

a. the number of enrollees ages 21 to 64 who received treatment in an IMD through managed care organizations or plans in the base data period;

b. the range of and the average number of months and of length of stay during those months that enrollees received care in an IMD;

viii. the impact that providing treatment through IMDs has had on the capitation rates or rate ranges.

B. Appropriate Documentation	Documentation Reference	
	Certification #1	**Certification #2**
i. The rate certification must clearly document the final projected benefit costs by relevant level of detail (e.g., rate cell, or aligned with how the state makes payments to the plans).	• Appendix Q: Non-Expansion Loaded Rate Development	•
ii. The rate certification and supporting documentation must describe the development of the projected benefit costs included in the capitation rates, including:		
a. a description of the data, assumptions, and methodologies used to develop the projected benefit costs and, in particular, all significant and material items in	• Mercer Rate Certification o Section 1, Part C: Non-Expansion Capitation Rate Development, page 21	•

SECTION I. MEDICAID MANAGED CARE RATES		
3. Projected Benefit Costs and Trends		
developing the projected benefit costs.		
b. any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last rate certification must be described.	• Mercer Rate Certification o Section 1, Part C: Non-Expansion Capitation Rate Development, page 21	• Mercer Rate Certification o Technical Changes for ABA Services, page 2
iii. The rate certification and supporting documentation must include a section on projected benefit cost trends (i.e. an estimate the projected change in benefit costs from the historical base data period(s) to the rating period of the rate certification) in accordance with 42 CFR §438.7(b)(2). a. this section must include:		
i. any data used or assumptions made in developing projected benefit cost trends, including a description of the sources of those data and assumptions. A. the descriptions of data and assumptions should include citations	• Mercer Rate Certification o Historical Trend, page 13 o Trend, page 21	•

SECTION I. MEDICAID MANAGED CARE RATES		
3. Projected Benefit Costs and Trends		
whenever possible. B. the description should state whether the trend is developed primarily with actual experience from the Medicaid population or provide rationale for the experience from a similar population that is utilized, and consideration of other factors expected to impact trend.		
ii. the methodologies used to develop projected benefit trends.	• Mercer Rate Certification o Historical Trend, page 13 o Trend, page 21	•
iii. any comparisons to historical benefit cost trends, or other program benefit cost trends, that were analyzed as part of the development of the trend for the rating period of the rate certification.	• Mercer Rate Certification o Historical Trend, page 13 o Trend, pages 21	•
b. this section must include the projected benefit cost trends		

SECTION I. MEDICAID MANAGED CARE RATES		
3. Projected Benefit Costs and Trends		
separated into components, specifically:		
i. the projected benefit cost trends should be separated into: A. changes in price (i.e., pricing differences due to different provider reimbursement rates or payment models); and B. changes in utilization (i.e., differences in the amount, duration, or mix of benefits or services provided).	• Mercer Rate Certification o Appendix G	•
ii. if the actuary did not develop the projected benefit cost trends using price and utilization components, the actuary should describe and justify the method(s)used to develop projected benefit cost trends.	• Mercer Rate Certification o Trend, page 21	•
iii. the projected benefit cost trends may include other	• N/A	•

SECTION I. MEDICAID MANAGED CARE RATES		
3. Projected Benefit Costs and Trends		
components as applicable and used by the actuary in developing rates (e.g., changes in location of service delivery; the effect of utilization or care management on projected benefit cost trends; regional differences or variations).		
c. variations in the projected benefit cost trends must be explained. Projected benefit cost trends may vary by: i. Medicaid populations. ii. rate cells. iii. subsets of benefits within a category of services (e.g., specialty vs. non-specialty drugs).	• Mercer Rate Certification o Historical Trend, page 13 o Trend, page 21	•
d. any other material adjustments to projected benefit cost trends must be described in accordance with 42 CFR §438.7(b)(4), including: i. a description of the data,	iv. Mercer Rate Certification o Historical Trend, page 13 o Trend, page 21	•

SECTION I. MEDICAID MANAGED CARE RATES		
3. Projected Benefit Costs and Trends		
assumptions, and methodologies used to determine each adjustment. ii. the cost impact of each material adjustment. iii. where in the rate setting process the material adjustment was applied.		
e. any other adjustments to projected benefit costs trends must be listed. CMS also requests the following detail about non-material adjustments: i. the impact of managed care on the utilization and the unit costs of health care services. ii. changes to projected benefit costs trend in the rating period outside of regular changes in utilization or unit cost of services.	• N/A	•
iv. If the projected benefit costs include additional services deemed by the state to be necessary to comply with the parity standards of the Mental	• N/A	•

SECTION I. MEDICAID MANAGED CARE RATES		
3. Projected Benefit Costs and Trends		
Health Parity and Addiction Equity Act as required by 42 CFR §438.3(c)(1)(ii), the following must be described: a. the categories of service that contain these additional services necessary for parity. b. the percentage of cost that these services represent in each category of service. c. how these services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service.		
v. For in-lieu-of services defined at 42 CFR §438.3(e)(2) (i.e., substitutes for State Plan services), the following information must be provided and documented: a. the categories of covered service that contain in-lieu-of-services. b. the percentage of cost that in-	• Mercer Rate Certification o In-Lieu of Services, page 22 o IMD, page 22-23	•

SECTION I. MEDICAID MANAGED CARE RATES

3. Projected Benefit Costs and Trends

lieu-of services represent in each category of service. c. how the in-lieu-of services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service. d. for inpatient psychiatric or substance use disorder services provided in an IMD setting, rate development must comply with the requirements of 42 CFR §438.6(e) and the data and assumptions utilized should be described in the rate certification.		
vi. The rate certification must describe how retrospective eligibility periods are accounted for in rate development, including but not limited to: a. the managed care plan's responsibility to pay for claims incurred during the retroactive	• Mercer Rate Certification o Retroactive Eligibility Adjustment, pages 23-24 o Appendix M	•

SECTION I. MEDICAID MANAGED CARE RATES		
3. Projected Benefit Costs and Trends		
eligibility period. b. how the claims information are included in the base data. c. how the enrollment or exposure information is included in the base data. d. how the capitation rates are adjusted to reflect the retroactive eligibility period, and the assumptions and methodologies used to develop those adjustments.		
ix. The rate certification must clearly document the impact on projected costs for all material changes to covered benefits or services since the last rate certification, including, but not limited to: a. more or fewer state plan benefits covered by Medicaid managed care. b. any recoveries of overpayments made to providers by health plans in accordance with 42 CFR §438.608(d).	• Mercer Rate Certification O New Services, page 7 › Prospective Rating adjustments, Pages 20-21	• Mercer Rate Certification o Technical Changes for ABA services, page 2

SECTION I. MEDICAID MANAGED CARE RATES

3. Projected Benefit Costs and Trends

c. requirements related to payments from health plans to any providers or class of providers. d. requirements or conditions of any applicable waivers. e. requirements or conditions of any litigation to which the state is subjected.		
x. For each change related to covered benefits or services, the rate certification must include an estimated impact of the change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment.	xi. Mercer Rate Certification O New Services, page 7 » Prospective Rating adjustments, Pages 20-21	• Mercer Rate Certification • Technical Changes for ABA services, page 2 and Appendices B & C
a. any change determined by the actuary to be non-material can be grouped with other non-material changes and described within the rate certification, provided that: i. the rate certification includes a list of all non-material adjustments used in the rate development process.	• N/A	•

SECTION I. MEDICAID MANAGED CARE RATES		
3. Projected Benefit Costs and Trends		
ii. the actuary must give a description of why the changes were not considered material and how they were aggregated into a single adjustment. iii. the rate certification provides a description of where in the rate setting process the adjustments were applied. iv. The rate certification documents the aggregate cost impact of all non-material adjustments.		

SECTION I. MEDICAID MANAGED CARE RATES
4. Special Contract Provisions Related to Payment
A. Incentive Arrangements
i. Rate Development Standards

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4. Special Contract Provisions Related to Payment

a. the rate certification and supporting documentation must describe any incentives included in the contract between the state and the health plans. An incentive arrangement, as defined in 42 CFR §438.6(a), is any payment mechanism under which a health plan may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract.

ii. the rate certification must include documentation that the incentive arrangement will not exceed 105% of the approved capitation payments under the contract that are attributable to the enrollees or services covered by the incentive arrangements as required in 42 CFR §438.6(b)(2).

i. Appropriate Documentation	**Documentation Reference**	
	Certification #1	**Certification #2**
a. the rate certification must include a description of the incentive arrangement. An adequate description includes at least: i. time period of the arrangement, if different than the rating period. ii. enrollees, services, and providers covered by the incentive program. iii. the purpose of the incentive arrangement (e.g. specified activities, targets, performance measures, or quality-based outcomes, etc.). iv. a description of any effect that each incentive arrangement has on the development of the capitation rates.	• N/A	•

B. Withhold Arrangements

i. Rate Development Standards

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4. Special Contract Provisions Related to Payment

a. the rate certification and supporting documentation must describe any withhold arrangements in the contract between the state and the health plans. As defined in 42 CFR §438.6(a), a withhold arrangement is any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract.
   i. the targets for a withhold arrangement are distinct from general operational requirements under the contract.
   ii. arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement.

b. in accordance with 42 CFR §438.6(b)(3), the capitation payment(s) minus any portion of the withhold that is not reasonably achievable must be actuarially sound.

ii. Appropriate Documentation	Documentation Reference	
	Certification #1	**Certification #2**
a. the rate certification must include a description of the withhold arrangement. An adequate description includes at least the following: i. the time period of the arrangement, if different than the rating period and the purpose of the arrangement (e.g. specified activities, targets, performance measures, or quality-based outcomes, etc.). ii. a description of the total percentage of the certified	•	• N/A

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

	capitation rates being withheld through withhold arrangements. iii. an estimate of the percentage of the withheld amount in a withhold arrangement that is not reasonably achievable and the basis for that determination, including the data, assumptions, and methodologies used to make this determination. iv. a description of how the total withhold arrangement, achievable or not, is reasonable and takes into consideration the health plan's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the health plan's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves. v. a description of any effect that the withhold arrangements have on the development of the capitation		

SECTION I. MEDICAID MANAGED CARE RATES		
4. Special Contract Provisions Related to Payment		
rates.		
C. Risk-Sharing Mechanisms		
i. Rate Development Standards a. in accordance with 42 CFR §438.6(b), if the state utilizes risk-sharing mechanisms with its health plan(s), such as reinsurance, risk corridors, or stop-loss limits, these arrangements must be described in the contract(s) and must be developed in accordance with §438.4, the rate development standards in §438.5, and generally accepted actuarial principles and practices. b. the rate certification and supporting documentation must describe any risk mitigation that may affect the rates, rate ranges, or the final net payments to the health plan(s) under the applicable contract.		
ii. Appropriate Documentation	**Documentation Reference**	
	Certification #1	**Certification #2**
a. the rate certification and supporting documentation must include a description of any other risk-sharing arrangements, such as a risk corridor or a large claims pool. An adequate description of these includes at least the following: i. a rationale for the use of the risk sharing arrangement. iii. a detailed description of how the risk-sharing arrangement is implemented. iv. a description of any effect that the	– Mercer Rate Certification o Subpart C.4: Risk Mitigation, Non-Expansion Minimum Medical Loss Ratio (MLR), page 26	•

SECTION I. MEDICAID MANAGED CARE RATES

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risk-sharing arrangements have on the development of the capitation rates. v. documentation demonstrating that the risk-sharing mechanism has been developed in accordance with generally accepted actuarial principles and practices.		
b. if the contract includes a remittance/payment requirement for being below/above a specified medical loss ratio (MLR), the rate certification and supporting documentation must include a description of this MLR arrangement. An adequate description includes at least the following: i. the methodology used to calculate the medical loss ratio. ii. the formula for calculating a remittance/payment for having a medical loss ratio below/above the minimum requirements. iii. any other consequences for a	– Mercer Rate Certification o Subpart C.4: Risk Mitigation, Non-Expansion Minimum Medical Loss Ratio (MLR), page 26 iv.	•

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4. Special Contract Provisions Related to Payment

remittance/payment for a medical loss ratio below/above the minimum requirements.		
c. if the contract has reinsurance requirements, the rate certification and supporting document must include a description of the reinsurance requirements. An adequate description includes at least the following: i. a detailed description of any reinsurance requirements under the contract associated with the rate certification, including the reinsurance premiums and any relevant historical reinsurance experience. ii. identification of any effect that the reinsurance requirements have on the development of the capitation rates. iii. documentation that the reinsurance mechanism has been developed in accordance with generally accepted actuarial		

SECTION I. MEDICAID MANAGED CARE RATES		
4. Special Contract Provisions Related to Payment		
principles and practices. iv. if the actuary develops the reinsurance premiums, a description of how the reinsurance premiums were developed, including the data, assumptions and methodology used.		
D. Delivery System and Provider Payment Initiatives		
i. Rate Development Standards a. consistent with 42 CFR §438.6(c), states may utilize delivery system and provider payment initiatives, including requiring managed care plans to: i. implement value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services. ii. participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative. iii. adopt a minimum fee schedule for network providers that provide a particular service under the contract. iv. provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. v. adopt a maximum fee schedule for network providers that provide a particular service under the contract, so long as the health plan retains the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.		
ii. Appropriate Documentation	**Documentation Reference**	
	Certification #1	**Certification #2**
a. the rate certification and supporting documentation must include a		

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

	description of any delivery system and provider payment initiatives. An adequate description includes at least the following: i. a brief description of the delivery system and provider payment initiatives included in the rates for this rating period. ii. the amount of these payments within the rate development, both in total and on a per member per month basis (if applicable). iii. the providers receiving these payments. iv. a description of any effect the delivery system or provider payment initiative has on the development of capitation rates, including the data, assumptions and methodologies used to make this determination.		
E.	Pass-Through Payments		
	i. Rate Development Standards a. a pass-through payment is any amount required by the state to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between MCOs, PIHPs, or PAHPs and hospitals, physicians, or nursing facilities that is not for one of		

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

the following purposes[7]:

i. a specific service or benefit provided to a specific enrollee covered under the contract;

ii. a provider payment methodology permitted under 42 CFR §438.6(c)(1)(i) through (iii) for services and enrollees covered under the contract;

iii. a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract;

iv. graduate Medical Education (GME) payments; or

v. Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) wrap around payments.

b. pass-through payments to hospitals must comply with the requirements of 42 CFR §438.6(d). The aggregate pass-through payments to hospitals may not exceed the base amount.

c. the base amount is determined as the sum of (i) and (ii) below:

i. for inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period and that were provided to the eligible populations under MCO, PIHP, or PAHP contracts two years prior to the rating period, the state must determine reasonable estimates of the aggregate difference between:

A. the amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under the MCO, PIHP, or PAHP contracts for the 12-month period immediately two years prior to the rating period that will include pass-through payments; and

B. the amount the MCOs, PIHPs, or PAHPs paid (not including pass-through payments) for those inpatient and outpatient hospital services utilized by the eligible populations under MCO, PIHP, or PAHP contracts for the 12-month period immediately 2 years prior to the rating period.

ii. for inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for

[7] States may not require health plans to make pass-through payments other than those permitted to network providers that are hospitals, physicians, and nursing facilities in accordance with 42 CFR 438.6(d)(1).

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

the rating period and that were provided to the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period, the state must determine reasonable estimates of the aggregate difference between:

A. the amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments; and

B. the amount the state paid under Medicaid FFS (not including pass-through payments) for those inpatient and outpatient hospital services utilized by the eligible populations for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments.

d. the base amount should be the actual amount calculated in the Section I, Item 4.E.i.c of the guide and should not be trended forward.

e. states may calculate reasonable estimates of the aggregate differences in paragraph (c) in accordance with the upper payment limit requirements in 42 CFR part 447.

f. capitation rates may only include pass-through payments to hospitals, physicians and nursing facilities in accordance with 42 CFR 438.6(d); states may not include pass-through payments to providers other than hospitals, physicians, and nursing facilities in the capitation rates.

ii. Appropriate Documentation	Documentation Reference	
	Certification #1	**Certification #2**
a. the rate certification and supporting documentation must include a description of all existing pass-through payments incorporated into the rates for this rating period. An adequate description includes at least the following: i. a description of the pass-through	• N/A •	•

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

payment. ii. the amount of the pass-through payments, both in total and on a per member per month basis (if applicable). iii. the providers receiving the pass-through payments. iv. the financing mechanism for the pass-through payment. v. the amount of pass-through payments incorporated into capitation rates in the previous rating period. vi. the amount of pass-through payments incorporated into capitation rates for the rating period in effect on July 5, 2016.		
b. the certification must document the following information about the base amount for hospital pass-through payments: i. the data, methodologies, and assumptions used to calculate the base amount. ii. the aggregate amounts calculated	• N/A •	•

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

	for Section I, Item 4.E.i.c.i.A, Section I, Item 4.E.i.c.i.B, Section I, Item 4.E.i.c.ii.A, and Section I, Item 4.E.i.c.ii.B.		

SECTION I. MEDICAID MANAGED CARE RATES

5. Projected Non-Benefit Costs

A. Rate Development Standards

i. In accordance with 42 CFR §438.5(e), the development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO, PIHP or PAHP administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital. In addition, the non-benefit component must include other operational costs associated with the provision of services under the contract, including those to comply with the parity standards of the Mental Health Parity and Addiction Equity Act, as required by 42 CFR §438.3(c)(1)(ii).

ii. Non-benefit costs may be developed as per member per month (PMPM) costs or as a percentage of projected benefit costs or capitation rates, and different approaches can be taken for different categories of costs. For non-benefit costs that may be difficult to allocate to specific enrollees or groups of enrollees, or for taxes and fees that are assessed as a percentage of premiums, it may be reasonable to calculate those non-benefit costs as a percentage of benefit costs or capitation rates.

iii. Variations in the assumptions used to develop the projected non-benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

iv. Section 9010 of the Patient Protection and Affordable Care Act imposes a Health Insurance Providers Fee on each covered entity engaged in the business of providing health insurance for United States health risk. CMS policy regarding how this fee may be considered in Medicaid managed care rate development is outlined in CMS's "Medicaid and CHIP FAQs: Health Insurance Providers Fee for Medicaid Managed Care

SECTION I. MEDICAID MANAGED CARE RATES		
5. Projected Non-Benefit Costs		
Plans," dated October 2014.[8] States have the flexibility to account for the Health Insurance Providers Fee on a prospective or retrospective basis into rate development for either the data year or fee year. Any payment for the fee must be incorporated in the health plan capitation rates. v. due to the health insurance provider fee moratorium established by the Consolidated Appropriations Act of 2016, CMS does not expect any health insurance provider fees to be paid for calendar year 2017 by managed care plans that are subject to that fee. Therefore, no amounts should be included in Medicaid managed care capitation rates for fees that would have been paid by plans to the IRS for 2017 (which would have been assessed off of 2016 net premiums).[9] This fee remains in effect for calendar year 2018 and beyond.		
B. Appropriate Documentation	**Documentation Reference**	
	Certification #1	**Certification #2**

[8] Federal Policy Guidance FAQS

[9] More information on this issue can be found at: Affordable Care Act Provisions

SECTION I. MEDICAID MANAGED CARE RATES

5. Projected Non-Benefit Costs

i. rate certification and supporting documentation must describe the development of the projected non-benefit costs included in the capitation rates in enough detail so CMS or an actuary applying generally accepted actuarial principles and practices can identify each type of non-benefit expense that is included in the rate and evaluate the reasonableness of the cost assumptions underlying each expense in accordance with 42 CFR §438.7(b)(3). To meet this standard, the documentation must include: a. a description of the data, assumptions, and methodologies used to develop the projected non-benefit costs, and in particular, all significant and material items in developing the projected non-benefit costs. b. any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last rate certification.	• Mercer Rate Certification o Subpart C.3: Projected Non-Benefit Costs, page 25	•

SECTION I. MEDICAID MANAGED CARE RATES		
5. Projected Non-Benefit Costs		
c. any other material adjustments must be described in accordance with 42 CFR §438.7(b)(4), including: i. a description of the data, assumptions, and methodologies used to determine each adjustment. ii. where in the rating setting process each adjustment was applied. iii. the cost impact of each material adjustment.		
ii. States and actuaries should estimate the projected non-benefit costs for each of the following categories of costs:	e. Mercer Rate Certification o Subpart C.3: Projected Non-Benefit Costs, page 25	•

SECTION I. MEDICAID MANAGED CARE RATES		
5. Projected Non-Benefit Costs		
a. administrative costs. b. taxes, licensing and regulatory fees, and other assessments and fees. c. contribution to reserves, risk margin, and cost of capital. d. other material non-benefit costs.		
iii. Regarding the Health Insurance Providers Fee, the rate certification and supporting documentation must: a. specifically address how this fee is incorporated into capitation rates if the managed care plan is required to pay the fee. b. if the fee is incorporated into the rates in the initial rate certification, an explanation of whether the amount included in the rates is based on the data year or fee year during the rating period of the rate certification. c. a description of how the amount of the fee was determined, and whether or not any adjustments would be made to the rates once the actual amount of the fee is known.	f. Mercer Rate Certification o Subpart C.3: Projected Non-Benefit Costs: Federal Health Insurer Fee, page 26	•

SECTION I. MEDICAID MANAGED CARE RATES

5. Projected Non-Benefit Costs

d. if the fee is not incorporated into the rates in the rate certification because the rates will be adjusted to account for the fee subsequently, an explicit statement that the fee is not included, and a description of when and how the rates will ultimately be adjusted to account for the fee.		
e. if the capitation rates include benefits as described in 26 CFR §57.2(h)(2)(ix)(e.g., long-term care, nursing home care, home health care, or community-based care), CMS recommends that the per member per month cost associated with those benefits be explicitly reported as a separate amount in the rate certification in order to more accurately account for the appropriate revenue on which the plans will be assessed.		

SECTION I. MEDICAID MANAGED CARE RATES

6. Risk Adjustment and Acuity Adjustments

SECTION I. MEDICAID MANAGED CARE RATES

6. Risk Adjustment and Acuity Adjustments

A. Rate Development Standards

i. Risk adjustment is a methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of MCOs, PIHPs, or PAHPs contracted with the state.

ii. As required by 42 CFR §438.5(g), if risk adjustment is applied prospectively or retrospectively, states and their actuaries must select a risk adjustment methodology that uses generally accepted models and must apply it in a budget neutral manner, consistent with generally accepted actuarial principles and practices, across all MCOs, PIHPs or PAHPs in the program to calculate adjustments to the payments as necessary.

iii. An adjustment applied to the total payments across all managed care plans to account for significant uncertainty about the health status or risk of a population is considered an acuity adjustment, which is a permissible adjustment under 42 CFR §438.5(f). (81 FR 27595)

   a. acuity adjustments may be used prospectively or retrospectively.

   b. while retrospective acuity adjustments may be permissible, they are intended solely as a mechanism to account for differences between assumed and actual health status when there is significant uncertainty about the health status or risk of a population, such as: (1) new populations coming into the Medicaid program; or (2) a Medicaid population that is moving from FFS to managed care when enrollment is voluntary and there may be concerns about adverse selection. In the latter case, there may be significant uncertainty about the health status of which individuals would remain in FFS versus move to managed care; although this uncertainty is expected to decrease as the program matures.

iv. CMS may also consider acuity adjustments as a risk mitigation strategy when there is unusual and significant uncertainty about the health status of the population (e.g., covering a new population in Medicaid).

B. Appropriate Documentation	**Documentation Reference**	
	Certification #1	**Certification #2**

SECTION I. MEDICAID MANAGED CARE RATES

6. Risk Adjustment and Acuity Adjustments

i. In accordance with 42 CFR §438.7(b)(5)(i), the rate certification must describe all prospective risk adjustment methodologies, including: a. the data, and any adjustments to that data, to be used to calculate the adjustment. b. the model, and any adjustments to that model, to be used to calculate the adjustment. c. the method for calculating the relative risk factors and the reasonableness and appropriateness of the method in measuring the risk factors of the respective populations. d. the magnitude of the adjustment on the capitation rate per MCO, PIHP, or PAHP. e. an assessment of the predictive value of the methodology compared to prior rating periods. f. any concerns the actuary has with the risk adjustment process.	• Mercer Rate Certification o Subpart C.4: Risk Mitigation, page 26	•

SECTION I. MEDICAID MANAGED CARE RATES		
6. Risk Adjustment and Acuity Adjustments		
ii. In accordance with 42 CFR §438.7(b)(5)(ii), the rate certification must describe all retrospective risk adjustment methodologies, including: a. the party calculating the risk adjustment. b. the data, and any adjustments to that data, to be used to calculate the adjustment. c. the model, and any adjustments to that model, to be used to calculate the adjustment. d. the timing and frequency of the application of the risk adjustment. e. any concerns the actuary has with the risk adjustment process.	f. Mercer Rate Certification a. Subpart C.4: Risk Mitigation, page 26	•
iii. The rate certification and supporting documentation must also specifically include: a. any changes that are made to risk adjustment models since the last rating period. b. documentation that the risk adjustment model is budget neutral	c. Mercer Rate Certification a. Subpart C.4: Risk Mitigation, page 26	•

SECTION I. MEDICAID MANAGED CARE RATES

6. Risk Adjustment and Acuity Adjustments

in accordance with 42 CFR §438.5(g).		
iv. If an acuity adjustment is being used, the rate certification must include a description of the acuity adjustment and its basis that is adequate to evaluate its reasonableness and whether it is consistent with generally accepted actuarial principles and practices. Such a description includes at least: a. the reason that there is significant uncertainty about the health status of the population and the need for an acuity adjustment. b. the acuity adjustment model(s) being used to calculate acuity adjustment scores. c. the specific data, including the source(s) of the data, being used by the acuity adjustment model(s). d. the relationship and potential interactions between the acuity adjustment. e. how frequently the acuity adjustment scores are calculated.		•

SECTION I. MEDICAID MANAGED CARE RATES		
6. Risk Adjustment and Acuity Adjustments		
f. a description of how the acuity adjustment scores are being used to adjust the capitation rates. g. documentation that the acuity adjustment mechanism has been developed in accordance with generally accepted actuarial principles and practices.		

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS		
1. Managed Long-Term Services and Supports		
A. For managed long-term services and supports (MLTSS) programs, or for programs that include MLTSS as part of the covered benefits, the guidance above in Section I regarding the required standards for rate development and CMS's expectations for appropriate documentation required in the rate certification is also applicable for rates for provision of MLTSS.		
B. Rate Development Standards		
i. States may take different approaches for rate setting for MLTSS. The two most common approaches are to structure the rate cells: a. by health care status and the level of need of the beneficiaries ("blended"); or b. by the long-term care setting that the beneficiary uses ("non-blended").		
C. Appropriate Documentation	**Documentation Reference**	
	Certification #1	**Certification #2**
i. The rate certification and supporting	• N/A	•

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS

1. Managed Long-Term Services and Supports

documentation for MLTSS programs, or for programs that include MLTSS as part of the covered benefits must also specifically address the following considerations: a. the structure of the capitation rates and rate cells or rating categories (e.g. blended, non-blended, etc.). b. the structure of the rates and the rate cells, and the data, assumptions, and methodology used to develop the rates in light of the overall rate setting approach. c. any other payment structures, incentives, or disincentives used to pay the MCOs, PIHPs or PAHPs (for example, states may provide additional payments to plans that transition beneficiaries from institutional long-term care settings into other settings, or may pay adjusted rates during time periods of setting transitions). d. the expected effect that managing LTSS has on the utilization and unit costs of services.		

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS		
1. Managed Long-Term Services and Supports		
e. any effect that the management of this care is expected to have within each care setting and any effect in managing the level of care that the beneficiary receives (e.g., in-home care, community long-term care, nursing facility care).		
ii. The projected non-benefit costs, such as administrative costs and care coordination costs, may differ for populations receiving MLTSS from other managed care programs, and the rate certification should describe how the projected non-benefit costs were developed for populations receiving these services.	• N/A	•
iii. The rate certification should provide information on historical experience, analysis, and other sources (e.g., studies or research) used to develop the assumptions used for rate setting.	• N/A	•

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE	
	CERTIFICATION #1	CERTIFICATION #2
1. Data		
A. In addition to the expectations for all Medicaid managed care rate certifications, as supported by assurances from the State, described in Section I, the rate certification must describe any data used to develop new adult group rates.	• Mercer Rate Certification o Section 2: Expansion Capitation Rate Development, pages 26-29	•
B. For states that have covered the new adult group in Medicaid managed care plans in previous rating periods (i.e. starting in 2014, 2015, 2016, and/or January through June 2017), CMS expects the rate certification, as supported by assurances from the State, to describe: i. Any new data that is available for use in this rate setting. ii. How the state and the actuary followed through on any plans to monitor costs and experience for newly eligible adults. iii. How actual experience and costs in previous rating periods have differed from assumptions and expectations in previous rate certifications. iv. How differences between projected and	v. Mercer Rate Certification o Section 2: Expansion Capitation Rate Development, pages 26-29	•

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE	
	CERTIFICATION #1	CERTIFICATION #2
1. Data		
actual experience in previous rating periods have been used to adjust these rates.		

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE	
	CERTIFICATION #1	CERTIFICATION #2
2. Projected Benefit Costs		
A. In addition to the guidance for all Medicaid managed care rate certifications described in Section I, states should include in the rate certification submission and supporting documentation a description of the following issues related to the projected benefit costs for the new adult group: i. For states that covered the new adult group in previous rating periods:		
a. any data and experience specific to newly eligible adults covered in previous rating periods that was used to develop projected benefits	b. Mercer Rate Certification o Section 2: Expansion Capitation Rate Development,	•

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE	
	CERTIFICATION #1	CERTIFICATION #2
2. Projected Benefit Costs		
costs for capitation rates.	pages 26-29	
c. any changes in data sources, assumptions, or methodologies used to develop projected benefits costs for capitation rates since the last certification.	d. Mercer Rate Certification o Section 2: Expansion Capitation Rate Development, pages 26-29	•
e. how assumptions changed from rate certification(s) for previous rating periods on the following issues: i. acuity or health status adjustments (in most cases comparing the new adult group enrollees to other Medicaid adult enrollees). ii. adjustments for pent-up demand. iii. adjustments for adverse selection. iv. adjustments for the demographics of newly eligible adults.	– Mercer Rate Certification o Section 2: Expansion Capitation Rate Development, pages 26-29 o Appendix R	•

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE	
	CERTIFICATION #1	CERTIFICATION #2
2. Projected Benefit Costs		
v. differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for newly eligible adult rates and other Medicaid population rates. A. variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations. vi. other material adjustments to newly eligible adults projected benefit costs.		
B. For any state that is covering the new adult group, regardless if they have been covered	• Mercer Rate Certification › o Section 2: Expansion	•

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE	
	CERTIFICATION #1	CERTIFICATION #2
2. Projected Benefit Costs		
in previous rating periods, the following key assumptions related to the new adult group must be included in the rate certification and supporting documentation: i. Acuity or health status adjustments (in most cases comparing new adult group enrollees to other Medicaid adult enrollees). ii. Adjustments for pent-up demand. iii. Adjustments for adverse selection. iv. Adjustments for the demographics of the new adult group. vi. Differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for the new adult group rates and other Medicaid population rates. vii. Other material adjustments to the new adult group projected benefit costs.	Capitation Rate Development, pages 26-29	
C. The rate certification and supporting documentation must describe any changes	• Mercer Rate Certification o Rate Cell Structure, pages 26-	•

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE	
	CERTIFICATION #1	CERTIFICATION #2
2. Projected Benefit Costs		
to the benefit plan offered to the new adult group.	27 o Additional Rate Adjustments, page 27 • o Appendix R	
D. The rate certification and supporting documentation must describe any other material changes or adjustments to projected benefit costs.	• N/A	• Mercer Rate Certification o Technical Changes for ABA services, page 2 and Appendix C

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE	
	CERTIFICATION #1	CERTIFICATION #2
3. Projected Non-Benefit Costs		
A. In addition to the guidance all Medicaid managed care rate certifications described in Section I, states must include in the rate certification submission and supporting documentation a description of the following issues related to the projected non-benefit	• Mercer Rate Certification o Non-Medical Expense Load, pages 28-29 o Appendix W	•

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE	
	CERTIFICATION #1	CERTIFICATION #2
3. Projected Non-Benefit Costs		
costs for the new adult group: i. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, any changes in data sources, assumptions, or methodologies used to develop projected non-benefit costs since the last rate certification. ii. How assumptions changed from the rate certification(s) for previous rating periods on the following issues: a. administrative costs. b. care coordination and care management. c. provision for operating or profit margin. d. taxes, fees, and assessments. e. other material non-benefit costs.		
B. The rate certification and supporting documentation must include information on key assumptions related to the new adult group and any differences between the	• Mercer Rate Certification o Non-Medical Expense Load, pages 28-29 o Appendix W	•

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE	
	CERTIFICATION #1	CERTIFICATION #2
3. Projected Non-Benefit Costs		
assumptions for this population and the assumptions used to develop projected non-benefit costs for other Medicaid populations for the following issues: i. Administrative costs. ii. Care coordination and care management. iii. Provision for operating or profit margin. iv. Taxes, fees, and assessments. v. Other material non-benefit costs.		

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE	
	CERTIFICATION #1	CERTIFICATION #2
4. Final Certified Rates or Rate Ranges		
A. In addition to the expectations for all Medicaid managed care rate certifications described in Section I, CMS requests under	• Mercer Rate Certification o Appendix Q	•

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE	
	CERTIFICATION #1	CERTIFICATION #2
42 CFR §438.7(d)[10] that states that covered the new adult group in Medicaid managed care plans in previous rating periods provide: i. A comparison to the final certified rates or rate ranges in the previous rate certification. ii. A description of any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.		

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE	
	CERTIFICATION #1	CERTIFICATION #2
5. Risk Mitigation Strategies		
A. CMS requests under 42 CFR §438.7(d) that	• Mercer Rate Certification	•

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

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE	
	CERTIFICATION #1	CERTIFICATION #2
states describe the risk mitigation strategy specific to the new adult group rates.	o Part C: Risk Mitigation Strategies, page 29	
B. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, CMS requests the following information: i. Any changes in the risk mitigation strategy from those used during previous rating periods. ii. The rationale for making the change in the risk mitigation strategy or removing the risk mitigation strategy used during previous rating periods. iii. Any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during previous rating periods.	• Mercer Rate Certification – Part C: Risk Mitigation Strategies, page 29	•

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Bureau of Health Services Financing
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March 5, 2018

Subject: Healthy Louisiana Program – Full Risk Bearing Managed Care Organization Rate Development and Actuarial Certification for the Period February 1, 2018 through January 31, 2019

Dear Ms. Diez:

The Louisiana Department of Health (LDH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound[1] capitation rate ranges for the State of Louisiana's Healthy Louisiana (f/k/a Bayou Health) program for the period of February 1, 2018 through January 31, 2019.

Until February 2015, Healthy Louisiana included two payment models: Shared Savings (an enhanced primary care case management model) and Prepaid (a full risk-bearing capitation model). Effective February 1, 2015, the two programs merged into a single, full-risk-bearing capitation program. Effective December 1, 2015, the Healthy Louisiana plans integrated specialized behavioral health (SBH) services into their coverage. Previously, these services were covered through the Louisiana Behavioral Health Partnership (LBHP) managed by Magellan. The LBHP included individuals who were not enrolled in Healthy Louisiana for Physical Health (PH) services. As part of the SBH services integration, the former LBHP-only population was enrolled in Healthy Louisiana for SBH services and Non-Emergency Medical Transportation (NEMT) services only. During the initial phase-in of services, the Healthy Louisiana MCOs received separate capitation payments for SBH services which were effective December 1, 2015 through January 31, 2016. The MCOs continued to receive a payment for all other Healthy Louisiana covered services. Starting February 1, 2016, Healthy Louisiana MCOs began receiving a single, comprehensive capitation payment per enrollee. In particular, capitation rates covering enrollees receiving PH services

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

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

through an MCO encompass PH, SBH, and NEMT services. For enrollees who are not eligible for PH services or elect not to receive PH services through an MCO, the capitation payment for an enrollee covers SBH and NEMT services. Effective July 1, 2016, Louisiana expanded Medicaid coverage under the Affordable Care Act (ACA). The Expansion program's covered services include PH, SBH, and NEMT services.

This letter presents an overview of the methodology used in Mercer's managed care rate development for the purpose of satisfying the requirements of the Centers for Medicare and Medicaid Services (CMS). This rate development process relied on Medicaid FFS medical and pharmacy claims, Healthy Louisiana Shared Savings claims experience, Healthy Louisiana Prepaid encounter data, and LBHP claims experience. It resulted in the development of a range of actuarially sound rates for each rate cell. The capitation rate ranges are summarized in Appendix A and represent payment in full for the covered services.

The remainder of this letter is structured as follows:

Section 1: Medicaid Managed Care Rates
- Part A: General Information
- Part B: Base Data Development
- Part C: Non-Expansion Capitation Rate Development
  - *Subpart C.1: Projected Benefit Costs*
  - *Subpart C.2: Special Contract Provisions*
  - *Subpart C.3: Projected Non-Benefits Costs*
  - *Subpart C.4: Risk Mitigation*

Section 2: New Adult Group Capitation Rates
- Part A: Projected Benefit Costs
- Part B: Projected Non-Benefit Costs
- Part C: Risk Mitigation

Section 3: Certification of Final Rate Ranges

SECTION 1: MEDICAID MANAGED CARE RATES

Part A: General Information

Capitation rate ranges for the Healthy Louisiana program were developed in accordance with rate-setting guidelines established by CMS. For rate range development for the Healthy Louisiana MCOs, Mercer used

calendar year 2015 (CY 2015) and CY 2016 Medicaid FFS medical and pharmacy claims, Healthy Louisiana Shared Savings claims experience, Healthy Louisiana Prepaid encounter data, and LBHP claims experience. All data was reported on an incurred basis and included payment dates through June 2017. Restrictions were applied to the enrollment and claims data so that it was appropriate for the populations and benefit package defined in the Healthy Louisiana MCO contract.

Mercer reviewed the data provided by LDH, the Healthy Louisiana MCOs, and the LBHP for consistency and reasonableness and determined the data was appropriate for the purpose of setting actuarially sound Medicaid managed care capitation rates. The data reliance attestation shown in Appendix Y has been provided by LDH, and its purpose is to certify the accuracy, completeness, and consistency of the base data.

Adjustments were made to the selected base data to match the covered populations and Healthy Louisiana benefit packages for rating year 2018 (RY 2018). Additional adjustments were then applied to the base data to incorporate:

- Provision for incurred but not reported (IBNR) claims
- Financial adjustments to encounter data for under-reporting
- Prospective and retrospective program changes not fully reflected in the base data
- Trend factors to forecast the expenditures and utilization to the contract period
- Changes in benefits covered by managed care
- Addition of new populations to the Healthy Louisiana program
- Opportunities for managed care efficiencies
- Administration and underwriting profit/risk/contingency loading

In addition to these adjustments, LDH takes two additional steps in the matching of payment to risk:

- Application of maternity supplemental (kick) payments
- Application of risk-adjusted regional rate

The resulting rate ranges for each individual rate cell were developed net of Graduate Medical Education (GME) payments to teaching hospitals provided in the Louisiana Medicaid State Plan. Appendices N - Q shows the full rate development for the Non-Expansion population from the base data as shown in the data book released by LDH, dated January 8, 2018, and applies all the rate setting adjustments as described in this letter. Appendices U - W shows the full rate development for the Expansion population.

Healthy Louisiana Populations

Effective February 1, 2016, the Healthy Louisiana Non-Expansion program had two major rating categories:

1. Individuals who meet the eligibility criteria for the Healthy Louisiana PH program; their PH, SBH, and NEMT services are the responsibility of the MCO. This rating group is referred to as the Healthy Louisiana PH program.

2. Individuals, who do not meet the eligibility criteria for the Healthy Louisiana PH program, yet remain eligible for the Legacy LBHP/Medicaid program; only their SBH and NEMT services are the responsibility of the MCO. This rating group is referred to as the Healthy Louisiana SBH program.

PH Program

In general, the Healthy Louisiana PH program includes individuals classified as Supplemental Security Income (SSI), Family & Children (F&C), Foster Care Children (FCC), Breast and Cervical Cancer (BCC), and Louisiana Children's Health Insurance Program (LaCHIP) Affordable Plan (LAP) as mandatory populations. Voluntary opt-in populations include Home- and Community-Based Services (HCBS) waiver participants and Chisholm Class Members (CCM).

Mandatory Populations

Please see Appendix B for detail on which Aid Category and Type Case combinations are considered Mandatory populations for the PH Program.

Voluntary Opt-In Populations

Individuals in a voluntary opt-in population group are not automatically enrolled into the Healthy Louisiana PH program, but they may choose to initially enroll at any time. Likewise, they may choose to dis-enroll at any time, effective the earliest possible month the action can be administratively handled. Moreover, a voluntary opt-in individual may re-enroll during the annual, open enrollment period. Such members include the following:

- Individuals receiving services through any 1915(c) HCBS waiver:
  - Adult Day Health Care (ADHC)
  - New Opportunities waiver
  - Children's Choice (CC)
  - Residential Options waiver
  - Supports waiver
  - Community Choices waiver
  - Other HCBS waivers as may be approved by CMS

- Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the Office for Citizens with Developmental Disabilities' (OCDD's) Request for Services Registry who are CCM

Excluded Populations

Please see Appendix B for detail on which Aid Category and Type Case combinations are considered Excluded populations for the PH Program.

SBH Program

The Healthy Louisiana SBH program includes individuals classified as SBH Dual and SBH Other as mandatory populations. The voluntary opt-in populations that did not choose to opt into Healthy Louisiana for PH services are automatically included in the SBH program. These populations are denoted as SBH HCBS Waiver participants and SBH CCM.

Effective April 1, 2017, the Louisiana Health Insurance Premium Payment (LaHIPP) program is reinstated. Members that are enrolled in the LaHIPP program will receive SBH and NEMT services only through Healthy Louisiana. A separate adjustment that will be discussed later in this letter was applied to the base data to incorporate the coverage of the LaHIPP population by the SBH program.

Mandatory Populations

Please see Appendix B for detail on which Aid Category and Type Case combinations are considered Mandatory populations for the SBH Program.

Excluded Populations

Please see Appendix B for detail on which Aid Category and Type Case combinations are considered Excluded populations for the SBH Program.

Rate Cell Structure

PH Program

Mercer summarized the PH, SBH, and NEMT services data for the Healthy Louisiana PH program rating category by rate cell. Historical claim costs vary by age and eligibility category, and separate rate cells were developed accordingly to reflect differences in risk. Fourteen distinct rate cells were established within this rating category based on Mercer's review of historical cost and utilization patterns in the available experience. In addition, a Maternity Kick Payment will be paid to the MCOs for each qualifying delivery event that takes place.

Table 1A: PH Rate Category Groupings	
SSI	
Newborn, 0–2 Months, Male & Female	Child, 1–20 Years, Male & Female
Newborn, 3–11 Months, Male & Female	Adult, 21+ Years, Male & Female
Family & Children (TANF)	
Newborn, 0–2 Months, Male & Female	Child, 1–20 Years, Male & Female
Newborn, 3–11 Months, Male & Female	Adult, 21+ Years, Male & Female
HCBS Waiver	
20 and Under, Male & Female	21+ Years, Male & Female
FCC	
All Ages, Male & Female	
BCC	
All Ages, Female	
CCM	
All Ages, Male & Female	
LAP	
All Ages, Male & Female	
Maternity Kick Payment	
Maternity Kick Payment	Early Elective Delivery - Kick Payment

SBH Program

Mercer summarized the SBH and NEMT only service data for the Healthy Louisiana SBH program rating category by rate cell. Historical SBH costs vary by age and eligibility category and separate rate cells were developed accordingly to reflect differences in risk. Four distinct rate cells were established within this rating category based on Mercer's review of historical cost and utilization patterns in the available experience.

SBH program eligible individuals may qualify under more than one rate cell definition therefore the classification of logic is applied in a hierarchical manner in the order presented in Table 1B.

Table 1B: SBH Rate Category Groupings	
SBH — Dual Eligibles and LAHIPP	
All Ages, Male & Female	
SBH — HCBS Waiver	
20 and Under, Male & Female	21+ Years, Male & Female
SBH — CCM	
All Ages, Male & Female	
SBH — Other	
All Ages, Male & Female	

HEALTHY LOUISIANA BENEFIT PACKAGE

Covered Services

Appendix C lists the services the Healthy Louisiana MCOs must provide to the members in the Healthy Louisiana PH and SBH programs, respectively. The MCOs also have the ability to develop creative and innovative solutions to care for their members (i.e., provide other cost-effective alternative services), as long as the contractually-required Medicaid services are covered. Costs of alternative services are expected to be funded through savings on the contractually-required services for which these services are a cost-effective substitute.

New Services

LDH is adding Applied Behavioral Analysis (ABA) services, which were covered on a FFS basis during CY 2015 and CY 2016, to the list of services to be provided by the MCOs effective February 1, 2018.

Effective February 1, 2018, Positron Emission Tomography (PET) scans for cancer-related purposes became a State Plan service. The MCOs will be responsible for covering these services for Healthy Louisiana PH enrollees effective February 1, 2018 as well.

Mercer applied two separate adjustments to the base data to incorporate the coverage of the two new services. These adjustments will be discussed later in this letter.

Medicare Crossover Claims

For dually eligible individuals, Medicare "Crossover" claims (claims that include primary payment from Medicare) for Inpatient, Outpatient, Emergency Room, and Professional services are excluded from the base data. These services will be paid directly by the State after coordinating with Medicare.

In order to exclude Crossover claims from the base data, Mercer identified claims submitted to LDH and coded with claim type "14" (Medicare Crossover Institutional) or claim type "15" (Medicare Crossover Professional). This includes claims with a Medicare qualifying Electronic Media Claim submitter ID and claim format 837-I (Institutional) or 837-P (Professional), as well as hard copy claims with an Explanation of Benefits from Medicare attached. Mercer then cross-referenced these claims to the encounter data and excluded matching records from the base data.

Excluded Services

Healthy Louisiana MCOs are not responsible for providing PH services and other Medicaid services not identified in Appendix C, including the following services:

- Dental services, with the exception of Early and Periodic Screening and Diagnosis Treatment (EPSDT) varnishes provided in a Primary Care setting
- Intermediate care facilities for the developmentally disabled (ICF/DD) services
- Personal Care services 21 and older
- Institutional LTC Facility/Nursing Home services

- School-based Individualized services
- Education Plan services provided by a school district and billed through the intermediate school district, or School-based services funded with certified public expenditures, including school nurses
- HCBS waiver services
- Targeted Case Management services
- Services provided through Louisiana Department of Health's Early-Steps program
- Coordinated System of Care (CSoC) services previously covered under 1915(c) or 1915(b)(3) waiver authority
- Medicare Crossover services
- Services covered under a non-CSoC 1915(c) waiver

For more specific information on covered services, please refer to the Healthy Louisiana Behavioral Health Integration Amendment issued by LDH.

HEALTHY LOUISIANA SERVICES ELIGIBLE FOR DIFFERENT FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)

There are two groups of services for which LDH receives a different FMAP than the regular state FMAP:

- Family Planning services
- A list of specified preventive services and adult vaccines established under ACA section 4106

Mercer has analyzed the component of the rates associated with each group of services so that LDH may claim the enhanced FMAP on these services. Specific details on codes used to identify the family planning and preventive services can be found in Appendices D and E, respectively, which contain the PMPMs that are eligible for the enhanced match rate.

REGION GROUPINGS

For rating purposes, Louisiana has been split into four different regions. Table 2 lists the associated parishes for each of the four regions. The region groupings are the same in all three programs.

Table 2: Region Groupings

Region Description	Associated Parishes (Counties)
Gulf	Assumption, Jefferson (East Bank), Jefferson (West Bank), Lafourche, New Orleans (Algiers), New Orleans (Downtown), New Orleans (Gentilly), New Orleans (Uptown), Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John, St. Mary, and Terrebonne

Table 2: Region Groupings	
Capital	Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, St. Tammany, Tangipahoa, Washington, West Baton Rouge, and West Feliciana
South Central	Acadia, Alexandria, Allen, Avoyelles, Beauregard, Calcasieu, Cameron, Catahoula, Concordia, Evangeline, Grant, Iberia, Jefferson Davis, Lafayette, Lasalle, Rapides, St. Landry, St. Martin, Vermilion, Vernon, and Winn
North	Bienville, Bossier, Caddo, Caldwell, Claiborne, DeSoto, East Carroll, Franklin, Jackson, Lincoln, Madison, Monroe, Morehouse, Natchitoches, Ouachita, Red River, Richland, Sabine, Shreveport, Tensas, Union, Webster, and West Carroll

PART B: BASE DATA DEVELOPMENT

For rate range development for the Healthy Louisiana program, Mercer used CY 2015 and CY 2016 data from the following sources:

- Encounter data reported from the State's Healthy Louisiana Prepaid program
- Claims data from the State's Healthy Louisiana Shared Savings program
- Encounter data reported from the State's LBHP program for adults
- Claims data from the State's LBHP program for children
- Fee-for-service (FFS) data for services and populations to be covered under the Healthy Louisiana program, but historically covered under Legacy Medicaid/FFS

All data was reported on an incurred basis and included payment dates through June 2017. Restrictions were applied to the enrollment and claims data so that it was appropriate for the populations and benefit package defined in the contract.

Mercer reviewed the data provided by LDH, the Healthy Louisiana plans, and the LBHP for consistency and reasonableness and determined the data was appropriate for the purpose of setting capitation rates for the MCO program. The data reliance attestation shown in Appendix Y has been provided by LDH, and its purpose is to certify the accuracy, completeness, and consistency of the base data.

Effective February 1, 2015, members were granted retroactive eligibility, based on their eligibility for Healthy Louisiana, for up to 12 months prior to enrollment in an MCO. The MCO selected by these members will then receive one capitation payment per month of retroactive enrollment, and will be liable for all claims incurred during this retroactive eligibility period. Retroactive eligibility and claims are excluded from the base data and handled as a separate adjustment. This adjustment will be discussed later in this letter.

IBNR

Capitation rate ranges were developed using claims data for services incurred in CY 2015 and CY 2016 and reflects payments processed through June 2017. Mercer deemed claims incurred in CY 2015 as complete as they have at least 18 months of runout. Mercer developed IBNR factors for encounters incurred in CY 2016 in order to incorporate consideration for any outstanding claims liability. This adjustment resulted in an overall aggregate increase of 2.37%.

UNDER-REPORTING ADJUSTMENTS

Under-reporting adjustments were developed by comparing encounter data from the Medicaid Management Information System (MMIS) to financial information provided by the MCOs and the LBHP PIHP. This adjustment was computed and applied on an MCO/PIHP basis. Table 3 summarizes the overall aggregate increases applied to CY 2015 and CY 2016 expenses.

Table 3: Under-Reporting Adjustment	CY 2015		CY 2016	
Category of Service	**PH Program**	**SBH Program**	**PH Program**	**SBH Program**
Prescribed Drugs	1.0405		1.0877	
Transportation and SBH	1.0204	1.0108	1.0089	0.9269
All other	1.0294		1.0371	

RX REBATES

Mercer reviewed the CY 2015 and CY 2016 financial data and estimated a pharmacy rebates adjustment percentage of -3.4%, which was applied to the projected pharmacy benefit costs.

THIRD-PARTY LIABILITIES

All claims are reported net of third-party liability, therefore no adjustment is required.

FRAUD AND ABUSE RECOVERIES

LDH provided data related to fraud and abuse recoveries on the LBHP, Shared Savings, and Legacy FFS programs. The total adjustment applied to the FFS and Shared Savings PH services was -0.04% for CY 2015. The total adjustment for SBH services was -0.01% of the SBH services for CY 2015. Prepaid plans included fraud and abuse recoveries in their financial reports. These recoveries were included in the development of the under-reporting adjustment for PH services. No adjustment was needed for CY 2016 because only encounter data was used.

COPAYMENTS

Copayments are only applicable to prescription drugs. Pharmacy claims are reported net of any copayments so no additional adjustment is necessary.

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

DSH payments are made outside of the MMIS system and have not been included in the capitation rates.

RETROSPECTIVE PROGRAM CHANGE ADJUSTMENTS

Program change adjustments that were applied to each calendar year of base data before blending the two years of data are referred to as Historical Rating Adjustments.

Inpatient Services

Using the last fee schedule published by LDH in CY 2016 (i.e. July 1, 2016 fee schedule), inpatient claims were adjusted to reflect changes in the fee schedule between the January 1, 2015 – June 30, 2016 period and the July 1, 2016 – December 31, 2016 period. The non-GME part of the per diems were used in this fee adjustment process to be consistent with LDH's intention to continue paying GME amounts directly to the teaching hospitals.

The total impact of the inpatient fee change is summarized in Table 4A below.

Table 4A: Historical Inpatient Fee Change Impact			Impact as % of	
Time Period	Historical Cost	Adjustment Dollar Impact	Historical Cost	All Services Cost
CY 2015	$621,724,247	$8,356,608	1.34%	0.30%
CY 2016	$604,500,545	$987,743	0.16%	0.03%

Preventive Services

Section 4106(b) of the ACA established a one percentage point increase in the FMAP effective January 1, 2013, applied to expenditures for adult vaccines and clinical preventive services to states that cover, without cost-sharing, a full list of specified preventive services and adult vaccines. In order to meet the eligibility requirements for the one percentage point FMAP increase, LDH decided to expand the list of adult vaccines and clinical preventive services covered under the State Plan, effective July 1, 2016. These services are included on the applicable published fee schedules on the Medicaid website www.lamedicaid.com. The impact of the change is an increase of $0.08 in the projected benefit cost PMPM for the PH program. The change has no impact on the SBH program.

Table 4B: Preventive Services Fee Change Impact			Impact as % of	
Time Period	Historical Cost	Adjustment Dollar Impact	Historical Cost	All Services Cost
CY 2015	$165,950,474	$580,536	0.35%	0.02%
CY 2016	$195,993,923	$272,999	0.14%	0.01%

Pediatric Day Health Care (PDHC) Program Change

Effective September 1, 2016, LDH issued three policy changes to PDHC services. These policy changes include changes in the eligibility criteria, per diem requirement, and re-evaluation period.

Eligibility Criteria

Medicaid recipients are required to meet all criteria on the PDHC prior authorization checklist to be eligible for PDHC services. Effective September 1, 2016, LDH issued a more restrictive prior authorization checklist that will reduce the number of PDHC recipients.

Per Diem Requirement

Prior to September 1, 2016, PDHC providers billed an hourly rate for PDHC stays of up to 4 hours in a day and a per diem rate for stays between 4-12 hours. Effective September 1, 2016, the state fee schedule is changing to an hourly rate for stays up to 6 hours and a per diem rate for stays between 6-12 hours.

Re-evaluation Period

Effective September 1, 2016, the days between a PDHC recipient's re-evaluations changed from 120 days to 90 days.

Mercer completed a pre/post analysis of the policy changes and adjusted the base data to reflect the impact of the changes.

Table 4C: Historical PDHC Fee Change Impact			Impact as % of	
Time Period	Historical Cost	Adjustment Dollar Impact	Historical Cost	All PH Services Cost
CY 2015	$21,380,807	($2,605,508)	-12.19%	-0.09%
CY 2016	$21,239,467	($2,246,561)	-10.58%	-0.08%

Overall, as shown in Table 5, the combined effect of all the historical fee adjustments was a 0.22% increase in CY 2015 base data and a 0.03% decrease in CY 2016.

Table 5: Summary of Historical Fee Change Impact for All Claims			Impact as % of
Time Period	Historical Cost	Adjustment Dollar Impact	Historical Cost
CY 2015	$2,815,383,438	$6,331,637	0.22%
CY 2016	$2,909,259,268	($985,820)	-0.03%

ACT 399 (Provider Fee Reimbursement)

Effective December 1, 2015, Act 399 creates an appeal board to review pharmacy reimbursement disputes. It is the obligation of a health insurance issuer or its agent to reimburse a pharmacist or his agent for fees remitted by a pharmacy or pharmacist or his agent in compliance with R.S. 46:2625 or risk being sanctioned. Mercer reviewed this requirement and its underlying details and estimated the impact to the base period data to be approximately 0.13%.

Managed Care Savings Adjustment

A portion of CY 2015 base expenses was incurred outside of a managed care delivery system by the former voluntary opt-out population which became mandatory enrolled effective December 1, 2015. Also, the January 2015 DME and NEMT expenses incurred by enrollees in the legacy Shared Savings program were paid for through the FFS system. For those expenses incurred outside of a full-risk managed care delivery system, Mercer adjusted the capitation rates to reflect areas for managed care efficiency. Managed care is able to generate savings by:

- Encouraging the use of preventive services so that acute conditions are not exacerbated to the point that requires a visit to the emergency room or hospitalization
- Using alternatives to the emergency room for conditions that are non-emergent in nature
- Increasing access and providing member education
- Minimizing duplication of services

- Hospital discharge planning to ensure a smooth transition from facility-based care to community resources and minimize readmissions

Appendix F summarizes the managed care savings adjustments that were applied to the Shared Savings/Legacy Medicaid FFS data.

1915(c) CSoC Regional Expansion

LDH submitted an amendment to the 1915(c) CSoC waiver to increase the number of waiver slots to 2,400 slots. The amendment was approved by CMS on September 9th, 2014. Upon expansion, certain children previously classified in a Healthy Louisiana rating group shifted to the CSoC program. The CSoC population has select services covered by Healthy Louisiana MCOs, including PRTF, Therapeutic Group Home (TGH), and SUD services. Magellan continues to administer the remaining SBH services for this population. Mercer calculated the volume of CSoC transitions by comparing the average 2015 and 2016 CSoC enrollment to emerging levels as of June 2017. The growth by region is outlined in Table 6:

Table 6: CSoC Enrollment's Growth by Region

CSoC Enrollment	Average 2015	Average 2016	As of May, 2017	Projected RY18 CSOC Recipients
Gulf	512	694	739	702
Capital	454	606	595	565
South Central	355	466	527	500
North	515	551	667	633
Statewide	**1,835**	**2,316**	**2,528**	**2400**

Mercer then analyzed the historic SBH expenses associated with CSoC enrollees and noted that it is materially higher when compared to the PMPM for other Healthy Louisiana rating groups ($1,062.20 and $29.85, respectively for CY 2015; $82.74 and $31.49, respectively for CY 2016). Because of this differential, the movement of those higher needs children out of Healthy Louisiana rating groups resulted in a reduction in the average PMPM by region. The transition analysis was performed on a regional basis using the underlying PMPMs for each region, as well as CSoC-specific PMPMs for each region.

Overall, this represents a decrease of 1.67% and 0.02% to CY 2015 and CY 2016 SBH services, respectively, and impacts child rating groups only.

HISTORICAL TRENDS

Mercer reviewed the 2015 and 2016 cost and utilization data and elected to apply a historical trend adjustment to the CY 2015 base data to project it to CY 2016 before blending the two years of base data.

The historical trends by population are shown in Appendix G.

DATA SMOOTHING

As part of the rate development process, Mercer blended the CY 2015 and CY 2016 base data with the goal of obtaining a set of base data that has sufficient credibility and reasonableness to develop actuarially

sound capitation rates. Mercer applied weights of 40.0% and 60.0% to the CY 2015 and CY 2016 data, respectively, after accounting for historical rating adjustments described in Part B of this certification.

Additionally, Mercer determined that certain rate cells did not contain enough member months (MMs) within each region to be credible. For rate cells that were deemed not sufficiently credible at the regional level, Mercer calculated a single statewide capitation rate. Affected rate cells include:

- SSI newborns 0-1 years of age
- BCC, All Ages
- LAP, All Ages
- HCBS, All Ages
- CCM, All Ages
- SBH – CCM, All Ages
- SBH – HCBS, All Ages
- SBH – Other, All Ages

PROSPECTIVE RATING ADJUSTMENTS

Program change adjustments that were applied once the base data was blended are referred to as Prospective Rating Adjustments.

Fee Schedule Changes

The capitation rates reflect changes in covered services' fee schedules and unit costs, between the base period and the contract period. Beginning in April 2014, LDH implemented a series of program changes to ensure consistent pricing in the Medicaid program for hospital services, including inpatient hospital, outpatient hospital, hospital-based physician and ambulance services. This change required the use of Full Medicaid Pricing (FMP) in the calculation of PMPM payments to MCOs. LDH expects this rate increase will lead to increased payments to those providers contracting with the MCOs to maintain and increase access to inpatient hospital, outpatient hospital, hospital-based physician, and ambulance services to the enrolled Medicaid populations. Mercer and LDH reviewed the aggregate funding levels for these services between the base period and the contract period and determined that an addition to the historical data was necessary in order to ensure the capitation rate ranges reflect adequate statewide pricing levels. Separate adjustments were made to each of the four services to capture the full impact of statewide funding. FMP adjustments were implemented for inpatient and outpatient services effective April 2014. Physician and ambulance FMP adjustments were implemented effective July 2015.

Inpatient Services

Inpatient claims were adjusted to reflect changes in the fee schedule between the base period and the contract period, using the fee schedule effective January 1, 2018. The non-GME part of the per diems

were used in this fee adjustment process to be consistent with LDH's intention to continue paying GME amounts directly to the teaching hospitals.

Mercer relied upon an analysis of Medicare Diagnosis Related Group (DRG) equivalent pricing of Medicaid services provided by LDH for the FMP adjustment. CY 2016 encounter data was analyzed and compared the adjusted Medicare payments to the Medicaid payment on a per discharge basis at each hospital. The Medicare payments were adjusted to reflect the treatment of Medicaid patients and reflected the reimbursement level applicable to the rate period. The CY 2016 Medicaid payments were adjusted to reflect applicable fee changes and payments made outside of the claims system (outlier payments). The Medicaid payments were also trended to the rate period and the ratio between the projected Medicare and Medicaid payments was calculated. Mercer applied the ratio between the two payments to the base data at a hospital specific level.

The total impact of the inpatient fee changes is summarized below in Table 7A below.

Table 7A: Prospective Inpatient Fee Change Impact				Impact as % of	
Historical Cost	Fee Change Impact	FMP Impact	Total Dollar Impact	Historical Cost	All Services Cost
$605,488,287	$69,295,345	$410,041,383	$479,336,728	79.17%	16.48%

Outpatient Services

Outpatient claims were adjusted to reflect the most recent cost−to−charge ratios (CCRs) available. The CCRs were reported on hospital fiscal year bases, which varied by hospital from June 30, 2015 to December 31, 2016. The adjustment also included estimation of cost settlements and reflected the most up-to-date cost settlement percentages for each facility. For most non−rural, non-state facilities, the cost settlement percentage effective January 1, 2018 is 74.56%; however, the remaining facilities are settled at different percentages. Rural facilities are cost settled at 110%.

The outpatient FMP was developed according to the State Plan using the CCRs and the billed charges from the base data. The calculation was completed at a hospital level.

The total impact of the outpatient fee changes is summarized in Table 7B below.

Table 7B: Prospective Outpatient Fee Change Impact				Impact as % of	
Historical Cost	Fee Change Impact	FMP Impact	Total Dollar Impact	Historical Cost	All Services Cost
$433,564,317	$49,476,514	$125,551,873	$175,028,387	40.37%	6.02%

Hospital-Based Physician Services

Mercer calculated the FMP payments for hospital-based physician services provided at participating facilities by participating physicians according to the State Plan methodology. This methodology is designed to bring the payments for the physician services up to the community rate level. The community rate is defined as the rates paid by commercial payers for the same service. For state-owned or operated entities, Mercer calculated the FMP payments according to the State plan using the billed charges from the

base data and the commercial charges-to-paid conversion factors provided by LDH. For non-state owned or operated entities, Mercer calculated the FMP payments according to the State plan using the units of service from the base data, the most currently available Medicare fees and the Medicare-to-commercial conversion factors provided by LDH. The conversion factors are maintained by LDH and updated periodically. For state-owned or operated entities, the conversion factors are updated annually. For non-state owned or operated entities, the factors are updated every three years.

LDH provided the latest available factors, which were last updated as recently as October 2017. Table 8 below shows the impact of FMP on the adjusted base cost of hospital-based physician services meeting the State Plan's criteria for FMP.

Table 8: Hospital-Based Physician FMP Impact

	[A]	[B]	[C] = [A] + [B]	[D]	[E] = [D] / [C]
Time Period	Historical Cost	Adjustment Dollar Impact	Adjusted Cost	FMP Impact	FMP Impact as % of Adjusted Cost
CY 2016	$133,105,769	$0	$133,105,769	$156,230,835	117.37%

Ambulance Services

Mercer calculated the ambulance FMP payments according to the State Plan using Medicare fee schedules and average commercial rates as a percentage of Medicare. Ambulance providers were classified as either Large Urban Governmental (LUG) or non-LUGs. LUGs have historically received 100.0% of the gap between average commercial rate and the Medicaid fee schedule while non-LUGs have historically received 17.35% of the gap. Mercer developed increases using these assumed funding levels. Average commercial rates as a percentage of Medicare were provided by LDH for RY 2018. According to the State Plan, average commercial rates are updated every three years. Table 9 below shows the impact of FMP on the adjusted base cost of ambulance services meeting the State Plan's criteria for FMP.

Table 9: Ambulance FMP Impact

	[A]	[B]	[C] = [A] + [B]	[D]	[E] = [D] / [C]
Time Period	Historical Cost	Adjustment Dollar Impact	Adjusted Cost	FMP Impact	FMP Impact as % of Adjusted Cost
CY 2016	$31,447,677	$0	$31,447,677	$20,078,997	63.85%

Overall, as shown in Table 10, the combined effect of all the prospective fee adjustments was a 28.55% increase in CY 2016 base data.

Table 10: All Services Prospective Fee Change & FMP Impact					Impact as % of	
Time Period	Historical Cost	Fee Change Impact	FMP Impact	Total Dollar Impact	Historical Cost	All Services Cost
CY 2016	$1,203,606,051	$118,771,859	$711,903,089	$830,674,948	69.02%	28.55%

Efficiency Adjustments

Mercer distinguishes efficiency adjustments (which are applied to previously managed populations) from managed care savings adjustments (which are applied to previously unmanaged populations). Efficiency

adjustments are intended to reflect improved efficiency in the hospital inpatient, emergency department (ED), and pharmacy settings, and are consistent with LDH's goal that the Healthy Louisiana program be operated in an efficient, high-quality manner.

Inpatient Hospital Efficiency Adjustment

Illness prevention is an important medical care element for all health care providers. LDH expects the MCOs to help their members stay healthy by preventing diseases or preventing complications of existing diseases. Since hospital expense represents a significant portion of all medical expenditures, Mercer performed a retrospective data analysis of the MCOs' CY 2016 encounter data using indicators developed by the Agency for Healthcare Research and Quality (AHRQ). These conditions are collectively referred to as Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI), respectively. Mercer utilized 13 adult and five pediatric PQIs as part of the analysis. Evidence suggests that hospital admissions for these conditions could have been avoided through high-quality outpatient care and/or the conditions could have been less severe if treated early and appropriately. AHRQ's technical specifications provide specific criteria that define each PQI and PDI that Mercer utilized in the analysis of the MCOs' inpatient hospital encounter data. Although AHRQ acknowledges that there are factors outside of the direct control of the health care system that can result in a hospitalization (e.g., environmental, patient compliance), AHRQ does recognize these analyses can be utilized to benchmark health care system efficiency between facilities and across geographies.

While the AHRQ technical specifications include exclusionary criteria specific to each PQI and PDI, Mercer also considered clinically-based global exclusion criteria that removed a member's inpatient admissions from all inpatient efficiency analyses. The global exclusion criteria was utilized to identify certain conditions and situations (e.g., indications of trauma, burns, HIV/AIDS) that may require more complex treatment for members. Based on a review of the CY 2016 inpatient encounter data, any member identified as having indications of any of the qualifying criteria resulted in all of that member's admissions being removed from the analyses. Once all clinical global exclusions data was removed from the analysis, the embedded AHRQ exclusions, by PQI/PDI were then applied.

Additionally, even though the AHRQ technical specifications do not explicitly mention enrollment duration, Mercer considered enrollment duration as one of the contributing factors to review that would be associated with the applicability of a PQI/PDI-based adjustment. Enrollment duration was used as a proxy for issues such as patient compliance, health plan outreach and education, time to intervene, and other related concepts. A variable-month enrollment duration ranging from two to twelve months, depending on PQI or PDI condition, was applied to the RY 2018 rates. This assumption meant that an individual had to be enrolled with the same plan for a minimum number of consecutive months prior to that individual's PQI or PDI hospital admission to be considered subject to the adjustment. Only the dollars associated with the PQI and PDI hospital admissions that met this enrollment duration criteria were included in the base data adjustment. Recipient eligibility data supplied by the State provided the information to make this duration test assessment.

ED Efficiency Adjustment

Mercer performed a retrospective analysis of the MCOs' CY 2016 ED encounter data to identify ED visits that were considered preventable/pre-emptible. For the RY 2018 rate development, Mercer analyzed

preventable/pre-emptible Low Acuity Non-Emergent (LANE) visits. This analysis was not intended to imply that members should be denied access to EDs or that the MCOs should deny payment for the ED visits. Instead, the analysis was designed to reflect the State's objective that more effective, efficient, and innovative managed care could have prevented or pre-empted the need for some members to seek care in the ED setting in the first place.

The criteria used to define LANE ED visits was based on publicly available studies, input from Mercer's clinical staff, as well as review by practicing ED and PCPs. ICD-9 primary diagnosis code information was the basis for identifying an ED visit. A limited set of diagnosis codes was agreed upon by all physicians involved in developing the methodology for the analysis. Preventable percentages ranging from 5.0% to 90.0% were assigned to each diagnosis code to account for external factors that can influence and impact variation in ED use. Using procedure code information, the ED visits were evaluated from low complexity clinical decision making to high complexity clinical decision making. In addition, LANE ED visits that resulted in an inpatient admission or observation stay (observation revenue code 0762) were excluded. No adjustment was made for any possible up coding by providers.

For the RY 2018, Mercer excluded low unit cost visits from the LANE analysis to account for improvements in the MCOs' use of triage fees and/or more appropriate health services management. A hierarchical process was used for the remaining LANE visits to identify those that could have been prevented or pre-empted. Beginning with the lowest acuity visits, data was accumulated until the percentage of preventable/pre-emptible visits was achieved for each respective diagnosis code. Regardless of the targeted percentage, no LANE ED visit/dollars associated with the most complex clinical decision making procedure codes (99284-99285) were included in the final adjustment. In addition, a replacement cost amount (average cost physician visit) was made for the majority of LANE visits that were deemed preventable/pre-emptible. To account for additional cost off-sets that will be included in the next LANE analysis, LDH decreased the TEL to 25% for RY 2018.

PHARMACY EFFICIENCY ADJUSTMENTS

Appropriate Diagnosis for Selected Drug Classes (DxRx)

The DxRx efficiency adjustment is used to ensure appropriate utilization of selected drug classes in historical claims data, based on supporting diagnosis information in the recipients medical history. The selected drug classes were identified based on high cost, safety concerns, and/or high potential for abuse or misuse. Diagnosis information from 30 months (24 months prior to date of service, 6 months after date of service) of medical, professional, pharmacy and inpatient data is reviewed for each recipient. Appropriate drug-diagnosis pairs are reviewed annually by Mercer's team of clinicians, and include consideration for:

- FDA Approved Indications (both drug specific, and by drug class)
- Clinically-accepted, off-label utilization as identified by published literature and clinical/ professional expertise
- Industry standard practices

LDH elected to remove the component of this adjustment related to the Opioid dependence category by selecting a targeted efficiency level (TEL) of 58.7%.

Retrospective Pharmacy Claims Analysis
The clinical edits efficiency adjustment used a retrospective pharmacy claims analysis to identify inappropriate prescribing and/or dispensing patterns using a customized series of pharmacy utilization management edits that are clinically based on rules. Edits were developed by Mercer's managed pharmacy practice based on:

- Published literature
- Industry standard practices
- Clinical appropriateness review
- Professional expertise
- Information gathered during the review of several Medicaid FFS and managed care pharmacy programs across the country

Pharmacy HCPCS (Healthcare Common Procedure Coding System)

The HCPCS efficiency adjustment benchmarks each MCOs' reimbursement for clinician-administered drugs (billed via HCPCS) to determine if the plan's per unit reimbursement is efficient compared to the national rate established by Medicare.

The State decided that to reflect its response for value-focused purchasing, the final retrospective pharmacy claims analysis efficiency adjustment should reflect a 50% targeted efficiency level applied to the final adjustment identified.

The overall impact of the Inpatient, ED, and Pharmacy efficiency adjustments was a decrease of $2.79 to the PH program.

Contralateral Breast Reduction (CBR) Services

Effective February 1, 2017, the Healthy Louisiana program will cover breast reconstruction post mastectomy of the contralateral unaffected breast to achieve symmetry for patients diagnosed with breast cancer. The added CBR services will result in a 2.55% increase to the BCC rate cell, as shown in Appendix H.

Reinstatement of LaHIPP Program

Effective April 1, 2017, the LaHIPP program is reinstated. Members that are enrolled in the LaHIPP program will receive PH services through FFS and will receive SBH and NEMT services through Healthy Louisiana. The LaHIPP members will be included in the SBH Dual and LaHIPP rate cell (f/k/a SBH Dual Eligible). As shown in Appendix I, the addition of the LaHIPP members results in a decrease of 0.80% to the SBH Dual Eligible and LaHIPP rate cell.

Outliers

As part of the State Plan, inpatient hospitals receive an additional payment for high-cost stays for children under six, called outliers. These payments are for inpatient stays with a total cost to the hospital in excess of $150,000, where the cost is determined based on the hospital's Neonatal Intensive Care Unit (NICU) or Pediatric Intensive Care Unit (PICU)–specific CCR. LDH makes payments to a maximum of $10 million annually. As payment of outlier liability is the responsibility of Healthy Louisiana MCOs, this additional $10 million was built into the rates based on the distribution by rate cell observed in state fiscal year (SFY) 2016 payments. Outliers added an average cost of $0.88 PMPM to the base data used in rate setting. Table 11 details the impact of outliers on the rates by rate cell.

Table 11: Outlier Claims to be Added into Healthy Louisiana from $10 Million Pool

COA Description	Rate Cell Description	Projected MMs	Outlier PMPM*	Adjustment Dollars
SSI	Newborn, 0-2 Months	963	$ 2,345.01	$ 2,258,259
SSI	Newborn, 3-11 Months	6,983	$ 97.45	$ 680,496
SSI	Child, 1-20 Years	456,675	$ -	$ -
Family and Children	Newborn, 0-2 Months	113,728	$ 60.58	$ 6,889,290
Family and Children	Newborn, 3-11 Months	395,749	$ 0.32	$ 127,754
Family and Children	Child, 1-20 Years	7,939,771	$ 0.01	$ 44,201
Total		**8,913,870**	**$ 1.12**	**$ 10,000,000**
Total PH COAs**		**11,383,491**	**$ 0.88**	**$ 10,000,000**

*Outlier distribution is based on SFY2016 experience.
**Total includes projected member months for all PH population.

Early Elective Delivery (EED)

Beginning February 2015, facility and delivering physician costs for EEDs will not be covered under the Healthy Louisiana program. MCOs receive an EED 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. Mercer identified the average facility and delivering physician costs embedded in the Maternity Kick Payment by region and excluded those costs to arrive at the EED Kick Payment. The EED Kick Payment is calculated by applying the EED percentage of 22.3% to the regular Maternity Kick Payment.

PET Scans

Effective February 1, 2018, Healthy Louisiana will cover PET scans for cancer-related purposes. This is a new State Plan service and is considered a physical health service. Thus, only the physical health program is affected for Healthy Louisiana.

Mercer developed a projection of the Healthy Louisiana PET scan costs using fee schedule information provided by LDH and an estimate of expected PET scan utilization. As PET scans are a new State Plan service, the projected utilization was developed based on experience in Louisiana for a Commercial population (Blue Cross Blue Shield of Louisiana – Individual line of business) and PET scan utilization in other Medicaid managed care programs covering similar populations and services in other states. The

overall impact on the Non-Expansion rates and the aggregate rate due to the addition of the PET scan benefit was 0.18% and 0.19%, respectively. Please see Appendix J for more details.

Applied Behavioral Analysis

Effective February 1, 2018, Healthy Louisiana will cover ABA services as a part of the physical health services in the Healthy Louisiana benefit package. During the two base years (CY 2015 and CY 2016), ABA services were provided in FFS.

ABA FFS experience for populations who are eligible to receive physical health services through the Healthy Louisiana program was used to develop the ABA adjustment. Mercer also worked closely with LDH to understand how factors affecting rates could reasonably be expected to change between the base years and RY 2018. The ABA adjustment added $2.61 to the PH program PMPM and $1.58 to the aggregate PMPM. Please see Appendix K for more details.

MENTAL HEALTH REHABILITATION

Effective October 1, 2017, LDH implemented an initiative with the MCOs to improve utilization management of Community Psychiatric Support (CPST) and Psychosocial Rehabilitation (PSR) services for child and adult recipients. LDH worked directly with each of the Healthy Louisiana MCOs to revise their approach to the management of these services by including utilization management protocols. LDH expects this initiative to reduce CPST and PSR utilization by approximately 3.75%.

Mercer reviewed the utilization management plans for all Healthy Louisiana MCOs, as well as LDH's estimated utilization impacts for this initiative and determined they are reasonable and attainable. Accordingly, Mercer applied a utilization reduction of 3.75%. The overall impact to the Non-Expansion rates and aggregate rate due to the reduction in CPST and PSR services is -0.34% and -0.22%, respectively.

PART C: NON-EXPANSION CAPITATION RATE DEVELOPMENT

Mercer followed rate development standards related to base data and described in Part B of this letter to develop an adjusted base data. To obtain the final projected benefit costs, the base data was further adjusted to account for trends and other contract provisions.

SUBPART C.1: PROJECTED BENEFIT COSTS

Trend

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

Prospective trends were applied to the blended base data. The trend factors by population are shown in Appendix G.

IN-LIEU OF SERVICES

The costs in the base data reflect costs for State Plan services delivered in a managed care environment. In some cases for the adult population, the MCOs provided an approved service in lieu of a State plan service. The utilization and unit costs of the in-lieu-of services were taken into account in developing the projected benefit costs of the covered services (as opposed to utilization and unit costs of the State plan services or settings) with the exception of the Inpatient Psychiatric Institutions for Mental Diseases (IMD) stays for which utilization was repriced at the cost of the same services through providers included under the state plan. Additional detail regarding the repricing of the Inpatient Psychiatric IMD stays is described in more detail in the section below. Please refer to Appendix L for a summary of these costs and the percentage of cost that the in-lieu-of services represent in each category of service.

INSTITUTIONS FOR MENTAL DISEASES

On May 6, 2016, CMS published the Medicaid and CHIP Programs Final Rule. Provision §438.6(e) states the following, "…the State may make a monthly capitation payment to an MCO or PIHP for adults receiving inpatient treatment in an IMD, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder (SUD) crisis residential services, and length of stay in the IMD is for a short-term stay of no more than 15 days during the period of the monthly capitation payment." This requirement was effective as of July 6, 2016.

No adjustments were made in rate development to IMD SUD services as they were approved as covered services via Louisiana's 1115 Waiver effective February 1, 2018.

For Inpatient Psychiatric IMD stays, Mercer received a list of IMD facilities that existed during the base data period (CY 2015 and CY 2016). Using this list of IMD facilities, Mercer identified all individuals within the base data who had an overnight stay in an IMD and sorted them into short stays (15 cumulative days or less in a given month) versus long stays (16 or more cumulative days in a given month). The table below shows user counts and costs within the base associated with IMD users by CY.

Table 12a: IMD Inpatient Psychiatric Short Stays

CY	User Months	IP Psych Overnight Stay Service		Non-IP Psych Service		All Services	
		Cost	Cost Per User Month	Cost	Cost Per User Month	Cost	Cost Per User Month
2015	7,966	$15,517,256	$1,947.94	$14,571,880	$1,829.26	$30,089,136	$3,777.20
2016	8,382	$16,538,851	$1,973.14	$15,218,553	$1,815.62	$31,757,404	$3,788.76

Table 12b: IMD Inpatient Psychiatric Long Stays

CY	User Months	IP Psych Overnight Stay Service		Non-IP Psych Service		All Services	
		Cost	Cost Per User Month	Cost	Cost Per User Month	Cost	Cost Per User Month
2015	384	$1,117,623	$2,910.48	$379,395	$988.01	$1,497,018	$3,898.49
2016	471	$1,771,262	$3,760.64	$626,598	$1,330.36	$2,397,860	$5,091.00

Please note that the extent that there were IMDs in the base period that were not included on the IMD facilities list utilized by Mercer for this analysis and/or that there were overnight IMD stays paid for an entity other than Medicaid, the methodology described in this section would not have been able to identify them. If new or better data becomes available, it may be necessary to refine the IMD adjustments described below accordingly.

For Inpatient Psychiatric IMD long stays, adjustment factors were developed by region, rate cell and year to remove all costs associated with the IMD stays from the Inpatient Services – Mental Health service category. This includes the MMs and costs for the IMD itself as well as non-IMD services incurred during the month of the IMD long stay. In aggregate, the impact of these adjustments on the base were a 0.05% reduction to the CY 2015 PMPM and a 0.08% reduction to the CY 2016 PMPM.

Another component of §438.6(e) requires that States "must price utilization at the cost of the same services through providers included under the State Plan." Mercer evaluated the average cost per diem of IMD stays and compared this to the average cost per diem of Inpatient Psychiatric stays in non-IMD hospitals. Repricing the short stay Inpatient Psychiatric IMD utilization at the non-IMD per diem resulted in an increase to inpatient services of 4.0% in CY 2015 and 6.9% in CY 2016, respectively.

The net impact of both removing IMD long stays and repricing the IMD short stay utilization resulted in an increase of 1.9% for CY 2015 and 3.2% for CY 2016 to Inpatient Services – Mental Health costs.

RETROACTIVE ELIGIBILITY ADJUSTMENT

MCOs are liable for all claims incurred during a retroactive eligibility period. Eligible members are granted retroactive eligibility, based on their eligibility for Healthy Louisiana, for up to 12 months prior to enrollment in an MCO. The MCO selected by these members receive one capitation payment per month of retroactive enrollment.

Mercer reviewed the retroactive eligibility and claims experience data and developed adjustment factors that were applied to the projected benefit costs. 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 supplied in Appendix M.

Table 13 summarizes the overall adjustment by rate cell for retroactive eligibility.

Table 13: Retroactive Eligibility Adjustment

COA Description	Rate Cell Description	Adjustment (%)
SSI	0 - 2 Months	0.00%
SSI	3 - 11 Months	0.00%
SSI	Child 1 – 20	0.00%
SSI	Adult 21+	0.00%
Family & Children	0 - 2 Months	0.00%
Family & Children	3 - 11 Months	0.00%
Family & Children	Child 1 – 20	0.00%
Family & Children	Adult 21+	0.00%
FCC	FCC, All Ages	0.00%
BCC	BCC, All Ages	1.80%
LAP	LAP, All Ages	0.00%
HCBS	Child 0 – 20	0.00%
HCBS	Adult 21+	0.00%
CCM	CCM, All Ages	0.00%
SBH — CCM	SBH — Chisholm, All Ages Male & Female	0.00%
SBH — Duals	SBH — Dual Eligible and LAHIPP, All Ages	0.00%
SBH — HCBS	SBH — 20 & Under, Male and Female	0.00%
SBH — HCBS	SBH — 21+ Years, Male and Female	0.00%
SBH — Other	SBH — Other, All Ages	0.00%
Maternity Kick Payment	Maternity Kick Payment	0.00%

Subpart C.2: Special Contract Provisions

Withhold Arrangement

Effective February 1, 2018, a withhold of the monthly capitated payment shall be applied to incentivize quality, health outcomes, and value-based payments. The withhold amount will be equal to two percent of the monthly capitated payment for physical and basic behavioral health for all MCO members, exclusive of maternity kick payments and the FMP component of the monthly capitated payment. Quality and health outcomes, along with value-based payments will each account for one percent (half of the withhold) and are intended to incentivize the MCOs to meet all requirements.

Based on recent Healthy Louisiana MCO performance, Mercer determined that two of the 16 quality or health outcome measures were deemed not reasonably attainable. These two measures are Emergency Department (ED) visits per 1,000 and Controlling High Blood Pressure. All other measures for quality and health outcomes were deemed reasonably attainable. All value-based payments were deemed reasonably attainable.

Due to two quality and health outcomes being deemed not reasonably attainable, there will be an adjustment to the actuarially sound lower bound. For those rate cells impacted by the withhold, a factor of 1.00125 (1% * 2/16 = 0.125%) will be applied to all impacted rate cells prior to the application of the FMP adjustment in order to comply with the relevant actuarial standards of practice.

SUBPART C.3: PROJECTED NON-BENEFIT COSTS

Non-Medical Expense Load

Administrative Expense Load

The actuarially sound capitation rate ranges developed include a provision for MCO administration and other non-medical expenses. Mercer reviewed line item detail of each MCO's administrative expenses, which tied back to the FRRs as well as relied on its professional experience in working with numerous State Medicaid programs to develop the administrative load. The development included consideration for increases in expenses including items such as additional case management due to claims volume, increases in staff compensation over time, and consideration for enrollment growth. Final Administrative cost expectation is shown by program in Table 14.

Table 14: Non-Expansion Final Administrative Cost Expectation

Program	Low	High
Physical Health	$ 28.10	$ 28.10
Maternity Kicks	$ 309.84	$ 309.84
Specialized Behavioral Health	$ 5.16	$ 5.16

The load for each rate cell was determined using a fixed and variable cost model. Under this model, a fixed administrative expense is attributed to each rate cell, which reflects program requirements, such as state-mandated staffing, and other indirect operational expenses. Added to this is a variable administrative amount, based on claims volume. This methodology results in administrative expense loads that vary as a percentage by rate cell. The resulting variance in administrative expense determined using this methodology results in a higher allocation of administrative expenses on the rate cells with higher utilization, which Mercer believes is more accurate in reflecting the drivers of plan administration requirements.

Underwriting Gain Load

Additionally, a provision has been made in the rate development for a 2.00% underwriting gain calculated before applying any adjustment for FMP.

Premium-based Taxes

Final rates also include a provision for Louisiana's 5.50% premium tax.

FEDERAL HEALTH INSURER FEE

Section 9010 of the ACA established a health insurance provider fee (HIPF), which applies to certain for-profit/tax-paying health insurers. For-profit Medicaid health plans are not exempt from the HIPF, which will become a cost of doing business that is appropriate to recognize in actuarially sound capitation rates.

At the time of this certification, many aspects of the calculation and application of this fee are not yet determined and/or finalized. These fees, associated with 2018 experience, will be calculated and become payable sometime during the third quarter of 2019. As these fees are not yet defined by insurer and by marketplace, no adjustment has been made in the rate range development for the Healthy Louisiana program. An adjustment and revised certification will be considered when the fee amount and impacted entities applicable to this rate period are announced in 2019.

SUBPART C.4: RISK MITIGATION

Risk Adjustment

Risk adjustment will be applied to the rates in Appendix A to reflect differences in health status of the members served in each MCO using the Adjusted Clinical Groups (ACG) model. The risk adjustment process does not increase nor decrease the overall cost of the program, but can change the distribution across the various Healthy Louisiana MCOs according to the relative risk of their enrolled members. Table 15 shows the rate cells that will be risk adjusted.

Table 15: Risk-Adjusted Rate Cells	
SSI	
Child, 1–20 Years, Male & Female	Adult, 21+ Years, Male & Female
Family and Children (TANF)	
Child, 1–20 Years, Male & Female	Adult, 21+ Years, Male & Female
FCC	
All Ages, Male & Female	
LAP	
All Ages, Male & Female	

Non-Expansion Minimum Medical Loss Ratio (MLR)

In accordance with the MCO Financial Reporting Guide published by LDH, each MCO shall provide an annual Medical Loss Ratio report following the end of the MLR reporting year, which shall be a calendar year. An MLR shall be reported in the aggregate, including all medical services covered under the contract. If the aggregate MLR (cost for health care benefits and services and specified quality expenditures) is less than 85%, the MCO shall refund LDH the difference.

SECTION 2: EXPANSION CAPITATION RATE DEVELOPMENT

The rate development for the Expansion enrollment relied upon base data and rate-setting adjustments used to develop the Non-Expansion Healthy Louisiana February 1, 2018 effective capitation rates. The expansion rate development relied primarily upon F&C experience and rate adjustments. From there, additional data adjustments were applied to reflect anticipated differences in the health status and

utilization patterns of the expansion population. The expansion-specific adjustments will be discussed below.

RATE CELL STRUCTURE

Expansion rates will vary by region as defined for the existing population: Gulf, Capital, South Central, and North. Additionally, rates are divided into four age groupings and segregated into Male and Female rates which produces 8 distinct rate cells. The factors for each of these splits are shown in Table 16. Rate cells for Maternity Kick Payments were created for the expansion population, but will receive the same rate as the existing population. Additionally, a Medicare SBH rate cell was created to account for the rare but potential situation in which an individual is found to be eligible for Medicare retro-actively overlapping enrollment in expansion. Medicare eligibility disqualifies an individual for the expansion program; however, the State will pay the Healthy Louisiana MCOs to cover the SBH services not covered by Medicare incurred during any retro enrollment period. This service coverage is identical to the SBH-Only Dual eligible and LaHIPP coverage; therefore, the rate from the existing Healthy Louisiana population for SBH-Dual Eligible and LaHIPP will be used in this scenario.

Table 16: Age Gender Factors

Rate Cell Description	Age/Gender Factor
Female Age 19 - Age 24	0.6298
Male Age 19 - Age 24	0.4998
Female Age 25 - Age 39	0.8994
Male Age 25 - Age 39	0.9021
Female Age 40 - Age 49	1.4048
Male Age 40 - Age 49	1.3710
Female Age 50 - Age 64	1.7206
Male Age 50 - Age 64	1.8351
High Needs	1.1366
SBH Medicare Eligible, All Sex/Ages	NA

PART A: PROJECTED BENEFIT COSTS

Trend

A separate and distinct trend analysis was performed for the Expansion population by COS. For pharmacy, actual expansion emerging experience was reviewed to set the expansion trend. For all other COS, a weighting between F&C Adults and SSI Adults as well using professional judgment in regards to the width of range was applied to determine the expansion trend. The resulting trends by COS can be seen in Appendix R.

Additional Rate Adjustments

Several adjustments unique to the expansion population were considered to account for expected key differences between the Expansion and Non-Expansion Healthy Louisiana enrollees. Based on a review of the available Expansion experience, Mercer determined that only such adjustment that was necessary in developing RY 2018 rates an acuity adjustment was needed.

Expansion Acuity Adjustment

The Expansion Acuity adjustment is designed to account for expected differences in cost due to differences in disease prevalence and health status between the F&C population, from which the Expansion base data was developed, and the Expansion population. The Acuity Adjustment factors, which vary at the Lower Bound and Upper Bound of the rate, were developed based on a review of cost and risk adjustment data between non-disabled adult Medicaid populations and Medicaid Expansion populations Louisiana and other Expansion states. The final RY 2018 Acuity Adjustment factors selected were 1.171 at the Lower Bound and 1.231 at the Upper Bound.

HIGH-NEEDS RATE DEVELOPMENT

Effective January 1, 2017 LDH began working with the Department of Corrections (DOC) on a pre-release enrollment program for the offender population that will now be covered by Medicaid under the New Adult Group through expansion. Part of this population will be considered "High Need" by the DOC based on a set of high-risk health criteria. For those identified as high needs, the MCO will conduct case management within 30 days prior to release. Given these extra requirements and the high-risk health criteria, a new rate cell was developed to handle this population.

The DOC provided available, relevant data, so that a sound actuarial rate could be determined. The pharmacy data, which covered periods July 2013 through March 2016 proved to be the best source to estimate this population, since other types of services were sparse. The pharmacy analysis showed that the top therapeutic categories of prescriptions filled by DOC patients remained consistent over the time studied. Based on the top therapeutic categories of prescriptions filled this population most closely resembled the SSI Adult 21+ rate cell. A rate adjustment of 3.000 was developed based upon this conclusion to produce a rate similar to the SSI Adult 21+ population. Additionally, an age/gender factor was developed to reflect the demographic difference between the base data and the population expected to be released during the rating period. The age/gender factor adjustment relied upon the same age/gender factors used by other expansion rate cells. The rate adjustments were applied to the expansion rate development at the midpoint can be seen in Appendix S.

PART B: PROJECTED NON-BENEFIT COSTS

Non-Medical Expense Load

The actuarially sound capitation rate ranges developed include a provision for MCO administration and other non-medical expenses. Mercer reviewed line item detail of each MCO's administrative expenses, which tied back to the FRRs as well as relied on its professional experience in working with numerous State Medicaid programs to develop the administrative load. The development included consideration for increases in expenses including items such as additional case management due to claims volume, increases in staff compensation over time, and consideration for enrollment growth. Final Administrative cost expectation is shown by program in Table 17.

Table 17: Expansion Final Administrative Cost Expectation

Program	Low	High
Expansion	$ 31.84	$ 31.84

Note: High-Needs rate cells receive a 1.125 factor relative to expansion due to the extra month of case management.

The load for each rate cell was determined using a fixed and variable cost model. Under this model, a fixed administrative expense is attributed to each rate cell, which reflects program requirements, such as state-mandated staffing, and other indirect operational expenses. Added to this is a variable administrative amount, based on claims volume. This methodology results in administrative expense loads that vary as a percentage by rate cell. The resulting variance in administrative expense determined using this methodology results in a higher allocation of administrative expenses on the rate cells with higher utilization, which Mercer believes is more accurate in reflecting the drivers of plan administration requirements.

UNDERWRITING GAIN LOAD

Additionally, provision has been made in the rate development for a 2.00% underwriting gain calculated before applying any adjustment for FMP.

Premium-based Taxes

Final rates also include provision for Louisiana's 5.50% premium tax.

PART C: RISK MITIGATION STRATEGIES

Medicaid Expansion Minimum Medical Loss Ratio

In accordance with the MCO Financial Reporting Guide published by LDH, each MCO shall provide an annual Medical Loss Ratio report following the end of the MLR reporting year, which shall be a calendar year. An MLR shall be reported in the aggregate, including all medical services covered under the contract. If the aggregate MLR (cost for health care benefits and services and specified quality expenditures) is less than 85%, the MCO shall refund LDH the difference.

SECTION 3: CERTIFICATION OF FINAL RATE RANGES

This certification assumes items in the Medicaid State Plan or Waiver, as well as the Healthy Louisiana MCO contract, have been approved by CMS.

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

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

an indication that prior assumptions were unreasonable, inappropriate, or unattainable when they were made.

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

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

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

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

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

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

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

Sincerely,

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

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Appendix A: Healthy Louisiana Capitation Rate Range

Region Description	Category of Aid Description	Rate Cell Description	Projected Member Months/Deliveries	Lower Bound PMPM or Cost per Delivery	Reasonably Attainable PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
Gulf	SSI	0 - 2 Months	288	$ 34,606.48	$ 34,635.79	$ 36,479.56
Gulf	SSI	3 - 11 Months	2,085	$ 5,814.84	$ 5,819.96	$ 6,153.41
Gulf	SSI	Child 1 - 20 Years	132,759	$ 767.15	$ 767.95	$ 815.20
Gulf	SSI	Adult 21+ Years	278,885	$ 1,447.58	$ 1,449.00	$ 1,538.68
Gulf	Family & Children	0 - 2 Months	33,958	$ 3,148.47	$ 3,150.92	$ 3,328.07
Gulf	Family & Children	3 - 11 Months	118,165	$ 311.62	$ 311.92	$ 331.07
Gulf	Family & Children	Child 1 - 20 Years	2,211,981	$ 180.72	$ 180.92	$ 192.79
Gulf	Family & Children	Adult 21+ Years	381,028	$ 372.71	$ 373.09	$ 394.79
Gulf	Foster Care Children	All Ages Male & Female	27,754	$ 474.80	$ 475.36	$ 510.44
Gulf	BCC	BCC, All Ages	1,842	$ 2,204.92	$ 2,207.10	$ 2,325.48
Gulf	LAP	LAP, All Ages	8,886	$ 206.68	$ 206.91	$ 220.03
Gulf	HCBS	Child 1 - 20 Years	1,223	$ 1,836.31	$ 1,838.27	$ 1,961.99
Gulf	HCBS	Adult 21+ Years	4,394	$ 1,514.62	$ 1,516.22	$ 1,624.13
Gulf	CCM	CCM, All Ages	11,336	$ 1,356.30	$ 1,357.79	$ 1,435.28
Gulf	SBH - CCM	SBH - CCM, All Ages	11,863	$ 126.20	$ 126.20	$ 132.25
Gulf	SBH - Duals	SBH – Dual Eligible & LaHIPP, All Ages	334,772	$ 33.09	$ 33.09	$ 34.20
Gulf	SBH - HCBS	SBH - Child 1 - 20 Years	5,271	$ 47.16	$ 47.16	$ 49.30
Gulf	SBH - HCBS	SBH - Adult 21+ Years	11,317	$ 66.07	$ 66.07	$ 68.95
Gulf	SBH - Other	SBH - All Ages	11,338	$ 188.22	$ 188.22	$ 195.81
Gulf	Maternity Kick Payment	Maternity Kick Payment	9,173	$ 13,550.33	$ 13,550.33	$ 14,039.00
Gulf	EED Kick Payment	EED Kick Payment	1	$ 7,316.96	$ 7,316.96	$ 7,425.94
Gulf	Medicaid Expansion	Female Age 19 - Age 24	254,031	$ 280.92	$ 281.21	$ 300.85
Gulf	Medicaid Expansion	Male Age 19 - Age 24	153,172	$ 225.48	$ 225.71	$ 241.29
Gulf	Medicaid Expansion	Female Age 25 - Age 39	489,877	$ 396.19	$ 396.60	$ 424.66
Gulf	Medicaid Expansion	Male Age 25 - Age 39	264,296	$ 397.10	$ 397.51	$ 425.65
Gulf	Medicaid Expansion	Female Age 40 - Age 49	210,335	$ 612.35	$ 612.98	$ 656.86
Gulf	Medicaid Expansion	Male Age 40 - Age 49	134,712	$ 597.60	$ 598.21	$ 641.01
Gulf	Medicaid Expansion	Female Age 50 - Age 64	287,816	$ 748.31	$ 749.07	$ 802.90
Gulf	Medicaid Expansion	Male Age 50 - Age 64	202,206	$ 796.83	$ 797.64	$ 855.03
Gulf	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	7,420	$ 33.09	$ 33.09	$ 34.20
Gulf	Medicaid Expansion	SBH - Other, All Ages	163	$ 188.22	$ 188.22	$ 195.81
Gulf	Medicaid Expansion	SBH - Chisholm, All Ages	299	$ 126.20	$ 126.20	$ 132.25
Gulf	Medicaid Expansion	High Needs	1,804	$ 1,448.74	$ 1,448.74	$ 1,580.86
Gulf	Medicaid Expansion	Maternity Kick Payment	9,173	$ 13,550.33	$ 13,550.33	$ 14,039.00
Gulf	Medicaid Expansion	EED Kick Payment	1	$ 7,316.96	$ 7,316.96	$ 7,425.94
Capital	SSI	0 - 2 Months	217	$ 34,606.48	$ 34,635.79	$ 36,479.56
Capital	SSI	3 - 11 Months	1,573	$ 5,814.84	$ 5,819.96	$ 6,153.41
Capital	SSI	Child 1 - 20 Years	97,313	$ 767.57	$ 768.44	$ 819.91
Capital	SSI	Adult 21+ Years	195,669	$ 1,396.98	$ 1,398.48	$ 1,493.05
Capital	Family & Children	0 - 2 Months	25,616	$ 2,918.71	$ 2,921.18	$ 3,099.62
Capital	Family & Children	3 - 11 Months	89,137	$ 287.97	$ 288.26	$ 307.05
Capital	Family & Children	Child 1 - 20 Years	1,916,871	$ 182.39	$ 182.60	$ 195.16
Capital	Family & Children	Adult 21+ Years	300,951	$ 392.53	$ 392.95	$ 416.90
Capital	Foster Care Children	All Ages Male & Female	40,519	$ 474.80	$ 475.36	$ 510.44
Capital	BCC	BCC, All Ages	2,242	$ 2,204.92	$ 2,207.10	$ 2,325.48
Capital	LAP	LAP, All Ages	11,562	$ 206.68	$ 206.91	$ 220.03
Capital	HCBS	Child 1 - 20 Years	1,184	$ 1,836.31	$ 1,838.27	$ 1,961.99
Capital	HCBS	Adult 21+ Years	3,407	$ 1,514.62	$ 1,516.22	$ 1,624.13
Capital	CCM	CCM, All Ages	8,726	$ 1,356.30	$ 1,357.79	$ 1,435.28
Capital	SBH - CCM	SBH - CCM, All Ages	12,470	$ 126.20	$ 126.20	$ 132.25
Capital	SBH - Duals	SBH – Dual Eligible & LaHIPP, All Ages	265,049	$ 23.57	$ 23.57	$ 24.29
Capital	SBH - HCBS	SBH - Child 1 - 20 Years	6,022	$ 47.16	$ 47.16	$ 49.30
Capital	SBH - HCBS	SBH - Adult 21+ Years	10,929	$ 66.07	$ 66.07	$ 68.95
Capital	SBH - Other	SBH - All Ages	12,714	$ 188.22	$ 188.22	$ 195.81
Capital	Maternity Kick Payment	Maternity Kick Payment	7,917	$ 10,887.25	$ 10,887.25	$ 11,316.04
Capital	EED Kick Payment	EED Kick Payment	1	$ 5,382.73	$ 5,382.73	$ 5,478.35
Capital	Medicaid Expansion	Female Age 19 - Age 24	188,193	$ 295.67	$ 295.99	$ 317.67
Capital	Medicaid Expansion	Male Age 19 - Age 24	94,165	$ 237.19	$ 237.44	$ 254.65
Capital	Medicaid Expansion	Female Age 25 - Age 39	357,853	$ 417.22	$ 417.67	$ 448.66
Capital	Medicaid Expansion	Male Age 25 - Age 39	141,812	$ 418.20	$ 418.65	$ 449.72
Capital	Medicaid Expansion	Female Age 40 - Age 49	135,702	$ 645.16	$ 645.85	$ 694.30
Capital	Medicaid Expansion	Male Age 40 - Age 49	71,061	$ 629.64	$ 630.31	$ 677.55
Capital	Medicaid Expansion	Female Age 50 - Age 64	157,655	$ 788.48	$ 789.32	$ 848.73
Capital	Medicaid Expansion	Male Age 50 - Age 64	104,412	$ 839.67	$ 840.56	$ 903.91
Capital	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	4,846	$ 23.57	$ 23.57	$ 24.29
Capital	Medicaid Expansion	SBH - Other, All Ages	105	$ 188.22	$ 188.22	$ 195.81
Capital	Medicaid Expansion	SBH - Chisholm, All Ages	221	$ 126.20	$ 126.20	$ 132.25
Capital	Medicaid Expansion	High Needs	1,572	$ 1,526.30	$ 1,526.30	$ 1,672.03
Capital	Medicaid Expansion	Maternity Kick Payment	7,917	$ 10,887.25	$ 10,887.25	$ 11,316.04
Capital	Medicaid Expansion	EED Kick Payment	1	$ 5,382.73	$ 5,382.73	$ 5,478.35

Appendix A: Healthy Louisiana Capitation Rate Range

Region Description	Category of Aid Description	Rate Cell Description	Projected Member Months/Deliveries	Lower Bound PMPM or Cost per Delivery	Reasonably Attainable PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
South Central	SSI	0 - 2 Months	253	$ 34,606.48	$ 34,635.79	$ 36,479.56
South Central	SSI	3 - 11 Months	1,838	$ 5,814.84	$ 5,819.96	$ 6,153.41
South Central	SSI	Child 1 - 20 Years	105,972	$ 737.25	$ 738.08	$ 785.11
South Central	SSI	Adult 21+ Years	243,844	$ 1,277.84	$ 1,279.16	$ 1,361.83
South Central	Family & Children	0 - 2 Months	29,937	$ 3,276.05	$ 3,278.83	$ 3,480.54
South Central	Family & Children	3 - 11 Months	104,174	$ 286.62	$ 286.91	$ 305.68
South Central	Family & Children	Child 1 - 20 Years	2,156,070	$ 182.20	$ 182.41	$ 194.93
South Central	Family & Children	Adult 21+ Years	337,770	$ 365.42	$ 365.81	$ 387.73
South Central	Foster Care Children	All Ages Male & Female	50,835	$ 474.80	$ 475.36	$ 510.44
South Central	BCC	BCC, All Ages	1,370	$ 2,204.92	$ 2,207.10	$ 2,325.48
South Central	LAP	LAP, All Ages	10,797	$ 206.68	$ 206.91	$ 220.03
South Central	HCBS	Child 1 - 20 Years	1,289	$ 1,836.31	$ 1,838.27	$ 1,961.99
South Central	HCBS	Adult 21+ Years	4,262	$ 1,514.62	$ 1,516.22	$ 1,624.13
South Central	CCM	CCM, All Ages	11,368	$ 1,356.30	$ 1,357.79	$ 1,435.28
South Central	SBH - CCM	SBH - CCM, All Ages	12,321	$ 126.20	$ 126.20	$ 132.25
South Central	SBH - Duals	SBH – Dual Eligible & LaHIPP, All Ages	349,901	$ 23.43	$ 23.43	$ 24.15
South Central	SBH - HCBS	SBH - Child 1 - 20 Years	5,428	$ 47.16	$ 47.16	$ 49.30
South Central	SBH - HCBS	SBH - Adult 21+ Years	11,765	$ 66.07	$ 66.07	$ 68.95
South Central	SBH - Other	SBH - All Ages	16,206	$ 188.22	$ 188.22	$ 195.81
South Central	Maternity Kick Payment	Maternity Kick Payment	9,159	$ 9,692.36	$ 9,692.36	$ 10,119.96
South Central	EED Kick Payment	EED Kick Payment	1	$ 4,202.37	$ 4,202.37	$ 4,297.72
South Central	Medicaid Expansion	Female Age 19 - Age 24	219,085	$ 275.28	$ 275.57	$ 295.39
South Central	Medicaid Expansion	Male Age 19 - Age 24	111,194	$ 221.01	$ 221.24	$ 236.97
South Central	Medicaid Expansion	Female Age 25 - Age 39	418,440	$ 388.10	$ 388.51	$ 416.83
South Central	Medicaid Expansion	Male Age 25 - Age 39	169,270	$ 389.00	$ 389.41	$ 417.81
South Central	Medicaid Expansion	Female Age 40 - Age 49	161,105	$ 599.66	$ 600.29	$ 644.57
South Central	Medicaid Expansion	Male Age 40 - Age 49	85,084	$ 585.24	$ 585.86	$ 629.04
South Central	Medicaid Expansion	Female Age 50 - Age 64	189,203	$ 732.70	$ 733.47	$ 787.79
South Central	Medicaid Expansion	Male Age 50 - Age 64	125,577	$ 780.20	$ 781.02	$ 838.93
South Central	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	5,738	$ 23.43	$ 23.43	$ 24.15
South Central	Medicaid Expansion	SBH - Other, All Ages	82	$ 188.22	$ 188.22	$ 195.81
South Central	Medicaid Expansion	SBH - Chisholm, All Ages	204	$ 126.20	$ 126.20	$ 132.25
South Central	Medicaid Expansion	High Needs	1,943	$ 1,417.96	$ 1,417.96	$ 1,551.28
South Central	Medicaid Expansion	Maternity Kick Payment	9,159	$ 9,692.36	$ 9,692.36	$ 10,119.96
South Central	Medicaid Expansion	EED Kick Payment	1	$ 4,202.37	$ 4,202.37	$ 4,297.72
North	SSI	0 - 2 Months	205	$ 34,606.48	$ 34,635.79	$ 36,479.56
North	SSI	3 - 11 Months	1,487	$ 5,814.84	$ 5,819.96	$ 6,153.41
North	SSI	Child 1 - 20 Years	120,631	$ 753.29	$ 754.13	$ 802.44
North	SSI	Adult 21+ Years	220,396	$ 1,193.27	$ 1,194.49	$ 1,270.86
North	Family & Children	0 - 2 Months	24,218	$ 2,983.72	$ 2,986.08	$ 3,156.24
North	Family & Children	3 - 11 Months	84,273	$ 281.10	$ 281.38	$ 299.13
North	Family & Children	Child 1 - 20 Years	1,654,849	$ 198.05	$ 198.27	$ 211.79
North	Family & Children	Adult 21+ Years	251,972	$ 353.95	$ 354.32	$ 375.02
North	Foster Care Children	All Ages Male & Female	33,928	$ 474.80	$ 475.36	$ 510.44
North	BCC	BCC, All Ages	1,770	$ 2,204.92	$ 2,207.10	$ 2,325.48
North	LAP	LAP, All Ages	8,055	$ 206.68	$ 206.91	$ 220.03
North	HCBS	Child 1 - 20 Years	1,039	$ 1,836.31	$ 1,838.27	$ 1,961.99
North	HCBS	Adult 21+ Years	3,552	$ 1,514.62	$ 1,516.22	$ 1,624.13
North	CCM	CCM, All Ages	7,764	$ 1,356.30	$ 1,357.79	$ 1,435.28
North	SBH - CCM	SBH - CCM, All Ages	10,563	$ 126.20	$ 126.20	$ 132.25
North	SBH - Duals	SBH – Dual Eligible & LaHIPP, All Ages	282,304	$ 28.26	$ 28.26	$ 29.18
North	SBH - HCBS	SBH - Child 1 - 20 Years	3,490	$ 47.16	$ 47.16	$ 49.30
North	SBH - HCBS	SBH - Adult 21+ Years	8,966	$ 66.07	$ 66.07	$ 68.95
North	SBH - Other	SBH - All Ages	14,864	$ 188.22	$ 188.22	$ 195.81
North	Maternity Kick Payment	Maternity Kick Payment	6,796	$ 10,688.83	$ 10,688.83	$ 11,117.89
North	EED Kick Payment	EED Kick Payment	1	$ 5,181.05	$ 5,181.05	$ 5,276.73
North	Medicaid Expansion	Female Age 19 - Age 24	189,149	$ 266.63	$ 266.91	$ 285.60
North	Medicaid Expansion	Male Age 19 - Age 24	94,786	$ 214.14	$ 214.36	$ 229.19
North	Medicaid Expansion	Female Age 25 - Age 39	359,986	$ 375.77	$ 376.16	$ 402.88
North	Medicaid Expansion	Male Age 25 - Age 39	142,891	$ 376.63	$ 377.02	$ 403.81
North	Medicaid Expansion	Female Age 40 - Age 49	136,830	$ 580.44	$ 581.04	$ 622.82
North	Medicaid Expansion	Male Age 40 - Age 49	71,639	$ 566.47	$ 567.05	$ 607.80
North	Medicaid Expansion	Female Age 50 - Age 64	159,091	$ 709.19	$ 709.92	$ 761.18
North	Medicaid Expansion	Male Age 50 - Age 64	105,344	$ 755.13	$ 755.91	$ 810.54
North	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	3,296	$ 28.26	$ 28.26	$ 29.18
North	Medicaid Expansion	SBH - Other, All Ages	129	$ 188.22	$ 188.22	$ 195.81
North	Medicaid Expansion	SBH - Chisholm, All Ages	145	$ 126.20	$ 126.20	$ 132.25
North	Medicaid Expansion	High Needs	1,604	$ 1,372.53	$ 1,372.53	$ 1,498.40
North	Medicaid Expansion	Maternity Kick Payment	6,796	$ 10,688.83	$ 10,688.83	$ 11,117.89
North	Medicaid Expansion	EED Kick Payment	1	$ 5,181.05	$ 5,181.05	$ 5,276.73

Appendix B: Healthy Louisiana Eligibility Designation

Aid Category Description	Type Case Description	Adult/Child/All Ages	Mandatory	Voluntary Opt-In	SBH & NEMT
CCM*				●	●
Dual Eligibles**					●
ABD (Aged, Blind, and Disabled)					
	Acute Care Hospitals (LOS > 30 days)	All Ages	●		
	ADHC (Adult Day Health Services Waiver)	All Ages		●	
	BPL (Walker vs. Bayer)	All Ages	●		
	Children's Waiver - Louisiana Children's Choice	All Ages		●	
	Community Choice Waiver	All Ages		●	
	Disability Medicaid	All Ages	●		
	Disabled Adult Child	All Ages	●		
	Disabled Widow/Widower (DW/W)	All Ages	●		
	Early Widow/Widowers	All Ages	●		
	Excess Home Equity Over SIL & NF Fee (Aged)	Adult			●
	Excess Home Equity Over SIL & NF Fee (Blind and Disabled)	All Ages			●
	Excess Home Equity SSI Under SIL (Aged)	Adult			●
	Excess Home Equity SSI Under SIL (Blind and Disabled)	All Ages			●
	Excess Home Equity SSI Under SIL-Reg LTC (Aged)	Adult			●
	Excess Home Equity SSI Under SIL-Reg LTC (Blind and Disabled)	All Ages			●
	Family Opportunity Program	All Ages	●		
	Forced Benefits (Aged)	Adult			●
	Forced Benefits (Blind)	All Ages			●
	Former SSI	All Ages	●		
	LaCHIP Phase IV: Non-Citizen Pregnant Women Expansion	All Ages	●		
	LTC (Long Term Care) (Aged)	Adult			●
	LTC (Long Term Care) (Blind and Disabled)	All Ages			●
	LTC MNP/Transfer of Resources (Aged)	Adult			●
	LTC MNP/Transfer of Resources (Blind and Disabled)	All Ages			●
	LTC Payment Denial/Late Admission Packet (Aged)	Adult			●
	LTC Payment Denial/Late Admission Packet (Blind and Disabled)	All Ages			●
	LTC Spenddown MNP (Aged)	Adult			●
	LTC Spenddown MNP (Blind and Disabled)	All Ages			●
	Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	All Ages	●		
	New Opportunities Waiver - SSI	All Ages		●	
	New Opportunities Waiver Fund	All Ages		●	
	New Opportunities Waiver, non-SSI	All Ages		●	
	PICKLE	All Ages	●		
	Private ICF/DD (Blind)	Child			●
	Private ICF/DD MNP Transfer of Resources (Blind and Disabled)	Child			●
	Private ICF/DD Spendown Medically Needy Program (Blind)	Child			●
	Private ICF/DD Transfer of Resources (Blind and Disabled)	Child			●
	Provisional Medicaid	All Ages	●		
	Public ICF/DD (Blind)	Child			●
	Public ICF/DD MNP Transfer of Resources (Blind and Disabled)	Child			●
	Public ICF/DD Spendown Medically Needy Program (Blind and Disabled)	Child			●
	Public ICF/DD Transfer of Resources (Blind and Disabled)	Child			●
	QDWI	All Ages			●
	Residential Options Waiver - NON-SSI	All Ages		●	
	Residential Options Waiver - SSI	All Ages		●	
	Section 4913 Children	All Ages	●		
	SGA Disabled W/W/DS	All Ages	●		
	Spendown Denial of Payment/Late Packet (Blind)	Child			●
	SSI (Supplemental Security Income)	All Ages	●		
	SSI Children's Waiver - Louisiana Children's Choice	All Ages		●	
	SSI Community Choice Waiver	All Ages		●	
	SSI Conversion	All Ages	●		
	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	All Ages	●		
	SSI New Opportunities Waiver Fund	All Ages		●	
	SSI Payment Denial/Late Admission (Aged)	Adult			●
	SSI Payment Denial/Late Admission (Blind and Disabled)	All Ages			●
	SSI Private ICF/DD Transfer of Resources (Blind and Disabled)	Child			●
	SSI Public ICF/DD Transfer of Resources (Blind and Disabled)	Child			●
	SSI Transfer of Resource(s)/LTC (Aged)	Adult			●
	SSI Transfer of Resource(s)/LTC (Blind and Disabled)	All Ages			●
	SSI/ADHC	All Ages		●	
	SSI/LTC (Aged)	Adult			●
	SSI/LTC (Blind and Disabled)	All Ages			●
	SSI/Private ICF/DD (Blind)	Child			●
	SSI/Public ICF/DD (Blind)	Child			●
	Supports Waiver	All Ages		●	
	Supports Waiver SSI	All Ages		●	
	Transfer of Resource(s)/LTC (Aged)	Adult			●
	Transfer of Resource(s)/LTC (Blind and Disabled)	All Ages			●

Appendix B: Healthy Louisiana Eligibility Designation

Aid Category Description	Type Case Description	Adult/Child/All Ages	Mandatory	Voluntary Opt-In	SBH & NEMT
Families and Children					
	Breast and/or Cervical Cancer	All Ages	●		
	CHAMP Child	All Ages	●		
	CHAMP Pregnant Woman (to 133% of FPIG)	All Ages	●		
	CHAMP Pregnant Woman Expansion (to 185% FPIG)	All Ages	●		
	Deemed Eligible	All Ages	●		
	ELE - Food Stamps (Express Lane Eligibility-Food Stamps)	All Ages	●		
	Forced Benefits	All Ages			●
	Former Foster Care children	All Ages	●		
	LaCHIP Affordable Plan	All Ages	●		
	LACHIP Phase 1	All Ages	●		
	LACHIP Phase 2	All Ages	●		
	LACHIP Phase 3	All Ages	●		
	LaCHIP Phase IV: Non-Citizen Pregnant Women Expansion	All Ages	●		
	LIFC Basic	All Ages	●		
	LTC (Long Term Care)	All Ages			●
	LTC Spenddown MNP	All Ages			●
	PAP - Prohibited AFDC Provisions	All Ages	●		
	Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL	All Ages	●		
	Public ICF/DD	Child			●
	Regular MNP (Medically Needy Program)	All Ages	●		
	Transitional Medicaid	All Ages	●		
	Youth Aging Out of Foster Care (Chaffee Option)	All Ages	●		
LIFC					
	Grant Review/Child Support Continuance	All Ages	●		
	LIFC - Unemployed Parent / CHAMP	All Ages	●		
	LIFC Basic	All Ages	●		
	Transitional Medicaid	All Ages	●		
Medicaid Expansion					
	Adult Group	All Ages	●		
	Adult Group - High Need	All Ages	●		
Non Traditional					
	CSOC	All Ages	●		
OCS/OYD					
	CHAMP Child	All Ages	●		
	CHAMP Pregnant Woman (to 133% of FPIG)	All Ages	●		
	CHAMP Pregnant Woman Expansion (to 185% FPIG)	All Ages	●		
	Children's Waiver - Louisiana Children's Choice	All Ages		●	
	Forced Benefits	Child			●
	Former SSI	All Ages	●		
	Foster Care IV-E - Suspended SSI	All Ages	●		
	IV-E Foster Care	All Ages	●		
	LACHIP Phase 1	All Ages	●		
	LTC (Long Term Care)	All Ages			●
	LTC (Long Term Care)	Child			●
	New Opportunities Waiver - SSI	All Ages		●	
	New Opportunities Waiver Fund	All Ages		●	
	New Opportunities Waiver, non-SSI	All Ages		●	
	OYD - V Category Child	All Ages	●		
	Private ICF/DD	Child			●
	Public ICF/DD	Child			●
	Regular Foster Care Child	All Ages	●		
	Regular Foster Care Child - MNP	All Ages	●		
	Residential Options Waiver - NON-SSI	All Ages		●	
	Residential Options Waiver - SSI	All Ages		●	
	SSI (Supplemental Security Income)	All Ages	●		
	SSI Children's Waiver - Louisiana Children's Choice	All Ages		●	
	SSI New Opportunities Waiver Fund	All Ages		●	
	SSI/LTC	All Ages			●
	SSI/LTC	Child			●
	SSI/Private ICF/DD	Child			●
	SSI/Public ICF/DD	Child			●
	YAP (Young Adult Program) (OCS/OYD (XIX))	All Ages	●		
	YAP/OYD	All Ages	●		
Presumptive Eligible					
	Adult Group	All Ages	●		
	HPE B/CC	All Ages	●		
	HPE CHAMP	All Ages	●		
	HPE Children under age 19	All Ages	●		
	HPE Former Foster Care	All Ages	●		
	HPE LaCHIP	All Ages	●		
	HPE LaCHIP Unborn	All Ages	●		
	HPE Parent/Caretaker Relative	All Ages	●		
	HPE Pregnant Woman	All Ages	●		
TB					
	Tuberculosis (TB)	All Ages	●		

* Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the OCDD's Request for Services Registry who are CCM.

** Dual eligibles included in Healthy Louisiana for SBH and NEMT services must be in a mandatory, voluntary opt-in or SBH and NEMT population listed above in Attachment C. They must also be eligible for Medicare, which is identified based on the Medicare Duals Eligibility table supplied by the State's fiscal agent. Dually eligible individuals are represented by Dual Status code 02, 04, and 08.

Table 1: PH and Expansion Programs

Medicaid COS	Units of Measurement
Inpatient Hospital	Days
Outpatient Hospital	Claims
Primary Care Physician	Visits
Specialty Care Physician	Visits
Federally Qualified Health Center/ Rural Health Clinic	Visits
EPSDT	Visits
Certified Nurse Practitioners/Clinical Nurse	Claims
Lab/Radiology	Units
Home Health	Visits
Emergency Transportation	Units
NEMT	Units
Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech Therapy)	Visits
DME	Units
Clinic	Claims
Family Planning	Visits
Other	Units
Prescribed Drugs	Scripts
Emergency Room	Visits
Basic Behavioral Health	Claims
Hospice*	Admits
Personal Care Services (Age 0–20)*	Units
Inpatient Services — Mental Health*	Days
Emergency Room — Mental Health*	Visits
Professional/Other — Mental Health*	Units

* Services that were excluded during the base periods from the Healthy Louisiana program and now are included.

Table 2: SBH Program

Medicaid COS	Units of Measurement
Inpatient Services — Mental Health*	Days
Emergency Room — Mental Health*	Visits
Professional/Other — Mental Health*	Units
NEMT	Units

* Services that were excluded during the base periods from the Healthy Louisiana program and now are included.

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APPENDIX D

FAMILY PLANNING ADDENDUM

The Louisiana Department of Health (LDH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for the State of Louisiana's Healthy Louisiana program for the period of February 1, 2018 through January 31, 2019. As part of this work, Mercer was asked to develop the family planning component of the capitation rates using the same data that was used to develop the capitation rate ranges. This Appendix D presents an overview of the analyses and methodology used in Mercer's family planning rate development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS), in order for LDH to receive the 90.0% federal match for eligible family planning services. This addendum should be read in conjunction with the rate certification letter. Attachment A within this addendum displays the percent of the capitation rates that are attributable to family planning services. These percentages should be applied directly to capitation rates to determine the family planning amount. The resulting family planning amount does not include load for premium tax, administration, or underwriting gain.

BASE DATA

The capitation rates were developed using the medical expenses incurred during calendar year 2015 and 2016 with runout through June 2017, as reported through the Medicaid Management Information Systems (MMIS). All family planning services were assigned to the appropriate rate cells. Please see the rate certification letter for more details.

METHODOLOGY FOR IDENTIFYING FAMILY PLANNING SERVICES

Using data from the State's MMIS, a multi-step process was followed to measure the amount of family planning for the calendar year, region, and rate tier. Each of these steps is described below:

1. **Family Planning Service Identification**

   Family planning can be identified through procedure codes that are specifically indicative of a family planning service. Tables 1 and 2 contain the lists of procedure codes that were used to identify family planning services, solely on a procedure code match basis. Table 1 contains sterilization services and Table 2 contains contraception services.

TABLE 1: STERILIZATION SERVICES ALWAYS REIMBURSABLE AT THE 90.0% FEDERAL MATCH RATE

WOMEN	MEN
00851	55250

WOMEN	MEN
00921	55450
58565	
58600	
58605	
58611	
58615	
58670	
58671	

TABLE 2: CONTRACEPTION SERVICES ALWAYS REIMBURSABLE AT THE 90.0% FEDERAL MATCH RATE

WOMEN	MEN
11975	A4267 (condoms)
11976	
11977	
57170	
58300	
58301	
A4261	
A4266	
A4268	
A4269	
H1010	
J7304	
J1055	
J1056	
J7300	

WOMEN	MEN
J7302	
J7303	
J7306	
J7307	
S4989	
S4993	

Family planning can also be identified with other procedure codes if the family planning service can be confirmed through the use of contraceptive management diagnosis codes in the V25 series and Z30 series for ICD-9 and ICD-10, respectively. Table 3 contains the list of procedure codes that require a V25 series and Z30 series diagnosis code to be present in order to classify a service as family planning.

TABLE 3: PROCEDURE CODES THAT REQUIRE A V25 SERIES (ICD-9) OR Z30 SERIES (ICD-10) DIAGNOSES CODE

CPT/HCPCS CODES THAT MAY OR MAY NOT REPRESENT CONTRACEPTION/STERILIZATION FAMILY PLANNING SERVICES						
00952	76880	99058	99238	99360	A9900	T1023
11981	76977	99070	99239	99371	E1399	
11982	77078	99071	99241	99372	J1885	
11983	77079	99080	99242	99373	G0101	
36415	77080	99144	99243	99383	G0123	
36416	77081	99145	99244	99384	G0141	
57800	77082	99201	99245	99385	H0034	
58100	77083	99202	99251	99386	J3490**	
58340	*	99203	99252	99393	P3000	
58345	88300	99204	99253	99394	P3001	
62311	88302	99205	99254	99395	Q0091	
62319	89310	99211	99255	99396	Q0111	
64435	89321	99212	99261	99401	Q0112	

CPT/HCPCS CODES THAT MAY OR MAY NOT REPRESENT CONTRACEPTION/STERILIZATION FAMILY PLANNING SERVICES						
72190	96372	99213	99262	99402	Q3014	
74000	99000	99214	99263	99403	S0610	
74010	99001	99215	99271	99404	S0612	
74740	99002	99221	99272	99411	S9445	
74742	99024	99222	99273	99412	S9446	
76830	99050	99223	99274	99420	T1001	
76831	99052	99231	99275	99429	T1002	
76856	99054	99232	99281	A4550	T1013	
76857	99056	99233	99282	A4931	T1015	

* Also included: 80047–88189 (except 82143)
** Used to indicate SubQ Depro Provera

Professional service claim lines were classified as family planning if the service contained a procedure code from Table 1 or Table 2, or a procedure code from Table 3 accompanied by a V25 (ICD-9) or Z30 (ICD-10) diagnosis code in either the primary or the secondary position.

2. Identification of Family Planning Prescription Drug Claims

In identifying eligible family planning claims from prescription drug data, Mercer identified all drug claims containing one of the HIC3 codes listed in Table 4. These codes have been determined by Mercer's pharmacy team to represent those drugs eligible for the enhanced federal match rate.

TABLE 4: DRUGS ELIGIBLE FOR THE ENHANCED FEDERAL MATCH RATE

HIC3	HIC3 DESCRIPTION
G8A	Contraceptives, oral
G8B	Contraceptives, implantable
G8C	Contraceptives, injectable
G8D	Abortifacient, progesterone receptor, antagonist type
G8F	Contraceptives, transdermal
G9A	Contraceptives, intravaginal
G9B	Contraceptives, intravaginal, systemic

HIC3	HIC3 DESCRIPTION
X1A	Condoms
X1B	Diaphragms/cervical cap
X1C	Intrauterine devices

Process of Developing Family Planning Portion of Rate

In order to determine what portion of the capitation payment was eligible for the enhanced federal match rate, Mercer totaled all of the family planning-eligible claims for a given rate cell and determined what percentage these claims represented of the total claims for that rate cell. This percentage was then applied to the claims cost per member per month (PMPM) (without administration, profit, and Full Medicaid Pricing {FMP} payment), at the rate cell level, to determine the family planning PMPM that LDH could claim at the enhanced federal match rate.

In a similar manner, Mercer determined what percentage of the FMP add-on was due to family planning services and eligible for the enhanced federal match rate. This percentage was then applied to the FMP PMPM add-on (without premium tax) at the rate cell level to determine the amount LDH could claim at the enhanced federal match rate.

The enhanced match on the claims cost PMPMs and the FMP PMPM were added together to generate the total family planning PMPM LDH could claim at the enhanced rate. Mercer then calculated a new percentage as the ratio of the total family planning PMPM (claims cost + FMP PMPMs) to the final loaded rate with FMP to provide the final family planning percent.

Note that the family planning component of the Healthy Louisiana Expansion rates was not calculated due to the fact that Expansion population is already at an enhanced FMAP rate greater than 90%.

Limitations and Considerations

In preparing these calculations, Mercer has used and relied upon enrollment, fee-for-service claims, encounter data, and other information supplied by LDH and its fiscal intermediary. LDH and its fiscal intermediary are responsible for the validity and completeness of the data supplied. We have reviewed that data and information for internal consistency and reasonableness but we did not audit it. In our opinion, it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in the attached exhibits may need to be revised accordingly. Use of this information for any purposes beyond that stated may not be appropriate.

If you have any questions on any of the information provided, please feel free to contact Erik Axelsen at +1 404 442 3517 or Kodzo Dekpe at +1 404 442 3296.

Attachment A: Family Planning Rate Summary

Region Description	Category of Aid Description	Rate Cell Description	Family Planning %
Gulf	SSI	0 - 2 Months	0.00%
Gulf	SSI	3 - 11 Months	0.00%
Gulf	SSI	Child 1 - 20	0.22%
Gulf	SSI	Adult 21+	0.10%
Gulf	Family & Children	0 - 2 Months	0.00%
Gulf	Family & Children	3 - 11 Months	0.00%
Gulf	Family & Children	Child 1 - 20	0.75%
Gulf	Family & Children	Adult 21+	3.07%
Gulf	Foster Care Children	FCC, All Ages	0.46%
Gulf	BCC	BCC, All Ages	0.08%
Gulf	LAP	LAP, All Ages	0.76%
Gulf	HCBS	Child 0 - 20	0.12%
Gulf	HCBS	Adult 21+	0.18%
Gulf	CCM	CCM, All Ages	0.08%
Gulf	SBH - CCM	SBH - Chisholm, All Ages Male & Female	0.00%
Gulf	SBH - Duals	SBH - Dual Eligible, All Ages	0.00%
Gulf	SBH - HCBS	SBH - 20 & Under, Male and Female	0.00%
Gulf	SBH - HCBS	SBH - 21+ Years, Male and Female	0.00%
Gulf	SBH - Other	SBH - Other, All Ages	0.00%
Gulf	Maternity Kick Payment	Maternity Kick Payment	0.32%
Gulf	EED Kick Payment	EED Kick Payment	0.60%
Capital	SSI	0 - 2 Months	0.00%
Capital	SSI	3 - 11 Months	0.00%
Capital	SSI	Child 1 - 20	0.19%
Capital	SSI	Adult 21+	0.09%
Capital	Family & Children	0 - 2 Months	0.00%
Capital	Family & Children	3 - 11 Months	0.00%
Capital	Family & Children	Child 1 - 20	0.74%
Capital	Family & Children	Adult 21+	2.58%
Capital	Foster Care Children	FCC, All Ages	0.46%
Capital	BCC	BCC, All Ages	0.08%
Capital	LAP	LAP, All Ages	0.76%
Capital	HCBS	Child 0 - 20	0.12%
Capital	HCBS	Adult 21+	0.18%
Capital	CCM	CCM, All Ages	0.08%
Capital	SBH - CCM	SBH - Chisholm, All Ages Male & Female	0.00%
Capital	SBH - Duals	SBH - Dual Eligible, All Ages	0.00%
Capital	SBH - HCBS	SBH - 20 & Under, Male and Female	0.00%
Capital	SBH - HCBS	SBH - 21+ Years, Male and Female	0.00%
Capital	SBH - Other	SBH - Other, All Ages	0.00%
Capital	Maternity Kick Payment	Maternity Kick Payment	0.25%
Capital	EED Kick Payment	EED Kick Payment	0.51%

Attachment A: Family Planning Rate Summary

Region Description	Category of Aid Description	Rate Cell Description	Family Planning %
South Central	SSI	0 - 2 Months	0.00%
South Central	SSI	3 - 11 Months	0.00%
South Central	SSI	Child 1 - 20	0.20%
South Central	SSI	Adult 21+	0.10%
South Central	Family & Children	0 - 2 Months	0.00%
South Central	Family & Children	3 - 11 Months	0.00%
South Central	Family & Children	Child 1 - 20	0.81%
South Central	Family & Children	Adult 21+	2.61%
South Central	Foster Care Children	FCC, All Ages	0.46%
South Central	BCC	BCC, All Ages	0.08%
South Central	LAP	LAP, All Ages	0.76%
South Central	HCBS	Child 0 - 20	0.12%
South Central	HCBS	Adult 21+	0.18%
South Central	CCM	CCM, All Ages	0.08%
South Central	SBH - CCM	SBH - Chisholm, All Ages Male & Female	0.00%
South Central	SBH - Duals	SBH - Dual Eligible, All Ages	0.00%
South Central	SBH - HCBS	SBH - 20 & Under, Male and Female	0.00%
South Central	SBH - HCBS	SBH - 21+ Years, Male and Female	0.00%
South Central	SBH - Other	SBH - Other, All Ages	0.00%
South Central	Maternity Kick Payment	Maternity Kick Payment	0.22%
South Central	EED Kick Payment	EED Kick Payment	0.52%
North	SSI	0 - 2 Months	0.00%
North	SSI	3 - 11 Months	0.00%
North	SSI	Child 1 - 20	0.25%
North	SSI	Adult 21+	0.13%
North	Family & Children	0 - 2 Months	0.00%
North	Family & Children	3 - 11 Months	0.00%
North	Family & Children	Child 1 - 20	0.84%
North	Family & Children	Adult 21+	2.90%
North	Foster Care Children	FCC, All Ages	0.46%
North	BCC	BCC, All Ages	0.08%
North	LAP	LAP, All Ages	0.76%
North	HCBS	Child 0 - 20	0.12%
North	HCBS	Adult 21+	0.18%
North	CCM	CCM, All Ages	0.08%
North	SBH - CCM	SBH - Chisholm, All Ages Male & Female	0.00%
North	SBH - Duals	SBH - Dual Eligible, All Ages	0.00%
North	SBH - HCBS	SBH - 20 & Under, Male and Female	0.00%
North	SBH - HCBS	SBH - 21+ Years, Male and Female	0.00%
North	SBH - Other	SBH - Other, All Ages	0.00%
North	Maternity Kick Payment	Maternity Kick Payment	0.31%
North	EED Kick Payment	EED Kick Payment	0.65%

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APPENDIX E

PREVENTIVE SERVICES ADDENDUM

The Louisiana Department of Health (LDH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for the State of Louisiana's Healthy Louisiana program for the period of February 1, 2018 through January 31, 2019. As part of this work, Mercer was asked to develop the preventive services component of the capitation rates using the same data that was used to develop the capitation rate ranges. Authorized by Section 4106 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-152), clinical preventive services recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF) and adult immunizations recommended by the Advisory Committee on Immunization Practices will receive a one percentage point increase in their Federal Medical Assistance Percentage (FMAP) for those services. This Appendix E presents an overview of the analyses and methodology used in Mercer's preventive services rate development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS), in order for LDH to receive the +1.0% federal match for eligible preventive services. This addendum should be read in conjunction with the rate certification letter.

BASE DATA

The capitation rates were developed using the medical expenses incurred during calendar year 2015 and 2016 with runout through June 2017, as reported through the Medicaid Management Information Systems (MMIS). All preventive services were assigned to the appropriate rate cells. Please see the rate certification letter for more details.

METHODOLOGY FOR IDENTIFYING PREVENTIVE SERVICES

Using data from the State's MMIS, a multi-step process was followed to measure the amount of preventive services for the calendar year, region, and rate tier. Each of these steps is described below:

1. **Grade A and B Preventive Services Identification**

   Preventive services can be identified through the list of recommended services by the USPSTF. Mercer and LDH cooperated in identifying corresponding criteria for each service listed by the USPSTF. Attachment A contains the list of these services and agreed upon criteria that were used to identify preventive services based on a procedure code, diagnosis code, age, and gender criteria match basis.

2. **Adult Immunization Preventive Services Identification**

   According to the USPSTF, immunizations for adults (ages 19 and above) and the administration of those immunizations are eligible for the additional 1.0% federal match. In identifying eligible preventive

services claims from the data, Mercer identified procedure codes related to immunizations listed by the USPSTF. Table 1 shows the procedure codes determined by Mercer's clinical team to identify those immunizations eligible for the enhanced federal match rate.

The administration costs of the immunizations are not directly linked to the procedure codes in Table 1. Therefore, the administration costs were estimated using the units administered, Louisiana's Medicaid Fee schedule, and the weighted average of the administration procedure codes utilized for people aged 19 and above. Administration procedure codes used include the following: 90471, 90472, 90473, and 90474.

TABLE 1: PROCEDURE CODES IDENTIFYING ELIGIBLE IMMUNIZATIONS

CPT/HCPCS CODES FOR ELIGIBLE IMMUNIZATIONS				
90645	90748	90661	90688	90718
90646	90649	90662	90707	90716
90647	90650	90663	90620	90736
90648	90651	90664	90621	
90632	90630	90666	90733	
90739	90653	90667	90734	
90740	90654	90668	90670	
90746	90656	90672	90732	
90747	90658	90673	90714	
90636	90660	90686	90715	

Process of Developing Preventive Services Portion of Rate

In order to determine what portion of the capitation payment was eligible for the enhanced federal match rate, Mercer totaled all of the preventive services-eligible claims for a given rate cell and determined what percentage these claims represented of the total claims for that rate cell. This percentage was then applied to the claims cost per member per month (PMPM) (without administration, profit, and Full Medicaid Pricing {FMP} payment), at the rate cell level, to determine the preventive services PMPM that LDH could claim at the enhanced federal match rate.

In a similar manner, Mercer determined what percentage of the FMP add-on was due to preventive services and eligible for the enhanced federal match rate. This percentage was then applied to the FMP PMPM add-on (without premium tax), at the rate cell level, to determine the amount LDH could claim at the enhanced federal match rate.

The enhanced match on the claims cost PMPMs and the FMP PMPM were added together to generate the total preventive services PMPM LDH could claim at the enhanced rate. Mercer then calculated a new percentage as the ratio of the total preventive services PMPM (claims cost + FMP PMPMs) to the final loaded rate with FMP to provide the final preventive services percent.

In line with the methodology for setting Expansion rates, the preventive services component of the final Expansion PMPM was based on the Family & Children Adult experience.

Attachment B within this addendum displays the percent of the capitation rates that are attributable to preventive services. These percentages should be applied directly to capitation rates to determine the preventive services amount. The resulting preventive services amount does not include load for premium tax, administration, or underwriting gain.

Limitations and Considerations

In preparing these calculations, Mercer has used and relied upon enrollment, fee-for-service claims, encounter data, and other information supplied by LDH and its fiscal intermediary. LDH and its fiscal intermediary are responsible for the validity and completeness of the data supplied. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. In our opinion, it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in the attached exhibits may need to be revised accordingly. Use of this information for any purposes beyond that stated may not be appropriate.

If you have any questions on any of the information provided, please feel free to contact Erik Axelsen at +1 404 442 3517 or Kodzo Dekpe at +1 404 442 3296.

Attachment A: Preventive Services Logic

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B	Age 65 years to 75 years	Male	76700 76705 76770 76775 G0389	Z87.891 F17.200 F17.201 F17.210 F17.211 F17.220 F17.221 F17.290 F17.291	V15.82 305.1	Include
Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B	18 years and older	Male and Female	99401 - 99404 99411 - 99412 99408 99409 G0442 G0443 G0396 G0397	Z71.41 Z71.42 Z71.51 Z71.52 Z71.6	V65.42	Include for procedure codes 99401-99404 and 99411-99412; Exclude for procedure codes 99408 - 99409 and G-codes
Anemia Screening: Pregnant Women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.	B	No restrictions	Female	85004 85007 85008 85009 85013 85014 85018 85025 85027 85032 85041 82728 G0306 G0307	Z34.00 - Z34.93 O09.**** O10.011 - O16.9 O20.0 - O29.93	V22.x - V23.9	Include
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	No restrictions	Female	81007 87077 87086 87181 87088	Z34.00 - Z34.93 O09.**** O10.011 - O16.9 O20.0 - O29.93	V22.x - V23.9	Include
High Blood Pressure Screening in Adults	The USPSTF recommends screening for high blood pressure in adults age 18 years and older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A	Age 18 years or older	Male and Female	99201 - 99205 99211-99215	Z13.6	V81.1 V81.2	Include
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with	B	No restrictions	Female	81211 81212 81213 81214 81215 81216 81217 81162 96040	Z80.3 Z80.41 Z15.01 Z15.02	V16.3 V16.41 V84.01 V84.02	Include

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
	positive screening results should receive genetic counseling and, if indicated after				G0452 S0265			

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Appendix E: Preventive Services Addendum

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B	Age 50 to 74	Female	77052 77055 77056 77057 77063 G0202			Exclude
Breastfeeding: Primary Care Intervention	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.	B	No restrictions	Female	99201-99215 S9443	Z39.1 O92.3 O91.011 - O91.23 O92.011 - O92.79 Q83.0 - Q83.9 P92.1 P92.2 P92.3 P92.4 P92.5 P92.8 P92.9 R63.3	V24.1 676.4 675.xx 676.xx 684 757.6 779.31 783.3	Include for procedure codes 99201-99215; Exclude for procedure code S9443
Cervical Cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years	A	21 to 65	Female	G0101 G0123 G0124 G0141 G0143 G0144 G0145 G0147 G0148 P3000 P3001 Q0091 87623 87624 87625 88141 88142 88143 88147 88148 88150 88152 88153 88154 88155 88164 88165 88166 88167 88174 88175			Exclude

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Appendix E: Preventive Services Addendum

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	No restrictions	Female	86631 86632 87081 87110 87205 87270 87320 87490 87491 87492 87810			Exclude
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders	A	35 years or older	Male	80061 82465 83718 83719 83721 84478			Exclude
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.	B	20-35 years	Male	80061 82465 83718 83719 83721 84478	Z13.6	V81.0 V81.1 V81.2	Include
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease	A	45 years and older	Female	80061 82465 83718 83719 83721 84478	Z13.6	V81.0 V81.1 V81.2	Include
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.	B	20 to 45 years	Female	80061 82465 83718 83719 83721 84478	Z13.6	V81.0 V81.1 V81.2	Include

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Appendix E: Preventive Services Addendum

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	**A**	Age 50 years to 75 years	Male or Female	G0104 G0105 G0106 G0120 G0121 G0122 G0328 44389 44390 44391 44392 44393 44394 44397 44401 44402 44393 44394 45330 45331 45333 45334 45338 45339 45346 45378 45380 45381 45382 45383 45384 45385 45386 45387 45388 45389 45391 45392 74263 82270 82274	Z12.12 Z12.11	V76.41 V76.51	Include for Barium Enema G-codes (G0106, G0120, G0122); Exclude for all other procedure codes
Dental Caries in Children from Birth Through Age 5 Years: Screening	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.	**B**	6 months to 5 years	Male or Female	D1206 99188			Exclude

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Appendix E: Preventive Services Addendum

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Depression Screening: Adult	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	Age 18 years or older	Male or Female	G0444 99201 - 99215 99420	Z13.89	V79.0	Include
Depression Screening: Adolescents	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	12 to 18 years	Male or Female	99201 - 99215 99420	Z23.89	V79.0	Include
Diabetes screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	B	Age 40 to 70 years	Male and Female	82947 82948 82950 82951 82952 83036	E66.01 - E66.9 Z68.25 - Z68.29 Z68.30 - Z68.39 Z68.41 - Z68.45 R73.01 - R73.9	278.00 - 278.03 V85.2x V85.3x V85.4x 790.21 - 790.29	Include
Falls Prevention in Older Adults: Counseling and Preventive Medication	The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls. No single recommended tool or brief approach can reliably identify older adults at increased risk for falls, but several reasonable and feasible approaches are available for primary care clinicians.	B	Age 65 years or older	Male or Female	97001 97002 97110 97112 97113 97116 97750 97530 97799 G0159 G8990 G9131	Z91.81	V15.88	Include
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.	B	No restrictions	Female	82950 82951 82952	Z34.00 - Z34.93 O09.**** O10.011 - O16.9 O20.0 - O29.93	V22.x - V23.9	Include
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	No restriction	Female	87590 87591 87592 87801 87850			Exclude

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Appendix E: Preventive Services Addendum

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.	B	Age 18 years and older	Male or Female	97802 97803 97804 99401-99404 99411 99412 G0270 G0271 S9470 G0446 G0447 G0473	E10.10 E10.11 E10.21 E10.311 E10.319 E10.36 E10.39 E10.40 E10.65 E10.69 E10.8 E11.00 E11.01 E11.21 E11.311 E11.319 E11.36 E11.39 E11.40 E11.51 E11.65 E11.69 E11.8 E13.10 E66.09 E66.1 E66.8 E66.9 E66.01 E78.4 E78.5 F17.200 F17.201 F17.210 F17.211 F17.220 F17.221 F17.290 F17.291 F43.0 F78.2 I10 Z82.49 Z82.41 Z82.49 Z71.3 Z13.6	250.xx (5th digit is 2&3) 272.2 272.4 278.00 278.01 305.1 308.0 - 308.3 401.0 V17.41 V17.49 V65.3 V81.2	Include
Hearing Loss Screening: Newborns	The USPSTF recommends screening for hearing loss in all newborn infants.	B	(Newborn) 0 to 59 days	Male or Female	92551 92552 92558 92567 92586 V5008			Exclude

Appendix E: Preventive Services Addendum

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Hepatitis B screening: non-pregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.	B	No restrictions	Male or Female	86704 86705 86706 87340 87341 87350 87515 87516 87517 G0499	F11.10 - F11.99 F13.10 - F13.99 F14.10 - F14.99 F15.10 - F15.99 R74.0 Z20.2 Z20.5 Z20.6 Z21 Z22.4 Z22.50 - Z22.59 Z51.11 Z72.51 - Z72.53 Z94.0 - Z94.9 Z99.2	292.0 - 292.2 292.81 292.84 292.85 292.89 292.9 304.00 - 304.03 304.10 - 304.13 304.20 - 304.23 304.40 - 304.43 305.40 - 305.43 305.50 - 305.53 305.60 - 305.63 307.70 - 305.73 790.4 V01.6 V01.79 V02.7 V02.8 V02.60 - V02.9 V06 V42.0 - V42.9 V45.11 V58.11 V69.2	Include
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A	No restrictions	Female	86704 86705 86706 87340 87341 87350 87380	Z34.00 - Z34.93 O09.**** O10.011 - O16.9 O20.0 - O29.93	V22.x - V23.9	Include
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	B	No restrictions	Male or Female	86803 86804 87520 87521 87522 G0472	B20 B97.35 D65 - D69.9 F11.10 - F11.99 F13.10 - F13.99 F14.10 - F14.99 F15.10 - F15.99 T80.61X* Z20.5 Z22.50 - Z22.59 Z94.0 - Z94.9 Z99.2	042 079.53 286.0 - 287.9 289.81 - 289.82 292.0 - 292.9 304.00 - 304.03 304.10 - 304.13 304.20 - 304.23 305.40 - 305.43 305.50 - 305.53 305.60 - 305.63 305.70 - 305.73 999.51 V01.79 V42.0 - V42.7 V45.11	Include

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
HIV screening: non-pregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	A	No restriction	Male or Female	86689 86701 86702 86703 87389 87390 87391 87534 87535 87536 87537 87538 87539 87806 G0432 G0433 G0435 G0475 S3645	B20 Z11.4 Z20.6 Z20.828 Z21 F11.10 - F11.99 F13.10 - F13.99 F14.10 - F14.99 F15.10 - F15.99 Z72.51 - Z72.53	042 V73.89 V01.79 V08 V69.2 292.0 - 292.9 304.00 - 304.03 304.10 - 304.13 304.20 - 304.23 305.40 - 305.43 305.50 - 305.53 305.60 - 305.63 305.70 - 305.73	Include
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown	A	No restriction	Female	86689 86701 86702 86703 87389 87390 87391 87534 87535 87536 87537 87538 87539 87806 G0432 G0433 G0435 G0475 S3645	Z34.00 - Z34.93 O09.****	V22.x - V23.9	Include
Hypothyroidism Screening: Newborns	Note: USPSTF defers to the HRSA Advisory Committee on Heritable Disorders in Newborns and Children, which recommends the uniform screening panel for core conditions.	A	(Newborn) 0 to 59 days	Male or Female	84436 84437 84439 84443			Exclude
Intimate Partner Violence Screening: Women of Childbearing Age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs for symptoms of abuse.	B	Childbearing Age: 12 to 55 years	Female	99201 - 99205 99211 - 99215	T74.91XA T76.91XA T74.11XA T76.11XA T74.31XA T76.31XA T74.21XA T76.21XA T74.01XA	995.80 995.81 995.82 995.83 995.84 995.85	Include

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
						T76.01XA T74.91XA T76.91XA		

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Appendix E: Preventive Services Addendum

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Latent Tuberculosis Infection: Screening	The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.	B	No restrictions	Male or Female	86480 86481 86580 87116 87555 87556	Z59.0 Z59.3 Z11.1 Z20.1	V60.0 V60.6 V74.1 V01.1	Include
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B	Age 55 to 80 years	Male or Female	S8032 G0296 G0297 71250 71260 71270 71275	F17.200 F17.201 F17.210 F17.211 F17.220 F17.221 F17.290 F17.291 Z87.891 Z12.2	305.1 V15.82 V76.0	Include
Obesity in Adults: Screening and Management	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m2 or higher to intensive, multicomponent, behavioral interventions.	B	Age 18 years or older	Male or Female	G0446 G0447 96150 96151 96152 96153 96154 96155 97802 97803 97804 99401 - 99404	Z13.89 E66.01 - E66.9 Z68.30 - Z68.39 Z68.41 - Z68.45	V77.8 278.00 - 278.03 V85.3x V85.4x	Include for all other procedure codes; Exclude for G-codes
Obesity Screening and Counseling: Children	The USPSTF recommends that clinicians screen children ages 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	B	Age 6 years to 17 years	Male or Female	99401 - 99404 96150 96151 96152 96153 96154 96155 97802 97803 97804	Z13.89 E66.01 - E66.9 Z68.54	V77.8 278.00 - 278.03 V85.54	Include
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	B	No restrictions	Female	76977 77078 77080 77081 77082 77085 77086 78350 78351 G0130			Exclude
Phenylketonuria Screening: Newborns	The USPSTF recommends screening for phenylketonuria in newborns.	B	(Newborn) 0 to 59 days	Male or Female	84030			Exclude
Rh incompatibility screening:	The USPSTF strongly recommends Rh (D)	A	No restrictions	Female	86900	Z34.00 - Z34.93	V22.x - V23.9	Include

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
first pregnancy visit	blood typing and antibody testing for all pregnant women during their first visit for				86901	O09.**** O10.011 - O16.9 O20.0 - O29.93		

Appendix E: Preventive Services Addendum

Topic	Description	Grade	Age Criteria	Gender Criteria	Procedure Code	ICD-10 Diagnosis Codes	ICD-9 Diagnosis Codes	Include/Exclude Diagnosis Code in Criteria
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B			Captured in above criteria	Captured in above criteria	Captured in above criteria	Captured in above criteria
Sexually Transmitted Infections Counseling	The USPSTF recommends high-intensity behavioral counseling to prevent sexually	B	No restrictions	Male or Female	99401 - 99404	Z11.89 Z72.89 Z11.3	V65.45 V69.8 V74.5	Include
Sickle Cell Disease (Hemoglobinopathies) in Newborns: Screening	Note: USPSTF defers to the HRSA Advisory Committee on Heritable Disorders in Newborns and Children, which recommends the uniform screening panel for core conditions.	A	(Newborn) 0 to 59 days	Male or Female	83020 83021 83030 83033 83051			Exclude
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A	No restrictions	Male or Female	86592 86593 87164 87166 87285	**Exclude:** Z34.00 - Z34.93 **Exclude:** O09.**** **Exclude:** O10.011 - O16.9 **Exclude:** O20.0 - O29.93	**Exclude** V22.x - V23.9	Include
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection	A	No restrictions	Female	86592 86593 87164 87166 87285	Z34.00 - Z34.93 O09.**** O10.011 - O16.9 O20.0 - O29.93	V22.x - V23.9	Include
Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco. The USPSTF recommends that clinicians ask	A	No restrictions	Male or Female	99078 99401-99404 99406 99407 96150 - 96155 G0436 G0437 S9453	Z87.891 F17.200 F17.201 F17.210 F17.211 F17.220 F17.221 F17.290 F17.291	V15.82 305.1	Include for procedure codes 99401-99404, 96150-96155 and 99078; Exclude for procedure codes 99406, 99407, S9453, G0436, and G0437
Tobacco Use Interventions: children and adolescents	The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged	B	Ages 5 to 17	Male or Female	Captured in above criteria	Captured in above criteria	Captured in above criteria	Captured in above criteria
Visual acuity screening in children	The USPSTF recommends vision screening for all children at least once between the ages	B	Age 3 years to 5 years	Male or Female	99172 99173 99174			Exclude

Attachment B: Preventive Services Rate Summary

Region Description	Category of Aid Description	Rate Cell Description	Preventive Services %
Gulf	SSI	0 - 2 Months	0.03%
Gulf	SSI	3 - 11 Months	0.00%
Gulf	SSI	Child 1 - 20	0.11%
Gulf	SSI	Adult 21+	0.60%
Gulf	Family & Children	0 - 2 Months	0.60%
Gulf	Family & Children	3 - 11 Months	0.05%
Gulf	Family & Children	Child 1 - 20	0.25%
Gulf	Family & Children	Adult 21+	1.31%
Gulf	Foster Care Children	FCC, All Ages	0.17%
Gulf	BCC	BCC, All Ages	0.96%
Gulf	LAP	LAP, All Ages	0.17%
Gulf	HCBS	Child 0 - 20	0.02%
Gulf	HCBS	Adult 21+	0.31%
Gulf	CCM	CCM, All Ages	0.02%
Gulf	SBH - CCM	SBH - Chisholm, All Ages Male & Female	0.00%
Gulf	SBH - Duals	SBH - Dual Eligible, All Ages	0.00%
Gulf	SBH - HCBS	SBH - 20 & Under, Male and Female	0.00%
Gulf	SBH - HCBS	SBH - 21+ Years, Male and Female	0.00%
Gulf	SBH - Other	SBH - Other, All Ages	0.00%
Gulf	Maternity Kick Payment	Maternity Kick Payment	1.07%
Gulf	EED Kick Payment	EED Kick Payment	2.01%
Gulf	Medicaid Expansion	Female Age 19 - Age 24	1.29%
Gulf	Medicaid Expansion	Male Age 19 - Age 24	1.27%
Gulf	Medicaid Expansion	Female Age 25 - Age 39	1.31%
Gulf	Medicaid Expansion	Male Age 25 - Age 39	1.31%
Gulf	Medicaid Expansion	Female Age 40 - Age 49	1.33%
Gulf	Medicaid Expansion	Male Age 40 - Age 49	1.33%
Gulf	Medicaid Expansion	Female Age 50 - Age 64	1.34%
Gulf	Medicaid Expansion	Male Age 50 - Age 64	1.34%
Gulf	Medicaid Expansion	SBH - Dual Eligible, All Ages	0.00%
Gulf	Medicaid Expansion	SBH - Other, All Ages	0.00%
Gulf	Medicaid Expansion	SBH - Chisholm, All Ages	0.00%
Gulf	Medicaid Expansion	High Needs	1.35%
Gulf	Medicaid Expansion	Maternity Kick Payment	1.07%
Gulf	Medicaid Expansion	EED Kick Payment	2.01%

Attachment B: Preventive Services Rate Summary

Region Description	Category of Aid Description	Rate Cell Description	Preventive Services %
Capital	SSI	0 - 2 Months	0.03%
Capital	SSI	3 - 11 Months	0.00%
Capital	SSI	Child 1 - 20	0.07%
Capital	SSI	Adult 21+	0.52%
Capital	Family & Children	0 - 2 Months	0.35%
Capital	Family & Children	3 - 11 Months	0.06%
Capital	Family & Children	Child 1 - 20	0.23%
Capital	Family & Children	Adult 21+	1.03%
Capital	Foster Care Children	FCC, All Ages	0.17%
Capital	BCC	BCC, All Ages	0.96%
Capital	LAP	LAP, All Ages	0.17%
Capital	HCBS	Child 0 - 20	0.02%
Capital	HCBS	Adult 21+	0.31%
Capital	CCM	CCM, All Ages	0.02%
Capital	SBH - CCM	SBH - Chisholm, All Ages Male & Female	0.00%
Capital	SBH - Duals	SBH - Dual Eligible, All Ages	0.00%
Capital	SBH - HCBS	SBH - 20 & Under, Male and Female	0.00%
Capital	SBH - HCBS	SBH - 21+ Years, Male and Female	0.00%
Capital	SBH - Other	SBH - Other, All Ages	0.00%
Capital	Maternity Kick Payment	Maternity Kick Payment	1.54%
Capital	EED Kick Payment	EED Kick Payment	3.14%
Capital	Medicaid Expansion	Female Age 19 - Age 24	1.01%
Capital	Medicaid Expansion	Male Age 19 - Age 24	0.99%
Capital	Medicaid Expansion	Female Age 25 - Age 39	1.03%
Capital	Medicaid Expansion	Male Age 25 - Age 39	1.03%
Capital	Medicaid Expansion	Female Age 40 - Age 49	1.04%
Capital	Medicaid Expansion	Male Age 40 - Age 49	1.04%
Capital	Medicaid Expansion	Female Age 50 - Age 64	1.05%
Capital	Medicaid Expansion	Male Age 50 - Age 64	1.05%
Capital	Medicaid Expansion	SBH - Dual Eligible, All Ages	0.00%
Capital	Medicaid Expansion	SBH - Other, All Ages	0.00%
Capital	Medicaid Expansion	SBH - Chisholm, All Ages	0.00%
Capital	Medicaid Expansion	High Needs	1.05%
Capital	Medicaid Expansion	Maternity Kick Payment	1.54%
Capital	Medicaid Expansion	EED Kick Payment	3.14%

Attachment B: Preventive Services Rate Summary

Region Description	Category of Aid Description	Rate Cell Description	Preventive Services %
South Central	SSI	0 - 2 Months	0.03%
South Central	SSI	3 - 11 Months	0.00%
South Central	SSI	Child 1 - 20	0.05%
South Central	SSI	Adult 21+	0.50%
South Central	Family & Children	0 - 2 Months	0.58%
South Central	Family & Children	3 - 11 Months	0.04%
South Central	Family & Children	Child 1 - 20	0.19%
South Central	Family & Children	Adult 21+	0.83%
South Central	Foster Care Children	FCC, All Ages	0.17%
South Central	BCC	BCC, All Ages	0.96%
South Central	LAP	LAP, All Ages	0.17%
South Central	HCBS	Child 0 - 20	0.02%
South Central	HCBS	Adult 21+	0.31%
South Central	CCM	CCM, All Ages	0.02%
South Central	SBH - CCM	SBH - Chisholm, All Ages Male & Female	0.00%
South Central	SBH - Duals	SBH - Dual Eligible, All Ages	0.00%
South Central	SBH - HCBS	SBH - 20 & Under, Male and Female	0.00%
South Central	SBH - HCBS	SBH - 21+ Years, Male and Female	0.00%
South Central	SBH - Other	SBH - Other, All Ages	0.00%
South Central	Maternity Kick Payment	Maternity Kick Payment	1.28%
South Central	EED Kick Payment	EED Kick Payment	2.99%
South Central	Medicaid Expansion	Female Age 19 - Age 24	0.81%
South Central	Medicaid Expansion	Male Age 19 - Age 24	0.80%
South Central	Medicaid Expansion	Female Age 25 - Age 39	0.83%
South Central	Medicaid Expansion	Male Age 25 - Age 39	0.83%
South Central	Medicaid Expansion	Female Age 40 - Age 49	0.84%
South Central	Medicaid Expansion	Male Age 40 - Age 49	0.84%
South Central	Medicaid Expansion	Female Age 50 - Age 64	0.84%
South Central	Medicaid Expansion	Male Age 50 - Age 64	0.84%
South Central	Medicaid Expansion	SBH - Dual Eligible, All Ages	0.00%
South Central	Medicaid Expansion	SBH - Other, All Ages	0.00%
South Central	Medicaid Expansion	SBH - Chisholm, All Ages	0.00%
South Central	Medicaid Expansion	High Needs	0.85%
South Central	Medicaid Expansion	Maternity Kick Payment	1.28%
South Central	Medicaid Expansion	EED Kick Payment	2.99%

Attachment B: Preventive Services Rate Summary

Region Description	Category of Aid Description	Rate Cell Description	Preventive Services %
North	SSI	0 - 2 Months	0.03%
North	SSI	3 - 11 Months	0.00%
North	SSI	Child 1 - 20	0.09%
North	SSI	Adult 21+	0.61%
North	Family & Children	0 - 2 Months	0.47%
North	Family & Children	3 - 11 Months	0.05%
North	Family & Children	Child 1 - 20	0.23%
North	Family & Children	Adult 21+	1.10%
North	Foster Care Children	FCC, All Ages	0.17%
North	BCC	BCC, All Ages	0.96%
North	LAP	LAP, All Ages	0.17%
North	HCBS	Child 0 - 20	0.02%
North	HCBS	Adult 21+	0.31%
North	CCM	CCM, All Ages	0.02%
North	SBH - CCM	SBH - Chisholm, All Ages Male & Female	0.00%
North	SBH - Duals	SBH - Dual Eligible, All Ages	0.00%
North	SBH - HCBS	SBH - 20 & Under, Male and Female	0.00%
North	SBH - HCBS	SBH - 21+ Years, Male and Female	0.00%
North	SBH - Other	SBH - Other, All Ages	0.00%
North	Maternity Kick Payment	Maternity Kick Payment	1.64%
North	EED Kick Payment	EED Kick Payment	3.42%
North	Medicaid Expansion	Female Age 19 - Age 24	1.07%
North	Medicaid Expansion	Male Age 19 - Age 24	1.06%
North	Medicaid Expansion	Female Age 25 - Age 39	1.10%
North	Medicaid Expansion	Male Age 25 - Age 39	1.10%
North	Medicaid Expansion	Female Age 40 - Age 49	1.11%
North	Medicaid Expansion	Male Age 40 - Age 49	1.11%
North	Medicaid Expansion	Female Age 50 - Age 64	1.12%
North	Medicaid Expansion	Male Age 50 - Age 64	1.12%
North	Medicaid Expansion	SBH - Dual Eligible, All Ages	0.00%
North	Medicaid Expansion	SBH - Other, All Ages	0.00%
North	Medicaid Expansion	SBH - Chisholm, All Ages	0.00%
North	Medicaid Expansion	High Needs	1.13%
North	Medicaid Expansion	Maternity Kick Payment	1.64%
North	Medicaid Expansion	EED Kick Payment	3.42%

Appendix F: Managed Care Savings Assumptions

Table 1: Managed Care Savings Assumptions

	HCBS Waiver/CCM						Historically VOO					
	Utilization		Unit Cost		PMPM		Utilization		Unit Cost		PMPM	
COS Description	Low	High	Low	High	Low	High	Low	High	Low	High	Low	High
IP Hospital	-12.5%	-10.0%	1.0%	5.0%	-11.6%	-5.5%	Varies by COA, please see Table 2					
OP Hospital	-10.0%	-7.5%	1.0%	3.0%	-9.1%	-4.7%	-20.0%	-15.0%	1.0%	3.0%	-19.2%	-12.5%
PCP	2.5%	5.0%	5.0%	7.0%	7.6%	12.4%	5.0%	10.0%	5.0%	7.0%	10.3%	17.7%
Specialty Care Physician	-12.5%	-10.0%	0.0%	2.0%	-12.5%	-8.2%	-25.0%	-20.0%	0.0%	2.0%	-25.0%	-18.4%
FQHC/Rural Health Clinic	0.0%	2.5%	0.0%	2.0%	0.0%	4.5%	0.0%	5.0%	0.0%	2.0%	0.0%	7.1%
EPSDT	0.0%	0.0%	5.0%	7.0%	5.0%	7.0%	5.0%	10.0%	5.0%	7.0%	10.3%	17.7%
CNP/CN	2.5%	5.0%	5.0%	7.0%	7.6%	12.4%	5.0%	10.0%	5.0%	7.0%	10.3%	17.7%
Lab/Radiology	-10.0%	-5.0%	0.0%	2.0%	-10.0%	-3.1%	-20.0%	-10.0%	0.0%	2.0%	-20.0%	-8.2%
Home Health	0.0%	0.0%	0.0%	2.0%	0.0%	2.0%	0.0%	5.0%	0.0%	2.0%	0.0%	7.1%
Emergency Transportation	-5.0%	-2.5%	0.0%	2.0%	-5.0%	-0.6%	-10.0%	-5.0%	0.0%	2.0%	-10.0%	-3.1%
NEMT[1]	0.0%	2.5%	0.0%	2.0%	0.0%	4.5%	0.0%	5.0%	0.0%	2.0%	0.0%	7.1%
Rehabilitation Services (OT, PT, ST)	-5.0%	-2.5%	0.0%	2.0%	-5.0%	-0.6%	-10.0%	-5.0%	0.0%	2.0%	-10.0%	-3.1%
Durable Medical Equipment (DME)[1]	-10.0%	-7.5%	0.0%	2.0%	-10.0%	-5.6%	-20.0%	-15.0%	0.0%	2.0%	-20.0%	-13.3%
Clinic	-10.0%	-7.5%	0.0%	2.0%	-10.0%	-5.6%	-20.0%	-15.0%	0.0%	2.0%	-20.0%	-13.3%
Family Planning	0.0%	2.5%	0.0%	2.0%	0.0%	4.5%	0.0%	5.0%	0.0%	2.0%	0.0%	7.1%
Other	0.0%	2.5%	0.0%	2.0%	0.0%	4.5%	0.0%	5.0%	0.0%	2.0%	0.0%	7.1%
Prescribed Drugs	-10.4%	-10.4%	0.0%	0.0%	-10.4%	-10.4%	Varies by COA, please see Table 3					
Emergency Room	-12.5%	-10.0%	5.0%	7.0%	-8.1%	-3.7%	-25.0%	-20.0%	5.0%	7.0%	-21.3%	-14.4%
Basic Behavioral Health	0.0%	0.0%	0.0%	2.0%	0.0%	2.0%	0.0%	5.0%	0.0%	2.0%	0.0%	7.1%
Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	Varies by COA, please see Table 4					
Personal Care Services[2]					-10.0%	-5.0%					-10.0%	-5.0%

Table 2: Inpatient Managed Care Savings Assumptions by COA

	Utilization		Unit Cost		PMPM	
1 - IP Hospital	Low	High	Low	High	Low	High
SSI/FCC/BCC/LaCHIP	-25.0%	-20.0%	1.0%	5.0%	-24.3%	-16.0%
Family and Children	-30.0%	-25.0%	1.0%	5.0%	-29.3%	-21.3%

Table 3: Prescribed Drugs Managed Care Savings Assumptions by COA

	Utilization		Unit Cost		PMPM	
2 - Prescribed Drugs	Low	High	Low	High	Low	High
SSI	-20.8%	-20.8%	-5.6%	-5.6%	-25.2%	-25.2%
Family and Children	-23.1%	-23.1%	-2.6%	-2.6%	-25.1%	-25.1%
Foster Care Children	-18.5%	-18.5%	-1.5%	-1.5%	-19.8%	-19.8%
Breast and Cervical Cancer	-12.4%	-12.4%	-8.7%	-8.7%	-20.1%	-20.1%
LaCHIP Affordable Plan	-20.8%	-20.8%	-5.6%	-5.6%	-25.2%	-25.2%

Table 4: Hospice Managed Care Savings Assumptions by COA

	Utilization		Unit Cost		PMPM	
3 - Hospice	Low	High	Low	High	Low	High
SSI/FCC/BCC/LaCHIP	-25.0%	-20.0%	1.0%	5.0%	-24.3%	-16.0%
Family and Children	-30.0%	-25.0%	1.0%	5.0%	-29.3%	-21.3%

Notes

1 – Managed care savings adjustments were applied to NEMT and DME services incurred by the Legacy Shared Savings program populations, as these services were not historically covered under the Shared Savings program.

2 – Managed care savings adjustments were applied to Personal Care Services incurred by the Legacy Shared Savings and Prepaid programs populations, as these services were not historically covered under the Shared Savings program.

Table 1: Historical Trend CY15 to CY16 -- PH Services

SSI/HCBS/BCC/CCM	PMPM Selections	
COS Group	Child	Adult
Inpatient	0.5%	-1.0%
Outpatient	3.5%	4.0%
Physician	4.0%	1.0%
Transportation	3.0%	1.0%
Other	-7.0%	-5.0%

F&C/FCC/LAP	PMPM Selections	
COS Group	Child	Adult
Inpatient	0.5%	-1.0%
Outpatient	4.2%	-7.5%
Physician	4.0%	1.0%
Transportation	1.0%	0.5%
Other	-12.0%	-12.0%

Rx Class	PMPM Selections	
COS Group	Child	Adult
BCC		29.0%
CCM	10.0%	
Family & Children	-3.9%	4.5%
Foster Care Children	-12.0%	
HCBS	-0.7%	-0.7%
LAP	-8.2%	
SSI	-0.2%	6.0%

Table 2: Historical Trend CY15 to CY16 -- SBH & NEMT Services

SSI/HCBS/BCC/CCM	PMPM Selections	
COS Group	Child	Adult
SBH Inpatient Class	-15.0%	0.0%
SBH Other Class	20.0%	5.0%

F&C/FCC/LAP	PMPM Selections	
COS Group	Child	Adult
SBH Inpatient Class	-15.0%	0.0%
SBH Other Class	30.0%	20.0%

SBH COAs	PMPM Selections	
COS Group	Child	Adult
SBH Inpatient Class	10.0%	10.0%
SBH Other Class	10.0%	10.0%

NEMT Services	PMPM Selections	
COS Group	Child	Adult
Dual	16.0%	
Non-Dual	-10.0%	

Table 3: Prospective Trend by Major COS

Rate Cell	Annualized RY18 Trends by Major COS							
	PH		Rx		SBH		All Services	
	Low	High	Low	High	Low	High	Low	High
Families & Children								
0-2 Months	0.7%	5.2%	-1.1%	3.4%	4.3%	8.8%	0.8%	5.3%
3-11 Months	2.1%	6.4%	1.0%	5.3%	6.4%	10.6%	2.0%	6.3%
Child	2.7%	7.0%	4.7%	8.9%	7.1%	11.3%	4.3%	8.6%
Adult	0.9%	4.7%	6.2%	9.9%	4.7%	8.4%	2.7%	6.5%
Families & Children Total	**1.9%**	**6.1%**	**5.0%**	**9.1%**	**6.8%**	**11.0%**	**3.4%**	**7.6%**
SSI								
0-2 Months	2.0%	6.5%	0.6%	5.1%	0.4%	4.9%	2.0%	6.5%
3-11 Months	2.4%	6.7%	1.8%	6.1%	2.6%	6.8%	2.4%	6.6%
Child	2.3%	6.3%	8.6%	12.6%	4.9%	8.9%	4.8%	8.8%
Adult	0.8%	4.8%	4.9%	8.9%	0.3%	4.3%	2.1%	6.1%
SSI Total	**1.2%**	**5.2%**	**5.5%**	**9.5%**	**2.4%**	**6.4%**	**2.7%**	**6.7%**
HCBS								
Child	3.1%	7.3%	5.4%	9.7%	4.9%	9.2%	3.7%	7.9%
Adult	0.1%	4.3%	4.4%	8.7%	-0.2%	4.1%	1.7%	6.0%
HCBS Total	**1.0%**	**5.3%**	**4.6%**	**8.8%**	**1.3%**	**5.5%**	**2.2%**	**6.5%**
Other Populations								
Foster Care Children	2.2%	6.5%	2.9%	7.1%	6.5%	10.7%	4.7%	8.9%
BCC	0.6%	4.1%	10.4%	13.9%	1.9%	5.4%	2.6%	6.1%
LAP	2.4%	6.4%	5.3%	9.3%	6.6%	10.6%	3.7%	7.7%
CCM	1.9%	5.9%	2.5%	6.5%	3.8%	7.8%	2.3%	6.3%

Table 3: Prospective Trend by Major COS

Rate Cell	Annualized RY18 Trends by Major COS							
	PH		Rx		SBH		All Services	
	Low	High	Low	High	Low	High	Low	High
SBH Only HCBS								
Child	3.5%	6.0%	0.0%	0.0%	3.5%	6.0%	3.5%	6.0%
Adult	3.5%	6.0%	0.0%	0.0%	3.9%	6.4%	3.8%	6.3%
SBH Only HCBS Total	**3.5%**	**6.0%**	**0.0%**	**0.0%**	**3.8%**	**6.3%**	**3.8%**	**6.3%**
SBH Only All Other								
SBH - CCM	2.5%	5.0%	0.0%	0.0%	2.5%	5.0%	2.5%	5.0%
SBH - Duals	3.5%	5.5%	0.0%	0.0%	6.3%	8.3%	5.2%	7.2%
SBH - Other	3.5%	6.0%	0.0%	0.0%	2.0%	4.5%	2.5%	5.0%
Maternity Kick Payment								
Maternity Kick Payment	-0.5%	2.5%	0.0%	0.0%	0.0%	0.0%	-0.5%	2.5%
Medicaid Expansion								
Male & Female Age 19 - 64	1.2%	3.2%	7.6%	9.6%	3.0%	5.0%	3.1%	5.1%
High Needs	0.2%	3.2%	6.6%	9.6%	2.0%	5.0%	2.1%	5.1%
SBH - Dual Eligible, All Ages	3.5%	5.5%	0.0%	0.0%	6.2%	8.2%	5.2%	7.2%
SBH - Other, All Ages	3.5%	6.0%	0.0%	0.0%	2.7%	5.2%	2.9%	5.4%
SBH - Chisholm, All Ages	2.5%	5.0%	0.0%	0.0%	2.5%	5.0%	2.5%	5.0%
Expansion Kick Payment	-0.5%	2.5%	0.0%	0.0%	0.0%	0.0%	-0.5%	2.5%

CBR Services		
Projected BCC Member Months		7,224
Projected Single Breast Mastectomies		359
Projected Recipients Receiving CBR Services		147
PMPM		
1. Tattooing	$	1.59
2. New Contralateral Services	$	21.86
3. Additional Surgical Costs	$	10.11
CBR Adjustment	**$**	**33.57**
Statewide BCC Rate	$	1,313.88
CBR Adjustment	$	33.57
BCC Rate after CBR Adjustment	$	1,347.44
Rating Adjustment		**2.55%**

COA Description	LaHIPP		Non-LaHIPP		Adjusted Data to Include LaHIPP		
	Projected MMs[1]	CY15 PMPM	Projected MMs[1]	CY15 PMPM	Projected MMs[1]	CY15 PMPM	% Adjustment
SBH -- Dual Eligible and LaHIPP	22,769	$ 9.02	1,181,401	$ 15.69	1,204,170	$ 15.56	-0.8%

1- Projected enrollment for February 2018- January 2019

Appendix J: PET Scans Adjustment

Table 1: PET Scan Procedure Codes and Fee Schedule

CPT/HCPCS CODE	DESCRIPTION	Technical Component	Physician Component	Total
78811	PET LIMITED AREA	910.40	364	1,275
78812	PET SKULL-MID THIGH	922.79	369	1,292
78813	PET WHOLE BODY	925.94	370	1,296
78814	PET/CT LIMITED AREA	933.54	373	1,307
78815	PET/CT SKULL-MID THIGH	941.97	377	1,319
78816	PET/CT WHOLE BODY	942.87	377	1,320
78608	PET BRAIN IMAGING	906.30	363	1,269
A9552	FLUORODEOXYGLUCOSE (Tracer for scan)	162.74	-	163
High-Cost code average		**939.46**	**376**	**1,315**
Total Average Cost (High-Cost Avg + Tracer cost)		**1,102.20**	**375.79**	**1477.99**

Notes:
1. Unit Cost prices are from LDH as of September 28, 2017.

Table 2: Estimated Cancer Patients

Calendar Year 2016		[A]1	[B]	[C] = [A]/([B]/(1,000*12))	[D]	[E] = [C]*[D]/(1,000*12)
COA	Rate Cell	Cancer Patient ID Count	MMs	Cancer Ptnt/1000 Enrollee	RY18 Projected MMs	RY18 Projected Cancer Patients
SSI	Newborn, 0-2 Months	6	1,542	46.69	963	4
SSI	Newborn, 3-11 Months	2	6,513	3.68	6,983	2
SSI	Child, 1 - 20 Years	232	450,579	6.18	456,675	235
SSI	Adult, 21+ Years	5,000	911,183	65.85	938,794	5,152
Family & Children	Newborn, 0-2 Months	14	169,472	0.99	113,728	9
Family & Children	Newborn, 3-11 Months	18	391,630	0.55	395,749	18
Family & Children	Child, 1 - 20 Years	509	8,082,941	0.76	7,939,771	500
Family & Children	Adult, 21+ Years	1,843	1,438,392	15.38	1,271,721	1,629
Foster Care Children	FLL	19	141,929	1.61	153,036	20
BCC	BLL	1,008	11,585	1,044.11	7,224	629
LAP	LLL	4	34,404	1.40	39,300	5
HCBS	H01	3	4,260	8.45	4,736	3
HCBS	H02	34	12,082	33.77	15,616	44
CCM	CCM	11	21,226	6.22	39,194	20
Total		**8,703**	**11,677,738**	**8.94**	**11,383,491**	**8,271**

MOS 201606 - 201612		[A] 1	[B]	[C] = [A]/([B]/(1,000*6))	[D]	[E] = [C]*[D]/(1,000*12)
COA	Rate Cell	Cancer Patient ID Count	MMs	Cancer Ptnt/1000 Enrollee	RY18 Projected MMs	RY18 Projected Cancer Patients
Medicaid Expansion	Female, Age 19 - Age 24	97	269,967	2.16	850,457	153
Medicaid Expansion	Female, Age 25 - Age 39	607	508,035	7.17	1,626,156	971
Medicaid Expansion	Female, Age 40 - Age 49	561	192,699	17.47	643,973	937
Medicaid Expansion	Female, Age 50 - Age 64	1393	227,692	36.71	793,766	2,428
Medicaid Expansion	Male, Age 19 - Age 24	39	142,431	1.64	453,317	62
Medicaid Expansion	Male, Age 25 - Age 39	143	223,914	3.83	718,269	229
Medicaid Expansion	Male, Age 40 - Age 49	226	107,496	12.61	362,496	381
Medicaid Expansion	Male, Age 50 - Age 64	826	150,755	32.87	537,539	1,473
Total		**3892**	**1,822,989**	**12.81**	**5,985,974**	**6,635**

Notes

1. Cancer patients were identified using diagnosis codes for cancers that commonly use PET scan imaging. The count is a unique count of eligibility IDs over the time period specified.

Table 3: Estimated Utilization and Final Costs

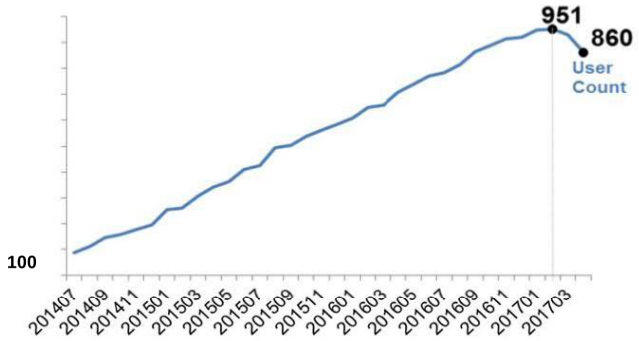
[A] 1	BCBS Experience-Based Util/1000	4.15
[B]	Total RY18 Projected MMs	18,796,589
[C] = [A]*([B]/(1,000*12))	Total PET Scan Units	6,500

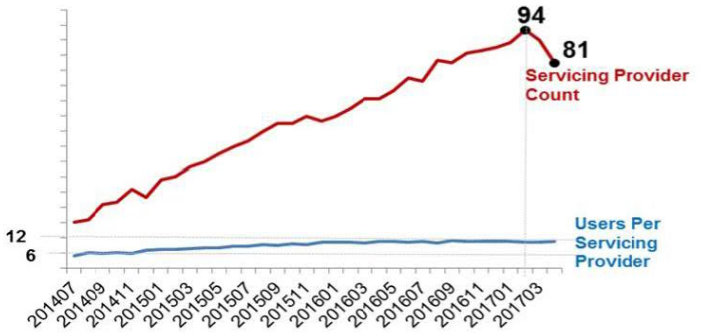
		[D]	[E]	[F]	[G] = [F]*[C]	[H]	[I] = [G]*[H]	[J] = [I]/[D]
COA	Rate Cell	RY18 Projected MMs	RY18 Est. Cancer Patient Count	Cancer Patient Count Dist.	Est. RY18 PET Scan Units	Unit Cost	PET Scan Cost	PET Scan PMPM
SSI	Newborn, 0-2 Months	963	4	0.0%	2	$ 1,477.99	$ 2,415	$ 2.51
SSI	Newborn, 3-11 Months	6,983	2	0.0%	1	$ 1,477.99	$ 1,382	$ 0.20
SSI	Child, 1 - 20 Years	456,675	235	1.6%	103	$ 1,477.99	$ 151,563	$ 0.33
SSI	Adult, 21+ Years	938,794	5,152	34.6%	2,247	$ 1,477.99	$ 3,320,488	$ 3.54
Family & Children	Newborn, 0-2 Months	113,728	9	0.1%	4	$ 1,477.99	$ 6,056	$ 0.05
Family & Children	Newborn, 3-11 Months	395,749	18	0.1%	8	$ 1,477.99	$ 11,724	$ 0.03
Family & Children	Child, 1 - 20 Years	7,939,771	500	3.4%	218	$ 1,477.99	$ 322,273	$ 0.04
Family & Children	Adult, 21+ Years	1,271,721	1,629	10.9%	711	$ 1,477.99	$ 1,050,286	$ 0.83
Foster Care Children	Foster Care, All Ages, Male & Female	153,036	20	0.1%	9	$ 1,477.99	$ 13,205	$ 0.09
BCC	BCC, All Ages, Female	7,224	629	4.2%	274	$ 1,477.99	$ 405,144	$ 56.08
LAP	LAP, Child, Male & Female	39,300	5	0.0%	2	$ 1,477.99	$ 2,945	$ 0.07
HCBS	Male & Female, Age 20 & Under	4,736	3	0.0%	1	$ 1,477.99	$ 2,150	$ 0.45
HCBS	Male & Female, Age 21+	15,616	44	0.3%	19	$ 1,477.99	$ 28,325	$ 1.81
CCM	Chisholm, All Ages, Male & Female	39,194	20	0.1%	9	$ 1,477.99	$ 13,092	$ 0.33
Medicaid Expansion	Female, Age 19 - Age 24	850,457	153	1.0%	67	$ 1,477.99	$ 98,481	$ 0.12
Medicaid Expansion	Female, Age 25 - Age 39	1,626,156	971	6.5%	424	$ 1,477.99	$ 626,173	$ 0.39
Medicaid Expansion	Female, Age 40 - Age 49	643,973	937	6.3%	409	$ 1,477.99	$ 604,211	$ 0.94
Medicaid Expansion	Female, Age 50 - Age 64	793,766	2,428	16.3%	1,059	$ 1,477.99	$ 1,565,069	$ 1.97
Medicaid Expansion	High Needs, All Ages, Male & Female	6,923	-	0.0%	-	$ 1,477.99	$ 24,487	$ 3.54
Medicaid Expansion	Male, Age 19 - Age 24	453,317	62	0.4%	27	$ 1,477.99	$ 40,004	$ 0.09
Medicaid Expansion	Male, Age 25 - Age 39	718,269	229	1.5%	100	$ 1,477.99	$ 147,836	$ 0.21
Medicaid Expansion	Male, Age 40 - Age 49	362,496	381	2.6%	166	$ 1,477.99	$ 245,616	$ 0.68
Medicaid Expansion	Male, Age 50 - Age 64	537,539	1,473	9.9%	642	$ 1,477.99	$ 949,196	$ 1.77
Total (Applicable COAs)		**17,376,388**	**14,906**	**100.0%**	**6,500**	**$ 1,481.75**	**$ 9,632,120**	**$ 0.55**
Total (All COAs)		**18,796,589**	**14,906**	**100.0%**	**6,500**	**$ 1,481.75**	**$ 9,632,120**	**$ 0.51**

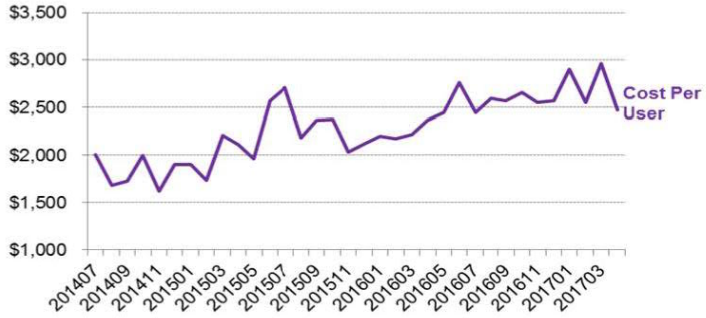
Notes:

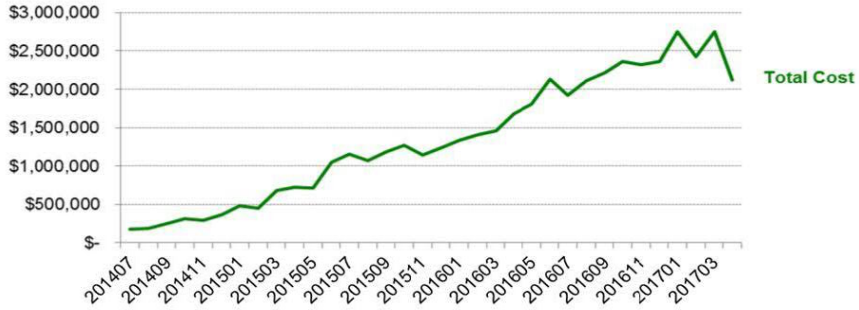
1. Util/1000 is based on BCBS in Louisiana experience for PET Scans.
2. Expansion High Needs is using SSI Adult PMPM adjustment.

Table 1: Statewide View





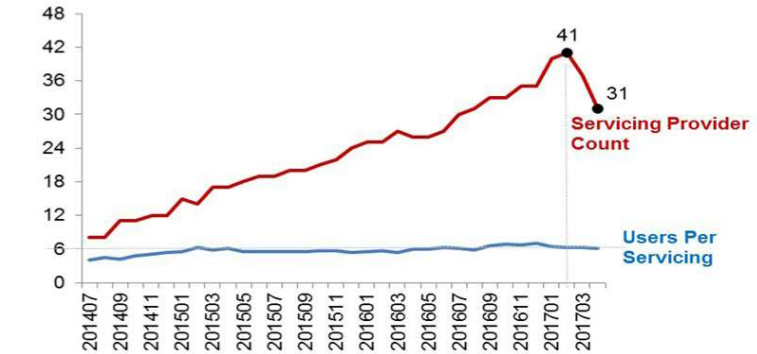


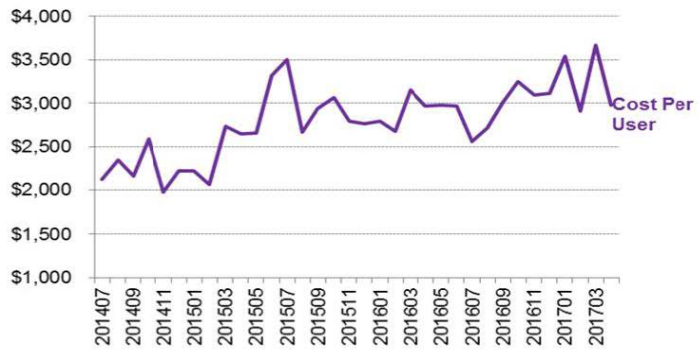


Fee-for-service Experience_May 2016 - April 2017			
Provider Count Per Month (Observed Maximum):	[A]		94
Average User Count Per Provider Per Month:	[B]		10
Average Cost Per User Per Month:	[C]	$	2,625.03
Average Cost Per Month:	[D]	$	2,270,434
Total Cost:	**[E]**	**$**	**27,245,207**

Table 2:

Gulf

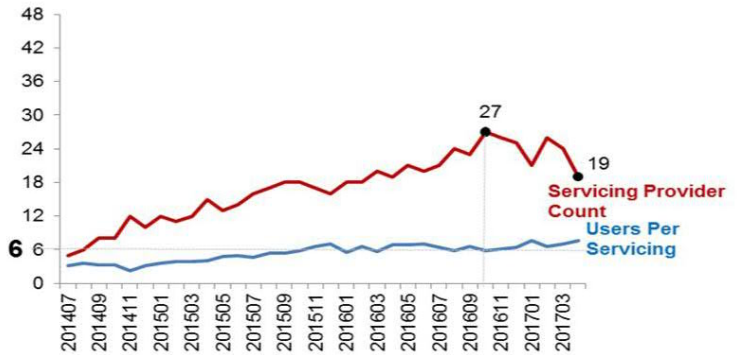


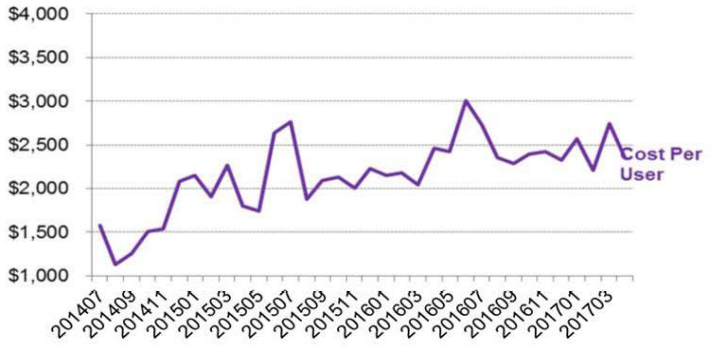


Fee-for-service Experience_May 2016 - April 2017		Gulf
Provider Count Per Month (Observed Maximun	[A]	41
Average User Count Per Provider Per Month:	[B]	6
Average Cost Per User Per Month:	[C]	$ 3,090.72

February 2018 - January 2019 Projection		Gulf
Provider Count Per Month (Assumed Average)	[D] = [A]	41
Assumed Average User Count Per Provider Pe	[E] = [B]	6
Assumed Average Cost Per User	[F] = [C]	$ 3,090.72
Total Projected Cost Per Month:	[G] = [D]*[E]*[F]	$ 760,318
Total Projected Cost for All Users (HLA & FFS)		**$ 9,123,819**

Capital



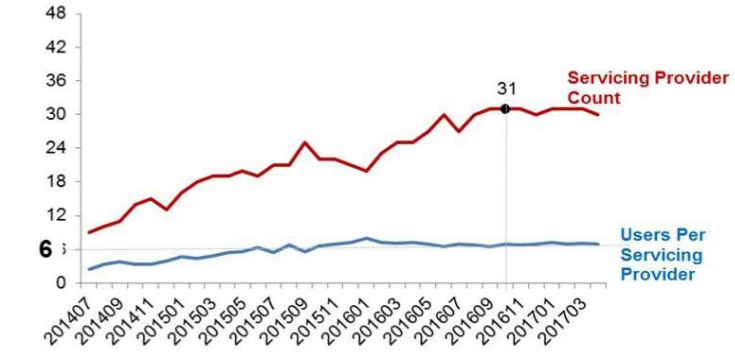


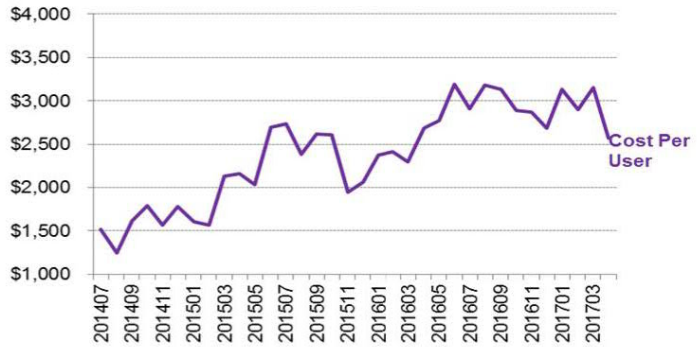
Fee-for-service Experience_May 2016 - April 2017		Capital
Provider Count Per Month (Observed Maximur	[A]	27
Average User Count Per Provider Per Month:	[B]	7
Average Cost Per User Per Month:	[C]	$ 2,478.26

February 2018 - January 2019 Projection		Capital
Provider Count Per Month (Assumed Average)	[D] = [A]	27
Assumed Average User Count Per Provider Pe	[E] = [B]	7
Assumed Average Cost Per User	[F] = [C]	$ 2,478.26
Total Projected Cost Per Month:	[G] = [D]*[E]*[F]	$ 468,390
Total Projected Cost for All Users (HLA & FFS)		**$ 5,620,685**

Table 2:

South Central

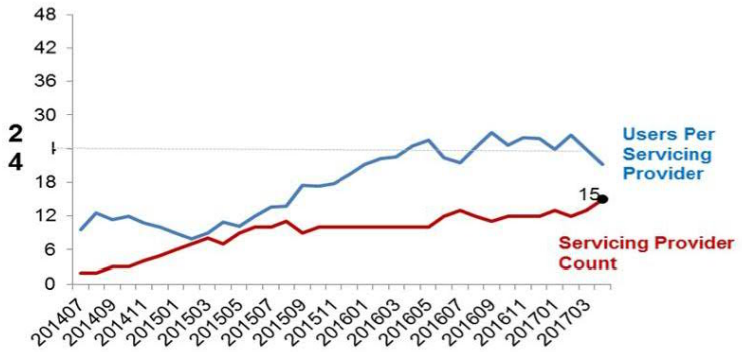


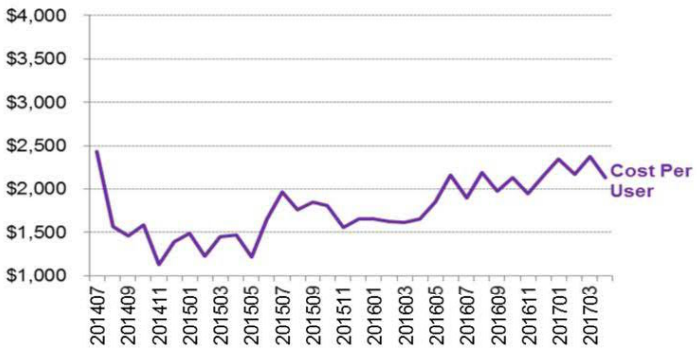


Fee-for-service Experience_May 2016 - April 2017		South Central
Provider Count Per Month (Observed Maximum):	[A]	31
Average User Count Per Provider Per Month:	[B]	7
Average Cost Per User Per Month:	[C]	$ 2,950.74

February 2018 - January 2019 Projection		South Central
Provider Count Per Month (Assumed Average):	[D]	46
Assumed Average User Count Per Provider Per Month:	[E] = [B]	7
Assumed Average Cost Per User	[F] = [C]	$ 2,950.74
Total Projected Cost Per Month:	[G] = [D]*[E]*[F]	$ 939,812
Total Projected Cost for All Users (HLA & FFS)		**$ 11,277,744**

North





Fee-for-service Experience_May 2016 - April 2017		North
Provider Count Per Month (Observed Maximun	[A]	15
Average User Count Per Provider Per Month:	[B]	24
Average Cost Per User Per Month:	[C]	$ 2,114.82

February 2018 - January 2019 Projection		North
Provider Count Per Month (Assumed Average)	[D]	18
Assumed Average User Count Per Provider Pe	[E] = [B]	24
Assumed Average Cost Per User	[F] = [C]	$ 2,114.82
Total Projected Cost Per Month:	[G] = [D]*[E]*[F]	$ 913,601
Total Projected Cost for All Users (HLA & FFS)		**$ 10,963,217**

Appendix K: Applied Behavioral Analysis (ABA) Adjustment

Table 3:

		[A]	[B]	[C]	[D]
May 2016 - April 2017 Total FFS Historical Paid Amount		**Gulf**	**Capital**	**South Central**	**North**
Eligibles to be covered in Healthy Louisiana	**[1] = [2] + … + [7]**	**$ 5,819,572**	**$ 3,225,203**	**$ 6,021,102**	**$ 6,621,524**
SSI_Child, 1 - 20 Years	[2]	$ 1,658,929	$ 1,246,436	$ 2,366,139	$ 2,677,268
Family & Children_Child, 1 - 20 Years	[3]	$ 2,208,967	$ 1,059,906	$ 2,207,538	$ 2,606,218
Foster Care Children	[4]	$ 125,007	$ 97,749	$ 289,000	$ 451,875
LaCHIP Affordable Plan, Child	[5]	$ 24,995	$ 5,345	$ 74,549	$ -
HCBS_Male & Female, Age 20 & Under (PH Program)	[6]	$ 1,940	$ 69,069	$ 16,722	$ 74,802
CCM_Chisholm, All Ages, Male & Female (PH Program)	[7]	$ 1,799,734	$ 746,697	$ 1,067,155	$ 811,362
All Other Eligibles to be covered in FFS	**[8]**	**$ 2,043,235**	**$ 1,322,398**	**$ 1,284,939**	**$ 907,156**
All Eligibles to be covered in HLA and FFS	**[9] = [1] + [8]**	**$ 7,862,807**	**$ 4,547,600**	**$ 7,306,042**	**$ 7,528,680**

February 2018 - January 2019 Projection		**Gulf**	**Capital**	**South Central**	**North**
All Eligibles to be covered in HLA and FFS					
Provider Count Per Month (Assumed Average):	[11]	41	27	46	18
Assumed Average User Count Per Provider Per Month:	[12]	6	7	7	24
Assumed Average Cost Per User	[13]	$ 3,090.72	$ 2,478.26	$ 2,950.74	$ 2,114.82
Total Projected Cost Per Month:	[14] = [11]*[12]*[13]	$ 760,318	$ 468,390	$ 939,812	$ 913,601
Total Projected Cost for All Users (HLA & FFS)	**[15] = 12*[14]**	**$ 9,123,819**	**$ 5,620,685**	**$ 11,277,744**	**$ 10,963,217**
Total Projected Cost for All Users (HLA & FFS) -- Statewide	**[16]**	**$ 36,985,464**			
Eligibles to be covered in Healthy Louisiana		**$ 6,752,896**	**$ 3,986,245**	**$ 9,294,287**	**$ 9,642,222**
SSI_Child, 1 - 20 Years	[17]	$ 1,924,983	$ 1,540,555	$ 3,652,417	$ 3,898,622
Family & Children_Child, 1 - 20 Years	[18]	$ 2,563,234	$ 1,310,010	$ 3,407,597	$ 3,795,158
Foster Care Children	[19]	$ 145,055	$ 120,815	$ 446,105	$ 658,017
LaCHIP Affordable Plan, Child	[20]	$ 29,004	$ 6,606	$ 115,074	$ -
HCBS_Male & Female, Age 20 & Under (PH Program)	[21]	$ 2,251	$ 85,367	$ 25,812	$ 108,925
CCM_Chisholm, All Ages, Male & Female (PH Program)	[22]	$ 2,088,370	$ 922,893	$ 1,647,281	$ 1,181,500

February 2018 - January 2019_Projected Claim Expense PMPM		**$ 2.82**	**$ 1.92**	**$ 3.98**	**$ 5.28**
SSI_Child, 1 - 20 Years	[23]	$ 14.50	$ 15.83	$ 34.47	$ 32.32
Family & Children_Child, 1 - 20 Years	[24]	$ 1.16	$ 0.68	$ 1.58	$ 2.29
Foster Care Children	[25]	$ 5.23	$ 2.98	$ 8.78	$ 19.39
LaCHIP Affordable Plan, Child	[26]	$ 3.26	$ 0.57	$ 10.66	$ -
HCBS_Male & Female, Age 20 & Under (PH Program)	[27]	$ 1.84	$ 72.10	$ 20.02	$ 104.81
CCM_Chisholm, All Ages, Male & Female (PH Program)	[28]	$ 184.23	$ 105.76	$ 144.90	$ 152.18

Table 1a: CY15 Base Expense

		Categories of Covered Services that Contain In-Lieu-of Services/Settings					
		Inpatient	Outpatient	Physician	Maternity Kick Payment	Other (PH Services)	Specialized Behavioral Health
In-lieu-of Services/Settings	Covered Services Provided in Skilled Nursing Facilities	$ 1,260,268	$ 217,718	$ 2,042	$ 40,236	$ 142,902	$ 212,283
	Crisis Stabilization Units for All Medicaid Eligible Adults						$ 313,943
	Inpatient Treatment Provided to Adults age 21 to 64 in an IMD for a short term stay of no more than 15 days						$ 15,517,256
	In-lieu-of Services/Settings Subtotal	$ 1,260,268	$ 217,718	$ 2,042	$ 40,236	$ 142,902	$ 16,043,482
	State Plan Services/Settings	$ 445,650,204	$ 442,454,809	$ 488,924,404	$ 192,951,653	$ 111,607,519	$ 392,440,618
	All Services/Settings	$ 446,910,473	$ 442,672,526	$ 488,926,445	$ 192,991,888	$ 111,750,421	$ 408,484,100

Table 1b: Percentage of Cost that In-lieu-of Services Represent in each Category of Service (CY15 Base Cost)

	[A]	[B]	[C] = [B]/[A]
Category of Service	COS Total	In-lieu-of Services Total	In-lieu-of Services Percentage
Inpatient	$ 446,910,473	$ 1,260,268	0.3%
Outpatient	$ 442,672,526	$ 217,718	0.0%
Physician	$ 488,926,445	$ 2,042	0.0%
Maternity Kick Payment	$ 192,991,888	$ 40,236	0.0%
Other (PH Services)	$ 111,750,421	$ 142,902	0.1%
Specialized Behavioral Health	$ 408,484,100	$ 16,043,482	3.9%

Table 2a: CY16 Base Expense

		Categories of Covered Services that Contain In-Lieu-of Services/Settings				
		Inpatient	Outpatient	Physician	Other (PH Services)	Specialized Behavioral Health
In-lieu-of Services/Settings	Physical Health Services Provided in Skilled Nursing Facilities	$ 1,654,209	$ 61,082	$ 14,366	$ 77,602	$ 2,831,762
	Crisis Stabilization Units for All Medicaid Eligible Adults					$ 160,795
	Inpatient Treatment Provided to Adults age 21 to 64 in an IMD for a short term stay of no more than 15 days					$ 16,538,851
	In-lieu-of Services/Settings Subtotal	$ 1,654,209	$ 61,082	$ 14,366	$ 77,602	$ 19,531,407
	State Plan Services/Settings	$ 428,974,256	$ 451,913,373	$ 499,078,973	$ 108,118,928	$ 461,047,275
	All Services	$ 430,628,466	$ 451,974,455	$ 499,093,339	$ 108,196,530	$ 480,578,683

Table 2b: Percentage of Cost that In-lieu-of Services Represent in each Category of Service (CY16 Base Cost)

	[A]	[B]	[C] = [B]/[A]
Category of Service	COS Total	In-lieu-of Services Total	In-lieu-of Services Percentage
Inpatient	$ 430,628,466	$ 1,654,209	0.4%
Outpatient	$ 451,974,455	$ 61,082	0.0%
Physician	$ 499,093,339	$ 14,366	0.0%
Transportation	$ 70,103,896	$ -	0.0%
Prescribed Drugs	$ 657,046,534	$ -	0.0%
Other (PH Services)	$ 108,196,530	$ 77,602	0.1%
Specialized Behavioral Health	$ 480,578,683	$ 19,531,407	4.1%

Table 1: Retroactive Eligibility Adjustment Factors Development

		CY16 Base Data from Data Book		CY16 Retroactive Experience		Adjustment Factors Development			
COA Description	Rate Cell Description	MMs	PMPM	MMs	PMPM	MMs	PMPMs	Observed Retro Adj. Factor	Final Retro Adj. Factor
SSI	Newborn, 0-2 Months	969	$ 16,412.30			969	$ 16,412.30	1.000	1.000
SSI	Newborn, 3-11 Months	7,086	$ 3,503.37			7,086	$ 3,503.37	1.000	1.000
SSI	Child, 1 - 20 Years	450,579	$ 537.32	2,238	$ 131.60	452,817	$ 535.31	0.996	1.000
SSI	Adult, 21+ Years	911,183	$ 909.00	16,455	$ 865.61	927,638	$ 908.23	0.999	1.000
Family & Children	Newborn, 0-2 Months	124,438	$ 1,694.01			124,438	$ 1,694.01	1.000	1.000
Family & Children	Newborn, 3-11 Months	436,664	$ 187.13			436,664	$ 187.13	1.000	1.000
Family & Children	Child, 1 - 20 Years	8,082,941	$ 121.64	77,098	$ 60.26	8,160,039	$ 121.06	0.995	1.000
Family & Children	Adult, 21+ Years	1,438,392	$ 245.71	52,645	$ 247.86	1,491,037	$ 245.79	1.000	1.000
Foster Care Children	Foster Care, All Ages, Male & Female	141,929	$ 332.17	628	$ 144.44	142,557	$ 331.34	0.998	1.000
BCC	BCC, All Ages, Female	11,585	$ 1,315.89	230	$ 2,541.49	11,815	$ 1,339.75	1.018	1.018
LAP	LAP, Child, Male & Female	34,404	$ 137.60	53	$ 76.90	34,457	$ 137.50	0.999	1.000
HCBS	Male & Female, Age 20 & Under	4,260	$ 1,304.80	-	$ -	4,260	$ 1,304.80	1.000	1.000
HCBS	Male & Female, Age 21+	12,082	$ 1,030.70	6	$ 47.47	12,088	$ 1,030.21	1.000	1.000
CCM	Chisholm, All Ages, Male & Female	21,226	$ 787.34	278	$ 61.86	21,504	$ 777.96	0.988	1.000
SBH - CCM	SBH - Chisholm, All Ages, Male & Female	52,260	$ 98.17	215	$ 1.49	52,475	$ 97.78	0.996	1.000
SBH - Duals	SBH - Dual Eligible, All Ages, Male & Fema	1,198,522	$ 18.49	13,024	$ 8.31	1,211,546	$ 18.38	0.994	1.000
SBH - HCBS	SBH - Male & Female, Age 20 & Under	22,981	$ 29.99	104	$ -	23,085	$ 29.85	0.995	1.000
SBH - HCBS	SBH - Male & Female, Age 21+	44,863	$ 40.94	60	$ 1.39	44,923	$ 40.88	0.999	1.000
SBH - Other	SBH - Other, All Ages, Male & Female	38,788	$ 110.43	1,220	$ 53.11	40,008	$ 108.68	0.984	1.000

Notes:

The retroactive eligibility adjustment does not apply to the newborn rate cells as retroactive experience is included in the base data for these rate cells.

E = A + C

F = ((A * B) + (C * D)) / E

G = F / B

H = MAX(G,1)

Appendix N: Physical Health Projected Claims PMPM Development

Table 1: PH Historical Rating Adjustments

					Historical Adjustments												Historical Adjustments					
Region Name	COA Description	Rate Cell Description	CY2015 MMs	CY2015 PMPM	Fee Adjustment	Act 399	Historical Trend	Managed Care Savings	KI Adj	CY2015 MMs After Adj	IMD Adj	Rx Rebates	Fraud and Abuse	CY2015 PMPM After Adj	CY2016 MMs	CY2016 PMPM	Fee Adjustment	KI Adj	CY2016 MMs After Adj	IMD Adj	Rx Rebates	CY2016 PMPM After Adj
Gulf	SSI	Newborn, 0-2 Months	287	$ 14,563.59	-0.46%	0.00%	0.86%	-1.01%	0.00%	287	0.00%	-0.01%	-0.07%	$ 14,462.63	260	$ 20,844.64	0.09%	0.00%	260	0.00%	0.00%	$ 20,863.00
Gulf	SSI	Newborn, 3-11 Months	2,212	$ 3,195.77	-2.99%	0.06%	1.15%	-0.03%	0.00%	2,212	0.00%	-0.35%	-0.06%	$ 3,123.62	1,847	$ 3,150.06	-3.28%	0.00%	1,847	0.00%	-0.49%	$ 3,031.84
Gulf	SSI	Child, 1-20 Years	138,448	$ 327.78	-3.36%	0.20%	1.27%	-0.97%	0.00%	138,448	0.00%	-1.24%	-0.07%	$ 314.16	129,329	$ 374.00	-4.91%	0.00%	129,329	0.00%	-1.20%	$ 351.35
Gulf	SSI	Adult, 21+ Years	277,184	$ 801.21	-0.08%	0.21%	2.56%	-0.50%	0.00%	277,184	-0.02%	-1.40%	-0.05%	$ 806.71	269,606	$ 853.29	0.04%	0.00%	269,606	-0.02%	-1.42%	$ 841.33
Gulf	Family and Children	Newborn, 0-2 Months	36,410	$ 1,569.52	-0.26%	0.00%	0.95%	-0.46%	0.00%	36,410	0.00%	-0.01%	-0.08%	$ 1,571.60	34,449	$ 1,624.33	0.03%	0.00%	34,449	0.00%	-0.01%	$ 1,624.65
Gulf	Family and Children	Newborn, 3-11 Months	123,187	$ 178.98	0.41%	0.06%	2.64%	-0.14%	0.00%	123,187	0.00%	-0.33%	-0.05%	$ 183.58	123,668	$ 182.55	0.14%	0.00%	123,668	0.00%	-0.36%	$ 182.15
Gulf	Family and Children	Child, 1-20 Years	2,215,811	$ 79.12	1.46%	0.16%	1.41%	-0.02%	0.00%	2,215,811	0.00%	-0.96%	-0.04%	$ 80.71	2,207,066	$ 85.20	1.44%	0.00%	2,207,066	0.00%	-0.97%	$ 85.59
Gulf	Family and Children	Adult, 21+ Years	448,937	$ 206.03	0.04%	0.16%	-0.70%	-0.15%	0.00%	448,937	0.00%	-1.07%	-0.04%	$ 202.44	437,017	$ 216.48	0.04%	0.00%	437,017	0.00%	-1.14%	$ 214.10
Gulf	Foster Care Children	Foster Care, All Ages Male & Female	25,112	$ 154.33	-0.91%	0.21%	-2.79%	-1.01%	0.00%	25,112	0.00%	-1.20%	-0.06%	$ 145.61	26,201	$ 151.91	-0.65%	0.00%	26,201	0.00%	-1.30%	$ 148.96
Gulf	Breast and Cervical Cancer	BCC, All Ages Female	4,293	$ 1,187.74	0.99%	0.07%	5.00%	-0.04%	0.00%	4,293	0.00%	-0.58%	-0.03%	$ 1,252.19	3,342	$ 1,413.05	0.52%	0.00%	3,342	0.00%	-0.55%	$ 1,412.60
Gulf	LaCHIP Affordable Plan	All Ages	9,208	$ 125.04	-4.08%	0.22%	-1.23%	-0.02%	0.00%	9,208	0.00%	-1.30%	-0.04%	$ 117.12	8,020	$ 130.77	-3.74%	0.00%	8,020	0.00%	-1.17%	$ 124.41
Gulf	HCBS Waiver	20 & Under, Male and Female	767	$ 1,119.48	-4.49%	0.13%	0.38%	0.00%	0.00%	767	0.00%	-0.82%	0.00%	$ 1,065.92	1,079	$ 1,076.91	-7.15%	0.00%	1,079	0.00%	-0.68%	$ 993.14
Gulf	HCBS Waiver	21+ Years, Male and Female	1,941	$ 1,069.98	0.14%	0.24%	-0.49%	0.00%	0.00%	1,941	0.00%	-1.49%	-0.03%	$ 1,052.46	3,299	$ 973.14	0.01%	0.00%	3,299	0.00%	-1.58%	$ 957.84
Gulf	Chisholm Class Members	Chisholm, All Ages Male & Female	2,480	$ 875.75	-4.77%	0.07%	2.42%	0.00%	0.00%	2,480	0.00%	-0.46%	-0.01%	$ 850.83	5,822	$ 584.14	-8.44%	0.00%	5,822	0.00%	-0.78%	$ 530.66
Gulf	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	15,323	$ 3.63	0.00%	0.00%	-10.00%	0.00%	0.00%	15,323	0.00%	0.00%	0.00%	$ 3.27	12,854	$ 2.84	0.00%	0.00%	12,854	0.00%	0.00%	$ 2.84
Gulf	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	317,628	$ 5.05	0.00%	0.00%	16.00%	0.00%	0.00%	317,628	-0.07%	0.00%	0.00%	$ 5.85	324,331	$ 4.97	0.00%	0.00%	324,331	0.00%	0.00%	$ 4.97
Gulf	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	6,583	$ 2.03	0.00%	0.00%	-10.00%	0.00%	0.00%	6,583	0.00%	0.00%	0.00%	$ 1.83	6,120	$ 1.96	0.00%	0.00%	6,120	0.00%	0.00%	$ 1.96
Gulf	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	12,324	$ 6.76	0.00%	0.00%	-10.00%	0.00%	0.00%	12,324	-2.21%	0.00%	0.00%	$ 5.95	11,838	$ 5.43	0.00%	0.00%	11,838	0.00%	0.00%	$ 5.43
Gulf	SBH -Other	SBH - Other, All Ages	7,409	$ 53.82	0.00%	0.00%	-10.00%	0.00%	0.00%	7,409	0.00%	0.00%	0.00%	$ 48.43	7,889	$ 31.17	0.00%	0.00%	7,889	-0.20%	0.00%	$ 31.11
Gulf	Maternity Kick payment	Maternity Kick payment, All Ages	10,546	$ 5,764.66	0.01%	0.00%	1.66%	0.01%	0.25%	10,520	0.00%	0.00%	-0.06%	$ 5,873.01	10,015	$ 7,219.43	0.04%	0.53%	9,962	0.00%	0.00%	$ 7,260.67
Capital	SSI	Newborn, 0-2 Months	331	$ 21,189.07	0.97%	0.00%	0.89%	-0.11%	0.00%	331	0.00%	0.00%	-0.05%	$ 21,549.11	234	$ 18,551.92	0.06%	0.00%	234	0.00%	0.00%	$ 18,561.61
Capital	SSI	Newborn, 3-11 Months	1,965	$ 3,143.17	-7.23%	0.11%	1.06%	-0.13%	0.00%	1,965	0.00%	-0.70%	-0.04%	$ 2,924.68	1,842	$ 4,542.95	-4.56%	0.00%	1,842	0.00%	-0.37%	$ 4,320.06
Capital	SSI	Child, 1-20 Years	104,014	$ 406.73	-9.83%	0.23%	1.33%	-0.86%	0.00%	104,014	0.00%	-1.42%	-0.06%	$ 363.85	98,139	$ 464.41	-7.79%	0.00%	98,139	0.00%	-1.38%	$ 422.30
Capital	SSI	Adult, 21+ Years	198,760	$ 866.79	0.30%	0.21%	3.27%	-0.39%	0.00%	198,760	-0.02%	-1.36%	-0.04%	$ 883.34	194,002	$ 918.99	0.03%	0.00%	194,002	-0.05%	-1.32%	$ 906.67
Capital	Family and Children	Newborn, 0-2 Months	31,347	$ 1,544.96	0.50%	0.00%	0.75%	-0.21%	0.00%	31,347	0.00%	-0.01%	-0.07%	$ 1,559.79	31,263	$ 1,670.85	0.02%	0.00%	31,263	0.00%	-0.01%	$ 1,670.89
Capital	Family and Children	Newborn, 3-11 Months	107,254	$ 173.91	0.20%	0.07%	1.51%	0.00%	0.00%	107,254	0.00%	-0.41%	-0.06%	$ 176.19	108,251	$ 184.54	0.47%	0.00%	108,251	0.00%	-0.30%	$ 184.87
Capital	Family and Children	Child, 1-20 Years	2,008,861	$ 88.88	1.90%	0.18%	0.12%	-0.01%	0.00%	2,008,861	0.00%	-1.07%	-0.04%	$ 89.83	1,987,440	$ 91.72	2.09%	0.00%	1,987,440	0.00%	-1.05%	$ 92.64
Capital	Family and Children	Adult, 21+ Years	347,656	$ 239.16	0.15%	0.17%	-2.76%	-0.17%	0.00%	347,656	0.00%	-1.15%	-0.04%	$ 230.14	345,519	$ 239.39	0.05%	0.00%	345,519	-0.01%	-1.11%	$ 236.82
Capital	Foster Care Children	Foster Care, All Ages Male & Female	35,630	$ 170.65	-0.05%	0.25%	-4.48%	-1.25%	0.00%	35,630	0.00%	-1.41%	-0.05%	$ 158.93	36,707	$ 163.26	0.00%	0.00%	36,707	0.00%	-1.41%	$ 160.95
Capital	Breast and Cervical Cancer	BCC, All Ages Female	4,253	$ 1,101.79	0.53%	0.07%	6.62%	-0.12%	0.00%	4,253	0.00%	-0.55%	-0.05%	$ 1,173.19	3,584	$ 1,124.47	0.15%	0.00%	3,584	0.00%	-0.60%	$ 1,119.42
Capital	LaCHIP Affordable Plan	All Ages	10,048	$ 117.63	0.00%	0.24%	-1.97%	-0.01%	0.00%	10,048	0.00%	-1.39%	-0.04%	$ 113.93	9,963	$ 146.41	0.00%	0.00%	9,963	0.00%	-1.23%	$ 144.61
Capital	HCBS Waiver	20 & Under, Male and Female	535	$ 1,212.27	-5.22%	0.14%	-0.04%	0.00%	0.00%	535	0.00%	-0.91%	-0.01%	$ 1,139.65	1,029	$ 2,037.20	-7.55%	0.00%	1,029	0.00%	-0.67%	$ 1,870.89
Capital	HCBS Waiver	21+ Years, Male and Female	1,539	$ 1,055.57	0.09%	0.20%	0.13%	0.00%	0.00%	1,539	0.00%	-1.28%	-0.01%	$ 1,046.29	2,605	$ 980.66	0.01%	0.00%	2,605	0.00%	-1.28%	$ 968.24
Capital	Chisholm Class Members	Chisholm, All Ages Male & Female	2,052	$ 1,584.61	-7.54%	0.05%	1.40%	0.00%	0.00%	2,052	0.00%	-0.34%	0.00%	$ 1,481.24	4,889	$ 692.48	-19.01%	0.00%	4,889	0.00%	-0.94%	$ 555.59
Capital	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	15,626	$ 4.69	0.00%	0.00%	-10.00%	0.00%	0.00%	15,626	0.00%	0.00%	0.00%	$ 4.22	13,385	$ 3.91	0.00%	0.00%	13,385	0.00%	0.00%	$ 3.91
Capital	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	252,330	$ 8.18	0.00%	0.00%	16.00%	0.00%	0.00%	252,330	0.03%	0.00%	-0.01%	$ 9.49	258,025	$ 7.55	0.00%	0.00%	258,025	0.00%	0.00%	$ 7.55
Capital	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	6,958	$ 5.10	0.00%	0.00%	-10.00%	0.00%	0.00%	6,958	0.00%	0.00%	0.00%	$ 4.59	6,736	$ 1.54	0.00%	0.00%	6,736	0.00%	0.00%	$ 1.54
Capital	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	11,341	$ 13.29	0.00%	0.00%	-10.00%	0.00%	0.00%	11,341	0.00%	0.00%	0.00%	$ 11.96	11,465	$ 9.00	0.00%	0.00%	11,465	0.00%	0.00%	$ 9.00
Capital	SBH -Other	SBH - Other, All Ages	8,164	$ 31.14	0.00%	0.00%	-10.00%	0.00%	0.00%	8,164	0.00%	0.00%	0.00%	$ 28.03	8,907	$ 28.67	0.00%	0.00%	8,907	-0.23%	0.00%	$ 28.60
Capital	Maternity Kick payment	Maternity Kick payment, All Ages	8,841	$ 5,311.43	0.08%	0.00%	1.66%	0.00%	-0.19%	8,858	0.00%	0.00%	-0.06%	$ 5,390.06	9,015	$ 5,989.26	0.00%	0.74%	8,948	0.00%	0.00%	$ 6,033.70

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Appendix N: Physical Health Projected Claims PMPM Development

Table 1: PH Historical Rating Adjustments

					Historical Adjustments												Historical Adjustments					
Region Name	COA Description	Rate Cell Description	CY2015 MMs	CY2015 PMPM	Fee Adjustment	Act 399	Historical Trend	Managed Care Savings	KI Adj	CY2015 MMs After Adj	IMD Adj	Rx Rebates	Fraud and Abuse	CY2015 PMPM After Adj	CY2016 MMs	CY2016 PMPM	Fee Adjustment	KI Adj	CY2016 MMs After Adj	IMD Adj	Rx Rebates	CY2016 PMPM After Adj
South Central	SSI	Newborn, 0-2 Months	237	$ 15,384.06	2.02%	0.00%	1.19%	0.00%	0.00%	237	0.00%	0.00%	-0.05%	$ 15,873.01	263	$ 12,599.35	0.06%	0.00%	263	0.00%	-0.01%	$ 12,606.60
South Central	SSI	Newborn, 3-11 Months	2,049	$ 2,890.76	-1.97%	0.07%	0.65%	-0.05%	0.00%	2,049	0.00%	-0.45%	-0.04%	$ 2,838.82	1,778	$ 3,526.66	-4.63%	0.00%	1,778	0.00%	-0.41%	$ 3,349.46
South Central	SSI	Child, 1-20 Years	108,419	$ 382.85	-5.13%	0.24%	0.11%	-1.56%	0.00%	108,419	0.00%	-1.47%	-0.08%	$ 353.21	104,561	$ 384.25	-5.83%	0.00%	104,561	0.00%	-1.59%	$ 356.11
South Central	SSI	Adult, 21+ Years	241,043	$ 733.06	0.55%	0.20%	3.32%	-0.22%	0.00%	241,043	-0.02%	-1.28%	-0.04%	$ 751.15	236,714	$ 793.99	0.09%	0.00%	236,714	-0.03%	-1.28%	$ 784.29
South Central	Family and Children	Newborn, 0-2 Months	34,380	$ 1,748.88	1.21%	0.00%	0.90%	-0.19%	0.00%	34,380	0.00%	-0.01%	-0.07%	$ 1,781.23	33,923	$ 1,869.54	0.11%	0.00%	33,923	0.00%	-0.01%	$ 1,871.28
South Central	Family and Children	Newborn, 3-11 Months	118,176	$ 158.61	0.14%	0.06%	2.13%	0.00%	0.00%	118,176	0.00%	-0.38%	-0.05%	$ 161.63	118,134	$ 197.98	-0.14%	0.00%	118,134	0.00%	-0.33%	$ 197.05
South Central	Family and Children	Child, 1-20 Years	2,178,706	$ 92.75	1.23%	0.20%	0.43%	-0.03%	0.00%	2,178,706	0.00%	-1.20%	-0.03%	$ 93.29	2,194,353	$ 96.62	1.26%	0.00%	2,194,353	0.00%	-1.20%	$ 96.66
South Central	Family and Children	Adult, 21+ Years	359,295	$ 216.53	0.24%	0.16%	-1.51%	-0.10%	0.00%	359,295	-0.01%	-1.06%	-0.03%	$ 211.53	369,565	$ 214.60	0.05%	0.00%	369,565	-0.01%	-1.02%	$ 212.48
South Central	Foster Care Children	Foster Care, All Ages Male & Female	47,534	$ 150.65	-0.74%	0.24%	-3.87%	-1.24%	0.00%	47,534	0.00%	-1.40%	-0.06%	$ 140.25	48,322	$ 153.62	0.16%	0.00%	48,322	0.00%	-1.44%	$ 151.64
South Central	Breast and Cervical Cancer	BCC, All Ages Female	2,812	$ 1,212.82	0.65%	0.11%	8.73%	-0.22%	0.00%	2,812	0.00%	-0.80%	-0.04%	$ 1,314.62	2,199	$ 1,338.69	0.10%	0.00%	2,199	0.00%	-0.84%	$ 1,328.86
South Central	LaCHIP Affordable Plan	All Ages	10,749	$ 107.72	0.00%	0.22%	-1.55%	-0.05%	0.00%	10,749	0.00%	-1.32%	-0.04%	$ 104.80	10,593	$ 110.77	0.00%	0.00%	10,593	0.00%	-1.39%	$ 109.23
South Central	HCBS Waiver	20 & Under, Male and Female	633	$ 954.31	-5.30%	0.11%	-0.26%	0.00%	0.00%	633	0.00%	-0.68%	-0.02%	$ 896.09	1,136	$ 934.27	-8.58%	0.00%	1,136	0.00%	-0.83%	$ 847.08
South Central	HCBS Waiver	21+ Years, Male and Female	1,981	$ 820.41	0.64%	0.21%	0.13%	0.00%	0.00%	1,981	0.00%	-1.29%	-0.02%	$ 817.63	3,325	$ 810.20	0.06%	0.00%	3,325	0.00%	-1.85%	$ 795.67
South Central	Chisholm Class Members	Chisholm, All Ages Male & Female	2,782	$ 885.11	-11.29%	0.08%	2.16%	0.00%	0.00%	2,782	0.00%	-0.58%	-0.03%	$ 797.93	6,295	$ 737.56	-16.57%	0.00%	6,295	0.00%	-0.84%	$ 610.23
South Central	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	16,503	$ 7.92	0.00%	0.00%	-10.00%	0.00%	0.00%	16,503	0.00%	0.00%	0.00%	$ 7.13	13,655	$ 4.55	0.00%	0.00%	13,655	0.00%	0.00%	$ 4.55
South Central	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	340,071	$ 7.68	0.00%	0.00%	16.00%	0.00%	0.00%	340,071	0.02%	0.00%	0.00%	$ 8.90	342,354	$ 7.38	0.00%	0.00%	342,354	0.01%	0.00%	$ 7.39
South Central	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	6,367	$ 6.55	0.00%	0.00%	-10.00%	0.00%	0.00%	6,367	0.00%	0.00%	0.00%	$ 5.90	6,205	$ 6.01	0.00%	0.00%	6,205	0.00%	0.00%	$ 6.01
South Central	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	12,554	$ 16.83	0.00%	0.00%	-10.00%	0.00%	0.00%	12,554	-0.54%	0.00%	0.00%	$ 15.07	12,146	$ 12.87	0.00%	0.00%	12,146	0.00%	0.00%	$ 12.87
South Central	SBH -Other	SBH - Other, All Ages	10,240	$ 65.77	0.00%	0.00%	-10.00%	0.00%	0.00%	10,240	0.00%	0.00%	0.00%	$ 59.20	11,406	$ 40.14	0.00%	0.00%	11,406	-0.01%	0.00%	$ 40.13
South Central	Maternity Kick payment	Maternity Kick payment, All Ages	9,783	$ 5,214.93	6.24%	0.00%	1.66%	0.00%	-0.27%	9,809	0.00%	0.00%	-0.06%	$ 5,614.23	9,769	$ 5,850.32	0.23%	0.40%	9,729	0.00%	0.00%	$ 5,887.57
North	SSI	Newborn, 0-2 Months	209	$ 11,138.85	0.89%	0.00%	1.25%	-0.51%	0.00%	209	0.00%	-0.01%	-0.05%	$ 11,314.45	212	$ 13,292.12	0.25%	0.00%	212	0.00%	0.00%	$ 13,325.56
North	SSI	Newborn, 3-11 Months	1,666	$ 3,177.19	-4.06%	0.08%	0.70%	-0.39%	0.00%	1,666	0.00%	-0.50%	-0.04%	$ 3,043.53	1,619	$ 2,674.20	-9.14%	0.00%	1,619	0.00%	-0.37%	$ 2,420.81
North	SSI	Child, 1-20 Years	121,133	$ 340.02	-10.34%	0.19%	0.65%	-0.82%	0.00%	121,133	0.00%	-1.18%	-0.08%	$ 301.05	118,550	$ 343.30	-9.47%	0.00%	118,550	0.00%	-1.13%	$ 307.28
North	SSI	Adult, 21+ Years	213,449	$ 677.90	0.28%	0.18%	1.91%	-0.51%	0.00%	213,449	-0.01%	-1.19%	-0.06%	$ 681.85	210,861	$ 746.48	0.11%	0.00%	210,861	0.00%	-1.20%	$ 738.28
North	Family and Children	Newborn, 0-2 Months	25,745	$ 1,440.41	0.45%	0.00%	0.93%	-0.33%	0.00%	25,745	0.00%	-0.01%	-0.05%	$ 1,454.60	24,803	$ 1,541.63	0.19%	0.00%	24,803	0.00%	-0.01%	$ 1,544.43
North	Family and Children	Newborn, 3-11 Months	88,460	$ 170.23	0.54%	0.06%	1.12%	-0.01%	0.00%	88,460	0.00%	-0.37%	-0.05%	$ 172.46	86,611	$ 173.72	0.77%	0.00%	86,611	0.00%	-0.33%	$ 174.48
North	Family and Children	Child, 1-20 Years	1,705,064	$ 81.52	2.91%	0.14%	-0.16%	-0.01%	0.00%	1,705,064	0.00%	-0.88%	-0.04%	$ 83.09	1,694,082	$ 83.10	3.31%	0.00%	1,694,082	0.00%	-0.90%	$ 85.09
North	Family and Children	Adult, 21+ Years	288,507	$ 200.35	0.11%	0.14%	-2.30%	-0.13%	0.00%	288,507	0.00%	-0.93%	-0.04%	$ 194.07	286,291	$ 205.70	0.05%	0.00%	286,291	0.00%	-0.94%	$ 203.85
North	Foster Care Children	Foster Care, All Ages Male & Female	27,510	$ 174.28	-4.31%	0.20%	-3.97%	-0.74%	0.00%	27,510	0.00%	-1.16%	-0.05%	$ 157.35	30,699	$ 169.94	-2.33%	0.00%	30,699	0.00%	-1.20%	$ 163.99
North	Breast and Cervical Cancer	BCC, All Ages Female	2,788	$ 1,466.25	0.29%	0.13%	6.73%	-0.48%	0.00%	2,788	0.00%	-0.96%	-0.06%	$ 1,548.02	2,460	$ 1,374.02	0.26%	0.00%	2,460	0.00%	-1.00%	$ 1,363.77
North	LaCHIP Affordable Plan	All Ages	5,570	$ 137.56	0.07%	0.14%	-3.00%	-0.01%	0.00%	5,570	0.00%	-0.86%	-0.04%	$ 132.51	5,828	$ 104.64	0.00%	0.00%	5,828	0.00%	-0.95%	$ 103.65
North	HCBS Waiver	20 & Under, Male and Female	606	$ 1,055.06	-10.20%	0.10%	-1.03%	0.00%	0.00%	606	0.00%	-0.61%	-0.04%	$ 932.48	1,016	$ 962.34	-6.90%	0.00%	1,016	0.00%	-0.73%	$ 889.36
North	HCBS Waiver	21+ Years, Male and Female	1,835	$ 1,205.39	0.15%	0.23%	-0.59%	0.00%	0.00%	1,835	0.00%	-1.45%	-0.03%	$ 1,185.07	2,853	$ 1,097.42	0.13%	0.00%	2,853	0.00%	-1.54%	$ 1,081.89
North	Chisholm Class Members	Chisholm, All Ages Male & Female	1,695	$ 689.76	-38.55%	0.16%	3.70%	0.00%	0.00%	1,695	0.00%	-1.04%	0.00%	$ 435.61	4,220	$ 694.19	-29.77%	0.00%	4,220	0.00%	-0.72%	$ 484.00
North	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	14,847	$ 3.42	0.00%	0.00%	-10.00%	0.00%	0.00%	14,847	0.00%	0.00%	0.00%	$ 3.08	12,366	$ 4.38	0.00%	0.00%	12,366	0.00%	0.00%	$ 4.38
North	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	271,372	$ 8.80	0.00%	0.00%	16.00%	0.00%	0.00%	271,372	0.01%	0.00%	-0.01%	$ 10.21	273,812	$ 7.55	0.00%	0.00%	273,812	0.01%	0.00%	$ 7.55
North	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	4,115	$ 9.96	0.00%	0.00%	-10.00%	0.00%	0.00%	4,115	0.00%	0.00%	0.00%	$ 8.97	3,920	$ 4.41	0.00%	0.00%	3,920	0.00%	0.00%	$ 4.41
North	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	9,767	$ 14.45	0.00%	0.00%	-10.00%	0.00%	0.00%	9,767	0.00%	0.00%	0.00%	$ 13.00	9,414	$ 5.17	0.00%	0.00%	9,414	0.00%	0.00%	$ 5.17
North	SBH -Other	SBH - Other, All Ages	9,584	$ 49.75	0.00%	0.00%	-10.00%	0.00%	0.00%	9,584	0.01%	0.00%	0.00%	$ 44.78	10,586	$ 21.61	0.00%	0.00%	10,586	-0.12%	0.00%	$ 21.58
North	Maternity Kick payment	Maternity Kick payment, All Ages	7,491	$ 5,370.72	1.82%	0.00%	1.66%	0.01%	-0.24%	7,509	0.00%	0.00%	-0.05%	$ 5,544.01	7,275	$ 6,062.36	0.30%	0.03%	7,273	-0.01%	0.00%	$ 6,081.79

Appendix N: Physical Health Projected Claims PMPM Development

Table 2: PH Prospective Rating Adjustments

					Prospective Adjustments												
Region Name	COA Description	Rate Cell Description	Projected Membership	Blended*** CY2015/CY2016 PMPM	CBR	LaHIPP	PET Scans	Retro Adjustment	Fee Adj	Low Trend	High Trend	Clinical/Rx Efficiencies	Outliers	ABA	Credibility	Low Projected PMPM	High Projected PMPM
Gulf	SSI	Newborn, 0-2 Months	288	$ 18,302.85	0.00%	0.00%	0.01%	0.00%	6.18%	4.25%	14.06%	$ (133.56)	$ 2,345.01	$ -	0%	$ 20,485.34	$ 22,204.25
Gulf	SSI	Newborn, 3-11 Months	2,085	$ 3,068.56	0.00%	0.00%	0.01%	0.00%	5.17%	5.05%	14.34%	$ (21.43)	$ 97.45	$ -	0%	$ 3,608.84	$ 3,921.26
Gulf	SSI	Child, 1-20 Years	132,759	$ 336.47	0.00%	0.00%	0.10%	0.00%	3.68%	9.51%	18.42%	$ (1.45)	$ -	$ 14.50	100%	$ 395.45	$ 426.57
Gulf	SSI	Adult, 21+ Years	278,885	$ 827.48	0.00%	0.00%	0.43%	0.00%	3.62%	5.13%	13.86%	$ (3.65)	$ -	$ -	100%	$ 901.66	$ 976.85
Gulf	Family and Children	Newborn, 0-2 Months	33,958	$ 1,603.43	0.00%	0.00%	0.00%	0.00%	5.55%	1.53%	11.21%	$ (79.17)	$ 60.58	$ -	100%	$ 1,699.80	$ 1,863.60
Gulf	Family and Children	Newborn, 3-11 Months	118,165	$ 182.72	0.00%	0.00%	0.02%	0.00%	5.34%	4.02%	13.26%	$ (3.37)	$ 0.32	$ -	100%	$ 197.20	$ 214.99
Gulf	Family and Children	Child, 1-20 Years	2,211,981	$ 83.64	0.00%	0.00%	0.05%	0.00%	4.72%	6.69%	16.05%	$ (1.38)	$ 0.01	$ 1.16	100%	$ 93.26	$ 101.47
Gulf	Family and Children	Adult, 21+ Years	381,028	$ 209.44	0.00%	0.00%	0.39%	0.00%	5.70%	5.32%	13.51%	$ (4.28)	$ -	$ -	100%	$ 229.80	$ 247.99
Gulf	Foster Care Children	Foster Care, All Ages Male & Female	27,754	$ 147.62	0.00%	0.00%	0.06%	0.00%	4.55%	5.06%	14.35%	$ (2.74)	$ -	$ 5.23	0%	$ 173.55	$ 188.33
Gulf	Breast and Cervical Cancer	BCC, All Ages Female	1,842	$ 1,348.43	2.55%	0.00%	4.06%	1.80%	4.35%	4.43%	12.02%	$ (18.15)	$ -	$ -	0%	$ 1,519.49	$ 1,630.40
Gulf	LaCHIP Affordable Plan	All Ages	8,886	$ 121.49	0.00%	0.00%	0.06%	0.00%	6.39%	6.89%	15.70%	$ (2.75)	$ -	$ 3.26	0%	$ 134.56	$ 145.55
Gulf	HCBS Waiver	20 & Under, Male and Female	1,223	$ 1,022.25	0.00%	0.00%	0.04%	0.00%	3.65%	7.76%	17.16%	$ -	$ -	$ 1.84	0%	$ 1,264.28	$ 1,370.65
Gulf	HCBS Waiver	21+ Years, Male and Female	4,394	$ 995.69	0.00%	0.00%	0.18%	0.00%	3.81%	4.10%	13.35%	$ -	$ -	$ -	0%	$ 1,049.76	$ 1,143.03
Gulf	Chisholm Class Members	Chisholm, All Ages Male & Female	11,336	$ 658.72	0.00%	0.00%	0.05%	0.00%	8.07%	4.21%	12.91%	$ -	$ -	$ 184.23	0%	$ 902.00	$ 964.82
Gulf	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	11,863	$ 3.01	0.00%	0.00%	0.00%	0.00%	0.00%	5.28%	10.70%	$ -	$ -	$ -	0%	$ 4.36	$ 4.58
Gulf	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	334,772	$ 5.32	0.00%	-0.80%	0.00%	0.00%	0.00%	7.43%	11.80%	$ -	$ -	$ -	100%	$ 5.67	$ 5.90
Gulf	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	5,271	$ 1.91	0.00%	0.00%	0.00%	0.00%	0.00%	7.43%	12.91%	$ -	$ -	$ -	0%	$ 4.30	$ 4.51
Gulf	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	11,317	$ 5.64	0.00%	0.00%	0.00%	0.00%	0.00%	7.43%	12.91%	$ -	$ -	$ -	0%	$ 10.28	$ 10.81
Gulf	SBH -Other	SBH - Other, All Ages	11,338	$ 38.04	0.00%	0.00%	0.00%	0.00%	0.00%	7.43%	12.91%	$ -	$ -	$ -	0%	$ 39.46	$ 41.47
Gulf	Maternity Kick payment	Maternity Kick payment, All Ages	9,173	$ 6,705.60	0.00%	0.00%	0.00%	0.00%	6.70%	-1.04%	5.28%	$ -	$ -	$ -	100%	$ 7,080.49	$ 7,532.52
Capital	SSI	Newborn, 0-2 Months	217	$ 19,756.61	0.00%	0.00%	0.01%	0.00%	7.64%	4.22%	14.03%	$ (133.57)	$ 2,345.01	$ -	0%	$ 20,485.34	$ 22,204.25
Capital	SSI	Newborn, 3-11 Months	1,573	$ 3,761.91	0.00%	0.00%	0.01%	0.00%	6.20%	4.95%	14.24%	$ (21.30)	$ 97.45	$ -	0%	$ 3,608.84	$ 3,921.26
Capital	SSI	Child, 1-20 Years	97,313	$ 398.92	0.00%	0.00%	0.08%	0.00%	2.87%	10.33%	19.28%	$ (1.50)	$ -	$ 15.83	100%	$ 467.44	$ 504.19
Capital	SSI	Adult, 21+ Years	195,669	$ 897.34	0.00%	0.00%	0.39%	0.00%	3.63%	4.97%	13.69%	$ (3.73)	$ -	$ -	100%	$ 976.24	$ 1,057.70
Capital	Family and Children	Newborn, 0-2 Months	25,616	$ 1,626.45	0.00%	0.00%	0.00%	0.00%	5.54%	1.53%	11.20%	$ (79.17)	$ 60.58	$ -	100%	$ 1,724.19	$ 1,890.32
Capital	Family and Children	Newborn, 3-11 Months	89,137	$ 181.39	0.00%	0.00%	0.02%	0.00%	4.40%	4.19%	13.44%	$ (3.37)	$ 0.32	$ -	100%	$ 194.30	$ 211.81
Capital	Family and Children	Child, 1-20 Years	1,916,871	$ 91.51	0.00%	0.00%	0.04%	0.00%	3.65%	7.02%	16.39%	$ (1.39)	$ 0.01	$ 0.68	100%	$ 100.85	$ 109.75
Capital	Family and Children	Adult, 21+ Years	300,951	$ 234.15	0.00%	0.00%	0.35%	0.00%	5.32%	5.38%	13.56%	$ (4.29)	$ -	$ -	100%	$ 256.49	$ 276.74
Capital	Foster Care Children	Foster Care, All Ages Male & Female	40,519	$ 160.14	0.00%	0.00%	0.05%	0.00%	3.90%	5.17%	14.46%	$ (2.73)	$ -	$ 2.98	0%	$ 173.55	$ 188.33
Capital	Breast and Cervical Cancer	BCC, All Ages Female	2,242	$ 1,140.93	2.55%	0.00%	4.79%	1.80%	4.41%	4.54%	12.13%	$ (11.83)	$ -	$ -	0%	$ 1,519.49	$ 1,630.40
Capital	LaCHIP Affordable Plan	All Ages	11,562	$ 132.34	0.00%	0.00%	0.06%	0.00%	4.65%	7.21%	16.03%	$ (2.74)	$ -	$ 0.57	0%	$ 134.56	$ 145.55
Capital	HCBS Waiver	20 & Under, Male and Female	1,184	$ 1,578.39	0.00%	0.00%	0.03%	0.00%	3.71%	7.23%	16.62%	$ -	$ -	$ 72.10	0%	$ 1,264.28	$ 1,370.65
Capital	HCBS Waiver	21+ Years, Male and Female	3,407	$ 999.46	0.00%	0.00%	0.18%	0.00%	4.13%	3.47%	12.69%	$ -	$ -	$ -	0%	$ 1,049.76	$ 1,143.03
Capital	Chisholm Class Members	Chisholm, All Ages Male & Female	8,726	$ 925.85	0.00%	0.00%	0.04%	0.00%	4.76%	4.03%	12.72%	$ -	$ -	$ 105.76	0%	$ 902.00	$ 964.82
Capital	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	12,470	$ 4.03	0.00%	0.00%	0.00%	0.00%	0.00%	5.28%	10.70%	$ -	$ -	$ -	0%	$ 4.36	$ 4.58
Capital	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	265,049	$ 8.32	0.00%	-0.80%	0.00%	0.00%	0.00%	7.43%	11.80%	$ -	$ -	$ -	100%	$ 8.87	$ 9.23
Capital	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	6,022	$ 2.76	0.00%	0.00%	0.00%	0.00%	0.00%	7.43%	12.91%	$ -	$ -	$ -	0%	$ 4.30	$ 4.51
Capital	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	10,929	$ 10.19	0.00%	0.00%	0.00%	0.00%	0.00%	7.43%	12.91%	$ -	$ -	$ -	0%	$ 10.28	$ 10.81
Capital	SBH -Other	SBH - Other, All Ages	12,714	$ 28.37	0.00%	0.00%	0.00%	0.00%	0.00%	7.43%	12.91%	$ -	$ -	$ -	0%	$ 39.46	$ 41.47
Capital	Maternity Kick payment	Maternity Kick payment, All Ages	7,917	$ 5,776.24	0.00%	0.00%	0.00%	0.00%	8.69%	-1.04%	5.28%	$ -	$ -	$ -	100%	$ 6,212.81	$ 6,609.44

Appendix N: Physical Health Projected Claims PMPM Development

Table 2: PH Prospective Rating Adjustments

					Prospective Adjustments												
Region Name	COA Description	Rate Cell Description	Projected Membership	Blended*** CY2015/CY2016 PMPM	CBR	LaHIPP	PET Scans	Retro Adjustment	Fee Adj	Low Trend	High Trend	Clinical/Rx Efficiencies	Outliers	ABA	Credibility	Low Projected PMPM	High Projected PMPM
South Central	SSI	Newborn, 0-2 Months	253	$ 13,913.16	0.00%	0.00%	0.02%	0.00%	9.96%	4.43%	14.25%	$ (133.55)	$ 2,345.01	$ -	0%	$ 20,485.34	$ 22,204.25
South Central	SSI	Newborn, 3-11 Months	1,838	$ 3,145.20	0.00%	0.00%	0.01%	0.00%	8.23%	5.04%	14.33%	$ (21.30)	$ 97.45	$ -	0%	$ 3,608.84	$ 3,921.26
South Central	SSI	Child, 1-20 Years	105,972	$ 354.95	0.00%	0.00%	0.09%	0.00%	2.48%	11.05%	20.03%	$ (1.36)	$ -	$ 34.47	100%	$ 437.46	$ 470.14
South Central	SSI	Adult, 21+ Years	243,844	$ 771.04	0.00%	0.00%	0.46%	0.00%	3.64%	4.77%	13.49%	$ (3.67)	$ -	$ -	100%	$ 837.38	$ 907.36
South Central	Family and Children	Newborn, 0-2 Months	29,937	$ 1,835.26	0.00%	0.00%	0.00%	0.00%	6.28%	1.54%	11.22%	$ (79.17)	$ 60.58	$ -	100%	$ 1,962.11	$ 2,150.90
South Central	Family and Children	Newborn, 3-11 Months	104,174	$ 182.88	0.00%	0.00%	0.02%	0.00%	3.33%	4.44%	13.70%	$ (3.37)	$ 0.32	$ -	100%	$ 194.35	$ 211.85
South Central	Family and Children	Child, 1-20 Years	2,156,070	$ 95.31	0.00%	0.00%	0.04%	0.00%	2.58%	7.43%	16.82%	$ (1.38)	$ 0.01	$ 1.58	100%	$ 105.29	$ 114.48
South Central	Family and Children	Adult, 21+ Years	337,770	$ 212.10	0.00%	0.00%	0.39%	0.00%	4.46%	5.15%	13.33%	$ (4.28)	$ -	$ -	100%	$ 229.59	$ 247.78
South Central	Foster Care Children	Foster Care, All Ages Male & Female	50,835	$ 147.08	0.00%	0.00%	0.06%	0.00%	3.01%	5.46%	14.76%	$ (2.73)	$ -	$ 8.78	0%	$ 173.55	$ 188.33
South Central	Breast and Cervical Cancer	BCC, All Ages Female	1,370	$ 1,323.16	2.55%	0.00%	4.13%	1.80%	0.72%	6.01%	13.66%	$ (13.54)	$ -	$ -	0%	$ 1,519.49	$ 1,630.40
South Central	LaCHIP Affordable Plan	All Ages	10,797	$ 107.46	0.00%	0.00%	0.07%	0.00%	2.48%	7.74%	16.58%	$ (2.73)	$ -	$ 10.66	0%	$ 134.56	$ 145.55
South Central	HCBS Waiver	20 & Under, Male and Female	1,289	$ 866.68	0.00%	0.00%	0.05%	0.00%	3.55%	7.70%	17.10%	$ -	$ -	$ 20.02	0%	$ 1,264.28	$ 1,370.65
South Central	HCBS Waiver	21+ Years, Male and Female	4,262	$ 804.46	0.00%	0.00%	0.23%	0.00%	2.61%	4.31%	13.56%	$ -	$ -	$ -	0%	$ 1,049.76	$ 1,143.03
South Central	Chisholm Class Members	Chisholm, All Ages Male & Female	11,368	$ 685.31	0.00%	0.00%	0.05%	0.00%	3.95%	4.30%	13.00%	$ -	$ -	$ 144.90	0%	$ 902.00	$ 964.82
South Central	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	12,321	$ 5.58	0.00%	0.00%	0.00%	0.00%	0.00%	5.28%	10.70%	$ -	$ -	$ -	0%	$ 4.36	$ 4.58
South Central	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	349,901	$ 7.99	0.00%	-0.80%	0.00%	0.00%	0.00%	7.43%	11.80%	$ -	$ -	$ -	100%	$ 8.52	$ 8.86
South Central	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	5,428	$ 5.97	0.00%	0.00%	0.00%	0.00%	0.00%	7.43%	12.91%	$ -	$ -	$ -	0%	$ 4.30	$ 4.51
South Central	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	11,765	$ 13.75	0.00%	0.00%	0.00%	0.00%	0.00%	7.43%	12.91%	$ -	$ -	$ -	0%	$ 10.28	$ 10.81
South Central	SBH -Other	SBH - Other, All Ages	16,206	$ 47.76	0.00%	0.00%	0.00%	0.00%	0.00%	7.43%	12.91%	$ -	$ -	$ -	0%	$ 39.46	$ 41.47
South Central	Maternity Kick payment	Maternity Kick payment, All Ages	9,159	$ 5,778.23	0.00%	0.00%	0.00%	0.00%	8.35%	-1.04%	5.28%	$ -	$ -	$ -	100%	$ 6,195.53	$ 6,591.06
North	SSI	Newborn, 0-2 Months	205	$ 12,521.12	0.00%	0.00%	0.02%	0.00%	8.59%	4.43%	14.25%	$ (133.56)	$ 2,345.01	$ -	0%	$ 20,485.34	$ 22,204.25
North	SSI	Newborn, 3-11 Months	1,487	$ 2,669.90	0.00%	0.00%	0.01%	0.00%	6.38%	4.93%	14.22%	$ (21.30)	$ 97.45	$ -	0%	$ 3,608.84	$ 3,921.26
North	SSI	Child, 1-20 Years	120,631	$ 304.79	0.00%	0.00%	0.11%	0.00%	2.64%	9.36%	18.27%	$ (1.40)	$ -	$ 32.32	100%	$ 373.39	$ 401.29
North	SSI	Adult, 21+ Years	220,396	$ 715.71	0.00%	0.00%	0.49%	0.00%	2.99%	4.65%	13.37%	$ (3.52)	$ -	$ -	100%	$ 771.68	$ 836.22
North	Family and Children	Newborn, 0-2 Months	24,218	$ 1,508.50	0.00%	0.00%	0.00%	0.00%	6.40%	1.58%	11.26%	$ (79.17)	$ 60.58	$ -	100%	$ 1,611.89	$ 1,767.27
North	Family and Children	Newborn, 3-11 Months	84,273	$ 173.67	0.00%	0.00%	0.02%	0.00%	3.02%	4.31%	13.56%	$ (3.37)	$ 0.32	$ -	100%	$ 183.62	$ 200.18
North	Family and Children	Child, 1-20 Years	1,654,849	$ 84.29	0.00%	0.00%	0.05%	0.00%	2.24%	6.90%	16.27%	$ (1.38)	$ 0.01	$ 2.29	100%	$ 93.09	$ 101.17
North	Family and Children	Adult, 21+ Years	251,972	$ 199.94	0.00%	0.00%	0.41%	0.00%	3.41%	4.93%	13.09%	$ (4.26)	$ -	$ -	100%	$ 213.58	$ 230.53
North	Foster Care Children	Foster Care, All Ages Male & Female	33,928	$ 161.33	0.00%	0.00%	0.05%	0.00%	2.17%	5.15%	14.44%	$ (2.75)	$ -	$ 19.39	0%	$ 173.55	$ 188.33
North	Breast and Cervical Cancer	BCC, All Ages Female	1,770	$ 1,437.47	2.55%	0.00%	3.80%	1.80%	0.79%	7.11%	14.80%	$ (11.45)	$ -	$ -	0%	$ 1,519.49	$ 1,630.40
North	LaCHIP Affordable Plan	All Ages	8,055	$ 115.19	0.00%	0.00%	0.07%	0.00%	3.00%	6.40%	15.19%	$ (2.77)	$ -	$ -	0%	$ 134.56	$ 145.55
North	HCBS Waiver	20 & Under, Male and Female	1,039	$ 906.61	0.00%	0.00%	0.05%	0.00%	2.40%	7.97%	17.39%	$ -	$ -	$ 104.81	0%	$ 1,264.28	$ 1,370.65
North	HCBS Waiver	21+ Years, Male and Female	3,552	$ 1,123.16	0.00%	0.00%	0.16%	0.00%	3.53%	3.99%	13.23%	$ -	$ -	$ -	0%	$ 1,049.76	$ 1,143.03
North	Chisholm Class Members	Chisholm, All Ages Male & Female	7,764	$ 464.65	0.00%	0.00%	0.07%	0.00%	1.79%	4.51%	13.21%	$ -	$ -	$ 152.18	0%	$ 902.00	$ 964.82
North	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	10,563	$ 3.86	0.00%	0.00%	0.00%	0.00%	0.00%	5.28%	10.70%	$ -	$ -	$ -	0%	$ 4.36	$ 4.58
North	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	282,304	$ 8.61	0.00%	-0.80%	0.00%	0.00%	0.00%	7.43%	11.80%	$ -	$ -	$ -	100%	$ 9.18	$ 9.55
North	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	3,490	$ 6.23	0.00%	0.00%	0.00%	0.00%	0.00%	7.43%	12.91%	$ -	$ -	$ -	0%	$ 4.30	$ 4.51
North	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	8,966	$ 8.30	0.00%	0.00%	0.00%	0.00%	0.00%	7.43%	12.91%	$ -	$ -	$ -	0%	$ 10.28	$ 10.81
North	SBH -Other	SBH - Other, All Ages	14,864	$ 30.86	0.00%	0.00%	0.00%	0.00%	0.00%	7.43%	12.91%	$ -	$ -	$ -	0%	$ 39.46	$ 41.47
North	Maternity Kick payment	Maternity Kick payment, All Ages	6,796	$ 5,866.68	0.00%	0.00%	0.00%	0.00%	7.08%	-1.04%	5.28%	$ -	$ -	$ -	100%	$ 6,216.70	$ 6,613.58

Appendix O: Specialized Behavioral Health Projected Claims PMPM Development

Table 1: SBH Historical Rating Adjustments

Region Name	COA Description	Rate Cell Description	CY2015 MMs	CY2015 PMPM	Historical Adjustments					CY2015 PMPM After Adj	CY2016 MMs	CY2016 PMPM	Historical Adjustments			CY2016 PMPM After Adj
					Fee Adjustment	Historical Trend	CSOC Expansion	IMD Adj	Fraud and Abuse				Fee Adjustment	CSOC Expansion	IMD Adj	
Gulf	SSI	Newborn, 0-2 Months	287	$ 1,330.63	-0.04%	-14.73%	0.00%	0.00%	0.00%	$ 1,134.15	260	$ 15.65	0.00%	0.00%	0.00%	$ 15.65
Gulf	SSI	Newborn, 3-11 Months	2,212	$ 39.41	-0.04%	-10.59%	0.00%	0.00%	-0.01%	$ 35.22	1,847	$ 4.48	0.00%	0.00%	0.00%	$ 4.48
Gulf	SSI	Child, 1-20 Years	138,448	$ 130.60	-0.01%	15.25%	-1.51%	0.00%	-0.04%	$ 148.18	129,329	$ 143.01	0.00%	0.00%	0.00%	$ 143.02
Gulf	SSI	Adult, 21+ Years	277,184	$ 87.75	-0.01%	3.39%	0.00%	1.07%	-0.25%	$ 91.44	269,606	$ 93.88	0.00%	0.00%	1.57%	$ 95.37
Gulf	Family and Children	Newborn, 0-2 Months	36,410	$ 39.39	0.95%	-13.00%	0.00%	0.00%	0.00%	$ 34.59	34,449	$ 8.73	0.00%	0.00%	0.00%	$ 8.73
Gulf	Family and Children	Newborn, 3-11 Months	123,187	$ 1.60	0.29%	16.97%	0.00%	0.00%	-0.01%	$ 1.88	123,668	$ 2.29	0.00%	0.00%	0.00%	$ 2.29
Gulf	Family and Children	Child, 1-20 Years	2,215,811	$ 25.10	0.08%	26.42%	-0.52%	0.00%	-0.04%	$ 31.58	2,207,066	$ 28.63	0.00%	0.00%	0.00%	$ 28.63
Gulf	Family and Children	Adult, 21+ Years	448,937	$ 20.67	0.28%	14.32%	0.00%	2.34%	-0.23%	$ 24.20	437,017	$ 25.52	0.00%	0.00%	3.45%	$ 26.40
Gulf	Foster Care Children	Foster Care, All Ages Male & Female	25,112	$ 131.28	0.16%	24.58%	-2.44%	0.01%	-0.07%	$ 159.74	26,201	$ 145.66	0.00%	0.02%	0.20%	$ 145.98
Gulf	Breast and Cervical Cancer	BCC, All Ages Female	4,293	$ 6.95	0.00%	4.44%	0.00%	0.00%	-0.37%	$ 7.23	3,342	$ 19.35	0.00%	0.00%	1.48%	$ 19.63
Gulf	LaCHIP Affordable Plan	All Ages	9,208	$ 11.71	0.20%	21.40%	-0.01%	0.00%	-0.07%	$ 14.23	8,020	$ 15.18	0.00%	0.00%	0.00%	$ 15.18
Gulf	HCBS Waiver	20 & Under, Male and Female	767	$ 200.79	0.00%	20.00%	-1.67%	0.00%	-0.01%	$ 236.91	1,079	$ 17.36	0.00%	0.00%	0.00%	$ 17.36
Gulf	HCBS Waiver	21+ Years, Male and Female	1,941	$ 55.45	0.00%	4.00%	0.00%	3.49%	-0.11%	$ 59.62	3,299	$ 83.27	0.00%	0.00%	2.23%	$ 85.13
Gulf	Chisholm Class Members	Chisholm, All Ages Male & Female	2,480	$ 63.31	0.23%	18.78%	-1.01%	0.00%	-0.07%	$ 74.56	5,822	$ 87.76	0.00%	0.01%	0.00%	$ 87.76
Gulf	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	15,323	$ 68.39	-0.57%	10.00%	-11.61%	0.00%	-0.10%	$ 66.05	12,854	$ 69.45	0.00%	0.00%	0.00%	$ 69.45
Gulf	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	317,628	$ 14.81	0.00%	10.00%	-0.09%	0.05%	-0.26%	$ 16.24	324,331	$ 18.83	0.00%	0.00%	0.04%	$ 18.84
Gulf	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	6,583	$ 22.86	1.03%	10.00%	-1.19%	0.00%	-0.13%	$ 25.06	6,120	$ 21.78	0.00%	0.04%	0.00%	$ 21.79
Gulf	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	12,324	$ 37.94	5.17%	10.00%	0.00%	-2.74%	-0.32%	$ 42.55	11,838	$ 28.25	0.00%	0.00%	6.39%	$ 30.05
Gulf	SBH -Other	SBH - Other, All Ages	7,409	$ 54.72	0.01%	10.00%	-0.17%	12.97%	-0.19%	$ 67.76	7,889	$ 86.10	0.00%	0.00%	2.84%	$ 88.55
Gulf	Maternity Kick payment	Maternity Kick payment, All Ages														
Capital	SSI	Newborn, 0-2 Months	331	$ 0.79	0.00%	20.00%	0.00%	0.00%	-1.08%	$ 0.93	234	$ 21.80	0.00%	0.00%	0.00%	$ 21.80
Capital	SSI	Newborn, 3-11 Months	1,965	$ 10.88	0.00%	20.00%	0.00%	0.00%	-1.08%	$ 12.91	1,842	$ 5.98	0.00%	0.00%	0.00%	$ 5.98
Capital	SSI	Child, 1-20 Years	104,014	$ 114.39	0.52%	13.38%	-0.71%	0.00%	-0.07%	$ 129.35	98,139	$ 124.51	0.00%	-0.02%	0.00%	$ 124.49
Capital	SSI	Adult, 21+ Years	198,760	$ 70.39	1.30%	2.65%	0.00%	1.18%	-0.10%	$ 73.98	194,002	$ 72.46	0.01%	0.00%	2.03%	$ 73.94
Capital	Family and Children	Newborn, 0-2 Months	31,347	$ 16.13	6.68%	-9.22%	0.00%	0.00%	-0.09%	$ 15.61	31,263	$ 5.16	0.00%	0.00%	0.00%	$ 5.16
Capital	Family and Children	Newborn, 3-11 Months	107,254	$ 1.14	0.00%	30.00%	0.00%	0.00%	-0.48%	$ 1.47	108,251	$ 1.47	0.00%	0.00%	0.00%	$ 1.47
Capital	Family and Children	Child, 1-20 Years	2,008,861	$ 24.16	0.80%	25.05%	-0.31%	0.00%	-0.06%	$ 30.34	1,987,440	$ 28.44	0.00%	-0.01%	0.00%	$ 28.44
Capital	Family and Children	Adult, 21+ Years	347,656	$ 21.53	2.53%	13.13%	0.00%	3.43%	-0.17%	$ 25.78	345,519	$ 24.29	0.00%	0.00%	5.36%	$ 25.59
Capital	Foster Care Children	Foster Care, All Ages Male & Female	35,630	$ 152.89	1.48%	19.04%	-0.64%	0.05%	-0.10%	$ 183.41	36,707	$ 158.73	0.00%	-0.03%	0.05%	$ 158.77
Capital	Breast and Cervical Cancer	BCC, All Ages Female	4,253	$ 10.50	0.00%	3.41%	0.00%	0.52%	-0.43%	$ 10.87	3,584	$ 13.04	0.00%	0.00%	9.56%	$ 14.29
Capital	LaCHIP Affordable Plan	All Ages	10,048	$ 11.70	0.43%	26.23%	-0.06%	0.00%	-0.05%	$ 14.81	9,963	$ 8.56	0.00%	0.00%	0.00%	$ 8.56
Capital	HCBS Waiver	20 & Under, Male and Female	535	$ 124.61	0.00%	20.00%	0.00%	0.00%	-0.11%	$ 149.36	1,029	$ 38.46	0.00%	0.00%	0.00%	$ 38.46
Capital	HCBS Waiver	21+ Years, Male and Female	1,539	$ 67.53	0.00%	3.28%	0.00%	7.50%	-0.11%	$ 74.90	2,605	$ 54.88	0.00%	0.00%	7.26%	$ 58.87
Capital	Chisholm Class Members	Chisholm, All Ages Male & Female	2,052	$ 99.90	2.17%	12.24%	-0.39%	0.00%	-0.05%	$ 114.05	4,889	$ 81.05	0.00%	0.00%	0.00%	$ 81.05
Capital	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	15,626	$ 75.57	3.86%	10.00%	-7.12%	0.00%	-0.15%	$ 80.07	13,385	$ 70.72	0.00%	-0.08%	0.00%	$ 70.67
Capital	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	252,330	$ 5.51	0.00%	10.00%	0.00%	0.87%	-0.04%	$ 6.11	258,025	$ 7.36	0.00%	0.00%	0.60%	$ 7.41
Capital	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	6,958	$ 31.19	1.98%	10.00%	-4.84%	0.00%	-0.21%	$ 33.23	6,736	$ 21.94	0.00%	-0.01%	0.00%	$ 21.94
Capital	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	11,341	$ 34.42	2.31%	10.00%	0.00%	3.99%	-0.10%	$ 40.24	11,465	$ 30.17	0.00%	0.00%	3.71%	$ 31.29
Capital	SBH -Other	SBH - Other, All Ages	8,164	$ 49.96	0.00%	10.00%	0.00%	7.66%	-0.08%	$ 59.12	8,907	$ 86.41	0.01%	0.00%	-0.75%	$ 85.77
Capital	Maternity Kick payment	Maternity Kick payment, All Ages														

Appendix O: Specialized Behavioral Health Projected Claims PMPM Development

Table 1: SBH Historical Rating Adjustments

					Historical Adjustments								Historical Adjustments			
Region Name	COA Description	Rate Cell Description	CY2015 MMs	CY2015 PMPM	Fee Adjustment	Historical Trend	CSOC Expansion	IMD Adj	Fraud and Abuse	CY2015 PMPM After Adj	CY2016 MMs	CY2016 PMPM	Fee Adjustment	CSOC Expansion	IMD Adj	CY2016 PMPM After Adj
South Central	SSI	Newborn, 0-2 Months	237	$ 347.57	0.29%	-14.67%	0.00%	0.00%	0.00%	$ 297.47	263	$ 2.12	0.00%	0.00%	0.00%	$ 2.12
South Central	SSI	Newborn, 3-11 Months	2,049	$ 2.03	0.00%	20.00%	0.00%	0.00%	-0.01%	$ 2.43	1,778	$ 2.69	0.00%	0.00%	0.00%	$ 2.69
South Central	SSI	Child, 1-20 Years	108,419	$ 104.81	0.04%	14.70%	-0.87%	0.00%	-0.06%	$ 119.14	104,561	$ 129.78	0.00%	0.02%	0.00%	$ 129.81
South Central	SSI	Adult, 21+ Years	241,043	$ 69.74	0.12%	2.96%	-0.01%	1.40%	-0.24%	$ 72.71	236,714	$ 79.69	0.01%	0.00%	1.58%	$ 80.96
South Central	Family and Children	Newborn, 0-2 Months	34,380	$ 1.58	0.01%	28.69%	0.00%	0.00%	0.00%	$ 2.03	33,923	$ 2.04	0.00%	0.00%	0.00%	$ 2.04
South Central	Family and Children	Newborn, 3-11 Months	118,176	$ 1.05	0.00%	30.00%	0.00%	0.00%	0.00%	$ 1.36	118,134	$ 1.44	0.00%	0.00%	0.00%	$ 1.44
South Central	Family and Children	Child, 1-20 Years	2,178,706	$ 20.49	0.04%	25.09%	-0.29%	0.00%	-0.05%	$ 25.55	2,194,353	$ 26.01	0.00%	0.01%	0.00%	$ 26.02
South Central	Family and Children	Adult, 21+ Years	359,295	$ 22.09	0.12%	13.52%	0.00%	2.60%	-0.19%	$ 25.71	369,565	$ 26.49	0.00%	0.00%	4.68%	$ 27.73
South Central	Foster Care Children	Foster Care, All Ages Male & Female	47,534	$ 136.28	0.26%	23.61%	-0.76%	0.09%	-0.05%	$ 167.66	48,322	$ 137.28	0.00%	0.03%	0.19%	$ 137.59
South Central	Breast and Cervical Cancer	BCC, All Ages Female	2,812	$ 15.65	0.00%	2.01%	0.00%	0.00%	-0.36%	$ 15.91	2,199	$ 12.72	0.00%	0.00%	1.63%	$ 12.92
South Central	LaCHIP Affordable Plan	All Ages	10,749	$ 10.33	0.00%	24.73%	-0.02%	0.00%	-0.05%	$ 12.87	10,593	$ 11.61	0.00%	0.01%	0.00%	$ 11.61
South Central	HCBS Waiver	20 & Under, Male and Female	633	$ 134.77	0.00%	14.60%	0.00%	0.00%	-0.01%	$ 154.43	1,136	$ 90.83	0.00%	0.00%	0.00%	$ 90.83
South Central	HCBS Waiver	21+ Years, Male and Female	1,981	$ 89.01	0.00%	3.52%	0.00%	4.14%	-0.19%	$ 95.78	3,325	$ 53.02	0.00%	0.00%	0.60%	$ 53.34
South Central	Chisholm Class Members	Chisholm, All Ages Male & Female	2,782	$ 194.23	0.00%	12.60%	-1.58%	0.00%	-0.07%	$ 215.10	6,295	$ 120.05	0.00%	0.02%	0.00%	$ 120.08
South Central	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	16,503	$ 108.71	0.32%	10.00%	-5.20%	0.00%	-0.15%	$ 113.55	13,655	$ 89.45	0.00%	0.05%	0.00%	$ 89.49
South Central	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	340,071	$ 5.94	0.00%	10.00%	-0.12%	-1.19%	-0.23%	$ 6.43	342,354	$ 7.78	0.00%	0.00%	-0.34%	$ 7.75
South Central	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	6,367	$ 31.27	-0.03%	10.00%	0.00%	0.00%	-0.11%	$ 34.35	6,205	$ 29.42	0.00%	0.18%	0.00%	$ 29.48
South Central	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	12,554	$ 26.56	-0.05%	10.00%	0.00%	-1.88%	-0.31%	$ 28.57	12,146	$ 29.38	0.01%	0.00%	5.73%	$ 31.07
South Central	SBH -Other	SBH - Other, All Ages	10,240	$ 78.75	-0.02%	10.00%	0.00%	1.09%	-0.17%	$ 87.40	11,406	$ 88.56	0.01%	0.00%	1.37%	$ 89.78
South Central	Maternity Kick payment	Maternity Kick payment, All Ages														
North	SSI	Newborn, 0-2 Months	209	$ 202.54	-0.25%	-14.61%	0.00%	0.00%	0.00%	$ 172.52	212	$ 6.98	0.03%	0.00%	0.00%	$ 6.98
North	SSI	Newborn, 3-11 Months	1,666	$ 26.19	-0.24%	-12.77%	0.00%	0.00%	-0.01%	$ 22.79	1,619	$ 9.03	0.00%	0.00%	0.00%	$ 9.03
North	SSI	Child, 1-20 Years	121,133	$ 160.45	-0.03%	15.85%	-0.85%	0.00%	-0.03%	$ 184.20	118,550	$ 194.01	0.58%	0.03%	0.00%	$ 195.20
North	SSI	Adult, 21+ Years	213,449	$ 63.94	-0.10%	3.03%	0.00%	0.50%	-0.09%	$ 66.08	210,861	$ 77.49	0.01%	0.00%	0.13%	$ 77.60
North	Family and Children	Newborn, 0-2 Months	25,745	$ 62.54	-0.15%	-13.47%	0.00%	0.00%	0.00%	$ 54.03	24,803	$ 16.90	0.01%	0.00%	0.00%	$ 16.90
North	Family and Children	Newborn, 3-11 Months	88,460	$ 1.02	-0.04%	18.61%	0.00%	0.00%	0.00%	$ 1.21	86,611	$ 1.30	0.00%	0.00%	0.00%	$ 1.30
North	Family and Children	Child, 1-20 Years	1,705,064	$ 33.99	-0.01%	26.64%	-0.37%	0.00%	-0.04%	$ 42.86	1,694,082	$ 49.17	0.00%	0.02%	0.00%	$ 49.18
North	Family and Children	Adult, 21+ Years	288,507	$ 21.75	-0.04%	14.88%	0.00%	0.65%	-0.09%	$ 25.11	286,291	$ 29.95	0.00%	0.00%	2.36%	$ 30.66
North	Foster Care Children	Foster Care, All Ages Male & Female	27,510	$ 229.46	-0.03%	23.25%	-0.83%	0.00%	-0.03%	$ 280.31	30,699	$ 268.86	0.18%	0.15%	0.04%	$ 269.88
North	Breast and Cervical Cancer	BCC, All Ages Female	2,788	$ 9.78	0.00%	3.12%	0.00%	-1.52%	-0.17%	$ 9.92	2,460	$ 11.73	0.00%	0.00%	0.00%	$ 11.73
North	LaCHIP Affordable Plan	All Ages	5,570	$ 20.99	0.00%	24.58%	-0.06%	0.00%	-0.02%	$ 26.13	5,828	$ 19.43	0.00%	0.00%	0.00%	$ 19.43
North	HCBS Waiver	20 & Under, Male and Female	606	$ 92.91	0.00%	8.48%	-0.25%	0.00%	-0.02%	$ 100.52	1,016	$ 98.07	0.00%	0.00%	0.00%	$ 98.07
North	HCBS Waiver	21+ Years, Male and Female	1,835	$ 69.59	0.00%	3.43%	0.00%	5.33%	-0.06%	$ 75.76	2,853	$ 94.30	0.00%	0.00%	0.88%	$ 95.13
North	Chisholm Class Members	Chisholm, All Ages Male & Female	1,695	$ 129.32	-1.36%	14.79%	-1.26%	0.00%	-0.07%	$ 144.49	4,220	$ 163.60	0.00%	0.01%	0.00%	$ 163.61
North	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	14,847	$ 117.01	0.00%	10.00%	-7.67%	0.00%	-0.03%	$ 118.80	12,366	$ 150.79	0.00%	0.20%	0.00%	$ 151.09
North	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	271,372	$ 7.38	0.00%	10.00%	0.00%	0.91%	-0.04%	$ 8.19	273,812	$ 12.18	0.00%	0.00%	0.42%	$ 12.24
North	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	4,115	$ 53.93	0.00%	10.00%	-2.75%	0.00%	-0.03%	$ 57.68	3,920	$ 37.87	0.00%	0.03%	0.00%	$ 37.88
North	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	9,767	$ 34.51	0.00%	10.00%	-1.01%	0.27%	-0.16%	$ 37.61	9,414	$ 45.34	0.00%	0.00%	0.48%	$ 45.55
North	SBH -Other	SBH - Other, All Ages	9,584	$ 48.81	0.00%	10.00%	-0.99%	-0.41%	-0.18%	$ 52.85	10,586	$ 60.13	0.01%	0.00%	4.87%	$ 63.06
North	Maternity Kick payment	Maternity Kick payment, All Ages														

Appendix O: Specialized Behavioral Health Projected Claims PMPM Development

Table 2: SBH Prospective Rating Adjustments

					Prospective Adjustments									
Region Name	COA Description	Rate Cell Description	Projected Membership	Blended*** CY2015/CY2016 PMPM	CBR	LaHIPP	Retro Adjustment	Fee Adj	Low Trend	High Trend	MHR Reduction	Credibility	Low Projected PMPM	High Projected PMPM
Gulf	SSI	Newborn, 0-2 Months	288	$ 463.05	0.00%	0.00%	0.00%	25.32%	0.73%	10.37%	$ (0.07)	0%	$ 237.73	$ 260.47
Gulf	SSI	Newborn, 3-11 Months	2,085	$ 16.78	0.00%	0.00%	0.00%	18.25%	3.76%	12.99%	$ (0.12)	0%	$ 12.74	$ 13.88
Gulf	SSI	Child, 1-20 Years	132,759	$ 145.08	0.00%	0.00%	0.00%	2.55%	10.65%	19.62%	$ (5.05)	100%	$ 159.58	$ 172.92
Gulf	SSI	Adult, 21+ Years	278,885	$ 93.80	0.00%	0.00%	0.00%	8.71%	0.64%	9.18%	$ (1.01)	100%	$ 101.62	$ 110.33
Gulf	Family and Children	Newborn, 0-2 Months	33,958	$ 19.07	0.00%	0.00%	0.00%	14.04%	9.39%	19.44%	$ (0.00)	100%	$ 23.79	$ 25.98
Gulf	Family and Children	Newborn, 3-11 Months	118,165	$ 2.12	0.00%	0.00%	0.00%	1.61%	13.57%	23.24%	$ (0.00)	100%	$ 2.45	$ 2.66
Gulf	Family and Children	Child, 1-20 Years	2,211,981	$ 29.81	0.00%	0.00%	0.00%	1.16%	15.37%	25.12%	$ (0.97)	100%	$ 33.83	$ 36.76
Gulf	Family and Children	Adult, 21+ Years	381,028	$ 25.52	0.00%	0.00%	0.00%	4.77%	10.05%	18.43%	$ (0.14)	100%	$ 29.29	$ 31.53
Gulf	Foster Care Children	Foster Care, All Ages Male & Female	27,754	$ 151.48	0.00%	0.00%	0.00%	2.13%	14.06%	23.75%	$ (3.57)	0%	$ 210.63	$ 228.83
Gulf	Breast and Cervical Cancer	BCC, All Ages Female	1,842	$ 14.67	2.55%	0.00%	1.80%	7.16%	4.52%	12.12%	$ (0.05)	0%	$ 15.59	$ 16.73
Gulf	LaCHIP Affordable Plan	All Ages	8,886	$ 14.80	0.00%	0.00%	0.00%	2.11%	14.08%	23.19%	$ (0.42)	0%	$ 16.46	$ 17.80
Gulf	HCBS Waiver	20 & Under, Male and Female	1,223	$ 105.18	0.00%	0.00%	0.00%	0.07%	11.80%	21.39%	$ (1.36)	0%	$ 113.86	$ 123.79
Gulf	HCBS Waiver	21+ Years, Male and Female	4,394	$ 74.92	0.00%	0.00%	0.00%	9.61%	-0.37%	8.67%	$ (0.36)	0%	$ 80.53	$ 87.87
Gulf	Chisholm Class Members	Chisholm, All Ages Male & Female	11,336	$ 82.48	0.00%	0.00%	0.00%	2.69%	8.52%	17.39%	$ (2.89)	0%	$ 133.67	$ 144.86
Gulf	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	11,863	$ 68.09	0.00%	0.00%	0.00%	2.87%	5.28%	10.70%	$ (2.79)	0%	$ 100.21	$ 105.52
Gulf	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	334,772	$ 17.80	0.00%	-0.80%	0.00%	0.94%	13.81%	18.31%	$ (0.33)	100%	$ 19.95	$ 20.75
Gulf	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	5,271	$ 23.10	0.00%	0.00%	0.00%	1.07%	7.43%	12.91%	$ (1.32)	0%	$ 32.64	$ 34.37
Gulf	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	11,317	$ 35.05	0.00%	0.00%	0.00%	10.57%	8.21%	13.71%	$ (0.34)	0%	$ 41.34	$ 43.46
Gulf	SBH -Other	SBH - Other, All Ages	11,338	$ 80.23	0.00%	0.00%	0.00%	22.15%	4.71%	10.12%	$ (0.05)	0%	$ 95.24	$ 100.17
Gulf	Maternity Kick payment	Maternity Kick payment, All Ages												
Capital	SSI	Newborn, 0-2 Months	217	$ 13.45	0.00%	0.00%	0.00%	0.25%	9.06%	19.10%	$ (0.07)	0%	$ 237.73	$ 260.47
Capital	SSI	Newborn, 3-11 Months	1,573	$ 8.75	0.00%	0.00%	0.00%	0.23%	10.15%	19.67%	$ (0.12)	0%	$ 12.74	$ 13.88
Capital	SSI	Child, 1-20 Years	97,313	$ 126.44	0.00%	0.00%	0.00%	3.35%	10.26%	19.21%	$ (3.13)	100%	$ 140.95	$ 152.64
Capital	SSI	Adult, 21+ Years	195,669	$ 73.95	0.00%	0.00%	0.00%	11.70%	0.48%	9.01%	$ (0.49)	100%	$ 82.51	$ 89.56
Capital	Family and Children	Newborn, 0-2 Months	25,616	$ 9.34	0.00%	0.00%	0.00%	13.04%	9.80%	19.88%	$ (0.06)	100%	$ 11.53	$ 12.59
Capital	Family and Children	Newborn, 3-11 Months	89,137	$ 1.47	0.00%	0.00%	0.00%	0.04%	14.02%	23.70%	$ (0.02)	100%	$ 1.66	$ 1.80
Capital	Family and Children	Child, 1-20 Years	1,916,871	$ 29.20	0.00%	0.00%	0.00%	1.62%	15.27%	25.01%	$ (0.80)	100%	$ 33.41	$ 36.30
Capital	Family and Children	Adult, 21+ Years	300,951	$ 25.67	0.00%	0.00%	0.00%	6.78%	9.85%	18.21%	$ (0.08)	100%	$ 30.03	$ 32.32
Capital	Foster Care Children	Foster Care, All Ages Male & Female	40,519	$ 168.63	0.00%	0.00%	0.00%	3.25%	13.67%	23.34%	$ (3.57)	0%	$ 210.63	$ 228.83
Capital	Breast and Cervical Cancer	BCC, All Ages Female	2,242	$ 12.92	2.55%	0.00%	1.80%	9.09%	3.48%	11.04%	$ (0.05)	0%	$ 15.59	$ 16.73
Capital	LaCHIP Affordable Plan	All Ages	11,562	$ 11.06	0.00%	0.00%	0.00%	0.01%	14.44%	23.56%	$ (0.42)	0%	$ 16.46	$ 17.80
Capital	HCBS Waiver	20 & Under, Male and Female	1,184	$ 82.82	0.00%	0.00%	0.00%	3.26%	10.58%	20.11%	$ (1.36)	0%	$ 113.86	$ 123.79
Capital	HCBS Waiver	21+ Years, Male and Female	3,407	$ 65.28	0.00%	0.00%	0.00%	11.78%	-0.44%	8.60%	$ (0.36)	0%	$ 80.53	$ 87.87
Capital	Chisholm Class Members	Chisholm, All Ages Male & Female	8,726	$ 94.25	0.00%	0.00%	0.00%	5.33%	7.34%	16.16%	$ (2.89)	0%	$ 133.67	$ 144.86
Capital	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	12,470	$ 74.43	0.00%	0.00%	0.00%	5.46%	5.28%	10.70%	$ (2.79)	0%	$ 100.21	$ 105.52
Capital	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	265,049	$ 6.89	0.00%	-0.80%	0.00%	4.25%	13.03%	17.52%	$ (0.09)	100%	$ 7.96	$ 8.28
Capital	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	6,022	$ 26.46	0.00%	0.00%	0.00%	8.28%	7.43%	12.91%	$ (1.32)	0%	$ 32.64	$ 34.37
Capital	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	10,929	$ 34.87	0.00%	0.00%	0.00%	11.53%	8.02%	13.51%	$ (0.34)	0%	$ 41.34	$ 43.46
Capital	SBH -Other	SBH - Other, All Ages	12,714	$ 75.11	0.00%	0.00%	0.00%	21.69%	4.24%	9.63%	$ (0.05)	0%	$ 95.24	$ 100.17
Capital	Maternity Kick payment	Maternity Kick payment, All Ages												

Appendix O: Specialized Behavioral Health Projected Claims PMPM Development

Table 2: SBH Prospective Rating Adjustments

					Prospective Adjustments									
Region Name	COA Description	Rate Cell Description	Projected Membership	Blended*** CY2015/CY2016 PMPM	CBR	LaHIPP	Retro Adjustment	Fee Adj	Low Trend	High Trend	MHR Reduction	Credibility	Low Projected PMPM	High Projected PMPM
South Central	SSI	Newborn, 0-2 Months	253	$ 120.26	0.00%	0.00%	0.00%	24.75%	0.69%	10.32%	$ (0.07)	0%	$ 237.73	$ 260.47
South Central	SSI	Newborn, 3-11 Months	1,838	$ 2.59	0.00%	0.00%	0.00%	0.34%	10.15%	19.67%	$ (0.12)	0%	$ 12.74	$ 13.88
South Central	SSI	Child, 1-20 Years	105,972	$ 125.54	0.00%	0.00%	0.00%	3.28%	10.39%	19.34%	$ (3.37)	100%	$ 139.76	$ 151.37
South Central	SSI	Adult, 21+ Years	243,844	$ 77.66	0.00%	0.00%	0.00%	10.96%	0.54%	9.08%	$ (0.61)	100%	$ 86.03	$ 93.38
South Central	Family and Children	Newborn, 0-2 Months	29,937	$ 2.03	0.00%	0.00%	0.00%	0.33%	12.86%	23.08%	$ (0.03)	100%	$ 2.27	$ 2.48
South Central	Family and Children	Newborn, 3-11 Months	104,174	$ 1.41	0.00%	0.00%	0.00%	0.19%	14.02%	23.70%	$ (0.01)	100%	$ 1.59	$ 1.73
South Central	Family and Children	Child, 1-20 Years	2,156,070	$ 25.83	0.00%	0.00%	0.00%	2.28%	15.26%	24.99%	$ (0.70)	100%	$ 29.75	$ 32.32
South Central	Family and Children	Adult, 21+ Years	337,770	$ 26.92	0.00%	0.00%	0.00%	8.83%	9.89%	18.26%	$ (0.09)	100%	$ 32.11	$ 34.57
South Central	Foster Care Children	Foster Care, All Ages Male & Female	50,835	$ 149.62	0.00%	0.00%	0.00%	3.24%	13.96%	23.65%	$ (3.57)	0%	$ 210.63	$ 228.83
South Central	Breast and Cervical Cancer	BCC, All Ages Female	1,370	$ 14.12	2.55%	0.00%	1.80%	14.71%	4.03%	11.61%	$ (0.05)	0%	$ 15.59	$ 16.73
South Central	LaCHIP Affordable Plan	All Ages	10,797	$ 12.12	0.00%	0.00%	0.00%	3.29%	14.05%	23.15%	$ (0.42)	0%	$ 16.46	$ 17.80
South Central	HCBS Waiver	20 & Under, Male and Female	1,289	$ 116.27	0.00%	0.00%	0.00%	4.54%	9.78%	19.28%	$ (1.36)	0%	$ 113.86	$ 123.79
South Central	HCBS Waiver	21+ Years, Male and Female	4,262	$ 70.32	0.00%	0.00%	0.00%	8.37%	-0.38%	8.66%	$ (0.36)	0%	$ 80.53	$ 87.87
South Central	Chisholm Class Members	Chisholm, All Ages Male & Female	11,368	$ 158.08	0.00%	0.00%	0.00%	4.74%	7.71%	16.55%	$ (2.89)	0%	$ 133.67	$ 144.86
South Central	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	12,321	$ 99.12	0.00%	0.00%	0.00%	5.72%	5.28%	10.70%	$ (2.79)	0%	$ 100.21	$ 105.52
South Central	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	349,901	$ 7.23	0.00%	-0.80%	0.00%	2.57%	13.31%	17.80%	$ (0.12)	100%	$ 8.21	$ 8.54
South Central	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	5,428	$ 31.43	0.00%	0.00%	0.00%	4.25%	7.43%	12.91%	$ (1.32)	0%	$ 32.64	$ 34.37
South Central	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	11,765	$ 30.07	0.00%	0.00%	0.00%	10.96%	7.06%	12.52%	$ (0.34)	0%	$ 41.34	$ 43.46
South Central	SBH -Other	SBH - Other, All Ages	16,206	$ 88.83	0.00%	0.00%	0.00%	19.71%	3.70%	9.08%	$ (0.05)	0%	$ 95.24	$ 100.17
South Central	Maternity Kick payment	Maternity Kick payment, All Ages												
North	SSI	Newborn, 0-2 Months	205	$ 73.20	0.00%	0.00%	0.00%	28.65%	0.68%	10.32%	$ (0.07)	0%	$ 237.73	$ 260.47
North	SSI	Newborn, 3-11 Months	1,487	$ 14.53	0.00%	0.00%	0.00%	16.84%	4.71%	13.98%	$ (0.12)	0%	$ 12.74	$ 13.88
North	SSI	Child, 1-20 Years	120,631	$ 190.80	0.00%	0.00%	0.00%	2.87%	10.64%	19.61%	$ (6.31)	100%	$ 210.86	$ 228.46
North	SSI	Adult, 21+ Years	220,396	$ 72.99	0.00%	0.00%	0.00%	10.21%	0.62%	9.16%	$ (0.62)	100%	$ 80.32	$ 87.19
North	Family and Children	Newborn, 0-2 Months	24,218	$ 31.75	0.00%	0.00%	0.00%	27.26%	8.79%	18.82%	$ -	100%	$ 43.96	$ 48.01
North	Family and Children	Newborn, 3-11 Months	84,273	$ 1.26	0.00%	0.00%	0.00%	3.61%	13.34%	23.00%	$ (0.01)	100%	$ 1.47	$ 1.60
North	Family and Children	Child, 1-20 Years	1,654,849	$ 46.65	0.00%	0.00%	0.00%	1.49%	15.42%	25.16%	$ (1.31)	100%	$ 53.34	$ 57.95
North	Family and Children	Adult, 21+ Years	251,972	$ 28.44	0.00%	0.00%	0.00%	6.29%	10.13%	18.51%	$ (0.16)	100%	$ 33.13	$ 35.66
North	Foster Care Children	Foster Care, All Ages Male & Female	33,928	$ 274.05	0.00%	0.00%	0.00%	3.00%	13.98%	23.66%	$ (3.57)	0%	$ 210.63	$ 228.83
North	Breast and Cervical Cancer	BCC, All Ages Female	1,770	$ 11.00	2.55%	0.00%	1.80%	8.83%	4.44%	12.04%	$ (0.05)	0%	$ 15.59	$ 16.73
North	LaCHIP Affordable Plan	All Ages	8,055	$ 22.11	0.00%	0.00%	0.00%	3.23%	14.06%	23.16%	$ (0.42)	0%	$ 16.46	$ 17.80
North	HCBS Waiver	20 & Under, Male and Female	1,039	$ 99.05	0.00%	0.00%	0.00%	3.81%	10.16%	19.67%	$ (1.36)	0%	$ 113.86	$ 123.79
North	HCBS Waiver	21+ Years, Male and Female	3,552	$ 87.38	0.00%	0.00%	0.00%	7.48%	-0.34%	8.71%	$ (0.36)	0%	$ 80.53	$ 87.87
North	Chisholm Class Members	Chisholm, All Ages Male & Female	7,764	$ 155.97	0.00%	0.00%	0.00%	2.74%	8.75%	17.63%	$ (2.89)	0%	$ 133.67	$ 144.86
North	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	10,563	$ 138.17	0.00%	0.00%	0.00%	4.08%	5.28%	10.70%	$ (2.79)	0%	$ 100.21	$ 105.52
North	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	282,304	$ 10.62	0.00%	-0.80%	0.00%	1.34%	13.75%	18.25%	$ (0.13)	100%	$ 12.01	$ 12.49
North	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	3,490	$ 45.80	0.00%	0.00%	0.00%	3.47%	7.43%	12.91%	$ (1.32)	0%	$ 32.64	$ 34.37
North	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	8,966	$ 42.38	0.00%	0.00%	0.00%	4.50%	10.16%	15.71%	$ (0.34)	0%	$ 41.34	$ 43.46
North	SBH -Other	SBH - Other, All Ages	14,864	$ 58.98	0.00%	0.00%	0.00%	18.67%	4.85%	10.26%	$ (0.05)	0%	$ 95.24	$ 100.17
North	Maternity Kick payment	Maternity Kick payment, All Ages												

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Appendix P: NEMT Projected Claims PMPM Development (SBH Population Only)

Table 1: NEMT Historical Rating Adjustments (SBH Population Only)

					Historical Adjustments						Historical Adj	
Region Name	COA Description	Rate Cell Description	CY2015 MMs	CY2015 PMPM	Historical Trend	IMD Adj	Fraud and Abuse	CY2015 PMPM After Adj	CY2016 MMs	CY2016 PMPM	IMD Adj	CY2016 PMPM After Adj
Gulf	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	15,323	$ 3.63	-10.00%	0.00%	0.00%	$ 3.27	12,854	$ 2.84	0.00%	$ 2.84
Gulf	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	317,628	$ 5.05	16.00%	-0.07%	0.00%	$ 5.85	324,331	$ 4.97	0.00%	$ 4.97
Gulf	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	6,583	$ 2.03	-10.00%	0.00%	0.00%	$ 1.83	6,120	$ 1.96	0.00%	$ 1.96
Gulf	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	12,324	$ 6.76	-10.00%	-2.21%	0.00%	$ 5.95	11,838	$ 5.43	0.00%	$ 5.43
Gulf	SBH -Other	SBH - Other, All Ages	7,409	$ 53.82	-10.00%	0.00%	0.00%	$ 48.43	7,889	$ 31.17	-0.20%	$ 31.11
Capital	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	15,626	$ 4.69	-10.00%	0.00%	0.00%	$ 4.22	13,385	$ 3.91	0.00%	$ 3.91
Capital	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	252,330	$ 8.18	16.00%	0.03%	-0.01%	$ 9.49	258,025	$ 7.55	0.00%	$ 7.55
Capital	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	6,958	$ 5.10	-10.00%	0.00%	0.00%	$ 4.59	6,736	$ 1.54	0.00%	$ 1.54
Capital	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	11,341	$ 13.29	-10.00%	0.00%	0.00%	$ 11.96	11,465	$ 9.00	0.00%	$ 9.00
Capital	SBH -Other	SBH - Other, All Ages	8,164	$ 31.14	-10.00%	0.00%	0.00%	$ 28.03	8,907	$ 28.67	-0.23%	$ 28.60
South Central	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	16,503	$ 7.92	-10.00%	0.00%	0.00%	$ 7.13	13,655	$ 4.55	0.00%	$ 4.55
South Central	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	340,071	$ 7.68	16.00%	0.02%	0.00%	$ 8.90	342,354	$ 7.38	0.01%	$ 7.39
South Central	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	6,367	$ 6.55	-10.00%	0.00%	0.00%	$ 5.90	6,205	$ 6.01	0.00%	$ 6.01
South Central	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	12,554	$ 16.83	-10.00%	-0.54%	0.00%	$ 15.07	12,146	$ 12.87	0.00%	$ 12.87
South Central	SBH -Other	SBH - Other, All Ages	10,240	$ 65.77	-10.00%	0.00%	0.00%	$ 59.20	11,406	$ 40.14	-0.01%	$ 40.13
North	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	14,847	$ 3.42	-10.00%	0.00%	0.00%	$ 3.08	12,366	$ 4.38	0.00%	$ 4.38
North	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	271,372	$ 8.80	16.00%	0.01%	-0.01%	$ 10.21	273,812	$ 7.55	0.01%	$ 7.55
North	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	4,115	$ 9.96	-10.00%	0.00%	0.00%	$ 8.97	3,920	$ 4.41	0.00%	$ 4.41
North	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	9,767	$ 14.45	-10.00%	0.00%	0.00%	$ 13.00	9,414	$ 5.17	0.00%	$ 5.17
North	SBH -Other	SBH - Other, All Ages	9,584	$ 49.75	-10.00%	0.01%	0.00%	$ 44.78	10,586	$ 21.61	-0.12%	$ 21.58

Appendix P: NEMT Projected Claims PMPM Development (SBH Population Only)

Table 2: NEMT Prospective Rating Adjustments (SBH Population Only)

					Prospective Adjustments					
Region Name	COA Description	Rate Cell Description	Projected Membership	Blended*** CY2015/CY2016 PMPM	LaHIPP	Low Trend	High Trend	Credibility	Low Projected PMPM	High Projected PMPM
Gulf	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	11,863	$ 3.01	0.00%	5.28%	10.70%	0%	$ 4.36	$ 4.58
Gulf	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	334,772	$ 5.32	-0.80%	7.43%	11.80%	100%	$ 5.67	$ 5.90
Gulf	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	5,271	$ 1.91	0.00%	7.43%	12.91%	0%	$ 4.30	$ 4.51
Gulf	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	11,317	$ 5.64	0.00%	7.43%	12.91%	0%	$ 10.28	$ 10.81
Gulf	SBH -Other	SBH - Other, All Ages	11,338	$ 38.04	0.00%	7.43%	12.91%	0%	$ 39.46	$ 41.47
Capital	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	12,470	$ 4.03	0.00%	5.28%	10.70%	0%	$ 4.36	$ 4.58
Capital	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	265,049	$ 8.32	-0.80%	7.43%	11.80%	100%	$ 8.87	$ 9.23
Capital	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	6,022	$ 2.76	0.00%	7.43%	12.91%	0%	$ 4.30	$ 4.51
Capital	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	10,929	$ 10.19	0.00%	7.43%	12.91%	0%	$ 10.28	$ 10.81
Capital	SBH -Other	SBH - Other, All Ages	12,714	$ 28.37	0.00%	7.43%	12.91%	0%	$ 39.46	$ 41.47
South Central	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	12,321	$ 5.58	0.00%	5.28%	10.70%	0%	$ 4.36	$ 4.58
South Central	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	349,901	$ 7.99	-0.80%	7.43%	11.80%	100%	$ 8.52	$ 8.86
South Central	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	5,428	$ 5.97	0.00%	7.43%	12.91%	0%	$ 4.30	$ 4.51
South Central	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	11,765	$ 13.75	0.00%	7.43%	12.91%	0%	$ 10.28	$ 10.81
South Central	SBH -Other	SBH - Other, All Ages	16,206	$ 47.76	0.00%	7.43%	12.91%	0%	$ 39.46	$ 41.47
North	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Female	10,563	$ 3.86	0.00%	5.28%	10.70%	0%	$ 4.36	$ 4.58
North	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	282,304	$ 8.61	-0.80%	7.43%	11.80%	100%	$ 9.18	$ 9.55
North	SBH -HCBS Waiver	SBH - 20 & Under, Male and Female	3,490	$ 6.23	0.00%	7.43%	12.91%	0%	$ 4.30	$ 4.51
North	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	8,966	$ 8.30	0.00%	7.43%	12.91%	0%	$ 10.28	$ 10.81
North	SBH -Other	SBH - Other, All Ages	14,864	$ 30.86	0.00%	7.43%	12.91%	0%	$ 39.46	$ 41.47

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Appendix Q: Non-Expansion Loaded Rate Development

Table 1: Non-Expansion Loaded Rate Development

				PH Services		SBH Services		All Services		Retention Load						
Region Name	COA Description	Rate Cell Description	Projected Membership	Low PMPM	High PMPM	Low PMPM	High PMPM	Low PMPM	High PMPM	Fixed Admin Load	Variable Admin Low	Variable Admin High	Profit @ 2%	Premium Tax @ 5.5%	Low Rates w/out FMP	High Rates w/out FMP
Gulf	SSI	Newborn, 0-2 Months	288	$ 20,485.34	$ 22,204.25	$ 237.73	$ 260.47	$ 20,723.07	$ 22,464.72	$ 13.60	$ 951.51	$ 942.46	2.00%	5.50%	$ 23,446.68	$ 25,319.76
Gulf	SSI	Newborn, 3-11 Months	2,085	$ 3,608.84	$ 3,921.26	$ 12.74	$ 13.88	$ 3,621.59	$ 3,935.14	$ 13.60	$ 155.72	$ 155.34	2.00%	5.50%	$ 4,098.28	$ 4,436.84
Gulf	SSI	Child, 1-20 Years	132,759	$ 395.45	$ 426.57	$ 159.58	$ 172.92	$ 555.03	$ 599.49	$ 13.60	$ 21.88	$ 21.86	2.00%	5.50%	$ 638.39	$ 686.44
Gulf	SSI	Adult, 21+ Years	278,885	$ 901.66	$ 976.85	$ 101.62	$ 110.33	$ 1,003.28	$ 1,087.18	$ 13.60	$ 36.47	$ 36.83	2.00%	5.50%	$ 1,138.75	$ 1,229.85
Gulf	Family and Children	Newborn, 0-2 Months	33,958	$ 1,699.80	$ 1,863.60	$ 23.79	$ 25.98	$ 1,723.59	$ 1,889.58	$ 13.60	$ 79.02	$ 79.17	2.00%	5.50%	$ 1,963.47	$ 2,143.08
Gulf	Family and Children	Newborn, 3-11 Months	118,165	$ 197.20	$ 214.99	$ 2.45	$ 2.66	$ 199.65	$ 217.65	$ 13.60	$ 8.71	$ 8.70	2.00%	5.50%	$ 239.96	$ 259.40
Gulf	Family and Children	Child, 1-20 Years	2,211,981	$ 93.26	$ 101.47	$ 33.83	$ 36.76	$ 127.09	$ 138.23	$ 13.60	$ 5.19	$ 5.21	2.00%	5.50%	$ 157.71	$ 169.77
Gulf	Family and Children	Adult, 21+ Years	381,028	$ 229.80	$ 247.99	$ 29.29	$ 31.53	$ 259.09	$ 279.51	$ 13.60	$ 9.98	$ 9.98	2.00%	5.50%	$ 305.59	$ 327.67
Gulf	Foster Care Children	Foster Care, All Ages Male & Female	27,754	$ 173.55	$ 188.33	$ 210.63	$ 228.83	$ 384.18	$ 417.16	$ 13.60	$ 16.04	$ 16.03	2.00%	5.50%	$ 447.37	$ 483.02
Gulf	Breast and Cervical Cancer	BCC, All Ages Female	1,842	$ 1,519.49	$ 1,630.40	$ 15.59	$ 16.73	$ 1,535.08	$ 1,647.12	$ 13.60	$ 61.48	$ 60.96	2.00%	5.50%	$ 1,740.71	$ 1,861.28
Gulf	LaCHIP Affordable Plan	All Ages	8,886	$ 134.56	$ 145.55	$ 16.46	$ 17.80	$ 151.02	$ 163.35	$ 13.60	$ 5.75	$ 5.77	2.00%	5.50%	$ 184.18	$ 197.54
Gulf	HCBS Waiver	20 & Under, Male and Female	1,223	$ 1,264.28	$ 1,370.65	$ 113.86	$ 123.79	$ 1,378.14	$ 1,494.44	$ 13.60	$ 56.66	$ 56.61	2.00%	5.50%	$ 1,565.84	$ 1,691.52
Gulf	HCBS Waiver	21+ Years, Male and Female	4,394	$ 1,049.76	$ 1,143.03	$ 80.53	$ 87.87	$ 1,130.29	$ 1,230.89	$ 13.60	$ 40.03	$ 40.72	2.00%	5.50%	$ 1,279.91	$ 1,389.42
Gulf	Chisholm Class Members	Chisholm, All Ages Male & Female	11,336	$ 902.00	$ 964.82	$ 133.67	$ 144.86	$ 1,035.67	$ 1,109.68	$ 13.60	$ 54.40	$ 53.45	2.00%	5.50%	$ 1,193.16	$ 1,272.14
Gulf	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Fema	11,863	$ 4.36	$ 4.58	$ 100.21	$ 105.52	$ 104.57	$ 110.10	$ 2.58	$ 9.37	$ 9.44	2.00%	5.50%	$ 125.97	$ 132.02
Gulf	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	334,772	$ 5.67	$ 5.90	$ 19.95	$ 20.75	$ 25.62	$ 26.66	$ 2.58	$ 2.30	$ 2.29	2.00%	5.50%	$ 32.98	$ 34.08
Gulf	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	5,271	$ 4.30	$ 4.51	$ 32.64	$ 34.37	$ 36.93	$ 38.88	$ 2.58	$ 3.31	$ 3.34	2.00%	5.50%	$ 46.30	$ 48.44
Gulf	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	11,317	$ 10.28	$ 10.81	$ 41.34	$ 43.46	$ 51.62	$ 54.26	$ 2.58	$ 4.63	$ 4.65	2.00%	5.50%	$ 63.60	$ 66.48
Gulf	SBH - Other	SBH - Other, All Ages	11,338	$ 39.46	$ 41.47	$ 95.24	$ 100.17	$ 134.70	$ 141.64	$ 2.58	$ 12.07	$ 12.15	2.00%	5.50%	$ 161.46	$ 169.05
Gulf	Maternity Kick payment	Maternity Kick payment, All Ages	9,173	$ 7,080.49	$ 7,532.52			$ 7,080.49	$ 7,532.52	$ -	$ 340.18	$ 340.18	2.00%	5.50%	$ 8,022.35	$ 8,511.02
Capital	SSI	Newborn, 0-2 Months	217	$ 20,485.34	$ 22,204.25	$ 237.73	$ 260.47	$ 20,723.07	$ 22,464.72	$ 13.60	$ 951.51	$ 942.46	2.00%	5.50%	$ 23,446.68	$ 25,319.76
Capital	SSI	Newborn, 3-11 Months	1,573	$ 3,608.84	$ 3,921.26	$ 12.74	$ 13.88	$ 3,621.59	$ 3,935.14	$ 13.60	$ 155.72	$ 155.34	2.00%	5.50%	$ 4,098.28	$ 4,436.84
Capital	SSI	Child, 1-20 Years	97,313	$ 467.44	$ 504.19	$ 140.95	$ 152.64	$ 608.39	$ 656.83	$ 13.60	$ 21.88	$ 21.86	2.00%	5.50%	$ 696.08	$ 748.42
Capital	SSI	Adult, 21+ Years	195,669	$ 976.24	$ 1,057.70	$ 82.51	$ 89.56	$ 1,058.75	$ 1,147.26	$ 13.60	$ 36.47	$ 36.83	2.00%	5.50%	$ 1,198.73	$ 1,294.80
Capital	Family and Children	Newborn, 0-2 Months	25,616	$ 1,724.19	$ 1,890.32	$ 11.53	$ 12.59	$ 1,735.72	$ 1,902.91	$ 13.60	$ 79.02	$ 79.17	2.00%	5.50%	$ 1,976.58	$ 2,157.49
Capital	Family and Children	Newborn, 3-11 Months	89,137	$ 194.30	$ 211.81	$ 1.66	$ 1.80	$ 195.95	$ 213.61	$ 13.60	$ 8.71	$ 8.70	2.00%	5.50%	$ 235.96	$ 255.04
Capital	Family and Children	Child, 1-20 Years	1,916,871	$ 100.85	$ 109.75	$ 33.41	$ 36.30	$ 134.26	$ 146.04	$ 13.60	$ 5.19	$ 5.21	2.00%	5.50%	$ 165.46	$ 178.22
Capital	Family and Children	Adult, 21+ Years	300,951	$ 256.49	$ 276.74	$ 30.03	$ 32.32	$ 286.52	$ 309.07	$ 13.60	$ 9.98	$ 9.98	2.00%	5.50%	$ 335.24	$ 359.62
Capital	Foster Care Children	Foster Care, All Ages Male & Female	40,519	$ 173.55	$ 188.33	$ 210.63	$ 228.83	$ 384.18	$ 417.16	$ 13.60	$ 16.04	$ 16.03	2.00%	5.50%	$ 447.37	$ 483.02
Capital	Breast and Cervical Cancer	BCC, All Ages Female	2,242	$ 1,519.49	$ 1,630.40	$ 15.59	$ 16.73	$ 1,535.08	$ 1,647.12	$ 13.60	$ 61.48	$ 60.96	2.00%	5.50%	$ 1,740.71	$ 1,861.28
Capital	LaCHIP Affordable Plan	All Ages	11,562	$ 134.56	$ 145.55	$ 16.46	$ 17.80	$ 151.02	$ 163.35	$ 13.60	$ 5.75	$ 5.77	2.00%	5.50%	$ 184.18	$ 197.54
Capital	HCBS Waiver	20 & Under, Male and Female	1,184	$ 1,264.28	$ 1,370.65	$ 113.86	$ 123.79	$ 1,378.14	$ 1,494.44	$ 13.60	$ 56.66	$ 56.61	2.00%	5.50%	$ 1,565.84	$ 1,691.52
Capital	HCBS Waiver	21+ Years, Male and Female	3,407	$ 1,049.76	$ 1,143.03	$ 80.53	$ 87.87	$ 1,130.29	$ 1,230.89	$ 13.60	$ 40.03	$ 40.72	2.00%	5.50%	$ 1,279.91	$ 1,389.42
Capital	Chisholm Class Members	Chisholm, All Ages Male & Female	8,726	$ 902.00	$ 964.82	$ 133.67	$ 144.86	$ 1,035.67	$ 1,109.68	$ 13.60	$ 54.40	$ 53.45	2.00%	5.50%	$ 1,193.16	$ 1,272.14
Capital	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Fema	12,470	$ 4.36	$ 4.58	$ 100.21	$ 105.52	$ 104.57	$ 110.10	$ 2.58	$ 9.37	$ 9.44	2.00%	5.50%	$ 125.97	$ 132.02
Capital	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	265,049	$ 8.87	$ 9.23	$ 7.96	$ 8.28	$ 16.83	$ 17.51	$ 2.58	$ 2.30	$ 2.29	2.00%	5.50%	$ 23.47	$ 24.20
Capital	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	6,022	$ 4.30	$ 4.51	$ 32.64	$ 34.37	$ 36.93	$ 38.88	$ 2.58	$ 3.31	$ 3.34	2.00%	5.50%	$ 46.30	$ 48.44
Capital	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	10,929	$ 10.28	$ 10.81	$ 41.34	$ 43.46	$ 51.62	$ 54.26	$ 2.58	$ 4.63	$ 4.65	2.00%	5.50%	$ 63.60	$ 66.48
Capital	SBH - Other	SBH - Other, All Ages	12,714	$ 39.46	$ 41.47	$ 95.24	$ 100.17	$ 134.70	$ 141.64	$ 2.58	$ 12.07	$ 12.15	2.00%	5.50%	$ 161.46	$ 169.05
Capital	Maternity Kick payment	Maternity Kick payment, All Ages	7,917	$ 6,212.81	$ 6,609.44			$ 6,212.81	$ 6,609.44	$ -	$ 340.18	$ 340.18	2.00%	5.50%	$ 7,084.32	$ 7,513.11

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Appendix Q: Non-Expansion Loaded Rate Development

Table 1: Non-Expansion Loaded Rate Development

				PH Services		SBH Services		All Services		Retention Load						
Region Name	COA Description	Rate Cell Description	Projected Membership	Low PMPM	High PMPM	Low PMPM	High PMPM	Low PMPM	High PMPM	Fixed Admin Load	Variable Admin Low	Variable Admin High	Profit @ 2%	Premium Tax @ 5.5%	Low Rates w/out FMP	High Rates w/out FMP
South Central	SSI	Newborn, 0-2 Months	253	$ 20,485.34	$ 22,204.25	$ 237.73	$ 260.47	$ 20,723.07	$ 22,464.72	$ 13.60	$ 951.51	$ 942.46	2.00%	5.50%	$ 23,446.68	$ 25,319.76
South Central	SSI	Newborn, 3-11 Months	1,838	$ 3,608.84	$ 3,921.26	$ 12.74	$ 13.88	$ 3,621.59	$ 3,935.14	$ 13.60	$ 155.72	$ 155.34	2.00%	5.50%	$ 4,098.28	$ 4,436.84
South Central	SSI	Child, 1-20 Years	105,972	$ 437.46	$ 470.14	$ 139.76	$ 151.37	$ 577.22	$ 621.51	$ 13.60	$ 21.88	$ 21.86	2.00%	5.50%	$ 662.38	$ 710.24
South Central	SSI	Adult, 21+ Years	243,844	$ 837.38	$ 907.36	$ 86.03	$ 93.38	$ 923.41	$ 1,000.74	$ 13.60	$ 36.47	$ 36.83	2.00%	5.50%	$ 1,052.41	$ 1,136.40
South Central	Family and Children	Newborn, 0-2 Months	29,937	$ 1,962.11	$ 2,150.90	$ 2.27	$ 2.48	$ 1,964.38	$ 2,153.38	$ 13.60	$ 79.02	$ 79.17	2.00%	5.50%	$ 2,223.78	$ 2,428.27
South Central	Family and Children	Newborn, 3-11 Months	104,174	$ 194.35	$ 211.85	$ 1.59	$ 1.73	$ 195.94	$ 213.58	$ 13.60	$ 8.71	$ 8.70	2.00%	5.50%	$ 235.95	$ 255.01
South Central	Family and Children	Child, 1-20 Years	2,156,070	$ 105.29	$ 114.48	$ 29.75	$ 32.32	$ 135.04	$ 146.80	$ 13.60	$ 5.19	$ 5.21	2.00%	5.50%	$ 166.30	$ 179.03
South Central	Family and Children	Adult, 21+ Years	337,770	$ 229.59	$ 247.78	$ 32.11	$ 34.57	$ 261.71	$ 282.34	$ 13.60	$ 9.98	$ 9.98	2.00%	5.50%	$ 308.42	$ 330.73
South Central	Foster Care Children	Foster Care, All Ages Male & Female	50,835	$ 173.55	$ 188.33	$ 210.63	$ 228.83	$ 384.18	$ 417.16	$ 13.60	$ 16.04	$ 16.03	2.00%	5.50%	$ 447.37	$ 483.02
South Central	Breast and Cervical Cancer	BCC, All Ages Female	1,370	$ 1,519.49	$ 1,630.40	$ 15.59	$ 16.73	$ 1,535.08	$ 1,647.12	$ 13.60	$ 61.48	$ 60.96	2.00%	5.50%	$ 1,740.71	$ 1,861.28
South Central	LaCHIP Affordable Plan	All Ages	10,797	$ 134.56	$ 145.55	$ 16.46	$ 17.80	$ 151.02	$ 163.35	$ 13.60	$ 5.75	$ 5.77	2.00%	5.50%	$ 184.18	$ 197.54
South Central	HCBS Waiver	20 & Under, Male and Female	1,289	$ 1,264.28	$ 1,370.65	$ 113.86	$ 123.79	$ 1,378.14	$ 1,494.44	$ 13.60	$ 56.66	$ 56.61	2.00%	5.50%	$ 1,565.84	$ 1,691.52
South Central	HCBS Waiver	21+ Years, Male and Female	4,262	$ 1,049.76	$ 1,143.03	$ 80.53	$ 87.87	$ 1,130.29	$ 1,230.89	$ 13.60	$ 40.03	$ 40.72	2.00%	5.50%	$ 1,279.91	$ 1,389.42
South Central	Chisholm Class Members	Chisholm, All Ages Male & Female	11,368	$ 902.00	$ 964.82	$ 133.67	$ 144.86	$ 1,035.67	$ 1,109.68	$ 13.60	$ 54.40	$ 53.45	2.00%	5.50%	$ 1,193.16	$ 1,272.14
South Central	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Fema	12,321	$ 4.36	$ 4.58	$ 100.21	$ 105.52	$ 104.57	$ 110.10	$ 2.58	$ 9.37	$ 9.44	2.00%	5.50%	$ 125.97	$ 132.02
South Central	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	349,901	$ 8.52	$ 8.86	$ 8.21	$ 8.54	$ 16.72	$ 17.40	$ 2.58	$ 2.30	$ 2.29	2.00%	5.50%	$ 23.36	$ 24.08
South Central	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	5,428	$ 4.30	$ 4.51	$ 32.64	$ 34.37	$ 36.93	$ 38.88	$ 2.58	$ 3.31	$ 3.34	2.00%	5.50%	$ 46.30	$ 48.44
South Central	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	11,765	$ 10.28	$ 10.81	$ 41.34	$ 43.46	$ 51.62	$ 54.26	$ 2.58	$ 4.63	$ 4.65	2.00%	5.50%	$ 63.60	$ 66.48
South Central	SBH - Other	SBH - Other, All Ages	16,206	$ 39.46	$ 41.47	$ 95.24	$ 100.17	$ 134.70	$ 141.64	$ 2.58	$ 12.07	$ 12.15	2.00%	5.50%	$ 161.46	$ 169.05
South Central	Maternity Kick payment	Maternity Kick payment, All Ages	9,159	$ 6,195.53	$ 6,591.06			$ 6,195.53	$ 6,591.06	$ -	$ 340.18	$ 340.18	2.00%	5.50%	$ 7,065.63	$ 7,493.23
North	SSI	Newborn, 0-2 Months	205	$ 20,485.34	$ 22,204.25	$ 237.73	$ 260.47	$ 20,723.07	$ 22,464.72	$ 13.60	$ 951.51	$ 942.46	2.00%	5.50%	$ 23,446.68	$ 25,319.76
North	SSI	Newborn, 3-11 Months	1,487	$ 3,608.84	$ 3,921.26	$ 12.74	$ 13.88	$ 3,621.59	$ 3,935.14	$ 13.60	$ 155.72	$ 155.34	2.00%	5.50%	$ 4,098.28	$ 4,436.84
North	SSI	Child, 1-20 Years	120,631	$ 373.39	$ 401.29	$ 210.86	$ 228.46	$ 584.26	$ 629.74	$ 13.60	$ 21.88	$ 21.86	2.00%	5.50%	$ 669.98	$ 719.14
North	SSI	Adult, 21+ Years	220,396	$ 771.68	$ 836.22	$ 80.32	$ 87.19	$ 852.00	$ 923.41	$ 13.60	$ 36.47	$ 36.83	2.00%	5.50%	$ 975.22	$ 1,052.80
North	Family and Children	Newborn, 0-2 Months	24,218	$ 1,611.89	$ 1,767.27	$ 43.96	$ 48.01	$ 1,655.85	$ 1,815.28	$ 13.60	$ 79.02	$ 79.17	2.00%	5.50%	$ 1,890.24	$ 2,062.76
North	Family and Children	Newborn, 3-11 Months	84,273	$ 183.62	$ 200.18	$ 1.47	$ 1.60	$ 185.10	$ 201.78	$ 13.60	$ 8.71	$ 8.70	2.00%	5.50%	$ 224.22	$ 242.25
North	Family and Children	Child, 1-20 Years	1,654,849	$ 93.09	$ 101.17	$ 53.34	$ 57.95	$ 146.43	$ 159.12	$ 13.60	$ 5.19	$ 5.21	2.00%	5.50%	$ 178.61	$ 192.36
North	Family and Children	Adult, 21+ Years	251,972	$ 213.58	$ 230.53	$ 33.13	$ 35.66	$ 246.71	$ 266.19	$ 13.60	$ 9.98	$ 9.98	2.00%	5.50%	$ 292.20	$ 313.27
North	Foster Care Children	Foster Care, All Ages Male & Female	33,928	$ 173.55	$ 188.33	$ 210.63	$ 228.83	$ 384.18	$ 417.16	$ 13.60	$ 16.04	$ 16.03	2.00%	5.50%	$ 447.37	$ 483.02
North	Breast and Cervical Cancer	BCC, All Ages Female	1,770	$ 1,519.49	$ 1,630.40	$ 15.59	$ 16.73	$ 1,535.08	$ 1,647.12	$ 13.60	$ 61.48	$ 60.96	2.00%	5.50%	$ 1,740.71	$ 1,861.28
North	LaCHIP Affordable Plan	All Ages	8,055	$ 134.56	$ 145.55	$ 16.46	$ 17.80	$ 151.02	$ 163.35	$ 13.60	$ 5.75	$ 5.77	2.00%	5.50%	$ 184.18	$ 197.54
North	HCBS Waiver	20 & Under, Male and Female	1,039	$ 1,264.28	$ 1,370.65	$ 113.86	$ 123.79	$ 1,378.14	$ 1,494.44	$ 13.60	$ 56.66	$ 56.61	2.00%	5.50%	$ 1,565.84	$ 1,691.52
North	HCBS Waiver	21+ Years, Male and Female	3,552	$ 1,049.76	$ 1,143.03	$ 80.53	$ 87.87	$ 1,130.29	$ 1,230.89	$ 13.60	$ 40.03	$ 40.72	2.00%	5.50%	$ 1,279.91	$ 1,389.42
North	Chisholm Class Members	Chisholm, All Ages Male & Female	7,764	$ 902.00	$ 964.82	$ 133.67	$ 144.86	$ 1,035.67	$ 1,109.68	$ 13.60	$ 54.40	$ 53.45	2.00%	5.50%	$ 1,193.16	$ 1,272.14
North	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Fema	10,563	$ 4.36	$ 4.58	$ 100.21	$ 105.52	$ 104.57	$ 110.10	$ 2.58	$ 9.37	$ 9.44	2.00%	5.50%	$ 125.97	$ 132.02
North	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	282,304	$ 9.18	$ 9.55	$ 12.01	$ 12.49	$ 21.19	$ 22.04	$ 2.58	$ 2.30	$ 2.29	2.00%	5.50%	$ 28.18	$ 29.09
North	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	3,490	$ 4.30	$ 4.51	$ 32.64	$ 34.37	$ 36.93	$ 38.88	$ 2.58	$ 3.31	$ 3.34	2.00%	5.50%	$ 46.30	$ 48.44
North	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	8,966	$ 10.28	$ 10.81	$ 41.34	$ 43.46	$ 51.62	$ 54.26	$ 2.58	$ 4.63	$ 4.65	2.00%	5.50%	$ 63.60	$ 66.48
North	SBH - Other	SBH - Other, All Ages	14,864	$ 39.46	$ 41.47	$ 95.24	$ 100.17	$ 134.70	$ 141.64	$ 2.58	$ 12.07	$ 12.15	2.00%	5.50%	$ 161.46	$ 169.05
North	Maternity Kick payment	Maternity Kick payment, All Ages	6,796	$ 6,216.70	$ 6,613.58			$ 6,216.70	$ 6,613.58	$ -	$ 340.18	$ 340.18	2.00%	5.50%	$ 7,088.52	$ 7,517.58

Appendix Q: Non-Expansion Loaded Rate Development

Table 1: Non-Expansion Loaded Rate Development

Region Name	COA Description	Rate Cell Description	Projected Membership	Low Rates w/out FMP	High Rates w/out FMP	FMP Add-On Total	Low Rates with FMP	High Rates with FMP
Gulf	SSI	Newborn, 0-2 Months	288	$ 23,446.68	$ 25,319.76	$ 11,159.80	$ 34,606.48	$ 36,479.56
Gulf	SSI	Newborn, 3-11 Months	2,085	$ 4,098.28	$ 4,436.84	$ 1,716.57	$ 5,814.84	$ 6,153.41
Gulf	SSI	Child, 1-20 Years	132,759	$ 638.39	$ 686.44	$ 128.76	$ 767.15	$ 815.20
Gulf	SSI	Adult, 21+ Years	278,885	$ 1,138.75	$ 1,229.85	$ 308.83	$ 1,447.58	$ 1,538.68
Gulf	Family and Children	Newborn, 0-2 Months	33,958	$ 1,963.47	$ 2,143.08	$ 1,185.00	$ 3,148.47	$ 3,328.07
Gulf	Family and Children	Newborn, 3-11 Months	118,165	$ 239.96	$ 259.40	$ 71.67	$ 311.62	$ 331.07
Gulf	Family and Children	Child, 1-20 Years	2,211,981	$ 157.71	$ 169.77	$ 23.01	$ 180.72	$ 192.79
Gulf	Family and Children	Adult, 21+ Years	381,028	$ 305.59	$ 327.67	$ 67.12	$ 372.71	$ 394.79
Gulf	Foster Care Children	Foster Care, All Ages Male & Female	27,754	$ 447.37	$ 483.02	$ 27.42	$ 474.80	$ 510.44
Gulf	Breast and Cervical Cancer	BCC, All Ages Female	1,842	$ 1,740.71	$ 1,861.28	$ 464.20	$ 2,204.92	$ 2,325.48
Gulf	LaCHIP Affordable Plan	All Ages	8,886	$ 184.18	$ 197.54	$ 22.49	$ 206.68	$ 220.03
Gulf	HCBS Waiver	20 & Under, Male and Female	1,223	$ 1,565.84	$ 1,691.52	$ 270.48	$ 1,836.31	$ 1,961.99
Gulf	HCBS Waiver	21+ Years, Male and Female	4,394	$ 1,279.91	$ 1,389.42	$ 234.71	$ 1,514.62	$ 1,624.13
Gulf	Chisholm Class Members	Chisholm, All Ages Male & Female	11,336	$ 1,193.16	$ 1,272.14	$ 163.14	$ 1,356.30	$ 1,435.28
Gulf	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Fema	11,863	$ 125.97	$ 132.02	$ 0.23	$ 126.20	$ 132.25
Gulf	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	334,772	$ 32.98	$ 34.08	$ 0.12	$ 33.09	$ 34.20
Gulf	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	5,271	$ 46.30	$ 48.44	$ 0.86	$ 47.16	$ 49.30
Gulf	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	11,317	$ 63.60	$ 66.48	$ 2.47	$ 66.07	$ 68.95
Gulf	SBH - Other	SBH - Other, All Ages	11,338	$ 161.46	$ 169.05	$ 26.76	$ 188.22	$ 195.81
Gulf	Maternity Kick payment	Maternity Kick payment, All Ages	9,173	$ 8,022.35	$ 8,511.02	$ 5,527.98	$ 13,550.33	$ 14,039.00
Capital	SSI	Newborn, 0-2 Months	217	$ 23,446.68	$ 25,319.76	$ 11,159.80	$ 34,606.48	$ 36,479.56
Capital	SSI	Newborn, 3-11 Months	1,573	$ 4,098.28	$ 4,436.84	$ 1,716.57	$ 5,814.84	$ 6,153.41
Capital	SSI	Child, 1-20 Years	97,313	$ 696.08	$ 748.42	$ 71.49	$ 767.57	$ 819.91
Capital	SSI	Adult, 21+ Years	195,669	$ 1,198.73	$ 1,294.80	$ 198.25	$ 1,396.98	$ 1,493.05
Capital	Family and Children	Newborn, 0-2 Months	25,616	$ 1,976.58	$ 2,157.49	$ 942.12	$ 2,918.71	$ 3,099.62
Capital	Family and Children	Newborn, 3-11 Months	89,137	$ 235.96	$ 255.04	$ 52.01	$ 287.97	$ 307.05
Capital	Family and Children	Child, 1-20 Years	1,916,871	$ 165.46	$ 178.22	$ 16.94	$ 182.39	$ 195.16
Capital	Family and Children	Adult, 21+ Years	300,951	$ 335.24	$ 359.62	$ 57.29	$ 392.53	$ 416.90
Capital	Foster Care Children	Foster Care, All Ages Male & Female	40,519	$ 447.37	$ 483.02	$ 27.42	$ 474.80	$ 510.44
Capital	Breast and Cervical Cancer	BCC, All Ages Female	2,242	$ 1,740.71	$ 1,861.28	$ 464.20	$ 2,204.92	$ 2,325.48
Capital	LaCHIP Affordable Plan	All Ages	11,562	$ 184.18	$ 197.54	$ 22.49	$ 206.68	$ 220.03
Capital	HCBS Waiver	20 & Under, Male and Female	1,184	$ 1,565.84	$ 1,691.52	$ 270.48	$ 1,836.31	$ 1,961.99
Capital	HCBS Waiver	21+ Years, Male and Female	3,407	$ 1,279.91	$ 1,389.42	$ 234.71	$ 1,514.62	$ 1,624.13
Capital	Chisholm Class Members	Chisholm, All Ages Male & Female	8,726	$ 1,193.16	$ 1,272.14	$ 163.14	$ 1,356.30	$ 1,435.28
Capital	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Fema	12,470	$ 125.97	$ 132.02	$ 0.23	$ 126.20	$ 132.25
Capital	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	265,049	$ 23.47	$ 24.20	$ 0.10	$ 23.57	$ 24.29
Capital	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	6,022	$ 46.30	$ 48.44	$ 0.86	$ 47.16	$ 49.30
Capital	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	10,929	$ 63.60	$ 66.48	$ 2.47	$ 66.07	$ 68.95
Capital	SBH - Other	SBH - Other, All Ages	12,714	$ 161.46	$ 169.05	$ 26.76	$ 188.22	$ 195.81
Capital	Maternity Kick payment	Maternity Kick payment, All Ages	7,917	$ 7,084.32	$ 7,513.11	$ 3,802.93	$ 10,887.24	$ 11,316.03

Appendix Q: Non-Expansion Loaded Rate Development

Table 1: Non-Expansion Loaded Rate Development

Region Name	COA Description	Rate Cell Description	Projected Membership	Low Rates w/out FMP	High Rates w/out FMP	FMP Add-On Total	Low Rates with FMP	High Rates with FMP
South Central	SSI	Newborn, 0-2 Months	253	$ 23,446.68	$ 25,319.76	$ 11,159.80	$ 34,606.48	$ 36,479.56
South Central	SSI	Newborn, 3-11 Months	1,838	$ 4,098.28	$ 4,436.84	$ 1,716.57	$ 5,814.84	$ 6,153.41
South Central	SSI	Child, 1-20 Years	105,972	$ 662.38	$ 710.24	$ 74.87	$ 737.25	$ 785.11
South Central	SSI	Adult, 21+ Years	243,844	$ 1,052.41	$ 1,136.40	$ 225.44	$ 1,277.84	$ 1,361.83
South Central	Family and Children	Newborn, 0-2 Months	29,937	$ 2,223.78	$ 2,428.27	$ 1,052.27	$ 3,276.05	$ 3,480.54
South Central	Family and Children	Newborn, 3-11 Months	104,174	$ 235.95	$ 255.01	$ 50.67	$ 286.62	$ 305.68
South Central	Family and Children	Child, 1-20 Years	2,156,070	$ 166.30	$ 179.03	$ 15.90	$ 182.20	$ 194.93
South Central	Family and Children	Adult, 21+ Years	337,770	$ 308.42	$ 330.73	$ 57.00	$ 365.42	$ 387.73
South Central	Foster Care Children	Foster Care, All Ages Male & Female	50,835	$ 447.37	$ 483.02	$ 27.42	$ 474.80	$ 510.44
South Central	Breast and Cervical Cancer	BCC, All Ages Female	1,370	$ 1,740.71	$ 1,861.28	$ 464.20	$ 2,204.92	$ 2,325.48
South Central	LaCHIP Affordable Plan	All Ages	10,797	$ 184.18	$ 197.54	$ 22.49	$ 206.68	$ 220.03
South Central	HCBS Waiver	20 & Under, Male and Female	1,289	$ 1,565.84	$ 1,691.52	$ 270.48	$ 1,836.31	$ 1,961.99
South Central	HCBS Waiver	21+ Years, Male and Female	4,262	$ 1,279.91	$ 1,389.42	$ 234.71	$ 1,514.62	$ 1,624.13
South Central	Chisholm Class Members	Chisholm, All Ages Male & Female	11,368	$ 1,193.16	$ 1,272.14	$ 163.14	$ 1,356.30	$ 1,435.28
South Central	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Fema	12,321	$ 125.97	$ 132.02	$ 0.23	$ 126.20	$ 132.25
South Central	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	349,901	$ 23.36	$ 24.08	$ 0.07	$ 23.43	$ 24.15
South Central	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	5,428	$ 46.30	$ 48.44	$ 0.86	$ 47.16	$ 49.30
South Central	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	11,765	$ 63.60	$ 66.48	$ 2.47	$ 66.07	$ 68.95
South Central	SBH - Other	SBH - Other, All Ages	16,206	$ 161.46	$ 169.05	$ 26.76	$ 188.22	$ 195.81
South Central	Maternity Kick payment	Maternity Kick payment, All Ages	9,159	$ 7,065.63	$ 7,493.23	$ 2,626.73	$ 9,692.36	$ 10,119.96
North	SSI	Newborn, 0-2 Months	205	$ 23,446.68	$ 25,319.76	$ 11,159.80	$ 34,606.48	$ 36,479.56
North	SSI	Newborn, 3-11 Months	1,487	$ 4,098.28	$ 4,436.84	$ 1,716.57	$ 5,814.84	$ 6,153.41
North	SSI	Child, 1-20 Years	120,631	$ 669.98	$ 719.14	$ 83.30	$ 753.29	$ 802.44
North	SSI	Adult, 21+ Years	220,396	$ 975.22	$ 1,052.80	$ 218.06	$ 1,193.27	$ 1,270.86
North	Family and Children	Newborn, 0-2 Months	24,218	$ 1,890.24	$ 2,062.76	$ 1,093.48	$ 2,983.72	$ 3,156.24
North	Family and Children	Newborn, 3-11 Months	84,273	$ 224.22	$ 242.25	$ 56.88	$ 281.10	$ 299.13
North	Family and Children	Child, 1-20 Years	1,654,849	$ 178.61	$ 192.36	$ 19.43	$ 198.05	$ 211.79
North	Family and Children	Adult, 21+ Years	251,972	$ 292.20	$ 313.27	$ 61.75	$ 353.95	$ 375.02
North	Foster Care Children	Foster Care, All Ages Male & Female	33,928	$ 447.37	$ 483.02	$ 27.42	$ 474.80	$ 510.44
North	Breast and Cervical Cancer	BCC, All Ages Female	1,770	$ 1,740.71	$ 1,861.28	$ 464.20	$ 2,204.92	$ 2,325.48
North	LaCHIP Affordable Plan	All Ages	8,055	$ 184.18	$ 197.54	$ 22.49	$ 206.68	$ 220.03
North	HCBS Waiver	20 & Under, Male and Female	1,039	$ 1,565.84	$ 1,691.52	$ 270.48	$ 1,836.31	$ 1,961.99
North	HCBS Waiver	21+ Years, Male and Female	3,552	$ 1,279.91	$ 1,389.42	$ 234.71	$ 1,514.62	$ 1,624.13
North	Chisholm Class Members	Chisholm, All Ages Male & Female	7,764	$ 1,193.16	$ 1,272.14	$ 163.14	$ 1,356.30	$ 1,435.28
North	SBH - Chisholm Class Members	SBH - Chisholm, All Ages Male & Fema	10,563	$ 125.97	$ 132.02	$ 0.23	$ 126.20	$ 132.25
North	SBH - Dual Eligible	SBH - Dual Eligible, All Ages	282,304	$ 28.18	$ 29.09	$ 0.09	$ 28.26	$ 29.18
North	SBH - HCBS Waiver	SBH - 20 & Under, Male and Female	3,490	$ 46.30	$ 48.44	$ 0.86	$ 47.16	$ 49.30
North	SBH - HCBS Waiver	SBH - 21+ Years, Male and Female	8,966	$ 63.60	$ 66.48	$ 2.47	$ 66.07	$ 68.95
North	SBH - Other	SBH - Other, All Ages	14,864	$ 161.46	$ 169.05	$ 26.76	$ 188.22	$ 195.81
North	Maternity Kick payment	Maternity Kick payment, All Ages	6,796	$ 7,088.52	$ 7,517.58	$ 3,600.32	$ 10,688.84	$ 11,117.89

Expansion Annual Trend Factors

COS Description	Trend Low	Trend High
Inpatient Hospital	1.8%	3.8%
Outpatient Hospital	0.8%	2.8%
Primary Care Physician	1.5%	3.5%
Specialty Care Physician	1.5%	3.5%
FQHC/RHC	1.5%	3.5%
EPSDT	1.5%	3.5%
Certified Nurse Practitioners/clinical Nurse	1.5%	3.5%
Lab/Radiology	1.0%	3.1%
Home Health	1.0%	3.1%
Emergency Transportation	1.0%	3.0%
Non-Emergency Transportation	1.0%	3.0%
Rehabilitation Services (OT, PT, ST)	1.0%	3.1%
DME	1.0%	3.1%
Clinic	1.5%	3.5%
Family Planning	1.5%	3.5%
Other	1.0%	3.0%
Prescribed drugs	7.6%	9.6%
Emergency Room	0.8%	2.8%
Basic Behavioral Health	1.5%	3.5%
Hospice	1.8%	3.8%
Personal Care Services	0.0%	0.0%
Inpatient Services -- Mental Health	1.0%	3.0%
Emergency Room -- Mental Health	4.0%	6.0%
Professional/Other -- Mental Health	4.0%	6.0%

High Needs Rate Buildup					
	[A]	[B]	[C]=[A]*[B]	[D]	[E]=[C]*[D]
Region	Expansion Projected Claims PMPM	High Needs Factor	High Needs Adjusted PMPM	Age/Gender Factor	Age/Gender Adjusted PMPM
Gulf	$ 364.26	3.000	$ 1,092.79	1.137	$ 1,242.06
Capital	$ 388.00	3.000	$ 1,164.01	1.137	$ 1,323.01
South Central	$ 355.43	3.000	$ 1,066.29	1.137	$ 1,211.95
North	$ 333.80	3.000	$ 1,001.41	1.137	$ 1,138.21
Statewide	**$ 360.63**	**3.000**	**$ 1,081.89**	**1.137**	**$ 1,229.68**

Appendix T: Expansion Assumption Comparison

Table 1a: 2/1/2018 (Non-Gulf)

Assumption	Low	High
Acuity	1.1710	1.2310
Pent-Up Demand		
Adverse Selection		
Reverse Managed Care		

Table 1b: 2/1/2018 (Gulf)

Assumption	Low	High
Acuity	1.1710	1.2310
Pent-Up Demand		
Adverse Selection		
Reverse Managed Care		

Table 2a: 2/1/2017 (Non-Gulf)

Assumption	Low	High
Acuity	1.1760	1.2560
Pent-Up Demand	1.0757	1.0757
Adverse Selection	1.0026	1.0026
Reverse Managed Care	1.0393	1.0393

Table 2b: 2/1/2017 (Gulf)

Assumption	Low	High
Acuity	1.1760	1.2560
Pent-Up Demand	1.0695	1.0695
Adverse Selection	1.0017	1.0017
Reverse Managed Care	1.0393	1.0393

Table 3: Admin Comparison

Assumption	2/1/2018	2/1/2017
Admin	$ 31.84	$ 26.49

Appendix U: Expansion Physical Health Projected Claims PMPM Development

Table 1: Creation of Expansion Data (PH Services)

					Expansion Assumptions					
Region Name	COA Description	Rate Cell Description	Projected MMs	CY15/CY16 Blended TANF ADT PMPM	Age-Sex Factors	Low Acuity Factor	High Acuity Factor	High Needs Factor	Expansion PMPM Low	Expansion PMPM High
Gulf	Medicaid Expansion	Female, Age 19 - Age 24	254,031	$ 209.44	0.63	1.17	1.23	1.00	$ 154.46	$ 162.38
Gulf	Medicaid Expansion	Male, Age 19 - Age 24	153,172	$ 209.44	0.50	1.17	1.23	1.00	$ 122.58	$ 128.87
Gulf	Medicaid Expansion	Female, Age 25 - Age 39	489,877	$ 209.44	0.90	1.17	1.23	1.00	$ 220.58	$ 231.88
Gulf	Medicaid Expansion	Male, Age 25 - Age 39	264,296	$ 209.44	0.90	1.17	1.23	1.00	$ 221.24	$ 232.57
Gulf	Medicaid Expansion	Female, Age 40 - Age 49	210,335	$ 209.44	1.40	1.17	1.23	1.00	$ 344.53	$ 362.18
Gulf	Medicaid Expansion	Male, Age 40 - Age 49	134,712	$ 209.44	1.37	1.17	1.23	1.00	$ 336.24	$ 353.46
Gulf	Medicaid Expansion	Female, Age 50 - Age 64	287,816	$ 209.44	1.72	1.17	1.23	1.00	$ 421.99	$ 443.61
Gulf	Medicaid Expansion	Male, Age 50 - Age 64	202,206	$ 209.44	1.84	1.17	1.23	1.00	$ 450.06	$ 473.12
Gulf	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	7,420	$ 5.32	1.00	1.00	1.00	1.00	$ 5.32	$ 5.32
Gulf	Medicaid Expansion	SBH - Other, All Ages, Male & Female	163	$ 38.04	1.00	1.00	1.00	1.00	$ 38.04	$ 38.04
Gulf	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	299	$ 3.01	1.00	1.00	1.00	1.00	$ 3.01	$ 3.01
Gulf	Medicaid Expansion	High Needs, All Ages, Male & Female	1,804	$ 209.44	1.14	1.17	1.23	3.00	$ 836.26	$ 879.11
Gulf	Medicaid Expansion - Maternity Kick Payme	Maternity Kick Payment	9,173	$ 6,705.60	1.00	1.00	1.00	1.00	$ 6,705.60	$ 6,705.60
Capital	Medicaid Expansion	Female, Age 19 - Age 24	188,193	$ 234.15	0.63	1.17	1.23	1.00	$ 172.69	$ 181.54
Capital	Medicaid Expansion	Male, Age 19 - Age 24	94,165	$ 234.15	0.50	1.17	1.23	1.00	$ 137.05	$ 144.07
Capital	Medicaid Expansion	Female, Age 25 - Age 39	357,853	$ 234.15	0.90	1.17	1.23	1.00	$ 246.60	$ 259.24
Capital	Medicaid Expansion	Male, Age 25 - Age 39	141,812	$ 234.15	0.90	1.17	1.23	1.00	$ 247.34	$ 260.01
Capital	Medicaid Expansion	Female, Age 40 - Age 49	135,702	$ 234.15	1.40	1.17	1.23	1.00	$ 385.18	$ 404.91
Capital	Medicaid Expansion	Male, Age 40 - Age 49	71,061	$ 234.15	1.37	1.17	1.23	1.00	$ 375.91	$ 395.17
Capital	Medicaid Expansion	Female, Age 50 - Age 64	157,655	$ 234.15	1.72	1.17	1.23	1.00	$ 471.78	$ 495.95
Capital	Medicaid Expansion	Male, Age 50 - Age 64	104,412	$ 234.15	1.84	1.17	1.23	1.00	$ 503.16	$ 528.94
Capital	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	4,846	$ 8.32	1.00	1.00	1.00	1.00	$ 8.32	$ 8.32
Capital	Medicaid Expansion	SBH - Other, All Ages, Male & Female	105	$ 28.37	1.00	1.00	1.00	1.00	$ 28.37	$ 28.37
Capital	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	221	$ 4.03	1.00	1.00	1.00	1.00	$ 4.03	$ 4.03
Capital	Medicaid Expansion	High Needs, All Ages, Male & Female	1,572	$ 234.15	1.14	1.17	1.23	3.00	$ 934.92	$ 982.83
Capital	Medicaid Expansion - Maternity Kick Payme	Maternity Kick Payment	7,917	$ 5,776.24	1.00	1.00	1.00	1.00	$ 5,776.24	$ 5,776.24
South Central	Medicaid Expansion	Female, Age 19 - Age 24	219,085	$ 212.10	0.63	1.17	1.23	1.00	$ 156.43	$ 164.44
South Central	Medicaid Expansion	Male, Age 19 - Age 24	111,194	$ 212.10	0.50	1.17	1.23	1.00	$ 124.14	$ 130.50
South Central	Medicaid Expansion	Female, Age 25 - Age 39	418,440	$ 212.10	0.90	1.17	1.23	1.00	$ 223.38	$ 234.82
South Central	Medicaid Expansion	Male, Age 25 - Age 39	169,270	$ 212.10	0.90	1.17	1.23	1.00	$ 224.05	$ 235.53
South Central	Medicaid Expansion	Female, Age 40 - Age 49	161,105	$ 212.10	1.40	1.17	1.23	1.00	$ 348.90	$ 366.78
South Central	Medicaid Expansion	Male, Age 40 - Age 49	85,084	$ 212.10	1.37	1.17	1.23	1.00	$ 340.51	$ 357.95
South Central	Medicaid Expansion	Female, Age 50 - Age 64	189,203	$ 212.10	1.72	1.17	1.23	1.00	$ 427.35	$ 449.25
South Central	Medicaid Expansion	Male, Age 50 - Age 64	125,577	$ 212.10	1.84	1.17	1.23	1.00	$ 455.77	$ 479.12
South Central	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	5,738	$ 7.99	1.00	1.00	1.00	1.00	$ 7.99	$ 7.99
South Central	Medicaid Expansion	SBH - Other, All Ages, Male & Female	82	$ 47.76	1.00	1.00	1.00	1.00	$ 47.76	$ 47.76
South Central	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	204	$ 5.58	1.00	1.00	1.00	1.00	$ 5.58	$ 5.58
South Central	Medicaid Expansion	High Needs, All Ages, Male & Female	1,943	$ 212.10	1.14	1.17	1.23	3.00	$ 846.88	$ 890.27
South Central	Medicaid Expansion - Maternity Kick Payme	Maternity Kick Payment	9,159	$ 5,778.23	1.00	1.00	1.00	1.00	$ 5,778.23	$ 5,778.23
North	Medicaid Expansion	Female, Age 19 - Age 24	189,149	$ 199.94	0.63	1.17	1.23	1.00	$ 147.46	$ 155.01
North	Medicaid Expansion	Male, Age 19 - Age 24	94,786	$ 199.94	0.50	1.17	1.23	1.00	$ 117.02	$ 123.02
North	Medicaid Expansion	Female, Age 25 - Age 39	359,986	$ 199.94	0.90	1.17	1.23	1.00	$ 210.57	$ 221.36
North	Medicaid Expansion	Male, Age 25 - Age 39	142,891	$ 199.94	0.90	1.17	1.23	1.00	$ 211.20	$ 222.03
North	Medicaid Expansion	Female, Age 40 - Age 49	136,830	$ 199.94	1.40	1.17	1.23	1.00	$ 328.90	$ 345.76
North	Medicaid Expansion	Male, Age 40 - Age 49	71,639	$ 199.94	1.37	1.17	1.23	1.00	$ 320.99	$ 337.43
North	Medicaid Expansion	Female, Age 50 - Age 64	159,091	$ 199.94	1.72	1.17	1.23	1.00	$ 402.85	$ 423.49
North	Medicaid Expansion	Male, Age 50 - Age 64	105,344	$ 199.94	1.84	1.17	1.23	1.00	$ 429.64	$ 451.66
North	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	3,296	$ 8.61	1.00	1.00	1.00	1.00	$ 8.61	$ 8.61
North	Medicaid Expansion	SBH - Other, All Ages, Male & Female	129	$ 30.86	1.00	1.00	1.00	1.00	$ 30.86	$ 30.86
North	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	145	$ 3.86	1.00	1.00	1.00	1.00	$ 3.86	$ 3.86
North	Medicaid Expansion	High Needs, All Ages, Male & Female	1,604	$ 199.94	1.14	1.17	1.23	3.00	$ 798.33	$ 839.23
North	Medicaid Expansion - Maternity Kick Payme	Maternity Kick Payment	6,796	$ 5,866.68	1.00	1.00	1.00	1.00	$ 5,866.68	$ 5,866.68

Appendix U: Expansion Physical Health Projected Claims PMPM Development

Table 2: Expansion Prospective Rating Adjustments (PH Services)

						Prospective Adjustments								
Region Name	COA Description	Rate Cell Description	Projected MMs	Expansion PMPM Low	Expansion PMPM High	LaHIPP	PET Scans	Fee Adj	Low Trend	High Trend	Clinical/Rx Efficiencies	Low Projected PMPM	High Projected PMPM
Gulf	Medicaid Expansion	Female, Age 19 - Age 24	254,031	$ 154.46	$ 162.38	0.0%	0.1%	5.7%	6.7%	11.1%	$ (4.28)	$ 170.11	$ 186.53
Gulf	Medicaid Expansion	Male, Age 19 - Age 24	153,172	$ 122.58	$ 128.87	0.0%	0.1%	5.7%	6.7%	11.1%	$ (4.28)	$ 134.12	$ 147.14
Gulf	Medicaid Expansion	Female, Age 25 - Age 39	489,877	$ 220.58	$ 231.88	0.0%	0.2%	5.7%	6.7%	11.1%	$ (4.28)	$ 244.98	$ 268.44
Gulf	Medicaid Expansion	Male, Age 25 - Age 39	264,296	$ 221.24	$ 232.57	0.0%	0.1%	5.7%	6.7%	11.1%	$ (4.28)	$ 245.54	$ 269.06
Gulf	Medicaid Expansion	Female, Age 40 - Age 49	210,335	$ 344.53	$ 362.18	0.0%	0.3%	5.7%	6.7%	11.1%	$ (4.28)	$ 385.40	$ 422.08
Gulf	Medicaid Expansion	Male, Age 40 - Age 49	134,712	$ 336.24	$ 353.46	0.0%	0.2%	5.7%	6.7%	11.1%	$ (4.28)	$ 375.78	$ 411.55
Gulf	Medicaid Expansion	Female, Age 50 - Age 64	287,816	$ 421.99	$ 443.61	0.0%	0.5%	5.7%	6.7%	11.1%	$ (4.28)	$ 473.86	$ 518.86
Gulf	Medicaid Expansion	Male, Age 50 - Age 64	202,206	$ 450.06	$ 473.12	0.0%	0.4%	5.7%	6.7%	11.1%	$ (4.28)	$ 505.31	$ 553.28
Gulf	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	7,420	$ 5.32	$ 5.32	-0.8%	0.0%	0.0%	7.4%	11.8%	$ -	$ 5.67	$ 5.90
Gulf	Medicaid Expansion	SBH - Other, All Ages, Male & Female	163	$ 38.04	$ 38.04	0.0%	0.0%	0.0%	7.4%	12.9%	$ -	$ 39.46	$ 41.47
Gulf	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	299	$ 3.01	$ 3.01	0.0%	0.0%	0.0%	5.3%	10.7%	$ -	$ 4.36	$ 4.58
Gulf	Medicaid Expansion	High Needs, All Ages, Male & Female	1,804	$ 836.26	$ 879.11	0.0%	0.4%	5.7%	4.6%	11.1%	$ (4.28)	$ 923.86	$ 1,032.02
Gulf	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	9,173	$ 6,705.60	$ 6,705.60	0.0%	0.0%	6.7%	-1.0%	5.3%	$ -	$ 7,080.49	$ 7,532.52
Capital	Medicaid Expansion	Female, Age 19 - Age 24	188,193	$ 172.69	$ 181.54	0.0%	0.1%	5.3%	6.8%	11.1%	$ (4.29)	$ 190.06	$ 208.35
Capital	Medicaid Expansion	Male, Age 19 - Age 24	94,165	$ 137.05	$ 144.07	0.0%	0.1%	5.3%	6.8%	11.1%	$ (4.29)	$ 149.94	$ 164.46
Capital	Medicaid Expansion	Female, Age 25 - Age 39	357,853	$ 246.60	$ 259.24	0.0%	0.2%	5.3%	6.8%	11.1%	$ (4.29)	$ 273.47	$ 299.61
Capital	Medicaid Expansion	Male, Age 25 - Age 39	141,812	$ 247.34	$ 260.01	0.0%	0.1%	5.3%	6.8%	11.1%	$ (4.29)	$ 274.12	$ 300.32
Capital	Medicaid Expansion	Female, Age 40 - Age 49	135,702	$ 385.18	$ 404.91	0.0%	0.2%	5.3%	6.8%	11.1%	$ (4.29)	$ 429.90	$ 470.76
Capital	Medicaid Expansion	Male, Age 40 - Age 49	71,061	$ 375.91	$ 395.17	0.0%	0.2%	5.3%	6.8%	11.1%	$ (4.29)	$ 419.21	$ 459.06
Capital	Medicaid Expansion	Female, Age 50 - Age 64	157,655	$ 471.78	$ 495.95	0.0%	0.4%	5.3%	6.8%	11.1%	$ (4.29)	$ 528.37	$ 578.50
Capital	Medicaid Expansion	Male, Age 50 - Age 64	104,412	$ 503.16	$ 528.94	0.0%	0.4%	5.3%	6.8%	11.1%	$ (4.29)	$ 563.45	$ 616.88
Capital	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	4,846	$ 8.32	$ 8.32	-0.8%	0.0%	0.0%	7.4%	11.8%	$ -	$ 8.87	$ 9.23
Capital	Medicaid Expansion	SBH - Other, All Ages, Male & Female	105	$ 28.37	$ 28.37	0.0%	0.0%	0.0%	7.4%	12.9%	$ -	$ 39.46	$ 41.47
Capital	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	221	$ 4.03	$ 4.03	0.0%	0.0%	0.0%	5.3%	10.7%	$ -	$ 4.36	$ 4.58
Capital	Medicaid Expansion	High Needs, All Ages, Male & Female	1,572	$ 934.92	$ 982.83	0.0%	0.4%	5.3%	4.6%	11.1%	$ (4.29)	$ 1,029.72	$ 1,150.20
Capital	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	7,917	$ 5,776.24	$ 5,776.24	0.0%	0.0%	8.7%	-1.0%	5.3%	$ -	$ 6,212.81	$ 6,609.44
South Central	Medicaid Expansion	Female, Age 19 - Age 24	219,085	$ 156.43	$ 164.44	0.0%	0.1%	4.5%	6.5%	10.8%	$ (4.28)	$ 169.87	$ 186.27
South Central	Medicaid Expansion	Male, Age 19 - Age 24	111,194	$ 124.14	$ 130.50	0.0%	0.1%	4.5%	6.5%	10.8%	$ (4.28)	$ 133.92	$ 146.94
South Central	Medicaid Expansion	Female, Age 25 - Age 39	418,440	$ 223.38	$ 234.82	0.0%	0.2%	4.5%	6.5%	10.8%	$ (4.28)	$ 244.64	$ 268.08
South Central	Medicaid Expansion	Male, Age 25 - Age 39	169,270	$ 224.05	$ 235.53	0.0%	0.1%	4.5%	6.5%	10.8%	$ (4.28)	$ 245.20	$ 268.69
South Central	Medicaid Expansion	Female, Age 40 - Age 49	161,105	$ 348.90	$ 366.78	0.0%	0.3%	4.5%	6.5%	10.8%	$ (4.28)	$ 384.86	$ 421.51
South Central	Medicaid Expansion	Male, Age 40 - Age 49	85,084	$ 340.51	$ 357.95	0.0%	0.2%	4.5%	6.5%	10.8%	$ (4.28)	$ 375.25	$ 410.99
South Central	Medicaid Expansion	Female, Age 50 - Age 64	189,203	$ 427.35	$ 449.25	0.0%	0.5%	4.5%	6.5%	10.8%	$ (4.28)	$ 473.20	$ 518.16
South Central	Medicaid Expansion	Male, Age 50 - Age 64	125,577	$ 455.77	$ 479.12	0.0%	0.4%	4.5%	6.5%	10.8%	$ (4.28)	$ 504.61	$ 552.53
South Central	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	5,738	$ 7.99	$ 7.99	-0.8%	0.0%	0.0%	7.4%	11.8%	$ -	$ 8.52	$ 8.86
South Central	Medicaid Expansion	SBH - Other, All Ages, Male & Female	82	$ 47.76	$ 47.76	0.0%	0.0%	0.0%	7.4%	12.9%	$ -	$ 39.46	$ 41.47
South Central	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	204	$ 5.58	$ 5.58	0.0%	0.0%	0.0%	5.3%	10.7%	$ -	$ 4.36	$ 4.58
South Central	Medicaid Expansion	High Needs, All Ages, Male & Female	1,943	$ 846.88	$ 890.27	0.0%	0.4%	4.5%	4.3%	10.8%	$ (4.28)	$ 922.55	$ 1,030.63
South Central	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	9,159	$ 5,778.23	$ 5,778.23	0.0%	0.0%	8.3%	-1.0%	5.3%	$ -	$ 6,195.53	$ 6,591.06
North	Medicaid Expansion	Female, Age 19 - Age 24	189,149	$ 147.46	$ 155.01	0.0%	0.1%	3.4%	6.2%	10.5%	$ (4.26)	$ 157.78	$ 173.05
North	Medicaid Expansion	Male, Age 19 - Age 24	94,786	$ 117.02	$ 123.02	0.0%	0.1%	3.4%	6.2%	10.5%	$ (4.26)	$ 124.34	$ 136.45
North	Medicaid Expansion	Female, Age 25 - Age 39	359,986	$ 210.57	$ 221.36	0.0%	0.2%	3.4%	6.2%	10.5%	$ (4.26)	$ 227.37	$ 249.19
North	Medicaid Expansion	Male, Age 25 - Age 39	142,891	$ 211.20	$ 222.03	0.0%	0.1%	3.4%	6.2%	10.5%	$ (4.26)	$ 227.87	$ 249.75
North	Medicaid Expansion	Female, Age 40 - Age 49	136,830	$ 328.90	$ 345.76	0.0%	0.3%	3.4%	6.2%	10.5%	$ (4.26)	$ 357.87	$ 391.99
North	Medicaid Expansion	Male, Age 40 - Age 49	71,639	$ 320.99	$ 337.43	0.0%	0.2%	3.4%	6.2%	10.5%	$ (4.26)	$ 348.91	$ 382.19
North	Medicaid Expansion	Female, Age 50 - Age 64	159,091	$ 402.85	$ 423.49	0.0%	0.5%	3.4%	6.2%	10.5%	$ (4.26)	$ 440.13	$ 482.00
North	Medicaid Expansion	Male, Age 50 - Age 64	105,344	$ 429.64	$ 451.66	0.0%	0.4%	3.4%	6.2%	10.5%	$ (4.26)	$ 469.34	$ 513.97
North	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	3,296	$ 8.61	$ 8.61	-0.8%	0.0%	0.0%	7.4%	11.8%	$ -	$ 9.18	$ 9.55
North	Medicaid Expansion	SBH - Other, All Ages, Male & Female	129	$ 30.86	$ 30.86	0.0%	0.0%	0.0%	7.4%	12.9%	$ -	$ 39.46	$ 41.47
North	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	145	$ 3.86	$ 3.86	0.0%	0.0%	0.0%	5.3%	10.7%	$ -	$ 4.36	$ 4.58
North	Medicaid Expansion	High Needs, All Ages, Male & Female	1,604	$ 798.33	$ 839.23	0.0%	0.4%	3.4%	4.0%	10.5%	$ (4.26)	$ 858.28	$ 958.95
North	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	6,796	$ 5,866.68	$ 5,866.68	0.0%	0.0%	7.1%	-1.0%	5.3%	$ -	$ 6,216.70	$ 6,613.58

Appendix V: Expansion Specialized Behavioral Health Projected Claims PMPM Development

Table 1: Creation of Expansion Data (SBH Services)

					Expansion Assumptions					
Region Name	COA Description	Rate Cell Description	Projected MMs	CY15/CY16 Blended TANF ADT PMPM	Age-Sex Factors	Low Acuity Factor	High Acuity Factor	High Needs Factor	Expansion PMPM Low	Expansion PMPM High
Gulf	Medicaid Expansion	Female, Age 19 - Age 24	254,031	$ 25.52	0.63	1.17	1.23	1.00	$ 18.82	$ 19.79
Gulf	Medicaid Expansion	Male, Age 19 - Age 24	153,172	$ 25.52	0.50	1.17	1.23	1.00	$ 14.94	$ 15.70
Gulf	Medicaid Expansion	Female, Age 25 - Age 39	489,877	$ 25.52	0.90	1.17	1.23	1.00	$ 26.88	$ 28.25
Gulf	Medicaid Expansion	Male, Age 25 - Age 39	264,296	$ 25.52	0.90	1.17	1.23	1.00	$ 26.96	$ 28.34
Gulf	Medicaid Expansion	Female, Age 40 - Age 49	210,335	$ 25.52	1.40	1.17	1.23	1.00	$ 41.98	$ 44.13
Gulf	Medicaid Expansion	Male, Age 40 - Age 49	134,712	$ 25.52	1.37	1.17	1.23	1.00	$ 40.97	$ 43.07
Gulf	Medicaid Expansion	Female, Age 50 - Age 64	287,816	$ 25.52	1.72	1.17	1.23	1.00	$ 51.42	$ 54.05
Gulf	Medicaid Expansion	Male, Age 50 - Age 64	202,206	$ 25.52	1.84	1.17	1.23	1.00	$ 54.84	$ 57.65
Gulf	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	7,420	$ 17.80	1.00	1.00	1.00	1.00	$ 17.80	$ 17.80
Gulf	Medicaid Expansion	SBH - Other, All Ages, Male & Female	163	$ 80.23	1.00	1.00	1.00	1.00	$ 80.23	$ 80.23
Gulf	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	299	$ 68.09	1.00	1.00	1.00	1.00	$ 68.09	$ 68.09
Gulf	Medicaid Expansion	High Needs, All Ages, Male & Female	1,804	$ 25.52	1.14	1.17	1.23	3.00	$ 101.90	$ 107.12
Capital	Medicaid Expansion	Female, Age 19 - Age 24	188,193	$ 25.67	0.63	1.17	1.23	1.00	$ 18.93	$ 19.90
Capital	Medicaid Expansion	Male, Age 19 - Age 24	94,165	$ 25.67	0.50	1.17	1.23	1.00	$ 15.02	$ 15.79
Capital	Medicaid Expansion	Female, Age 25 - Age 39	357,853	$ 25.67	0.90	1.17	1.23	1.00	$ 27.03	$ 28.42
Capital	Medicaid Expansion	Male, Age 25 - Age 39	141,812	$ 25.67	0.90	1.17	1.23	1.00	$ 27.11	$ 28.50
Capital	Medicaid Expansion	Female, Age 40 - Age 49	135,702	$ 25.67	1.40	1.17	1.23	1.00	$ 42.22	$ 44.39
Capital	Medicaid Expansion	Male, Age 40 - Age 49	71,061	$ 25.67	1.37	1.17	1.23	1.00	$ 41.21	$ 43.32
Capital	Medicaid Expansion	Female, Age 50 - Age 64	157,655	$ 25.67	1.72	1.17	1.23	1.00	$ 51.72	$ 54.37
Capital	Medicaid Expansion	Male, Age 50 - Age 64	104,412	$ 25.67	1.84	1.17	1.23	1.00	$ 55.16	$ 57.98
Capital	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	4,846	$ 6.89	1.00	1.00	1.00	1.00	$ 6.89	$ 6.89
Capital	Medicaid Expansion	SBH - Other, All Ages, Male & Female	105	$ 75.11	1.00	1.00	1.00	1.00	$ 75.11	$ 75.11
Capital	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	221	$ 74.43	1.00	1.00	1.00	1.00	$ 74.43	$ 74.43
Capital	Medicaid Expansion	High Needs, All Ages, Male & Female	1,572	$ 25.67	1.14	1.17	1.23	3.00	$ 102.48	$ 107.74
South Central	Medicaid Expansion	Female, Age 19 - Age 24	219,085	$ 26.92	0.63	1.17	1.23	1.00	$ 19.86	$ 20.88
South Central	Medicaid Expansion	Male, Age 19 - Age 24	111,194	$ 26.92	0.50	1.17	1.23	1.00	$ 15.76	$ 16.57
South Central	Medicaid Expansion	Female, Age 25 - Age 39	418,440	$ 26.92	0.90	1.17	1.23	1.00	$ 28.36	$ 29.81
South Central	Medicaid Expansion	Male, Age 25 - Age 39	169,270	$ 26.92	0.90	1.17	1.23	1.00	$ 28.44	$ 29.90
South Central	Medicaid Expansion	Female, Age 40 - Age 49	161,105	$ 26.92	1.40	1.17	1.23	1.00	$ 44.29	$ 46.56
South Central	Medicaid Expansion	Male, Age 40 - Age 49	85,084	$ 26.92	1.37	1.17	1.23	1.00	$ 43.23	$ 45.44
South Central	Medicaid Expansion	Female, Age 50 - Age 64	189,203	$ 26.92	1.72	1.17	1.23	1.00	$ 54.25	$ 57.03
South Central	Medicaid Expansion	Male, Age 50 - Age 64	125,577	$ 26.92	1.84	1.17	1.23	1.00	$ 57.86	$ 60.82
South Central	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	5,738	$ 7.23	1.00	1.00	1.00	1.00	$ 7.23	$ 7.23
South Central	Medicaid Expansion	SBH - Other, All Ages, Male & Female	82	$ 88.83	1.00	1.00	1.00	1.00	$ 88.83	$ 88.83
South Central	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	204	$ 99.12	1.00	1.00	1.00	1.00	$ 99.12	$ 99.12
South Central	Medicaid Expansion	High Needs, All Ages, Male & Female	1,943	$ 26.92	1.14	1.17	1.23	3.00	$ 107.51	$ 113.02
North	Medicaid Expansion	Female, Age 19 - Age 24	189,149	$ 28.44	0.63	1.17	1.23	1.00	$ 20.98	$ 22.05
North	Medicaid Expansion	Male, Age 19 - Age 24	94,786	$ 28.44	0.50	1.17	1.23	1.00	$ 16.65	$ 17.50
North	Medicaid Expansion	Female, Age 25 - Age 39	359,986	$ 28.44	0.90	1.17	1.23	1.00	$ 29.95	$ 31.49
North	Medicaid Expansion	Male, Age 25 - Age 39	142,891	$ 28.44	0.90	1.17	1.23	1.00	$ 30.04	$ 31.58
North	Medicaid Expansion	Female, Age 40 - Age 49	136,830	$ 28.44	1.40	1.17	1.23	1.00	$ 46.79	$ 49.18
North	Medicaid Expansion	Male, Age 40 - Age 49	71,639	$ 28.44	1.37	1.17	1.23	1.00	$ 45.66	$ 48.00
North	Medicaid Expansion	Female, Age 50 - Age 64	159,091	$ 28.44	1.72	1.17	1.23	1.00	$ 57.30	$ 60.24
North	Medicaid Expansion	Male, Age 50 - Age 64	105,344	$ 28.44	1.84	1.17	1.23	1.00	$ 61.12	$ 64.25
North	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	3,296	$ 10.62	1.00	1.00	1.00	1.00	$ 10.62	$ 10.62
North	Medicaid Expansion	SBH - Other, All Ages, Male & Female	129	$ 58.98	1.00	1.00	1.00	1.00	$ 58.98	$ 58.98
North	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	145	$ 138.17	1.00	1.00	1.00	1.00	$ 138.17	$ 138.17
North	Medicaid Expansion	High Needs, All Ages, Male & Female	1,604	$ 28.44	1.14	1.17	1.23	3.00	$ 113.56	$ 119.38

Appendix V: Expansion Specialized Behavioral Health Projected Claims PMPM Development

Table 2: Expansion Prospective Rating Adjustments (SBH Services)

						Prospective Adjustments						
Region Name	COA Description	Rate Cell Description	Projected MMs	Expansion PMPM Low	Expansion PMPM High	LaHIPP	Fee Adj	Low Trend	High Trend	MHR Adj	Low Projected PMPM	High Projected PMPM
Gulf	Medicaid Expansion	Female, Age 19 - Age 24	254,031	$ 18.82	$ 19.79	0.0%	4.8%	6.6%	11.0%	$ (0.14)	$ 20.89	$ 22.87
Gulf	Medicaid Expansion	Male, Age 19 - Age 24	153,172	$ 14.94	$ 15.70	0.0%	4.8%	6.6%	11.0%	$ (0.14)	$ 16.55	$ 18.12
Gulf	Medicaid Expansion	Female, Age 25 - Age 39	489,877	$ 26.88	$ 28.25	0.0%	4.8%	6.6%	11.0%	$ (0.14)	$ 29.89	$ 32.71
Gulf	Medicaid Expansion	Male, Age 25 - Age 39	264,296	$ 26.96	$ 28.34	0.0%	4.8%	6.6%	11.0%	$ (0.14)	$ 29.98	$ 32.81
Gulf	Medicaid Expansion	Female, Age 40 - Age 49	210,335	$ 41.98	$ 44.13	0.0%	4.8%	6.6%	11.0%	$ (0.14)	$ 46.76	$ 51.17
Gulf	Medicaid Expansion	Male, Age 40 - Age 49	134,712	$ 40.97	$ 43.07	0.0%	4.8%	6.6%	11.0%	$ (0.14)	$ 45.63	$ 49.94
Gulf	Medicaid Expansion	Female, Age 50 - Age 64	287,816	$ 51.42	$ 54.05	0.0%	4.8%	6.6%	11.0%	$ (0.14)	$ 57.30	$ 62.71
Gulf	Medicaid Expansion	Male, Age 50 - Age 64	202,206	$ 54.84	$ 57.65	0.0%	4.8%	6.6%	11.0%	$ (0.14)	$ 61.12	$ 66.89
Gulf	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	7,420	$ 17.80	$ 17.80	-0.8%	0.9%	13.8%	18.3%	$ (0.33)	$ 19.95	$ 20.75
Gulf	Medicaid Expansion	SBH - Other, All Ages, Male & Female	163	$ 80.23	$ 80.23	0.0%	22.1%	4.7%	10.1%	$ (0.05)	$ 95.24	$ 100.17
Gulf	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	299	$ 68.09	$ 68.09	0.0%	2.9%	5.3%	10.7%	$ (2.79)	$ 100.21	$ 105.52
Gulf	Medicaid Expansion	High Needs, All Ages, Male & Female	1,804	$ 101.90	$ 107.12	0.0%	4.8%	4.5%	11.0%	$ (0.14)	$ 111.40	$ 124.40
Capital	Medicaid Expansion	Female, Age 19 - Age 24	188,193	$ 18.93	$ 19.90	0.0%	6.8%	6.0%	10.4%	$ (0.08)	$ 21.35	$ 23.37
Capital	Medicaid Expansion	Male, Age 19 - Age 24	94,165	$ 15.02	$ 15.79	0.0%	6.8%	6.0%	10.4%	$ (0.08)	$ 16.93	$ 18.53
Capital	Medicaid Expansion	Female, Age 25 - Age 39	357,853	$ 27.03	$ 28.42	0.0%	6.8%	6.0%	10.4%	$ (0.08)	$ 30.53	$ 33.41
Capital	Medicaid Expansion	Male, Age 25 - Age 39	141,812	$ 27.11	$ 28.50	0.0%	6.8%	6.0%	10.4%	$ (0.08)	$ 30.62	$ 33.51
Capital	Medicaid Expansion	Female, Age 40 - Age 49	135,702	$ 42.22	$ 44.39	0.0%	6.8%	6.0%	10.4%	$ (0.08)	$ 47.72	$ 52.23
Capital	Medicaid Expansion	Male, Age 40 - Age 49	71,061	$ 41.21	$ 43.32	0.0%	6.8%	6.0%	10.4%	$ (0.08)	$ 46.57	$ 50.97
Capital	Medicaid Expansion	Female, Age 50 - Age 64	157,655	$ 51.72	$ 54.37	0.0%	6.8%	6.0%	10.4%	$ (0.08)	$ 58.47	$ 63.99
Capital	Medicaid Expansion	Male, Age 50 - Age 64	104,412	$ 55.16	$ 57.98	0.0%	6.8%	6.0%	10.4%	$ (0.08)	$ 62.37	$ 68.25
Capital	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	4,846	$ 6.89	$ 6.89	-0.8%	4.3%	13.0%	17.5%	$ (0.09)	$ 7.96	$ 8.28
Capital	Medicaid Expansion	SBH - Other, All Ages, Male & Female	105	$ 75.11	$ 75.11	0.0%	21.7%	4.2%	9.6%	$ (0.05)	$ 95.24	$ 100.17
Capital	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	221	$ 74.43	$ 74.43	0.0%	5.5%	5.3%	10.7%	$ (2.79)	$ 100.21	$ 105.52
Capital	Medicaid Expansion	High Needs, All Ages, Male & Female	1,572	$ 102.48	$ 107.74	0.0%	6.8%	3.9%	10.4%	$ (0.08)	$ 113.61	$ 126.89
South Central	Medicaid Expansion	Female, Age 19 - Age 24	219,085	$ 19.86	$ 20.88	0.0%	8.8%	6.1%	10.5%	$ (0.09)	$ 22.85	$ 25.01
South Central	Medicaid Expansion	Male, Age 19 - Age 24	111,194	$ 15.76	$ 16.57	0.0%	8.8%	6.1%	10.5%	$ (0.09)	$ 18.12	$ 19.83
South Central	Medicaid Expansion	Female, Age 25 - Age 39	418,440	$ 28.36	$ 29.81	0.0%	8.8%	6.1%	10.5%	$ (0.09)	$ 32.67	$ 35.76
South Central	Medicaid Expansion	Male, Age 25 - Age 39	169,270	$ 28.44	$ 29.90	0.0%	8.8%	6.1%	10.5%	$ (0.09)	$ 32.77	$ 35.86
South Central	Medicaid Expansion	Female, Age 40 - Age 49	161,105	$ 44.29	$ 46.56	0.0%	8.8%	6.1%	10.5%	$ (0.09)	$ 51.08	$ 55.90
South Central	Medicaid Expansion	Male, Age 40 - Age 49	85,084	$ 43.23	$ 45.44	0.0%	8.8%	6.1%	10.5%	$ (0.09)	$ 49.85	$ 54.55
South Central	Medicaid Expansion	Female, Age 50 - Age 64	189,203	$ 54.25	$ 57.03	0.0%	8.8%	6.1%	10.5%	$ (0.09)	$ 62.58	$ 68.49
South Central	Medicaid Expansion	Male, Age 50 - Age 64	125,577	$ 57.86	$ 60.82	0.0%	8.8%	6.1%	10.5%	$ (0.09)	$ 66.75	$ 73.05
South Central	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	5,738	$ 7.23	$ 7.23	-0.8%	2.6%	13.3%	17.8%	$ (0.12)	$ 8.21	$ 8.54
South Central	Medicaid Expansion	SBH - Other, All Ages, Male & Female	82	$ 88.83	$ 88.83	0.0%	19.7%	3.7%	9.1%	$ (0.05)	$ 95.24	$ 100.17
South Central	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	204	$ 99.12	$ 99.12	0.0%	5.7%	5.3%	10.7%	$ (2.79)	$ 100.21	$ 105.52
South Central	Medicaid Expansion	High Needs, All Ages, Male & Female	1,943	$ 107.51	$ 113.02	0.0%	8.8%	4.0%	10.5%	$ (0.09)	$ 121.60	$ 135.81
North	Medicaid Expansion	Female, Age 19 - Age 24	189,149	$ 20.98	$ 22.05	0.0%	6.3%	6.9%	11.2%	$ (0.16)	$ 23.66	$ 25.90
North	Medicaid Expansion	Male, Age 19 - Age 24	94,786	$ 16.65	$ 17.50	0.0%	6.3%	6.9%	11.2%	$ (0.16)	$ 18.74	$ 20.52
North	Medicaid Expansion	Female, Age 25 - Age 39	359,986	$ 29.95	$ 31.49	0.0%	6.3%	6.9%	11.2%	$ (0.16)	$ 33.86	$ 37.06
North	Medicaid Expansion	Male, Age 25 - Age 39	142,891	$ 30.04	$ 31.58	0.0%	6.3%	6.9%	11.2%	$ (0.16)	$ 33.96	$ 37.17
North	Medicaid Expansion	Female, Age 40 - Age 49	136,830	$ 46.79	$ 49.18	0.0%	6.3%	6.9%	11.2%	$ (0.16)	$ 52.97	$ 57.97
North	Medicaid Expansion	Male, Age 40 - Age 49	71,639	$ 45.66	$ 48.00	0.0%	6.3%	6.9%	11.2%	$ (0.16)	$ 51.69	$ 56.57
North	Medicaid Expansion	Female, Age 50 - Age 64	159,091	$ 57.30	$ 60.24	0.0%	6.3%	6.9%	11.2%	$ (0.16)	$ 64.92	$ 71.05
North	Medicaid Expansion	Male, Age 50 - Age 64	105,344	$ 61.12	$ 64.25	0.0%	6.3%	6.9%	11.2%	$ (0.16)	$ 69.25	$ 75.78
North	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Female	3,296	$ 10.62	$ 10.62	-0.8%	1.3%	13.7%	18.2%	$ (0.13)	$ 12.01	$ 12.49
North	Medicaid Expansion	SBH - Other, All Ages, Male & Female	129	$ 58.98	$ 58.98	0.0%	18.7%	4.9%	10.3%	$ (0.05)	$ 95.24	$ 100.17
North	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Female	145	$ 138.17	$ 138.17	0.0%	4.1%	5.3%	10.7%	$ (2.79)	$ 100.21	$ 105.52
North	Medicaid Expansion	High Needs, All Ages, Male & Female	1,604	$ 113.56	$ 119.38	0.0%	6.3%	4.7%	11.2%	$ (0.16)	$ 126.22	$ 140.95

Appendix W: Expansion Loaded Rates Development

Table 1: Expansion Loaded Rate Development

				PH Services		SBH Services		All Services		Retention Load						
Region Name	COA Description	Rate Cell Description	Projected MMs	Low PMPM	High PMPM	Low PMPM	High PMPM	Low PMPM	High PMPM	Fixed Admin Load	Variable Admin Low	Variable Admin High	Profit @ 2%	Premium Tax @ 5.5%	Low Rates w/out FMP	High Rates w/out FMP
Gulf	Medicaid Expansion	Female, Age 19 - Age 24	254,031	$ 170.11	$ 186.53	$ 20.89	$ 22.87	$ 191.00	$ 209.39	$ 15.92	$ 6.62	$ 6.66	2.0%	5.5%	$ 230.85	$ 250.78
Gulf	Medicaid Expansion	Male, Age 19 - Age 24	153,172	$ 134.12	$ 147.14	$ 16.55	$ 18.12	$ 150.66	$ 165.26	$ 15.92	$ 5.23	$ 5.26	2.0%	5.5%	$ 185.75	$ 201.56
Gulf	Medicaid Expansion	Female, Age 25 - Age 39	489,877	$ 244.98	$ 268.44	$ 29.89	$ 32.71	$ 274.87	$ 301.16	$ 15.92	$ 9.53	$ 9.58	2.0%	5.5%	$ 324.67	$ 353.14
Gulf	Medicaid Expansion	Male, Age 25 - Age 39	264,296	$ 245.54	$ 269.06	$ 29.98	$ 32.81	$ 275.52	$ 301.87	$ 15.92	$ 9.54	$ 9.60	2.0%	5.5%	$ 325.38	$ 353.94
Gulf	Medicaid Expansion	Female, Age 40 - Age 49	210,335	$ 385.40	$ 422.08	$ 46.76	$ 51.17	$ 432.16	$ 473.25	$ 15.92	$ 14.97	$ 15.05	2.0%	5.5%	$ 500.59	$ 545.11
Gulf	Medicaid Expansion	Male, Age 40 - Age 49	134,712	$ 375.78	$ 411.55	$ 45.63	$ 49.94	$ 421.41	$ 461.49	$ 15.92	$ 14.60	$ 14.67	2.0%	5.5%	$ 488.57	$ 531.98
Gulf	Medicaid Expansion	Female, Age 50 - Age 64	287,816	$ 473.86	$ 518.86	$ 57.30	$ 62.71	$ 531.16	$ 581.57	$ 15.92	$ 18.40	$ 18.49	2.0%	5.5%	$ 611.33	$ 665.93
Gulf	Medicaid Expansion	Male, Age 50 - Age 64	202,206	$ 505.31	$ 553.28	$ 61.12	$ 66.89	$ 566.43	$ 620.17	$ 15.92	$ 19.62	$ 19.72	2.0%	5.5%	$ 650.78	$ 708.98
Gulf	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Fe	7,420	$ 5.67	$ 5.90	$ 19.95	$ 20.75	$ 25.62	$ 26.66	$ 15.92	$ 1.05	$ 0.98	2.0%	5.5%	$ 46.25	$ 47.30
Gulf	Medicaid Expansion	SBH - Other, All Ages, Male & Female	163	$ 39.46	$ 41.47	$ 95.24	$ 100.17	$ 134.70	$ 141.64	$ 15.92	$ 5.89	$ 5.58	2.0%	5.5%	$ 180.09	$ 187.77
Gulf	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Fema	299	$ 4.36	$ 4.58	$ 100.21	$ 105.52	$ 104.57	$ 110.10	$ 15.92	$ 3.02	$ 2.86	2.0%	5.5%	$ 100.60	$ 104.71
Gulf	Medicaid Expansion	High Needs, All Ages, Male & Female	1,804	$ 923.86	$ 1,032.02	$ 111.40	$ 124.40	$ 1,035.25	$ 1,156.42	$ 15.92	$ 40.32	$ 41.36	2.0%	5.5%	$ 1,179.99	$ 1,312.11
Gulf	Medicaid Expansion - I	Maternity Kick Payment	9,173	$ 7,080.49	$ 7,532.52	$ -	$ -	$ 7,080.49	$ 7,532.52	$ -	$ 340.18	$ 340.18	2.0%	5.5%	$ 8,022.35	$ 8,511.02
Capital	Medicaid Expansion	Female, Age 19 - Age 24	188,193	$ 190.06	$ 208.35	$ 21.35	$ 23.37	$ 211.41	$ 231.72	$ 15.92	$ 6.62	$ 6.66	2.0%	5.5%	$ 252.92	$ 274.92
Capital	Medicaid Expansion	Male, Age 19 - Age 24	94,165	$ 149.94	$ 164.46	$ 16.93	$ 18.53	$ 166.87	$ 182.99	$ 15.92	$ 5.23	$ 5.26	2.0%	5.5%	$ 203.27	$ 220.72
Capital	Medicaid Expansion	Female, Age 25 - Age 39	357,853	$ 273.47	$ 299.61	$ 30.53	$ 33.41	$ 303.99	$ 333.02	$ 15.92	$ 9.53	$ 9.58	2.0%	5.5%	$ 356.16	$ 387.59
Capital	Medicaid Expansion	Male, Age 25 - Age 39	141,812	$ 274.12	$ 300.32	$ 30.62	$ 33.51	$ 304.73	$ 333.83	$ 15.92	$ 9.54	$ 9.60	2.0%	5.5%	$ 356.97	$ 388.48
Capital	Medicaid Expansion	Female, Age 40 - Age 49	135,702	$ 429.90	$ 470.76	$ 47.72	$ 52.23	$ 477.63	$ 522.99	$ 15.92	$ 14.97	$ 15.05	2.0%	5.5%	$ 549.75	$ 598.88
Capital	Medicaid Expansion	Male, Age 40 - Age 49	71,061	$ 419.21	$ 459.06	$ 46.57	$ 50.97	$ 465.78	$ 510.03	$ 15.92	$ 14.60	$ 14.67	2.0%	5.5%	$ 536.54	$ 584.46
Capital	Medicaid Expansion	Female, Age 50 - Age 64	157,655	$ 528.37	$ 578.50	$ 58.47	$ 63.99	$ 586.84	$ 642.49	$ 15.92	$ 18.40	$ 18.49	2.0%	5.5%	$ 671.52	$ 731.78
Capital	Medicaid Expansion	Male, Age 50 - Age 64	104,412	$ 563.45	$ 616.88	$ 62.37	$ 68.25	$ 625.81	$ 685.13	$ 15.92	$ 19.62	$ 19.72	2.0%	5.5%	$ 714.97	$ 779.21
Capital	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Fe	4,846	$ 8.87	$ 9.23	$ 7.96	$ 8.28	$ 16.83	$ 17.51	$ 15.92	$ 1.05	$ 0.98	2.0%	5.5%	$ 36.65	$ 37.32
Capital	Medicaid Expansion	SBH - Other, All Ages, Male & Female	105	$ 39.46	$ 41.47	$ 95.24	$ 100.17	$ 134.70	$ 141.64	$ 15.92	$ 5.89	$ 5.58	2.0%	5.5%	$ 160.77	$ 167.48
Capital	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Fema	221	$ 4.36	$ 4.58	$ 100.21	$ 105.52	$ 104.57	$ 110.10	$ 15.92	$ 3.02	$ 2.86	2.0%	5.5%	$ 111.37	$ 116.04
Capital	Medicaid Expansion	High Needs, All Ages, Male & Female	1,572	$ 1,029.72	$ 1,150.20	$ 113.61	$ 126.89	$ 1,143.33	$ 1,277.09	$ 15.92	$ 40.32	$ 41.36	2.0%	5.5%	$ 1,296.83	$ 1,442.56
Capital	Medicaid Expansion - I	Maternity Kick Payment	7,917	$ 6,212.81	$ 6,609.44	$ -	$ -	$ 6,212.81	$ 6,609.44	$ -	$ 340.18	$ 340.18	2.0%	5.5%	$ 7,084.32	$ 7,513.11
South Central	Medicaid Expansion	Female, Age 19 - Age 24	219,085	$ 169.87	$ 186.27	$ 22.85	$ 25.01	$ 192.72	$ 211.28	$ 15.92	$ 6.62	$ 6.66	2.0%	5.5%	$ 232.72	$ 252.83
South Central	Medicaid Expansion	Male, Age 19 - Age 24	111,194	$ 133.92	$ 146.94	$ 18.12	$ 19.83	$ 152.04	$ 166.77	$ 15.92	$ 5.23	$ 5.26	2.0%	5.5%	$ 187.23	$ 203.19
South Central	Medicaid Expansion	Female, Age 25 - Age 39	418,440	$ 244.64	$ 268.08	$ 32.67	$ 35.76	$ 277.31	$ 303.83	$ 15.92	$ 9.53	$ 9.58	2.0%	5.5%	$ 327.30	$ 356.04
South Central	Medicaid Expansion	Male, Age 25 - Age 39	169,270	$ 245.20	$ 268.69	$ 32.77	$ 35.86	$ 277.97	$ 304.55	$ 15.92	$ 9.54	$ 9.60	2.0%	5.5%	$ 328.03	$ 356.84
South Central	Medicaid Expansion	Female, Age 40 - Age 49	161,105	$ 384.86	$ 421.51	$ 51.08	$ 55.90	$ 435.94	$ 477.41	$ 15.92	$ 14.97	$ 15.05	2.0%	5.5%	$ 504.68	$ 549.59
South Central	Medicaid Expansion	Male, Age 40 - Age 49	85,084	$ 375.25	$ 410.99	$ 49.85	$ 54.55	$ 425.10	$ 465.54	$ 15.92	$ 14.60	$ 14.67	2.0%	5.5%	$ 492.56	$ 536.36
South Central	Medicaid Expansion	Female, Age 50 - Age 64	189,203	$ 473.20	$ 518.16	$ 62.58	$ 68.49	$ 535.78	$ 586.65	$ 15.92	$ 18.40	$ 18.49	2.0%	5.5%	$ 616.32	$ 671.41
South Central	Medicaid Expansion	Male, Age 50 - Age 64	125,577	$ 504.61	$ 552.53	$ 66.75	$ 73.05	$ 571.36	$ 625.58	$ 15.92	$ 19.62	$ 19.72	2.0%	5.5%	$ 656.10	$ 714.83
South Central	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Fe	5,738	$ 8.52	$ 8.86	$ 8.21	$ 8.54	$ 16.72	$ 17.40	$ 15.92	$ 1.05	$ 0.98	2.0%	5.5%	$ 36.55	$ 37.21
South Central	Medicaid Expansion	SBH - Other, All Ages, Male & Female	82	$ 39.46	$ 41.47	$ 95.24	$ 100.17	$ 134.70	$ 141.64	$ 15.92	$ 5.89	$ 5.58	2.0%	5.5%	$ 199.64	$ 208.36
South Central	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Fema	204	$ 4.36	$ 4.58	$ 100.21	$ 105.52	$ 104.57	$ 110.10	$ 15.92	$ 3.02	$ 2.86	2.0%	5.5%	$ 143.07	$ 149.37
South Central	Medicaid Expansion	High Needs, All Ages, Male & Female	1,943	$ 922.55	$ 1,030.63	$ 121.60	$ 135.81	$ 1,044.15	$ 1,166.43	$ 15.92	$ 40.32	$ 41.36	2.0%	5.5%	$ 1,189.61	$ 1,322.93
South Central	Medicaid Expansion - I	Maternity Kick Payment	9,159	$ 6,195.53	$ 6,591.06	$ -	$ -	$ 6,195.53	$ 6,591.06	$ -	$ 340.18	$ 340.18	2.0%	5.5%	$ 7,065.63	$ 7,493.23
North	Medicaid Expansion	Female, Age 19 - Age 24	189,149	$ 157.78	$ 173.05	$ 23.66	$ 25.90	$ 181.44	$ 198.95	$ 15.92	$ 6.62	$ 6.66	2.0%	5.5%	$ 220.52	$ 239.50
North	Medicaid Expansion	Male, Age 19 - Age 24	94,786	$ 124.34	$ 136.45	$ 18.74	$ 20.52	$ 143.08	$ 156.98	$ 15.92	$ 5.23	$ 5.26	2.0%	5.5%	$ 177.55	$ 192.60
North	Medicaid Expansion	Female, Age 25 - Age 39	359,986	$ 227.37	$ 249.19	$ 33.86	$ 37.06	$ 261.22	$ 286.25	$ 15.92	$ 9.53	$ 9.58	2.0%	5.5%	$ 309.91	$ 337.03
North	Medicaid Expansion	Male, Age 25 - Age 39	142,891	$ 227.87	$ 249.75	$ 33.96	$ 37.17	$ 261.83	$ 286.92	$ 15.92	$ 9.54	$ 9.60	2.0%	5.5%	$ 310.59	$ 337.77
North	Medicaid Expansion	Female, Age 40 - Age 49	136,830	$ 357.87	$ 391.99	$ 52.97	$ 57.97	$ 410.84	$ 449.97	$ 15.92	$ 14.97	$ 15.05	2.0%	5.5%	$ 477.55	$ 519.93
North	Medicaid Expansion	Male, Age 40 - Age 49	71,639	$ 348.91	$ 382.19	$ 51.69	$ 56.57	$ 400.60	$ 438.76	$ 15.92	$ 14.60	$ 14.67	2.0%	5.5%	$ 466.08	$ 507.41
North	Medicaid Expansion	Female, Age 50 - Age 64	159,091	$ 440.13	$ 482.00	$ 64.92	$ 71.05	$ 505.05	$ 553.05	$ 15.92	$ 18.40	$ 18.49	2.0%	5.5%	$ 583.10	$ 635.09
North	Medicaid Expansion	Male, Age 50 - Age 64	105,344	$ 469.34	$ 513.97	$ 69.25	$ 75.78	$ 538.59	$ 589.75	$ 15.92	$ 19.62	$ 19.72	2.0%	5.5%	$ 620.68	$ 676.09
North	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Fe	3,296	$ 9.18	$ 9.55	$ 12.01	$ 12.49	$ 21.19	$ 22.04	$ 15.92	$ 1.05	$ 0.98	2.0%	5.5%	$ 41.42	$ 42.27
North	Medicaid Expansion	SBH - Other, All Ages, Male & Female	129	$ 39.46	$ 41.47	$ 95.24	$ 100.17	$ 134.70	$ 141.64	$ 15.92	$ 5.89	$ 5.58	2.0%	5.5%	$ 139.74	$ 145.36
North	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Fema	145	$ 4.36	$ 4.58	$ 100.21	$ 105.52	$ 104.57	$ 110.10	$ 15.92	$ 3.02	$ 2.86	2.0%	5.5%	$ 185.53	$ 194.01
North	Medicaid Expansion	High Needs, All Ages, Male & Female	1,604	$ 858.28	$ 958.95	$ 126.22	$ 140.95	$ 984.51	$ 1,099.90	$ 15.92	$ 40.32	$ 41.36	2.0%	5.5%	$ 1,125.13	$ 1,251.00
North	Medicaid Expansion - I	Maternity Kick Payment	6,796	$ 6,216.70	$ 6,613.58	$ -	$ -	$ 6,216.70	$ 6,613.58	$ -	$ 340.18	$ 340.18	2.0%	5.5%	$ 7,088.52	$ 7,517.58

Appendix W: Expansion Loaded Rates Development

Table 1: Expansion Loaded Rate Development

Region Name	COA Description	Rate Cell Description	Projected MMs	Low Rates w/out FMP	High Rates w/out FMP	FMP Add-On Total	Low Rates with FMP	High Rates with FMP
Gulf	Medicaid Expansion	Female, Age 19 - Age 24	254,031	$ 230.85	$ 250.78	$ 50.07	$ 280.92	$ 300.85
Gulf	Medicaid Expansion	Male, Age 19 - Age 24	153,172	$ 185.75	$ 201.56	$ 39.73	$ 225.48	$ 241.29
Gulf	Medicaid Expansion	Female, Age 25 - Age 39	489,877	$ 324.67	$ 353.14	$ 71.52	$ 396.19	$ 424.66
Gulf	Medicaid Expansion	Male, Age 25 - Age 39	264,296	$ 325.38	$ 353.94	$ 71.71	$ 397.10	$ 425.65
Gulf	Medicaid Expansion	Female, Age 40 - Age 49	210,335	$ 500.59	$ 545.11	$ 111.75	$ 612.35	$ 656.86
Gulf	Medicaid Expansion	Male, Age 40 - Age 49	134,712	$ 488.57	$ 531.98	$ 109.03	$ 597.60	$ 641.01
Gulf	Medicaid Expansion	Female, Age 50 - Age 64	287,816	$ 611.33	$ 665.93	$ 136.98	$ 748.31	$ 802.90
Gulf	Medicaid Expansion	Male, Age 50 - Age 64	202,206	$ 650.78	$ 708.98	$ 146.05	$ 796.83	$ 855.03
Gulf	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Fe	7,420	$ 46.25	$ 47.30	$ 0.12	$ 46.37	$ 47.42
Gulf	Medicaid Expansion	SBH - Other, All Ages, Male & Female	163	$ 180.09	$ 187.77	$ 26.75	$ 206.84	$ 214.52
Gulf	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Fema	299	$ 100.60	$ 104.71	$ 0.59	$ 101.19	$ 105.30
Gulf	Medicaid Expansion	High Needs, All Ages, Male & Female	1,804	$ 1,179.99	$ 1,312.11	$ 268.75	$ 1,448.74	$ 1,580.86
Gulf	Medicaid Expansion - I	Maternity Kick Payment	9,173	$ 8,022.35	$ 8,511.02	$ 5,527.98	$ 13,550.33	$ 14,039.00
Capital	Medicaid Expansion	Female, Age 19 - Age 24	188,193	$ 252.92	$ 274.92	$ 42.75	$ 295.67	$ 317.67
Capital	Medicaid Expansion	Male, Age 19 - Age 24	94,165	$ 203.27	$ 220.72	$ 33.93	$ 237.19	$ 254.65
Capital	Medicaid Expansion	Female, Age 25 - Age 39	357,853	$ 356.16	$ 387.59	$ 61.07	$ 417.22	$ 448.66
Capital	Medicaid Expansion	Male, Age 25 - Age 39	141,812	$ 356.97	$ 388.48	$ 61.23	$ 418.20	$ 449.72
Capital	Medicaid Expansion	Female, Age 40 - Age 49	135,702	$ 549.75	$ 598.88	$ 95.42	$ 645.16	$ 694.30
Capital	Medicaid Expansion	Male, Age 40 - Age 49	71,061	$ 536.54	$ 584.46	$ 93.10	$ 629.64	$ 677.55
Capital	Medicaid Expansion	Female, Age 50 - Age 64	157,655	$ 671.52	$ 731.78	$ 116.95	$ 788.48	$ 848.73
Capital	Medicaid Expansion	Male, Age 50 - Age 64	104,412	$ 714.97	$ 779.21	$ 124.70	$ 839.67	$ 903.91
Capital	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Fe	4,846	$ 36.65	$ 37.32	$ 0.10	$ 36.75	$ 37.42
Capital	Medicaid Expansion	SBH - Other, All Ages, Male & Female	105	$ 160.77	$ 167.48	$ 23.90	$ 184.67	$ 191.38
Capital	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Fema	221	$ 111.37	$ 116.04	$ 0.07	$ 111.45	$ 116.11
Capital	Medicaid Expansion	High Needs, All Ages, Male & Female	1,572	$ 1,296.83	$ 1,442.56	$ 229.47	$ 1,526.30	$ 1,672.03
Capital	Medicaid Expansion - I	Maternity Kick Payment	7,917	$ 7,084.32	$ 7,513.11	$ 3,802.93	$ 10,887.24	$ 11,316.03
South Central	Medicaid Expansion	Female, Age 19 - Age 24	219,085	$ 232.72	$ 252.83	$ 42.57	$ 275.28	$ 295.39
South Central	Medicaid Expansion	Male, Age 19 - Age 24	111,194	$ 187.23	$ 203.19	$ 33.78	$ 221.01	$ 236.97
South Central	Medicaid Expansion	Female, Age 25 - Age 39	418,440	$ 327.30	$ 356.04	$ 60.80	$ 388.10	$ 416.83
South Central	Medicaid Expansion	Male, Age 25 - Age 39	169,270	$ 328.03	$ 356.84	$ 60.97	$ 389.00	$ 417.81
South Central	Medicaid Expansion	Female, Age 40 - Age 49	161,105	$ 504.68	$ 549.59	$ 94.98	$ 599.66	$ 644.57
South Central	Medicaid Expansion	Male, Age 40 - Age 49	85,084	$ 492.56	$ 536.36	$ 92.68	$ 585.24	$ 629.04
South Central	Medicaid Expansion	Female, Age 50 - Age 64	189,203	$ 616.32	$ 671.41	$ 116.38	$ 732.70	$ 787.79
South Central	Medicaid Expansion	Male, Age 50 - Age 64	125,577	$ 656.10	$ 714.83	$ 124.10	$ 780.20	$ 838.93
South Central	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Fe	5,738	$ 36.55	$ 37.21	$ 0.07	$ 36.62	$ 37.28
South Central	Medicaid Expansion	SBH - Other, All Ages, Male & Female	82	$ 199.64	$ 208.36	$ 44.45	$ 244.09	$ 252.81
South Central	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Fema	204	$ 143.07	$ 149.37	$ 0.22	$ 143.29	$ 149.58
South Central	Medicaid Expansion	High Needs, All Ages, Male & Female	1,943	$ 1,189.61	$ 1,322.93	$ 228.35	$ 1,417.96	$ 1,551.28
South Central	Medicaid Expansion - I	Maternity Kick Payment	9,159	$ 7,065.63	$ 7,493.23	$ 2,626.73	$ 9,692.36	$ 10,119.96
North	Medicaid Expansion	Female, Age 19 - Age 24	189,149	$ 220.52	$ 239.50	$ 46.11	$ 266.63	$ 285.60
North	Medicaid Expansion	Male, Age 19 - Age 24	94,786	$ 177.55	$ 192.60	$ 36.59	$ 214.14	$ 229.19
North	Medicaid Expansion	Female, Age 25 - Age 39	359,986	$ 309.91	$ 337.03	$ 65.86	$ 375.77	$ 402.88
North	Medicaid Expansion	Male, Age 25 - Age 39	142,891	$ 310.59	$ 337.77	$ 66.04	$ 376.63	$ 403.81
North	Medicaid Expansion	Female, Age 40 - Age 49	136,830	$ 477.55	$ 519.93	$ 102.89	$ 580.44	$ 622.82
North	Medicaid Expansion	Male, Age 40 - Age 49	71,639	$ 466.08	$ 507.41	$ 100.40	$ 566.47	$ 607.80
North	Medicaid Expansion	Female, Age 50 - Age 64	159,091	$ 583.10	$ 635.09	$ 126.09	$ 709.19	$ 761.18
North	Medicaid Expansion	Male, Age 50 - Age 64	105,344	$ 620.68	$ 676.09	$ 134.45	$ 755.13	$ 810.54
North	Medicaid Expansion	SBH - Dual Eligible, All Ages, Male & Fe	3,296	$ 41.42	$ 42.27	$ 0.09	$ 41.51	$ 42.36
North	Medicaid Expansion	SBH - Other, All Ages, Male & Female	129	$ 139.74	$ 145.36	$ 10.89	$ 150.63	$ 156.24
North	Medicaid Expansion	SBH - Chisholm, All Ages, Male & Fema	145	$ 185.53	$ 194.01	$ 0.02	$ 185.55	$ 194.03
North	Medicaid Expansion	High Needs, All Ages, Male & Female	1,604	$ 1,125.13	$ 1,251.00	$ 247.40	$ 1,372.53	$ 1,498.40
North	Medicaid Expansion - I	Maternity Kick Payment	6,796	$ 7,088.52	$ 7,517.58	$ 3,600.32	$ 10,688.84	$ 11,117.89

Table 1: 2/1/2018 vs 2/1/2017 Loaded Rates

			2/1/2018 Loaded Rates		2/1/2017 Loaded Rates	
Region Name	Age - Sex Factor	Rate Cell Description	Low	High	Low	High
Gulf	0.630	Female Age 19 - Age 24	$ 280.92	$ 300.85	$ 239.15	$ 266.85
Gulf	0.500	Male Age 19 - Age 24	$ 225.48	$ 241.29	$ 200.40	$ 223.00
Gulf	0.899	Female Age 25 - Age 39	$ 396.19	$ 424.66	$ 340.35	$ 381.37
Gulf	0.902	Male Age 25 - Age 39	$ 397.10	$ 425.65	$ 305.36	$ 341.77
Gulf	1.405	Female Age 40 - Age 49	$ 612.35	$ 656.86	$ 513.52	$ 577.33
Gulf	1.371	Male Age 40 - Age 49	$ 597.60	$ 641.01	$ 503.83	$ 566.37
Gulf	1.721	Female Age 50 - Age 64	$ 748.31	$ 802.90	$ 608.53	$ 684.84
Gulf	1.835	Male Age 50 - Age 64	$ 796.83	$ 855.03	$ 692.33	$ 779.67
Capital	0.630	Female Age 19 - Age 24	$ 295.67	$ 317.67	$ 281.40	$ 314.61
Capital	0.500	Male Age 19 - Age 24	$ 237.19	$ 254.65	$ 234.87	$ 261.97
Capital	0.899	Female Age 25 - Age 39	$ 417.22	$ 448.66	$ 402.91	$ 452.10
Capital	0.902	Male Age 25 - Age 39	$ 418.20	$ 449.72	$ 360.90	$ 404.56
Capital	1.405	Female Age 40 - Age 49	$ 645.16	$ 694.30	$ 610.84	$ 687.35
Capital	1.371	Male Age 40 - Age 49	$ 629.64	$ 677.55	$ 599.21	$ 674.19
Capital	1.721	Female Age 50 - Age 64	$ 788.48	$ 848.73	$ 724.91	$ 816.42
Capital	1.835	Male Age 50 - Age 64	$ 839.67	$ 903.91	$ 825.54	$ 930.26
South Central	0.630	Female Age 19 - Age 24	$ 275.28	$ 295.39	$ 260.49	$ 290.91
South Central	0.500	Male Age 19 - Age 24	$ 221.01	$ 236.97	$ 217.81	$ 242.63
South Central	0.899	Female Age 25 - Age 39	$ 388.10	$ 416.83	$ 371.96	$ 417.00
South Central	0.902	Male Age 25 - Age 39	$ 389.00	$ 417.81	$ 333.42	$ 373.40
South Central	1.405	Female Age 40 - Age 49	$ 599.66	$ 644.57	$ 562.68	$ 632.74
South Central	1.371	Male Age 40 - Age 49	$ 585.24	$ 629.04	$ 552.02	$ 620.67
South Central	1.721	Female Age 50 - Age 64	$ 732.70	$ 787.79	$ 667.33	$ 751.11
South Central	1.835	Male Age 50 - Age 64	$ 780.20	$ 838.93	$ 759.63	$ 855.52
North	0.630	Female Age 19 - Age 24	$ 266.63	$ 285.60	$ 243.86	$ 272.34
North	0.500	Male Age 19 - Age 24	$ 214.14	$ 229.19	$ 204.24	$ 227.48
North	0.899	Female Age 25 - Age 39	$ 375.77	$ 402.88	$ 347.33	$ 389.51
North	0.902	Male Age 25 - Age 39	$ 376.63	$ 403.81	$ 311.56	$ 348.99
North	1.405	Female Age 40 - Age 49	$ 580.44	$ 622.82	$ 524.38	$ 589.98
North	1.371	Male Age 40 - Age 49	$ 566.47	$ 607.80	$ 514.47	$ 578.77
North	1.721	Female Age 50 - Age 64	$ 709.19	$ 761.18	$ 621.51	$ 699.97
North	1.835	Male Age 50 - Age 64	$ 755.13	$ 810.54	$ 707.19	$ 796.99

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

Mr. Ron Ogborne, FSA, CERA, MAAA
Partner
Mercer Government Human Services
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016

November 28, 2017

Subject: Capitation Rate Certification for the Healthy Louisiana Program – Implementation Year (February 1, 2018 through January 31, 2019)

Dear Ron:

I, Pam Diez, Medicaid Deputy Director, for the Louisiana Department of Health (LDH), hereby affirm that the data prepared and submitted to Mercer Government Human Services Consulting (Mercer) for the purpose of certifying the February 1, 2018 through January 31, 2019 Healthy Louisiana Rates were prepared under my direction, and to the best of my knowledge and belief, are accurate, complete, and consistent with the data used to develop the capitation rates. This data includes calendar years 2015 and 2016 fee-for-service (FFS) data files, managed care organization submitted encounter data, pre-paid inpatient health plans-submitted encounter data, and supplemental information on payments made outside of Louisiana's Medicaid Management Information Systems.

Signature

11/28/17
Date

MERCER
MAKE TOMORROW, TODAY

JULY 2017–JUNE 2018 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE

Louisiana — February 1, 2018– January 31, 2019

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

A. Rate Development Standards

i. Rate certifications must be done on a 12-month rating period.[4] CMS will consider a time period other than 12 months to address unusual circumstance. For example, CMS would approve a time period other than 12 months for the following reasons:

a. when the state is trying to align program rating periods, which may require rating period longer than one year (but less than two years); or

b. when the state needs to make an amendment to the contract and the rates for an already approved rating period need to be adjusted accordingly.

ii. In accordance with 42 CFR §438.4, 438.5, 438.6, and 438.7, an acceptable rate certification submission, as supported by the assurances from the state, includes the following items and information:

a. a letter from the certifying actuary, who meets the requirements for an actuary in 42 CFR §438.2, who certifies that the final capitation rates or rate ranges meet the standards in 42 CFR §438.3(c), 438.3(e), 438.4 (excluding paragraphs (b)(3), (b)(4) and (b)(9)), 438.5, 438.6, and 438.7 (excluding paragraph (c)(3)).

[4] Per 42 CFR §438.2, "rating period" means a period of 12 months selected by the state for which the actuarially sound capitation rates are developed and documented in the rate certification.

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1. General Information

b. the final and certified capitation rates or the final and certified rate ranges for all rate cells and all regions (as applicable).[5] Additionally, the contract must specify the final capitation rate(s) in accordance with 42 CFR §438.3(c)(1)(i).

c. if rate ranges are certified, assurances that rates at any point within the rate range would be actuarially sound and that the capitation rate for each rate cell is within the certified rate range.

d. brief descriptions of the following information (to show that the actuary developing and/or certifying the rates has an appropriate understanding of the program for which he or she is developing rates):

   i. a summary of the specific state Medicaid managed care programs covered by the rate certification, including, but not limited to:

      A. the types and numbers of managed care plans included in the rate development (e.g., type should include the program type, such as managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans).

      B. a general description or list of the benefits that are required to be provided by the managed care plan or plans (e.g., types of medical services, behavioral health or mental health services, long-term care services, etc.), particularly noting any benefits that are carved out of the managed care program or that are new to the managed care program in that rating period covered.

      C. the areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.

   ii. the rating period covered by the rate certification.

   iii. the Medicaid population(s) covered through the managed care programs to which the rate certification applies.

   iv. any eligibility or enrollment criteria that could have a significant influence on the specific population to be covered within the managed care program (e.g., the definition of medically frail, or if enrollment in managed care plans is voluntary or mandatory).

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[5] Beginning with rate periods on or after July 1, 2018, actuaries must certify specific rates for each rate cell in accordance with 42 CFR §438.4(b)(4) and 438.7(c), and it will no longer be permissible to certify rate ranges. However, 42 CFR §438.7(c)(3) will be for rate periods on or after July 1, 2018 which allows states to increase or decrease the capitation rate per rate cell up to 1.5 percent without submitting a revised rate certification. If states or their actuaries have questions on this upcoming regulatory change, please feel free to reach out to your CMS Regional Office to schedule a technical assistance call.

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v. a summary of the special contract provisions related to payment that, per 42 CFR §438.6, are included within rate development (e.g. risk-sharing mechanisms, incentive arrangements, withhold arrangements, state-directed delivery system reform and provider payment initiatives,[6] pass-through payments, and payments to MCOs and PIHPs for enrollees that are a patient in an Institution of Mental Disease (IMD)).

vi. if the state determines that a retroactive adjustment to the capitation rates is necessary, these retroactive adjustments must be certified by an actuary in a revised rate certification and submitted as a contract amendment in accordance with 42 CFR §438.7(c)(2). The rate certification must:

A. describe the rationale for the adjustment; and

B. the data, assumptions and methodologies used to develop the magnitude of the adjustment.

iii. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

iv. Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments from any other rate cell.

v. The effective dates of changes to the Medicaid managed care program (including eligibility, benefits, payment rate requirements, incentive programs, and program initiatives) should be consistent with the assumptions used to develop the capitation rates.

vi. As part of CMS's determination of whether or not the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider whether the submission demonstrates the following:

a. all adjustments to the capitation rates, or to any portion of the capitation rates, must reflect reasonable, appropriate, and attainable costs in

[6] State direction of managed care plan expenditures under the contract (e.g., value-based purchasing arrangements, multi-payer initiatives, quality/performance incentive programs, and all fee schedules) must meet the requirements in 42 CFR 438.6(c) and receive prior approval before implementation. In order to ensure that States can have these directed payment arrangements reviewed and approved prior to developing rates, CMS has a separate process for submitting payment arrangements under 42 CR 438.6(c).

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the actuary's judgment and must be included in the rate certification.

b. adjustments to the rates or rate ranges that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4. Therefore, the rates or rate ranges will not be considered actuarially sound if adjustments are made outside of the rate setting process described in the rate certification.

c. consistent with 42 CFR §438.7(c), the final contracted rates in each cell must either match the capitation rates or be within the rate ranges in the rate certification. This is required in total and for each and every rate cell.

vii. Rates must be certified for all time periods in which they are effective, and a certification must be provided for rates for all time periods. Rates from a previous rating period cannot be used for a future time period without an actuarial certification of the rates for the new rating period.

viii. Procedures for rate certifications for rate and contract amendments, include:

a. CMS requires that the state submit a new rate certification when the rates or rate ranges change, except for changes permitted in 42 CFR §438.7(c)(3).

b. for contract amendments that do not affect the rates or rate range, CMS does not require a new rate certification from the state. However, if the contract amendment revises the covered populations, services furnished under the contract or other changes that could reasonably change the rate development and rates, the state and its actuary must provide supporting documentation indicating the rationale as to why the rates continue to be actuarially sound in accordance with 42 CFR §438.4.

c. there are several circumstances when CMS would not require a new rate certification:

i. a state changes the capitation rates paid to the plans, but the capitation rates still fall within the certified rate ranges for that rating period and of the contract.

ii. a state applies risk scores to the capitation rates paid to the plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR §438.7(b)(5)(iii).

d. any time a rate changes for any reason other than application of an approved payment term (e.g., risk adjustment methodology), which was included in the initial managed care contract, the state must submit a contract amendment to CMS, even if the rate change does not need a new rate certification.

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B. Appropriate Documentation	Documentation Reference
i. States and their actuaries must document all the elements described within their rate certifications to provide adequate detail that CMS is able to determine whether or not the regulatory standards are met. In evaluating the rate certification, CMS will look to the reasonableness of the information contained in the rate certification for the purposes of rate development and may require additional information or documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented: a. data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources. b. assumptions made, including any basis or justification for the assumption. c. methods for analyzing data and developing assumptions and adjustments.	– Mercer Rate Certification – Data Book
ii. The rate certification must include an index that documents the page number or the section number for the items described within this guidance. In cases where not all sections of this guidance are relevant for a particular rate certification (i.e., an amended certification that adds a new benefit for part of the year), inapplicable sections of the guidance should be included and marked as "Not Applicable" in the index.	– Mercer Rate Certification – CMS RDG attached at end of document
iii. There are services, populations, or programs for which the state	– Mercer Rate Certification

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receives a different federal medical assistance percentage (FMAP) than the regular state FMAP. In those cases, the portions or amounts of the costs subject to the different FMAP should be shown as part of the rate certification to the extent possible.	› Healthy Louisiana Services Eligible for Different Federal Medical Assistance Percentage (FMAP) page 8
iv. In cases when the actuary develops and certifies rate ranges on behalf of a state, the rate certification and supporting documentation must describe how the rate ranges were developed, including: a. any assumptions for which values are varied in order to develop rate ranges. b. the values of each of the assumptions used to develop the minimum, the mid-point or best estimate (as applicable), and the maximum of the rate ranges. c. a description of the data, assumptions, and methodologies that were used to develop the values of the assumptions for the minimum, the mid-point or best estimate (as applicable), and the maximum of the rate ranges.	• Mercer Rate Certification o Managed Care Savings Adjustment, page 12 o Trend, pages 20-21 o Appendix F o Appendix G
v. The information related to rate range development must be included in either the relevant sections of the rate certification or in a separate section related to specifically to the rate range development. For example, a description of how certain assumptions related to projected benefit costs vary to develop the rate ranges may be included with the description of other information related to projected benefit costs, or may be included in a section that describes all of the assumptions that were varied	• See section A above for more detail.

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

to develop the rates. The rate certification index (described in Section I, Item 1.B.ii) must identify where these are described.

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2. Data

A. Rate Development Standards

i. In accordance with 42 CFR §438.5(c), states and actuaries must follow rate development standards related to base data, including:

a. states must provide all the validated encounter data and/or fee-for-service (FFS) data (as appropriate) and audited financial reports (as defined in see §438.3(m)) that demonstrates experience for the populations to be served by the health plan to the state's actuary developing the capitation rates for at least the three most recent and complete years prior to the rating period.

b. states and their actuaries must use the most appropriate base data, from the three most recent and complete years prior to the rating period, for developing capitation rates.

c. base data must be derived from the Medicaid population, or, if data on the Medicaid population is not available, derived from a similar population and adjusted to make the utilization and price data comparable to data from the Medicaid population.

d. states that are unable to develop rates using data that is no older than from the three most recent and complete years prior to the rating period may request approval for an exception as follows:

i. this request should be submitted by the state as soon as the actuary starts developing the rate certification and makes a determination that encounter data will not comply with 42 CFR §438.5(c)(1)-(2).

ii. the request must describe why an exception is necessary and describe the actions the state intends to take to come into compliance with those requirements.

iii. the request must also describe the state's proposed corrective action plan outlining how the state will come into compliance with the base data standards per 42 CFR §438.5(c) no later than two years from the rating period for which the deficiency is identified.

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2. Data	
B. Appropriate Documentation	**Documentation Reference**
i. In accordance with 42 CFR §438.7(b)(1), the rate certification must include: a. a description of base data requested by the actuary for the rate setting process, including: i. a summary of the base data that was requested by the actuary. ii. a summary of the base data that was provided by the state. iii. an explanation of why any base data requested was not provided by the state.	• Data Book • Mercer Rate Certification o Section 1: Medicaid Managed Care Rates ▪ Part A: General Information, pages 2-3
ii. The rate certification, as supported by the assurances from the state, must thoroughly describe the data used to develop the capitation rates, including: a. a description of the data, including:	
i. the types of data used, which may include, but is not limited to: fee-for-service claims data; managed care encounter data; health plan financial data; information from program integrity audits; or other Medicaid program data.	• Mercer Rate Certification o o Section 1: Medicaid Managed Care Rates ▪ Part A: General Information, pages 2-3 ▪ Part B: Base Data Development, pages 8-9
ii. the age or time periods of all data used.	• Mercer Rate Certification o Section 1: Medicaid Managed Care Rates ▪ Part A: General Information, pages 2-3

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	▪ Part B: Base Data Development, pages 8-9
iii. the sources of all data used (e.g., State Medicaid Agency; other state agencies; health plans; or other third parties).	• Mercer Rate Certification o Section 1: Medicaid Managed Care Rates ▪ Part A: General Information, pages 2-3 ▪ Part B: Base Data Development, pages 8-9
iv. if a significant portion of the benefits under the contract with the managed care entity are provided through arrangements with subcontractors that are also paid on a capitated basis (or subcapitated arrangements), a description of the data received from the subcapitated plans or providers; or, if data is not received from the subcapitated plans or providers, a description of how the historical costs related to subcapitated arrangements were developed or verified.	• N/A
b. information related to the availability and the quality of the data used for rate development, including:	
i. the steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including: A. completeness of the data. B. accuracy of the data.	• Mercer Rate Certification o o Section 1: Medicaid Managed Care Rates ▪ Part B: Base Data Development, pages 8-10

SECTION I. MEDICAID MANAGED CARE RATES	
2. Data	
C. consistency of the data across data sources.	
ii. a summary of the actuary's assessment of the data.	• Mercer Rate Certification o Part B: Base Data Development, pages 8-10 o Section 3: Certification of Final Rate Ranges, pages 28-29
iii. any other concerns that the actuary has over the availability or quality of the data.	• N/A
c. a description of how the actuary determined what data was appropriate to use for the rating period, including:	
i. if fee-for-service claims or managed care encounter data are not used (or are not available), this description should include an explanation of why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.	• N/A
ii. if managed care encounter data was not used in the rate development, this description should include an explanation of why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data.	• N/A
d. if there is any reliance or use of a data book in the rate development, the details of the template and relevant instructions used in the data book.	• Mercer Rate Certification o Section 1: Medicaid Managed Care Rates ▪ Part A: General Information, pages 2-3 ▪ Appendix Y

SECTION I. MEDICAID MANAGED CARE RATES	
2. Data	
	▪ Part B: Base Data Development, pages 8-9
iii. The rate certification, as supported by the assurances from the state, must thoroughly describe any significant adjustments, and the basis for the adjustments, that are made to the data, including but not limited to adjustments for:	
a. the credibility of the data.	• Mercer Rate Certification o Part B: Base Data Development, pages 8-9 o Base Data Adjustments, page 13
b. completion factors.	• Mercer Rate Certification o Part B: Base Data Development, pages 8-9 o Base Data Adjustments, page 9
c. errors found in the data.	• N/A
d. changes in the program between the time period from which the data is obtained and the rating period (e.g., changes in the population covered; changes in benefits or services; changes to payment models or reimbursement rates to providers; or changes to the structure of the managed care program).	• Mercer Rate Certification o Prospective Rating Adjustments, pages 14-18
e. exclusions of certain payments or services from the data.	• Mercer Rate Certification o Healthy Louisiana Services, pages 5-7

SECTION I. MEDICAID MANAGED CARE RATES

3. Projected Benefit Costs and Trends

A. Rate Development Standards

i. Final capitation rates must be based only upon the services allowed in 42 CFR §438.3(c)(1)(ii) and 438.3(e).

ii. Variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

iii. In accordance with 42 CFR §438.5(d), each projected benefit cost trend assumption must be reasonable and developed in accordance with generally accepted actuarial principles and practices. Trend assumptions must be developed primarily from actual experience of the Medicaid population or from a similar population, and including consideration of other factors that may affect projected benefit cost trends through the rating period.

iv. If the projected benefit costs include costs for in-lieu-of services defined at 42 CFR §438.3(e)(2) (i.e., substitutes for State Plan services or settings), the utilization and unit costs of the in-lieu-of services must be taken into account in developing the projected benefit costs of the covered services (as opposed to utilization and unit costs of the State plan services or settings), unless a statute or regulation explicitly requires otherwise. The costs of an IMD as an in-lieu-of-service must not be used in rate development. See Section I, item 3.A.v.

v. States may make a monthly capitation payment to an MCO or PIHP (in a “risk contract” as defined in 42 CFR §438.2) for an enrollee age 21 to 64 receiving inpatient treatment in an Institution for Mental Diseases (IMD) (as defined in 42 CFR §435.1010) for a short-term stay of no more than 15 days during the period of the monthly capitation payment in accordance with 42 CFR §438.6(e). In this case, when developing the projected benefit costs for these services, the actuary must use the unit costs of providers delivering the same services included in the State Plan, as opposed to the unit costs of the IMD services. The actuary may use the utilization of the services provided to an enrollee in an IMD in developing the utilization component of projected benefit costs. The data used for developing the projected benefit costs for these services must not include:

   a. costs associated with an IMD stay of more than 15 days.

   b. any other costs for any services delivered during the time an enrollee is in an IMD for more than 15 days.

vi. In connection with section 12002 of the 21st Century Cures Act (P.L. 114-255), CMS requests the following information be provided in the certification for programs that allow IMDs to be used an in lieu of service provider:

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3. Projected Benefit Costs and Trends	
a. the number of enrollees ages 21 to 64 who received treatment in an IMD through managed care organizations or plans in the base data period; b. the range of and the average number of months and of length of stay during those months that enrollees received care in an IMD; c. the impact that providing treatment through IMDs has had on the capitation rates or rate ranges.	
B. Appropriate Documentation	**Documentation Reference**
i. The rate certification must clearly document the final projected benefit costs by relevant level of detail (e.g., rate cell, or aligned with how the state makes payments to the plans).	• N/A
ii. The rate certification and supporting documentation must describe the development of the projected benefit costs included in the capitation rates, including:	
a. a description of the data, assumptions, and methodologies used to develop the projected benefit costs and, in particular, all significant and material items in developing the projected benefit costs.	• Mercer Rate Certification o Section 1, Part C: Non-Expansion Capitation Rate Development, pages 20-24
b. any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last rate certification must be described.	• Mercer Rate Certification o Section 1, Part C: Non-Expansion Capitation Rate Development, pages 20-24
iii. The rate certification and supporting documentation must include a section on projected benefit cost trends (i.e. an estimate the projected change in benefit costs from the historical base data period(s) to the rating period of the rate certification) in accordance with 42 CFR §438.7(b)(2).	

SECTION I. MEDICAID MANAGED CARE RATES	
3. Projected Benefit Costs and Trends	
a. this section must include:	
i. any data used or assumptions made in developing projected benefit cost trends, including a description of the sources of those data and assumptions. A. the descriptions of data and assumptions should include citations whenever possible. B. the description should state whether the trend is developed primarily with actual experience from the Medicaid population or provide rationale for the experience from a similar population that is utilized, and consideration of other factors expected to impact trend.	• Mercer Rate Certification o Historical Trend, page 13 o Trend, pages 20
ii. the methodologies used to develop projected benefit trends.	• Mercer Rate Certification o Historical Trend, page 13 o Trend, pages 20
iii. any comparisons to historical benefit cost trends, or other program benefit cost trends, that were analyzed as part of the development of the trend for the rating period of the rate certification.	• Mercer Rate Certification o Historical Trend, page 13 o Trend, pages 20
b. this section must include the projected benefit cost trends separated into components, specifically:	
i. the projected benefit cost trends should be separated into:	• Mercer Rate Certification o Appendix F

SECTION I. MEDICAID MANAGED CARE RATES	
3. Projected Benefit Costs and Trends	
A. changes in price (i.e., pricing differences due to different provider reimbursement rates or payment models); and B. changes in utilization (i.e., differences in the amount, duration, or mix of benefits or services provided).	
ii. if the actuary did not develop the projected benefit cost trends using price and utilization components, the actuary should describe and justify the method(s)used to develop projected benefit cost trends.	• Mercer Rate Certification o Trend, pages 20
iii. the projected benefit cost trends may include other components as applicable and used by the actuary in developing rates (e.g., changes in location of service delivery; the effect of utilization or care management on projected benefit cost trends; regional differences or variations).	• N/A
c. variations in the projected benefit cost trends must be explained. Projected benefit cost trends may vary by: i. Medicaid populations. ii. rate cells. iii. subsets of benefits within a category of services (e.g., specialty vs. non-specialty drugs).	• Mercer Rate Certification o Historical Trend, page 13 o Trend, pages 20
d. any other material adjustments to projected benefit cost trends must be described in accordance with 42 CFR §438.7(b)(4), including:	• N/A

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3. Projected Benefit Costs and Trends	
i. a description of the data, assumptions, and methodologies used to determine each adjustment. ii. the cost impact of each material adjustment. iii. where in the rate setting process the material adjustment was applied.	
e. any other adjustments to projected benefit costs trends must be listed. CMS also requests the following detail about non-material adjustments: i. the impact of managed care on the utilization and the unit costs of health care services. ii. changes to projected benefit costs trend in the rating period outside of regular changes in utilization or unit cost of services.	• N/A
iv. If the projected benefit costs include additional services deemed by the state to be necessary to comply with the parity standards of the Mental Health Parity and Addiction Equity Act as required by 42 CFR §438.3(c)(1)(ii), the following must be described: a. the categories of service that contain these additional services necessary for parity. b. the percentage of cost that these services represent in each category of service. c. how these services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services	• N/A

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3. Projected Benefit Costs and Trends	
in the categories of service.	
v. For in-lieu-of services defined at 42 CFR §438.3(e)(2) (i.e., substitutes for State Plan services), the following information must be provided and documented: a. the categories of covered service that contain in-lieu-of-services. b. the percentage of cost that in-lieu-of services represent in each category of service. c. how the in-lieu-of services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service. d. for inpatient psychiatric or substance use disorder services provided in an IMD setting, rate development must comply with the requirements of 42 CFR §438.6(e) and the data and assumptions utilized should be described in the rate certification.	• Mercer Rate Certification o In-Lieu of Services, page 21 o IMD, pages 21-22
vi. The rate certification must describe how retrospective eligibility periods are accounted for in rate development, including but not limited to: a. the managed care plan's responsibility to pay for claims incurred during the retroactive eligibility period. b. how the claims information are included in the base data. c. how the enrollment or exposure information is included in the	• Mercer Rate Certification o Retroactive Eligibility Adjustment, pages 22-23 o Appendix M • Databook o Contents of this Data Book, page 4

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base data. d. how the capitation rates are adjusted to reflect the retroactive eligibility period, and the assumptions and methodologies used to develop those adjustments.	
vii. The rate certification must clearly document the impact on projected costs for all material changes to covered benefits or services since the last rate certification, including, but not limited to: a. more or fewer state plan benefits covered by Medicaid managed care. b. any recoveries of overpayments made to providers by health plans in accordance with 42 CFR §438.608(d). c. requirements related to payments from health plans to any providers or class of providers. d. requirements or conditions of any applicable waivers. e. requirements or conditions of any litigation to which the state is subjected.	• Mercer Rate Certification o Pages 20-25 • Databook o Contents of this Data Book, page 4
viii. For each change related to covered benefits or services, the rate certification must include an estimated impact of the change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment.	• N/A
a. any change determined by the actuary to be non-material can be grouped with other non-material changes and described	• N/A

SECTION I. MEDICAID MANAGED CARE RATES	
3. Projected Benefit Costs and Trends	
within the rate certification, provided that: i. the rate certification includes a list of all non-material adjustments used in the rate development process. ii. the actuary must give a description of why the changes were not considered material and how they were aggregated into a single adjustment. iii. the rate certification provides a description of where in the rate setting process the adjustments were applied. iv. The rate certification documents the aggregate cost impact of all non-material adjustments.	

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4. Special Contract Provisions Related to Payment
A. Incentive Arrangements
i. Rate Development Standards a. the rate certification and supporting documentation must describe any incentives included in the contract between the state and the health plans. An incentive arrangement, as defined in 42 CFR §438.6(a), is any payment mechanism under which a health plan may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract. i. the rate certification must include documentation that the incentive arrangement will not exceed 105% of the approved capitation

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4. Special Contract Provisions Related to Payment

payments under the contract that are attributable to the enrollees or services covered by the incentive arrangements as required in 42 CFR §438.6(b)(2).

ii. Appropriate Documentation	Documentation Reference
a. the rate certification must include a description of the incentive arrangement. An adequate description includes at least: i. time period of the arrangement, if different than the rating period. ii. enrollees, services, and providers covered by the incentive program. iii. the purpose of the incentive arrangement (e.g. specified activities, targets, performance measures, or quality-based outcomes, etc.). iv. a description of any effect that each incentive arrangement has on the development of the capitation rates.	• N/A

B. Withhold Arrangements

i. Rate Development Standards

a. the rate certification and supporting documentation must describe any withhold arrangements in the contract between the state and the health plans. As defined in 42 CFR §438.6(a), a withhold arrangement is any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract.

i. the targets for a withhold arrangement are distinct from general operational requirements under the contract.

ii. arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement.

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4. Special Contract Provisions Related to Payment

b. in accordance with 42 CFR §438.6(b)(3), the capitation payment(s) minus any portion of the withhold that is not reasonably achievable must be actuarially sound.

ii. Appropriate Documentation	Documentation Reference
a. the rate certification must include a description of the withhold arrangement. An adequate description includes at least the following: i. the time period of the arrangement, if different than the rating period and the purpose of the arrangement (e.g. specified activities, targets, performance measures, or quality-based outcomes, etc.). ii. a description of the total percentage of the certified capitation rates being withheld through withhold arrangements. iii. an estimate of the percentage of the withheld amount in a withhold arrangement that is not reasonably achievable and the basis for that determination, including the data, assumptions, and methodologies used to make this determination. iv. a description of how the total withhold arrangement, achievable or not, is reasonable and takes into consideration the health plan's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the health plan's capital reserves as measured by the risk-based capital level, months of claims reserve, or other	• N/A

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4. Special Contract Provisions Related to Payment	
appropriate measure of reserves. v. a description of any effect that the withhold arrangements have on the development of the capitation rates.	
C. Risk-Sharing Mechanisms	
i. Rate Development Standards a. in accordance with 42 CFR §438.6(b), if the state utilizes risk-sharing mechanisms with its health plan(s), such as reinsurance, risk corridors, or stop-loss limits, these arrangements must be described in the contract(s) and must be developed in accordance with §438.4, the rate development standards in §438.5, and generally accepted actuarial principles and practices. b. the rate certification and supporting documentation must describe any risk mitigation that may affect the rates, rate ranges, or the final net payments to the health plan(s) under the applicable contract.	
ii. Appropriate Documentation	**Documentation Reference**
a. the rate certification and supporting documentation must include a description of any other risk-sharing arrangements, such as a risk corridor or a large claims pool. An adequate description of these includes at least the following: i. a rationale for the use of the risk sharing arrangement. iii. a detailed description of how the risk-sharing arrangement is implemented. iv. a description of any effect that the risk-sharing arrangements have on the development of the capitation rates. v. documentation demonstrating that the risk-sharing mechanism has been developed in accordance with	• N/A

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4. Special Contract Provisions Related to Payment	
generally accepted actuarial principles and practices.	
b. if the contract includes a remittance/payment requirement for being below/above a specified medical loss ratio (MLR), the rate certification and supporting documentation must include a description of this MLR arrangement. An adequate description includes at least the following: i. the methodology used to calculate the medical loss ratio. ii. the formula for calculating a remittance/payment for having a medical loss ratio below/above the minimum requirements. iii. any other consequences for a remittance/payment for a medical loss ratio below/above the minimum requirements.	• N/A
c. if the contract has reinsurance requirements, the rate certification and supporting document must include a description of the reinsurance requirements. An adequate description includes at least the following: i. a detailed description of any reinsurance requirements under the contract associated with the rate certification, including the reinsurance premiums and any relevant historical reinsurance experience. ii. identification of any effect that the reinsurance requirements have on the development of the capitation rates.	• Mercer Rate Certification o Medicaid Expansion Minimum/Maximum Medical Loss Ratio (MLR), page 28

SECTION I. MEDICAID MANAGED CARE RATES	
4. Special Contract Provisions Related to Payment	
iii. documentation that the reinsurance mechanism has been developed in accordance with generally accepted actuarial principles and practices. iv. if the actuary develops the reinsurance premiums, a description of how the reinsurance premiums were developed, including the data, assumptions and methodology used.	
D. Delivery System and Provider Payment Initiatives	
i. Rate Development Standards a. consistent with 42 CFR §438.6(c), states may utilize delivery system and provider payment initiatives, including requiring managed care plans to: i. implement value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services. ii. participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative. iii. adopt a minimum fee schedule for network providers that provide a particular service under the contract. iv. provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. v. adopt a maximum fee schedule for network providers that provide a particular service under the contract, so long as the health plan retains the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.	
ii. Appropriate Documentation	**Documentation Reference**
a. the rate certification and supporting documentation must include a description of any delivery system and provider payment initiatives. An adequate description includes at least the following:	• Mercer Rate Certification o Medicaid Expansion Minimum/Maximum Medical Loss Ratio (MLR), page 28

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

i. a brief description of the delivery system and provider payment initiatives included in the rates for this rating period.

ii. the amount of these payments within the rate development, both in total and on a per member per month basis (if applicable).

iii. the providers receiving these payments.

iv. a description of any effect the delivery system or provider payment initiative has on the development of capitation rates, including the data, assumptions and methodologies used to make this determination.

E. Pass-Through Payments

i. Rate Development Standards

a. a pass-through payment is any amount required by the state to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between MCOs, PIHPs, or PAHPs and hospitals, physicians, or nursing facilities that is not for one of the following purposes[7]:

i. a specific service or benefit provided to a specific enrollee covered under the contract;

ii. a provider payment methodology permitted under 42 CFR §438.6(c)(1)(i) through (iii) for services and enrollees covered under the contract;

[7] States may not require health plans to make pass-through payments other than those permitted to network providers that are hospitals, physicians, and nursing facilities in accordance with 42 CFR 438.6(d)(1).

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

iii. a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract;

iv. graduate Medical Education (GME) payments; or

v. Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) wrap around payments.

b. pass-through payments to hospitals must comply with the requirements of 42 CFR §438.6(d). The aggregate pass-through payments to hospitals may not exceed the base amount.

c. the base amount is determined as the sum of (i) and (ii) below:

i. for inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period and that were provided to the eligible populations under MCO, PIHP, or PAHP contracts two years prior to the rating period, the state must determine reasonable estimates of the aggregate difference between:

A. the amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under the MCO, PIHP, or PAHP contracts for the 12-month period immediately two years prior to the rating period that will include pass-through payments; and

B. the amount the MCOs, PIHPs, or PAHPs paid (not including pass-through payments) for those inpatient and outpatient hospital services utilized by the eligible populations under MCO, PIHP, or PAHP contracts for the 12-month period immediately 2 years prior to the rating period.

ii. for inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period and that were provided to the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period, the state must determine reasonable estimates of the aggregate difference between:

A. the amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments; and

B. the amount the state paid under Medicaid FFS (not including pass-through payments) for those inpatient and outpatient hospital services utilized by the eligible populations for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments.

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

d. the base amount should be the actual amount calculated in the Section I, Item 4.E.i.c of the guide and should not be trended forward.

e. states may calculate reasonable estimates of the aggregate differences in paragraph (c) in accordance with the upper payment limit requirements in 42 CFR part 447.

f. capitation rates may only include pass-through payments to hospitals, physicians and nursing facilities in accordance with 42 CFR 438.6(d); states may not include pass-through payments to providers other than hospitals, physicians, and nursing facilities in the capitation rates.

ii. Appropriate Documentation	Documentation Reference
a. the rate certification and supporting documentation must include a description of all existing pass-through payments incorporated into the rates for this rating period. An adequate description includes at least the following: i. a description of the pass-through payment. ii. the amount of the pass-through payments, both in total and on a per member per month basis (if applicable). iii. the providers receiving the pass-through payments. iv. the financing mechanism for the pass-through payment. v. the amount of pass-through payments incorporated into capitation rates in the previous rating period. vi. the amount of pass-through payments incorporated into capitation rates for the rating period in effect on July 5, 2016.	• N/A
b. the certification must document the following information about the base amount for hospital pass-through payments:	• N/A

SECTION I. MEDICAID MANAGED CARE RATES	
4. Special Contract Provisions Related to Payment	
i. the data, methodologies, and assumptions used to calculate the base amount. ii. the aggregate amounts calculated for Section I, Item 4.E.i.c.i.A, Section I, Item 4.E.i.c.i.B, Section I, Item 4.E.i.c.ii.A, and Section I, Item 4.E.i.c.ii.B.	

SECTION I. MEDICAID MANAGED CARE RATES
5. Projected Non-Benefit Costs
A. Rate Development Standards
i. In accordance with 42 CFR §438.5(e), the development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO, PIHP or PAHP administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital. In addition, the non-benefit component must include other operational costs associated with the provision of services under the contract, including those to comply with the parity standards of the Mental Health Parity and Addiction Equity Act, as required by 42 CFR §438.3(c)(1)(ii).
ii. Non-benefit costs may be developed as per member per month (PMPM) costs or as a percentage of projected benefit costs or capitation rates, and different approaches can be taken for different categories of costs. For non-benefit costs that may be difficult to allocate to specific enrollees or groups of enrollees, or for taxes and fees that are assessed as a percentage of premiums, it may be reasonable to calculate those non-benefit costs as a percentage of benefit costs or capitation rates.
iii. Variations in the assumptions used to develop the projected non-benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.
iv. Section 9010 of the Patient Protection and Affordable Care Act imposes a Health Insurance Providers Fee on each covered entity engaged in the business of providing health insurance for United States health risk. CMS policy regarding how this fee may be considered in Medicaid

SECTION I. MEDICAID MANAGED CARE RATES	
5. Projected Non-Benefit Costs	
managed care rate development is outlined in CMS's "Medicaid and CHIP FAQs: Health Insurance Providers Fee for Medicaid Managed Care Plans," dated October 2014.[8] States have the flexibility to account for the Health Insurance Providers Fee on a prospective or retrospective basis into rate development for either the data year or fee year. Any payment for the fee must be incorporated in the health plan capitation rates. a. due to the health insurance provider fee moratorium established by the Consolidated Appropriations Act of 2016, CMS does not expect any health insurance provider fees to be paid for calendar year 2017 by managed care plans that are subject to that fee. Therefore, no amounts should be included in Medicaid managed care capitation rates for fees that would have been paid by plans to the IRS for 2017 (which would have been assessed off of 2016 net premiums).[9] This fee remains in effect for calendar year 2018 and beyond.	
B. Appropriate Documentation	**Documentation Reference**

[8] Federal Policy Guidance FAQS

[9] More information on this issue can be found at: Affordable Care Act Provisions

SECTION I. MEDICAID MANAGED CARE RATES	
5. Projected Non-Benefit Costs	
i. rate certification and supporting documentation must describe the development of the projected non-benefit costs included in the capitation rates in enough detail so CMS or an actuary applying generally accepted actuarial principles and practices can identify each type of non-benefit expense that is included in the rate and evaluate the reasonableness of the cost assumptions underlying each expense in accordance with 42 CFR §438.7(b)(3). To meet this standard, the documentation must include: a. a description of the data, assumptions, and methodologies used to develop the projected non-benefit costs, and in particular, all significant and material items in developing the projected non-benefit costs. b. any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last rate certification. c. any other material adjustments must be described in accordance with 42 CFR §438.7(b)(4), including: i. a description of the data, assumptions, and methodologies used to determine each adjustment. ii. where in the rating setting process each adjustment was applied. iii. the cost impact of each material adjustment.	• Mercer Rate Certification o Section 2: Expansion Capitation Rate Development, Pages 25 - 27
ii. States and actuaries should estimate the projected non-benefit costs for each of the following categories of costs:	• Mercer Rate Certification o Section 2: Expansion Capitation Rate Development, Pages 25 - 27

SECTION I. MEDICAID MANAGED CARE RATES	
5. Projected Non-Benefit Costs	
a. administrative costs. b. taxes, licensing and regulatory fees, and other assessments and fees. c. contribution to reserves, risk margin, and cost of capital. d. other material non-benefit costs.	
iii. Regarding the Health Insurance Providers Fee, the rate certification and supporting documentation must: a. specifically address how this fee is incorporated into capitation rates if the managed care plan is required to pay the fee. b. if the fee is incorporated into the rates in the initial rate certification, an explanation of whether the amount included in the rates is based on the data year or fee year during the rating period of the rate certification. c. a description of how the amount of the fee was determined, and whether or not any adjustments would be made to the rates once the actual amount of the fee is known. d. if the fee is not incorporated into the rates in the rate certification because the rates will be adjusted to account for the fee subsequently, an explicit statement that the fee is not included, and a description of when and how the rates will ultimately be adjusted to account for the fee. e. if the capitation rates include benefits as described in 26 CFR §57.2(h)(2)(ix)(e.g., long-term care, nursing home care, home health care, or community-based care), CMS recommends that the per member per month cost associated with those	• Mercer Rate Certification o Federal Health Insurer Fee, page 25

SECTION I. MEDICAID MANAGED CARE RATES

5. Projected Non-Benefit Costs

benefits be explicitly reported as a separate amount in the rate certification in order to more accurately account for the appropriate revenue on which the plans will be assessed.

SECTION I. MEDICAID MANAGED CARE RATES

6. Risk Adjustment and Acuity Adjustments

A. Rate Development Standards

i. Risk adjustment is a methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of MCOs, PIHPs, or PAHPs contracted with the state.

ii. As required by 42 CFR §438.5(g), if risk adjustment is applied prospectively or retrospectively, states and their actuaries must select a risk adjustment methodology that uses generally accepted models and must apply it in a budget neutral manner, consistent with generally accepted actuarial principles and practices, across all MCOs, PIHPs or PAHPs in the program to calculate adjustments to the payments as necessary.

iii. An adjustment applied to the total payments across all managed care plans to account for significant uncertainty about the health status or risk of a population is considered an acuity adjustment, which is a permissible adjustment under 42 CFR §438.5(f). (81 FR 27595)

   a. acuity adjustments may be used prospectively or retrospectively.

   b. while retrospective acuity adjustments may be permissible, they are intended solely as a mechanism to account for differences between assumed and actual health status when there is significant uncertainty about the health status or risk of a population, such as: (1) new populations coming into the Medicaid program; or (2) a Medicaid population that is moving from FFS to managed care when enrollment is voluntary and there may be concerns about adverse selection. In the latter case, there may be significant uncertainty about the health status of which individuals would remain in FFS versus move to managed care; although this uncertainty is expected to decrease as the program matures.

SECTION I. MEDICAID MANAGED CARE RATES	
6. Risk Adjustment and Acuity Adjustments	
c. CMS may also consider acuity adjustments as a risk mitigation strategy when there is unusual and significant uncertainty about the health status of the population (e.g., covering a new population in Medicaid).	
B. Appropriate Documentation	**Documentation Reference**
i. In accordance with 42 CFR §438.7(b)(5)(i), the rate certification must describe all prospective risk adjustment methodologies, including: a. the data, and any adjustments to that data, to be used to calculate the adjustment. b. the model, and any adjustments to that model, to be used to calculate the adjustment. c. the method for calculating the relative risk factors and the reasonableness and appropriateness of the method in measuring the risk factors of the respective populations. d. the magnitude of the adjustment on the capitation rate per MCO, PIHP, or PAHP. e. an assessment of the predictive value of the methodology compared to prior rating periods. f. any concerns the actuary has with the risk adjustment process.	• N/A
ii. In accordance with 42 CFR §438.7(b)(5)(ii), the rate certification must describe all retrospective risk adjustment methodologies, including: a. the party calculating the risk adjustment.	• Mercer Rate Certification o Risk Adjustment, page 25

SECTION I. MEDICAID MANAGED CARE RATES	
6. Risk Adjustment and Acuity Adjustments	
b. the data, and any adjustments to that data, to be used to calculate the adjustment. c. the model, and any adjustments to that model, to be used to calculate the adjustment. d. the timing and frequency of the application of the risk adjustment. e. any concerns the actuary has with the risk adjustment process.	
iii. The rate certification and supporting documentation must also specifically include: a. any changes that are made to risk adjustment models since the last rating period. b. documentation that the risk adjustment model is budget neutral in accordance with 42 CFR §438.5(g).	• Mercer Rate Certification o Risk Adjustment, page 25
iv. If an acuity adjustment is being used, the rate certification must include a description of the acuity adjustment and its basis that is adequate to evaluate its reasonableness and whether it is consistent with generally accepted actuarial principles and practices. Such a description includes at least: a. the reason that there is significant uncertainty about the health status of the population and the need for an acuity adjustment. b. the acuity adjustment model(s) being used to calculate acuity adjustment scores.	• Mercer Rate Certification o Part A: Projected Benefits Costs, page 26

SECTION I. MEDICAID MANAGED CARE RATES	
6. Risk Adjustment and Acuity Adjustments	
c. the specific data, including the source(s) of the data, being used by the acuity adjustment model(s). d. the relationship and potential interactions between the acuity adjustment. e. how frequently the acuity adjustment scores are calculated. f. a description of how the acuity adjustment scores are being used to adjust the capitation rates. g. documentation that the acuity adjustment mechanism has been developed in accordance with generally accepted actuarial principles and practices.	

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS	
1. Managed Long-Term Services and Supports	
A. For managed long-term services and supports (MLTSS) programs, or for programs that include MLTSS as part of the covered benefits, the guidance above in Section I regarding the required standards for rate development and CMS's expectations for appropriate documentation required in the rate certification is also applicable for rates for provision of MLTSS.	
B. Rate Development Standards	
i. States may take different approaches for rate setting for MLTSS. The two most common approaches are to structure the rate cells: a. by health care status and the level of need of the beneficiaries ("blended"); or b. by the long-term care setting that the beneficiary uses ("non-blended").	
C. Appropriate Documentation	**Documentation Reference**

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS	
1. Managed Long-Term Services and Supports	
i. The rate certification and supporting documentation for MLTSS programs, or for programs that include MLTSS as part of the covered benefits must also specifically address the following considerations: a. the structure of the capitation rates and rate cells or rating categories (e.g. blended, non-blended, etc.). b. the structure of the rates and the rate cells, and the data, assumptions, and methodology used to develop the rates in light of the overall rate setting approach. c. any other payment structures, incentives, or disincentives used to pay the MCOs, PIHPs or PAHPs (for example, states may provide additional payments to plans that transition beneficiaries from institutional long-term care settings into other settings, or may pay adjusted rates during time periods of setting transitions). d. the expected effect that managing LTSS has on the utilization and unit costs of services. e. any effect that the management of this care is expected to have within each care setting and any effect in managing the level of care that the beneficiary receives (e.g., in-home care, community long-term care, nursing facility care).	• N/A
ii. The projected non-benefit costs, such as administrative costs and care coordination costs, may differ for populations receiving MLTSS from other managed care programs, and the rate certification should describe how the projected non-benefit costs	• N/A

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS	
1. Managed Long-Term Services and Supports	
were developed for populations receiving these services.	
iii. The rate certification should provide information on historical experience, analysis, and other sources (e.g., studies or research) used to develop the assumptions used for rate setting.	• N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
1. Data	
A. In addition to the expectations for all Medicaid managed care rate certifications, as supported by assurances from the State, described in Section I, the rate certification must describe any data used to develop new adult group rates.	• Mercer Rate Certification o Section 2: Expansion Capitation Rate Development, page 26 o Additional Rate Adjustments, page 27
B. For states that have covered the new adult group in Medicaid managed care plans in previous rating periods (i.e. starting in 2014, 2015, 2016, and/or January through June 2017), CMS expects the rate certification, as supported by assurances from the State, to describe: i. Any new data that is available for use in this rate setting. ii. How the state and the actuary followed through on any plans to monitor costs and experience for newly eligible adults. iii. How actual experience and costs in previous rating periods have	• N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
1. Data	
differed from assumptions and expectations in previous rate certifications. iv. How differences between projected and actual experience in previous rating periods have been used to adjust these rates.	

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
2. Projected Benefit Costs	
A. In addition to the guidance for all Medicaid managed care rate certifications described in Section I, states should include in the rate certification submission and supporting documentation a description of the following issues related to the projected benefit costs for the new adult group: i. For states that covered the new adult group in previous rating periods:	
a. any data and experience specific to newly eligible adults covered in previous rating periods that was used to develop projected benefits costs for capitation rates.	• N/A
b. any changes in data sources, assumptions, or methodologies used to develop projected benefits costs for capitation rates since the last certification.	• N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
2. Projected Benefit Costs	
c. how assumptions changed from rate certification(s) for previous rating periods on the following issues: i. acuity or health status adjustments (in most cases comparing the new adult group enrollees to other Medicaid adult enrollees). ii. adjustments for pent-up demand. iii. adjustments for adverse selection. iv. adjustments for the demographics of newly eligible adults. v. differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for newly eligible adult rates and other Medicaid population rates. A. variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations. vi. other material adjustments to newly eligible adults projected benefit costs.	• Mercer Rate Certification o Section 2: Expansion Capitation Rate Development, page 26 o Appendix R
B. For any state that is covering the new adult group, regardless if they have been covered in previous rating periods, the following key assumptions related to the new adult group must be included in the rate certification and supporting documentation:	• Mercer Rate Certification o Rate Cell Structure, pages 26-27 o Additional Rate Adjustments, page 27 o Appendix R

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
2. Projected Benefit Costs	
i. Acuity or health status adjustments (in most cases comparing new adult group enrollees to other Medicaid adult enrollees). ii. Adjustments for pent-up demand. iii. Adjustments for adverse selection. iv. Adjustments for the demographics of the new adult group. v. Differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for the new adult group rates and other Medicaid population rates. vi. Other material adjustments to the new adult group projected benefit costs.	
C. The rate certification and supporting documentation must describe any changes to the benefit plan offered to the new adult group.	• N/A
D. The rate certification and supporting documentation must describe any other material changes or adjustments to projected benefit costs.	• N/A

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
3. Projected Non-Benefit Costs	
A. In addition to the guidance all Medicaid managed care rate certifications described in Section I, states must include in the rate	• Mercer Rate Certification o Non-Medical Expense Load, pages 24-25

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
3. Projected Non-Benefit Costs	
certification submission and supporting documentation a description of the following issues related to the projected non-benefit costs for the new adult group: i. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, any changes in data sources, assumptions, or methodologies used to develop projected non-benefit costs since the last rate certification. ii. How assumptions changed from the rate certification(s) for previous rating periods on the following issues: a. administrative costs. b. care coordination and care management. c. provision for operating or profit margin. d. taxes, fees, and assessments. e. other material non-benefit costs.	o Appendix W
B. The rate certification and supporting documentation must include information on key assumptions related to the new adult group and any differences between the assumptions for this population and the assumptions used to develop projected non-benefit costs for other Medicaid populations for the following issues: i. Administrative costs. ii. Care coordination and care management. iii. Provision for operating or profit margin. iv. Taxes, fees, and assessments.	• Mercer Rate Certification o Non-Medical Expense Load, pages 24-25 o Appendix W

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
3. Projected Non-Benefit Costs	
v. Other material non-benefit costs.	

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
4. Final Certified Rates or Rate Ranges	
A. In addition to the expectations for all Medicaid managed care rate certifications described in Section I, CMS requests under 42 CFR §438.7(d)[10] that states that covered the new adult group in Medicaid managed care plans in previous rating periods provide: i. A comparison to the final certified rates or rate ranges in the previous rate certification. ii. A description of any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.	• Mercer Rate Certification o Appendix Q

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

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE
5. Risk Mitigation Strategies	
A. CMS requests under 42 CFR §438.7(d) that states describe the risk mitigation strategy specific to the new adult group rates.	• Mercer Rate Certification o Pages 25, 26
B. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, CMS requests the following information: i. Any changes in the risk mitigation strategy from those used during previous rating periods. ii. The rationale for making the change in the risk mitigation strategy or removing the risk mitigation strategy used during previous rating periods. iii. Any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during previous rating periods.	• N/A

Performance Measures

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source	2019 (2018 data measurement year) and Subsequent Years Target for Improvement
PTB $$	Initiation of Injectable Progesterone for Preterm Birth Prevention	The percentage of women 15-45 years of age with evidence of a previous preterm singleton birth event (24-36 weeks completed gestation) who received one or more progesterone injections between the 16th and 24th week of gestation for deliveries during the measurement year.	State	None	Children's and Maternal Health	Perinatal and Reproductive Health	Section V	20.65
AWC $$	Adolescent Well Care Visit	The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.	NCQA	CHIPRA	Children's Health	Utilization	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
ADD $$	Follow-up Care for Children Prescribed ADHD Medication-Initiation Phase	The percentage of children 6-12 years of age as of the index period start date with a newly prescribed ambulatory prescription dispensed for attention-deficit /hyperactivity disorder (ADHD) medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.	NCQA	CHIPRA, MU2	Children's Health	Behavioral Health	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
ADD $$	Follow-up Care for Children Prescribed ADHD Medication-Continuation Phase	The percentage of children 6-12 years of age as of the index period start date with a newly prescribed ambulatory prescription dispensed for attention-deficit /hyperactivity disorder (ADHD) medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	NCQA	CHIPRA, MU2	Children's Health	Behavioral Health	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source	2019 (2018 data measurement year) and Subsequent Years Target for Improvement
AMB-ED $$	Ambulatory Care-ED Visits	This measure summarizes utilization of ambulatory care ED Visits per 1,000 member months.	NCQA	CHIPRA	Population Health	Utilization	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
PPC $$	Prenatal and Postpartum Care - Timeliness of Prenatal Care	The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.	NCQA	MEDICAID ADULT	Maternal Health	Perinatal and Reproductive Health	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
PPC $$	Prenatal and Postpartum Care – Postpartum Care (PPC Numerator 2)	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	NCQA	MEDICAID ADULT	Maternal Health	Perinatal and Reproductive Health	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
FUH $$	Follow-Up After Hospitalization for Mental Illness - Within 30 days of discharge	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days of discharge.	NCQA	MEDICAID ADULT	Behavioral Health	Behavioral Health	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source	2019 (2018 data measurement year) and Subsequent Years Target for Improvement
CBP $$	Controlling High Blood Pressure - Total	The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year based on the following criteria: • Members 18-59 whose BP was <140/90 • Members 60-85 with diagnosis of diabetes who BP was 150-90 • Members 60-85 without a diagnosis of diabetes whose BP was 150/90	NCQA	MEDICAID ADULT, MU2, CMS HEALTH HOMES	Chronic Disease	Cardiovascular Care	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
CDC $$	Comprehensive Diabetes Care - Hemoglobin A1c (HBA1c) testing	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with a Hemoglobin A1c (HbA1c) test.	NCQA	MEDICAID ADULT	Chronic Disease	Diabetes	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
CDC $$	Comprehensive Diabetes Care - Eye exam (retinal) performed	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with an eye exam (retinal) performed.	NCQA	MEDICAID ADULT	Chronic Disease	Diabetes	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
CDC $$	Comprehensive Diabetes Care - Medical attention for nephropathy	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with medical attention for nephropathy.	NCQA	CHIPRA	Chronic Disease	Diabetes	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source	2019 (2018 data measurement year) and Subsequent Years Target for Improvement
W15 $$	Well-Child Visits in the First 15 Months of Life - Six or more well-child visits.	The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.	NCQA	CHIPRA	Children's Health	Utilization	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
W34 $$	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	The percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	NCQA	CHIPRA	Children's Health	Utilization	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
CPA $$	CAHPS Health Plan Survey 5.0H, Adult (Rating of Health Plan, 8+9+10)	This measure provides information on the experiences of Medicaid members with the organization and gives a general indication of how well the organization meets members' expectations.	NCQA	MEDICAID ADULT	Adult	Member Satisfaction	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
CPC $$	CAHPS Health Plan Survey 5.0H, Child (Rating of Health Plan-General Population, 8+9+10)	This measure provides information on parents' experience with their child's Medicaid organization.	NCQA	MEDICAID, CHIPRA	Child	Member Satisfaction	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
HEDIS Measures							
CIS	Childhood Immunization Status	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	NCQA	CHIPRA, MU2	Children's Health	Prevention	HEDIS
IMA	Immunization Status for Adolescents	Percentage of adolescents that turned 13 years old during the measurement year and had specific vaccines by their 13th birthday. Report all individual vaccine numerators and combinations.	NCQA	CHIPRA	Children's Health	Prevention	HEDIS
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/ Adolescents	Percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index percentile for age and gender. The percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner, with evidence of : • BMI percentile documentation • Counseling for nutrition • Counseling for physical activity	NCQA	CHIPRA, MU2	Children's Health	Prevention	HEDIS

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	The measure calculates the percentage of individuals 19 years of age or greater as of the beginning of the measurement year with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement year (12 consecutive months).	NCQA	MEDICAID ADULT	Population Health	Behavioral Health	HEDIS
MPM	Annual Monitoring for Patients on Persistent Medications	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the four rates separately and as a total rate.	NCQA	MEDICAID ADULT	Chronic Disease	Prevention	HEDIS
ABA	Adult BMI Assessment	The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement or the year prior to the measurement year.	NCQA	MEDICAID ADULT, CMS HEALTH HOMES	Population Health	Prevention	HEDIS
AMM	Antidepressant Medication Management	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.	NCQA	MEDICAID ADULT, MU2	Population Health	Behavioral Health	HEDIS

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
CCS	Cervical Cancer Screening	Percentage of women 21–64 years of age who were screened for cervical cancer: • Women 21-64 who had cervical cytology performed every 3 years • Women 30-64 who had cervical cytology/HPV co-testing performed every 5 years	NCQA	MEDICAID ADULT, MU2	Population Health	Prevention	HEDIS
AMR	Asthma Medication Ratio	The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	NCQA	MEDICAID	Population Health	Pulmonary/ Critical Care	HEDIS
FVA	Flu Vaccinations for Adults Ages 18 to 64	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period.	NCQA	MEDICAID ADULT	Population Health	Prevention	HEDIS/CAHPS
MSC	Medical Assistance With Smoking and Tobacco Use Cessation	Assesses different facets of providing medical assistance with smoking and tobacco use cessation. MCOs will report three components (questions): • Advising Smokers and Tobacco Users to Quit • Discussing Cessation Medications • Discussing Cessation Strategies	NCQA	MEDICAID ADULT	Population Health	Prevention	HEDIS/CAHPS
MMA	Medication Management for People with Asthma	The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported.	NCQA	CHIPRA	Population Health	Pulmonary/ Critical Care	HEDIS

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
CHL	Chlamydia Screening in Women	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.	NCQA	CHIPRA, MEDICAID ADULT	Population Health, Maternal Health	Perinatal and Reproductive Health, Sexually Transmitted Infectious Diseases	HEDIS
BCS	Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	NCQA	MEDICAID ADULT, MU2	Senior Care	Prevention	HEDIS
CAP	Child and Adolescents' Access to Primary Care Practitioners	Percentage of children ages 12 months – 19 years who had a visit with a PCP. The MCO reports four separate percentages: • Children 12-24 months and 25 months – 6 years who had a visit with a PCP in the measurement year • Children 7-11 years and adolescents 12-19 years who had a visit with a PCP in the measurement year or the year prior to the measurement year.	NCQA	CHIPRA	Children's Health	Access/ Availability of Care	HEDIS
COL	Colorectal screening	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.	NCQA	MEDICAID ADULT	Population Health	Prevention	HEDIS
SSD	Diabetes screening for people with Schizophrenia or Bipolar who are using Antipsychotic medications	The percentage of members 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NCQA	MEDICAID ADULT	Population Health	Behavioral Health	HEDIS

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
SPC	Statin Therapy for Patients with Cardiovascular Disease	• The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who received statin therapy (were dispensed at least one high or moderate-intensity statin medication during the measurement year.) • The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who had statin adherence of at least 80% (who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.)	NCQA	MEDICAID ADULT	Population Health	Cardiovascular Care	HEDIS
CDC	Comprehensive Diabetes Care - HbA1c poor control (>9.0%)	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with HbA1c poor control (>9.0%).	NCQA	MEDICAID ADULT	Chronic Disease	Diabetes	HEDIS
CDC	Comprehensive Diabetes Care - HbA1c control (<8.0%)	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with HbA1c control (<8.0%).	NCQA	MEDICAID ADULT	Chronic Disease	Diabetes	HEDIS
CDC	Comprehensive Diabetes Care - BP control (<140/90 mm Hg).	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with BP control (<140/90 mm Hg).	NCQA	MEDICAID ADULT	Chronic Disease	Diabetes	HEDIS
PCR	Plan All-Cause Readmissions	For members 18 -64 years of age, the risk-adjusted rate of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	NCQA	MEDICAID ADULT	Population Health	All Cause Readmissions	HEDIS

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
AAP	Adults' Access to Preventive/ Ambulatory Health Services	The percentage of members age 20 years and older who had an ambulatory or preventive care visit during the measurement year. Three age stratifications and a total rate are reported: • 20-44 years • 45-64 years • 65 years and older • Total	NCQA	MEDICAID ADULT	Population Health	Prevention	HEDIS
FUH	Follow-Up After Hospitalization for Mental Illness - Within 7 days of discharge	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 7 days of discharge.	NCQA	CHIPRA	Behavioral Health	Behavioral Health	HEDIS
AMB	Ambulatory Care-Outpatient Visits	This measure summarizes utilization of ambulatory care Outpatient Visits per 1,000 member months.	NCQA	MEDICAID	Population Health	Utilization	HEDIS
PQI Measures							
PQI01	Diabetes Short Term Complications Admission Rate	Number of discharges for diabetes short term complications per 100,000 member months per Medicaid enrollees age 18 and older.	AHRQ	MEDICAID ADULT	Chronic Disease	Diabetes	Section V
PQI05	COPD and Asthma in Older Adults Admission Rate	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population. The number of discharges for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months for Medicaid enrollees age 40 and older.	AHRQ	MEDICAID ADULT	Population Health	Pulmonary/ Critical Care	Section V

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
PQI08	Heart Failure Admission Rate	Percent of population with an admissions for heart failure (reported by Recipient Parish). The number of discharges for heart failure per 100,000 member months for Medicaid enrollees age 18 and older (reported by Recipient Parish).	AHRQ	MEDICAID ADULT	Chronic Disease	Cardiovascular Care	Section V
PQI15	Asthma in Younger Adults Admission Rate	Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions. Number of discharges for asthma per 100,000 member months for Medicaid enrollees ages 18 to 39.	AHRQ	MEDICAID ADULT	Population Health	Pulmonary/ Critical Care	Section V
Vital Record Measures							
LBW	Percentage of low birth weight births	Percentage of live births that weighted less than 2,500 grams in the state during the reporting period.	CDC	CHIPRA, HRSA	Children's and Maternal Health	Perinatal and Reproductive Health	Section V
NQF (PC-01)	Elective Delivery	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed	TJC	MEDICAID ADULT, MU2	Maternal Health	Perinatal and Reproductive Health	Section V
CMS Measures							
HIV	HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200.	HRSA HIV/AIDS Bureau	MEDICAID ADULT	Chronic Disease	HIV	Section V
CCP-CH	Contraceptive Care-Postpartum (ages 15-20)	The percentage of women ages 15-20 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 60 days of delivery. Four rates are reported.	CMS	CHIPRA	Maternal Health	Perinatal and Reproductive Health	OPA

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
CCP-AD	Contraceptive Care-Postpartum (ages 21-44)	The percentage of women ages 21-44 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 60 days of delivery. Four rates are reported.	CMS	MEDICAID ADULT	Maternal Health	Perinatal and Reproductive Health	OPA
NSV	Cesarean Rate for Low-Risk First Birth Women	The percentage of cesareans in live births at or beyond 37.0 weeks gestation to women that are having their first delivery and are singleton (no twins or beyond) and are vertex presentation (no breech or transverse positions).	TJC	CHIPRA	Children's and Maternal Health	Perinatal and Reproductive Health	Section V

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated.
For questions on terms see the Definitions tab.

Payment Approach		Provider Payments	Percentage of Provider Payments	
1. Total Annual Provider Payments				
All provider payments	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified payment period (Calendar Year 2017 or State Fiscal Year 2019). Managed Care Incentive Program (MCIP) payments should be excluded from any calculations in this report.	$0	Percentage of Total Provider Payments	#DIV/0!
Payment Approach		**Provider Payments**	**Percentage of Provider Payments**	
2. Alternative Payment Model Framework - Category 2 (All methods below are linked to quality).				
Category 2A Incentive Payments only (Foundational Payments for Infrastructure & Operations)	**Category 2A APMs ONLY** - Total dollars paid to providers for foundational spending to improve care , e.g. care coordination payments, PCMH payments, infrastructure payments, during payment period. Do not include FFS/base payments, just report the portion of the provider payment that is for foundational spending to improve care.	$0	% of Total provider payments that are paid under Category 2A APMs ONLY	#DIV/0!
Contracts that include Category 2A APMs	**Provider Payments under Contracts that include Category 2A APMs** - Total dollars paid under provider contracts that include FFS/base payments **plus** foundational spending to improve care.	$0	% of Total provider payments that are paid under contracts that include at least one Category 2A APM	#DIV/0!
		For Provider Contracts with Category 2A APMs - % of provider payments that are linked to foundational payments		#DIV/0!
Category 2B Incentive Payments only (Pay for Reporting)	**Category 2B APMs ONLY** - Total dollars paid to providers for pay for reporting , e.g. payments for reporting on HEDIS measures ('pay-per-click') during payment period. Do not include FFS/base payments, just report the portion of the provider payment that is linked to pay for reporting.	$0	% of Total provider payments that are paid under Category 2B APMs ONLY	#DIV/0!
Contracts that include Category 2B APMs	**Provider Payments under Contracts that include Category 2B APMs** - Total dollars paid under provider contracts that include FFS/base payments **plus** pay for reporting.	$0	% of Total provider payments that are paid under contracts that include at least one Category 2B APM	#DIV/0!

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated. For questions on terms see the Definitions tab.		
	For Provider Contracts with Category 2B APMs - % of provider payments that are linked to pay for reporting	#DIV/0!

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated. For questions on terms see the Definitions tab.				
Category 2C Incentives only (Rewards for Performance)	**Category 2C APMs ONLY** - Total dollars paid to providers for pay for performance (P4P) rewards to improve care, such as provider performance to population-based target for quality such as a target HEDIS rate. Do not include FFS or base payments to providers. Do not include payments to providers for reporting HEDIS or other measures.	$0	% of Total provider payments that are paid under Category 2C APMs ONLY	#DIV/0!
Category 2C Penalties only (Penalties for Performance)	**Category 2C APMs ONLY** - Total dollars for any penalties applied to providers based on performance to quality measures. Do not include FFS or base payments to providers. Do not include penalties for non-reporting.	$0	% of Total provider payments that are paid under Category 2C APMs ONLY	#DIV/0!
Contracts that include Category 2C APMs	Total dollars paid under provider contracts that include FFS/base payment **plus (or minus)** any P4P payments or penalties, as applicable, (linked to quality) during payment period	$0	% of Total provider payments that are paid under contracts that include at least one Category 2C APM	#DIV/0!
		For Provider Contracts with Category 2C APMs - % of provider payments that are linked to P4P		#DIV/0!

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated.
For questions on terms see the Definitions tab.

Payment Approach		Provider Payments	Percentage of Provider Payments	
Alternative Payment Model Framework - Category 3 (All methods below are linked to quality)				
Category 3 - Only **Shared Savings** Payments to providers	Total **shared savings** dollars ONLY paid to providers under contracts that include Category 3 APMs paid on FFS architecture (with links to quality). Do not include FFS or base payments to providers.	$0	% of Total provider payments that are paid out under Category 3 shared savings arrangements	#DIV/0!
Category 3 - Only **Downside Risk** 'recoupments' applied to providers	Total **downside risk** collections or recoupments applied to providers under contracts that include Category 3 APMs and paid on FFS architecture (with links to quality). Do not include FFS or base payments to providers.	$0	% of Total provider payments that are collected or applied to providers under Category 3 shared risk arrangements	#DIV/0!
Contracts that include Category 3 APMs	Total dollars paid to providers under contracts that include Category 3 APMs paid on FFS architecture (with links to quality), include FFS/base payment **plus** any shared savings **or minus** downside risk applied during payment period, as applicable.	$0	% of Total provider payments that are paid under contracts that include at least one Category 3 APM	#DIV/0!
Alternative Payment Model Framework - Category 4 (All methods below are linked to quality)				
Contracts with Category 4 APMs	Total dollars paid in Population-based APMs (Category 4) during payment period. (Include the full prospective payment/capitation)	$0	% of Total provider payments that are paid under contracts that include Category 4 APMs	#DIV/0!
For calculation only - Contracts with one or more APMs in category 2A, 2C, 3 or 4 (excludes contracts with only Category 2B APMs)				
Automated calculation of payments under provider contract with one or more APMs in categories 2A, 2C, 3 and 4	Total dollars paid to providers during the payment period under contracts that include Category 2A, 2C, 3 or 4 APMs as reported above. **If an MCO reported a contract(s) with more than one APM Categories (e.g., Category 2 and 3) in more than one of the following cells: C8, C15, C21 or C23, this total it will be overstated.**	$0		
Overstated provider payments in contracts with multiple APMs	In cases of provider contracts that include mulitple APM categories, enter total amount of the overstated provider contract(s) so that no provider contract is counted more than once in cells C8, C15, C21, or C23.	$0		
VBP BENCHMARK (Contracts with one or more APMs in category 2A, 2C, 3 or 4)				

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated. For questions on terms see the Definitions tab.				
Contracts that include Category 2A, 2C, 3 or 4 APMs (unduplicated)	Total dollars paid to providers during the payment period under contracts that include Category 2A, 2C, 3 or 4 APMs (all with links to quality). This may be less than the combination of provider contract payments reported under each applicable LAN category as calculated in cell C25. If a contract includes more than one type of APM, it should only be counted once in the VBP benchmark.	$0	% of Total provider payments that are paid under contracts that include at least one Category 2A, 2C, 3 or 4 APM	**#DIV/0!**