Rev 2/10/08

ORIGINAL 2

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

(Regional/ Program/ Facility): Medical Vendor Administration / Bureau of Health Services Financing

AND

AmeriHealth Caritas Louisiana, Inc.
Contractor Name

Amendment #: 8
CFMS #: 708102
DOA #: 305-200567
DHH #: 057750
Original Contract Amt: 925,792,432
Original Contract Begin Date: 02-01-2012
Original Contract End Date: 01-31-2015

AMENDMENT PROVISIONS

Change Contract From: Maximum Amount: 1,274,956,273

See Attachment A-8.

Contractor/Vendor Name: AmeriHealth Mercy of Louisiana, Inc.

Change To: Maximum Amount: 1,274,956,273

See Attachment A-8.

Contractor/Vendor Name: AmeriHealth Caritas Louisiana, Inc.

Justification:

The changes contained in Attachment A-8 are necessary for the continued operation of the Medicaid managed care program.

This Amendment Becomes Effective: 04-01-2014

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

AmeriHealth Caritas Louisiana, Inc.

CONTRACTOR SIGNATURE: J Michael Jernigan DATE: 7/1/14

PRINT NAME: J. Michael Jernigan

CONTRACTOR TITLE: President

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Secretary, Department of Health and Hospital or Designee

SIGNATURE: DATE: 7-24-14

NAME: W. Jeff Reynolds

TITLE: Undersecretary

OFFICE: Department of Health and Hospitals

PROGRAM SIGNATURE DATE

NAME

APPROVED
Office of the Governor
Office of Contractual Review

SEP 16 2014

Pamela Barthay Rice

DIRECTOR

Bayou Health – Prepaid Contract Amendment Attachment A-8

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA	**3.5 Voluntary CCN Populations** Medicaid groups whose eligibility in the CCN Program is voluntary include the following: 3.5.1 Children under 19 years of age who are: 3.5.1.1 Eligible for SSI under title XVI; 3.5.1.2 Eligible under section 1902(e)(3) of the Act; 3.5.1.3 In foster care or other out-of-home placement; 3.5.1.4 Receiving foster care or adoption assistance; 3.5.1.5 Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the DHH in terms of either program participation or special health care needs; or 3.5.1.6 Enrolled in the Family Opportunity Act Medicaid Buy-In Program.	**3.5 Voluntary Opt-Out Populations** 3.5.1 Medicaid populations that are automatically enrolled into Bayou Health but may voluntarily disenroll from Bayou Health include: 3.5.1.1 Children under nineteen (19) years of age who are: • Eligible for SSI under title XVI of the Social Security Act; • Eligible under section 1902(e)(3) of the Social Security Act; • In foster care or other out-of-home placement; • Receiving foster care or adoption assistance; • Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V of the Social Security Act, and is defined by the DHH in terms of either program participation or special health care needs; or • Enrolled in the Family Opportunity Act Medicaid Buy-In Program.	To rename the subsection and provide for voluntary opt out of certain recipients

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		3.5.2 Native Americans who are members of federally recognized tribes, except when the MCO is: 3.5.2.1 The Indian Health Service; or 3.5.2.2 An Indian health program or urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.	3.5.1.2 Native Americans who are members of federally recognized tribes, except when the MCO is: • The Indian Health Service; or • An Indian health program or urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service 3.5.2. Voluntary opt-out populations may voluntarily disenroll within ninety (90) days of initial enrollment and during annual open enrollment.	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA	**3.6 Excluded CCN Populations** Medicaid groups that cannot voluntarily enroll with a CCN and are excluded include: 3.6.1 Individuals receiving hospice services; 3.6.2 Individuals residing in Nursing Facilities (NF) or Intermediate Care Facilities for People with Developmental Disabilities	**3.1 Voluntary Opt-In populations** Medicaid populations that are not automatically enrolled into Bayou Health but may voluntarily enroll into Bayou Health include: 3.1.1 Individuals receiving services through any 1915(c) Home and Community-Based Waiver not otherwise excluded from Bayou Health, including but not limited to: • Adult Day Health Care Waiver (ADHC) - Direct care in a licensed adult day health care facility	To rename the subsection and provide for voluntary opt-in of certain recipients and to delete reference to the EDA waiver

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		(ICF/DD); 3.6.3 Individuals who receive both Medicaid and Medicare (Medicare dual eligibles); 3.6.4 Individuals who have been diagnosed with tuberculosis, or are suspected of having tuberculosis, and are receiving tuberculosis-related services through the Tuberculosis Infected Individual Program; 3.6.5 Individuals receiving services through any 1915(c) Home and Community-Based Waiver including, but not limited to: 3.6.5.1 Adult Day Health Care (ADHC) - Direct care in a licensed adult day health care facility for those individuals who would otherwise require nursing facility services; 3.6.5.2 New Opportunities Waiver (NOW) – Services to individuals who would otherwise require ICF/DD services; 3.6.5.3 Elderly and Disabled Adult (EDA) - Services to persons aged 65 and older or disabled adults who would otherwise require	for those individuals who would otherwise require nursing facility services; • New Opportunities Waiver (NOW) – Services to individuals who would otherwise require ICF/DD services; • Children's Choice Waiver (CC) - Supplemental support services to children with disabilities under age 18 on the Request for Services Registry; • Residential Options Waiver (ROW) – Services to individuals living in the community who would otherwise require ICF/DD services; • Supports Waiver – Services to individuals 18 years and older with mental retardation or a developmental disability which manifested prior to age 22; • Community Choices Waiver (CCW) – Services to persons aged 65 and older or, persons with adult-onset disabilities age 22 or older, who would otherwise require nursing facility services; and • Other Home and Community Based Services (HCBS) waivers as may be approved by CMS.	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		nursing facility services; 3.6.5.4 Children's Choice (CC) - Supplemental support services to disabled children under age 18 on the NOW waiver registry; 3.6.5.5 Residential Options Waiver (ROW) – Services to individuals living in the community who would otherwise require ICF/DD services; 3.6.5.6 Supports Waiver – Services to individuals 18 years and older with mental retardation or a developmental disability which manifested prior to age 22; and 3.6.5.7 Other HCBS waivers as may be approved by CMS. 3.6.6 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, also known as Chisholm Class Members; 3.6.7 Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE), a	3.1.2.1 Voluntary opt in populations may initially enroll in Bayou Health at any time. 3.1.2.2 Voluntary opt in populations may disenroll from Bayou Health at any time. 3.1.2.3 Voluntary opt in populations who have previously disenrolled from Bayou Health may reenroll in Bayou Health only during the annual open enrollment period.	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		community-based alternative to placement in a nursing facility that includes a complete "managed care" type benefit combining medical, social and long-term care services; 3.6.8 Individuals with a limited eligibility period including: 3.6.8.1 Spend-down Medically Needy Program - An individual or family who has income in excess of the prescribed income standard can reduce excess income by incurring medical and/or remedial care expenses to establish a temporary period of Medicaid coverage (up to three (3) months); 3.6.8.2 Emergency Services Only - Emergency services for aliens who do not meet Medicaid citizenship/ 5-year residency requirements; and 3.6.8.3 Continued Medicaid Program - Short-term coverage for families who lose LIFC or TANF eligibility because of child support collections, an increase in earnings, or an increase in the hours of employment; 3.6.9 Individuals enrolled in the Section 1115 Family Planning Waiver, known as Take		

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		Charge, that provides family-planning-services-only to uninsured women ages 19 – 44 who are not otherwise eligible for the Medicaid program; and 3.6.10 Individuals enrolled in the Louisiana Health Insurance Premium Payment (LaHIPP) Program (Section 1906).		
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA	**Addition of Section**	**3.7 Excluded Populations** **3.7.1** Medicaid populations that cannot participate in Bayou Health include: **3.7.1.1** Individuals receiving hospice services; **3.7.1.2** Individuals residing in Nursing Facilities (NF) or Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD); **3.7.1.3** Individuals who receive both Medicaid and Medicare (Medicare dual eligibles); **3.7.1.4** Individuals who have been diagnosed with tuberculosis, or are suspected of having tuberculosis, and are receiving tuberculosis-related services through the Tuberculosis Infected Individual Program; **3.7.1.5** Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE), a community-	Clarify populations excluded from managed care

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			based alternative to placement in a nursing facility that includes a complete "managed care" type benefit combining medical, social and long-term care services; **3.7.1.6** Individuals with a limited eligibility period including: • Spend-down Medically Needy Program - An individual or family who has income in excess of the prescribed income standard can reduce excess income by incurring medical and/or remedial care expenses to establish a temporary period of Medicaid coverage (up to three (3) months); • Emergency Services Only - Emergency services for aliens who do not meet Medicaid citizenship/ 5-year residency requirements; • Individuals enrolled in the Family Planning Program, that provides family-planning-services-only to uninsured who are not otherwise eligible for the Medicaid program; and • Individuals enrolled in the Louisiana Health Insurance Premium Payment (LaHIPP) Program (Section 1906); and **3.7.1.7** Individuals under the age of 21 otherwise	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			eligible for Medicaid who are listed on the Office for Citizens with Developmental Disabilities' (OCDD's) Request for Services Registry who are Chisholm Class Members.	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA	**6.26. Care Coordination, Continuity of Care, and Care Transition** **6.26.1.** The CCN shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to CCN members. The CCN shall establish a process to coordinate the delivery of core benefits and services with services that are reimbursed on a fee-for-service basis by DHH. The CCN shall ensure member-appropriate PCP choice within the CCN and interaction with providers outside the CCN. Continuity of care activities shall ensure that the appropriate personnel, including the PCP, are kept informed of the member's treatment needs, changes, progress or problems. Continuity of care	**6.26. Care Coordination, Continuity of Care, and Care Transition** **6.26.1.** The CCN shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to CCN members. The CCN shall establish a process to coordinate the delivery of core benefits and services with services that are reimbursed on a fee-for-service basis by DHH or DHH's dental benefit manager. The CCN shall ensure member-appropriate PCP choice within the CCN and interaction with providers outside the CCN. Continuity of care activities shall ensure that the appropriate personnel, including the PCP, are kept informed of the member's treatment needs, changes, progress or problems. Continuity of care activities shall provide processes by which CCN members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The	Provides for collaboration with the dental benefit program manager.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		activities shall provide processes by which CCN members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The CCN shall ensure that service delivery is properly monitored to identify and overcome barriers to primary and preventive care that a CCN member may encounter.	CCN shall ensure that service delivery is properly monitored to identify and overcome barriers to primary and preventive care that a CCN member may encounter.	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA	**7.7.2.3 Examples of Acceptable PCP After-Hours Coverage** Add bullet point	**7.7.2.3 Examples of Acceptable PCP After-Hours Coverage** • The PCPs office telephone is answered after hours by a "monitored" voice mail, with a message advising the caller that the call will be returned by a clinician within 30 minutes and instructing the caller to leave his or her name and contact number. In order to meet acceptable after-hours coverage requirements, messages left on the "monitored" voice mail must be returned within the 30 minute timeframe;	Allows clinicians to receive compliance credit for returning the call within 30 minutes.
Exhibit E	RFP 305 PUR-	**7.7.2.4 Examples of Unacceptable PCP After**	**7.7.2.4 Examples of Unacceptable PCP After Hours**	Clarifies circumstance where monitored

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
	DHHRFP-CCN-P-MVA	**Hours Coverage** • The PCP's office telephone is answered after-hours by a recording that tells patients to leave a message;	**Coverage** • The PCP's office telephone is answered after-hours by a recording that tells patients to leave a message (unless it meets the criteria of a monitored voice mail system described in section 7.7.2.3)	voice mail system is acceptable.
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA	**8.5.1.3 Post Authorization** The CCN may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the CCN justifies to DHH a need for additional information and how the extension is in the member's best interest. **8.5.1.3.1.** The CCN shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.	**8.5.1.3 Post Authorization** **8.5.1.3.1** The CCN shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service. **8.5.1.3.2** The CCN shall not subsequently retracts its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.	Corrects a placement error.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		8.5.1.3.2. The CCN shall not subsequently retracts its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.		
Exhibit E		**8.5.1.2 Expedited Service Authorization** **8.5.1.2.1.** In the event a provider indicates, or the CCN determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCN shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for	**8.5.1.2 Expedited Service Authorization** **8.5.1.2.1** In the event a provider indicates, or the CCN determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCN shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service. **8.5.1.2.2** The CCN may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the CCN justifies to DHH a need for additional information and how the extension is in the member's best interest.	Corrects a placement error.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		service.		
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA	**14.3.2.2** Based on a CCN's Performance Measure outcomes for CYE 12/31/2013, a maximum of 2.5% (0.5% for each of 5 specific IB measures) of the total monthly capitation payments may be deducted effective October following the measurement CY if specified performance measures fall below DHH's established benchmarks for improvement.	**14.3.2.2** Based on a CCN's Performance Measure outcomes for CYE 12/31/2013, a maximum of 2.5% (0.5% for each of 5 specific IB measures) of the total monthly capitation payment may be deducted from the monthly capitation payment to be made in October following the measurement CY if specified performance measures fall below DHH's established benchmarks for improvement.	Clarifies period to which the penalty deduction applies.
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA	**15.1.1.1.** An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The CCN shall comply with all applicable provisions of 42 CFR Part 376 (2009, as amended), pertaining to debarment and/or	**15.1.1.1.** An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The CCN shall comply with all applicable provisions of 42 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. The CCN shall screen all employees and contractors to determine whether they have been excluded from	Updates web links.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		suspension. The CCN shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the CCN shall search the following websites: • Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) http://exclusions.oig.hhs.gov/search.aspx ; • Health Care Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.jsp; and • Excluded Parties List Serve (EPLS) www.EPLS.gov	participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the CCN shall search the following websites: • Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) http://exclusions.oig.hhs.gov/search.aspx ; and • Excluded Parties List Serve (EPLS) www.EPLS.gov	
Exhibit E		**18.20** **18.20.1** Not later than 60 days following the Paid Through Date of each semi-annual reconciliation period as specified in	**18.10 ACA Primary Care Services Enhanced Reimbursement Reporting** **18.10.1** Not later than 60 days following the Paid Through Date of each semi-annual reconciliation	Corrects numbering error and adds subsection title.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		§5.16.3.2, the CCN shall complete and submit to DHH the ACA Primary Care Services Enhanced Reimbursement Semi-Annual Reconciliation workbook for reconciling rate differentials of amounts for each specified service, pursuant to the CMS approved Bayou Health Prepaid MCO Model for Implementation of ACA Section 1202: Increased Payments for Medicaid Primary Care Services and consistent with the process specified by DHH. **18.20.2** The CCN must submit a report regarding the Timeliness of Payment in accordance with §9.10.3.4 as specified by DHH The CCN shall submit the report to DHH not later than 90 days following CCN's receipt of the capitated rate inclusive of the enhanced rates.	period as specified in §5.16.3.2, the CCN shall complete and submit to DHH the ACA Primary Care Services Enhanced Reimbursement Semi-Annual Reconciliation workbook for reconciling rate differentials of amounts for each specified service, pursuant to the CMS approved Bayou Health Prepaid MCO Model for Implementation of ACA Section 1202: Increased Payments for Medicaid Primary Care Services and consistent with the process specified by DHH. **18.10.2** The CCN must submit a report regarding the Timeliness of Payment in accordance with §9.10.3.4 as specified by DHH. The CCN shall submit the report to DHH not later than 90 days following CCN's receipt of the capitated rate inclusive of the enhanced rates.	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA	Effective 1/1/2013 Appendix G becomes the Mercer letter dated "January 17, 2013" and entitled "REVISED Louisiana BAYOU HEALTH Plans – Prepaid Program Rate Development and Actuarial Certification for the period January 1 through June 30, 2013." (See	Effective 1/1/2014 Appendix G becomes the Mercer letter dated "April 1, 2014" and entitled "REVISED Louisiana BAYOU HEALTH Plans – Prepaid Program Rate Development and Actuarial Certification for the period January 1 through June 30, 2014." (See attached.)	Updates periodic actuarial certification.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		attached.)		
Appendix J	RFP 305 PUR-DHHRFP-CCN-P-MVA	Appendix J – CCN Performance Measures	Replace with new version of Appendix J Prepaid Administrative Measures. (See attached.)	Conforms chart to reporting requirements.
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA	9.9. Supplemental Provider Payments The CCN is not responsible for reimbursement of graduate medical education (GME) payments, disproportionate share hospital (DSH) payments, or upper payment limit (UPL) payments to providers.	9.9. Hospital Provider Payments The CCN is not responsible for reimbursement of graduate medical education (GME) payments or disproportionate share hospital (DSH) payments to providers. The CNN must use the increased hospital funds received above the base rate to the Full Medicaid Payment, as detailed in Prepaid Program Rate Development and Actuarial Certifications for the period April 1, 2014 through January 31, 2015 (See attached), for reimbursement of inpatient and outpatient hospital services.	Clarifies affected providers and payments.

Appendix C1

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Principal

Jaredd Simons, ASA, MAAA
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MERCER

Ms. Mary Johnson
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Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
628 North 4th Street
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April 1, 2014

Subject: Louisiana Bayou Health Program — Overview of Methodology for Developing the REVISED Physician Fee Increase Adjustments for the Prepaid Rates Effective January 1 through June 30, 2014

Dear Ms. Johnson:

This letter outlines the methodology that Mercer Government Human Services Consulting (Mercer) used in developing the revised Affordable Care Act (ACA) Section 1202 physician fee increase adjustments for the State of Louisiana's Bayou Health Prepaid program rates for the period January 1 through June 30, 2014 (Calendar Year (CY) 14A). The revised rates include an updated attested physician provider list supplied by the Department of Health and Hospitals (DHH) to restrict the fee-for-service (FFS) data to eligible providers who would receive the primary care physician (PCP) physician increase; and an updated 2014 ACA 1202 Medicare Fee schedule published by the Centers for Medicare & Medicaid (CMS) in January 2014. This rate certification replaces the rate certification letter dated December 23, 2013.

This letter presents an overview of the methodology used in Mercer's managed care rate development for the purpose of satisfying the requirements of CMS. This rate development process resulted in the development of a range of actuarially sound rates for each rate cell. We then worked with DHH to develop a single proposed set of statewide actuarially sound rates for each category of aid, which are attached to and certified within this letter.

Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government mandated assessments, fees, and taxes, and the cost of capital. Note: Please see pages 8 and 9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.

Rate Methodology

Overview

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

Base Data

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

Administration/Profit Loading

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

Other Elements

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

Physician Fee Increase for Primary Care Services Under ACA Section 1202

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

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

Summary of Methodology

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

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

Data Sources

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

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

relied on an attested physician provider list supplied by DHH to further restrict the FFS data to eligible providers who would receive the PCP physician increase.

Calculation of the CY 14A Rate Unit Costs

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

2014 Medicare Fee Schedule Rates

Mercer developed the ACA PCP fee increase for the CY 14A period using the greater of the 2014 and 2009 Medicare conversion factors. Since the 2014 Medicare conversion factor released in January 2014 is below the 2009 Medicare conversion factor, the 2009 factor is utilized in setting the 2014 ACA 1202 Medicare fee schedule.

The 2014 Medicare fee schedule rates are those used in the FFS program using the methodology approved in the SPA based on the 2009 Medicare conversion factor and 2014 relative value units, consistent with the geographic practice cost index (GPCI) schedule published by CMS in January 2014. The 2014 Medicare rates utilized will conform to the approach Louisiana's FFS program utilizes for each of the specified evaluation and management and vaccine billing codes. The rates are statewide and reflect the mean value among all counties (parishes) for each code

and were developed using the following formula (per Attachment 4.19-B in the SPA): mean over all parishes/counties per code = (4/64 x GPCIs for Region 01) + (60/64 x GPCIs for Region 99), in which Region 01 and Region 99 represents New Orleans and the rest of Louisiana, respectively.

For vaccine administration codes, Louisiana is utilizing the computed 2014 Medicare rate utilized in the FFS program methodology as approved in the SPA. The 2014 100% of Medicare benchmark unit costs are displayed in Attachment A, identified with the label {Medicare CY 2014 Unit Cost (CMS)}.

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

To account for utilization for payment levels already above 100% of Medicare, Mercer only considered into its PCP increase calculations, base utilization for codes paid below the 2014 Medicare fee schedule. For the codes paying above 100% of Medicare, the current payment levels were maintained in the calculation.

The unit cost levels inherent in the CY 14A rates were compared to the adjusted 2014 Medicare fee schedule rates. The differential between the adjusted 2014 Medicare fee schedule rates and the CY 14A unit costs by individual procedure code determines the unit cost rate adjustment needed to bring the overall capitation rate to a level that compensates MCOs with an appropriate amount to be able to pay at least the 2014 Medicare fee schedule benchmark (in other words, the amount attributed to the qualifying PCP services in the updated rates). By utilizing the adjusted 2014 Medicare benchmarks for this calculation, Mercer has accounted for payment levels made above 100% of Medicare to ensure those costs do not artificially reduce the amount needed to bring payment levels up to 100% of Medicare. Mercer also separated physician and advanced practice registered nurse and physician assistant claim data to account for these providers being reimbursed at 80% of physician fees. The CY 14A unit cost differentials were calculated by category of aid for the evaluation and management codes, separately from vaccine administration codes, and are displayed in Attachment A, identified with the label {Difference in Unit Cost}. This amount will also be used in the calculation of the rate differential eligible for enhanced 100% federal match as described in the Rate Setting Documentation for Federal Claiming section of this letter.

CY 14A PCP Utilization

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

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

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

CY 14A PCP Procedure Fee Differential PMPM

For purposes of prospective capitation payments under the Model 2 methodology, Mercer calculated the PMPM add-ons associated with the increased costs of implementing the ACA Section 1202 PCP fee increase separately for evaluation and management codes and vaccine administration codes. The vaccine administration fee differential was calculated using an aggregate weighted average of 2014 vaccines for children Medicare rates by age group across the SFY 2011 and 2012 utilization data. The resulting weighted average vaccine administration Medicare rates were utilized as the benchmark for comparison to the unit costs inherent in the CY 14A capitation rates. The CY 14A procedure fee differential PMPMs, excluding administration/profit loading and premium tax, are displayed in Attachment A, identified with the label {Projected ACA PCP PMPM – Total Claims Increase}. The CY 14A procedure fee differential PMPMs, including administration/profit loading and premium tax, are displayed in Attachment A, identified with the label {Projected ACA PCP PMPM – Total Rate Increase}.

Reconciliation Process

In accordance with the approved managed care methodology, DHH will reconcile payments made to the MCOs through the prospective capitation rates with actual utilization reported by the MCOs at the 2014 Medicare computed FFS fee schedule also utilized by the Medicaid FFS program. DHH is requiring each MCO to submit detailed, semi-annual files with claims data on each applicable code for eligible providers, documenting the paid amount made to the providers. Since the various reconciliation components described in this letter were calculated at a category of aid level and not at specific age categories, the reconciliation process will be completed at the same level to ensure consistency. Once DHH receives the semi-annual files documenting the appropriate payments by code to the eligible PCPs, DHH will reconcile with the MCOs and CMS any overpayment or underpayment. The MCOs will be reimbursed (or funds recouped) through the reconciliation process for the amount of unit cost rate differential (the aggregate unit cost differential established in the process of the capitation rate adjustment defined above and not based on the individual current payment amounts) based on actual utilization relative to the utilization level utilized in the capitation rate development. This step will include detailed instructions to the MCOs on how to document to DHH utilization and unit cost rate paid for PCPs. *Note: this reconciliation will be performed separately for evaluation and management codes versus vaccine administration codes.*

Certification of Revised Rate Ranges

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

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

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

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

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

Rate Setting Documentation for Federal Claiming

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

Calculation of the 2009 Base Rate Unit Costs

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

calculations described above were excluded from the aggregate calculation (this exclusion had an immaterial impact on the final aggregate unit costs). This is the same CY 14A utilization that was applied in the calculation of the 2014 Medicare fee schedule rates to establish a comparable aggregate unit cost level. The calculated aggregate 2009 base rate unit costs are displayed in Attachment B, identified with the label {Medicaid "July 2009" Unit Cost}.

Calculation of the PMPM Differential that Qualifies for 100% FFP

As DHH is using Risk Model 2, the portion of the CY 14A PCP capitation payment that is eligible for 100% FFP is determined by calculating the difference between the base 2009 aggregate weighted average unit cost calculation and the aggregate weighted average unit cost in the 2014 Medicare rate. Any additional payments (or recoupment) made through annual utilization reconciliation of the unit cost differential only are eligible for 100% FFP. Using the projected utilization assumed in the CY 14A capitation rates, the differential was put on a total dollar basis by multiplying the unit cost differential by the expected CY 14A utilization. This calculation was performed separately for evaluation and management codes versus vaccine administration codes, and by category of aid. The calculated unit cost differentials, total dollar, and PMPM amounts (excluding administration/profit and premium tax) are displayed in Attachment B, identified with the labels {Difference in Unit Cost (Medicare CY2014 – July 2009)} and {Total PMPM (Medicare CY2014 – July 2009)}.

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

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

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

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

If you have any questions on any of the information provided, please feel free to call Sudha Shenoy at +1 404 442 3249 or Jaredd Simons at +1 404 442 3358.

Sincerely,

Sudha Shenoy

Sudha Shenoy, FSA, MAAA, CERA
Principal

Jaredd Simons, ASA, MAAA
Senior Associate Actuary

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Attachment A

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

ACA PCP PMPM Rate Increase

	ACA PCP Change to Utilization				ACA PCP Change to Unit Cost			Increase from ACA PCP Changes				Projected ACA PCP PMPM			
Procedure Code Set	Trended & Adjusted Utilization/1000 (FFS)	Adjusted Blended Utilization/1000 (FFS & Encounter)	Induced Utilization*	Adjusted Trended Utilization/1000 (FFS & Encounter)	Adjusted Unit Cost (FFS)	Adjusted Blended Unit Cost (FFS & Encounter)	Medicare CY2014 Unit Cost (CMS)	Difference in Unit Cost	Total ACA PCP Dollars	Attestation Factor	Attestation Adj ACA PCP Dollars	CY 14A MMs	Total Claims Increase	Total Admin and Profit Load Increase	Total Rate Increase
All Vaccines															
SSI	300	222	1.1%	224	$ 11.63	$ 12.17	$ 17.47	$ 5.30	$ 40,981	100%	$ 40,981	414,270	$ 0.10	$ 0.01	$ 0.11
Family and Children	1,291	1,062	1.1%	1,073	$ 11.07	$ 11.67	$ 16.14	$ 4.47	$ 873,250	100%	$ 873,250	2,185,206	$ 0.40	$ 0.04	$ 0.44
Foster Care Children	1,091	885	1.1%	895	$ 11.38	$ 11.95	$ 16.86	$ 4.91	$ 8,350	100%	$ 8,350	22,812	$ 0.37	$ 0.03	$ 0.40
Breast and Cervical Cancer	23	30	1.1%	30	$ 14.00	$ 14.13	$ 23.15	$ 9.02	$ 107	100%	$ 107	4,764	$ 0.02	$ 0.00	$ 0.02
LaCHIP Affordable Plan	1,291	1,062	1.1%	1,073	$ 11.07	$ 11.67	$ 16.14	$ 4.47	$ 2,697	100%	$ 2,697	6,750	$ 0.40	$ 0.04	$ 0.44
Total	1,131	927	1.1%	936	$ 11.10	$ 11.69	$ 16.20	$ 4.50	$ 925,386	100%	$ 925,386	2,633,802	$ 0.35	$ 0.03	$ 0.38
Primary Medical															
SSI	3,302	2,827	1.1%	2,857	$ 69.45	$ 68.07	$ 97.19	$ 29.12	$ 2,871,935	100%	$ 2,871,935	414,270	$ 6.93	$ 0.66	$ 7.59
Family and Children	2,432	2,432	1.1%	2,458	$ 50.89	$ 61.07	$ 85.72	$ 24.65	$ 11,034,953	100%	$ 11,034,953	2,185,206	$ 5.05	$ 0.48	$ 5.53
Foster Care Children	2,735	2,659	1.1%	2,688	$ 55.97	$ 58.18	$ 81.73	$ 23.56	$ 120,359	100%	$ 120,359	22,812	$ 5.28	$ 0.50	$ 5.78
Breast and Cervical Cancer	3,692	3,843	1.1%	3,884	$ 56.07	$ 56.98	$ 80.01	$ 23.03	$ 35,511	100%	$ 35,511	4,764	$ 7.45	$ 0.71	$ 8.16
LaCHIP Affordable Plan	2,432	2,432	1.1%	2,458	$ 59.89	$ 61.07	$ 85.72	$ 24.65	$ 34,086	100%	$ 34,086	6,750	$ 5.05	$ 0.48	$ 5.53
Total	2,574	2,499	1.1%	2,525	$ 61.77	$ 62.28	$ 87.71	$ 25.43	$ 14,096,843	100%	$ 14,096,843	2,633,802	$ 5.35	$ 0.51	$ 5.86
Grand Total															
SSI	3,601	3,048	1.1%	3,081	$ 64.64	$ 64.01	$ 91.40	$ 27.39	$ 2,913,001	100%	$ 2,913,001	414,270	$ 7.03	$ 0.67	$ 7.70
Family and Children	3,723	3,495	1.1%	3,532	$ 42.96	$ 46.06	$ 64.58	$ 18.52	$ 11,909,551	100%	$ 11,909,551	2,185,206	$ 5.45	$ 0.52	$ 5.97
Foster Care Children	3,826	3,545	1.1%	3,583	$ 43.25	$ 46.64	$ 65.54	$ 18.90	$ 128,722	100%	$ 128,722	22,812	$ 5.64	$ 0.54	$ 6.18
Breast and Cervical Cancer	3,715	3,872	1.1%	3,914	$ 55.81	$ 56.65	$ 79.57	$ 22.92	$ 35,618	100%	$ 35,618	4,764	$ 7.48	$ 0.71	$ 8.19
LaCHIP Affordable Plan	3,723	3,495	1.1%	3,532	$ 42.96	$ 46.06	$ 64.58	$ 18.52	$ 36,788	100%	$ 36,788	6,750	$ 5.45	$ 0.52	$ 5.97
Grand Total	3,704	3,425	1.1%	3,462	$ 46.30	$ 46.60	$ 64.37	$ 19.77	$ 15,023,679	100%	$ 15,023,679	2,633,802	$ 5.70	$ 0.54	$ 6.25

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

Notes:
- Figures include only procedure codes included in the Louisiana SPA
- Utilization and Unit Cost figures are based off of procedure codes by rate tier where the Medicare CY2014 CMS rates exceeds the FFS rates

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Attachment B

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

ACA PCP PMPM Funding Exhibit

		ACA PCP Change to Unit Cost					Projected ACA PCP PMPM				
Procedure Code Set	Adjusted Blended Utilization/1000 (FFS & Encounter)	Adjusted Blended "Base" Unit Cost (FFS & Encounter)	Medicaid "July 2009" Unit Cost	"Medicare CY2014" Unit Cost (CMS)	Difference in Unit Cost (July 2009 - Base)	Difference in Unit Cost (Medicare CY2014 - July 2009)	CY 14A MMs	Total PMPM (July 2009 - Base)	Total PMPM (Medicare CY2014 - July 2009)**	Total PMPM (Administration and Profit Load)	Total Rate Increase
All Vaccines											
SSI	224	$ 12.17	$ 12.68	$ 17.47	$ 0.51	$ 4.79	414,270	$ 0.01	$ 0.09	$ 0.01	$ 0.11
Family and Children*	1,073	$ 11.67	$ 12.02	$ 16.14	$ 0.34	$ 4.12	2,185,206	$ 0.03	$ 0.37	$ 0.04	$ 0.44
Foster Care Children	895	$ 11.95	$ 12.28	$ 16.86	$ 0.33	$ 4.57	22,812	$ 0.02	$ 0.34	$ 0.03	$ 0.40
Breast and Cervical Cancer	30	$ 14.13	$ 15.22	$ 23.15	$ 1.09	$ 7.93	4,764	$ 0.00	$ 0.02	$ 0.00	$ 0.02
LaCHIP Affordable Plan	1,073	$ 11.67	$ 12.02	$ 16.14	$ 0.34	$ 4.12	6,750	$ 0.03	$ 0.37	$ 0.04	$ 0.44
Total	936	$ 11.69	$ 12.04	$ 16.20	$ 0.35	$ 4.15	2,633,802	$ 0.03	$ 0.32	$ 0.03	$ 0.38
Primary Medical											
SSI	2,857	$ 68.07	$ 78.36	$ 97.19	$ 10.28	$ 18.84	414,270	$ 2.45	$ 4.48	$ 0.66	$ 7.59
Family and Children*	2,458	$ 61.07	$ 65.55	$ 85.72	$ 4.48	$ 20.17	2,185,206	$ 0.92	$ 4.13	$ 0.48	$ 5.53
Foster Care Children	2,688	$ 58.18	$ 62.11	$ 81.73	$ 3.93	$ 19.63	22,812	$ 0.88	$ 4.40	$ 0.50	$ 5.78
Breast and Cervical Cancer	3,884	$ 56.98	$ 68.48	$ 80.01	$ 11.50	$ 11.53	4,764	$ 3.72	$ 3.73	$ 0.71	$ 8.16
LaCHIP Affordable Plan	2,458	$ 61.07	$ 65.55	$ 85.72	$ 4.48	$ 20.17	6,750	$ 0.92	$ 4.13	$ 0.48	$ 5.53
Total	2,525	$ 62.28	$ 67.80	$ 87.71	$ 5.52	$ 19.91	2,633,802	$ 1.16	$ 4.19	$ 0.51	$ 5.86
Grand Total											
SSI	3,081	$ 64.01	$ 73.58	$ 91.40	$ 9.57	$ 17.82	414,270	$ 2.46	$ 4.57	$ 0.67	$ 7.70
Family and Children*	3,532	$ 46.06	$ 49.28	$ 64.58	$ 3.22	$ 15.30	2,185,206	$ 0.95	$ 4.50	$ 0.52	$ 5.97
Foster Care Children	3,583	$ 46.64	$ 49.67	$ 65.54	$ 3.03	$ 15.87	22,812	$ 0.91	$ 4.74	$ 0.54	$ 6.18
Breast and Cervical Cancer	3,914	$ 56.65	$ 68.07	$ 79.57	$ 11.42	$ 11.51	4,764	$ 3.72	$ 3.75	$ 0.71	$ 8.19
LaCHIP Affordable Plan	3,532	$ 46.06	$ 49.28	$ 64.58	$ 3.22	$ 15.30	6,750	$ 0.95	$ 4.50	$ 0.52	$ 5.97
Grand Total	3,462	$ 48.60	$ 52.72	$ 68.37	$ 4.12	$ 15.65	2,633,802	$ 1.19	$ 4.51	$ 0.54	$ 6.25

* Includes LaCHIP Non-Citizen Pregnant Women Expansion membership which is not eligible for the enhanced 100% FFP match

** Enhanced 100% FFP match for eligible populations, which excludes LaCHIP Non-Citizen Pregnant Women Expansion and LaCHIP Affordable Plan members

Notes:

- Figures include only procedure codes included in the Louisiana SPA.
- Utilization and Unit Cost figures are based off of procedure codes by rate tier where the Medicare CY2014 CMS rates exceeds the FFS rates.

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Louisiana Administrative Performance Measurement Set

Measure	Minimum Performance Standard
Percent of PCP Practices that provide verified 24/7 phone access with ability to speak with a PCP Practice clinician (MD, DO, NP, PA, RN, LPN) within 30 minutes of member contact	≥95%
Percent of DME service authorization requests processed in 25 calendar days after receipt of the request for service	100%
Percent of Expedited Service Authorization requests processed within 72 hours after receipt of the request for service	100%
Percent of calls to Health Plan's Member Services answered by a live person or directed to an automated call pickup system with IVR options within 30 seconds	≥90%
Average hold time for calls to Members Service	≤3.0 minutes
Percent of calls to Member Services that are abandoned	≤5%
Percent of calls to Health Plan's Provider Services answered by a live person or directed to an automated call pickup system with IVR options within 30 seconds	≥90%
Average hold time for calls to Provider Services	≤ 3.0 minutes
Percent of calls to Provider Services that are abandoned	≤ 5%
Percent of Member Appeals received by the Health Plan and resolved within 30 calendar days from the date of receipt of the Member Appeal	100%
Percent of Member grievance decisions reversed at the State Fair Hearing level during a 12 month period	≤10%
Percent of clean claims paid for each provider type within 15 business days of the date of receipt of the clean claim	≥90%
Percent of clean claims paid for each provider type within 30 calendar days of the date of receipt of the clean claim	≥99%
Denied claims returned to provider with reason code within 15 business days of the date of receipt of claims submission	≥99%

Louisiana CCN Performance Measurement Set

Incentive Based Measures

Access and Availability of Care	Effectiveness of Care		Use of Services
$$ Adults' Access to Preventive/ Ambulatory Health Services ** *HEDIS*	$$ Comprehensive Diabetes Care HgbA1C ***HEDIS*	$$ Chlamydia Screening in Women ***HEDIS/CHIPRA*	$$ Well-Child Visits in the Third, Fourth, Fifth and Sixth of Life ***HEDIS/CHIPRA*
			$$ Adolescent Well-Care Visits ***HEDIS/CHIPRA*

Level I Measures

Access and Availability of Care	Effectiveness of Care		Prevention Quality Indicators	Use of Services
Children and Adolescents Access to PCP ** *HEDIS/CHIPRA*	Childhood Immunization Status ***HEDIS/CHIPRA*	Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents ***HEDIS/CHIPRA*	Adult Asthma Admission Rate ***AHRQ*	Well-Child Visits in the First 15 Months of Life ***HEDIS/CHIPRA*
Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care) ***HEDIS/CHIPRA*	Immunizations for Adolescents ***HEDIS/CHIPRA*	Use of Medication for people with Asthma ***HEDIS/CHIPRA*	CHF Admission Rate ***AHRQ*	Ambulatory Care (ER Utilization) ***HEDIS*
	Cholesterol Management for Patients with cardiovascular conditions ***HEDIS*	Comprehensive Diabetes Care ***HEDIS*	Uncontrolled Diabetes Admission Rate ***AHRQ*	
	Cervical CA Screening ***HEDIS*	Breast CA Screening ***HEDIS/CHIPRA*	Plan All-Cause Readmissions ** *HEDIS-Adapted for Medicaid*	
	EPSDT Screening Rate ***CMS 416*			

Level II Measures

Effectiveness of Care		Use of Services	Satisfaction and Outcomes
Follow-Up Care for Children Prescribed ADHD Medication ***HEDIS/CHIPRA*	Cesarean Rate for Low-Risk First Birth Women ***CHIPRA*	Emergency Utilization-Avg # of ED visits per member per reporting period ***CHIPRA*	CAHPS Health Plan Survey 4.0, Adult Version ***HEDIS*
Otitis Media Effusion ***CHIPRA*	Appropriate Testing for Children With Pharyngitis ***HEDIS/CHIPRA*	Annual # of asthma patients (1yr old) with 1 asthma related ER visit ***CHIPRA*	CAHPS Health Plan Survey 4.0, Child Version including Children With Chronic Conditions ***HEDIS/CHIPRA*
Controlling High Blood Pressure ***HEDIS*	% of Pregnant Women who are screened for tobacco usage and secondhand smoke exposure and are offered an appropriate and individualized intervention *** State*	Frequency of Ongoing Prenatal care ***HEDIS/CHIPRA*	Provider Satisfaction ***State*
Pediatric Central-Line Associated Bloodstream Infections ***CHIPRA*	Total number of eligible women who receive 17-OH progesterone during pregnancy, and % of preterm births at fewer than 37 weeks and fewer than 32 weeks in those recipients *** State*		
Percent of live births weighing less than 2,500 grams ***CHIPRA*			