7/18/14
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BOBBY JINDAL
GOVERNOR

KRISTY H. NICHOLS
COMMISSIONER OF ADMINISTRATION

State of Louisiana

Division of Administration
Office of Contractual Review

June 26, 2014

Ms. Mary Fuentes
Contract Review Administrator
Department of Health & Hospitals
Contract Management
Bienville Building
Post Office Box 4094
Baton Rouge, LA 70821-4904

Dear Ms. Fuentes:

Enclosed are approved copies of the following contract received in our officeon May 15, 2014.

Department of Health & Hospitals
CFMS # 728349 Mercer Health & Benefits, LLC

The number listed prior to the contractor's name has been assigned by this office and is used as identification for the contract. Please use these numbers when referring to the contract in correspondence or amendment(s).

For succeeding fiscal years of these contracts, a BA-22 specifying the funds available for that particular year shall be submitted by September 30th to the Office of Contractual Review.

Approval of continuing services contracts is contingent upon the receipt of a final performance evaluation report on the prior contract as required under Revised Statute 39:1500.

The Internal Revenue Service (IRS) may find that this contract creates an employment relationship between your agency and the contractor. You should be advised that your agency is responsible for all taxes and penalties if such a finding is forthcoming. It is incumbent upon your agency to determine if an employee/employer relationship exists. Your agency must make the appropriate withholdings in accordance with law and IRS regulations, if applicable.

We appreciate your continued cooperation.

Sincerely,

Pamela Bartfay Rice

Pamela Bartfay Rice, Esq.
Interim Director

State Contracts/Grants Officer
Enclosures

RECEIVED
DHH CONTRACTS
2014 JUN 30 AM 11:44

Validate

DHH - CF - 1
Revised: 2011-06

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MVA

ORIGINAL

CONTRACT BETWEEN STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

Medical Vendor Administration

CFMS: 728349
DHH: 060056
Agency # 305 305

AND

Mercer Health & Benefits, LLC

FOR

☐ Personal Services ☒ Professional Services ☐ Consulting Services ☐ Social Services

1) **Contractor (Legal Name if Corporation)** Mercer Health & Benefits, LLC	5) **Federal Employer Tax ID# or Social Security #** 34201546302 **(Must be 11 Digits)**
2) **Street Address** 3560 Lenox Road, Suite 2400	6) **Parish(es) Served** Statewide ST
City Atlanta **State** GA **Zip Code** 30326	7) **License or Certification #**
3) **Telephone Number** (404) 442-3100	8) Contractor Status ! Subrecipient: ☐ Yes ☒ No; Corporation: ☒ Yes ☐ No; For Profit: ☒ Yes ☐ No; Publicly Traded: ☐ Yes ☒ No
4) **Mailing Address (if different)**	
City **State** **Zip Code**	8a) **CFDA#**(Federal Grant #)

9) **Brief Description Of Services To Be Provided:** !

The contractor will provide methods for the development and calculation of capitation rates for the Medicaid Managed Care Program and other support services that must be provided by an actuary and other similarly qualified staff employed by contractor. Methods will be analytically sound, acceptable to the Centers for Medicare and Medicaid Services, and readily replicated.

10) **Effective Date** 05-16-2014	11) **Termination Date** 05-15-2017

12) This contract may be terminated by either party upon giving thirty (30) days advance written notice to the other party with or without cause but in no case shall continue beyond the specified termination date.

13) **Maximum Contract Amount** $ 9,849,374.00 SF14 $410,390 SF15 $3,283,125 SF16 $3,283,125 SF17$2,872,734

14) **Terms of Payment** !

If progress and/or completion of services are provided in accordance to the terms of this contract, payments are to be made as follows:

DHH shall pay such invoice within thirty (30) days of approval, which shall not be unreasonably withheld or delayed. DHH will promptly notify contractor of any good faith dispute and the parties shall work together to resolve such dispute expeditiously and the time for payment of such portion of the invoice shall be extended until a resolution is reached. If any invoice has not been paid within 90 days from date submitted by Contractor to DHH, Contractor may suspend the provision of services here until payment is received. Contractor will be paid based on the hourly rates listed in Attachment B upon the submission and approval of detailed invoices.

Contractor obligated to submit final invoices to Agency within thirty (30) days after termination of contract.

PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:	**First Name** Marisa	**Last Name** Naquin
	Title Medicaid Program Manager 2	**Phone Number** (504)568-8280

15) **Special or Additional Provisions which are incorporated herein, if any (IF NECESSARY, ATTACH SEPARATE SHEET AND REFERENCE):**

Attachment A: HIPAA Addendum
Attachment B: Statement of Work
Attachment C: Additional Provisions

Exhibit 1: Resumes
Exhibit 2: Board Resolution
Exhibit 3: Out of State Justification and Multi-Year Request
Exhibit 4: Emergency Preparedness Plan

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Attachment:HIPAA Addendum
Attachment:Standard Provisions
Attachment:Special Provisions
Attachment:Statement of Work
Attachment:Fee Schedule
Attachment:Budget
Attachment:
Exhibit:Board Resolution
Exhibit:Disclosure of Ownership
Exhibit:Multi Year Letter
Exhibit:Late Letter
Exhibit:Out of State Justification
Exhibit:Certificate of Authority
Exhibit:Resume
Exhibit:License
Exhibit:

During the performance of this contract, the Contractor hereby agrees to the following terms and conditions:

1. Contractor hereby agrees to adhere as applicable to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990 as amended; the Rehabilitation Act of 1973 as amended; Sec. 202 of Executive Order 11246 as amended, and all applicable requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services. Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status, or any other non-merit factor.

2. Contractor shall abide by the laws and regulations concerning confidentiality which safeguard information and the patient/client confidentiality. Information shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. The Department hereby approves the confidentiality rules and facility access procedures of the Contractor. Contractor shall adhere to the federal regulations known as the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules found at 45 CFR Parts 160 and 164 and the HIPAA Business Associate Addendum attached and made a part of this contract as it relates to patients.

3. The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a three year period following final payment upon reasonable prior written notice to the Contractor. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Department of Health and Hospitals, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records directly (or as otherwise ordered by a Louisiana state or federal court) pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.

   Contractor shall comply with federal and state laws and/or DHH Policy requiring an audit of the Contractor's operation as a whole or of specific program activities. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the contract period, for any period, four (4) copies of the audit report shall be sent to the Department of Health and Hospitals, Attention: **Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-3797** and one (1) copy of the audit shall be sent to the **originating DHH Office**.

4. Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records or copies thereof to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department upon reasonable prior written notice to the Contractor.

5. Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of Contractual Review.

6. Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds.

7. Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Department of Health and Hospitals, and the State of Louisiana from all claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department in Attachment C.

8. In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses.

9. No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.

10. Should contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify his/her appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.

11. All non-third party software and source code, records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract. All non-third party software and source code, records, reports, documents, or other material related to this contract and obtained or prepared specifically and exclusively for the Department by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract.

12. Contractor shall not enter into any subcontract for work or services contemplated under this contract without obtaining prior written approval of the Department. Any subcontracts approved by the Department shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this contract, such prior written approval shall not be required for the purchase by the contractor of supplies and services which are incidental but necessary for the performance of the work required under this contract. No subcontract shall relieve the Contractor of the responsibility for the performance of contractual obligations described herein.

13. No person and no entity providing services pursuant to this contract on behalf of contractor or any subcontractor is prohibited from providing such services by the provisions of R.S. 42:1113 as amended in the 2008 Regular Session of the Louisiana Legislature.

14. No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department.

15. This contract is subject to and conditioned upon the availability and appropriation of Federal and/or State funds; and no liability for performance or obligation for payment will develop between the parties until the contract has been approved by required authorities of the Department and Contractor; and, if contract exceeds $20,000, the Director of the Office of Contractual Review, Division of Administration in accordance with La. R.S. 39:1502.

16. The continuation of this contract is contingent upon the appropriation of funds from the legislature to fulfill the requirements of the contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

17. Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of the Contractor and the Department; and, if contract exceeds $20,000, approved by the Director of the Office of Contractual Review, Division of Administration. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.

18. Any contract disputes will be interpreted under applicable Louisiana laws and regulations in Louisiana administrative tribunals or state or federal district courts as appropriate.

19. Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against DHH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in DHH's name, but at Contractor's expense and shall indemnify and hold harmless DHH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services. This provision is subject to the additional provisions contained in Attachment C.

20. Deleted.

21. Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, DHH, from all claims for damages, costs, expenses and reasonable attorney fees arising in breach of contract or tort from this contract or arising from Contractor's negligent acts or omissions or bad faith of Contractor. Contractor's agents, employees, officers or directors in its performance hereunder. This provision does not apply to actions or omissions for which LA R.S. 40:1299.39 provides malpractice coverage to the contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (R.S. 13:5108.1(E)). Further it does not apply to premises liability when the services are being performed on premises owned and operated by DHH.

22. Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.

23. Contractor agrees that the current contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of the current contract.

THIS CONTRACT CONTAINS OR HAS ATTACHED HERETO ALL THE TERMS AND CONDITIONS AGREED UPON BY THE CONTRACTING PARTIES. IN WITNESS THEREOF, THIS CONTRACT IS SIGNED ON THE DATE INDICATED BELOW.

Mercer Health & Benefits, LLC

Robert C. Butler 5/12/14

SIGNATURE **DATE**

Robert C. Butler

NAME

Principal

TITLE

SIGNATURE **DATE**

NAME

TITLE

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

SIGNATURE **DATE**

NAME

TITLE

Medical Vendor Administration

5/15/14

SIGNATURE **DATE**

J. Ruth Kennedy

NAME

Medicaid Director

TITLE

APPROVED
Office of the Governor
Office of Contractual Review

JUN 26 2014

DIRECTOR

HIPAA Business Associate Addendum

This HIPAA Business Associate Addendum is hereby made a part of this contract in its entirety as Attachment A to the contract.

1. The Louisiana Department of Health and Hospitals ("DHH") is a Covered Entity, as that term is defined herein, because it functions as a health plan and as a health care provider that transmits health information in electronic form.
2. Contractor is a Business Associate of DHH, as that term is defined herein, because contractor either: (a) creates, receives, maintains, or transmits PHI for or on behalf of DHH; or (b) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services for DHH involving the disclosure of PHI.
3. Definitions: As used in this addendum –
   A. The term "HIPAA Rules" refers to the federal regulations known as the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, found at 45 C.F.R. Parts 160 and 164, which were originally promulgated by the U. S. Department of Health and Human Services (DHHS) pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") of 1996 and were subsequently amended pursuant to the Health Information Technology for Economic and Clinical Health ("HITECH") Act of the American Recovery and Reinvestment Act of 2009.
   B. The terms "Business Associate", "Covered Entity", "disclosure", "electronic protected health information" ("electronic PHI"), "health care provider", "health information", "health plan", "protected health information" ("PHI"), "subcontractor", and "use" have the same meaning as set forth in 45 C.F.R. § 160.103.
   C. The term "security incident" has the same meaning as set forth in 45 C.F.R. § 164.304.
   D. The terms "breach" and "unsecured protected health information" ("unsecured PHI") have the same meaning as set forth in 45 C.F.R. § 164.402.
4. Contractor and its agents, employees and subcontractors shall comply with all applicable requirements of the HIPAA Rules and shall maintain the confidentiality of all PHI obtained by them pursuant to this contract and addendum as required by the HIPAA Rules and by this contract and addendum.
5. Contractor shall use or disclose PHI solely: (a) for meeting its obligations under the contract; or (b) as required by law, rule or regulation (including the HIPAA Rules) or as otherwise required or permitted by this contract and addendum.
6. Contractor shall implement and utilize all appropriate safeguards to prevent any use or disclosure of PHI not required or permitted by this contract and addendum, including administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of DHH.
7. In accordance with 45 C.F.R. § 164.502(e)(1)(ii) and (if applicable) § 164.308(b)(2), contractor shall ensure that any agents, employees, subcontractors or others that create, receive, maintain, or transmit PHI on behalf of contractor agree to the same restrictions, conditions and requirements that apply to contractor with respect to such information, and it shall ensure that they implement reasonable and appropriate safeguards to protect such information. Contractor shall take all reasonable steps to ensure that its agents', employees' or subcontractors' actions or omissions do not cause contractor to violate this contract and addendum.
8. Contractor shall, within three (3) days of becoming aware of any use or disclosure of PHI, other than as permitted by this contract and addendum, report such disclosure in writing to the person(s) named in section 14 (Terms of Payment), page 1 of the CF-1. Disclosures which must be reported by contractor include, but are not limited to, any successful security incident, any breach of unsecured PHI, and any "breach of the security system" as defined in the Louisiana Database Security Breach Notification Law, La.R.S. 51:3071 *et seq.* The parties acknowledge and agree that this section constitutes notice by Business Associate to Covered Entity of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to Covered Entity shall be required. "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI. At the option of DHH, any harm or damage resulting from any use or disclosure which violates this contract and addendum shall be mitigated, to the extent practicable, either: (a) by contractor at its own expense; or (b) by DHH, in which case contractor shall reimburse DHH for all expenses that DHH is required to incur in undertaking such mitigation activities.
9. To the extent that contractor is to carry out one or more of DHH's obligations under 45 C.F.R. Part 164, Subpart E, contractor shall comply with the requirements of Subpart E that apply to DHH in the performance of such obligation(s).
10. Contractor shall make available such information in its possession which is required for DHH to provide an accounting of disclosures in accordance with 45 CFR § 164.528. In the event that a request for accounting is made directly to contractor, contractor shall forward such request to DHH within two (2) days of such receipt. Contractor shall implement an appropriate record keeping process to enable it to comply with the requirements of this provision. Contractor shall maintain data on all disclosures of PHI for which accounting is required by 45 CFR § 164.528 for at least six (6) years after the date of the last such disclosure.
11. Contractor shall make PHI available to DHH upon request in accordance with 45 CFR § 164.524.
12. Contractor shall make PHI available to DHH upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR § 164.526.
13. Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by contractor on behalf of DHH available to the Secretary of the U. S. DHHS for purposes of determining DHH's compliance with the HIPAA Rules.
14. Contractor shall indemnify and hold DHH harmless from and against any and all liabilities, claims for damages, costs, expenses and attorneys' fees resulting from any violation of this addendum by contractor or by its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.
15. The parties agree that the legal relationship between DHH and contractor is strictly an independent contractor relationship. Nothing in this contract and addendum shall be deemed to create a joint venture, agency, partnership, or employer-employee relationship between DHH and contractor.
16. Notwithstanding any other provision of the contract, DHH shall have the right to terminate the contract immediately if DHH determines that contractor has violated any provision of the HIPAA Rules or any material term of this addendum.

17. At the termination of the contract, or upon request of DHH, whichever occurs first, contractor shall return or destroy (at the option of DHH) all PHI received or created by contractor that contractor still maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, contractor shall extend the confidentiality protections of the contract to the information and limit further uses and disclosure to those purposes that make the return or destruction of the information infeasible.

Attachment B
Statement of Work
Mercer Health & Benefits, LLC

Goal/Purpose

The purpose is to establish an actuarial services contract that will allow for rate development and other Louisiana Medicaid financial support activities by Mercer Health & Benefits, LLC (the Contractor). Contractor will provide methods for, and calculation of, capitation rates for the Medicaid managed care programs and other support services that must be provided by an actuary or other similarly qualified staff employed by the Contractor. Contractor's methods must be analytically sound, acceptable to the Centers for Medicare and Medicaid Services (CMS), and readily replicated.

DHH manages approximately 875,000 Medicaid enrollees in its Bayou Health Prepaid and Shared Savings Plans and will manage approximately 1,100,000 Medicaid enrollees in a Dental Benefit Plan to be implemented in Spring 2014. Such management requires ongoing assistance with rate setting, risk adjustment, financial analysis, analysis of claims and encounters, evaluation of expenditures, budget projections, and financial and other reporting requirements as may be mandated by federal or state law.

Services that the Contractor shall perform to assist DHH in accomplishing its goals include:

1. Developing actuarially-sound rate ranges for capitated Managed Care Organizations (MCOs), and rates/fees for enhanced care case management fees for Primary Care Case Management (PCCM) entities and any additional Medicaid managed care models that may be developed by DHH.
2. Applying its broad base of knowledge of federal and state statutes and economic systems using mathematical models and techniques to ensure that capitated plans are paid actuarially sound rates.
3. Providing actuarial opinions and testimony on reimbursement methodology and managed care plans that have actuarial value in accordance with the principles and guidelines of the American Academy of Actuaries.
4. Applying its broad base of knowledge of federal and state policies, procedures and economic and payment systems for the support and implementation of Medicaid managed care models.
5. Assisting in the development and ongoing implementation of a risk adjustment methodology for the Medicaid managed care programs.
6. Developing actuarially-determined benchmarks for the Shared Savings (PCCM) program and savings determinations for each participating Shared Savings plan.
7. Preparing analyses and reports of cost effectiveness and related issues.
8. Other related assistance as requested by DHH.

Deliverables

1. Actuarial Rate Development

Perform capitation rate setting according to generally accepted actuarial principles and practices that use a variety of parameters including recipients' age, gender, eligibility category, and geographic location for Medicaid managed care models. In addition, perform periodic adjustments due to changes in the eligibility category of aid. The development of capitation rates must be performed annually and as requested by DHH in accordance with 42 CFR §438.6.

- Complete rate development and submit documents required by CMS to the Department on a date mutually agreed upon by DHH and the Contractor of each year.
- Provide DHH with a certification, at the conclusion of each specific Medicaid Managed Care program rate setting cycle which states that Federal regulations regarding rate setting were complied with (as necessary) and which includes a detailed description of the rate setting methodology, including all necessary assurances and explanations or other material specified by DHH including but not limited to:
    - The rates and time period for the rates;
    - A description of risk-sharing mechanisms;
    - A projection of expenditures;
    - An explanation of rate setting;
    - Provide documentation and assurance that all payment rates are:
        - Based only upon services covered under the Louisiana Medicaid State Plan or costs related to providing these services, such as health plan administration, and to Medicaid-eligible individuals.
    - Provided documentation of any adjustments to the base year data including detailing the policy assumptions, size, and effect of the adjustments. Adjustments may include services covered, administration, medical service cost, trend inflation and utilization;
    - Provide documentation identifying each rate cell by category for each rate setting period;
    - Provide documentation that the Contractor has examined base year data for distortions, such as special populations with catastrophic costs, and adjusted rates in a cost-neutral manner; and
    - Provide documentation of any use of state provided reinsurance and other risk-sharing mechanisms.
- Follow the parameters and priorities of Medicaid managed care rate development, as set by DHH, in each rate period and advise DHH if there appears to be any conflict with other requirements herein.
- Meet the work plan timeline, as agreed upon by DHH and the Contractor, of Medicaid managed care rate development in each rating period.
- Perform actuarial analyses to make recommendations on proposed rates for subsequent Medicaid managed care entity contract year(s).
- Review encounter data and financial performance of participating Medicaid managed care plans for use in determining rates and fees.
- Ensure that the methodology developed and rates calculated under all tasks meet all federal and state requirements. All reports and rate setting methodologies will be submitted to DHH for approval by CMS.
- Incorporate federal requirements, including those required by the Affordable Care Act (ACA), into managed care rates, and assist DHH in the reporting and reconciliation of such requirements as requested by DHH.
- Provide technical assistance concerning the rate setting methodology to DHH as needed. Technical assistance may include statistical data analysis and litigation support if litigation involves rates or rate setting as determined by DHH.
- Provide actuarial assistance in development of trends for Medicaid, LaCHIP and/or other populations.
- Assist DHH in budget projections pertaining to managed care rates.
- Assist in answering any and all rate related questions.

2. Data Quality

- Perform reasonable reliability and validity checks not requiring an audit on all Medicaid managed care capitation rate development data provided by Medicaid managed care entities and DHH. Work directly with Medicaid managed care entities and DHH to collect financial and encounter data from Medicaid managed care entities and provide guidance to assist health plans in resolving reliability and validity problems with their data.
- Provide an actuarial analysis of the encounter data collected from capitated Medicaid managed care entities.
- Provide supporting documentation to DHH and offer mechanisms to verify the accuracy of analysis completed and base data.
- Evaluate and validate encounter data completeness for risk adjustment purposes.

3. Risk Adjustments

The Department pays risk bearing Medicaid managed care entities a risk based per member per month (PMPM) payment utilizing the Adjusted Clinical Group (ACG) Case-Mix System by Johns Hopkins University or another risk adjustment method specified by the Department consistent with Medicaid managed care plan contracts. In addition, the Shared Savings benchmarks will also be risk adjusted using the same underlying method as the universal rates. Plan specific scores are a function of its ACG distribution of enrollees multiplied by the relative weight.

The contractor will be responsible for:

- Developing initial individual risk scores based on the health of recipients using the diagnostic data captured within the relevant claims and encounter data.
- Developing plan risk scores based on the individual risk scores and enrollment data to assign members to the appropriate plan.
- Adjust the plan risk scores (as appropriate) to maintain budget neutrality and avoid double counting the risk already addressed through existing age/sex universal rates.
- Applying adjusted plan risk scores to develop risk-adjusted per member per month (PMPM) capitation rates and Shared Savings benchmarks for Medicaid managed care entities.
- Providing periodic updates of risk adjustments over time.
- Evaluating and validating encounter data completeness for risk adjustment purposes.
- Providing ongoing assistance in relation to risk adjustment, including agreed upon reports between DHH and Mercer.

4. Pay for Performance Plan

Assistance with evaluation and/or validation of the actuarial value of enhanced payments to providers and expanded benefits to members that may be proposed by prospective Medicaid managed care entities in response to the Request for Proposals for Medicaid managed care plans.

5. Shared Savings Program Support

Develop fees and benchmarks for the Bayou Health Shared Savings Program, and periodic Shared Savings Determinations comparing Shared entity performance to benchmarks.

Enhanced Primary Care Case Management Fees (ePCCM fees) are paid to Shared entities for case management services. DHH may periodically review and/or revise these rates, and the contractor shall establish such revised fees using actuarial principles for periods requested by DHH. Such work is not anticipated to occur annually.

Develop Bayou Health Shared Savings Benchmarks for periods requested by DHH. The benchmarks should be based upon actuarial principles that use a variety of parameters including recipients' age, gender, eligibility category, and geographic location for Medicaid managed care models. In addition, perform periodic adjustments due to changes in the eligibility category of aid. Such work will include:

- Complete benchmark development and submit documents required by CMS to the Department on dates mutually agreed upon by DHH and the Contractor each year.
- Provide DHH with a Shared Savings benchmark letter for each specific Bayou Health Shared program benchmark cycle which states that Federal regulations regarding Shared Savings benchmarks were complied with (as necessary) and which includes a detailed description of the benchmark methodology, including all necessary assurances and explanations or other material specified by DHH including but not limited to:
    - The rates and time period for the rates;
    - An explanation of Shared Savings benchmark development;
    - Provide documentation and assurance that all Shared Savings benchmarks are:
        - Based only upon services covered under the Louisiana Medicaid State Plan or costs related to providing these services, and to Medicaid-eligible individuals.
    - Provided documentation of any adjustments to the base year data including detailing the policy assumptions, size, and effect of the adjustments. Adjustments may include services covered, medical service cost, trend inflation and utilization;
    - Provide documentation identifying each benchmark rate cell by category for each rate setting period;
    - Provide documentation that the Contractor has examined base year data for distortions, such as special populations with catastrophic costs, and adjusted rates in a cost-neutral manner; and
    - Provide documentation of any use of state provided reinsurance and other risk-sharing mechanisms.
- Follow the parameters and priorities of Medicaid managed care benchmark development, as set by DHH, in each rate period. Advise DHH if there appears to be any conflict with other requirements herein.
- Meet the work plan timeline, as agreed upon by DHH and the Contractor, of Medicaid managed care benchmark development in each benchmark period.
- Perform actuarial analyses to make recommendations on proposed benchmarks for subsequent Medicaid managed care entity contract year(s).
- Review financial performance of participating Bayou Health plans for use in determining benchmarks and fees as determined appropriate.

- Document that the methodology developed and Shared Savings benchmarks calculated under all tasks meet all federal and state requirements. All reports and benchmark setting methodologies will be submitted to DHH for approval by CMS.
- Incorporate federal requirements, including those required by the Affordable Care Act (ACA), into benchmarks as applicable, and assist DHH in the reporting and reconciliation of such requirements as requested by DHH.
- Provide technical assistance concerning the rate setting methodology to DHH as needed. Technical assistance may include statistical data analysis and litigation support if litigation involves rates or rate setting as determined by DHH.
- Provide actuarial assistance in development of trends for Medicaid, LaCHIP and/or other populations.
- Assist DHH in budget projections pertaining to Shared Savings ePCCM rates.
- Assist in answering any and all rate related questions.

Calculate Shared Savings Determinations periodically as requested by DHH. The Shared Savings Determinations shall be based upon the difference in Shared entity expenditures and the established benchmarks for that period. Such work will include:

- Perform period initial Shared Savings Determinations as requested by DHH based upon the claims completion period specified by DHH for the periodic initial determination.
- Perform periodic final Shared Savings Determinations following the claim completion period specified by DHH for the period final determination.
- Provide technical assistance concerning the savings determinations to the Shared entities and to DHH as needed. Technical assistance may include statistical data analysis and litigation support if litigation involves rates or rate setting as determined by DHH.
- Provide actuarial assistance in development of analyses for Medicaid, LaCHIP and/or other populations.
- Assist DHH in budget projections pertaining to the Shared Savings Program.
- Assist in answering any and all benchmark and savings determination related questions.

6. Fee Development

Develop fees as requested by DHH, engage stakeholders regarding the development of such fees, and assist DHH in the implementation, budgeting, and monitoring or such fees as requested by DHH. Fees may include, but not be limited to, develop of Diagnostic Resource Groups (DRGs) for hospital inpatient fees.

7. Waivers and Federal Reporting

Assist DHH in the development, submission, renewal and financial projections related to federal waivers for new and existing programs as requested by DHH. Such work may include support for the capitated dental program and managed care/utilization management/prior authorization for other services such as Medicaid radiology, laboratory and durable medical equipment services.

8. Procurement

Assist DHH in the development of Requests for Proposals (RFPs), data books, contracts, fees, capitation rates and budget projections for new programs and re-procurement of existing programs.

9. Reports

- Provide DHH with reports, data sets, analysis, and documents relevant to the rate setting process and calculations in the format(s) specified by DHH. The Contractor shall provide all documents and data in the electronic media format(s) designated by DHH, and the Contractor shall be required to accept and be able to process electronic documents and files in the electronic media format(s) by DHH.
- Provide complete explanations of all calculations as requested by DHH and provide all formulas to DHH as requested.
- Provide reports outlining how rate development complies with the CMS Medicaid Managed Care Rate Setting Checklist and that reflect the necessary costs associated with meeting requirements in technical and general areas.
- Provide personnel and documentation of formulas and methodologies to document and explain challenges by CMS or other parties relative to the matters herein contracted.
- Provide rate certification letters and benchmark letters and related documents as prescribed by DHH to be submitted to CMS for approval.
- Provide risk adjustment scores and related documents as prescribed by DHH to be used to adjust capitation rates and Shared Savings benchmarks.
- Respond timely to *ad hoc* data requests.
- Provide all data, program and regulatory analysis requested by DHH.
- Prepare quarterly and annual Medicaid managed care plan financial reports for review by DHH as requested.
- All reports should be submitted within timeframes agreed upon by DHH and the Contractor.

10. Participation in Meetings and Work Groups

- Participate in periodic meetings with DHH staff throughout each capitation rate cycle to discuss the parameters, priorities, methodology, and ongoing results of capitation rate development in each rate cycle. Provide documents and data, as directed by DHH to discuss at these meetings.
- Participate in meetings with DHH, legislative committees and CMS representatives as requested. Meetings may be scheduled on very short notice.
- Participate in meetings with Medicaid managed care entities, provider groups and other concerned parties as requested by DHH.

11. Technical, Clinical and Policy Assistance

- Perform technical, clinical and policy assistance and ongoing support of Medicaid managed care initiatives and the Louisiana Medicaid fee-for-service program. This may include but is not limited to assistance with *ad hoc* requests, interpretation of new federal regulations, preparation of waiver and state plan amendments in accordance with CMS and federal policy requirements, and other assistance as requested by DHH.

12. Turnover

At the end of the contract period, work cooperatively with DHH and any of their contracting organizations to develop and successfully implement a plan to turn over all non-proprietary data, methodologies, documentation, and ongoing projects to the succeeding contracting organization, vendor, or firm. The turnover plan must be delivered to DHH 90 days prior to the scheduled termination date of the contract unless DHH advises otherwise.

13. Actuarial Personnel

The Contractor must have available at least two actuaries and a data analyst on staff that are able to provide the following services:

- The principle actuary must be a Fellow in the Society of Actuaries (FSA) and a Member of the American Academy of Actuaries (MAAA) with proven experience with a Medicaid and/or CHIP program.
- One actuary must be either an ASA or FSA and MAAA and have proven experience with a Medicaid/or CHIP program.
- Non-actuaries must work under the supervision of the principle actuary to perform actuarial work.
- At least one actuary must be available either in person or by phone within four hours every Monday through Friday between the hours of 7:30 AM and 5:00 PM CT to discuss actuarial matters and work on pressing issues.
- At least one actuary must be available in person, within 72 hours, seven days a week during any State Legislative Session to discuss and testify on actuarial matters and work on pressing issues.
- As requested by DHH, provide resumes for all key personnel, including the project manager, who will be involved in providing the services of this contract. The resumes must include: name, education, and years of experience and employment history.
- Provide the name and qualifications of any subcontractor who will be involved with this contract. Describe the work and estimate the percentage of total work the subcontractor will be performing.

Performance Measure

The contractor will submit detailed monthly invoices due on the 20th of each month documenting the activities performed and the status of outstanding deliverables.

Monitoring Plan

The DHH contract monitor will:

1. Be available for consultation by phone, e-mail, and face-to-face meetings to discuss priorities and provide direction;
2. Meet with the contractor on a weekly basis, if needed, by telephone to ensure that work toward the completion of deliverables is being accomplished; and
3. Review and approve monthly detailed invoices.

Actuarial Errors, Corrective Action Plans, & Monetary Penalties

In the event of an actuarial error in a final deliverable, the Contractor shall provide written notice of the error to DHH. The notice shall include a detailed description of the error, including its scope and severity.

The Contractor agrees to correct actuarial errors at its own expense and without significant delay to the schedule for Contract deliverables. The Contractor shall not bill nor will DHH pay for the cost of correcting actuarial errors.

In the event of an actuarial error significant enough to require revision of a major deliverable, such as capitated rate certification, risk adjustment, or Shared Savings benchmark or determination, DHH may require submission of a corrective action plan and may assess monetary penalties as defined below.

The purpose of establishing and imposing monetary penalties is to provide a means for DHH to obtain the services and level of performance required for successful operation of the Contract.

The decision to impose monetary penalties may include consideration of some or all of the following factors:

- The duration of the violation;
- Whether the error (or one that is substantially similar) has previously occurred;
- The Contractor's history of errors;
- The severity of the error;
- The "good faith" exercised by the Contractor in attempting to avoid errors.

If assessed, the penalties will be used to reduce DHH's payments to the Contractor or if the penalties exceed amounts due from DHH, the Contractor will be required to make cash payments to DHH for the amount in excess.

For each occurrence of a significant actuarial error, the Contractor may be liable to DHH for monetary penalties in an amount as specified in the table below. Monetary penalties escalate by occurrence over the term of this Contract.

Occurrence	Penalty Per Occurrence
1-2	$25,000
3-4	$50,000
5 and beyond	$75,000

Excessive actuarial errors may result in termination of the contract.

Terms of Payment

This is a fixed price contract to be paid in accordance with the following rates:

Position	Hourly Rate
Principal/Partner	$450
Senior Consultant/Actuary/Project Manager/Project Coordinator	$395
Clinician	$375
Senior Associate	$335
Associate	$300
Analyst	$235

Policy/Waiver Subcontractor	$275
Policy/Operations Subcontractor	$300
Administrative Support	$90

Itemized invoices containing the tasks, deliverables completed, hours worked, and the personnel that performed the work shall be submitted to DHH by the 20th of the month following the month in which the work was performed.

The term of this contract is for the period 3 years. With all proper approvals and concurrence with the successful contractor, agency may also exercise an option to extend for up to twenty-four (24) additional months at the same rates, terms and conditions of the initial contract term. Subsequent to the extension of the contract beyond the initial 36 month term, prior approval by the Joint Legislative Committee on the Budget (JLCB) or other approval authorized by law shall be obtained. Such written evidence of JLCB approval shall be submitted, along with the contract amendment to the Office of Contractual Review (OCR) to extend contract terms beyond the initial 3 year term. No contract/amendment shall be valid, nor shall the state be bound by the contract/amendment, until it has first been executed by the head of the using agency, or his designee, the contractor and has been approved in writing by the director of the Office of Contractual Review. Total contract term, with extensions, shall not exceed five (5) years.

The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract.

Attachment C

ADDITIONAL PROVISIONS

1. **Indemnity:**
Contractor's indemnity obligations under CF-1 page 3, clause 19 shall not apply to any claim for infringement or misappropriation of intellectual property rights to the extent that any such infringement or misappropriation is caused by : (i) information or materials provided by the Department, (ii) modifications made by the Department or a third party other than Contractor or Contractor's subcontractors to services, work product or other materials provided to the Department in connection with the services or any parts thereof, or (iii) Department's use of the services, work product or such other materials or any parts thereof, in a manner inconsistent with terms of the contract.

2. **Ownership and Use of Work; Intellectual Property:**
   A. All materials prepared by Contractor specifically and exclusively for the State pursuant to this contract (the "Work") shall be owned exclusively by the State. Notwithstanding anything to the contrary set forth in this contract, Contractor will retain all copyright, patent and other intellectual property rights in the methodologies, methods of analysis, ideas, concepts, know-how, models, tools, techniques, skills, knowledge and experience owned or possessed by Contractor before the commencement of, or developed or acquired by Contractor after, the performance of the services, including without limitation, all such systems, software, specifications, documentation and other materials created, owned or licensed and used by Contractor or its affiliates or subcontractors in the course of providing the services (the "Intellectual Property"). To the extent any Work incorporates any Intellectual Property, Contractor hereby grants the State a non-exclusive, royalty-free, non-transferable right to use such Intellectual Property in accordance with the terms of this contract.

   B. The State shall be responsible for, and Contractor shall have no liability with respect to, (a) modifications made by any person other than Contractor (or third parties under the control of Contractor) to the Work, Intellectual Property or other work product provided to the State by Contractor or (b) any use of any Work or Intellectual Property or other material supplied by Contractor under this contract in a manner other than as mutually contemplated when Contractor was first retained to perform the applicable services.

3. **Limitation of Liability:**
   A. The aggregate liability of Contractor, its affiliates and any officer, director or employee of Contractor and its affiliates ("Contractor Parties") to the Department, its affiliates, its officers or employees or those of its affiliates for any and all Losses arising out of or relating to the provision of any services at any time by any of the Contractor Parties shall not exceed, the greater of, three times the compensation for the services giving rise to such Loss, or three million dollars. Contractor shall have no liability for the acts or omissions of any third party other than its affiliates or subcontractors.

   B. In no event shall either party or its affiliates be liable in connection with this contract or the services to the other party, its affiliates or any third party for any loss of profit or incidental, consequential, special, indirect, punitive or similar damages.

C. For purposes of this contract "Loss" means damages, claims, liabilities, losses, awards, judgments, penalties, third party claims, interest, costs and expenses, including reasonable attorneys' fees, whether arising under any legal theory including, but not limited to claims sounding in tort (such as for negligence, misrepresentation or otherwise), contract (whether express or implied), by statute, or otherwise, claims seeking any kind of damages and claims seeking to apply any standard of liability such as negligence, statutory violation or otherwise

4. **Third Party Beneficiaries:**
Neither the contract nor the provision of the services is intended to confer any right or benefit on any third party.

5. **Severability:**
In addition to the provisions of CF-1 page 4, clause 22, it is the intent of the parties hereto that the provisions of this contract shall be enforced to the fullest extent permitted by applicable law. To the extent that the terms set forth herein are found to be illegal or unenforceable by a court of law for any reason, such term shall be modified, deleted or interpreted in such a manner so as to afford the party for whose benefit it was intended the fullest benefit commensurate with making this contract, as modified, enforceable and the other terms of this contact shall not be affected thereby. The parties agree to enter into an amendment of the contract as necessary to effect the ruling of the court.

6. **The Department's Information:**
In performing the services, Contractor will use all information supplied by the Department without having independently verified the same, and the Contractor assumes no responsibility for the accuracy or completeness of such information.

7. **Involvement in Third Party Disputes:**
If Contractor becomes involved in a dispute between the Department and a third party, the Department shall pay Contractor at its hourly rates set forth in the Contract for such additional services, except to the extent the Contractor is at fault.

Exhibit 1

MERCER

PATTY ANDERSON, MBA

Role: Government Consultant

Overview

In her Government Consultant and Project Management roles, Patty combines her organizational, communication and leadership skills to help effectively manage multiple projects for Mercer Medicaid clients. She works on several state clients including Connecticut, Louisiana, Massachusetts and New York.

Experience/Accomplishments

Before joining Mercer in August 2008, Patty worked for Blue Cross Blue Shield of Arizona for five years as an actuarial analyst.

In her role as Government Consultant, Patty's accomplishments include:

- Managing and coordinating project communications, tasks and deadlines related to Connecticut's Medicaid Payment Rate Increase for Primary Care Providers across several entities including the State, the State's vendors and Mercer subcontractors.
- Facilitating client and internal communication for several client teams, including Massachusetts Behavioral Health Program (MBHP), Massachusetts Primary Care Payment reform, Louisiana risk adjustment, Connecticut rate reviews and New York Managed Long Term Care (MLTC).
- Coordinating and writing final reports of findings and recommendations for several projects, including the State of Connecticut's Hospital Payment Systems Reform and the Massachusetts Primary Care Payment reform projects.
- Presenting final findings and recommendations to State Agencies, Health Plans and other state vendors for several clients, including Louisiana, Connecticut and MLTC.
- Providing high level consultant review of the rate setting process for several clients, including New York MLTC and MBHP.
- Reviewing risk adjustment results and final risk adjusted rates for Louisiana and Pennsylvania.
- Analyzing claims, utilization and other health care data to inform the rate-setting process on several clients, including MLTC, MBHP and Massachusetts Primary Care Payment reform.
- Managing internal project activities and deadlines for several clients.
- Analyzing claims and other health care data to support the Massachusetts Comprehensive Behavioral Health Program and Management Support Services Request for Proposal selection process.
- Projecting the state costs of different options of moving eligible individuals into a Basic Health Plan (BHP) or a Qualified Health Plan (QHP) for the Commonwealth of Massachusetts.

Education

- Master's degree in Business Administration, Arizona State University
- Bachelor's degree in Mathematics, Arizona State University

MERCER

DENISE BLANK

Role: Risk-Assessment Strategist or Specialist / Senior Project Manger

Overview

Denise is a Principal in Mercer's Phoenix office, and has been with Mercer since 1994. Denise specializes in the design and application of risk adjustment concepts to capitation rate development and clinical support activities. Denise has worked directly with the stakeholders to successfully implement and apply risk adjustment concepts including the evaluation of available risk adjustment models, risk adjustment application design/review, development of cost weights, and sufficiency determination of the encounter data. Risk adjustment has been growing in the marketplace over the last decade, and Mercer has implemented about half of these programs within Medicaid. In addition, Mercer works side-by-side with leading-edge industry risk-adjustment model developers.

In addition to her risk adjustment consulting, Denise manages numerous complex engagements with state Medicaid clients. In this role, she works closely with Mercer's client relationship manager, the state's contract management, and all internal and external resources to ensure that the project is on time and on budget to reach the clients' end goal. Her strength is her ability to see the big picture of the project and how all of the pieces fold together.

Experience/Accomplishments

Denise's specific experience includes:

- Consulting on uses of risk assessment models including capitation rate adjustment, bid evaluation, provider profiling, and targeting recipients for intervention activities
- Evaluating of eligibility, encounter, and fee-for-service claims data to support various financial initiatives including risk assessment, rate development, quality measurements, and other management activities
- Leading project teams that support various Medicaid initiatives, including capitation rate development, cost effectiveness evaluations, cost driver analyses, risk assessments and reviews of health plan encounter operations
- Creating a risk adjusted rates implementation strategy for Delaware, Florida, Louisiana, New Jersey, New York, Missouri, Ohio, Oklahoma and Pennsylvania
- Providing independent evaluation of risk-adjustment methodologies used in Colorado, Massachusetts, and Oregon along with Minnesota's encounter data to support future risk-adjustment model updates
- Assessing health plan operations from management oversight, provider relations, claims systems, and encounter report to determine areas of potential data loss that could adversely impact risk adjustment and other encounter-based analyses
- Developing a long term care risk-adjustment model in conjunction with the State of New York Department of Health
- Leading the overall direction and strategy of consulting services for the risk adjustment programs in Delaware, Louisiana, New York, Ohio and Pennsylvania
- Consulting on Medicaid managed care initiatives including numerous health areas for consideration to legislative and political challenges from strategic and technical perspectives

- Providing technical assistance to state staff, health plans, and other stakeholders, including on-site presentations and answering submitted questions on a variety of topics including data issues, risk-adjustment and rate setting methods
- Discussing strategy with key state staff and risk assessment model developers
- Developing actuarially-sound capitation rates and evaluating impact of waiver programs for various models, benefits, and populations
- Collecting detail-level encounters directly from health plans to support risk adjustment, rate-setting and other management activities
- Evaluating reimbursement strategies to address the unique aspects of individuals at risk of institutionalization, including condition-specific rates and risk-adjustment techniques
- Leading the overall activities for the actuarial contract for Delaware and Ohio, which includes rate development, financial reporting, encounter/claim data summarization and other analyses
- Participating on Mercer's bid review team for the Medicare Advantage (Part C and Part D) bid submissions

Education

- Bachelor's degree in Actuarial Science and Economics, Easter Michigan University

MERCER

RUI DAI, PhD, FSA, MAAA

Role: Senior Associate

Overview

Rui is a Senior Associate in Mercer's Atlanta office. She has been involved in Florida and Louisiana Medicaid rate setting, feasibility study of the Medicare and Medicaid dual eligible population demonstration program and financial projection of Georgia Medicaid program. Her other responsibilities include Health Care Reform analysis, Basic Health Plan feasibility analysis, risk adjustment, CMS bid review and audits.

Rui has extensive experience working in the area of Medicare and Medicaid pricing, risk adjustment and actuarial modeling. Prior to joining Mercer, Rui has six years experience working at a Medicare Advantage Health Plan and a consulting firm.

Experience/Accomplishments

Rui joined Mercer in November 2011. Her experience include:

- Collecting, analyzing and interpreting Medicaid FFS, health plan financial and encounter data
- Developing rate-setting methods, selecting pricing assumptions and managing the rate-setting process
- Participating on Mercer's Bid Review teams for CMS 2013 Medicare Advantage (MA) and Prescription Drug Plan (PDP) bid submission
- Participating on Mercer's Bid Audit team for CMS 2012-2013 Medicare Advantage (MA) and Prescription Drug Plan (PDP) bid submission
- Developing CMS 2007-2012 Medicare Advantage (MA) and Prescription Drug Plan (PDP) bids
- Financial modeling of an integrated Medicare and Medicaid demonstration program for Medicare and Medicaid Dually Eligible population
- Pricing, reserving, and forecasting for commercial and Medicare Advantage plans
- Analyzing prescription drug AWP and rebates and involved in PBM contacting
- Pricing commercial dental products and developing Medicaid dental rates
- Performing HCCs analysis and calculating risk scores for Medicare Advantage plan enrollees
- Providing actuarial consulting services for states including Exchange EHB, risk adjustment methodology and implementation etc

Education

- PhD in Business Administration, University of South Florida
- Master's degree in Economics, University of South Florida
- Master's degree in International Relations, Waseda University, Japan

Affiliations / Designations

- Member, Fellow of the Society of Actuaries
- Member, American Academy of Actuaries

MERCER

SCOTT BANKEN, CPA

Role: Financial Operations and Reporting

Overview

Scott joined the Government Human Services Consulting practice, a part of Mercer Health & Benefits LLC (Mercer) in the Minneapolis office as a Senior Associate in 2012. Scott has been a certified public accountant (CPA) for over 20 years and has over 10 years of experience managing finance teams in both national and regional Managed Care Organizations (MCOs), with both Medicare and Medicaid experience.

Scott's experience allows him to understand different strategies for financial oversight of capitation rate plans, risk-sharing and risk corridor negotiation, benefit management, and interventions to maximize efficiency and minimize costs. He has extensive experience in setting up alternative payment arrangements to incent health outcomes.

Scott enjoys working with clients to improve the quality and efficiency of their Dual Eligible and Long Term Care programs. In addition, Scott brings expertise in systems development to create efficient, auditable reporting solutions for financial, regulatory and operational reporting.

Experience/Accomplishments

Scott's experience includes:

- Participating in on-site reviews for financial oversight of managed care plans.
- Developing oversight strategies for finance and program integrity.
- Working in conjunction with Actuarial teams to develop models for Medicaid rates and Medicare bids for special needs populations, including seniors and disabled.
- Participating in annual Medicaid rate negotiations for dual and care-coordinated products.
- Participated with pricing teams for Medicare products to ensure viability, including 1915(c) waiver products for elderly waiver and waiver for disabled individuals.
- Managing CMS audits for Medicare Advantage with Part D (MAPD) contracts. Working with Actuarial teams to ensure compliance in the Medicare bid process.
- Managing the Medicare and Medicaid financial operations of a non-profit MCO, including regulatory reporting for National Association of Insurance Commissioners (NAIC) filings, Medicaid program financial results and Department of Commerce filings.
- Negotiating profit-sharing and risk-sharing contracts with providers around Medicaid and Dual-Eligible member programs to improve levels of care and manage risk.
- Developing actionable reports for care coordinators and nurse practitioners to reduce improper or ineligible services and identify revenue opportunities for eligible members.

Education

- Master's degree of Business Administration: Information Technology from the University of Minnesota – Carlson School of Management
- Bachelor's degree in Accounting, University of St. Thomas

Affiliations/Designations

- Certified Public Accountant (CPA)

MERCER

ROBERT BUTLER

Role: Client Relationship Manager

Overview

Robert is currently a Principal in Mercer's Atlanta office and has been with Mercer since 2008. Robert provides comprehensive client management for state clients and ensures that there is a strong level of coordination among the vast resources that Mercer brings to a project. Robert has a keen ability to relate to his clients and to understand their issues, making him a true partner. Robert also serves as Mercer's Long-Term Care (LTC) specialist.

Experience/Accomplishments

Robert has been working in the Long-Term Care arena since 1994. His experience and accomplishments include:

- Strategic management of large client engagements
- Rate development for home and community based services
- Nursing home right-sizing strategic planning
- Desk review of CMS Medicare Advantage bids
- Developing and planning transformation of the Louisiana Medicaid program through managed care, including policies, rates and MMIS systems
- Developing fees and rates for multiple Medicaid programs, including federally qualified health clinics and psychiatric residential treatment facilities for children
- Leading Medicaid stakeholder and provider meetings, and training on reporting requirements
- Developing and negotiating the Florida Medicaid Reform 1115 Waiver
- Oversight of the preparation of Medicaid rates for hospitals, nursing homes, facilities for the developmentally disabled and other institutional providers
- Management and implementation of managed care rates for Medicaid HMOs, Nursing Home Diversion Programs and Prepaid Mental Health Plans
- Reviewing and managing financial projections for multiple federal waivers, including those related to home and community based services and managed care programs
- Management of the program auditing institutional provider cost reports
- Reviewing and managing Medicaid caseload and program expenditure projections for the state budget
- Assisting with the development and management of a Medicaid Disproportionate Share Program and Low Income Pool
- Preparation of nursing home costs reports
- Preparation of financial projections for regulatory filings for long-term care facilities, including certificates of need
- Reviewing and analyzing managed care rates and related methodologies
- Promoting integration of Medicaid and Medicare services through coordinated rate development for Medicare Special Needs Plans (SNPs)

Education

- Bachelor's degree in accounting, Florida State University

MERCER

Meredith Mayeri

Role: Principal

Overview

Meredith is a Principal with Mercer and is one of Mercer's federal Medicaid and CHIP policy and waiver specialists. As a former CMS Technical Director and policy advisor, she has experience in the planning, design and implementation of Medicaid waivers, state plan amendments, managed care programs and delivery system innovations since 1998. Meredith specializes in health program strategy and program development, including federal requirements.

Before joining Mercer in March 2010, Meredith held senior positions in the CMS San Francisco Regional Office's Division of Medicaid and Children's Health. Meredith specialized in Medicaid managed care, waivers and demonstrations and provided technical assistance and support to CMS staff nationally and states in the development and implementation of these programs.

Experience/Accomplishments

Meredith's experience includes:

- Designing new Medicaid managed care programs (policy advice, contract and state plan requirements, readiness review training)
- Conducting a comprehensive assessment and operational plan, including waiver, contract and operational requirements, for the implementation of a Medicaid managed long-term care expansion program
- Development and implementation of a successful new section 1115 demonstration waiver program, including benefit and payment model design
- Development of a successful proposal to the Centers for Medicare & Medicaid Services (CMS) for demonstration planning funding for persons dually eligible for Medicare and Medicaid
- Evaluating alternative (benchmark) benefit package options for clients
- Evaluating authorities and options under the Affordable Care Act for increasing home and community based services and implementation of health homes for individuals with chronic conditions
- Identifying operational efficiencies in home and community-based services programs and developing recommendations for improvement and associated cost savings
- Advising clients on changes in federal laws, regulations and policy in the area of health care reform, managed care, state funding mechanisms, waiver renewals, fee-for-service and managed care rate setting, LTSS and dual-eligibles
- Serving as the CMS Region IX Technical Director for Medicaid and CHIP Program and Financial Management and the Program Branch Manager responsible for Medicaid and CHIP eligibility, coverage and delivery system policy
- Oversight of Medicaid managed care programs for California, Arizona, Nevada and Hawaii for ten years, including multiple program readiness and performance reviews
- Regional CMS lead for the implementation of the Medicaid managed care regulations in 2003

- Serving on the CMS team that developed the section 1915(b) waiver cost-effectiveness test
- Regional CMS lead for California's Section 1115 Medi-Cal/Uninsured Care and Family Planning demonstrations

Education

- Bachelor's degree in Economics, LaSalle University, Philadelphia, PA

MERCER

George Nyakairu

Role: Senior Informatics Consultant

Overview

George Nyakairu is a Senior Informatics Consultant in Mercer's Government Human Services Consulting (GHSC) Atlanta office. George works on claims data loading, validation and processing using SAS (Statistical Analysis Software) for states of Florida, Texas, Alabama, Louisiana and District of Columbia.

Experience/Accomplishments

George's responsibilities at Mercer include:

- Providing technical support in form of SAS programming for Medicaid claims and eligibility data requested by Atlanta's actuarial team
- SAS code development, documentation and peer review as needed for client reporting
- Process ad-hoc client data requests from Atlanta's GHSC team
- Providing claims data technical review for the Actuarial team
- Providing disease management and Hedis expertise on various clinical projects for Mercer's clients
- Overall technical and data support for Florida, Alabama, Louisiana, Texas and DC
- Training and technical support for the Informatics group in general

Prior to joining Mercer, George's experience included:

- Working as a Senior SAS Programmer at Alere (former Matria Healthcare), Marietta, GA
- Senior Healthcare Analyst at Ingenix, Waltham, MA
- Actuarial Analyst at Harvard Pilgrim Healthcare, Wellesley, MA

Education/Affiliations/Designations

- Bachelor's degree in Statistics and Economics, Makerere University (Uganda)
- Certifications in SAS programming (I,II,III), Macro SAS programming, SAS programming using Proc SQL, Advanced SAS programming from SAS Institute in Boston, MA
- Member, Business Intelligence and Analytics Group
- Member, Global Analytics Network.

Years of Experience

- 12 years of SAS programming experience in the Healthcare Industry

MERCER

BRANDON ODELL, FSA, MAAA

Role: Associate Actuary

Overview

Brandon is an Associate in Mercer's Atlanta office. He has been involved in Louisiana Medicaid rate setting, legislative analyses, and Medicare Advantage cost modeling. His other responsibilities include Health Care Reform analysis, risk adjustment, and CMS Medicare Advantage bid reviews.

Brandon has extensive experience working in the area of financial analysis, forecasting, and Medicare Advantage bidding. Prior to joining Mercer, Brandon had five years experience working at an insurance company and consulting firms.

Experience/Accomplishments

His experience includes:

- Medicaid managed care capitation rate development
- Analysis of Medicaid managed care cost savings
- Pricing, reserving, and forecasting for commercial and Medicare Advantage plans
- Analysis of claims seasonality for commercial CDHP populations
- Commercial PPO network cost comparison
- Pricing and rate filing of Medicare Advantage and Part D plans
- CMS bid reviews of Medicare Advantage and Part D plans
- Work on cross-functional teams working to streamline financial reporting at a large insurance company
- Projection of multi-year premium deficiency reserves for health policies
- Assist clients with application process for HHS Consumer Owned and Operated (Co-Op) health insurance loans
- Completion of actuarial portions of orange (health) blank for a large commercial insurer
- Analysis and presentation to executive leadership of line of business (LOB) financial results

Education

- B.S. in Applied Mathematics with Honors, Ferris State University

Affiliations / Designations

- Fellow of the Society of Actuaries (2012)
- Member, American Academy of Actuaries (2009)

MERCER

MIKE PRINISKI, CPA

Role: Principal

Overview

Mike is a Principal in the Phoenix office of Mercer Government Human Services Consulting (Mercer). Mike has served as a lead for numerous Mercer contracts to examine Medicaid and Medicare Managed Care Organizations (MCOs). In addition, he serves as a client leader for the Centers for Medicare and Medicaid Services (CMS) and has assisted states in developing and implementing financial reporting and solvency monitoring protocols. He is most proud of an administrative expense review he developed that saved a client approximately $35 million.

Experience/Accomplishments

Prior to joining Mercer in 2000, Mike served as the chief financial officer for 2 ½ years with the Arizona Department of Health Services/Division of Behavioral Health Services (DBHS). He was responsible for directing the daily financial and encounter operations of DBHS. Mike also served as a financial consultant and claim administrator for Arizona's Medicaid program (AHCCCS) for three years. While at AHCCCS, he evaluated the financial stability and operations of Medicaid managed care contractors and was responsible for the AHCCCS fee-for-service claim system.

Prior to his work at Mercer and the State, he worked as a senior auditor for two of the nation's largest public accounting firms, PriceWaterhouseCoopers and Ernst & Young LLC for three years.

Mike's experience includes:

- Leading several large client engagements related to the financial and operational examination of Medicaid and Medicare MCOs and providers
- Drafting and evaluating request for proposals including scoring and performing readiness reviews of healthcare contractors
- Assessing claims systems, financial and accounting systems, medical management systems, provider and member satisfaction systems and eligibility systems
- Performing and supervising all aspects of Mercer's examinations, planning through report writing and finalization
- Developing, revising and implementing reporting requirements and monitoring procedures within numerous states, including Florida, Arizona, California, New Jersey, North Carolina, New Mexico and Pennsylvania
- Performing on-site assistance to start-up MCOs to ensure appropriate solvency and fiscal policies and procedures are in place
- Developing review protocols to assess the "true" administration expenses and profit of MCOs through review of cost allocations and related party transactions
- Evaluating and assessing financial solvency and risk factors associated with MCO financial reports

Education

- Master's degree in Accountancy/Taxation, Arizona State University
- Bachelor's degree in Accounting, Arizona State University

Affiliations/Designations

- Licensed Certified Public Accountant in the State of Arizona

MERCER

JAREDD SIMONS, ASA, MAAA

Role: Lead Actuary

Overview

Jaredd is a Senior Associate in Mercer's Atlanta office. He has been involved in Louisiana and Florida Managed Care rate setting. Before joining Mercer, he spent six years working for Coventry Health Care on both commercial products and Medicaid managed care. During that time, Jaredd was also involved in the early implementation of ACA requirements corporate wide and helped with coordination across business units.

Experience/Accomplishments

Jaredd brings his experience in the health insurance industry.

Some of Jaredd's accomplishments include:

- Implementing ACA 1202 fee schedules and supplemental capitation rate development
- Developing Medicaid managed care capitation rates
- Developing Managed Long-term care capitation rates
- Pricing, reserving, and forecasting for commercial products in Georgia, Louisiana, Virginia, and West Virginia
- Reserving and forecasting for Medicaid managed care plans in Virginia and Pennsylvania
- Commercial rate reviews and rate recommendations
- Rate filing of commercial rates
- Developed traditional and non-traditional benefit designs

Education

- Bachelor's degree in Finance, University of North Carolina at Charlotte

Affiliations/Designations

- Member, Associate of the Society of Actuaries

MERCER

CERTIFICATE OF THE ASSISTANT SECRETARY

OF

MERCER HEALTH & BENEFITS LLC

I, Margaret M. O'Brien, Assistant Secretary of Mercer Health & Benefits LLC, a Delaware limited liability company (the "LLC") certify that at a duly authorized meeting of the Board of Directors of the LLC, dated February 11, 2010, the Board adopted procedures authorizing any Principal, Partner or Senior Partner of the LLC, including the list of individuals attached hereto, to execute contracts, agreements, applications and other instruments on behalf of the LLC. This resolution has neither been amended nor rescinded and is in full force and effect as of the date hereof.

IN WITNESS WHEREOF, I hereunto set my hand and affix the seal of the LLC this 11th day of March 2014

Margaret M. O'Brien
Assistant Secretary

State of New York)
County of New York)

Subscribed and sworn to before me on this 11th day of March 2014

Notary Public

Sandra Davenport
Notary Public - State of New York
No. 01DA6139698
Qualified in Nassau County
Certified in New York County
Commission Expires February 20, 2018

MERCER

AUTHORIZED SIGNATORIES

Name	Title
Alicia Smith	Partner
Angela WasDyke	Partner
Branch McNeal	Senior Partner
David Parrella	Principal
Deidra Abbott	Principal
Denise Podeschi	Partner
Ed Fischer	Principal
Frederick Gibison	Partner
Jared Nason	Partner
Katie Falls	Principal
Marcia Morgan	Partner
Mike Nordstrom	Partner
Robert Butler	Principal
Ryan Johnson	Principal
Russell H. Ackerman	Principal
Sam Espinosa	Partner
Shawna Kittridge	Principal
Stephanie Davis	Senior Partner
Sundee Easter	Principal
Thomas Steiner	Partner

MERCER HEALTH & BENEFITS LLC

(Delaware)

(the "LLC")

CONSENT TO ACTION WITHOUT A MEETING OF THE BOARD OF DIRECTORS

The undersigned, being all the members of the Board of Directors of this LLC, hereby consent to the following action being taken without a meeting:

RESOLVED: any employee of this LLC who has achieved a grade level "E" is automatically elected to serve in the office of Associate of this LLC until his or her termination, removal or resignation from office or such other date as specified in this LLC's by-laws, whichever first occurs and further,

RESOLVED: any employee of this LLC who has achieved a grade level "F" is automatically elected to serve in the office of Senior Associate of this LLC until his or her termination, removal or resignation from office or such other date as specified in this LLC's by-laws, whichever first occurs and further,

RESOLVED: any employee of this LLC who has achieved a grade level "G" or a grade level "H" is automatically elected to serve in the office of Principal of this LLC until his or her termination, removal or resignation from office or such other date as specified in this LLC's by-laws, whichever first occurs and further,

RESOLVED: any employee of this LLC who has achieved a grade level "I" or a grade level "J" is automatically elected to serve in the office of Partner of this LLC until his or her termination, removal or resignation from office or such other date as specified in this LLC's by-laws, whichever first occurs and further,

RESOLVED: the President of this LLC may appoint employees to serve in the office of Senior Partner of this LLC and each such Senior Partner shall serve in such office until his or her termination, removal or resignation from office or such other date as specified in this LLC's by-laws, whichever first occurs and further,

RESOLVED: that any elected Principal, Partner or Senior Partner of this LLC is authorized and empowered, in accordance with the guidelines set forth in the then in-effect Mercer Approval Procedures, to execute contracts, agreements, applications and other documents on behalf of the LLC.

Effective: February 11, 2010

Thomas L. Elliott

Roy A. Gonella

Diane O'Neill

Bobby Jindal
GOVERNOR

Kathy Kliebert
SECRETARY

Exhibit 3

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

May 13, 2014

Ms. Pamela Rice, Esq., Director
Office of Contractual Review, Division of Administration
P.O. Box 94095 Capital Annex – Room 207
Baton Rouge, Louisiana 70804-9095

RE: Justification for Out-of-State Contract and Request for Multi-Year Contract

Dear Ms. Rice:

The Department of Health and Hospitals' Bureau of Health Services Financing would like to contract with Mercer Heath and Benefits, LLC (hereafter "Mercer"), to function as the department's actuary for the Medicaid Bayou Health and Dental managed care programs. Mercer will be required to provide methods for, and calculation of, capitation rates, which must be actuarially sound and readily replicated according to federal law and regulations. Mercer has been providing excellent actuarial services to DHH for the past six years and has similar contracts to establish Medicaid rates for a number of other states. The expertise required for this type of work simply does not exist within Louisiana. The contractor will not be in the state for more than 30 days.

Through this letter, I am also requesting approval to enter into a three-year contract with Mercer. These actuarial services are required for the managed care contracts that are in place for almost all Medicaid recipients and it is anticipated that these contracts will be in place for a minimum of four more years. The department understands that payment for subsequent fiscal years shall be subject to the availability of funds.

We appreciate your assistance in this matter and we hope that you will give this contract your favorable consideration and approval.

Should you need further information, please contact me via telephone at (337) 233-9627 or via e-mail at jen.steele@la.gov.

Sincerely,

Jen Steele
Medicaid Deputy Director

MARSH & McLENNAN COMPANIES

STATEMENT OF RECOVERABILITY

Summary of Marsh & McLennan Companies Business Resiliency Program as of June, 2012

A cornerstone of Marsh & McLennan Companies client relationships is our commitment to the protection of client information and to our continuation of services, even in the event of a disaster. To support that commitment, we maintain a robust business resiliency program which includes conducting Business Impact Analyses; establishing and maintaining business resiliency, disaster recovery, crisis management and incident response plans; and testing of recovery capabilities, in order to ensure our ability to continue to serve and support our clients in the event of a business disruption.

Business Resiliency Management (BRM)

The Marsh & McLennan Companies Business Resiliency Management (BRM) Group provides business continuity guidance and overall program management to all of our operating companies (Marsh, Mercer, Guy Carpenter and Oliver Wyman). BRM also coordinates communications and other shared response resources, including emergency communication systems, business resiliency planning systems and external vendor contracts for items such as space in recovery locations and computer equipment for use in a recovery.

Business Resiliency/Disaster Recovery Plans

Marsh & McLennan Companies mandates that every one of our offices maintain Business Resiliency/Disaster Recovery plans with specific provisions for staff mobilization, alternate work spaces, recovery of network and telecommunications systems, restoration of data and communication with clients. These plans were created based on a Business Impact Analysis that identifies every location's recovery requirements and priorities.

The Business Resiliency/Disaster Recovery plans address loss of:

- Office facilities and personnel;
- Data, operating systems or application software; and
- Network services or mission-critical components

Our offices are required to maintain copies of their current Business Resiliency/Disaster Recovery plans in three separate locations: onsite, at an offsite storage facility, and on the Business Resiliency Management internet portal. Additionally, so that staff can effectively respond to any incident at any time, key employees keep a copy of the plan in their offices and at home.

Business Resiliency/Disaster Recovery plans include:

- Daily differential and weekly full backup cycles
- Daily and weekly onsite and offsite storage of backup files and documentation
- Ongoing cross-site replication of critical or high-volume data
- Staff and client notification of communications procedures and details
- Disaster impact assessment, timetables, and action plans
- Coordination of national assistance, if needed
- Plans for implementing long and short-term alternate operations

- Contingency plans to replace lost equipment
- Contingency plans to use other corporate or operating company offices, data centers and resources in the event of facility loss
- Contracts with external parties for data center and work-area equipment and facilities

Alternate Work Sites

Marsh & McLennan Companies uses a multi-layered matrix approach to providing alternate work sites in the event that an office is unable to provide service for any reason. This approach is aligned closely with each of our businesses and functions, and it recognizes important support requirements of all phases of our operations. In this matrix approach, our staff may work from any of the following places:

- Home, using high-speed internet connections and VPN to access internal data networks
- An alternate space, where prior arrangements for recovery support has been made
- Commercial fixed and mobile work sites
- Other corporate or operating company offices, either directly or where critical client support activity has been transferred

Local Office Technology

Local area networks in all Marsh & McLennan Companies offices use a fault-tolerant approach to system designs. That is, we have implemented technologies that limit our vulnerabilities in case of a systems failure, office location failure or natural disaster. Each office's computing environment is established using global standards that facilitate remote support.

All workstations are secured against use by unauthorized persons. Employees are required to enter a user ID and password to gain access to our systems and can enter only appropriate areas on the network.

Marsh & McLennan Companies uses a full range of commercial and custom software applications, all of which are centrally maintained and installed. Also, all employees use the same core suite of industry standard applications.

Data Backup

We back up data nightly (differential backup) and weekly (full backup). Backups are stored both at offsite storage facilities and in secured onsite data-storage facilities. We also perform cross-site replication of critical or high-volume data. The standardization of backup systems and storage procedures across our offices enables recovery efforts at alternate sites.

Operations at an Alternate Facility

Should there be a complete facility disaster, critical operations of an affected office can be up and running at another corporate or operating company facility within 72 hours for locations, processes and applications designated as Tier One. Alternate local equipment and facilities can be available within one week after the disaster.

MARSH & McLENNAN COMPANIES

Marsh & McLennan Companies maintains two strategic data centers in each of three global regions. Recovery plans for critical systems are aligned to the requirements specified by Business Impact Analyses and include:

- Recovery from a local data center to a strategic data center
- Recovery from one strategic center to another
- Recovery at a recovery services vendor site

Critical system recovery plans are tested and updated annually, with results reported to senior management and assessed by internal and external auditors.

Successful Plan Execution

Marsh & McLennan Companies has successfully supported critical business activities during disruptions of normal business processes resulting from both natural and man-made disasters. On each occasion where the Plan has been invoked, it has been executed successfully. Some examples include:

- Power Blackouts: Northeast US, Memphis (11 days)
- Potential Mass Transit Outages: New York, Los Angeles, Toronto
- Terrorist Activities: Spain Train Bombings, London Bombings; India Attacks
- Hurricanes: Bermuda, Cayman Islands, Florida, regions bordering the Gulf of Mexico
- Typhoons: Japan, China, Taiwan, India, and Philippines
- Pacific Tsunamis
- Flooding: Thailand, Major Data Center
- Pandemic: Sudden Acute Respiratory Syndrome (SARS), Influenza H1N1 (Swine Flu)
- WTO and G20 Global Summit Meetings (Pittsburgh, Toronto)
- Earthquakes: Chile, Japan, New Zealand (Christchurch)

Pandemic Preparedness

The Marsh & McLennan Companies Business Resiliency Management Group, in concert with our Health and Life Safety Committee, identifies and assesses the potential issues relating to communicable diseases and develops and helps implement protocols to mitigate the effect they may have on our operations, our colleagues, and our ability to serve clients.

The Marsh & McLennan Companies Business Resiliency Management Group and our Health and Life Safety Committee monitors and develops responses to communicable disease issues, including pandemics such as avian (H5N1) and swine (H1N1) flu, supported by third-party advisors such as International SOS, iJET Intelligent Risk Systems, and by risk and pandemic preparedness experts at our operating companies, including Marsh and Mercer.

MARSH & McLENNAN COMPANIES

Ongoing Commitment

At Marsh & McLennan Companies, planning for the continuity of business and service to our clients is part of the way we do business. We are committed to ensuring that our Business Resiliency, Disaster Recovery, Crisis Management and Incident Response plans are reviewed, updated and tested regularly.

(Rev.12/04)

SUMMARY OF INFORMATION

CONTRACTOR NAME	Amount
Mercer Benefits & Health, LLC	**$ 9,849,374.00**
CONTRACT DATES	**BA-22 ATTACHED**
Effective Date 05-16-2014 **Termination Date** 05-15-2017	☒

Certification Requirements: (Check Applicable Items)

☒ 1. Either no employee of this agency is both competent and available to perform the services called for by the proposed contract and/or the services called for are not the type readily susceptible of being performed by persons who are employed by the State on a continuing basis.

☒ 2. The services are not available as a product of a prior or existing professional, personal contract.

☒ 3. When applicable, the requirements for consultant contracts, as provided for under R.S. 39:1503-1507, have been complied with (proper documentation should be provided).

☒ 4. The using agency has developed and fully intends to implement a written plan providing for the assignment of specific using personnel to a monitoring and liaison function. Identify name of individual of staff unit responsible for monitoring this contract:

Name	**Phone No.**
Marisa Naquin	(504)568-8280
Location	
New Orleans, Louisiana	

Summary of Monitoring Plan: (This must include periodic review of specified reports, documents, exception reporting, or other indicia or performance, etc.). Additional pages may be attached if necessary.

The DHH contractor monitor will:
1. Be available for consultation by phone, e-mail, and face-to-face meetings to discuss priorities and provide direction;
2. Meet with the contractor weekly as necessary to ensure that work toward the completion of deliverables is being accomplished;
3. Review monthly activity reports; and
4. Review and approve monthly invoices.

The ultimate use of the final product of the services: (Specify)

The ultimate use will be the establishment of actuarially sound rates for Medicaid Bayou Health and Dental managed care programs as required by federal law and regulations.

☒ 5. Respond to questions A or B on all contracts except those funded by "Other Charges" (3600 series) of Budget:

A. What critical services will go unprovided and to whom?

Per member, per month rates cannot be paid to managed care entities to provide services to Medicaid eligibles unless certified by an actuary.

B. How many hours will the contractor have to work?

☒ 6. Completed monitoring report will be submitted to the Office of Contractual Review within **60** days after termination of contract. **(For Personal, Professional, Consulting contracts exceeding $20,000)**

☒ 7. The services have not been artificially divided to as to constitute a small purchase (not exceeding $20,000).

☒ 8. A cost-benefit analysis has been conducted which indicates that obtaining such services from the private sector is more cost-effective than providing such services the agency itself or by any agreement with another state agency and includes both a short-term and long-term analysis and is available for review.

☒ 9. The cost basis for the proposed contract is justified and reasonable.

☒ 10. A description of the specific goals and objectives, deliverables, performance measures and a plan for monitoring the services to be provided are contained in the proposed contract.

PRIOR CONTRACT INFORMATION MUST BE FILLED OUT (IF NO PRIOR CONTRACT PUT N/A)

PRIOR YEAR SERVICES PROVIDED BY (Contractor Name): Mercer Benefits & Health, LLC			
CFMS#: 702598	**DHH#:** 057414	**EFF:** 05-15-2011	**TERM:** 05-15-2014
AMOUNT: $ 7,226,501.00	**PREVIOUSLY ISSUED UNDER RFP?** IF YES, DATE: ☐ YES ☒ NO	DATE:	

Certification of Minimum Contract Content: (SOI) - Page 2

YES	NO		
☒	☐	1.	Contains a date upon which the contract is to begin and upon which the contract will terminate.
☒	☐	2.	Contains a description of the work to be performed and objectives to be met.
☒	☐	3.	Contains an amount and time payment to be made.
☒	☐	4.	Contains a description of reports or other deliverables to be received, when applicable.
☒	☐	5.	Contains a date of reports or other deliverables to be received, when applicable.
☒	☐	6.	When a contract includes travel and/or other reimbursable expenses, it contains language to effect the following:
☒	☐		A. Travel and other reimbursable expenses shall constitute part of the total maximum payable under the contract; (or)
☒	☐		B. No more than (a certain sum) of the total maximum amount payable under this contract shall be paid or received as reimbursement for travel and other reimbursable expenses; (and)
☒	☐		C. Travel expenses shall be reimbursed in accordance with Division of Administration Policy and Procedure memorandum 49 (The State General Travel Regulations).
☒	☐	7.	Contains the responsibility for payment of taxes.
☒	☐	8.	Contains the circumstances under which the contract can be terminated either with or without cause and contains the remedies for default.
☒	☐	9.	Contains a statement giving the Legislative Auditor the authority to audit records of the individual(s) or firm(s).
☒	☐	10.	Contains an assignability clause as provided for under LAC-4:4.
☒	☐	11.	Budget From BA-22, fully completed and attached to back of each contract.

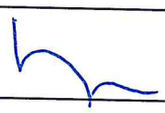
DETERMINATION OF RESPONSIBILITY

YES	NO		
☒	☐	1.	Had adequate financial resources for performance, or has the ability to obtain such resources as required during performance.
☒	☐	2.	Has the necessary experience, organization, technical qualifications, skills and facilities or has the ability to obtain them (including probable subcontractor arrangements).
☒	☐	3.	Is able to comply with the proposed or required time of delivery or performance schedule.
☒	☐	4.	Has a satisfactory record of integrity, judgment and performance (contractors which are seriously delinquent in current contract performance, considering the number of contracts and the extent of delinquencies of each, shall in the absences of evidence to the contrary or compelling circumstances presumed to be unable to fulfill this agreement).
☒	☐	5.	Is otherwise qualified and eligible to receive an award under applicable laws and regulations.
☒	☐	6.	If a contract for consulting services is for $50,000 or more: The head of the using agency has prepared, signed and placed in the contract file a statement of the facts on which a determination of responsibility of offer or potential subcontractors have been filed with the statement.
☒	☐	7.	On subcontracting, it has been established that contractors recent performance history indicates acceptable subcontracting systems; or, major subcontractors have been determined by the heads of the using agency to satisfy this standard

R.F.P. CONSULTING CONTRACTS FOR $50,000 OR MORE; UNLESS DETERMINED EXEMPT AS PER ACT 673 of 1985, R.S. 39:1494.1 (A).

☐ Contract file attached and this includes:
☐ Criteria for selection ☐ Proposals ☐ Pertinent Documents ☐ Selection Memorandum

PROGRAM / FACILITY SIGNATURE



OFFICE	PHONE NUMBER
Bureau of Health Services Financing	(337)233-9627

ASSISTANT SECRETARY OR DESIGNEE SIGNATURE

OFFICE

Bureau of Health Services Financing

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION

Date: 4/14/2014 Dept/Budget Unit/Program #: 09-305 / Prg 200

Dept/Agency/Program Name: DHH / Medical Vendor Administration / MVA OCR/CFMS Contract #: 728349

Agency/Program BA-22 # : 86 Agency/Program Contract #: 060056

Fiscal Year for this BA-22: 2013-2014 (yyyy-yy) **BA-22 Start/End Dates:** 05/16/14 (Start Date) 06/30/14 (End Date)

Multi-year Contract (Yes/No): Yes *If "Yes", provide contract dates:* 05/16/14 (Start Date) 05/15/17 (End Date)

Mercer Health & Benefits, LLC (Contractor/Vendor Name) 34201546302 (Contractor/Vendor No.)

Contractor to provide methods for development and calculation of capitation rates for Medicaid Managed Care Program and other support services that must be provdied by an actuary and other similarly qualified staff employed by contractor.

Contract Amendment (Yes/No): No **Amendment Start/End Dates:** (Start Date) (End Date)

Contract Cancellation (Yes/No): No **Date of Cancellation:**

(Provide rationale for amendment or cancellation)

This information is to be provided at the Agency/Program Level

MEANS OF FINANCING	AMOUNT			
	Current Year	%	Total Contract	%
State General Fund	$205,195.00	50.00%	$4,924,687.00	50.00%
Interagency Transfers	$0.00	0.00%	$0.00	0.00%
Fees and Self Gen.	$0.00	0.00%	$0.00	0.00%
Statutory Dedication	$0.00	0.00%	$0.00	0.00%
Federal	$205,195.00	50.00%	$4,924,687.00	50.00%
TOTALS	$410,390.00	100.00%	$9,849,374.00	100.00%

*Specify Source (i.e., grant name, fund name, IAT sending agency and revenue source, fee type and source, etc.)

Are revenue collections for funds utilized above in line with budgeted amounts? ***(Yes/No)*** Yes

If not, explain.

This information is to be provided at the Agency/Program Level

Name of Object Code/Category:	Professional Services
Object Code/Category Number:	3460
Amount Budgeted:	$262,192,561
Amount Previously Obligated:	$126,624,058
Amount this BA-22:	$410,390
Balance:	$135,158,113

The approval of the aforementioned contract will not cause this agency/program to be placed in an Object Category deficit.

Agy/Prg Contact: Jenny Borders
Name: Jenny Borders
Title: Medicaid Program Monitor
Phone: 225-342-1264

Reviewed/Approved By: Teresa Bravo
Name: Teresa Bravo
Title: Medicaid Program Manager 4
Phone: 225-342-9480

FOR AGENCY USE ONLY

AGENCY	PROGRAM	ACTIVITY	ORGANIZ.	OBJECT	REPT CAT	AMOUNT
305	200		7113	3460	4436	$410,390.00

From: Contract & Procurement Support [mailto:DHHNet@la.gov]
Sent: Thursday, May 15, 2014 8:10 AM
To: Stacy Guidry
Cc: Ruth Kennedy (DHH-MVA); LaShunda Sullivan (DHH); Carmen Valliere; Kristie Haydel
Subject: Contract Approval has completed on 728349 Mercer Health and Benefits, LLC

Contract Approval on 728349 Mercer Health and Benefits, LLC has successfully completed. All approval stages have completed.

305-010

Request for Expenditure Freeze Exemption

For DHH internal use only. Please do not send outside Department.

Agency Number and Name	Date
305-MVA	4/14/14

Category of Request (Double-click a checkbox, and then choose *Checked* under *Default value.*)

- ☐ Operating Services
- ☐ Supplies
- ☐ Travel
- ☒ Professional Services
- ☐ Acquisitions
- ☐ Other (Explain)

Source of Funding (Double-click a checkbox, and then choose *Checked* under *Default value.*)

☒ State General Fund ☐ Interagency Transfer ☐ Fees and Self-Generated ☒ Federal

Agency Number	Organization	Object	Amount
305	7113	3460	$9,849,374
			FY 14 - $410,390

Description of Request

Exemption request for CFMS# 728349, Mercer Health & Benefits, LLC

Justification of Request (Cite Executive Order BJ 14-04)

This contract is a professional services contract not automatically exempt from BJ 14-04. An exemption from that executive order is sought because the contractor provides actuarial services that are required by federal law for the operation of the Medicaid managed care health plans.

Preparer Name	Preparer Title	Preparer Phone Number
Stacy Guidry	Medicaid Program Manager 1-B	337-857-6115

Assistant Secretary or Medicaid Director Signature	Assistant Secretary or Medicaid Director Date
Ruth J Kennedy	4-16-14
Undersecretary Signature	**Undersecretary Date**
	4-17-14

☒ Approved by Undersecretary ☐ Disapproved by Undersecretary

TAC