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Ms. Mary Johnson
BAYOU HEALTH Program Director
Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821

November 6, 2013

Subject: Louisiana BAYOU HEALTH Program – Overview of methodology for developing the physician fee increase adjustments for the prepaid rates, effective January 1 through June 30, 2013

Dear Ms. Johnson:

This letter outlines the methodology that Mercer Government Human Services Consulting (Mercer) used in developing the Affordable Care Act (ACA) Section 1202 physician fee increase adjustments for the State of Louisiana's BAYOU HEALTH prepaid program rates for the period January 1 through June 30, 2013 (CY 13A).

Rate Methodology

Overview

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

Base Data

There have been no changes made to the base data in the development of the revised rate ranges. For more details related to the development of the base data, please refer to Mercer's January 17, 2013 certification letter and supporting documents.

Administration/Profit Loading

With respect to the per-member-per-month (PMPM) add-ons developed to address the PCP fee increase (described in more detail below), Mercer added an appropriate administration/profit load specific to those PMPM add-ons. Based on an analysis of fixed and variable administrative costs for consideration of these additional services, Mercer utilized half of the administration/profit load applied in the CY 13A rate development. The overall administration/profit load factor used in the

development of the PCP PMPM add-ons was 6.74%. For more detail related to the development of the original administration/profit load, please refer to Mercer's January 17, 2013 certification letter and supporting documents.

Other Elements

There have been no changes made to the trends, prior program changes analyses, the rate range modeling approach, or any of the other rate development components. For more details related to these elements of the certification, please refer to Mercer's January 17, 2013 certification letter and supporting documents.

Physician Fee Increase for Primary Care Services Under ACA Section 1202

CMS completed their review and approved the Louisiana Department of Health and Hospitals (Department) State Plan Amendment (SPA) LA-13-12 on June 6, 2013, which authorized increased payments to physicians in accordance with Section 1202 of the ACA. Additionally, CMS approved Louisiana's managed care methodology for implementation of the PCP fee increase on July 11, 2013. Consistent with the approved SPA and managed care methodology, the following sections describe the approach Mercer used to calculate the applicable adjustment to the CY 13A capitation rates, including components critical to the Department's ability to claim the portion of the capitation rates eligible for the enhanced 100% federal financial participation (FFP) associated with the PCP increase.

Summary of Methodology

In accordance with the approved managed care methodology, the Department has opted to utilize the prospective capitation risk model with a retrospective reconciliation (Model 2). Under this approach, the higher costs associated with complying with the PCP increase rule are reflected in the capitation rates via a PMPM add-on specific to the PCP increase. Combining the rate ranges prior to the PCP PMPM increase with the PCP PMPM increase produces the revised CY 13A certified rate ranges. The PCP PMPM add-ons for each category of aid are displayed in attachment A.

The Department will pay capitation rates to the contracted managed care organizations (MCOs) prospectively that are inclusive of the enhanced PCP fees and expected utilization. The Department will reconcile with the MCOs based on actual utilization, retrospectively. Thus, the capitation rates paid will be inclusive of the enhanced PCP fees and expected utilization, with actual data being used to reconcile the expected utilization with actual utilization. Based on the difference in utilization actually experienced, the Department will reimburse/recoup from the MCOs the unit cost differential between the original CY 13A unit costs and the updated (reflective of Medicare fees) CY 13A aggregate unit costs, multiplied by the differing utilization. All

calculations will be performed separately for evaluation and management codes versus vaccine administration codes.

Data Sources

Capitated managed care under the BAYOU HEALTH prepaid program did not exist until February 2012 and was not fully phased in until July 2012. Therefore, Mercer utilized historical state fiscal year (SFY) 2010 and 2011 fee-for-service (FFS) base data (the same data source used in the CY 13A rate development) to determine the portion of the capitation rates attributed to qualifying PCP services. The data sources utilized represent the best and most reliable data available to Mercer and the Department.

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

Calculation of the CY 13A Rate Unit Costs

To calculate the portion of the capitation rate attributed to qualifying PCP services in CY 13A, Mercer analyzed the FFS data and calculated, by individual procedure code, SFY 2010 and 2011 unit costs associated with the applicable services eligible for the PCP increase. The SFY 2010 and 2011 unit costs include base cost adjustments (incurred but not reported (IBNR) and other) applied to each year separately, utilizing the same factors as the CY 13A rate development. Please refer to the CY 13A rate certification dated January 17, 2013, for further details regarding the base cost adjustments discussed above. Once the adjusted SFY 2010 and 2011 unit costs were calculated, Mercer utilized actual professional and immunization services fee schedules provided by the Department to calculate a one-time fee adjustment factor to account for any fee cuts made between the base data time period and the rate effective period. The resulting adjusted SFY 2010 and 2011 unit costs were then blended at a 40/60 rate, respectively, consistent with CY 13A rate development methodology. Aggregate SFY 2010 and 2011 unit costs were then developed by multiplying unit costs at procedure code level by expected CY 13A utilization and dividing by total CY 13A expected utilization, respectively. These calculations were completed by category of aid, and separately for evaluation and management codes versus vaccine administration codes. The resulting unit costs are displayed in Attachment A, identified with the label {Adjusted Unit Cost (FFS)}.

2013 Medicare Fee Schedule Rates

The 2013 Medicare fee schedule rates are those used in the FFS program using the methodology approved in the SPA based on the 2009 conversion factor and 2009 relative value units, consistent with the geographic practice cost index (GPCI) schedule published by CMS in January 2013. The 2013/2014 Medicare rates utilized will conform to the approach Louisiana's FFS program utilizes for each of the specified evaluation and management, and vaccine billing codes. The rates are statewide and reflect the mean value among all counties (parishes) for each code and were developed using the following formula (per attachment 4.19-B in the SPA): Mean over all parishes/counties per code = (4/64 x GPCIs for Region 01) + (60/64 x GPCIs for Region 99), in which Region 01 and Region 99 represents New Orleans and the rest of Louisiana, respectively.

For vaccine administration codes, Louisiana is utilizing the computed 2013 Medicare rate utilized in the FFS program as approved in the SPA. The 2013 100% of Medicare benchmark unit costs are displayed in Attachment A, identified with the label {Medicare CY 2013 Unit Cost (CMS)}.

Calculation of the CY 13A Rate Unit Costs Attributed to Qualifying PCP Services

To account for utilization for payment levels already above 100% of Medicare, Mercer only considered into its PCP increase calculations, base utilization for codes paid below the 2013 Medicare fee schedule. For the codes paying above 100% of Medicare, the current payment levels were maintained in the calculation.

The unit cost levels inherent in the CY 13A rates were compared to the adjusted 2013 Medicare fee schedule rates. The differential between the adjusted 2013 Medicare fee schedule rates and the CY 13A unit costs by individual procedure code determines the unit cost rate adjustment needed to bring the overall capitation rate to a level that compensates MCOs with an appropriate amount to be able to pay at least the 2013 Medicare fee schedule benchmark (in other words, the amount attributed to the qualifying PCP services in the updated rates). By utilizing the adjusted 2013 Medicare benchmarks for this calculation, Mercer has accounted for payment levels made above 100% of Medicare to ensure those costs do not artificially reduce the amount needed to bring payment levels up to 100% of Medicare. Also, Mercer separated physician and advanced practice registered nurse and physician assistant claim data to account for these providers being reimbursed at 80% of physician fees. The CY 13A unit cost differentials were calculated by category of aid for the evaluation and management codes, separately from vaccine administration codes, and are displayed in Attachment A, identified with the label {Difference in Unit Cost}. This amount will also be used in the calculation of the rate differential eligible for enhanced 100% federal match as described in the Federal Claiming section of this letter.

CY 13A PCP Utilization

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

To calculate the estimated CY 13A PCP utilization, Mercer analyzed SFY 2010 and 2011 FFS data and calculated, by individual procedure code, SFY 2010 and 2011 utilization associated with the eligible providers for the PCP increase. The SFY 2010 and 2011 utilization includes base period adjustments (IBNR and other) applied to each year separately and trended forward to the midpoint of the rating effective period. Mercer utilized base adjustments and utilization trends consistent with the physician services trends in the CY 13A rate development. Please refer to the CY 13A rate certification dated January 17, 2013 for further details regarding the base adjustments and utilization trends discussed above. The resulting adjusted SFY 2010 and 2011 utilizations were then blended at a 40/60 rate, respectively, in order to be consistent with CY 13A rate development methodology. Also, Mercer applied a one-time induced utilization factor to capture the expected additional utilization created by higher reimbursement rates. The overall, aggregate induced utilization factor was set at a 1.1% increase.

These calculations were completed by category of aid, and separately for evaluation and management codes versus vaccine administration codes. The expected utilization for CY 13A is displayed in Attachment A, identified with the label {Adjusted Trended Utilization/1000 (FFS)}.

CY 13A PCP Procedure Fee Differential PMPM

For purposes of prospective capitation payments under the Model 2 methodology, Mercer calculated the PMPM add-ons associated with the increased costs of implementing the ACA Section 1202 PCP fee increase separately for evaluation and management codes and vaccine administration codes. The vaccine administration fee differential was calculated using an aggregate weighted average of 2013 vaccines for children Medicare rates by age group across the SFY 2010 and 2011 utilization data. The resulting weighted average vaccine administration Medicare rates were utilized as the benchmark for comparison to the unit costs inherent in the CY 13A capitation rates. The CY 13A procedure fee differential PMPMs, excluding administration/profit loading and premium tax, are displayed in Attachment A, identified with the label {Projected PMPM for Total ACA PCP Claims Increase}. The CY 13A procedure fee differential PMPMs, including administration/profit loading and premium tax, are displayed in Attachment A, identified with the label {Projected PMPM for Total ACA PCP Rate Increase}.

Reconciliation Process

In accordance with the approved managed care methodology, the Department will reconcile payments made to the MCOs through the prospective capitation rates with actual utilization reported by the MCOs at the 2013 Medicare computed FFS fee schedule also utilized by the Medicaid FFS program. The Department is requiring each MCO to submit detailed, semi-annual files with claims data on each applicable code for eligible providers, documenting the paid amount made to the providers. Since the various reconciliation components described in this letter were calculated at a category of aid level and not at specific age categories, the reconciliation process will be completed at the same level to ensure consistency. Once the Department receives the semi-annual files documenting the appropriate payments by code to the eligible PCPs, the Department will reconcile with the MCOs and CMS any overpayment or underpayment. The MCO will be reimbursed (or funds recouped) through the reconciliation process for the amount of unit cost rate differential (the aggregate unit cost differential established in the process of the capitation rate adjustment defined above and not based on the individual current payment amounts) based on actual utilization relative to the utilization level utilized in the capitation rate development. This step will include detailed instructions to the MCOs on how to document to the Department utilization and unit cost rate paid for PCPs. *Note: this reconciliation will be performed separately for evaluation and management codes versus vaccine administration codes.*

Certification of Revised Rate Ranges

In preparing the rate ranges underlying the rates shown in Attachment A, Mercer has used and relied upon enrollment, FFS claims, reimbursement level, benefit design, and other information supplied by the Department and its fiscal agent. The Department and its fiscal agent are responsible for the validity and completeness of the data supplied. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. In our opinion, it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

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

Rates and ranges developed by Mercer are actuarial projections of future contingent events. Actual BAYOU HEALTH plan costs will differ from these projections. Mercer has developed these

rates on behalf of the Department to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and in accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

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

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

Rate-Setting Documentation for Federal Claiming

In addition to the Department's approved managed care methodology and the CY 13A capitation rates described in the January 17, 2013 certification letter and supporting documentation, the following section provides the additional rate-setting documentation required in Section 6 of the CMS "Technical Guidance and Rate Setting Practices" checklist for Section 1202. For the Department's use in claiming the portion of the capitation rates eligible for enhanced 100% FFP associated with the PCP increase, Mercer calculated the aggregate 2009 base rate, and the differential between the aggregate Medicare rate and the aggregate 2009 base rate, to determine the amount eligible for 100% federal match. The following sections describe each component.

Calculation of the 2009 Base Rate Unit Costs

To calculate the 2009 base rate unit costs (for federal claiming purposes), Mercer utilized the July 2009 Medicaid fee schedule, as there was no capitated managed care in Louisiana in 2009. The aggregate 2009 base rate was developed by multiplying July 2009 unit costs at procedure code level by expected CY 13A utilization and dividing by total expected CY 13A utilization. This puts the 2009 unit costs on a comparable basis with the CY 13A unit costs. For any procedure code with expected utilization in CY 13A, in which there was no unit cost rate assumed in the 2009 Medicaid fee schedule rate, the unit cost and associated CY 13A utilization included in the calculations described above were excluded from the aggregate calculation (this exclusion had an immaterial impact on the final aggregate unit costs). This is the same CY 13A utilization that was applied in the calculation of the 2013 Medicare fee schedule rates to establish a comparable

aggregate unit cost level. The calculated aggregate 2009 base rate unit costs are displayed in Attachment B, identified with the label {July 2009 "Base Rate" Unit Cost}.

Calculation of the PMPM Differential That Qualifies for 100% FFP

As the Department is using Risk Model 2, the portion of the CY 13A PCP capitation payment that is eligible for 100% FFP is determined by calculating the difference between the base 2009 aggregate weighted average unit cost calculation and the aggregate weighted average unit costs in the 2013 Medicare rate. Also, any additional payments (or recoupment) made through annual utilization reconciliation of the unit cost differential only are eligible for 100% FFP. Using the projected utilization assumed in the CY 13A capitation rates, the differential was put on a total dollar basis by multiplying the unit cost differential by the expected CY 13A utilization. This calculation was performed separately for evaluation and management codes versus vaccine administration codes, and by category of aid. The calculated unit cost differentials and total dollar amounts (excluding administration/profit and premium tax) are displayed in Attachment B, identified with the labels {Difference in Unit Cost (Medicare 2013–July 2009)} and {100% FFP Total Amount}.

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

As the capitation rates paid at the time of this submission include unit costs below the 2009 unit cost levels, the Department will claim only the regular State federal medical assistance percentage (FMAP) for capitation payments or additional payments representing unit costs up to the 2009 levels. The portion of the CY 13A PCP capitation payment that is eligible for regular State FMAP is determined by calculating the difference between the CY 13A base aggregate weighted average unit cost calculation and the aggregate weighted average unit costs in the 2009 rate. Using the projected utilization assumed in the CY 13A capitation rates, the differential was put on a total dollar basis by multiplying the unit cost differential by the expected CY 13A utilization. This calculation was performed separately for evaluation and management codes versus vaccine administration codes, and by category of aid. The calculated unit cost differentials and total dollar amounts (excluding administration/profit and premium tax) are displayed in Attachment B, identified with the labels {Difference in Unit Cost (July 2009 – Base)}, and {Regular State FMAP Total Amount}.

All amounts for MCO administration and underwriting gain, including taxes and fees, will be claimed at the State's regular FMAP rate, as they are not eligible for 100% federal match according to CMS requirements. The federal share of any MCO recoupment resulting from the reconciliation with the MCOs will also be returned to CMS in accordance with regular CMS 64 claiming rules at the applicable match rate.

If you have any questions on any of the information provided, please feel free to call me at +1 404 442 3249.

Sincerely,

Sudha Shenoy

Sudha Shenoy, FSA, MAAA, CERA
Principal

MERCER

Attachment A

BAYOU HEALTH ACA 1202
January 2013–June 2013 (CY 13A)

Jan-Jun 2013 PCP PMPM Exhibit - Best Estimate

	ACA PCP Utilization				ACA PCP Unit Cost			Increase from ACA PCP Changes				ACA PCP Impact		
Procedure Code Set	SFY 10 & 11 Utilization/1000 (FFS)	Trended & Adjusted Utilization/1000 (FFS)	Induced Utilization*	Adjusted Trended Utilization/1000 (FFS)	SFY 10 & 11 Unit Cost (FFS)	Adjusted Unit Cost (FFS)	Medicare CY2013 Unit Cost (CMS)	Difference in Unit Cost	Total ACA PCP Dollars	Attestation Factor	Attestation Adj. ACA PCP Dollars	CY 13A MMs	Projected PMPM for Total ACA PCP Claims Increase	Projected PMPM for Total ACA PCP Rate Increase
All Vaccines														
SSI	210	244	1.1%	247	$ 11.98	$ 11.59	$ 17.40	$ 5.81	$ 50,689	100%	$ 50,689	423,906	$ 0.12	$ 0.13
TANF	973	1,109	1.0%	1,120	$ 11.45	$ 11.09	$ 16.30	$ 5.20	$ 1,117,545	100%	$ 1,117,545	2,300,928	$ 0.49	$ 0.53
FCC	810	942	1.1%	952	$ 11.72	$ 11.35	$ 16.90	$ 5.55	$ 10,311	100%	$ 10,311	23,418	$ 0.44	$ 0.48
BCC	11	13	1.1%	13	$ 14.05	$ 13.57	$ 24.87	$ 11.30	$ 58	100%	$ 58	4,812	$ 0.01	$ 0.01
Total	852	972	1.0%	983	$ 11.47	$ 11.12	$ 16.34	$ 5.23	$ 1,178,604	100%	$ 1,178,604	2,753,064	$ 0.43	$ 0.47
Primary Medical														
SSI	2,237	2,599	1.1%	2,627	$ 73.18	$ 70.46	$ 97.98	$ 27.52	$ 2,553,523	100%	$ 2,553,523	423,906	$ 6.02	$ 6.61
TANF	1,897	2,163	1.0%	2,185	$ 61.65	$ 59.34	$ 83.70	$ 24.36	$ 10,207,910	100%	$ 10,207,910	2,300,928	$ 4.44	$ 4.87
FCC	2,133	2,478	1.1%	2,504	$ 57.16	$ 55.02	$ 78.53	$ 23.51	$ 114,906	100%	$ 114,906	23,418	$ 4.91	$ 5.38
BCC	2,481	2,882	1.1%	2,913	$ 59.78	$ 57.58	$ 79.32	$ 21.74	$ 25,389	100%	$ 25,389	4,812	$ 5.28	$ 5.79
Total	1,952	2,234	1.1%	2,257	$ 63.64	$ 61.29	$ 86.20	$ 24.91	$ 12,901,728	100%	$ 12,901,728	2,753,064	$ 4.69	$ 5.14
Grand Total														
SSI	2,448	2,844	1.1%	2,874	$ 67.92	$ 65.40	$ 91.05	$ 25.65	$ 2,604,209	100%	$ 2,604,209	423,906	$ 6.14	$ 6.74
TANF	2,870	3,271	1.0%	3,306	$ 44.64	$ 42.99	$ 60.86	$ 17.87	$ 11,325,405	100%	$ 11,325,405	2,300,928	$ 4.92	$ 5.40
FCC	2,943	3,420	1.1%	3,456	$ 44.64	$ 43.00	$ 61.56	$ 18.57	$ 125,216	100%	$ 125,216	23,418	$ 5.35	$ 5.86
BCC	2,491	2,895	1.1%	2,926	$ 59.58	$ 57.39	$ 79.08	$ 21.69	$ 25,447	100%	$ 25,447	4,812	$ 5.29	$ 5.80
Grand Total	2,805	3,206	1.1%	3,240	$ 47.79	$ 46.07	$ 65.01	$ 18.94	$ 14,080,276	100%	$ 14,080,276	2,753,064	$ 5.11	$ 5.61

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

Notes:

- Figures include only procedure codes included in the Louisiana SPA.
- Utilization and Unit Cost figures are based off of procedure codes by rate tier where the Medicare CY2013 CMS rates exceeds the FFS rates.

MARSH & McLENNAN COMPANIES

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Attachment B

BAYOU HEALTH ACA 1202
January 2013–June 2013 (CY 13A)

Jan-Jun 2013 PCP FMAP Funding Exhibit - Best Estimate

		ACA PCP Change to Unit Cost			Increase from ACA PCP Changes			
Procedure Code Set	Adjusted Trended Utilization/1000 (FFS)	Adjusted Base Unit Cost (FFS)	July 2009 "Base Rate" Unit Cost	Medicare CY2013 Unit Cost (CMS)	Difference in Unit Cost (July 2009 - Base)	Regular State FMAP Total Amount (July 2009 - Base)	Difference in Unit Cost (Medicare CY2013 - July 2009)	100% FFP Total Amount (Medicare CY2013 - July 2009)
All Vaccines								
SSI	247	$ 11.59	$ 12.36	$ 17.40	$ 0.77	$ 6,726	$ 5.04	$ 43,963
TANF	1,120	$ 11.09	$ 11.74	$ 16.30	$ 0.65	$ 139,251	$ 4.55	$ 978,295
FCC	952	$ 11.35	$ 12.04	$ 16.90	$ 0.69	$ 1,276	$ 4.87	$ 9,035
BCC	13	$ 13.57	$ 15.22	$ 24.87	$ 1.65	$ 8	$ 9.65	$ 49
Total	983	$ 11.12	$ 11.77	$ 16.34	$ 0.65	$ 147,262	$ 4.58	$ 1,031,342
Primary Medical								
SSI	2,627	$ 70.46	$ 77.52	$ 97.98	$ 7.06	$ 655,337	$ 20.46	$ 1,898,186
TANF	2,185	$ 59.34	$ 62.78	$ 83.70	$ 3.44	$ 1,441,926	$ 20.92	$ 8,765,985
FCC	2,504	$ 55.02	$ 58.01	$ 78.53	$ 2.99	$ 14,612	$ 20.52	$ 100,293
BCC	2,913	$ 57.58	$ 67.01	$ 79.32	$ 9.43	$ 11,018	$ 12.30	$ 14,371
Total	2,257	$ 61.29	$ 65.38	$ 86.20	$ 4.10	$ 2,122,893	$ 20.81	$ 10,778,835
Grand Total								
SSI	2,874	$ 65.40	$ 71.92	$ 91.05	$ 6.52	$ 662,062	$ 19.13	$ 1,942,146
TANF	3,306	$ 42.99	$ 45.48	$ 60.86	$ 2.49	$ 1,581,169	$ 15.37	$ 9,744,235
FCC	3,456	$ 43.00	$ 45.35	$ 61.56	$ 2.36	$ 15,889	$ 16.21	$ 109,328
BCC	2,926	$ 57.39	$ 66.79	$ 79.08	$ 9.40	$ 11,026	$ 12.29	$ 14,420
Grand Total	3,240	$ 46.07	$ 49.12	$ 65.01	$ 3.05	$ 2,270,146	$ 15.89	$ 11,810,130

Notes:
- Figures include only procedure codes included in the Louisiana SPA.
- Utilization and Unit Cost figures are based off of procedure codes by rate tier where the Medicare CY2013 CMS rates exceeds the FFS rates.

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