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November 20, 2015

Subject: Louisiana Bayou Health Program – Specialized Behavioral Health (BH) Actuarial Certification for Capitation Rate Ranges Effective December 1, 2015 through January 31, 2016

Dear Jen:

The State of Louisiana (State) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop actuarially sound capitation rate ranges for use in the State's contracts with the managed care organizations (MCOs) for Medicaid Specialized BH services provided to Medicaid-eligible adults and children in the Bayou Health program. The rate ranges were developed for specialized BH services covered under the managed care program for Medicaid-eligible adults and children for the contract period, effective from December 1, 2015 through January 31, 2016 (rating period).

This letter presents an overview of the analyses and methodology used in Mercer's managed care rate range development for Medicaid services for the purpose of satisfying the requirements of the Centers for Medicare and Medicaid Services (CMS) in a manner consistent with CMS regulations, 42 CFR 438.6(c).

Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government-mandated assessments, fees and taxes, and the cost of capital.

This letter describes the development of the draft rate ranges in Appendix B. The assumptions detailed in the memo illustrate the development of the midpoint rates for each rate cell on a statewide basis. The regional development of the rate ranges is included in the Appendices, which include the individual impacts of the programmatic change adjustments by region and rate cell.

Program Overview

The Louisiana Behavioral Health Partnership (LBHP) began March 1, 2012, and has operated under an at-risk capitation contract for the Adult population since the program inception. The Children's program has been administered on a non-risk basis by the Prepaid Inpatient Health Plan (PIHP). Effective December 1, 2015, the specialized BH services will be covered under the contracts with the Bayou Health MCOs. The initial rating period will be December 1, 2015 through January 31, 2016 to align with the remainder of the current Bayou Health rating period. Effective February 1, 2016, the specialized BH services will be integrated into the overall Bayou Health rating structure.

Separate capitation payments will be made for specialized behavioral health services effective December 1, 2015. The MCOs will continue to receive a payment for prior Bayou Health covered services under the Bayou Health rate cell structure. In addition, a separate payment will be made for eligible individuals for their specialized behavioral services under the current LBHP rate cell structure as outlined later in this letter.

Covered Populations

Bayou Health covers a broad array of Medicaid eligible populations. Specific information on the covered populations is contained in the contract. The following categories of aid (COA) are covered for a BH capitated payment under the contract and considered in rate setting:

- Non-Disabled Adults, Ages 21+
- Disabled Adults, Ages 21+
- Dually Eligibles, All Ages
- Non-Disabled Children, Ages 0-20
- Foster Care and Disabled Children, Ages 0-20

Mercer summarized the specialized behavioral health service utilization and cost data for the Medicaid eligible individuals into the rate cell structure. This structure is based on the prior LBHP rate structure for specialized BH services from Mercer's review of the historical cost and utilization patterns in the available experience.

The historical BH costs vary by age and eligibility category. Separate rate cells were designed for the Child and Adult populations. Non-Disabled populations have significantly lower BH costs compared to Disabled/Foster Care populations. As such, separate rate cells were created for the non-Disabled and Disabled/Foster Care populations. The dually eligible population is eligible for services where Medicare is the primary payer. As the Medicare crossover services will be excluded from the Bayou Health capitated program, a separate rate cell was necessary to address

the cost differences for the dually eligible populations. Due to the small number of dual eligibles under the age of 21, Mercer included all dual eligibles regardless of age into a single rate cell.

Populations that remain fee-for-service (FFS) or part of the non-risk program and are not covered under the capitation payment are as follows:

- Eligible under the Refugee Cash/Medical Assistance program
- Eligible under the Medicare Savings Program (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, Qualified Individuals, and Qualified Disabled Working Individuals)
- Eligible under the Emergency Services Only program (aliens who do not meet Medicaid citizenship/ 5-year residency requirements)
- Eligible under the Long-Term Care Medicare Co-insurance program
- Eligible under the Section 1115 Greater New Orleans Community Health Connection Waiver
- Eligible under the Family Planning Eligibility Option (FPEO) that provides family-planning-services
- Eligible under the Program of All-Inclusive Care for the Elderly (PACE), a community-based alternative to placement in a nursing facility that includes a complete “managed care” type benefit combining medical, social and long-term care services
- Adults residing in Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD)
- Non-Medicaid adult on the eligibility file who is eligible for a Low-Income Subsidy program administered by the Social Security Administration
- Any Medicaid eligible person during a period of incarceration

Covered Services

The Bayou Health program will cover a broad array of specialized mental health and addiction services, including the following services covered under the State Plan:

- Inpatient Psychiatric Hospital services
- Psychiatric Emergency Room services
- Outpatient Psychiatric services
- Crisis Intervention services
- Community Psychiatric Support services
- Addiction services.
- Assertive Community Treatment
- Multi-systemic Treatment
- Medical Physician / Psychiatrist / Nurse Practitioner

- Psychosocial Rehabilitation
- Other BH Professional (Mental Health (MH) Providers and Clinics, Nurses, and Other Licensed Providers)
- Federally Qualified Health Center (FQHC)
- Psychiatric Residential Treatment Facility
- Therapeutic Group Home
- 1915(b)(3) Services - Case Conference

Medicaid eligibles receive Physical Health and other Medicaid-covered services from the Bayou Health MCOs or through the State's fee-for-service (FFS) program. The acute care portion of Bayou Health includes coverage for prescription drugs for both Physical Health and BH medications. As such, prescription drugs are not included in these capitation rate ranges nor any prescription drug considerations discussed in this letter.

Children who are enrolled in the CSoC 1915(c) waiver program or included in the 1915(b)(3) CSoC program will only be in Bayou Health for Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH) and Substance Use Disorder (SUD) Residential services in terms of BH coverage. The other specialized BH services will be managed by Magellan. More information on CSoC considerations is included later in this letter. The State maintains a list of the individuals enrolled in the CSoC program as well as a waiver segment code on the eligibility records. This logic was utilized to exclude the requisite services from the rate development.

For the dually eligible individuals, Medicare crossover claims have been excluded from the base data and rate development. These services are paid directly by the State after coordinating with Medicare and have been excluded from the services covered under the capitation rates.

This actuarial certification is specific to the capitation rates for the Specialized BH portion of the Bayou Health program effective December 1, 2015 through January 31, 2016.

Rate Methodology

Overview

Capitation rate ranges for the Specialized BH services were developed in accordance with rate-setting guidelines established by CMS. One of the key considerations in the development of the rate ranges was the base data. The primary base data used to develop the rate ranges were managed care encounter data provided by the State.

The encounter data are submitted by the PIHP to the State's fiscal agent, Molina. Molina provided an extract of the encounter data to Mercer in March 2014 for use in the preparation of the Data

Book. The encounter data extract included recipient-level claims and utilization detail. The eligibility information used in the encounter data analysis is summarized from the State's eligibility file, which outlines enrollment segments for each member. The contents of the Data Book are consistent with the data summarized for the current LBHP rate period of March 2015 through November 2015 with the exception of additional breakouts by region. The decision was made to utilize the same base data for the December 2015 through January 2016 rate development and prepare updated Data Books for Specialized BH services with the use of 2014 data for the February 2016 rates consistent with the plan for the Bayou Health program.

Mercer reviewed the Specialized BH contract to identify covered services. Then, the following adjustments to the base data were evaluated:

- Trend factors to forecast the expenditures and utilization for the rating period
- Programmatic changes not reflected in the base data
- Managed care adjustments
- Administration and risk margin loading

The various steps in the rate range development are described in the following paragraphs.

Base Data

The base data used to establish the capitation rates are summarized in the Data Book. The Data Book contains demographic, cost, and utilization data related to specialized BH services only. The Data Book is included along with this certification letter.

PIHP Encounter Data

The State provided Mercer with 2012 and CY 2013 encounter data submitted by the PIHP for services delivered to adults (on an at-risk basis) and children (on a non-risk basis). Mercer used this data to support the rate calculations. After review of the data, Mercer determined that actual experience incurred from January 1, 2013 through December 31, 2013, paid through February 2014 was suitable for rate development and as noted consistent with the Data Book utilized in the development of the March 2015 through November 2015 rates. Data prior to this time period reflected lower volume of services as the adult managed care program began in March, 2012.

Mercer performed a review of the PIHP encounter data for the State. This review included:

- Checks for month-to-month consistency of claims and eligibility
- Checks for reasonability of the utilization and unit cost information
- Comparisons to PIHP financial data and historical FFS data

- Analysis of claims lag triangles

Note that Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, and financial data and information supplied by the State and the PIHP. The State and the PIHP are solely responsible for the validity and completeness of these supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion they are appropriate for the intended rate-setting purpose. However, if the data and information are incomplete and/or inaccurate, the values shown in this report may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this report.

Base Data Adjustments

After analysis of historical payment patterns and discussions with the State, Mercer was able to assess the accuracy and completeness of the information and estimate any necessary adjustments. Mercer applied adjustments to the encounter data so that they reflected the populations and services covered under the contract, including the considerations of the new mixed services protocol effective March 2015.

Mercer reviewed the PIHP encounter data to ensure they were appropriate for the populations and services covered. The following items were not included in the encounter data or were already deducted from the paid amounts in the encounter data, and therefore no further adjustment was necessary:

- Third-party liability recoveries are already deducted from the payments used in rate setting. No material amounts were paid outside the claim system.
- Copayments, coinsurance, and deductibles
- Disproportionate Share Hospital payments (AA.3.5)

Mercer understands that payment rates for Graduate Medical Education (GME) hospitals included in the claim data are consistent with applicable State fee schedule rates which do not include the GME portion of Inpatient payments. Because Mercer relied on the payment information included in the dataset submitted by the PIHP, the GME portion of Inpatient payments are not included in the base data and won't be included in the capitation rates. The State will continue to make supplemental payments to hospitals for GME, as applicable.

Completion factors were applied to the encounter data to reflect claims not yet adjudicated (see step AA.3.14 in the CMS Rate-setting Checklist). Financial lags were available separately for

Inpatient and all other services. Mercer compared the results of the encounter completion analysis to the financial lags to evaluate whether an encounter underreporting adjustment was necessary. .

For more information on the adjustments listed above, please refer to Section 4 of the Data Book included in this submission.

Other Base Data Considerations

Excluded Populations and Services

Certain adjustments were not necessary due to exclusions made in the data summarization process. These adjustments include:

- **Excluding non-covered populations** (for example, qualified Medicare beneficiaries, Medically Needy spend-down individuals, etc., see step AA.2.1) — Please see Data Book Section 2 for more information.
- **Excluding non-covered services** (for example, Physical Health services, 1915(c) Waiver services, etc., see step AA.3.1) — Please see Data Book Section 3 for more information.

State Plan Service Considerations

The rate development considers expected costs for State Plan services delivered in a managed care environment. In some cases for the Adult population, the prior PIHP provided an approved service in-lieu-of a State Plan service. In these cases, Mercer has reflected the costs of the State Plan service and applied a managed care discount to arrive at total costs consistent with actual paid expenses. The table below identified the key services priced using this methodology.

2013 Paid Encounter Claims

State Plan	In Lieu Of	Non-Dual	Dual Eligble	Encounter Unit Cost	State Plan Unit Cost	Managed Care Discount
Inpatient	IP IMD (21-64)	$ 13,021,841	N/A	$ 489.45	$ 646.94	-24%
Acute Detox Facilities	SUD Residential	$ 4,163,515	$ 338,654	$ 67.14	$ 145.51	-54%
ER	Crisis	$ 141,408	$ 25,365	$ 81.79	$ 249.12	-67%

The unit costs for the in-lieu-of services was less than the alternative State Plan services, demonstrating the cost-effectiveness of these services.

New Mixed Service Protocol

The State has implemented changes to the services classified as specialized behavioral health services. Previously, Institutional services (Inpatient, Outpatient, and ER) were covered as specialized behavioral health services under LBHP if the claim was identified with a qualifying BH

diagnosis. Effective March 1, 2015, only claims from BH facilities or services provided by BH specialists will be classified as specialized behavioral health services, as described below.

- **Inpatient and Outpatient services —** BH facilities include freestanding psychiatric hospitals, general hospital distinct part psych (DPP) units, MH clinics and rehab facilities, substance use disorder facilities, residential settings, and other BH providers.
- **Professional BH services —** BH specialists include physicians, doctors of osteopathic medicine (DO), and advanced practice registered nurses with specialty in psychiatry, as well as psychologist and licensed MH professionals. Unlicensed BH providers are covered for Rehab services only. Coverage includes services provided by BH specialists regardless of service location, including consults and services provided by a BH specialist in a general Inpatient or ER setting. Servicing provider specialty (as opposed to billing provider) is used to determine classification of specialized behavioral health services. Services billed and provided separately by non-BH specialists (such as general nurse practitioner) where place of service is a BH facility are classified as Acute care services under Bayou Health and not classified as specialized behavioral health services.
- **ER Services —** ER services are not classified as specialized BH, except for professional components billed by BH specialists or when the facility component is billed by a BH facility (for example, a freestanding psychiatric facility or DPP unit billing revenue code 450).
- **Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services —** FQHC and RHC services are covered in full when any service provided during a visit is provided by a BH specialist. All other FQHC and RHC visits are not classified as specialized BH services.

The details of the mixed service protocol are summarized in the Data Book. The net impact of the changes to the mixed service protocol resulted in approximately $13.8 M of historical 2013 encounter data being reclassified as basic BH, which was already accounted for in the Bayou Health February 2015 rates.

Trend

Trend is an estimate of the change in the overall cost of providing health care services over a finite period of time (AA.3.10). Capitation rate ranges are actuarial projections of future contingent events and a trend factor is necessary to estimate the expenses of providing health care services in the future rating period.

To develop the December 1, 2015 through January 31, 2016 rate ranges using the CY 2013 encounter data as a base, Mercer projected costs based on a review of historical experience, emerging trends, and expected costs and utilization during the rating period. The midpoint of the

base data was July 1, 2013. The midpoint of the rating period is January 1, 2016, which necessitated 30 months of total trend to project from the base time period to the rating period.

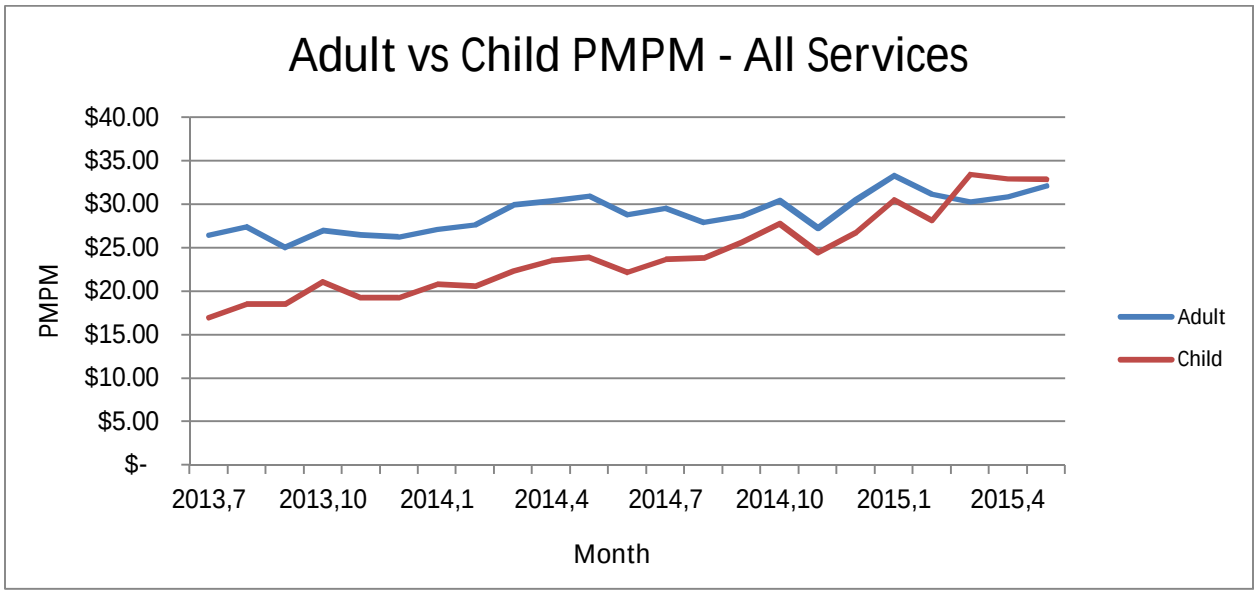
Trend Data Sources

As more recent utilization and cost data has become available for Specialized BH services beyond the 2013 base data period, Mercer focused the trend analysis on the actual trend patterns from the midpoint of the base data period (July 2013) through the most recently available data through May 2015.Mercer created rolling-average Per Member Per Month (PMPM) summaries using the managed care encounter data for various time intervals (three month, six month, nine month and 12 month) by region, rating group, and major service category.

The trend analysis focused on the emerging PMPM trends, which encompassed both the unit cost and utilization components. Each rate cell in the State experience exhibited unique trends reflecting the underlying characteristics of the population and the mix of services received. The CY 2014 and emerging 2015 data indicated significant increases in utilization for many services. The trends for the community psychiatric and psychosocial rehabilitation service categories exhibited significant PMPM growth from the beginning of 2013 through May 2015. Given the limited projection period from the end of the available data (May 2015) through the midpoint of the rate period (January 1, 2016), Mercer assumed prospective trend patterns for the Specialized BH services consistent with the trend levels exhibited in the emerging data through May 2015.

Mercer reviewed trend information in other state's Medicaid programs and national indices as reasonability checks. These sources were reviewed, but the trend observations in the LA specific program experience were determined to be the most credible base for future projections. The significant utilization trends exhibited in the LA program experience are higher than other state programs that have higher established historical utilization levels.

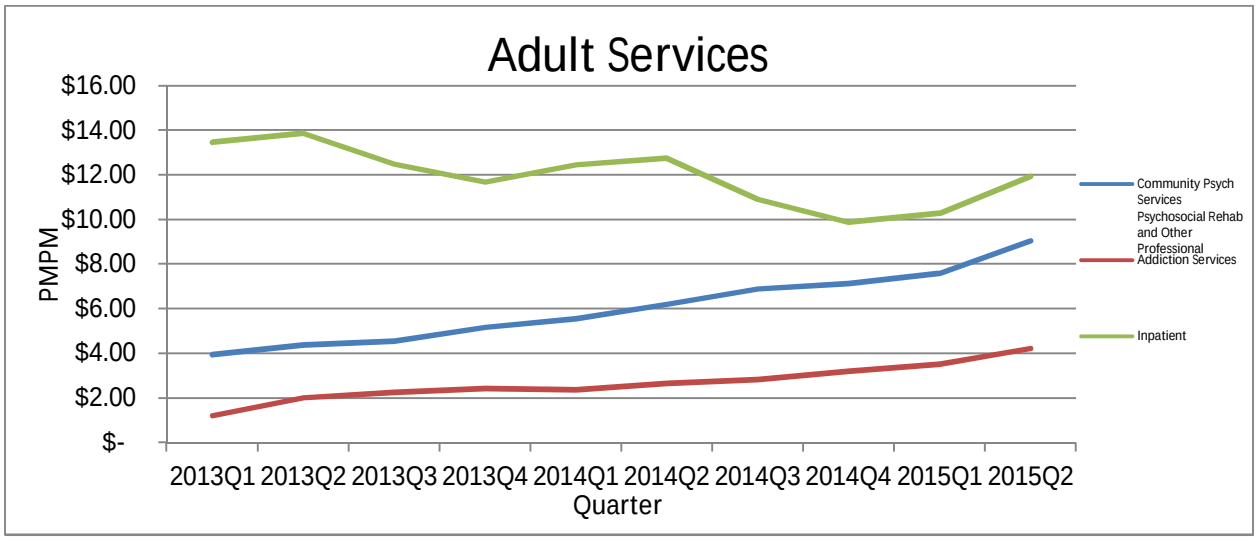
Trends observed in the data through May 2015 indicate significant growth in the overall service utilization for all regions and rate cells, particularly the children's services. The graphs below show quarterly PMPM growth between CY 2013 and May 2015.



The PMPM progression illustrates that, while Adult trends appeared to mitigate during 2014 from the historic growth, trends in the first two quarters of 2015 have re-emerged for certain services. While children's services have historically been low compared to that of adults, recent utilization growth has driven notably high PMPM trends in 2014 and 2015. Mercer developed trend assumptions at the region and category of service level based on the specific trend patterns reflected in the data. Generally, the trend drivers were consistent by region. As such, the trend observations are provided below on a statewide basis specific to each population.

Adult Trend Observations

The adult trends are primarily driven by utilization growth in Community Psych, Psychosocial Rehab and Addiction Services throughout 2013 and into the first two quarters of 2015. There was significant growth of community based services starting in CY 2013 that has continued into 2015. Utilization of addiction treatment services has experienced more significant trends in 2015. The higher trends for community-based services were partially offset in 2014 by decreasing utilization of Inpatient services. The table below shows the trends in the historic quarterly adult PMPMs for these three categories of service.



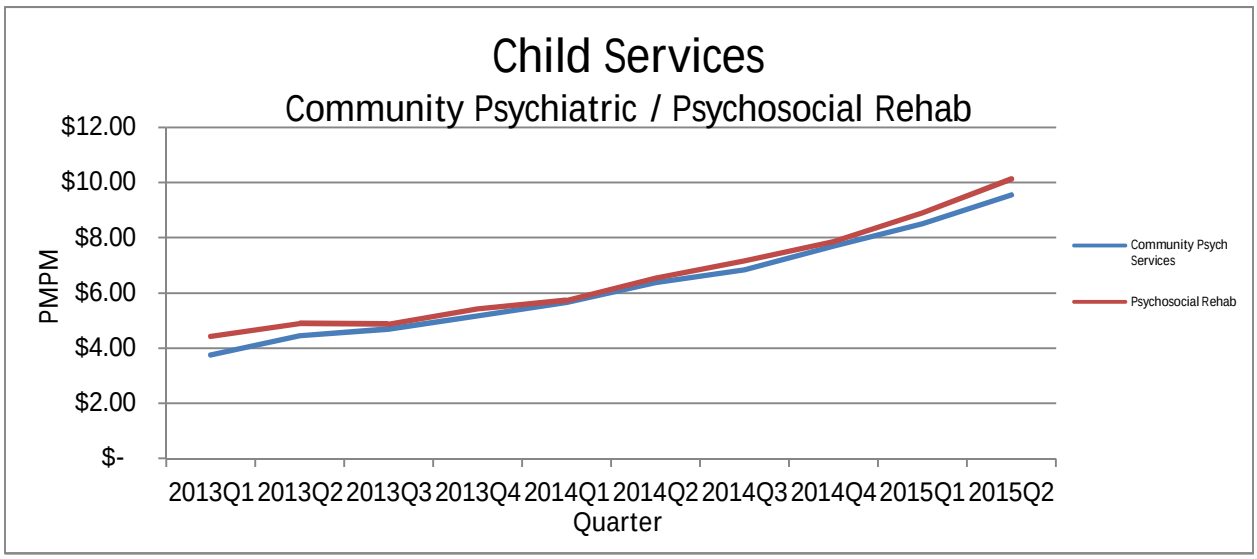
The composite annual PMPM trends for each category of service for adults are listed in the table below. Mercer grouped similar categories of service that had similar trend patterns together to increase credibility for the smaller categories of service. Trends were applied for 30 months from the midpoint of CY 2013 to the midpoint of the December 1, 2015 through January 31, 2016 rating period.

Categories of Service	**Annualized PMPM Trend**
Inpatient, Inpatient Detox	-3.5%
Emergency Room, Outpatient, Medical Physician/Psychiatrist, Other Professional, FQHC,	18.2%
Community Psychiatric Support, Psychosocial Rehab, ACT	22.7%
Addiction Services	39.5%
Crisis Intervention, MST, and Other Services	31.3%
Total	11.5%

Child Trend Observations

The Child trends are driven by utilization growth in Community Psych and Psychosocial Rehab, and recently Other Professional services. Significant growth in these services was observed throughout the entire period between CY 2013 and the early months of CY 2015. Based on the continued growth into CY 2015, Mercer expects higher trends to continue throughout CY 2015, and into the rating period for children's services. The table below shows the trends in the historic

quarterly child PMPMs for the categories of service that are driving the growth in children's services.



The overall trend projection for each category of service for children is listed in the table below.

Categories of Service	Annualized PMPM Trend
Inpatient, Inpatient Detox	9.0%
Emergency Room, Outpatient, Medical Physician/Psychiatrist, Other Professional, FQHC,	18.6%
Community Psychiatric Support, Psychosocial Rehab, ACT	42.1%
PRTF	16.6%
Crisis Intervention, MST, Addiction Services, Other Services, Therapeutic Group Home	12.6%
Total	29.7%

The overall annualized projected BH service trend assumption is 11.5% for adults, 29.7% for children, or 24.4% overall including increases in both utilization and general cost inflation. Mercer recognizes that prospective trends can vary based, on fluctuations in service utilization and has considered this variability in the development of the trend ranges. To project the final rate ranges, Mercer varied the trend assumptions by varying the annualized trend from an overall annual rate of 21.1% at the Lower Bound to 27.0% at the Upper Bound. The Lower Bound represents lower

rates of growth as initial period trends moderate and the Upper Bound represents continued utilization growth at the higher levels observed during the initial years of the program.

Programmatic Changes

Mercer and the State discussed programmatic changes that may impact the managed care contract. This included a review of changes to the State's hospital fee schedules, adjustments to account for changes in population mix, rate changes for certain providers after the 2013 base data time period, and adjustments for final decisions on program coverage after the development of the base data. The following sections describe the analysis for each program change as well as the statewide impact of the adjustment. Mercer has included Appendix C which details the percentage and PMPM impact of each adjustment by region and rate cell.

Inpatient Hospital Fee Schedules

Inpatient Hospital fee schedules have changed in Medicaid from the levels reported in the base data. Most notably, rates for certain public hospitals changed as a result of the public/private partnership. The changes to the hospital rates represent both increases and decreases depending on the hospital.

Mercer has included an adjustment to the capitation rates to account for the changes to the hospital reimbursement, including the public/private partnership. In order to account for this change, Mercer analyzed the base data by hospital and region separately for adults and children services. For adults, Mercer compared the PIHP fee schedules and per diem costs reported in the encounter data to the new State Medicaid fee schedule. Based on this comparison, Mercer determined no adjustment was needed for the Adult rates as the PIHP fee schedule underlying the encounter data generally aligned with the new State Medicaid fee schedule. For children, however, hospital reimbursement levels in the encounter data generally followed historic State Medicaid fee schedules. As a result, an adjustment was necessary to reflect changes between the historic and the new fee schedule for the children's rates.

Overall, this represents a 0.3% increase to the rate ranges and impacts child rating groups only.

Medication Management Rate Change

Effective January 2013, the prior Medication Management procedure code of 90862 was eliminated and the services were required to be billed under General Evaluation and Management codes 99211-99214, 90863. These codes, as reflected in the base data, were reimbursed at lower rates averaging approximately $47 per unit than the prior medication management services in 2012. The PIHP revised the fee schedule in 2014 to adjust the fees for medication management

services up to prior historical levels. The State indicated it expects providers to continue to be paid at the higher reimbursement level under the Bayou Health program.

Mercer analyzed 2014 encounter data by region and observed an increase in the average reimbursement rate for these services to roughly $73 per unit. Mercer calculated the program change impact based on reported service utilization in each region.

As the Medication Management service costs are captured in both the Medical Physician/Psychiatrist category and the Other Professional category along with other procedures, Mercer calculated a proportionate program change to each category to incorporate the expected impact on the broader service category for this fee increase. Specifically, Mercer applied adjustments to Medical Physician/Psychiatrist and to Other Professional categories of service.

Overall, this represents a 1.4% increase to the rates and impacts all rating groups.

Population Mix Considerations

Disability Medicaid Closure

In 2014, the State eliminated coverage of the Disability Medicaid category identified by Type Case code 125. This group included coverage for approximately 10,000 aged, blind and disabled adults. Although this coverage category was discontinued, approximately 50% of individuals previously eligible are expected to enroll through either provisional Medicaid (Type case 211) or Supplemental Security Income eligibility. Mercer evaluated the historical costs for the Disability Medicaid population identified under Type Case code 125 and compared this group to the remaining population in the Disabled Adult and Dual Eligible Adult rates cells. The Disability Medicaid group had higher-than-average costs in each of the rate cells. Based on the assumption that not all individuals previously covered under Disability Medicaid individuals would reenroll (which is supported by emerging 2014 enrollment), Mercer calculated a downward adjustment to reflect the lower average cost of the remaining population.

LaCHIP – Family and Children

Subsequent to the summarization of the CY 2013 base data, the State informed Mercer of an eligibility group that will be covered under the managed care program for specialized BH services but was not included in the CY 2013 base data. Mercer analyzed historic CY 2013 claim experience for this population group and developed an adjustment factor that reflects the PMPM impact to the existing CY 2013 average PMPM.

The impact of these two population adjustments is a decrease of 0.5% to the rates overall and impacts adult rating groups only.

Retroactive Eligibility Adjustment

The retroactivity considerations for Specialized BH services will mirror the coverage responsibility of the Bayou Health plans for acute care services. As a reminder, beginning in February 2015 members granted retroactive eligibility were capitated retroactively, based on their eligibility for Bayou Health, for up to 12 months prior to enrollment in an MCO. The MCO selected by these members will then receive one capitation payment per month of retroactive enrollment, and will be liable for all claims incurred during this retroactive eligibility period. For Specialized BH services this policy goes into effect on December 1, 2015. Mercer developed an adjustment factor to apply to the base data in the capitation rate development.

The retroactive eligibility adjustment was developed specific to each rate cell as utilization levels for specialized BH services varied between retroactive and non-retroactive enrollees. Retroactive enrollment in any given rate cell will generate the same capitation payment per month to the MCO as any other enrollee in that same rate cell. The factors were developed at a rate cell level on a statewide basis (i.e., all regions used the same factors). The calculation relied upon retroactive claims PMPM, unique enrollee counts, and the average duration to develop the expected increase to Bayou Health claims.

Mercer reviewed the average duration of enrollees who were retroactively enrolled during 2013. The program change was calculated by summarizing the PMPM for the retroactive eligibles and blending it with the respective rate cell PMPM based on enrollment. The program change adjustment reflects the impact on average rate cell PMPMs as a result of adding these retroactive eligibles. The table below summarizes the impact of the Retroactive Eligibility Adjustment.

Population	Adjustment
Non-Disabled Adults	-0.1%
Disabled Adults	0.2%
Non-Disabled Children	-0.2%
Disabled Children	-0.1%
Dually Eligibles	0.0%

Other Populations

The State has outlined recent decisions to further clarity the Bayou Health covered populations for specialized BH services. As these populations represent a change from what was captured in the base data or Data Book, Mercer analyzed the impact on the PMPM for these changes for the final rates. The table below summarized the impact for the following population changes.

- Coverage of Spend-down populations

- Coverage of Medically Needy populations
- Removal of Denied SSI, Forced Benefits and Terminated SSI populations

Population	Adjustment
Non-Disabled Adults	-0.3%
Disabled Adults	-0.0%
Non-Disabled Children	+0.0%
Disabled Children	+0.0%
Dually Eligibles	0.0%

These other population considerations added 23,165 member months (or 0.2%) to the populations included in the Data Book.

Overall, the adjustments for Disability Medicaid Closure, LaCHIP – Family and Child, Retroactive Eligibility and Other Population considerations represent a decrease of 0.6% to the capitation rate ranges on a statewide basis.

Permanent Supportive Housing Provider Rate Increase

Subsequent to CY 2013, the State implemented a 5% rate increase to certain providers delivering community psych services to individuals in the permanent supportive housing (PSH) program. Using the list of PSH providers from the State, Mercer summarized historic cost and utilization data for community psych services for these providers and calculated the impact of the 5% increase. Mercer applied this impact to rating group and region based on historic utilization patterns.

Overall, this represents a 0.1% increase to the rates and impacts all rating groups.

1915(c) CSoC Regional Expansion

As noted earlier in this letter, the CSoC population will be generally excluded from Bayou Health for specialized BH services. Magellan will continue to administer this program. From 2013 through early 2015, the CSoC population has expanded. Mercer evaluated the implications of this expansion on the rate cells for the Bayou Health program.

The State submitted an amendment to the 1915(c) CSoC waiver to increase the number of waiver slots and expand the waiver program statewide starting in 2014. Upon expansion, certain Children previously classified in a disabled or non-disabled rating group shifted to the CSoC program. Mercer calculated the volume of CSoC transitions by comparing the average 2013 CSoC

enrollment to emerging levels as of April, 2015. The growth by region is outlined in the table below:

CSoC Enrollment	Average 2013	As of April, 2015
Gulf	198	449
Capital	214	426
South Central	152	341
North	491	510
Statewide	1,054	1,726

Mercer then analyzed the historic Specialized BH expenses associated with CSoC enrollees and noted that it is materially higher when compared to the PMPM for other child rating groups ($554 PMPM vs $18 PMPM, respectively). Because of this differential, the movement of those higher needs children out of disabled or non-disabled rating groups resulted in a reduction in the average PMPM by region. The transition analysis was performed on a regional basis using the underlying PMPMs for each region as well as CSoC-specific PMPMs for each region.

Overall, this represents a decrease of 1.8% to the rates and impacts child rating groups only.

Bayou Retained Liability for CSoC Specialized BH Services

As individuals change eligibility status between the CSoC program and other Bayou rate cells, the State has implemented policies that warrant program change consideration from the Data Book.

Month One Claim Liability

If individuals transition from a Bayou rate cell to CSoC after the first day of the month, Bayou will retain liability for specialized BH services for the remainder of that month. After the first month of CSoC eligibility, claim liability for specialized BH services will no longer be the responsibility of Bayou. For the capitation rate development, Mercer has assumed full capitation payment for Specialized BH services will be made to the Bayou Health MCOs for the first month for which they are identified for the CSoC waiver, even if the individual is only enrolled in CSoC for a partial month.

To calculate this adjustment, Mercer summarized the initial month of specialized BH services and eligibility for those individuals transitioning to CSoC. Mercer then compared this data to that of non-Disabled and Disabled children to develop an appropriate PMPM adjustment. Because individuals transitioning to CSoC typically have higher utilization levels than that of non-Disabled

or Disabled children, this coverage change results in an upward PMPM adjustment to the costs captured in the Data Book.

SUD Residential/PRTF/TGH Coverage
All SUD Residential, PRTF and TGH services delivered to CSoC individuals will remain with Bayou Health regardless of CSoC eligibility status. Mercer summarized SUD Residential, PRTF and TGH claims for CSoC eligibles and included these expenses in the respective non-Disabled Child or Disabled Child rate cells. This coverage decision results in an upward adjustment to the costs captured in the data book.

The impact of these two considerations is a 0.8% increase to the rates overall and impacts child rating groups only.

Historic Outpatient Cost Settlements
The State has historically implemented fee schedule adjustments for various outpatient services. For outpatient providers, the fee schedule adjustment process includes an estimation of cost settlements that are not captured in the historic base data. Since cost settlements will become the responsibility of the MCOs under managed care, an adjustment to the Bayou Health rates was necessary. Because outpatient services do not constitute a material portion of the service array for Specialized BH, this adjustment was not expected to be material.

To calculate the historic outpatient cost settlement impact, Mercer analyzed provider-level cost settlement information provided by the State. Comparing this information to claim payment data, Mercer calculated the historic cost settlement impact by provider. These cost settlements were included as a program change to the Specialized BH portion of the Bayou Health rates.

Overall, this represents a slight positive impact, rounded to 0.0%, to the rates and impacts all rating groups.

PRTF Per Diem Adjustment
The State informed Mercer of two PRTF providers that have historically been subject to risk sharing arrangements that have had recent per diem changes. The prior risk sharing process resulted in additional payments to the providers as the per diem documented in the cost reports was higher than the interim rates. Mercer has built in consideration of provider specific rates for these providers based on the cost report per diems.

To calculate the impact, the State provided Mercer with the risk sharing calculations that were based on base paid and final targeted per diem rates for these two providers. The final cost

impact was calculated by another firm on behalf of the State. Mercer reviewed these calculations for reasonability but did not audit them. Mercer leveraged the final calculations to determine the net impact to the CY 2013 time period to develop the program change impact. Mercer incorporated the expected cost for the per diem change based on utilization during the 2013 time period and applied an upward adjustment to the PRTF COS.

Overall, this represents an increase 0.2% to the rates on a statewide basis and impacts child rating groups only.

Inpatient Concurrent Review

Based on the contract with the State, Magellan currently authorizes Inpatient stays up to seven day increments, and will be responsible for any current Inpatient authorization period that extends beyond the effective date of December 1, 2105. The Bayou Health MCOs will be responsible for concurrent review of any open authorizations and will assume responsibility for the inpatient stay after the Magellan authorization period ends.

Mercer analyzed the impact of transitioning the responsibility for the concurrent review portion of IP stays that were authorized in the prior month by analyzing 2014 and 2015 claims data. As the Data Book is summarized based on the service begin date for the inpatient stay, this transition of responsibility in the middle of stays that cross-over December 1, 2015 creates an additional liability for the Bayou Health program. This adjustment was applied for one month as only December 2015 will be impacted by the transition from Magellan to Bayou.

Mercer understands that Magellan authorizations are typically seven days. Mercer has assumed any concurrent reviews and continued authorizations by Magellan would occur in seven day increments. As such, Mercer analyzed the average monthly volume of inpatient expenses that start in one month and continue into another month and segmented the stay into a period that concludes Magellan's coverage based on seven day increments with the remainder of the stay transitioning over to Bayou Health. For example, a stay that began on November 14th and continued through December 12th was assumed to be Magellan's responsibility from November 14th through December 5th (first 21 days, 3 7-day increments) with the December 6th through the 12th as the responsibility of the Bayou Health plan.

While this adjustment is only expected to impact the December 2015 coverage month as the average length of stay is approximately 7 days, the adjustment has been scaled to impact half of the rating period of December 2015 and January 2016.

Average monthly expense associated with remainder of stays	$238,000

Average monthly inpatient expense	$5,143,000
Average monthly inpatient impact associated with continuing stays	4.6%
Final impact to the rating period (impact to one of two months only)	2.3%

The table below summarizes the impact by rate cell across all service categories.

Population	Adjustment
Non-Disabled Adults	0.5%
Disabled Adults	1.0%
Non-Disabled Children	0.2%
Disabled Children	0.2%
Dually Eligibles	0.1%

Elimination of the 1915(i) Program Authority and Amendment of the State Plan

In order to accelerate receipt of medically necessary specialized mental health services for adults and make community-based LMHP services available to more individuals, the State intends to transition services currently in the 1915(i) to the Medicaid State Plan. The prior 1915(i) authority limited the availability of certain services to adults requiring acute stabilization or meeting certain functional criteria for a major mental disorder and the seriously mentally ill (SMI). The services covered under the 1915(i) included community psychiatric services including ACT, psychosocial rehab services, and services provided by other licensed mental health professionals. Another aspect of the 1915(i) program was the requirement of an independent assessment to confirm an individual met the population criteria before services could be received.

While the services will be covered under the State Plan, individuals will need to meet medical necessity criteria in order to be authorized for the services. Mercer understands the medical necessity criteria for community psychiatric and psychosocial rehab services will generally align with the diagnosis criteria associated with major mental disorders and SMI. The criteria for other licensed mental health professionals will apply to a broader segment of the covered population and not be specific to major mental disorders or SMI.

Mercer has reviewed the changes to the delivery of these former 1915(i) services with Mercer clinicians and policy consultants and identified two specific rate considerations.

- Elimination of the Independent Assessment will likely result in individuals accessing services more quickly. The State has indicated that individuals have experienced on average a 30-day wait period for services while they await the independent assessment. Mercer analyzed the historical claims data to identify the subset of the 1915(i) users that were new to the program and expected to utilize more services in a 12-month period if the independent assessment was eliminated. Specifically, Mercer evaluated the individuals

who utilized services up through December 2013 and made an assumption about the number of clients who utilized services in December that would have utilized more services had their authorizations started earlier in the year. For example, individuals with 12-months of annual utilization were not impacted by the change, but 87% of the individuals with authorizations starting in December were assumed to use an additional month of service. The summary below shows the program change calculation.

Total 1915(i) recipients in 2013	5,555
Subset of recipients that projected to receive an additional month of service	1,363
Average monthly cost of 1915(i) services	$587
Annualized program change impact	$799,868
Total 2013 1915(i) expenses	$9,753,804

- Expanded access to services provided by other licensed professionals (OLP) will likely result in an increase to the penetration rate over time for other professional services. Individuals will still need to meet medical necessity criteria to access other professional services, but more individuals are expected to meet the criteria than historically when the 1915(i) services were limited to SMI or major mental disorder. To evaluate the potential change in utilization, Mercer reviewed the service utilization and penetration rates for other states where other professional services have been covered in the State Plan. The penetration rates in these other states are higher for adults indicating broader utilization of the services. The penetration rate findings are as follows:

2013 Penetration Rate for OLP Services in Louisiana	2.5% of Adults
Penetration Rate for similar OLP Services in Other States	Up to 10% of Adults

Mercer assumed the utilization of these services would increase over time essentially modeling a two-fold expansion of these services from November 2015 to January 2017. The utilization has been assumed to progressively increase over time as provider capacity may need to be developed to meet the demand as individuals understand the availability of these services.

Projected November 2015 users based on emerging data	3,549
Projected January 2017 users	7,097
Total new users in rating period for December 2015 and January 2016	760
Average monthly cost of services provided by other licensed professionals	$82

Annualized program change impact ($62,455 multiplied by 6)	$374,733
Total 2013 services provided by other licensed professionals	$6,563,731

This issue will continue to be monitored and evaluated as part of future rate-setting exercises as more data becomes available. The overall impact of the adjustment to account for the elimination of the 1915(i) authority and coverage of these services under the State Plan is a 0.6% impact overall and impacts the adult rate cells only.

The overall impact all of all the programmatic changes described above is a 1.3% increase to the rates. Again, the regional and rate cell impacts of these changes are summarized in Appendix C.

1915(b)(3) Services

The historical utilization of Physician Case Consultation services has been minimal in the initial years of the program. As such, the 1915(b)(3) rate for this service is essentially $0.00 on a PMPM basis. The service utilization will continue to be analyzed and the rate adjusted accordingly, as necessary. This is within the requested waiver authority of $0.13 PMPM.

Managed Care Assumptions

Mercer evaluated whether additional adjustments were necessary to address changes to utilization as a result of care management practices. As the adult encounter data are from a period of time when capitated managed care was in operation, Mercer did not incorporate any further adjustment for future changes as a result of managed care. Similarly, Mercer made no adjustment to the Children's capitation rate calculations for additional impact of managed care. While the data from the Children's program are from a non-risk setting, the current PIHP did perform utilization review and care management of the Children's population under the non-risk contract. Also, the two-month rating period of December/January does not provide sufficient time to impact the service utilization patterns.

Administration and Risk Margin Loading

Mercer included an assumption for administrative expenses under a managed care program with particular consideration for the impact of integration with the existing Bayou Health acute care program. The State provided Mercer with anticipated staffing requirements for the upcoming Bayou Health contract period beginning December 1, 2015. Mercer reviewed the behavioral health staffing requirements as they apply to each MCO participating in the Bayou Health program. Each staffing position was evaluated to determine if it would be already fulfilled within the current Bayou health program, and therefore would not need to be considered as part of the behavioral health program. The administrative costs for the required staffing positions were

modeled based on wage and other employee-related expense information from the Bureau of Labor and Statistics. Mercer also included consideration for MCO overhead for these staffing positions. Mercer developed a PMPM cost expectation for these additional staffing needs and converted the PMPM to a percentage based on the final service cost projection underlying the rates.

Based on this review, Mercer included a general administrative allowance of 8.0%, which is similar to the prior administrative assumption under the current adult capitation rates. This is due to the fact that the State is now contracting with multiple MCOs rather than just one. In addition to the general administrative allowance, an underwriting gain/risk margin of 2.0% has been included in the capitation rates. The administration and risk margin load factor (AA.3.2) is expressed as a percentage of the gross capitation rate (that is, premium) before premium tax adjustment, and is consistent with the current Bayou Health rates.

Health Insurer Provider Fee Consideration

The State plans to address the Health Insurer Provider Fee and associated implications of non-deductibility through a retrospective payment once the fees are known for the impacted premium years. As such, no consideration has been made for the fee in these capitation rates. Further discussion between the MCOs and the State will occur as fee notices become available from the IRS for the respective premium year.

Premium Tax Adjustment

Louisiana Statute 22:842 requires businesses issuing life, accident, health or service insurance or other forms of contracts or obligations covering such risks to pay certain premium taxes. The tax for businesses with revenue exceeding $7,000 amounts to 2.25% of gross annual premiums. The State has determined that the PIHP contract for the Medicaid Adult capitated BH program is subject to this taxation. This is a uniform, broad-based fee imposed on all health maintenance organizations and preferred provider organizations and all lines of business.

This premium tax is a legitimate cost of doing business in the State of Louisiana for Medicaid managed care organizations and PIHPs, and reasonable to include in the consideration of actuarially sound capitation rate ranges. Since this is a cost of doing business in the State, Mercer included consideration for this tax in the rate range development.

The premium tax adjustment is expressed as a percentage of the gross capitation rate (that is, premium). Mercer applied a 2.25% upward adjustment to the rate to account for the premium tax.

Rate Ranges

In order to develop the rate ranges, Mercer varied the trend assumptions outlined above to reflect the potential fluctuations in service utilization growth beyond observed experience. The lower bound trend accounts for mitigation of trend from the observed early 2015 levels, whereas the upper bound reflects higher consideration of trends from 2015 Mercer recognizes that prospective trends can vary based, not only on fluctuations in service utilization but also on the achieved degree of care management. Variation in these trend assumptions results in a rate range of approximately 5.9% below the 50th %-ile rate for the Lower Bound and 5.9% above the 50th %-ile rate for the Upper Bound.

The rate ranges can be found on Appendix B.

Rate Development Overview

To provide additional detail on the rate development, Mercer has provided an overview of the adjustments applied to each rate cell in Appendices B and C. The exhibits present the breakdown of the assumptions used to calculate the 50th %-ile rates within the actuarially sound rate ranges for each region.

Rate Certification

In preparing the rate ranges shown in Appendix B for the December 1, 2015 through January 31, 2016 contract period for the Louisiana BH program, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, and financial data and information supplied by the State and the PIHP. The State and the PIHP are solely responsible for the validity and completeness of these supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion they are appropriate for the intended rate-setting purpose. However, if the data and information are incomplete and/or inaccurate, the values shown in this report may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this report.

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

about the future, and other factors. A change in assumptions is not an indication that prior assumptions were unreasonable, inappropriate, or unattainable when they were made.

Mercer certifies that the rate ranges in Appendix B, 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. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rate ranges developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time, and are subject to unforeseen and random events. Therefore any projection must be interpreted as having a likely, and potentially wide range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual MCO costs will differ from these projections. Mercer has developed these rate ranges on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by the MCOs for any purpose. Mercer recommends that the MCOs 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 State.

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

This certification letter assumes the reader is familiar with the Louisiana managed care program, Medicaid eligibility rules and actuarial rating techniques. It is intended for the State 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. This document should only be reviewed in its entirety. Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

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

If you have any questions on any of the information provided, please feel free to call me at 612 642 8940, Brad at 612 642 8756 or Bennett at 612 642 8609.

Sincerely,

Jonathan Marsden, FSA, MAAA
Partner

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Appendices

Appendix A
Louisiana Behavioral Health Partnership Medicaid Capitation Rates
Effective December 1, 2015 to January 31, 2016
50th Percentile Rates by Rate Cell and Region for Specialized BH Services

50th Percentile Rates by Rate Cell and Region
December 1, 2015 - January 31, 2016

		Contract Period December 1, 2015 - January 31, 2016			
Rate Cell	Age	Gulf Region	Capital Region	South Central Region	North Region
Non-Disabled Adults	21+	$ 29.26	$ 25.76	$ 25.91	$ 28.76
Disabled Adults	21+	$ 104.37	$ 84.66	$ 84.27	$ 75.27
Non-Disabled Children	0-20	$ 28.52	$ 28.14	$ 23.58	$ 40.90
Foster Care and Disabled Children	0-20	$ 170.07	$ 139.10	$ 152.44	$ 246.19
Dually Eligible	Any	$ 18.50	$ 6.78	$ 7.49	$ 8.84

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Appendices

Appendix B
Louisiana Behavioral Health Partnership Medicaid Capitation Rate Development
Effective December 1, 2015 to January 31, 2016
Adult and Child Rate Cells

Rate Development Summary
December 1, 2015 - January 31, 2016

Gulf Region		Base Year		Rate Development Data Adjustments				Rate Development Loads			Contract Period December 1, 2015 - January 31, 2016		
		A	B	C	D	E	F	G	H	I			
Rate Cell	Age	MMs	PMPM	Trend *	Program Changes	Managed Care Adjustment	Target Service Cost	Underwriting Gain **	Administration **	Premium Tax **	50th Percentile Rate ***	Lower Bound Rate	Upper Bound Rate
Non-Disabled Adults	21+	386,912	$ 13.85	25.9%	4.6%	0.0%	$ 25.72	2.0%	8.0%	2.25%	$ 29.26	$ 27.57	$ 30.95
Disabled Adults	21+	305,452	$ 66.79	11.1%	5.8%	0.0%	$ 91.76	2.0%	8.0%	2.25%	$ 104.37	$ 99.78	$ 108.97
Non-Disabled Children	0-20	2,248,412	$ 12.98	30.3%	-0.3%	0.0%	$ 25.02	2.0%	8.0%	2.25%	$ 28.52	$ 26.66	$ 30.38
Foster Care and Disabled Children	0-20	186,151	$ 74.76	32.2%	-0.4%	0.0%	$ 149.20	2.0%	8.0%	2.25%	$ 170.07	$ 159.24	$ 180.91
Dually Eligible	Any	275,235	$ 9.17	22.7%	6.3%	0.0%	$ 16.26	2.0%	8.0%	2.25%	$ 18.50	$ 17.45	$ 19.55
Total		**3,402,162**	**$ 20.88**	**25.3%**	**1.6%**	**0.0%**	**$ 37.18**	**2.0%**	**8.0%**	**2.25%**	**$ 42.35**	**$ 39.84**	**$ 44.86**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

** Admin & Underwriting Gain shown as a % of the total rate before premium tax. Premium Tax is shown as a percent of total premium.

*** Rate Development Formula: 50th Percentile Rate = [B*(1+C)^(30/12)*(1+D)*(1+E)]/(1-G-H)/(1-I)

Rate Development Summary
December 1, 2015 - January 31, 2016

Capital Region		Base Year		Rate Development Data Adjustments				Rate Development Loads			Contract Period December 1, 2015 - January 31, 2016		
		A	B	C	D	E	F	G	H	I			
Rate Cell	Age	MMs	PMPM	Trend *	Program Changes	Managed Care Adjustment	Target Service Cost	Underwriting Gain **	Administration **	Premium Tax **	50th Percentile Rate ***	Lower Bound Rate	Upper Bound Rate
Non-Disabled Adults	21+	282,441	$ 14.29	18.1%	4.6%	0.0%	$ 22.65	2.0%	8.0%	2.25%	$ 25.76	$ 24.56	$ 26.96
Disabled Adults	21+	239,540	$ 60.83	7.7%	1.8%	0.0%	$ 74.44	2.0%	8.0%	2.25%	$ 84.66	$ 81.66	$ 87.66
Non-Disabled Children	0-20	2,028,943	$ 12.18	31.9%	1.8%	0.0%	$ 24.72	2.0%	8.0%	2.25%	$ 28.14	$ 26.36	$ 29.91
Foster Care and Disabled Children	0-20	159,015	$ 60.36	31.2%	2.8%	0.0%	$ 122.25	2.0%	8.0%	2.25%	$ 139.10	$ 130.65	$ 147.55
Dually Eligible	Any	222,400	$ 3.17	26.9%	3.8%	0.0%	$ 5.96	2.0%	8.0%	2.25%	$ 6.78	$ 6.46	$ 7.11
Total		**2,932,339**	**$ 18.29**	**24.7%**	**2.2%**	**0.0%**	**$ 32.45**	**2.0%**	**8.0%**	**2.25%**	**$ 36.92**	**$ 34.85**	**$ 38.99**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

** Admin & Underwriting Gain shown as a % of the total rate before premium tax. Premium Tax is shown as a percent of total premium.

*** Rate Development Formula: 50th Percentile Rate = [B*(1+C)^(30/12)*(1+D)*(1+E)]/(1-G-H)/(1-I)

Rate Development Summary
December 1, 2015 - January 31, 2016

South Central Region		Base Year		Rate Development Data Adjustments				Rate Development Loads			Contract Period December 1, 2015 - January 31, 2016		
		A	B	C	D	E	F	G	H	I			
Rate Cell	Age	MMs	PMPM	Trend *	Program Changes	Managed Care Adjustment	Target Service Cost	Underwriting Gain **	Administration **	Premium Tax **	50th Percentile Rate ***	Lower Bound Rate	Upper Bound Rate
Non-Disabled Adults	21+	295,987	$ 15.38	15.4%	3.7%	0.0%	$ 22.77	2.0%	8.0%	2.25%	$ 25.91	$ 24.53	$ 27.28
Disabled Adults	21+	282,541	$ 67.29	4.2%	-0.5%	0.0%	$ 74.09	2.0%	8.0%	2.25%	$ 84.27	$ 81.00	$ 87.54
Non-Disabled Children	0-20	2,220,847	$ 10.68	32.0%	-2.9%	0.0%	$ 20.69	2.0%	8.0%	2.25%	$ 23.58	$ 22.16	$ 25.01
Foster Care and Disabled Children	0-20	171,952	$ 70.60	29.5%	-0.4%	0.0%	$ 133.69	2.0%	8.0%	2.25%	$ 152.44	$ 142.86	$ 162.03
Dually Eligible	Any	296,258	$ 5.00	11.7%	-0.1%	0.0%	$ 6.59	2.0%	8.0%	2.25%	$ 7.49	$ 7.09	$ 7.89
Total		**3,267,585**	**$ 18.64**	**22.0%**	**-1.3%**	**0.0%**	**$ 30.16**	**2.0%**	**8.0%**	**2.25%**	**$ 34.36**	**$ 32.45**	**$ 36.28**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

** Admin & Underwriting Gain shown as a % of the total rate before premium tax. Premium Tax is shown as a percent of total premium.

*** Rate Development Formula: 50th Percentile Rate = [B*(1+C)^(30/12)*(1+D)*(1+E)]/(1-G-H)/(1-I)

Rate Development Summary
December 1, 2015 - January 31, 2016

North Region		Base Year		Rate Development Data Adjustments				Rate Development Loads			Contract Period December 1, 2015 - January 31, 2016		
		A	B	C	D	E	F	G	H	I			
Rate Cell	Age	MMs	PMPM	Trend *	Program Changes	Managed Care Adjustment	Target Service Cost	Underwriting Gain **	Administration **	Premium Tax **	50th Percentile Rate ***	Lower Bound Rate	Upper Bound Rate
Non-Disabled Adults	21+	223,944	$ 15.62	19.2%	4.4%	0.0%	$ 25.27	2.0%	8.0%	2.25%	$ 28.76	$ 27.15	$ 30.37
Disabled Adults	21+	239,483	$ 47.21	13.2%	2.8%	0.0%	$ 66.16	2.0%	8.0%	2.25%	$ 75.27	$ 71.65	$ 78.89
Non-Disabled Children	0-20	1,731,176	$ 16.87	34.6%	1.4%	0.0%	$ 35.34	2.0%	8.0%	2.25%	$ 40.90	$ 38.08	$ 43.71
Foster Care and Disabled Children	0-20	158,711	$ 134.32	19.3%	3.8%	0.0%	$ 213.36	2.0%	8.0%	2.25%	$ 246.19	$ 230.17	$ 262.21
Dually Eligible	Any	232,802	$ 3.99	27.6%	5.9%	0.0%	$ 7.77	2.0%	8.0%	2.25%	$ 8.84	$ 8.27	$ 9.41
Total		**2,586,116**	**$ 25.62**	**25.6%**	**2.5%**	**0.0%**	**$ 45.76**	**2.0%**	**8.0%**	**2.25%**	**$ 52.74**	**$ 49.35**	**$ 56.14**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

** Admin & Underwriting Gain shown as a % of the total rate before premium tax. Premium Tax is shown as a percent of total premium.

*** Rate Development Formula: 50th Percentile Rate = [B*(1+C)^(30/12)*(1+D)*(1+E)]/(1-G-H)/(1-I)

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Appendix C
Program Change Calculations
Effective December 1, 2015 to January 31, 2016

Gulf Region		Individual Program Changes - PMPM Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	$ 24.60	$ 0.10	$ -	$ 0.44	$ (0.10)	$ 0.01	$ -	$ -	$ 0.00	$ -	$ 0.67	$ 1.12
Disabled Adults	21+	$ 86.76	$ 0.73	$ -	$ 1.75	$ 0.34	$ 0.22	$ -	$ -	$ (0.01)	$ -	$ 1.97	$ 5.00
Non-Disabled Children	0-20	$ 25.08	$ 0.04	$ 0.07	$ 0.30	$ (0.09)	$ 0.01	$ (0.69)	$ 0.27	$ 0.00	$ 0.02	$ -	$ (0.06)
Foster Care and Disabled Children	0-20	$ 149.78	$ 0.27	$ 0.30	$ 2.29	$ (0.12)	$ 0.13	$ (5.15)	$ 1.11	$ 0.01	$ 0.58	$ -	$ (0.59)
Dually Eligible	Any	$ 15.30	$ 0.01	$ -	$ 0.01	$ 0.24	$ 0.08	$ -	$ -	$ 0.00	$ -	$ 0.61	$ 0.96
Total		**$ 36.60**	**$ 0.12**	**$ 0.06**	**$ 0.53**	**$ (0.03)**	**$ 0.04**	**$ (0.74)**	**$ 0.24**	**$ 0.00**	**$ 0.04**	**$ 0.30**	**$ 0.58**

		Individual Program Changes - Percent Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	n/a	0.4%	0.0%	1.8%	-0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	2.7%	4.6%
Disabled Adults	21+	n/a	0.8%	0.0%	2.0%	0.4%	0.2%	0.0%	0.0%	0.0%	0.0%	2.3%	5.8%
Non-Disabled Children	0-20	n/a	0.2%	0.3%	1.2%	-0.4%	0.1%	-2.8%	1.1%	0.0%	0.1%	0.0%	-0.3%
Foster Care and Disabled Children	0-20	n/a	0.2%	0.2%	1.5%	-0.1%	0.1%	-3.4%	0.7%	0.0%	0.4%	0.0%	-0.4%
Dually Eligible	Any	n/a	0.1%	0.0%	0.1%	1.6%	0.6%	0.0%	0.0%	0.0%	0.0%	4.0%	6.3%
Total		**n/a**	**0.3%**	**0.2%**	**1.5%**	**-0.1%**	**0.1%**	**-2.0%**	**0.7%**	**0.0%**	**0.1%**	**0.8%**	**1.6%**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

Capital Region		Individual Program Changes - PMPM Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	$ 21.64	$ 0.15	$ -	$ 0.50	$ (0.09)	$ 0.00	$ -	$ -	$ 0.10	$ 0.00	$ 0.35	$ 1.00
Disabled Adults	21+	$ 73.13	$ 0.82	$ -	$ 1.71	$ (2.66)	$ 0.01	$ -	$ 0.00	$ 0.25	$ -	$ 1.20	$ 1.31
Non-Disabled Children	0-20	$ 24.29	$ 0.05	$ 0.40	$ 0.60	$ (0.01)	$ 0.00	$ (0.94)	$ 0.28	$ 0.02	$ 0.04	$ -	$ 0.44
Foster Care and Disabled Children	0-20	$ 118.88	$ 0.30	$ 2.57	$ 2.73	$ (0.09)	$ 0.06	$ (5.96)	$ 2.93	$ 0.09	$ 0.74	$ -	$ 3.37
Dually Eligible	Any	$ 5.74	$ 0.01	$ -	$ 0.04	$ 0.02	$ 0.01	$ -	$ -	$ 0.00	$ -	$ 0.15	$ 0.22
Total		**$ 31.75**	**$ 0.13**	**$ 0.41**	**$ 0.75**	**$ (0.24)**	**$ 0.01**	**$ (0.98)**	**$ 0.35**	**$ 0.05**	**$ 0.07**	**$ 0.14**	**$ 0.71**

		Individual Program Changes - Percent Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	n/a	0.7%	0.0%	2.3%	-0.4%	0.0%	0.0%	0.0%	0.4%	0.0%	1.6%	4.6%
Disabled Adults	21+	n/a	1.1%	0.0%	2.3%	-3.6%	0.0%	0.0%	0.0%	0.3%	0.0%	1.6%	1.8%
Non-Disabled Children	0-20	n/a	0.2%	1.6%	2.5%	0.0%	0.0%	-3.9%	1.1%	0.1%	0.2%	0.0%	1.8%
Foster Care and Disabled Children	0-20	n/a	0.2%	2.2%	2.3%	-0.1%	0.0%	-5.0%	2.5%	0.1%	0.6%	0.0%	2.8%
Dually Eligible	Any	n/a	0.1%	0.0%	0.6%	0.3%	0.1%	0.0%	0.0%	0.1%	0.0%	2.5%	3.8%
Total		**n/a**	**0.4%**	**1.3%**	**2.4%**	**-0.7%**	**0.0%**	**-3.1%**	**1.1%**	**0.2%**	**0.2%**	**0.5%**	**2.2%**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

South Central Region		Individual Program Changes - PMPM Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	$ 21.96	$ 0.14	$ -	$ 0.37	$ (0.09)	$ 0.01	$ -	$ -	$ (0.00)	$ -	$ 0.39	$ 0.82
Disabled Adults	21+	$ 74.47	$ 0.84	$ -	$ 1.14	$ (3.47)	$ 0.08	$ -	$ -	$ (0.00)	$ -	$ 1.04	$ (0.37)
Non-Disabled Children	0-20	$ 21.30	$ 0.04	$ 0.01	$ 0.08	$ (0.08)	$ 0.00	$ (0.76)	$ 0.07	$ 0.00	$ 0.03	$ -	$ (0.61)
Foster Care and Disabled Children	0-20	$ 134.24	$ 0.30	$ (0.07)	$ 0.56	$ (0.11)	$ 0.01	$ (3.70)	$ 1.36	$ 0.00	$ 1.10	$ -	$ (0.55)
Dually Eligible	Any	$ 6.59	$ 0.01	$ -	$ 0.01	$ (0.18)	$ 0.01	$ -	$ -	$ 0.01	$ -	$ 0.13	$ (0.01)
Total		**$ 30.57**	**$ 0.13**	**$ 0.00**	**$ 0.22**	**$ (0.39)**	**$ 0.01**	**$ (0.71)**	**$ 0.12**	**$ 0.00**	**$ 0.08**	**$ 0.14**	**$ (0.40)**

		Individual Program Changes - Percent Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	n/a	0.6%	0.0%	1.7%	-0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	3.7%
Disabled Adults	21+	n/a	1.1%	0.0%	1.5%	-4.7%	0.1%	0.0%	0.0%	0.0%	0.0%	1.4%	-0.5%
Non-Disabled Children	0-20	n/a	0.2%	0.0%	0.4%	-0.4%	0.0%	-3.6%	0.3%	0.0%	0.2%	0.0%	-2.9%
Foster Care and Disabled Children	0-20	n/a	0.2%	-0.1%	0.4%	-0.1%	0.0%	-2.8%	1.0%	0.0%	0.8%	0.0%	-0.4%
Dually Eligible	Any	n/a	0.2%	0.0%	0.1%	-2.7%	0.2%	0.0%	0.0%	0.1%	0.0%	2.0%	-0.1%
Total		**n/a**	**0.4%**	**0.0%**	**0.7%**	**-1.3%**	**0.0%**	**-2.3%**	**0.4%**	**0.0%**	**0.3%**	**0.4%**	**-1.3%**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

North Region		Individual Program Changes - PMPM Impacts												
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	$ 24.20	$ 0.12	$ -	$ 0.46	$ (0.10)	$ 0.00	$ -	$ -	$ (0.03)	$ -	$ 0.63	$ 1.07
Disabled Adults	21+	$ 64.34	$ 0.55	$ -	$ 1.43	$ (1.40)	$ 0.04	$ -	$ -	$ (0.32)	$ -	$ 1.52	$ 1.82
Non-Disabled Children	0-20	$ 34.86	$ 0.06	$ (0.01)	$ 0.25	$ (0.05)	$ 0.01	$ (0.09)	$ 0.30	$ (0.01)	$ 0.01	$ -	$ 0.48
Foster Care and Disabled Children	0-20	$ 205.64	$ 0.42	$ (0.20)	$ 1.46	$ (0.16)	$ 0.03	$ (0.34)	$ 4.32	$ (0.11)	$ 2.30	$ -	$ 7.71
Dually Eligible	Any	$ 7.33	$ 0.02	$ -	$ 0.03	$ 0.08	$ 0.02	$ -	$ -	$ 0.01	$ -	$ 0.27	$ 0.44
Total		**$ 44.67**	**$ 0.13**	**$ (0.02)**	**$ 0.43**	**$ (0.17)**	**$ 0.02**	**$ (0.08)**	**$ 0.47**	**$ (0.04)**	**$ 0.15**	**$ 0.22**	**$ 1.10**

		Individual Program Changes - Percent Impacts											
Rate Cell	Age	Base PMPM plus Trend *	IP LOS	IP Fee Schedule	Med Mgmt	Changes to Medicaid Populations	PSH	CSoC Regional Adj	Bayou Retained Liability	OP, ER Cost Settlement	PRTF Per Diem	1915i Program Authority	Total Program Changes
Non-Disabled Adults	21+	n/a	0.5%	0.0%	1.9%	-0.4%	0.0%	0.0%	0.0%	-0.1%	0.0%	2.6%	4.4%
Disabled Adults	21+	n/a	0.9%	0.0%	2.2%	-2.2%	0.1%	0.0%	0.0%	-0.5%	0.0%	2.4%	2.8%
Non-Disabled Children	0-20	n/a	0.2%	0.0%	0.7%	-0.1%	0.0%	-0.3%	0.9%	0.0%	0.0%	0.0%	1.4%
Foster Care and Disabled Children	0-20	n/a	0.2%	-0.1%	0.7%	-0.1%	0.0%	-0.2%	2.1%	-0.1%	1.1%	0.0%	3.8%
Dually Eligible	Any	n/a	0.2%	0.0%	0.5%	1.1%	0.2%	0.0%	0.0%	0.2%	0.0%	3.7%	5.9%
Total		**n/a**	**0.3%**	**0.0%**	**1.0%**	**-0.4%**	**0.0%**	**-0.2%**	**1.0%**	**-0.1%**	**0.3%**	**0.5%**	**2.5%**

* The trend shown is annualized from the 30 month period to the midpoint of the new contract period (July 1, 2013 - January 1, 2016)

Appendices

Appendix D
CMS Consultation Guide
Effective December 1, 2015 to January 31, 2016

Section I. December 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
1. General Information	
A. A letter from the certifying actuary, who meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, that certifies that the final capitation rates or rate ranges meet the standards in 42 CFR §438.6(c).	Please refer to the Mercer rate certification letter. All following page and exhibit references are specific to this certification.
B. The final and certified capitation rates or the final and certified rate ranges for all rate cells and regions, as applicable.	Please refer to Appendix B for a summary of all rate ranges by rate cell and region.
C. Brief descriptions of:	
i. The specific state Medicaid managed care programs covered by the certification.	Please refer to pages 1-2.
ii. The rating periods covered by the certification.	Please refer to page 1.
iii. The Medicaid populations covered through the managed care programs for which the certification applies.	A brief description can be found on pages 2-3. Section 2 of the Data Book encompasses a comprehensive list of Bayou Health's covered and excluded populations.
iv. The services that are required to be provided by the managed care plans.	A brief description can be found on pages 3-4. Section 3 of the Data Book encompasses a comprehensive list of Bayou Health's covered services.
2. Data	
A. A description of the data used to develop capitation rates. This description should include:	
i. The types of data used, which may include (but is not limited to) claims data, encounter data, plan financial data, or other Medicaid program data.	Please refer to pages 4-9.
ii. The age of all data used.	Please refer to pages 4-9.
iii. The sources of all data used.	Please refer to pages 4-9.
iv. To the extent that a significant portion of benefits are provided through subcapitated arrangements, a description of the data received from the subcapitated plans or providers.	N/A

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Section I. December 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
v. To the extent that claims or encounter data are not used or not available, an explanation of why that data was not used or was not available.	N/A
B. Information related to the availability and the quality of the data used:	
i. The steps taken by the actuary or by others (which may include but is not limited to the state Medicaid program or the managed care organizations) to validate or improve the quality and accuracy of the data.	Please refer to the base data adjustment section beginning on page 6.
ii. Any concerns that the actuary has over the availability or quality of the data.	N/A
C. Any information related to changes in data used when compared to the most recent rating period:	
i. Any new data sources used by the actuary since the last certification and any data sources that the actuary has not continued to use since the last certification.	The Children's program has been administered on a non-risk basis by the PIHP. This data was not included in the prior LBHP certification for the Adult population at-risk capitation contract.
ii. How the data sources used have changed since the last certification.	Please refer to the base data adjustment section beginning on page 6.
D. Any plans or efforts to improve the data sources used for future certifications and any new data sources that are expected to be available and potentially used for future certifications.	Please refer to the base data adjustment section beginning on page 6.
E. Any adjustments that are made to the data.	Please refer to the base data adjustment section beginning on page 6.
3. Projected Benefit Costs	
A. Covered services and benefits	
i. Any changes related to the benefits covered by the Medicaid managed care organizations since the last certification, including but not limited to:	
a. More or fewer state plan benefits covered by the Medicaid managed care organization.	Please refer to the covered services section on pages 3-4.

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Section I. December 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
b. Requirements deemed necessary by the state to ensure access or proper delivery of covered services, for minimum or maximum levels of payment from managed care organizations to any providers or class of providers.	Please refer to the covered services section on pages 3-4, as well as the base data adjustments section on pages 6-8.
c. Requirements or conditions of any applicable waivers.	N/A
ii. For each change related to benefits covered, the estimated impact of the change on amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment.	Please refer to the covered services section on pages 3-4, as well as the base data adjustments section on pages 6-8. Section 4 of the Data Book outlines adjustments Mercer made to the encounter data and the impacts of each adjustment.
B. Projected benefit cost trends	
i. The projected change in benefit costs from the historical period to the rating period, or trend, including but not limited to:	
a. The methodologies used to develop projected benefit costs trends.	Please refer to the trend section beginning on page 8.
b. Any data used or assumptions made in developing projected benefit cost trends.	Please refer to the trend section beginning on page 8.
c. Any applicable comparisons to historical benefit cost trends or other program benefit cost trends.	Please refer to the trend section beginning on page 8.
d. The different components of projected benefit cost trends, including but not limited to changes in price (such as provider reimbursement rates) and changes in utilization (such as the volume of services provided).	Please refer to the trend section beginning on page 8.
e. Any other material adjustments to projected benefit cost trends, and a description of the data, assumptions, and methodologies used to determine those adjustments.	N/A
f. To the extent there are any differences, projected benefit cost trends by:	
i. Service or category of service.	Please refer to the trend section beginning on page 8.
ii. Rate cell or Medicaid population.	Please refer to the trend section beginning on page 8.

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Section I. December 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
C. Other adjustments to projected benefit costs:	
i. Any other adjustments made to projected benefit costs excluding those described above, including but not limited to:	
a. The impact of managed care on the utilization on the unit costs of health care services.	Please refer to the managed care assumptions section on page 22.
b. Changes to projected benefit costs in the rating period outside of regular changes in utilization or unit cost of services.	Please refer to the program changes section beginning on page 13.
D. Final projected benefit costs by relevant level of detail (for example, by Medicaid population or by rate cell).	Please refer to Appendices A and B.
4. Projected Non-benefit Costs	
E. Non-benefit costs including but not limited to:	
i. Administrative costs.	Please refer to the administration and risk margin loading section beginning on page 22.
ii. Care management or coordination costs.	Included as a component of Administrative costs. Please refer to the administration and risk margin loading section beginning on page 22.
iii. Provisions for:	
a. Cost of capital.	Please refer to the administration and risk margin loading section beginning on page 22.
b. Risk margin.	Considered in the Margin component. Please refer to the administration and risk margin loading section beginning on page 22.
c. Contingency margin.	N/A
d. Underwriting gain.	Included as a component of Administrative costs. Please refer to the administration and risk margin loading section beginning on page 22.
e. Profit margin.	N/A
iv. Taxes, fees, and assessments.	Please refer to the health insurer provider fee consideration and premium tax adjustment sections beginning on page 23.
v. Any other material non-benefit costs.	N/A
5. Rate Range Development	
A. Any assumptions for which values vary in order to develop rate ranges.	Please refer to the trend section beginning on page 8, the administration and risk margin loading section beginning on page 22 and the rate ranges section on page 24.

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Section I. December 1, 2015 – January 31, 2016 Medicaid Managed Care Rates	Documentation Reference
B. The values of each of the assumptions used to develop the minimum, the mid-point (as applicable), and the maximum of the rate ranges.	Please refer to sections related to trend assumptions, prospective program change adjustments, administration and risk margin loading considerations and rate range assumptions.
C. A description of the data, assumptions, and methodologies that were used to develop the values of the assumptions for the minimum, the mid-point (as applicable), and maximum of the rate ranges.	Please refer to sections related to trend assumptions, prospective program change adjustments, administration and risk margin loading considerations and rate range assumptions.
6. Risk and Contractual Provisions	
A. Risk adjustment processes.	Please refer to the administration and risk margin loading section beginning on page 22.
B. Risk sharing arrangements, such as risk corridor or large claims pool.	N/A
C. Medical loss ratio requirements, such as a minimum medical loss ratio requirement.	N/A
D. Reinsurance requirements.	N/A
E. Incentives or withhold amounts.	N/A
7. Other Rate Development Considerations	
A. All adjustments to the capitation rates, or to any portion of the capitation rates, should reflect reasonable, appropriate, and attainable costs in the actuary's opinion and must be included in the rate certification. CMS notes that adjustments that are performed at the end of the rate setting process without adequate justification might not be considered actuarially sound.	Please see Actuarial soundness definition on page 1, as well as the rate certification section on pages 24-26.
B. The final contracted rates should either match the capitation rates or be within the rate ranges in the actuarial certification. This is required in total and by each rate cell.	This letter certifies the rate range. Rates are being set at the 50th percentile for all rating categories and illustrated on Appendices A and B.