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

July 9, 2018

Subject: Healthy Louisiana Program Program – Full Risk-Bearing Managed Care Organization (MCO) Rate Development and Actuarial Certification for the Period Effective February 1, 2018 through April 30, 2018

Dear Ms. Diez:

The Louisiana Department of Health (LDH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound[1] capitation rate ranges for the State of Louisiana's Healthy Louisiana program for the period of February 1, 2018 through January 31, 2019. This certification amends the previous certification issued on March 5, 2018 and amended on April 30, 2018 for rates effective February 1, 2018 through January 31, 2019; and applies to the period of February 1, 2018 through April 30, 2018. The amendment reflects the impact of a technical change related to Centers for Medicare & Medicaid Services (CMS) approved State Plan Amendment (SPA) effective February 21, 2017. The SPA modified the qualifying criteria and the payment methodology for payments to physicians and other professional services practitioners.

This letter presents an overview of the impact of the revised program change, and the resulting capitation rate ranges effective February 1, 2018 through April 30, 2018 for the purpose of satisfying the requirements of the CMS. This rate development process used Medicaid fee-for-service (FFS) medical and pharmacy claims, Healthy Louisiana Shared Savings claims experience, Healthy Louisiana Prepaid encounter data and Louisiana Behavioral Health Partnership claims experience. It resulted in the

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

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

development of a range of actuarially sound rates for each rate cell. The capitation rate ranges are summarized in Appendix A and represent payment in full for the covered services.

The impact of the revised program change on capitation rate ranges applicable to the periods of February 21, 2017 through January 31, 2018 and May 1, 2018 through January 31, 2019 will be provided in separate letters.

TECHNICAL CHANGE

Background

The Louisiana State Plan provides a methodology for payments to qualified physicians and other professional services practitioners. This methodology is designed to bring the payments for the physician services up to the community rate level. The community rate is defined as the rates paid by commercial payers for the same service.

For purposes of qualifying for the payments, the State Plan distinguishes two groups of physicians/practitioners based on the entity that employs or has a contract with the physicians/practitioners. Additional qualifying criteria related to the entities and the provider types are described in the State Plan.

Prior to February 21, 2017, the methodology used in establishing the payments to qualified physicians/practitioners was based on either 1) billed charges for state owned or operated entities, or 2) units of services for non-state owned or operated governmental entities.

- For state owned or operated entities, the billed charges (from the base data) were multiplied by the commercial charges-to-paid conversion factors provided by LDH, to calculate the payments.

- For non-state owned or operated entities, the units of service (from the base data) were multiplied by the most currently available Medicare fees (at the time of rate setting) and the Medicare-to-commercial conversion factors provided by LDH, to calculate the payments.

Fee Schedule Changes

Effective February 21, 2017, the State amended the qualifying criteria and the payment methodology. The payment methodology was standardized so that all qualified providers were paid on the same basis (units of services). Specifically, the payments for all qualified providers are determined by multiplying the units of service (from the base data) by the most currently available Medicare fees (at the time of rate setting) and the Medicare-to-commercial conversion factors provided by LDH as of the effective date.

Mercer evaluated the impact of the program changes and adjusted the capitation rates accordingly. Table 1 below shows the impact on the adjusted base cost of physician services meeting the State Plan's criteria.

		CY 2016 Base Cost[1]	Adjusted Base Cost Underlying Full Rate		Change in Adjusted Base Cost	
			Effective 2/1/18[1]	Effective 5/1/18	$ Change	% Change
Total	[1] = [2] + [5]	**$ 150,203,350**	$ 289,336,604	**$ 334,129,994**	**$ 44,793,389**	**15.5%**
Qualified Providers Effective 2/1/18[1]	[2] = [3] + [4]	**$ 133,105,769**	**$ 289,336,604**	**$ 293,144,737**	**$ 3,808,133**	**1.3%**
State Owned or Operated Entities	*[3]*	*$ 37,919,336*	*$ 48,561,797*	*$ 52,369,930*	*$ 3,808,133*	*7.8%*
Non-State Owned or Operated Governmental Entities	*[4]*	*$ 95,186,434*	*$ 240,774,808*	*$ 240,774,808*	*$ -*	*0.0%*
Newly Added Providers Effective 5/1/18	[5]	**$ 17,097,580**		**$ 40,985,256**	**$ 40,985,256**	

Notes:

1. *CY 2016 Base Cost for Qualified Providers Effective 2/1/18*: Column [A] from Table 8 in February 2018–January 2019 certification letter.
   Adjusted Base Cost Underlying Full Rate Effective 2/1/18: Sum of Column [A] and Column [D] from Table 8 in February 2018–January 2019 certification letter.

CERTIFICATION OF FINAL RATE RANGES

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

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

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

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

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

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

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

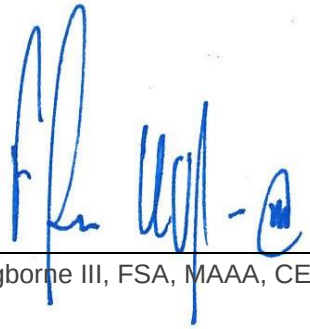
LDH understands that Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends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

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

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

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

Sincerely,



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APPENDIX A: HEALTHY LOUISIANA CAPITATION RATE RANGE

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Gulf	SSI	0–2 Months	$34,673.79	$34,703.10	$36,546.87
Gulf	SSI	3–11 Months	$5,824.10	$5,829.22	$6,162.67
Gulf	SSI	Child 1– 20 Years	$765.58	$766.38	$813.63
Gulf	SSI	Adult 21+ Years	$1,441.96	$1,443.38	$1,533.06
Gulf	Family & Children	0–2 Months	$3,148.68	$3,151.13	$3,328.28
Gulf	Family & Children	3–11 Months	$311.66	$311.96	$331.11
Gulf	Family & Children	Child 1–20 Years	$180.73	$180.93	$192.80
Gulf	Family & Children	Adult 21+ Years	$372.39	$372.77	$394.47
Gulf	Foster Care Children	All Ages Male & Female	$475.15	$475.71	$510.79
Gulf	BCC	BCC, All Ages	$2,197.37	$2,199.55	$2,317.93
Gulf	LAP	LAP, All Ages	$207.01	$207.24	$220.36
Gulf	HCBS	Child 1–20 Years	$1,837.17	$1,839.13	$1,962.85
Gulf	HCBS	Adult 21+ Years	$1,515.41	$1,517.01	$1,624.92

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Gulf	CCM	CCM, All Ages	$1,360.62	$1,362.11	$1,439.60
Gulf	SBH – CCM	SBH – CCM, All Ages	$252.92	$252.92	$258.97
Gulf	SBH – Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	$33.07	$33.07	$34.18
Gulf	SBH – HCBS	SBH – Child 1–20 Years	$141.77	$141.77	$143.91
Gulf	SBH – HCBS	SBH – Adult 21+ Years	$66.21	$66.21	$69.09
Gulf	SBH – Other	SBH – All Ages	$188.80	$188.80	$196.39
Gulf	Maternity Kick Payment	Maternity Kick Payment	$13,515.39	$13,515.39	$14,004.06
Gulf	EED Kick Payment	EED Kick Payment	$7,282.02	$7,282.02	$7,391.00
Gulf	Medicaid Expansion	Female Age 19–24	$280.68	$280.97	$300.61
Gulf	Medicaid Expansion	Male Age 19–24	$225.30	$225.53	$241.11
Gulf	Medicaid Expansion	Female Age 25–39	$395.86	$396.27	$424.33
Gulf	Medicaid Expansion	Male Age 25–39	$396.78	$397.19	$425.33
Gulf	Medicaid Expansion	Female Age 40–49	$611.84	$612.47	$656.35

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Gulf	Medicaid Expansion	Male Age 40–49	$597.10	$597.71	$640.51
Gulf	Medicaid Expansion	Female Age 50–64	$747.65	$748.41	$802.24
Gulf	Medicaid Expansion	Male Age 50–64	$796.14	$796.95	$854.34
Gulf	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	$33.07	$33.07	$34.18
Gulf	Medicaid Expansion	SBH – Other, All Ages	$188.80	$188.80	$196.39
Gulf	Medicaid Expansion	SBH – Chisholm, All Ages	$252.92	$252.92	$258.97
Gulf	Medicaid Expansion	High Needs	$1,447.46	$1,447.46	$1,579.58
Gulf	Medicaid Expansion	Maternity Kick Payment	$13,515.39	$13,515.39	$14,004.06
Gulf	Medicaid Expansion	EED Kick Payment	$7,282.02	$7,282.02	$7,391.00
Capital	SSI	0–2 Months	$34,673.79	$34,703.10	$36,546.87
Capital	SSI	3–11 Months	$5,824.10	$5,829.22	$6,162.67
Capital	SSI	Child 1–20 Years	$767.73	$768.60	$820.07
Capital	SSI	Adult 21+ Years	$1,396.88	$1,398.38	$1,492.95
Capital	Family & Children	0–2 Months	$2,919.69	$2,922.16	$3,100.60

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Capital	Family & Children	3–11 Months	$288.15	$288.44	$307.23
Capital	Family & Children	Child 1–20 Years	$182.48	$182.69	$195.25
Capital	Family & Children	Adult 21+ Years	$392.59	$393.01	$416.96
Capital	Foster Care Children	All Ages Male & Female	$475.15	$475.71	$510.79
Capital	BCC	BCC, All Ages	$2,197.37	$2,199.55	$2,317.93
Capital	LAP	LAP, All Ages	$207.01	$207.24	$220.36
Capital	HCBS	Child 1–20 Years	$1,837.17	$1,839.13	$1,962.85
Capital	HCBS	Adult 21+ Years	$1,515.41	$1,517.01	$1,624.92
Capital	CCM	CCM, All Ages	$1,360.62	$1,362.11	$1,439.60
Capital	SBH - CCM	SBH – CCM, All Ages	$252.92	$252.92	$258.97
Capital	SBH – Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	$23.57	$23.57	$24.29
Capital	SBH – HCBS	SBH – Child 1–20 Years	$141.77	$141.77	$143.91
Capital	SBH – HCBS	SBH – Adult 21+ Years	$66.21	$66.21	$69.09
Capital	SBH – Other	SBH – All Ages	$188.80	$188.80	$196.39

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Capital	Maternity Kick Payment	Maternity Kick Payment	$10,893.61	$10,893.61	$11,322.40
Capital	EED Kick Payment	EED Kick Payment	$5,389.09	$5,389.09	$5,484.71
Capital	Medicaid Expansion	Female Age 19–24	$295.71	$296.03	$317.71
Capital	Medicaid Expansion	Male Age 19–24	$237.22	$237.47	$254.68
Capital	Medicaid Expansion	Female Age 25–39	$417.29	$417.74	$448.73
Capital	Medicaid Expansion	Male Age 25–39	$418.27	$418.72	$449.79
Capital	Medicaid Expansion	Female Age 40–49	$645.28	$645.97	$694.42
Capital	Medicaid Expansion	Male Age 40–49	$629.75	$630.42	$677.66
Capital	Medicaid Expansion	Female Age 50–Age 64	$788.61	$789.45	$848.86
Capital	Medicaid Expansion	Male Age 50–64	$839.80	$840.69	$904.04
Capital	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	$23.57	$23.57	$24.29
Capital	Medicaid Expansion	SBH – Other, All Ages	$188.80	$188.80	$196.39
Capital	Medicaid Expansion	SBH – Chisholm, All Ages	$252.92	$252.92	$258.97

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Capital	Medicaid Expansion	High Needs	$1,526.55	$1,526.55	$1,672.28
Capital	Medicaid Expansion	Maternity Kick Payment	$10,893.61	$10,893.61	$11,322.40
Capital	Medicaid Expansion	EED Kick Payment	$5,389.09	$5,389.09	$5,484.71
South Central	SSI	0–2 Months	$34,673.79	$34,703.10	$36,546.87
South Central	SSI	3–11 Months	$5,824.10	$5,829.22	$6,162.67
South Central	SSI	Child 1–20 Years	$737.75	$738.58	$785.61
South Central	SSI	Adult 21+ Years	$1,278.46	$1,279.78	$1,362.45
South Central	Family & Children	0–2 Months	$3,277.49	$3,280.27	$3,481.98
South Central	Family & Children	3–11 Months	$286.94	$287.23	$306.00
South Central	Family & Children	Child 1–20 Years	$182.35	$182.56	$195.08
South Central	Family & Children	Adult 21+ Years	$365.57	$365.96	$387.88
South Central	Foster Care Children	All Ages Male & Female	$475.15	$475.71	$510.79
South Central	BCC	BCC, All Ages	$2,197.37	$2,199.55	$2,317.93
South Central	LAP	LAP, All Ages	$207.01	$207.24	$220.36
South Central	HCBS	Child 1–20 Years	$1,837.17	$1,839.13	$1,962.85

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
South Central	HCBS	Adult 21+ Years	$1,515.41	$1,517.01	$1,624.92
South Central	CCM	CCM, All Ages	$1,360.62	$1,362.11	$1,439.60
South Central	SBH – CCM	SBH – CCM, All Ages	$252.92	$252.92	$258.97
South Central	SBH – Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	$23.43	$23.43	$24.15
South Central	SBH – HCBS	SBH – Child 1–20 Years	$141.77	$141.77	$143.91
South Central	SBH – HCBS	SBH – Adult 21+ Years	$66.21	$66.21	$69.09
South Central	SBH – Other	SBH – All Ages	$188.80	$188.80	$196.39
South Central	Maternity Kick Payment	Maternity Kick Payment	$9,698.50	$9,698.50	$10,126.10
South Central	EED Kick Payment	EED Kick Payment	$4,208.51	$4,208.51	$4,303.86
South Central	Medicaid Expansion	Female Age 19–24	$275.40	$275.69	$295.51
South Central	Medicaid Expansion	Male Age 19–24	$221.09	$221.32	$237.05
South Central	Medicaid Expansion	Female Age 25–39	$388.26	$388.67	$416.99
South Central	Medicaid Expansion	Male Age 25–39	$389.16	$389.57	$417.97

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
South Central	Medicaid Expansion	Female Age 40–49	$599.90	$600.53	$644.81
South Central	Medicaid Expansion	Male Age 40–49	$585.48	$586.10	$629.28
South Central	Medicaid Expansion	Female Age 50–64	$733.00	$733.77	$788.09
South Central	Medicaid Expansion	Male Age 50–64	$780.52	$781.34	$839.25
South Central	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	$23.43	$23.43	$24.15
South Central	Medicaid Expansion	SBH – Other, All Ages	$188.80	$188.80	$196.39
South Central	Medicaid Expansion	SBH – Chisholm, All Ages	$252.92	$252.92	$258.97
South Central	Medicaid Expansion	High Needs	$1,418.55	$1,418.55	$1,551.87
South Central	Medicaid Expansion	Maternity Kick Payment	$9,698.50	$9,698.50	$10,126.10
South Central	Medicaid Expansion	EED Kick Payment	$4,208.51	$4,208.51	$4,303.86
North	SSI	0–2 Months	$34,673.79	$34,703.10	$36,546.87
North	SSI	3–11 Months	$5,824.10	$5,829.22	$6,162.67
North	SSI	Child 1–20 Years	$758.08	$758.92	$807.23
North	SSI	Adult 21+ Years	$1,200.35	$1,201.57	$1,277.94

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
North	Family & Children	0–2 Months	$2,992.08	$2,994.44	$3,164.60
North	Family & Children	3–11 Months	$282.51	$282.79	$300.54
North	Family & Children	Child 1–20 Years	$198.76	$198.98	$212.50
North	Family & Children	Adult 21+ Years	$354.68	$355.05	$375.75
North	Foster Care Children	All Ages Male & Female	$475.15	$475.71	$510.79
North	BCC	BCC, All Ages	$2,197.37	$2,199.55	$2,317.93
North	LAP	LAP, All Ages	$207.01	$207.24	$220.36
North	HCBS	Child 1–20 Years	$1,837.17	$1,839.13	$1,962.85
North	HCBS	Adult 21+ Years	$1,515.41	$1,517.01	$1,624.92
North	CCM	CCM, All Ages	$1,360.62	$1,362.11	$1,439.60
North	SBH – CCM	SBH - CCM, All Ages	$252.92	$252.92	$258.97
North	SBH – Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	$28.26	$28.26	$29.18
North	SBH – HCBS	SBH – Child 1–20 Years	$141.77	$141.77	$143.91
North	SBH – HCBS	SBH – Adult 21+ Years	$66.21	$66.21	$69.09

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
North	SBH – Other	SBH – All Ages	$188.80	$188.80	$196.39
North	Maternity Kick Payment	Maternity Kick Payment	$10,961.65	$10,961.65	$11,390.71
North	EED Kick Payment	EED Kick Payment	$5,453.87	$5,453.87	$5,549.55
North	Medicaid Expansion	Female Age 19–24	$267.17	$267.45	$286.14
North	Medicaid Expansion	Male Age 19–24	$214.57	$214.79	$229.62
North	Medicaid Expansion	Female Age 25–39	$376.54	$376.93	$403.65
North	Medicaid Expansion	Male Age 25–39	$377.40	$377.79	$404.58
North	Medicaid Expansion	Female Age 40–49	$581.65	$582.25	$624.03
North	Medicaid Expansion	Male Age 40–49	$567.65	$568.23	$608.98
North	Medicaid Expansion	Female Age 50–64	$710.66	$711.39	$762.65
North	Medicaid Expansion	Male Age 50–64	$756.70	$757.48	$812.11
North	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	$28.26	$28.26	$29.18
North	Medicaid Expansion	SBH – Other, All Ages	$188.80	$188.80	$196.39

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	REASONABLY ATTAINABLE PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
North	Medicaid Expansion	SBH – Chisholm, All Ages	$252.92	$252.92	$258.97
North	Medicaid Expansion	High Needs	$1,375.42	$1,375.42	$1,501.29
North	Medicaid Expansion	Maternity Kick Payment	$10,961.65	$10,961.65	$11,390.71
North	Medicaid Expansion	EED Kick Payment	$5,453.87	$5,453.87	$5,549.55

APPENDIX B:

2-1-18 Rate Update: FMP
Impact to the Full Non-Expansion Rate

			Feb 2018 - Jan 2019 Rates						
			A	B	C	D	E = A + B + C + D	F	G = E + F
COA Description	Rate Cell Description	CY2016 MMs	Claims PMPM	Total Admin PMPM	UW Gain PMPM	Prem Tax PMPM	Limited Rate PMPM	FMP Add On PMPM	Full Rate PMPM
SSI	Newborn, 0-2 Months	963	$ 20,723.07	$ 965.11	$ 1,289.57	$ 468.93	$ 23,446.68	$ 11,159.80	$ 34,606.48
SSI	Newborn, 3-11 Months	6,983	$ 3,621.59	$ 169.32	$ 225.41	$ 81.97	$ 4,098.28	$ 1,716.57	$ 5,814.84
SSI	Child, 1-20 Years	456,675	$ 579.27	$ 35.48	$ 36.55	$ 13.29	$ 664.59	$ 92.04	$ 756.64
SSI	Adult, 21+ Years	938,794	$ 958.58	$ 50.07	$ 59.97	$ 21.81	$ 1,090.43	$ 242.81	$ 1,333.24
Family and Children	Newborn, 0-2 Months	113,728	$ 1,775.28	$ 92.62	$ 111.06	$ 40.39	$ 2,019.35	$ 1,075.87	$ 3,095.22
Family and Children	Newborn, 3-11 Months	395,749	$ 194.74	$ 22.31	$ 12.91	$ 4.69	$ 234.65	$ 58.56	$ 293.21
Family and Children	Child, 1-20 Years	7,939,771	$ 135.01	$ 18.79	$ 9.14	$ 3.33	$ 166.27	$ 18.87	$ 185.14
Family and Children	Adult, 21+ Years	1,271,721	$ 263.82	$ 23.58	$ 17.09	$ 6.21	$ 310.70	$ 61.04	$ 371.74
Foster Care Children	Foster Care, All Ages M & F	153,036	$ 384.18	$ 29.64	$ 24.61	$ 8.95	$ 447.37	$ 27.42	$ 474.80
Breast and Cervical Cancer	BCC, All Ages Female	7,224	$ 1,535.08	$ 75.08	$ 95.74	$ 34.81	$ 1,740.71	$ 464.20	$ 2,204.92
LaCHIP Affordable Plan	All Ages	39,300	$ 151.02	$ 19.35	$ 10.13	$ 3.68	$ 184.18	$ 22.49	$ 206.68
HCBS Waiver	20 & Under, M & F	4,736	$ 1,378.14	$ 70.26	$ 86.12	$ 31.32	$ 1,565.84	$ 270.48	$ 1,836.31
HCBS Waiver	21+ Years, M & F	15,616	$ 1,130.29	$ 53.63	$ 70.40	$ 25.60	$ 1,279.91	$ 234.71	$ 1,514.62
Chisholm Class Members	Chisholm, All Ages M & F	39,194	$ 1,035.67	$ 68.00	$ 65.62	$ 23.86	$ 1,193.16	$ 163.14	$ 1,356.30
SBH - Chisholm Class Members	SBH - Chisholm, All Ages M & F	47,217	$ 221.62	$ 11.95	$ 13.89	$ 5.05	$ 252.51	$ 0.23	$ 252.74
SBH - Dual Eligible	SBH - Dual Eligible, All Ages	1,232,026	$ 20.19	$ 4.88	$ 1.49	$ 0.54	$ 27.10	$ 0.09	$ 27.19
SBH - HCBS Waiver	SBH - 20 & Under, M & F	20,210	$ 124.38	$ 5.89	$ 7.75	$ 2.82	$ 140.83	$ 0.86	$ 141.69
SBH - HCBS Waiver	SBH - 21+ Years, M & F	42,977	$ 51.62	$ 7.21	$ 3.50	$ 1.27	$ 63.60	$ 2.47	$ 66.07
SBH -Other	SBH - Other, All Ages	55,122	$ 134.99	$ 14.65	$ 8.90	$ 3.24	$ 161.77	$ 26.76	$ 188.53
Maternity Kickpayment	Maternity Kickpayment, All Ages	33,044	$ 6,449.69	$ 340.18	$ 403.72	$ 146.81	$ 7,340.40	$ 3,914.13	$ 11,254.53
	Aggregate	**12,781,043**	**$ 257.99**	**$ 22.89**	**$ 16.70**	**$ 6.07**	**$ 303.65**	**$ 63.89**	**$ 367.54**

			Feb 2018 - April 2018 Rates						
			H	I = A + H	J	K	L	M = I + J + K + L	N	O = M + N
COA Description	Rate Cell Description	CY2016 MMs	Claims PMPM	Total Admin PMPM	UW Gain PMPM	Prem Tax PMPM	Limited Rate PMPM	Revised FMP Add On PMPM	Full Rate PMPM
SSI	Newborn, 0-2 Months	963	$ 20,723.07	$ 965.11	$ 1,289.57	$ 468.93	$ 23,446.68	$ 11,227.11	$ 34,673.79
SSI	Newborn, 3-11 Months	6,983	$ 3,621.59	$ 169.32	$ 225.41	$ 81.97	$ 4,098.28	$ 1,725.82	$ 5,824.09
SSI	Child, 1-20 Years	456,675	$ 579.27	$ 35.48	$ 36.55	$ 13.29	$ 664.59	$ 93.01	$ 757.60
SSI	Adult, 21+ Years	938,794	$ 958.58	$ 50.07	$ 59.97	$ 21.81	$ 1,090.43	$ 242.94	$ 1,333.38
Family and Children	Newborn, 0-2 Months	113,728	$ 1,775.28	$ 92.62	$ 111.06	$ 40.39	$ 2,019.35	$ 1,078.31	$ 3,097.67
Family and Children	Newborn, 3-11 Months	395,749	$ 194.74	$ 22.31	$ 12.91	$ 4.69	$ 234.65	$ 59.00	$ 293.65
Family and Children	Child, 1-20 Years	7,939,771	$ 135.01	$ 18.79	$ 9.14	$ 3.33	$ 166.27	$ 19.08	$ 185.35
Family and Children	Adult, 21+ Years	1,271,721	$ 263.82	$ 23.58	$ 17.09	$ 6.21	$ 310.70	$ 61.14	$ 371.85
Foster Care Children	Foster Care, All Ages M & F	153,036	$ 384.18	$ 29.64	$ 24.61	$ 8.95	$ 447.37	$ 27.77	$ 475.15
Breast and Cervical Cancer	BCC, All Ages Female	7,224	$ 1,535.08	$ 75.08	$ 95.74	$ 34.81	$ 1,740.71	$ 456.71	$ 2,197.42
LaCHIP Affordable Plan	All Ages	39,300	$ 151.02	$ 19.35	$ 10.13	$ 3.68	$ 184.18	$ 22.82	$ 207.00
HCBS Waiver	20 & Under, M & F	4,736	$ 1,378.14	$ 70.26	$ 86.12	$ 31.32	$ 1,565.84	$ 271.27	$ 1,837.10
HCBS Waiver	21+ Years, M & F	15,616	$ 1,130.29	$ 53.63	$ 70.40	$ 25.60	$ 1,279.91	$ 235.47	$ 1,515.38
Chisholm Class Members	Chisholm, All Ages M & F	39,194	$ 1,035.67	$ 68.00	$ 65.62	$ 23.86	$ 1,193.16	$ 167.46	$ 1,360.61
SBH - Chisholm Class Members	SBH - Chisholm, All Ages M & F	47,217	$ 221.62	$ 11.95	$ 13.89	$ 5.05	$ 252.51	$ 0.41	$ 252.91
SBH - Dual Eligible	SBH - Dual Eligible, All Ages	1,232,026	$ 20.19	$ 4.88	$ 1.49	$ 0.54	$ 27.10	$ 0.09	$ 27.19
SBH - HCBS Waiver	SBH - 20 & Under, M & F	20,210	$ 124.38	$ 5.89	$ 7.75	$ 2.82	$ 140.83	$ 0.95	$ 141.78
SBH - HCBS Waiver	SBH - 21+ Years, M & F	42,977	$ 51.62	$ 7.21	$ 3.50	$ 1.27	$ 63.60	$ 2.60	$ 66.20
SBH -Other	SBH - Other, All Ages	55,122	$ 134.99	$ 14.65	$ 8.90	$ 3.24	$ 161.77	$ 27.03	$ 188.80
Maternity Kickpayment	Maternity Kickpayment, All Ages	33,044	$ 6,449.69	$ 340.18	$ 403.72	$ 146.81	$ 7,340.40	$ 3,963.76	$ 11,304.16
	Aggregate	**12,781,043**	**$ 257.99**	**$ 22.89**	**$ 16.70**	**$ 6.07**	**$ 303.65**	**$ 64.26**	**$ 367.91**
	Difference		$ -	$ -	$ -	$ -	$ -	$ 0.38	$ 0.38

APPENDIX C:

2-1-18 Rate Update: FMP
Impact to the Full Expansion Rate

			Feb 2018 - Jan 2019 Rates						
			A	B	C	D	E = A + B + C + D	F	G = E + F
COA Description	Rate Cell Description	Projected MMs	Claims PMPM	Total Admin PMPM	UW Gain PMPM	Prem Tax PMPM	Limited Rate PMPM	FMP Add On PMPM	Full Rate PMPM
Expansion	Aggregate	6,015,546	$ 379.26	$ 29.55	$ 24.31	$ 8.84	$ 441.96	$ 102.11	$ 544.07

			Feb 2018 - April 2018 Rates						
		H	I = A + H	J	K	L	M = I + J + K + L	N	O = M + N
COA Description	Rate Cell Description	Projected MMs	Claims PMPM	Total Admin PMPM	UW Gain PMPM	Prem Tax PMPM	Limited Rate PMPM	FMP Add On PMPM	Full Rate PMPM
Expansion	Aggregate	6,015,546	$ 379.26	$ 29.55	$ 24.31	$ 8.84	$ 441.96	$ 102.50	$ 544.46
	Difference		$ -	$ -	$ -	$ -	$ -	$ 0.39	$ 0.39

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MAKE TOMORROW, TODAY

JULY 2017–JUNE 2018 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE

Louisiana — February 1, 2018– January 31, 2019

Documentation Reference

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

- Certification #1 – Rate Certification dated March 5, 2018 for effective period February 1, 2018 through January 31, 2019. This certification was revised by certification #2 for the entire period of February 1, 2018 through January 31, 2019.
- Certification #2 – Rate Certification dated April 30, 2018 for effective period February 1, 2018 through January 31, 2019.
- Certification #3 – Rate Certification dated July 9, 2018 for effective period February 1, 2018 through April 30, 2018

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

A. Rate Development Standards

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

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

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

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

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

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

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

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

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

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

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

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

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

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

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

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

ii. the rating period covered by the rate certification.

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

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

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

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

A. describe the rationale for the adjustment; and

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

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

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

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

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

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

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

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

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

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

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

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

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

   b. for contract amendments that do not affect the rates or rate range, CMS does not require a new rate certification from the state. However, if the contract amendment revises the covered populations, services furnished under the contract or other changes that could reasonably

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

change the rate development and rates, the state and its actuary must provide supporting documentation indicating the rationale as to why the rates continue to be actuarially sound in accordance with 42 CFR §438.4.

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

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

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

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

B. Appropriate Documentation	Documentation Reference		
	Certification #1	**Certification #2**	**Certification #3**
i. States and their actuaries must document all the elements described within their rate certifications to provide adequate detail that CMS is able to determine whether or not the regulatory standards are met. In evaluating the rate certification, CMS will look to the reasonableness of the information contained in the rate certification for the purposes of rate development and may require additional information or documentation as necessary to review and approve the rates. States and	• Mercer Rate Certification – Part A: General Information, pages 2–9 – Data Book	•	•

SECTION I. MEDICAID MANAGED CARE RATES			
1. General Information			
their actuaries must ensure that the following elements are properly documented:			
a. data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources. b. assumptions made, including any basis or justification for the assumption. c. methods for analyzing data and developing assumptions and adjustments.			
i. The rate certification must include an index that documents the page number or the section number for the items described within this guidance. In cases where not all sections of this guidance are relevant for a particular rate certification (i.e., an amended certification that adds a new benefit for part of the year), inapplicable sections of the guidance should be included and marked as "Not Applicable" in the index.	• Mercer Rate Certification– CMS RDG attached at end of document, pages 105–147	• Mercer Rate Certification– CMS RDG attached at end of document, pages 18–60	• Mercer Rate Certification– CMS RDG attached at end of document, pages 17–100
ii. There are services, populations, or programs for which the state receives a different federal medical assistance percentage (FMAP) than the regular state FMAP. In those cases, the portions or amounts of the	• Mercer Rate Certification – Healthy Louisiana Services Eligible for	•	•

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

	costs subject to the different FMAP should be shown as part of the rate certification to the extent possible.	Different FMAP page 8		
iii.	In cases when the actuary develops and certifies rate ranges on behalf of a state, the rate certification and supporting documentation must describe how the rate ranges were developed, including: a. any assumptions for which values are varied in order to develop rate ranges. b. the values of each of the assumptions used to develop the minimum, the mid-point or best estimate (as applicable), and the maximum of the rate ranges. c. a description of the data, assumptions, and methodologies that were used to develop the values of the assumptions for the minimum, the mid-point or best estimate (as applicable), and the maximum of the rate ranges.	• Mercer Rate Certification – Subpart C.1: Projected Benefit Costs, Trend, page 21 – Appendix G	•	•
iv.	The information related to rate range development must be included in either the relevant sections of the rate certification or in a separate section related to specifically to the rate range development. For example, a	• See section A above for more detail.	•	•

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

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

SECTION I. MEDICAID MANAGED CARE RATES

2. Data

A. Rate Development Standards

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

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

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

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

SECTION I. MEDICAID MANAGED CARE RATES

2. Data

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

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

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

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

B. Appropriate Documentation	Documentation Reference		
	Certification #1	**Certification #2**	**Certification #3**
i. In accordance with 42 CFR §438.7(b)(1), the rate certification must include: a. a description of base data requested by the actuary for the rate setting process, including: i. a summary of the base data that was requested by the actuary. ii. a summary of the base data that was provided by the state. iii. an explanation of why any base data requested was not provided by the state.	• Mercer Rate Certification – Data Book – Section 1: Medicaid Managed Care Rates › Part B: Base Data Development, page 9	•	•

SECTION I. MEDICAID MANAGED CARE RATES			
2. Data			
ii. The rate certification, as supported by the assurances from the state, must thoroughly describe the data used to develop the capitation rates, including: a. a description of the data, including:			
i. the types of data used, which may include, but is not limited to: fee-for-service claims data; managed care encounter data; health plan financial data; information from program integrity audits; or other Medicaid program data.	• Mercer Rate Certification – Section 1: Medicaid Managed Care Rates › Part A: General Information, pages 2–3 › Part B: Base Data Development, page 9	•	•
ii. the age or time periods of all data used.	• Mercer Rate Certification – Section 1: Medicaid Managed Care Rates › Part A: General Information, pages 2–3 › Part B: Base Data Development, page 9	•	•

SECTION I. MEDICAID MANAGED CARE RATES				
2. Data				
	iii. the sources of all data used (e.g., State Medicaid Agency; other state agencies; health plans; or other third parties).	• Mercer Rate Certification – Section 1: Medicaid Managed Care Rates › Part A: General Information, pages 2–3 › Part B: Base Data Development, page 9	•	•
	iv. if a significant portion of the benefits under the contract with the managed care entity are provided through arrangements with subcontractors that are also paid on a capitated basis (or subcapitated arrangements), a description of the data received from the subcapitated plans or providers; or, if data is not received from the subcapitated plans or providers, a description of how the historical costs related to subcapitated arrangements were developed or verified.	• N/A	•	•

SECTION I. MEDICAID MANAGED CARE RATES			
2. Data			
b. information related to the availability and the quality of the data used for rate development, including:			
i. the steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including: A. completeness of the data. B. accuracy of the data. C. consistency of the data across data sources.	• Mercer Rate Certification – Section 1: Medicaid Managed Care Rates › Part B: Base Data Development, pages 9–10	•	•
ii. a summary of the actuary's assessment of the data.	• Mercer Rate Certification – Part B: Base Data Development, pages 9–10 – Section 3: Certification of Final Rate Ranges, pages 29–30	•	•

SECTION I. MEDICAID MANAGED CARE RATES			
2. Data			
iii. any other concerns that the actuary has over the availability or quality of the data.	• N/A	•	•
c. a description of how the actuary determined what data was appropriate to use for the rating period, including:			
i. if fee-for-service claims or managed care encounter data are not used (or are not available), this description should include an explanation of why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.	• N/A	•	•
ii. if managed care encounter data was not used in the rate development, this description should include an explanation of why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data.	• N/A	•	•
d. if there is any reliance or use of a data book in the rate development, the details	• Mercer Rate Certification	•	•

SECTION I. MEDICAID MANAGED CARE RATES			
2. Data			
of the template and relevant instructions used in the data book.	– Section 1: Medicaid Managed Care Rates › Part A: General Information, pages 2–3 › Appendix Y › Part B: Base Data Development, pages 8–9		
iii. The rate certification, as supported by the assurances from the state, must thoroughly describe any significant adjustments, and the basis for the adjustments, that are made to the data, including but not limited to adjustments for:			
a. the credibility of the data.	• Mercer Rate Certification – Part B: Base Data Development, pages 8–9 – Base Data Adjustments, page 13	•	•
b. completion factors.	• Mercer Rate Certification	•	•

SECTION I. MEDICAID MANAGED CARE RATES			
2. Data			
	– Part B: Base Data Development, pages 8–9 – IBNR, page 10 – Under-reporting Adjustment, page 10		
c. errors found in the data.	• N/A	•	•
d. changes in the program between the time period from which the data is obtained and the rating period (e.g., changes in the population covered; changes in benefits or services; changes to payment models or reimbursement rates to providers; or changes to the structure of the managed care program).	• Mercer Rate Certification – Prospective Rating Adjustments, pages 14–21	• Mercer Rate Certification – Technical Changes for ABA services, page 2	• Mercer Rate Certification – Technical Change, pages 2–3
e. exclusions of certain payments or services from the data.	• Mercer Rate Certification – Excluded services, pages 7–8	•	•

SECTION I. MEDICAID MANAGED CARE RATES

3. Projected Benefit Costs and Trends

A. Rate Development Standards

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

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

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

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

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

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

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

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

SECTION I. MEDICAID MANAGED CARE RATES

3. Projected Benefit Costs and Trends

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

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

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

B. Appropriate Documentation	Documentation Reference		
	Certification #1	**Certification #2**	**Certification #3**
i. The rate certification must clearly document the final projected benefit costs by relevant level of detail (e.g., rate cell, or aligned with how the state makes payments to the plans).	• Appendix Q: Non-Expansion Loaded Rate Development	•	•
ii. The rate certification and supporting documentation must describe the development of the projected benefit costs included in the capitation rates, including:			
a. a description of the data, assumptions, and methodologies used to develop the projected benefit costs and, in particular, all significant and material items in developing the projected benefit costs.	• Mercer Rate Certification – Section 1, Part C: Non-Expansion Capitation Rate Development, page 21	•	•
b. any material changes to the data, assumptions, and methodologies used to	• Mercer Rate Certification – Section 1, Part C: Non-Expansion	• Mercer Rate Certification	• Mercer Rate Certification – Technical Change for, pages 2–3

SECTION I. MEDICAID MANAGED CARE RATES			
3. Projected Benefit Costs and Trends			
develop projected benefit costs since the last rate certification must be described.	Capitation Rate Development, page 21	– Technical Changes for ABA Services, page 2	
iii. The rate certification and supporting documentation must include a section on projected benefit cost trends (i.e. an estimate the projected change in benefit costs from the historical base data period(s) to the rating period of the rate certification) in accordance with 42 CFR §438.7(b)(2). a. this section must include:			
i. any data used or assumptions made in developing projected benefit cost trends, including a description of the sources of those data and assumptions. A. the descriptions of data and assumptions should include citations whenever possible. B. the description should state whether the trend is developed primarily with actual experience from the Medicaid population or provide rationale for the experience from a similar	• Mercer Rate Certification – Historical Trend, page 13 – Trend, page 21	•	•

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3. Projected Benefit Costs and Trends			
population that is utilized, and consideration of other factors expected to impact trend.			
ii. the methodologies used to develop projected benefit trends.	• Mercer Rate Certification – Historical Trend, page 13 – Trend, page 21	•	•
iii. any comparisons to historical benefit cost trends, or other program benefit cost trends, that were analyzed as part of the development of the trend for the rating period of the rate certification.	• Mercer Rate Certification – Historical Trend, page 13 – Trend, pages 21	•	•
b. this section must include the projected benefit cost trends separated into components, specifically:			
i. the projected benefit cost trends should be separated into: A. changes in price (i.e., pricing differences due to different provider reimbursement rates or payment models); and B. changes in utilization (i.e., differences in the amount,	• Mercer Rate Certification – Appendix G	•	•

SECTION I. MEDICAID MANAGED CARE RATES			
3. Projected Benefit Costs and Trends			
duration, or mix of benefits or services provided).			
ii. if the actuary did not develop the projected benefit cost trends using price and utilization components, the actuary should describe and justify the method(s)used to develop projected benefit cost trends.	• Mercer Rate Certification – Trend, page 21	•	•
iii. the projected benefit cost trends may include other components as applicable and used by the actuary in developing rates (e.g., changes in location of service delivery; the effect of utilization or care management on projected benefit cost trends; regional differences or variations).	• N/A	•	•
c. variations in the projected benefit cost trends must be explained. Projected benefit cost trends may vary by: i. Medicaid populations. ii. rate cells. iii. subsets of benefits within a category of services (e.g., specialty vs. non-specialty drugs).	• Mercer Rate Certification – Historical Trend, page 13 – Trend, page 21	•	•

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3. Projected Benefit Costs and Trends			
d. any other material adjustments to projected benefit cost trends must be described in accordance with 42 CFR §438.7(b)(4), including: i. a description of the data, assumptions, and methodologies used to determine each adjustment. ii. the cost impact of each material adjustment. iii. where in the rate setting process the material adjustment was applied.	• Mercer Rate Certification – Historical Trend, page 13 – Trend, page 21	•	•
e. any other adjustments to projected benefit costs trends must be listed. CMS also requests the following detail about non-material adjustments: i. the impact of managed care on the utilization and the unit costs of health care services. ii. changes to projected benefit costs trend in the rating period outside of regular changes in utilization or unit cost of services.	• N/A	•	•
iv. If the projected benefit costs include additional services deemed by the state to be	• N/A	•	•

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

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

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

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3. Projected Benefit Costs and Trends			
an estimated impact of the change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment.	– New Services, page 7 – Prospective Rating adjustments, Pages 20–21	– Technical Changes for ABA services, page 2 and Appendices B & C	– Technical Change, pages 2–3 and Appendices B & C
a. any change determined by the actuary to be non-material can be grouped with other non-material changes and described within the rate certification, provided that: i. the rate certification includes a list of all non-material adjustments used in the rate development process. ii. the actuary must give a description of why the changes were not considered material and how they were aggregated into a single adjustment. iii. the rate certification provides a description of where in the rate setting process the adjustments were applied. iv. The rate certification documents the aggregate cost impact of all non-material adjustments.	• N/A	•	•

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

i. Rate Development Standards

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

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

i. Appropriate Documentation	**Documentation Reference**		
	Certification #1	**Certification #2**	**Certification #3**
a. the rate certification must include a description of the incentive arrangement. An adequate description includes at least: i. time period of the arrangement, if different than the rating period. ii. enrollees, services, and providers covered by the incentive program.	• N/A	•	•

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iii. the purpose of the incentive arrangement (e.g. specified activities, targets, performance measures, or quality-based outcomes, etc.). iv. a description of any effect that each incentive arrangement has on the development of the capitation rates.			
B. Withhold Arrangements			
i. Rate Development Standards a. the rate certification and supporting documentation must describe any withhold arrangements in the contract between the state and the health plans. As defined in 42 CFR §438.6(a), a withhold arrangement is any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract. i. the targets for a withhold arrangement are distinct from general operational requirements under the contract. ii. arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement. b. in accordance with 42 CFR §438.6(b)(3), the capitation payment(s) minus any portion of the withhold that is not reasonably achievable must be actuarially sound.			
ii. Appropriate Documentation	**Documentation Reference**		
	Certification #1	**Certification #2**	**Certification #3**
a. the rate certification must include a description of the withhold arrangement.	•	• N/A	•

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4. Special Contract Provisions Related to Payment			
An adequate description includes at least the following: i. the time period of the arrangement, if different than the rating period and the purpose of the arrangement (e.g. specified activities, targets, performance measures, or quality-based outcomes, etc.). ii. a description of the total percentage of the certified capitation rates being withheld through withhold arrangements. iii. an estimate of the percentage of the withheld amount in a withhold arrangement that is not reasonably achievable and the basis for that determination, including the data, assumptions, and methodologies used to make this determination. iv. a description of how the total withhold arrangement, achievable or not, is reasonable and takes into consideration the health plan's financial operating needs accounting for the size and characteristics of the populations covered under the			

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4. Special Contract Provisions Related to Payment			
contract, as well as the health plan's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves. v. a description of any effect that the withhold arrangements have on the development of the capitation rates.			
C. Risk-Sharing Mechanisms			
i. Rate Development Standards a. in accordance with 42 CFR §438.6(b), if the state utilizes risk-sharing mechanisms with its health plan(s), such as reinsurance, risk corridors, or stop-loss limits, these arrangements must be described in the contract(s) and must be developed in accordance with §438.4, the rate development standards in §438.5, and generally accepted actuarial principles and practices. b. the rate certification and supporting documentation must describe any risk mitigation that may affect the rates, rate ranges, or the final net payments to the health plan(s) under the applicable contract.			
ii. Appropriate Documentation	**Documentation Reference**		
	Certification #1	**Certification #2**	**Certification #3**
a. the rate certification and supporting documentation must include a description of any other risk-sharing arrangements, such as a risk corridor or a large claims pool. An adequate	• Mercer Rate Certification – Subpart C.4: Risk Mitigation, Non-Expansion Minimum Medical Loss Ratio (MLR), page 26	•	•

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

SECTION I. MEDICAID MANAGED CARE RATES			
4. Special Contract Provisions Related to Payment			
i. the methodology used to calculate the medical loss ratio. ii. the formula for calculating a remittance/payment for having a medical loss ratio below/above the minimum requirements. iii. any other consequences for a remittance/payment for a medical loss ratio below/above the minimum requirements.			
c. if the contract has reinsurance requirements, the rate certification and supporting document must include a description of the reinsurance requirements. An adequate description includes at least the following: i. a detailed description of any reinsurance requirements under the contract associated with the rate certification, including the reinsurance premiums and any relevant historical reinsurance experience. ii. identification of any effect that the reinsurance requirements have on			

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

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4. Special Contract Provisions Related to Payment			
	Certification #1	**Certification #2**	**Certification #3**
a. the rate certification and supporting documentation must include a description of any delivery system and provider payment initiatives. An adequate description includes at least the following: i. a brief description of the delivery system and provider payment initiatives included in the rates for this rating period. ii. the amount of these payments within the rate development, both in total and on a per member per month basis (if applicable). iii. the providers receiving these payments. iv. a description of any effect the delivery system or provider payment initiative has on the development of capitation rates, including the data, assumptions and methodologies used to make this determination.			
E. Pass-Through Payments			

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

i. Rate Development Standards

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

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

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

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

iv. graduate Medical Education (GME) payments; or

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

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

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

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

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

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

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

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

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

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

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

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

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

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

ii. Appropriate Documentation	Documentation Reference		
	Certification #1	Certification #2	Certification #3
a. the rate certification and supporting documentation must include a description of all existing pass-through payments incorporated into the rates for	• N/A	•	•

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

SECTION I. MEDICAID MANAGED CARE RATES

4. Special Contract Provisions Related to Payment

i. the data, methodologies, and assumptions used to calculate the base amount. ii. the aggregate amounts calculated for Section I, Item 4.E.i.c.i.A, Section I, Item 4.E.i.c.i.B, Section I, Item 4.E.i.c.ii.A, and Section I, Item 4.E.i.c.ii.B.			

SECTION I. MEDICAID MANAGED CARE RATES

5. Projected Non-Benefit Costs

A. Rate Development Standards

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

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

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5. Projected Non-Benefit Costs

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

iv. Section 9010 of the Patient Protection and Affordable Care Act imposes a Health Insurance Providers Fee on each covered entity engaged in the business of providing health insurance for United States health risk. CMS policy regarding how this fee may be considered in Medicaid managed care rate development is outlined in CMS's "Medicaid and CHIP FAQs: Health Insurance Providers Fee for Medicaid Managed Care Plans," dated October 2014.[8] States have the flexibility to account for the Health Insurance Providers Fee on a prospective or retrospective basis into rate development for either the data year or fee year. Any payment for the fee must be incorporated in the health plan capitation rates.

v. due to the health insurance provider fee moratorium established by the Consolidated Appropriations Act of 2016, CMS does not expect any health insurance provider fees to be paid for calendar year 2017 by managed care plans that are subject to that fee. Therefore, no amounts should be included in Medicaid managed care capitation rates for fees that would have been paid by plans to the IRS for 2017 (which would have been assessed off of 2016 net premiums).[9] This fee remains in effect for calendar year 2018 and beyond.

B. Appropriate Documentation	Documentation Reference		
	Certification #1	Certification #2	Certification #3

[8] Federal Policy Guidance FAQS

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

SECTION I. MEDICAID MANAGED CARE RATES			
5. Projected Non-Benefit Costs			
i. rate certification and supporting documentation must describe the development of the projected non-benefit costs included in the capitation rates in enough detail so CMS or an actuary applying generally accepted actuarial principles and practices can identify each type of non-benefit expense that is included in the rate and evaluate the reasonableness of the cost assumptions underlying each expense in accordance with 42 CFR §438.7(b)(3). To meet this standard, the documentation must include: a. a description of the data, assumptions, and methodologies used to develop the projected non-benefit costs, and in particular, all significant and material items in developing the projected non-benefit costs. b. any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last rate certification. c. any other material adjustments must be described in accordance with 42 CFR §438.7(b)(4), including:	• Mercer Rate Certification – Subpart C.3: Projected Non-Benefit Costs, page 25	•	•

SECTION I. MEDICAID MANAGED CARE RATES			
5. Projected Non-Benefit Costs			
i. a description of the data, assumptions, and methodologies used to determine each adjustment. ii. where in the rating setting process each adjustment was applied. iii. the cost impact of each material adjustment.			
ii. States and actuaries should estimate the projected non-benefit costs for each of the following categories of costs: a. administrative costs. b. taxes, licensing and regulatory fees, and other assessments and fees. c. contribution to reserves, risk margin, and cost of capital. d. other material non-benefit costs.	• Mercer Rate Certification – Subpart C.3: Projected Non-Benefit Costs, page 25	•	•
iii. Regarding the Health Insurance Providers Fee, the rate certification and supporting documentation must: a. specifically address how this fee is incorporated into capitation rates if the	• Mercer Rate Certification – Subpart C.3: Projected Non-Benefit Costs: Federal Health Insurer Fee, page 26	•	•

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5. Projected Non-Benefit Costs

managed care plan is required to pay the fee. b. if the fee is incorporated into the rates in the initial rate certification, an explanation of whether the amount included in the rates is based on the data year or fee year during the rating period of the rate certification. c. a description of how the amount of the fee was determined, and whether or not any adjustments would be made to the rates once the actual amount of the fee is known. d. if the fee is not incorporated into the rates in the rate certification because the rates will be adjusted to account for the fee subsequently, an explicit statement that the fee is not included, and a description of when and how the rates will ultimately be adjusted to account for the fee. e. if the capitation rates include benefits as described in 26 CFR §57.2(h)(2)(ix)(e.g., long-term care, nursing home care, home health care, or community-based care), CMS recommends that the per			

SECTION I. MEDICAID MANAGED CARE RATES			
5. Projected Non-Benefit Costs			
member per month cost associated with those benefits be explicitly reported as a separate amount in the rate certification in order to more accurately account for the appropriate revenue on which the plans will be assessed.			

SECTION I. MEDICAID MANAGED CARE RATES
6. Risk Adjustment and Acuity Adjustments
A. Rate Development Standards
i. Risk adjustment is a methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of MCOs, PIHPs, or PAHPs contracted with the state.
ii. As required by 42 CFR §438.5(g), if risk adjustment is applied prospectively or retrospectively, states and their actuaries must select a risk adjustment methodology that uses generally accepted models and must apply it in a budget neutral manner, consistent with generally accepted actuarial principles and practices, across all MCOs, PIHPs or PAHPs in the program to calculate adjustments to the payments as necessary.
iii. An adjustment applied to the total payments across all managed care plans to account for significant uncertainty about the health status or risk of a population is considered an acuity adjustment, which is a permissible adjustment under 42 CFR §438.5(f). (81 FR 27595) a. acuity adjustments may be used prospectively or retrospectively. b. while retrospective acuity adjustments may be permissible, they are intended solely as a mechanism to account for differences between assumed and actual health status when there is significant uncertainty about the health status or risk of a population, such as: (1) new

SECTION I. MEDICAID MANAGED CARE RATES

6. Risk Adjustment and Acuity Adjustments

populations coming into the Medicaid program; or (2) a Medicaid population that is moving from FFS to managed care when enrollment is voluntary and there may be concerns about adverse selection. In the latter case, there may be significant uncertainty about the health status of which individuals would remain in FFS versus move to managed care; although this uncertainty is expected to decrease as the program matures.

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

B. Appropriate Documentation	Documentation Reference		
	Certification #1	**Certification #2**	**Certification #3**
i. In accordance with 42 CFR §438.7(b)(5)(i), the rate certification must describe all prospective risk adjustment methodologies, including: a. the data, and any adjustments to that data, to be used to calculate the adjustment. b. the model, and any adjustments to that model, to be used to calculate the adjustment. c. the method for calculating the relative risk factors and the reasonableness and appropriateness of the method in measuring the risk factors of the respective populations.	• Mercer Rate Certification – Subpart C.4: Risk Mitigation, page 26	•	•

SECTION I. MEDICAID MANAGED CARE RATES			
6. Risk Adjustment and Acuity Adjustments			
d. the magnitude of the adjustment on the capitation rate per MCO, PIHP, or PAHP. e. an assessment of the predictive value of the methodology compared to prior rating periods. f. any concerns the actuary has with the risk adjustment process.			
ii. In accordance with 42 CFR §438.7(b)(5)(ii), the rate certification must describe all retrospective risk adjustment methodologies, including: a. the party calculating the risk adjustment. b. the data, and any adjustments to that data, to be used to calculate the adjustment. c. the model, and any adjustments to that model, to be used to calculate the adjustment. d. the timing and frequency of the application of the risk adjustment. e. any concerns the actuary has with the risk adjustment process.	• Mercer Rate Certification – Subpart C.4: Risk Mitigation, page 26	•	•
iii. The rate certification and supporting documentation must also specifically include:	• Mercer Rate Certification	•	•

SECTION I. MEDICAID MANAGED CARE RATES			
6. Risk Adjustment and Acuity Adjustments			
a. any changes that are made to risk adjustment models since the last rating period. b. documentation that the risk adjustment model is budget neutral in accordance with 42 CFR §438.5(g).	– Subpart C.4: Risk Mitigation, page 26		
iv. If an acuity adjustment is being used, the rate certification must include a description of the acuity adjustment and its basis that is adequate to evaluate its reasonableness and whether it is consistent with generally accepted actuarial principles and practices. Such a description includes at least: a. the reason that there is significant uncertainty about the health status of the population and the need for an acuity adjustment. b. the acuity adjustment model(s) being used to calculate acuity adjustment scores. c. the specific data, including the source(s) of the data, being used by the acuity adjustment model(s). d. the relationship and potential interactions between the acuity adjustment.		•	•

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

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS			
1. Managed Long-Term Services and Supports			
A. For managed long-term services and supports (MLTSS) programs, or for programs that include MLTSS as part of the covered benefits, the guidance above in Section I regarding the required standards for rate development and CMS's expectations for appropriate documentation required in the rate certification is also applicable for rates for provision of MLTSS.			
B. Rate Development Standards			
i. States may take different approaches for rate setting for MLTSS. The two most common approaches are to structure the rate cells: a. by health care status and the level of need of the beneficiaries ("blended"); or b. by the long-term care setting that the beneficiary uses ("non-blended").			
C. Appropriate Documentation	**Documentation Reference**		
	Certification #1	**Certification #2**	**Certification #3**

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

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

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE		
	CERTIFICATION #1	CERTIFICATION #2	CERTIFICATION #3
1. Data			
A. In addition to the expectations for all Medicaid managed care rate certifications, as supported by assurances from the State, described in Section I, the rate certification must describe any data used to develop new adult group rates.	• Mercer Rate Certification – Section 2: Expansion Capitation Rate Development, pages 26–29	•	•
B. For states that have covered the new adult group in Medicaid managed care plans in previous rating periods (i.e. starting in 2014, 2015, 2016, and/or January through June 2017), CMS expects the rate certification, as supported by assurances from the State, to describe: i. Any new data that is available for use in this rate setting. ii. How the state and the actuary followed through on any plans to monitor costs and experience for newly eligible adults. iii. How actual experience and costs in previous rating periods have differed from assumptions and expectations in previous rate certifications.	• Mercer Rate Certification – Section 2: Expansion Capitation Rate Development, pages 26–29	•	•

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE		
	CERTIFICATION #1	CERTIFICATION #2	CERTIFICATION #3
iv. How differences between projected and actual experience in previous rating periods have been used to adjust these rates.			

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE		
	CERTIFICATION #1	CERTIFICATION #2	CERTIFICATION #3
2. Projected Benefit Costs			
A. In addition to the guidance for all Medicaid managed care rate certifications described in Section I, states should include in the rate certification submission and supporting documentation a description of the following issues related to the projected benefit costs for the new adult group: i. For states that covered the new adult group in previous rating periods:			
a. any data and experience specific to newly eligible adults covered in previous rating periods that was used to develop projected benefits costs for capitation rates.	• Mercer Rate Certification – Section 2: Expansion Capitation Rate Development, pages 26–29	•	•

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE		
	CERTIFICATION #1	CERTIFICATION #2	CERTIFICATION #3
2. Projected Benefit Costs			
b. any changes in data sources, assumptions, or methodologies used to develop projected benefits costs for capitation rates since the last certification.	• Mercer Rate Certification – Section 2: Expansion Capitation Rate Development, pages 26–29	•	•
c. how assumptions changed from rate certification(s) for previous rating periods on the following issues: i. acuity or health status adjustments (in most cases comparing the new adult group enrollees to other Medicaid adult enrollees). ii. adjustments for pent-up demand. iii. adjustments for adverse selection. iv. adjustments for the demographics of newly eligible adults. v. differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement	• Mercer Rate Certification – Section 2: Expansion Capitation Rate Development, pages 26–29 – Appendix R	•	•

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE		
	CERTIFICATION #1	CERTIFICATION #2	CERTIFICATION #3
2. Projected Benefit Costs			
rates or provider networks for newly eligible adult rates and other Medicaid population rates. A. variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations. vi. other material adjustments to newly eligible adults projected benefit costs.			
B. For any state that is covering the new adult group, regardless if they have been covered in previous rating periods, the following key assumptions related to the new adult group must be included in the rate certification and supporting documentation:	• Mercer Rate Certification – Section 2: Expansion Capitation Rate Development, pages 26–29	•	•

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE		
	CERTIFICATION #1	CERTIFICATION #2	CERTIFICATION #3
2. Projected Benefit Costs			
i. Acuity or health status adjustments (in most cases comparing new adult group enrollees to other Medicaid adult enrollees). ii. Adjustments for pent-up demand. iii. Adjustments for adverse selection. iv. Adjustments for the demographics of the new adult group. v. Differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for the new adult group rates and other Medicaid population rates. vi. Other material adjustments to the new adult group projected benefit costs.			
C. The rate certification and supporting documentation must describe any changes to the benefit plan offered to the new adult group.	• Mercer Rate Certification – Rate Cell Structure, pages 26–27 – Additional Rate Adjustments, page 27 – Appendix R	•	•

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE		
	CERTIFICATION #1	CERTIFICATION #2	CERTIFICATION #3
2. Projected Benefit Costs			
D. The rate certification and supporting documentation must describe any other material changes or adjustments to projected benefit costs.	• N/A	• Mercer Rate Certification – Technical Changes for ABA services, page 2 and Appendix C	• Mercer Rate Certification – Technical Revisions, pages 2–3 and Appendix C

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE		
	CERTIFICATION #1	CERTIFICATION #2	CERTIFICATION #3
3. Projected Non-Benefit Costs			
A. In addition to the guidance all Medicaid managed care rate certifications described in Section I, states must include in the rate certification submission and supporting documentation a description of the following issues related to the projected non-benefit costs for the new adult group: i. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, any changes in data sources, assumptions, or methodologies used to	• Mercer Rate Certification – Non-Medical Expense Load, pages 28–29 – Appendix W	•	•

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

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE		
	CERTIFICATION #1	CERTIFICATION #2	CERTIFICATION #3
3. Projected Non-Benefit Costs			
iv. Taxes, fees, and assessments. v. Other material non-benefit costs.			

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE		
	CERTIFICATION #1	CERTIFICATION #2	CERTIFICATION #3
4. Final Certified Rates or Rate Ranges			
A. In addition to the expectations for all Medicaid managed care rate certifications described in Section I, CMS requests under 42 CFR §438.7(d)[10] that states that covered the new adult group in Medicaid managed care plans in previous rating periods provide: i. A comparison to the final certified rates or rate ranges in the previous rate certification.	• Mercer Rate Certification – Appendix Q	• Mercer Rate Certification – Technical Changes for ABA services, page 2 and Appendix C	• Mercer Rate Certification – Technical Revisions, pages 2–3 and Appendix C

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

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE		
	CERTIFICATION #1	CERTIFICATION #2	CERTIFICATION #3
ii. A description of any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.			

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE		
	CERTIFICATION #1	CERTIFICATION #2	CERTIFICATION #3
5. Risk Mitigation Strategies			
A. CMS requests under 42 CFR §438.7(d) that states describe the risk mitigation strategy specific to the new adult group rates.	• Mercer Rate Certification – Part C: Risk Mitigation Strategies, page 29	•	•
B. For states that covered the new adult group in Medicaid managed care plans in previous rating periods, CMS requests the following information: i. Any changes in the risk mitigation strategy from those used during previous rating periods. ii. The rationale for making the change in the risk mitigation strategy or removing the risk	• Mercer Rate Certification – Part C: Risk Mitigation Strategies, page 29	•	•

SECTION III. NEW ADULT GROUP CAPITATION RATES	DOCUMENTATION REFERENCE		
	CERTIFICATION #1	CERTIFICATION #2	CERTIFICATION #3
mitigation strategy used during previous rating periods. iii. Any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during previous rating periods.			