F. Ronald Ogborne III, FSA, CERA, MAAA
Partner

Erik Axelsen, ASA, MAAA
Senior Associate
3560 Lenox Road NE, Suite 2400
Atlanta, GA 30326
+1 404 442 3100
www.mercer-government.mercer.com

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 October 1, 2017 through January 31, 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 October 1, 2017 through January 31, 2018. This certification amends the previous certification issued January 8, 2018 for rates effective October 1, 2017 through January 31, 2018; and applies to the period of October 1, 2017 through January 31, 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 October 1, 2017 through January 31, 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

[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 September 30, 2017 and February 1, 2018 through April 30, 2018 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.

		RY 2017 Base Cost[1]	Adjusted Base Cost Underlying Full Rate		Change in Adjusted Base Cost	
			Effective 2/1/17[2]	Effective 10/1/17	$ Change	% Change
Qualified Providers Effective 2/1/17[1]	[1] = [2] + [3]	**$ 185,502,458**	**$ 392,494,237**	**$ 404,237,051**	**$ 11,742,814**	**3.0%**
State Owned or Operated Entities	*[2]*	*$ 77,738,893*	*$ 99,321,578*	*$ 111,064,392*	*$ 11,742,814*	*11.8%*
Non-State Owned or Operated Governmental Entities	*[3]*	*$ 107,763,566*	*$ 293,172,659*	*$ 293,172,659*	*$ -*	*0.0%*

Notes:

1. *RY 2017 Base Cost for Qualified Providers Effective 2/1/17*: Column [A] from Tables 20a and 20b in February 2017–January 2018 certification letter.
2. *Adjusted Base Cost Underlying Full Rate Effective 2/1/17*: Sum of Column [A] and Column [D] from Tables 20a and 20b in February 2017–January 2018 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 Mercer issued it. 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.

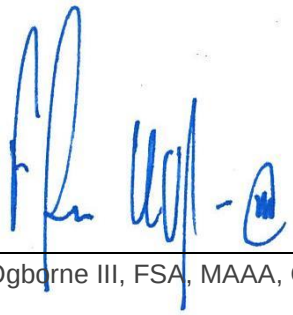
LDH understands that Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends 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,



F. Ronald Ogborne III, FSA, MAAA, CERA

Partner

Erik Axelsen, ASA, MAAA

Senior Associate

Copy:
Amanda Joyner, Deputy Assistant Secretary – OBH/LDH
Marisa Naquin, Managed Care Finance – LDH
Jen Steele, Medicaid Director – LDH
Karen Stubbs, Deputy Assistant Secretary – OBH/LDH

Robert Butler, Principal – Mercer
Christina Coleman, Associate – Mercer
Kodzo Dekpe, ASA, MAAA, Associate – Mercer

APPENDIX A: HEALTHY LOUISIANA CAPITATION RATE RANGE

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Gulf	SSI	0–2 Months	$27,336.43	$29,097.52
Gulf	SSI	3–11 Months	$7,432.06	$7,911.02
Gulf	SSI	Child 1– 20 Years	$784.36	$849.02
Gulf	SSI	Adult 21+ Years	$1,304.07	$1,384.37
Gulf	Family & Children	0–2 Months	$1,648.51	$1,765.52
Gulf	Family & Children	3–11 Months	$272.28	$289.14
Gulf	Family & Children	Child 1–20 Years	$168.26	$181.15
Gulf	Family & Children	Adult 21+ Years	$339.83	$358.94
Gulf	Foster Care Children	All Ages Male & Female	$613.87	$675.64
Gulf	BCC	BCC, All Ages	$2,334.59	$2,463.42
Gulf	LAP	LAP, All Ages	$198.22	$212.81
Gulf	HCBS	Child 1–20 Years	$2,487.48	$2,720.46
Gulf	HCBS	Adult 21+ Years	$1,073.13	$1,150.01

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Gulf	CCM	CCM, All Ages	$1,289.78	$1,420.07
Gulf	SBH – CCM	SBH – CCM, All Ages	$197.88	$222.06
Gulf	SBH – Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	$25.60	$27.17
Gulf	SBH – HCBS	SBH – Child 1–20 Years	$91.40	$101.64
Gulf	SBH – HCBS	SBH – Adult 21+ Years	$79.88	$84.40
Gulf	SBH – Other	SBH – All Ages	$193.53	$203.39
Gulf	Maternity Kick Payment	Maternity Kick Payment	$11,393.99	$11,620.54
Gulf	EED Kick Payment	EED Kick Payment	$6,655.41	$6,720.20
Gulf	Medicaid Expansion	Female Age 19–24	$315.31	$343.00
Gulf	Medicaid Expansion	Male Age 19–24	$276.58	$299.17
Gulf	Medicaid Expansion	Female Age 25–39	$416.46	$457.46
Gulf	Medicaid Expansion	Male Age 25–39	$381.49	$417.88
Gulf	Medicaid Expansion	Female Age 40–49	$589.54	$653.32
Gulf	Medicaid Expansion	Male Age 40–49	$579.86	$642.36

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Gulf	Medicaid Expansion	Female Age 50–64	$684.50	$760.77
Gulf	Medicaid Expansion	Male Age 50–64	$768.26	$855.56
Gulf	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	$25.60	$27.17
Gulf	Medicaid Expansion	SBH – Other, All Ages	$193.53	$203.39
Gulf	Medicaid Expansion	SBH – Chisholm, All Ages	$197.88	$222.06
Gulf	Medicaid Expansion	High Needs	$1,329.86	$1,472.61
Gulf	Medicaid Expansion	Maternity Kick Payment	$11,393.99	$11,620.54
Gulf	Medicaid Expansion	EED Kick Payment	$6,655.41	$6,720.20
Capital	SSI	0–2 Months	$27,336.43	$29,097.52
Capital	SSI	3–11 Months	$7,432.06	$7,911.02
Capital	SSI	Child 1–20 Years	$798.35	$866.05
Capital	SSI	Adult 21+ Years	$1,355.09	$1,444.22
Capital	Family & Children	0–2 Months	$1,719.82	$1,843.34
Capital	Family & Children	3–11 Months	$265.60	$282.35
Capital	Family & Children	Child 1–20 Years	$176.09	$189.67

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Capital	Family & Children	Adult 21+ Years	$396.70	$419.08
Capital	Foster Care Children	All Ages Male & Female	$613.87	$675.64
Capital	BCC	BCC, All Ages	$2,334.59	$2,463.42
Capital	LAP	LAP, All Ages	$198.22	$212.81
Capital	HCBS	Child 1–20 Years	$2,487.48	$2,720.46
Capital	HCBS	Adult 21+ Years	$1,073.13	$1,150.01
Capital	CCM	CCM, All Ages	$1,289.78	$1,420.07
Capital	SBH - CCM	SBH – CCM, All Ages	$197.88	$222.06
Capital	SBH – Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	$20.85	$22.12
Capital	SBH – HCBS	SBH – Child 1–20 Years	$91.40	$101.64
Capital	SBH – HCBS	SBH – Adult 21+ Years	$79.88	$84.40
Capital	SBH – Other	SBH – All Ages	$193.53	$203.39
Capital	Maternity Kick Payment	Maternity Kick Payment	$9,225.22	$9,425.27
Capital	EED Kick Payment	EED Kick Payment	$5,038.85	$5,096.06

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
Capital	Medicaid Expansion	Female Age 19–24	$359.03	$392.24
Capital	Medicaid Expansion	Male Age 19–24	$312.52	$339.62
Capital	Medicaid Expansion	Female Age 25–39	$480.52	$529.70
Capital	Medicaid Expansion	Male Age 25–39	$438.51	$482.17
Capital	Medicaid Expansion	Female Age 40–49	$688.39	$764.88
Capital	Medicaid Expansion	Male Age 40–49	$676.76	$751.73
Capital	Medicaid Expansion	Female Age 50–Age 64	$802.44	$893.92
Capital	Medicaid Expansion	Male Age 50–64	$903.04	$1,007.74
Capital	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	$20.85	$22.12
Capital	Medicaid Expansion	SBH – Other, All Ages	$193.53	$203.39
Capital	Medicaid Expansion	SBH – Chisholm, All Ages	$197.88	$222.06
Capital	Medicaid Expansion	High Needs	$1,551.24	$1,722.37
Capital	Medicaid Expansion	Maternity Kick Payment	$9,225.22	$9,425.27
Capital	Medicaid Expansion	EED Kick Payment	$5,038.85	$5,096.06
South Central	SSI	0–2 Months	$27,336.43	$29,097.52

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
South Central	SSI	3–11 Months	$7,432.06	$7,911.02
South Central	SSI	Child 1–20 Years	$758.71	$822.91
South Central	SSI	Adult 21+ Years	$1,209.34	$1,284.50
South Central	Family & Children	0–2 Months	$2,089.91	$2,220.27
South Central	Family & Children	3–11 Months	$282.51	$299.64
South Central	Family & Children	Child 1–20 Years	$170.54	$183.17
South Central	Family & Children	Adult 21+ Years	$366.24	$386.73
South Central	Foster Care Children	All Ages Male & Female	$613.87	$675.64
South Central	BCC	BCC, All Ages	$2,334.59	$2,463.42
South Central	LAP	LAP, All Ages	$198.22	$212.81
South Central	HCBS	Child 1–20 Years	$2,487.48	$2,720.46
South Central	HCBS	Adult 21+ Years	$1,073.13	$1,150.01
South Central	CCM	CCM, All Ages	$1,289.78	$1,420.07
South Central	SBH – CCM	SBH – CCM, All Ages	$197.88	$222.06
South Central	SBH – Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	$17.81	$18.89

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
South Central	SBH – HCBS	SBH – Child 1–20 Years	$91.40	$101.64
South Central	SBH – HCBS	SBH – Adult 21+ Years	$79.88	$84.40
South Central	SBH – Other	SBH – All Ages	$193.53	$203.39
South Central	Maternity Kick Payment	Maternity Kick Payment	$9,116.30	$9,321.63
South Central	EED Kick Payment	EED Kick Payment	$4,818.86	$4,877.59
South Central	Medicaid Expansion	Female Age 19–24	$336.28	$366.69
South Central	Medicaid Expansion	Male Age 19–24	$293.62	$318.43
South Central	Medicaid Expansion	Female Age 25–39	$447.72	$492.74
South Central	Medicaid Expansion	Male Age 25–39	$409.19	$449.15
South Central	Medicaid Expansion	Female Age 40–49	$638.38	$708.42
South Central	Medicaid Expansion	Male Age 40–49	$627.72	$696.35
South Central	Medicaid Expansion	Female Age 50–64	$743.00	$826.75
South Central	Medicaid Expansion	Male Age 50–64	$835.27	$931.13
South Central	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	$17.81	$18.89

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
South Central	Medicaid Expansion	SBH – Other, All Ages	$193.53	$203.39
South Central	Medicaid Expansion	SBH – Chisholm, All Ages	$197.88	$222.06
South Central	Medicaid Expansion	High Needs	$1,438.44	$1,595.12
South Central	Medicaid Expansion	Maternity Kick Payment	$9,116.30	$9,321.63
South Central	Medicaid Expansion	EED Kick Payment	$4,818.86	$4,877.59
North	SSI	0–2 Months	$27,336.43	$29,097.52
North	SSI	3–11 Months	$7,432.06	$7,911.02
North	SSI	Child 1–20 Years	$844.94	$920.07
North	SSI	Adult 21+ Years	$1,122.60	$1,191.56
North	Family & Children	0–2 Months	$2,042.91	$2,172.42
North	Family & Children	3–11 Months	$281.26	$298.59
North	Family & Children	Child 1–20 Years	$174.11	$188.35
North	Family & Children	Adult 21+ Years	$337.20	$356.54
North	Foster Care Children	All Ages Male & Female	$613.87	$675.64
North	BCC	BCC, All Ages	$2,334.59	$2,463.42

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
North	LAP	LAP, All Ages	$198.22	$212.81
North	HCBS	Child 1–20 Years	$2,487.48	$2,720.46
North	HCBS	Adult 21+ Years	$1,073.13	$1,150.01
North	CCM	CCM, All Ages	$1,289.78	$1,420.07
North	SBH – CCM	SBH - CCM, All Ages	$197.88	$222.06
North	SBH – Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	$19.90	$21.11
North	SBH – HCBS	SBH – Child 1–20 Years	$91.40	$101.64
North	SBH – HCBS	SBH – Adult 21+ Years	$79.88	$84.40
North	SBH – Other	SBH – All Ages	$193.53	$203.39
North	Maternity Kick Payment	Maternity Kick Payment	$10,273.39	$10,473.57
North	EED Kick Payment	EED Kick Payment	$6,081.80	$6,139.05
North	Medicaid Expansion	Female Age 19–24	$312.61	$341.07
North	Medicaid Expansion	Male Age 19–24	$273.02	$296.24
North	Medicaid Expansion	Female Age 25–39	$416.02	$458.17

REGION DESCRIPTION	CATEGORY OF AID DESCRIPTION	RATE CELL DESCRIPTION	LOWER BOUND PMPM OR COST PER DELIVERY	UPPER BOUND PMPM OR COST PER DELIVERY
North	Medicaid Expansion	Male Age 25–39	$380.26	$417.68
North	Medicaid Expansion	Female Age 40–49	$592.96	$658.52
North	Medicaid Expansion	Male Age 40–49	$583.06	$647.31
North	Medicaid Expansion	Female Age 50–64	$690.04	$768.44
North	Medicaid Expansion	Male Age 50–64	$775.66	$865.40
North	Medicaid Expansion	SBH – Dual Eligible & LaHIPP, All Ages	$19.90	$21.11
North	Medicaid Expansion	SBH – Other, All Ages	$193.53	$203.39
North	Medicaid Expansion	SBH – Chisholm, All Ages	$197.88	$222.06
North	Medicaid Expansion	High Needs	$1,333.22	$1,479.94
North	Medicaid Expansion	Maternity Kick Payment	$10,273.39	$10,473.57
North	Medicaid Expansion	EED Kick Payment	$6,081.80	$6,139.05

APPENDIX B:

10-1-17 Rate Update: FMP
Impact to the Full Non-Expansion Rate

			Oct 2017 - Jan 2018 Rates						
			A	B	C	D	E = A + B + C + D	F	G = E + F
COA Description	Rate Cell Description	CY2014 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	1,777	$ 17,896.89	$ 966.71	$ 407.86	$ 1,121.62	$ 20,393.08	$ 6,843.58	$ 27,236.66
SSI	Newborn, 3-11 Months	7,473	$ 4,801.92	$ 251.62	$ 109.27	$ 300.48	$ 5,463.28	$ 1,958.67	$ 7,421.95
SSI	Child, 1-20 Years	438,102	$ 617.91	$ 41.28	$ 14.25	$ 39.19	$ 712.63	$ 83.76	$ 796.39
SSI	Adult, 21+ Years	908,893	$ 906.60	$ 50.77	$ 20.70	$ 56.92	$ 1,034.99	$ 212.19	$ 1,247.18
Family and Children	Newborn, 0-2 Months	181,298	$ 1,165.21	$ 75.17	$ 26.82	$ 73.75	$ 1,340.95	$ 519.13	$ 1,860.08
Family and Children	Newborn, 3-11 Months	408,855	$ 191.50	$ 22.48	$ 4.63	$ 12.72	$ 231.33	$ 43.57	$ 274.89
Family and Children	Child, 1-20 Years	8,163,747	$ 126.20	$ 19.13	$ 3.14	$ 8.64	$ 157.12	$ 14.73	$ 171.85
Family and Children	Adult, 21+ Years	1,405,973	$ 258.22	$ 24.80	$ 6.12	$ 16.83	$ 305.96	$ 53.40	$ 359.36
Foster Care Children	Foster Care, All Ages M & F	145,854	$ 510.52	$ 38.35	$ 11.87	$ 32.64	$ 593.37	$ 20.15	$ 613.52
Breast and Cervical Cancer	BCC, All Ages Female	11,167	$ 1,585.54	$ 86.67	$ 36.16	$ 99.43	$ 1,807.80	$ 514.58	$ 2,322.38
LaCHIP Affordable Plan	All Ages	32,566	$ 148.88	$ 19.87	$ 3.65	$ 10.03	$ 182.43	$ 15.51	$ 197.93
HCBS Waiver	20 & Under, M & F	4,275	$ 2,078.41	$ 115.34	$ 47.43	$ 130.44	$ 2,371.62	$ 114.87	$ 2,486.49
HCBS Waiver	21+ Years, M & F	12,346	$ 809.17	$ 44.71	$ 18.46	$ 50.77	$ 923.11	$ 148.97	$ 1,072.09
Chisholm Class Members	Chisholm, All Ages M & F	20,773	$ 1,033.03	$ 71.71	$ 23.89	$ 65.69	$ 1,194.31	$ 93.73	$ 1,288.05
SBH - Chisholm Class Members	SBH - Chisholm, All Ages M & F	54,449	$ 172.71	$ 10.32	$ 3.96	$ 10.88	$ 197.88	$ -	$ 197.88
SBH - Dual Eligible & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	1,240,232	$ 16.75	$ 2.31	$ 0.41	$ 1.13	$ 20.60	$ 0.48	$ 21.08
SBH - HCBS Waiver	SBH - 20 & Under, M & F	23,926	$ 74.77	$ 5.30	$ 1.73	$ 4.76	$ 86.56	$ 4.79	$ 91.34
SBH - HCBS Waiver	SBH - 21+ Years, M & F	47,163	$ 61.95	$ 4.60	$ 1.44	$ 3.96	$ 71.95	$ 7.90	$ 79.85
SBH -Other	SBH - Other, All Ages	37,833	$ 137.12	$ 8.38	$ 3.15	$ 8.65	$ 157.31	$ 36.21	$ 193.51
Maternity Kickpayment	Maternity Kickpayment, All Ages	76,325	$ 5,405.85	$ 286.50	$ 123.08	$ 338.46	$ 6,153.90	$ 3,909.03	$ 10,062.93
	Aggregate	**13,146,701**	**$ 261.30**	**$ 24.14**	**$ 6.17**	**$ 16.97**	**$ 308.59**	**$ 66.78**	**$ 375.37**

			Oct 2017 - Jan 2018 Revised Rates						
			H	I	J	K	L	M = I + J + K + L	N	O = M + N
COA Description	Rate Cell Description	CY2014 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	1,777	$ 17,896.89	$ 966.71	$ 407.86	$ 1,121.62	$ 20,393.08	$ 6,943.35	$ 27,336.42
SSI	Newborn, 3-11 Months	7,473	$ 4,801.92	$ 251.62	$ 109.27	$ 300.48	$ 5,463.28	$ 1,968.76	$ 7,432.04
SSI	Child, 1-20 Years	438,102	$ 617.91	$ 41.28	$ 14.25	$ 39.19	$ 712.63	$ 84.76	$ 797.39
SSI	Adult, 21+ Years	908,893	$ 906.60	$ 50.77	$ 20.70	$ 56.92	$ 1,034.99	$ 213.36	$ 1,248.35
Family and Children	Newborn, 0-2 Months	181,298	$ 1,165.21	$ 75.17	$ 26.82	$ 73.75	$ 1,340.95	$ 521.87	$ 1,862.83
Family and Children	Newborn, 3-11 Months	408,855	$ 191.50	$ 22.48	$ 4.63	$ 12.72	$ 231.33	$ 43.99	$ 275.32
Family and Children	Child, 1-20 Years	8,163,747	$ 126.20	$ 19.13	$ 3.14	$ 8.64	$ 157.12	$ 14.90	$ 172.01
Family and Children	Adult, 21+ Years	1,405,973	$ 258.22	$ 24.80	$ 6.12	$ 16.83	$ 305.96	$ 53.64	$ 359.60
Foster Care Children	Foster Care, All Ages M & F	145,854	$ 510.52	$ 38.35	$ 11.87	$ 32.64	$ 593.37	$ 20.50	$ 613.87
Breast and Cervical Cancer	BCC, All Ages Female	11,167	$ 1,585.54	$ 86.67	$ 36.16	$ 99.43	$ 1,807.80	$ 526.77	$ 2,334.57
LaCHIP Affordable Plan	All Ages	32,566	$ 148.88	$ 19.87	$ 3.65	$ 10.03	$ 182.43	$ 15.77	$ 198.20
HCBS Waiver	20 & Under, M & F	4,275	$ 2,078.41	$ 115.34	$ 47.43	$ 130.44	$ 2,371.62	$ 115.87	$ 2,487.49
HCBS Waiver	21+ Years, M & F	12,346	$ 809.17	$ 44.71	$ 18.46	$ 50.77	$ 923.11	$ 150.02	$ 1,073.13
Chisholm Class Members	Chisholm, All Ages M & F	20,773	$ 1,033.03	$ 71.71	$ 23.89	$ 65.69	$ 1,194.31	$ 95.46	$ 1,289.78
SBH - Chisholm Class Members	SBH - Chisholm, All Ages M & F	54,449	$ 172.71	$ 10.32	$ 3.96	$ 10.88	$ 197.88	$ -	$ 197.88
SBH - Dual Eligible & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	1,240,232	$ 16.75	$ 2.31	$ 0.41	$ 1.13	$ 20.60	$ 0.44	$ 21.05
SBH - HCBS Waiver	SBH - 20 & Under, M & F	23,926	$ 74.77	$ 5.30	$ 1.73	$ 4.76	$ 86.56	$ 4.85	$ 91.40
SBH - HCBS Waiver	SBH - 21+ Years, M & F	47,163	$ 61.95	$ 4.60	$ 1.44	$ 3.96	$ 71.95	$ 7.93	$ 79.88
SBH -Other	SBH - Other, All Ages	37,833	$ 137.12	$ 8.38	$ 3.15	$ 8.65	$ 157.31	$ 36.21	$ 193.52
Maternity Kickpayment	Maternity Kickpayment, All Ages	76,325	$ 5,405.85	$ 286.50	$ 123.08	$ 338.46	$ 6,153.90	$ 3,964.79	$ 10,118.69
	Aggregate	**13,146,701**	**$ 261.30**	**$ 24.14**	**$ 6.17**	**$ 16.97**	**$ 308.59**	**$ 67.43**	**$ 376.02**
	Difference		$ -	$ -	$ -	$ -	$ -	$ 0.65	$ 0.65

APPENDIX C:

10-1-17 Rate Update: FMP
Impact to the Full Expansion Rate

			Oct 2017 - Jan 2018 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	4,771,283	$ 370.85	$ 26.49	$ 8.59	$ 23.63	$ 429.55	$ 74.61	$ 504.16

			Oct 2017 - Jan 2018 Revised Rates						
		H	I	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	4,771,283	$ 370.85	$ 26.49	$ 8.59	$ 23.63	$ 429.55	$ 74.95	$ 504.50
		Difference	$ -	$ -	$ -	$ -	$ -	$ 0.34	$ 0.34

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2017 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE

Louisiana — February 1, 2017 through January 31, 2018

Documentation Reference

The 2017 Medicaid Managed Care Rate Development Guide below documents 3 rate certifications for the period February 1, 2017 through January 31, 2018. 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, 2017 through January 31, 2018. Items not marked in Certification #2 are not altered by the revision.

- Certification #1- Rate Certification dated March 13, 2017 for effective period February 1, 2017 through January 31, 2018. This certification was revised by certification #2 for the period October 1, 2017 through January 31, 2018.
- Certification #2- Rate Certification dated December 1, 2017 for effective period October 1, 2017 through January 31, 2018.
- Certification #3- Rate Certification dated July 9, 2018 for effective period October 1, 2017 through January 31, 2018.

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
1. General Information			
A. Rate certifications must be done on a 12-month rating period.[1] CMS will consider a time period other than 12-months to address unusual circumstances. For example, CMS will approve a time period other than 12 months for the following reasons: i. When the state is trying to align program rating periods, which may require a rating period longer than one year (but less than two years); or	• N/A	•	•

[1] As required by 42 CFR §438.2, the definition of a rating period is 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	Documentation Reference		
	Certification #1	Certification #2	Certification #3
1. General Information			
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.			
B. 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 the regulatory standards are met. In evaluating the certification, CMS will look to the reasonableness of the information contained in the certification for the purposes of rate development and may require additional information or documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented: i. Data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources. ii. Assumptions made, including any basis or justification for the assumption; and	• Mercer Rate Certification – Data Book	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
1. General Information			
iii. Methods for analyzing data and developing assumptions and adjustments.			
C. 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.			
D. An acceptable rate certification submission, as supported by the assurances from the state, must include the following items and information:			
i. 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(a), 438.4(b)(1), 438.4(b)(2), 438.4(b)(5), 438.4(b)(6), 438.5(a), 438.5(g), 438.6(a), 438.6(b)(1), 438.6(b)(2), and 438.6(e);	• Mercer Rate Certification – Part E: Certification of Final Rate Ranges, pages 41–42	• Mercer Rate Certification – Certification Final Rate Ranges, pages 2–4	• Mercer Rate Certification – Certification Final Rate Ranges, pages 3–5

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	**Certification #2**	**Certification #3**
1. General Information			
ii. The final and certified capitation rates or the final and certified rate ranges for all rate cells and regions.	• Mercer Rate Certification — Appendix A	• Mercer Rate Certification — Appendix A, pages 5–9	• Mercer Rate Certification — Appendix A, pages 6–15
iii. If rate ranges are certified, assurances that the capitation rate for each rate cell is within the certified rate range; and	• Mercer Rate Certification — Introduction, page 1 — Part E: Certification of Final Rate Ranges, pages 41–42	• Mercer Rate Certification — Introduction, pages 1–2 — Certification of Final Rate Ranges, pages 2–4	• Mercer Rate Certification — Introduction, pages 1–2 — Certification of Final Rate Ranges, pages 3–5
iv. 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 setting rates):			
a. A summary of the specific state Medicaid managed care programs covered by the certification. This would include, but not be limited to, 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; and the general types of benefits	• Mercer Rate Certification — Introduction, pages 1–2	• Mercer Rate Certification — Introduction, pages 1–2	• Mercer Rate Certification — Introduction, pages 1–2

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
1. General Information			
offered, such as medical or physical health, behavioral or mental health, dental health, and long-term services and supports), the areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.			
b. The rating periods covered by the certification.	• Mercer Rate Certification – Introduction, page 1	• Mercer Rate Certification – Introduction, pages 1–2	• Mercer Rate Certification – Introduction, pages 1–2
c. The Medicaid populations covered through the managed care programs for which the certification applies.	• Mercer Rate Certification – Introduction, pages 1–2 – Healthy Louisiana Populations, pages 3–9 – Appendix B	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
1. General Information			
d. 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).	• Mercer Rate Certification – Healthy Louisiana Populations, pages 3–9 – Appendix B	•	•
e. 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.	• Mercer Rate Certification – Healthy Louisiana Services, pages 9–11 – Appendix C	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
2. Data			
A. The rate certification, as supported by the assurances from the State, must thoroughly describe the data used to develop the capitation rates including:			
i. A description of the data, including:			
f. 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 — Part A: Base Data Development, pages 2–3	• Mercer Rate Certification — Intro, page 2	• Mercer Rate Certification — Intro, page 2
g. The age or time periods of all data used.	• Mercer Rate Certification — Part A: Base Data Development, pages 2–3	•	•
h. The sources of all data used (e.g., State Medicaid Agency; other state agencies; health plans; or other third parties).	• Mercer Rate Certification — Part A: Base Data Development, pages 2–3	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
2. Data			
i. 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	•	•
ii. Information related to the availability and the quality of the data used for rate development, including:			
a. 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: (i) Completeness of the data. (ii) Accuracy of the data. (iii) Consistency of the data across data sources.	• Mercer Rate Certification – Part A: Base Data Development, pages 2–3 – Base Data Adjustments, pages 12–13	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
2. Data			
b. A summary of the actuary's assessment of the data.	• Mercer Rate Certification – Part A: Base Data Development, pages 2–3 – Part E: Certification of Final Rate Ranges, pages 40–41	•	•
c. Any other concerns that the actuary has over the availability or quality of the data.	• N/A	•	•
iii. If fee-for-service claims or managed care encounter data are not used (or are not available), an explanation of why that data was not used (or was not available) and why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.	• N/A	•	•
iv. If managed care encounter data was not used in the rate development, 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	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
2. Data			
v. If there is any reliance or use of a data book in the rate development, the details of the template and relevant instructions used in the data book.	• N/A	•	•
B. 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:			
i. The credibility of the data.	• Mercer Rate Certification – Part A: Base Data Development, pages 2–3 – Base Data Adjustments, pages 12–13	•	•
ii. Completion factors.	• Mercer Rate Certification – Part A: Base Data Development, pages 2–3 – Base Data Adjustments, pages 12–13	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
2. Data			
iii. Errors found in the data.	• Mercer Rate Certification – Assertive Community Treatment (ACT) Services Payment Adjustment, pages 12–13	•	•
iv. 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 – Part B, Subpart B-1, Section 1, Subsection 1.a, pages 14–23 – Part B, Subpart B-1, Section 1, Subsection 1.a, pages 23–28	• Mercer Rate Certification – Operational Changes, page 2	• Mercer Rate Certification – Technical Changes, page 2
v. Exclusions of certain payments or services from the data.	• Mercer Rate Certification – Healthy Louisiana Services, pages 9–11	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
3. Projected Benefit Costs and Trends			
A. Final capitation rates must comply with 42 CFR 438.4(b)(6) and must be based only upon services described in 42 CFR 438.3(c)(1)(ii) and 438.3(e).			
B. 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.			

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
3. Projected Benefit Costs and Trends			
C. The rate certification and supporting documentation must describe the development of the projected benefit costs included in the capitation rates, including:			
i. 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 — Part B, Subpart B-1, Section 1, pages 14–33	• Mercer Rate Certification — Operational Changes, page 2	• Mercer Rate Certification — Technical Changes, page 2
ii. Any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last certification must be described.	• Mercer Rate Certification — Part B, Subpart B-1, Section 1, pages 14–33	• Mercer Rate Certification — Operational Changes, page 2	• Mercer Rate Certification — Technical Changes, page 2
D. 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).			
i. This section must include:			

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
3. Projected Benefit Costs and Trends			
a. Any data used or assumptions made in developing projected benefit cost trends, including a description of the sources of those data and assumptions. The descriptions of data and assumptions should include citations whenever possible.	• Mercer Rate Certification – PH Trend, page 18 – Historical Trend, page 26 – SBH Trend, page 27	•	•
b. The methodologies used to develop projected benefit trends.	• Mercer Rate Certification – PH Trend, page 18 – Historical Trend, page 26 – SBH Trend, page 28	•	•
c. 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 – PH Trend, page 18 – Historical Trend, page 26 – SBH Trend, page 28	•	•
ii. This section must include the projected benefit cost trends separated into components, specifically:			

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
3. Projected Benefit Costs and Trends			
a. The projected benefit cost trends should be separated into: (i) Changes in price (i.e., pricing differences due to different provider reimbursement rates or payment models). (ii) Changes in utilization (i.e., differences in the amount, duration, or mix of benefits or services provided).	• Mercer Rate Certification – Appendix E	•	•
b. If the actuary did not develop the projected benefit cost trends using price and utilization components, the actuary must describe and justify the method(s) used to develop projected benefit cost trends.	• Mercer Rate Certification – PH Trend, page 18 – SBH Trend, page 28	•	•
c. 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	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
3. Projected Benefit Costs and Trends			
iii. Variations in the projected benefit cost trends must be explained. Projected benefit cost trends may vary by: a. Medicaid populations; b. Rate cells; or c. Subsets of benefits within a category of services (e.g., specialty vs. non-specialty drugs).	• Mercer Rate Certification – PH Trend, page 18 – Historical Trend, page 26 – SBH Trend, page 28	•	•
iv. Any other material adjustments to projected benefit cost trends, including a description of the data, assumptions, and methodologies used to determine those adjustments must be included.	• N/A	•	•
v. Any other adjustments to projected benefit costs trends must be described, including: a. The impact of managed care on the utilization and the unit costs of health care services; or b. Changes to projected benefit costs trend in the rating period outside of regular changes in utilization or unit cost of services.	• Mercer Rate Certification – PH Efficiency and Managed Care Savings Adjustments, pages 19–22 – Appendix F	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
3. Projected Benefit Costs and Trends			
E. If the projected benefit costs include additional services deemed by the State to be necessary to comply with the parity standards of the Mental Health Parity and Addiction Equity Act as required by 42 CFR §438.3(c)(ii), the following must be described: i. The categories of service that contain these services; ii. The percentage of cost that these services represent in each category of service; and iii. 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 category of service.	• N/A	•	•
F. 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 relevant State plan services (as opposed to utilization and unit costs of the State plan services), unless a statute or regulation	• Mercer Rate Certification – State Plan Service Considerations, page 10	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
3. Projected Benefit Costs and Trends			
explicitly requires otherwise. The following documentation must be described: i. The categories of service that contain in lieu of services. ii. The percentage of cost that in-lieu-of services represent in each category of service; and iii. 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.			
G. 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 these cases, 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. The actuary may use the utilization of the services	• Mercer Rate Certification – IMD, page 28	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
3. Projected Benefit Costs and Trends			
provided to an enrollee in an IMD in developing the projected benefit costs. The data used for developing the projected benefit costs for these services must not include: i. Costs associated with an IMD stay of more than 15 days; ii. Any other managed care plan costs for services delivered in a month when an enrollee has an IMD stay of more than 15 days; and iii. A member month for any month when an enrollee has an IMD stay of more than 15 days The data and assumptions should be described in the certification.			

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
3. Projected Benefit Costs and Trends			
H. The rate certification must describe how retrospective eligibility periods are accounted for in rate development, including but not limited to: i. The managed care plan's responsibility to pay for claims incurred during the retroactive eligibility period. ii. How the claims information are included in the base data. iii. How the enrollment or exposure information is included in the base data. iv. How the capitation rates are adjusted to reflect the retroactive eligibility period, and the assumptions and methodologies used to develop those adjustments.	• Mercer Rate Certification – Retroactive Eligibility Adjustment, pages 28–29 – Appendix H – Databook – Contents of this Data Book, page 4	•	•
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).	• Mercer Rate Certification – Appendix L – Table 1: Final Projected Claims PMPM Development	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
3. Projected Benefit Costs and Trends			
J. 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: i. More or fewer state plan benefits covered by Medicaid managed care. ii. Requirements related to payments from health plans to any providers or class of providers. iii. Requirements or conditions of any applicable waivers. iv. Requirements or conditions of any litigation to which the state is subjected.	• Mercer Rate Certification – Introduction, pages 1–2 – Part B, Subpart B-1, Section 1, pages 14–33	• Mercer Rate Certification – Operational Changes, page 2	• Mercer Rate Certification – Technical Changes, page 2

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
3. Projected Benefit Costs and Trends			
K. For each change related to covered benefits or services, the rate certification must include 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. Any change not determined by the actuary to be material can be grouped with other non-material changed and described within the rate certification. If this is done, the actuary must give a description of why the changes were not considered material and how they were aggregated into a single adjustment.	• N/A	• Mercer Rate Certification – Operational Changes, page 2 Appendix B, page 10	• Mercer Rate Certification – Technical Changes, page 2 – Appendix B, page 16

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
4. Pass-Through Payments			
A. A pass-through payment is any amount required by the State to be added to the contracted payment rates between MCOs, PIHPs, or PAHPs and hospitals, physicians, or nursing facilities that is not for one of the following purposes: 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;[2] 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. The rate certification and supporting documentation must describe all existing pass-through payments included in the rates for this rating period, including: 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 made to providers in previous years. In general, this should include the same years of historical	• N/A		

[2] Please note that States must be in compliance with 42 CFR 438.6(c) by the rating period for managed care contracts beginning on or after July 1, 2017.

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
4. Pass-Through Payments			
claims data and financial data used to develop the rates.			
C. A common practice in fee-for-service methodologies in Medicaid is to pay providers a supplemental amount beyond the reimbursement rate for the service (e.g., upper payment limit (UPL) payments and disproportionate share hospital (DSH) payments). If states are using a supplemental payment methodology in fee-for-service, it may cause the fee-for-service fee schedule to be lower than a managed care plans' expected negotiated rate. Hence, it may be reasonable to assume higher reimbursements on a per-service basis when looking at the projected benefit costs under managed care in order to ensure that the plan has sufficient capitation rates to cover the expected costs of the enrollees. When transitioning from fee-for-service to managed care, and therefore incorporating a fee-for-service supplemental payment in the managed care rates, the actuary must describe: i. A description of the supplemental payment.	• Mercer Rate Certification – PH Historical Adjustments – Inpatient Services, page 14–15 – Full Medicaid Pricing (FMP), pages 30–33	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
4. Pass-Through Payments			
ii. The total amount of the supplemental payments. iii. The providers who received the supplemental payments under fee-for-service; iv. The methodology that the actuary used to incorporate the supplemental payment into the capitation rates. v. Any payment mechanisms associated with incorporating the supplemental payment into the capitation rates.			

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
5. Projected Non-Benefit Costs			
A. 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.			
B. The rate certification and supporting documentation must describe the development of the projected non-benefit costs included in the capitation rates, including: i. 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	• Mercer Rate Certification — Non-Medical Expense Load, pages 38–39	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
5. Projected Non-Benefit Costs			
developing the projected non-benefit costs. ii. Any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last rate certification.			
C. States and actuaries must estimate the projected non-benefit costs for each of the following categories of costs: i. Administrative costs. ii. Care coordination and care management. iii. Provision for margin (which may include profit margin, operating margin, risk margin, contingency margin, cost of capital, or underwriting gain). iv. Taxes, fees, and assessments; and v. Other material non-benefit costs.	• Mercer Rate Certification – Non-Medical Expense Load, pages 38–39	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
5. Projected Non-Benefit Costs			
D. 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.	• Mercer Rate Certification – Non-Medical Expense Load, pages 38–39	•	•
E. Regarding the Health Insurance Providers Fee (HIPF), CMS issued guidance in October 2014 (Medicaid and CHIP FAQs: Health Insurance Providers Fee for Medicaid Managed Care Plans, http://medicaid.gov/federal-policy-guidance/downloads/faq-10-06-2014.pdf). The rate certification and supporting documentation must: i. Specifically address how this fee is incorporated into capitation rates. ii. 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	• Mercer Rate Certification – Federal Health Insurer Fee, pages 39–40	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
5. Projected Non-Benefit Costs			
data year or fee year during the rating period of the rate certification. iii. 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. iv. 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. v. 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 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	Documentation Reference		
	Certification #1	Certification #2	Certification #3
5. Projected Non-Benefit Costs			
F. 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 collected in calendar year 2017. Therefore, no amounts should be included in Medicaid managed care capitation rates for fees that would have been paid by plans to the IRS in 2017 (which would have been assessed off of 2016 net premiums). More information can be found here: https://www.irs.gov/Businesses/Corporations/Affordable-Care-Act-Provision-9010			

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
6. Rate Range Development			
A. 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: i. Any assumptions for which values vary in order to develop rate ranges. ii. 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. iii. 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 – PH Trend, page 18 – Managed Care Savings Adjustment, page 22 – SBH Trend, page 28 – Appendix E – Appendix F	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
6. Rate Range Development			
B. 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 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 certification index, described in Section I, Item 1.C, must note where these are described.	• See section A above for more detail.	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
7. Risk Mitigation, Incentives and Related Contractual Provisions			
A. The rate certification and supporting documentation must describe any risk mitigation, incentives, or similar contractual provisions that may affect the rates, rate ranges, or the final net payments to the health plans under the applicable contract.	• Mercer Rate Certification – Risk Adjustment, page 40	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
7. Risk Mitigation, Incentives and Related Contractual Provisions			
B. The rate certification and supporting documentation must specifically address: i. The risk adjustment model(s) being used to calculate risk scores. ii. The specific data, including the source(s) of the data, being used by the risk adjustment model(s), including any adjustments made to the data. iii. Any changes that are made to risk adjustment model (e.g. conditions for excluding enrollees or data from the risk adjustment model, changes in how the risk scores are determined). iv. How frequently the risk scores are calculated. v. How the risk scores are being used to adjust the capitation rates. vi. An attestation that the risk adjustment model is cost neutral. (42 CFR §438.5(g).)	• Mercer Rate Certification – Risk Adjustment, page 40	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
7. Risk Mitigation, Incentives and Related Contractual Provisions			
C. The rate certification and supporting documentation must indicate if a risk-sharing model is being used to account for the health status of the population in a manner that is not cost neutral (i.e., in a manner that may cause the total projected costs to increase or decrease based on the actual health status of the population). These types of risk-sharing models should only be used prospectively as part of the rate development process and not to adjust the final capitation rates or payments to managed care plans (e.g., estimating how projected changes in the risk of the Medicaid population may affect projected benefit costs). CMS may also consider these 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). CMS characterizes this type of adjustment as an "Acuity Adjustment." If an acuity adjustment is being used, the rate certification must include: i. The reason that there is significant uncertainty about the health status of the population and the need for an acuity adjustment.	• N/A	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
7. Risk Mitigation, Incentives and Related Contractual Provisions			
ii. The risk adjustment or acuity adjustment model(s) being used to calculate acuity adjustment scores. iii. The specific data, including the source(s) of the data, being used by the risk adjustment or acuity adjustment model(s). iv. The relationship and potential interactions between the acuity adjustment and the risk adjustment. v. How frequently the acuity adjustment scores are calculated. vi. A description of how the acuity adjustment scores are being used to adjust the capitation rates; and vii. An attestation that the acuity adjustment mechanism has been developed in accordance with generally accepted actuarial principles and practices.			

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
7. Risk Mitigation, Incentives and Related Contractual Provisions			
D. The rate certification and supporting documentation must detail any other risk-sharing arrangements, such as a risk corridor or a large claims pool. This includes: i. A rationale for the use of the risk sharing arrangement. ii. A detailed description of how the risk-sharing arrangement is implemented. iii. A description of any effect that the risk-sharing arrangements have on the development of the capitation rates. iv. An attestation that the risk-sharing mechanism has been developed in accordance with generally accepted actuarial principles and practices.	• N/A	•	•
E. If the contract has a medical loss ratio requirements, such as a minimum medical loss ratio requirement, the rate certification and supporting documentation must include: i. A detailed description of, or citation for, the methodology used to calculate the medical loss ratio. ii. A description of the consequences for having a medical loss ratio below the minimum requirements (e.g., financial recovery; contractual penalties).	• N/A	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
7. Risk Mitigation, Incentives and Related Contractual Provisions			
F. The rate certification and supporting documentation must provide a detailed description of any reinsurance requirements under the contract associated with the rate certification, including a description of any effect that the reinsurance requirements have on the development of the capitation rates. The rate certification must also include an attestation that the reinsurance mechanism has been developed in accordance with generally accepted actuarial principles and practices.	• N/A	•	•
G. The rate certification must include an attestation 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 arrangement as required in 42 CFR §438.6(b)(2);	• N/A	•	•
H. The rate certification and supporting documentation must describe any incentives or withhold amounts in the contract between the state and the health plans. The rate certification must include: i. A description of the percentage of the certified capitation rates being	• N/A	•	•

Section I. Medicaid Managed Care Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
7. Risk Mitigation, Incentives and Related Contractual Provisions			
withheld through withhold arrangements; ii. An estimate of the percentage of the withheld amount through a withhold arrangement that is expected to be returned and the basis for that determination; and iii. A description of any effect that the incentive or withhold arrangements have on the development of the capitation rates.			

Section I. Medicaid Managed Care Rates	Documentation Reference
8. Other Rate Development Considerations	
A. 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 costs subject to the different FMAP should be shown as part of the rate certification to the extent possible.	
B. 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.	
C. 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.	

Section I. Medicaid Managed Care Rates	Documentation Reference
8. Other Rate Development Considerations	
D. In determining whether the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider the following: i. 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. ii. 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. iii. The final contracted rates 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.	

Section I. Medicaid Managed Care Rates	Documentation Reference
9. Procedures for Rate Certifications for Rate and Contract Amendments	
A. CMS requires that the State will submit a new rate certification when the rates or rate ranges change.	
B. For contract amendments that do not affect the rates or rate ranges, CMS does not require a new rate certification from the State.	
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 contract. ii. A state applies risk scores to the capitation rates paid to the plans under a risk adjustment methodology described in the certification for that rating period and contract.	
D. Any time a rate changes for any reason other than application of a 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.	

Section II. Medicaid Managed Care Rates with Long-Term Services and Supports	Documentation Reference		
	Certification #1	Certification #2	Certification #3
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 about the required content of the actuarial rate certification is also applicable for rates for provision of MLTSS.			
B. 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:			
i. The structure of the capitation rates and rate cells or rating categories. 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"). b. By the long-term care setting that the beneficiary uses ("non-blended").	• N/A	•	•

Section II. Medicaid Managed Care Rates with Long-Term Services and Supports	Documentation Reference		
	Certification #1	Certification #2	Certification #3
1. Managed Long-Term Services and Supports			
ii. 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. States that are currently using a structure that differentiates rates by long-term care setting will need to describe why a blended rate structure is not feasible at this time, and CMS will work with the state to move to a blended rate structure in the coming rating periods in order to align with the 2013 guidance around MLTSS programs found here. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf	• N/A	•	•

Section II. Medicaid Managed Care Rates with Long-Term Services and Supports	Documentation Reference		
	Certification #1	Certification #2	Certification #3
1. Managed Long-Term Services and Supports			
C. The rate certification must describe the expected effect that managing LTSS has on the utilization and unit costs of services. The certification must describe 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).	• N/A	•	•
D. 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	•	•
E. 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 Population, page 33–34 – Expansion Data A	•	•
B. For states that have covered the new adult group in Medicaid managed care plans in 2014, 2015 and/or 2016, CMS expects the rate certification, as supported by assurances from the State, to describe:			
i. Any new data that is available for use in 2017 rate setting;	• N/A	•	•
ii. How the state and the actuary followed through on any plans to monitor costs and experience for newly eligible adults.	• N/A	•	•
iii. How actual experience and costs in 2014, 2015 and/or 2016 have differed from assumptions and expectations in previous rate certifications; and	• N/A	•	•
iv. How differences between projected and actual experience in 2014, 2015 and/or 2016 have been used to adjust the 2017 rates.	• N/A	•	•

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 2014, 2015 and/or 2016:			
a. Any data and experience specific to newly eligible adults covered in 2014, 2015 and/or 2016 that was used to develop projected benefits costs for capitation rates.	• N/A	•	•
b. Any changes in data sources, assumptions, or methodologies used to develop projected benefits costs for capitation rates since the last certification.	• N/A	•	•

Section III. New Adult Group Capitation Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
2. Projected Benefit Costs			
c. How assumptions changed from the 2014, 2015 and/or 2016 rate certification(s) 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.	• Mercer Rate Certification – Additional Rate Adjustments, pages 35–38 – Appendix P	•	•

Section III. New Adult Group Capitation Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
2. Projected Benefit Costs			
iv. Adjustments for the demographics of newly eligible adults. v. Differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement 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.			

Section III. New Adult Group Capitation Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
2. Projected Benefit Costs			
B. For any state that is covering the new adult group, regardless if they have been covered in 2014, 2015 and/or 2016, the following key assumptions related to the new adult group must be included in the rate certification and supporting documentation: 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.	• Mercer Rate Certification – Rate Cell Structure, page 34 – Additional Rate Adjustments, pages 35–38 – Appendix P	•	•
C. The rate certification and supporting documentation must describe any changes to the benefit plan offered to the new adult group.	• N/A	•	•

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.	• Mercer Rate Certification – Removed and Revised Data Adjustments, page 34–35 – Expansion FMP Development, page 38	• Mercer Rate Certification – Operational Changes, page 2 – Appendix C, page 10	• Mercer Rate Certification – Technical Changes, page 2 – Appendix C, page

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 2014, 2015 and/or 2016, any changes in data sources, assumptions, or methodologies used to develop projected non-benefit costs since the last rate certification.	• Mercer Rate Certification – Non-Medical Expense Load, pages 38–39 – Appendix P	•	•
ii. How assumptions changed from the 2014, 2015 and/or 2016 rate certification(s) on the following issues: a. Administrative costs. b. Care coordination and care management.	• Mercer Rate Certification – Non-Medical Expense Load, pages 38-39 – Appendix P	•	•

Section III. New Adult Group Capitation Rates	Documentation Reference		
	Certification #1	Certification #2	Certification #3
3. Projected Non-Benefit Costs			
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. 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 §438.7(d)[3] that states that covered the new adult group in Medicaid managed care plans in 2014, 2015 and/or 2016 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 – Appendix C, page 11	• Mercer Rate Certification – Appendix C, page
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 §438.7(d) that states describe the risk mitigation strategy specific to the new adult group rates.	• Mercer Rate Certification – Medicaid Expansion Minimum/Maximum Medical Loss Ratio (MLR), page 40–41	•	•

[3] 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 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
5. Risk Mitigation Strategies			
B. For states that covered the new adult group in Medicaid managed care plans in 2014, 2015 and/or 2016, CMS requests the following information: i. Any changes in the risk mitigation strategy from those used during 2014, 2015 and/or 2016; ii. The rationale for making the change in the risk mitigation strategy or removing the risk mitigation strategy used during 2014, 2015 and/or 2016; and iii. Any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during 2014, 2015 and/or 2016.			