# Office of State Procurement
# Contract Certification of Approval

## This certificate serves as a confirmation that the Office of State Procurement has reviewed and approved the contract referenced below.

**Reference Number:** 2000683511

**Amendment Number:** 5

**Vendor:** LOUISIANA HEALTHCARE CONNECTIONS INC

**Description:** Managed Care Organizations 3.0

**Approved By:** PAMELA RICE

**Approval Date:** 02/22/2024 15:05:24

**AMENDMENT TO**

**AGREEMENT BETWEEN STATE OF LOUISIANA**

**LOUISIANA DEPARTMENT OF HEALTH**

Medical Vendor Administration

(Regional/ Program/ Facility)

Bureau of Health Services Financing

**AND**

Louisiana Healthcare Connections, Inc.

Contractor Name

Amendment #: 5

LAGOV#: 2000683511

LDH #:

Original Contract Amount: $10,807,338,057.00

Original Contract Begin Date: 01-01-2023

Original Contract End Date: 12-31-2025

RFP Number: 3000017417

## AMENDMENT PROVISIONS

**Change Contract From:** Current Maximum Amount: $11,730,803,118.00 Current Contract Term: 01/01/23-12/31/25

Attachment A - Model Contract
Attachment C - In Lieu of Services
Attachment D3 - Rate Certification effective 7/1/2023

**Change Contract To:** If Changed, Maximum Amount: $11,730,803,118.00 If Changed, Contract Term: N/A

Amd 5 Attachment A5 - Changes to Attachment A Model Contract
Amd 5 Attachment C5 - Changes to Attachment C In Lieu of Services
Attachment D3 - Rate Certification effective 7/1/2023
Amd 5 Attachment D5 - Rate Certification Amendment effective 7/1/2023

**Justifications For Amendment:**

Revisions contained in this amendment are within scope and comply with the terms and conditions as set forth in the RFP.

This amendment adds four new in lieu of services, new state directed payments, and a blended rate for Humana for the month of October. These revisions are necessary in order to align with all provisions of state and federal laws and regulations.

This Amendment Becomes Effective: 07-01-2023

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

**CONTRACTOR**

Louisiana Healthcare Connections, Inc.

DocuSigned by: Joseph M. Sullivan AA305A3877394C7... 12/21/2023

CONTRACTOR SIGNATURE DATE

PRINT NAME: Joseph M. Sullivan

CONTRACTOR TITLE: Chief Executive Officer

**STATE OF LOUISIANA**
**LOUISIANA DEPARTMENT OF HEALTH**

**Secretary, Louisiana Department of Health or Designee**

DocuSigned by: Kimberly Sullivan 6F18D2F97367420... 12/21/2023

SIGNATURE DATE

NAME: Kimberly Sullivan

TITLE: Interim Medicaid Executive Director

OFFICE: Louisiana Department of Health

PROGRAM SIGNATURE DATE

NAME

LOUISIANA DEPARTMENT OF HEALTH

# MCO Amendment 5
## Attachment A5 – Changes to Attachment A, *Model Contract*

| Item | Change From | Change To | Justification |
|---|---|---|---|
| 1 | **2.11 Provider Reimbursement**<br>**…**<br>**[new provision]** | 2.11.16 Payment for Incentives for NEMT Providers<br><br>In accordance with 42 CFR §438.6(c), LDH will utilize a CMS-approved directed payment arrangement for specified NEMT Providers. The payment arrangement will utilize a series of uniform incentive payments dependent upon the Provider meeting monthly thresholds of provided trips. CMS approval of a directed payment arrangement is for one (1) rating period and it is not renewed automatically.<br><br>This directed payment arrangement will be made through a separate payment term outside of the monthly Capitation Payment.<br><br>The Contractor shall make directed payments to eligible NEMT Providers as directed by LDH and in accordance with the written approval from CMS for the applicable rating period.<br><br>2.11.16.1 For each State Fiscal Year (SFY), pursuant to CMS approval, LDH will provide incentive payments for NEMT Providers who have delivered at least one non-emergency medical round trip, consisting of a minimum of two (2) legs, per calendar day for an Enrollee for a minimum of twenty (20) Calendar Days per previous calendar month and is fully credentialed in the Louisiana Medicaid Program during the reporting period.<br><br>2.11.16.2 NEMT Providers are only eligible for one (1) incentive payment per vehicle, up to a maximum of three (3) vehicles, per month for which they qualify.<br><br>2.11.16.3 This directed payment arrangement shall be detailed in Attachment D, *Actuarial Rate Certification Letter*. | This addition is necessary to implement a directed payment arrangement, approved by CMS and funded through the American Rescue Plan Act (ARPA), to improve access to NEMT services. |

LOUISIANA DEPARTMENT OF HEALTH

# MCO Amendment 5
## Attachment C5 – Changes to Attachment C, *In Lieu of Services*

<table>
<tr><th>Item</th><th>New ILOS</th><th>Justification</th></tr>
<tr><td>1</td><td>Physical Health
<table>
<tr><th>Name and description</th><th>Covered Medicaid State Plan service or setting for which each ILOS is a substitute</th><th>Clinically oriented definition(s) for the target population(s) for each ILOS</th><th>Specific coding for each ILOS to be used on claims and encounter data</th></tr>
<tr><td>Remote Patient Monitoring<br>Effective 7/1/2023<br><br>Remote patient monitoring (RPM) means digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment, recommendations, and interventions. RPM devices include (1) non-invasive remote monitoring devices that measure or detect common physiological parameters, and (2) non-invasive monitoring devices that wirelessly transmit the beneficiary's medical information to their health care provider or other monitoring entity. The device must be reliable and valid, and the beneficiary must be trained or sufficiently knowledgeable in the proper use/wearing of the device to ensure appropriate recording of medical information. Medical information may include, but is not limited to, blood pressure and heart rate and</td><td>Physician services (office visits), emergency services, and inpatient hospitals</td><td>Members with hypertensive disorders and/or diabetes, ages 18-75 (HEDIS), with the following characteristics:<ul><li>Members with hypertension and a PPA/PPR/PPV* event within the last 18 months.</li><li>Members with diabetes and a PPA/PPR/PPV events within last 18 months</li><li>Poorly controlled hypertension (>140/90), at risk for PPA/PPR/PPV</li><li>Poorly controlled diabetes (HbA1c >9.0%), at risk for PPA/PPR/PPV</li><li>Smart phone or tablet access</li></ul>Pregnant women with hypertensive disorders and/or diabetes, ages 16-50, with the following characteristics:<ul><li>Poorly controlled hypertension (>140/90)</li></ul></td><td>99453<br>99454<br>99199 – with appropriate modifiers</td></tr>
</table></td><td>This addition seeks to improve enrollee outcomes and reduce preventable hospitalizations.</td></tr>
</table>

<table>
<tr><th>Item</th><th>New ILOS</th><th>Justification</th></tr>
<tr><td></td><td>
<table>
<tr><td>rhythm monitoring for members with hypertension and blood glucose control for members with diabetes. Members enrolled should have smart phone or tablet access and connectivity for data reporting.</td><td></td><td>• Insulin dependent diabetes in pregnancy<br>• Smart phone or tablet access</td><td></td></tr>
</table>
</td><td></td></tr>
<tr><td>2</td><td>
Physical Health
<table>
<tr><th>Name and description</th><th>Covered Medicaid State Plan service or setting for which each ILOS is a substitute</th><th>Clinically oriented definition(s) for the target population(s) for each ILOS</th><th>Specific coding for each ILOS to be used on claims and encounter data</th></tr>
<tr><td>Outpatient Lactation Support<br>Effective 1/1/2024<br><br>Outpatient lactation support services for the purpose of providing breastfeeding care and for the diagnosis and treatment of breastfeeding or pumping issues are covered without the requirement of prior authorization for up to six total treatment sessions that occur during pregnancy or while less than 24 months postpartum. Qualified lactation support providers must have achieved and maintain certification as a Breastfeeding Counselor or Lactation Consultant, as described by the United States Breastfeeding Committee.</td><td>Physician services, outpatient hospital services.</td><td>Any Enrollee who is pregnant, breastfeeding, or expressing breastmilk for the purposes of providing nutrition to an infant.</td><td>S9445 – with modifier 33<br>S9443</td></tr>
</table>
</td><td>This addition seeks to provide additional breastfeeding support which promotes health benefits for both the Enrollee and their infant.</td></tr>
</table>

<table>
<tr><th>Item</th><th>New ILOS</th><th>Justification</th></tr>
<tr><td>3</td><td>

**Behavioral Health**

<table>
<tr><th>Name and description</th><th>Covered Medicaid State Plan service or setting for which each ILOS is a substitute</th><th>Clinically oriented definition(s) for the target population(s) for each ILOS</th><th>Specific coding for each ILOS to be used on claims and encounter data</th></tr>
<tr><td>Therapeutic Day Center for ages 5-20<br>Effective 7/1/2023<br><br>The Center for Resilience is a therapeutic day center which provides educational and intensive mental health supports in an innovative partnership with the Tulane University Medical School Department of Child and Adolescent Psychiatry to ensure the emotional well-being and academic readiness of children with behavioral health needs. Children receive instructional, medical, and therapeutic services at the day program site with the goal of building the skills necessary to successfully transition back to the traditional school setting. Center for Resilience provides a caring, non-punitive, therapeutic milieu with positive behavioral supports, trauma-informed approaches, evidence-based mental health practices, small-group classroom instruction, and therapeutic recreation activities. The leadership team is comprised of clinicians, educators, and medical doctors, and the therapeutic milieu is a result of this intentionally interdisciplinary collaboration. The goal of this ILOS is to reduce incidents of</td><td>Inpatient psychiatric hospitals, psychiatric residential treatment facility (PRTF)</td><td>Children and adolescents with behavioral health diagnoses, 5 to <21, with the following characteristics:<br>• PTSD, anger, depression, mood disorders, developmental disabilities, learning disabilities, psychosis<br>• High risk behaviors & juvenile justice-involvement<br>• Unresponsive to school and agency/MHR intervention</td><td>G0177<br>H0035</td></tr>
</table>

</td><td>This addition seeks to reduce incidents of crisis hospitalization and residential psychiatric care.</td></tr>
</table>

<table>
<tr><th>Item</th><th>New ILOS</th><th>Justification</th></tr>
<tr><td></td><td>
<table>
<tr><td>crisis hospitalization and residential psychiatric care.</td><td></td><td></td><td></td></tr>
</table>
</td><td></td></tr>
<tr><td>4</td><td>Behavioral Health
<table>
<tr><th>Name and description</th><th>Covered Medicaid State Plan service or setting for which each ILOS is a substitute</th><th>Clinically oriented definition(s) for the target population(s) for each ILOS</th><th>Specific coding for each ILOS to be used on claims and encounter data</th></tr>
<tr><td>Integrated Behavioral Health Homes Effective 7/1/2023<br><br>Integrated Behavioral Health Homes (IBHH) is a value-based program that furthers alternative payment methodologies and integration by improving medical, behavioral, and social healthcare outcomes for participants while decreasing the overall total cost of care. MCOs who offer this ILOS will contract with qualified providers to deliver the six core services that are central to Medicaid health homes, as outlined by the ACA and endorsed by CMS, Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Council for Mental Wellbeing:<br>• Comprehensive care management;<br>• Care coordination;</td><td>Inpatient psychiatric hospitals, psychiatric residential treatment facility (PRTF)</td><td>Medicaid and dual eligible beneficiaries, all ages, with the following characteristics: Members with SMI, SED and/or SUD diagnoses who have complex medical comorbidities and high utilization of ER/ED, Medical IP, or Behavioral IP/Residential care</td><td>G9002</td></tr>
</table>
</td><td>This addition seeks to improve the health and recovery of Enrollees with Serious Mental Illness (SMI), Substance Use Disorder (SUD) and Serious Emotional Disturbance (SED) by allowing for different methods of payment and furthering behavioral health integration.</td></tr>
</table>

| Item | New ILOS | | | | Justification |
|---|---|---|---|---|---|
| | • Health promotion;<br>• Comprehensive transitional care and follow-up;<br>• Patient and family support; and<br>• Referrals to community and social support services.<br>The eligible population will be identified by the MCO and assigned to the participating providers within the eligible population's geographical area. This is an opt-in model and does not require enrollees to change or adjust any of their existing provider relationships. | | | | |

MILLIMAN CLIENT REPORT

# State Fiscal Year 2024 Healthy Louisiana Medicaid Managed Care Capitation Rate Certification

## State of Louisiana Department of Health

June 23, 2023


Anders Larson, FSA, MAAA, Principal and Consulting Actuary

Jason Clarkson, FSA, MAAA, Principal and Consulting Actuary

Paul Houchens, FSA, MAAA, Principal and Consulting Actuary

Zach Fohl, FSA, MAAA, Consulting Actuary

Amine Elmeghni, FSA, MAAA, Actuary

Jennifer Prather, Pharm D, Pharmacy Management Consultant


Milliman


Milliman

# Table of Contents

# Introduction & Executive Summary

## BACKGROUND

Milliman, Inc. (Milliman) has been retained by the State of Louisiana, Department of Health (LDH) to provide actuarial and consulting services related to the development of capitation rates for the Physical Health (PH) and Specialized Behavioral Health (SBH) programs within the Healthy Louisiana managed care program. This report documents the development of the actuarially sound capitation rates for the state fiscal year (SFY) 2024 rating period. It also includes the required actuarial certification in Appendix 1.

To facilitate review, this document has been organized in the same manner as the 2023-2024 Medicaid Managed Care Rate Development Guide, finalized by the Centers for Medicare and Medicaid Services in May 2023 (CMS guide). Section II of the CMS guide is not applicable to Healthy Louisiana because long-term care supports and services (LTSS) are not covered. Section III of the CMS Guide and this certification is only applicable to the Medicaid Expansion population.

## CONTRACTED MCOS AND PAYMENT METHODOLOGY

The following six MCOs participate in the Medicaid managed care program on a statewide basis during SFY 2024:

- Amerihealth Caritas Louisiana
- Healthy Blue of Louisiana
- Louisiana Healthcare Connections
- Aetna Better Health
- UnitedHealthcare of Louisiana
- Humana Healthy Horizons

Each MCO will receive a separate capitation payment for each rate cell. For most rate cells, the capitation rates vary by region and will be risk-adjusted based on the relative acuity of members enrolled with each MCO. Rate cells with statewide rates are described in Section 1, subsection 2.B.iii.a. Risk adjustment is discussed in more detail in Section 1, subsection 6. The regions and rate cells are described in more detail in Section I, subsection 4.A.iii(c)(iii). The parishes in Louisiana will be grouped into the same four rating regions used for the SFY 2023 Healthy Louisiana managed care capitation rate development. These regions are listed below. A mapping of the parishes to regions can be found in Appendix 5.

- Gulf
- Capital
- South Central
- North

## FISCAL IMPACT ESTIMATE

The certified capitation rates for the Medicaid managed care populations are illustrated in Figure 1. These rates are effective from July 1, 2023 through June 30, 2024 (SFY 2024). The rates are inclusive of directed payments and Full Medicaid Pricing (FMP) amounts. The composite rates illustrated for SFY 2024 have been developed based on an estimate of projected enrollment in SFY 2024. The January 2023 capitation rates are consistent with the following documents:

- *Healthy Louisiana Final Rate Certification*, dated August 24, 2022
- *Healthy Louisiana Rate Certification Addendum*, dated December 16, 2022

**FIGURE 1: COMPARISON WITH JANUARY 2023 PMPM RATES**

| POPULATION | ESTIMATED SFY 2024 AVERAGE MONTHLY ENROLLMENT | COMPOSITE MCO EXPECTED PAYMENTS | | |
|---|---|---|---|---|
| | | JANUARY 2023 | SFY 2024 | % CHANGE |
| SSI | 106,910 | $1,786.85 | $1,973.21 | 10.4% |
| F&C | 826,180 | 362.52 | 380.15 | 4.9% |
| SBH | 130,375 | 43.96 | 45.45 | 3.4% |
| Medicaid Expansion | 680,449 | 729.09 | 749.37 | 2.8% |
| All Other Populations | 27,165 | 1,081.36 | 1,229.06 | 13.7% |
| Maternity Kick – Expansion | 1,166 | 19,638.43 | 19,889.64 | 1.3% |
| Maternity Kick – Non-Expansion | 2,128 | 16,941.71 | 20,381.90 | 20.3% |
| **Composite** | 1,771,079 | 610.20 | 644.14 | 5.6% |

Notes:
1. January 2023 and SFY 2024 composite rates were developed based on SFY 2024 projected monthly enrollment.
2. Monthly enrollment values are rounded to the nearest thousand.
3. All Other Populations includes HCBS, Act 421, Foster Care Children, Breast and Cervical Cancer, LaHIPP Affordable Plan, and non-SBH Chisholm Class Members rate cells.

Figure 2 provides similar information as contained in Figure 1; however, illustrated rate values reflect the limited rate (the capitated amount excluding state directed payment and FMP amounts).

**FIGURE 2: COMPARISON WITH JANUARY 2023 PMPM RATES**

| POPULATION | ESTIMATED SFY 2024 AVERAGE MONTHLY ENROLLMENT | COMPOSITE LIMITED RATES | | |
|---|---|---|---|---|
| | | JANUARY 2023 | SFY 2024 | % CHANGE |
| SSI | 106,910 | $1,283.37 | $1,422.79 | 10.9% |
| F&C | 826,180 | 252.96 | 269.55 | 6.6% |
| SBH | 130,375 | 42.92 | 42.86 | (0.1%) |
| Medicaid Expansion | 680,449 | 542.06 | 573.58 | 5.8% |
| All Other Populations | 27,165 | 902.97 | 970.75 | 7.5% |
| Maternity Kick – Expansion | 1,166 | 11,295.45 | 9,109.22 | (19.4%) |
| Maternity Kick – Non-Expansion | 2,128 | 9,286.26 | 8,844.82 | (4.7%) |
| **Composite** | 1,771,079 | 439.33 | 466.67 | 6.2% |

Notes:
1. January 2023 and SFY 2024 composite rates were developed based on SFY 2024 projected monthly enrollment.
2. Monthly enrollment values are rounded to the nearest thousand.
3. All Other Populations includes HCBS, Act 421, Foster Care Children, Breast and Cervical Cancer, LaHIPP Affordable Plan, and non-SBH Chisholm Class Members rate cells.

Figure 3 compares the estimated federal and state expenditures under the SFY 2024 rates, based on estimated enrollment in SFY 2024. Revenue shown in Figure 3 includes state directed payment and FMP amounts.

**FIGURE 3: COMPARISON WITH JANUARY 2023 RATES (AGGREGATE EXPENDITURES $ MILLIONS)**

| | TOTAL MCO EXPECTED PAYMENTS | | |
|---|---|---|---|
| POPULATION | JANUARY 2023 | SFY 2024 | CHANGE |
| SSI | $ 2,292.4 | $ 2,531.5 | $ 239.1 |
| F&C | 3,594.1 | 3,768.9 | 174.8 |
| SBH | 68.8 | 71.1 | 2.3 |
| Medicaid Expansion | 5,953.3 | 6,118.9 | 165.6 |
| All Other Populations | 352.5 | 400.6 | 48.1 |
| Maternity Kick – Expansion | 274.8 | 278.3 | 3.5 |
| Maternity Kick – Non-Expansion | 432.6 | 520.5 | 87.9 |
| **Composite** | $ 12,968.5 | $ 13,689.8 | $ 721.4 |
| **Federal** | $ 10,159.9 | $ 10,685.3 | $ 525.4 |
| **State** | $ 2,808.5 | $ 3,004.5 | $ 196.0 |

Notes:
1. January 2023 and SFY 2024 composite rates were developed based on SFY 2024 projected monthly enrollment.
2. State expenditures based on Federal Fiscal Year (FFY) 2023 FMAP of 67.28% for 3 months and FFY 2024 FMAP of 67.67% for 9 months for all except the Expansion population. FMAP values do not include additional FFCRA-related enhanced FMAP during the phase-out period ending December 31, 2023.
3. State expenditures based on FMAP of 90% for the Expansion population.
4. All Other Populations includes HCBS, Act 421, Foster Care Children, Breast and Cervical Cancer, LaHIPP Affordable Plan, and non-SBH Chisholm Class Members rate cells.

Figure 4 provides similar information as contained in Figure 3; however, illustrated rate values reflect the limited rate (the capitated amount excluding state directed payment and FMP amounts).

**FIGURE 4: COMPARISON WITH JANUARY 2023 RATES (AGGREGATE EXPENDITURES $ MILLIONS)**

| | TOTAL LIMITED RATE PAYMENTS | | |
|---|---|---|---|
| POPULATION | JANUARY 2023 | SFY 2024 | CHANGE |
| SSI | $ 1,646.5 | $ 1,825.3 | $ 178.9 |
| F&C | 2,507.9 | 2,672.4 | 164.5 |
| SBH | 67.1 | 67.1 | (0.1) |
| Medicaid Expansion | 4,426.1 | 4,683.5 | 257.4 |
| All Other Populations | 294.4 | 316.4 | 22.1 |
| Maternity Kick – Expansion | 158.0 | 127.5 | (30.6) |
| Maternity Kick – Non-Expansion | 237.1 | 225.9 | (11.3) |
| **Composite** | $ 9,337.2 | $ 9,918.0 | $ 580.9 |
| **Federal** | $ 7,337.5 | $ 7,780.8 | $ 443.4 |
| **State** | $ 1,999.7 | $ 2,137.2 | $ 137.5 |

Notes:
1. January 2023 and SFY 2024 composite rates were developed based on SFY 2024 projected monthly enrollment.
2. State expenditures based on Federal Fiscal Year (FFY) 2023 FMAP of 67.28% for 3 months and FFY 2024 FMAP of 67.67% for 9 months for all except the Expansion population. FMAP values do not include additional FFCRA-related enhanced FMAP during the phase-out period ending December 31, 2023.
3. State expenditures based on FMAP of 90% for the Expansion population.
4. All Other Populations includes HCBS, Act 421, Foster Care Children, Breast and Cervical Cancer, LaHIPP Affordable Plan, and non-SBH Chisholm Class Members rate cells.

# Section I. Medicaid Managed Care Rates

## 1. General Information

This section provides information listed under the General Information section of CMS guide, Section I.

The capitation rates provided under this certification are "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 12 (Risk Classification (for all Practice Areas)); ASOP 23 (Data Quality); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification); and ASOP 56 (Modeling).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective for the SFY 2024 managed care program rating period.
- The most recent *Medicaid Managed Care Rate Development Guide* published by CMS.

Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term "actuarially sound" will be defined as in ASOP 49:

- *"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."*[1]

The capitation rates developed may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The health plan may require rates above, equal to, or below the "actuarially sound" capitation rates that are associated with this certification.

### A. RATE DEVELOPMENT STANDARDS

#### i. All standards and documentation expectations for rate ranges

Unless otherwise stated, all standards and documentation outlined in the CMS guide apply to the development of the rates in this certification. This certification does not include rate ranges.

#### ii. 12-month rating period

The actuarial certification contained in this report is effective for the capitation rates for the one-year rating period from July 1, 2023, through June 30, 2024.

[1] http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/

### iii. Required elements

#### (a) Actuarial certification

The actuarial certification, signed by Anders Larson, FSA, is in Appendix 1. Mr. Larson meets the qualification standards established by the American Academy of Actuaries, follows the practice standards established by the Actuarial Standards Board, and certifies that the rates meet the applicable standards in 42 CFR 438 that are effective for the SFY 2024 managed care program rating period.

#### (b) Certified capitation rates for each rate cell

The certified rates by region, rate cell, and MCO are contained in Appendix 3. Prior to risk adjustment, capitation rates are the same for all MCOs, with the exception of Humana, which will receive rates excluding the cost of prescription drug coverage for the months of July through September 2023. Further description of the prescription drug exclusion from Humana's capitation rates is provided later in this report. The prescription drug carve-out rates are shown in Appendix 4. These rates represent the contracted capitation rates prior to risk adjustment. Projected member months illustrated in Appendix 3 and 4 represent estimated values for SFY 2024 across all MCOs combined.

#### (c) Program information

##### (i) Managed care program

This certification was developed for the Healthy Louisiana Medicaid managed care program operated by the State of Louisiana.

Since 2012, LDH has contracted with the following three managed care organization (MCOs) participating in the Healthy Louisiana program on a statewide basis:

- Amerihealth Caritas Louisiana
- Healthy Blue of Louisiana
- Louisiana Healthcare Connections

Aetna Better Health of Louisiana and UnitedHealthcare of Louisiana joined the Healthy Louisiana program in 2015. Starting in January 2023, Humana Healthy Horizons entered the Healthy Louisiana program. Due to the delayed implementation of the single statewide Pharmacy Benefit Manager (PBM), Humana is not covering prescription drugs until the Single PBM is fully implemented, which is expected to be October 1, 2023. All other plans have continued to cover prescription drugs using their own PBMs.

Each MCO will receive a regional, risk adjusted capitation payment for each rate cell. The parishes in Louisiana will be grouped into the same four rating regions used for the Healthy Louisiana managed care capitation rate development and payment used for SFY 2023. These regions are listed below. A mapping of the parishes to regions can be found in Appendix 1.

- Gulf
- Capital
- South Central
- North

Healthy Louisiana is split into separate physical health (PH) and specialized behavioral health (SBH) programs. The PH program broadly covers medical, prescription drugs, and behavioral health services. The SBH program covers a subset of the PH program services, limited to certain behavioral health services and non-emergency transportation (NEMT). All programs exclude LTSS. The covered services and populations are described in more detail later in this section.

##### (ii) Rating period

This actuarial certification is effective for the one-year rating period of July 1, 2023 through June 30, 2024.

### (iii) Covered populations

Healthy Louisiana is split into separate PH and SBH programs. This section will describe the managed care populations covered under each program. Appendix 6 also includes details on inclusions and exclusions for Healthy Louisiana.

#### Physical Health

There are several mandatory populations in the PH program:

***Supplemental Security Income (SSI)***

The SSI population includes disabled children and adults who are not eligible for Medicare. This population is divided into the following rate cells:

- 0 to 2 months
- 3 to 11 months
- Child 1 to 20 years
- Adult 21+ years

***Family & Children (F&C)***

The F&C population includes non-disabled children and adults who are not eligible for Medicare and do not qualify for one of the other populations noted below. This population is divided into the following rate cells:

- 0 to 2 months
- 3 to 11 months
- Child 1 to 20 years
- Adult 21+ years

***Foster Care Children (FCC)***

The FCC population includes children currently residing in Foster Care. There is only a single rate cell for the FCC population. Note that Former Foster Care Children and Youth Aging Out of Foster Care are separately included within the F&C population.

***Breast and Cervical Cancer (BCC)***

The BCC population includes non-disabled children and adults who are identified through the Centers for Disease Control and Prevention (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and who need treatment for breast or cervical cancer. There is only a single rate cell for the BCC population.

***Louisiana Children's Health Insurance Program (LaCHIP)***

The LaCHIP population includes children qualifying for coverage under the Children's Health Insurance Program (CHIP). For capitation rate purposes, these members are included within the F&C rate cells.

***Affordable Plan (LAP)***

The LAP population includes uninsured children in moderate income families whose income is too much to qualify for regular LaCHIP. A monthly premium per household applies for families that have at least one child enrolled in LAP. There is only a single rate cell for the LAP population.

***Act 421 Children's Medicaid Option (CMO)***

Act 421 CMO expanded Medicaid eligibility effective January 1, 2022, to certain children with disabilities, even if their parents earn too much money to qualify for Medicaid.

Disabled children living at home with their family that apply for Act 421-CMO must meet an institutional level of care for an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Nursing Facility or Hospital to be considered for this program.

Members without third-party insurance (e.g., individual or employer sponsored coverage), or with third-party insurance and not enrolled in the Louisiana Health Insurance Premium Payment Program (LaHIPP) will receive all PH program services through Healthy Louisiana. This population is divided into the following rate cells:

- Non-TPL
  - 0 to 2 months
  - 3 to 11 months
  - Child 1 to 18 years
- Non-LaHIPP TPL
  - 0 to 2 months
  - 3 to 11 months
  - Child 1 to 18 years

***Medicaid Expansion***

The Affordable Care Act Expansion Adults (ACA) population is comprised of Louisiana residents between 19 and 64 years of age, who are U.S. citizens or who have legal status and are eligible for Medicaid and have a monthly income less than 138% of the federal poverty level (FPL). This population is divided into the following rate cells:

- Age 19-64
- High Needs

***Voluntary Populations***

Home and Community Based Services (HCBS) waiver participants and Chisholm Class Members (CCM) can enroll in Healthy Louisiana on a voluntary basis. These members are not automatically enrolled into the Healthy Louisiana PH program, but they may choose to enroll at any time. They may also choose to disenroll at any time, effective in the earliest possible month the action can be administratively handled. Voluntary opt-in individuals may also re-enroll during the annual open enrollment period. The voluntary populations are divided into the following rate cells:

- HCBS Waiver
  - Child 1 to 20 Years
  - Adult 21+ Years
- CCM
  - All Ages

***Excluded Populations***

Appendix 6 includes details on aid category and type case combinations that are excluded for the PH program.

***Maternity Kick Payment***

For populations covered under the PH program, maternity delivery services are included in separate kick payment rate cells. There are four kick payment rate cells:

- Maternity Kick Payment (non-Expansion)
- Early Elective Delivery (EED) Kick Payment (non-Expansion)
- Medicaid Expansion – Maternity Kick Payment
- Medicaid Expansion – EED Kick Payment

### Specialized Behavioral Health

The Healthy Louisiana SBH program includes individuals classified as SBH Dual and SBH Other as mandatory populations. The voluntary opt-in populations that did not opt into the Healthy Louisiana PH program are automatically included in the SBH program. These populations are identified as SBH HCBS waiver participants and SBH CCM for purposes of capitation rate setting.

In addition, members in the LaHIPP program will receive SBH and NEMT services only through Healthy Louisiana.

Finally, members in the Act 421 CMO population who have third party insurance and are enrolled in LaHIPP will receive only SBH and NEMT only through Healthy Louisiana. For purposes of the SBH covered services, Applied Behavioral Analysis (ABA therapy) is treated as an SBH service, although it is shown under the Professional service category in the actuarial cost models.

The SBH program is divided into the following rate cells:

- SBH – Duals
  - Non-Expansion, SBH – Dual Eligible, All Ages
  - Expansion, Age 19-64
- SBH – LaHIPP
  - Non-Expansion, LaHIPP – Dual Eligible, All Ages
  - Expansion, Age 19-64
- SBH – HCBS Waiver
  - Child 1 to 20 Years
  - Adult 21+ Years
- SBH – CCM
  - Non-Expansion, CCM, All Ages
  - Expansion, Age 19-64
- SBH – Other
  - Non-Expansion, CCM, All Ages
  - Expansion, Age 19-64
- Act 421 LaHIPP TPL
  - 0 to 2 months
  - 3 to 11 months
  - Child 1 to 18 years

### Summary Groupings

Throughout this certification, we have aggregated rate cells into several groupings for purposes of summarizing various components of our rate development. The rate cell groupings are listed below:

- SSI
  - Includes all SSI rate cells
- F&C
  - Includes all F&C rate cells
  - Excludes kick payments
- SBH
  - Includes all SBH rate cells, except for Act 421 LaHIPP TPL
- Medicaid Expansion
  - Includes both Medicaid Expansion rate cells
  - Excludes kick payments
- Other Populations
  - Includes HCBS, Act 421, Foster Care Children, BCC, LaHIPP Affordable Plan, and non-SBH CCM rate cells
- Maternity Kick – Non-Expansion
  - Includes both EED and non-EED kick payments
  - Includes deliveries for members from any above population except Medicaid Expansion
- Maternity Kick – Expansion
  - Includes both EED and non-EED kick payments

## (iv) Eligibility criteria

Appendix 6 includes details on which aid category and type combinations are considered mandatory and which are excluded populations for the PH and SBH programs.

#### (v) Special contract provisions

This rate certification report contains documentation of the following special contract provisions related to payment included within rate development.

- Withhold arrangement
- Minimum medical loss ratio requirement
- Directed payments made as separate payment terms
- Incentive program
- Risk adjustment
- Hepatitis C risk corridor
- High cost drug pool

Please see Section I, subsection 4 for additional detail and documentation.

#### (vi) Retroactive adjustment to capitation rates

This rate certification report is for prospective SFY 2024 capitation rates.

### iv. Differences among capitation rates

Any proposed differences among capitation rates according to covered populations are based on valid rate development standards and are not based on the rate of federal financial participation (FFP) associated with the covered populations.

### v. Cross-subsidization of rate cell payment

The capitation rates were developed at the rate cell level and neither cross-subsidize nor are cross-subsidized by payments from any other rate cell.

### vi. Effective dates

To the best of our knowledge, the effective dates of changes to the Medicaid managed care program are consistent with the assumptions used in the development of the certified SFY 2024 contracted capitation rates.

### vii. Minimum medical loss ratio

The capitation rates were developed such that the MCOs are reasonably expected to achieve a medical loss ratio (MLR), as calculated under 42 CFR 438.8, greater than 85 percent for the rate year. The capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs. The Healthy Louisiana contract has remittance provisions with a minimum MLR of 85 percent separately for the Medicaid Expansion and all other populations combined. The terms and conditions are outlined in Section I, subsection 4.C.ii.(b).

### viii. Conditions for actuarially sound rate ranges

This certification does not include rate ranges.

### ix. Documentation for actuarially sound rate ranges

This certification does not include rate ranges.

### x. Generally accepted actuarial practices and principles

#### (a) Reasonable, appropriate, and attainable

In our judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs. To our knowledge, there are no reasonable, appropriate, and attainable costs that have not been included in the certification.

#### (b) Outside the rate setting process

There are no adjustments to the rates performed outside the rate setting process.

### (c) Final contracted rates

The SFY 2024 capitation rates certified in this report represent the final contracted rates by rate cell prior to risk adjustment.

#### xi. Rate certification for effective time periods

This actuarial certification is effective for the one-year rating period of July 1, 2023, through June 30, 2024.

#### xii. COVID-19 public health emergency

Please see Section 1, subsection 1.B.x for details on rate adjustments related to the COVID-19 public health emergency (PHE).

#### xiii. Procedures for rate certification and amendment

In general, a new rate certification will be submitted when the capitation rates change. The following exceptions are allowed per §438.7 of CMS 2390-F:

1. A contract amendment that does not affect the rates.
2. A de minimis increase or decrease of up to 1.5% in the capitation rate per rate cell.
3. Risk adjustment, under a methodology described in the initial certification, that changes the rates paid to the MCOs.

In cases 1 and 2, a contract amendment must still be submitted to CMS. In the event program provisions are invalidated by courts of law or by changes in statutes, regulations, or approvals, an amendment will be submitted.

## B. APPROPRIATE DOCUMENTATION

#### i. Actuarial certification

The actuary is certifying capitation rates for the MCOs. This certification does not include rate ranges.

#### ii. Documentation of required elements

This report contains appropriate documentation of all elements described in the rate certification, including data used, assumptions made, and methods for analyzing data and developing assumptions and adjustments.

#### iii. Ranges of assumptions

The specific assumptions underlying the capitation rates have been disclosed in this certification. We have not developed ranges around assumptions used in the capitation rate development.

#### iv. Requirements for a certified capitation rate range

This certification does not include rate ranges.

#### v. Index

The index to this rate certification is the table of contents, found immediately after the title page. The index includes section numbers and related page numbers. Sections not relevant to this certification continue to be provided, with an explanation of why they are not applicable.

#### vi. Consistency with rate of FFP

The capitation rates for all populations were developed in a manner consistent with 42 CFR 438.4(b)(1), including that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and that these differences do not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs.

### vii. Different FMAP

Capitated payments made for children enrolled in the F&C population who are eligible for Title XXI benefits receive an enhanced FMAP rate of 77.10% during federal fiscal year (FFY) 2023. A portion of capitated payments attributable to family planning services in all populations except Medicaid Expansion receive an enhanced FMAP rate of 90.0%.

Capitated payments made for the Medicaid Expansion population receive an FMAP rate of 90.0% during SFY 2024. All other capitated payments made receive the regular state FMAP of 67.28% for FFY 2023 and 67.67% for FFY 2024. The enhanced FMAP percentages (with the exception of the 90.0% rate for the Medicaid Expansion population) are not reflected in values provided in this certification. The FMAP enhancement available following the end of the COVID-19 PHE is also not reflected in values provided in this certification.

### viii. Comparison to prior rates

#### (a) Comparison to prior rates

Figures 1 and 2 above provide a summarized comparison of the SFY 2024 capitation rates to the prior rates for January 2023. A summarized comparison by population with amounts attributable to each adjustment is provided in Appendix 2. Comparisons at the rate cell level are provided in Appendix 3.

As demonstrated in Appendix 2, the following are the key drivers of the rate changes:

- New base period benefit expenses
- Medical utilization trend
- Pharmacy utilization and unit cost trends
- Managed care efficiency adjustments
- Acuity adjustments related to PHE unwinding
- Outpatient hospital reimbursement trend
- Single PBM implementation
- Other program changes effective after January 2023

#### (b) Description of other material changes

There are no material changes to the capitation rates or the rate development process that are not otherwise addressed in this report.

#### (c) De minimis adjustment in prior rating period

LDH did not adjust the actuarially sound capitation rates in the previous rating period by a *de minimis* amount using the authority in 42 C.F.R 438.7(c)(3).

### ix. Known amendments

We anticipate that the capitation rates may be amended to reflect program changes effective January 1, 2024. These future program changes are not known as of the date of this certification. If applicable, this amendment is anticipated to be provided in the second half of 2023.

### x. COVID-19

#### (a) State specific, and other applicable national or regional data

The following data sources were examined in developing rate setting adjustments for the COVID-19 PHE:

- Changes in delivery system utilization since the onset of the COVID-19 PHE, including analysis of Healthy Louisiana emergency room visits, telehealth services, office visits, and preventive services.
- Enrollment and estimated acuity changes by region and Healthy Louisiana rate cell, monitoring changes in per member cost and risk scores using MCO encounter data.
- Seasonality patterns in CY 2019, CY 2021, and CY 2022.
- Emerging financial experience reported by the MCOs during the third and fourth quarters of CY 2022.
- Direct testing, treatment, and vaccine costs related to COVID-19 in MCO encounter data incurred from the start of the COVID-19 national health emergency through June 2022.

- Centers for Disease Control and Prevention, COVID Data Tracker[2]: statewide data for COVID cases, deaths, testing volume, hospitalizations, and vaccination trends.
- Louisiana COVID-19 Dashboard[3]: statewide and regional data for COVID cases, deaths, hospitalization, testing, and vaccination trends.

### (b) Direct and indirect impacts reflected in capitation rates

We are applying two adjustments to the SFY 2024 capitation rates for items related to the COVID-19 PHE and related unwinding. These adjustments are summarized in Figure 5 and described below.

**FIGURE 5: COVID-19 RELATED ADJUSTMENTS**

| | | % IMPACT BY POPULATION | | | | | | |
|---|---|---|---|---|---|---|---|---|
| INDEX | COVID-19 ADJUSTMENT | SSI | F&C | SBH | EXPANSION | OTHER | KICK - EXP | KICK – NON-EXP |
| 5.a | Unwinding Acuity Adjustment | 0.0% | 0.5% | 0.0% | 1.4% | 0.0% | 0.0% | 0.0% |
| 5.b | Upper Respiratory Testing | (0.0%) | (0.2%) | 0.0% | (0.5%) | 0.0% | 0.0% | (0.1%) |
| 5.c | COVID-19 and other respiratory acute inpatient hospitalizations | 0.0% | (0.6%) | 0.0% | (1.4%) | 0.0% | 0.0% | (0.0%) |

#### 5.a. Unwinding acuity adjustment general acuity adjustment

As part of the Consolidated Appropriations Act, 2023, continuous enrollment requirements were decoupled from the PHE on March 31, 2023, allowing eligibility reviews to begin prior to the expiration of the PHE. As such, the COVID-19 unwinding period is anticipated to begin prior to SFY 2024, with the first disenrollments anticipated for July 1, 2023. Based on discussions with LDH, the unwinding process is expected to be randomized over the 12-month review process. To the extent the PHE unwinding differs from assumptions, associated impacts may be evaluated as the unwinding results become known.

We reviewed the enrollment changes for all rate cells and populations during the COVID-19 PHE to evaluate which rate cells experienced the greatest cumulative change since March 2020 (the start of the COVID-19 PHE). Based on the enrollment projections provided by LDH, the F&C Child 1-20 Years and Medicaid Expansion 19-64 rate cells have experienced the greatest membership growth during the PHE and are anticipated to have a material proportion of members disenrolled during the unwinding process. In addition, we believe that the acuity of enrollees that maintained eligibility due to the continuous enrollment provision differs from Medicaid members that would have been eligible for Medicaid absent this provision. As a result, we reviewed the estimated acuity during SFY 2022 (base period) and the projected acuity during SFY 2024 (projection period) to estimate the impact of changing membership at the rate cell level. With the exception of the F&C Child 1-20 Years and Medicaid Expansion 19-64 rate cells, we believe the population morbidity covered by the managed care programs during SFY 2022 is reasonably reflective of the estimated SFY 2024 population morbidity.

Please note that no acuity adjustment was made for the F&C Adult 21+ rate cell. This is for two reasons:

1. This population did not experience material enrollment growth during the COVID-19 PHE.
2. Uncertainty related to the Transitional Medicaid population. The Transitional Medicaid program provides up to 12 months of Medicaid coverage for individuals who lose Parent and Caretaker Relatives (PCR) Group coverage because of an increase in income. LDH is awaiting additional guidance from CMS on the Transitional Medicaid population.

As a result, this rate certification assumes that the SFY 2022 morbidity in the F&C Adult 21+ rate cell will be reflective of the estimated SFY 2024 morbidity and no acuity adjustment will be made. Depending on the future guidance provided by CMS, we may revisit the acuity assumption for the F&C Adult 21+ rate cell in future rate amendment materials.

[2] https://covid.cdc.gov/covid-data-tracker/#datatracker-home

[3] https://ldh.la.gov/Coronavirus

To evaluate the change in membership acuity impact for the Medicaid Expansion and F&C Child rate cells from SFY 2022 to SFY 2024, we stratified the populations into the following cohorts: pre-COVID trended enrollment, increased participation, and categorically ineligible population. We assigned a relative acuity level to each rate cell assumed to have a membership impact as a result of the COVID-19 PHE based on actual experience in the Healthy Louisiana program. These cohorts and their relative acuity level are described in more detail below.

- **Pre-COVID trended enrollment**. The anticipated enrollment by rate cell absent the COVID-19 PHE. To project this enrollment, we applied a historical enrollment trend prior to the COVID-19 PHE to the pre-COVID enrollment for each rate cell. The total pre-COVID trended enrollment was assumed to represent a relative acuity of 1.0 and is anticipated to remain in the program through SFY 2024.
- **Increased participation**. This population entered Medicaid during the COVID-19 PHE and is projected to remain through SFY 2024 as a result of increased exposure to Medicaid during the COVID-19 PHE. We estimated the relative acuity of this population by stratifying enrollment within each rate cell into the members that joined during COVID-19 PHE and members that were enrolled prior to the COVID-19 PHE. We compared the average prospective risk score of the new joining cohort with the pre-PHE cohort to determine a relative acuity factor.
- **Categorically ineligible population.** The portion of individuals enrolled during the COVID-19 PHE who are assumed to be categorically ineligible for Medicaid and are projected to be disenrolled during the unwinding period. The categorically ineligible population is estimated to have the lowest relative acuity of all the cohorts. We estimated the relative acuity by comparing CY 2019 per capita expenditures of experience for members that disenrolled during CY 2019 to members that maintained enrollment throughout CY 2019. For purposes of this analysis, members who disenrolled due to death were included in the cohort that maintained enrollment, given that disenrollments due to death continued throughout the PHE.

Figure 6 illustrates the projected relative acuity by rate cell for each of the populations described above for SFY 2022 and SFY 2024.

**FIGURE 6: PROJECTED CHANGE IN MEMBERSHIP ACUITY FOR IMPACTED RATE CELLS**

**ACUITY ASSUMPTIONS**

| RATE CELL | PRE-COVID TRENDED | GROWTH POPULATION | UNWINDING |
|---|---|---|---|
| F&C - Child 1-20 Years | 1.0000 | 0.9000 | 0.7000 |
| Medicaid Expansion - Age 19-64 | 1.0000 | 0.9000 | 0.8000 |

**SFY 2022 PROJECTED MEMBER MONTHS**

| RATE CELL | PRE-COVID TRENDED | GROWTH POPULATION | UNWINDING | SFY 2022 PROJECTED ACUITY |
|---|---|---|---|---|
| F&C - Child 1-20 Years | 7,485,528 | 192,591 | 638,111 | **0.9747** |
| Medicaid Expansion - Age 19-64 | 5,701,368 | 566,725 | 2,042,223 | **0.9440** |

**SFY 2024 PROJECTED MEMBER MONTHS**

| RATE CELL | PRE-COVID TRENDED | GROWTH POPULATION | UNWINDING | SFY 2024 PROJECTED ACUITY | ACUITY ADJUSTMENT |
|---|---|---|---|---|---|
| F&C - Child 1-20 Years | 7,485,528 | 413,361 | 336,538 | **0.9827** | **1.0083** |
| Medicaid Expansion - Age 19-64 | 5,701,368 | 1,265,242 | 1,092,886 | **0.9572** | **1.0139** |

## 5.b. Upper respiratory testing

The upper respiratory testing cost assumptions for the SFY 2024 capitation rates are based on a review of SFY 2022 and emerging experience and include testing costs for COVID-19, Flu, and Respiratory Syncytial Virus (RSV).

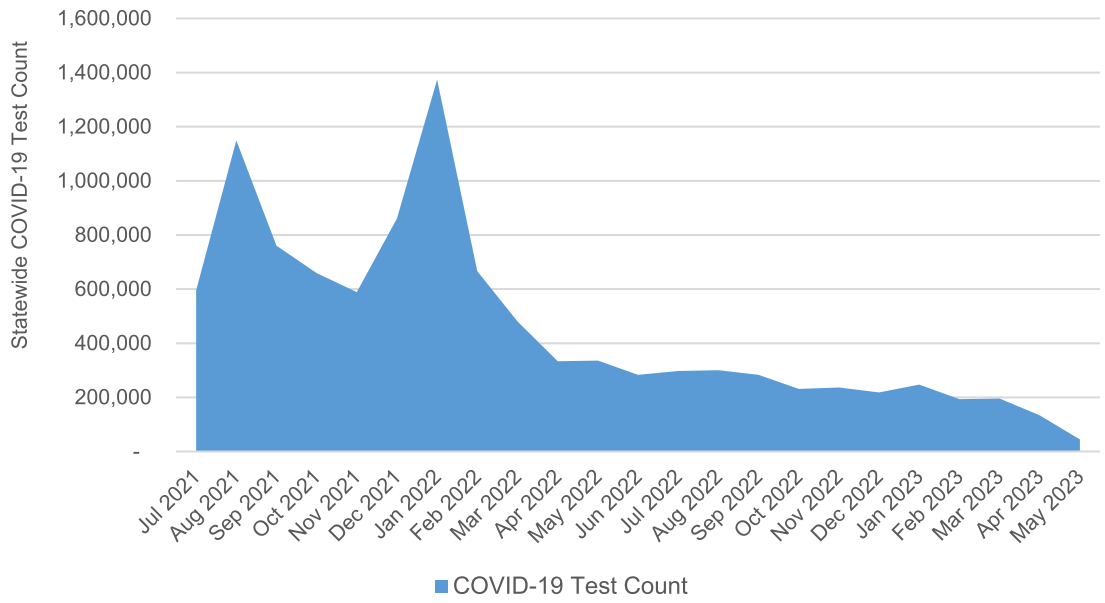
Based on our review of monthly incurred expenditures, we made an adjustment to the base data to reflect the anticipated utilization of upper respiratory testing during the projection period. This adjustment incorporates two items that are anticipated to impact the projection period differently.

COVID-19 Testing

The base year was impacted by the emergence of two COVID-19 variants (Delta during the Summer of 2021 and Omicron in late CY 2021 and early 2022) which increased the number of COVID-19 tests during the base experience period.

As illustrated in Figure 7 below, emerging data indicates that the COVID-19 testing has stabilized at a lower volume when compared to SFY 2022. The statewide monthly COVID-19 testing data are reported on LDH's website at https://ldh.la.gov/Coronavirus/.

**FIGURE 7: MONTHLY LOUISIANA COVID-19 TESTING**



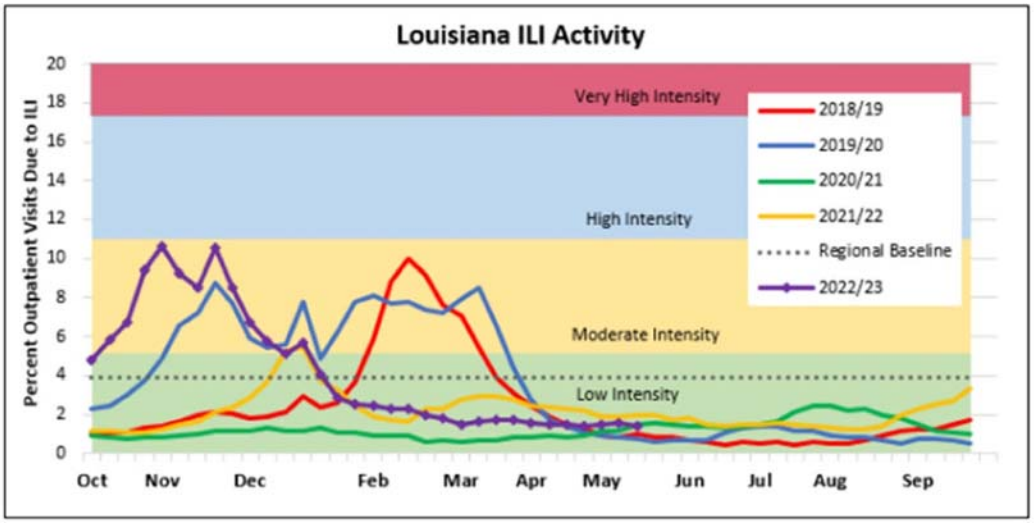

To be more representative of the emerging utilization and the utilization anticipated during the projection period, we applied an adjustment to remove approximately half of the COVID-19 tests provided through the Other Ancillary detailed service category during SFY 2022, which represents a reduction of approximately $35 million. To partially offset this reduction, we increased the utilization of COVID-19 at-home tests to reflect increased utilization during SFY 2023 compared to the base period. The impact of additional at-home test utilization is projected to increase SFY 2022 expenditures by approximately $4M.

Flu and RSV Testing

The Centers for Disease Control and Prevention (CDC) reported low levels of influenza-like illnesses in Louisiana during SFY 2022 when compared to the regional baseline. In addition, the CDC reported that the presence of influenza-like illnesses in Louisiana significantly increased during the fourth quarter of calendar year 2022.[4] The figure below illustrates the Influenza-like illness activity in Louisiana relative to the regional baseline for the last few years.

[4] https://ldh.la.gov/assets/docs/SurveillanceReports/InfluenzaSurveillance/Weekly22-23/2319_WeekEnding053023.pdf

**FIGURE 8: LOUISIANA INFLUENZA-LIKE ILLNESS (ILI) ACTIVITY**



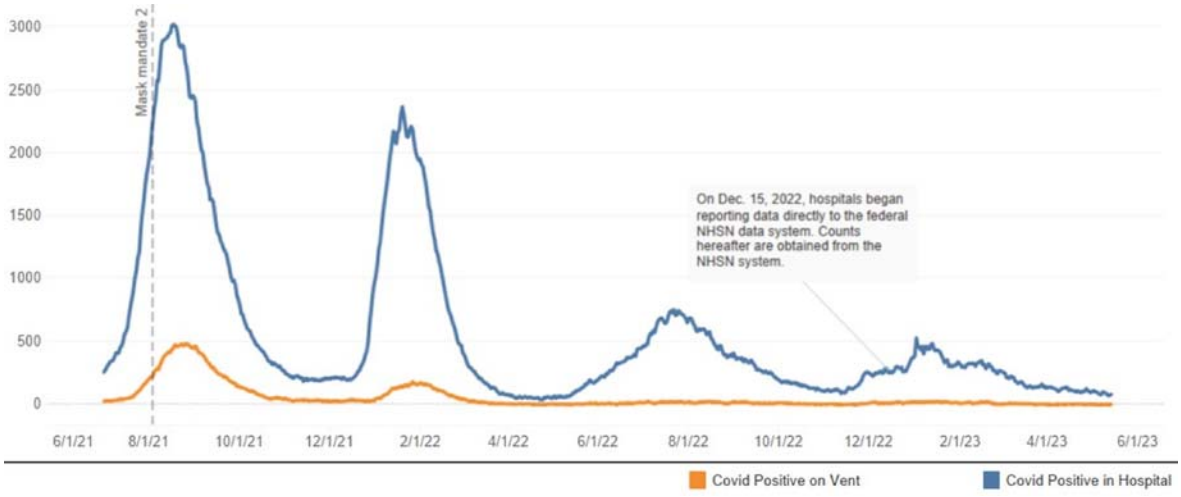

Based on this information, we made an adjustment to increase the influenza-like testing expenditures for the projection period by $10 million.

### 5.c. COVID-19 and other respiratory treatment costs

We evaluated differences in the expected treatment cost related to COVID-19 and other upper respiratory infections between the SFY 2022 base experience period and SFY 2024 rating period. We evaluated SFY 2022 PMPM claim expenses by service category for member months receiving COVID-19 and/or upper respiratory treatment and all other member months. We developed the adjustment by re-weighting the expected prevalence of upper respiratory infections during SFY 2024 relative to the base period.

We reviewed Louisiana specific trends in prevalence rates for COVID-19 hospitalizations by reviewing the LDH COVID-19 hospitalization rates since the beginning of the PHE. COVID-19 hospitalizations in Louisiana have fluctuated with the emergence of new COVID-19 variants, availability of vaccines, and natural immunity levels from prior infection[5]. The figure below illustrates the number COVID-19 patients hospitalized since July 2021, which represents the beginning of the base data period. The statewide COVID-19 hospitalization data is reported on LDH's website at https://ldh.la.gov/Coronavirus/.

**FIGURE 9: LOUISIANA COVID-19 PATIENTS HOSPITALIZED AND ON VENTS**




[5] https://www.healthdata.org/news-release/lancet-most-comprehensive-study-date-provides-evidence-natural-immunity-protection#:~:text=For%20people%20who%20have%20been,at%2010%20months%20post%20infection).

As the result of highly transmissible variants in SFY 2022 that increased population-level immunity (reflected by decreased levels of hospitalization during recent months relative to the base experience period), we anticipate lower utilization of COVID treatment during the rating period when compared to the base period. We projected both COVID treatment by evaluating July through October 2022 in the encounter data, with adjustments for changes in statewide COVID hospitalizations and emergency room visits reported by the CDC through the end of May 2023. The result of this modeling process is intended to reflect an estimate of COVID-related utilization and costs during the 12 months ending May 2023. We separately projected utilization and costs for influenza-like treatment by assuming utilization would be consistent with CY 2022. The net adjustment for both COVID and influenza-like illnesses reduces the projected hospital expenditures for the treatment of these illnesses by approximately $57 million.

### (c) COVID-19 costs covered on non-risk basis

COVID-19 vaccine administration costs are covered by LDH on a fee-for-service basis and therefore are not reflected in the Healthy Louisiana capitation rates. There are no other COVID-19 related costs that are covered on a non-risk basis.

### (d) Risk mitigation strategies

As documented in Section 1, subsection 4.C.ii.(b), LDH has elected to maintain its minimum medical loss ratio (MLR) requirement at 85% for the SFY 2024 contract year. Other risk mitigation strategies are structurally consistent with the prior rating period, although LDH has made some adjustments to the drugs to be included in the high-cost drug risk pool. This is discussed further in Section 1, subsection 4.C.

# 2. Data

This section provides information on the base data used to develop the capitation rates. The base experience data described in this section is illustrated in Appendix 2.

## A. RATE DEVELOPMENT STANDARDS

In accordance with 42 CFR §438.5(c), we have followed the rate development standards related to base data. The remainder of Section 1, subsection 2 provides documentation of the data types, sources, validation process, material adjustments, and other information related to the documentation standards required by CMS.

## B. APPROPRIATE DOCUMENTATION

### i. Requested data

We requested and received data specifically for the capitation rate development. In addition, we intake and summarize monthly eligibility and expenditure data using information provided by LDH. The remainder of this section details the base data and validation processes utilized in the SFY 2024 capitation rate development. In addition, Appendix 2 summarizes the adjusted base data.

### ii. Data used to develop the capitation rates

#### (a) Description of the data

##### (i) Types of data

The SFY 2024 capitation rate development utilized the following data sources:

- Historical eligibility files provided by LDH
- Encounter data submitted by the LDH
- LDH fee schedules applicable to services affected by reimbursement changes
- Summarized enrollment projections related to the PHE unwinding
- Results of historical wage checks
- Preferred drug lists (PDLs) and other pharmacy coverage policies
- Financial reporting templates submitted by the MCOs
  - Standard Financial Reporting Requirements (FRRs)
  - MCO survey
- MCO statutory financial statements

The capitation rates for all populations and regions were developed from historical SFY 2022 claims and enrollment data from the managed care enrolled populations. We used utilization and expenditures from the encounter data with runout through February 2023. We applied an adjustment to gross up the expenditures to the level reported in the MCO surveys. This adjustment is described in more detail in Section 1, subsection 2.B.iii.

##### (ii) Age of the data

The data utilized as the base experience in the rate development for this report represents benefit expenses incurred during SFY 2022 (claims runout through February 2023). We used encounter data corresponding to the same time period for the purposes of evaluating the impact of policy and program adjustments.

For the purposes of non-pharmacy trend development, we reviewed monthly MCO financial data and FFS experience on an incurred basis over the period from January 2019 through June 2022. Trend assumptions for the SFY 2024 rates considered emerging 2H 2022 data to the extent it is credible. Judgment was applied when reviewing the data due to disruptions related to the COVID-19 pandemic.

For pharmacy trend development, we reviewed quarterly pharmacy expenditures on an incurred basis over the period from January 2019 through December 2022.

### (iii) Data sources

#### Capitation payment and eligibility information

In a series of transmissions during January through March 2023, we received eligibility and enrollment extracts from the State's Medicaid Management Information System (MMIS) for encounters, fee-for-service claims, and eligibility data from January 2019 through February 2023. After this initial data transfer, we established a process to receive updated MMIS data on a monthly basis.

#### FFS and MCO encounter data

We received FFS claims and MCO encounter data extracts from the State's MMIS concurrently with the eligibility and enrollment extracts noted above. Our analysis was based on data submitted to the MMIS through February 2023.

#### LDH fee schedules

We received LDH fee schedules for services affected by reimbursement changes during or after the base experience period. In some cases, these fee schedules were accessed through the LDH website; however, in other cases, LDH provided these to us directly. For certain reimbursement changes, in lieu of providing a complete fee schedule, LDH confirmed that reimbursement for a set of services would increase by a specific percentage or amount.

#### Summarized enrollment projections related to the PHE unwinding

We received enrollment projections from LDH for each population from April 2023 through June 2024. Based on discussions with LDH, the redetermination process resumed on May 1, 2023, with the first disenrollment occurring July 1, 2023, and will be completed over a 12-month period. The eligibility review process is anticipated to be random and not prioritize one population over another.

#### PDLs and other pharmacy coverage policies

We received weekly preferred drug list (PDL) files from LDH for July 2021 through March 2023. These PDL files were used to review and estimate changes in pharmacy utilization as a result of LDH's PDL updates. In addition, LDH provided us with other information to appropriately project MCO pharmacy expenditures during SFY 2024. This included items such as 340B pharmacy lists, clotting factor reimbursement, and local pharmacy providers.

#### Financial reports – Standard FRRs

On a quarterly basis, each MCO was requested to complete a financial reporting template. The recent submission includes data paid through December 2022. Utilization and expenditures were reported by each MCO by region, rate cell, and high-level category of service. The financial reporting template also captured information related to sub-capitated arrangements, affiliated party contracts, non-benefit costs, and other information pertinent to the SFY 2024 rate development. Information in the standard FRRs is generally reported on a cash basis for the most recent calendar year.

#### Financial reports – MCO survey

The MCO survey requests incurred experience during SFY 2022 with runout through December 2022 to align with the base data period. The MCO survey is intended to validate the base data used in the development of the SFY 2024 capitation rates. In addition, it allows the MCOs to provide information on the anticipated provider reimbursement for SFY 2024.

#### MCO statutory financial statements

CY 2018 through CY 2022 statutory financial statements were accessed through S&P Global Market Intelligence.

### (iv) Sub-capitation

As part of the data collection process, each MCO was required to provide the following information in the FRRs and MCO Survey for each sub-capitated arrangement effective in the base period:

- Vendor
- Vendor risk arrangement
- Classification of services provided

- Related party (yes or no)
- Member value-added service
- Amount of sub-capitation attributable to healthcare quality improvement
- Amount of sub-capitation attributable to administrative costs
- Amount of sub-capitation attributable to health care expenses

This information was used to allocate costs associated with sub-capitated arrangements between benefit and non-benefit expenses. For sub-capitated benefit expenses, we included the sum of the health care expenses and proxy reserves. Amounts delegated for healthcare quality improvement and administrative costs are included in the development of the non-benefit expense assumptions used in the capitation rates.

#### (v) Exception to base data requirements

We have not requested an exception to the base data requirements due to the COVID-19 public health emergency.

### (b) Availability and quality of the data

#### (i) Steps taken to validate the data

In a series of transmissions during January through March 2023, we received eligibility and enrollment extracts from the State's Medicaid Management Information System (MMIS) for encounters, fee-for-service claims, and eligibility data from January 2019 through February 2023. The actuary, the MCOs, and LDH all play a role in validating the quality of encounter and financial reporting information used in the development of the capitation rates. The MCOs play the initial role, collecting and summarizing data sent to the State. In addition, LDH focuses on encounter data quality and MCO performance measurement, with measures focused on completeness, accuracy, and comparison between data sources. We perform independent analysis of encounter data and financial reporting information to evaluate the quality of the data being used in the rate development process. Below is a summary of measures specific to each quality area that are applied by either Milliman or LDH.

##### Completeness

We first validated that we had received complete transmissions by comparing summarized values to control totals provided by the state's fiscal agent contractor (FAC). After processing the data, we compared aggregate encounter claims dollars for each MCO to values in the Encounter Data Reconciliation Reports[6] produced by Myers and Stauffer, on behalf of LDH.

##### Accuracy

MCO encounter data was reviewed relative to utilization and expenditures reported in the MCO surveys. We found material amounts of utilization and expenditures were missing from MCO encounter data and determined that it was not appropriate to use the encounter data as the base experience for rate development without additional adjustments to align with the MCO surveys. The magnitude of these adjustments was similar to prior capitation rate certifications. We reviewed that the allocation of encounter utilization and expenditures by population, region, and service category was reasonably consistent with the reported financial experience, making it appropriate to use for most program change adjustments, acuity adjustments, trend analysis, and other modeling.

##### Consistency of data across data sources

We compared data across all sources during our base data review and analysis. Through the data validation process, we identified some inconsistencies in reported data across sources. We addressed deviations in MCO survey submissions on an individual basis with each MCO. After addressing the deviations, we believe that the encounter data is reasonably consistent with the MCO surveys, such that it is appropriate to use as the base experience in rate development, with adjustment to gross up the expenditures to the level reported in the MCO surveys.

[6] https://ldh.la.gov/page/4371

#### (ii) Actuary's assessment

As required by Actuarial Standard of Practice (ASOP) No. 23, Data Quality, we disclose that we have relied upon certain data and information provided by LDH and its vendors, primarily the MCOs. The values presented in this report are dependent upon this reliance.

We find the data used to develop the SFY 2024 capitation rates to be suitable for the purpose of developing actuarially sound rates, with certain adjustments as outlined in the following sections. The data has been reviewed by multiple parties for completeness, accuracy, and consistency. The managed care experience base data used in the development of the SFY 2024 certified rates is reasonably consistent with the reported financial experience of MCOs.

#### (iii) Data concerns

Minor data adjustments were made to the data submitted by the MCOs to account for various issues identified during the review process. For example, expenditures reported in the MCO survey in physical health service categories (excluding prescription drugs) for the SBH rate cells were assumed to be mis-categorized and represented valid SBH or NEMT services. We also found that MCOs tended to allocate too few expenditures to newborn (0-2 month) rate cells and too many expenditures to other child rate cells in the F&C and SSI populations. This was addressed through the true-up process, as described in more detail in Section 2.B.iii.a.

### (c) Appropriate data

#### (i) Use of encounter and fee-for-service data

Fee-for-service data was not used during the rate development process.

#### (ii) Use of managed care encounter data

Managed care encounter data in SFY 2022 was used as base experience in the rate development for all populations. We applied an adjustment to gross up the expenditures to the level reported in the MCO surveys.

### (d) Reliance on a data book

We did not rely on a data book for the SFY 2024 capitation rate development.

## iii. Data adjustments

The capitation rates were developed from SFY 2022 reported in managed care encounter data for all regions and rate cells. Adjustments were made to the base experience to gross-up expenditures to the level reported in the MCO surveys. Additional adjustments were made for credibility, completion, policy/program changes, and other data adjustments.

#### True-up to MCO surveys

For all regions and populations, encounter data submitted by the MCOs served as the base data. However, due to concerns with the completeness of the encounter data, we adjusted the data such that the total expenditures are consistent with the MCO surveys. This process is summarized below.

1. Prior to applying any data adjustments described later in this section, we first removed expenditures from our base data related to physical health services for members who were in an SBH rate cell at the date of service. This adjustment is described in more detail in Section 1, subsection 2.B.iii.e.
2. We summarized the remaining expenditures from the encounter data by region, rate cell, and major service type (medical vs. prescription drugs). These summaries reflected only services incurred in SFY 2022.
3. We summarized comparable expenditures from the MCO surveys, by region, and major service type (medical vs. prescription drugs), and major service type (medical vs. prescription drugs). The expenditures include values reported by the MCOs for benefit expenses, excluding "Other Contractual Requirements", which included a combination of settlements and FMP payments.

4. Claims were composited across rate cells into the following enrollment groupings:
    - SSI
    - F&C
    - Act 421 rate cells
    - HCBS rate cells
    - SBH rate cells
    - Medicaid Expansion
    - Other rate cells (excluding kick payments)
    - Non-expansion kick payment
    - Expansion kick payment
5. We developed initial factors to apply to the encounter data. These factors are equal to the total expenditures from the MCO surveys divided by the total expenditures from the base data, by region, rate cell grouping, and major service type (medical vs. prescription drugs).
6. We adjusted encounter completion factors based on a comparison of member months in the base data relative to the MCO surveys. Because we did not directly adjust our base member months, we instead adjusted the final true-up factors to account for differences in member months between the base data and the MCO surveys. This adjustment was equal to total member months from the base data divided by the total expenditures from the MCO surveys, by region and rate cell grouping.

In addition, we added costs associated with value-based payments, which were reported by the MCOs in the FRRs by service category and major population (expansion, non-expansion physical health, and SBH). We also added settlements for non-outpatient service categories. Outpatient settlements were incorporated later as part of the outpatient reimbursement adjustment, described in Section 1, subsection 2.B.iii.d.

We made some modifications to the reported financial data based on our review and discussions with the MCOs.

- We excluded non-emergency transportation (NEMT) from the development of the medical true-up factors, both in the encounter data and the financial data. Most MCOs indicated that these services were sub-capitated and the expenses reported in the MCO surveys represented the capitation payments made to the NEMT vendor, not the proxy paid amount for the services actually rendered. After completing the true-up without NEMT services, we applied the medical true-up factors to the NEMT base experience, which implicitly assumes that NEMT encounters have the same level of completeness as other medical services.
- We adjusted the pharmacy expenses in the MCO Survey for one MCO to exclude amounts related to the Hepatitis C risk pool payables and COVID vaccines (which are not included in the risk-based capitation rate).
- We removed all dental and a portion of the vision expenses for one MCO because the MCO indicated these were value-added services and/or administrative expenses for the delegated vendor.
- Value-based payments for two MCOs were not added separately because the MCOs indicated these amounts were already included within the expense lines on the MCO Survey.
- We subtracted outpatient settlements for one MCO because the MCO indicated these were included along with other claims-based hospital expenses. These settlements were incorporated separately as part of the outpatient reimbursement adjustment.

The figure below summarizes the impact of the true-up adjustments by region and population.

**FIGURE 10: TRUE-UP ADJUSTMENT IMPACT BY REGION AND POPULATION**

| POPULATION | GULF | CAPITAL | SOUTH CENTRAL | NORTH |
|---|---|---|---|---|
| SSI | (5.7%) | (1.2%) | (1.9%) | (1.7%) |
| F&C | 4.6% | 6.9% | 5.7% | 4.9% |
| SBH | (2.0%) | (4.3%) | (1.2%) | (6.2%) |
| Medicaid Expansion | 3.4% | 4.5% | 5.2% | 3.9% |
| All Other Populations | 3.4% | 8.1% | 4.6% | 2.7% |
| Maternity Kick – Expansion | (12.7%) | (13.0%) | (8.3%) | 1.4% |
| Maternity Kick – Non-Expansion | 1.6% | 12.0% | 15.7% | 20.9% |

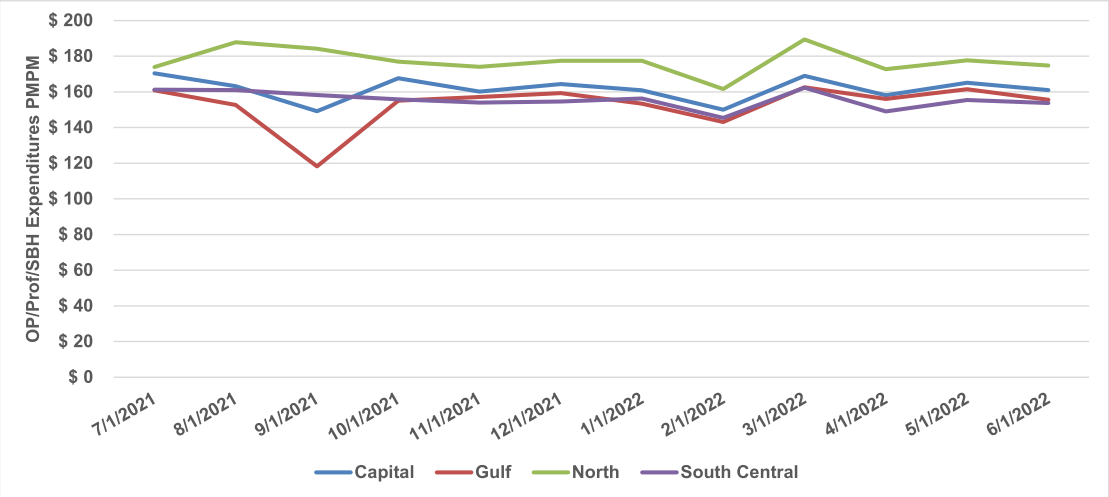
Notes:

1. The percentage impact is illustrated as a percentage of the base period benefit expenses.

### Hurricane Ida adjustment

Based on a review of monthly historical data, we observed that outpatient hospital, professional, and SBH services were materially suppressed in September 2021 in the Gulf and Capital regions. We determined this was likely a result of disruptions due to Hurricane Ida, which caused severe damage to coastal areas of Louisiana in late August 2021. Figure 11 below illustrates the monthly PMPM expenditures for outpatient hospital, professional, and SBH service categories, by region. The dip in the Gulf and Coastal regions is notable in September 2021.

**FIGURE 11: SFY 2022 MONTHLY OUTPATIENT HOSPITAL, PROFESSIONAL, AND SBH EXPENDITURES, BY REGION**




We adjusted the base experience in the Gulf and Capital regions for the F&C, Medicaid Expansion, and SSI populations to account for the expenditure decrease in September 2021. We applied a multiplicative adjustment factor to these service categories such that the adjusted PMPM in September 2021 was equal to an expected September value. The expected September value was based on a comparison of the September 2019 and September 2022 PMPM costs to the average PMPM costs of all other months in CY 2019 and CY 2022, limited to the applicable service categories.

In addition, we made an adjustment to reflect the likelihood of a hurricane of similar magnitude occurring during the rating period. To estimate this likelihood, we reviewed information from the National Oceanic and Atmospheric Administration (NOAA) that projects hurricane "return periods" for each coastal segment in the US. The return periods indicate the average number of years between hurricanes; alternatively, they can be used to roughly indicate the probability of a hurricane in a given year. There are five coastal segments in Louisiana, as well as one in neighboring Mississippi and one on the northeastern edge of Texas. For each of these segments, the return periods for a major hurricane (category 3-5) ranges from 20 to 34 years. However, the likelihood of a hurricane in *any* of these segments in a given year is likely higher, which we assume to be 10% to 20% depending on the correlation of hurricane probability in each segment.

We also reviewed historical data for hurricanes making landfall in this area as a category 3-5 storm. Since 2000, there have been five storms of this magnitude hitting Louisiana, plus one additional making landfall in Texas. This averages to approximately 0.23 to 0.27 major storms per year. There have also been other natural disasters causing health care delivery system disruption in Louisiana not caused by hurricanes, including the 2016 floods that caused damages exceeding $10 billion.

Based on the data points above, we believe it is reasonable to assume a roughly 1 in 4 chance of a major natural disaster (hurricane, flood, etc.) affecting Louisiana in a given year that would cause similar disruption as observed with Hurricane Ida. Under this assumption, we dampened the Hurricane Ida adjustment by 25% to reflect an "average" year, resulting in the adjustment to the base data to adding back only 75% of the observed cost reduction. This resulted in the final adjustment adding approximately $16 million in Gulf and $6 million in Capital to our base data. *Note, in future rate setting years, if a major hurricane or similar natural disaster did not occur in the base experience, we would make a downward adjustment to the base data.*

### (a) Credibility adjustment

Several rate cells had low enrollment within each region (fewer than 1,000 members in each region). Due to low enrollment, we established the capitation rates on a statewide basis for several rate cells:

- SSI 0-2 months
- SSI 3-11 months
- Breast & Cervical Cancer
- HCBS rate cells
- SBH – HCBS rate cells
- LaHIPP Affordable Plan

There were also instances where separate rate cells were expected to have similar membership profiles, but each of the rate cells had low membership. In these cases, we developed statewide rates that were also blended across multiple rate cells. These situations are noted below:

- SBH – Other + Medicaid Expansion – SBH – Other

Similarly, there were other instances where separate rate cells were expected to have similar membership profiles, but one of the rate cells had much higher membership than the other. In these cases, we developed regional rates, but blended across multiple rate cells within each region. These situations are noted below:

- Medicaid Expansion – Age 19-64 + Medicaid Expansion – High Needs
- SBH – Dual Eligible + SBH – LaHIPP
- SBH – Chisholm Class Members + Medicaid Expansion – SBH – Chisholm Class members
- Medicaid Expansion – SBH – Dual Eligible + Medicaid Expansion – SBH – LaHIPP

Finally, for the Act 421 rate cells, we determined we did not have sufficient historical data for these populations to use for establishing capitation rates. Instead, we used a proxy population comprised of SSI rate cells as the base experience and applied acuity, cost-sharing, and coverage adjustments. This is discussed in more detail in Section 1, Subsection 3.B.ii.a.

### (b) Completion adjustment

The capitation rates are based on SFY 2022 MCO experience. In the MCO surveys and quarterly FRRs, MCOs were requested to provide monthly incurred but not paid (IBNP) estimates by major service category and population. We analyzed reported MCO claims completion for reasonableness. Based on discussions with the MCOs, we adjusted the IBNP estimates to remove reserves related to FMP payments, which are excluded from our base data and added separately at the end of capitation rate development. Otherwise, we have not made modifications to reported claim reserve estimates provided by the MCOs.

The impact of applying the claim completion factors to the base data is illustrated by region and population in Figure 12 below. The detailed adjustments by rate cell and service category can be found in Appendix 2 of this report.

**FIGURE 12: COMPLETION ADJUSTMENT IMPACT BY REGION AND POPULATION**

| POPULATION | GULF | CAPITAL | SOUTH CENTRAL | NORTH |
|---|---|---|---|---|
| SSI | 0.8% | 0.6% | 0.9% | 1.0% |
| F&C | 1.5% | 0.9% | 1.0% | 1.0% |
| SBH | (0.1%) | (0.1%) | (0.2%) | (0.1%) |
| Medicaid Expansion | (0.0%) | 0.1% | (0.1%) | 0.1% |
| All Other Populations | 0.8% | 1.0% | 0.8% | 0.7% |
| Maternity Kick – Expansion | 0.2% | 0.2% | 0.2% | 0.2% |
| Maternity Kick – Non-Expansion | 0.9% | 1.0% | 0.9% | 1.0% |

Notes:

1. The percentage impact is illustrated as a percentage of the base period benefit expenses.

### (c) Errors found in the data

On an overall basis, we believe that the encounter data was reasonably consistent with the MCO surveys, such that we were comfortable using it as the base experience, with an adjustment to true-up the expenditures to the level reported in the MCO surveys.

### (d) Program change adjustments

Figure 13 lists program and reimbursement changes that occurred since the beginning of the base experience period used in rate development.

Figure 13 includes the program change, effective date of the change, as well as the percentage impact to the SFY 2024 benefit expenses by population. The impacts shown in Figure 13 are prior to the application of trend and managed care efficiency adjustments.

Item 13.a through 13.e occurred prior to the end of the base experience period, necessitating a retrospective adjustment, and is illustrated in Appendix 8. The remaining items in Figure 13 occurred after the end of the base experience period, requiring a prospective adjustment, and are illustrated in Appendix 9. Medicaid FFS reimbursement changes are reflected in the rate development because based upon reimbursement information submitted with the MCO surveys, the vast majority of MCO provider reimbursement is tied to FFS reimbursement.

**FIGURE 13: PROGRAM CHANGE ADJUSTMENTS**

| | | | % IMPACT BY POPULATION | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| INDEX | PROGRAM CHANGE | EFFECTIVE DATE | SSI | F&C | SBH | EXPANSION | OTHER | KICK - EXP | KICK - NON-EXP |
| 13.a | FQHC RHC APM | 1/1/2022 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 13.b | BH Service Expansion | 2/21/2022 | 0.1% | 0.0% | 2.4% | 0.2% | 0.0% | 0.0% | 0.0% |
| 13.c | NEMT Fee Schedule Change | 3/1/2022 | 0.1% | 0.0% | 2.1% | 0.0% | 0.0% | 0.0% | 0.0% |
| 13.d | EPSDT Personal Care Services Fee Schedule Change | 4/1/2022 | 0.0% | 0.0% | 0.0% | 0.0% | 0.6% | 0.0% | 0.0% |
| 13.e | COVID-19 Laboratory Testing Fee Schedule Change | 4/8/2022 | (0.0%) | (0.0%) | 0.0% | (0.0%) | (0.0%) | (0.0%) | (0.0%) |
| 13.f | Applied Behavior Analysis Fee Schedule Change | 7/1/2022 | 0.2% | 0.1% | 0.9% | 0.0% | 1.0% | 0.0% | 0.0% |
| 13.g | Pediatric Day Health Care Fee Schedule Update | 7/1/2022 | 0.1% | 0.0% | 0.0% | 0.0% | 0.7% | 0.0% | 0.0% |
| 13.h | Hospice Fee Schedule Change | 7/15/2022 | (0.0%) | (0.0%) | 0.0% | (0.0%) | (0.0%) | 0.0% | 0.0% |
| 13.i | Young Adult & Adult Immunization Fee Schedule Change | 7/26/2022 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 13.j | CGM Coverage Criteria Change | 8/1/2022 | (0.2%) | (0.7%) | 0.0% | 0.2% | (0.4%) | 0.0% | 0.0% |
| 13.k | Six-Month Supply of Contraceptives | 11/20/2022 | (0.0%) | (0.0%) | 0.0% | (0.0%) | 0.0% | 0.0% | 0.0% |
| 13.l | Outpatient Hospital Reimbursement Changes | 1/1/2023 | 2.0% | 2.1% | 0.0% | 2.3% | 1.2% | 3.3% | 2.5% |
| 13.m | Other January 1, 2023 Fee Schedule Changes | 1/1/2023 | 0.1% | 0.1% | 0.2% | 0.1% | 0.6% | 0.2% | 0.2% |
| 13.n | Home Health Fee Schedule Change | 4/3/2023 | 0.4% | 0.0% | 0.0% | 0.1% | 1.8% | 0.0% | 0.0% |
| 13.o | Resumption of Rx Copays | 5/12/2023 | (0.1%) | (0.0%) | 0.0% | (0.2%) | (0.0%) | 0.0% | 0.0% |
| 13.p | Tobacco Counseling | 6/20/2023 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 13.q | Inpatient Hospital Reimbursement Changes | 7/1/2023 | 0.4% | 0.1% | 0.1% | 0.4% | 0.1% | 0.5% | 0.6% |
| 13.r | FQHC/RHC Fee Schedule Update | 7/1/2023 | 0.4% | 1.2% | 0.0% | 0.7% | 0.5% | 0.0% | 0.0% |
| 13.s | Ambulance Fee Schedule Change | 7/1/2023 | 1.5% | 0.9% | 0.4% | 1.4% | 0.7% | 0.0% | 0.0% |
| 13.t | Single PDL | 7/1/2023 | (0.8%) | 0.6% | 0.0% | (0.3%) | (0.1%) | 0.0% | 0.0% |
| 13.u | Single PBM | 10/1/2023 | (0.2%) | (0.7%) | 0.0% | 0.2% | (0.4%) | 0.0% | 0.0% |

Notes: 1. The percentage impact is illustrated as a percentage of the SFY 2024 benefit expenses.

2. Percentage impacts illustrated at 0.0% indicate minimal change at a population level; however, these adjustments were determined to be material for at least one rate cell.

### 13.a. FQHC/RHC APM for Community Health Workers

Effective January 1, 2022, LDH established an alternative payment methodology (APM) for federally qualified health centers (FQHCs) and rural health clinics (RHCs) allowing for reimbursement outside of the current prospective payment system rate for community health worker services provided in these sites. We evaluated the impact of the APM for FQHCs and RHCs based on emerging experience. Based on our review, we increased the base period expenditures by less than $1 million to account for this change.

### 13.b. Behavioral Health Services Expansion

In compliance with an agreement signed by the Department of Health and the U.S. Department of Justice in 2018, LDH adopted a provision to cover personal care services (PCS) and individual placement and support (IPS) supported-employment services for individuals at least 21 years of age with mental health disorders who have transitioned from a nursing facility or have been diverted from nursing facility level of care. These are the additional services and their effective dates:

- Individual Placement Support: February 21, 2022
- Personal Care Services: February 21, 2022
- Mobile Crisis: March 1, 2022
- Community Brief Crisis Support: March 1, 2022
- Behavioral Health Crisis Care: April 1, 2022
- Crisis Stabilization: April 20, 2022

We reviewed expenditures associated with these services after the effective date. Based on our review of emerging data and assuming continued ramp up of services during SFY 2023, we increased the base period expenditures by approximately $10 million to account for this change.

### 13.c. NEMT Fee Schedule Change

The most recent NEMT fee schedule, effective March 1, 2022, was updated during SFY 2022. To model this reimbursement change, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective March 1, 2022.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the two fee schedule effective dates.

### 13.d. EPSDT Personal Care Services Fee Schedule Change

The most recent EPSDT Personal Care Services fee schedule, effective April 1, 2022, was updated during SFY 2022. To model this reimbursement change, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective April 1, 2022.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the two periods.

### 13.e. COVID-19 Laboratory Testing Fee Schedule Change

The most recent COVID-19 Laboratory Testing fee schedule, effective April 8, 2022, was updated during SFY 2022. To model this reimbursement change, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective April 8, 2022.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the two fee schedule effective dates.

### 13.f. Applied Behavior Analysis Fee Schedule Update

The most recent Applied Behavior Analysis fee schedule, effective July 1, 2022, was updated prior to the prospective rating period. To model this reimbursement change, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective July 1, 2022.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the two fee schedule effective dates.

### 13.g. Pediatric Day Health Fee Schedule Update

The most recent pediatric day health fee schedule, effective July 1, 2022, was updated prior to the prospective rating period. To model this reimbursement change, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective July 1, 2022.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the fee schedule effective dates.

### 13.h. Hospice Fee Schedule Change

The Hospice fee schedule was recently updated, effective July 15, 2022. To model this reimbursement change, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective on July 15, 2022.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the two fee schedule effective dates.

### 13.i. Young Adult & Adult Immunization Fee Schedule Change

The young adult and adult immunization fee schedule is frequently updated, as recently as July 26, 2022. To model this reimbursement change, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective on July 26, 2022.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the two fee schedule effective dates.

### 13.j. Continuous Glucose Monitor Coverage Criteria Change

Effective August 1, 2022, LDH expanded coverage of continuous glucose monitors (CGMs) to Medicaid enrollees who met any of the following conditions:

- Any type of diabetes with the use of insulin more than two times daily or evidence of level 2 or level 3 hypoglycemia
- Glycogen storage disorder disease Type 1a

In addition, effective October 1, 2022, LDH expanded coverage of adjunctive CGMs, receivers, and supplies in the DME program by adding two Healthcare Common Procedure Coding System (HCPCS) codes to the Durable Medical Equipment (DME) fee schedule.

We reviewed expenditures associated with these services after both effective dates. Based on our review of emerging data, we increased the base period expenditures by approximately $9 million to account for this change.

### 13.k. Six-month Supply of Contraceptives

Effective November 20, 2022, in compliance with Act 708, LDH amended the Pharmacy Benefits Management Program to allow for a six-month supply of contraceptives. Based on our review of emerging data and discussions with LDH, we decreased the projected SFY 2024 expenditures by approximately $0.2 million to account for this change.

### 13.l. Outpatient Hospital Reimbursement Changes

Outpatient hospital services are reimbursed in one of two ways:

1. Using a CPT/HCPCS fee schedule for lab services, as well as surgery and clinic services at non-rural hospitals. The fee schedules vary for different types of hospitals, such as small rural, state hospital, sole community, etc.
2. Using a cost percentage for all other services. Hospital-specific cost percentages are established by LDH based and are generally higher for rural hospitals compared to other hospitals. Claims are paid on an interim basis using a prospectively established cost-to-charge ratio but are ultimately settled using actual cost reports for each hospital. The cost settlements are handled outside the claims system and are often completed multiple years after the date of service. These settlements result in positive or negative payments to each hospital.

To model these reimbursement changes, we used separate approaches for claims subject to a fee schedule and claims subject to a cost percentage. Note that in Figure 13, we have labeled this adjustment with an effective date of January 1, 2023, which is consistent with the most recent cost settlement percentages available to us.

***Fee Schedule-Based Reimbursement***

We repriced all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective on January 1, 2022.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the two fee schedule effective dates.

***Cost-Based Reimbursement***

First, we adjusted the base claims cost by incorporating the estimated settlements applicable to SFY 2022 dates of service. Settlement values were estimated by each MCO and accounted for invoices paid, invoices received but not yet paid, and any accruals for settlements not yet received. This included both payables and receivables. Total settlement dollars were converted to an MCO-specific uniform percentage adjustment, which was applied to each claim in our base data. We then applied a cost trend adjustment to the settlement-adjusted claims. The selected annualized cost trend was 4.2%, which is consistent with the CMS Market Basket[7] projections for Inpatient Prospective Payment System (IPPS) Hospital services from SFY 2022 to SFY 2024. We also adjusted the projected data to account for a small number of hospitals that had a change in their cost settlement percentage since the base period.

***Summary***

The figure below summarizes the adjustments applied to each type of outpatient hospital service. Values shown represent the impact to the base benefit expenses and do not account for true-up adjustment, completion, trend, or any other capitation rate adjustments.

**FIGURE 14: OUTPATIENT HOSPITAL ADJUSTMENT ($ MILLIONS)**

| REIMBURSEMENT TYPE | BASE CLAIMS COST | SETTLEMENTS | FEE SCHEDULE ADJUSTMENT | COST TREND ADJUSTMENT | FINAL ADJUSTED CLAIMS COST | NET ADJUSTMENT |
|---|---|---|---|---|---|---|
| Fee schedule-based | $ 257.8 | $ 0.0 | $ (1.1) | $ 0.0 | $ 256.7 | $ (1.1) |
| Cost-based | $ 1,006.5 | $ 75.3 | $ 0.0 | $ 94.8 | $ 1,176.6 | $ 170.1 |

Notes:
1. Values shown represent the impact to the base benefit expenses and do not account for true-up adjustment, completion, trend, or any other capitation rate adjustments.

## 13.m. Other January 1, 2023 Fee Schedule Changes

We recognize that other fee schedules were updated on January 1, 2023. Fee schedules with a material change relative to the base experience time period are listed below:

- Louisiana State University Physician Fee Schedule

[7] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData

- American Indians Facilities Fee Schedule
- PRTF Fee Schedule
- COVID-19 Vaccine and Treatment Fee Schedule
- Specialized Behavioral Health Fee Schedule

To model this reimbursement change, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedules effective on the date of service.
2. Using the fee schedules effective January 1, 2023.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the two fee schedule effective dates. We did note that fee schedule changes to Community Psychiatric Supportive Treatment and Psychosocial Rehabilitation were estimated to be budget neutral, since changes in billing requirements for these services have caused a shift in utilization toward the lower-cost Psychosocial Rehabilitation.

### 13.n. Home Health Fee Schedule Change

The Home Health fee schedule was recently updated, effective April 3, 2023. To model this reimbursement change, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective April 3, 2023.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the two fee schedule effective dates.

### 13.o. Resumption of Rx copays

Effective May 12, 2023, copays for prescription drugs are anticipated to be resumed consistent with the policies in place prior to the COVID-19 public health emergency. We estimated the impact of this adjustment by evaluating copays as a percentage of total retail pharmacy expenditures (including copays and plan paid amounts) in CY 2019. We adjusted this percentage to reflect changes in drug mix since CY 2019. Although the required copay varies based on the cost of the drug, the average cost per script has increased at a faster rate than the average required copay, which will result in copays making up a slightly smaller portion of overall retail pharmacy expenditures in SFY 2024.

### 13.p. Tobacco Cessation Counseling

Effective June 20, 2023, LDH intends to expand coverage for tobacco cessation counseling services to all Medicaid beneficiaries.

These services were previously only covered for pregnant beneficiaries in the Medical Assistance Program. We estimated the impact of this change based on information provided by LDH. During SFY 2024, we expect the expansion of tobacco cessation counseling coverage to increase expenditures by approximately $1.4 million.

### 13.q. Inpatient Hospital Reimbursement Changes

Inpatient hospital per diems have been updated as recently as January 1, 2023. Among the notable changes since the base experience period were:

- July 1, 2022 – Updated reimbursement for Baton Rouge General Hospital due to change in criteria for urban MSA facility
- October 11, 2022 – Updated reimbursement for New Orleans East Hospital due to change in criteria for urban MSA facility
- January 1, 2023 – Updates to per diems for certain other hospitals

- July 1, 2023 – Updates to per diems for certain other hospitals

To model these reimbursement changes, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the per diem rates effective on the date of service.
2. Using the per diem rates effective on July 1, 2023.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the two fee schedule effective dates.

### 13.r. FQHC/RHC Fee Schedule Update

The FQHC and RHC fee schedules are frequently updated. Both fee schedules will be updated on July 1, 2023 to reflect annual cost inflation adjustments. The FQHC fee schedule is also expected to include an additional $30 increase for all providers. Finally, RHCs that are associated with a small rural hospital will be reimbursed at 110% of cost as of July 1, 2023. To model these reimbursement changes, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the encounter rates effective on the date of service.
2. Using the most current encounter rates.
    a. For RHCs not associated with a small rural hospital, we used encounter rates effective 7/1/2023.
    b. For RHCs associated with a small rural hospital, we repriced to the expected cost-based reimbursement, based on data shared with us by LDH.
    c. For FQHCs, we used encounter rates effective 7/1/2023, plus $30 for each facility.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the two fee schedule effective dates.

### 13.s. Ambulance Fee Schedule Changes

The ground and air ambulance fee schedules have been recently updated. The ground ambulance fee schedule is expected to be updated effective July 1, 2023, under a new minimum fee schedule directed payment. The air ambulance fee schedule was updated most recently on October 1, 2022. To model these reimbursement changes, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedules effective on the date of service.
2. Using the fee schedules effective July 1, 2023.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the two fee schedule effective dates.

### 13.t. PDL Changes

The MCOs are required to use a single preferred drug list (PDL), which is maintained by LDH. We adjusted the benefit expenses to reflect the expected drug mix under the single PDL anticipated for SFY 2024 relative to the drug mix during SFY 2022. To estimate the impact of anticipated drug mix changes from SFY 2022 to SFY 2024, we summarized retail pharmacy expenditures by market basket, product name, GPI and current preferred status based on the most recent PDL provided by LDH. For each product name, we estimated the projected SFY 2024 market share will be similar to the 4Q 2022 retail pharmacy utilization in the Healthy Louisiana program for PDL changes that occurred through CY 2022. Next, we reviewed known changes that have occurred or anticipated to occur through the rating period.

The net impact to pharmacy expenditures as a result of the PDL changes, both during SFY 2022 and through SFY 2024, is a decrease to the base experience by approximately $13 million and is reflected in the Retail Pharmacy service line in the retrospective cost models.

The composite decrease was largely due to the anticipated change, effective July 1, 2023, to prefer generic Latuda® and change the status of brand Latuda® to non-preferred.

### 13.u. Single PBM

Effective October 1, 2023, LDH intends to implement a single pharmacy benefit manager (PBM). The single PBM will interface with each MCO to process all pharmacy claims. Based on discussions with LDH, we anticipate the following items will be impacted as a result of single PBM implementation:

- Non-local pharmacies reimbursement methodology
- Increased dispensing fee for local pharmacies
- Clotting factor and diabetic supplies reimbursement methodology
- Coverage of certain clotting factor and diabetic supplies will move from the medical benefit to the pharmacy
- Shift of certain drugs from billing as retail pharmacy to office administered drugs

Based on our review of these anticipated changes, we estimate that implementation of the single PBM effective October 1, 2023, will decrease SFY 2024 expenditures by approximately $12 million.

As a result of the single PBM, the MCOs will no longer be able to receive supplemental rebates on diabetic supplies. Please note that an explicit adjustment was not made to reflect the removal of the diabetic supply rebates because the base experience is gross of supplemental rebates retained by the MCOs during SFY 2022.

### Program changes deemed immaterial to benefit expenses in the rate period

We define a program or policy adjustment to be “material” if the total benefit expense for any individual rate cell is impacted by more than 0.10% and the effects are not fully reflected in the base experience. All policy changes provided to us by LDH were analyzed for their effect on the Medicaid managed care program. Program adjustments that were made in the SFY 2024 rate development had policy or reimbursement changes that were deemed to have a material cost impact to the MCOs. Adjustment factors that did not meet this minimum threshold criteria were deemed immaterial and were not applied to the base experience. The following is a list of program adjustments deemed immaterial based on our review of the experience data and policy change.

- *Inpatient and outpatient COVID-19 test criteria changes.* Effective September 20, 2021, inpatient COVID-19 tests are to be billed separately from inpatient hospital per-diem payments and ambulatory surgical center reimbursement amounts. Over-the-counter at-home COVID-19 tests are covered under the Pharmacy Benefits Management Program effective January 17, 2022. Effective February 1, 2022, reimbursement for laboratory testing for COVID-19 is to be billed separately from outpatient hospital fee schedule payments. We have separately accounted for the total projected volume of COVID-19 testing through an upper respiratory testing adjustment, described in Section 1, subsection 1.B.x.b.
- *MPS1/Pompe Newborn Screening.* Effective January 1, 2022, physicians attending to newborns are required to conduct a test for MPS1 and Pompe. We reviewed the emerging experience since the effective date and did not identify a material increase in expenditures associated with this program change.
- *Genetic Testing of Critically Ill Infants.* Effective August 1, 2022, genetic testing of critically ill infants will receive reimbursement separately from the inpatient hospital per diem payments. We reviewed the emerging experience since the effective date and did not identify a material volume of expenditures for these services.
- *Other fee schedule updates.* LDH periodically updates other fee schedules to incorporate new procedure codes or make minor rate adjustments. We have reviewed the impact of these other fee schedule changes and determined they do not have a material impact on capitation rate development.

Each of the program adjustments listed above were determined to be immaterial on a stand-alone basis (i.e., impacted the rates for each individual rate cell by less than 0.10%). We evaluated the composite impact of all of the immaterial items listed above to assess whether an aggregate impact should be applied in the SFY 2024 rate development process. Based on this analysis, the impact of immaterial program adjustments is immaterial on a composite basis so no further adjustments were applied.

### Full Medicaid Pricing (FMP)

LDH intends to maintain the physician FMP program for the SFY 2024 rating period, which provides needing funding and ensures continued access of physician rendered services to Medicaid recipients. CMS has previously communicated to LDH that it considers FMP programs to be "grey area" payments[8] which should be transitioned to an approved state directed payment arrangement. LDH has successfully transitioned its hospital, dental, and ambulance FMP programs to state directed payment arrangements. Based on conversations with CMS, LDH anticipates receiving approval to maintain the physician FMP program for the SFY 2024 rating period. During this time, LDH will continue to work with stakeholders to develop a revised physician payment program which is anticipated to be in place for the SFY 2025 rating period.

SFY 2024 FMP amounts by region and rate cell are included in Appendix 2.

### Other data adjustments

The following adjustments are not policy or program changes. The data adjustments listed in Figure 15 were identified by LDH or through our review of the base experience as outlined in Section I, subsection 2.A.ii of this report.

**FIGURE 15: OTHER DATA ADJUSTMENTS**

| | | % IMPACT BY POPULATION | | | | | | |
|---|---|---|---|---|---|---|---|---|
| INDEX | OTHER DATA ADJUSTMENT | SSI | F&C | SBH | EXPANSION | OTHER | KICK - EXP | KICK – NON-EXP |
| 15.a | IMD adjustment | 0.1% | 0.0% | 0.5% | 0.2% | 0.0% | 0.0% | 0.0% |
| 15.b | EED kick payment adjustment | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 15.c | Outlier adjustment | 0.3% | 0.7% | 0.0% | 0.0% | 0.3% | 0.0% | 0.0% |

Notes:
1. The percentage impact is illustrated as a percentage of the SFY 2024 benefit expenses.
2. IMD adjustment reflects the impact of removing all costs associated with long stay IMD visits for members 21 to 64.
3. EED adjustment impacts not shown due to difficulty in projecting this subset of deliveries
3. Percentage impacts illustrated at 0.0% indicate minimal change at a population level; however, these adjustments were determined to be material for at least one rate cell.

### 15.a. IMD adjustment

We adjusted the base data to remove all costs and member months for months in which a member aged 21 to 64 had an inpatient stay at an institution for mental disease (IMD) that exceeded 15 days in a given month (long stay IMD). In addition, for inpatient stays at an IMD for individuals aged 21 to 64 that are less than 15 days in a given month (short stay IMD), we adjusted the cost of these services such that the unit costs are comparable to the same services through providers included under the State Plan. Figure 15 illustrates the net impact of both the short stay and long stay IMD adjustments.

### 15.b. EED kick payment adjustment

Facility and delivering physician costs for early elective deliveries (EED) are not covered under the Healthy Louisiana Program. MCOs receive an EED kick payment for deliveries that occur prior to 39 weeks for reasons that are not medically indicated in the Louisiana Electronic Event Registration System (LEERS) maintained by the Office of Public Health/Vital Records. Deliveries that occur prior to 39 weeks for reasons that are medically indicated in LEERS will receive the maternity kick payment. To develop the EED kick payment capitation rates, we developed an adjustment to the standard kick payment by calculating the portion of kick payment costs that were associated with facility and delivering physician costs in the base experience. These adjustments were equal to 39.8% and 46.1% for the Non-Expansion and Medicaid Expansion maternity kick payments, respectively.

### 15.c. Outlier adjustment

As part of the State Plan, hospitals receive an additional payment for high-cost inpatient stays for children under six years, called outliers. These payments are for inpatient stays with a total cost to the hospital in excess of $150,000, in which the cost is determined based on the hospital's Neonatal Intensive Care Unit-specific or Pediatric Intensive Care Unit-specific cost-to-charge ratio (CCR).

[8] Medicaid and CHIP Managed Care Access, Finance and Quality, 88 Fed. Reg. 28112, May 3, 2023

LDH makes payments up to a maximum of $20,921,381 annually, which are paid by the MCOs to the applicable hospitals. We incorporated a PMPM add-on for applicable rate cells to fund the outlier payments. The PMPMs were allocated to rate cells based on their proportion of inpatient hospital expenses for members under age 6, such that the total add-ons were equivalent to $20,921,381 when applied to projected SFY 2024 enrollment.

## (e) Exclusion of payments or services from benefit expense data

Figure 16 summarizes the impact of adjustments made to the MCO base experience to reflect encounters for carved-out services, third-party liability recoveries, and fraud, waste, and abuse recoveries.

**FIGURE 16: EXCLUSIONS**

| | | % IMPACT BY POPULATION | | | | | | |
|---|---|---|---|---|---|---|---|---|
| INDEX | OTHER DATA ADJUSTMENT | SSI | F&C | SBH | EXPANSION | OTHER | KICK - EXP | KICK – NON-EXP |
| 16.a. | In rate criteria | 0.0% | 0.0% | (18.1%) | (0.1%) | 0.0% | 0.0% | 0.0% |
| 16.b | Recoveries | (0.3%) | (0.3%) | (0.2%) | (0.3%) | (0.3%) | (0.3%) | (0.3%) |

Notes:
1. The percentage impact is illustrated as a percentage of the SFY 2024 benefit expenses.
2. Percentage impacts illustrated at 0.0% indicate minimal change at a population level; however, these adjustments were determined to be material for at least one rate cell.

### 16.a. In rate criteria

Healthy Louisiana plans are only required to cover SBH and NEMT services for members in SBH rate cells. In the base experience, we identified claims for members in these rate cells that fell in other service categories and excluded them from capitation rate development.

### 16.b. Recoveries

In the MCO survey, we requested information from each MCO about fraud, waste, and abuse (FWA) and third-party liability (TPL) recoveries. These amounts were reported separately for recoveries reflected in the encounter data (as a reduction to the paid amount on each claim) and recoveries outside of the encounter data. We adjusted the base experience downward to account for recoveries outside of the encounter data. This adjustment was applied as a uniform multiplicative factor across all regions and rate cells, separately for medical and prescription drugs.

# 3. Projected Benefit Cost and Trends

This section provides information on the development of projected benefit costs in the capitation rates.

## A. RATE DEVELOPMENT STANDARDS

### i. Final capitation rate compliance

The final capitation rates are in compliance with 42 CFR 438.4(b)(6) and are only based on services outlined in 42 CFR 438.3(c)(1)(ii) and 438.3(e). Non-covered services provided by the MCOs, with the exception of approved in lieu of services (ILOS), have been excluded from the capitation rate development. MCOs utilize institutions for mental disease (IMD) as an approved ILOS.

### ii. Benefit cost trend assumptions

Projected benefit cost trend assumptions are developed in accordance with generally accepted actuarial principles and practices. The primary data used to develop benefit cost trends is historical claims and enrollment from the covered populations. In addition, consideration of other factors and data sources appropriate for benefit cost trend development is further documented in Section I, item 3.B.iii.

### iii. In lieu of services

The projected benefit costs reflect the utilization and unit costs of ILOSs, with the exception of short-stay IMDs.

### iv. ILOS Cost Percentages

In accordance with the State Medicaid Directors Letter published on January 4, 2023, when a managed care program includes ILOSs, with the exception of short term stays in an IMD, states must provide documentation of the projected ILOS of the projected ILOS Cost Percentage and the final ILOS Cost Percentage, as well as summary of actuarial managed care plan costs for delivering ILOSs. The projected ILOS Cost Percentage is the portion of the total capitation payments attributable to all ILOSs, excluding short term stays in an IMD, for the specific managed care program (numerator) divided by the total projected dollar amount of capitation payments specific to the Medicaid managed care program that includes the ILOS (denominator), which must include all state directed payments in accordance with 42 CFR § 438.6(c) and pass-through payments in accordance with 42 CFR § 438.6(d). The projected ILOS Cost Percentage is shown in Section 1, Subsection 3.B.v.b.

The projected ILOS Cost Percentage will be updated and documented with each applicable amendment. In addition, a separate actuarial report documenting the final ILOS Cost Percentage will be submitted to CMS no later than two years after the completion of the contract year.

### v. Benefit expenses associated with members residing in an IMD

LDH allows MCOs to authorize short term IMD stays for members aged 21 to 64 as an in lieu of service under §438.6(e). We utilized benefit expenses reported by the MCOs as the base experience for the IMD base managed care experience. Reimbursement for short stay IMDs in capitation rate development was adjusted such that the unit costs are comparable to the same services through providers included under the State Plan. In addition, we excluded all costs and member months for months in which a member had a stay at an IMD of greater than 15 days in a given month. These adjustments are described and quantified in Section 1, subsection 2.B.iii(d).

## B. APPROPRIATE DOCUMENTATION

### i. Projected benefit costs

This section provides documentation of the methodology utilized to develop the benefit cost component of the capitation rates at the rate cell level.

### ii. Development of projected benefit costs

#### (a) Description of the data, assumptions, and methodologies

This section of the report outlines the data, assumptions, and methodology used to project the benefit costs to the rating period. The baseline benefit costs were developed using the following steps:

Step 1: Create per member per month (PMPM) cost summaries

For all populations and regions, the capitation rates were developed from historical SFY 2022 claims and enrollment data.

We used utilization and expenditures from the encounter data with runout through February 2023. We applied adjustments to true-up the expenditures to the level reported in the MCO surveys, to the extent these values appeared reasonable. Utilization and costs are reported by population, rate cell, region, and detailed service category. We reviewed the allocation of costs by region and rate cell relative to encounter data for each MCO survey submission. To the extent the cost allocation is not consistent between the two data sources, we evaluated the need to re-allocate utilization and expenditures contained in the MCO surveys.

Claims experience was summarized on a rate cell and region basis, with rate cell assignment based on SFY 2024 criteria.

The base data was described further in section 2.B.ii.

Step 2: Apply historical and other adjustments to cost summaries

As documented in a previous section, utilization and cost per service rates from the base experience period were adjusted for a number of items, including, but not limited to, non-covered services, recoveries, and policy and program changes that occurred during the base data experience period. Note, based on the MCO surveys, the vast majority of Healthy Louisiana provider reimbursement is based on methodologies linked to the state Medicaid fee schedule. Therefore, we apply adjustments to the MCO experience to account for LDH fee schedule changes.

Step 3: Adjust for prospective program and policy changes and trend to state fiscal year 2024

We adjusted the base experience for known policy and program changes that have occurred or are expected to be implemented between the base data experience period and the end of the SFY 2024 rate period. In a previous section, we documented these items and the adjustment factors for each covered population.

Assumed trend factors were applied for 24 months to the adjusted utilization and unit cost values, or per member per month (PMPM) values, as appropriate, from the midpoint of the base experience period (January 1, 2022) to the midpoint of the rate period (January 1, 2024).

Step 4: Adjust for managed care efficiency gains

We estimated adjustments to the base experience data to reflect the utilization and cost per unit differential between the base period and the levels targeted for the rating period managed care environment.

Managed care efficiency adjustments by major category of service were developed based on SFY 2022 utilization as reported in encounter data and the MCO surveys. We estimated adjustments to the base experience data to reflect the utilization and cost per unit differential between the base period and the levels targeted for the rating period managed care environment.

Figure 17 illustrates the composite, statewide impact of managed care efficiency adjustments by population and major category of service. Note, for categories of service not listed in Figure 17, managed care efficiency adjustments were not applied.

**FIGURE 17: MANAGED CARE EFFICIENCY ADJUSTMENTS COMPOSITED BY POPULATION GROUP AND MAJOR SERVICE CATEGORY**

| ADJUSTMENT | SERVICE CATEGORY | STATEWIDE IMPACT UTILIZATION | STATEWIDE IMPACT COST PER UNIT | STATEWIDE IMPACT TOTAL |
|---|---|---|---|---|
| Inpatient Potentially Avoidable Admissions | | | | |
| | Inpatient Hospital | (0.26%) | (0.02%) | (0.27%) |
| | **Composite** | **(0.04%)** | **(0.00%)** | **(0.04%)** |
| Inpatient Length of Stay | | | | |
| | Inpatient Hospital | (2.87%) | 0.00% | (2.87%) |
| | **Composite** | **(0.32%)** | **0.00%** | **(0.32%)** |
| Maternity Delivery Mix | | | | |
| | Inpatient Hospital | (0.11%) | 0.00% | (0.11%) |
| | Outpatient Hospital | (0.04%) | 0.00% | (0.04%) |
| | Professional | (0.03%) | 0.00% | (0.03%) |
| | **Composite** | **(0.03%)** | **0.00%** | **(0.03%)** |
| Contracting | | | | |
| | Inpatient Hospital | 0.00% | (0.17%) | (0.17%) |
| | Professional | 0.00% | (0.17%) | (0.17%) |
| | LTSS | 0.00% | (11.38%) | (11.38%) |
| | **Composite** | **0.00%** | **(0.16%)** | **(0.16%)** |
| **All adjustments** | | **(0.38%)** | **(0.16%)** | **(0.54%)** |

Notes: 1. The percentage impact is illustrated as a percentage of the SFY 2024 benefit expenses in the applicable service category.
2. Values have been rounded. Values shown as 0.00% may have a non-zero impact to SFY 2024 benefit expenses.

*Inpatient hospital length of stay*

Inpatient hospital services in the Healthy Louisiana program are reimbursed on a per diem basis, and therefore longer lengths of stay will lead to higher expenditures. We analyzed the average length of stay by MCO, region, and MS-DRG code[9]. For each MS-DRG code, we compared the observed length of stay to benchmarks published by CMS. We then aggregated the observed and benchmark length of stay by MCO and region and calculated an actual-to-expected ratio. Next, we developed a target actual-to-expected ratio equal to the 75$^{th}$ percentile value[10] across the 20 MCO/region combinations. For MCO/region combinations above this benchmark, we adjusted inpatient days downward to achieve the target ratio. When applying the adjustment, we assumed the avoided days would be replaced by an equivalent number of days in a lower acuity setting, such as home health or hospice. No adjustments were applied to MCO/region combinations below the benchmark. The adjustment was applied as a multiplicative factor to the Inpatient Hospital service category, with separate factors by region.

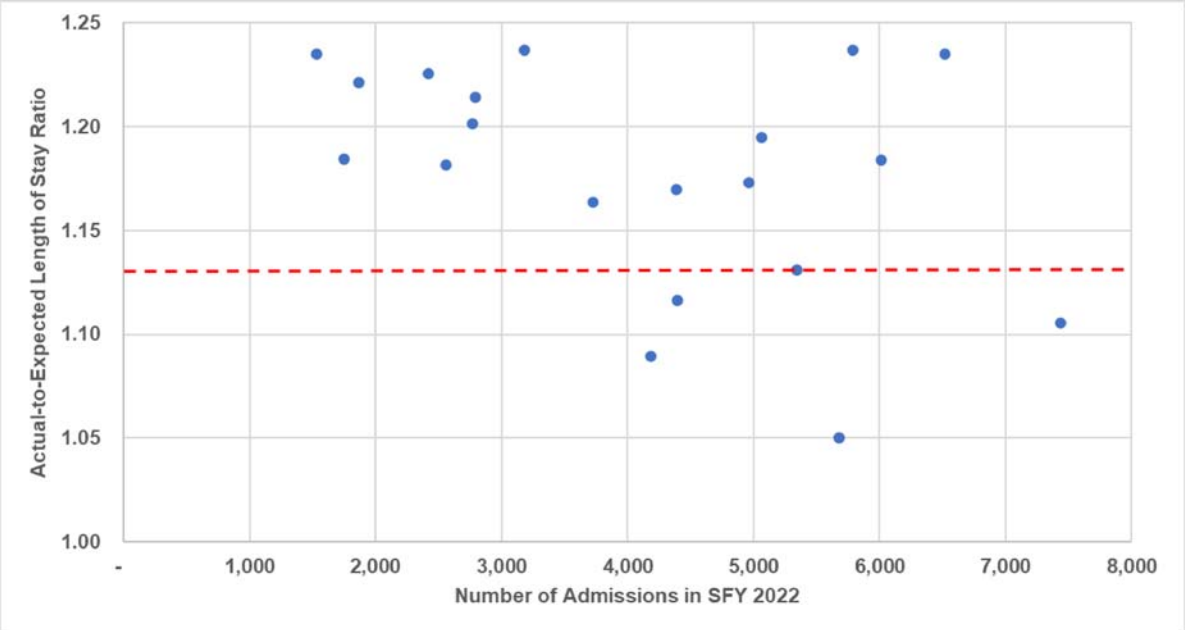
To avoid interactions with the inpatient hospital outlier program, which is a fixed annual pool for high-cost inpatient hospital admissions for members under age 6, we excluded infant rate cells from this analysis. In addition, for other claims for members under age 6, we set the benchmark length of stay equal to the observed length of stay, effectively assuming no savings potential for these admissions. Similarly, we set the benchmark length of stay equal to the observed length of stay for COVID-related admissions to avoid interactions with the separate COVID-related adjustments described in Section 1, Subsection 1.B.x.

In Figure 18, each point represents one of the health plan/region combinations in our analysis. The position on the vertical axis represents the actual-to-expected ratio and the position on the horizontal axis represents the number of admissions included in the analysis. The dashed line indicates the target actual-to-expected ratio used to develop the adjustment factor.

[9] MS-DRG was not directly available on the encounter data. We mapped this onto the encounter data using the MS-DRG grouper, version 38.

[10] In this calculation, higher percentile values represent lower (more favorable) actual-to-expected ratios.

**FIGURE 18: INPATIENT ADMISSIONS COMPARED TO ACTUAL-TO-EXPECTED LENGTH OF STAY RATIOS FOR EACH MCO/REGION COMBINATION**




*Inpatient hospital potentially avoidable admissions*

We also developed inpatient managed care adjustments based on SFY 2022 experience to reflect higher levels of care management during the rating period relative to the base period. These managed care adjustments were developed by applying assumed reductions to potentially avoidable inpatient admissions. We analyzed the frequency of potentially avoidable admissions using the Agency for Healthcare Research and Quality (AHRQ) prevention quality indicators (PQI).

Our analysis was conducted by reducing admissions for select PQIs by 5%. In completing our analysis, we estimated inpatient hospital unit cost changes based on the utilization reductions outlined above. All SBH inpatient admissions were excluded from this analysis, and hospital admissions related to COVID-19 were not considered avoidable and were not reduced in this adjustment.

Figure 19 outlines the PQIs included in our analysis.

**FIGURE 19: PREVENTION QUALITY INDICATORS**

| PQI Number | Description |
|---|---|
| PQI #01 | Diabetes short-term complications admission rate |
| PQI #02 | Perforated appendix admission rate |
| PQI #03 | Diabetes long-term complications admission rate |
| PQI #05 | Chronic obstructive pulmonary disease (COPD) admission rate |
| PQI #07 | Hypertension admission rate |
| PQI #08 | Congestive heart failure (CHF) admission rate |
| PQI #10 | Dehydration admission rate |
| PQI #11 | Bacterial pneumonia admission rate |
| PQI #12 | Urinary tract infection admission rate |
| PQI #13 | Angina without procedure admission rate |
| PQI #14 | Uncontrolled diabetes admission rate |
| PQI #15 | Adult asthma admission rate |
| PQI #16 | Rate of lower-extremity amputation among patients with diabetes |

*Maternity delivery mix*

We reviewed the mix of vaginal and cesarean section deliveries by MCO to determine appropriate efficiency adjustments for kick payments. Delivery managed care efficiency adjustments were developed by analyzing the percent of cesarean and vaginal deliveries by MCO and region in the SFY 2022 base period. Next, we developed a target delivery mix equal to the 75th percentile value[11] across the 20 MCO/region combinations. This target mix was 69.0% vaginal / 31.0% cesarean. For MCO/region combinations above this benchmark, managed care savings were estimated by evaluating the maternity cost difference between cesarean and vaginal deliveries, then re-calculating the average maternity cost at the target mix. No adjustments were applied to MCO/region combinations already below the target. No adjustment was made to the total number of deliveries.

*Provider contracting*

In the MCO Survey, each MCO reported its average provider reimbursement levels for various service categories as a percentage of the LDH FFS fee schedule. In cases where specific MCOs were contracted above 100%, we applied an adjustment to reduce unit costs to a level consistent with the LDH FFS fee schedule. In each case where an adjustment was applied, at least two of the MCOs reported paying at 100% of the LDH FFS fee schedule, indicating these reimbursement levels should be reasonably achievable. Adjustments were applied on a regional basis to reflect variation in the portion of providers contracted above 100%.

*Emergency room*

We reviewed the encounter data to evaluate the need for a managed care efficiency adjustment related to emergency department utilization. We determined that emergency room utilization in the base period was materially below pre-COVID levels, although utilization rates have been increasing since mid-2020, particularly for the child populations. It is likely that both potentially avoidable and clinically appropriate emergency room visits have been avoided to a greater degree during the base period. Based on this review, we did not apply a managed care efficiency adjustment to emergency room services. However, the trend assumption (shown in Section 1, subsection 3.iii.a.iv) reflects an expectation that as overall emergency room utilization continues to increase, MCOs will mitigate potentially avoidable services from returning to pre-COVID levels.

*Prescription drugs*

We have accounted for anticipated changes in prescription drug behavior patterns relative to the base experience period through the Single PBM adjustment and pharmacy trend assumptions, and therefore we have not applied a separate managed care efficiency adjustment to prescription drugs.

### Step 5: Acuity adjustments

The COVID-19 pandemic has driven significant changes in Medicaid enrollment since CY 2020 as a result of the pause in redeterminations and newly-eligible persons entering the Medicaid program. We reviewed potential acuity changes from the SFY 2022 experience period through the SFY 2024 rating period. There is uncertainty related to the unwinding process. For purposes of this certification, we have assumed that the redeterminations started in May 2023 with the first disenrollment occurring July 2023. The redetermination process is anticipated to be completed over 12 months. We have applied acuity adjustments related to COVID-19, as discussed in Section 1. The remainder of this subsection describes other acuity adjustments unrelated to COVID-19.

*Act 421 children acuity and coverage adjustments*

Act 421 CMO expanded Medicaid eligibility effective January 1, 2022, to certain children with disabilities, even if their parents earn too much money to qualify for Medicaid. These children are broken into nine rate cells based on age and third-party insurance coverage status. The base experience period included fewer than 3,000 member months for all rate cells combined. We determined it would be inappropriate to rely on the base experience for this population. Instead, we have used proxy rate cells from the SSI population to establish the capitation rates for the Act 421 children, with further adjustments to reflect differences in acuity, covered services, and third-party insurance coverage.

- To develop the acuity adjustment, we compared prospective CDPS+Rx risk scores for the January 2023 enrollees in the Act 421 rate cell to the January 2023 enrollees in the comparable proxy population.

[11] In this calculation, higher percentile values represent lower (more favorable) cesarean percentages.

We included medical and prescription drug claims incurred in CY 2022 and used CDPS+Rx version 6.5 with standard weights for this adjustment. We also applied a duration adjustment to account for differences in the average number of enrollment months in the diagnosis capture period between the proxy population and the Act 421 population.

- Because risk scores are not reliable for newborns, we set the acuity adjustment for the 0-2 month rate cells equal to the acuity adjustment for the 3-11 month rate cells.
- There were no members enrolled in the Act 421 LaHIPP TPL rate cells as of January 2023. We applied the Act 421 Non-LaHIPP TPL acuity adjustments to these rate cells.

- For rate cells with TPL coverage, we also applied an adjustment to account for the portion of expenditures that are expected to be covered by the third-party insurer. To estimate the impact of the TPL coverage, we compared the risk-adjusted costs during CY 2022 between the Non-LaHIPP TPL and Non-TPL rate cells. The residual difference was assumed to be related to the TPL coverage.
- For the LaHIPP TPL rate cells, we also applied an adjustment to exclude services not covered under the SBH program. These adjustment factors were based on the percentage of expenditures in the projected benefit expenses for the proxy populations that were for services not covered under the PH program. We have assumed a TPL adjustment of 1.000 for the LaHIPP TPL rate cells under the assumption that the remaining services covered for these populations will not receive any TPL coverage.

Figure 20 below summarizes the adjustments for each Act 421 rate cell.

**FIGURE 20: ACT 421 ADJUSTMENT FACTORS, BY RATE CELL**

| RATE CELL | PROXY RATE CELL | ACUITY ADJUSTMENT | TPL ADJUSTMENT | SBH ADJUSTMENT | FINAL ADJUSTMENT APPLIED |
|---|---|---|---|---|---|
| Act 421 - LaHIPP TPL - 0-2 Months | SSI 0-2 Months | 0.3801 | 1.0000 | 0.0005 | 0.0002 |
| Act 421 - LaHIPP TPL - 3-11 Months | SSI 3-11 Months | 0.3801 | 1.0000 | 0.0053 | 0.0020 |
| Act 421 - LaHIPP TPL - Child 1-18 Years | SSI Child 1-20 Years | 1.2010 | 1.0000 | 0.2193 | 0.2634 |
| Act 421 - Non-LaHIPP TPL - 0-2 Months | SSI 0-2 Months | 0.3801 | 0.1664 | 1.0000 | 0.0632 |
| Act 421 - Non-LaHIPP TPL - 3-11 Months | SSI 3-11 Months | 0.3801 | 0.4894 | 1.0000 | 0.1860 |
| Act 421 - Non-LaHIPP TPL - Child 1-18 Years | SSI Child 1-20 Years | 1.2010 | 0.4850 | 1.0000 | 0.5825 |
| Act 421 - Non-TPL - 0-2 Months | SSI 0-2 Months | 0.4801 | 1.0000 | 1.0000 | 0.4801 |
| Act 421 - Non-TPL - 3-11 Months | SSI 3-11 Months | 0.4801 | 1.0000 | 1.0000 | 0.4801 |
| Act 421 - Non-TPL - Child 1-18 Years | SSI Child 1-20 Years | 0.8209 | 1.0000 | 1.0000 | 0.8209 |

Notes: SBH adjustment values in table represent statewide aggregate impact. This adjustment was applied at the service category level at the end of our capitation rate development, and therefore the impact will vary slightly by region.

### (b) Material changes to the data, assumptions, and methodologies

Material changes to the data and methodologies for this rate development in comparison to the prior rate development include:

- Use of base experience period that is two years prior to the rating period. This change was made due to having experience that is expected to be void of material disruptions to utilization patterns caused by COVID-19.

All material assumptions are documented in this rate certification report.

### (c) Overpayments to providers

We are not aware of any overpayments to providers reflected in the base experience period. Outpatient hospital claims are cost settled after the end of each year, which may result in the base encounter data reflecting higher or lower expenditures than the final cost settlements for certain hospital/MCO combinations. However, we have accounted for these differences by including the settlements as part of our true-up adjustment, as described in Section 1, subsection 2.B.iii.

## iii. Projected benefit cost trends

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period to the rating period of this certification. We evaluated prospective trend rates using base and emerging experience, as well as external data sources. Note, trend rates do not reflect any changes in population acuity or delivery system utilization changes resulting from the COVID-19 pandemic.

### (a) Required elements

#### (i) Data

We analyzed January 2019 through December 2022 non-pharmacy expenditure data from the encounter data to develop estimated prospective trend rates. For pharmacy, we analyzed expenditure data from January 2019 through December 2022 from the encounter data to develop estimated prospective trend rates. In addition, we evaluated observed trend rates against external data sources to determine the trend assumptions that would be applied to the base experience data. We referenced the Medicaid Pharmacy Trend Report™ 2022 Seventh Edition by Magellan Rx Management[12]. We also reviewed internal sources that are not publicly available, such as historical experience from other programs and trends used by other Milliman actuaries.

#### (ii) Methodology

##### Non-pharmacy utilization trends

To evaluate prospective non-pharmacy trend, we primarily focused on a mix of long-term and emerging trends, including data between January 2019 and December 2022. Prior to evaluation, encounter claims were adjusted for completion and changes in population acuity. We then stratified encounter claims experience by population and age group, and summarized by trend category of service. Rate cells and categories of service were reviewed at a more granular level and were then consolidated into more credible trend populations and categories of service. Trends were evaluated and applied on a statewide basis.

The resulting utilization per 1,000 and PMPM data points were compared to historical experience and internal sources from other managed care programs. As part of our evaluation, we also considered how categories of service with prolonged suppressed utilization during the PHE may rebound towards levels seen in pre-PHE experience.

##### Non-pharmacy unit cost trends

Unit cost trends were applied for certain outpatient hospital services that are reimbursed using a cost settlement percentage. However, these trends were incorporated as part of the outpatient hospital reimbursement program change, discussed in Section 1, subsection 2.B.iii.d. All other changes in reimbursement are accounted for through program changes related to fee schedule changes. Therefore, no unit cost changes are incorporated as part of the trend component of our capitation rate development.

##### Pharmacy trends

Pharmacy trends were developed by the following populations: Infant, F&C - Child, F&C - Adult, Medicaid Expansion, Specialized Behavioral Health, SSI – Child, and SSI - Adult.

To evaluate prospective pharmacy utilization trend, we summarized historical scripts by population, brand/generic, and age group on a monthly basis. The data was normalized for changes in population acuity. To account for changes in underlying utilization patterns, we reviewed emerging data through December 2022.

[12] https://issuu.com/magellanrx/docs/mrx-05_medicaid_trend_report_v7?fr=sZTNkNTU1NTUwMjE

Rolling 12-month, 9-month, 6-month, and 3-month trends were calculated to identify changes in the underlying patterns over time. We applied the composite annualized utilization trend rates from the midpoint of the adjusted base period to the midpoint of the rating period.

To evaluate prospective pharmacy unit cost trend, we evaluated experience in 1Q 2023 by therapeutic class. We adjusted the data to include estimated claims incurred by members enrolled with Humana, since these claims are paid on a FFS basis and are substantially understated in the data warehouse at this time as a result of data submission issues. This adjustment was developed by comparing historical pharmacy expenditures during CY 2022 between members that joined Humana in 1Q2023 and members that stayed enrolled with other MCOs. We further adjusted the 1Q 2023 per member costs for anticipated price increases through SFY 2024, as well as increased utilization of glucagon-like peptide-1 (GLP-1) drugs. Absent any interventions, GLP-1 utilization was assumed to increase at a rate of approximately 40% annually. However, we then reduced the projected utilization by 20% to reflect a new pharmacy edit to be implemented on July 1, 2023 that requires a diagnosis of Type-2 diabetes for the GLP-1 drugs to be covered. Finally, we adjusted the unit cost trends to reflect recent and anticipated reductions in the price of the following insulin products during SFY 2024:

- Insulin lispro vial – 70% price reduction effective May 1, 2023
- Humalog® and Humulin® pens and vials – 70% price reduction effective in 4Q 2023
- Lantus® vial and Lantus® Solostar® – 78% price reduction effective January 1, 2024
- Apidra® vial and Apidra® Solostar® – 70% price reduction effective January 1, 2024
- Levemir® vial, Levemir® FlexPen®, Novolin® vial, and Novolin® FlexPen® – 65% price reduction effective January 1, 2024
- Novolog® vial, Novolog FlexPen®, Novolog Mix® vial, and Novolog Mix® FlexPen® – 75% price reduction effective January 1, 2024
- Insulin aspart and insulin aspart mix vials and pens – 50% price reduction effective January 1, 2024

We reviewed the combined impact of the utilization and unit cost trends to ensure they aligned with expected pharmacy costs PMPM during the projection period. The estimated pharmacy trends account for price changes on existing products and dispensing fees, expansion of clinical indications for existing products, new pipeline products entering the market, provider prescribing practices, and patient behavior up through the rating period. We did not make any adjustments for upcoming brand drug patent expirations through the rating period because the single PDL will not necessarily designate the new generic alternatives as preferred. Changes to the single PDL were evaluated separately and a program change adjustment was made as discussed in Section I.2.B.iii.(d).

#### High-cost drug risk pool

In SFY 2024, LDH will be maintaining a high-cost drug risk pool, which is described further in Section 1, Subsection 4.C. The estimated costs for drugs in this pool were developed separately from the pharmacy trend assumptions. Based on a review of members potentially eligible for these treatments, we projected total costs associated with these drugs in SFY 2024. To avoid double-counting in the overall capitation rate development, we removed one high-cost claim from the base data and added the full value of expected costs in SFY 2024. This is shown in Appendix 2.

### (iii) Comparisons

Historical trends should not be used in a simple, formulaic manner to determine future trends; a great deal of actuarial judgment is also needed. We referred to the sources listed in the prior section as well as considered changing practice patterns and the impact of reimbursement changes on utilization in the managed care populations.

Explicit adjustments were made outside of trend to reflect all recent or planned changes in benefits and reimbursement from the base experience period to the rating period.

For this capitation rate development, we did not review the overall trend assumptions by population relative to CMS Office of the Actuary projections because they would include impacts related to the COVID-19 pandemic.

### (iv) Documentation of Trends

Documentation supporting the chosen trend selections is provided in Section I, subsection 3.B.iii.(b) below. There were no outlier or negative trends selected for the Healthy Louisiana program.

## (b) Required elements

Figure 21 illustrates the utilization component of the trend rate assumptions by population and category of service for non-pharmacy services from the base experience period to the rating period for all regions.

As directed by CMS in its rate setting guide, utilization trend assumptions also account for estimated future changes in the mix or intensity of services. The trend assumptions reflect projected utilization changes in the absence of managed care efficiency gains. Note, the trend values in Figure 21 reflect the average annualized trend rates.

**FIGURE 21: ANNUALIZED UTILIZATION TREND ASSUMPTIONS, ALL REGIONS**

| POPULATION | F&C - ADULT | F&C - CHILD | F&C - INFANT | SSI - ADULT | SSI - CHILD | SSI - INFANT | EXPANSION | SBH | OTHER POPULATIONS |
|---|---|---|---|---|---|---|---|---|---|
| Ancillary | 4.0% | 2.0% | 2.0% | 4.0% | 2.0% | 2.0% | 4.0% | 4.0% | 2.0% |
| Inpatient Hospital | 0.0% | 2.0% | 2.0% | 0.0% | 2.0% | 2.0% | 0.0% | n/a | 2.0% |
| Outpatient Other | 0.0% | 2.0% | 2.0% | 0.0% | 0.0% | 0.0% | 0.0% | n/a | 2.0% |
| Outpatient ER | 1.0% | 4.0% | 4.0% | 1.0% | 4.0% | 4.0% | 1.0% | n/a | 4.0% |
| Professional | 0.0% | 4.0% | 4.0% | 0.0% | 4.0% | 4.0% | 0.0% | 4.0% | 4.0% |
| Professional ER | 1.0% | 4.0% | 4.0% | 1.0% | 4.0% | 4.0% | 1.0% | n/a | 4.0% |
| SBH Other | 3.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 3.0% | 0.0% | 0.0% |
| SBH Inpatient | 0.0% | 0.0% | 0.0% | 3.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |

Figure 22 illustrates the pharmacy unit cost and utilization trend rate assumptions by population rate group. Pharmacy trend rates were developed consistently across all regions. Note, the pharmacy trend assumptions illustrated in Figure 22 reflect the annualized trend from the base period to the rating period.

**FIGURE 22: ANNUALIZED PHARMACY TREND ASSUMPTIONS**

| RATE GROUP | UTILIZATION | COST PER UNIT | COMPOSITE |
|---|---|---|---|
| F&C - Adult | 0.5% | 13.0% | 13.6% |
| F&C - Child | 3.0% | 7.5% | 10.7% |
| F&C - Infant | 2.5% | 5.5% | 8.1% |
| SSI - Adult | 0.0% | 10.5% | 10.5% |
| SSI - Child | 0.5% | 10.0% | 10.6% |
| SSI - Infant | 2.5% | 5.5% | 8.1% |
| Expansion | 0.5% | 11.0% | 11.6% |
| SBH | n/a | n/a | n/a |
| All Other Populations | 1.5% | 10.0% | 11.1% |

*Pharmacy trends were rounded to the 0.5%

## (c) Variation

We developed trends by population rate group and major category of service as outlined in the prior subsection of this report. The estimated trend rates reflect variation due to mix of services and the case-mix for each population. We did not observe significant variation within a credible population and have made no further delineations in the application of trend rates other than those outlined herein. The trend rate assumptions outlined in the previous section were applied to all populations accordingly.

### (d) Material adjustments

Historical trends should not be used in a simple formulaic manner to determine future trends; a great deal of actuarial judgment is also needed. We did not explicitly rely on the historical experience-based trend projections due to anomalies observed in the data as well as impact from managed care expansion.

We referred to the sources listed in the prior section, considered changing practice patterns, the impact of reimbursement changes on utilization in the Medicaid managed care populations, and shifting population mix.

We made adjustments to the non-pharmacy trend rates derived from historical experience in cases where the resulting trends did not appear reasonably sustainable or were not within consensus parameters derived from other sources. For many rate cells and categories of services, raw model output was outside of a range of reasonable results. In these situations, we relied on the methodologies identified to develop prospective trend.

### (e) Any other adjustments

#### (i) Impact of managed care

We did not adjust the trend rates to reflect impacts related to managed care efficiencies for utilization or unit cost. The capitation rates have separate, explicit adjustments for the managed care efficiencies. As stated in our illustration of overall estimated benefit expense trends by population, we made an explicit adjustment for estimated managed care efficiency changes within the managed care population.

#### (ii) Trend changes other than utilization and cost

We did not adjust the benefit cost trend for changes other than utilization or unit cost.

## iv. Mental Health Parity and Addiction Equity Act Service Adjustment

LDH assessed the State's compliance with the parity standards of the Mental Health Parity and Addiction Equity Act (MHPAEA) as required by 42 CFR 438.3(c)(1)(ii). Results of the analysis indicate compliance with MHPAEA for both quantitative and non-quantitative treatment limits. Accordingly, we have not made any rating adjustments to accommodate parity compliance.

## v. In Lieu of Services

### (a) Description of ILOSs

The following provides a brief description of each ILOS in the managed care program and whether the ILOS was provided as benefit during the base data period

#### IMD

LDH allows the usage of IMDs as an in lieu of service for the 21 to 64-year-old population for all inpatient psychiatric or substance use disorders for up to 15 days per month. This program change was implemented in compliance with the conditions outlined in the final Medicaid managed care regulations.

The projected benefit costs include costs for in lieu of services associated with beneficiaries residing in an IMD up to fifteen days during a given month. The IMD services are classified within the Inpatient SBH service category detail.

Managed care enrollees aged 21 to 64 and residing in an IMD for more than fifteen days were identified using the encounter data. These beneficiaries and all associated enrollment and expenditures, both related to IMD stays and other services rendered, have been excluded from capitation rate development.

#### Other ILOSs

Additional ILOS are described below. Each of these ILOS were provided as a benefit during the SFY 2022 base period. The benefit expense included in the SFY 2024 capitation rates for these ILOS is consistent with state plan services unless specified elsewhere in the certification.

- Covered services provided in skilled nursing facilities
- 23-hour observation bed services for all Medicaid eligible adults, age 21 and above
- Long-term acute care

- Mental health intensive outpatient services
- Injection services provided by licensed nurses for recipients age 21 and above
- Crisis stabilization services
- Behavioral health urgent care
- Mobile crisis response

### (b) ILOS Cost Percentages

ILOS cost percentages are shown below in Figure 23. The ILOS cost percentages were developed using ILOS paid amounts in the base period, included in the MCO survey submissions, as a percentage of the total paid amounts for all services. All ILOS other than IMD account for approximately 0.15% of the projected capitation rates, including directed payments. We are considering each of these ILOSs as immaterial on their own and are calculating only a composite ILOS percentage across all of them combined.

**FIGURE 23: SUMMARY OF IN-LIEU-OF SERVICES ($ MILLIONS)**

| IN-LIEU-OF SERVICES/SETTINGS | OUTPATIENT | LTSS | SPECIALIZED BEHAVORIAL HEALTH | ALL OTHER SERVICES | TOTAL |
|---|---|---|---|---|---|
| Covered Services provided in Skilled Nursing Facilities | $ 0.0 | $ 0.8 | $ 0.0 | $ 0.0 | $ 0.8 |
| 23-Hour Observation Bed Services for all Medicaid Eligible Adults (Age 21 and Above) | 0.4 | 0.0 | 0.0 | 0.0 | 0.4 |
| LTAC | 0.0 | 1.6 | 0.0 | 0.0 | 1.6 |
| Mental Health Intensive Outpatient Services | 5.0 | 0.0 | 5.3 | 0.0 | 10.3 |
| Crisis Stabilization | 0.0 | 0.0 | 0.5 | 0.0 | 0.5 |
| Injection Services Provided by Licensed Nurses (Age 21 and Above) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Behavioral Health Urgent care | 0.0 | 0.0 | 4.4 | 0.0 | 4.4 |
| Mobile Crisis Response | 0.0 | 0.0 | 0.6 | 0.0 | 0.6 |
| **In-Lieu-Of Services/Setting Subtotal (A)** | **$ 5.5** | **$ 2.4** | **$ 10.7** | **$ 0.0** | **$ 18.6** |
| | | | | | |
| **State Plan Services/Settings (B)** | **$ 1,302.9** | **$ 43.0** | **$ 681.6** | **$ 5,486.7** | **$ 7,514.2** |
| **All Services (C)** | **$ 1,308.4** | **$ 45.4** | **$ 692.3** | **$ 5,486.7** | **$ 7,532.8** |
| **ILOS Costs as a Percentage of the Base Data (D = A / C)** | **0.42%** | **5.29%** | **1.55%** | **0.00%** | **0.25%** |
| | | | | | |
| **Total Projected Benefit Expense (E)** | | | | | **$ 8,471.6** |
| **Total Projected ILOS Costs (F = D x E)** | | | | | **$ 20.9** |
| **Total Projected Payments (G)** | | | | | **$ 13,689.8** |
| **ILOS Costs as a Percentage of Total Projected Payments (H = F / G)** | | | | | **0.15%** |

### (c) Incorporation into rate development

Other than IMDs, all other ILOSs were incorporated into rate development consistent with other state plan services. Cost and utilization associated with these services was included in the base experience and was adjusted for trend, program changes, acuity, and other factors, consistent with other state plan services. IMD services were adjusted, as described in Section 1, subsection 2.B.iii.d.

### (d) Inclusion of IMD services

IMD services were adjusted to remove long-stay IMDs for individuals between 21 and 64 years old. In addition, the final SFY 2024 capitation rate will include an adjustment to reimburse short-stay IMDs for individuals between 21 and 64 years old to be consistent with comparable services provided in a different setting, as described in Section 1, subsection 2.B.iii.d.

## vi. Retrospective Eligibility Periods

### (a) MCO responsibility

During the base period, MCOs were responsible for periods of retroactive eligibility of up to 12 months. MCO requirements for the rating period are consistent with the base period and continue to be responsible for periods of retroactive eligibility.

#### (b) Claims treatment

As noted earlier, claims for retrospective eligibility periods are reflected in the MCO base data.

#### (c) Enrollment treatment

Enrollment is treated consistently with claims.

#### (d) Adjustments

It was not necessary to make any adjustments to the MCO base data for retroactive eligibility.

### vii. Impact of Material Changes

This section relates to material changes to covered benefits or services since the last rate certification. The last rate certification was for the SFY 2023 rating period, with an amendment to rates effective January through June 2023.

#### (a) Change to covered benefits

Material changes to covered benefits have been described in program adjustments described in Section I, subsection 2.B.iii Program Change Adjustments.

#### (b) Recoveries of overpayments

To the best of our knowledge, all information related to any payment recoveries not reflected in the base period encounter data was provided to us by the MCOs in the MCO survey and FRRs and an adjustment factor was applied to reflect any such recoveries.

#### (c) Change to payment requirements

Material changes to required provider payments have been described in program adjustments in Section I, subsection 2.B.iii Program Change Adjustments.

#### (d) Change to waiver requirements

There were no material changes related to waiver requirements or conditions.

#### (e) Change due to litigation

There were no material changes due to litigation.

### viii. Documentation of Material Changes

Material changes to covered benefits and provider payments have been described in program adjustments described in Section I, subsection 2.B.iii Program Change Adjustments. This information includes the data, assumptions, and methodology used in developing the adjustment, estimated impact by population, and aggregate impact on the managed care program’s benefit expense. Non-material changes to covered benefits or provider payments have also been described in that section of the report.

# 4. Special Contract Provisions Related to Payment

## A. INCENTIVE ARRANGEMENTS

### i. Rate development standards

This section provides documentation of the incentive payment structure in the Medicaid managed care program.

### ii. Appropriate documentation

#### (a) Managed Care Incentive Program (MCIP)

Since February 2018, MCOs have been able to earn up to 5.0% above the approved capitation payment attributable to enrollees or services covered by the incentive arrangements implemented by LDH. These incentives will support the activities, targets, performance measures, or quality-based outcomes specified in LDH's quality strategy.

(i) Time period

The incentive arrangement is in effect on a state fiscal year basis.

(ii) Covered enrollees, services, and providers

The incentive arrangement covers enrollees in the Healthy Louisiana program.

(iii) Purpose

The purpose of the incentive is to improve the quality of care provided to Healthy Louisiana enrollees.

(iv) Payments will not exceed 105 percent

LDH will evaluate total capitation payments after the state fiscal year and ensure that the total incentive payments does not exceed 105 percent of the total capitation payments during the state fiscal year.

(v) Effect on capitation rates

The incentive arrangement has no effect on the development of the capitation rates.

## B. WITHHOLD ARRANGEMENTS

### i. Rate development standards

This section provides documentation of the withhold arrangement in the Medicaid managed care program.

### ii. Appropriate documentation

#### (a) Withhold description

(i) Time period

The withhold arrangement in the Healthy Louisiana program is for SFY 2024, consistent with the rate period.

(ii) Enrollees, services, and providers

The withhold arrangement applies to all services and enrollees covered by the Healthy Louisiana contract.

(iii) Purpose

The purpose of the withhold is to improve MCO quality performance measures.

(iv) Percentage withheld

The withheld percentage will be 2.0% of the limited rate (i.e., excluding FMP and directed payments) for SFY 2024 for all rate cells except maternity kick payments.

Quality and health outcomes will account for 1.0% of the withhold, value-based payments (VBP) will account for 0.5% of the withhold, and health equity measures will account for 0.5% of the withhold.

#### (v) Not reasonably achievable percentage

Based on our review of the applicable measures, we believe 100% of the withhold is reasonably achievable.

#### (vi) Reasonability of total withhold arrangement

To assess the overall reasonableness of the withhold metrics, we evaluated the three components of the withhold arrangement separately for reasonableness:

*Quality measures (1%).* MCOs may earn back the quality withhold for the measurement year based on its performance on incentive-based measures relative to targets as established by LDH. LDH aligns HEDIS benchmarks to NCQA Quality Compass Medicaid National 50th percentile. Targets for non-HEDIS incentive-based measures are equal to the best performance reported to LDH by any MCO for the prior measurement year. To earn back the full withhold amount associated with each incentive-based measure, MCO performance must either meet the target for that measure or improve by at least two points from the prior measurement year. Based on LDH using the national 50$^{th}$ percentile, the best MCO performance value in the prior measurement period, and also allowing the full amount of the withhold to be returned based on a two-percentage point improvement, we believe it is reasonably achievable for an MCO to receive the full 1% related to the quality measure withhold.

*Value-based payments (0.5%).* The VBP requirements include the MCOs establishing a minimum VBP threshold for the total percentage of provider reimbursement linked to a VBP model, at least one new network provider agreement for a VBP model, and submission of an annual report to LDH demonstrating how the MCO is progressing on its VBP model. Based on discussions with LDH, it was determined that these measures can be reasonably achieved by the MCOs during the rating period.

*Health equity measure (0.5%).* The health equity measures are process oriented and include, but not limited to, the following measures: developing a multi-year Health Equity Plan, stratification of quality measures to identify/address disparities, staff/provider training requirements related to equity, the inclusion of social needs / equity questions in member Health Needs Assessments, and reporting requirements. We do not believe any of these process requirements impose unreasonable requirements on the MCOs.

#### (vii) Effect on capitation rates

The withhold arrangement has no effect on the development of the capitation rates.

### (b) Actuarial soundness of withhold

We are certifying that the capitation rates, minus any portion of the withhold that is not reasonably achievable, as actuarially sound.

## C. RISK SHARING MECHANISMS

### i. Rate development standards

This section provides documentation of the risk-sharing mechanisms in the Medicaid managed care program.

### ii. Appropriate documentation

### (a) Description of the risk-sharing mechanism

LDH has two risk-sharing mechanisms that will apply in SFY 2024: a Hepatitis C risk corridor and high-cost drug risk pool.

#### Hepatitis C risk corridor

Since implementation of LDH's Hepatitis C Subscription Model on July 1, 2019, LDH has maintained a risk corridor for Hepatitis C-related pharmacy, physician, and laboratory costs.

Under the risk corridor, if the actual costs related to these services during the contract year exceed the amount assumed in the capitation rate development by more than 1.0%, LDH will reimburse MCOs for 99.0% of the difference between actual and assumed costs. Additional detail on the development of the funding for the Hepatitis C risk corridor can be found in Appendix 10.

#### High-cost drug risk pool

Since 2020, LDH has maintained a budget-neutral risk pool for Zolgensma, a treatment for spinal muscular atrophy (SMA) that can exceed $2 million per individual. In SFY 2024, the pool has expanded and now includes the following drugs:

- Zolgensma
- Skysona
- Rethymic
- Hemgenix
- Zynteglo

The risk pool is funded separately for each of several applicable rate cells based on the projected utilization and cost per service of these drugs during the rating year. These projections are included in the capitation rate certification prior to the start of the year. After the rating year is complete, the risk pool funding through the capitation rates is determined for each of the MCOs based on their share of the members in the applicable rate cells. This share of the funding is then compared to the MCO's actual share of high-cost drug utilization during the rating period. Based on a comparison of each MCO's share of funding through the capitation rates to their share of actual utilization, transfer payments will be made to/(from) the MCO in line with their shortfall/(excess) in the funding received through the capitation rates. All Healthy Louisiana members are included in the high-cost drug risk pool and transfer payments are calculated based on the aggregate MCO experience rather than experience at the rate cell level.

### (b) Medical loss ratio

#### Description

For CY 2022, LDH required all MCOs participating in the Healthy Louisiana managed care program to maintain a minimum medical loss ratio (MLR) of 85%, separately for the Medicaid Expansion and all other populations combined. For each of the two MLR calculations, the MLR is defined as the ratio of the numerator, as defined in accordance with 42 CFR 438.8(e), to the denominator, as defined in accordance with 42 CFR 438.8(f), plus a credibility adjustment, as defined in accordance with 42 CFR 438.8(h). These items will be accrued on an incurred year basis for the MLR calculation. MLR will be measured on a SFY basis starting on July 1, 2023.

#### Financial consequences

If an MCO does not meet the minimum MLR threshold, then LDH will recoup the capitation revenue that represents the difference between the total capitation revenue for the applicable population multiplied by the minimum medical loss ratio, less actual benefit expenses incurred.

### (c) Reinsurance requirements and effect on capitation rates

LDH does not require that MCOs participating in the Medicaid managed care program maintain a specific stop-loss reinsurance policy. Reinsurance premiums and recoveries have not been reflected in the rate development.

## D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

### i. Rate development standards

This section provides information on directed payments for certain providers which are pertinent to the SFY 2024 capitation rates.

### (a) Description of Managed Care Plan Requirement

Since July 1, 2022, LDH has paid hospitals a uniform percentage increase directed payment for both inpatient and outpatient services. There are several classes of hospitals, each with a separate percentage increase. These payments are incorporated into the capitation rates as separate payment term.

Starting on July 1, 2022, LDH will make directed payments to licensed mental health professionals (LMHPs) and providers who are certified Evidence-Based Practice (EBP) practitioners. The payments will be made as a lump sum payment to each provider. These payments are incorporated into the capitation rates as separate payment term.

LDH also has minimum fee schedules for the following services:

- HCBS services
- Inpatient hospital services
- Outpatient hospital services
- Physician administered drugs
- FQHC and RHC
- LSU enhanced physician fee schedule
- Hospital-based physician services
- Ground and air ambulance
- NEMT
- General anesthesia and facility dental treatment

All directed payments described in this rate certification are consistent with LDH descriptions of the 438.6(c) pre-prints which have been submitted to CMS, if required. For minimum fee schedules, CMS does not require preprints if the fee schedules are consistent with approved State plan rates.

### (b) Approval by CMS and consistency with preprints

All directed payments described in this rate certification have been submitted to CMS. The descriptions in this rate certification are consistent with the 438.6(c) pre-prints that have been submitted to CMS.

### (c) Contract arrangements with MCOs

All contract arrangements that direct MCO's expenditures were developed in accordance with 42 CFR §438.4 and 42 CFR §438.5.

### (d) Inclusion of Provider Payment Initiatives in Capitation Rates

***Hospital directed payments***

The payments for the two hospital directed payment initiatives are done so on a retrospective basis to the managed care health plans.

***LMHP/EBP directed payments***

The payments for the LMHP/EBP directed payment are made on a retrospective basis to the managed care health plans.

***Minimum fee schedules***

The required fee schedule amounts for are assumed to be included in the base experience since MCOs were required to contract at these levels during the base experience period. Adjustments are made in the rate development for reimbursement changes that have occurred between the base experience period and the rating period, as described in the Section 1, Subsection 2.B.iii.d.

#### (i) Documentation related to separate payment term included in the rate certification

Documentation related to the separate payment term is addressed in Section I, Item 4.D.ii.a.iii.

#### (ii) PMPM estimate of directed payments addressed through separate payment term

The estimated rating period PMPM amounts of the directed payments are illustrated by rate cell in Appendix 3.

#### (iii) Final documentation of total directed payment amount by rate cell

After the rating period is complete, a separate report documenting the actual directed payment amounts by region and rate cell will be provided to CMS.

#### (iv) Changes from initial base rate certification

The rate certification will be updated through a rate amendment if the total payment amount or distribution methodology varies from the initial estimates presented in Appendix 2.

### ii. Appropriate documentation

### (a) Description of Delivery System and Provider Payment Initiatives

#### (i) Description of delivery system and provider payment initiatives included in the capitation rates

State directed payments incorporated in the capitation rates are listed in Figure 24 below.

**FIGURE 24: SUMMARY OF DIRECTED PAYMENTS INCLUDED IN CERTIFICATION**

| CONTROL NAME OF THE STATE DIRECTED PAYMENT | TYPE OF PAYMENT | BRIEF DESCRIPTION | IS THE PAYMENT INCLUDED AS A RATE ADJUSTMENT OR SEPARATE PAYMENT TERM? |
|---|---|---|---|
| LA_Fee_IPH.OPH_Renewal_20230701-20240630 | Add-on based on utilization | Add-on paid to acute hospitals based on utilization of inpatient and outpatient services | Separate payment term |
| LA_Fee_IPH.OPH1_Renewal_20230701-20240630 | Add-on based on utilization | Add-on paid to non-acute hospitals based on utilization of inpatient and outpatient services | Separate payment term |
| LA_Fee_BHO_New_20230701-20240630 | Add-on based on utilization | Add-on paid to LMHPs and EBP-certified practitioners based on participation and retention in MCO networks | Separate payment term |
| Various minimum fee schedules[1] | Minimum fee schedule | Minimum fee schedule for HCBS providers | Rate adjustment |

Note: LDH is not required to submit pre-prints for minimum fee schedules on an annual basis and therefore we do not have a current control name for these directed payments.

Separate payment term directed payments were established for the SFY2024 rating period:

- **LA_Fee_IPH.OPH_Renewal_20230701-20240630**

  The acute hospital directed payment is established as a uniform percentage increase for inpatient and outpatient hospital services provided by acute care providers. The estimated total payment was developed based on grouping eligible providers into five separate tiers with uniform percent rate increases calculated separately for each tier to target 95% (for tiers 2 through 5) of an average commercial rate (ACR).

- **LA_Fee_IPH.OPH1_Renewal_20230701-20240630**

  The Non-Acute (LPR) Hospital Directed Payment is established as a uniform percentage increase for inpatient and outpatient hospital services for long-term acute care, psychiatric, and rehabilitation providers. The estimated total payment was developed based on grouping eligible providers into the three separate classes with uniform percent rate increases calculated separately for each class to target 95% of an average commercial rate (ACR).

- **LA_Fee_BHO_New_20230701-20240630**

  The LMHP/EBP Directed Payment will be made from LDH to the MCOs as a one-time payment to each MCO, based on the number of EBP providers recruited into the network, the number of EBP providers retained for at least six months, and the number of LMHPs participating in the MCO's network. There are separate payment amounts for each of the measures. The total amount of the directed payment was estimated based on the anticipated number of qualifying providers who will participate and/or be retained in the MCOs' networks.

MCOs are required to contract at or above the state plan fee schedule for the following services:

- HCBS services
- Inpatient hospital services
- Outpatient hospital services
- Physician administered drugs
- FQHC and RHC
- LSU enhanced physician fee schedule
- Hospital-based physician services
- Ground and air ambulance
- NEMT
- General anesthesia and facility dental treatment

### (ii) Description of payment arrangements incorporated as a rate adjustment

State directed payments incorporated in the capitation rates as a rate adjustment are listed in Figure 25 below, with more description following the table.

**FIGURE 25: DIRECTED PAYMENTS INCORPORATED AS RATE ADJUSTMENTS**

| CONTROL NAME OF THE STATE DIRECTED PAYMENT | RATE CELLS AFFECTED | IMPACT | DESCRIPTION OF THE ADJUSTMENT | CONFIRMATION THE RATES ARE CONSISTENT WITH PREPRINT | ADDITIONAL INFORMATION OR MAXIMUM FEE SCHEDULES |
|---|---|---|---|---|---|
| Various minimum fee schedules | All | Included in base experience | Included in base experience | Yes | N/A |

The minimum fee schedule directed payments are incorporated into the base capitation rates, with any changes in fee schedules incorporated through the program changes adjustments, described in Section 1, subsection 2.B.iii.d . MCOs were required to contract with these providers during the base experience period used for this rate development, so we have assumed that the base experience for each rate cell reflects the minimum fee schedule requirements. These directed payments are accounted for in a manner consistent with their approved 438.6(c) pre-prints.

### (iii) Description of payment arrangements incorporated as a separate payment term

State directed payments incorporated in the capitation rates as a separate payment term are listed in Figure 26 below, with more description following the table.

**FIGURE 26: DIRECTED PAYMENTS INCORPORATED AS SEPARATE PAYMENT TERMS**

| CONTROL NAME OF THE STATE DIRECTED PAYMENT | AGGREGATE AMOUNT INCLUDED IN THE CERTIFICATION | STATEMENT THE ACTUARY IS CERTIFYING THE SEPARATE PAYMENT TERM | MAGNITUDE ON A PMPM BASIS | CONFIRMATION THE RATES ARE CONSISTENT WITH PREPRINT | CONFIRMATION THE ACTUARY WILL SUBMIT REQUIRED DOCUMENTATION AT END OF RATING PERIOD |
|---|---|---|---|---|---|
| LA_Fee_IPH.OPH_Renewal_20230701-20240630 | $ 2,735.9 million | Yes | $128.73 | Yes | Yes |
| LA_Fee_IPH.OPH1_Renewal_20230701-20240630 | $ 64.5 million | Yes | $3.03 | Yes | Yes |
| LA_Fee_BHO_New_20230701-20240630 | $ 22.6 million | Yes | $1.06 | Yes | Yes |

Note: Values shown are net of premium tax.

***Actuarial certification of separate payment terms.***

The actuary certifies the amounts of the separate payment terms provided in this document.

***Provider types receiving the payment***

Providers who are part of the acute hospital directed payment include in-state providers of inpatient and outpatient hospital services licensed and enrolled in Medicaid on or before December 31, 2022, excluding freestanding psychiatric hospitals, freestanding rehabilitation hospitals, and long-term acute care hospitals.

The non-acute directed payment includes in-state hospital providers of long-term acute care, psychiatric services, and rehabilitation services for both inpatient and outpatient hospital services licensed and enrolled in Medicaid on or before December 31, 2022. Notwithstanding the foregoing, all public state-operated hospitals and freestanding psychiatric hospitals participating in DSH are not included in the psychiatric provider class and are excluded from participating in the state directed payment program.

The LMHP/EBP directed payment will be made to LMHPs and other practitioners who are EBP-certified. In order to receive the LMHP participation payment, the practitioner must provide at least one direct care service meeting the criteria described in the preprint.

***Distribution methodology***

MCO encounter data will be used to directly link payments to utilization of inpatient and outpatient services for MCO enrollees. Once the encounter submitted by the MCOs is accepted, LDH will calculate the hospital's payment increase. The uniform percentage add-on will differ for inpatient and outpatient services. The development of the payment increases is described in Section I, Item 4.D.ii(a)(i).

For the LMHP/EBP directed payment, LDH will employ a process to ensure EBP practitioners will only receive one-sixth of the total payment from each MCO so that each practitioner joins all networks to receive the entire signing bonus. MCOs will pay EBP practitioners based on the addition of the EBP to its network, submittal of paperwork or receipt of a claim six months after enrollment. MCOs will pay LMHPs who are enrolled and provide at least one service during the rating period. LDH will pay MCOs an upfront lump sum representing the expected participation under the contracts for EBP practitioners and LMHPs. LDH has retained auditing rights to determine if payments have been paid to the correct practitioners.

***Estimated PMPM payout by rate cell***

The estimated PMPM payout by population, rate cell, and region is provided in Appendix 2.

***Consistency with 438.6(c) preprint***

The directed payments, as described in this rate certification, are consistent with 438.6(c) preprints submitted to CMS.

***Statement that certification will be amended if rates vary from initial estimate***

To the extent the final directed payments by rate cell vary from the initial estimates presented in Appendix 2, the rate certification will be amended to reflect the final payments made to the providers.

### (b) Additional directed payments not addressed in the certification

There are not any additional directed payments in the managed care program that are not addressed in this certification.

### (c) Other requirements regarding reimbursement rates

There are not any additional requirements regarding the reimbursement rates the plans must pay to any providers unless specified in this certification as a directed payment or authorized under applicable law, regulation, or waiver.

## E. PASS-THROUGH PAYMENTS

### i. Rate development standards

There are no pass-through payments applicable to the Healthy Louisiana program in SFY 2024.

# 5. Projected Non-Benefit Costs

## A. RATE DEVELOPMENT STANDARDS

### i. Overview

In accordance with 42 CFR §438.5(e), the non-benefit cost component of the capitation rates includes reasonable, appropriate, and attainable expenses related to MCO operation of the Medicaid managed care program.

The remainder of Section I, item 5 provides documentation of the data, assumptions, and methodology that we utilized to develop the non-benefit cost component of the capitation rates.

### ii. PMPM versus percentage

The non-benefit cost was developed as a percentage of the capitation rates.

## B. APPROPRIATE DOCUMENTATION

### i. Development of non-benefit costs

#### (a) Description of the data, assumptions, and methodologies

##### Data

The SFY 2024 MCO survey rate setting data request, containing SFY 2022 reported administrative costs by MCO and population, was the primary data source used in the development of the SFY 2024 non-benefit costs. Non-benefit costs were established for each population as a percentage of the of the limited capitation rates (excluding directed payments and FMP amounts).

In addition, we reviewed average costs from the financial statements of Medicaid health plans nationally, as summarized by Palmer, Pettit, McCulla, and Kinnick. These reports date from 2012 through 2023, analyzing financial results from 2011 through 2021. Note, while not yet published, we reviewed values that will be in the upcoming 2023 report for the purposes of developing the non-benefit assumptions for the SFY 2024 Healthy Louisiana rates.

##### Assumptions and methodology

In developing the non-benefit costs, we reviewed historical MCO administrative and healthcare quality improvement (HCQI) expenses for the Medicaid managed care program along with national Medicaid health plan administrative expenses. We considered the size of participating health plans and the resulting economies of scale that could be achieved, along with the benefits covered and the demographics of the managed care populations.

Historical, reported administrative and HQI expenses were reconciled between the available data sources for the purpose of evaluating the quality of the data provided. Administrative and HQI expenses reported in the SFY 2024 MCO Survey were analyzed for reasonableness and completeness. In addition, we reviewed changes in the report administrative expenses contained in the Standard FRRs for the CY 2019 through CY 2022 reporting periods. Overall, values contained in the Standard FRRs were consistent with values reported in the SFY 2024 MCO Survey for the SFY 2022 experience period.

This data included delegated administrative and care coordination costs related to subcapitated arrangements that were otherwise reported as benefit expense in the statutory financial data. This data formed the targeted baseline for projected non-benefit expense amounts for the rating period.

We developed the non-benefit expense assumptions using the following steps:

1. SFY 2022 administrative costs were summarized in the SFY 2024 MCO Survey. Administrative costs included delegated administrative costs associated with state plan services. MCO penalties were deducted from reported administrative costs. Pharmacy administrative costs were separately identified.
2. For the purposes of evaluating the reasonableness of individual MCO-reported administrative costs, reported administrative costs for each MCO were normalized to the statewide SFY 2022 population mix.

Individual MCI-reported administrative costs were then capped and floored at a 10% variance relative to the MCO composite, resulting in a 0.5% reduction to the reported SFY 2022 MCO-reported administrative costs. Note, after making this adjustment, 3 of the 5 historical MCOs' SFY 2022 normalized administrative costs were below the capped and floored composite administrative cost PMPM.

3. Adjusted SFY 2022 administrative costs were then then trended for a 24-month period at an annualized 3.0% trend rate. This trend rate was chosen based on published inflationary values as of May 2023 and forecasts for the SFY 2024 rating period[13].

4. In recognition of the resumption of Medicaid redeterminations in July 2023, we evaluated estimated changes in administrative economies of scale that may occur with changes in total Healthy Louisiana enrollment between the SFY 2022 experience period and SFY 2024 rating period. Based on projected enrollment changes between SFY 2022 and SFY 2024, historical administrative PMPM costs and enrollment reported in the FRRs from CY 2019 through CY 2022, and historical inflation since CY 2019, we applied a 0.4% increase to the administrative costs for SFY 2024.

5. A $0.13 PMPM adjustment reflecting January 1, 2023 MCO contractual changes was added to the composite administrative cost for the managed care program, and then distributed across populations and rate cells based on historical medical cost relativities. The $0.13 PMPM amount was determined based on a review of MCO-reported incremental staffing changes necessary to fulfill the contract changes, as well as LDH and the Office of Behavioral Health's (OBH) assessment of the reasonableness and necessity of reported staffing changes.

6. The implementation of the single PBM on October 1, 2023, is projected to result in administrative cost savings to Healthy Louisiana managed care program, reducing pharmacy-related administrative costs from approximately $2 PMPM as collectively reported by the MCOs to $0.73 PMPM under the single PBM arrangement. The $0.73 PMPM amount was estimated based on the single PBM's per script administrative fee provided to Milliman and the projected pharmacy utilization during SFY 2024. The final adjustment was further prorated to reflect the October 1, 2023 single PBM implementation date, resulting in the inclusion of approximately a $1 PMPM program-wide for pharmacy administrative costs in the SFY 2024 capitation rates. This amount was adjusted at the population and rate cell level to reflect historical pharmacy cost relativities.

*Risk margin.* Risk margin assumptions have been maintained from SFY 2023 and apply to all benefit expenses included in the limited rate (which excludes FMP and directed payments made as a separate payment term). As MCO's will have additional risk-based capital requirements related to reimbursement adjustments, we believe it is appropriate to apply the margin assumptions to all incremental benefit expense changes.

In evaluating the reasonableness of the margin assumptions, we have considered the minimum medical loss ratio requirement for SFY 2024, which is 85% and applied separately for the expansion and non-expansion populations to each MCO's reported experience. Under CFR 438.8, adjustments are made to each MCO's medical loss ratio calculation for quality improvement expenses (numerator) and taxes and regulatory fees (denominator). Based on NAIC health industry filings for Medicaid business, we estimate there is a spread of approximately 4% to 6% between a traditional medical loss ratio (claims / premium) and the CMS medical loss ratio definition with adjustments for quality improvement expenses and taxes and fees. Relative to the limited rate net of premium tax, the composite breakeven medical loss ratio is approximately 92% for both the Medicaid expansion and non-expansion populations, allowing for significant margin opportunities with the 85% minimum MLR requirement for the expansion and non-expansion populations.

In addition, we reviewed the underwriting gain model released in June 2022 by the Society of Actuaries (SOA).[14] In evaluating the model's results and with consideration for investment income earned by health insurers, we believe the margin assumptions included in rates provide a reasonable allowance for capital requirements and experience fluctuation.

*Premium tax*. The final limited rate is grossed up for a 5.5% premium tax.

[13] https://www.philadelphiafed.org/surveys-and-data/real-time-data-research/spf-q2-2023

[14] https://www.soa.org/resources/research-reports/2022/medicaid-underwriting-margin-model/

### (b) Material changes since last rate certification

There were no material changes since the prior certification.

### (c) Other material adjustments

No other material adjustments were made.

## ii. Non-benefit costs, by cost category

The SFY 2024 non-benefit cost allowance was developed as a percentage of the limited rate (net of premium tax) for each rate cell on a statewide basis.

Figure 27 illustrates the individual components and percentages that comprise the non-benefit costs. The resulting values of these items on a PMPM basis can be reviewed by region and rate cell in Appendix 2.

**FIGURE 27: NON-BENEFIT COSTS AS A PERCENTAGE OF LIMITED RATES, PRIOR TO PREMIUM TAX**

| | LIMITED RATE | | |
|---|---|---|---|
| POPULATION | ADMIN | QUALITY | MARGIN |
| SSI | 6.25% | 1.50% | 1.50% |
| F&C | 6.75% | 1.75% | 1.50% |
| SBH | 9.50% | 2.50% | 1.50% |
| Medicaid Expansion | 6.50% | 1.75% | 1.50% |
| All Other Populations | 5.50% | 1.50% | 1.50% |
| Maternity Kick | 4.50% | 1.00% | 1.50% |

## iii. Historical non-benefit cost data

Figure 28 below summarizes the administrative and quality expenses incurred by the Healthy Louisiana MCOs on a PMPM basis for CY 2020, CY 2021, and SFY 2022.

These values are based on MCO financial reporting contained in the FRRs for the CY 2020 and CY 2021, and the SFY 2024 MCO survey for SFY 2022. For the administrative and quality expenses, we compared the historical actuals to the loads included in previous capitation rates to help assess the adequacy of the loads in the SFY 2024 capitation rates.

**FIGURE 28: HISTORICAL NON-BENEFIT COSTS PMPM**

| TIME PERIOD | TOTAL NON-BENEFIT EXPENSE PMPM |
|---|---|
| CY 2020 | $ 34.83 |
| CY 2021 | $ 34.23 |
| SFY 2022 | $ 34.66 |

# 6. Risk adjustment and acuity adjustments

This section provides information on risk adjustment included in the contract.

## A. RATE DEVELOPMENT STANDARDS

### i. Overview

The Medicaid managed care capitation rates have been developed as full risk rates. The MCOs assume risk for the cost of services covered under the contract and incur losses if the cost of furnishing the services exceeds the payments under the contract.

The composite rates for all populations will be risk adjusted using prospective risk adjustment by MCO on a regional basis to reflect estimated prospective morbidity differences in the underlying population enrolling with each MCO.

### ii. Risk adjustment model

Detail regarding the risk adjustment models is provided in Section I, item 6.B.i.(b) below.

### iii. Acuity adjustments

Acuity adjustments made in rate development are discussed in Section III(B)(ii)(a), “Step 5 acuity adjustments.”

## B. APPROPRIATE DOCUMENTATION

### i. Prospective risk adjustment

#### (a) Data

We anticipate that SFY 2024 capitation rates will be risk adjusted on a semi-annual basis. Risk adjustment for the first half of SFY 2024 will reflect MCO experience incurred during CY 2022 (January 1, 2022 through December 31, 2022), while risk adjustment for the second half of SFY 2024 will utilize SFY 2023 experience. Additional adjustments may be applied to the risk adjusted rates for enrollment changes resulting from the economic impact of COVID-19. We will monitor enrollment changes during the unwinding process and consider more frequent risk adjustment updates if appropriate.

#### (b) Risk adjustment model

The Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) version 7.0 or the most recent version of CDPS+Rx available will be used for the risk adjustment model. To the extent the national drug codes (NDCs) included in the algorithm are out-of-date, we anticipate updating the algorithm to include additional NDCs based on therapeutic class mapping to disease risk categories. If applicable, we will document additional NDCs.

We will recalibrate the weights between the diagnostic and pharmacy components of the CDPS+Rx model based on observed experience for the Healthy Louisiana population. Diagnosis code and NDC information from SFY 2021 will be utilized to train a model to explain MCO covered claims expenditures from SFY 2022. The weights will be developed on a statewide basis. Due to the differences in covered benefits for some of the MCOs during CY 2023, separate models will be trained with and without prescription drugs in the MCO covered claims expenditures (i.e., the response variable); however, both models will use prescription drug claims to identify clinical conditions. MCO expenditures incorporated as part of the Maternity kick payment will not be included in the training of the risk adjustment model.

#### (c) Risk adjustment methodology

We expect to perform risk adjustment for the 2H 2023 and 1H 2024 rating periods. In each period, risk scores will be calculated for each MCO by region and rate group. The rate groups for the purposes of risk adjustment are:

- SSI – Child 1-20 Years
- SSI – Adult 21+ Years
- Family and Children – Child 1-20 Years
- Family and Children – Adult 21+ Years
- Foster Care Children
- LaCHIP Affordable Plan

- Medicaid Expansion – Age 19-64

The following rate cells will not be risk-adjusted:

- Newborn rate cells (< 1 year)
- Breast and cervical cancer
- HCBS waiver
- Chisholm Class members
- SBH program
- Act 421 rate cells
- Maternity kick payments

Risk adjustment is performed on a budget neutral basis, separately for each rate group. Relative risk scores will be normalized to result in a risk score of 1.000 for each rate group, across all MCOs. For rate groups with significant enrollment, we will consider implementing the normalization process on a regional basis.

Prospective risk adjustment is expected to take place on a semi-annual basis for the July 2023 through June 2024 period:

- **July 2023 through December 2023 rates:** Prospective risk adjustment will be performed using the member risk scores weighted based on actual MCO enrollment from April 2023.
- **January 2024 through June 2024 rates:** Prospective risk adjustment will be performed using the member risk scores weighted based on actual MCO enrollment from October 2023.

Members with six or more months of full benefit Medicaid eligibility during the diagnosis capture period will be assigned a risk score. We will consider a credibility adjustment for rate cells with limited enrollment. Unscored members and partial credibility will be incorporated into the calculation of the MCO risk factor and adjusted to ensure budget neutrality.

#### (d) Magnitude of the adjustment

We will provide full documentation of the results and methodology for the risk adjustment analysis in a separate correspondence.

#### (e) Assessment of predictive value

We will provide full documentation of the results and methodology for the risk adjustment analysis in a separate correspondence.

#### (f) Any concerns the actuary has with the risk adjustment process

At this time, we have no concerns with the risk adjustment process.

### ii. Retrospective risk adjustment

#### Hepatitis C Risk Corridor

Since implementation of LDH's Hepatitis C Subscription Model on July 1, 2019, LDH has maintained a risk corridor for Hepatitis C-related pharmacy, physician, and laboratory costs. Under the risk corridor, if the actual costs related to these services during the contract year exceed the amount assumed in the capitation rate development by more than 1.0%, LDH will reimburse MCOs for 99.0% of the difference between actual and assumed costs.

#### High-Cost Drug Risk Pool

Since 2020, LDH has maintained a budget-neutral risk pool for Zolgensma, a treatment for spinal muscular atrophy (SMA) that can exceed $2 million per individual. In SFY 2024, the pool has expanded and now includes the following drugs:

- Zolgensma
- Skysona
- Rethymic
- Hemgenix

- Zynteglo

The risk pool is funded separately for each of several applicable rate cells based on the projected utilization and cost per service of these drugs during the rating year. These projections are included in the capitation rate certification prior to the start of the year. After the rating year is complete, the risk pool funding through the capitation rates is determined for each of the MCOs based on their share of the members in the applicable rate cells. This share of the funding is then compared to the MCO's actual share of high-cost drug utilization during the rating period. Based on a comparison of each MCO's share of funding through the capitation rates to their share of actual utilization, transfer payments will be made to/(from) the MCO in line with their shortfall/(excess) in the funding received through the capitation rates. All Healthy Louisiana members are included in the high-cost drug risk pool and transfer payments are calculated based on the aggregate MCO experience rather than experience at the rate cell level.

### iii. Risk adjustment documentation

#### (a) Risk adjustment model

Since the last rating period, we have made the following changes to the risk adjustment model:

- The acute care risk adjustment model will use a prospective risk adjustment model from version 7.0 of the CDPS+Rx software.
    - Risk adjustment for July through December 2022 used the Johns Hopkins Adjusted Clinical Groups (ACG) model.
    - Risk adjustment for January through June 2023 has not yet been completed but will use a concurrent risk adjustment model from version 7.0 of the CDPS+Rx software.

#### (b) Budget neutrality

The risk adjustment model is budget neutral in accordance with 42 CFR 438.5(g).

### iv. Acuity adjustments

Acuity adjustments made in rate development are discussed in Section III(B)(ii)(a), "Step 6 acuity adjustments."

# Section II. Medicaid Managed Care Rates with Long Term Services and Supports

Section II of the CMS Guide is not applicable to the Healthy Louisiana program. Managed long-term services and supports (MLTSS) populations are generally excluded from the Healthy Louisiana program. MCOs are required to cover certain home and community based services (HCBS) services, such as personal care services for individuals under age 20. Nursing home services are not covered.

# Section III. New Adult Group Capitation Rates

LDH began enrolling beneficiaries into the Medicaid Expansion population beginning July 1, 2016.

## 1. Data

### A. DATA USED IN CERTIFICATION

Section I, subsection 2 of this report thoroughly describes the data used in developing actuarially sound SFY 2024 capitation rates for the Medicaid Expansion population.

### B. 2021 EXPERIENCE VS. ASSUMPTIONS

Figure 29 illustrates a comparison of SFY 2023 estimated and actual member months for the Medicaid Expansion population. The actual SFY 2023 member months are based on observed member months from July through December 2022, multiplied by two. Using this method, actual member months were approximately 22% above estimated member months.

**FIGURE 29: SFY 2023 PROJECTED VERSUS ACTUAL MEMBER MONTHS FOR THE MEDICAID EXPANSION POPULATION**

| POPULATION | ESTIMATED MEMBER MONTHS | ACTUAL MEMBER MONTHS | % DIFFERENCE |
|---|---|---|---|
| Medicaid Expansion | 7,296,201 | 8,872,080 | 21.6% |
| Medicaid Expansion - Kick | 13,531 | 15,004 | 10.9% |
| Composite | 7,296,201 | 8,872,080 | 21.6% |

Note: Values in member months column for kick payment rate cells represent deliveries.

Figure 30 illustrates a comparison of SFY 2023 estimated and actual benefit costs for the Medicaid Expansion population. On an aggregate basis, actual experience was approximately 11.5% below the estimated benefit expenses. Note that the actual benefit costs in the figure below are based on encounter data incurred from July to December 2022, paid through February 2023, and does not include any adjustments for encounter data completeness or IBNR.

**FIGURE 30: SFY 2023 PROJECTED VERSUS ACTUAL BENEFIT COST PMPMS FOR THE MEDICAID EXPANSION POPULATION**

| POPULATION | ESTIMATED BENEFIT COST | ACTUAL BENEFIT COST | % DIFFERENCE |
|---|---|---|---|
| Medicaid Expansion | $ 458.20 | $ 408.61 | (10.8%) |
| Medicaid Expansion - Kick | $ 10,038.56 | $ 7,825.60 | (22.0%) |
| Composite | $ 476.81 | $ 421.85 | (11.5%) |

Note: Values for kick payment rate cells represent costs per delivery.

We have made no specific adjustments to reflect differences in projected versus actual experience.

## 2. Projected Benefit Costs

### A. DESCRIPTION OF PROJECTED BENEFIT COSTS

#### i. Description of projected benefit costs

#### (a) Experience specific to newly eligible adults

SFY 2022 MCO experience for the Medicaid Expansion population comprised the underlying data used in the development of the SFY 2024 Medicaid Expansion capitation rates as outlined in Section 1 of this report.

#### (b) Changes in data sources, assumptions, or methodologies since last certification

The data sources, assumptions, and methodologies are consistent with the SFY 2023 certification with the exceptions outlined in Section 1 of this report.

### (c) Assumption changes since last certification

SFY 2022 MCO experience was used as the underlying data source in the development of the SFY 2024 capitation rates. CY 2019 MCO and FFS experience was used as the underlying data source for SFY 2023 capitation rates. Other assumptions are generally consistent with the SFY 2023 rate certification.

### C. DESCRIPTION OF KEY ASSUMPTIONS

*Adjustment for pent-up demand*. Consistent with the SFY 2023 rate setting, it was assumed that the baseline experience data did not require these adjustments.

*Adjustment for adverse selection*. Consistent with the SFY 2023 rate setting, it was assumed that the baseline experience data did not require these adjustments.

*Adjustment for demographics of the new adult group***.** We believe the current rate cell structure of the Expansion population appropriately adjusts capitation payments to the extent the demographic mix of the Expansion population changes significantly during the SFY 2024 rate period.

*Differences in provider reimbursement rates or provider networks*. We are not aware of any provider network differences between the Medicaid Expansion population and other Medicaid populations. Variations in assumptions by covered population were not based on the rate of federal financial participation associated with the population.

### D. CHANGES TO BENEFIT PLAN

No benefit changes have been made to services covered under the state plan for the Expansion population, other than those discussed in Section 1 of this report.

### E. OTHER MATERIAL CHANGES OR ADJUSTMENTS TO BENEFIT COSTS

No other material changes or adjustments were made in the rate development process other than those discussed in Section 1 of this report.

# 3. Projected Non-Benefit Costs

### A. CHANGES IN DATA SOURCES, ASSUMPTIONS, OR METHODOLOGIES SINCE LAST CERTIFICATION

MCO non-benefit costs were available for SFY 2023. We reviewed this information as we developed non-benefit cost assumptions as outlined in Section 1, subsection 5 of this report. Figure 31 illustrates the non-benefit cost assumptions for the SFY 2023 and SFY 2024 Medicaid Expansion capitation rates. The quality values in this figure reflect the care management add-on in addition to the original quality allowance. Note that the SFY 2023 rates had both a low and high end rate, whereas we only developed a single rate for SFY 2024.

**FIGURE 31: NON-BENEFIT COSTS AS A PERCENTAGE OF LIMITED RATES FOR THE MEDICAID EXPANSION POPULATION**

| | ADMIN + QUALITY | PREMIUM TAX | RISK MARGIN | TOTAL NON-BENEFIT COSTS |
|---|---|---|---|---|
| SFY 2023 Low End Rate | 7.8% | 5.5% | 1.5% | 14.8% |
| SFY 2023 High End Rate | 7.1% | 5.5% | 1.5% | 14.1% |
| SFY 2024 Rate | 7.7% | 5.5% | 1.5% | 14.7% |

### B. ASSUMPTION DIFFERENCES RELATIVE TO OTHER MEDICAID POPULATIONS

Figure 32 provides the non-benefit expense assumptions for the Medicaid Expansion population and other Medicaid managed care populations for the SFY 2024 rates. The quality values in these figures reflect the care management add-on in addition to the original quality allowance.

**FIGURE 32: NON-BENEFIT COSTS AS A PERCENTAGE OF LIMITED RATES**

| POPULATION | ADMINISTRATIVE EXPENSES | QUALITY | RISK MARGIN | TOTAL NON-BENEFIT COSTS |
|---|---|---|---|---|
| SSI | 6.25% | 1.50% | 1.50% | 9.25% |
| F&C | 6.75% | 1.75% | 1.50% | 10.00% |
| SBH | 9.50% | 2.50% | 1.50% | 13.50% |
| Medicaid Expansion | 6.50% | 1.75% | 1.50% | 9.75% |
| All Other Populations | 5.50% | 1.50% | 1.50% | 8.50% |
| Kick | 4.50% | 1.00% | 1.50% | 7.00% |

# 4. Final Certified Rates

## A. COMPARISON TO PREVIOUS CERTIFICATION

Figure 33 illustrates the changes in estimated member months and capitation rates from SFY 2023 to SFY 2024 rates. The SFY 2023 rates reflect the SFY 2023 capitation rate certification, dated August 24, 2022. All values reflect total expected payments, including directed payments and FMP payments. On an aggregate basis, the SFY 2023 rates are estimated to increase by approximately 3.0%.

**FIGURE 33: COMPARISON OF SFY 2023 AND SFY 2024 MEMBERS AND RATES FOR THE MEDICAID POPULATION**

| POPULATION | ESTIMATED SFY 2023 MONTHLY MEMBERS | ESTIMATED SFY 2024 MONTHLY MEMBERS | % DIFFERENCE | SFY 2023 COMPOSITE STATEWIDE RATE | SFY 2024 COMPOSITE STATEWIDE RATE | % DIFFERENCE |
|---|---|---|---|---|---|---|
| Medicaid Expansion | 7,296,201 | 8,165,384 | 11.9% | $ 724.26 | $ 749.38 | 3.5% |
| Medicaid Expansion - Kick | 13,531 | 13,996 | 3.4% | $ 19,559.64 | $ 19,889.61 | 1.7% |
| **Composite** | 7,296,201 | 8,165,384 | 11.9% | $ 760.54 | $ 783.48 | 3.0% |

Notes: Values include FMP payments as well as the estimated value of directed payments made as separate payment terms.

## B. DESCRIPTION OF OTHER MATERIAL CHANGES TO THE CAPITATION RATES

All material changes to the Medicaid Expansion rate development methodology are outlined in Section I of this report.

# 5. Risk Mitigation Strategies

## A. DESCRIPTION OF RISK MITIGATION STRATEGY

The risk mitigation strategy for the Medicaid Expansion population is outlined in Section I, subsection 7 of this report. No additional risk mitigation strategies are in effect for the SFY 2024 rating period.

## B. CHANGES TO RISK MITIGATION STRATEGY RELATIVE TO PRIOR YEARS

Consistent with the other Healthy Louisiana populations, the minimum medical loss ratio (MLR) requirement will remain at 85% for the SFY 2024 contract year. Other risk mitigation strategies are structurally consistent with the prior rating period, although LDH has made some adjustments to the drugs to be included in the high-cost drug risk pool. This is discussed further in Section 1, subsection 4.C.

# Limitations

The services provided for this project were performed under the contract between Milliman and LDH, effective January 1, 2023.

The information contained in this report has been prepared for the State of Louisiana, Department of Health (LDH) and their consultants and advisors to provide documentation of the development of the state fiscal year 2024 actuarially sound capitation rates for the populations served under the Healthy Louisiana Medicaid managed care program. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report will be shared with CMS and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for LDH by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to develop actuarially sound capitation rates for the state fiscal year 2024 rating period. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models rely on data and information as input to the models. We have relied upon certain data and information provided by LDH for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman's data and information reliance includes eligibility and FFS claims and encounter data, MCO-reported financial experience, as well as information related to LDH's eligibility system and assignment of enrollees to rate cells. The models, including all input, calculations, and output may not be appropriate for any other purpose.

Although the capitation rates have been certified as actuarially sound, the capitation rates may not be appropriate for any individual MCO. Results will differ if actual experience is different from the assumptions contained in the capitation rate setting documentation. LDH and Milliman provide no guarantee, either written or implied, that the data and information is 100% accurate or error free.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

We acknowledge the unique nature of the COVID-19 Public Health Emergency and the anticipated resumption of redeterminations and terminations of coverage that will occur during the rating period. The assumptions documented in this certification report reflect information known to us at the time of this report. We acknowledge that the resumption of redeterminations and enrollment unwinding period could have a material impact on utilization, acuity, Medicaid enrollment, service delivery, and other factors related to the capitation rates illustrated in this rate certification.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report who are actuaries are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

# APPENDIX 1: ACTUARIAL CERTIFICATION

**State of Louisiana**
**Department of Health**
**Healthy Louisiana Medicaid Managed Care Program**
**State Fiscal Year 2024 Capitation Rates**
**Actuarial Certification**

I, Anders Larson, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of Louisiana, Department of Health to perform an actuarial review and certification regarding the development of capitation rates for the Healthy Louisiana Medicaid managed care program effective July 1, 2023. I am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

The capitation rates provided with this certification are considered "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- *the capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the MCO for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).*

For the purposes of this certification and consistent with the requirements under 42 CFR 438.4(a), "actuarial soundness" is defined as in ASOP 49:

*"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."*

The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with the State of Louisiana. The "actuarially sound" capitation rates that are associated with this certification are effective for state fiscal year 2024.

The "actuarially sound" capitation rates are based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the rates.

In developing the "actuarially sound" capitation rates, I have relied upon data and information provided by the State and MCOs. I have relied upon the State for audit of the data. However, I did review the data for reasonableness and consistency.

I acknowledge that LDH may elect to amend the capitation rates in accordance with 42 CFR 438.7(c)(3), which indicates that a capitation rate certification is not required for adjustments that increase or decrease capitation rates by 1.5% or less. The capitation rates developed may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The health plan may require rates above, equal to, or below the "actuarially sound" capitation rates that are associated with this certification.

I acknowledge the unique nature of the COVID-19 Public Health Emergency and the anticipated resumption of redeterminations and terminations of coverage that will occur during the rating period. The assumptions documented in this certification report reflect information known to us at the time of this report. I acknowledge that the resumption of redeterminations and enrollment unwinding period could have a material impact on utilization, acuity, Medicaid enrollment, service delivery, and other factors related to the capitation rates illustrated in this rate certification.


Anders Larson, FSA
Member, American Academy of Actuaries

June 23, 2023
Date

# APPENDIX 2: RATE DEVELOPMENT (PROVIDED IN EXCEL)

# APPENDIX 3: RATE CHANGE SUMMARIES (PROVIDED IN EXCEL)

# APPENDIX 4: RATES EXCLUDING PRESCRIPTION DRUGS (PROVIDED IN EXCEL)

# APPENDIX 5: PARISH TO REGION MAPPING

**State of Louisiana**
**Department of Health**
**Healthy Louisiana Medicaid Managed Care Program**
**State Fiscal Year 2024 Capitation Rate Certification**
**Appendix 5 - Parish Mapping**

| Parish | Region |
|---|---|
| Ascension | Capital |
| East Baton Rouge | Capital |
| East Feliciana | Capital |
| Iberville | Capital |
| Livingston | Capital |
| Pointe Coupee | Capital |
| St. Helena | Capital |
| St. Tammany | Capital |
| Tangipahoa | Capital |
| Washington | Capital |
| West Baton Rouge | Capital |
| West Feliciana | Capital |
| Assumption | Gulf |
| Jefferson | Gulf |
| Lafourche | Gulf |
| Orleans | Gulf |
| Plaquemines | Gulf |
| St. Bernard | Gulf |
| St. Charles | Gulf |
| St. James | Gulf |
| St. John The Baptist | Gulf |
| St. Mary | Gulf |
| Terrebonne | Gulf |
| Bienville | North |
| Bossier | North |
| Caddo | North |
| Caldwell | North |
| Claiborne | North |
| DeSoto | North |
| East Carroll | North |
| Franklin | North |
| Jackson | North |
| Lincoln | North |
| Madison | North |
| Morehouse | North |
| Natchitoches | North |
| Ouachita | North |
| Red River | North |
| Richland | North |
| Sabine | North |
| Tensas | North |
| Union | North |
| Webster | North |
| West Carroll | North |
| Acadia | South Central |
| Allen | South Central |
| Avoyelles | South Central |
| Beauregard | South Central |
| Calcasieu | South Central |
| Cameron | South Central |
| Catahoula | South Central |
| Concordia | South Central |
| Evangeline | South Central |
| Grant | South Central |
| Iberia | South Central |
| Jefferson Davis | South Central |
| LaSalle | South Central |
| Lafayette | South Central |
| Rapides | South Central |
| St. Landry | South Central |
| St. Martin | South Central |
| Vermilion | South Central |
| Vernon | South Central |
| Winn | South Central |

# APPENDIX 6: COVERED POPULATIONS

**State of Louisiana**
**Department of Health**
**Healthy Louisiana Medicaid Managed Care Program**
**State Fiscal Year 2024 Capitation Rate Certification**
**Appendix 6a - Covered Populations**

| Aid Category Description | Type Case Description | Adult/Child/All Ages | Mandatory | Voluntary Opt In | SBH and NEMT |
|---|---|---|---|---|---|
| **CCM*** | | | | x | x |
| **Dual Eligibles**** | | | | | x |
| **ABD (Aged, Blind, and** | | | | | |
| | Acute Care Hospitals (LOS > 30 days) | All Ages | x | | |
| | ADHC (Adult Day Health Services Waiver) | All Ages | | x | |
| | BPL (Walker vs. Bayer) | All Ages | x | | |
| | Children's Medicaid Option (LaHIPP) | Child | | | x |
| | Children's Medicaid Option (Non-LaHIPP TPL) | Child | x | | |
| | Children's Medicaid Option (Non-TPL) | Child | x | | |
| | Children's Waiver - Louisiana Children's Choice | All Ages | | x | |
| | Community Choice Waiver | All Ages | | x | |
| | Disability Medicaid | All Ages | x | | |
| | Disabled Adult Child | All Ages | x | | |
| | Disabled Widow/Widower (DW/W) | All Ages | x | | |
| | Early Widow/Widowers | All Ages | x | | |
| | Excess Home Equity Over SIL and NF Fee (Aged) | Adult | | | x |
| | Excess Home Equity Over SIL and NF Fee (Blind and Disabled) | All Ages | | | x |
| | Excess Home Equity SSI Under SIL (Aged) | Adult | | | x |
| | Excess Home Equity SSI Under SIL (Blind and Disabled) | All Ages | | | x |
| | Excess Home Equity SSI Under SIL-Reg LTC (Aged) | Adult | | | x |
| | Excess Home Equity SSI Under SIL-Reg LTC (Blind and Disabled) | All Ages | | | x |
| | Family Opportunity Program | All Ages | x | | |
| | Forced Benefits (Aged) | Adult | | | x |
| | Forced Benefits (Blind) | All Ages | | | x |
| | Former SSI | All Ages | x | | |
| | LaCHIP Phase IV: Non-Citizen Pregnant Women Expansion | All Ages | x | | |
| | LTC (Long Term Care) (Aged) | Adult | | | x |
| | LTC (Long Term Care) (Blind and Disabled) | All Ages | | | x |
| | LTC MNP/Transfer of Resources (Aged) | Adult | | | x |
| | LTC MNP/Transfer of Resources (Blind and Disabled) | All Ages | | | x |
| | LTC Payment Denial/Late Admission Packet (Aged) | Adult | | | x |
| | LTC Payment Denial/Late Admission Packet (Blind and Disabled) | All Ages | | | x |
| | LTC Spenddown MNP (Aged) | Adult | | | x |
| | LTC Spenddown MNP (Blind and Disabled) | All Ages | | | x |
| | Medicaid Buy-In Working Disabled (Medicaid Purchase Plan) | All Ages | x | | |
| | New Opportunities Waiver - SSI | All Ages | | x | |
| | New Opportunities Waiver Fund | All Ages | | x | |
| | New Opportunities Waiver, non-SSI | All Ages | | x | |
| | PICKLE | All Ages | x | | |
| | Provisional Medicaid | All Ages | x | | |
| | Residential Options Waiver - NON-SSI | All Ages | | x | |
| | Residential Options Waiver - SSI | All Ages | | x | |
| | Section 4913 Children | All Ages | x | | |
| | SGA Disabled W/W/DS | All Ages | x | | |
| | SSI (Supplemental Security Income) | All Ages | x | | |
| | SSI Children's Waiver - Louisiana Children's Choice | All Ages | | x | |
| | SSI Community Choice Waiver | All Ages | | x | |
| | SSI Conversion | All Ages | x | | |
| | SSI Conversion/Refugee Cash Assistance (RCA) / LIFC Basic | All Ages | x | | |
| | SSI New Opportunities Waiver Fund | All Ages | | x | |
| | SSI Payment Denial/Late Admission (Aged) | Adult | | | x |
| | SSI Payment Denial/Late Admission (Blind and Disabled) | All Ages | | | x |
| | SSI Private ICF/DD Transfer of Resources (Blind and Disabled) | Child | | | x |
| | SSI Public ICF/DD Transfer of Resources (Blind and Disabled) | Child | | | x |
| | SSI Transfer of Resource(s)/LTC (Aged) | Adult | | | x |
| | SSI Transfer of Resource(s)/LTC (Blind and Disabled) | All Ages | | | x |
| | SSI/ADHC | All Ages | | x | |
| | SSI/LTC (Aged) | Adult | | | x |
| | SSI/LTC (Blind and Disabled) | All Ages | | | x |
| | SSI/Private ICF/DD (Blind) | Child | | | x |
| | SSI/Public ICF/DD (Blind) | Child | | | x |
| | Supports Waiver | All Ages | | x | |
| | Supports Waiver SSI | All Ages | | x | |
| | Transfer of Resource(s)/LTC (Aged) | Adult | | | x |
| | Transfer of Resource(s)/LTC (Blind and Disabled) | All Ages | | | x |

**State of Louisiana**
**Department of Health**
**Healthy Louisiana Medicaid Managed Care Program**
**State Fiscal Year 2024 Capitation Rate Certification**
**Appendix 6a - Covered Populations**

| Aid Category Description | Type Case Description | Adult/Child/All Ages | Mandatory | Voluntary Opt In | SBH and NEMT |
|---|---|---|---|---|---|
| **Families and Children** | | | | | |
| | Breast and/or Cervical Cancer | All Ages | x | | |
| | CHAMP Child | All Ages | x | | |
| | CHAMP Pregnant Woman (to 133% of FPIG) | All Ages | x | | |
| | CHAMP Pregnant Woman Expansion (to 185% FPIG) | All Ages | x | | |
| | Deemed Eligible | All Ages | x | | |
| | ELE - Food Stamps (Express Lane Eligibility-Food Stamps) | All Ages | x | | |
| | Forced Benefits | All Ages | | | x |
| | Former Foster Care children | All Ages | x | | |
| | LaCHIP Affordable Plan | All Ages | x | | |
| | LACHIP Phase 1 | All Ages | x | | |
| | LACHIP Phase 2 | All Ages | x | | |
| | LACHIP Phase 3 | All Ages | x | | |
| | LaCHIP Phase IV: Non-Citizen Pregnant Women Expansion | All Ages | x | | |
| | LIFC Basic | All Ages | x | | |
| | LTC (Long-Term Care) | All Ages | | | x |
| | LTC Spenddown MNP | All Ages | | | x |
| | PAP - Prohibited AFDC Provisions | All Ages | x | | |
| | Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL | All Ages | x | | |
| | Public ICF/DD | Child | | | x |
| | Regular MNP (Medically Needy Program) | All Ages | x | | |
| | Transitional Medicaid | All Ages | x | | |
| | Youth Aging Out of Foster Care (Chaffee Option) | All Ages | | | |
| **LIFC** | | | | | |
| | Grant Review/Child Support Continuance | All Ages | x | | |
| | LIFC - Unemployed Parent / CHAMP | All Ages | x | | |
| | LIFC Basic | All Ages | x | | |
| | Transitional Medicaid | All Ages | x | | |
| **Medicaid Expansion** | | | | | |
| | Adult Group | All Ages | x | | |
| | Adult Group - High Need | All Ages | x | | |
| **Non Traditional** | | | | | |
| | CSOC | All Ages | x | | |
| **OCS/OYD** | | | | | |
| | CHAMP Child | All Ages | x | | |
| | CHAMP Pregnant Woman (to 133% of FPIG) | All Ages | x | | |
| | CHAMP Pregnant Woman Expansion (to 185% FPIG) | All Ages | x | | |
| | Children's Waiver - Louisiana Children's Choice | All Ages | | x | |
| | Forced Benefits | Child | | | x |
| | Former SSI | All Ages | x | | |
| | Foster Care IV-E - Suspended SSI | All Ages | x | | |
| | IV-E Foster Care | All Ages | x | | |
| | LACHIP Phase 1 | All Ages | x | | |
| | LTC (Long-Term Care) | All Ages | | | x |
| | LTC (Long-Term Care) | Child | | | x |
| | New Opportunities Waiver - SSI | All Ages | | x | |
| | New Opportunities Waiver Fund | All Ages | | x | |
| | New Opportunities Waiver, non-SSI | All Ages | | x | |
| | OYD - V Category Child | All Ages | x | | |
| | Private ICF/DD | Child | | | x |
| | Public ICF/DD | Child | | | x |
| | Regular Foster Care Child | All Ages | x | | |
| | Regular Foster Care Child - MNP | All Ages | x | | |
| | Residential Options Waiver - NON-SSI | All Ages | | x | |
| | Residential Options Waiver - SSI | All Ages | | x | |
| | SSI (Supplemental Security Income) | All Ages | x | | |
| | SSI Children's Waiver - Louisiana Children's Choice | All Ages | | x | |
| | SSI New Opportunities Waiver Fund | All Ages | | x | |
| | SSI/LTC | All Ages | | | x |
| | SSI/LTC | Child | | | x |
| | SSI/Private ICF/DD | Child | | | x |
| | SSI/Public ICF/DD | Child | | | x |
| | YAP (Young Adult Program) (OCS/OYD (XIX)) | All Ages | x | | |
| | YAP/OYD | All Ages | x | | |
| **Presumptive Eligible** | | | | | |
| | Adult Group | All Ages | x | | |
| | HPE B/CC | All Ages | x | | |
| | HPE CHAMP | All Ages | x | | |
| | HPE Children Under Age 19 Years | All Ages | x | | |
| | HPE Former Foster Care | All Ages | x | | |
| | HPE LaCHIP | All Ages | x | | |
| | HPE LaCHIP Unborn | All Ages | x | | |
| | HPE Parent/Caretaker Relative | All Ages | x | | |
| | HPE Pregnant Woman | All Ages | x | | |
| **TB** | | | | | |
| | Tuberculosis (TB) | All Ages | x | | |

* Individuals under the age of 21 years otherwise eligible for Medicaid who are listed on the OCDD's Request for Services Registry who are CCM.
** Dual eligibles included in Healthy Louisiana for SBH and NEMT services must be in a mandatory, voluntary opt-in or SBH and NEMT population. They must also be eligible for Medicare, which is identified based on the Medicare Duals Eligibility table supplied by the State's fiscal agent. Dually eligible individuals are represented by Dual Status code 02, 04, and 08.

**State of Louisiana**
**Department of Health**
**Healthy Louisiana Medicaid Managed Care Program**
**State Fiscal Year 2024 Capitation Rate Certification**
**Appendix 6b - Excluded Populations**

| Aid Category Description | Type Case Description | Adult/Child/AllAges |
|---|---|---|
| **ABD (Aged, Blind, and Disabled)** | | |
| | DD Waiver | All Ages |
| | Denied SSI Prior Period | All Ages |
| | Disabled Adults Authorized for Special Hurricane Katrina Assistance | All Ages |
| | EDA Waiver | All Ages |
| | Excess Home Equity Over SIL and NF Fee (Aged) | Child |
| | Excess Home Equity SSI Under SIL (Aged) | Child |
| | Excess Home Equity SSI Under SIL-Reg LTC (Aged) | Child |
| | Forced Benefits (Aged) | Child |
| | Forced Benefits (Disabled) | All Ages |
| | Illegal/Ineligible Aliens Emergency Services | All Ages |
| | LBHP - Adult 1915(i) | All Ages |
| | LTC (Long-Term Care) (Aged) | Child |
| | LTC Co-Insurance | All Ages |
| | LTC MNP/Transfer of Resources (Aged) | Child |
| | LTC Payment Denial/Late Admission Packet (Aged) | Child |
| | LTC Spenddown MNP (Aged) | Child |
| | LTC Spenddown MNP (Income > Facility Fee) | All Ages |
| | PACE SSI | All Ages |
| | PACE SSI-related | All Ages |
| | PCA Waiver | All Ages |
| | Private ICF/DD (Aged and Disabled) | All Ages |
| | Private ICF/DD (Blind) | Adult |
| | Private ICF/DD MNP Transfer of Resources (Blind and Disabled) | Adult |
| | Private ICF/DD Spenddown Medically Needy Program (Aged and Disabled) | All Ages |
| | Private ICF/DD Spenddown Medically Needy Program (Blind) | Adult |
| | Private ICF/DD Spenddown MNP/Income Over Facility Fee | All Ages |
| | Private ICF/DD Transfer of Resources (Blind and Disabled) | Adult |
| | Public ICF/DD (Aged and Disabled) | All Ages |
| | Public ICF/DD (Blind) | Adult |
| | Public ICF/DD MNP Transfer of Resources (Blind and Disabled) | Adult |
| | Public ICF/DD Spenddown MNP | All Ages |
| | Public ICF/DD Spenddown Medically Needy Program (Blind and Disabled) | Adult |
| | Public ICF/DD Spenddown MNP/Income Over Facility Fee | All Ages |
| | Public ICF/DD Transfer of Resources (Blind and Disabled) | Adult |
| | QI-1 (Qualified Individual - 1) | All Ages |
| | QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002) | All Ages |
| | SLMB (Specified Low-Income Medicare Beneficiary) | All Ages |
| | Spenddown MNP | All Ages |
| | Spenddown Denial of Payment/Late Packet (Aged and Disabled) | All Ages |
| | Spenddown Denial of Payment/Late Packet (Blind) | Adult |
| | SSI DD Waiver | All Ages |
| | SSI Payment Denial/Late Admission (Aged) | Child |
| | SSI PCA Waiver | All Ages |
| | SSI Private ICF/DD Transfer of Resources (Blind and Disabled) | Adult |
| | SSI Public ICF/DD Transfer of Resources (Blind and Disabled) | Adult |
| | SSI Transfer of Resource(s)/LTC (Aged) | Child |
| | SSI/EDA Waiver | All Ages |
| | SSI/LTC (Aged) | Child |
| | SSI/Private ICF/DD (Aged and Disabled) | All Ages |
| | SSI/Private ICF/DD (Blind) | Adult |
| | SSI/Public ICF/DD (Aged and Disabled) | All Ages |
| | SSI/Public ICF/DD (Blind) | Adult |
| | Terminated SSI Prior Period | All Ages |
| | Transfer of Resource(s)/LTC (Aged) | Child |

**State of Louisiana**
**Department of Health**
**Healthy Louisiana Medicaid Managed Care Program**
**State Fiscal Year 2024 Capitation Rate Certification**
**Appendix 6b - Excluded Populations**

| Aid Category Description | Type Case Description | Adult/Child/AllAges |
|---|---|---|
| **Families and Children** | | |
| | DD Waiver | All Ages |
| | Grant Review | All Ages |
| | Illegal/Ineligible Aliens Emergency Services | All Ages |
| | LBHP - Adult 1915(i) | All Ages |
| | Public ICF/DD | Adult |
| | Spenddown MNP | All Ages |
| **Family Planning** | | |
| | Take Charge Plus | All Ages |
| **GNOCHC** | | All Ages |
| **Hurricane Evacuees** | | All Ages |
| **Med Asst/Appeal** | | |
| | Community Choice Waiver | All Ages |
| | LTC (Long-Term Care) | All Ages |
| | PCA Waiver | All Ages |
| | Regular MNP (Medically Needy Program) | All Ages |
| | State Retirees | All Ages |
| **Non Traditional** | | |
| | Family Planning, New eligibility/Non LaMOMS | All Ages |
| | Family Planning, Previous LaMOMS eligibility | All Ages |
| **OCS/OYD** | | |
| | DD Waiver | All Ages |
| | Forced Benefits | Adult |
| | LTC (Long-Term Care) | Adult |
| | OCS Child Under Age 18 Years (State Funded) | All Ages |
| | OYD (Office of Youth Development) | All Ages |
| | Private ICF/DD | Adult |
| | Public ICF/DD | Adult |
| | SSI DD Waiver | All Ages |
| | SSI/LTC | Adult |
| | SSI/Private ICF/DD | Adult |
| | SSI/Public ICF/DD | Adult |
| | YAP (Young Adult Program) (OCS/OYD Child) | All Ages |
| **Presumptive Eligible** | | |
| | HPE Family Planning | All Ages |
| | HPE Take Charge Plus | All Ages |
| **QMB** | | All Ages |
| **Refugee Asst** | | |
| | Forced Benefits | All Ages |
| | Regular MNP (Medically Needy Program) | All Ages |
| | SSI Conversion / Refugee Cash Assistance (RCA)/LIFC Basic | All Ages |

# APPENDIX 7: COVERED SERVICES

**State of Louisiana**
**Department of Health**
**Healthy Louisiana Medicaid Managed Care Program**
**State Fiscal Year 2024 Capitation Rate Certification**
**Appendix 7 - Covered Services**

| MCO Covered Service | Category |
|---|---|
| Ambulatory Surgical Services | Physical Health |
| Applied Behavioral Analysis (Age 0–20) | Physical Health |
| Audiology Services | Physical Health |
| Chiropractic Services (Age 0-20) | Physical Health |
| Durable Medical Equipment (DME) | Physical Health |
| Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Age 0-20) | Physical Health |
| Emergency Services | Physical Health |
| End Stage Renal Disease Services | Physical Health |
| Eye Care and Vision Services | Physical Health |
| Family Planning Services | Physical Health |
| Federally Qualified Health Center (FQHC)/Rural Health Clinic | Physical Health |
| Home Health - Extended Services (Age 0-20) | Physical Health |
| Home Health Services | Physical Health |
| Hospice Services | Physical Health |
| Immunizations | Physical Health |
| Inpatient Hospital Services | Physical Health |
| Laboratory and Radiology Services | Physical Health |
| Limited Abortion Services | Physical Health |
| Medical Transportation Services (Emergency and Non-Emergency) | Physical Health |
| Outpatient Hospital Services | Physical Health |
| Pediatric Day Healthcare Services (Age 0-20) | Physical Health |
| Personal Care Services (Age 0–20) | Physical Health |
| Pharmacy Services | Physical Health |
| Physician/Professional Services | Physical Health |
| Podiatry Services | Physical Health |
| Pregnancy-related Services | Physical Health |
| Routine Qualifying Clinical Trial Costs (Section 1905(gg) of SSA) | Physical Health |
| Telemedicine | Physical Health |
| Therapy Services | Physical Health |
| Tobacco Cessation Services | Physical Health |
| Basic Behavioral Health Services | Behavioral Health |
| Licensed Practitioner Outpatient Therapy | Behavioral Health (SBH) |
| Mental Health Rehabilitation Services | Behavioral Health (SBH) |
| • Community Psychiatric Support and Treatment (CPST) | Behavioral Health (SBH) |
| ◦ Multi Systemic Therapy (MST) (Age 0 20) | Behavioral Health (SBH) |
| ◦ Functional Family Therapy (FFT) (Age 0-20) | Behavioral Health (SBH) |
| ◦ Homebuilders® (Age 0-20) | Behavioral Health (SBH) |
| ◦ Assertive Community Treatment (Age 18 and older) | Behavioral Health (SBH) |
| • Psychosocial Rehabilitation (PSR) | Behavioral Health (SBH) |
| • Crisis Intervention | Behavioral Health (SBH) |
| Crisis Stabilization | Behavioral Health (SBH) |
| Therapeutic Group Homes (Age 0-20) | Behavioral Health (SBH) |
| Crisis Response Services (Age 21+) | Behavioral Health (SBH) |
| • Mobile Crisis Response (MCR) | Behavioral Health (SBH) |
| • Community Brief Crisis Support (CBCS) | Behavioral Health (SBH) |
| • Behavioral Health Crisis Care (BHCC) | Behavioral Health (SBH) |
| Peer Support Services (Age 21+) | Behavioral Health (SBH) |
| Psychiatric Residential Treatment Facilities (Age 0-20) | Behavioral Health (SBH) |
| Inpatient Hospitalization in a Freestanding Psychiatric Hospital (Age 0-20, 65+) | Behavioral Health (SBH) |
| Inpatient Hospitalization in a Distinct Part Psychiatric Unit | Behavioral Health (SBH) |
| Outpatient, Residential, and Inpatient Substance Use Disorder Services | Behavioral Health (SBH) |
| Medication Assisted Treatment | Behavioral Health (SBH) |
| Personal Care Services for DOJ Agreement Target Population (Age 21+) | Behavioral Health (SBH) |
| Individual Placement Support Services for DOJ Agreement Target Population (Age 21+) | Behavioral Health (SBH) |

Note: For SBH rate cells, MCOs are only responsible for services identified as SBH in the table above. For all other Healthy Louisiana rate cells, MCOs are responsible for all services listed above.

# APPENDIX 8: RETROSPECTIVE COST MODELS

# (PROVIDED IN EXCEL)

# APPENDIX 9: PROSPECTIVE COST MODELS (PROVIDED IN EXCEL)

## APPENDIX 10: HEPATITIS C RISK CORRIDOR (PROVIDED IN EXCEL)

# APPENDIX 11: ATTRIBUTION (PROVIDED IN EXCEL)

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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MILLIMAN CLIENT REPORT

# State Fiscal Year 2024 Healthy Louisiana Medicaid Managed Care Capitation Rate Amendment

## State of Louisiana Department of Health

December 6, 2023

Anders Larson, FSA, MAAA, Principal and Consulting Actuary
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Milliman

# Table of Contents

# 1. Background

## BACKGROUND

Milliman, Inc. (Milliman) has been retained by the State of Louisiana, Department of Health (LDH) to provide actuarial and consulting services related to the development of capitation rates for the Physical Health (PH) and Specialized Behavioral Health (SBH) programs within the Healthy Louisiana managed care program. This report is an amendment to the capitation rates developed for state fiscal year (SFY) 2024. The previously certified capitation rates and documentation of their development were published in the following correspondence:

- *State Fiscal Year 2024 Healthy Louisiana Medicaid Managed Care Capitation Rate Certification*, dated June 23, 2023

We have updated the capitation rates that were provided in the original certification to incorporate updated physician Full Medicaid Pricing (FMP) amounts and non-emergency transportation (NEMT), home health (HH), and dialectical behavior therapy (DBT) state directed payments as a separate payment term. Additionally, we have documented new in lieu of services (ILOSs) that were not described in the original certification and calculated the October 2023 blended rate for Humana as a result of the implementation of the single pharmacy benefit manager (PBM). Unless otherwise stated, the methodology and assumptions utilized are consistent with the capitation rate documentation included in the original certification. The required actuarial certification is in Appendix 1.

The capitation rates provided under this certification are “actuarially sound” for purposes of 42 CFR 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the managed care plan for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 12 (Risk Classification (for all Practice Areas)); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); ASOP 56 (Modeling); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective for the CY 2021 managed care program rating period.
- The most recent Medicaid Managed Care Rate Development Guide published by CMS.

Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term “actuarially sound” is defined as in ASOP 49:

> *“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.”*[1]

1 http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/

# 2. Executive Summary

This report is an amendment to the capitation rate certification report developed for SFY 2024. The previously certified capitation rates were published in the following correspondence (original certification):

- *State Fiscal Year 2024 Healthy Louisiana Medicaid Managed Care Capitation Rate Certification*, dated June 23, 2023

We have updated the capitation rates that were provided in the certification report mentioned above to reflect the following items:

- Development of October 2023 capitation rates for Humana, reflecting implementation of the single PBM on October 28, 2023
- Updated physician FMP amounts
- Inclusion of NEMT state directed payments as a separate payment term
- Inclusion of HH state directed payments as a separate payment term
- Inclusion of DBT state directed payments as a separate payment term
- Inclusion of new ILOSs not described in the original certification

Unless otherwise stated, the methodology and assumptions utilized are consistent with the capitation rate documentation included in the original certification.

## A. SUMMARY OF METHODOLOGY

The methodology used in developing this amendment to the certified SFY 2024 capitation rates is outlined below.

### i. Step 1: Development of October 2023 capitation rates for Humana

To reflect the implementation of the single PBM on October 28, we developed capitation rates to be paid to Humana in October 2023 that reflect risk for prescription drug services once the single PBM was implemented. These rates are a blend of two sets of rates that were each previously included in the original certification.

Documentation about the October 2023 capitation rates for Humana is provided in Section 3 of this report.

### ii. Step 2: Incorporate updated physician FMP and additional state directed payments

Based on additional information received after the original certification was completed, LDH has re-calculated the amount of physician FMP payments included in the SFY 2024 Healthy Louisiana capitation rates. The updated physician FMP amounts are shown in Appendix 2.

Separately, we estimated the value of the three new directed payments by region and rate cell based on information available in the preprint that was submitted to CMS. These costs are shown on a PMPM basis in Appendix 2 and are incorporated in the total expected payments of Appendix 3. The directed payments have no effect on the risk-based capitation rates paid to MCOs.

Documentation about the updated physician FMP and directed payments is provided in Section 4 of this report.

### iii. Step 3: Document new in-lieu of services

We have provided required documentation of the new ILOSs, consistent with requirements in the 2023-2024 Managed Care Rate Setting Guide and guidance in the State Medicaid Directors Letter dated January 4, 2023. These new ILOS had no effect on the risk-based capitation rates or total expected payments.

Documentation for the new ILOSs is provided in Section 5 of this report.

### iv. Step 4: Issuance of actuarial certification

An actuarial certification is included in Appendix 1 and signed by Anders Larson, FSA, a Principal and Consulting Actuary of Milliman. Mr. Larson meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, in order to certify that the final rates meet the standards in 42 CFR §438.4(a).

## B. FISCAL IMPACT ESTIMATE

The amended capitation rates for the Medicaid managed care populations are illustrated in Figure 1. These rates are effective from July 1, 2023 through June 30, 2024. Figure 1 also provides a comparison to the previously effective capitation rates for July 1, 2023. The rates are inclusive of directed payments and Full Medicaid Pricing (FMP) amounts. The composite rates illustrated for SFY 2024 have been developed based on an estimate of projected enrollment in SFY 2024. This figure was developed using the rates including full risk for prescription drugs and does not reflect the October 2023 rate adjustment for Humana. The estimated fiscal impact of the October 2023 Humana capitation rate adjustment is discussed at the end of this section.

**FIGURE 1: COMPARISON WITH ORIGINAL JULY 2023 PMPM RATES**

| POPULATION | ESTIMATED SFY 2024 AVERAGE MONTHLY ENROLLMENT | COMPOSITE MCO EXPECTED PAYMENTS | | |
|---|---|---|---|---|
| | | ORIGINAL SFY 2024 | AMENDED SFY 2024 | % CHANGE |
| SSI | 106,910 | $1,973.21 | $1,976.00 | 0.1% |
| F&C | 826,180 | 380.15 | 380.37 | 0.1% |
| SBH | 130,375 | 45.37 | 45.82 | 1.0% |
| Medicaid Expansion | 680,449 | 749.38 | 749.63 | 0.0% |
| All Other Populations | 27,165 | 1,229.09 | 1,234.73 | 0.5% |
| Maternity Kick – Expansion | 1,166 | 19,889.64 | 19,925.75 | 0.2% |
| Maternity Kick – Non-Expansion | 2,128 | 20,381.90 | 20,406.22 | 0.1% |
| **Composite** | 1,771,079 | 644.14 | 644.68 | 0.1% |

Notes:
1. Original and amended SFY 2024 composite rates were developed based on SFY 2024 projected monthly enrollment. This figure reflects capitation rates with full risk for prescription drugs and does not reflect the October 2023 rate adjustment for Humana
2. All Other Populations includes HCBS, Act 421, Foster Care Children, Breast and Cervical Cancer, LaHIPP Affordable Plan, and non-SBH Chisholm Class Members rate cells.

Figure 2 compares the estimated federal and state expenditures under the SFY 2024 rates, based on estimated enrollment in SFY 2024. Revenue shown in Figure 3 includes state directed payment and FMP amounts.

**FIGURE 2: COMPARISON WITH ORIGINAL JULY 2023 RATES (AGGREGATE EXPENDITURES $ MILLIONS)**

| POPULATION | TOTAL MCO EXPECTED PAYMENTS | | |
|---|---|---|---|
| | ORIGINAL SFY 2024 | AMENDED SFY 2024 | % CHANGE |
| SSI | $ 2,531.5 | $ 2,535.0 | $ 3.6 |
| F&C | 3,768.9 | 3,771.0 | 2.2 |
| SBH | 71.0 | 71.7 | 0.7 |
| Medicaid Expansion | 6,119.0 | 6,121.0 | 2.0 |
| All Other Populations | 400.7 | 402.5 | 1.8 |
| Maternity Kick – Expansion | 278.4 | 278.9 | 0.5 |
| Maternity Kick – Non-Expansion | 520.6 | 521.2 | 0.6 |
| **Composite** | $ 13,689.9 | $ 13,701.3 | $ 11.5 |
| **Federal** | $ 10,685.4 | $ 10,693.7 | $ 8.3 |
| **State** | $ 3,004.5 | $ 3,007.7 | $ 3.1 |

Notes:
1. Original and amended SFY 2024 composite rates were developed based on SFY 2024 projected monthly enrollment. This figure reflects capitation rates with full risk for prescription drugs and does not reflect the October 2023 rate adjustment for Humana.
2. State expenditures based on Federal Fiscal Year (FFY) 2023 FMAP of 67.28% for 3 months and FFY 2024 FMAP of 67.67% for 9 months for all except the Expansion population. FMAP values do not include additional FFCRA-related enhanced FMAP during the phase-out period ending December 31, 2023.
3. State expenditures based on FMAP of 90% for the Expansion population.
4. All Other Populations includes HCBS, Act 421, Foster Care Children, Breast and Cervical Cancer, LaHIPP Affordable Plan, and non-SBH Chisholm Class Members rate cells.

As noted earlier, the figures above were developed using the rates including full risk for prescription drugs and does not reflect the October 2023 rate adjustment for Humana. Separately, we estimated the impact of the adjusted October 2023 capitation rate for Humana, relative to the original assumption that Humana would be fully at risk for prescription drugs in October 2023. In developing this adjustment, we reflected actual June 2023 enrollment for Humana and risk-adjustment results that have been shared with the MCOs. Figure 3 below presents the estimated payments due to Humana for October under the adjusted rates in this amendment relative to the full-risk rates they were slated to be paid.

**FIGURE 3: COMPARISON OF OCTOBER 2023 HUMANA CAPITATION RATES (AGGREGATE EXPENDITURES $ MILLIONS)**

| | TOTAL MCO EXPECTED PAYMENTS | | |
|---|---|---|---|
| POPULATION | ORIGINAL (FULL RX RISK) | AMENDED | CHANGE |
| SSI | $ 6.1 | $ 5.1 | ($ 1.1) |
| F&C | 24.1 | 21.6 | (2.5) |
| SBH | 0.3 | 0.3 | (0.0) |
| Medicaid Expansion | 31.2 | 24.8 | (6.4) |
| All Other Populations | 0.6 | 0.5 | (0.1) |
| Maternity Kick – Expansion | 0.8 | 0.8 | 0.0 |
| Maternity Kick – Non-Expansion | 1.7 | 1.7 | 0.0 |
| **Composite** | $ 64.7 | $ 54.7 | (10.0) |
| **Federal** | $ 50.9 | $ 42.7 | (8.2) |
| **State** | $ 13.8 | $ 12.0 | (1.8) |

Notes:

1. Original and amended composite rates were developed based on June 2023 Humana enrollment. Values reflect Humana's risk-adjustment results for July through December 2023.
2. State expenditures based on Federal Fiscal Year (FFY) 2024 of 67.67% for all except the Expansion population. FMAP values do not include additional FFCRA-related enhanced FMAP during the phase-out period ending December 31, 2023.
3. State expenditures based on FMAP of 90% for the Expansion population.
4. All Other Populations includes HCBS, Act 421, Foster Care Children, Breast and Cervical Cancer, LaHIPP Affordable Plan, and non-SBH Chisholm Class Members rate cells.

# 3. Adjusted October 2023 Humana Capitation Rates

This section describes the adjusted capitation rates to be paid to Humana in October 2023.

For the past year, LDH has been working to implement a single PBM to be used by all MCOs in the Healthy Louisiana managed care program. Additionally, Humana entered the program in January 2023, and under its managed care contract, it will not be at risk for retail pharmacy services until the implementation of the single PBM. In the original SFY 2024 certification, separate capitation rates were developed with and without retail pharmacy services. All incumbent MCOs would receive the full rates (with pharmacy services), while Humana would receive the pharmacy carve-out rates until the implementation of the single PBM, at which time it would switch to the full rates.

At the time the original rate certification was completed, the anticipated start date for the single PBM was October 1, 2023. However, the implementation date of the single PBM was delayed until October 28, 2023. As a result, Humana will be at risk for retail pharmacy services for 4 of 31 days during October. To fairly compensate Humana, LDH will pay the new entrant a blended capitation rate for October that reflects 27 days of the pharmacy carve-out rates and 4 days of the full rates.

In this amendment, we calculated blended October 2023 rates for Humana by using a weighted average of the Rx carve-out rates (27 / 31 = 87.1%) and the full-risk rates (4 / 31 = 12.9%). The October 2023 Humana rates are shown in Appendix 5 of this amendment. The July through September 2023 Humana rates are shown in Appendix 4. Starting in November 2023, Humana will be paid the same rates as other MCOs, which are shown in Appendix 3. Note, appendix values have not been adjusted for Humana's risk scores. As a result, the values reported in Appendix 5 will not match the values reported in Figure 3 of this report.

# 4. Updated Physician FMP and New State Directed Payments

This section describes three new state directed payments that are being incorporated into the capitation rates, as well as a change to FMP amounts.

## Physician FMP

Based on additional information received after the original certification was completed, LDH has re-calculated the amount of physician FMP payments included in the SFY 2024 Healthy Louisiana capitation rates. The additional amount is estimated to be approximately $3.2 million, or approximately $0.15 PMPM. However, the change was not uniform across regions and rate cells. The updated FMP amounts by region and rate cell are included in Appendix 2.

## State Directed Payments

The information regarding the new state directed payments has been presented consistently with requirements in the managed care rate setting guide, similar to Section 1, subsection 4.D of the original certification.

### D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

#### i. Rate development standards

This section provides information on new directed payments for certain providers which are pertinent to the SFY 2024 capitation rates. All other directed payments applicable to the SFY 2024 capitation rates were documented in the original certification.

#### (a) Description of Managed Care Plan Requirement

Effective January 1, 2024, MCOs will pay qualifying NEMT providers add-on payments based on the number of vehicles in use each month.

Effective January 1, 2024, MCOs will pay qualifying home health providers recruitment and retention add-on payments.

Effective January 1, 2024, MCOs will pay qualifying licensed mental health professionals (LMHPs) an add-on when providing dialectical behavioral therapy (DBT) services.

All directed payments described in this amendment are consistent with LDH descriptions of the 438.6(c) pre-prints which have been submitted to CMS, if required.

#### (b) Approval by CMS and consistency with preprints

All directed payments described in this rate certification have been submitted to CMS. The descriptions in this rate certification are consistent with the 438.6(c) pre-prints that have been submitted to CMS.

#### (c) Contract arrangements with MCOs

All contract arrangements that direct MCO's expenditures were developed in accordance with 42 CFR §438.4 and 42 CFR §438.5.

#### (d) Inclusion of Provider Payment Initiatives in Capitation Rates

***Non-emergency transportation directed payments***

The payments for the NEMT directed payment are made on a retrospective basis to the managed care health plans.

***Home health directed payments***

The payments for the home health directed payment are made on a retrospective basis to the managed care health plans.

***DBT directed payments***

The payments for the DBT directed payment are made on a retrospective basis to the managed care health plans.

(i) Documentation related to separate payment term included in the rate certification

Documentation related to the separate payment term is addressed in Section I, Item 4.D.ii.a.iii.

(ii) PMPM estimate of directed payments addressed through separate payment term

The estimated rating period PMPM amounts of the directed payments are illustrated by rate cell in Appendix 3.

(iii) Final documentation of total directed payment amount by rate cell

After the rating period is complete, a separate report documenting the actual directed payment amounts by region and rate cell will be provided to CMS.

(iv) Changes from initial base rate certification

The rate certification will be updated through a rate amendment if the total payment amount or distribution methodology varies from the initial estimates presented in Appendix 2.

**ii. Appropriate documentation**

**(a) Description of Delivery System and Provider Payment Initiatives**

(i) Description of delivery system and provider payment initiatives included in the capitation rates

State directed payments incorporated in the capitation rates are listed in Figure 4 below.

**FIGURE 4: SUMMARY OF NEW DIRECTED PAYMENTS INCLUDED IN CERTIFICATION**

| CONTROL NAME OF THE STATE DIRECTED PAYMENT | TYPE OF PAYMENT | BRIEF DESCRIPTION | IS THE PAYMENT INCLUDED AS A RATE ADJUSTMENT OR SEPARATE PAYMENT TERM? |
|---|---|---|---|
| LA_Fee_OTH1_Amend_20230701-20240630 | Add-on based on utilization | Add-on paid to NEMT providers based on the number of vehicles in use each month | Separate payment term |
| LA_Fee_HCBS2_New_20230701-20240630 | Add-on based on utilization | Add-on paid to home health providers based on the number of nurses providing services to enrollees under the age of 21 | Separate payment term |
| LA_Fee_BHO2_New_20240101-20241231 | Add-on based on utilization | Add-on paid to LMHPs for each DBT service provided | Separate payment term |

New separate payment term directed payments included in this amendment:

- **LA_ Fee_OTH1_Amend_20230701-20240630**

  The NEMT providers will be eligible for a bonus payment of $500 per month for each vehicle that was in use for the previous month, with a maximum of $1,500 per provider per month.

- **LA_Fee_HCBS2_New_20230701-20240630**

  The home health providers will be eligible for a bonus payment of up to $200 per month for each nurse providing a minimum of 120 hours a month to enrollees under the age of 21. Additionally, new or existing nurses may be eligible to receive a one-time bonus payment of $5,000 dollars.

- **LA_Fee_BHO2_New_20240101-20241231**

  LMHPs that are certified to provide DBT services will be paid an add-on for each DBT service provided. The add-ons are structured so that the total reimbursement per visit will be $200.00 for individual therapy and $177.68 per member for group therapy.

(ii) Description of payment arrangements incorporated as a rate adjustment

There are no new state directed payments incorporated in the capitation rates as a rate adjustment, other than those described in the original certification.

(iii) Description of payment arrangements incorporated as a separate payment term

New state directed payments incorporated in the capitation rates as a separate payment term are listed in Figure 5 below, with more description following the table.

**FIGURE 5: DIRECTED PAYMENTS INCORPORATED AS SEPARATE PAYMENT TERMS**

| CONTROL NAME OF THE STATE DIRECTED PAYMENT | AGGREGATE AMOUNT INCLUDED IN THE CERTIFICATION | STATEMENT THE ACTUARY IS CERTIFYING THE SEPARATE PAYMENT TERM | MAGNITUDE ON A PMPM BASIS | CONFIRMATION THE RATES ARE CONSISTENT WITH PREPRINT | CONFIRMATION THE ACTUARY WILL SUBMIT REQUIRED DOCUMENTATION AT END OF RATING PERIOD |
|---|---|---|---|---|---|
| LA_Fee_OTH1_Amend_20230701-20240630 | $ 2.8 million | Yes | $0.13 | Yes | Yes |
| LA_Fee_HCBS2_New_20230701-20240630 | $3.3 million | Yes | $0.16 | Yes | Yes |
| LA_Fee_BHO2_New_20240101-20241231 | $1.7 million | Yes | $0.08 | Yes | Yes |

Note: Values shown are net of premium tax. Preprint for LA_Fee_BHO2_New_20240101-20241231 is for calendar year 2024 and covers both Healthy Louisiana and Coordinated System of Care programs. The dollar values shown in this figure reflect only the Healthy Louisiana portion and are pro-rated to reflect only the January through June 2024 time period.

***Actuarial certification of separate payment terms.***

The actuary certifies the amounts of the separate payment terms provided in this document.

***Provider types receiving the payment***

Providers who are part of the NEMT directed payment include NEMT providers as defined in the LDH state plan.

Providers who are part of the home health directed payment include pediatric home health nurses and home health agencies.

Providers who are part of the DBT directed payment include psychiatrists, advanced practice registered nurses (APRN), physician assistants (PA), clinical nurse specialists (CNS), psychologists, medical psychologists, licensed clinical social workers (LCSW), licensed professional counselors (LPC), licensed marriage and family therapists (LMFT), and licensed addiction counselors (LAC), limited to those who are trained and/or certified to provide DBT as an evidence-based therapy option.

***Distribution methodology***

The NEMT providers will be eligible for a bonus payment of $500 per month for each vehicle that was in use for the previous month, with a maximum of $1,500 per provider per month. NEMT providers will invoice MCOs on a quarterly basis, and LDH will pay each MCO an add-on payment equal to the amount invoiced by providers, plus a quarterly administrative fee for the MCOs, which totals approximately 5% of expected payments for the administrative entity.

The home health providers will receive recruitment and retention bonus payments as follows:

- Up to $200 a month for each nurse that provides 120 hours of home health service to enrollees under the age of 21.
- A one-time payment of $5,000 dollars to a new nurse that commits to providing 120 hours of home health services to enrollees under the age of 21.
- A one-time payment of $5,000 dollars to existing nurses that provided 120 hours of home health services to enrollees under the age of 21 in the month previous to the start of the recruitment and retention payments.

The State will monitor the MCOs to ensure no nurse receives more than one lump-sum payment.

Providers trained in DBT and who otherwise meet the provider class definition that bill the specific codes for psychotherapy services will receive reimbursement from the managed care organization upon processing the initial claim that represents the current reimbursement rate for psychotherapy services plus the DBT state directed payment add-on. The managed care organization will then invoice LDH quarterly for the state directed payment add-on portion of the reimbursement. LDH will pay the managed care organizations based on the invoices.

***Estimated PMPM payout by rate cell***

The estimated PMPM payout by population, rate cell, and region is provided in Appendix 2.

***Consistency with 438.6(c) preprint***

The directed payments, as described in this rate certification, are consistent with 438.6(c) preprints submitted to CMS.

***Statement that certification will be amended if rates vary from initial estimate***

To the extent the final directed payments by rate cell vary from the initial estimates presented in Appendix 2, the rate certification will be amended to reflect the final payments made to the providers.

### (b) Additional directed payments not addressed in the certification

There are not any additional directed payments in the managed care program that are not addressed in this certification.

### (c) Other requirements regarding reimbursement rates

There are not any additional requirements regarding the reimbursement rates the plans must pay to any providers unless specified in this certification as a directed payment or authorized under applicable law, regulation, or waiver.

# 5. Additional In Lieu of Services

This section describes the additional in-lieu of services (ILOS) that are being incorporated into the capitation rates. The information has been presented consistently with requirements in the managed care rate setting guide, similar to Section 1, subsection 3.B.v. of the original certification.

## B. APPROPRIATE DOCUMENTATION

### v. In Lieu of Services

#### (a) Description of ILOSs

The following are new ILOSs in the managed care program that were not described in the original certification. These ILOSs were not provided as a benefit during the base data period.

- Therapeutic Day Center for Age 5-20
  - Effective 7/1/2023
- Integrated Behavioral Health Homes
  - Effective 7/1/2023
- Remote Patient Monitoring
  - Effective 7/1/2023
- Outpatient Lactation Consultation
  - Effective 1/1/2024

Additionally, there are four other ILOS that were approved prior to SFY 2024 but had no utilization in the base period used in SFY 2024 capitation rate development.

- Population health management programs
  - Effective 1/5/2022
- Chiropractic services for adults age 21 and older
  - Effective 1/1/2022
- Hospital-based care coordination for pregnant and postpartum individuals with substance use disorder and their newborns
  - Effective 1/1/2022
- Doula services
  - Effective 1/1/2022

#### (b) ILOS Cost Percentages

In the original certification, we estimated the ILOS cost percentage for all ILOSs other than IMD to be 0.15%. This calculation was based on the portion of the base data represented by these services. As noted above, there are several ILOSs that will be offered in SFY 2024 that had no utilization during the base data period. Based on the information provided by LDH and the MCOs, we have estimated the ILOS cost percentages in Figure 6 below for each of the ILOSs not included in the original certification. Figure 6 also includes a cost percentage for all ILOSs other than IMD which was included in the original certification and used to estimate the total ILOS costs as a percentage of the total projected payments. The method for developing the estimates below varied by ILOS, depending on the level of information available to us. We relied on MCOs to indicate whether they were offering each service, and where possible, we relied on MCO projections for the take-up of these services.

**FIGURE 6: ESTIMATED ILOS PERCENTAGE FOR NEW ILOS**

| IN-LIEU-OF SERVICES/SETTINGS | TOTAL |
|---|---|
| All ILOSs other than IMD in original certification | 0.15% |
| Therapeutic day center for age 5-20 | 0.00% |
| Integrated behavioral health homes | 0.20% |
| Remote patient monitoring | 0.02% |
| Outpatient lactation support | 0.00% |
| Population health management programs | 0.03% |
| Chiropractic services for adults age 21 and older | 0.12% |
| Hospital-based care coordination for pregnant and postpartum individuals with substance use disorder and their newborns | 0.01% |
| Doula services | 0.00% |
| **ILOS Costs as a Percentage of Total Projected Payments** | **0.54%** |

Note: Values above shown as 0.00% are non-zero; however, these services are expected to account for less than 0.005% of SFY 2024 total expected payments.

### (c) Incorporation into rate development

The ILOSs in this section had no utilization during the base data period. Because ILOSs are provided as a cost-effective alternative to existing state plan services, they should not result in any incremental costs. Based on information from the MCOs and LDH, we do not anticipate material cost savings as a result of these services being offered. Therefore, no explicit adjustment was made to the capitation rate development to account for these new ILOSs.

# Limitations

The services provided for this project were performed under the contract between Milliman and LDH, effective January 1, 2023.

The information contained in this report has been prepared for the State of Louisiana, Department of Health (LDH) and their consultants and advisors to provide documentation of the development of the amended state fiscal year 2024 actuarially sound capitation rates for the populations served under the Healthy Louisiana Medicaid managed care program. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report will be shared with CMS and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for LDH by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to develop amended actuarially sound capitation rates for the state fiscal year 2024 rating period. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models rely on data and information as input to the models. We have relied upon certain data and information provided by LDH for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman's data and information reliance includes eligibility and FFS claims and encounter data, MCO-reported financial experience, as well as information related to LDH's eligibility system and assignment of enrollees to rate cells. The models, including all input, calculations, and output may not be appropriate for any other purpose.

Although the capitation rates have been certified as actuarially sound, the capitation rates may not be appropriate for any individual MCO. Results will differ if actual experience is different from the assumptions contained in the capitation rate setting documentation. LDH and Milliman provide no guarantee, either written or implied, that the data and information is 100% accurate or error free.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

We acknowledge the unique nature of the COVID-19 Public Health Emergency and the anticipated resumption of redeterminations and terminations of coverage that will occur during the rating period. The assumptions documented in this certification report reflect information known to us at the time of this report. We acknowledge that the resumption of redeterminations and enrollment unwinding period could have a material impact on utilization, acuity, Medicaid enrollment, service delivery, and other factors related to the capitation rates illustrated in this rate certification.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report who are actuaries are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

# APPENDIX 1: ACTUARIAL CERTIFICATION

**State of Louisiana**
**Department of Health**
**Healthy Louisiana Medicaid Managed Care Program**
**Amended State Fiscal Year 2024 Capitation Rates**
**Actuarial Certification**

I, Anders Larson, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of Louisiana, Department of Health to perform an actuarial review and certification regarding the development of capitation rates for the Healthy Louisiana Medicaid managed care program effective July 1, 2023. I am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

The capitation rates provided with this certification are considered "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- *the capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the MCO for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).*

For the purposes of this certification and consistent with the requirements under 42 CFR 438.4(a), "actuarial soundness" is defined as in ASOP 49:

*"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."*

The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with the State of Louisiana. The "actuarially sound" capitation rates that are associated with this certification reflect an amendment to the state fiscal year 2024 capitation rates, originally certified on June 23, 2023.

The "actuarially sound" capitation rates are based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the rates.

In developing the "actuarially sound" capitation rates, I have relied upon data and information provided by the State and MCOs. I have relied upon the State for audit of the data. However, I did review the data for reasonableness and consistency.

I acknowledge that LDH may elect to amend the capitation rates in accordance with 42 CFR 438.7(c)(3), which indicates that a capitation rate certification is not required for adjustments that increase or decrease capitation rates by 1.5% or less. The capitation rates developed may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The health plan may require rates above, equal to, or below the "actuarially sound" capitation rates that are associated with this certification.

I acknowledge the unique nature of the COVID-19 Public Health Emergency and the anticipated resumption of redeterminations and terminations of coverage that will occur during the rating period. The assumptions documented in this certification report reflect information known to us at the time of this report. I acknowledge that the resumption of redeterminations and enrollment unwinding period could have a material impact on utilization, acuity, Medicaid enrollment, service delivery, and other factors related to the capitation rates illustrated in this rate certification.


Anders Larson, FSA
Member, American Academy of Actuaries

December 6, 2023
Date

# APPENDIX 2: RATE DEVELOPMENT (PROVIDED IN EXCEL)

# APPENDIX 3: RATE CHANGE SUMMARIES (PROVIDED IN EXCEL)

# APPENDIX 4: RATES EXCLUDING PRESCRIPTION DRUGS (PROVIDED IN EXCEL)

# APPENDIX 5: HUMANA RATES FOR OCTOBER 2023 (PROVIDED IN EXCEL)

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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