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: 2000441826

Amendment Number: 8

Vendor: LOUISIANA HEALTHCARE CONNECTIONS INC

Description: Managed Care Organizations - Emergency

Approved By: PAMELA RICE

Approval Date: 12/21/2021 14:52:27

AMENDMENT TO
AGREEMENT BETWEEN STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 8
LAGOV#: 2000441826
LDH #:
Original Contract Amount
Original Contract Begin Date 01-01-2020
Original Contract End Date 12-31-2020
RFP Number: N/A

MVA
(Regional/ Program/ Facility)
Medical Vendor Administration
Bureau of Health Services Financing

AND

Louisiana Healthcare Connections, Inc.
Contractor Name

DS JS

AMENDMENT PROVISIONS

DS PG

Change Contract From: Current Maximum Amount: $6,457,832,732.50 Current Contract Term: 01/01/20-12/31/21

CF-1
12) Maximum Contract Amount: $6,457,832,732.50
13) Estimated Amounts by Fiscal Year: FY20: $1,374,044,865.50; FY21: $3,368,612,295.00 ; FY22: $1,715,175,572

Attachment D - Rate Certification ending December 31, 2021.

DS JS DS PG

Change Contract To: If Changed, Maximum Amount: $9,665,714,532.40 If Changed, Contract Term: 01/01/20-12/31/22

CF-1
12) Maximum Contract Amount: $9,665,714,532.40
13) Estimated Amounts by Fiscal Year: FY20: $1,374,044,865.50; FY21: $3,368,612,295.00 ; FY22: $3,290,734,081.32; FY23: $1,632,323,290.58

Attachment D - Rate Certification effective January 1, 2022.

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 will extend the MCO contract through December 31, 2022, and establish new actuarially sound capitation rates for the managed care organizations for calendar year 2022. The previous rate certification ends on December 31, 2021.

This Amendment Becomes Effective: 12-31-2021

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.

CONTRACTOR SIGNATURE: DocuSigned by: Jamie Schlottman 8858A6F7BA7942E... DATE: /29/2021

PRINT NAME: James E. Schlottman

CONTRACTOR TITLE: CEO / Plan President

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE: DocuSigned by: Patrick Gillies 7D2608CB02464F4... DATE: 11/30/2021

NAME: Patrick Gillies

TITLE: Medicaid Executive Director

OFFICE: Louisiana Department of Health

PROGRAM SIGNATURE DATE

NAME

Mercer

Healthy Louisiana Rate Certification

Effective January 1, 2022 through December 31, 2022

Louisiana Department of Health
November 15, 2021

Mr. Daniel Cocran
Chief Financial Officer
Louisiana Department of Health
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821

Subject: Healthy Louisiana Program – Full Risk Bearing Managed Care Organization Rate Development and Preliminary Actuarial Certification for the Period January 1, 2022 through December 31, 2022

November 15, 2021

Dear Mr. Cocran:

The Louisiana Department of Health (LDH) has contracted with Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, to develop actuarially sound[1] capitation rates for the State of Louisiana's (State's) Healthy Louisiana program for the period of January 1, 2022 through December 31, 2022, or rate year 2022 (RY22). This certification addresses the development of the physical health (PH) and specialized behavioral health (SBH) only capitation rates, as well as maternity kick payments.

This letter presents an overview of the methodology used in Mercer's managed care rate development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS). This rate development process primarily relied upon Healthy Louisiana Prepaid encounter data provided by LDH and submitted by the contracted managed care organizations (MCOs). It resulted in the development of a range of actuarially sound rates for each rate cell. The final capitation rates are summarized in Appendix A and represent payment in full for the covered services.

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

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

Contents

1
General Information

Overview

Capitation rates for the Healthy Louisiana program were developed in accordance with rate-setting guidelines established by CMS. For rate development for the Healthy Louisiana program, Mercer used data from calendar year 2019 (CY 2019) which spans the period of January 1, 2019 through December 31, 2019. All data was reported on an incurred basis and includes payment dates through December 2020. Restrictions were applied to the enrollment and claims data to align appropriately with the populations and benefit package defined in the Healthy Louisiana MCO contract.

Mercer reviewed the encounter data provided by LDH and the Healthy Louisiana MCOs for consistency and reasonableness and determined the data was appropriate for the purpose of setting actuarially sound Medicaid managed care capitation rates.

Adjustments were made to the selected base data to align with the covered populations and Healthy Louisiana benefit packages for RY22. Additional adjustments were then applied to the base data to incorporate:

- Provision for incurred but not reported (IBNR) claims
- Adjustments to encounter data for non-claims and financial reporting
- Prospective and retrospective program changes not fully reflected in the base data
- Trend factors to forecast the expenditures and utilization to the contract period
- Changes in benefits covered by managed care
- Opportunities for managed care efficiencies
- Administration and underwriting profit/risk/contingency loading

Healthy Louisiana Populations

Effective February 1, 2016, the Healthy Louisiana program had two major programs:

1. Individuals who meet the eligibility criteria for the Healthy Louisiana PH program. For these members, their PH, SBH, and non-emergency medical transportation (NEMT) services are the responsibility of the MCO. This population includes those eligible starting July 1, 2016 through Louisiana's Medicaid Expansion.

2. Individuals who do not meet the eligibility criteria for the Healthy Louisiana PH program, yet remain eligible to receive SBH services through the Medicaid program. For this program, only their SBH

and NEMT services are the responsibility of the MCO. This rating group is referred to as the Healthy Louisiana SBH program.

PH Program

In general, the Healthy Louisiana PH program includes individuals classified as Supplemental Security Income (SSI), Family & Children (F&C), Foster Care Children (FCC), Breast and Cervical Cancer (BCC), Louisiana Children's Health Insurance Program (LaCHIP), LaCHIP Affordable Plan (LAP), and Medicaid Expansion as mandatory populations. Voluntary opt-in populations include Home- and Community-Based Services (HCBS) waiver participants and Chisholm Class Members (CCM).

Mandatory Populations

Please see Appendix B for detail on which aid category and type case combinations are considered mandatory populations for the PH program.

Voluntary Opt-in Populations

Individuals in a voluntary opt-in population group 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 the earliest possible month the action can be administratively handled. Moreover, a voluntary opt-in individual may re-enroll during the annual, open enrollment period. Such members include the following:

- Individuals receiving services through any 1915(c) HCBS waiver:
  - Adult Day Health Care
  - New Opportunities waiver
  - Children's Choice
  - Residential Options waiver
  - Supports waiver
  - Community Choices waiver
  - Other HCBS waivers as may be approved by CMS
- Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the Office for Citizens with Developmental Disabilities' Request for Services Registry who are CCM

Excluded Populations

Please see Appendix B for detail on which aid category and type case combinations are considered excluded populations for the PH program.

SBH Program

The Healthy Louisiana SBH program includes individuals classified as SBH Dual and SBH Other as mandatory populations. The voluntary opt-in populations who did not opt into Healthy Louisiana for PH services are automatically included in the SBH program. These populations are denoted as SBH HCBS waiver participants and SBH CCM.

Effective April 1, 2017, the Louisiana Health Insurance Premium Payment (LaHIPP) program was reinstated. Members that are enrolled in the LaHIPP program will receive SBH and NEMT services only through Healthy Louisiana.

Mandatory and Excluded Populations

Please see Appendix B for detail on which aid category and type case combinations are considered mandatory and which are considered excluded populations for the SBH program.

Rate Cell Structure

PH Program

Mercer summarized the PH, SBH, and NEMT services data for the Healthy Louisiana PH program by rate cell. Historical claim costs vary by age and eligibility category and separate rate cells were developed accordingly to reflect differences in risk. Sixteen distinct rate cells were established based on Mercer's review of historical cost and utilization patterns in the available experience. In addition, a maternity kick payment will be paid to the MCOs for each qualifying delivery event that takes place.

Table 1A

PH Rate Cell Groupings	
SSI	
Newborn, 0-2 Months, Male & Female	Child, 1-20 Years, Male & Female
Newborn, 3-11 Months, Male & Female	Adult, 21+ Years, Male & Female
F&C	
Newborn, 0-2 Months, Male & Female	Child, 1-20 Years, Male & Female
Newborn, 3-11 Months, Male & Female	Adult, 21+ Years, Male & Female
HCBS Waiver	
20 And Under, Male & Female	21+ Years, Male & Female
FCC: All Ages, Male & Female	
BCC: All Ages, Female	
CCM: All Ages, Male & Female	
LAP: All Ages, Male & Female	
Maternity Kick Payment	
Early Elective Delivery (EED) Kick Payment	

PH Rate Cell Groupings	
Medicaid Expansion: Age 19-64, Male & Female	
Medicaid Expansion – High Needs: Age 19-64, Male & Female	
Medicaid Expansion – Maternity Kick Payment	
Medicaid Expansion – EED Kick Payment	

SBH Program

Mercer summarized the SBH and NEMT only service data for the Healthy Louisiana SBH program by rate cell. Historical SBH costs vary by age and eligibility category; separate rate cells were developed accordingly to reflect differences in risk. While there are eight distinct rates cells, only five distinct capitation rates are developed for the SBH program based on Mercer's review of historical cost and utilization patterns in the available experience. For the populations where a Non-Expansion and Expansion rate cell exist, a single rate is developed for both rate cells.

SBH program eligible individuals may qualify under more than one rate cell definition; therefore, the classification of logic is applied in a hierarchical manner in the order presented in Table 1B.

Table 1B

SBH Rate Cell Groupings	
SBH – Dual Eligible	
Non-Expansion, All Ages, Male & Female	Expansion Adults, Male & Female
SBH – LaHIPP	
Non-Expansion, All Ages, Male & Female	Expansion Adults, Male & Female
SBH – HCBS Waiver	
20 And Under, Male & Female	21+ Years, Male & Female
SBH – CCM	
Non-Expansion, All Ages, Male & Female	Expansion Adults, Male & Female
SBH – Other	
Non-Expansion, All Ages, Male & Female	Expansion Adults, Male & Female

Healthy Louisiana Benefit Package

Covered Services

Appendix C lists the services the Healthy Louisiana MCOs must provide to the members in the Healthy Louisiana PH and SBH programs, respectively. The MCOs also have the ability to develop creative and innovative solutions to care for their members (i.e., provide other cost-effective alternative services), as long as the contractually-required Medicaid services are covered. Costs of alternative

services are expected to be funded through savings on the contractually-required services for which these services are a cost-effective substitute.

New Services

Effective January 1, 2022, LDH will provide community health worker services to eligible members. The adjustment is discussed in the Prospective Rating Adjustment section of this report.

Effective January 1, 2022, LDH will provide mucopolysaccharidosis type I (MPS1) and glycogen storage disorder type II (Pompe) testing, in addition to the conditions already established for testing upon birth. The adjustment is discussed in the Prospective Rating Adjustment section of this report.

Effective at various dates throughout RY22, LDH will expand behavioral health (BH) services to include additional mental health (MH) intervention and support services. The adjustment is discussed in the Prospective Rating Adjustment section of this report.

Medicare Crossover Claims

For dually eligible individuals, Medicare "Crossover" claims (claims that include primary payment from Medicare) for inpatient, outpatient, emergency department (ED), and professional services are excluded from the base data, as these services will be paid directly by the State after coordinating with Medicare.

In order to exclude Crossover claims from the prepaid encounters, Mercer identified records in which the Medicare paid field (CLQ_Medicare_Amt) indicated an amount greater than zero dollars. Mercer removed all records fitting these criteria from our base data.

Excluded Services

Healthy Louisiana MCOs are not responsible for providing PH services and other Medicaid services not identified in Appendix C, including the following services:

- Dental services, with the exception of Early and Periodic Screening & Diagnosis Treatment varnishes provided in a Primary Care setting
- Intermediate care facilities for the developmentally disabled services
- Personal care services 21 and older
- Institutional long-term care (LTC) facility/nursing home services
- School-based individualized services
- Education plan services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures, including school nurses
- HCBS waiver services
- Targeted case management services

- Services provided through LDH's Early-Steps program
- Coordinated System of Care (CSoC) services previously covered under 1915(c) or 1915(b)(3) waiver authority
- Medicare crossover services
- Services covered under a non-CSoC 1915(c) waiver

For more specific information on covered services, please refer to the Healthy Louisiana Behavioral Health Integration Amendment issued by LDH.

Healthy Louisiana Services Eligible for Different Federal Medical Assistance Percentage

There are two groups of services for which LDH receives a different Federal medical assistance percentage (FMAP) than the regular State FMAP:

- Family planning services
- A list of specified preventive services and adult vaccines established under the Affordable Care Act (ACA) Section 4106

Mercer analyzed the component of the rates associated with each group of services so that LDH may claim the enhanced FMAP on these services. Specific details on codes used to identify the family planning and preventive services can be found in a separate memoranda, which contains the percentages of the per member per month (PMPM) eligible for the enhanced match rate.

Region Groupings

For rating purposes, Louisiana has been split into four distinct regions. Table 2 lists the associated parishes for each of the four regions. The region groupings are the same in both the PH and SBH programs.

Table 2

Region Description	Associated Parishes (Counties)
Gulf	Assumption, Jefferson (East Bank), Jefferson (West Bank), Lafourche, New Orleans (Algiers), New Orleans (Downtown), New Orleans (Gentilly), New Orleans (Uptown), Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John, St. Mary, and Terrebonne
Capital	Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, St. Tammany, Tangipahoa, Washington, West Baton Rouge, and West Feliciana

Region Description	Associated Parishes (Counties)
South Central	Acadia, Alexandria, Allen, Avoyelles, Beauregard, Calcasieu, Cameron, Catahoula, Concordia, Evangeline, Grant, Iberia, Jefferson Davis, Lafayette, La Salle, Rapides, St. Landry, St. Martin, Vermilion, Vernon, and Winn
North	Bienville, Bossier, Caddo, Caldwell, Claiborne, DeSoto, East Carroll, Franklin, Jackson, Lincoln, Madison, Monroe, Morehouse, Natchitoches, Ouachita, Red River, Richland, Sabine, Shreveport, Tensas, Union, Webster, and West Carroll

2
Base Data Development

Overview

For rate development for the Healthy Louisiana program, Mercer used CY 2019 data from the following sources:

- Louisiana Medicaid eligibility and enrollment data
- Encounter data reported from the State's Healthy Louisiana Prepaid program

All data was reported on an incurred basis and included payment dates through December 2020. Restrictions were applied to the enrollment and claims data so that it was appropriate for the populations and benefit package defined in the contract. This included consideration for retroactive eligibility periods for which the MCOs were responsible.

IBNR

Capitation rates were developed using claims data for services incurred in CY 2019 and reflect payments processed through December 2020. Mercer developed IBNR factors for CY 2019 encounter data in order to reflect considerations for any unpaid claims liability. This adjustment resulted in an overall aggregate increase of 0.32%.

Non-Claims and Financial Reporting Adjustments

Non-Claims and Financial Reporting adjustments were developed by comparing encounter data from the Medicaid Management Information System (MMIS) to financial information provided by the MCOs. This adjustment was calculated and applied on an MCO-specific basis. Table 3 summarizes the overall aggregate increases applied to CY 2019 expenses. A factor less than 1.0 indicates the encounter experience was higher than comparable financial information.

Table 3

Non-Claims and Financial Reporting Adjustment			
Category of Service (COS)	**Non-Expansion PH Program**	**Non-Expansion SBH Program**	**Expansion**
Prescribed Drugs	0.9819		1.0254
Transportation and SBH	0.9696	1.0220	1.0888
All Other	1.0410		1.0908

Third-Party Liabilities

All claims are reported net of third-party liability, therefore no adjustment is required.

Fraud and Abuse Recoveries

Healthy Louisiana MCOs included fraud and abuse recoveries in their financial reports. These recoveries were included in the development of the non-claims and financial reporting adjustment. Therefore, no further adjustment was needed for CY 2019.

Member Cost Sharing

Member cost sharing for Healthy Louisiana members is limited to co-payments for prescription drugs. Pharmacy claims are reported net of any co-payments so no additional adjustment is necessary. Effective January 1, 2020, LDH implemented a policy to limit cost sharing. The adjustment is discussed in the Base Data Adjustment section of this report.

Disproportionate Share Hospital Payments

Disproportionate share hospital payments are made outside of the MMIS and have not been included in the capitation rates.

Graduate Medical Education Payments

Capitation payments are developed net of graduate medical education (GME) payments and are not included in the base data.

Data Smoothing

In forming the base data, Mercer used CY 2019 base date by region and rate cell. The data was reviewed to ensure sufficient credibility of all rate cells to develop actuarially sound capitation rates.

In some instances, Mercer determined certain rate cells were not sufficiently credible at the regional level. For the rate cells identified below, Mercer calculated a single statewide capitation rate:

- SSI, Newborn, 0-2 Months, Male & Female
- SSI, Newborn, 3-11 Months, Male & Female
- BCC, All Ages, Female
- LAP, All Ages, Male & Female
- HCBS, 20 And Under, Male & Female
- HCBS, 21+ Years, Male & Female
- CCM, All Ages, Male & Female

- SBH – CCM, All Ages, Male & Female
- SBH – HCBS, 20 And Under, Male & Female
- SBH – HCBS, 21+ Years, Male & Female
- SBH – Other, All Ages, Male & Female

3
Base Rating Adjustments

Base rating adjustments recognize the impact of benefit or eligibility changes to services reflected in the base data period. CMS requires the rate-setting methodology used to determine actuarially sound rates incorporate the results of any program changes that have taken place, or are anticipated to take place, between the start of the base data period and the conclusion of the contract period.

Program changes that occurred during the base data period are referred to as Base Rating Adjustments.

Urine Drug Testing

LDH adopted the following changes to the coverage of Urine Drug Testing:

- Effective July 1, 2019 presumptive drug testing was limited to 24 total tests per member per calendar year
- Effective January 1, 2021, definitive drug testing was limited to 12 total tests per member per calendar year; CPT Codes 80320-80377 for individual substance(s) or metabolites will no longer be covered; providers are required to use Healthcare Common Procedure Coding System (HCPCS) codes G0480, G0481, or their successors
- No more than one presumptive and one definitive test will be reimbursed per day per recipient, from the same or different provider

Additional details can be found on LDH's website[2]. Table 4 summarizes the impact of the changes to the coverage of urine drug testing on projected costs on each category of aid (COA).

Table 4

Urine Drug Testing			
COA	Historical Cost	Total Adjustment	% Impact of Base Expenses
SSI	$2,452,909	($967,343)	-0.07%
F&C	$3,388,590	($1,665,914)	-0.10%
FCC	$194,685	($93,038)	-0.17%
BCC	$3,327	($1,638)	-0.02%

[2] https://www.lamedicaid.com/provweb1/default.htm

Urine Drug Testing			
COA	Historical Cost	Total Adjustment	% Impact of Base Expenses
LAP	$2,679	($1,202)	-0.03%
HCBS	$22,516	($8,339)	-0.02%
CCM	$17,526	($7,591)	-0.02%
Maternity Kick Payment	$351,496	($120,677)	-0.07%
Medicaid Expansion	$8,999,630	($4,395,499)	-0.21%
Medicaid Expansion – Maternity Kick Payment	$289,553	$(100,570)	-0.10%

EED

Beginning February 2015, facility and delivering physician costs for EEDs will not be 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. Mercer identified the average facility and delivering physician costs embedded in the maternity kick payment by region and excluded those costs to arrive at the EED kick payment. The EED kick payment is calculated by applying the EED adjustment to the regular maternity kick payment, as it reflects only the prenatal and postpartum portion of the kick payment. For RY22, the EED adjustment is equivalent to 39.8% and 46.1% for the Non-Expansion and Expansion maternity kick payments, respectively.

Local Pharmacy Adjustment

Effective May 1, 2019, LDH changed its reimbursement for pharmacies for fee-for-service (FFS) prescriptions. The ingredient cost portion of the reimbursement shifts from local Average Acquisition Cost (AAC) to National Average Drug Acquisition Cost (NADAC). The dispensing fee portion of the reimbursement also increases from $10.41 per prescription to $10.99 per prescription.

These changes in FFS pharmacy reimbursement affect the Healthy Louisiana program because the MCOs are required to reimburse local pharmacies, at minimum, at the FFS level. Per §460.36 of Louisiana's register, local pharmacies are defined as satisfying the two following conditions:

1. Contracts with the MCO or the MCO's contractor in its own name or through a pharmacy services administration organization and not under the authority of a group purchasing organization

2. Has fewer than 10 retail outlets under its corporate umbrella

Mercer reviewed an analysis by Myers and Stauffer in which they estimated the difference between local AAC and NADAC ingredient costs. Myers and Stauffer performed the pricing analysis on local

pharmacy encounter experience incurred on dates of service from May 11, 2017 through May 10, 2018. The results of this analysis, in conjunction with the historical utilization of local pharmacies in the Healthy Louisiana program, were used to estimate the impact of the local pharmacy pricing changes on projected pharmacy costs. Table 5 summarizes the updated impact of local pharmacy pricing changes on projected pharmacy costs on each rate cell.

Table 5

COA	Local Pharmacy Adjustment (Unit Cost)
SSI	0.15%
F&C	0.16%
FCC	0.19%
BCC	0.04%
LAP	0.14%
HCBS	0.13%
CCM	0.10%
Medicaid Expansion – Age 19-64	0.11%
Medicaid Expansion – High Needs	0.11%

Single Preferred Drug List

Effective May 1, 2019, LDH implemented a Single Preferred Drug List (PDL) for selected therapeutic classes. LDH selected the therapeutic classes and drugs included, with LDH and the MCO pharmacy directors establishing the prior authorization criteria applicable to the drugs included in the Single PDL. MCOs are required to follow the Single PDL and only list as preferred those products preferred by LDH. For branded products listed as preferred over available generics, the MCOs are to consider the generic form non-preferred and not require the prescriber to indicate in writing the branded product is medically necessary.

To estimate the impact of the Single PDL on pharmacy costs, Mercer's actuaries and pharmacists reviewed the historical utilization of drugs in the affected classes and developed assumptions regarding the expected changes in utilization from non-preferred to preferred agents, which were reviewed by LDH pharmacists. The estimated impact of the Single PDL program change on projected pharmacy costs on each rate cell are summarized in Table 6.

Table 6

COA	Single PDL Adjustment (Unit Cost)
SSI	0.53%
F&C	0.87%
FCC	1.94%
BCC	-1.02%

COA	Single PDL Adjustment (Unit Cost)
LAP	0.88%
HCBS	2.30%
CCM	5.00%
Medicaid Expansion	0.42%

Pharmacy Rebates

As part of the implementation of the Single PDL, the MCOs are prohibited from entering into rebate agreements with manufacturers of drugs. Any existing drug rebate agreements were discontinued by May 1, 2019. The MCOs are still allowed to collect rebates on non-drug items such as diabetic testing supplies since implementation of the Single PDL.

In order to determine an appropriate pharmacy rebate adjustment, Mercer analyzed historical utilization patterns, as reported in the encounter data, by rate cell and therapeutic class. The historical experience was projected to the rating period and rebate adjustments were developed by rate cell. The resulting pharmacy rebate adjustments are shown in Table 7.

Table 7

Pharmacy Rebates				
COA	Historical Cost	Total Adjustment	Adjusted Cost	% Impact of Base Rx Expenses
SSI	$457,378,483	$(2,286,892)	$455,091,591	-0.50%
F&C	$331,135,442	$(1,324,542)	$329,810,900	-0.40%
FCC	$9,702,091	$(29,106)	$9,672,985	-0.30%
BCC	$2,546,244	$(10,185)	$2,536,059	-0.40%
LAP	$1,201,319	$(8,409)	$1,192,910	-0.70%
HCBS	$13,471,561	$(67,358)	$13,404,203	-0.50%
CCM	$6,997,969	$(6,998)	$6,990,971	-0.10%
Medicaid Expansion – Age 19-64	$679,173,959	$(3,395,870)	$675,778,089	-0.50%
Medicaid Expansion – High Needs	$769,059	$(3,845)	$765,214	-0.50%

Severe Combined Immunodeficiency Screening

Effective November 1, 2019, severe combined immunodeficiency (SCID) screening became an added benefit to newborns in the Healthy Louisiana Program. This is a blood test that can identify SCID, as well as other serious immune deficiencies in newborns early enough to allow for less expensive and more effective treatment. The impact of the SCID adjustment on the maternity kick payment is summarized in Tables 8A and 8B.

Table 8A

Region	SCID Adjustment % Impact of Base Expenses – Non-Expansion
Gulf	0.12%
Capital	0.13%
South Central	0.13%
North	0.12%
Statewide	**0.13%**

Table 8B

Region	SCID Adjustment % Impact of Base Expenses – Expansion
Gulf	0.11%
Capital	0.11%
South Central	0.11%
North	0.11%
Statewide	**0.11%**

Pharmacy Co-Payment Limit

Per 42 CFR §447.56(f), LDH must have in place measures to limit the amount of cost sharing that members of a Medicaid household may incur each month to 5.0% of the family income. Per the State Plan, LDH only charges cost sharing on prescription drugs. Therefore, only pharmacy service costs need to be adjusted in order to comply with this requirement.

Effective January 1, 2020, LDH implemented a policy to comply with the cost-sharing limitation. In order to estimate the impact of this program change, Mercer utilized information provided by LDH summarizing the total amount of co-payments they expected to shift from the Medicaid recipient's responsibility to the MCO's responsibility. The underlying analysis was performed on CY 2019 encounters at the family (i.e., household) level. Mercer used the relevant household IDs provided by LDH and the co-payments associated with them in our data for the corresponding time period to estimate the impact of this policy change. Table 9 summarizes the impact of the Pharmacy Co-Payment Limit Adjustment on the base expenses.

Table 9

COA	Pharmacy Co-pay Adjustment % Impact of Base Expenses
SSI	0.03%
F&C	0.01%
FCC	0.00%
BCC	0.01%
LAP	0.00%
HCBS	0.01%
CCM	0.00%
Medicaid Expansion – Age 19-64	0.02%
Medicaid Expansion – High Needs	0.04%

Diabetic Testing

Effective January 1, 2021, LDH limited the number of glucose test strips and lancets for diabetics. For non-gestational diabetes without insulin therapy, the limit will be 100 lancets or 100 test strips in a 90-day rolling period. For non-gestational diabetes with insulin therapy and gestational diabetes, the limit will be 200 test strips or 200 lancets in a 30-day rolling period. The impact of this limit is shown in Table 10.

Table 10

Diabetic Testing			
COA	Historical Cost	Total Adjustment	% Impact of Base Expenses
SSI	$3,136,121	$(519,767)	-0.04%
F&C	$1,752,123	$(636,568)	-0.04%
FCC	$35,428	$(18,675)	-0.03%
BCC	$17,136	$(972)	-0.01%
LAP	$15,284	$(13,325)	-0.33%
HCBS	$85,383	$(17,421)	-0.04%
CCM	$12,629	$(5,655)	-0.01%
Medicaid Expansion	$4,362,393	$(487,989)	-0.02%

HCBS Fee Schedule Change

Effective July 1, 2019, LDH released an updated HCBS fee schedule, which can be located on LDH's website. The total impact of the fee schedule changes is summarized in Table 11.

Table 11

HCBS Fee Schedule Change				
Time Period	Historical Cost	Fee Schedule Change Impact	% Change to Historical Cost	% Impact of Base Expenses
CY 2019	$3,852,146	$1,150,761	29.87%	0.02%

In-Lieu of Services

The costs in the base data reflect costs for State Plan services delivered in a managed care environment. In some cases, for the adult population, the MCOs provided an approved service in-lieu of a State Plan service. The utilization and unit costs of the in-lieu of services were taken into account in developing the projected benefit costs of the covered services (as opposed to utilization and unit costs of the State Plan services or settings) with the exception of the Inpatient Psychiatric Institutions for Mental Diseases (IMD) stays for which utilization was repriced at the cost of the same services through providers included under the State Plan. Additional detail regarding the repricing of the Inpatient Psychiatric IMD stays is described in more detail in the section below. Please see Appendix D for a summary of these costs and the percentage of cost the in-lieu of services represent in each COS.

IMDs

On May 6, 2016, CMS published the Medicaid and CHIP Programs Final Rule. Provision §438.6(e) states the following, "…the State may make a monthly capitation payment to an MCO or PIHP for adults receiving inpatient treatment in an IMD, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder (SUD) crisis residential services, and length of stay in the IMD is for a short-term stay of no more than 15 days during the period of the monthly capitation payment." This requirement was effective as of July 6, 2016.

No adjustments were made in rate development to IMD SUD services as they were approved as covered services via Louisiana's 1115 waiver effective February 1, 2018.

For Inpatient Psychiatric IMD stays, Mercer received a list of IMD facilities from LDH that existed during the CY 2019 base data period. Using this list of IMD facilities, Mercer identified all individuals within the base data who had an overnight stay in an IMD and sorted them into short stays (15 cumulative days or less in a given month) versus long stays (16 or more cumulative days in a given month). Table 12 shows user month counts and costs within the base associated with IMD users for CY 2019.

To the extent there were IMDs in the base period that were not included on the IMD facilities list utilized by Mercer for this analysis and/or there were overnight IMD stays paid for an entity other than Medicaid, the methodology described in this section would not have been able to identify them. If new or better data becomes available, it may be necessary to refine the IMD adjustments described below accordingly.

For Inpatient Psychiatric IMD long stays, adjustment factors were developed by region, rate cell, and year to remove all costs and user months incurred during the IMD long stay. This includes the member months (MMs) and costs for the IMD itself as well as non-IMD services incurred during the days in which the individual was in the IMD during the month of the IMD long stay. The adjustment percentages result in a reduction of 0.13% to the aggregate Non-Expansion base data and a reduction of 0.15% to the Expansion base data.

Another component of §438.6(e) requires that States "…must price utilization at the cost of the same services through providers included under the State Plan." Mercer evaluated the average cost per diem of IMD stays and compared this to the average cost per diem of Inpatient Psychiatric stays in non-IMD hospitals. Repricing the short stay Inpatient Psychiatric IMD utilization at the non-IMD per diem resulted in an increase to SBH Inpatient services of 3.7% in CY 2019.

Table 12A

IMD Inpatient Psychiatric Short Stays							
Time Period	User Months	IP Psych Overnight Stay Service		Non-IP Psych Service		All Services	
		Cost	Cost per User Month	Cost	Cost per User Month	Cost	Cost per User Month
CY 2019	23,978	$80,966,609	$3,376.70	$16,926,285	$705.91	$97,892,894	$4,082.61

Table 12B

IMD Inpatient Psychiatric Long Stays							
Time Period	User Months	IP Psych Overnight Stay Service		Non-IP Psych Service		All Services	
		Cost	Cost per User Month	Cost	Cost per User Month	Cost	Cost per User Month
CY 2019	762	$6,701,739	$8,794.93	$1,106,007	$1,451.45	$7,807,746	$10,246.39

Efficiency Adjustments

Mercer distinguishes efficiency adjustments (which are applied to managed care-enrolled populations) from managed care savings adjustments (which are applied to previously unmanaged populations). Efficiency adjustments are intended to reflect improved efficiency in the hospital inpatient, ED, and pharmacy settings, and are consistent with LDH's goal that the Healthy Louisiana program be operated in an efficient, high-quality manner.

Clinical Efficiency Adjustments – Potentially Preventable Admissions

Illness prevention is an important medical care element for all health care providers. LDH expects the MCOs to help their members stay healthy by preventing diseases or preventing complications of existing diseases. Since hospital admission expenses represent a significant portion of all medical expenditures, Mercer performed a retrospective data analysis of the MCOs' CY 2019 encounter data using indicators developed by the Agency for Healthcare Research and Quality (AHRQ). These conditions are collectively referred to as Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI). Mercer utilized 10 adult and four pediatric PQIs as part of the analysis. Evidence suggests hospital admissions for these conditions could have been avoided through high-quality outpatient care and/or the conditions could have been less severe if treated early and appropriately. AHRQ's technical specifications provide specific criteria that define each PQI and PDI that Mercer utilized in the analysis of the MCOs' inpatient hospital encounter data. Although AHRQ acknowledges there are factors outside the direct control of the health care system that can result in a hospitalization (e.g., environmental, patient compliance), it does recognize these analyses can be utilized to benchmark health care system efficiency between facilities and across geographies.

While the AHRQ technical specifications include exclusionary criteria specific to each PQI and PDI, Mercer also applied clinically-based global exclusion criteria, which removes a member's inpatient admissions from all inpatient efficiency analyses. The global exclusion criteria were utilized to identify certain conditions and situations (e.g., indications of trauma, burns, HIV/AIDS) that may require more complex treatment for members. Based on a review of inpatient encounter data, any member identified as having indications of any of the qualifying criteria resulted in all of that member's admissions being removed from the analyses.

Additionally, even though the AHRQ technical specifications do not explicitly mention enrollment duration, Mercer considered enrollment duration as one of the contributing factors to review what would be associated with the applicability of a PQI/PDI-based adjustment. Enrollment duration was used as a proxy for issues such as patient compliance, health plan outreach and education, time to intervene, and other related concepts. A variable-month enrollment duration ranging from two to 12 months, depending on PQI or PDI condition, was applied to the RY22 rates. This assumption meant an individual had to be enrolled with the same plan for a minimum number of consecutive months prior to that individual's PQI or PDI hospital admission to be considered subject to the adjustment. Only the dollars associated with the PQI and PDI hospital admissions that met these enrollment duration criteria were included in the base data adjustment. Recipient eligibility data supplied by the State provided the information to make this duration test assessment.

Clinical Efficiency Adjustments – Low Acuity, Non-Emergent

Mercer performed a retrospective analysis of the MCOs' CY 2019 ED encounter data to identify ED visits that were considered preventable/pre-emptible. For the RY22 rate development, Mercer analyzed preventable/pre-emptible low acuity, non-emergent (LANE) visits. This analysis was not intended to imply members should be denied access to EDs or that the MCOs should deny payment for the ED visits. Instead, the analysis was designed to reflect the State's objective that more effective, efficient, and innovative managed care could have prevented or pre-empted the need for some members to initially seek care in the ED setting.

The criteria used to define LANE ED visits was based on publicly-available studies, input from Mercer's clinical staff, as well as review by practicing ED and primary care physicians. ICD-10 group diagnosis code information was the basis for identifying an ED visit. A limited set of group codes were agreed upon by all physicians involved in developing the methodology for the analysis. Preventable percentages ranging from 0.0% to 95.0% were assigned to each diagnosis code to account for external factors that can influence and impact variation in ED use. Using procedure code information, the ED visits were evaluated from low complexity clinical decision making to high complexity clinical decision making. In addition, LANE ED visits that resulted in an inpatient admission or observation stay (observation revenue code 0762) were excluded. No adjustment was made for any possible up-coding by providers.

For RY22, Mercer excluded low unit cost visits from the LANE analysis to account for improvements in the MCOs' use of triage fees and/or more appropriate health services management. A hierarchical process was used for the remaining LANE visits to identify those that could have been prevented or pre-empted. Beginning with the lowest acuity visits, data was accumulated until the percentage of preventable/pre-emptible visits was achieved for each respective diagnosis code. Regardless of the targeted percentage, no LANE ED visits/dollars associated with the most complex clinical decision making procedure codes (99284-99285) were included in the final adjustment. In addition, a replacement cost amount (average cost physician visit and, if applicable, average laboratory and radiology costs) was made for the majority of LANE visits that were deemed preventable/pre-emptible.

Pharmacy Efficiency Adjustments – Appropriate Diagnosis for Selected Drug Classes (DxRx)

The DxRx efficiency adjustment is used to ensure appropriate utilization of selected drug classes in MCO CY 2019 pharmacy encounter data, based on supporting diagnosis information in the recipient's medical history. The selected drug classes were identified based on high cost, safety concerns, and/or high potential for abuse or misuse. Diagnosis information from 30 months (24 months prior to date of service [DOS] and six months after DOS) of medical, professional, pharmacy, and inpatient data was reviewed for each recipient. Appropriate drug/diagnosis pairs are reviewed annually by Mercer's team of clinicians and include consideration for:

- Food and Drug Administration approved indications (both drug specific and by drug class)
- Clinically-accepted, off-label utilization as identified by published literature and clinical/professional expertise
- Industry standard practices

In consideration of provider enrollment issues that may impact the ability of the DxRx algorithm to identify opiate dependence diagnoses, the Opiate Dependence category was not used in developing the DxRx efficiency adjustment.

Pharmacy Efficiency Adjustments – Retrospective Pharmacy Claims Analysis

The clinical edits efficiency adjustment used a retrospective analysis of CY 2019 pharmacy encounter data to identify inappropriate prescribing and/or dispensing patterns using a customized series of

pharmacy utilization management edits based on clinical best practice. Edits were developed by Mercer's pharmacists based on:

- Published literature
- Industry standard practices
- Clinical appropriateness review
- Professional expertise
- Information gathered during the review of several Medicaid FFS and managed care pharmacy programs across the country

Mercer and LDH staff discussed the approach of this analysis for each custom pharmacy edit. Although the criteria associated with each edit is clinically sound, it is expected that situations exist in which clinical or operational rationale support the payment of a claim that did not meet the initial criteria resulting in an adjustment factor that varied by edit. Such rationale includes, but is not limited to, clinical practice guidelines, eligibility data issues, off label prescribing practices, medication titration issues, individual patient response to therapy, and professional judgment.

Finally, the adjustment value for this analysis took into consideration the probability that a certain percentage of the pharmacy claims that met the edit criteria could have been modified and appropriately prescribed in another manner (e.g., prescribed as a different medication or as a different dosage strength). Mercer considered these cost offsets, which were directly applied to decrease the final adjustment value.

Pharmacy Efficiency Adjustments – HCPCS Benchmark Adjustment

The HCPCS efficiency is an analysis to identify potentially avoidable costs due to reimbursement inefficiencies for physician-administered medications and the corresponding drug-related HCPCS codes. Mercer reviewed the MCO CY 2019 professional encounter data for all HCPCS codes. Mercer excluded the following claims: those with zero paid amounts or negative paid amounts, those with zero units, those for which a third party contributed any portion of the claim payment, and 340B claims. Blood factor products, vaccines, and other non-drug items were also excluded from the analysis.

To identify the potentially avoidable costs, Mercer compared the MCO per unit reimbursement rate to an industry benchmark. For the industry benchmark, Mercer used the Medicare Part B per unit reimbursement rate (CMS average sales price + 6.0%) for the same time period. Prior to calculating the avoidable dollars, Mercer adjusted for outlier claims for which MCO unit prices were not consistent with the benchmark unit price or other MCO unit prices for a given HCPCS code.

To calculate avoidable costs for each HCPCS code, Mercer multiplied the units dispensed by the benchmark unit price and compared the benchmark total paid amount to the MCO total paid amount. The benchmark paid amount was then subtracted from the actual paid amount to come up with the avoidable cost for each HCPCS code. For claims in which the MCO unit price was less than the

benchmark, the difference was counted against the benchmark savings (i.e., negative avoidable cost value).

Aggregate Efficiency Adjustments

The overall impact of the Inpatient, ED, and Pharmacy efficiency adjustments was a decrease of $5.37 PMPM to the PH program.

Table 13

COA	Efficiency Adjustments % Impact of Base Expenses
SSI	-2.37%
F&C	-1.20%
FCC	-0.55%
BCC	-1.07%
LAP	-0.61%
HCBS	-1.52%
CCM	-0.73%
SBH – CCM	0.00%
SBH – Duals	0.00%
SBH – LaHIPP	0.00%
SBH – HCBS	0.00%
SBH – Other	0.00%
Maternity Kick Payment	-0.03%
Medicaid Expansion	-1.69%
Medicaid Expansion – Maternity Kick Payment	-0.05%

4
Prospective Rating Adjustments

Prospective rating adjustments recognize the impact of new benefits or other changes not reflected or not fully reflected in the base period. CMS requires the rate-setting methodology used to determine actuarially sound rates incorporate the results of any program changes that have taken place, or are anticipated to take place, between the start of the base data period and the conclusion of the contract period.

Fee Schedule Changes

The capitation rates reflect changes in covered services' fee schedules and unit costs, between the base period and the contract period.

Beginning in April 2014, LDH implemented a series of program changes to ensure consistent pricing in the Medicaid program for hospital services, including inpatient hospital, outpatient hospital, hospital-based physician and ambulance services. This change required the use of full Medicaid pricing (FMP) in the calculation of PMPM payments to MCOs. LDH expects this rate increase will lead to increased payments to those providers contracting with the MCOs to maintain and increase access to inpatient hospital, outpatient hospital, hospital-based physician, and ambulance services to the enrolled Medicaid populations. Mercer and LDH reviewed the aggregate funding levels for these services between the base period and the contract period and determined that an addition to the historical data was necessary in order to ensure the capitation rate ranges reflect adequate statewide pricing levels. Separate adjustments were made to each of the four services to capture the full impact of statewide funding. FMP adjustments were implemented for inpatient and outpatient services effective April 2014. Physician and ambulance FMP adjustments were implemented effective July 2015.

For the non-FMP fee schedule changes discussed in this section, the fee schedule changes are expected to impact MCO costs as MCOs usually contract with providers at rates that are proportional to the Medicaid fee schedule for these services. Please note that for Tables 14A – 14H, the Adjusted Cost represents the sum of the applicable historical cost and the fee schedule adjustment for each respective category. For Table 14I, the Adjusted Base represents the sum of the total HLA base experience and the aggregated fee schedule adjustments from Tables 14A – 14H.

Inpatient Services

Inpatient claims were adjusted to reflect changes in the fee schedule between the base period and the contract period, using the fee schedule effective July 1, 2021. The non-GME portion of the per diems were used in this fee adjustment process to be consistent with LDH's intention to continue paying GME amounts directly to the teaching hospitals.

Mercer relied upon an analysis of Medicare cost-based equivalent pricing of Medicaid services provided by LDH for the FMP adjustment. CY 2019 encounter data and hospital-specific cost-to-charge ratios (CCRs) using the most recent cost reports from Medicare's Healthcare Cost Report Information System database were used to calculate the Medicare-equivalent payments. The Medicare payments were then adjusted to the rating period. The Medicaid payments were also adjusted to reflect applicable fee schedule changes and payments made outside of the claims system (outlier payments). Ultimately, the adjusted Medicaid and estimated Medicare payments were compared for each hospital. Mercer applied the ratio between the two payments to the base data at the hospital-specific level.

The upper payment limit is calculated by multiplying Medicaid charges and hospital-specific CCRs to estimate cost.

The total impact of the inpatient fee schedule changes is summarized in Table 14A.

Table 14A

Inpatient Fee Schedule Change					
Time Period	Historical Cost	Fee Schedule Change Impact	% Impact of Historical Cost	FMP Impact	% Impact of Adjusted Cost
CY 2019	$1,127,743,020	$106,474,712	9.44%	$337,620,862	27.36%

Outpatient Services

Outpatient claims as of this certification date reflect the most recent CCRs available. The CCRs were reported according to each hospital's fiscal year, which varied by hospital from December 31, 2018 to September 30, 2020. The adjustment also included estimation of cost settlements and reflected the most up-to-date cost settlement percentages for each facility.

Effective January 1, 2021, House Concurrent Resolution 2 adjusted reimbursement rates for surgery/operation services for all hospitals except rural hospitals and Our Lady of the Lake. The rates for the affected facilities increased by 3.2%. Cost settlement percentages remain unchanged from those effective January 1, 2020. Rural facilities are cost settled at 110.0%.

The outpatient FMP was developed according to the State Plan using the CCRs from LDH and the billed charges from the CY 2019 base data. The calculation was completed at the hospital level.

The total impact of the outpatient fee schedule changes is summarized in Table 14B.

Table 14B

Outpatient Fee Schedule Change					
Time Period	Historical Cost	Fee Schedule Change Impact	% Impact of Historical Cost	FMP Impact	% Impact of Adjusted Cost
CY 2019	$1,043,528,757	$107,748,015	10.33%	$227,455,144	19.76%

Physician-Administered Drug Fee Schedule Change

Effective January 1, 2020, LDH made changes to the physician-administered drug (PAD) reimbursement rates. The new rates will be posted on LDH's fee schedule website[3]. Mercer identified the affected services and estimated the impact of the fee schedule changes to develop adjustments to the capitation rates. The total impact of the PAD fee schedule changes is summarized in Table 14C.

Table 14C

PAD Fee Schedule Change					
Time Period	Historical Cost	Fee Schedule Change Impact	% Impact of Historical Cost	FMP Impact	% Impact of Adjusted Cost
CY 2019	$8,172,009	$861,642	10.54%	N/A	N/A

Federally Qualified Health Center and Rural Health Clinic Fee Schedule Change

Federally qualified health center (FQHC) and rural health clinic (RHC) claims were adjusted to reflect changes in the fee schedule between the base period and the contract period, using the fee schedule effective July 1, 2021, which can be located on LDH's website. The total impact of the fee schedule changes is summarized in Table 14D.

Table 14D

FQHC and RHC Fee Schedule Change					
Time Period	Historical Cost	Fee Schedule Change Impact	% Impact of Historical Cost	FMP Impact	% Impact of Adjusted Cost
CY 2019	$204,121,896	$12,877,339	6.31%	N/A	N/A

Hospice Fee Schedule Change

Effective October 1, 2020, LDH released a new fee schedule for the Hospice Program, which can be located on LDH's website[4]. The total impact of the fee schedule changes is summarized in Table 14E.

Table 14E

Hospice Fee Schedule Change					
Time Period	Historical Cost	Fee Schedule Change Impact	% Impact of Historical Cost	FMP Impact	% Impact of Adjusted Cost
CY 2019	$7,907,760	$281,830	3.56%	N/A	N/A

[3] https://www.lamedicaid.com/provweb1/fee_schedules/ProServLabXRayRadASC_Fee.htm

[4] https://www.lamedicaid.com/provweb1/fee_schedules/Hospice_Fee.htm

Louisiana State University Physician Fee Schedule Change

Effective January 1, 2022, LDH released a new fee schedule for Louisiana State University (LSU) Enhanced Professional Services, which can be located on LDH's website[5]. The total impact of the fee schedule changes is summarized in Table 14F.

Table 14F

LSU Physician Fee Schedule Change					
Time Period	Historical Cost	Fee Schedule Change Impact	% Impact of Historical Cost	FMP Impact	% Impact of Adjusted Cost
CY 2019	$84,887,618	$53,015,793	62.45%	N/A	N/A

Hospital-Based Physician Services

Mercer calculated the FMP payments for hospital-based physician services provided at participating facilities by participating physicians according to the State Plan methodology. This methodology is designed to bring the payments for the physician services up to the community rate level. The community rate is defined as the rate paid by commercial payers for the same service. For state-owned or operated entities and for non-state owned or operated entities, Mercer calculated the FMP payments according to the State Plan using the units of service from the base data, the most currently available Medicare fees and the Medicare-to-commercial conversion factors provided by LDH. The conversion factors are maintained by LDH and updated annually for state-owned or operated entities and triennially for non-state owned or operated entities.

Table 14G

Hospital-Based Physician FMP					
Time Period	Historical Cost	Fee Schedule Change Impact	% Impact of Historical Cost	FMP Impact	% Impact of Adjusted Cost
CY 2019	$224,308,147	$0	0.00%	$455,834,906	203.22%

Ambulance Services

Mercer calculated the ambulance FMP payments according to the State Plan using Medicare fee schedules and average commercial rates as a percentage of Medicare. Ambulance providers were classified as either Large Urban Governmental (LUG) or non-LUGs. LUGs have historically received 100.0% of the gap between average commercial rate and the Medicaid fee schedule while non-LUGs have historically received 17.35% of the gap after taking 80.0% of the average commercial rate. Mercer developed increases using these assumed funding levels. Average commercial rates as a percentage of Medicare were provided by LDH for RY22. According to the State Plan, average

[5] https://www.lamedicaid.com/provweb1/fee_schedules/LSU_Enhanced_Pro_Serv_Fee.htm

commercial rates are updated every three years. Table 14H shows the impact of FMP on the adjusted base cost of ambulance services meeting the State Plan's criteria for FMP.

Table 14H

Ambulance FMP					
Time Period	Historical Cost	Fee Schedule Change Impact	% Impact of Historical Cost	FMP Impact	% Impact of Adjusted Cost
CY 2019	$66,245,954	$0	0.00%	$40,282,898	60.81%

Aggregate Fee Schedule Adjustments

The prospective aggregate fee adjustment as a percent impact of base expenses is 5.03% as shown in Table 14I.

Table 14I

Aggregate Fee Schedule Changes					
Time Period	Base Expense	Fee Schedule Change Impact	% Impact of Base Expense	FMP Impact	% Impact of Adjusted Base
CY 2019	$5,590,133,302	$281,259,330	5.03%	$1,061,193,811	18.07%

Other Fee Schedule Updates

In recent legislation, LDH has updated other fee schedules, as listed below.

NEMT Fee Schedule Change

Effective July 1, 2020, LDH updated its fee schedule for NEMT services and effective January 1, 2022, LDH will make further changes to the fee schedule for NEMT services, which can be found on its website[6]. Mercer identified the affected services and estimated the impact of the fee schedule changes to develop adjustments to the capitation rates. The impact of this fee adjustment is in Table 15.

Table 15

NEMT Fee Schedule Change				
Time Period	Historical Cost	Fee Schedule Change Impact	% Impact of Historical Cost	% Impact of Base Expenses
CY 2019	$35,375,855	$7,455,195	21.07%	0.13%

[6] https://www.lamedicaid.com/provweb1/fee_schedules/NEMT_Fee.htm

Air Ambulance Fee Schedule Change

Effective January 1, 2022, LDH will implement changes to its fee schedule for Air Ambulance services, which can be found on its website[7]. Mercer identified the affected services and estimated the impact of the fee schedule changes to develop adjustments to the capitation rates. The impact of this fee schedule adjustment is in Table 16.

Table 16

Air Ambulance Fee Schedule Change				
Time Period	Historical Cost	Fee Schedule Change Impact	% Impact of Historical Cost	% Impact of Base Expenses
CY 2019	$6,104,963	$1,482,751	24.29%	0.03%

General Anesthesia and Facility Reimbursement Increase for Dental Treatment

Effective July 1, 2021, LDH increased the reimbursement for general anesthesia procedure and the facility reimbursement rate for dental treatment provided in a hospital outpatient setting. For general anesthesia procedures, the additional reimbursement is $20.00 per time unit (each time unit is equal to 15 minutes). For facility reimbursement, the additional reimbursement is at least $400.00 per procedure. Mercer identified the affected services and estimated the impact of the fee schedule changes to develop adjustments to the capitation rates. The impact of this adjustment is in Table 17.

Table 17

General Anesthesia and Facility Reimbursement Increase for Dental Treatment				
Time Period	Historical Cost	Fee Schedule Change Impact	% Impact of Historical Cost	% Impact of Base Expenses
CY 2019	$5,308,186	$5,021,139	94.59%	0.09%

Outliers

As part of the State Plan, inpatient hospitals receive an additional payment for high-cost stays for children under six, called outliers. These payments are for inpatient stays with a total cost to the hospital in excess of $150,000, where the cost is determined based on the hospital's Neonatal Intensive Care Unit or Pediatric Intensive Care Unit-specific CCR. LDH makes payments up to a maximum of $20,896,450 annually. As payment of outlier liability is the responsibility of the Healthy Louisiana MCOs, these additional funds were built into the rates based on the distribution by rate cell observed in CY 2019 payments. For the PH Non-Expansion rate cells, outliers added an average cost of $1.90 PMPM to the base data used in rate setting. Table 18 details the impact of outliers on the rates by rate cell.

[7] https://www.lamedicaid.com/provweb1/fee_schedules/APDTIP_Fee.htm

Table 18

Outliers				
COA	**Rate Cell**	**RY22 Projected MMs**	**Total Adjustment**	**PMPM**
SSI	0-2 Months	562	$2,417,790	$4,300.20
SSI	3-11 Months	5,010	$721,606	$144.03
F&C	0-2 Months	108,955	$17,720,127	$162.64
F&C	3-11 Months	402,987	$36,927	$0.09
Total Non-Expansion PH		**10,975,227**	**$20,896,450**	**$1.90**

Inpatient Subspecialty and Neonatology Rate Restoration

Effective January 1, 2021, LDH implemented an inpatient subspecialist coding adjustment. This will allow inpatient subspecialists to code an initial visit instead of only coding a subsequent visit the first time they see a patient. Effective February 1, 2021, LDH will implement a 5.0% rate restoration for neonatology services. Mercer identified the affected services and estimated the impact of the changes to develop adjustments to the capitation rates. The impact of this adjustment is in Table 19.

Table 19

Inpatient Subspecialty and Neonatology Rate Restoration			
COA	**Historical Cost**	**Total Adjustment**	**% Impact of Base Expenses**
SSI	$226,100,214	$1,144,174	0.08%
F&C	$269,195,534	$1,872,366	0.12%
FCC	$2,928,815	$14,323	0.03%
BCC	$587,996	$2,876	0.03%
LAP	$49,954	$244	0.01%
HCBS	$6,541,758	$31,992	0.08%
CCM	$2,055,339	$10,052	0.02%
Medicaid Expansion	$284,775,188	$2,081,422	0.10%

Vitamin D Testing

Effective January 1, 2021, Vitamin D testing was limited to four tests per year when coded against the specified list of diagnosis codes (82306 and 82652). Mercer identified the affected services and estimated the impact of the changes to develop adjustments to the capitation rates. The impact of this limit is shown in Table 20.

Table 20

Vitamin D Testing			
Time Period	**Historical Cost**	**Total Adjustment**	**% Impact of Base Expenses**
CY 2019	$3,316,831	$(1,337,054)	-0.03%

Tobacco Cessation for Pregnant Women

Effective February 20, 2020, LDH began covering tobacco cessation counseling and pharmacotherapy for pregnant women.

Pregnant women may receive four counseling sessions, face-to-face with the appropriate health care professional, per quit attempt and up to two quit attempts per calendar year. The period of coverage for these services shall include the prenatal period through 60 days postpartum. Mercer identified the affected services and estimated the impact of the changes to develop adjustments to the maternity kick payments. The impact of this limit is shown in Table 21.

Table 21

Tobacco Cessation for Pregnant Women			
COA	**Historical Cost**	**Total Adjustment**	**% Impact of Base Expenses**
Non-Expansion – Maternity Kick Payment	$212,734,674	$189,090	0.09%
Expansion – Maternity Kick Payment	$137,642,470	$99,399	0.07%

Peer Support Services

Effective February 1, 2021, LDH included peer support services in their State Plan to assist members with their recovery from mental illness and/or substance use. These are rehabilitative services to reduce the disabling effects of an illness or disability and restore the beneficiary to the best possible functional level in the community. Peer support services are face-to-face interventions that are person-centered and recovery focused. Table 22 shows the impact of this adjustment.

Table 22

Peer Support Services				
COA	**Rate Cell**	**RY22 Projected MMs**	**Total Adjustment**	**PMPM**
SSI	Adult 21+ Years	1,004,059	$1,891,379	$1.88
F&C	Adult 21+ Years	1,127,446	$685,607	$0.61

Peer Support Services				
COA	Rate Cell	RY22 Projected MMs	Total Adjustment	PMPM
FCC	All Ages Male & Female	174,732	$8,964	$0.05
BCC	BCC, All Ages, Female	3,948	$1,057	$0.27
HCBS	Male & Female, Age 21+	26,789	$23,846	$0.89
SBH – Duals	SBH – Dual Eligible, All Ages	1,438,236	$352,330	$0.24
SBH – HCBS	Adult 21+ Years	34,247	$30,076	$0.88
SBH – Other	SBH - All Ages	31,985	$56,477	$1.77
Medicaid Expansion	Age 19-64	7,118,523	$3,874,233	$0.54
Medicaid Expansion	High Needs	1,956	$5,271	$2.69

BH Services Expansion

Effective at various dates throughout RY22, LDH will be expanding BH Services to include additional MH intervention and support services. These expanded services include:

- Mobile Crisis (effective March 1, 2022)
- Community Brief Crisis Support (effective March 1, 2022)
- Crisis Stabilization Units (effective July 1, 2022)
- Behavioral Health Urgent Care (effective April 1, 2022)
- Individual Placement Support (effective February 1, 2022)
- Personal Care Services (effective February 1, 2022)

The impact of these adjustments by rate cell is shown in Table 23.

Table 23

BH Services Expansion				
COA	Rate Cell	RY22 Projected MMs	Total Adjustment	PMPM
SSI	Adult, 21+ Years	1,004,059	$7,201,219	$7.17
F&C	Adult, 21+ Years	1,127,446	$3,296,767	$2.92

BH Services Expansion				
COA	Rate Cell	RY22 Projected MMs	Total Adjustment	PMPM
FCC	All Ages Male & Female	174,732	$28,079	$0.16
BCC	BCC, All Ages, Female	3,948	$4,492	$1.14
HCBS	Male & Female, Age 21+	26,789	$110,892	$4.14
SBH - Duals	SBH - Dual Eligible, All Ages	1,438,236	$2,141,040	$1.49
SBH - HCBS	Adult 21+ Years	34,247	$128,257	$3.75
SBH - Other	SBH - All Ages	31,985	$161,300	$5.04
Medicaid Expansion	Age 19-64	7,118,523	$15,216,169	$2.14
Medicaid Expansion	High Needs	1,956	$17,841	$9.12

Enrollment Acuity Adjustment

Effective May 2019, LDH implemented the Wage Verification process, which was scheduled to take place on a quarterly basis. Through this process, members were disenrolled if they no longer met Medicaid income eligibility criteria. While a few individuals were from other eligibility categories, a majority were individuals previously meeting the Medicaid Expansion eligibility requirements. In prior rate cycles, an upward adjustment was made to recognize the disenrollment of these individuals, as it was determined their average acuity was lower than the overall average acuity of the remaining members in the Medicaid Expansion rate cell.

As a result of the public health emergency (PHE) and maintenance of effort (MOE) restrictions due to the COVID-19 pandemic, LDH has ceased the wage verification checks since March 2020, as well as other redetermination processes, that would have resulted in individuals being disenrolled from the Healthy Louisiana program. At the time of this report, the PHE will continue through the end of CY 2021. Due to the uncertainty of when the PHE will expire and recent Federal guidance on the unwinding of the MOE requirements, for RY22, Mercer has assumed for purposes of setting capitation rates for RY22 the PHE will extend through the end of CY 2022 and there will be no disenrollment efforts during RY22. If the PHE expires during RY22 and Mercer and LDH determine disenrollment efforts will impact RY22, Mercer and LDH will evaluate the impact on the capitation rates.

To account for the presence of the wage verification in the base period (CY 2019) and extended PHE through RY22, Mercer decomposed projected enrollment into three distinct groups that are assumed to have differing acuity profiles:

- Members who would have been disenrolled through the wage verification process but who remain enrolled as a result of the MOE requirements
- Members who have recently enrolled in the program
- Existing members who enrolled prior to the pandemic and are expected to remain enrolled, regardless of the MOE requirements

Mercer estimated the relative acuity for the members in each of the three groups by comparing their historical costs or their risk scores to the population average. Mercer then calculated the expected acuity for the base period and rating period based off of their respective distributions of the three population groups. The resulting adjustment is the ratio of acuity between the base period and the rating period. Mercer determined the MOE would only materially impact the Medicaid Expansion Age 19-64 and F&C Child 1-20 Years rate cells. Table 24 shows the impact of this adjustment.

Table 24

Enrollment Acuity Adjustment			
Region	**COA**	**Rate Cell**	**% Impact of Base Expenses**
Gulf	Medicaid Expansion	Age 19-64	-2.47%
Capital	Medicaid Expansion	Age 19-64	-2.47%
South Central	Medicaid Expansion	Age 19-64	-2.47%
North	Medicaid Expansion	Age 19-64	-2.47%
Gulf	F&C	Child 1-20 Years	-2.43%
Capital	F&C	Child 1-20 Years	-2.43%
South Central	F&C	Child 1-20 Years	-2.43%
North	F&C	Child 1-20 Years	-2.43%

MPS1/Pompe Newborn Screening

Effective January 1, 2022, physicians attending a newborn child, or the person attending a newborn child who was not attended by a physician shall test the child for MPS1 and Pompe, in addition to the conditions already established for testing upon birth. The MPS1/Pompe Newborn screening adjustment is calculated by applying the testing per birth to the SSI and F&C 0-2 Months rate cells, as it reflects only the cost to a newborn child. For RY22, the MPS1/Pompe adjustment is equivalent to $6.93 for the aforementioned rate cells. Table 25 shows the impact of this adjustment.

Table 25

MPS1/Pompe Newborn Screening				
COA	Rate Cell	RY22 Projected MMs	Total Adjustment	PMPM
SSI	0-2 Months	562	$3,896	$6.93
F&C	0-2 Months	108,955	$755,066	$6.93

Maternity Postpartum Coverage Extension

Effective April 1, 2022, LDH will extend Medicaid coverage for maternity postpartum benefits up to twelve months after the end of a pregnancy for eligible members. The prior postpartum coverage mandate applied to the 60-day postpartum period after the end of a pregnancy. The eligible members will be exempt from wage verification checks and remain enrolled in Medicaid during this extended postpartum period. The impact of this adjustment by rate cell is shown in Table 26.

Table 26

Maternity Postpartum Coverage Extension				
COA	Rate Cell	RY22 Projected MMs	Total Adjustment	PMPM
F&C	Adult 21+ Years	1,127,446	$3,583,958	$3.18
Medicaid Expansion	Age 19-64	7,118,523	$339,370	$0.05

Community Health Workers

Effective January 1, 2022, LDH will provide community health worker services as a covered benefit to eligible members. A community health worker is defined as a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This enables the community health worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. Table 27 shows the impact of this adjustment.

Table 27

Community Health Workers				
COA	Rate Cell	RY22 Projected MMs	Total Adjustment	PMPM
SSI	Child 1-20 Years	397,318	$10,930	$0.03
SSI	Adult 21+ Years	1,004,059	$121,175	$0.12
F&C	Child 1-20 Years	7,641,740	$138,184	$0.02
F&C	Adult 21+ Years	1,127,446	$153,511	$0.14

Community Health Workers				
COA	Rate Cell	RY22 Projected MMs	Total Adjustment	PMPM
FCC	All Ages Male & Female	174,732	$3,829	$0.02
LAP	LAP, Child, Male & Female	23,628	$484	$0.02
Medicaid Expansion	Age 19-64	7,118,523	$480,386	$0.07

Streamlined Hepatitis C Screening and Treatment Algorithm

Effective July 15, 2019, LDH implemented its Hepatitis C "Subscription Model" agreement with Asegua Therapeutics LLC. As a part of this agreement, LDH also adopted a streamlined protocol for Hepatitis C screening and monitoring. As compared to the protocols in place prior to the implementation of this agreement, the streamlined protocol will eliminate or reduce the utilization of the many services for individuals associated with the testing and subsequent treatment of Hepatitis C; examples include:

- Genotype testing
- Fibrosure testing
- RNA testing

In order to evaluate the impact of these changes, Mercer estimated the impact of eliminating or reducing the services that are no longer expected to be a part of the new treatment protocol on a per individual basis. LDH's FFS fee schedule was used to price the services in question. The FFS prices were also benchmarked against MCO-reported unit costs. The overall change in screening and treatment costs were also adjusted to account for the increase in the number of Medicaid enrollees expected to be treated for Hepatitis C between January 1, 2022 and December 31, 2022. A summary of the estimated impact of these changes by rate cell are summarized in Table 28. Please refer to Appendix E for additional detail regarding this adjustment.

Table 28

COA	Rate Cell	% Impact of Base Expenses
SSI	0-2 Months	0.000%
SSI	3-11 Months	0.000%
SSI	Child 1-20 Years	0.000%
SSI	Adult 21+ Years	-0.001%
F&C	0-2 Months	0.000%
F&C	3-11 Months	0.000%
F&C	Child 1-20 Years	0.000%
F&C	Adult 21+ Years	-0.001%
FCC	All Ages Male & Female	0.000%
BCC	BCC, All Ages	0.000%
LAP	LAP, All Ages	0.000%
HCBS	Child 1-20 Years	0.000%
HCBS	Adult 21+ Years	0.000%
CCM	CCM, All Ages	0.000%
SBH – CCM	SBH – CCM, All Ages	0.000%
SBH – Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	0.000%
SBH – HCBS	Child 1-20 Years	0.000%
SBH – HCBS	Adult 21+ Years	0.000%
SBH – Other	SBH – All Ages	0.000%
Maternity Kick Payment	Maternity Kick Payment	0.000%
Medicaid Expansion	Age 19-64	-0.001%
Medicaid Expansion	High Needs	-0.004%

Medication-Assisted Treatment

Effective January 20, 2020, Healthy Louisiana covered medication-assisted treatment (MAT) provided by credentialed Opioid Treatment Program (OTP) providers. The benefit includes both MAT and NEMT transportation for Medicaid beneficiaries. OTP provider reimbursement is based on a daily/weekly all-inclusive rate, which includes drug dispensing and ingredient costs, counseling, evaluation and management visits, urine drug screening, and any other services required or provided.

As MAT is a newly covered service, Mercer relied upon projected costs and utilization provided by the State for the Non-Expansion and Expansion programs separately. Mercer identified individuals within the base data with an opioid abuse diagnosis to determine impacted populations and to determine

relative proportions within each program for the purposes of allocating projected costs. The impact of the MAT adjustment is summarized by rate cell in Table 29. Please see Appendix F for more detail.

Table 29

COA	Rate Cell	MAT PMPM Add-On
SSI	Child 1-20 Years	$0.16
SSI	Adult 21+ Years	$2.58
F&C	Child 1-20 Years	$0.03
F&C	Adult 21+ Years	$2.16
FCC	All Ages Male & Female	$0.27
Medicaid Expansion	Age 19-64	$1.84
Medicaid Expansion	High Needs	$18.80

COVID-19 Pandemic and Related Adjustments

RY22 capitation rates were adjusted to reflect the impact of the COVID-19 pandemic. Significant national uncertainty exists regarding the impact of COVID-19 during RY22 due to the changing situation with regionalized infection rates, the impact of variants and vaccination rates to name a few factors. Given the limited experience resulting from the COVID-19 pandemic, Mercer used several data sources to develop the COVID-19 impacts to RY22 capitation rates, including Mercer and Oliver Wyman internal modeling, national and state data sources, and additional program-specific data provided from LDH and the MCOs.

Given the uncertainty surrounding COVID-19, Mercer separated assumptions into the following categories.

Testing

Testing costs were developed using a bottom-up approach. An assumed testing rate was developed through a combination of statewide expected testing outcomes and the fee schedule provided on LDH's website. The analysis includes testing for current infection and antibody testing. Costs were included for both the test and associated administrative costs and any corresponding services (e.g., ED or office setting).

Treatment

Treatment costs considered the estimated cost of treatment based on case severity. Scenarios were considered that ranged from in-home care for mild cases to hospitalization, including intensive care units, for more severe cases. Average treatment costs were developed based on projected treatment protocols, including average days in the hospital. The treatment costs were then weighted based on an assumed distribution of incidence rate and severity of cases that varied by rate cell. For example, older members are assumed to be at higher risk for more severe infection, requiring more costly treatment, than younger members.

Deferred Care

Deferred care assumptions were developed based on an assumed percentage of projected utilization that is delayed, with a portion of these delayed services assumed to be canceled. Delayed or canceled services can result from restricted provider capacity, services considered elective or lower urgency, or services ultimately deemed unnecessary. Mercer varied these assumptions by service category. These deferred care utilization assumptions were then applied to projected expense by rate cell, which reflected a rate cell-specific mix of service categories. Mercer assumed the impact of deferred care will continue through partial periods of RY22. For Child rate cells, Mercer assumed a return to normal conditions by the end of the first quarter of RY22. For Adult rate cells, Mercer assumed a slower return to normal conditions to occur within the first two quarters of RY22.

Aggregate COVID-19 Pandemic and Related Adjustments

The PMPM impact of these adjustments is included in Table 30.

Table 30

% Impact to Projected Medical Expense	Gulf	Capital	South Central	North	Statewide
Testing Cost	0.21%	0.20%	0.22%	0.22%	0.21%
Anti-Body Cost	0.01%	0.01%	0.01%	0.01%	0.01%
Treatment Cost	0.12%	0.10%	0.12%	0.12%	0.11%
Net Deferred Care	-0.53%	-0.52%	-0.51%	-0.52%	-0.52%
Total Impact	-0.19%	-0.21%	-0.16%	-0.17%	-0.18%

Other Potential Changes Not Included in This Preliminary Report

At the time of this report, Mercer is aware of three changes that may be potentially effective during the RY22 period and may require updates to the rates. One of these updates is coverage for the newly eligible children under the Tax Equity and Fiscal Responsibility Act 421, currently with a planned effective date of January 1, 2022. For the second update, LDH intends to submit directed payment pre-prints which could impact this rating period once approved. Lastly, Mercer will be monitoring the PHE in case rating updates are needed during the course of RY22. Primarily, this is related to the length of the PHE and any impact on enrollment during RY22. At the time of this certification, the expiration date of the PHE and the resulting disenrollment plan are not yet known. In the event these changes are finalized or other changes arise, Mercer and LDH will amend this certification, as warranted, to address the impacts.

5
Trends

Medical Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the cost of providing health care services in a future period. Mercer studied historical cost and utilization data for the two data sources incorporated in the capitation rates: Healthy Louisiana encounters and Healthy Louisiana MCO financial reports. Trends were selected based on Louisiana experience, as well as national trend information. Due to the prevalence of COVID-19 during 2020, Mercer relied mainly on encounters for claims incurred through CY 2019 and processed through December 2020. However, Mercer did consider emerging experience from MCO financial reports and encounter data for certain populations and services to adjust for anticipation of longer recoveries to normal experience levels.

The trend factors by population are shown in Appendix G and are applied for 36 months from the base period mid-point to the contract period mid-point.

Pharmacy Trend

Mercer's pharmacy trend development process consists of two elements: a review of historical MCO pharmacy expenditures, including emerging experience beyond the base data, and a survey of publically-available information including, but not limited to:

- Publications and news reports regarding "pipeline" drugs
- Federal reports and publically-available industry reports from drug manufacturers and disease focused advocacy and research organizations
- Drug trend reports published by pharmacy benefit managers and health care organizations

Mercer incorporates marketplace intelligence into overall expected pharmacy trends for broad therapeutic categories based on the combination of the expectations for novel, traditional, and specialty drugs; price fluctuations of existing drugs; and the introduction of new generics, biosimilars, and follow-on biologics to the marketplace. Mercer's RY22 pharmacy trends reflect expected changes in utilization, per-prescription unit costs, brand to generic conversions, and the introduction of market breakthrough therapies. Mercer includes consideration of LDH's single PDL in trend assumptions. For example, if LDH prefers a branded product to an available generic version, Mercer does not assume the typical negative unit cost trend associated with adoption of the generic product.

Table 31

COA	Rate Cell	Pharmacy Trend
SSI	0-2 Months	5.45%
SSI	3-11 Months	1.94%
SSI	Child 1-20 Years	10.23%
SSI	Adult 21+ Years	10.53%
F&C	0-2 Months	3.81%
F&C	3-11 Months	5.09%
F&C	Child 1-20 Years	6.92%
F&C	Adult 21+ Years	9.38%
FCC	All Ages Male & Female	8.17%
BCC	BCC, All Ages	15.82%
LAP	LAP, All Ages	9.27%
HCBS	Child 1-20 Years	11.39%
HCBS	Adult 21+ Years	11.39%
CCM	CCM, All Ages	11.85%
Expansion	Age 19-64	10.02%
Expansion	High Needs	7.94%

Note: Pharmacy is not a covered benefit in the SBH and Maternity rate cells.

6

Special Contract Provisions Related to Payment

Withhold Arrangement

Effective February 1, 2018, a withhold of the monthly capitated payment shall be applied to incentivize quality, health outcomes, and value-based payments. The withhold amount will be equal to 2.0% of the monthly capitated payment for PH and basic BH for all MCO members, exclusive of maternity kick payments and the FMP component of the monthly capitated payment. Quality and health outcomes, along with value-based payments will each account for 1.0% (i.e., 50.0% each of the 2.0% total withhold) and are intended to incentivize the MCOs to meet all requirements.

Based on recent Healthy Louisiana MCO performance along with expert opinion, Mercer determined that all quality or health outcome measures were deemed reasonably attainable.

Incentive Arrangement

The CMS Rate Development Guide defines incentive arrangements as "any payment mechanism under which a health plan may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract."

Effective February 1, 2018, MCOs may earn incentive payments up to 5.0%, in total, above the approved capitation payment attributable to the enrollees or services covered by the incentive arrangements implemented by LDH. These incentive payments will support the activities, targets, performance measures, or quality-based outcomes specified in LDH's quality strategy. Mercer will work with LDH to ensure the incentive arrangement is consistently administered such that it complies with the regulations at 42 CFR §438.6(b)(2).

Risk Corridor

Since implementation of the Hepatitis C Subscription Model effective July 1, 2019, LDH has maintained a risk corridor for Hepatitis C-related pharmacy, physician, and laboratory costs. The corridor will remain unchanged for RY22 with the following parameters:

Table 32

Gain or Loss	Share of Contractor Loss/Gain	
	Contractor	LDH
Less than or equal to 1.0% of the aggregate Hepatitis C-related medical component of the risk adjusted capitation payment	100.0%	0.0%
Greater than 1.0% of the aggregate Hepatitis C-related medical component of the risk adjusted capitation payment	1.0%	99.0%

Risk Pool

Due to the inherent volatility related to the high cost, low frequency drug, Zolgensma®, LDH implemented a risk pool in RY20 to mitigate the risk that any MCO incurs a disproportionate share of Zolgensma. This risk pool will remain in place during the RY22 contract period. The risk pool will be budget neutral in aggregate and payments from the risk pool will be based on actual Zolgensma claims incurred during RY22. Mercer has allocated three claims each at $2.125 million for the Zolgensma risk pool in RY22 rates.

Minimum Medical Loss Ratio

In accordance with the MCO Financial Reporting Guide published by LDH, each MCO shall provide an annual medical loss ratio (MLR) report following the end of the MLR reporting year, which shall be a calendar year. An MLR shall be reported separately between the Expansion and Non-Expansion populations, including all medical services covered under the contract. If either the Expansion or Non-Expansion MLR (cost for health care benefits and services and specified quality expenditures) is less than 85.0%, the MCO shall refund LDH the difference.

Directed Payments

Mercer utilized fee schedule information from the State to develop its base and prospective fee schedule rating adjustments. In accordance with 42 C.F.R. § 438.6(a) and 42 C.F.R. § 438.6(c)(1)(iii)(A), Mercer has identified the minimum fee schedules that qualify as directed payments but that do not require a submitted preprint for prior approval by CMS because they reference approved State plan/waiver fee schedules. Further details for these fee schedules and their respective adjustments can be seen in the Base Rating Adjustments and Prospective Rating Adjustment sections. The qualified directed payments are as follows:

- HCBS Fee Schedule
- Inpatient Services Fee Schedule
- Outpatient Services Fee Schedule

- Physician-Administered Drug Fee Schedule
- FQHC and RHC Fee Schedule
- LSU Enhanced Fee Schedule
- Hospital-Based Physician Service Fee Schedule
- Ambulance Services Fee Schedule
- Non-Emergency Medical Transportation (NEMT) Fee Schedule
- Air Ambulance Fee Schedule
- General Anesthesia and Facility Dental Treatment Fee Schedule

7
Projected Non-Benefit Costs

Administrative Expense Load

The actuarially sound capitation rates developed include a provision for MCO administration and other non-medical expenses. Mercer reviewed line item detail of each MCO's administrative expenses, which tied back to the MCO financial reports, as well as relied on its professional experience in working with numerous State Medicaid programs to develop the administrative load. This process included consideration for increases in expenses including items such as additional case management due to claims volume, increases in staff compensation over time, and consideration for enrollment growth. As well, Mercer reviewed the potential impact on administrative expenses as a result of the CMS Interoperability and Patient Access final rule (CMS-9115-F), but determined no adjustment was necessary based on the expected impact specific to the Healthy Louisiana program as a portion of the MCOs' overall Medicaid business. Mercer and LDH will continue to monitor this issue for subsequent contract years.

Administrative Expense Load assumptions are summarized by program in Table 33.

Table 33

Administrative PMPM by Program	
Non-Expansion PH	$31.30
Non-Expansion SBH	$5.11
Maternity Kick Payment	$384.44
Expansion	$41.02

Due to the expected increase in the number of Medicaid enrollees projected to be treated for Hepatitis C between January 1, 2022 and December 31, 2022, Mercer determined it was necessary to increase the administrative expense load to account for additional Hepatitis C-related case management costs.

Mercer estimated historical Hepatitis C-related case management costs based on the MCO financial reports and developed an add-on commensurate with the expected increase in the number of Medicaid enrollees who will be treated for Hepatitis C between January 1, 2022 and December 31, 2022. A summary of the estimated impact of these changes by rate cell and region are summarized below in Table 34.

Table 34

COA	Rate Cell	Fixed Admin PMPM Add-On			
		Gulf	Capital	South Central	North
SSI	Child 1-20 Years	$0.00	$0.00	$0.00	$0.00
SSI	Adult 21+ Years	$0.21	$0.18	$0.10	$0.13
F&C	Child 1-20 Years	$0.00	$0.00	$0.00	$0.00
F&C	Adult 21+ Years	$0.05	$0.05	$0.02	$0.02
FCC	All Ages Male & Female	$0.00	$0.00	$0.00	$0.00
BCC	BCC, All Ages	$0.00	$0.00	$0.22	$0.00
HCBS	Adult 21+ Years	$0.05	$0.11	$0.07	$0.03
Medicaid Expansion	Age 19-64	$0.07	$0.06	$0.03	$0.04
Medicaid Expansion	High Needs	$1.04	$0.99	$0.50	$0.00

The load for each rate cell was determined using a fixed and variable cost model. Under this model, a fixed administrative expense is attributed to each rate cell, which reflects program requirements, such as State-mandated staffing, and other indirect operational expenses. Added to this is a variable administrative amount, based on claims volume. This methodology results in administrative expense loads that vary as a percentage by rate cell. The resulting variance in administrative expense determined using this methodology results in a higher allocation of administrative expenses on the rate cells with higher utilization, which is more accurate in reflecting the drivers of plan administration requirements.

Underwriting Gain Load

A provision was made in the final rates for underwriting gain. The rates reflect an assumption of 1.5%; the underwriting gain load is calculated prior to the application of FMP adjustments.

Premium-Based Taxes

Final rates also include a provision for Louisiana's 5.5% premium tax.

Federal Health Insurance Providers Fee

Section 9010 of the ACA established the Health Insurance Providers Fee (HIPF), which applies to certain for-profit/tax-paying health insurers. For-profit Medicaid health plans are not exempt from the HIPF, which will become a cost of doing business that is appropriate to recognize actuarially sound capitation rates. Due to the federal repeal of the HIPF for fee year 2021 and later, a HIPF adjustment is not applicable to the RY22 capitation rates.

8
Risk Adjustment

Risk adjustment will be applied to the rates in Appendix A to reflect differences in health status of the members served in each MCO using the Adjusted Clinical Groups (ACG) model. The ACG model uses diagnostic information along with member demographics (age and sex categories) to classify members into mutually exclusive ACG categories, which are indicative of health care resource usage in terms of cost consumption. The State typically updates risk scores semi-annually, but the update timing and frequency may change to account for key program changes and data availability.

The application of the ACG model was tailored to the Healthy Louisiana program by using Louisiana cost experience to determine the relative costs associated with each ACG category. This step produces Louisiana-specific cost weights, which assign a risk score to each member with sufficient experience (six or more months of enrollment with an MCO). An age/gender risk assumption is made for members without an ACG assignment. These member-level risk scores will be aggregated by MCO, producing MCO risk scores, which are adjusted for budget neutrality. The risk adjustment process does not increase nor decrease the overall cost of the program, but can change the distribution across the various Healthy Louisiana MCOs according to the relative risk of their enrolled members. This is consistent with the budget neutrality requirements outlined in 42 CFR 438.5(g). The FMP component of the rates will not be risk adjusted. The FMP component is added to the risk-adjusted rate to produce the final rate. Table 35 shows the rate cells that will be risk adjusted.

Table 35

Risk-Adjusted Rate Cells	
SSI	
Child, 1-20 Years, Male & Female	Adult, 21+ Years, Male & Female
F&C	
Child, 1-20 Years, Male & Female	Adult, 21+ Years, Male & Female
FCC: All Ages, Male & Female	
LAP: All Ages, Male & Female	
Medicaid Expansion: Age 19-64	

Separate sets of risk scores are developed for each rate cell and region, except for LAP where the risk scores are developed on a statewide basis.

For more detail regarding the risk adjustment process, please reference the separate risk-adjustment methodology letter that corresponds with each risk adjustment update.

9

Certification of Final Rates

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

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

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

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

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

applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

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

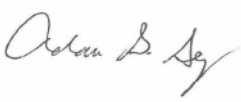
LDH understands that Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends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

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

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

If you have any questions on any of the above, please feel free to contact Adam Sery at +1 612 802 0780 or Rogelio Figueroa at +1 470 548 8862 at your convenience.

Sincerely,



Adam Sery FSA, MAAA
Principal

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Appendix A

Region Description	Category of Aid Description	Rate Cell Description	Projected Member Months/Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
Gulf	SSI	0-2 Months	151	$ 38,073.20	$ 39,537.01
Gulf	SSI	3-11 Months	1,206	$ 5,208.83	$ 5,513.30
Gulf	SSI	Child 1-20 Years	110,136	$ 858.30	$ 918.74
Gulf	SSI	Adult 21+ Years	293,322	$ 1,794.62	$ 1,925.11
Gulf	F&C	0-2 Months	29,672	$ 3,282.64	$ 3,473.94
Gulf	F&C	3-11 Months	112,565	$ 343.18	$ 364.44
Gulf	F&C	Child 1-20 Years	2,107,403	$ 191.49	$ 203.30
Gulf	F&C	Adult 21+ Years	318,236	$ 460.61	$ 487.64
Gulf	FCC	All Ages Male & Female	30,947	$ 521.50	$ 558.29
Gulf	BCC	BCC, All Ages	1,030	$ 3,172.43	$ 3,427.85
Gulf	LAP	LAP, All Ages	5,949	$ 244.04	$ 259.99
Gulf	HCBS	Child 1-20 Years	2,870	$ 2,789.33	$ 2,998.10
Gulf	HCBS	Adult 21+ Years	6,656	$ 1,933.98	$ 2,079.20
Gulf	CCM	CCM, All Ages	14,059	$ 1,528.06	$ 1,628.10
Gulf	SBH - CCM	SBH - CCM, All Ages	5,980	$ 179.86	$ 185.97
Gulf	SBH - Duals	SBH - Dual Eligible, All Ages	403,835	$ 37.41	$ 41.08
Gulf	SBH - LaHIPP	SBH - LaHIPP, All Ages	191	$ 37.41	$ 41.08
Gulf	SBH - HCBS	Child 1-20 Years	4,948	$ 148.39	$ 152.57
Gulf	SBH - HCBS	Adult 21+ Years	9,101	$ 82.92	$ 91.07
Gulf	SBH - Other	SBH - All Ages	6,039	$ 185.66	$ 202.93
Gulf	Maternity Kick Payment	Maternity Kick Payment	8,008	$ 12,569.59	$ 12,942.61
Gulf	EED Kick Payment	EED Kick Payment	1	$ 6,891.49	$ 7,039.82
Gulf	Medicaid Expansion	Age 19-64	2,135,784	$ 632.92	$ 669.83
Gulf	Medicaid Expansion	SBH - Dual Eligible, All Ages	21,224	$ 37.41	$ 41.08
Gulf	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 37.41	$ 41.08
Gulf	Medicaid Expansion	SBH - Other	17	$ 185.66	$ 202.93
Gulf	Medicaid Expansion	SBH - CCM, All Ages	222	$ 179.86	$ 185.97
Gulf	Medicaid Expansion	High Needs	707	$ 1,511.14	$ 1,616.50
Gulf	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,682	$ 15,959.46	$ 16,402.05
Gulf	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 9,930.79	$ 10,134.85
Capital	SSI	0-2 Months	197	$ 38,649.20	$ 40,118.92
Capital	SSI	3-11 Months	1,361	$ 5,093.01	$ 5,396.29
Capital	SSI	Child 1-20 Years	86,922	$ 854.16	$ 918.61
Capital	SSI	Adult 21+ Years	211,475	$ 1,795.67	$ 1,935.97
Capital	F&C	0-2 Months	27,794	$ 3,764.86	$ 3,953.15
Capital	F&C	3-11 Months	101,626	$ 334.18	$ 354.96
Capital	F&C	Child 1-20 Years	1,915,099	$ 197.75	$ 210.46
Capital	F&C	Adult 21+ Years	279,490	$ 479.70	$ 509.77
Capital	FCC	All Ages Male & Female	50,462	$ 454.17	$ 487.75
Capital	BCC	BCC, All Ages	1,301	$ 3,144.95	$ 3,400.09
Capital	LAP	LAP, All Ages	7,676	$ 242.31	$ 258.25
Capital	HCBS	Child 1-20 Years	3,352	$ 2,832.24	$ 3,041.45
Capital	HCBS	Adult 21+ Years	6,425	$ 1,939.28	$ 2,084.55
Capital	CCM	CCM, All Ages	10,332	$ 1,558.55	$ 1,658.91
Capital	SBH - CCM	SBH - CCM, All Ages	6,985	$ 181.86	$ 187.99
Capital	SBH - Duals	SBH - Dual Eligible, All Ages	322,020	$ 31.40	$ 34.14
Capital	SBH - LaHIPP	SBH - LaHIPP, All Ages	152	$ 31.40	$ 34.14
Capital	SBH - HCBS	Child 1-20 Years	6,146	$ 147.10	$ 151.27
Capital	SBH - HCBS	Adult 21+ Years	8,680	$ 84.60	$ 92.77
Capital	SBH - Other	SBH - All Ages	8,902	$ 178.90	$ 196.10
Capital	Maternity Kick Payment	Maternity Kick Payment	6,907	$ 12,029.48	$ 12,377.25
Capital	EED Kick Payment	EED Kick Payment	1	$ 6,737.84	$ 6,876.13
Capital	Medicaid Expansion	Age 19-64	1,723,325	$ 663.21	$ 704.78
Capital	Medicaid Expansion	SBH - Dual Eligible, All Ages	15,842	$ 31.40	$ 34.14
Capital	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 31.40	$ 34.14
Capital	Medicaid Expansion	SBH - Other	72	$ 178.90	$ 196.10
Capital	Medicaid Expansion	SBH - CCM, All Ages	251	$ 181.86	$ 187.99
Capital	Medicaid Expansion	High Needs	745	$ 2,093.13	$ 2,226.97
Capital	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,565	$ 17,279.44	$ 17,725.36
Capital	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 11,208.10	$ 11,413.69

Region Description	Category of Aid Description	Rate Cell Description	Projected Member Months/Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
South Central	SSI	0-2 Months	93	$ 37,649.42	$ 39,108.89
South Central	SSI	3-11 Months	1,173	$ 5,085.14	$ 5,388.34
South Central	SSI	Child 1-20 Years	96,851	$ 769.48	$ 825.25
South Central	SSI	Adult 21+ Years	262,880	$ 1,550.74	$ 1,670.95
South Central	F&C	0-2 Months	29,957	$ 3,509.43	$ 3,706.89
South Central	F&C	3-11 Months	110,043	$ 339.97	$ 365.02
South Central	F&C	Child 1-20 Years	2,075,697	$ 190.87	$ 204.08
South Central	F&C	Adult 21+ Years	307,604	$ 420.84	$ 447.93
South Central	FCC	All Ages Male & Female	54,998	$ 398.15	$ 428.24
South Central	BCC	BCC, All Ages	787	$ 3,106.58	$ 3,361.32
South Central	LAP	LAP, All Ages	6,013	$ 241.24	$ 257.16
South Central	HCBS	Child 1-20 Years	3,382	$ 2,809.20	$ 3,018.18
South Central	HCBS	Adult 21+ Years	7,778	$ 1,945.11	$ 2,090.44
South Central	CCM	CCM, All Ages	11,637	$ 1,537.84	$ 1,637.99
South Central	SBH - CCM	SBH - CCM, All Ages	5,964	$ 186.10	$ 192.26
South Central	SBH - Duals	SBH - Dual Eligible, All Ages	390,731	$ 33.81	$ 36.76
South Central	SBH - LaHIPP	SBH - LaHIPP, All Ages	185	$ 33.81	$ 36.76
South Central	SBH - HCBS	Child 1-20 Years	5,195	$ 144.55	$ 148.69
South Central	SBH - HCBS	Adult 21+ Years	9,661	$ 85.33	$ 93.51
South Central	SBH - Other	SBH - All Ages	9,255	$ 188.03	$ 205.32
South Central	Maternity Kick Payment	Maternity Kick Payment	7,440	$ 10,566.93	$ 10,913.51
South Central	EED Kick Payment	EED Kick Payment	1	$ 5,290.95	$ 5,428.76
South Central	Medicaid Expansion	Age 19-64	1,827,311	$ 574.41	$ 610.40
South Central	Medicaid Expansion	SBH - Dual Eligible, All Ages	20,109	$ 33.81	$ 36.76
South Central	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 33.81	$ 36.76
South Central	Medicaid Expansion	SBH - Other	44	$ 188.03	$ 205.32
South Central	Medicaid Expansion	SBH - CCM, All Ages	159	$ 186.10	$ 192.26
South Central	Medicaid Expansion	High Needs	372	$ 1,234.04	$ 1,325.12
South Central	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	4,113	$ 13,736.89	$ 14,164.62
South Central	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 7,910.66	$ 8,107.86
North	SSI	0-2 Months	121	$ 37,591.10	$ 39,049.97
North	SSI	3-11 Months	1,270	$ 5,029.21	$ 5,331.83
North	SSI	Child 1-20 Years	103,410	$ 732.53	$ 787.46
North	SSI	Adult 21+ Years	236,382	$ 1,509.03	$ 1,624.78
North	F&C	0-2 Months	21,532	$ 3,333.11	$ 3,523.70
North	F&C	3-11 Months	78,753	$ 320.62	$ 342.80
North	F&C	Child 1-20 Years	1,543,541	$ 193.70	$ 206.93
North	F&C	Adult 21+ Years	222,116	$ 414.90	$ 441.82
North	FCC	All Ages Male & Female	38,325	$ 536.78	$ 579.51
North	BCC	BCC, All Ages	830	$ 3,103.14	$ 3,357.85
North	LAP	LAP, All Ages	3,990	$ 242.25	$ 258.18
North	HCBS	Child 1-20 Years	2,572	$ 2,804.64	$ 3,013.57
North	HCBS	Adult 21+ Years	5,931	$ 1,947.82	$ 2,093.17
North	CCM	CCM, All Ages	9,847	$ 1,538.65	$ 1,638.80
North	SBH - CCM	SBH - CCM, All Ages	5,455	$ 183.60	$ 189.74
North	SBH - Duals	SBH - Dual Eligible, All Ages	321,651	$ 41.39	$ 45.20
North	SBH - LaHIPP	SBH - LaHIPP, All Ages	152	$ 41.39	$ 45.20
North	SBH - HCBS	Child 1-20 Years	3,356	$ 145.49	$ 149.65
North	SBH - HCBS	Adult 21+ Years	6,804	$ 90.10	$ 98.32
North	SBH - Other	SBH - All Ages	7,789	$ 184.06	$ 201.31
North	Maternity Kick Payment	Maternity Kick Payment	5,240	$ 12,669.65	$ 13,062.66
North	EED Kick Payment	EED Kick Payment	1	$ 6,699.62	$ 6,855.89
North	Medicaid Expansion	Age 19-64	1,432,102	$ 568.82	$ 604.38
North	Medicaid Expansion	SBH - Dual Eligible, All Ages	14,374	$ 41.39	$ 45.20
North	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 41.39	$ 45.20
North	Medicaid Expansion	SBH - Other	19	$ 184.06	$ 201.31
North	Medicaid Expansion	SBH - CCM, All Ages	139	$ 183.60	$ 189.74
North	Medicaid Expansion	High Needs	131	$ 1,078.73	$ 1,155.68
North	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,145	$ 15,821.80	$ 16,293.66
North	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 9,406.29	$ 9,623.84

Appendix B

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

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

* Individuals under the age of 21 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 listed above in Attachment C. 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.

Excluded Populations		
Aid Category Description	**Type Case Description**	**Adult/Child/All Ages**
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 & 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

Excluded Populations		
Aid Category Description	**Type Case Description**	**Adult/Child/All Ages**
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 (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 C

Table 1: PH and Expansion Programs		
Medicaid Category of Service	**Units of Measurement**	**IBNR Category Mapping**
Inpatient Hospital	Days	Inpatient
Outpatient Hospital	Claims	Outpatient
Primary Care Physician	Visits	Physician and Other
Specialty Care Physician	Visits	Physician and Other
Federally Qualified Health Center/Rural Health Clinic	Visits	Physician and Other
EPSDT	Visits	Physician and Other
Certified Nurse Practitioners/Clinical Nurse	Claims	Physician and Other
Lab/Radiology	Units	Physician and Other
Home Health	Visits	Physician and Other
Emergency Transportation	Units	Transportation and SBH
NEMT	Units	Transportation and SBH
Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech Therapy)	Visits	Physician and Other
DME	Units	Physician and Other
Clinic	Claims	Physician and Other
Family Planning	Visits	Physician and Other
Other	Units	Physician and Other
Prescribed Drugs	Scripts	Prescribed Drugs
Emergency Room	Visits	Outpatient
Basic Behavioral Health	Claims	Physician and Other
Hospice	Admits	Inpatient
Personal Care Services (Age 0-20)	Units	Physician and Other
Inpatient Services — Mental Health	Days	Transportation and SBH
Emergency Room — Mental Health	Visits	Transportation and SBH
Professional/Other — Mental Health	Units	Transportation and SBH

Table 2: SBH Program		
Medicaid Category of Service	**Units of Measurement**	**IBNR Category Mapping**
Inpatient Services — Mental Health	Days	Transportation and SBH
Emergency Room — Mental Health	Visits	Transportation and SBH
Professional/Other — Mental Health	Units	Transportation and SBH
NEMT	Units	Transportation and SBH

Appendix D

Table 1a: CY 2019 Base Expense

		Categories of Covered Services that Contain In-Lieu-of Services/Settings					
		Inpatient	Outpatient	Physician	Maternity Kick Payment	Other (PH Services)	Specialized Behavioral Health
In-lieu-of Services/Settings	Physical Health Services Provided in Skilled Nursing Facilities	$ 8,882,934	$ 19,434	$ 3,121	$ 20,487	$ 597	$ 616,715
	Crisis Stabilization Units for All Medicaid Eligible Adults						$ 180
	Inpatient Treatment Provided to Adults age 21 to 64 in an IMD for a short term stay of no more than 15 days						$ 80,966,609
	Psychiatric Intensive Outpatient Program		$ 1,022,605				
	23-Hour Observation Bed Services for all Medicaid Eligible Adults (Age 21 and Above)						$ 1,233
	Injection Services Provided by Licensed Nurses to All Medicaid Eligible Adults (Age 21 and Above)			$ 645			$ 33,349
	In-Lieu-of Services/Settings Subtotal	**$ 8,882,934**	**$ 1,042,039**	**$ 3,766**	**$ 20,487**	**$ 597**	**$ 81,618,086**
	State Plan Services/Settings	**$ 791,259,897**	**$ 1,083,966,175**	**$ 820,178,854**	**$ 268,693,001**	**$ 260,132,340**	**$ 653,870,736**
	All Services	**$ 800,142,831**	**$ 1,085,008,214**	**$ 820,182,620**	**$ 268,713,488**	**$ 260,132,937**	**$ 735,488,822**

Table 1b: Percentage of Cost that In-lieu-of Services Represent in each Category of Service (CY19 Base Cost)

	[A]	[B]	[C] = [B]/[A]
Category of Service	COS Total	In-Lieu-of Services Total	In-Lieu-of Services Percentage
Inpatient	$ 800,142,831	$ 8,882,934	1.11%
Outpatient	$ 1,085,008,214	$ 1,042,039	0.10%
Physician	$ 820,182,620	$ 3,766	0.00%
Transportation	$ 119,421,324	$ -	0.00%
Prescribed Drugs	$ 1,502,376,126	$ -	0.00%
Maternity Kick Payment	$ 268,713,488	$ 20,487	0.01%
Other (PH Services)	$ 260,132,937	$ 597	0.00%
Specialized Behavioral Health	$ 735,488,822	$ 81,618,086	11.10%

Appendix E

Service Type	FFS Unit Cost	Hepatitis C Treatment Protocol Change	
		Current Practice	Streamlined Practice
Antibody	$ 15.62	1	1
RNAs	$ 46.85	6	2
Genotype	$ 281.55	1	0
CMP	$ 9.25	2	1
CBC	$ 7.73	1	1
INR	$ 3.92	1	1
Liver tests	$ 8.93	2	1
Fibrosure	$ 51.14	1	0
HbsAg	$ 11.29	1	1
anti-HBs	$ 11.75	1	1
anti-HBc	$ 13.18	1	1
Office visit (level 3)	$ 41.53	7	5
Total		**25**	**15**

Impact Calculation	
Current Practice Cost Per User	$ 1,004.35
Streamlined Practice Cost Per User	$ 383.02
Discount	-61.9%
Hep C Recipients 2019 Q1 & Q2	491
Hep C Recipients 2019 Q3 & Q4	2,493
Hep C Recipients 2022 (Estimate)	3,680
Adherence to Streamlined Practice Rate	100%
	FFS Pricing
2019 Q1 & Q2 - Estimated Cost Under Current Practice	$ 493,136
2019 Q3 & Q4 - Estimated Cost Under Streamlined Practice	$ 954,869
2022 Estimated Cost Under Streamlined Practice	$ 1,409,349
Change in Cost for 2022	$ (38,656)
Percentage Change in Cost	-3%

*The $1,409,349 impact includes both the Expansion and Non–Expansion populations.

Appendix F

	Non-Expansion Program				Expansion Program			
SFY	Methadone Bundle	Buprenorphine bundle	Transportation	Total	Methadone Bundle	Buprenorphine bundle	Transportation	Total
SFY22	$4,235,685	$264,477	$787,473	$5,287,636	$10,297,354	$642,969	$1,914,423	$12,854,746
SFY23	$4,405,112	$275,056	$818,972	$5,499,141	$10,709,249	$668,688	$1,990,999	$13,368,936

Estimated MAT for 1/1/22-12/31/22		$5,393,388					$13,111,841

Notes:

1. Estimated cost for MAT for 1/1/22 - 12/31/22 = 1/2 x SFY22 totals + 1/2 x SFY23 totals

Appendix G

Annualized RY22 Trends by Major COS								
Rate Cell	PH		Rx		SBH		All Services	
	Low	High	Low	High	Low	High	Low	High
SSI								
0-2 Months	-1.27%	0.44%	3.73%	7.19%	-2.50%	0.50%	-1.25%	0.47%
3-11 Months	-0.46%	1.59%	0.10%	3.79%	-2.50%	0.50%	-0.40%	1.84%
Child 1-20 Years	0.29%	2.69%	8.88%	11.60%	-1.29%	0.94%	2.22%	4.67%
Adult 21+ Years	0.44%	3.03%	9.21%	11.85%	1.36%	4.68%	3.80%	6.48%
SSI Total	**0.38%**	**2.91%**	**9.13%**	**11.79%**	**0.51%**	**3.49%**	**3.45%**	**6.08%**
F&C								
0-2 Months	0.46%	2.70%	2.80%	4.83%	-7.15%	-4.71%	0.46%	2.70%
3-11 Months	1.14%	3.79%	4.07%	6.12%	-7.15%	-4.71%	1.34%	3.94%
Child 1-20 Years	1.18%	3.84%	5.89%	7.96%	-4.94%	-2.64%	1.14%	3.60%
Adult 21+ Years	0.09%	2.27%	8.25%	10.52%	1.68%	4.31%	2.97%	5.23%
Families & Children Total	**0.85%**	**3.34%**	**6.60%**	**8.74%**	**-3.78%**	**-1.41%**	**1.42%**	**3.82%**
HCBS								
Child 1-20 Years	1.20%	3.80%	10.16%	12.62%	-0.38%	0.88%	2.45%	4.89%
Adult 21+ Years	0.49%	3.03%	10.16%	12.62%	1.53%	4.92%	4.81%	7.35%
HCBS Total	**0.84%**	**3.41%**	**10.16%**	**12.62%**	**0.41%**	**2.57%**	**3.85%**	**6.35%**
Other Populations								
FCC, All Ages Male & Female	1.51%	4.34%	7.13%	9.22%	-4.65%	-2.18%	-0.17%	2.35%
BCC, All Ages	0.59%	3.46%	14.23%	17.42%	1.97%	5.33%	4.82%	7.79%
LAP, All Ages	1.17%	3.93%	8.23%	10.32%	-3.27%	-1.69%	2.71%	5.11%
CCM, All Ages	1.25%	3.91%	10.60%	13.12%	-0.40%	0.35%	2.36%	4.42%
SBH Only HCBS								
Child 1-20 Years	-6.54%	-4.59%	0.00%	0.00%	-0.19%	0.36%	-0.57%	0.05%
Adult 21+ Years	-6.54%	-4.59%	0.00%	0.00%	3.26%	6.98%	1.33%	4.72%
SBH Only HCBS Total	**-6.54%**	**-4.59%**	**0.00%**	**0.00%**	**1.27%**	**3.19%**	**0.30%**	**2.23%**
SBH Only All Other								
SBH - CCM	-6.54%	-4.59%	0.00%	0.00%	-0.31%	0.46%	-0.46%	0.33%
SBH - Duals	-6.54%	-4.59%	0.00%	0.00%	3.55%	7.58%	-0.37%	2.90%
SBH - Other	-6.54%	-4.59%	0.00%	0.00%	1.63%	5.04%	-0.05%	3.08%
Maternity Kick Payment								
Maternity Kick Payment	0.00%	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.00%

Annualized RY22 Expansion Trends by Major COS								
Rate Cell	PH		Rx		SBH		All Services	
	Low	High	Low	High	Low	High	Low	High
Medicaid Expansion								
Male & Female Age 19-64	-0.56%	1.32%	8.77%	11.28%	2.60%	5.74%	2.85%	5.09%
High Needs	-0.12%	1.67%	6.35%	9.55%	2.46%	5.48%	2.58%	5.09%

Appendix H

Appendix H: Rate Comparison			1/1/21 Rates			1/1/22 Rates		
Region Description	Category of Aid Description	Rate Cell Description	Projected Member Months/Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery	Projected Member Months/Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
Gulf	SSI	0-2 Months	248	$ 28,708.96	$ 30,036.65	151	$ 38,073.20	$ 39,537.01
Gulf	SSI	3-11 Months	1,770	$ 6,692.17	$ 7,068.68	1,206	$ 5,208.83	$ 5,513.30
Gulf	SSI	Child 1-20 Years	146,984	$ 818.50	$ 872.10	110,136	$ 858.30	$ 918.74
Gulf	SSI	Adult 21+ Years	325,477	$ 1,901.96	$ 2,015.20	293,322	$ 1,794.62	$ 1,925.11
Gulf	F&C	0-2 Months	32,958	$ 3,133.13	$ 3,356.88	29,672	$ 3,282.64	$ 3,473.94
Gulf	F&C	3-11 Months	116,389	$ 366.88	$ 392.54	112,565	$ 343.18	$ 364.44
Gulf	F&C	Child 1-20 Years	2,160,722	$ 184.68	$ 197.78	2,107,403	$ 191.49	$ 203.30
Gulf	F&C	Adult 21+ Years	368,271	$ 464.01	$ 491.25	318,236	$ 460.61	$ 487.64
Gulf	FCC	All Ages Male & Female	30,838	$ 445.26	$ 484.10	30,947	$ 521.50	$ 558.29
Gulf	BCC	BCC, All Ages	987	$ 3,061.37	$ 3,285.43	1,030	$ 3,172.43	$ 3,427.85
Gulf	LAP	LAP, All Ages	5,151	$ 223.66	$ 239.70	5,949	$ 244.04	$ 259.99
Gulf	HCBS	Child 1-20 Years	3,063	$ 2,712.07	$ 2,916.28	2,870	$ 2,789.33	$ 2,998.10
Gulf	HCBS	Adult 21+ Years	7,198	$ 1,797.65	$ 1,916.11	6,656	$ 1,933.98	$ 2,079.20
Gulf	CCM	CCM, All Ages	15,072	$ 1,393.40	$ 1,485.15	14,059	$ 1,528.06	$ 1,628.10
Gulf	SBH - CCM	SBH - CCM, All Ages	6,599	$ 145.27	$ 154.06	5,980	$ 179.86	$ 185.97
Gulf	SBH - Duals	SBH - Dual Eligible, All Ages	429,125	$ 29.82	$ 32.30	403,835	$ 37.41	$ 41.08
Gulf	SBH - LaHIPP	SBH - LaHIPP, All Ages	219	$ 29.82	$ 32.30	191	$ 37.41	$ 41.08
Gulf	SBH - HCBS	Child 1-20 Years	5,225	$ 123.62	$ 129.64	4,948	$ 148.39	$ 152.57
Gulf	SBH - HCBS	Adult 21+ Years	9,296	$ 59.11	$ 64.15	9,101	$ 82.92	$ 91.07
Gulf	SBH - Other	SBH - All Ages	6,816	$ 155.72	$ 168.17	6,039	$ 185.66	$ 202.93
Gulf	Maternity Kick Payment	Maternity Kick Payment	7,920	$ 17,550.98	$ 17,955.15	8,008	$ 12,569.59	$ 12,942.61
Gulf	EED Kick Payment	EED Kick Payment	1	$ 9,310.19	$ 9,427.74	1	$ 6,891.49	$ 7,039.82
Gulf	Medicaid Expansion	Age 19-64	1,973,495	$ 667.26	$ 706.14	2,135,784	$ 632.92	$ 669.83
Gulf	Medicaid Expansion	SBH - Dual Eligible, All Ages	19,488	$ 29.82	$ 32.30	21,224	$ 37.41	$ 41.08
Gulf	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 29.82	$ 32.30	1	$ 37.41	$ 41.08
Gulf	Medicaid Expansion	SBH - Other	56	$ 155.72	$ 168.17	17	$ 185.66	$ 202.93
Gulf	Medicaid Expansion	SBH - CCM, All Ages	207	$ 145.27	$ 154.06	222	$ 179.86	$ 185.97
Gulf	Medicaid Expansion	High Needs	741	$ 2,010.42	$ 2,120.09	707	$ 1,511.14	$ 1,616.50
Gulf	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,245	$ 17,136.85	$ 17,504.11	3,682	$ 15,959.46	$ 16,402.05
Gulf	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 10,705.40	$ 10,848.99	1	$ 9,930.79	$ 10,134.85
Capital	SSI	0-2 Months	227	$ 29,528.18	$ 30,864.27	197	$ 38,649.20	$ 40,118.92
Capital	SSI	3-11 Months	1,733	$ 6,610.36	$ 6,986.02	1,361	$ 5,093.01	$ 5,396.29
Capital	SSI	Child 1-20 Years	112,034	$ 794.34	$ 849.19	86,922	$ 854.16	$ 918.61
Capital	SSI	Adult 21+ Years	225,528	$ 1,838.83	$ 1,963.58	211,475	$ 1,795.67	$ 1,935.97
Capital	F&C	0-2 Months	29,012	$ 3,803.49	$ 4,060.61	27,794	$ 3,764.86	$ 3,953.15
Capital	F&C	3-11 Months	103,485	$ 327.02	$ 351.21	101,626	$ 334.18	$ 354.96
Capital	F&C	Child 1-20 Years	1,933,466	$ 193.71	$ 207.97	1,915,099	$ 197.75	$ 210.46
Capital	F&C	Adult 21+ Years	310,656	$ 492.09	$ 523.35	279,490	$ 479.70	$ 509.77
Capital	FCC	All Ages Male & Female	49,580	$ 444.49	$ 483.32	50,462	$ 454.17	$ 487.75
Capital	BCC	BCC, All Ages	1,475	$ 3,024.03	$ 3,247.71	1,301	$ 3,144.95	$ 3,400.09
Capital	LAP	LAP, All Ages	8,363	$ 220.96	$ 236.97	7,676	$ 242.31	$ 258.25
Capital	HCBS	Child 1-20 Years	3,235	$ 2,740.51	$ 2,945.00	3,352	$ 2,832.24	$ 3,041.45
Capital	HCBS	Adult 21+ Years	6,429	$ 1,813.07	$ 1,931.69	6,425	$ 1,939.28	$ 2,084.55
Capital	CCM	CCM, All Ages	10,761	$ 1,423.94	$ 1,516.01	10,332	$ 1,558.55	$ 1,658.91
Capital	SBH - CCM	SBH - CCM, All Ages	7,481	$ 147.61	$ 156.42	6,985	$ 181.86	$ 187.99
Capital	SBH - Duals	SBH - Dual Eligible, All Ages	336,657	$ 26.09	$ 27.93	322,020	$ 31.40	$ 34.14
Capital	SBH - LaHIPP	SBH - LaHIPP, All Ages	172	$ 26.09	$ 27.93	152	$ 31.40	$ 34.14
Capital	SBH - HCBS	Child 1-20 Years	6,092	$ 129.96	$ 136.05	6,146	$ 147.10	$ 151.27
Capital	SBH - HCBS	Adult 21+ Years	8,998	$ 60.52	$ 65.57	8,680	$ 84.60	$ 92.77
Capital	SBH - Other	SBH - All Ages	10,025	$ 153.44	$ 165.86	8,902	$ 178.90	$ 196.10
Capital	Maternity Kick Payment	Maternity Kick Payment	6,902	$ 12,489.77	$ 12,794.68	6,907	$ 12,029.48	$ 12,377.25
Capital	EED Kick Payment	EED Kick Payment	1	$ 6,273.99	$ 6,362.67	1	$ 6,737.84	$ 6,876.13
Capital	Medicaid Expansion	Age 19-64	1,525,358	$ 680.89	$ 724.95	1,723,325	$ 663.21	$ 704.78
Capital	Medicaid Expansion	SBH - Dual Eligible, All Ages	14,386	$ 26.09	$ 27.93	15,842	$ 31.40	$ 34.14
Capital	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 26.09	$ 27.93	1	$ 31.40	$ 34.14
Capital	Medicaid Expansion	SBH - Other	205	$ 153.44	$ 165.86	72	$ 178.90	$ 196.10
Capital	Medicaid Expansion	SBH - CCM, All Ages	187	$ 147.61	$ 156.42	251	$ 181.86	$ 187.99
Capital	Medicaid Expansion	High Needs	1,040	$ 1,825.77	$ 1,941.73	745	$ 2,093.13	$ 2,226.97
Capital	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	2,633	$ 16,567.16	$ 16,926.23	3,565	$ 17,279.44	$ 17,725.36
Capital	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 10,281.44	$ 10,421.84	1	$ 11,208.10	$ 11,413.69

Appendix H: Rate Comparison			1/1/21 Rates			1/1/22 Rates		
Region Description	Category of Aid Description	Rate Cell Description	Projected Member Months/Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery	Projected Member Months/Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
South Central	SSI	0-2 Months	189	$ 28,833.94	$ 30,162.91	93	$ 37,649.42	$ 39,108.89
South Central	SSI	3-11 Months	2,008	$ 6,657.84	$ 7,033.99	1,173	$ 5,085.14	$ 5,388.34
South Central	SSI	Child 1-20 Years	124,598	$ 741.93	$ 791.93	96,851	$ 769.48	$ 825.25
South Central	SSI	Adult 21+ Years	286,714	$ 1,546.22	$ 1,651.06	262,880	$ 1,550.74	$ 1,670.95
South Central	F&C	0-2 Months	31,521	$ 3,374.39	$ 3,648.71	29,957	$ 3,509.43	$ 3,706.89
South Central	F&C	3-11 Months	113,037	$ 339.31	$ 366.26	110,043	$ 339.97	$ 365.02
South Central	F&C	Child 1-20 Years	2,102,896	$ 183.22	$ 197.17	2,075,697	$ 190.87	$ 204.08
South Central	F&C	Adult 21+ Years	342,061	$ 420.37	$ 447.95	307,604	$ 420.84	$ 447.93
South Central	FCC	All Ages Male & Female	55,203	$ 441.94	$ 480.75	54,998	$ 398.15	$ 428.24
South Central	BCC	BCC, All Ages	786	$ 3,013.06	$ 3,236.63	787	$ 3,106.58	$ 3,361.32
South Central	LAP	LAP, All Ages	7,271	$ 219.96	$ 235.96	6,013	$ 241.24	$ 257.16
South Central	HCBS	Child 1-20 Years	3,624	$ 2,699.15	$ 2,903.23	3,382	$ 2,809.20	$ 3,018.18
South Central	HCBS	Adult 21+ Years	8,063	$ 1,807.97	$ 1,926.54	7,778	$ 1,945.11	$ 2,090.44
South Central	CCM	CCM, All Ages	13,409	$ 1,391.59	$ 1,483.33	11,637	$ 1,537.84	$ 1,637.99
South Central	SBH - CCM	SBH - CCM, All Ages	6,979	$ 148.68	$ 157.50	5,964	$ 186.10	$ 192.26
South Central	SBH - Duals	SBH - Dual Eligible, All Ages	413,841	$ 28.60	$ 30.62	390,731	$ 33.81	$ 36.76
South Central	SBH - LaHIPP	SBH - LaHIPP, All Ages	211	$ 28.60	$ 30.62	185	$ 33.81	$ 36.76
South Central	SBH - HCBS	Child 1-20 Years	5,395	$ 120.26	$ 126.25	5,195	$ 144.55	$ 148.69
South Central	SBH - HCBS	Adult 21+ Years	10,176	$ 61.06	$ 66.13	9,661	$ 85.33	$ 93.51
South Central	SBH - Other	SBH - All Ages	9,902	$ 160.91	$ 173.41	9,255	$ 188.03	$ 205.32
South Central	Maternity Kick Payment	Maternity Kick Payment	7,405	$ 10,409.89	$ 10,713.37	7,440	$ 10,566.93	$ 10,913.51
South Central	EED Kick Payment	EED Kick Payment	1	$ 4,218.68	$ 4,306.94	1	$ 5,290.95	$ 5,428.76
South Central	Medicaid Expansion	Age 19-64	1,671,110	$ 586.88	$ 626.67	1,827,311	$ 574.41	$ 610.40
South Central	Medicaid Expansion	SBH - Dual Eligible, All Ages	19,085	$ 28.60	$ 30.62	20,109	$ 33.81	$ 36.76
South Central	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 28.60	$ 30.62	1	$ 33.81	$ 36.76
South Central	Medicaid Expansion	SBH - Other	99	$ 160.91	$ 173.41	44	$ 188.03	$ 205.32
South Central	Medicaid Expansion	SBH - CCM, All Ages	182	$ 148.68	$ 157.50	159	$ 186.10	$ 192.26
South Central	Medicaid Expansion	High Needs	398	$ 1,887.23	$ 2,033.91	372	$ 1,234.04	$ 1,325.12
South Central	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,165	$ 12,895.51	$ 13,247.59	4,113	$ 13,736.89	$ 14,164.62
South Central	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 6,727.30	$ 6,864.95	1	$ 7,910.66	$ 8,107.86
North	SSI	0-2 Months	189	$ 28,388.61	$ 29,713.01	121	$ 37,591.10	$ 39,049.97
North	SSI	3-11 Months	1,771	$ 6,521.64	$ 6,896.40	1,270	$ 5,029.21	$ 5,331.83
North	SSI	Child 1-20 Years	137,851	$ 704.80	$ 754.11	103,410	$ 732.53	$ 787.46
North	SSI	Adult 21+ Years	264,269	$ 1,477.06	$ 1,578.06	236,382	$ 1,509.03	$ 1,624.78
North	F&C	0-2 Months	22,917	$ 2,358.91	$ 2,550.60	21,532	$ 3,333.11	$ 3,523.70
North	F&C	3-11 Months	80,741	$ 320.79	$ 345.35	78,753	$ 320.62	$ 342.80
North	F&C	Child 1-20 Years	1,582,681	$ 189.84	$ 204.79	1,543,541	$ 193.70	$ 206.93
North	F&C	Adult 21+ Years	246,946	$ 413.43	$ 441.47	222,116	$ 414.90	$ 441.82
North	FCC	All Ages Male & Female	36,674	$ 449.97	$ 488.85	38,325	$ 536.78	$ 579.51
North	BCC	BCC, All Ages	982	$ 2,980.75	$ 3,203.99	830	$ 3,103.14	$ 3,357.85
North	LAP	LAP, All Ages	5,875	$ 220.83	$ 236.85	3,990	$ 242.25	$ 258.18
North	HCBS	Child 1-20 Years	2,303	$ 2,721.12	$ 2,925.42	2,572	$ 2,804.64	$ 3,013.57
North	HCBS	Adult 21+ Years	6,510	$ 1,808.53	$ 1,927.11	5,931	$ 1,947.82	$ 2,093.17
North	CCM	CCM, All Ages	10,164	$ 1,406.54	$ 1,498.42	9,847	$ 1,538.65	$ 1,638.80
North	SBH - CCM	SBH - CCM, All Ages	5,927	$ 150.09	$ 158.92	5,455	$ 183.60	$ 189.74
North	SBH - Duals	SBH - Dual Eligible, All Ages	338,433	$ 35.47	$ 38.19	321,651	$ 41.39	$ 45.20
North	SBH - LaHIPP	SBH - LaHIPP, All Ages	173	$ 35.47	$ 38.19	152	$ 41.39	$ 45.20
North	SBH - HCBS	Child 1-20 Years	3,429	$ 123.56	$ 129.58	3,356	$ 145.49	$ 149.65
North	SBH - HCBS	Adult 21+ Years	7,176	$ 63.31	$ 68.39	6,804	$ 90.10	$ 98.32
North	SBH - Other	SBH - All Ages	8,700	$ 153.57	$ 165.99	7,789	$ 184.06	$ 201.31
North	Maternity Kick Payment	Maternity Kick Payment	5,170	$ 15,933.79	$ 16,351.79	5,240	$ 12,669.65	$ 13,062.66
North	EED Kick Payment	EED Kick Payment	1	$ 7,418.05	$ 7,539.61	1	$ 6,699.62	$ 6,855.89
North	Medicaid Expansion	Age 19-64	1,334,421	$ 560.63	$ 598.79	1,432,102	$ 568.82	$ 604.38
North	Medicaid Expansion	SBH - Dual Eligible, All Ages	11,048	$ 35.47	$ 38.19	14,374	$ 41.39	$ 45.20
North	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 35.47	$ 38.19	1	$ 41.39	$ 45.20
North	Medicaid Expansion	SBH - Other	60	$ 153.57	$ 165.99	19	$ 184.06	$ 201.31
North	Medicaid Expansion	SBH - CCM, All Ages	140	$ 150.09	$ 158.92	139	$ 183.60	$ 189.74
North	Medicaid Expansion	High Needs	325	$ 968.23	$ 1,043.79	131	$ 1,078.73	$ 1,155.68
North	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	2,625	$ 14,709.57	$ 15,081.18	3,145	$ 15,821.80	$ 16,293.66
North	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 8,209.27	$ 8,354.56	1	$ 9,406.29	$ 9,623.84

Appendix I

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

Mr. Adam Sery, FSA, MAAA
Principal
Mercer Government Human Services
3560 Lenox Rd, NE, Suite #2400
Atlanta, GA 30326

November 12, 2021

Subject: Capitation Rate Certification for the Healthy Louisiana Program – Implementation Year January 1, 2022 through December 31, 2022

Dear Adam:

I, Daniel Cocran, Chief Financial Officer, for the Louisiana Department of Health (LDH) - Medicaid, hereby affirm the data prepared and submitted to Mercer Government Human Services Consulting (Mercer) for the purpose of certifying the January 1, 2022 through December 31, 2022 Healthy Louisiana Rates were prepared under my direction, and to the best of my knowledge and belief, are accurate, complete, and consistent with the data used to develop the capitation rates. This data includes managed care organization-submitted encounter data and supplemental information on payments made outside of Louisiana's Medicaid Management Information Systems for the period of January 1, 2018 through December 31, 2019.

Mercer relied on LDH and its fiscal agent for the collection and processing of the encounter data, and other information used in setting these capitation rates. Mercer did not audit the data, but did assess the data for reasonableness as documented in the rate certification letter.

Daniel Cocran Digitally signed by Daniel Cocran Date: 2021.11.12 10:23:01 -06'00'
Signature

11/12/2021
Date

Copy:
Roger Figueroa, ASA, MAAA, Senior Associate

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