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: 2000441823

Amendment Number: 17

Vendor: UNITED HEALTHCARE OF LA DBA COMM HEALTH NTWK OF LA

Description: Managed Care Organizations - Emergency

Approved By: PAMELA RICE

Approval Date: 09/15/2022 20:43:53

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Medical Vendor Administration

(Regional/ Program/ Facility)

Bureau of Health Services Financing

AND

UnitedHealthcare of Louisiana, Inc. dba UnitedHealthcare Communit

Contractor Name

Amendment #: 17

LAGOV#: 2000441823

LDH #:

Original Contract Amount: $2,726,062,141.00

Original Contract Begin Date: 01-01-2020

Original Contract End Date: 12-31-2020

RFP Number: N/A

AMENDMENT PROVISIONS

Change Contract From: Current Maximum Amount: $9,938,690,240.95 Current Contract Term: 01/01/20-12/31/22

--CF-1
12) Maximum Contract Amount: $9,938,690,240.95
13) Estimated Amounts by Fiscal Year: FY20: $1,363,031,070.50; FY21: $3,493,221,374.00 ; FY22: $3,404,491,428.96; FY23: $1,677,946,367.49
--Attachment B - Statement of Work
--Attachment D15 - Rate Certification effective 7.1.2022 (dated 6/28/2022)
--Attachment E - APM Strategic Plan Requirements and Report
--Attachment F – In Lieu of Services

Change Contract To: If Changed, Maximum Amount: $10,236,981,919.63 If Changed, Contract Term: N/A

--CF-1
12) Maximum Contract Amount: $10,236,981,919.63
13) Estimated Amounts by Fiscal Year: FY20: $1,363,031,070.50; FY21: $3,493,221,374.00 ; FY22: $3,404,491,428.96; FY23: $1,976,238,045.12
--Attachment B17 - Changes to Statement of Work
--Attachment D17 - Rate Certification effective 7.1.2022 (dated 8/24/2022)
--Attachment E - APM Strategic Plan Requirements and Report
--Attachment F17 – Changes to In Lieu of Services

Justifications For Amendment:

Revisions contained in this amendment are within scope and comply with the terms and conditions as set forth in the contract. This amendment incorporates a rate certification to replace the one dated 6/28/22 as a result of CMS's approval of state directed payments. It also incorporates revisions to Attachment B - SOW, including addition of state directed payment language and associated monetary penalties for noncompliance, updates to covered services, the addition of a drug to the specialty prior authorization process, and clarifications of previous edits. Additionally, updates were made to Attachment E, APM Strategic Plan Requirements and Report, and Attachment F, In Lieu of Services.

This Amendment Becomes Effective: 07-01-2022

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

UnitedHealthcare of Louisiana, Inc. dba UnitedHealthcare Co

DocuSigned by: Karl Lirette 0B7C39DD6B6B404...

SIGNATURE 8/29/2022 DATE

PRINT NAME: Karl Lirette

CONTRACTOR TITLE: CEO

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

DocuSigned by: Tara A. Leblanc 338F7ABF393C405...

SIGNATURE 8/29/2022 DATE

NAME: Tara A. LeBlanc

TITLE: Medicaid Executive Director

OFFICE: Louisiana Department of Health

PROGRAM SIGNATURE DATE

NAME

Contract Amendment #17
Attachment B17

Changes to Statement of Work

Item	Change From:	Change To:	Justification
1	15.7.14 In the event LDH or its agent recovers any amounts assessed to a provider as a result of an LDH audit as provided for within this Section from the MCO's capitation payment or any other method, the MCO may pursue recovery from the provider. However, the MCO is prohibited from recouping a State-identified overpayment from a provider when the MCO is responsible for the overpayment, unless approved in writing by LDH. If the MCO recovers State-identified improper payments, the MCO shall submit corrected encounter data within thirty (30) calendar days upon notification by LDH.	15.7.14 In the event LDH or its agent recovers any amounts assessed to a provider as a result of an LDH audit as provided for within this Section from the MCO's capitation payment or any other method, the MCO may pursue recovery from the provider. However, the MCO is prohibited from recouping a State-identified overpayment from a provider when the MCO is responsible for the overpayment, unless approved in writing by LDH. ~~If the MCO recovers State-identified improper payments, t~~The MCO shall submit corrected encounter data within thirty (30) calendar days ~~upon notification by~~ of notice of the overpayment from LDH, regardless of whether the MCO recovers the overpayment from the provider.	This revision is to clarify the process for provider overpayments.
2	6.1.4. The MCO shall provide core benefits and services to Medicaid members. The core benefits and services that shall be provided to members are: … • Other benefits and services in the Alternative Benefit Plan approved by CMS.	6.1.4. The MCO shall provide core benefits and services to Medicaid members. The core benefits and services that shall be provided to members are: … • Routine patient costs for items and services furnished in connection with participation in a qualifying clinical trial in accordance with Section 1905(gg) of the Social Security Act • Other benefits and services in the Alternative Benefit Plan approved by CMS.	This revision corrects the omission of routine costs related to clinical trials, which has been a covered service.
3	6.3.4.2 As of January 1, 2019, the statewide universal prior authorization form shall be posted and utilized as specified in Act 423 of the 2018 Louisiana Regular Session. In order to obtain necessary information for prior authorization processing, the following therapeutic drug classes shall be considered specialty for prior authorization purposes only: Hepatitis C Direct Acting Antiviral Agents (as directed by LDH) Spinraza and Synagis. MCOs shall utilize the LDH form and criteria for these specialty classes filled in an outpatient pharmacy setting.	6.3.4.2 As of January 1, 2019, the statewide universal prior authorization form shall be posted and utilized as specified in Act 423 of the 2018 Louisiana Regular Session. In order to obtain necessary information for prior authorization processing, the following therapeutic drug classes shall be considered specialty for prior authorization purposes only: Hepatitis C Direct Acting Antiviral Agents (as directed by LDH), Spinraza®, Aduhelm®, and Synagis®. MCOs shall utilize the LDH form and criteria for these specialty classes filled in an outpatient pharmacy setting. The MCO shall adhere to the provisions of La. R.S. 46:153.3(C)(1) which exempt HIV/AIDS drugs from the prior authorization process.	This revision allows a specialty prior authorization (PA) form to collect necessary information to process a PA for Aduhelm.

Item	Change From:	Change To:	Justification
	The MCO shall adhere to the provisions of La. R.S. 46:153.3(C)(1) which exempt HIV/AIDS drugs from the prior authorization process.		
4	6.4.4. Specialized Behavioral Health Covered Services: … o Crisis Stabilization (under age 21) • Therapeutic Group Homes (under age 21): Therapeutic Group Homes have a non-Medicaid funded room and board component that must be addressed prior to placement. …	6.4.4. Specialized Behavioral Health Covered Services: … o Crisis Stabilization Youth (under age 21) • Crisis Stabilization Adults (age 21 and older) • Therapeutic Group Homes (under age 21): Therapeutic Group Homes have a non-Medicaid funded room and board component that must be addressed prior to placement. …	This revision adds crisis stabilization services for adults to the list of covered services following CMS approval of a State Plan Amendment.
5	6.27.1.3. The approved in lieu of services are authorized and identified in the MCO Manual.	6.27.1.3. The approved in lieu of services are authorized and identified in Attachment F, **In Lieu of Services** ~~the MCO Manual~~.	This revision corrects the reference to Attachment F, which includes the full list of authorized in lieu of services and their effective dates.
6	9.12 Payment for Hospital Services The MCO is not responsible for reimbursement of graduate medical education (GME) payments or disproportionate share hospital (DSH) payments to providers. The MCO must use the increased hospital funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in Attachment D – Rate Certification, for reimbursement of inpatient and outpatient hospital services.	9.12 Payment for Hospital Services The MCO is not responsible for reimbursement of graduate medical education (GME) payments or disproportionate share hospital (DSH) payments to providers. ~~The MCO must use the increased hospital funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in Attachment D – Rate Certification, for reimbursement of inpatient and outpatient hospital services.~~ In accordance with 42 CFR §438.6(c), the Department shall utilize a CMS approved directed payment arrangement for specified hospitals. The payment arrangement will utilize a uniform percentage increase for qualified hospitals, based upon assigned tiered provider classes, for inpatient and outpatient MCO Covered Services provided to Enrollees. CMS approval of a directed	This revision adds the directed payment arrangements approved by CMS for State Fiscal Year 2023.

Item	Change From:	Change To:	Justification
		payment arrangement is for one (1) rating period and it is not renewed automatically. As such, this directed payment arrangement must be approved by CMS annually. This directed payment arrangement will be made through a separate payment term outside of the monthly Capitation Payment. The Contractor shall make directed payments to qualified hospitals as directed by the Department and in accordance with the written approval from CMS for the applicable rating period. 9.12.1 For State Fiscal Year (SFY) 2023, pursuant to CMS approvals, LDH will provide a uniform percentage increase for in-state providers of inpatient and outpatient hospital services (excluding freestanding psychiatric hospitals, freestanding rehabilitation hospitals, and long-term acute care hospitals) and a separate uniform percentage increase for long-term acute care, psychiatric services, and rehabilitation services for both inpatient and outpatient hospital services for the rating period covering July 1, 2022 through June 30, 2023. This directed payment arrangement shall be detailed in Attachment D, Rate Certification. LDH shall utilize an interim payment process, whereby interim directed payments will be calculated based upon 2019 utilization data and paid to qualified hospitals on a quarterly basis. LDH shall provide a quarterly interim direct payment report to the Contractor for each quarter, which identifies the qualified hospitals and the applicable interim directed payment for that quarter. The Contractor shall pay the interim directed payments to the appropriate qualified hospitals, as specified in that report, within ten (10) Business Days of receipt of the report from LDH, unless otherwise directed in writing by the Hospital and Facility Finance Director or the LDH Undersecretary. The Contractor shall not deviate from the payments set forth in the quarterly interim direct payment report, unless otherwise directed in writing by the Hospital and Facility Finance Director or the LDH Undersecretary. If the Contractor fails to pay an interim directed payment in full or within the specified time period for a given quarter, LDH may penalize the Contractor using one (1) or more of the following: • One (1) or more remedies in the Contract Non-Compliance section, including, but not limited to, monetary penalties;	

<table>
<tr><th>Item</th><th>Change From:</th><th>Change To:</th><th>Justification</th></tr>
<tr><td></td><td></td><td>

Termination of the Contract; and
A partial or complete forfeiture of any interest earned on the directed payments provided to the Contractor.

In accordance with Federal regulations, directed payments must be based on actual utilization and delivery of services. As such, within twelve (12) months of the end of SFY 2023, LDH will perform a reconciliation and provide the Contractor with a reconciliation report that will contain the adjustments to be made to each qualified hospital's next quarterly interim directed payment. If the Contractor fails to perform the reconciliation in accordance with the instructions or within the specified time period, LDH may penalize the Contractor using one (1) or more of the following:

One (1) or more remedies in the Contract Non-Compliance section, including, but not limited to, Contract termination;
Table of Monetary Penalties; and
A partial or complete forfeiture of any interest earned on the net directed payments provided to the Contractor.

</td><td></td></tr>
<tr><td>7</td><td>20.3 Monetary Penalties

[new monetary penalties]</td><td>20.3 Monetary Penalties
<table>
<tr><td>Payment for Hospital Services – Interim Payments</td><td>Five thousand dollars ($5,000) per Calendar Day per instance for failure to pay an interim directed payment in full to a qualified hospital in accordance with the quarterly interim directed payment report within ten (10) business days of receipt of the report from LDH.</td></tr>
<tr><td>Payment for Hospital Services – Reconciliation</td><td>Five thousand dollars ($5,000) per Calendar Day per instance for failure to perform the directed payment reconciliation in accordance with the instructions provided by LDH within the specified time period.</td></tr>
</table>
</td><td>This revision adds monetary penalties for noncompliance with the directed payment provisions added in Item 6.</td></tr>
</table>

Mercer

Government Human Services Consulting

Healthy Louisiana
Final Rate Certification

Effective July 1, 2022 through June 30, 2023

Louisiana Department of Health

August 24, 2022

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 Final Actuarial Certification for the Period July 1, 2022 through June 30, 2023

August 24, 2022

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 July 1, 2022 through June 30, 2023, or rate year 2023 (RY23). 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 relied primarily 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.

This rate certification is intended to replace the certification dated June 28, 2022 and reflects changes as a result of CMS's approval of state directed payments for inpatient and outpatient services and long-term acute care, psychiatric, and rehabilitation (LPR) hospitals and removal of the full Medicaid pricing adjustments for inpatient and outpatient services. No other changes were made to the rate certification. The final capitation rates are summarized in Appendix A and represent payment in full for the covered services.

[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, cost of capital, and government-mandated assessments, fees, and taxes.
Reference: http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf.

Contents

Section 1
General Information

Overview

Capitation rates for the Healthy Louisiana program were developed in accordance with rate-setting guidelines established by CMS. For this rate update, Mercer utilized the data used in RY22 rate development, which was calendar year (CY) 2019 spanning 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 RY23. 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, the 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 the 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).

Effective January 1, 2022, the State passed legislation to expand eligibility for the Act 421 Children's Medicaid Option (CMO) population. Those members without third-party liability (TPL) insurance, or with TPL insurance and not enrolled in Louisiana Health Insurance Premium Payment (LaHIPP), will receive all PH program services through Healthy Louisiana.

Mandatory Populations

Please see Appendix C for details 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 reenroll 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 years 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 C for details 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 that 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 LaHIPP program was reinstated. Members enrolled in the LaHIPP program will receive SBH and NEMT services only through Healthy Louisiana.

Effective January 1, 2022, the State passed legislation to expand eligibility for the Act 421 CMO population. Those members with TPL insurance and enrolled in LaHIPP will receive SBH and NEMT services only through Healthy Louisiana.

Mandatory and Excluded Populations

Please see Appendix C for details 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. Twenty-one 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	
0–2 Months	Child 1–20 Years
3–11 Months	Adult 21+ Years
F&C	
0–2 Months	Child 1–20 Years
3–11 Months	Adult 21+ Years
HCBS Waiver	
Child 1–20 Years	Adult 21+ Years
FCC: All Ages, Male & Female	
BCC: BCC, All Ages	
CCM: CCM, All Ages	
LAP: LAP, All Ages	
Act 421 Non-TPL	
0–2 Months	Child 1–18 Years

PH Rate Cell Groupings	
3–11 Months	
Act 421 Non-LaHIPP TPL	
0–2 Months	Child 1–18 Years
3–11 Months	
Maternity Kick Payment	
Early Elective Delivery (EED) Kick Payment	
Medicaid Expansion: Age 19–64	
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. Although there are thirteen distinct rates cells, only six 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 in which 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 – Duals	
Non-Expansion, SBH – Dual Eligible, All Ages	Expansion, Age 19–64
SBH – LaHIPP	
Non-Expansion, LaHIPP, All Ages	Expansion, Age 19–64
SBH – HCBS Waiver	
Child 1–20 Years	Adult 21+ Years
SBH – CCM	
Non-Expansion, CCM, All Ages	Expansion, Age 19–64
SBH – Other	
Non-Expansion, SBH - All Ages	Expansion, Age 19–64
Act 421 LaHIPP TPL	
0–2 Months	Child 1–18 Years
3–11 Months	

Healthy Louisiana Benefit Package

Covered Services

Appendix D 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 began providing 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 began providing 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 CY 2022, LDH is expanding 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.

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 D, 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 for 21 years and older
- Institutional long-term care 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 is 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

Region Description	Associated Parishes (Counties)
Capital	Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, St. Tammany, Tangipahoa, Washington, West Baton Rouge, and West Feliciana
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

Section 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.

Incurred But Not Reported

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 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	**Non-Expansion PH Program**	**Non-Expansion SBH Program**	**Expansion**
Prescribed Drugs	0.9796		1.0215
Transportation and SBH	0.9598	0.9803	1.0885
All Other	1.0516		1.0898

Third-Party Liabilities

All claims are reported net of TPL; 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, 0–2 Months
- SSI, 3–11 Months
- BCC, All Ages
- LAP, All Ages
- HCBS, Child 1–20 Years
- HCBS, Adult 21+ Years
- CCM, All Ages
- SBH – CCM, All Ages
- SBH – HCBS, Child 1–20 Years
- SBH – HCBS, Adult 21+ Years
- SBH – Other, All Ages

Section 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 to 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.

Early Elective Deliveries

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 RY23, the EED adjustment is equivalent to 39.8% and 46.1% for the Non-Expansion and Expansion maternity kick payments, respectively.

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; current procedure terminology codes 80320 and 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. The impact of this adjustment is shown in Table 4.

Table 4

Urine Drug Adjustment			
Category of Aid (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%
LAP	$ 2,679	-$ 1,202	-0.03%
HCBS	$ 22,516	-$ 8,339	-0.02%

Urine Drug Adjustment			
Category of Aid (COA)	**Historical Cost**	**Total Adjustment**	**% Impact of Base Expenses**
CCM	$ 17,526	-$ 7,591	-0.02%
Medicaid Expansion	$8,999,630	-$4,395,499	-0.21%

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 it estimated the difference between the 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

Local Pharmacy Adjustment			
COA	**Historical Cost**	**Total Adjustment**	**% Impact of Base Expenses**
SSI	$159,051,635	$705,489	0.05%
F&C	$110,089,878	$541,345	0.03%
FCC	$ 3,928,736	$ 18,935	0.03%
BCC	$ 261,958	$ 1,069	0.01%
LAP	$ 340,336	$ 1,762	0.04%
HCBS	$ 4,367,271	$ 18,139	0.04%
CCM	$ 1,552,299	$ 7,339	0.02%
Medicaid Expansion	$174,848,222	$776,520	0.04%

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 that 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 is summarized in Table 6.

Table 6

Single Preferred Drug List			
COA	**Historical Cost**	**Total Adjustment**	**% Impact of Base Expenses**
SSI	$457,378,483	$ 6,083,134	0.45%
F&C	$331,135,442	$14,305,051	0.88%
FCC	$ 9,702,091	$ 774,227	1.38%
BCC	$ 2,546,244	($ 29,791)	-0.34%
LAP	$ 1,201,319	$ 26,309	0.65%
HCBS	$ 13,471,561	$ 332,748	0.79%
CCM	$ 6,997,969	$ 425,476	0.99%
Medicaid Expansion	$679,943,018	$ 5,235,561	0.25%

Pharmacy Rebates

As part of the implementation of the single PDL, the MCOs are prohibited from entering into rebate agreements with manufacturers of pharmacy 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.

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**	**% Impact of Base Expenses**
SSI	$457,378,483	-$1,829,514	-0.13%
F&C	$331,135,442	-$1,324,542	-0.08%

Pharmacy Rebates			
COA	Historical Cost	Total Adjustment	% Impact of Base Expenses
FCC	$ 9,702,091	-$ 29,106	-0.05%
BCC	$ 2,546,244	-$ 10,185	-0.12%
LAP	$ 1,201,319	-$ 7,208	-0.18%
HCBS	$ 13,471,561	-$ 53,886	-0.13%
CCM	$ 6,997,969	-$ 6,998	-0.02%
Medicaid Expansion	$679,943,018	-$2,719,772	-0.13%

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 Table 8.

Table 8

SCID Screening Adjustment			
COA	Historical Cost	Total Adjustment	% Impact of Base Expenses
Maternity Kick Payment	$171,207,993	$214,673	0.13%
Medicaid Expansion — Maternity Kick Payment	$ 97,505,496	$108,236	0.11%

Pharmacy Co-Payment Limit Adjustment

Effective January 1, 2020, LDH implemented a policy to limit cost sharing that members of a Medicaid household may incur each month to 5.0% of the family income. To estimate the impact of this program change, Mercer used information provided by LDH summarizing the total amount of co-payments it 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 the data for the corresponding time period to estimate the impact of this policy change. The impact of this limit is shown in Table 9.

Table 9

Pharmacy Co-Payment Limit Adjustment			
COA	Historical Cost	Total Adjustment	% Impact of Base Expenses
SSI	$ 3,692,824	$414,604	0.03%
F&C	$ 6,743,814	$107,007	0.01%
FCC	$ 17,694	$ 189	0.00%
BCC	$ 88,295	$ 588	0.01%

Pharmacy Co-Payment Limit Adjustment			
COA	Historical Cost	Total Adjustment	% Impact of Base Expenses
LAP	$ 0	$ 0	0.00%
HCBS	$ 170,811	$ 4,606	0.01%
CCM	$ 0	$ 0	0.00%
Medicaid Expansion	$75,606,498	$531,130	0.02%

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 Adjustment			
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	% Impact of Base Expenses
CY 2019	$4,181,839	$2,872,429	0.05%

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 Disease (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 F for a summary of these costs and the percentage of cost the in lieu of services represent in each category of service.

Institutions for Mental Disease

On May 6, 2016, CMS published the Medicaid and CHIP Program's 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 used 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 (IP) 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 IP 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 used 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 used 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 used to benchmark health care system efficiency between facilities and across geographies.

Although 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 used 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 RY23 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 RY23 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 preempted 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 RY23, 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 preempted. 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 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 and six months after date of service) 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 $5.12 PMPM to the PH program.

Table 13

COA	Efficiency Adjustments % Impact of Base Expenses
SSI	-2.28%
F&C	-1.15%
FCC	-0.52%
BCC	-0.16%
LAP	-0.60%
HCBS	-1.49%
CCM	-0.78%

COA	Efficiency Adjustments % Impact of Base Expenses
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	-1.61%
Medicaid Expansion – Maternity Kick Payment	-0.05%

Section 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 that 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 July 2015, LDH implemented a series of program changes to ensure consistent pricing in the Medicaid program for hospital-based physician services 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 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 to ensure the capitation rate ranges reflect adequate statewide pricing levels. Separate adjustments were made for both services to capture the full impact of statewide funding.

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 through 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 Healthy Louisiana base experience and the aggregated fee schedule adjustments from Tables 14A through 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. 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%	N/A	N/A

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 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	$103,994,626	9.97%	N/A	N/A

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.[2] 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	$241,061	2.95%	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.

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

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, 2021, LDH released a new fee schedule for the Hospice Program, which can be located on LDH's website.[3] 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	$464,309	5.87%	N/A	N/A

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.[4] 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	$47,975,134	56.52%	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

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

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

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	$260,411,425	N/A	N/A	$566,423,288	217.51%

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-LUG. 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 RY23. According to the State Plan, average 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	N/A	N/A	$40,282,898	60.81%

Aggregate Fee Schedule Adjustments

The prospective aggregate fee adjustment as a percent impact of base expenses is 4.87% as shown in Table 14I.

Table 14I

Aggregate Fee Schedule Changes					
Time Period	Historical Cost	Fee Schedule Change Impact	% Impact of Historical Cost	FMP Impact	% Impact of Adjusted Base
CY 2019	$5,590,133,302	$272,027,181	4.87%	$606,706,187	10.35%

Other Fee Schedule Updates

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

NEMT Fee Schedule Change

Subsequent to the base data time period of CY 2019, LDH made the following updates to the NEMT fee schedule:

- Fee schedule eliminating the for-profit/non-profit NEMT distinction (effective July 1, 2020)
- Fee schedule updating pickup fee by $4 (effective January 1, 2022)
- Fee schedule implementing a temporary mileage rate increase (effective March 1, 2022)

The impact of these fee adjustments is displayed 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	$5,590,133,302	$7,941,296	22.45%	0.14%

Air Ambulance Fee Schedule Change

Effective January 1, 2022, LDH implemented changes to its fee schedule for Air Ambulance services, which can be found on its website.[5] 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 per time unit (each time unit is equal to 15 minutes). For facility reimbursement, the additional reimbursement is at least $400 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.

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

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 years, called outliers. These payments are for inpatient stays with a total cost to the hospital in excess of $150,000, in which the cost is determined based on the hospital's Neonatal Intensive Care Unit or Pediatric Intensive Care Unit specific CCR. LDH makes payments up to a maximum of $20,921,381 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 $2.37 PMPM to the base data used in rate setting. Table 18 details the impact of outliers on the rates by rate cell.

Table 18

Outliers Adjustment				
COA	**Rate Cell**	**RY23 Projected MMs**	**Total Adjustment**	**PMPM**
SSI	0–2 Months	727	$ 1,715,197	$2,357.83
SSI	3–11 Months	5,018	$ 750,016	$ 149.45
F&C	0–2 Months	107,113	$18,417,787	$ 171.95
F&C	3–11 Months	375,410	$ 38,381	$ 0.10

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 Adjustment				
COA	**Rate Cell**	**RY23 Projected MMs**	**Total Adjustment**	**PMPM**
SSI	Adult 21+ Years	976,171	$ 855,938	$0.88
F&C	Adult 21+ Years	1,078,378	$ 145,733	$0.14
FCC	All Ages Male & Female	176,828	$ 14,323	$0.08
BCC	BCC, All Ages, Female	4,156	$ 2,876	$0.69
HCBS	Male & Female, Age 21+	27,950	$ 21,861	$0.78

Inpatient Subspecialty and Neonatology Rate Restoration Adjustment				
COA	Rate Cell	RY23 Projected MMs	Total Adjustment	PMPM
SBH – Duals	SBH – Dual Eligible, All Ages	1,422,992	$ 0.00	$0.00
SBH – HCBS	Adult 21+ Years	34,276	$ 0.00	$0.00
SBH – Other	SBH - All Ages	31,664	$ 0.00	$0.00
Medicaid Expansion	Age 19–64	7,221,829	$2,078,385	$0.29
Medicaid Expansion	High Needs	1,880	$ 3,038	$1.62

Vitamin D Testing

Effective January 1, 2021, Vitamin D testing was limited to four tests per year when coded against the specified list of procedure 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				
COA	Rate Cell	RY23 Projected MMs	Total Adjustment	PMPM
SSI	3–11 Months	5,018	-$ 481	-$0.10
SSI	Child 1-20 Years	404,828	-$ 27,161	-$0.07
SSI	Adult 21+ Years	976,171	-$211,380	-$0.22
F&C	0–2 Months	107,113	-$ 783	-$0.01
F&C	3–11 Months	375,410	-$ 2,667	-$0.01
F&C	Child 1–20 Years	7,677,287	-$152,322	-$0.02
F&C	Adult 21+ Years	1,078,378	-$131,729	-$0.12
FCC	All Ages Male & Female	176,828	-$ 4,985	-$0.03
BCC	BCC, All Ages	4,156	-$ 2,035	-$0.49
LAP	LAP, All Ages	22,376	-$ 914	-$0.04
HCBS	Child 1–20 Years	12,846	-$ 1,176	-$0.09
HCBS	Adult 21+ Years	27,950	-$ 5,006	-$0.18
CCM	CCM, All Ages	48,912	-$ 3,165	-$0.06
Maternity Kick Payment	Maternity Kick Payment	21,484	$ 0	$0.00
Medicaid Expansion	Age 19–64	7,221,829	-$760,914	-$0.11

Vitamin D Testing				
COA	**Rate Cell**	**RY23 Projected MMs**	**Total Adjustment**	**PMPM**
Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	13,527	-$ 13,925	-$1.03

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	**RY23 Projected MMs**	**Total Adjustment**	**PMPM**
Non-Expansion – Maternity Kick Payment	25,587	$179,982	$7.03
Expansion – Maternity Kick Payment	13,527	$ 95,154	$7.03

Peer Support Services

Effective February 1, 2021, LDH included peer support services in its 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**	**RY23 Projected MMs**	**Total Adjustment**	**Total PMPM**
SSI	Adult 21+ Years	976,171	$1,915,460	$1.96
F&C	Adult 21+ Years	1,078,378	$ 683,514	$0.63
FCC	Foster Care, All Ages, Male & Female	176,828	$ 8,921	$0.05
BCC	BCC, All Ages	4,156	$ 1,046	$0.25
HCBS	Age 21+	27,950	$ 23,958	$0.86

Peer Support Services				
COA	Rate Cell	RY23 Projected MMs	Total Adjustment	Total PMPM
SBH - Duals	SBH - Dual Eligible, All Ages	1,422,992	$ 361,177	$0.25
SBH - HCBS	Adult 21+ Years	34,276	$ 30,212	$0.88
SBH - Other	SBH - All Ages	31,664	$ 56,424	$1.78
Medicaid Expansion	Age 19–64	7,221,829	$3,843,502	$0.53
Medicaid Expansion	High Needs	1,880	$ 5,027	$2.67

Behavioral Health Services Expansion

Effective at various dates throughout CY 2022, LDH is expanding and increasing funding for BH services to include additional mental health 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 Crisis Care (effective April 1, 2022)
- Individual Placement Support (effective February 21, 2022)
- Personal Care Services (effective February 21, 2022)
- Adolescent Group Substance Use Disorder Intensive Outpatient Program fee schedule increase (effective July 1, 2022)

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

Table 23

BH Services Expansion				
COA	Rate Cell	RY23 Projected MMs	Total Adjustment	PMPM
SSI	Adult, 21+ Years	976,171	$10,170,347	$10.42
F&C	Adult, 21+ Years	1,078,378	$ 4,656,053	$ 4.32
FCC	All Ages Male & Female	176,828	$ 39,657	$ 0.22
BCC	BCC, All Ages, Female	4,156	$ 6,344	$ 1.53
HCBS	Male & Female, Age 21+	27,950	$ 156,614	$ 5.60
SBH – Duals	SBH – Dual Eligible, All Ages	1,422,992	$ 3,023,810	$ 2.12

BH Services Expansion				
COA	Rate Cell	RY23 Projected MMs	Total Adjustment	PMPM
SBH – HCBS	Adult 21+ Years	34,276	$ 181,138	$ 5.28
SBH – Other	SBH – All Ages	31,664	$ 227,806	$ 7.19
Medicaid Expansion	Age 19–64	7,221,829	$21,489,932	$ 2.98
Medicaid Expansion	High Needs	1,880	$ 25,197	$13.40

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. Although 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 that 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 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. Due to the uncertainty of when the PHE will expire and recent federal guidance on the unwinding of the MOE requirements, Mercer assumed for purposes of setting capitation rates that the PHE will remain in effect through at least June 30, 2023, meaning there would be no disenrollment efforts during RY23. If the PHE expires during the RY23 contract period, Mercer and LDH will determine how disenrollment efforts will impact RY23 and 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 RY23, 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 Year–20 Years rate cells. Table 24 shows the impact of this adjustment.

Table 24

Enrollment Acuity Adjustment		
COA	**Rate Cell**	**% Impact to Projected Medical Expense**
Medicaid Expansion	Age 19–64	-2.17%
F&C	Child 1–20 Years	-2.59%

MPS1/Pompe Newborn Screening

Effective January 1, 2022, physicians attending a newborn child or the person attending a newborn child who has not been attended to 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 RY23, the MPS1/Pompe adjustment is equivalent to $7.07 for the aforementioned rate cells. Table 25 shows the impact of this adjustment.

Table 25

MPS1/Pompe Newborn Screening				
COA	**Rate Cell**	**RY23 Projected MMs**	**Total Adjustment**	**PMPM**
SSI	0–2 Months	727	$ 5,145	$7.07
F&C	0–2 Months	107,113	$757,594	$7.07

Maternity Postpartum Coverage Extension

Effective April 1, 2022, LDH extended Medicaid coverage for maternity postpartum benefits one year after the end of a pregnancy for eligible pregnant women. These women will be exempt from wage verification checks and remain enrolled in Medicaid during this post-partum period. The prior post-partum coverage removed women after the end of a 60-day postpartum period. The impact of this adjustment by rate cell is shown in Table 26.

Table 26

Maternity Postpartum Coverage Extension				
COA	**Rate Cell**	**RY23 Projected MMs**	**Total Adjustment**	**PMPM**
F&C	Adult 21+ Years	1,078,378	$8,088,172	$7.50
Medicaid Expansion	Age 19–64	7,221,829	$ 755,605	$0.10

Community Health Workers

Effective January 1, 2022, LDH began providing 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**	**RY23 Projected MMs**	**Total Adjustment**	**PMPM**
SSI	Child 1 Year–20 Years	404,828	$ 20,060	$0.05
SSI	Adult 21+ Years	976,171	$ 262,126	$0.27
F&C	Child 1–20 Years	7,677,287	$ 253,626	$0.03
F&C	Adult 21+ Years	1,078,378	$ 332,075	$0.31
FCC	All Ages Male & Female	176,828	$ 7,028	$0.04
LAP	LAP, All Ages	22,376	$ 888	$0.04
Medicaid Expansion	Age 19–64	7,221,829	$1,039,172	$0.14

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

To evaluate the effect 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 July 1, 2022 and June 30, 2023. A summary of the estimated impact of these changes by rate cell are in Table 28. Please refer to Appendix G for additional detail regarding this adjustment.

Table 28

COA	Rate Cell	% Impact of Base Expenses
SSI	0–2 Months	0.000%

COA	Rate Cell	% Impact of Base Expenses
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.

For this adjustment, Mercer relied upon projected costs and utilization provided by the State for the Non-Expansion and Expansion programs. Mercer identified individuals within the base data that had 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 H for more detail.

Table 29

Medication-Assisted Treatment				
COA	**Rate Cell**	**RY23 Projected MMs**	**Total Adjustment**	**PMPM**
SSI	Child 1–20 Years	404,828	$ 66,255	$ 0.16
SSI	Adult 21+ Years	976,171	$ 2,639,588	$ 2.70
F&C	Child 1–20 Years	7,677,287	$ 265,019	$ 0.03
F&C	Adult 21+ Years	1,078,378	$ 2,480,576	$ 2.30
FCC	All Ages Male & Female	176,828	$ 47,703	$ 0.27
Medicaid Expansion	Age 19–64	7,221,829	$13,331,443	$ 1.85
Medicaid Expansion	High Needs	1,880	$ 37,493	$19.94

COVID-19 Pandemic Testing Costs

Uncertainty exists regarding the impact of COVID-19 during RY23 due to the changing situation with regionalized infection rates, the impact of variants, and vaccination rates to name a few factors. RY23 capitation rates were adjusted to reflect the impact of COVID-19 testing and treatment costs during the contract period.

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, office setting, and over-the-counter testing).

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.

Aggregate COVID-19 Pandemic and Related Adjustments

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

Table 30

COVID-19 Pandemic Testing and Treatment Costs	
Region	**% Impact to Projected Medical Expense**
Gulf	0.45%
Capital	0.42%
South Central	0.45%
North	0.44%

House Bill No.1 Impact

Effective July 1, 2022, a number of provider rate increases were included in the 2022 Regular Session under House Bill No. 1 (HB1) that was signed into legislation. The services impacted by this legislation include:

- Pediatric day health care (effective July 1, 2022)
- Emergency/Non-Emergency Transportation (effective July 1, 2022)
- Applied Behavioral Analysis (effective July 1, 2022)

The combined impact of these adjustments by rate cell is shown in Table 31.

Table 31

HB1 Rate Increases				
COA	**Rate Cell**	**RY23 Projected MMs**	**Total Adjustment**	**PMPM**
SSI	0–2 Months	727	$ 744	$ 1.02
SSI	3–11 Months	5,018	$ 269,523	$53.71
SSI	Child 1–20 Years	404,828	$6,701,660	$16.55
SSI	Adult 21+ Years	976,171	$ 826,933	$ 0.85
F&C	0–2 Months	107,113	$ 37,041	$ 0.35
F&C	3–11 Months	375,410	$ 159,640	$ 0.43
F&C	Child 1–20 Years	7,677,287	$4,723,343	$ 0.62
F&C	Adult 21+ Years	1,078,378	$ 222,775	$ 0.21
FCC	All Ages Male & Female	176,828	$ 420,619	$ 2.38
BCC	BCC, All Ages	4,156	$ 1,148	$ 0.28
LAP	LAP, All Ages	22,376	$ 45,041	$ 2.01
HCBS	Child 1–20 Years	12,846	$ 682,846	$53.16
HCBS	Adult 21+ Years	27,950	$ 24,183	$ 0.87
CCM	CCM, All Ages	48,912	$3,545,567	$72.49
SBH – CCM	SBH – CCM, All Ages	21,484	$ 781,469	$36.37

HB1 Rate Increases				
COA	**Rate Cell**	**RY23 Projected MMs**	**Total Adjustment**	**PMPM**
SBH – Duals	SBH – Dual Eligible, All Ages	1,422,992	$ 96,849	$ 0.07
SBH – HCBS	Child 1–20 Years	18,868	$ 443,253	$23.49
SBH – HCBS	Adult 21+ Years	34,276	$ 15,108	$ 0.44
SBH – Other	SBH – All Ages	31,664	$ 63,996	$ 2.02
Maternity Kick Payment	Maternity Kick Payment	25,587	$ 44,288	$ 1.73
Medicaid Expansion	Age 19–64	7,221,829	$1,298,609	$ 0.18
Medicaid Expansion	High Needs	1,880	$ 1,905	$ 1.01
Medicaid Expansion – Maternity Kick Payment	Maternity Kick Payment	13,527	$ 22,898	$ 1.69

Continuous Glucose Monitoring

Effective August 1, 2022, the State will expand Medicaid coverage of continuous glucose monitors for Medicaid enrollees who meet the following conditions:

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

The impact for this adjustment by rate cell is shown in Table 32.

Table 32

Continuous Glucose Monitoring				
COA	**Rate Cell**	**RY23 Projected MMs**	**Total Adjustment**	**Total PMPM**
SSI	Child 1–20 Years	404,828	$1,209,127	$ 2.99
SSI	Adult 21+ Years	976,171	$7,514,295	$ 7.70
F&C	0–2 Months	107,113	$ 811	$ 0.01
F&C	3–11 Months	375,410	$ 2,250	$ 0.01
F&C	Child 1-20 Years	7,677,287	$2,820,349	$ 0.37
F&C	Adult 21+ Years	1,078,378	$1,532,841	$ 1.42
FCC	All Ages Male & Female	176,828	$ 106,514	$ 0.60
BCC	BCC, All Ages	4,156	$ 47,379	$11.40

Continuous Glucose Monitoring				
COA	Rate Cell	RY23 Projected MMs	Total Adjustment	Total PMPM
LAP	LAP, All Ages	22,376	$ 46,364	$ 2.07
HCBS	Child 1–20 Years	12,846	$ 27,292	$ 2.12
HCBS	Adult 21+ Years	27,950	$ 198,864	$ 7.11
CCM	CCM, All Ages	48,912	$ 38,254	$ 0.78
Medicaid Expansion	Age 19–64	7,221,829	$11,419,361	$ 1.58
Medicaid Expansion	High Needs	1,880	$ 6,537	$ 3.48

Genetic Testing of Critically Ill Infants

Effective August 1, 2022, the State will include Medicaid coverage for rapid whole genome sequencing testing for critically ill infants with no diagnosis. The impact for this adjustment by rate cell is shown in Table 33.

Table 33

Infant Genetic Testing Coverage				
COA	Rate Cell	RY23 Projected MMs	Total Adjustment	PMPM
SSI	0–2 Months	727	$ 20,938	$28.78
F&C	0–2 Months	107,113	$3,083,037	$28.78

Human Breast Milk Coverage

Effective July 1, 2022, the State will include Medicaid outpatient coverage of pasteurized donor human milk prescribed for eligible infants for up to 60 days. Medicaid shall only reimburse outpatient expenditures for human milk obtained from a member bank of the Human Milk Banking Association of North America. The impact for this adjustment by rate cell is shown in Table 34.

Table 34

Human Breast Milk Coverage				
COA	Rate Cell	RY23 Projected MMs	Total Adjustment	PMPM
SSI	0–2 Months	727	$ 13,478	$18.53
F&C	0–2 Months	107,113	$1,984,522	$18.53

Act 421 Children's Medicaid Option

The Act 421 Children's Medicaid Option provides services to a new population that was not previously covered in Medicaid; therefore, there is no historical data on these children. To

develop rates for the Act 421 Children's Medicaid Option rate cells, Mercer used RY23 gross medical expenses from Healthy Louisiana rate cell populations that closely resemble the Act 421 Children's Medicaid Option group. The assignment of the Healthy Louisiana proxy population(s) to each Act 421 Children's Medicaid Option population is detailed in Appendix E.

Using the RY23 gross medical expense PMPM for each Healthy Louisiana proxy population as a starting point, Mercer developed and applied adjustments to account for differences in expected acuity and benefit costs between the Healthy Louisiana proxy population(s) and the Act 421 Children's Medicaid Option populations to establish projected medical expenses for the Act 421 Children's Medicaid Option populations.

Relative Acuity Adjustment

Although the RY23 Healthy Louisiana proxy populations include members who will resemble the Act 421 Children's Medicaid Option enrollees, it is expected that the Act 421 Children's Medicaid Option population will use a different mix of services than the broader Healthy Louisiana proxy populations. Therefore, Mercer gathered diagnosis level of detail for members in programs similar to the Act 421 Children's Medicaid Option operating in other states. Using those diagnosis profiles, Mercer analyzed the relative costs of members within the RY23 Healthy Louisiana proxy populations who have similar diagnosis profiles. Mercer compared the relative PMPM costs by major service category groupings, and in total, to develop a relative acuity adjustment for each Act 421 Children's Medicaid Option population.

A summary of the relative acuity adjustments by population is shown in Appendix E. The relative acuity adjustments are applied uniformly across all services for each population.

Third Party Liability Wrap-Around Adjustment

The TPL wrap-around adjustments are made for the Non-LaHIPP TPL and the LaHIPP TPL rate cells, to ensure that the final PMPMs for these populations reflect only the portion of the costs for which the Healthy Louisiana MCOs will be responsible, since Medicaid is the payer of last resort. Mercer reviewed Louisiana-specific premium assistance studies to estimate the expected reductions in Medicaid costs for individuals with TPL by major service category groupings. The TPL wrap-around adjustments by population are shown in Appendix E.

Other Potential Changes Not Included in This Report

At the time of this report, Mercer is aware of multiple changes that could potentially effect information during the RY23 period and may require updates to the rate certification. These changes are as follows:

- Procurement efforts by State for single Pharmacy Benefit Manager
- Procurement efforts by State for single NEMT vendor
- Expiration of PHE and resumption of wage verification efforts
- New contractual requirements stemming from MCO contract award
- Various changes to program funding and covered benefits from Louisiana legislation

Section 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. Mercer relied on encounters for claims incurred from July 2018 through December 2021 and processed through December 2021. Mercer also considered guidance from external parties for potential impacts stemming from the higher inflation trend on provider unit cost.

The trend factors by population are shown in Appendix I and are applied for 42 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 RY23 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 35

COA	Rate Cell	Pharmacy Trend
SSI	0–2 Months	5.64%
SSI	3–11 Months	5.96%
SSI	Child 1–20 Years	7.57%

COA	Rate Cell	Pharmacy Trend
SSI	Adult 21+ Years	9.78%
F&C	0–2 Months	3.56%
F&C	3–11 Months	5.37%
F&C	Child 1–20 Years	4.65%
F&C	Adult 21+ Years	9.17%
FCC	All Ages Male & Female	5.53%
BCC	BCC, All Ages	12.85%
LAP	LAP, All Ages	7.51%
HCBS	Child 1–20 Years	9.34%
HCBS	Adult 21+ Years	9.34%
CCM	CCM, All Ages	12.44%
Medicaid Expansion	Age 19–64	9.89%
Medicaid Expansion	High Needs	8.54%

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

Section 6

Special Contract Provisions Related to Payment

Withhold Arrangement

Effective February 1, 2018, the monthly capitated payment shall be subject to a quality withhold 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 RY23 with the following parameters:

Table 36

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%

On June 6, 2022, LDH received guidance from CMS related to an inquiry from LDH regarding risk mitigation changes, the shift in contract period, and the requirements for risk mitigation under 42 CFR 438.6(b)(1). CMS has advised LDH that risk mitigation mechanisms should remain consistent throughout the prior contract period for which rates were certified (CY 2022). It is anticipated that this risk corridor will remain consistent throughout RY23, as there has been no change in the risk corridor parameters since its inception.

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 RY23 contract period. However, LDH anticipates making adjustments to the risk pool during the RY23 contract period to include additional high-cost, low-frequency drugs expected to be approved during the RY23 contract period. On June 6, 2022, LDH received guidance from CMS related to an inquiry from LDH regarding risk mitigation changes, the shift in contract period, and the requirements for risk mitigation under 42 CFR 438.6(b)(1). CMS has advised LDH that risk mitigation mechanisms should remain consistent throughout the prior contract period for which rates were certified (CY 2022). Therefore, the risk pool will remain consistent through December 31, 2022, and risk pool payments will be based on actual Zolgensma® claims incurred from January 1, 2022, through December 31, 2022; the risk pool is budget neutral in aggregate. Mercer has allocated three claims, each at $2.125 million, for the Zolgensma risk pool in the current RY23 rates.

Should changes be made to the drugs included in the risk pool effective January 1, 2023, LDH will provide additional information to CMS. As well, if a change in the covered drugs results in a change in the risk pool and RY23 rates, Mercer and LDH will provide an updated certification for the RY23 rates for the time period from January 1, 2023, through June 30, 2023.

Table 37

Zolgensma® Risk Pool				
COA	Rate Cell	RY23 Projected MMs	Total Adjustment	PMPM
SSI	0–2 Months	727	$ 4,847	$6.66
SSI	3–11 Months	5,018	$ 33,437	$6.66
SSI	Child 1–20 Years	404,828	$ 87,275	$0.22
F&C	0–2 Months	107,113	$ 713,670	$6.66
F&C	3–11 Months	375,410	$2,501,286	$6.66
F&C	Child 1–20 Years	7,677,287	$3,034,485	$0.40

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.

On June 6, 2022, LDH received guidance from CMS related to an inquiry from LDH regarding risk mitigation changes, the shift in contract period, and the requirements for risk mitigation under 42 CFR 438.6(b)(1). CMS has advised LDH that risk mitigation mechanisms should remain consistent throughout the prior contract period for which rates were certified (CY 2022). Therefore, the MLR will be reported for CY 2022, and LDH will provide additional detail to the MCOs and CMS regarding a shift in the MLR measurement period to be consistent with the contract year.

State-Directed Payments

There are three State directed payments under 42 CFR § 438.6(c) proposed for the program in RY23. Preprints for applicable proposed payment arrangements were submitted to CMS in second quarter of 2022 and approved on August 19, 2022. The payments are accounted for in this rate certification in a manner that is consistent with the preprints submitted for CMS review. A summary of the State-directed payments described in this Section are provided in Table 38.

Table 38: State Directed Payment Overview

Control name	Type of payment	Brief description	Is the payment included as a rate adjustment or separate payment term
HLA Minimum Fee Schedule (no preprint required)	Minimum fee schedule	Minimum fee schedule set at Medicaid State plan rate	Rate adjustment
LA_Fee_IPH.OPH_New_20220701-20230630	Uniform percentage increase	Uniform percentage increase for services provided by eligible hospitals set as difference between 95% of average commercial rates and Medicaid base reimbursement	Separate payment term
LA_Fee_IPH.OPH1_New_20220701-20230630	Uniform percentage increase	Uniform percentage increase for services provided by eligible hospitals set as difference between 95% of average	Separate payment term

		commercial rates and Medicaid base reimbursement	

Additional detail related to the State-directed payment that was incorporated into this rate certification in the base capitation rates as a rate adjustment is provided in Table 39.

Table 39: Rate Adjustment State-Directed Payments

Control name	Rate cells affected	Impact	Description of the adjustment	Confirmation the rates are consistent with the preprint
HLA Minimum Fee Schedule (no preprint required)	All capitation rate cells	Adjustments are made as fee schedules change. See fee adjustment section.	Adjustments are made as fee schedules change. See fee adjustment section.	Not applicable

Additional detail related to the State-directed payments that will be incorporated as separate payment terms described in this Section are provided in Table 40.

Table 40: Separate Payment Term State-Directed Payments

Control name	Aggregate amount included in the certification	Statement that the actuary is certifying the separate payment term	The magnitude on a PMPM basis	Confirmation the rate development is consistent with the preprint	Confirmation that the state and actuary will submit required documentation at the end of the rating period
LA_Fee_IPH.OPH_New_20220701-20230630	$2,644.8 million	The signing actuary certifies the separate payment term.	Refer to Appendix B	Rate development is consistent with the submitted preprint. The preprint is approved by CMS.	After the RY23 rating period is complete, the State and actuary will submit documentation to CMS with the total payment based on actual inpatient and outpatient services.

Control name	Aggregate amount included in the certification	Statement that the actuary is certifying the separate payment term	The magnitude on a PMPM basis	Confirmation the rate development is consistent with the preprint	Confirmation that the state and actuary will submit required documentation at the end of the rating period
LA_Fee_IPH.OPH1_New_20220701-20230630	$40.8 million	The signing actuary certifies the separate payment term.	Refer to Appendix B	Rate development is consistent with the submitted preprint. The preprint is approved by CMS.	After the RY23 rating period is complete, the State and actuary will submit documentation to CMS with the total payment based on actual inpatient and outpatient services.

Minimum Fee Schedule

Mercer used fee schedule information from the State to develop its base and prospective fee schedule rating adjustments. In accordance with 42 CFR § 438.6(a) and 42 CFR § 438.6(c)(1)(iii)(A), Mercer 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
- PAD fee schedule
- FQHC and RHC fee schedule
- LSU enhanced fee schedule
- Hospital-based physician service fee schedule
- Ambulance services fee schedule
- NEMT fee schedule

- Air ambulance fee schedule
- General anesthesia and facility dental treatment fee schedule

Hospital Directed Payment

Effective July 1, 2022, the State will direct the Healthy Louisiana MCOs to provide a uniform percentage increase to their contracted rates with in-state providers of inpatient and outpatient hospital services, excluding freestanding psychiatric hospitals, freestanding rehabilitation hospitals, and long-term acute care hospitals. The uniform percentage increases are shown in Table 41 below. The payment increase supports achieving the Department's goals and objectives for this directed payment arrangement, which include ensuring equitable access to care for Medicaid beneficiaries. The State submitted a preprint to CMS and received approval on August 19, 2022 for a directed payment under 42 CFR §438.6(c)i.

Table 41

Provider Class	Inpatient % Increase	Outpatient % Increase
Tier 1	95.9%	131.0%
Tier 2	65.8%	87.3%
Tier 3	72.8%	135.1%
Tier 4	146.8%	158.9%
Tier 5	197.4%	238.0%

Eligible Providers

In-state providers of inpatient and outpatient hospital services, excluding freestanding psychiatric hospitals, freestanding rehabilitation hospitals, and long-term acute care hospitals, will be subject to the enhanced contracted rates.

Payment Amount

The uniform percentage increase has an estimated impact of approximately $1,092.3 million for inpatient and $1,407.0 million for outpatient. With the 5.5% premium tax accounted for, these amounts are $1,155.9 million for inpatient and $1,488.9 million for outpatient. After the RY23 rating period is complete, the State will submit documentation to CMS with the total payment based on actual inpatient and outpatient services. Since these payments will be made separately, no adjustment is applied to the rates included in Appendix A for these increases. Appendix B illustrates the PMPM amount estimated to each rate cell for this directed payment.

Distribution Methodology

Each hospital will receive quarterly interim lump-sum payments equal to the 'Interim Payment Increase Percentages' for the applicable hospital class multiplied by the hospital's 'Projected RY23 Managed Care Payments', divided by four. The projected RY23 Managed Care Payments are based on CY 2019 Medicaid managed care data.

The interim payments will be reconciled using actual utilization from the contract period after the end of the contract year. Approximately 12 months after end of the contract year, LDH will scale the 'Interim Payment Increase Percentages' by the same factor across the five hospital classes, separately for inpatient and outpatient, based on actual RY23 managed care payments to result in the total target statewide payment pools for inpatient and outpatient services. LDH will then calculate final directed payments for each hospital by multiplying the scaled Payment Increase Percentages against each hospital's actual RY23 managed care payments.

Any differences between the interim and final directed payments will be settled by the MCOs and each hospital through recoupment of payments (if the final payment amount based on actual utilization is less than the sum of the four quarterly interim payments based on projected utilization) or an additional payment (if the final payment based on actual utilization is more than the sum of the four quarterly interim payments based on projected utilization). Any recoupment or additional payment between the MCO and hospital due to the reconciliation process will take place concurrently with a regular quarterly payment during a separate contract year. As LDH is proposing a fixed payment pool, LDH does not anticipate there would be a need for recoupment from the MCOs as part of the annual reconciliation process. However, should an occasion arise where an MCO was paid more than its share at final settlement, LDH would follow a similar process for recoupment with the MCO, as necessary.

Long-Term Acute Care, Psychiatric, and Rehabilitation Hospitals Directed Payment

Effective July 1, 2022, the State will direct the Healthy Louisiana MCOs to provide a uniform percentage increase to their contracted rates with in-state Long-Term Acute Care (LTAC), Psychiatric, and Rehabilitation (LPR) providers of inpatient and outpatient hospital services. The uniform percentage increases are shown in Table 42 below. The payment increase supports achieving the Department's goals and objectives for this directed payment arrangement, which include ensuring equitable access to care for Medicaid beneficiaries. The State submitted a preprint to CMS and received approval on August 19, 2022 for a directed payment under 42 CFR §438.6(c)i.

Table 42

Provider Class	Inpatient % Increase	Outpatient % Increase
LTAC	22.8%	181.5%
Psychiatric	21.9%	2.8%
Rehabilitation	28.4%	191.7%

Eligible Providers

In-state hospital providers of LPR services for both inpatient and outpatient hospital services will be subject to the enhanced contracted rates. All public state-owned hospitals and freestanding psychiatric hospitals participating in DSH, as defined in the Louisiana's State plan, Attachment 4.19-A, Item 1, Page 10 (e) and (k)(9), respectively, are not included in the psychiatric provider class and are excluded from participating in the state directed payment program.

Payment Amount

The uniform percentage increase has an estimated impact of approximately $38.1 million for inpatient and $0.5 million for outpatient. With the 5.5% premium tax accounted for, these amounts are $40.3 million for inpatient and $0.5 million for outpatient. After the RY23 rating period is complete, the State will submit documentation to CMS with the total payment based on actual inpatient and outpatient services. Since these payments will be made separately, no adjustment is applied to the rates included in Appendix A for these increases. Appendix B illustrates the PMPM amount estimated to each rate cell for this directed payment.

Distribution Methodology

Each hospital will receive quarterly interim lump-sum payments equal to the ‘Interim Payment Increase Percentages’ for the applicable hospital class multiplied by the hospital’s ‘Projected RY23 Managed Care Payments’, divided by four. The projected RY23 Managed Care Payments are based on CY 2019 Medicaid managed care data.

The interim payments will be reconciled using actual contract period utilization after the end of the contract year. Approximately 12 months after end of the contract year, LDH will scale the ‘Interim Payment Increase Percentages’ by the same factor for all LTAC, Psychiatric, and Rehab hospitals across each of the three classes, separately for inpatient and outpatient, based on actual RY23 managed care payments to result in the total target statewide payment pools for inpatient and outpatient services. LDH will then calculate final directed payments for each hospital by multiplying the scaled Payment Increase Percentages against each hospital’s actual RY23 managed care payments.

Any differences between the interim and final directed payments will be settled by the MCOs and each hospital through recoupment of payments (if the final payment amount based on actual utilization is less than the sum of the four quarterly interim payments based on projected utilization) or an additional payment (if the final payment based on actual utilization is more than the sum of the four quarterly interim payments based on projected utilization). Any recoupment or additional payment between the MCO and hospital due to the reconciliation process will take place concurrently with a regular quarterly payment during a separate contract year. As LDH is proposing a fixed payment pool, LDH does not anticipate there would be a need for recoupment from the MCOs as part of the annual reconciliation process. However, should an occasion arise where an MCO was paid more than its share at final settlement, LDH would follow a similar process for recoupment with the MCO, as necessary.

Section 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 43.

Table 43

Administrative PMPM by Program	
Non-Expansion PH	$ 32.21
Non-Expansion SBH	$ 5.19
Maternity Kick Payment	$410.86
Expansion	$ 41.99

Due to the expected increase in the number of Medicaid enrollees projected to be treated for hepatitis C between July 1, 2022 and June 30, 2023, 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 July 1, 2022 and June 30, 2023. A summary of the estimated impact of these changes by rate cell and region are summarized below in Table 44.

Table 44

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	$0.21	$0.10	$0.14

COA	Rate Cell	Fixed Admin PMPM Add-On			
		Gulf	Capital	South Central	North
F&C	Child 1–20 Years	$0.00	$0.00	$0.00	$0.00
F&C	Adult 21+ Years	$0.04	$0.05	$0.02	$0.02
FCC	All Ages Male & Female	$0.01	$0.00	$0.01	$0.00
BCC	BCC, All Ages	$0.12	$0.00	$0.00	$0.00
HCBS	Adult 21+ Years	$0.04	$0.04	$0.02	$0.00
Medicaid Expansion	Age 19–64	$0.07	$0.07	$0.03	$0.03
Medicaid Expansion	High Needs	$1.16	$1.36	$0.79	$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 RY23 capitation rates.

Section 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 that 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 that 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 or 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 45 shows the rate cells that will be risk adjusted.

Table 45

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

Separate sets of risk scores are developed for each rate cell and region, except for LAP, in which 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.

Section 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. Mercer has reviewed the data and information for internal consistency and reasonableness, but did not audit them. In Mercer's opinion, they are appropriate for the intended purposes. The data reliance attestation will be provided in the final rate certification, 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 its judgment. Use of such simplifying techniques does not, in Mercer's 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.

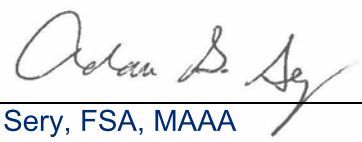
LDH understands that Mercer is not engaged in the practice of law or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends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

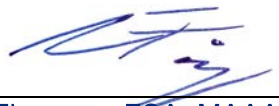
LDH agrees to notify Mercer within 30 days of receipt of this report if it disagrees with anything contained in this report or is aware of any information or data that would affect the results of this report that has not been communicated or provided to Mercer or incorporated herein. The report will 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



Rogelio Figueroa, FSA, MAAA
Senior Associate

Copy: Tara Leblanc, Medicaid Executive Director – LDH
Bogdan Constantin, Managed Care Finance – LDH
Karen Stubbs, Assistant Secretary – OBH/LDH
Amanda Joyner, Deputy Assistant Secretary – OBH/LDH
Rachel Butler, ASA, MAAA, Principal – Mercer
F. Ronald Ogborne III, FSA, CERA, MAAA, Partner – Mercer

Appendix A

RY23 Healthy Louisiana Capitation Rates

Region Description	Category of Aid Description	Rate Cell Description	Projected Member Months/Deliveries	Certified Rates
Gulf	SSI	0-2 Months	225	$ 29,151.32
Gulf	SSI	3-11 Months	1,362	$ 4,863.42
Gulf	SSI	Child 1-20 Years	112,081	$ 814.54
Gulf	SSI	Adult 21+ Years	285,554	$ 1,669.06
Gulf	F&C	0-2 Months	29,056	$ 2,966.63
Gulf	F&C	3-11 Months	102,424	$ 326.47
Gulf	F&C	Child 1-20 Years	2,109,226	$ 187.81
Gulf	F&C	Adult 21+ Years	297,547	$ 462.15
Gulf	FCC	All Ages Male & Female	31,457	$ 497.57
Gulf	BCC	BCC, All Ages	1,036	$ 2,795.03
Gulf	LAP	LAP, All Ages	5,642	$ 246.58
Gulf	HCBS	Child 1-20 Years	3,263	$ 2,486.92
Gulf	HCBS	Adult 21+ Years	6,992	$ 1,853.66
Gulf	CCM	CCM, All Ages	14,827	$ 1,513.25
Gulf	SBH - CCM	SBH - CCM, All Ages	5,370	$ 215.32
Gulf	SBH - Duals	SBH - Dual Eligible, All Ages	405,927	$ 36.63
Gulf	SBH - LaHIPP	SBH - LaHIPP, All Ages	193	$ 36.63
Gulf	SBH - HCBS	Child 1-20 Years	4,716	$ 168.89
Gulf	SBH - HCBS	Adult 21+ Years	9,211	$ 79.81
Gulf	SBH - Other	SBH - All Ages	5,861	$ 184.85
Gulf	Act 421, Non-TPL	0-2 Months	-	$ 28,007.45
Gulf	Act 421, Non-TPL	3-11 Months	229	$ 3,956.64
Gulf	Act 421, Non-TPL	Child 1-18 Years	2,631	$ 1,294.12
Gulf	Act 421, Non-LaHIPP TPL	0-2 Months	-	$ 4,280.72
Gulf	Act 421, Non-LaHIPP TPL	3-11 Months	343	$ 775.22
Gulf	Act 421, Non-LaHIPP TPL	Child 1-18 Years	3,946	$ 561.61
Gulf	Act 421, LaHIPP TPL	0-2 Months	-	$ 18.06
Gulf	Act 421, LaHIPP TPL	3-11 Months	343	$ 10.09
Gulf	Act 421, LaHIPP TPL	Child 1-18 Years	3,946	$ 304.83
Gulf	Maternity Kick Payment	Maternity Kick Payment	7,180	$ 11,644.33
Gulf	EED Kick Payment	EED Kick Payment	1	$ 5,911.37
Gulf	Medicaid Expansion	Age 19-64	2,172,921	$ 586.45
Gulf	Medicaid Expansion	SBH - Dual Eligible, All Ages	20,906	$ 36.63
Gulf	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 36.63
Gulf	Medicaid Expansion	SBH - Other	35	$ 184.85
Gulf	Medicaid Expansion	SBH - CCM, All Ages	171	$ 215.32
Gulf	Medicaid Expansion	High Needs	747	$ 586.45
Gulf	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,582	$ 13,889.38
Gulf	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 7,855.15
Capital	SSI	0-2 Months	178	$ 29,750.29
Capital	SSI	3-11 Months	1,299	$ 4,744.20
Capital	SSI	Child 1-20 Years	90,152	$ 842.00
Capital	SSI	Adult 21+ Years	207,213	$ 1,787.86
Capital	F&C	0-2 Months	27,823	$ 3,384.74
Capital	F&C	3-11 Months	96,825	$ 336.40
Capital	F&C	Child 1-20 Years	1,936,770	$ 198.67
Capital	F&C	Adult 21+ Years	269,063	$ 498.04
Capital	FCC	All Ages Male & Female	51,230	$ 455.41
Capital	BCC	BCC, All Ages	1,460	$ 2,767.09
Capital	LAP	LAP, All Ages	7,213	$ 244.76
Capital	HCBS	Child 1-20 Years	3,552	$ 2,531.66
Capital	HCBS	Adult 21+ Years	6,721	$ 1,858.86
Capital	CCM	CCM, All Ages	10,827	$ 1,545.10
Capital	SBH - CCM	SBH - CCM, All Ages	5,879	$ 217.55
Capital	SBH - Duals	SBH - Dual Eligible, All Ages	320,672	$ 30.76
Capital	SBH - LaHIPP	SBH - LaHIPP, All Ages	152	$ 30.76
Capital	SBH - HCBS	Child 1-20 Years	5,940	$ 167.59
Capital	SBH - HCBS	Adult 21+ Years	8,862	$ 81.67
Capital	SBH - Other	SBH - All Ages	9,038	$ 176.24
Capital	Act 421, Non-TPL	0-2 Months	-	$ 28,007.45
Capital	Act 421, Non-TPL	3-11 Months	229	$ 3,956.64
Capital	Act 421, Non-TPL	Child 1-18 Years	2,631	$ 1,294.12
Capital	Act 421, Non-LaHIPP TPL	0-2 Months	-	$ 4,280.72
Capital	Act 421, Non-LaHIPP TPL	3-11 Months	343	$ 775.22
Capital	Act 421, Non-LaHIPP TPL	Child 1-18 Years	3,946	$ 561.61
Capital	Act 421, LaHIPP TPL	0-2 Months	-	$ 18.06
Capital	Act 421, LaHIPP TPL	3-11 Months	343	$ 10.09
Capital	Act 421, LaHIPP TPL	Child 1-18 Years	3,946	$ 304.83
Capital	Maternity Kick Payment	Maternity Kick Payment	6,430	$ 10,744.75
Capital	EED Kick Payment	EED Kick Payment	1	$ 5,395.05
Capital	Medicaid Expansion	Age 19-64	1,767,938	$ 653.23
Capital	Medicaid Expansion	SBH - Dual Eligible, All Ages	16,267	$ 30.76
Capital	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 30.76
Capital	Medicaid Expansion	SBH - Other	113	$ 176.24
Capital	Medicaid Expansion	SBH - CCM, All Ages	235	$ 217.55
Capital	Medicaid Expansion	High Needs	638	$ 653.23
Capital	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,428	$ 13,715.66
Capital	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 7,645.10

Region Description	Category of Aid Description	Rate Cell Description	Projected Member Months/Deliveries	Certified Rates
South Central	SSI	0-2 Months	183	$ 28,713.76
South Central	SSI	3-11 Months	1,145	$ 4,735.85
South Central	SSI	Child 1-20 Years	98,051	$ 746.28
South Central	SSI	Adult 21+ Years	253,894	$ 1,518.07
South Central	F&C	0-2 Months	29,712	$ 2,979.98
South Central	F&C	3-11 Months	103,356	$ 338.76
South Central	F&C	Child 1-20 Years	2,086,258	$ 192.78
South Central	F&C	Adult 21+ Years	299,017	$ 440.97
South Central	FCC	All Ages Male & Female	55,209	$ 397.01
South Central	BCC	BCC, All Ages	816	$ 2,726.34
South Central	LAP	LAP, All Ages	5,610	$ 243.66
South Central	HCBS	Child 1-20 Years	3,392	$ 2,507.86
South Central	HCBS	Adult 21+ Years	8,178	$ 1,864.73
South Central	CCM	CCM, All Ages	12,502	$ 1,523.35
South Central	SBH - CCM	SBH - CCM, All Ages	5,460	$ 221.96
South Central	SBH - Duals	SBH - Dual Eligible, All Ages	382,388	$ 33.46
South Central	SBH - LaHIPP	SBH - LaHIPP, All Ages	181	$ 33.46
South Central	SBH - HCBS	Child 1-20 Years	4,958	$ 165.08
South Central	SBH - HCBS	Adult 21+ Years	9,610	$ 82.68
South Central	SBH - Other	SBH - All Ages	8,992	$ 187.04
South Central	Act 421, Non-TPL	0-2 Months	-	$ 28,007.45
South Central	Act 421, Non-TPL	3-11 Months	229	$ 3,956.64
South Central	Act 421, Non-TPL	Child 1-18 Years	2,631	$ 1,294.12
South Central	Act 421, Non-LaHIPP TPL	0-2 Months	-	$ 4,280.72
South Central	Act 421, Non-LaHIPP TPL	3-11 Months	343	$ 775.22
South Central	Act 421, Non-LaHIPP TPL	Child 1-18 Years	3,946	$ 561.61
South Central	Act 421, LaHIPP TPL	0-2 Months	-	$ 18.06
South Central	Act 421, LaHIPP TPL	3-11 Months	343	$ 10.09
South Central	Act 421, LaHIPP TPL	Child 1-18 Years	3,946	$ 304.83
South Central	Maternity Kick Payment	Maternity Kick Payment	7,057	$ 9,695.48
South Central	EED Kick Payment	EED Kick Payment	1	$ 4,369.50
South Central	Medicaid Expansion	Age 19-64	1,846,491	$ 562.87
South Central	Medicaid Expansion	SBH - Dual Eligible, All Ages	19,921	$ 33.46
South Central	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 33.46
South Central	Medicaid Expansion	SBH - Other	89	$ 187.04
South Central	Medicaid Expansion	SBH - CCM, All Ages	187	$ 221.96
South Central	Medicaid Expansion	High Needs	313	$ 562.87
South Central	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,754	$ 11,901.93
South Central	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 6,078.78
North	SSI	0-2 Months	141	$ 28,657.44
North	SSI	3-11 Months	1,213	$ 4,678.17
North	SSI	Child 1-20 Years	104,544	$ 704.08
North	SSI	Adult 21+ Years	229,509	$ 1,457.23
North	F&C	0-2 Months	20,521	$ 2,900.78
North	F&C	3-11 Months	72,805	$ 327.30
North	F&C	Child 1-20 Years	1,545,033	$ 197.15
North	F&C	Adult 21+ Years	212,750	$ 439.33
North	FCC	All Ages Male & Female	38,932	$ 542.10
North	BCC	BCC, All Ages	844	$ 2,725.12
North	LAP	LAP, All Ages	3,912	$ 244.73
North	HCBS	Child 1-20 Years	2,638	$ 2,503.96
North	HCBS	Adult 21+ Years	6,059	$ 1,869.42
North	CCM	CCM, All Ages	10,756	$ 1,524.25
North	SBH - CCM	SBH - CCM, All Ages	4,776	$ 219.23
North	SBH - Duals	SBH - Dual Eligible, All Ages	314,005	$ 40.66
North	SBH - LaHIPP	SBH - LaHIPP, All Ages	149	$ 40.66
North	SBH - HCBS	Child 1-20 Years	3,254	$ 165.84
North	SBH - HCBS	Adult 21+ Years	6,593	$ 88.93
North	SBH - Other	SBH - All Ages	7,773	$ 183.03
North	Act 421, Non-TPL	0-2 Months	-	$ 28,007.45
North	Act 421, Non-TPL	3-11 Months	229	$ 3,956.64
North	Act 421, Non-TPL	Child 1-18 Years	2,631	$ 1,294.12
North	Act 421, Non-LaHIPP TPL	0-2 Months	-	$ 4,280.72
North	Act 421, Non-LaHIPP TPL	3-11 Months	343	$ 775.22
North	Act 421, Non-LaHIPP TPL	Child 1-18 Years	3,946	$ 561.61
North	Act 421, LaHIPP TPL	0-2 Months	-	$ 18.06
North	Act 421, LaHIPP TPL	3-11 Months	343	$ 10.09
North	Act 421, LaHIPP TPL	Child 1-18 Years	3,946	$ 304.83
North	Maternity Kick Payment	Maternity Kick Payment	4,919	$ 10,780.46
North	EED Kick Payment	EED Kick Payment	1	$ 4,818.53
North	Medicaid Expansion	Age 19-64	1,434,478	$ 551.47
North	Medicaid Expansion	SBH - Dual Eligible, All Ages	14,390	$ 40.66
North	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 40.66
North	Medicaid Expansion	SBH - Other	35	$ 183.03
North	Medicaid Expansion	SBH - CCM, All Ages	140	$ 219.23
North	Medicaid Expansion	High Needs	182	$ 551.47
North	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	2,763	$ 12,929.45
North	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 6,570.58

Appendix B

Healthy Louisiana Directed Payment PMPMs

				PMPMs Without Premium Tax		PMPMs With Premium Tax	
Region Description	Category of Aid Description	Rate Cell Description	Projected Member Months/Deliveries	Hospital Directed Payment	LPR Hospital Directed Payment	Hospital Directed Payment	LPR Hospital Directed Payment
Gulf	SSI	0-2 Months	225	$ 16,265.62	$ 23.58	$ 17,212.30	$ 24.95
Gulf	SSI	3-11 Months	1,362	$ 3,061.96	$ 4.46	$ 3,240.17	$ 4.72
Gulf	SSI	Child 1-20 Years	112,081	$ 257.82	$ 2.74	$ 272.83	$ 2.90
Gulf	SSI	Adult 21+ Years	285,554	$ 475.75	$ 8.70	$ 503.44	$ 9.21
Gulf	F&C	0-2 Months	29,056	$ 2,090.03	$ 2.63	$ 2,211.67	$ 2.78
Gulf	F&C	3-11 Months	102,424	$ 142.43	$ 0.06	$ 150.72	$ 0.06
Gulf	F&C	Child 1-20 Years	2,109,226	$ 52.62	$ 0.30	$ 55.68	$ 0.32
Gulf	F&C	Adult 21+ Years	297,547	$ 136.65	$ 1.75	$ 144.60	$ 1.85
Gulf	FCC	All Ages Male & Female	31,457	$ 129.69	$ 3.40	$ 137.24	$ 3.60
Gulf	BCC	BCC, All Ages	1,036	$ 1,998.58	$ 0.25	$ 2,114.90	$ 0.26
Gulf	LAP	LAP, All Ages	5,642	$ 53.38	$ 0.42	$ 56.49	$ 0.44
Gulf	HCBS	Child 1-20 Years	3,263	$ 488.53	$ 0.54	$ 516.96	$ 0.57
Gulf	HCBS	Adult 21+ Years	6,992	$ 319.89	$ 3.09	$ 338.51	$ 3.27
Gulf	CCM	CCM, All Ages	14,827	$ 183.89	$ 0.37	$ 194.59	$ 0.39
Gulf	SBH - CCM	SBH - CCM, All Ages	5,370	$ 0.24	$ 1.91	$ 0.25	$ 2.02
Gulf	SBH - Duals	SBH - Dual Eligible, All Ages	405,927	$ 0.05	$ 0.24	$ 0.05	$ 0.25
Gulf	SBH - LaHIPP	SBH - LaHIPP, All Ages	193	$ 0.05	$ 0.24	$ 0.05	$ 0.25
Gulf	SBH - HCBS	Child 1-20 Years	4,716	$ 0.16	$ 0.49	$ 0.17	$ 0.52
Gulf	SBH - HCBS	Adult 21+ Years	9,211	$ 0.81	$ 1.73	$ 0.86	$ 1.83
Gulf	SBH - Other	SBH - All Ages	5,861	$ 2.71	$ 9.29	$ 2.87	$ 9.83
Gulf	Act 421, Non-TPL	0-2 Months	-	$ -	$ -	$ -	$ -
Gulf	Act 421, Non-TPL	3-11 Months	229	$ -	$ -	$ -	$ -
Gulf	Act 421, Non-TPL	Child 1-18 Years	2,631	$ -	$ -	$ -	$ -
Gulf	Act 421, Non-LaHIPP TPL	0-2 Months	-	$ -	$ -	$ -	$ -
Gulf	Act 421, Non-LaHIPP TPL	3-11 Months	343	$ -	$ -	$ -	$ -
Gulf	Act 421, Non-LaHIPP TPL	Child 1-18 Years	3,946	$ -	$ -	$ -	$ -
Gulf	Act 421, LaHIPP TPL	0-2 Months	-	$ -	$ -	$ -	$ -
Gulf	Act 421, LaHIPP TPL	3-11 Months	343	$ -	$ -	$ -	$ -
Gulf	Act 421, LaHIPP TPL	Child 1-18 Years	3,946	$ -	$ -	$ -	$ -
Gulf	Maternity Kick Payment	Maternity Kick Payment	7,180	$ 6,187.16	$ 7.71	$ 6,547.26	$ 8.16
Gulf	EED Kick Payment	EED Kick Payment	1	$ 6,187.16	$ 7.71	$ 6,547.26	$ 8.16
Gulf	Medicaid Expansion	Age 19-64	2,172,921	$ 126.13	$ 2.19	$ 133.47	$ 2.32
Gulf	Medicaid Expansion	SBH - Dual Eligible, All Ages	20,906	$ 0.05	$ 0.24	$ 0.05	$ 0.25
Gulf	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 0.05	$ 0.24	$ 0.05	$ 0.25
Gulf	Medicaid Expansion	SBH - Other	35	$ 2.71	$ 9.29	$ 2.87	$ 9.83
Gulf	Medicaid Expansion	SBH - CCM, All Ages	171	$ 0.24	$ 1.91	$ 0.25	$ 2.02
Gulf	Medicaid Expansion	High Needs	747	$ 246.48	$ 4.95	$ 260.83	$ 5.24
Gulf	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,582	$ 6,220.12	$ 8.64	$ 6,582.14	$ 9.14
Gulf	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 6,220.12	$ 8.64	$ 6,582.14	$ 9.14
Capital	SSI	0-2 Months	178	$ 38,255.11	$ 47.83	$ 40,481.60	$ 50.61
Capital	SSI	3-11 Months	1,299	$ 2,409.38	$ 2.69	$ 2,549.61	$ 2.85
Capital	SSI	Child 1-20 Years	90,152	$ 153.77	$ 2.87	$ 162.72	$ 3.04
Capital	SSI	Adult 21+ Years	207,213	$ 483.99	$ 12.20	$ 512.16	$ 12.91
Capital	F&C	0-2 Months	27,823	$ 2,180.01	$ 2.51	$ 2,306.89	$ 2.66
Capital	F&C	3-11 Months	96,825	$ 106.50	$ 0.07	$ 112.70	$ 0.07
Capital	F&C	Child 1-20 Years	1,936,770	$ 40.23	$ 0.39	$ 42.57	$ 0.41
Capital	F&C	Adult 21+ Years	269,063	$ 145.39	$ 2.91	$ 153.85	$ 3.08
Capital	FCC	All Ages Male & Female	51,230	$ 64.17	$ 3.72	$ 67.90	$ 3.94
Capital	BCC	BCC, All Ages	1,460	$ 1,434.90	$ 5.25	$ 1,518.41	$ 5.56
Capital	LAP	LAP, All Ages	7,213	$ 48.14	$ 0.01	$ 50.94	$ 0.01
Capital	HCBS	Child 1-20 Years	3,552	$ 445.69	$ 1.80	$ 471.63	$ 1.90
Capital	HCBS	Adult 21+ Years	6,721	$ 295.53	$ 7.19	$ 312.73	$ 7.61
Capital	CCM	CCM, All Ages	10,827	$ 127.41	$ 2.22	$ 134.83	$ 2.35
Capital	SBH - CCM	SBH - CCM, All Ages	5,879	$ 0.33	$ 0.68	$ 0.35	$ 0.72
Capital	SBH - Duals	SBH - Dual Eligible, All Ages	320,672	$ 0.04	$ 0.31	$ 0.04	$ 0.33
Capital	SBH - LaHIPP	SBH - LaHIPP, All Ages	152	$ 0.04	$ 0.31	$ 0.04	$ 0.33
Capital	SBH - HCBS	Child 1-20 Years	5,940	$ 0.13	$ 1.05	$ 0.14	$ 1.11
Capital	SBH - HCBS	Adult 21+ Years	8,862	$ 0.53	$ 2.97	$ 0.56	$ 3.14
Capital	SBH - Other	SBH - All Ages	9,038	$ 2.65	$ 3.98	$ 2.80	$ 4.21
Capital	Act 421, Non-TPL	0-2 Months	-	$ -	$ -	$ -	$ -
Capital	Act 421, Non-TPL	3-11 Months	229	$ -	$ -	$ -	$ -
Capital	Act 421, Non-TPL	Child 1-18 Years	2,631	$ -	$ -	$ -	$ -
Capital	Act 421, Non-LaHIPP TPL	0-2 Months	-	$ -	$ -	$ -	$ -
Capital	Act 421, Non-LaHIPP TPL	3-11 Months	343	$ -	$ -	$ -	$ -
Capital	Act 421, Non-LaHIPP TPL	Child 1-18 Years	3,946	$ -	$ -	$ -	$ -
Capital	Act 421, LaHIPP TPL	0-2 Months	-	$ -	$ -	$ -	$ -
Capital	Act 421, LaHIPP TPL	3-11 Months	343	$ -	$ -	$ -	$ -
Capital	Act 421, LaHIPP TPL	Child 1-18 Years	3,946	$ -	$ -	$ -	$ -
Capital	Maternity Kick Payment	Maternity Kick Payment	6,430	$ 6,097.69	$ 7.28	$ 6,452.58	$ 7.70
Capital	EED Kick Payment	EED Kick Payment	1	$ 6,097.69	$ 7.28	$ 6,452.58	$ 7.70
Capital	Medicaid Expansion	Age 19-64	1,767,938	$ 137.86	$ 3.30	$ 145.88	$ 3.49
Capital	Medicaid Expansion	SBH - Dual Eligible, All Ages	16,267	$ 0.04	$ 0.31	$ 0.04	$ 0.33
Capital	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 0.04	$ 0.31	$ 0.04	$ 0.33
Capital	Medicaid Expansion	SBH - Other	113	$ 2.65	$ 3.98	$ 2.80	$ 4.21
Capital	Medicaid Expansion	SBH - CCM, All Ages	235	$ 0.33	$ 0.68	$ 0.35	$ 0.72
Capital	Medicaid Expansion	High Needs	638	$ 794.59	$ 24.61	$ 840.84	$ 26.04
Capital	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,428	$ 6,220.87	$ 8.61	$ 6,582.93	$ 9.11
Capital	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 6,220.87	$ 8.61	$ 6,582.93	$ 9.11

				PMPMs Without Premium Tax		PMPMs With Premium Tax	
Region Description	Category of Aid Description	Rate Cell Description	Projected Member Months/Deliveries	Hospital Directed Payment	LPR Hospital Directed Payment	Hospital Directed Payment	LPR Hospital Directed Payment
South Central	SSI	0-2 Months	183	$ 14,083.37	$ 14.86	$ 14,903.04	$ 15.72
South Central	SSI	3-11 Months	1,145	$ 2,814.90	$ 2.82	$ 2,978.73	$ 2.98
South Central	SSI	Child 1-20 Years	98,051	$ 148.67	$ 4.05	$ 157.32	$ 4.29
South Central	SSI	Adult 21+ Years	253,894	$ 428.34	$ 11.38	$ 453.27	$ 12.04
South Central	F&C	0-2 Months	29,712	$ 2,131.11	$ 2.50	$ 2,255.14	$ 2.65
South Central	F&C	3-11 Months	103,356	$ 91.55	$ 0.06	$ 96.88	$ 0.06
South Central	F&C	Child 1-20 Years	2,086,258	$ 31.50	$ 0.65	$ 33.33	$ 0.69
South Central	F&C	Adult 21+ Years	299,017	$ 121.31	$ 1.84	$ 128.37	$ 1.95
South Central	FCC	All Ages Male & Female	55,209	$ 39.01	$ 4.45	$ 41.28	$ 4.71
South Central	BCC	BCC, All Ages	816	$ 1,125.25	$ 1.63	$ 1,190.74	$ 1.72
South Central	LAP	LAP, All Ages	5,610	$ 39.71	$ 0.34	$ 42.02	$ 0.36
South Central	HCBS	Child 1-20 Years	3,392	$ 409.54	$ 2.79	$ 433.38	$ 2.95
South Central	HCBS	Adult 21+ Years	8,178	$ 351.18	$ 7.38	$ 371.62	$ 7.81
South Central	CCM	CCM, All Ages	12,502	$ 127.08	$ 3.46	$ 134.48	$ 3.66
South Central	SBH - CCM	SBH - CCM, All Ages	5,460	$ 0.73	$ 5.12	$ 0.77	$ 5.42
South Central	SBH - Duals	SBH - Dual Eligible, All Ages	382,388	$ 0.06	$ 0.27	$ 0.06	$ 0.29
South Central	SBH - LaHIPP	SBH - LaHIPP, All Ages	181	$ 0.06	$ 0.27	$ 0.06	$ 0.29
South Central	SBH - HCBS	Child 1-20 Years	4,958	$ 0.16	$ 0.54	$ 0.17	$ 0.57
South Central	SBH - HCBS	Adult 21+ Years	9,610	$ 0.42	$ 1.38	$ 0.44	$ 1.46
South Central	SBH - Other	SBH - All Ages	8,992	$ 2.43	$ 12.48	$ 2.57	$ 13.21
South Central	Act 421, Non-TPL	0-2 Months	-	$ -	$ -	$ -	$ -
South Central	Act 421, Non-TPL	3-11 Months	229	$ -	$ -	$ -	$ -
South Central	Act 421, Non-TPL	Child 1-18 Years	2,631	$ -	$ -	$ -	$ -
South Central	Act 421, Non-LaHIPP TPL	0-2 Months	-	$ -	$ -	$ -	$ -
South Central	Act 421, Non-LaHIPP TPL	3-11 Months	343	$ -	$ -	$ -	$ -
South Central	Act 421, Non-LaHIPP TPL	Child 1-18 Years	3,946	$ -	$ -	$ -	$ -
South Central	Act 421, LaHIPP TPL	0-2 Months	-	$ -	$ -	$ -	$ -
South Central	Act 421, LaHIPP TPL	3-11 Months	343	$ -	$ -	$ -	$ -
South Central	Act 421, LaHIPP TPL	Child 1-18 Years	3,946	$ -	$ -	$ -	$ -
South Central	Maternity Kick Payment	Maternity Kick Payment	7,057	$ 5,071.50	$ 6.36	$ 5,366.67	$ 6.73
South Central	EED Kick Payment	EED Kick Payment	1	$ 5,071.50	$ 6.36	$ 5,366.67	$ 6.73
South Central	Medicaid Expansion	Age 19-64	1,846,491	$ 129.60	$ 2.72	$ 137.14	$ 2.88
South Central	Medicaid Expansion	SBH - Dual Eligible, All Ages	19,921	$ 0.06	$ 0.27	$ 0.06	$ 0.29
South Central	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 0.06	$ 0.27	$ 0.06	$ 0.29
South Central	Medicaid Expansion	SBH - Other	89	$ 2.43	$ 12.48	$ 2.57	$ 13.21
South Central	Medicaid Expansion	SBH - CCM, All Ages	187	$ 0.73	$ 5.12	$ 0.77	$ 5.42
South Central	Medicaid Expansion	High Needs	313	$ 256.91	$ 18.02	$ 271.86	$ 19.07
South Central	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,754	$ 5,429.21	$ 7.96	$ 5,745.20	$ 8.42
South Central	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 5,429.21	$ 7.96	$ 5,745.20	$ 8.42
North	SSI	0-2 Months	141	$ 15,263.11	$ 15.84	$ 16,151.44	$ 16.76
North	SSI	3-11 Months	1,213	$ 1,711.77	$ 1.47	$ 1,811.40	$ 1.56
North	SSI	Child 1-20 Years	104,544	$ 167.60	$ 5.19	$ 177.35	$ 5.49
North	SSI	Adult 21+ Years	229,509	$ 477.00	$ 8.41	$ 504.76	$ 8.90
North	F&C	0-2 Months	20,521	$ 2,245.87	$ 2.47	$ 2,376.58	$ 2.61
North	F&C	3-11 Months	72,805	$ 104.12	$ 0.05	$ 110.18	$ 0.05
North	F&C	Child 1-20 Years	1,545,033	$ 35.46	$ 0.85	$ 37.52	$ 0.90
North	F&C	Adult 21+ Years	212,750	$ 119.76	$ 1.57	$ 126.73	$ 1.66
North	FCC	All Ages Male & Female	38,932	$ 53.25	$ 6.83	$ 56.35	$ 7.23
North	BCC	BCC, All Ages	844	$ 1,685.45	$ 2.35	$ 1,783.54	$ 2.49
North	LAP	LAP, All Ages	3,912	$ 54.47	$ 0.29	$ 57.64	$ 0.31
North	HCBS	Child 1-20 Years	2,638	$ 211.72	$ 0.86	$ 224.04	$ 0.91
North	HCBS	Adult 21+ Years	6,059	$ 349.88	$ 9.70	$ 370.24	$ 10.26
North	CCM	CCM, All Ages	10,756	$ 96.71	$ 4.05	$ 102.34	$ 4.29
North	SBH - CCM	SBH - CCM, All Ages	4,776	$ 0.62	$ 4.91	$ 0.66	$ 5.20
North	SBH - Duals	SBH - Dual Eligible, All Ages	314,005	$ 0.03	$ 0.15	$ 0.03	$ 0.16
North	SBH - LaHIPP	SBH - LaHIPP, All Ages	149	$ 0.03	$ 0.15	$ 0.03	$ 0.16
North	SBH - HCBS	Child 1-20 Years	3,254	$ 0.47	$ 3.48	$ 0.50	$ 3.68
North	SBH - HCBS	Adult 21+ Years	6,593	$ 0.71	$ 3.00	$ 0.75	$ 3.17
North	SBH - Other	SBH - All Ages	7,773	$ 1.61	$ 4.99	$ 1.70	$ 5.28
North	Act 421, Non-TPL	0-2 Months	-	$ -	$ -	$ -	$ -
North	Act 421, Non-TPL	3-11 Months	229	$ -	$ -	$ -	$ -
North	Act 421, Non-TPL	Child 1-18 Years	2,631	$ -	$ -	$ -	$ -
North	Act 421, Non-LaHIPP TPL	0-2 Months	-	$ -	$ -	$ -	$ -
North	Act 421, Non-LaHIPP TPL	3-11 Months	343	$ -	$ -	$ -	$ -
North	Act 421, Non-LaHIPP TPL	Child 1-18 Years	3,946	$ -	$ -	$ -	$ -
North	Act 421, LaHIPP TPL	0-2 Months	-	$ -	$ -	$ -	$ -
North	Act 421, LaHIPP TPL	3-11 Months	343	$ -	$ -	$ -	$ -
North	Act 421, LaHIPP TPL	Child 1-18 Years	3,946	$ -	$ -	$ -	$ -
North	Maternity Kick Payment	Maternity Kick Payment	4,919	$ 6,079.26	$ 8.95	$ 6,433.08	$ 9.47
North	EED Kick Payment	EED Kick Payment	1	$ 6,079.26	$ 8.95	$ 6,433.08	$ 9.47
North	Medicaid Expansion	Age 19-64	1,434,478	$ 131.28	$ 1.94	$ 138.92	$ 2.05
North	Medicaid Expansion	SBH - Dual Eligible, All Ages	14,390	$ 0.03	$ 0.15	$ 0.03	$ 0.16
North	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 0.03	$ 0.15	$ 0.03	$ 0.16
North	Medicaid Expansion	SBH - Other	35	$ 1.61	$ 4.99	$ 1.70	$ 5.28
North	Medicaid Expansion	SBH - CCM, All Ages	140	$ 0.62	$ 4.91	$ 0.66	$ 5.20
North	Medicaid Expansion	High Needs	182	$ 757.83	$ 7.55	$ 801.94	$ 7.99
North	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	2,763	$ 6,706.97	$ 6.13	$ 7,097.32	$ 6.49
North	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 6,706.97	$ 6.13	$ 7,097.32	$ 6.49

Appendix C

Healthy Louisiana Eligibility Designation

Covered Populations					
Aid Category Description	**Type Case Description**	**Adult/Child/All Ages**	**Mandatory**	**Voluntary Opt In**	**SBH and 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 Medicaid Option (LaHIPP)	Child			●
	Children's Medicaid Option (Non-LaHIPP TPL)	Child	●		
	Children's Medicaid Option (Non-TPL)	Child	●		
	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 and NF Fee (Aged)	Adult			●
	Excess Home Equity Over SIL and 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 Years	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 years otherwise eligible for Medicaid who are listed on the OCDD's Request for Services Registry who are CCM.

** Dual eligibles included in Healthy Louisiana for SBH and NEMT services must be in a mandatory, voluntary opt-in or SBH and NEMT population 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 and NF Fee (Aged)	Child
	Excess Home Equity SSI Under SIL (Aged)	Child
	Excess Home Equity SSI Under SIL-Reg LTC (Aged)	Child
	Forced Benefits (Aged)	Child
	Forced Benefits (Disabled)	All Ages
	Illegal/Ineligible Aliens Emergency Services	All Ages
	LBHP - Adult 1915(i)	All Ages
	LTC (Long-Term Care) (Aged)	Child
	LTC Co-Insurance	All Ages
	LTC MNP/Transfer of Resources (Aged)	Child
	LTC Payment Denial/Late Admission Packet (Aged)	Child
	LTC Spenddown MNP (Aged)	Child
	LTC Spenddown MNP (Income > Facility Fee)	All Ages
	PACE SSI	All Ages
	PACE SSI-related	All Ages
	PCA Waiver	All Ages
	Private ICF/DD (Aged and Disabled)	All Ages
	Private ICF/DD (Blind)	Adult
	Private ICF/DD MNP Transfer of Resources (Blind and Disabled)	Adult
	Private ICF/DD Spenddown Medically Needy Program (Aged and Disabled)	All Ages
	Private ICF/DD Spenddown Medically Needy Program (Blind)	Adult
	Private ICF/DD Spenddown MNP/Income Over Facility Fee	All Ages
	Private ICF/DD Transfer of Resources (Blind and Disabled)	Adult
	Public ICF/DD (Aged and Disabled)	All Ages
	Public ICF/DD (Blind)	Adult
	Public ICF/DD MNP Transfer of Resources (Blind and Disabled)	Adult
	Public ICF/DD Spenddown MNP	All Ages
	Public ICF/DD Spenddown Medically Needy Program (Blind and Disabled)	Adult
	Public ICF/DD Spenddown MNP/Income Over Facility Fee	All Ages
	Public ICF/DD Transfer of Resources (Blind and Disabled)	Adult
	QI-1 (Qualified Individual - 1)	All Ages
	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	All Ages
	SLMB (Specified Low-Income Medicare Beneficiary)	All Ages
	Spenddown MNP	All Ages
	Spenddown Denial of Payment/Late Packet (Aged and Disabled)	All Ages
	Spenddown Denial of Payment/Late Packet (Blind)	Adult
	SSI DD Waiver	All Ages
	SSI Payment Denial/Late Admission (Aged)	Child
	SSI PCA Waiver	All Ages
	SSI Private ICF/DD Transfer of Resources (Blind and Disabled)	Adult
	SSI Public ICF/DD Transfer of Resources (Blind and Disabled)	Adult
	SSI Transfer of Resource(s)/LTC (Aged)	Child
	SSI/EDA Waiver	All Ages
	SSI/LTC (Aged)	Child
	SSI/Private ICF/DD (Aged and Disabled)	All Ages
	SSI/Private ICF/DD (Blind)	Adult
	SSI/Public ICF/DD (Aged and Disabled)	All Ages
	SSI/Public ICF/DD (Blind)	Adult
	Terminated SSI Prior Period	All Ages
	Transfer of Resource(s)/LTC (Aged)	Child

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 Years (State Funded)	All Ages
	OYD (Office of Youth Development)	All Ages
	Private ICF/DD	Adult
	Public ICF/DD	Adult
	SSI DD Waiver	All Ages
	SSI/LTC	Adult
	SSI/Private ICF/DD	Adult
	SSI/Public ICF/DD	Adult
	YAP (Young Adult Program) (OCS/OYD Child)	All Ages
Presumptive Eligible		
	HPE Family Planning	All Ages
	HPE Take Charge Plus	All Ages
QMB		All Ages
Refugee Asst		
	Forced Benefits	All Ages
	Regular MNP (Medically Needy Program)	All Ages
	SSI Conversion / Refugee Cash Assistance (RCA)/LIFC Basic	All Ages

Appendix D

Healthy Louisiana Covered Services

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 Years–20 Years)	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
Applied Behavioral Analysis	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
Applied Behavioral Analysis	Units	Transportation and SBH
NEMT	Units	Transportation and SBH

Appendix E

Act 421 Rating Adjustments

Table 1: Proxy Population Mapping

Act 421 Children's Medicaid Option Population	Healthy Louisiana Proxy Population(s)
0-2 Months	SSI, 0-2 Months
3-11 Months	SSI, 3-11 Months
Child 1-18 Years	SSI Child 1-20 Years (Non-I/DD, Child 1 Year-18 Years) Chisolm Class Members, All Ages (I/DD, Child 1 Year-18 Years)

Table 2: RY23 Proxy PMPMs by Population

Act 421 Children's Medicaid Option Population	Non-TPL/Non-LaHIPP TPL	LaHIPP TPL
0-2 Months	$19,616.14	$79.01
3-11 Months	$3,570.50	$60.08
Child 1-18 Years	$1,027.57	$303.49

Table 3: Relative Acuity Adjustments

Act 421 Children's Medicaid Option Population	Non-TPL/Non-LaHIPP TPL	LaHIPP TPL
0-2 Months	25.67%	34.15%
3-11 Months	-2.66%	-1.66%
Child 1-18 Years	8.78%	20.83%

Table 4: TPL Wrap-Around Adjustment

Act 421 Children's Medicaid Option Population	Non-LaHIPP TPL	LaHIPP TPL
0-2 Months	-84.74%	-85.00%
3-11 Months	-80.41%	-85.00%
Child 1-18 Years	-56.65%	-28.17%

Table 5: Admin PMPMs

Act 421 Children's Medicaid Option Population	Non-TPL	Non-LaHIPP TPL	LaHIPP TPL
0-2 Months	$ 1,412.32	$ 215.86	$ 0.91
3-11 Months	$ 207.41	$ 40.64	$ 0.53
Child 1-18 Years	$ 85.91	$ 37.33	$ 20.33

Appendix F

In Lieu of Services

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 Years to 64 Years 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 Years and Above)						$ 1,233
	Injection Services Provided by Licensed Nurses to All Medicaid-Eligible Adults (Age 21 Years 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**
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 G

Non-Rx Hepatitis C Expense Adjustment

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%
Hepatitis C Recipients 2019 Q1 & Q2	491
Hepatitis C Recipients 2019 Q3 & Q4	2,493
Hepatitis 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	-2.67%

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

Appendix H

Medication Assisted Treatment Adjustment

	Non-Expansion Program				Expansion Program			
SFY	Methadone Bundle	Buprenorphine Bundle	Tranportation	Total	Methadone Bundle	Buprenorphine Bundle	Tranportation	Total
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 7/1/22-6/30/23	$5,499,141		$13,368,936

Appendix I

Prospective Trend

Annualized RY23 Trends by Major COS								
Rate Cell	PH		Rx		SBH		All Services	
	Low	High	Low	High	Low	High	Low	High
SSI								
0-2 Months	-0.61%	1.13%	3.64%	7.67%	-1.00%	1.97%	-0.59%	1.16%
3-11 Months	-1.02%	0.98%	3.84%	8.11%	-1.00%	1.97%	-0.44%	1.86%
Child 1-20 Years	-1.36%	0.91%	5.96%	9.21%	-0.53%	1.69%	0.80%	3.34%
Adult 21+ Years	-0.10%	2.21%	8.24%	11.33%	1.17%	4.79%	3.18%	5.92%
SSI Total	**-0.33%**	**1.96%**	**7.93%**	**11.04%**	**0.60%**	**3.77%**	**2.69%**	**5.39%**
F&C								
0-2 Months	0.97%	3.23%	2.54%	4.58%	-6.56%	-4.12%	0.98%	3.23%
3-11 Months	1.57%	4.22%	4.13%	6.62%	-6.56%	-4.12%	1.76%	4.39%
Child 1-20 Years	1.58%	4.23%	3.54%	5.78%	-4.38%	-2.04%	0.98%	3.48%
Adult 21+ Years	0.71%	3.01%	7.86%	10.49%	2.09%	4.02%	3.29%	5.67%
Families and Children Total	**1.31%**	**3.83%**	**4.92%**	**7.30%**	**-3.28%**	**-1.01%**	**1.47%**	**3.92%**
HCBS								
Child 1-20 Years	-3.69%	-1.21%	7.90%	10.80%	-0.17%	1.10%	-1.40%	1.00%
Adult 21+ Years	0.15%	2.55%	7.90%	10.80%	0.98%	4.72%	3.62%	6.31%
HCBS Total	**-1.74%**	**0.70%**	**7.90%**	**10.80%**	**0.30%**	**2.60%**	**1.59%**	**4.18%**
Other Populations								
FCC, All Ages Male & Female	1.89%	4.68%	4.36%	6.72%	-4.05%	-1.53%	-0.22%	2.37%
BCC, All Ages	-0.53%	1.62%	10.99%	14.73%	1.57%	5.24%	2.99%	5.68%
LAP, All Ages	1.61%	4.38%	6.26%	8.76%	-2.90%	-1.28%	2.43%	4.98%
CCM, All Ages	-3.00%	-0.48%	10.90%	14.00%	-0.17%	0.59%	0.39%	2.49%
SBH Only HCBS								
Child 1-20 Years	-6.54%	-4.59%	0.00%	0.00%	0.36%	1.05%	-0.06%	0.70%
Adult 21+ Years	-6.54%	-4.59%	0.00%	0.00%	1.63%	5.39%	-0.01%	3.42%
SBH Only HCBS Total	**-6.54%**	**-4.59%**	**0.00%**	**0.00%**	**0.90%**	**2.93%**	**-0.03%**	**1.99%**
SBH Only All Other								
SBH - CCM	-6.54%	-4.59%	0.00%	0.00%	0.52%	1.49%	0.35%	1.34%
SBH - Duals	-6.54%	-4.59%	0.00%	0.00%	1.38%	5.01%	-1.70%	1.32%
SBH - Other	-6.54%	-4.59%	0.00%	0.00%	0.60%	4.35%	-0.89%	2.51%
Maternity Kick Payment								
Maternity Kick Payment	0.00%	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.00%

Annualized RY23 Expansion Trends by Major COS								
Rate Cell	PH		Rx		SBH		All Services	
	Low	High	Low	High	Low	High	Low	High
Medicaid Expansion								
Male and Female Age 19-64	-0.27%	1.94%	8.43%	11.36%	1.79%	3.80%	2.84%	5.28%
High Needs	-0.04%	2.11%	6.72%	10.39%	1.76%	3.77%	2.72%	5.44%

Appendix J

Rate Comparison

			1/1/22 Rates			7/1/22 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	151	$ 38,082.49	$ 39,546.30	225	$ 29,151.32	$ 30,745.80
Gulf	SSI	3-11 Months	1,206	$ 5,219.98	$ 5,524.45	1,362	$ 4,863.42	$ 5,227.85
Gulf	SSI	Child 1-20 Years	110,136	$ 858.50	$ 918.94	112,081	$ 814.54	$ 885.71
Gulf	SSI	Adult 21+ Years	293,322	$ 1,796.31	$ 1,926.80	285,554	$ 1,669.06	$ 1,824.63
Gulf	F&C	0-2 Months	29,672	$ 3,282.79	$ 3,474.09	29,056	$ 2,966.63	$ 3,192.93
Gulf	F&C	3-11 Months	112,565	$ 343.28	$ 364.54	102,424	$ 326.47	$ 351.97
Gulf	F&C	Child 1-20 Years	2,107,403	$ 191.58	$ 203.39	2,109,226	$ 187.81	$ 201.80
Gulf	F&C	Adult 21+ Years	318,236	$ 461.17	$ 488.20	297,547	$ 462.15	$ 496.70
Gulf	FCC	All Ages Male & Female	30,947	$ 521.86	$ 558.65	31,457	$ 497.57	$ 541.44
Gulf	BCC	BCC, All Ages	1,030	$ 3,188.12	$ 3,443.54	1,036	$ 2,795.03	$ 3,062.24
Gulf	LAP	LAP, All Ages	5,949	$ 246.02	$ 261.97	5,642	$ 246.58	$ 266.18
Gulf	HCBS	Child 1-20 Years	2,870	$ 2,794.76	$ 3,003.53	3,263	$ 2,486.92	$ 2,710.34
Gulf	HCBS	Adult 21+ Years	6,656	$ 1,952.38	$ 2,097.60	6,992	$ 1,853.66	$ 2,029.56
Gulf	CCM	CCM, All Ages	14,059	$ 1,532.32	$ 1,632.36	14,827	$ 1,513.25	$ 1,628.30
Gulf	SBH - CCM	SBH - CCM, All Ages	5,980	$ 179.86	$ 185.97	5,370	$ 215.32	$ 223.68
Gulf	SBH - Duals	SBH - Dual Eligible, All Ages	403,835	$ 37.41	$ 41.08	405,927	$ 36.63	$ 40.35
Gulf	SBH - LaHIPP	SBH - LaHIPP, All Ages	191	$ 37.41	$ 41.08	193	$ 36.63	$ 40.35
Gulf	SBH - HCBS	Child 1-20 Years	4,948	$ 148.39	$ 152.57	4,716	$ 168.89	$ 174.33
Gulf	SBH - HCBS	Adult 21+ Years	9,101	$ 83.02	$ 91.17	9,211	$ 79.81	$ 89.01
Gulf	SBH - Other	SBH - All Ages	6,039	$ 186.29	$ 203.56	5,861	$ 184.85	$ 206.02
Gulf	Act 421, Non-TPL	0-2 Months	-	$ 29,177.63	N/A	-	$ 28,007.45	N/A
Gulf	Act 421, Non-TPL	3-11 Months	286	$ 3,871.96	N/A	229	$ 3,956.64	N/A
Gulf	Act 421, Non-TPL	Child 1-18 Years	2,574	$ 1,344.72	N/A	2,631	$ 1,294.12	N/A
Gulf	Act 421, Non-LaHIPP TPL	0-2 Months	-	$ 4,451.73	N/A	-	$ 4,280.72	N/A
Gulf	Act 421, Non-LaHIPP TPL	3-11 Months	429	$ 752.40	N/A	343	$ 775.22	N/A
Gulf	Act 421, Non-LaHIPP TPL	Child 1-18 Years	3,861	$ 564.90	N/A	3,946	$ 561.61	N/A
Gulf	Act 421, LaHIPP TPL	0-2 Months	-	$ 19.80	N/A	-	$ 18.06	N/A
Gulf	Act 421, LaHIPP TPL	3-11 Months	429	$ 10.54	N/A	343	$ 10.09	N/A
Gulf	Act 421, LaHIPP TPL	Child 1-18 Years	3,861	$ 309.98	N/A	3,946	$ 304.83	N/A
Gulf	Maternity Kick Payment	Maternity Kick Payment	8,008	$ 12,613.48	$ 12,986.50	7,180	$ 11,644.33	$ 12,067.29
Gulf	EED Kick Payment	EED Kick Payment	1	$ 6,935.38	$ 7,083.71	1	$ 5,911.37	$ 6,079.56
Gulf	Medicaid Expansion	Age 19-64	2,135,784	$ 633.87	$ 670.81	2,172,921	$ 586.45	$ 633.47
Gulf	Medicaid Expansion	SBH - Dual Eligible, All Ages	21,224	$ 37.41	$ 41.08	20,906	$ 36.63	$ 40.35
Gulf	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 37.41	$ 41.08	1	$ 36.63	$ 40.35
Gulf	Medicaid Expansion	SBH - Other	17	$ 186.29	$ 203.56	35	$ 184.85	$ 206.02
Gulf	Medicaid Expansion	SBH - CCM, All Ages	222	$ 179.86	$ 185.97	171	$ 215.32	$ 223.68
Gulf	Medicaid Expansion	High Needs	707	$ 633.87	$ 670.81	747	$ 586.45	$ 633.47
Gulf	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,682	$ 16,013.61	$ 16,456.20	3,582	$ 13,889.38	$ 14,386.89
Gulf	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 9,984.94	$ 10,189.00	1	$ 7,855.15	$ 8,084.53
Capital	SSI	0-2 Months	197	$ 38,658.49	$ 40,128.21	178	$ 29,750.29	$ 31,350.92
Capital	SSI	3-11 Months	1,361	$ 5,104.16	$ 5,407.44	1,299	$ 4,744.20	$ 5,107.41
Capital	SSI	Child 1-20 Years	86,922	$ 855.70	$ 920.15	90,152	$ 842.00	$ 917.13
Capital	SSI	Adult 21+ Years	211,475	$ 1,808.10	$ 1,948.40	207,213	$ 1,787.86	$ 1,954.49
Capital	F&C	0-2 Months	27,794	$ 3,766.80	$ 3,955.09	27,823	$ 3,384.74	$ 3,607.76
Capital	F&C	3-11 Months	101,626	$ 335.76	$ 356.54	96,825	$ 336.40	$ 361.22
Capital	F&C	Child 1-20 Years	1,915,099	$ 198.60	$ 211.31	1,936,770	$ 198.67	$ 213.72
Capital	F&C	Adult 21+ Years	279,490	$ 484.32	$ 514.39	269,063	$ 498.04	$ 536.16
Capital	FCC	All Ages Male & Female	50,462	$ 455.19	$ 488.77	51,230	$ 455.41	$ 495.60
Capital	BCC	BCC, All Ages	1,301	$ 3,160.64	$ 3,415.78	1,460	$ 2,767.09	$ 3,034.02
Capital	LAP	LAP, All Ages	7,676	$ 244.29	$ 260.23	7,213	$ 244.76	$ 264.35
Capital	HCBS	Child 1-20 Years	3,352	$ 2,837.67	$ 3,046.88	3,552	$ 2,531.66	$ 2,755.53
Capital	HCBS	Adult 21+ Years	6,425	$ 1,957.68	$ 2,102.95	6,721	$ 1,858.86	$ 2,034.81
Capital	CCM	CCM, All Ages	10,332	$ 1,562.81	$ 1,663.17	10,827	$ 1,545.10	$ 1,660.48
Capital	SBH - CCM	SBH - CCM, All Ages	6,985	$ 181.86	$ 187.99	5,879	$ 217.55	$ 225.94
Capital	SBH - Duals	SBH - Dual Eligible, All Ages	322,020	$ 31.40	$ 34.14	320,672	$ 30.76	$ 33.65
Capital	SBH - LaHIPP	SBH - LaHIPP, All Ages	152	$ 31.40	$ 34.14	152	$ 30.76	$ 33.65
Capital	SBH - HCBS	Child 1-20 Years	6,146	$ 147.10	$ 151.27	5,940	$ 167.59	$ 173.02
Capital	SBH - HCBS	Adult 21+ Years	8,680	$ 84.70	$ 92.87	8,862	$ 81.67	$ 90.89
Capital	SBH - Other	SBH - All Ages	8,902	$ 179.53	$ 196.73	9,038	$ 176.24	$ 197.33
Capital	Act 421, Non-TPL	0-2 Months	-	$ 29,177.63	N/A	-	$ 28,007.45	N/A
Capital	Act 421, Non-TPL	3-11 Months	286	$ 3,871.96	N/A	229	$ 3,956.64	N/A
Capital	Act 421, Non-TPL	Child 1-18 Years	2,574	$ 1,344.72	N/A	2,631	$ 1,294.12	N/A
Capital	Act 421, Non-LaHIPP TPL	0-2 Months	-	$ 4,451.73	N/A	-	$ 4,280.72	N/A
Capital	Act 421, Non-LaHIPP TPL	3-11 Months	429	$ 752.40	N/A	343	$ 775.22	N/A
Capital	Act 421, Non-LaHIPP TPL	Child 1-18 Years	3,861	$ 564.90	N/A	3,946	$ 561.61	N/A
Capital	Act 421, LaHIPP TPL	0-2 Months	-	$ 19.80	N/A	-	$ 18.06	N/A
Capital	Act 421, LaHIPP TPL	3-11 Months	429	$ 10.54	N/A	343	$ 10.09	N/A
Capital	Act 421, LaHIPP TPL	Child 1-18 Years	3,861	$ 309.98	N/A	3,946	$ 304.83	N/A
Capital	Maternity Kick Payment	Maternity Kick Payment	6,907	$ 12,148.84	$ 12,496.61	6,430	$ 10,744.75	$ 11,139.63
Capital	EED Kick Payment	EED Kick Payment	1	$ 6,857.20	$ 6,995.49	1	$ 5,395.05	$ 5,552.07
Capital	Medicaid Expansion	Age 19-64	1,723,325	$ 668.75	$ 710.35	1,767,938	$ 653.23	$ 705.89
Capital	Medicaid Expansion	SBH - Dual Eligible, All Ages	15,842	$ 31.40	$ 34.14	16,267	$ 30.76	$ 33.65
Capital	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 31.40	$ 34.14	1	$ 30.76	$ 33.65
Capital	Medicaid Expansion	SBH - Other	72	$ 179.53	$ 196.73	113	$ 176.24	$ 197.33
Capital	Medicaid Expansion	SBH - CCM, All Ages	251	$ 181.86	$ 187.99	235	$ 217.55	$ 225.94
Capital	Medicaid Expansion	High Needs	745	$ 668.75	$ 710.35	638	$ 653.23	$ 705.89
Capital	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,565	$ 17,427.39	$ 17,873.31	3,428	$ 13,715.66	$ 14,216.42
Capital	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 11,356.05	$ 11,561.64	1	$ 7,645.10	$ 7,875.97

			1/1/22 Rates			7/1/22 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	93	$ 37,658.71	$ 39,118.18	183	$ 28,713.76	$ 30,303.76
South Central	SSI	3-11 Months	1,173	$ 5,096.29	$ 5,399.49	1,145	$ 4,735.85	$ 5,098.97
South Central	SSI	Child 1-20 Years	96,851	$ 776.72	$ 832.49	98,051	$ 746.28	$ 811.94
South Central	SSI	Adult 21+ Years	262,880	$ 1,580.65	$ 1,700.86	253,894	$ 1,518.07	$ 1,662.15
South Central	F&C	0-2 Months	29,957	$ 3,517.20	$ 3,714.66	29,712	$ 2,979.98	$ 3,213.17
South Central	F&C	3-11 Months	110,043	$ 347.85	$ 372.90	103,356	$ 338.76	$ 368.83
South Central	F&C	Child 1-20 Years	2,075,697	$ 195.25	$ 208.46	2,086,258	$ 192.78	$ 208.47
South Central	F&C	Adult 21+ Years	307,604	$ 434.17	$ 461.26	299,017	$ 440.97	$ 475.17
South Central	FCC	All Ages Male & Female	54,998	$ 402.67	$ 432.76	55,209	$ 397.01	$ 432.95
South Central	BCC	BCC, All Ages	787	$ 3,122.27	$ 3,377.01	816	$ 2,726.34	$ 2,992.84
South Central	LAP	LAP, All Ages	6,013	$ 243.22	$ 259.14	5,610	$ 243.66	$ 263.24
South Central	HCBS	Child 1-20 Years	3,382	$ 2,814.63	$ 3,023.61	3,392	$ 2,507.86	$ 2,731.49
South Central	HCBS	Adult 21+ Years	7,778	$ 1,963.51	$ 2,108.84	8,178	$ 1,864.73	$ 2,040.74
South Central	CCM	CCM, All Ages	11,637	$ 1,542.10	$ 1,642.25	12,502	$ 1,523.35	$ 1,638.51
South Central	SBH - CCM	SBH - CCM, All Ages	5,964	$ 186.10	$ 192.26	5,460	$ 221.96	$ 230.39
South Central	SBH - Duals	SBH - Dual Eligible, All Ages	390,731	$ 33.81	$ 36.76	382,388	$ 33.46	$ 36.57
South Central	SBH - LaHIPP	SBH - LaHIPP, All Ages	185	$ 33.81	$ 36.76	181	$ 33.46	$ 36.57
South Central	SBH - HCBS	Child 1-20 Years	5,195	$ 144.55	$ 148.69	4,958	$ 165.08	$ 170.48
South Central	SBH - HCBS	Adult 21+ Years	9,661	$ 85.43	$ 93.61	9,610	$ 82.68	$ 91.91
South Central	SBH - Other	SBH - All Ages	9,255	$ 188.66	$ 205.95	8,992	$ 187.04	$ 208.24
South Central	Act 421, Non-TPL	0-2 Months	-	$ 29,177.63	N/A	-	$ 28,007.45	N/A
South Central	Act 421, Non-TPL	3-11 Months	286	$ 3,871.96	N/A	229	$ 3,956.64	N/A
South Central	Act 421, Non-TPL	Child 1-18 Years	2,574	$ 1,344.72	N/A	2,631	$ 1,294.12	N/A
South Central	Act 421, Non-LaHIPP TPL	0-2 Months	-	$ 4,451.73	N/A	-	$ 4,280.72	N/A
South Central	Act 421, Non-LaHIPP TPL	3-11 Months	429	$ 752.40	N/A	343	$ 775.22	N/A
South Central	Act 421, Non-LaHIPP TPL	Child 1-18 Years	3,861	$ 564.90	N/A	3,946	$ 561.61	N/A
South Central	Act 421, LaHIPP TPL	0-2 Months	-	$ 19.80	N/A	-	$ 18.06	N/A
South Central	Act 421, LaHIPP TPL	3-11 Months	429	$ 10.54	N/A	343	$ 10.09	N/A
South Central	Act 421, LaHIPP TPL	Child 1-18 Years	3,861	$ 309.98	N/A	3,946	$ 304.83	N/A
South Central	Maternity Kick Payment	Maternity Kick Payment	7,440	$ 10,721.96	$ 11,068.54	7,057	$ 9,695.48	$ 10,088.38
South Central	EED Kick Payment	EED Kick Payment	1	$ 5,445.98	$ 5,583.79	1	$ 4,369.50	$ 4,525.73
South Central	Medicaid Expansion	Age 19-64	1,827,311	$ 589.06	$ 625.06	1,846,491	$ 562.87	$ 607.80
South Central	Medicaid Expansion	SBH - Dual Eligible, All Ages	20,109	$ 33.81	$ 36.76	19,921	$ 33.46	$ 36.57
South Central	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 33.81	$ 36.76	1	$ 33.46	$ 36.57
South Central	Medicaid Expansion	SBH - Other	44	$ 188.66	$ 205.95	89	$ 187.04	$ 208.24
South Central	Medicaid Expansion	SBH - CCM, All Ages	159	$ 186.10	$ 192.26	187	$ 221.96	$ 230.39
South Central	Medicaid Expansion	High Needs	372	$ 589.06	$ 625.06	313	$ 562.87	$ 607.80
South Central	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	4,113	$ 13,984.09	$ 14,411.82	3,754	$ 11,901.93	$ 12,382.03
South Central	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 8,157.86	$ 8,355.06	1	$ 6,078.78	$ 6,300.13
North	SSI	0-2 Months	121	$ 37,600.39	$ 39,059.26	141	$ 28,657.44	$ 30,246.86
North	SSI	3-11 Months	1,270	$ 5,040.36	$ 5,342.98	1,213	$ 4,678.17	$ 5,040.70
North	SSI	Child 1-20 Years	103,410	$ 747.22	$ 802.15	104,544	$ 704.08	$ 767.51
North	SSI	Adult 21+ Years	236,382	$ 1,548.23	$ 1,663.98	229,509	$ 1,457.23	$ 1,593.96
North	F&C	0-2 Months	21,532	$ 3,352.17	$ 3,542.76	20,521	$ 2,900.78	$ 3,125.79
North	F&C	3-11 Months	78,753	$ 341.42	$ 363.60	72,805	$ 327.30	$ 353.72
North	F&C	Child 1-20 Years	1,543,541	$ 202.69	$ 215.92	1,545,033	$ 197.15	$ 212.72
North	F&C	Adult 21+ Years	222,116	$ 436.26	$ 463.18	212,750	$ 439.33	$ 472.52
North	FCC	All Ages Male & Female	38,325	$ 543.99	$ 586.72	38,932	$ 542.10	$ 592.77
North	BCC	BCC, All Ages	830	$ 3,118.83	$ 3,373.54	844	$ 2,725.12	$ 2,991.61
North	LAP	LAP, All Ages	3,990	$ 244.23	$ 260.16	3,912	$ 244.73	$ 264.32
North	HCBS	Child 1-20 Years	2,572	$ 2,810.07	$ 3,019.00	2,638	$ 2,503.96	$ 2,727.55
North	HCBS	Adult 21+ Years	5,931	$ 1,966.22	$ 2,111.57	6,059	$ 1,869.42	$ 2,045.49
North	CCM	CCM, All Ages	9,847	$ 1,542.91	$ 1,643.06	10,756	$ 1,524.25	$ 1,639.42
North	SBH - CCM	SBH - CCM, All Ages	5,455	$ 183.60	$ 189.74	4,776	$ 219.23	$ 227.63
North	SBH - Duals	SBH - Dual Eligible, All Ages	321,651	$ 41.39	$ 45.20	314,005	$ 40.66	$ 44.54
North	SBH - LaHIPP	SBH - LaHIPP, All Ages	152	$ 41.39	$ 45.20	149	$ 40.66	$ 44.54
North	SBH - HCBS	Child 1-20 Years	3,356	$ 145.49	$ 149.65	3,254	$ 165.84	$ 171.25
North	SBH - HCBS	Adult 21+ Years	6,804	$ 90.20	$ 98.42	6,593	$ 88.93	$ 98.23
North	SBH - Other	SBH - All Ages	7,789	$ 184.69	$ 201.94	7,773	$ 183.03	$ 204.19
North	Act 421, Non-TPL	0-2 Months	-	$ 29,177.63	N/A	-	$ 28,007.45	N/A
North	Act 421, Non-TPL	3-11 Months	286	$ 3,871.96	N/A	229	$ 3,956.64	N/A
North	Act 421, Non-TPL	Child 1-18 Years	2,574	$ 1,344.72	N/A	2,631	$ 1,294.12	N/A
North	Act 421, Non-LaHIPP TPL	0-2 Months	-	$ 4,451.73	N/A	-	$ 4,280.72	N/A
North	Act 421, Non-LaHIPP TPL	3-11 Months	429	$ 752.40	N/A	343	$ 775.22	N/A
North	Act 421, Non-LaHIPP TPL	Child 1-18 Years	3,861	$ 564.90	N/A	3,946	$ 561.61	N/A
North	Act 421, LaHIPP TPL	0-2 Months	-	$ 19.80	N/A	-	$ 18.06	N/A
North	Act 421, LaHIPP TPL	3-11 Months	429	$ 10.54	N/A	343	$ 10.09	N/A
North	Act 421, LaHIPP TPL	Child 1-18 Years	3,861	$ 309.98	N/A	3,946	$ 304.83	N/A
North	Maternity Kick Payment	Maternity Kick Payment	5,240	$ 13,037.30	$ 13,430.31	4,919	$ 10,780.46	$ 11,221.20
North	EED Kick Payment	EED Kick Payment	1	$ 7,067.27	$ 7,223.54	1	$ 4,818.53	$ 4,993.78
North	Medicaid Expansion	Age 19-64	1,432,102	$ 588.90	$ 624.46	1,434,478	$ 551.47	$ 595.68
North	Medicaid Expansion	SBH - Dual Eligible, All Ages	14,374	$ 41.39	$ 45.20	14,390	$ 40.66	$ 44.54
North	Medicaid Expansion	SBH - LaHIPP, All Ages	1	$ 41.39	$ 45.20	1	$ 40.66	$ 44.54
North	Medicaid Expansion	SBH - Other	19	$ 184.69	$ 201.94	35	$ 183.03	$ 204.19
North	Medicaid Expansion	SBH - CCM, All Ages	139	$ 183.60	$ 189.74	140	$ 219.23	$ 227.63
North	Medicaid Expansion	High Needs	131	$ 588.90	$ 624.46	182	$ 551.47	$ 595.68
North	Medicaid Expansion - Maternity Kick Payment	Maternity Kick Payment	3,145	$ 16,301.62	$ 16,773.48	2,763	$ 12,929.45	$ 13,454.66
North	Medicaid Expansion - EED Kick Payment	EED Kick Payment	1	$ 9,886.11	$ 10,103.66	1	$ 6,570.58	$ 6,812.73

Appendix K

Data Reliance Letter

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

May 24, 2022

Subject: Capitation Rate Certification for the Healthy Louisiana Program – Implementation Year July 1, 2022 through June 30, 2023

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 July 1, 2022 through June 30, 2023 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.

Signature

May 25, 2022
Date

Copy:
Roger Figueroa, ASA, MAAA, Senior Associate
F. Ronald Ogborne, FSA, CERA, MAAA, Partner

Mercer Health & Benefits LLC
3560 Lenox Road, Suite 2400
Atlanta, GA 30326
www.mercer-government.mercer.com

Instructions: Fill in the cells that are shaded yellow in this worksheet and in the APM reporting template. For questions on terms see the Definitions tab.

MCO Name & Contact Person/e-mail for questions on APM Report (note reporting time period and if you are using an incurred/date of service approach)	

Alternative Payment Models are health care payment methods at the provider level that use financial incentives to promote or leverage greater value - including higher quality care and cost efficiency. The APM framework categories are based on definitions in the Health Care Payment Learning Action Network (LAN) and articulated in the APM Framework White Paper (https://hcp-lan.org/groups/apm-refresh-white-paper/). See 'refreshed' APM Framework tab for a summary graphic.

Types of APMs (Subcategories)

Question	LAN APM Category	APM Types - Subcategories Select all that apply by putting an X in column C in each applicable row		Brief description of type of providers/services involved (e.g. primary care, hospitals, maternity providers, etc.). May include additional APM detail such as noting provider payment arrangements that include multiple APMs or shared savings approaches that have not yet been reconciled.
Which types of APM payment models were in effect during any portion of the payment period.	**2A Care Management**		Payments for care management	
	2A Other		Foundational payments for infrastructure and operations (non-care management)	
	2B		Pay for Reporting	
	2C		Pay for Performance	
	3A		APMs with Shared Savings	
	3B		APMs with Shared Savings and Downside Risk	
	4A		Condition-specific population-based payment	
	4B		Comprehensive population-based payment	
	4C		Integrated Finance & Delivery System	

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated.
For questions on terms see the Definitions tab.

Payment Approach		Provider Payments	Percentage of Provider Payments	
1. Total Annual Provider Payments				
All provider payments	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified payment period. Managed Care Incentive Program (MCIP) payments should be excluded from any calculations in this report.	$0	Percentage of Total Provider Payments	#DIV/0!
Payment Approach		**Provider Payments**	**Percentage of Provider Payments**	
2. Alternative Payment Model Framework - Category 2 (All methods below are linked to quality).				
Category 2A Incentive Payments: Care Management Only	Total dollars paid to providers for care management related to VBP agreements during the payment period.	$0	% of Total provider payments for 2A Care Management incentive payments	#DIV/0!
Category 2A Incentive Payments (Other)	Total dollars paid to providers for foundational spending to improve care, e.g. infrastructure payments, during payment period, **except those for care management payments included in cell C7 above.** Do not include FFS/base payments.	$0	% of Total provider payments for Other Category 2A Incentive Payments	#DIV/0!
Contracts that include Category 2A APMs	**Provider Payments under Contracts that include Category 2A APMs** - Total dollars paid under provider contracts that include FFS/base payments **plus** care management/foundational spending to improve care.	$0	% of Total provider payments that are paid under contracts that include at least one Category 2A APM	#DIV/0!
		For Provider Contracts with Category 2A APMs - % of provider payments that are linked to foundational payments		#DIV/0!
Category 2B Incentive Payments only (Pay for Reporting)	**Category 2B APMs ONLY** - Total dollars paid to providers for pay for reporting , e.g. payments for reporting on HEDIS measures ('pay-per-click') during payment period. Do not include FFS/base payments, just report the portion of the provider payment that is linked to pay for reporting.	$0	% of Total provider payments that are incentives paid under Category 2B APMs ONLY	#DIV/0!
Contracts that include Category 2B APMs	**Provider Payments under Contracts that include Category 2B APMs** - Total dollars paid under provider contracts that include FFS/base payments **plus** pay for reporting.	$0	% of Total provider payments that are paid under contracts that include at least one Category 2B APM	#DIV/0!
		For Provider Contracts with Category 2B APMs - % of provider payments that are linked to pay for reporting		#DIV/0!

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated. For questions on terms see the Definitions tab.				
Category 2C Incentives only (Rewards for Performance)	**Category 2C APMs ONLY** - Total dollars paid to providers for pay for performance (P4P) rewards to improve care, such as provider performance to population-based target for quality such as a target HEDIS rate. Do not include FFS or base payments to providers. Do not include payments to providers for reporting HEDIS or other measures.	$0	% of Total provider payments that are incentives paid under Category 2C APMs ONLY	#DIV/0!
Category 2C Penalties only (Penalties for Performance)	**Category 2C APMs ONLY** - Total dollars for any penalties applied to providers based on performance to quality measures. Do not include FFS or base payments to providers. Do not include penalties for non-reporting.	$0	% of Total provider payments that are penalties collected under Category 2C APMs ONLY	#DIV/0!
Contracts that include Category 2C APMs	Total dollars paid under provider contracts that include FFS/base payment **plus (or minus)** any P4P payments or penalties, as applicable, (linked to quality) during payment period	$0	% of Total provider payments that are paid under contracts that include at least one Category 2C APM	#DIV/0!
		For Provider Contracts with Category 2C APMs - % of provider payments that are linked to P4P		#DIV/0!

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated.
For questions on terms see the Definitions tab.

Payment Approach		Provider Payments	Percentage of Provider Payments	
Alternative Payment Model Framework - Category 3 (All methods below are linked to quality)				
Category 3 - Only **Shared Savings** Payments to providers	Total **shared savings** dollars ONLY paid to providers under contracts that include Category 3 APMs paid on FFS architecture (with links to quality). Do not include FFS or base payments to providers.	$0	% of Total provider payments that are paid out as incentive payments under Category 3 shared savings arrangements	#DIV/0!
Category 3 - Only **Downside Risk** 'recoupments' applied to providers	Total **downside risk** collections or recoupments applied to providers under contracts that include Category 3 APMs and paid on FFS architecture (with links to quality). Do not include FFS or base payments to providers.	$0	% of Total provider payments that are collected or applied to providers as penalties under Category 3 shared risk arrangements	#DIV/0!
Contracts that include Category 3 APMs	Total dollars paid to providers under contracts that include Category 3 APMs paid on FFS architecture (with links to quality), plus any shared savings or minus downside risk based on a budget target or shared savings. In total cost of care (TCOC) models, all provider payments associated with attributed members for services included in the TCOC target for the accountable provider entity should be included in the amount reported here.	$0	% of Total provider payments that are paid under contracts that include at least one Category 3 APM	#DIV/0!
Alternative Payment Model Framework - Category 4 (All methods below are linked to quality)				
Category 4 - Population Based Payments to providers	Total dollars paid to providers for **population-based payments** as part of prospective payment/capitation. For example, PMPM primary care capitaton payments, prospective payments for specialty services, global budgets, and other payments made within prospective capitated arrangements.	$0	% of Total provider payments that are paid as capitation payments under Category 4 APMs	#DIV/0!
Contracts with Category 4 APMs	Total dollars paid to providers under contracts that include **Population-based APMs** (Category 4). Population-based payments include prospective primary care, condition-specific population-based payments, comprehensive population-based payments, and payments made within integrated finance and delivery systems.	$0	% of Total provider payments that are paid under contracts that include Category 4 APMs	#DIV/0!
For calculation only - Contracts with one or more APMs in category 2A, 2C, 3 or 4 (excludes contracts with only Category 2B APMs)				

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated. For questions on terms see the Definitions tab.					
Automated calculation of payments under provider contract with one or more APMs in categories 2A, 2C, 3 and 4	Total dollars paid to providers during the payment period under contracts that include Category 2A, 2C, 3 or 4 APMs as reported above. If an MCO reported a contract(s) with more than one APM Categories (e.g., Category 2 and 3) in more than one of the following cells: C9, C16, C22 or C25, this total it will be "**overstated."**	$0			
Overstated provider payments in contracts with multiple APMs	In cases of provider contracts that include mulitple APM categories, enter total amount of the overstated provider contract(s) so that no provider contract is counted more than once in cells C9, C16, C22, or C25.	$0			
VBP BENCHMARK (Contracts with one or more APMs in category 2A, 2C, 3 or 4)					
Total Provider Incentive Payment Payments in Category 2A, 2C, 3 and 4	Total dollars paid to providers during the payment period within Categories 2A, 2C, 3 and 4, counting downside risk and penalties as positive numbers.	$0	% of Total provider incentive payments paid under Category 2A, 2C, 3 or 4 APMs		**#DIV/0!**
Contracts that include Category 2A, 2C, 3 or 4 APMs (unduplicated)	Total dollars paid to providers during the payment period under contracts that include Category 2A, 2C, 3 or 4 APMs (all with links to quality). This may be less than the combination of provider contract payments reported under each applicable LAN category as calculated in cell C28. If a contract includes more than one type of APM, it should only be counted once in the VBP benchmark.	$0	% of Total provider payments that are paid under contracts that include at least one Category 2A, 2C, 3 or 4 APM		**#DIV/0!**

Definitions

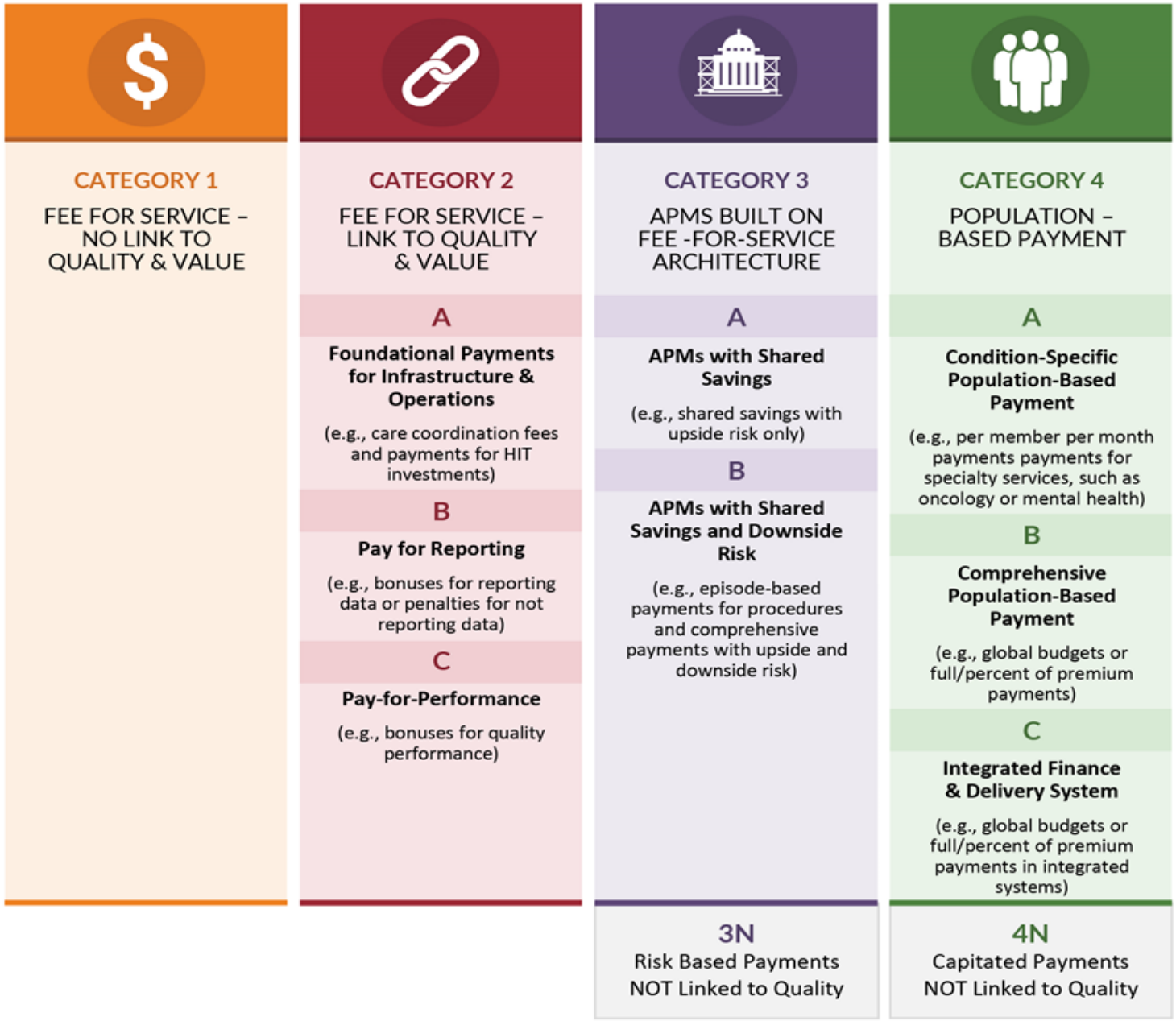
Terms	Definitions
Alternative Payment Model (APM)	Health care payment methods at the provider level that use financial incentives to promote or leverage greater value - including higher quality care and cost efficiency. The APM framework categories are based on the definitions in the Health Care Payment Learning Action Network (LAN) and articulated in the APM Framework White Paper and the graphic included on the 'refreshed' APM Framework tab. https://hcp-lan.org/groups/apm-refresh-white-paper/
Category 2 APM (must be linked to quality)	Fee-for-service linked to quality. These payments utilize traditional FFS payments, but are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well they perform on cost and quality metrics. Examples are described in more detail in other definitions and include: 2A: Foundational Payments for Infrastructure and Operations to improve care delivery such as care coordination fees and payments for HIT investments 2B: Pay for Reporting: Bonus payments/rewards for reporting on specified quality measures, including those paid in DRG systems 2C: Rewards and Penalties for Performance: Bonus payments/rewards and/or penalties for quality performance on specified measures, including those in DRG systems.
Category 3 APM (excludes risk-based payment models that are NOT linked to quality)	Alternative payment methods (APMs) built on **fee-for-service architecture** while providing mechanisms for effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account, payments are **based on cost performance against a target**, irrespective of how the financial benchmark is established, updated, or adjusted. Providers that meet their cost and quality targets are retrospectively eligible for shared savings, and those that do not may be held financially accountable. Examples include: 3A: APMs with upside gain sharing based on a budget target/shared savings: retrospective bundled payments with upside risk only, retrospective episode-based payments with shared savings (no shared risk); PCMH with retrospective shared savings (no shared risk); Oncology COE with retrospective shared savings (no shared risk). 3B: APMs with upside gain sharing and downside risk: retrospective bundled payments with up and downside risk, retrospective episode-based payments with shared savings and losses; PCMH with retrospective shared savings and losses; Oncology COE with retrospective shared savings and losses.

Definitions

Terms	Definitions
Category 4 APM (excludes capitated payment models that are NOT linked to quality)	**Prospective population-based payment**. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality person level care within a defined or overall budget. This holds providers accountable for meeting quality and, increasingly, person centered care goals for a population of patients or members. Payments are intended to cover a wide range of preventive health, health maintenance, and health improvement services, among other items. These payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Examples include: 4A: Condition-specific population-based payments, e.g. via an ACO, PCMH or Center of Excellence (COE), partial population-based payments for primary care, and episode-based payments for clinical conditions such as diabetes. 4B: Comprehensive population-based payments - full or % of premium population-based payment, e.g. via an ACO, PCMH or Center of Excellence (COE), integrated comprehensive population-based payment and delivery system, comprehensive population-based payment for pediatric or geriatric care. 4C: Integrated Finance & Delivery Systems - global budgets or full/percent of premium payments in integrated systems
Condition-specific bundled/episode payments	A single payment to providers and/or health care facilities for all services related to a specific condition (e.g. diabetes). The payment considers the quality, costs, and outcomes for a patient-centered course of care over a longer time period and across care settings. Providers assume financial risk for the cost of services for a particular condition, as well as costs associated with preventable complications. [APM Framework Category **4A]**
Diagnosis-related groups (DRGs)	A clinical category risk adjustment system that uses information about patient diagnoses and selected procedures to identify patients that are expected to have similar costs during a hospital stay - a form of case rate for a hospitalization. Each DRG is assigned a weight that reflects the relative cost of caring for patients in that category relative to other categories and is then multiplied by a conversion factor to establish payment rates.
Fee-for-service	Providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency. [APM Framework Category **1**]
Foundational spending	Includes but is not limited to payments to improve care delivery such as outreach and care coordination/management; after-hour availability; patient communication enhancements; health IT infrastructure use. May come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments and/or per-episode fees for specialists. [APM Framework Category **2A**]
Full or percent of premium population-based payments	A fixed dollar payment to providers for all the care that a patient population may receive in a given time period, such as a month or year, (e.g. inpatient, outpatient, specialists, out-of-network, etc.) with payment adjustments based on measured performance and patient risk. [APM Framework Category **4B** if there is a link to quality**]**
Legacy payments	Payments that utilize traditional payments and are not adjusted to account for infrastructure investments, provider reporting of quality data, or for provider performance on cost and quality metrics. This can include fee-for-service, diagnosis-related groups (DRGs) and per diems. [APM Framework Category **1**].
Linked to quality	Payments that are set or adjusted based on evidence that providers meet a quality standard(s) or improve care or clinical services, including for providers who report quality data, or providers who meet thresholds on cost and quality metrics.

Definitions

Terms	Definitions
Pay for performance	The use of financial incentives to providers to achieve improved performance by increasing the quality of care and/or reducing costs. Incentives are typically paid on top of a base payment, such as fee-for-service or population-based payment. [APM Framework Category **2C** if there is a link to quality].
Payment Period	The twelve month period, applicable to the specified MCO reporting requirements.
Population-based payment for conditions	A per member per month (PMPM) payment to providers for inpatient and outpatient care that a patient population may receive for a particular condition in a given time period including inpatient care and facility fees. [APM Framework Category **4A** if there is a link to quality].
Population-based payment not condition-specific	A per member per month (PMPM) payment to providers for outpatient or professional services that a patient population may receive in a given time period, such as a month or year, not including inpatient care or facility fees. The services for which the payment provides coverage is predefined and could be, for example, primary care services or professional services that are not specific to any particular condition. [APM Framework Category **3B** if there is a link to quality].
Procedure-based bundled/episode payment	Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g. hip replacement). The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers assume financial risk for the cost of services for a particular procedure and related services, as well as costs associated with preventable complications. [APM Framework Categories **3A** & **3B**].
Provider	For the purposes of this report, provider includes all providers for which there is MCO health care spending. For the purposes of reporting APMs, this definition of provider includes medical, behavioral, pharmacy, DME, PCMH/FCMH, dental, vision, transportation, and local health departments (e.g., lead screening) etc. as applicable.
Shared risk/losses	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending, but also puts them at financial risk for any overspending. Shared risk provides both an upside and downside financial incentive for providers or provider entities to meet quality targets and to reduce unnecessary spending for a defined population of patients or an episode of care and to meet quality targets.
Shared savings	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending. Shared savings provides an upside only financial incentive for providers or provider entities to meet quality targets and to reduce unnecessary spending for a defined population of patients or an episode of care and to meet quality targets.
Total Dollars	The total estimated in- and out-of-network health care spend (e.g. annual payment amount) made to providers in the applicable payment period.


CATEGORY 1
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE
CATEGORY 2
FEE FOR SERVICE – LINK TO QUALITY & VALUE
A
Foundational Payments for Infrastructure & Operations
(e.g., care coordination fees and payments for HIT investments)
B
Pay for Reporting
(e.g., bonuses for reporting data or penalties for not reporting data)
C
Pay-for-Performance
(e.g., bonuses for quality performance)
CATEGORY 3
APMS BUILT ON FEE -FOR-SERVICE ARCHITECTURE
A
APMs with Shared Savings
(e.g., shared savings with upside risk only)
B
APMs with Shared Savings and Downside Risk
(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)
3N
Risk Based Payments NOT Linked to Quality
CATEGORY 4
POPULATION – BASED PAYMENT
A
Condition-Specific Population-Based Payment
(e.g., per member per month payments payments for specialty services, such as oncology or mental health)
B
Comprehensive Population-Based Payment
(e.g., global budgets or full/percent of premium payments)
C
Integrated Finance & Delivery System
(e.g., global budgets or full/percent of premium payments in integrated systems)
4N
Capitated Payments NOT Linked to Quality

Contract Amendment #17
Attachment F17

Changes to Attachment F: In Lieu of Services

<table>
<tr><th>Item</th><th>Change From:</th><th>Change To:</th><th>Justification</th></tr>
<tr>
<td>1</td>
<td>
<table>
<tr><th>In Lieu of Service</th><th>Medicaid State Plan Service(s)</th><th>Effective Date</th></tr>
<tr><td>Crisis stabilization units for adults age 21 and older</td><td>Emergency services, inpatient hospitals</td><td>1/1/2020</td></tr>
<tr><td>Mobile crisis response</td><td>Emergency services, inpatient hospitals</td><td>9/22/2021[1]</td></tr>
<tr><td>Behavioral health urgent care</td><td>Emergency services, inpatient hospitals</td><td>11/12/2021</td></tr>
</table>
[1]The authorization for this in lieu of service will be terminated when comparable services are implemented in the State Plan.
</td>
<td>
<table>
<tr><th>In Lieu of Service</th><th>Medicaid State Plan Service(s)</th><th>Effective Date</th></tr>
<tr><td>~~Crisis stabilization units for adults age 21 and older~~</td><td>~~Emergency services, inpatient hospitals~~</td><td>~~1/1/2020~~</td></tr>
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</table>
~~[1]The authorization for this in lieu of service will be terminated when comparable services are implemented in the State Plan.~~
</td>
<td>
These services are now on the fee schedule.

Crisis stabilization was added on July 1, 2022.
Mobile crisis response was added on March 1, 2022.
Behavioral health urgent care was added on April 1, 2022.

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</table>