Office of State Procurement
PROACT Contract Certification of Approval

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

Reference Number: 2000441826 (4)
Vendor: Louisiana Healthcare Connections, Inc.
Description: Amd 4 rate certification only; no change to time or money
Approved By: Pamela Rice
Approval Date: 3/11/2021

Your amendment that was submitted to OSP has been approved.

Rev 2019-12

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

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

AND

Louisiana Healthcare Connections, Inc.
Contractor Name

Amendment #: 4
LAGOV#: 2000441826
LDH #:
Original Contract Amount: $2,748,089,731.00
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: $6,457,832,732.50 Current Contract Term: 01/01/20-12/31/21

See Attachment D - Rate Certification ending December 31, 2020.

Change Contract To: If Changed, Maximum Amount: If Changed, Contract Term:

See Attachment D - Rate Certification effective January 1, 2021.

Justifications For Amendment:

This amendment establishes new actuarially sound capitation rates for the managed care organizations for calendar year 2021. The previous rate certification ended on December 31, 2020.

This Amendment Becomes Effective: 01-01-2021

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

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

CONTRACTOR

Louisiana Healthcare Connections, Inc.

1/28/2021

CONTRACTOR SIGNATURE DATE

PRINT NAME: James E. Schlottman

CONTRACTOR TITLE: CEO / Plan President

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

Tara A LeBlanc Digitally signed by Tara A LeBlanc Date: 2021.01.29 09:06:38 -06'00'

SIGNATURE DATE

NAME: Tara LeBlanc

TITLE: Interim Medicaid Executive Director

OFFICE: Louisiana Department of Health

PROGRAM SIGNATURE DATE

NAME

MERCER

Healthy Louisiana Rate Certification

Effective January 1, 2021 through December 31, 2021

Louisiana Department of Health
January 14, 2021

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

Subject: Healthy Louisiana Program – Full Risk Bearing Managed Care Organization (MCO) Rate Development and Preliminary Actuarial Certification for the Period January 1, 2021 through December 31, 2021

January 14, 2021

Dear Mr. Cocran:

The Louisiana Department of Health (LDH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound[1] capitation rates for the State of Louisiana's (State's) Healthy Louisiana program for the period of January 1, 2021 through December 31, 2021, or rate year 2021 (RY21). This certification addresses the development of the physical health (PH) and specialized behavioral health (SBH) only capitation rates, as well as maternity kickpayments.

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

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

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

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1 General Information

Overview

Capitation rates for the Healthy Louisiana program were developed in accordance with rate-setting guidelines established by CMS. For rate development for the Healthy Louisiana program, Mercer used data from state fiscal year (SFY) 2019 which spans the period of July 1, 2018 through June 30, 2019. All data was reported on an incurred basis and includes payment dates through December 2019. 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 RY21. Additional adjustments were then applied to the base data to incorporate:

- Provision for incurred but not reported (IBNR) claims
- Adjustments to encounter data for under-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; their PH, SBH and non-emergency medical transportation (NEMT) services are the responsibility of the MCO. This population includes those eligible starting July 1, 2016 through Louisiana's Medicaid Expansion.

2. Individuals who do not meet the eligibility criteria for the Healthy Louisiana PH program, yet remain eligible to receive SBH services through the Medicaid program. For this program, only their SBH and NEMT services are the responsibility of the MCO. This rating group is referred to as the Healthy Louisiana SBH program.

PH Program

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

Mandatory Populations

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

Voluntary Opt-in Populations

Individuals in a voluntary opt-in population group are not automatically enrolled into the Healthy Louisiana PH program, but they may choose to enroll at any time. They may also choose to disenroll at any time, effective the earliest possible month the action can be administratively handled. Moreover, a voluntary opt-in individual may re-enroll during the annual, open enrollment period. Such members include the following:

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

Excluded Populations

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

SBH Program

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

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

Mandatory and Excluded Populations

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

Rate Cell Structure

PH Program

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

Table 1A

PH Rate Cell Groupings	
SSI	
Newborn, 0-2 Months, Male & Female	Child, 1-20 Years, Male & Female
Newborn, 3-11 Months, Male & Female	Adult, 21+ Years, Male & Female
F&C (Temporary Assistance to Needy Families [TANF])	
Newborn, 0-2 Months, Male & Female	Child, 1-20 Years, Male & Female
Newborn, 3-11 Months, Male & Female	Adult, 21+ Years, Male & Female
HCBS Waiver	
20 And Under, Male & Female	21+ Years, Male & Female
FCC: All Ages, Male & Female	
BCC: All Ages, Female	

PH Rate Cell Groupings	
CCM: All Ages, Male & Female	
LAP: All Ages, Male & Female	
Maternity Kickpayment	
Maternity Kickpayment	Early Elective Delivery (EED)
Medicaid Expansion: Ages 19-64, Male & Female	
Medicaid Expansion – High Needs: Ages 19-64, Male & Female	
Medicaid Expansion – Maternity Kickpayment	
Medicaid Expansion – EED Kickpayment	

SBH Program

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

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

Table 1B

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

Healthy Louisiana Benefit Package

Covered Services

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

New Services

Effective February 1, 2020, LDH will provide peer support services to those over the age of 21. Mercer applied a separate adjustment to the rates to incorporate the coverage of the new services. The adjustment is discussed in the Prospective Rating Adjustment section of this certification.

Medicare Crossover Claims

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

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

Excluded Services

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

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

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

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

Healthy Louisiana Services Eligible for Different Federal Medical Assistance Percentage (FMAP)

There are two groups of services for which LDH receives a different FMAP than the regular state FMAP:

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

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

Region Groupings

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

Table 2

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

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

2
Base Data Development

Overview

For rate development for the Healthy Louisiana program, Mercer used SFY 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 2019. Restrictions were applied to the enrollment and claims data so that it was appropriate for the populations and benefit package defined in the contract. This included consideration for retroactive eligibility periods for which the MCOs were responsible.

IBNR

Capitation rates were developed using claims data for services incurred in SFY 2019 and reflect payments processed through December 2019. Mercer developed IBNR factors for SFY 2019 encounter data in order to reflect considerations for any unpaid claims liability. This adjustment resulted in an overall aggregate increase of 1.65%.

Under-Reporting Adjustments

Under-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 a MCO-specific basis. Table 3 summarizes the overall aggregate increases applied to SFY 2019 expenses. Note that a factor less than 1.0 indicates the encounter experience was higher than comparable financial information.

Table 3

Under-Reporting Adjustment			
Category of Service (COS)	**Non-Expansion PH Program**	**Non-Expansion SBH Program**	**Expansion**
Prescribed Drugs	0.9891	0.9880	1.0217
Transportation and SBH	1.0006	0.9680	1.0852
All Other	1.0562	1.0195	1.0866

Third-Party Liabilities

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

Fraud and Abuse Recoveries

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

Co-Payments

Co-payments are only applicable to prescription drugs. Pharmacy claims are reported net of any co-payments so no additional adjustment is necessary.

Disproportionate Share Hospital (DSH) Payments

DSH payments are made outside of the MMIS system and have not been included in the capitation rates.

Graduate Medical Education (GME) Payments

Capitation payments are developed net of GME payments and are not included in the base data.

Data Smoothing

In forming the base data, Mercer used SFY 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 newborns 0-1 years of age
- BCC, All Ages
- LAP, All Ages
- HCBS, All Ages
- CCM, All Ages
- SBH – CCM, All Ages
- SBH – HCBS, All Ages
- SBH – Other, All Ages

3

Base Rating Adjustments

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

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

Urine Drug Testing

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

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

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

Table 4

COA	Historical Urine Testing Dollars	Adjustment Dollars	Urine Testing % Impact of Base Expenses
SSI	$4,085,880	$(1,600,290)	-0.13%
F&C	$5,964,748	$(2,894,534)	-0.19%
FCC	$325,941	$(151,935)	-0.29%
BCC	$5,739	$(2,852)	-0.03%

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

COA	Historical Urine Testing Dollars	Adjustment Dollars	Urine Testing % Impact of Base Expenses
LAP	$5,392	$(2,429)	-0.05%
HCBS	$40,216	$(13,991)	-0.04%
CCM	$32,225	$(12,121)	-0.03%
SBH – CCM	$-	$-	0.00%
SBH – Duals	$-	$235	0.00%
SBH - LaHIPP	$-	$-	0.00%
SBH – HCBS	$-	$235	0.01%
SBH – Other	$-	$-	0.00%
Maternity Kickpayment	$519,348	$(185,589)	-0.10%
Medicaid Expansion	$15,426,482	$(7,673,641)	-0.38%

EED

Beginning February 2015, facility and delivering physician costs for EEDs will not be covered under the Healthy Louisiana program. MCOs receive an EED kickpayment 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 kickpayment. Mercer identified the average facility and delivering physician costs embedded in the maternity kickpayment by region and excluded those costs to arrive at the EED kickpayment. The EED kickpayment is calculated by applying the EED adjustment to the regular maternity kickpayment, as it reflects only the prenatal and postpartum portion of the kickpayment. For RY21, the EED adjustment is equivalent to 29.1% and 39.1% for the Non-Expansion and Expansion maternity kickpayments, respectively.

Pharmacy Co-Payment Limit Adjustment

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

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

estimate the impact of this policy change. Table 5 summarizes the impact of the Pharmacy Co-Payment Limit Adjustment on the base encounters.

Table 5

COA	Rx Co-Payment % of Historical Encounters
SSI	0.10%
F&C	0.02%
FCC	0.00%
BCC	0.03%
LAP	0.00%
HCBS	0.04%
CCM	0.00%
Medicaid Expansion	0.07%
Medicaid Expansion – High Needs	0.15%

Vitamin D Testing

Effective January 1, 2021, Vitamin D testing will be limited to four tests per year when coded against the specified list of diagnosis codes (82306 and 82652). The impact of this limit is shown in Table 6.

Table 6

Time Period	Historical Vitamin D Expenses	Vitamin D Adjustment Dollars	Vitamin D Testing % Impact of Base Expenses
SFY 2019	$3,249,447	$(1,337,054)	-41.15%

Diabetic Testing

Effective January 1, 2021, LDH will limit 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 7.

Table 7

COA	Historical Diabetic Testing Dollars	Adjustment Dollars	Diabetic Testing % Impact of Base Expenses
SSI	$2,982,995	$(505,946)	-16.96%
F&C	$1,899,444	$(250,741)	-13.20%
FCC	$41,598	$(5,806)	-13.96%
BCC	$19,139	$(3,525)	-18.42%
LAP	$19,690	$(2,719)	-13.81%
HCBS	$69,651	$(12,154)	-17.45%
CCM	$11,821	$(1,712)	-14.48%
SBH – CCM	$-	$-	0.00%
SBH – Duals	$36,442	$(6,328)	-17.36%
SBH – LaHIPP	$-	$-	0.00%
SBH – HCBS	$3,583	$(588)	-16.43%
SBH – Other	$3,529	$(482)	-13.67%
Medicaid Expansion	$4,596,848	$(619,136)	-13.47%

Continuous Glucose Monitoring (CGM) Adjustment

Effective January 1, 2019, Healthy Louisiana MCOs became responsible for the coverage of continuous glucose monitors for all eligible recipients that meet the following criteria:

- Diagnosis of Type 1 diabetes with recurrent, unexplained, and severe hypoglycemia (glucose levels <50 mg/dl)
- Impaired hypoglycemia awareness that puts the recipient at risk or pregnant recipient with poorly controlled Type 1 diabetes evident by recurrent, unexplained hypoglycemic episodes, hypoglycemic unawareness or postprandial hyperglycemia or recurrent diabetic ketoacidosis

Mercer adjusted the base data to fully reflect this program change, which also included an adjustment for January 2019 to account for ramp-up of coverage. Table 8 reflects the impact to specific portions of the base data time period.

Table 8

Time Period	Historical CGM Expenses	Adjustment Dollar Impact	Impact as % of Historical CGM Expenses
July 2018 – December 2018	$84,479	$1,664,097	1969.84%
January 2019	$96,454	$202,931	210.39%
February 2019 – June 2019	$1,463,065	$0	0.00%
Total	**$1,643,998**	**$1,867,028**	**113.57%**

In-Lieu of Services

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

IMDs

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

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

For Inpatient Psychiatric IMD stays, Mercer received a list of IMD facilities from LDH that existed during the SFY 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 9 shows user month counts and costs within the base associated with IMD users for SFY 2019.

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

For Inpatient Psychiatric IMD long stays, adjustment factors were developed by region, rate cell and year to remove all costs and user months incurred during the IMD long stay. This includes the 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 0.11% to the aggregate non-Expansion base data and a reduction of 0.14% 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 4.3% in SFY 2019.

Table 9

IMD Inpatient Psychiatric Short Stays							
Time Period	User Months	IP Psych Overnight Stay Service		Non-IP Psych Service		All Services	
		Cost	Cost per User Month	Cost	Cost per User Month	Cost	Cost per User Month
SFY 2019	21,798	$76,136,642	$3,492.83	$14,439,975	$662.44	$90,576,617	$4,155.27

Table 10

IMD Inpatient Psychiatric Long Stays							
Time Period	User Months	IP Psych Overnight Stay Service		Non-IP Psych Service		All Services	
		Cost	Cost per User Month	Cost	Cost per User Month	Cost	Cost per User Month
SFY 2019	651	$5,677,190	$8,720.72	$846,290	$1,299.98	$6,523,480	$10,020.71

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 – Inpatient Hospital Efficiency Adjustment

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 expense represents a significant portion of all medical expenditures, Mercer performed a retrospective data analysis of the MCOs' most recent encounter data using indicators developed by the Agency for Healthcare Research and Quality (AHRQ). These conditions are collectively referred to as Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI). Mercer utilized ten adult and four pediatric PQIs as part of the analysis. Evidence suggests hospital admissions for these conditions could have been avoided through high-quality outpatient care and/or the conditions could have been less severe if treated early and appropriately. AHRQ's technical specifications provide specific criteria that define each PQI and PDI that Mercer utilized in the analysis of the MCOs' inpatient hospital encounter data. Although AHRQ acknowledges there are factors outside the direct control of the health care system that can result in a hospitalization (e.g., environmental, patient compliance), it does recognize these analyses can be utilized to benchmark health care system efficiency between facilities and across geographies.

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

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 RY21 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 – ED Efficiency Adjustment

Mercer performed a retrospective analysis of the MCOs' SFY 2019 ED encounter data to identify ED visits that were considered preventable/pre-emptible. For the RY21 rate development, Mercer analyzed preventable/pre-emptible low acuity non-emergent (LANE) visits. This analysis was not intended to imply members should be denied access to EDs or that the MCOs should deny payment for the ED visits. Instead, the analysis was designed to reflect the State's objective that more effective, efficient and innovative managed care could have prevented or pre-empted the need for some members to initially seek care in the ED setting.

The criteria used to define LANE ED visits was based on publicly-available studies, input from Mercer's clinical staff, as well as review by practicing ED and primary care physicians. ICD-10 primary diagnosis code information was the basis for identifying an ED visit. A limited set of diagnosis codes was agreed upon by all physicians involved in developing the methodology for the analysis. Preventable percentages ranging from 0.0% to 90.0% 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 RY21, Mercer excluded low unit cost visits from the LANE analysis to account for improvements in the MCOs' use of triage fees and/or more appropriate health services management. A hierarchical process was used for the remaining LANE visits to identify those that could have been prevented or pre-empted. Beginning with the lowest acuity visits, data was accumulated until the percentage of preventable/pre-emptible visits was achieved for each respective diagnosis code. Regardless of the targeted percentage, no LANE ED visits/dollars associated with the most complex clinical decision making procedure codes (99284-99285) were included in the final adjustment. In addition, a replacement cost amount (average cost physician visit) was made for the majority of LANE visits that were deemed preventable/pre-emptible.

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

The DxRx efficiency adjustment is used to ensure appropriate utilization of selected drug classes in MCO SFY19 pharmacy encounter data, based on supporting diagnosis information in the recipient's medical history. The selected drug classes were identified based on high cost, safety concerns and/or high potential for abuse or misuse. Diagnosis information from 30 months (24 months prior to date of service [DOS] and six months after DOS) of medical, professional, pharmacy and inpatient data was reviewed for each recipient. Appropriate drug/diagnosis pairs are reviewed annually by Mercer's team of clinicians and include consideration for:

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

- Industry standard practices

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

Pharmacy Efficiency Adjustments – Retrospective Pharmacy Claims Analysis

The clinical edits efficiency adjustment used a retrospective analysis of SFY19 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 fee-for-service (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 SFY19 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%) 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. Then, the benchmark paid amount was 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 $5.27 PMPM to the PH program.

Table 11

COA	Efficiencies Percent Impacts
SSI	-2.54%
F&C	-1.19%
FCC	-0.53%
BCC	-1.71%
LAP	-1.14%
HCBS	-1.88%
CCM	-0.70%
SBH – CCM	0.00%
SBH – Duals	0.00%
SBH – LaHIPP	0.00%
SBH – HCBS	0.00%
SBH – Other	0.00%
Maternity Kickpayment	-0.02%
Medicaid Expansion	-1.87%

4

Prospective Rating Adjustments

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

Fee Schedule Changes

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

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

For the non-FMP fee schedule changes discussed in this section, the fee schedule changes are expected to impact MCO costs as MCOs usually contract with providers at rates that are proportional to the Medicaid fee schedule for these services.

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, 2020. The non-GME portion of the per diems were used in this fee adjustment process to be consistent with LDH's intention to continue paying GME amounts directly to the teaching hospitals.

Mercer relied upon an analysis of Medicare cost-based equivalent pricing of Medicaid services provided by LDH for the FMP adjustment. SFY 2019 encounter data and hospital-specific cost-to-charge ratios (CCRs) using the most recent cost reports from Medicare's Healthcare Cost

Report Information System database were used to calculate the Medicare-equivalent payments. The Medicare payments were then adjusted to the rating period. The Medicaid payments were also adjusted to reflect applicable fee changes and payments made outside of the claims system (outlier payments). Ultimately, the adjusted Medicaid and estimated Medicare payments were compared for each hospital. Mercer applied the ratio between the two payments to the base data at the hospital-specific level.

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

The total impact of the inpatient fee changes is summarized in Table 12A.

Table 12A

Inpatient Fee Change					
Time Period	Historical Cost	Fee Change Impact	Adjusted Cost	FMP Impact	Adjusted Cost
SFY 2019	$1,044,497,943	$86,443,829	$1,130,941,771	$489,701,634	43.30%

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 December 31, 2019. The adjustment also included estimation of cost settlements and reflected the most up-to-date cost settlement percentages for each facility.

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

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

The total impact of the outpatient fee changes is summarized in Table 12B.

Table 12B

Outpatient Fee Change					
Time Period	Historical Cost	Fee Change Impact	Adjusted Cost	FMP Impact	Adjusted Cost
SFY 2019	$972,292,994	$113,409,942	$1,085,702,936	$207,316,584	19.10%

PAD Fee Schedule Change

Effective January 1, 2020, LDH made changes to the PAD reimbursement rates. The new rates will be posted on LDH's fee schedule website[3]. Mercer identified the affected services and estimated the impact of the fee schedule changes to develop adjustments to the capitation rates. The total impact of the PAD fee changes is summarized in Table 12C.

Table 12C

PAD Fee Change				
Time Period	Historical Cost	Fee Change Impact	Historical Cost	All Services Cost
SFY 2019	$6,379,172	$696,380	10.92%	0.01%

HCBS Fee Schedule Changes

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 12D.

Table 12D

HCBS Fee Change				
Time Period	Historical Cost	Fee Change Impact	Historical Cost	All Services Cost
SFY 2019	$3,854,356	$1,477,757	38.34%	0.03%

Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Fee Schedule Changes

FQHC and 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, 2020, which can be located on LDH's website. The total impact of the fee schedule changes is summarized in Table 12E.

Table 12E

FQHC and RHC Fee Change				
Time Period	Historical Cost	Fee Change Impact	Historical Cost	All Services Cost
SFY 2019	$196,108,586	$9,839,472	5.02%	0.19%

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

Hospice Fee Schedule

Effective October 1, 2019, LDH released a new fee schedule for the Hospice Program, which can be located on LDH's website. The total impact of the fee schedule changes is summarized in Table 12F.

Table 12F

Hospice Fee Change				
Time Period	Historical Cost	Fee Change Impact	Historical Cost	All Services Cost
SFY 2019	$8,268,549	$191,573	2.32%	0.00%

Louisiana State University (LSU) Physician Fee Schedule

Effective January 1, 2021, LDH released a new fee schedule for LSU Enhanced Professional Services, which can be located on LDH's website. The total impact of the fee schedule changes is summarized in Table 12G.

Table 12G

LSU Physician Fee Change				
Time Period	Historical Cost	Fee Change Impact	Historical Cost	All Services Cost
SFY 2019	$70,923,499	$34,899,610	49.21%	0.68%

Hospital-Based Physician Services

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

Table 12H

Hospital-Based Physician FMP				
Time Period	Historical Cost	Adjusted Cost	FMP Impact	Adjusted Cost
SFY19	$72,799,556	$109,217,155	$36,417,559	33.34%

Ambulance Services

Mercer calculated the ambulance FMP payments according to the State Plan using Medicare fee schedules and average commercial rates as a percentage of Medicare. Ambulance providers were classified as either Large Urban Governmental (LUG) or non-LUGs. LUGs have historically received 100.0% of the gap between average commercial rate and the Medicaid fee schedule while non-LUGs have historically received 17.35% of the gap. Mercer developed increases using these assumed funding levels. Average commercial rates as a percentage of Medicare were provided by LDH for RY21. According to the State Plan, average commercial rates are updated every three years. Table 12I shows the impact of FMP on the adjusted base cost of ambulance services meeting the State Plan's criteria for FMP.

Table 12I

Ambulance FMP				
Time Period	Historical Cost	Adjusted Cost	FMP Impact	Adjusted Cost
SFY 2019	$62,308,657	$62,308,657	$39,716,261	63.74%

Aggregate Fee Schedule Adjustments

Overall, as shown in Table 12J, the combined effect of all the prospective fee adjustments was a 4.79% increase in the base data.

Table 12J

Aggregate Fee Schedule Changes			
Time Period	All Services Cost	Fee Change Impact	All Services Cost
SFY 2019	$5,158,733,378	$246,958,562	4.79%

Pharmacy Rebates

Effective May 1, 2019, LDH implemented a Single Preferred Drug List (PDL) for selected therapeutic classes. As such, the MCOs are prohibited from entering into rebate agreements with manufacturers of drugs. Any existing drug rebate agreements were discontinued by May 1, 2019. The MCOs are still allowed to collect rebates on non-drug items such as diabetic testing supplies since the Single PDL was implemented.

In order to determine an appropriate pharmacy rebate adjustment, Mercer analyzed historical utilization patterns, as reported in the encounter data, by rate cell and therapeutic class. The historical experience was projected to the rating period and rebate adjustments were developed by rate cell. The resulting pharmacy rebate adjustments are shown in Table 13.

Table 13

Pharmacy Rebates				
COA	Base Expenses	Rx Adjustment Dollars	Adjusted Expenses	Adjustment %
SSI	$382,238,025	$(1,911,190)	$380,326,835	-0.50%
F&C	$303,269,015	$(1,516,345)	$301,752,670	-0.50%
FCC	$9,123,332	$(36,493)	$9,086,839	-0.40%
BCC	$2,657,265	$(10,629)	$2,646,636	-0.40%
LAP	$1,362,789	$(10,902)	$1,351,887	-0.80%
HCBS	$11,024,002	$(44,096)	$10,979,906	-0.40%
CCM	$6,279,069	$(6,279)	$6,272,790	-0.10%
Medicaid Expansion	$598,248,688	$(2,991,243)	$595,257,444	-0.50%
Medicaid Expansion – High Needs	$821,567	$(4,108)	$817,460	-0.50%

Outliers

As part of the State Plan, inpatient hospitals receive an additional payment for high-cost stays for children under six, called outliers. These payments are for inpatient stays with a total cost to the hospital in excess of $150,000, where the cost is determined based on the hospital's Neonatal Intensive Care Unit or Pediatric Intensive Care Unit-specific CCR. LDH makes payments up to a maximum of $20,492,179 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 SFY19 payments. For the PH Non-Expansion rate cells, outliers added an average cost of $1.78 PMPM to the base data used in rate setting. Table 14 details the impact of outliers on the rates by rate cell.

Table 14

Outliers Adjustment				
COA	Rate Cell	Projected MMs	PMPM	Total Adjustment
SSI	Newborn, 0 2 Months	853	$3,387.07	$2,889,131
SSI	Newborn, 3 11 Months	7,281	$216.40	$1,575,719
SSI	Child, 1 20 Years	521,467	$0.75	$391,452
F&C	Newborn, 0 2 Months	116,408	$126.16	$14,686,433

Outliers Adjustment				
COA	Rate Cell	Projected MMs	PMPM	Total Adjustment
F&C	Newborn, 3 11 Months	413,652	$1.85	$764,308
F&C	Child, 1 20 Years	7,779,765	$0.02	$185,135
Total		8,839,427	$2.32	$20,492,179
Total PH COAs*		**11,502,365**	**$1.78**	**$20,492,179**

*Total includes projected member months (MMs) for Non-Expansion PH population.

Non-Invasive Prenatal Testing (NIPT) Adjustment

Effective February 1, 2019, NIPT became a covered service in the Healthy Louisiana program. NIPT is a genetic test, which uses maternal blood that contains cell-free fetal deoxyribonucleic acid (DNA) from the placenta. NIPT is considered a medical necessity once per pregnancy to pregnant women over the age of 35, and for women under age 35 who meet one or more of certain high-risk criteria.

Although NIPT was not a contractually-required covered service historically, some Healthy Louisiana MCOs have paid for NIPT screenings in certain cases. Mercer relied on the available experience to estimate the NIPT program change adjustment for the seven months prior to the effective date within the SFY 2019 base period (July 2018 – January 2019). The impact of the NIPT adjustment on the maternity kickpayment is summarized in Table 15.

Table 15

NIPT Adjustment			
COA	Historical Cost	Dollar Impact	Impact %
Non Expansion – Maternity Kickpayment	$183,020,259	$121,793	0.07%
Expansion – Maternity kickpayment	$95,301,148	$77,049	0.08%
Total Program	**$5,255,573,822**	**$198,842**	**0.00%**

Severe Combined Immunodeficiency (SCID) Screening

Effective November 1, 2019, 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 kickpayment is summarized in Table 16.

Table 16A

Region	Rating Adjustment – Non-Expansion
Gulf	0.12%
Capital	0.16%
South Central	0.16%
North	0.12%
Statewide	0.14%

Table 16B

Region	Rating Adjustment – Expansion
Gulf	0.14%
Capital	0.14%
South Central	0.14%
North	0.14%
Statewide	0.14%

Tobacco Cessation for Pregnant Women

Beginning 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.

Table 17

Tobacco Cessation Adjustment			
COA	Historical Cost	Dollar Impact	Impact %
Non-Expansion – Maternity Kickpayment	$235,899,577	$187,730	0.08%
Expansion – Maternity Kickpayment	$102,842,174	$79,954	0.08%

FQHC/RHC Adjustments

Long-Acting Reversible Contraceptive (LARC)

Effective January 1, 2019, Healthy Louisiana MCOs became responsible for LARC devices. The Actual Acquisition Cost (AAC) to the FQHC will determine the reimbursement for LARC devices.

Same-Day Billing

Effective April 1, 2019, the Medicaid program shall establish an alternative payment methodology for behavioral health (BH) services provided in RHCs by one of the following practitioners:

- Physicians with a psychiatric specialty
- Nurse practitioners or clinical nurse specialist with a psychiatric specialty
- Licensed clinical social workers
- Clinical psychologist

The reimbursement for BH services will equal the all-inclusive encounter Prospective Payment Systems (PPS) rate on file for FFS on the DOS. This reimbursement will be in addition to any all-inclusive PPS rate on the same date for a medical visit.

Mercer developed the projection of these two changes by using updated fee schedules and supplemental information provided by LDH in conjunction with historical Healthy Louisiana data. Table 18 summarizes the projected impact to the rates related to these FQHC/RHC reimbursement methodology changes.

Table 18

FQHC/RHC Adjustments					
COA	Rate Cell	Base MMs	LARC PMPM	Same Day Billing PMPM	Total Adjustment PMPM
SSI	Newborn, 0-2 Months	753	$-	$-	$-
SSI	Newborn, 3-11 Months	6,292	$-	$-	$-
SSI	Child, 1-20 Years	430,135	$(0.01)	$0.33	$0.32
SSI	Adult 21+ Years	893,849	$(0.02)	$0.30	$0.28
F&C	Newborn, 0-2 Months	116,548	$-	$-	$-

FQHC/RHC Adjustments					
COA	Rate Cell	Base MMs	LARC PMPM	Same Day Billing PMPM	Total Adjustment PMPM
F&C	Newborn, 3-11 Months	407,681	$-	$0.00	$0.00
F&C	Child, 1-20 Years	7,706,832	$(0.01)	$0.15	$0.14
F&C	Adult 21+ Years	1,236,130	$(0.01)	$0.17	$0.16
FCC	FCC, All Ages, Male & Female	154,951	$-	$0.40	$0.40
BCC	BCC, All Ages, Male & Female	5,056	$-	$0.21	$0.21
LAP	LAP, All Ages, Male & Female	35,482	$-	$0.19	$0.19
HCBS	Male & Female, Age 20 & Under	7,332	$-	$0.27	$0.27
HCBS	Male & Female 21+	17,628	$(0.02)	$0.44	$0.42
CCM	CCM, All Ages, Male & Female	36,255	$-	$0.37	$0.37
SBH – CCM	SBH – CCM, All Ages	36,228	$-	$0.26	$0.26
SBH – Duals	SBH – Dual Eligible, All Ages	1,352,807	$-	$0.00	$0.00
SBH – HCBS	Child 1-20 Years	22,020	$-	$0.15	$0.15
SBH – HCBS	Adult 21+ Years	39,194	$-	$0.25	$0.25
SBH – Other	SBH – All Ages	36,587	$-	$0.04	$0.04
Medicaid Expansion	Ages 19-64	5,749,850	$(0.01)	$0.25	$0.23
Medicaid Expansion	High Needs	2,367	$(0.01)	$0.55	$0.54

Local Pharmacy Adjustment

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

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

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

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

Mercer reviewed an analysis by Myers and Stauffer in which they estimated the difference between local AAC and NADAC ingredient costs. Myers and Stauffer performed the pricing analysis on local pharmacy encounter experience incurred on days of service 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 19 summarizes the updated impact of local pharmacy pricing changes on projected pharmacy costs on each rate cell.

Table 19

COA	Local Pharmacy Adjustment
SSI	0.44%
F&C	0.44%
FCC	0.52%
BCC	0.11%
LAP	0.32%
HCBS	0.42%
CCM	0.29%
Medicaid Expansion	0.32%
Medicaid Expansion – High Needs	0.24%

Peer Support Services

Effective February 1, 2021, LDH will offer peer support services 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 will be face-to-face interventions that are person-centered and recovery focused. Table 20 shows the impact of this adjustment.

Table 20

Peer Support Services Adjustment				
COA	Rate Cell	Projected MMs	PMPM	Total Adjustment
SSI	Adult, 21+ Years	1,101,988	$1.46	$1,608,491
Family & Children	Adult, 21+ Years	1,267,935	$0.55	$698,582
Foster Care Children	Foster Care, All Ages, Male & Female	172,295	$0.06	$9,526
BCC	BCC, All Ages, Female	4,230	$0.22	$914
HCBS	Male & Female, Age 21+	28,200	$0.75	$21,081
SBH - Duals	SBH - Dual Eligible, All Ages	1,518,056	$0.19	$293,783
SBH - HCBS	Adult 21+ Years	35,647	$0.69	$24,539
SBH - Other	SBH - All Ages	35,443	$1.55	$55,003
Medicaid Expansion	Age 19 - 64	6,504,384	$0.56	$3,632,885
Medicaid Expansion	High Needs	2,505	$2.80	$7,006

NEMT Fee Schedule Change

Effective July 1, 2020, LDH updated its fee schedule for NEMT services, which can be found on its website[4]. The impact of this fee adjustment is in Table 21.

Table 21

NEMT Fee Change				
Time Period	Historical Cost	Fee Change Impact	Historical Cost	All Services Cost
SFY 2019	$33,953,711	$2,005,540	5.91%	0.07%

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

Inpatient Subspecialty and Neonatology Rate Restoration

Effective January 1, 2021, LDH will implement an inpatient subspecialist coding correction. 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.

Table 22

Inpatient Subspecialty and Neonatology Rate Restoration		
Population	Neonatal	Subspecialty
Non-Expansion	$558,390	$2,105,975
Expansion		$1,849,848

Enrollment Acuity Adjustment

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

Because of the Public Health Emergency (PHE) and Maintenance of Effort (MOE) restrictions due to the COVID-19 pandemic, LDH has ceased the wage verification checks, as well as other redetermination processes that would have resulted in individuals being disenrolled from the Healthy Louisiana program. As a result, Mercer and LDH reviewed the historical acuity of individuals previously disenrolled through these processes, as well as the actual and estimated enrollment remaining in the Healthy Louisiana program as a result of these suspensions.

While the result of these suspensions impacts various eligibility categories, LDH and Mercer observed that the impact of the increased enrollment, coupled with the historical acuity differences, only necessitates an adjustment at this time for the Medicaid Expansion rate cell.

Enrollment Estimates

In order to determine the estimated enrollment impact, Mercer relied upon enrollment projections provided by LDH on October 30, 2020, after the PHE was extended through January 20, 2021. Because of the uncertainty of whether or not the PHE will be extended again, Mercer has assumed, for purposes of this adjustment, the PHE would be extended throughout the entirety of RY21. Should the PHE expire between January 21, 2021 and December 31, 2021, Mercer and LDH would adjust the rates accordingly to reflect the resumption of wage verification checks and other redeterminations. The

enrollment projections provided by LDH included information on the following groups whose eligibility has been or will be impacted by the PHE MOE restrictions:

- Individuals for whom redeterminations were suppressed in 2020, but whose enrollment continues into RY21
- Estimated numbers of individuals who may be disenrolled in wage verification checks were resumed in RY21
- Individuals who would have regularly-scheduled redeterminations in RY21, but who may be suppressed as a result of an extended PHE

Acuity Estimates

Previously, data on actual individuals disenrolled in 2019 through wage verification checks revealed that individuals disenrolled through this process had lower costs, on average, than individuals who remained eligible for the Healthy Louisiana program. This information was utilized for the estimate of acuity differences for enrollment associated with potential wage verification checks.

For all other individuals whose redeterminations were either suppressed in 2020 or whose redeterminations may be suppressed in 2021, Mercer relied upon analyses completed prior to the PHE which segmented the Medicaid Expansion population into various spans and changes in eligibility. Similar to the wage verification data, it indicated these members had, on average, lower acuity than individuals remaining eligible. However, the difference in acuity for these individuals, which would include individuals disenrolled through the redetermination process, was less than the wage verification difference.

Adjustment Calculation

Based upon the enrollment estimates for the various groups described above, Mercer utilized the acuity information to estimate the impact this enrollment would have on the average Medicaid Expansion acuity and costs in 2021. On a statewide basis, the overall impact to the Medicaid Expansion rate cell is -1.63%, though there is some variation by region. The overall impact to the Healthy Louisiana program for this adjustment is -0.67%.

Single PDL

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

To estimate the impact of the Single PDL on pharmacy costs, Mercer's actuaries and pharmacists reviewed the historical utilization of drugs in the affected classes and developed assumptions

regarding the expected changes in utilization from non-preferred to preferred agents, which were reviewed by LDH pharmacists. The estimated impact of the Single PDL program change on projected pharmacy costs on each rate cell are summarized in Table 23.

Table 23

COA	Unit Cost Adjustment
SSI	1.13%
F&C	1.63%
FCC	3.69%
BCC	0.25%
LAP	4.00%
HCBS	3.02%
CCM	7.00%
Medicaid Expansion	1.44%
Medicaid Expansion – High Needs	1.44%

Streamlined Hepatitis C Screening and Treatment Algorithm

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

- Genotype testing
- Fibrosure testing
- RNA testing

In order to evaluate the impact of these changes, Mercer estimated the impact of eliminating or reducing the services that are no longer expected to be a part of the new treatment protocol on a per individual basis. LDH's FFS fee schedule was used to price the services in question. The FFS prices were also benchmarked against MCO-reported unit costs. The overall change in screening and treatment costs were also adjusted to account for the increase in the number of Medicaid enrollees expected to be treated for Hepatitis C between January 1, 2021 and December 31, 2021. A summary of the estimated impact of these changes by rate cell are summarized in Table 24. Please refer to Appendix E for additional detail regarding this adjustment.

Table 24

COA	Rate Cell	% Impact
SSI	0-2 Months	0.00%
SSI	3-11 Months	0.00%
SSI	Child 1-20 Years	0.00%
SSI	Adult 21+ Years	0.01%
F&C	0-2 Months	0.00%
F&C	3-11 Months	0.00%
F&C	Child 1-20 Years	0.00%
F&C	Adult 21+ Years	0.01%
FCC	All Ages Male & Female	0.00%
BCC	BCC, All Ages	0.00%
LAP	LAP, All Ages	0.00%
HCBS	Child 1-20 Years	0.00%
HCBS	Adult 21+ Years	0.01%
CCM	CCM, All Ages	0.00%
SBH – CCM	SBH – CCM, All Ages	0.00%
SBH – Duals & LaHIPP	SBH – Dual Eligible & LaHIPP, All Ages	0.00%
SBH – HCBS	Child 1-20 Years	0.00%
SBH – HCBS	Adult 21+ Years	0.00%
SBH – Other	SBH – All Ages	0.00%
Maternity Kickpayment	Maternity Kickpayment	0.00%
Medicaid Expansion	Age 19-64	0.02%
Medicaid Expansion	High Needs	0.07%

Medication-Assisted Treatment (MAT)

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

As MAT is a newly covered service, Mercer relied upon projected costs and utilization provided by the State for the Non-Expansion and Expansion programs separately. Mercer identified individuals within the base data with 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 25. Please see Appendix F for more detail.

Table 25

COA	Rate Cell	MAT PMPM Add-On
SSI	Child 1-20 Years	$0.10
SSI	Adult 21+ Years	$2.03
F&C	Child 1-20 Years	$0.03
F&C	Adult 21+ Years	$2.03
FCC	All Ages Male & Female	$0.33
Medicaid Expansion	Age 19-64	$1.93
Medicaid Expansion	High Needs	$ 11.88

COVID-19 Pandemic and Related Adjustments

RY21 capitation rates were adjusted to reflect the impact of the COVID-19 pandemic. Significant national uncertainty exists regarding the impact of COVID-19 during RY21 due to the ever-changing situation with regionalized infection rates, responses driven by local governments and new treatment protocols to name a few factors. Utilization and cost assumptions need to be developed, including infection rate and severity mix of cases, the impact of social distancing, the Federal Government's involvement in COVID-related funding and the availability of a vaccine. Given the limited experience resulting from the COVID-19 pandemic, Mercer used several data sources to develop the COVID-19 impacts to RY21 capitation rates, including Mercer and Oliver Wyman internal modeling, national and state data sources and additional program-specific data provided from LDH and the MCOs.

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

Testing

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

Treatment

Treatment costs considered the estimated cost of treatment based on case severity. Scenarios were considered that ranged from in-home care for mild cases to hospitalization, including intensive care units, for more severe cases. Average treatment costs were developed based on projected treatment protocols, including average days in the hospital. The treatment costs were then weighted based on

an assumed distribution of incidence rate and severity of cases that varied by rate cell. For example, older members are assumed to be at higher risk for more severe infection, requiring more costly treatment, than younger members.

Deferred Care

Deferred care assumptions were developed based on an assumed percentage of projected utilization that is delayed, with a portion of these delayed services assumed to be canceled. Delayed or canceled services can result from restricted provider capacity, services considered elective or lower urgency or services ultimately deemed unnecessary. Mercer varied these assumptions by service category. These deferred care utilization assumptions were then applied to projected expense by rate cell, which reflected a rate cell-specific mix of service categories. Mercer assumed the impact of deferred care will continue through the third quarter of RY21.

Aggregate COVID-19 Pandemic and Related Adjustments

The PMPM impact of these adjustments is included in Table 26.

Table 26

% Impact to Projected Medical Expense	Gulf	Capital	South Central	North	Statewide
Testing Cost	0.4%	0.3%	0.4%	0.4%	0.4%
Anti-body Cost	0.0%	0.0%	0.0%	0.0%	0.0%
Treatment Cost	0.4%	0.4%	0.4%	0.4%	0.4%
Net Deferred Care	-0.6%	-0.6%	-0.6%	-0.6%	-0.6%
Total Impact	0.2%	0.1%	0.2%	0.2%	0.2%

Other Prospective Changes Not Included in This Certification

At the time of this certification, Mercer is aware of three potential changes that may require an addendum to the rates certified herein. One of these updates is coverage for the newly eligible children under the (Tax Equity and Fiscal Responsibility Act) Act 421, currently with a planned effective date of April 1, 2021. For the second update, LDH has submitted a directed payment pre-print for a uniform percentage increase of reimbursement for acute care hospitals applicable to the prior rating cycle and would intend to renew it for this contract period once approved. Lastly, Mercer will be monitoring the PHE in case rating updates are needed during the course of RY21. Primarily, this is related to the length of the PHE and the impact of vaccine administration on the capitation rates; at the time of this certification, the necessary details to evaluate the impact of vaccine administration costs and other impacts are not yet known. In the event that these changes are finalized or other changes arise, Mercer and LDH will amend this certification, as warranted, to address the impacts.

5
Trends

Medical Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the cost of providing health care services in a future period. Mercer studied historical cost and utilization data for the two data sources incorporated in the capitation rates: Healthy Louisiana encounters and Healthy Louisiana MCO financial reports. Trends were selected based on Louisiana experience, as well as national trend information.

The trend factors by population are shown in Appendix G.

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 RY21 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 27

COA	Rate Cell	Pharmacy Trend
SSI	0-2 Months	2.05%
SSI	3-11 Months	1.89%
SSI	Child 1-20 Years	6.97%
SSI	Adult 21+ Years	10.01%

COA	Rate Cell	Pharmacy Trend
F&C	0-2 Months	1.96%
F&C	3-11 Months	3.54%
F&C	Child 1-20 Years	4.46%
F&C	Adult 21+ Years	8.32%
FCC	All Ages Male & Female	4.77%
BCC	BCC, All Ages	16.29%
LAP	LAP, All Ages	7.05%
HCBS	Child 1-20 Years	7.37%
HCBS	Adult 21+ Years	7.37%
CCM	CCM, All Ages	6.81%
Expansion	Age 19-64	10.70%
Expansion	High Needs	12.47%

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

6

Special Contract Provisions Related to Payment

Withhold Arrangement

Effective February 1, 2018, a withhold of the monthly capitated payment shall be applied to incentivize quality, health outcomes and value-based payments. The withhold amount will be equal to 2.0% of the monthly capitated payment for PH and basic BH for all MCO members, exclusive of maternity kickpayments and the FMP component of the monthly capitated payment. Quality and health outcomes, along with value-based payments will each account for 1.0% (half of the 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 RY21 with the following parameters:

Table 28

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

Risk Pool

Due to the inherent volatility related to the high cost, low frequency drug, Zolgensma®, LDH implemented a risk pool in RY20 to mitigate the risk that any MCO incurs a disproportionate share of Zolgensma. This risk pool will remain in place during the RY21 contract period. The risk pool will be budget neutral in aggregate and payments from the risk pool will be based on actual Zolgensma claims incurred during RY21. Mercer has allocated four claims each at $2.125 million for the Zolgensma risk pool in RY21 rates.

Minimum Medical Loss Ratio (MLR)

In accordance with the MCO Financial Reporting Guide published by LDH, each MCO shall provide an annual 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.

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 that 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 29.

Table 29

Administrative PMPM by Program	
Non-Expansion PH	$30.47
Non-Expansion SBH	$5.71
Maternity Kickpayment	$366.96
Expansion	$40.60

Due to the expected increase in the number of Medicaid enrollees projected to be treated for Hepatitis C between January 1, 2021 and December 31, 2021, Mercer determined it was necessary to increase the administrative expense load to account for additional Hepatitis C-related case management costs.

Mercer estimated historical Hepatitis C-related case management costs based on the MCO financial reports and developed an add-on commensurate with the expected increase in the number of Medicaid enrollees who will be treated for Hepatitis C between January 1, 2021 and December 31, 2021. A summary of the estimated impact of these changes by rate cell and region are summarized in Table 30.

Table 30

COA	Rate Cell	Fixed Admin PMPM Add-On			
		Gulf	Capital	South Central	North
SSI	Child 1-20 Years	$-	$-	$-	$0.00
SSI	Adult 21+ Years	$0.67	$0.60	$0.33	$0.42
F&C	Child 1-20 Years	$0.00	$0.00	$0.00	$-
F&C	Adult 21+ Years	$0.16	$0.15	$0.07	$0.07
FCC	All Ages Male & Female	$-	$-	$0.01	$-
BCC	BCC, All Ages	$-	$-	$0.78	$-
HCBS	Adult 21+ Years	$0.17	$0.38	$0.23	$0.09
Medicaid Expansion	Age 19-64	$0.27	$0.25	$0.12	$0.14
Medicaid Expansion	High Needs	$3.54	$2.52	$1.64	$-

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 (HIPF)

Section 9010 of the ACA established a 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. However, the

Further Consolidated Appropriations Act, 2020, Division N, Subtitle E §502, repealed the annual fee on health insurance providers, beginning after December 31, 2020 (fee years after the 2020 fee year).

Pending further legislation throughout 2021, many aspects of the calculation and application of this fee remain uncertain. The HIPF fees associated with calendar year 2021 experience will be calculated and become payable during the third quarter of 2022. As these fees are not yet defined by insurer and by marketplace, no adjustment has been made in the rate range development for the Healthy Louisiana program. An adjustment and revised certification will be considered when the fee amount and impacted entities applicable to this rate period are announced.

8
Risk Adjustment

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

The application of the ACG model was tailored to the Healthy Louisiana program by using Louisiana cost experience to determine the relative costs associated with each ACG category. This step produces Louisiana-specific cost weights, which assign a risk score to each member with sufficient experience (six or more months of enrollment with an MCO). An age/gender risk assumption is made for members without an ACG assignment. These member-level risk scores will be aggregated by MCO, producing MCO risk scores, which are adjusted for budget neutrality. The risk adjustment process does not increase nor decrease the overall cost of the program, but can change the distribution across the various Healthy Louisiana MCOs according to the relative risk of their enrolled members. This is consistent with the budget neutrality requirements outlined in 42 CFR 438.5(g). The FMP component of the rates will not be risk adjusted. The FMP component is added to the risk-adjusted rate to produce the final rate. Table 31 shows the rate cells that will be risk adjusted.

Table 31

Risk-Adjusted Rate Cells	
SSI	
Child, 1-20 Years, Male & Female	Adult, 21+ Years, Male & Female
Family and Children (TANF)	
Child, 1-20 Years, Male & Female	Adult, 21+ Years, Male & Female
FCC: All Ages, Male & Female	
LAP: All Ages, Male & Female	
Medicaid Expansion: Ages 19-64	

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

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

9
Certification of Final Rates

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

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

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

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

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

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

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

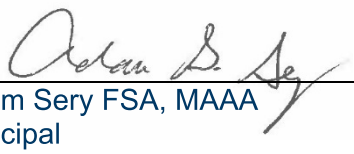
LDH understands that Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends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

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

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

If you have any questions on any of the above, please feel free to contact Adam Sery at +1 612 802 0780 or Erik Axelsen at +1 404 442 3517 at your convenience.

Sincerely,



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State of Louisiana

Appen

Region Description	Category of Aid Description	Rate Cell Description
Gulf	SSI	0–2 Months
Gulf	SSI	3–11 Months
Gulf	SSI	Child 1–20 Years
Gulf	SSI	Adult 21+ Years
Gulf	Family & Children	0–2 Months
Gulf	Family & Children	3–11 Months
Gulf	Family & Children	Child 1–20 Years
Gulf	Family & Children	Adult 21+ Years
Gulf	Foster Care Children	All Ages Male & Female
Gulf	BCC	BCC, All Ages
Gulf	LAP	LAP, All Ages
Gulf	HCBS	Child 1–20 Years
Gulf	HCBS	Adult 21+ Years
Gulf	CCM	CCM, All Ages
Gulf	SBH – CCM	SBH – CCM, All Ages
Gulf	SBH – Duals	SBH – Dual Eligible, All Ages
Gulf	SBH – LaHIPP	SBH – LaHIPP, All Ages
Gulf	SBH – HCBS	Child 1–20 Years
Gulf	SBH – HCBS	Adult 21+ Years
Gulf	SBH – Other	SBH – All Ages
Gulf	Maternity Kickpayment	Maternity Kickpayment
Gulf	EED Kickpayment	EED Kickpayment
Gulf	Medicaid Expansion	Age 19–64
Gulf	Medicaid Expansion	SBH – Dual Eligible, All Ages
Gulf	Medicaid Expansion	SBH – LaHIPP, All Ages
Gulf	Medicaid Expansion	SBH – Other
Gulf	Medicaid Expansion	SBH – CCM, All Ages
Gulf	Medicaid Expansion	High Needs
Gulf	Medicaid Expansion – Maternity Kickpayment	Maternity Kickpayment
Gulf	Medicaid Expansion – EED Kickpayment	EED Kickpayment
Capital	SSI	0–2 Months
Capital	SSI	3–11 Months
Capital	SSI	Child 1–20 Years
Capital	SSI	Adult 21+ Years
Capital	Family & Children	0–2 Months
Capital	Family & Children	3–11 Months
Capital	Family & Children	Child 1–20 Years
Capital	Family & Children	Adult 21+ Years
Capital	Foster Care Children	All Ages Male & Female
Capital	BCC	BCC, All Ages

State of Louisiana

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Region Description	Category of Aid Description	Rate Cell Description
South Central	SSI	0–2 Months
South Central	SSI	3–11 Months
South Central	SSI	Child 1–20 Years
South Central	SSI	Adult 21+ Years
South Central	Family & Children	0–2 Months
South Central	Family & Children	3–11 Months
South Central	Family & Children	Child 1–20 Years
South Central	Family & Children	Adult 21+ Years
South Central	Foster Care Children	All Ages Male & Female
South Central	BCC	BCC, All Ages
South Central	LAP	LAP, All Ages
South Central	HCBS	Child 1–20 Years
South Central	HCBS	Adult 21+ Years
South Central	CCM	CCM, All Ages
South Central	SBH – CCM	SBH – CCM, All Ages
South Central	SBH – Duals	SBH – Dual Eligible, All Ages
South Central	SBH – LaHIPP	SBH – LaHIPP, All Ages
South Central	SBH – HCBS	Child 1–20 Years
South Central	SBH – HCBS	Adult 21+ Years
South Central	SBH – Other	SBH – All Ages
South Central	Maternity Kickpayment	Maternity Kickpayment
South Central	EED Kickpayment	EED Kickpayment
South Central	Medicaid Expansion	Age 19–64
South Central	Medicaid Expansion	SBH – Dual Eligible, All Ages
South Central	Medicaid Expansion	SBH – LaHIPP, All Ages
South Central	Medicaid Expansion	SBH – Other
South Central	Medicaid Expansion	SBH – CCM, All Ages
South Central	Medicaid Expansion	High Needs
South Central	Medicaid Expansion – Maternity Kickpayment	Maternity Kickpayment
South Central	Medicaid Expansion – EED Kickpayment	EED Kickpayment
North	SSI	0–2 Months
North	SSI	3–11 Months
North	SSI	Child 1–20 Years
North	SSI	Adult 21+ Years
North	Family & Children	0–2 Months
North	Family & Children	3–11 Months
North	Family & Children	Child 1–20 Years
North	Family & Children	Adult 21+ Years
North	Foster Care Children	All Ages Male & Female
North	BCC	BCC, All Ages

State of Louisiana

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

State of Louisiana

Covered Populations	
Aid Category Description	Type Case Description
Families and Children	
	Breast and/or Cervical Cancer
	CHAMP Child
	CHAMP Pregnant Woman (to 133% of FPIG)
	CHAMP Pregnant Woman Expansion (to 185% FPIG)
	Deemed Eligible
	ELE – Food Stamps (Express Lane Eligibility–Food Stamps)
	Forced Benefits
	Former Foster Care children
	LaCHIP Affordable Plan
	LACHIP Phase 1
	LACHIP Phase 2
	LACHIP Phase 3
	LaCHIP Phase IV: Non–Citizen Pregnant Women Expansion
	LIFC Basic
	LTC (Long Term Care)
	LTC Spenddown MNP
	PAP – Prohibited AFDC Provisions
	Pregnant women with income greater than 118% of FPL and less than or equal to 133% of F
	Public ICF/DD
	Regular MNP (Medically Needy Program)
	Transitional Medicaid
	Youth Aging Out of Foster Care (Chaffee Option)
LIFC	
	Grant Review/Child Support Continuance
	LIFC – Unemployed Parent / CHAMP
	LIFC Basic
	Transitional Medicaid
Medicaid Expansion	
	Adult Group
	Adult Group – High Need
Non Traditional	
	CSOC
OCS/OYD	
	CHAMP Child
	CHAMP Pregnant Woman (to 133% of FPIG)
	CHAMP Pregnant Woman Expansion (to 185% FPIG)
	Children's Waiver – Louisiana Children's Choice
	Forced Benefits
	Former SSI
	Foster Care IV–E – Suspended SSI
	IV–E Foster Care
	LACHIP Phase 1
	LTC (Long Term Care)
	LTC (Long Term Care)
	New Opportunities Waiver – SSI
	New Opportunities Waiver Fund

State of Louisiana

Excluded Populations	
Aid Category Description	Type Case Description
ABD (Aged, Blind, and Disabled)	
	DD Waiver
	Denied SSI Prior Period
	Disabled Adults authorized for special hurricane Katrina assistance
	EDA Waiver
	Excess Home Equity Over SIL & NF Fee (Aged)
	Excess Home Equity SSI Under SIL (Aged)
	Excess Home Equity SSI Under SIL–Reg LTC (Aged)
	Forced Benefits (Aged)
	Forced Benefits (Disabled)
	Illegal/Ineligible Aliens Emergency Services
	LBHP – Adult 1915(i)
	LTC (Long Term Care) (Aged)
	LTC Co–Insurance
	LTC MNP/Transfer of Resources (Aged)
	LTC Payment Denial/Late Admission Packet (Aged)
	LTC Spenddown MNP (Aged)
	LTC Spenddown MNP (Income > Facility Fee)
	PACE SSI
	PACE SSI–related
	PCA Waiver
	Private ICF/DD (Aged and Disabled)
	Private ICF/DD (Blind)
	Private ICF/DD MNP Transfer of Resources (Blind and Disabled)
	Private ICF/DD Spendown Medically Needy Program (Aged and Dis
	Private ICF/DD Spendown Medically Needy Program (Blind)
	Private ICF/DD Spendown MNP/Income Over Facility Fee
	Private ICF/DD Transfer of Resources (Blind and Disabled)
	Public ICF/DD (Aged and Disabled)
	Public ICF/DD (Blind)
	Public ICF/DD MNP Transfer of Resources (Blind and Disabled)
	Public ICF/DD Spenddown MNP
	Public ICF/DD Spendown Medically Needy Program (Blind and Disa
	Public ICF/DD Spendown MNP/Income Over Facility Fee
	Public ICF/DD Transfer of Resources (Blind and Disabled)
	QI–1 (Qualified Individual – 1)
	QI–2 (Qualified Individual – 2) (Program terminated 12/31/2002)
	SLMB (Specified Low–Income Medicare Beneficiary)
	Spenddown MNP
	Spendown Denial of Payment/Late Packet (Aged and Disabled)
	Spendown Denial of Payment/Late Packet (Blind)
	SSI DD Waiver
	SSI Payment Denial/Late Admission (Aged)
	SSI PCA Waiver
	SSI Private ICF/DD Transfer of Resources (Blind and Disabled)
	SSI Public ICF/DD Transfer of Resources (Blind and Disabled)
	SSI Transfer of Resources(s)/LTC (Aged)

State of Louisiana

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

State of Louisiana

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

Table 2: SBH Program
Medicaid Category of Service
Inpatient Services — Mental Health
Emergency Room — Mental Health
Professional/Other — Mental Health
NEMT

Table 1a: SFY 2019 Base Expense

In-lieu-of Services/Settings	Categories of Covered Services that Contain In-Lieu-of Services				
	Inpatient	Outpatient	Physician	Maternity Kick Payment	Other (
Physical Health Services Provided in Skilled Nursing Facilities	$ 9,153,229	$ 12,587	$ 2,280	$ 23,480	$
Crisis Stabilization Units for All Medicaid Eligible Adults					
Inpatient Treatment Provided to Adults age 21 to 64 in an IMD for a short term stay of no more than 15 days					
Psychiatric Intensive Outpatient Program		$ 575,585			
23-Hour Observation Bed Services for all Medicaid Eligible Adults (Age 21 and Above)					
Injection Services Provided by Licensed Nurses to All Medicaid Eligible Adults (Age 21 and Above)			$ 211		
Utilization of Freestanding Psychiatric Hospitals instead of General Hospital Psychiatric Units for All Medicaid Eligible Adults (Age 21 - 64)					
Peer Support Services for All Medicaid Eligible Adults (Age 21 and Above)					
In-lieu-of Services/Settings Subtotal	**$ 9,153,229**	**$ 588,172**	**$ 2,492**	**$ 23,480**	**$**
State Plan Services/Settings	**$ 741,175,272**	**$ 1,036,267,542**	**$ 808,755,248**	**$ 278,297,926**	**$**
All Services	**$ 750,328,501**	**$ 1,036,855,714**	**$ 808,757,739**	**$ 278,321,407**	**$**

Table 1b: Percentage of Cost that In-lieu-of Services Represent in each Category of Service (SFY 2019 Base Cost)

	[A]	[B]	[C] = [B]/[A]
Category of Service	COS Total	In-lieu-of Services Total	In-lieu-of Services Percentage
Inpatient	$ 750,328,501	$ 9,153,229	1.2%
Outpatient	$ 1,036,855,714	$ 588,172	0.1%
Physician	$ 808,757,739	$ 2,492	0.0%
Transportation	$ 114,413,016	$ -	0.0%
Prescribed Drugs	$ 1,315,023,752	$ -	0.0%
Maternity Kick Payment	$ 278,321,407	$ 23,480	0.0%

Attachment D

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
Streamlined Practice Cost Per User
Discount
Hep C Recipients 2019 Q1 & Q2 (Annualized)
Hep C Recipients 2021 (Estimate)
Adherence to Streamlined Practice Rate
2019 Q1 & Q2 - Annualized Est. Cost Under Current Practice
2021 Estimated Cost Under Streamlined Practice
Change in Cost for 2021*
Percentage Change in Cost

*The $613,424 impact includes both the Expansion and Non-Expansi

	Non-Expansion Program				Expansion Program			
SFY	Methadone Bundle	Buprenorphine Bundle	Transportation	Total	Methadone Bundle	Buprenorphine Bundle	Transportation	To
SFY21	$4,072,774	$254,305	$757,186	$5,084,265	$9,901,302	$618,240	$1,840,791	$12,3
SFY22	$4,235,685	$264,477	$787,473	$5,287,636	$10,297,354	$642,969	$1,914,423	$12,8
Estimated MAT for 1/1/21 - 12/31/211				$5,185,950				$12,6

Notes:

1. Estimated cost for MAT for 1/1/21 - 12/31/21 = 1/2 x SFY21 totals + 1/2 x SFY22 totals

Annualized RY21 Trends by Major COS								
Rate Cell	PH		Rx		SBH		All Service	
	Low	High	Low	High	Low	High	Low	
Families & Children								
0-2 Months	-0.2%	3.8%	1.0%	3.0%	-9.8%	-5.9%	-0.2%	
3-11 Months	1.5%	5.2%	2.5%	4.6%	-9.8%	-5.9%	1.5%	
Child	1.7%	5.4%	3.4%	5.5%	-7.9%	-4.1%	0.2%	
Adult	2.6%	5.7%	7.3%	9.4%	-5.6%	-2.3%	2.9%	
Families & Children Total	**1.5%**	**5.1%**	**4.7%**	**6.7%**	**-7.5%**	**-3.8%**	**0.8%**	
SSI								
0-2 Months	-2.8%	-0.1%	1.0%	3.1%	-8.5%	-5.5%	-2.8%	
3-11 Months	-1.1%	1.8%	0.9%	2.9%	-8.5%	-5.5%	-0.9%	
Child	2.1%	5.3%	5.9%	8.0%	-6.4%	-4.1%	1.2%	
Adult	4.8%	8.3%	9.0%	11.1%	-0.5%	1.3%	5.6%	
SSI Total	**4.0%**	**7.5%**	**8.4%**	**10.5%**	**-2.6%**	**-0.6%**	**4.6%**	
HCBS								
Child	1.6%	4.9%	6.3%	8.4%	-3.2%	-2.0%	1.9%	
Adult	4.3%	7.7%	6.3%	8.4%	-0.5%	1.3%	4.9%	
HCBS Total	**3.0%**	**6.3%**	**6.3%**	**8.4%**	**-1.8%**	**-0.3%**	**3.6%**	
Other Populations								
Foster Care Children	1.7%	5.5%	3.7%	5.8%	-7.7%	-3.7%	-2.2%	
BCC	5.7%	9.6%	15.2%	17.4%	0.1%	2.0%	8.5%	
LAP	2.0%	5.7%	6.0%	8.1%	-5.9%	-3.0%	2.1%	
CCM	2.7%	6.0%	5.8%	7.8%	-2.6%	-1.6%	1.9%	
SBH Only HCBS								
Child	1.0%	3.0%	0.0%	0.0%	-4.9%	-3.3%	-4.5%	
Adult	-2.0%	0.0%	0.0%	0.0%	-4.1%	-0.5%	-3.6%	
SBH Only HCBS Total	**-1.1%**	**0.9%**	**0.0%**	**0.0%**	**-4.6%**	**-2.2%**	**-4.1%**	
SBH Only All Other								
SBH - CCM	1.0%	3.0%	0.0%	0.0%	-4.1%	-2.0%	-3.9%	
SBH - Duals	-2.0%	0.0%	0.0%	0.0%	-3.8%	0.1%	-3.0%	
SBH - Other	-2.0%	0.0%	0.0%	0.0%	-6.6%	-3.3%	-5.5%	
Maternity Kick Payment								
Maternity Kick Payment	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	

Annualized RY21 Expansion Trends by Major COS								
Rate Cell	PH		Rx		SBH		All Service	
	Low	High	Low	High	Low	High	Low	
Medicaid Expansion								
Male & Female Age 19 - 64	2.4%	5.5%	9.7%	11.8%	0.4%	5.0%	4.3%	
High Needs	2.3%	5.3%	11.4%	13.5%	0.8%	5.3%	5.2%	

Attachment D

State of Louisiana

Appendix H: Rate Comparison			
Region Description	Category of Aid Description	Rate Cell Description	Pro Mo
Gulf	SSI	0–2 Months	
Gulf	SSI	3–11 Months	
Gulf	SSI	Child 1–20 Years	
Gulf	SSI	Adult 21+ Years	
Gulf	Family & Children	0–2 Months	
Gulf	Family & Children	3–11 Months	
Gulf	Family & Children	Child 1–20 Years	
Gulf	Family & Children	Adult 21+ Years	
Gulf	Foster Care Children	All Ages Male & Female	
Gulf	BCC	BCC, All Ages	
Gulf	LAP	LAP, All Ages	
Gulf	HCBS	Child 1–20 Years	
Gulf	HCBS	Adult 21+ Years	
Gulf	CCM	CCM, All Ages	
Gulf	SBH – CCM	SBH – CCM, All Ages	
Gulf	SBH – Duals	SBH – Dual Eligible, All Ages	
Gulf	SBH – LaHIPP	SBH – LaHIPP, All Ages	
Gulf	SBH – HCBS	Child 1–20 Years	
Gulf	SBH – HCBS	Adult 21+ Years	
Gulf	SBH – Other	SBH – All Ages	
Gulf	Maternity Kickpayment	Maternity Kickpayment	
Gulf	EED Kickpayment	EED Kickpayment	
Gulf	Medicaid Expansion	Age 19–64	
Gulf	Medicaid Expansion	SBH – Dual Eligible, All Ages	
Gulf	Medicaid Expansion	SBH – LaHIPP, All Ages	
Gulf	Medicaid Expansion	SBH – Other	Attachment D
Gulf	Medicaid Expansion	SBH – CCM, All Ages	
Gulf	Medicaid Expansion	High Needs	
Gulf	Medicaid Expansion – Maternity Kickpayment	Maternity Kickpayment	
Gulf	Medicaid Expansion – EED Kickpayment	EED Kickpayment	
Capital	SSI	0–2 Months	
Capital	SSI	3–11 Months	
Capital	SSI	Child 1–20 Years	
Capital	SSI	Adult 21+ Years	
Capital	Family & Children	0–2 Months	

State of Louisiana

Appendix H: Rate Comparison			
Region Description	Category of Aid Description	Rate Cell Description	Pro Mo
South Central	SSI	0–2 Months	
South Central	SSI	3–11 Months	
South Central	SSI	Child 1–20 Years	
South Central	SSI	Adult 21+ Years	
South Central	Family & Children	0–2 Months	
South Central	Family & Children	3–11 Months	
South Central	Family & Children	Child 1–20 Years	
South Central	Family & Children	Adult 21+ Years	
South Central	Foster Care Children	All Ages Male & Female	
South Central	BCC	BCC, All Ages	
South Central	LAP	LAP, All Ages	
South Central	HCBS	Child 1–20 Years	
South Central	HCBS	Adult 21+ Years	
South Central	CCM	CCM, All Ages	
South Central	SBH – CCM	SBH – CCM, All Ages	
South Central	SBH – Duals	SBH – Dual Eligible, All Ages	
South Central	SBH – LaHIPP	SBH – LaHIPP, All Ages	
South Central	SBH – HCBS	Child 1–20 Years	
South Central	SBH – HCBS	Adult 21+ Years	
South Central	SBH – Other	SBH – All Ages	
South Central	Maternity Kickpayment	Maternity Kickpayment	
South Central	EED Kickpayment	EED Kickpayment	
South Central	Medicaid Expansion	Age 19–64	
South Central	Medicaid Expansion	SBH – Dual Eligible, All Ages	
South Central	Medicaid Expansion	SBH – LaHIPP, All Ages	
South Central	Medicaid Expansion	SBH – Other	Attachment D
South Central	Medicaid Expansion	SBH – CCM, All Ages	
South Central	Medicaid Expansion	High Needs	
South Central	Medicaid Expansion – Maternity Kickpayment	Maternity Kickpayment	
South Central	Medicaid Expansion – EED Kickpayment	EED Kickpayment	
North	SSI	0–2 Months	
North	SSI	3–11 Months	
North	SSI	Child 1–20 Years	
North	SSI	Adult 21+ Years	
North	Family & Children	0–2 Months	

John Bel Edwards
GOVERNOR

Dr. Courtney N
SECRETAR

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

Mr. Adam Sery, FSA, MAAA
Principal
Mercer Government Human Services
333 S 7th Street, Suite 1400
Minneapolis MN 55402

October 27, 2020

Subject: Capitation Rate Certification for the Healthy Louisiana Program – Implementation Year January 1, 2021 through December 31, 2021

Dear Adam:

I, Daniel Cocran, Medicaid Deputy Director for the Louisiana Department of Health (LDH), hereby affirm the data prepared and submitted to Mercer Government Human Services Consulting (Mercer) for the purpose of certifying the January 1, 2021 through December 31, 2021 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 July 1, 2017 through June 30, 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

11/9/2020
Date

Copy:
Erik Axelsen, ASA, MAAA, Senior Associate
F. Ronald Ogborne, FSA, CERA, MAAA, Partner

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