MILLIMAN CLIENT REPORT

State Fiscal Year 2025 Healthy Louisiana Medicaid Managed Care Capitation Rate Certification

State of Louisiana Department of Health

June 21, 2024

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Introduction & Executive Summary

BACKGROUND

Milliman, Inc. (Milliman) has been retained by the State of Louisiana, Department of Health (LDH) to provide actuarial and consulting services related to the development of capitation rates for the Physical Health (PH) and Specialized Behavioral Health (SBH) programs within the Healthy Louisiana managed care program. This report documents the development of the actuarially sound capitation rates for the state fiscal year (SFY) 2025 rating period. It also includes the required actuarial certification in Appendix 1.

To facilitate review, this document has been organized in the same manner as the 2024-2025 Medicaid Managed Care Rate Development Guide, finalized by the Centers for Medicare and Medicaid Services in January 2024 (CMS guide). Section II of the CMS guide is not applicable to Healthy Louisiana because long-term care supports and services (LTSS) are not covered by the managed care program. Section III of the CMS Guide and this certification is only applicable to the Medicaid Expansion population.

CONTRACTED MCOS AND PAYMENT METHODOLOGY

The following six MCOs will participate in the Medicaid managed care program on a statewide basis during SFY 2025:

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

Each MCO will receive a separate capitation payment for each rate cell. For most rate cells, the capitation rates vary by region and will be risk-adjusted based on the relative acuity of members enrolled with each MCO. Rate cells with statewide rates are described in Section 1, subsection 2.B.iii.a. Risk adjustment is discussed in more detail in Section 1, subsection 6. The regions and rate cells are described in more detail in Section I, subsection 4.A.iii(c)(iii). The parishes in Louisiana will be grouped into the same four rating regions used for the SFY 2024 Healthy Louisiana managed care capitation rate development. These regions are listed below. A mapping of the parishes to regions can be found in Appendix 4.

- Gulf
- Capital
- South Central
- North

FISCAL IMPACT ESTIMATE

The certified capitation rates for the Medicaid managed care populations are summarized in Figure 1. These rates are effective from July 1, 2024 through June 30, 2025 (SFY 2025). The rates are inclusive of directed payments and Full Medicaid Pricing (FMP) amounts. The composite rates illustrated for SFY 2025 have been developed based on an estimate of projected enrollment in SFY 2025. The January 2024 capitation rates are consistent with the following documents:

- *SFY 2024 Healthy Louisiana Medicaid Managed Care Rate Certification*, dated June 23, 2023
- *SFY 2024 Healthy Louisiana Medicaid Managed Care Rate Amendment,* dated December 6, 2023
- *January 2024 Healthy Louisiana Medicaid Managed Care Rate Amendment,* dated February 15, 2024

After the issuance of the January 2024 Healthy Louisiana Medicaid Managed Care Rate Amendment, the SFY 2024 capitation rates were also adjusted using the de minimis flexibility without a rate amendment. The impact of that rate change was less than 0.1% and only affected the FMP portion of the rates. Throughout this document, the January 2024 rates reflect the capitation rates *after* the de minimis adjustment.

FIGURE 1: COMPARISON WITH JANUARY 2024 PMPM RATES

POPULATION	ESTIMATED SFY 2025 AVERAGE MONTHLY ENROLLMENT	COMPOSITE MCO EXPECTED PAYMENTS JANUARY 2024	SFY 2025	% CHANGE
SSI	94,100	$2,005.69	$2,283.63	13.9%
F&C	769,300	393.63	409.96	4.1%
SBH	133,300	53.42	58.94	10.3%
Medicaid Expansion	575,500	758.93	821.29	8.2%
All Other Populations	28,900	1,284.39	1,340.44	4.4%
Maternity Kick – Expansion	1,200	19,646.71	23,371.83	19.0%
Maternity Kick – Non-Expansion	1,700	20,188.55	20,637.49	2.2%
Composite	**1,601,100**	**$643.92**	**$695.33**	**8.0%**

Notes:
1. January 2024 and SFY 2025 composite rates were developed based on SFY 2025 projected monthly enrollment.
2. Monthly enrollment values are rounded to the nearest thousand.
3. All Other Populations includes HCBS, Act 421, Foster Care Children, Breast and Cervical Cancer, LaHIPP Affordable Plan, and non-SBH Chisholm Class Members rate cells.

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

FIGURE 2: COMPARISON WITH JANUARY 2024 PMPM RATES

POPULATION	ESTIMATED SFY 2025 AVERAGE MONTHLY ENROLLMENT	COMPOSITE LIMITED RATES JANUARY 2024	SFY 2025	% CHANGE
SSI	94,100	$ 1,439.45	$ 1,606.80	11.6%
F&C	769,300	275.61	280.23	1.7%
SBH	133,300	50.41	55.39	9.9%
Medicaid Expansion	575,500	582.40	649.75	11.6%
All Other Populations	28,900	1,002.13	1,057.97	5.6%
Maternity Kick – Expansion	1,200	8,826.05	9,285.90	5.2%
Maternity Kick – Non-Expansion	1,700	8,623.28	7,891.15	(8.5%)
Composite	**1,601,100**	**$ 464.54**	**$ 501.81**	**8.0%**

Notes:
1. January 2024 and SFY 2025 composite rates were developed based on SFY 2025 projected monthly enrollment.
2. Monthly enrollment values are rounded to the nearest thousand.
3. All Other Populations includes HCBS, Act 421, Foster Care Children, Breast and Cervical Cancer, LaHIPP Affordable Plan, and non-SBH Chisholm Class Members rate cells.

Figure 3 compares the estimated federal and state expenditures under the SFY 2025 rates, based on estimated enrollment in SFY 2025. Revenue shown in Figure 3 includes state directed payment and FMP amounts.

FIGURE 3: COMPARISON WITH JANUARY 2024 RATES (AGGREGATE EXPENDITURES $ MILLIONS)

	TOTAL MCO EXPECTED PAYMENTS		
POPULATION	**JANUARY 2024**	**SFY 2025**	**CHANGE**
SSI	$ 2,264.0	$ 2,577.8	$ 313.7
F&C	3,634.0	3,784.7	150.8
SBH	85.4	94.3	8.8
Medicaid Expansion	5,241.6	5,672.2	430.7
All Other Populations	446.6	466.1	19.5
Maternity Kick – Expansion	291.6	346.9	55.3
Maternity Kick – Non-Expansion	409.4	418.5	9.1
Composite	**$ 12,372.6**	**$ 13,360.5**	**$ 987.9**
Federal	**$ 9,628.1**	**$ 10,406.6**	**$ 778.5**
State	**$ 2,744.5**	**$ 2,953.9**	**$ 209.4**

Notes:
1. January 2024 and SFY 2025 composite rates were developed based on SFY 2025 projected monthly enrollment.
2. State expenditures based on Federal Fiscal Year (FFY) 2024 FMAP of 67.67% for 3 months and FFY 2025 FMAP of 68.06% for 9 months for all except the Expansion population.
3. State expenditures based on FMAP of 90% for the Expansion population.
4. All Other Populations includes HCBS, Act 421, Foster Care Children, Breast and Cervical Cancer, LaHIPP Affordable Plan, and non-SBH Chisholm Class Members rate cells.
5. Values are rounded to the nearest hundred thousand.

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

FIGURE 4: COMPARISON WITH JANUARY 2024 RATES (AGGREGATE EXPENDITURES $ MILLIONS)

	TOTAL LIMITED RATE PAYMENTS		
POPULATION	**JANUARY 2024**	**SFY 2025**	**CHANGE**
SSI	$ 1,624.9	$ 1,813.8	$ 188.9
F&C	2,544.4	2,587.1	42.7
SBH	80.6	88.6	8.0
Medicaid Expansion	4,022.4	4,487.5	465.2
All Other Populations	348.5	367.9	19.4
Maternity Kick – Expansion	131.0	137.8	6.8
Maternity Kick – Non-Expansion	174.9	160.0	(14.8)
Composite	**$ 8,926.6**	**$ 9,642.7**	**$ 716.1**
Federal	**$ 6,982.0**	**$ 7,572.7**	**$ 590.7**
State	**$ 1,944.6**	**$ 2,070.0**	**$ 125.4**

Notes:
1. January 2024 and SFY 2025 composite rates were developed based on SFY 2025 projected monthly enrollment.
2. State expenditures based on Federal Fiscal Year (FFY) 2024 FMAP of 67.67% for 3 months and FFY 2025 FMAP of 68.06% for 9 months for all except the Expansion population.
3. State expenditures based on FMAP of 90% for the Expansion population.
4. All Other Populations includes HCBS, Act 421, Foster Care Children, Breast and Cervical Cancer, LaHIPP Affordable Plan, and non-SBH Chisholm Class Members rate cells.
5. Values are rounded to the nearest hundred thousand.

Section I. Medicaid Managed Care Rates

1. General Information

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

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

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

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

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 12 (Risk Classification (for all Practice Areas)); ASOP 23 (Data Quality); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification); and ASOP 56 (Modeling).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective for the SFY 2025 managed care program rating period.
- The most recent *Medicaid Managed Care Rate Development Guide* published by CMS.

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

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

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

A. RATE DEVELOPMENT STANDARDS

i. All standards and documentation expectations for rate ranges

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

ii. 12-month rating period

The actuarial certification contained in this report is effective for the capitation rates for the one-year rating period from July 1, 2024, through June 30, 2025.

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

iii. Required elements

(a) Actuarial certification

The actuarial certification, signed by Anders Larson, FSA, is in Appendix 1. Mr. Larson meets the qualification standards established by the American Academy of Actuaries, follows the practice standards established by the Actuarial Standards Board, and certifies that the rates meet the applicable standards in 42 CFR 438 that are effective for the SFY 2025 managed care program rating period.

(b) Certified capitation rates for each rate cell

The certified rates by region, rate cell, and MCO are contained in Appendix 3. Prior to risk adjustment, capitation rates are the same for all MCOs. These rates represent the contracted capitation rates prior to risk adjustment. Projected member months illustrated in Appendix 3 represent estimated values for SFY 2025 across all MCOs combined.

(c) Program information

(i) Managed care program

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

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

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

Aetna Better Health of Louisiana and UnitedHealthcare of Louisiana joined the Healthy Louisiana program in 2015. Starting in January 2023, Humana Healthy Horizons entered the Healthy Louisiana program. Due to the delayed implementation of the single statewide Pharmacy Benefit Manager (PBM), Humana did not cover prescription drugs until the Single PBM was implemented on October 28, 2023. Upon implementation of the Single PBM, the pharmacy benefit for all MCOs have been managed by Magellan Medicaid Administration Inc (Magellan).

Each MCO will receive a regional, risk adjusted capitation payment for each rate cell. The parishes in Louisiana will be grouped into the same four rating regions used for the Healthy Louisiana managed care capitation rate development and payment used for SFY 2024. These regions are listed below. A mapping of the parishes to regions can be found in Appendix 4.

- Gulf
- Capital
- South Central
- North

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

(ii) Rating period

This actuarial certification is effective for the one-year rating period of July 1, 2024 through June 30, 2025.

(iii) Covered populations

Healthy Louisiana is split into separate PH and SBH programs. This section will describe the managed care populations covered under each program. Appendix 5 also includes details on inclusions and exclusions for Healthy Louisiana.

Physical Health

There are several mandatory populations in the PH program:

Supplemental Security Income (SSI)

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

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

Family & Children (F&C)

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

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

Foster Care Children (FCC)

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

Breast and Cervical Cancer (BCC)

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

Louisiana Children's Health Insurance Program (LaCHIP)

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

Affordable Plan (LAP)

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

Act 421 Children's Medicaid Option (CMO)

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

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

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

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

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

Medicaid Expansion

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

- Age 19-64
- High Needs

Voluntary Populations

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

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

Excluded Populations

Appendix 5 includes details on aid category and type case combinations that are excluded for the PH program.

Maternity Kick Payment

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

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

Specialized Behavioral Health

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

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

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

The SBH program is divided into the following rate cells:

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

Summary Groupings

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

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

(iv) Eligibility criteria

Appendix 5 includes details on which aid category and type combinations are considered mandatory and which are excluded populations for the PH and SBH programs.

(v) Special contract provisions

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

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

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

(vi) Retroactive adjustment to capitation rates

This rate certification report is for prospective SFY 2025 capitation rates.

iv. Differences among capitation rates

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

v. Cross-subsidization of rate cell payment

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

vi. Effective dates

To the best of our knowledge, the effective dates of changes to the Medicaid managed care program are consistent with the assumptions used in the development of the certified SFY 2025 contracted capitation rates.

vii. Minimum medical loss ratio

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

viii. Conditions for actuarially sound rate ranges

This certification does not include rate ranges.

ix. Documentation for actuarially sound rate ranges

This certification does not include rate ranges.

x. Generally accepted actuarial practices and principles

(a) Reasonable, appropriate, and attainable

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

(b) Outside the rate setting process

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

(c) Final contracted rates

The SFY 2025 capitation rates certified in this report represent the final contracted rates by rate cell prior to risk adjustment.

xi. Rate certification for effective time periods

This actuarial certification is effective for the one-year rating period of July 1, 2024, through June 30, 2025.

xii. COVID-19 public health emergency

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

xiii. Procedures for rate certification and amendment

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

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

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

B. APPROPRIATE DOCUMENTATION

i. Actuarial certification

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

ii. Documentation of required elements

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

iii. Ranges of assumptions

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

iv. Requirements for a certified capitation rate range

This certification does not include rate ranges.

v. Index

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

vi. Consistency with rate of FFP

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

vii. Different FMAP

Capitated payments made for children enrolled in the F&C population who are eligible for Title XXI benefits receive an enhanced FMAP rate of 77.64% during federal fiscal year (FFY) 2025. A portion of capitated payments attributable to family planning services in all populations except Medicaid Expansion receive an enhanced FMAP rate of 90.0%.

Capitated payments made for the Medicaid Expansion population receive an FMAP rate of 90.0% during SFY 2025. All other capitated payments made receive the regular state FMAP of 67.67% for FFY 2024 and 68.06% for FFY 2025. The enhanced FMAP percentages (except for the 90.0% rate for the Medicaid Expansion population) are not reflected in values provided in this certification.

viii. Comparison to prior rates

(a) Comparison to prior rates

Figures 1 and 2 above provide a summarized comparison of the SFY 2025 capitation rates to the prior rates for January 2024. A summarized comparison by population with amounts attributable to each adjustment is provided in Appendix 11.

As demonstrated in Appendix 11, the following are the key drivers of the rate changes:

- New base period benefit expenses
- Pharmacy utilization and unit cost trends
- Changes to preferred drug list
- Acuity adjustments related to PHE unwinding
- Outpatient hospital reimbursement trend
- Non-benefit cost increases due to inflation and reduced economies of scale attributable to the PHE unwinding
- Base reimbursement changes for specific hospitals

(b) Description of other material changes

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

(c) De minimis adjustment in prior rating period

LDH adjusted the actuarially sound capitation rates in the previous rating period by a *de minimis* amount using the authority in 42 C.F.R 438.7(c)(3). The impact of this adjustment was less than 0.1% and only affected the FMP portion of the rates. Throughout this document, the January 2024 rates reflect the capitation rates *after* the de minimis adjustment.

ix. Known amendments

We anticipate that the capitation rates may be amended to reflect program changes effective January 1, 2025. These future program changes are not known as of the date of this certification. If applicable, this amendment is anticipated to be provided in the fourth quarter of calendar year 2024.

x. COVID-19

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

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

- Changes in delivery system utilization since the onset of the COVID-19 PHE, including analysis of Healthy Louisiana emergency room visits, telehealth services, office visits, and preventive services.
- Enrollment and estimated acuity changes by region and Healthy Louisiana rate cell, monitoring changes in per member cost and risk scores using MCO encounter data.
- Seasonality patterns in CY 2019, CY 2021, CY 2022, and CY 2023.
- Emerging financial experience reported by the MCOs during the third and fourth quarters of CY 2023.

- Direct testing, treatment, and vaccine costs related to COVID-19 in MCO encounter data incurred from the start of the COVID-19 national health emergency through December 2023.
- Centers for Disease Control and Prevention, COVID Data Tracker[2]: statewide data for COVID cases, deaths, testing volume, hospitalizations, and vaccination trends.
- Louisiana COVID-19 Dashboard[3]: statewide and regional data for COVID cases, deaths, hospitalization, testing, and vaccination trends.

(b) Direct and indirect impacts reflected in capitation rates

We are applying adjustments to the SFY 2025 capitation rates for items related to the COVID-19 PHE and related unwinding. These adjustments are summarized in Figure 5 and described below.

FIGURE 5: COVID-19 RELATED ADJUSTMENTS

		% IMPACT BY POPULATION						
INDEX	COVID-19 ADJUSTMENT	SSI	F&C	SBH	EXPANSION	OTHER	KICK - EXP	KICK – NON-EXP
5.a	Unwinding Acuity Adjustment	0.0%	6.1%	0.0%	14.4%	0.0%	0.0%	0.0%
5.b	COVID-19 Testing	(0.0%)	(0.3%)	(0.0%)	(0.1%)	(0.1%)	0.0%	0.0%
5.c	COVID-19 and Other Respiratory Treatment Costs	0.0%	(0.1%)	(0.0%)	(0.1%)	0.0%	0.0%	0.0%
5.d	COVID-19 Vaccines	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Notes: 1. The percentage impact is illustrated as a percentage of the SFY 2025 benefit expenses.
2. Percentage impacts illustrated at 0.0% indicate minimal change at a population level; however, these adjustments were determined to be material for at least one rate cell.

5.a. Unwinding acuity adjustment

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

We reviewed the enrollment changes for all rate cells and populations during the COVID-19 PHE and the unwinding period to evaluate which rate cells have experienced the greatest change during these periods. Based on actual enrollment and emerging acuity data, the acuity of the F&C Child 1-20 Years, the F&C Adult 21+, and Medicaid Expansion 19-64 rate cells have been materially impacted by the unwinding process. As a result, we reviewed the estimated acuity during SFY 2023 (base period) and the projected acuity during SFY 2025 (projection period) to estimate the impact of changing membership at the rate cell level. Except for the F&C Child 1-20 Years, the F&C Adult 21+, and Medicaid Expansion 19-64 rate cells, we believe the population morbidity covered by the managed care programs during SFY 2023 is reasonably reflective of the estimated SFY 2025 population morbidity.

To estimate the unwinding acuity through June 2024 (anticipated last month of unwinding disenrollments), we allocated the enrollment into the following cohorts: disenrolled members, returners, stayers, and joiners. To estimate the number of members and the relative acuity of each cohort, we reviewed information from LDH through January 2024 that provided details on the members and their redetermination decision during the unwinding process. Using this data, we were able to estimate the number of members that would be included in each cohort and the average acuity for each cohort and rate cell combination.

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

To calculate the average acuity, we created a relativity for each cohort and rate cell combination based on the SFY 2023 experience for each member that has been reviewed during the unwinding process. These cohorts and their relative acuity level are described in more detail below.

- **Disenrollees:** This cohort reflects the members that have been or are anticipated to be disenrolled from the Healthy Louisiana (HLA) program during the unwinding process for any reason. This cohort includes members that disenrolled from Medicaid because of death.
  For F&C children and F&C adults, this cohort also includes the net transition between Medicaid rate cells because this resulted in a net outflow of members from these rate cells to other HLA rate cells. We estimated that the relative acuity for this cohort to be a certain percentage of the acuity of SFY 2023 members. The percentages used were 80% for Medicaid Expansion 19-64, 70% for F&C children 1-20, and 70% for F&C adults 21+.
- **Returners:** This cohort reflects members that have been or will be disenrolled during the unwinding process, but are projected to reenroll prior to the end of SFY 2025. The HLA program allows members to be retroactively assigned to a managed care organization for up to 90 days if they return to Medicaid within 90 days of losing Medicaid eligibility. Since the unwinding process is still ongoing, data for this cohort is not complete, and therefore actuarial judgement along with emerging data was required to set the average acuity for this cohort. We estimated that the relative acuity for this cohort to be a certain percentage of the acuity of members that were not disenrolled during the unwinding process (the June 2024 stayer cohort) for each rate cell. The percentages used were 85% for Medicaid Expansion 19-64, 85% for F&C children 1-20, and 70% for F&C adults 21+[4].
- **Joiners:** This cohort reflects members who are newly eligible for the HLA program (i.e., these members join the HLA program during SFY 2024 and were not enrolled in the HLA program as of June 2023, the month before the first disenrollment). For the Medicaid Expansion 19-64 rate cell, this cohort also includes the net transition among Medicaid rate cells because this resulted in a net inflow of members for this rate cell from other HLA rate cells. We estimated the relative acuity of this population based upon emerging data and actuarial judgement. Based on our review, we estimated that the relative acuity for this cohort to be a certain percentage of the acuity of members that were not disenrolled during the unwinding process (the June 2024 stayer cohort) for each rate cell. The percentages used were 105% for Medicaid Expansion 19-64, 70% for F&C children 1-20, and 65% for F&C adults 21+[5]. The percentage over 100% for Medicaid Expansion is driven by higher acuity for members new to Medicaid and partially offset by members moving into the rate cell from other HLA populations.
- **Stayers:** This cohort reflects members who are reviewed during the unwinding process and are deemed eligible for coverage (i.e., these members do not lose Medicaid eligibility during SFY 2024). The acuity for this cohort is calculated each month based on the average acuity as of June 2023, adjusted for the removal of disenrollees and returners (described above) as of each month.

Beginning July 2024 (the first month after the anticipated last month of unwinding disenrollment), we estimate that the number of members entering and exiting each rate cell because of being disenrolled from Medicaid as a result of the normal review process, joining Medicaid, member deaths, and transitions among rate cells will be offsetting. As a result, the acuity and projected enrollment for each rate cell is assumed to change due to members who were disenrolled during the unwinding process and anticipated to return during SFY 2025.

LDH intends to restart a quarterly wage check process effective July 1, 2024, which will supplement the normal redetermination process by identifying individuals whose income appears to have exceeded the Medicaid eligibility limit. Based on the information provided by LDH, we were able to identify approximately 37,600 unique member records that are currently enrolled and will be included in the initial wage check process. These members are predominately from the following rate cells:

- Medicaid Expansion – Age 19-64: approximately 31,600 unique individuals
- F&C – Adult 21+ Years: approximately 3,700 unique individuals
- F&C – Child 1-20 Years: approximately 2,100 unique individuals

[4] When compared to SFY 2023 enrollees, the relativity acuity of the returners was 100% for Medicaid Expansion 19-64, 95% for F&C Child 1-20, and 90% for F&C Adult 21+.

[5] When compared to SFY 2023 enrollees, the relativity acuity of the joiners was 120% for Medicaid Expansion 19-64, 75% for F&C Child 1-20, and 80% for F&C Adult 21+.

Based on discussions with LDH, we have assumed that approximately 50% of the Expansion members and 15% of the F&C members included in the quarterly wage check process will be disenrolled, and the future quarterly wage checks will review approximately 40% as many members as the initial wage check process. We anticipate that the redetermination process will occur earlier for individuals included in the wage check. However, we believe these individuals would have ultimately been disenrolled during SFY 2025 as part of the normal review process. We estimate that the members disenrolled as a result of the wage check will have the same acuity as the disenrollee cohort described above.

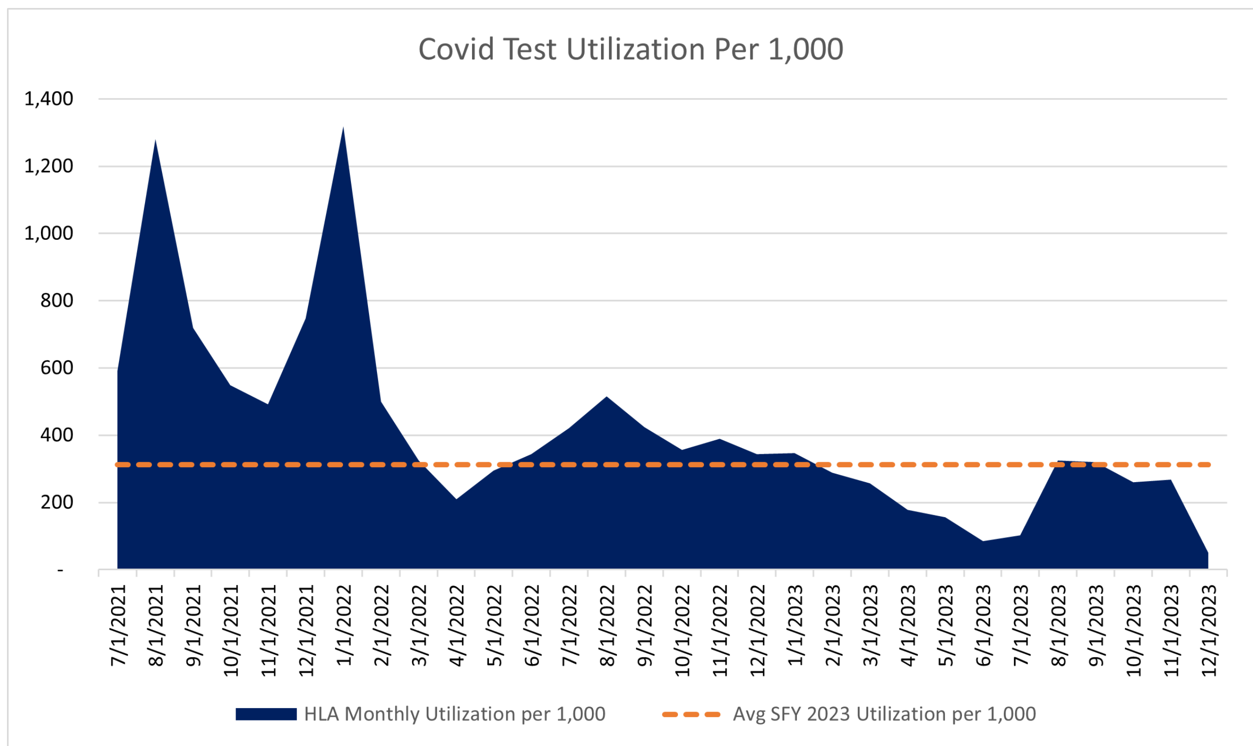
The unwinding acuity factors used to develop the SFY 2025 HLA capitation rates are 1.145 for Medicaid Expansion 19-64, 1.063 for F&C Children 1-20, and 1.119 for F&C Adults 21+.

Additional detail on the factors and enrollment estimates are provided in Appendix 7.

5.b. COVID-19 testing

The COVID-19 testing cost assumptions for the SFY 2025 capitation rates are based on a review of historical HLA experience. As illustrated in Figure 6 below, emerging data indicates that the COVID-19 testing has continued to decrease relative to SFY 2023 (the base data period) for Medicaid beneficiaries in Louisiana.

FIGURE 6: MONTHLY LOUISIANA MEDICAID COVID-19 TESTING



To be more representative of the emerging utilization and the utilization anticipated during the projection period, we applied an adjustment to remove approximately one fifth of the COVID-19 tests provided during SFY 2023, which represents a reduction of approximately $10 million.

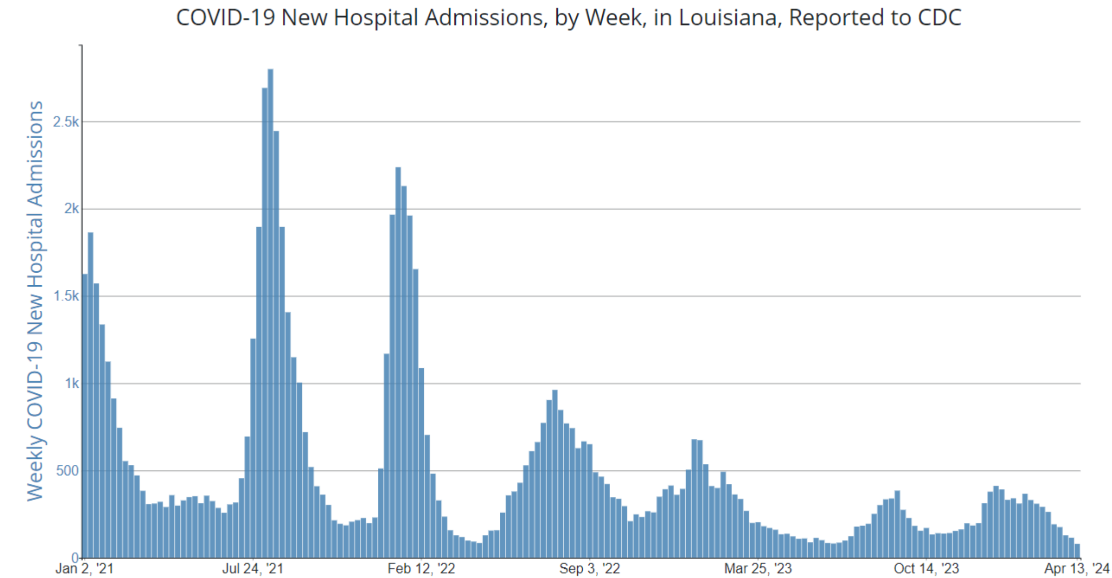
5.c. COVID-19 and other respiratory treatment costs

We evaluated differences in the expected treatment cost related to COVID-19 and other upper respiratory infections between the SFY 2023 base experience period and SFY 2025 rating period. We evaluated SFY 2023 PMPM claim expenses for members receiving COVID-19 and/or upper respiratory treatment. We developed the adjustment by re-weighting the expected prevalence and cost of upper respiratory infections during SFY 2025 relative to the base period.

COVID-19 Treatment Costs

We reviewed Louisiana specific trends for COVID-19 hospitalizations by reviewing the CDC reported COVID-19 hospitalizations since the beginning of CY 2021. COVID-19 hospitalizations in Louisiana have fluctuated with the emergence of new COVID-19 variants, availability of vaccines, and natural immunity levels from prior infection[6]. The figure below illustrates the number of new COVID-19 hospital admissions by week in Louisiana. The Louisiana statewide COVID-19 hospitalization data is reported on CDC's website at https://covid.cdc.gov/covid-data-tracker/#trends_weeklyhospitaladmissions_select_22.

FIGURE 7: LOUISIANA COVID-19 PATIENTS HOSPITALIZED AND ON VENTS



As the result of highly transmissible variants in SFY 2022 and SFY 2023 that increased population-level immunity (reflected by decreased levels of hospitalization during recent months relative to the base experience period), we anticipate lower utilization of COVID treatment during the rating period when compared to the base period. We projected COVID treatment by evaluating emerging encounter data, with adjustments for changes in statewide COVID hospitalizations and emergency room visits reported by the LDH through first quarter 2024. The net adjustment reduces the projected expenditures for COVID treatment by approximately $6 million.

RSV-like Treatment Costs

We reviewed Louisiana specific trends in prevalence rates for RSV emergency department visits since FFY 2020. RSV emergency department trends have fluctuated over the years in Louisiana. The figure below illustrates the prevalence of patients with RSV in the emergency department since FFY 2020. The statewide RSV emergency department prevalence is reported on LDH's in the Influenza & Other Respiratory Viruses Surveillance Report and posted on LDH's website at https://ldh.la.gov/assets/docs/SurveillanceReports/InfluenzaSurveillance/Weekly23_24/2415.pdf

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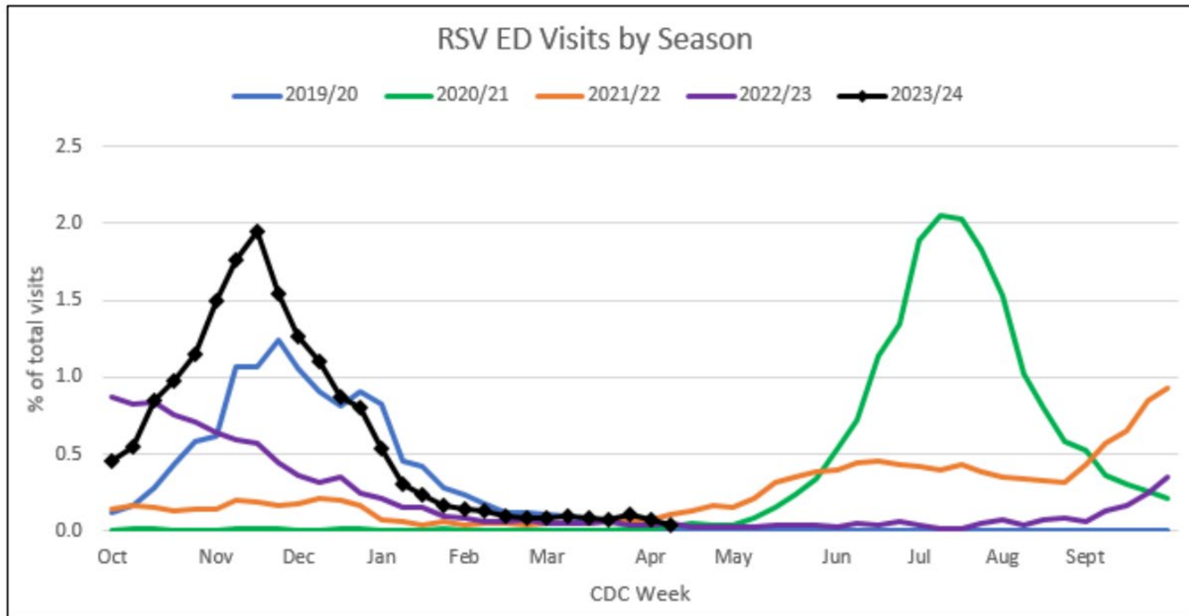
[6] https://www.healthdata.org/news-release/lancet-most-comprehensive-study-date-provides-evidence-natural-immunity-protection#:~:text=For%20people%20who%20have%20been,at%2010%20months%20post%20infection).

FIGURE 8: LOUISIANA RSV EMERGENCY DEPARTMENT PREVELANCE

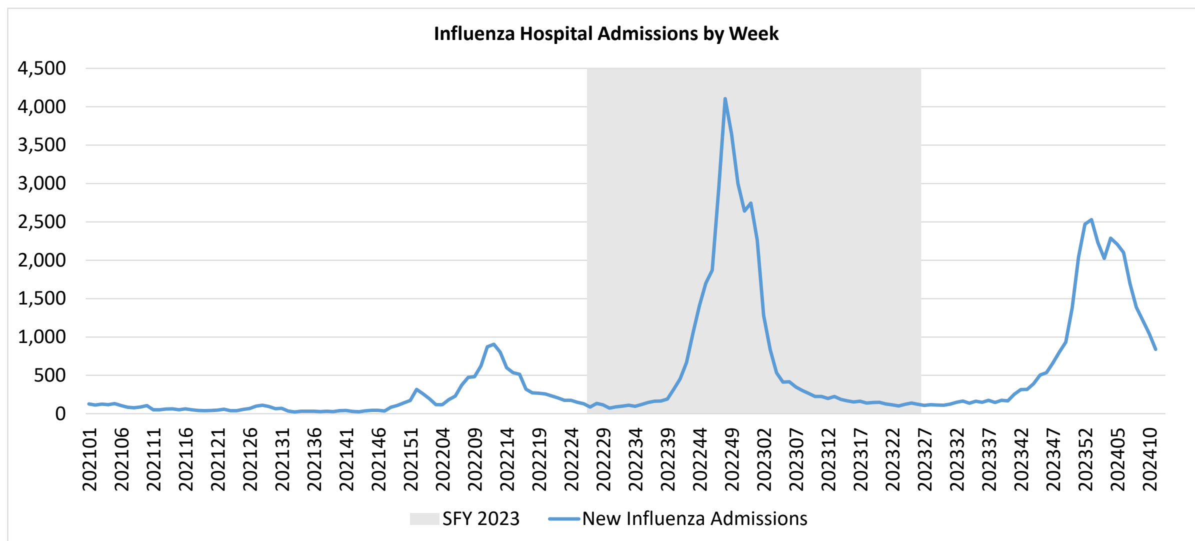


Based upon our review of this data, emerging RSV treatment data, and the recent approval and utilization of the RSV vaccine, we determined that no adjustment to the base data was necessary for RSV treatment.

Influenza-like Treatment Costs

We reviewed specific trends in prevalence rates for influenza-like hospitalizations by reviewing the COVID-19 hospitalization rates since CY 2021. Influenza-like hospitalizations in Louisiana have fluctuated over the years and was extremely low during the beginning of the COVID pandemic. The figure below illustrates the number of patients hospitalized with influenza-like symptoms since CY 2021 in CMS region 6. The statewide influenza-like hospitalization data is reported on LDH's website at https://gis.cdc.gov/grasp/fluview/FluView12.html.

FIGURE 9: CMS REGION 6 INFLUENZA HOSPITAL ADMISSIONS BY WEEK



Based upon our review of this data and emerging data, we project that treatment costs for influenza-like illnesses during the rating period will be similar to the base period. Therefore, no adjustment was applied.

5.d. COVID-19 Vaccine

Effective October 1, 2024, the MCOs will be reimbursed for both the COVID-19 vaccine and administration through the HLA capitation rate. To estimate the impact of this policy change, we reviewed emerging experience and anticipate the cost of the COVID-19 vaccine and administration to be approximately $160 per dose.

We estimated that the utilization of COVID-19 vaccinations during the rating period would be similar to October 2022 through September 2023. The net adjustment, prorated for October 2024 through June 2025, increases the projected expenditures by approximately $1 million.

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

The COVID-19 vaccine and administration costs are discussed in the previous section. There are no other COVID-19 related costs that are covered on a non-risk basis.

(d) Risk mitigation strategies

As documented in Section 1, subsection 4.C.ii.(b), LDH has elected to maintain its minimum medical loss ratio (MLR) requirement at 85% for the SFY 2025 contract year. Other risk mitigation strategies are structurally consistent with the prior rating period. This is discussed further in Section 1, subsection 4.C.

2. Data

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

A. RATE DEVELOPMENT STANDARDS

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

B. APPROPRIATE DOCUMENTATION

i. Requested data

We requested and received data specifically for the capitation rate development. In addition, we intake and summarize monthly eligibility and expenditure data using information provided by LDH. The remainder of this section details the base data and validation processes utilized in the SFY 2025 capitation rate development. In addition, Appendix 2 summarizes the adjusted base data.

ii. Data used to develop the capitation rates

(a) Description of the data

(i) Types of data

The SFY 2025 capitation rate development utilized the following data sources:

- Historical eligibility files provided by LDH
- Encounter data submitted to the LDH
- LDH fee schedules applicable to services affected by reimbursement changes
- Enrollment detail related to the PHE unwinding
- Preferred drug lists (PDLs) and other pharmacy coverage policies
- Financial reporting templates submitted by the MCOs
  - Financial reporting guide templates (FRGTs)
  - MCO survey
- MCO statutory financial statements

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

(ii) Age of the data

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

For the purposes of non-pharmacy trend development, we reviewed monthly MCO encounter data on an incurred basis over the period from January 2020 through June 2023. Trend assumptions for the SFY 2025 rates considered emerging July through December 2023 experience to the extent it is credible by major category of service. Actuarial judgment was applied when reviewing the data due to disruptions related to the COVID-19 pandemic and changes in emerging experience.

For pharmacy trend development, we reviewed quarterly pharmacy expenditures on an incurred basis over the period from January 2020 through January 2024. Additionally, specific adjustments were made to emerging experience to reflect the amounts included in the single pharmacy benefit manager contract.

(iii) Data sources

Capitation payment and eligibility information

On a monthly basis, we receive eligibility and enrollment extracts from the State's Medicaid Management Information System (MMIS) for encounters, fee-for-service claims, and eligibility data. To develop the SFY 2025 Healthy Louisiana capitation rates, we reviewed data from January 2020 through January 2024.

FFS and MCO encounter data

We received FFS claims and MCO encounter data extracts from the State's MMIS concurrently with the eligibility and enrollment extracts noted above. Our analysis was based on data submitted to the MMIS through March 2024.

LDH fee schedules

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

Enrollment detail related to the PHE unwinding

We received actual redetermination data for individuals that have been reviewed by LDH through January 2024. Additionally, we have received enrollment projections from LDH for each population from April 2024 through June 2024. The redetermination process in Louisiana resumed on May 1, 2023, with the first disenrollment occurring July 1, 2023. Based upon conversations with LDH, the redetermination process will be completed over a 12-month period with the last month of unwinding disenrollment occurring on June 1, 2024. Based on emerging data and discussions with LDH, member and population priority in the eligibility review process is random.

PDLs and other pharmacy coverage policies

We received weekly preferred drug list (PDL) files from LDH for July 2022 through March 2024. These PDL files were used to review and estimate changes in pharmacy utilization because of LDH's PDL updates. In addition, LDH provided us with other information to appropriately project MCO pharmacy expenditures during SFY 2025. This included items such as 340B pharmacy lists, clotting factor reimbursement, and local pharmacy providers.

Financial reports – FRGTs

On a quarterly basis, each MCO was requested to complete a financial reporting template. The recent submission includes data paid through December 2023. Utilization and expenditures were reported by each MCO by region, rate cell, and high-level category of service. The financial reporting template also captured information related to sub-capitated arrangements, affiliated party contracts, non-benefit costs, and other information pertinent to the SFY 2025 rate development. Information in the standard FRGTs is generally reported on an incurred basis.

Financial reports – MCO survey

The MCO survey requests incurred experience during SFY 2023 with runout through December 2023 to align with the base data period. The MCO survey is intended to provide additional data used in the development of the SFY 2025 capitation rates, including anticipated provider reimbursement for SFY 2025.

MCO statutory financial statements

CY 2020 through CY 2023 statutory financial statements were accessed through S&P Global Market Intelligence.

(iv) Sub-capitation

As part of the data collection process, each MCO was required to provide the following information in the FRGTs for each sub-capitated arrangement and non-state plan service effective during the base period:

- Subcontractor name
- Related party (yes or no)
- Service description

- Provider/benefit manager/other
- Proxy pricing methodology
- Member value-added service
- Amount of sub-capitation attributable to healthcare quality improvement
- Amount of sub-capitation attributable to administrative costs
- Amount of sub-capitation attributable to health care expenses

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

(v) Exception to base data requirements

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

(b) Availability and quality of the data

(i) Steps taken to validate the data

We received eligibility and enrollment extracts from the State's Medicaid Management Information System (MMIS) for encounters, fee-for-service claims, and eligibility data from January 2020 through February 2024. The actuary, the MCOs, and LDH all play a role in validating the quality of encounter and financial reporting information used in the development of the capitation rates. The MCOs play the initial role, collecting and summarizing data sent to the State. In addition, LDH focuses on encounter data quality and MCO performance measurement, with measures focused on completeness, accuracy, and comparison between data sources. We perform independent analysis of encounter data and financial reporting information to evaluate the quality of the data being used in the rate development process. Below is a summary of measures specific to each quality area that are applied by either Milliman or LDH.

Completeness

We validated that we had received complete transmissions by comparing summarized values to control totals provided by the state's fiscal agent contractor (FAC).

Accuracy

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

Consistency of data across data sources

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

(ii) Actuary's assessment

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

We find the data used to develop the SFY 2025 capitation rates to be suitable for the purpose of developing actuarially sound rates, with certain adjustments as outlined in the following sections. The data has been reviewed by multiple parties for completeness, accuracy, and consistency. The managed care experience base data used in the development of the SFY 2025 certified rates is reasonably consistent with the reported financial experience of MCOs.

(iii) Data concerns

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

(c) Appropriate data

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

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

(ii) Use of managed care encounter data

Managed care encounter data in SFY 2023 was used as base experience in the rate development for all populations. We applied an adjustment to gross up the expenditures to the level reported in the MCO reported financial templates.

(d) Reliance on a data book

We did not rely on a data book for the SFY 2025 capitation rate development.

iii. Data adjustments

The capitation rates were developed from SFY 2023 managed care encounter data for all regions and rate cells. Adjustments were made to the base experience to gross-up expenditures to the level reported in the MCO financial templates. Additional adjustments were made for credibility, completion, policy/program changes, and other data adjustments.

True-up to MCO surveys

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

1. Prior to applying any data adjustments described later in this section, we first removed expenditures from our base data related to physical health services for members who were in an SBH rate cell at the date of service. This adjustment is described in more detail in Section 1, subsection 2.B.iii.e.
2. We summarized the remaining expenditures from the encounter data by major service type (medical vs. prescription drugs). These summaries reflected only services incurred in SFY 2023.
3. We summarized comparable expenditures from the MCO financial reporting templates by major service type (medical vs. prescription drugs). The expenditures include values reported by the MCOs for benefit expenses, excluding settlements and FMP payments.
4. We developed initial factors to apply to the encounter data. These factors are equal to the total expenditures from the MCO reporting templates divided by the total expenditures from the base data, by major service type (medical vs. prescription drugs).
5. We adjusted encounter completion factors based on a comparison of member months in the base data relative to the MCO financial reporting templates. Because we did not directly adjust our base member months, we instead adjusted the final true-up factors to account for differences in member months between the base data and the FRGTs. This adjustment was equal to total member months from the base data divided by the total expenditures from the FRGTs.

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

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

- We removed all value-added services and/or administrative expenses for delegated vendors.
- We subtracted outpatient settlements if the MCO indicated these were included along with other claims-based hospital expenses. These settlements, if any, were incorporated separately as part of the outpatient reimbursement adjustment.

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

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

POPULATION	CAPITAL	GULF	NORTH	SOUTH CENTRAL
SSI	3.3%	3.2%	3.4%	3.2%
F&C	4.5%	4.5%	4.9%	4.7%
SBH	4.2%	4.0%	3.7%	4.2%
Medicaid Expansion	2.5%	2.5%	2.7%	2.6%
All Other Populations	4.5%	4.4%	4.4%	4.5%
Maternity Kick – Expansion	4.1%	4.1%	4.2%	4.1%
Maternity Kick – Non-Expansion	5.8%	5.7%	5.8%	5.8%

Notes:

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

Humana Rx data adjustment

Humana entered the HLA program as an MCO on January 1, 2023 and, at the direction of LDH, did not cover prescription drugs until the single PBM was implemented on October 28, 2023. To include the Humana prescription drug claims in our rate development, we developed explicit adjustment factors to include their member's pharmacy utilization and spend in the base data. As a result, SFY 2023 base data for the Retail Pharmacy service category increased by about $26 million.

Hurricane adjustment

Based on a review of monthly historical data, we did not observe suppressed expenditures because of a hurricane during the base data period.

Consistent with the methodology used last year, we reviewed information from the National Oceanic and Atmospheric Administration (NOAA) that projects hurricane "return periods" for each coastal segment in the US to estimate the likelihood of a disruptive hurricane hitting a specific region. The return periods indicate the average number of years between hurricanes; alternatively, they can be used to roughly indicate the probability of a hurricane in a given year. There are five coastal segments in Louisiana, as well as one in neighboring Mississippi and one on the northeastern edge of Texas. For each of these segments, the return periods for a major hurricane (category 3-5) ranges from 20 to 34 years. However, the likelihood of a hurricane in *any* of these segments in a given year is likely higher, which we assume to be 10% to 20% depending on the correlation of hurricane probability in each segment.

We also reviewed historical data for hurricanes making landfall in this area as a category 3-5 storm. Since 2000, there have been five storms of this magnitude hitting Louisiana, plus one additional making landfall in Texas, resulting in an average of approximately 0.23 to 0.27 major storms per year.

There have also been other natural disasters causing health care delivery system disruption in Louisiana not caused by hurricanes, including the 2016 floods that caused damages exceeding $10 billion.

Based on the data points above, we believe it is reasonable to assume a roughly 1 in 4 chance of a major natural disaster (hurricane, flood, etc.) affecting Louisiana each year that would cause similar disruption as observed with Hurricane Ida during SFY 2022.

Under this assumption, we made a downward adjustment to the base data to reflect 25% of the Hurricane Ida adjustment made to the SFY 2022 base data in the SFY 2024 HLA capitation rates. This is intended to reflect the expectation that SFY 2025 will be an "average" year in terms of hurricane prevalence. This resulted in the final adjustment removing approximately $8 million in Gulf and $2 million in Capital to our base data.

(a) Credibility adjustment

Several rate cells had low enrollment within each region (fewer than 1,000-5,000 members in each region). Due to low enrollment, we established the capitation rates on a statewide basis for several rate cells:

- SSI 0-2 months
- SSI 3-11 months
- Breast & Cervical Cancer
- HCBS Child 1-20 years
- SBH – HCBS Child 1-20 years
- LaHIPP Affordable Plan
- ACT 421 Non-TPL Child 1-18 years
- ACT 421 Non-LaHIPP TPL Child 1-18 years

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

- SBH – Other + Medicaid Expansion – SBH – Other

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

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

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

- LaHIPP TPL: all rate cells
- Non-TPL: infant rate cells only
- Non-LaHIPP TPL: infant rate cells only

Completion adjustment

The capitation rates are based on SFY 2023 MCO experience. In the quarterly FRGTs, MCOs were requested to provide monthly incurred but not paid (IBNP) estimates by major service category and population. We ran the MCO reported data through a Robust Time Series (RTS) reserving model and analyzed reported MCO claims completion for reasonableness. Based upon our review and comparison to the RTS model, we adjusted the MCO estimates downward by approximately $12 million, primarily in the inpatient hospital service category.

The impact of applying the claim completion factors to the base data is illustrated by region and population in Figure 11 below. The detailed adjustments by rate cell and service category can be found in Appendix 2 of this report.

FIGURE 11: COMPLETION ADJUSTMENT IMPACT BY REGION AND POPULATION

POPULATION	CAPITAL	GULF	NORTH	SOUTH CENTRAL
SSI	0.4%	0.4%	0.5%	0.4%
F&C	0.8%	0.7%	0.7%	0.8%
SBH	0.5%	0.5%	0.6%	0.6%
Medicaid Expansion	0.5%	0.4%	0.5%	0.4%
All Other Populations	0.7%	0.6%	0.5%	0.5%
Maternity Kick – Expansion	0.6%	0.6%	0.6%	0.6%
Maternity Kick – Non-Expansion	0.7%	0.8%	0.7%	0.8%

Notes:

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

(b) Errors found in the data

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

(c) Program change adjustments

Figure 12 lists program and reimbursement changes that occurred since the beginning of the base experience period used in rate development.

Figure 12 includes the program change, effective date of the change, as well as the percentage impact to the SFY 2025 benefit expenses by population. The impacts shown in Figure 12 are prior to the application of trend and managed care efficiency adjustments.

Item 12.a through 12.c occurred prior to the end of the base experience period, necessitating a retrospective adjustment, and is illustrated in Appendix 8. The remaining items in Figure 12 occurred after the end of the base experience period, requiring a prospective adjustment, and are illustrated in Appendix 9. Medicaid FFS reimbursement changes are reflected in the rate development because based upon reimbursement information submitted with the MCO surveys, the vast majority of MCO provider reimbursement is tied to FFS reimbursement.

FIGURE 12: PROGRAM CHANGE ADJUSTMENTS

			% IMPACT BY POPULATION						
INDEX	PROGRAM CHANGE	EFFECTIVE DATE	SSI	F&C	SBH	EXPANSION	OTHER	KICK - EXP	KICK - NON-EXP
12.a	Home Health (Fee Schedule Update)	4/3/2023	0.3%	0.0%	0.0%	0.1%	1.2%	0.0%	0.0%
12.b	Resumption of Rx Copays	5/20/2023	(0.0%)	(0.0%)	0.0%	(0.1%)	(0.0%)	0.0%	0.0%
12.c	Tobacco Counseling	6/20/2023	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
12.d	Emergency Ambulance Fee Schedules (Air and Ground)	7/1/2023	1.8%	1.3%	3.1%	1.4%	1.3%	0.0%	0.0%
12.e	Rural Health Clinic (Fee Schedule Update)	7/1/2023	0.1%	0.5%	0.0%	0.2%	0.1%	0.0%	0.0%
12.f	FQHC (Fee Schedule Update)	7/20/2023	0.2%	0.7%	0.0%	0.4%	0.3%	0.0%	0.0%
12.g	Out-of-State Hospital Reimbursement	9/20/2023	(0.4%)	(0.2%)	0.0%	(0.4%)	(0.2%)	(1.4%)	(1.4%)
12.h	Assertive Community Treatment Adjustment	10/1/2023	0.4%	0.0%	6.2%	0.1%	0.1%	0.0%	0.0%
12.i	Hospice (Fee Schedule Update)	10/1/2023	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
12.j	Single PBM	10/28/2023	0.1%	(0.6%)	0.0%	0.4%	(0.2%)	0.0%	0.0%
12.k	Paxlovid Coverage	11/1/2023	0.1%	0.1%	0.0%	0.2%	0.0%	0.0%	0.0%
12.l	LSU Enhanced Professional Services (Fee Schedule Update)	1/1/2024	(0.0%)	(0.0%)	0.0%	(0.0%)	(0.0%)	(0.1%)	(0.1%)
12.m	AMP Cap Removal	1/1/2024	(0.9%)	(0.3%)	0.0%	(0.8%)	(0.3%)	0.0%	0.0%
12.n	Outpatient Hospital	1/1/2024	1.7%	1.1%	0.0%	1.9%	0.8%	1.9%	1.6%
12.o	SBH Provider Specific Fee Schedule	1/1/2024	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%
12.p	Lab and Radiology Fee Schedule	1/1/2024	(0.0%)	(0.2%)	0.0%	(0.0%)	(0.0%)	(0.0%)	(0.0%)
12.q	Reimbursement for Clotting Factor	2/1/2024	(0.2%)	(0.1%)	0.0%	(0.1%)	(0.1%)	0.0%	0.0%
12.r	Supports Waiver	2/20/2024	0.0%	0.0%	3.8%	0.0%	0.9%	0.0%	0.0%
12.s	Youth Crisis	4/1/2024	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%
12.t	Single PDL	7/1/2024	(2.7%)	(2.7%)	0.0%	(2.6%)	(2.7%)	0.0%	0.0%
12.u	Inpatient Hospital (Fee Schedule Update)	7/1/2024	1.1%	0.3%	0.0%	1.1%	0.2%	0.6%	0.5%
12.v	Wegovy Adjustment	7/1/2024	0.4%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%

Notes:
1. The percentage impact is illustrated as a percentage of the SFY 2025 benefit expenses.
2. Percentage impacts illustrated at 0.0% indicate minimal change at a population level; however, these adjustments were determined to be material for at least one rate cell.

12.a. Home Health (Fee Schedule Update)

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

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

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

12.b. Resumption of Rx Copays

Effective May 12, 2023, copays for prescription drugs are anticipated to be resumed consistent with the policies in place prior to the COVID-19 public health emergency. We estimated the impact of this adjustment by evaluating copays as a percentage of total retail pharmacy expenditures (including copays and plan paid amounts) after the copays were reinstated. Based on our review, we expect the resumption of Rx copays will decrease projected expenditures by approximately $5 million.

12.c. Tobacco Cessation Counseling

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

These services were previously only covered for pregnant beneficiaries in the Medical Assistance Program. We estimated the impact of this change based on information provided by LDH. During SFY 2025, we expect the expansion of tobacco cessation counseling coverage to increase expenditures by approximately $2 million.

12.d. Emergency Ground Ambulance (Fee Schedule Update)

The ground ambulance fee schedules were updated effective July 1, 2023, under a new minimum fee schedule directed payment. To model these reimbursement changes, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

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

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

12.e. Rural Health Clinic (Fee Schedule Update)

Effective July 1, 2023, the Rural Health Clinic fee schedules were updated. This item includes two fee schedules: Provider Based Rural Health Clinic and Independent Rural Health Clinic. To model these reimbursement changes, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the encounter rates effective on the date of service.
2. Using the most current encounter rates.

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

12.f. FQHC (Fee Schedule Update)

The Federally Qualified Health Center (FQHC) fee schedule was recently updated, effective July 20, 2023. To model these reimbursement changes, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the encounter rates effective on the date of service.
2. Using the most current encounter rates.

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

12.g. Out of State Hospital Reimbursement

Effective September 20, 2023, LDH updated the inpatient hospital reimbursement for out-of-state providers to be consistent with the in-state inpatient hospital per diem rates for similar hospitals and services. To estimate the impact of this adjustment, we summarized the out-of-state inpatient hospital expenditures during SFY 2023, which represented the base data time period for the SFY 2025 capitation rates. Claims with non-zero third-party liability amounts were excluded.

Based on discussions with LDH, we determined that it would not be possible for MCOs to contract with certain providers at the lower rates during SFY 2025. In particular, we assumed that reimbursement would remain at historical levels for certain hospitals that provide specialized services not available at in-state hospitals. We repriced the remaining out-of-state hospital inpatient claims using the current in-state inpatient hospital per diem rates to calculate the annualized inpatient hospital savings of approximately $29 million.

12.h. Assertive Community Treatment (Fee Schedule Update)

Effective October 1, 2023, LDH updated the specialized behavioral health fee schedule to increase the assertive community treatment (ACT) reimbursement. To model this reimbursement change, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

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

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

12.i. Hospice (Fee Schedule Update)

The Hospice fee schedule was recently updated, effective October 1, 2023. To model these reimbursement changes, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

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

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

12.j. Single PBM

Effective October 28, 2023, LDH implemented a single pharmacy benefit manager (PBM). The single PBM will interface with each MCO to process all pharmacy claims. Based on discussions with LDH, we anticipate the following items were impacted as a result of single PBM implementation:

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

Based on our review, we estimate that implementation of the single PBM effective October 28, 2023, will increase SFY 2025 expenditures by approximately $3 million. We have repriced all claims paid by the single PBM to the contracted discount, based upon our understanding of the PBM contract through conversations with LDH.

As a result of the single PBM, the MCOs will no longer be able to receive supplemental rebates on diabetic supplies. Please note that an explicit adjustment was not made to reflect the removal of the diabetic supply rebates because the base experience is gross of supplemental rebates retained by the MCOs during SFY 2023.

12.k. Coverage of Paxlovid expenditures

On October 13, 2023, HHS and Pfizer reached an agreement to transition Paxlovid to the commercial market in November 2023 while ensuring individuals on Medicaid will continue to have access to Paxlovid without member copays through calendar year 2024. As a result of this agreement, the MCOs are responsible for paying for Paxlovid treatments beginning in November 2023. We estimated the fiscal impact based on emerging utilization of Paxlovid, with an assumed average treatment cost of approximately $1,396. The fiscal impact to pharmacy expenditures as a result of MCOs covering Paxlovid treatments beginning in November 2023 is an increase to the projected SFY 2025 expenditures of approximately $8 million.

12.l. LSU Enhanced Professional Services (Fee Schedule Update)

The LSU Enhanced Professional Services fee schedule was recently updated, effective January 1, 2024. This item includes four fee schedules: LSU Shreveport, LSU New Orleans, LSU Anesthesia, and LSU Maternity Anesthesia. To model this reimbursement change, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective January 1, 2024.

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

12.m. Average Manufacturer Price (AMP) Cap Removal

Effective January 1, 2024, provisions of the American Rescue Plan Act no longer capped the Federal Medicaid rebates at the average manufacturer price (AMP). As a result of these provisions, drug manufacturers have lowered the average manufacturer price of specific drugs. We followed the following steps to estimate the fiscal impact of this legislation on the HLA capitation rates.

Step 1: Identify drugs likely impacted by the AMP cap removal

We anticipate that manufacturers may reduce the price of drugs whose rebates were previously capped to avoid additional rebate liability. Therefore, to identify drugs that were likely impacted by these provisions, we reviewed drugs that had a recent price reduction of at least 15%. We acknowledge that instead of reducing prices, some manufacturers may discontinue certain drugs because of these legislative changes. The impact of discontinued drugs is included in the single preferred drug list updates. Therefore, to avoid double counting, discontinued drugs were excluded from this analysis.

Step 2: Estimate the fiscal impact by drug

To calculate the fiscal impact, we summarized expenditures for each drug identified as likely being impacted by the AMP cap removal and estimated the impact of the price reduction. The dollar impact by drug was adjusted to reflect changes in utilization resulting from changes to the preferred drug list. The fiscal impact to pharmacy expenditures as a result of the AMP cap removal is a decrease to the projected SFY 2025 expenditures of approximately $50 million, which is reflected in the Retail Pharmacy service category in the prospective cost models. The drugs with the largest impact are insulins and Victoza.

12.n. Outpatient Hospital Reimbursement Changes

Outpatient hospital services are reimbursed in one of two ways:

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

To model these reimbursement changes, we used separate approaches for claims subject to a fee schedule and claims subject to a cost percentage. Note that in Figure 12, we have labeled this adjustment with an effective date of January 1, 2024, which is consistent with the most recent cost settlement percentages available to us.

Fee Schedule-Based Reimbursement

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

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective on January 1, 2024.

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

Cost-Based Reimbursement

First, we adjusted the base claims cost by incorporating the estimated settlements applicable to SFY 2023 dates of service. Settlement values were estimated by each MCO and accounted for invoices paid, invoices received but not yet paid, and any accruals for settlements not yet received. This included both payables and receivables. Total settlement dollars were converted to an MCO-specific uniform percentage adjustment, which was applied to each claim in our base data. We then applied a cost trend adjustment to the settlement-adjusted claims. The selected annualized cost trend was 3.3%, which is consistent with the CMS Market Basket[7] projections for Inpatient Prospective Payment System (IPPS) Hospital services from SFY 2023 to SFY 2025. We also adjusted the projected data to account for a small number of hospitals that had a change in their cost settlement percentage since the base period. Notably, this includes a planned increase to the reimbursement for University Medical Center, effective July 1, 2024.

Summary

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

FIGURE 13: OUTPATIENT HOSPITAL ADJUSTMENT ($ MILLIONS)

REIMBURSEMENT TYPE	COST
Base Claims	$ 1,375.0
Settlements	$ 22.2
Fee Schedule Adjustment	$ (5.4)
Hospital Base Rate Changes	$51.4
Cost Trend Adjustment	$74.9
Final Adjusted Claims	$ 1,532.1
Net Adjustment	**$ 143.1**

Notes:

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

12.o. SBH Provider Specific Fee Schedule Changes

The Specialized Behavioral Health (SBH) provider-specific fee schedule was recently updated, effective January 1, 2024. To model these reimbursement changes, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective on January 1, 2024.

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

We did note that fee schedule changes to Community Psychiatric Supportive Treatment and Psychosocial Rehabilitation were estimated to be budget neutral, since changes in billing requirements for these services have caused a shift in utilization toward the lower-cost Psychosocial Rehabilitation.

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

12.p. Lab and Radiology Fee Schedule Changes

The Lab and Radiology fee schedule was recently updated, effective May 1, 2024. To model these reimbursement changes, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective on May 1, 2024.

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

12.q. Clotting Factor Reimbursement Implementation

As a result of the single PBM implementation, the clotting factor reimbursement methodology changed effective February 1, 2024. In addition, reimbursement for clotting factor that was previously paid under the medical benefit will now move to the pharmacy benefit. Based upon information provided by LDH and the single PBM, we estimate that this change will decrease the SFY 2025 projected expenditures by approximately $8 million.

12.r. Supports Waiver

Effective February 20, 2024, LDH updated the following services provided to supports waiver beneficiaries:

- Added incontinence supplies, transportation, and community life engagement development as covered services
- Allowed prevocational services to be delivered virtually

Based upon information provided by LDH, we estimate that this change will increase the SFY 2025 projected expenditure by approximately $5 million.

12.s. Youth Crisis

Effective April 1, 2024, LDH added mobile crisis response and community brief crisis support services for children to the Louisiana Medicaid State Plan. As a result, the MCOs will be responsible for covering these services. Based upon information provided by LDH and a review of utilization for comparable services in other states, we estimate the cost of covering these services for HLA children during SFY 2025 will be approximately $2 million.

12.t. PDL Changes

The MCOs have used a preferred drug list (PDL) maintained by LDH since 2019 which the single PBM continues to utilize. We adjusted the benefit expenses to reflect the expected drug mix changes based upon the current PDL, and PDL changes that occurred during or after the base data period. The adjustment also includes a recent policy change effective July 1, 2024 in which LDH will prefer generic alternatives for the brands that were previously part of the brand over generic list. To estimate the impact of anticipated drug mix changes, we summarized retail pharmacy expenditures by market basket, product name, Generic Product Indicator (GPI) and current preferred status based on the most recent PDL and known changes for July 1, 2024. For each product name, we estimated the projected SFY 2025 market share.

Some of the PDL changes resulted in adding additional funding due to the anticipated shifting to higher cost products. The drugs with the largest increase in program cost include Myrbetriq and Austedo XR.

The net impact to pharmacy expenditures as a result of the PDL changes and brand drug cost reductions is a decrease to the projected SFY 2025 expenditures of approximately $202 million, which is reflected in the Retail Pharmacy service category in the prospective cost models.

The drug categories with the largest impact including the assumed product market shares are listed below. The overall brand and generic utilization mix was informed by historical experience in drug classes with brand or generic market entrants, or program changes similar to those listed below noting that some drug classes have a lower rate of switching due to clinical considerations or market shortages.

- Stimulants and Related Agents:
  - Vyvanse: estimated 50% of the utilization would remain brand. We anticipate there to be continued utilization for brand with the ongoing drug shortages in this class.
  - Adderall XR: estimated 90% generic utilization.
- Opiate Dependence Treatments
  - Suboxone: estimated 90% generic utilization
- Inhaled Glucocorticoids
  - Symbicort: estimated 95% generic utilization
  - Advair: estimated 95% generic utilization
  - Flovent HFA: all utilization will switch to the generic due to discontinuation of brand product
- Antipsychotics
  - Latuda: estimated 98% generic utilization
- Anticonvulsants
  - Sabril: estimated 50% generic utilization
  - Carbatrol: estimated 80% generic utilization
  - Tegretol: estimated 80% generic utilization
  - Banzel: estimated 80% generic utilization
  - Trokendi: estimated 80% generic utilization
  - Vimpat: varies based upon strength but estimated over 95% generic utilization

12.u. Inpatient Hospital Reimbursement Changes

Inpatient hospital per diems have been updated as recently as July 1, 2024. Notably, this includes a planned increase to the reimbursement for University Medical Center, effective July 1, 2024. To model these reimbursement changes, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the per diem rates effective on the date of service.
2. Using the per diem rates effective on July 1, 2024.

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

12.v. Wegovy Adjustment

Wegovy® (semaglutide) was recently approved by the FDA to reduce the risk of heart attack, stroke, and cardiovascular disease in obese adults with cardiovascular disease. LDH has developed utilization criteria stipulating which HLA members would be eligible to receive Wegovy beginning July 1, 2024. We utilized the criteria to estimate the size of the eligible population within the program and estimate the fiscal impact during SFY 2025. ICD-10 diagnosis codes were used to identify the eligible population and an adjustment was made for the underreporting of obesity-related codes, using publicly-available data on the share of the Louisiana population with BMI levels that meet the criteria. Further, the fiscal impact estimate included the following assumptions:

- 15% of the eligible population to utilize the drug initially, ramping up to 20% by the middle of the rating period
- An average of eight annual scripts per member, based on recent Ozempic® (semaglutide) experience
- A monthly cost of $1,349 for Wegovy®

Program changes deemed immaterial to benefit expenses in the rate period

We define a program or policy adjustment to be "material" if the total benefit expense for any individual rate cell is impacted by more than 0.10% and the effects are not fully reflected in the base experience.

All policy changes provided to us by LDH were analyzed for their effect on the Medicaid managed care program. Program adjustments that were made in the SFY 2025 rate development had policy or reimbursement changes that were deemed to have a material cost impact to the MCOs. Adjustment factors that did not meet this minimum threshold criteria were deemed immaterial and were not applied to the base experience. The following is a list of program adjustments deemed immaterial based on our review of the experience data and policy change.

- *Six-month Supply of Contraceptives.* Effective November 20, 2022, in compliance with Act 708, LDH amended the Pharmacy Benefits Management Program to allow for a six-month supply of contraceptives and introduce a copay. Based on our review of emerging data, we determined that the cost savings created by this program change does not have a material impact on the capitation rate development.
- *Immunization (Fee Schedule Update).* The immunization fee schedules were updated on May 12, 2023. The immunization fee schedules includes three fee schedules: Child/Adolescents Immunization, Young Adult Immunization, and Adult Immunization. Based on our review, we determined an adjustment to the base data was not required.
- *Medicaid Reimbursement for Licensed Midwife or Certified Nurse Midwife Services.* Effective August 1, 2023, LDH adopted provisions in the Professional Services Program governing reimbursement for services provided by licensed midwives and certified nurse midwives and amended the provisions governing free-standing birth centers in order to increase the reimbursement rate for services rendered by these providers. We have reviewed the impact of this change and determined it does not have a material impact on the capitation rate development.
- *Continuous Glucose Monitor coverage change.* Effective August 1, 2022, LDH expanded coverage of continuous glucose monitors (CGMs) to additional Medicaid enrollees. In addition, effective October 1, 2022, LDH expanded coverage of adjunctive CGMs, receivers, and supplies in the DME program by adding two Healthcare Common Procedure Coding System (HCPCS) codes to the Durable Medical Equipment (DME) fee schedule. We reviewed expenditures associated with these services after both effective dates. Based on our review of emerging data and given that these coverage changes were in effect for nearly the entire base data period, we determined an adjustment to the base data was not required.
- *Mammogram coverage change.* Effective June 1, 2024, LDH revised the coverage of screening mammograms to include beneficiaries aged 30-39 meeting certain clinical criteria. We reviewed the potential utilization and cost associated with this coverage change and determined it does not have a material impact on the capitation rate development.
- *Other fee schedule updates.* LDH periodically updates other fee schedules to incorporate new procedure codes or make minor rate adjustments. We have reviewed the impact of these other fee schedule changes and determined they do not have a material impact on capitation rate development.

Each of the program adjustments listed above were determined to be immaterial on a stand-alone basis (i.e., impacted the rates for each individual rate cell by less than 0.10%). We evaluated the composite impact of the immaterial items listed above to assess whether an aggregate impact should be applied in the SFY 2025 rate development process. Based on this analysis, the aggregate impact of immaterial program adjustments was also determined to be immaterial so no further adjustments were applied.

Full Medicaid Pricing (FMP)

LDH intends to maintain the physician FMP program for the SFY 2025 rating period, which provides needed funding and ensures continued access of physician rendered services to Medicaid recipients. CMS has previously communicated to LDH that it considers FMP programs to be "grey area" payments[8] which should be transitioned to an approved state directed payment arrangement. LDH has successfully transitioned its hospital, dental, and ambulance FMP programs to state directed payment arrangements.

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

Based on conversations with CMS, LDH anticipates receiving approval to maintain the physician FMP program for the SFY 2025 rating period. During this time, LDH will continue to work with stakeholders to develop a revised physician payment program which is anticipated to be in place for the SFY 2026 rating period.

SFY 2025 FMP amounts by region and rate cell are included in Appendix 2.

Inpatient Outlier Pool

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

LDH makes payments up to a maximum of $20,921,381 annually, which are paid by the MCOs to the applicable hospitals. We incorporated a PMPM add-on for applicable rate cells to fund the outlier payments. The PMPMs were allocated to rate cells based on their proportion of inpatient hospital expenses for members under age 6, such that the total add-ons were equivalent to $20,921,381 when applied to projected SFY 2025 enrollment.

SFY 2025 outlier pool amounts by region and rate cell are included in Appendix 2.

Other data adjustments

The following adjustments are not policy or program changes. The data adjustments listed in Figure 14 were identified by LDH or through our review of the base experience as outlined in Section I, subsection 2.A.ii of this report.

FIGURE 14: OTHER DATA ADJUSTMENTS

		% IMPACT BY POPULATION						
INDEX	OTHER DATA ADJUSTMENT	SSI	F&C	SBH	EXPANSION	OTHER	KICK - EXP	KICK – NON-EXP
14.a	IMD adjustment	(0.1%)	(0.0%)	(1.0%)	(0.0%)	(0.0%)	0.0%	0.0%
14.b	EED kick payment adjustment	N/A	N/A	N/A	N/A	N/A	N/A	N/A
14.c	LAP large claim adjustment	0.4%	0.0%	0.0%	0.0%	(2.8%)	0.0%	0.0%

Notes:
1. The percentage impact is illustrated as a percentage of the SFY 2025 benefit expenses.
2. IMD adjustment reflects the impact of removing all costs associated with long stay IMD visits for members 21 to 64.
3. EED adjustment impacts not shown due to difficulty in projecting this subset of deliveries
3. Percentage impacts illustrated at 0.0% indicate minimal change at a population level; however, these adjustments were determined to be material for at least one rate cell.

14.a. IMD adjustment

We adjusted the base data to remove all costs and member months for months in which a member aged 21 to 64 had an inpatient stay at an institution for mental disease (IMD) that exceeded 15 days in a given month (long stay IMD) that are not covered by the 1115 waiver. Figure 14 illustrates the impact of the long stay IMD adjustment. Note that Louisiana received approval for an 1115 waiver to maintain access to care for Medicaid beneficiaries in need of Opioid Use Disorder and Substance Use Disorder (OUD/SUD) services in residential facilities. This waiver allows LDH to provide services to beneficiaries residing in IMDs with more than 16 beds and primarily serves individuals with OUD/SUD diagnosis for stays longer than 15 days. Services covered by this waiver were *not* removed as part of this adjustment.

For inpatient stays at an IMD for individuals aged 21 to 64 that are less than 15 days in a given month (short stay IMD), we are required to incorporate the unit cost of "providers delivering the same services included in the State plan, as opposed to the unit costs of the IMD services." We compared the average amount paid per day at IMDs and compared this to LDH's published inpatient psychiatric per diem rates for other hospitals. We determined that the average cost provided for the IMD short stays was comparable to what would have been had State Plan services been provided instead (i.e., non-IMD members). The resulting base experience reflects costs associated with the IMD stays of less than 15 days consistent with the standard inpatient psychiatric per diem rates.

14.b. EED kick payment adjustment

Facility and delivering physician costs for early elective deliveries (EED) are not covered under the Healthy Louisiana Program. MCOs receive an EED kick payment for deliveries that occur prior to 39 weeks for reasons that are not medically indicated in the Louisiana Electronic Event Registration System (LEERS) maintained by the Office of Public Health/Vital Records. Deliveries that occur prior to 39 weeks for reasons that are medically indicated in LEERS will receive the maternity kick payment.

To develop the EED kick payment capitation rates, we developed an adjustment to the standard kick payment by calculating the portion of kick payment costs that were associated with facility and delivering physician costs in the base experience. These adjustments were equal to 37.6% and 42.4% for the Non-Expansion and Medicaid Expansion maternity kick payments, respectively.

14.c. LAP large claimant adjustment

The base data for the LAP, All Ages rate cell included an exceptionally high-cost member that accounted for roughly two thirds of the spend for the entire rate cell. Upon further review, this member has moved to the SSI – Child 1-20 rate cell. We applied an adjustment to shift these costs out of the LAP, All Ages rate cell to the SSI – Child 1-20 rate cell. To avoid disproportionately affecting a single region, particularly since it is not clear that the costs for this member will continue at that level, we allocated these costs across all four regions.

(d) Exclusion of payments or services from benefit expense data

Figure 15 summarizes the impact of adjustments made to the MCO base experience to reflect encounters for carved-out services, third-party liability recoveries, and fraud, waste, and abuse recoveries.

FIGURE 15: EXCLUSIONS

		% IMPACT BY POPULATION						
INDEX	OTHER DATA ADJUSTMENT	SSI	F&C	SBH	EXPANSION	OTHER	KICK - EXP	KICK – NON-EXP
15.a.	In rate criteria	0.0%	0.0%	(16.6%)	(0.1%)	0.0%	0.0%	0.0%
15.b	Recoveries	(0.7%)	(0.7%)	(0.6%)	(0.7%)	(0.7%)	(0.7%)	(0.7%)

Notes:
1. The percentage impact is illustrated as a percentage of the SFY 2025 benefit expenses.
2. Percentage impacts illustrated at 0.0% indicate minimal change at a population level; however, these adjustments were determined to be material for at least one rate cell.

15.a. In rate criteria

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

15.b. Recoveries

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

3. Projected Benefit Cost and Trends

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

A. RATE DEVELOPMENT STANDARDS

i. Final capitation rate compliance

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

ii. Benefit cost trend assumptions

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

iii. In lieu of services

The projected benefit costs reflect the utilization and unit costs of ILOSs. For short stay IMDs, we are required to incorporate the unit cost of “providers delivering the same services included in the State plan, as opposed to the unit costs of the IMD services.” We compared the average amount paid per day at IMDs and compared this to LDH’s published inpatient psychiatric per diem rates for other hospitals. We determined that the average cost provided for the IMD short stays was comparable to what would have been had State Plan services been provided instead (i.e., non-IMD members). The resulting base experience reflects costs associated with the IMD stays of less than 15 days consistent with the standard inpatient psychiatric per diem rates.

iv. ILOS Cost Percentages

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

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

v. Benefit expenses associated with members residing in an IMD

LDH allows MCOs to authorize short term IMD stays for members aged 21 to 64 as an in lieu of service under §438.6(e). We utilized benefit expenses reported by the MCOs as the base experience for the IMD base managed care experience. Reimbursement for short stay IMDs in capitation rate development reflects unit costs that are comparable to the same services through providers included under the State Plan. We compared the average amount paid per day at IMDs and compared this to LDH’s published inpatient psychiatric per diem rates for other hospitals. We determined that the average cost provided for the IMD short stays was comparable to what would have been had State Plan services been provided instead (i.e., non-IMD members). The resulting base experience reflects costs associated with the IMD stays of less than 15 days consistent with the standard inpatient psychiatric per diem rates.

In addition, we excluded all costs and member months for months in which a member had a stay at an IMD of greater than 15 days in a given month. These adjustments are described and quantified in Section 1, subsection 2.B.iii(d). Note, services covered by the state's 1115 waiver were not excluded as part of this adjustment.

B. APPROPRIATE DOCUMENTATION

i. Projected benefit costs

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

ii. Development of projected benefit costs

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

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

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

For all populations and regions, the capitation rates were developed from historical SFY 2023 claims and enrollment data.

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

Claims experience was summarized on a rate cell and region basis, with rate cell assignment based on SFY 2025 criteria.

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

Step 2: Apply historical and other adjustments to cost summaries

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

Step 3: Adjust for prospective program and policy changes and trend to state fiscal year 2025

We adjusted the base experience for known policy and program changes that have occurred or are expected to be implemented between the base data experience period and the end of the SFY 2025 rate period. In a previous section, we documented these items and the adjustment factors for each covered population.

Assumed trend factors were applied for 24 months to the adjusted utilization and unit cost values, or per member per month (PMPM) values, as appropriate, from the midpoint of the base experience period (January 1, 2023) to the midpoint of the rate period (January 1, 2025).

Step 4: Adjust for managed care efficiency gains

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

Managed care efficiency adjustments by major category of service were developed based on SFY 2023 utilization as reported in encounter data and the FRGTs. We estimated adjustments to the base experience data to reflect the utilization and cost per unit differential between the base period and the levels targeted for the rating period managed care environment.

Figure 16 illustrates the composite, statewide impact of managed care efficiency adjustments by population and major category of service. Note, for categories of service not listed in Figure 16, managed care efficiency adjustments were not applied.

FIGURE 16: MANAGED CARE EFFICIENCY ADJUSTMENTS COMPOSITED BY POPULATION GROUP AND MAJOR SERVICE CATEGORY

			STATEWIDE IMPACT	
ADJUSTMENT	SERVICE CATEGORY	UTILIZATION	COST PER UNIT	TOTAL
Inpatient Potentially Avoidable Admissions				
	Inpatient Hospital	(0.27%)	(0.01%)	(0.28%)
	Composite	**(0.04%)**	**(0.00%)**	**(0.04%)**
Inpatient Length of Stay				
	Inpatient Hospital	(1.99%)	0.00%	(1.99%)
	Composite	**(0.22%)**	**0.00%**	**(0.22%)**
Maternity Delivery Mix				
	Inpatient Hospital	(0.08%)	0.00%	(0.08%)
	Outpatient Hospital	(0.03%)	0.00%	(0.03%)
	Professional	(0.02%)	0.00%	(0.02%)
	Composite	**(0.02%)**	**0.00%**	**(0.02%)**
Contracting				
	Inpatient Hospital	0.00%	(0.79%)	(0.79%)
	Professional	0.00%	(1.23%)	(1.23%)
	LTSS	0.00%	(0.69%)	(0.69%)
	SBH	0.00%	(0.97%)	(0.97%)
	Ancillary	0.00%	0.09%	0.09%
	Composite	**0.00%**	**(0.44%)**	**(0.44%)**
All adjustments		**(0.27%)**	**(0.44%)**	**(0.71%)**

Notes:
1. The percentage impact is illustrated as a percentage of the SFY 2025 benefit expenses in the applicable service category.
2. Values have been rounded. Values shown as 0.00% may have a non-zero impact to SFY 2025 benefit expenses.

Inpatient hospital length of stay

Inpatient hospital services in the Healthy Louisiana program are reimbursed on a per diem basis, and therefore longer lengths of stay will lead to higher expenditures. We analyzed the average length of stay by MCO, region, and MS-DRG code[9]. For each MS-DRG code, we compared the observed length of stay to benchmarks published by CMS. We then aggregated the observed and benchmark length of stay by MCO and region and calculated an actual-to-expected ratio. In order to account for improvements relative to the previous year, we maintained same the actual-to-expected ratio benchmark from the SFY 2024 capitation rate development.

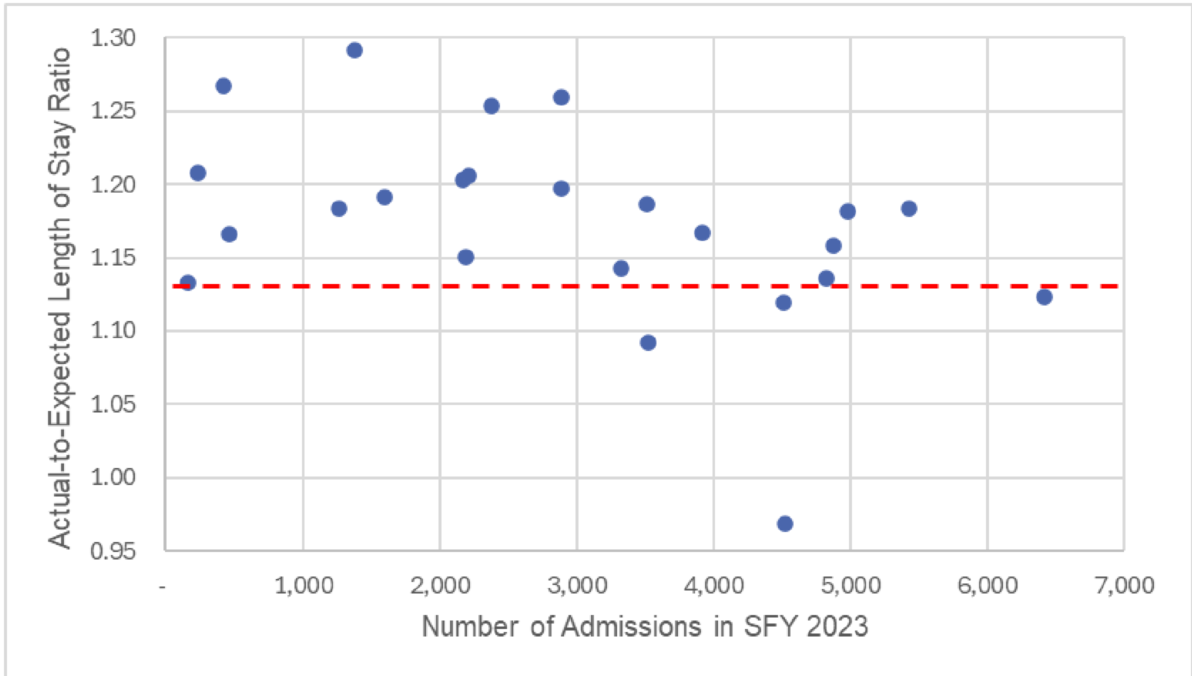
For MCO/region combinations above this benchmark, we adjusted inpatient days downward to achieve the target ratio. When applying the adjustment, we assumed the avoided days would be replaced by an equivalent number of days in a lower acuity setting, such as home health or hospice. No adjustments were applied to MCO/region combinations below the benchmark. The adjustment was applied as a multiplicative factor to the Inpatient Hospital service category, with separate factors by region.

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

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

In Figure 17, each point represents one of the health plan/region combinations in our analysis. The position on the vertical axis represents the actual-to-expected ratio and the position on the horizontal axis represents the number of admissions included in the analysis. The dashed line indicates the target actual-to-expected ratio used to develop the adjustment factor.

FIGURE 17: INPATIENT ADMISSIONS COMPARED TO ACTUAL-TO-EXPECTED LENGTH OF STAY RATIOS FOR EACH MCO/REGION COMBINATION



Inpatient hospital potentially avoidable admissions

We also developed inpatient managed care adjustments based on SFY 2023 experience to reflect higher levels of care management during the rating period relative to the base period. These managed care adjustments were developed by applying assumed reductions to potentially avoidable inpatient admissions. We analyzed the frequency of potentially avoidable admissions using the Agency for Healthcare Research and Quality (AHRQ) prevention quality indicators (PQI).

Our analysis was conducted by reducing admissions for select PQIs by 5%. In completing our analysis, we estimated inpatient hospital unit cost changes based on the utilization reductions outlined above. Unit cost changes were less than 1% for all regions and rate cells. All SBH inpatient admissions were excluded from this analysis, and hospital admissions related to COVID-19 were not considered avoidable and were not reduced in this adjustment.

Figure 18 outlines the PQIs included in our analysis.

FIGURE 18: PREVENTION QUALITY INDICATORS

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

Maternity delivery mix

We reviewed the mix of vaginal and cesarean section deliveries by MCO to determine appropriate efficiency adjustments for kick payments. Delivery managed care efficiency adjustments were developed by analyzing the percent of cesarean and vaginal deliveries by MCO and region in the SFY 2022 base period. Similar to the Inpatient Length of Stay analysis, we maintained same the target delivery mix from the SFY 2024 capitation rate development to capture improvements in efficiency relative to the previous year.

This target mix was 69.0% vaginal / 31.0% cesarean. For MCO/region combinations above this benchmark, managed care savings were estimated by evaluating the maternity cost difference between cesarean and vaginal deliveries, then re-calculating the average maternity cost at the target mix. No adjustments were applied to MCO/region combinations already below the target. No adjustment was made to the total number of deliveries.

Provider contracting

In the SFY 2025 MCO Survey, each MCO reported its average provider reimbursement levels as a percentage of the LDH FFS fee schedule by service category, population, and region. In cases where specific MCOs were contracted above 100% for any combination of service category, population, or region, we applied an adjustment to reduce unit costs to a level consistent with the LDH FFS fee schedule. In nearly every instance when an adjustment was applied, at least two of the MCOs reported paying at 100% of the LDH FFS fee schedule, indicating these reimbursement levels should be reasonably achievable. Adjustments were applied on a regional basis by population for each service category to reflect variation in the portion of providers contracted above 100%.

Emergency room

We reviewed the encounter data to evaluate the need for a managed care efficiency adjustment related to emergency department utilization. We determined that emergency room utilization in the base period was materially below pre-COVID levels and has not increased materially since SFY 2022. It is likely that both potentially avoidable and clinically appropriate emergency room visits have been avoided to a greater degree during the base period. Based on this review, we did not apply a managed care efficiency adjustment to emergency room services. However, the trend assumption (shown in Section 1, subsection 3.iii.a.iv) reflects an expectation that as overall emergency room utilization continues to increase, MCOs will mitigate potentially avoidable services from returning to pre-COVID levels.

Prescription drugs

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

Step 5: Acuity adjustments

The COVID-19 pandemic has driven significant changes in Medicaid enrollment since CY 2020 as a result of the pause in redeterminations and newly-eligible persons entering the Medicaid program. We reviewed potential acuity changes from the SFY 2023 experience period through the SFY 2025 rating period. Even though we considered emerging experience, there is uncertainty related to the unwinding process. The redeterminations started in May 2023 with the first disenrollment occurring July 2023. Based upon discussions with LDH, the redetermination process is anticipated to be completed over 12 months with the last disenrollment occurring June 1, 2024. We have applied acuity adjustments related to COVID-19, as discussed in Section 1. The remainder of this subsection describes other acuity adjustments unrelated to COVID-19.

Act 421 children acuity and coverage adjustments

Act 421 CMO expanded Medicaid eligibility effective January 1, 2022, to certain children with disabilities, even if their parents earn too much money to qualify for Medicaid. These children are broken into nine rate cells based on age and third-party insurance coverage status. The base experience period included roughly 1,000 member months for all rate cells combined, excluding the Non-TPL Child 1-18 years and Non-LaHIPP TPL Child 1-18 years rate cells. Besides these two rate cells, we determined it would be inappropriate to rely on the base experience. Instead, we have used proxy rate cells from the SSI population to establish the capitation rates for the Act 421 children, with further adjustments to reflect differences in acuity, covered services, and third-party insurance coverage. Experience for the Non-TPL Child 1-18 years and Non-LaHIPP TPL Child 1-18 years rate cells had sufficient credibility on a statewide basis, but was not credible on a regional basis. As a result, statewide rates were used for these two rate cells.

- To develop the acuity adjustment, we compared prospective CDPS+Rx risk scores for the December 2023 enrollees in the Act 421 rate cell to the December 2023 enrollees in the comparable proxy population. We included medical and prescription drug claims incurred in SFY 2023 and used CDPS+Rx version 7.0 with standard weights for this adjustment.
  - Because risk scores are not reliable for newborns, we set the acuity adjustment for the 0-2 month rate cells equal to the acuity adjustment for the 3-11 month rate cells.
  - There were no members enrolled in the Act 421 LaHIPP TPL rate cells as of December 2023. We applied the Act 421 Non-LaHIPP TPL acuity adjustments to the Act 421 LaHIPP TPL infant rate cells. We used the actual cost experience for the Act 421 Non-TPL rate cell compared to the SSI Child 1-18 rate cell to determine an acuity adjustment for the Act 421 LaHIPP Child 1-18 years rate cell.
- For rate cells with TPL coverage, we also applied an adjustment to account for the portion of expenditures that are expected to be covered by the third-party insurer. To estimate the impact of the TPL coverage, we compared the risk-adjusted costs during CY 2023 between the Non-LaHIPP TPL and Non-TPL rate cells. The residual difference was assumed to be related to the TPL coverage.
- For the LaHIPP TPL rate cells, we also applied an adjustment to exclude services not covered under the SBH program. These adjustment factors were based on the percentage of expenditures in the projected benefit expenses for the proxy populations that were for services not covered under the PH program. We have assumed a TPL adjustment of 1.000 for the LaHIPP TPL rate cells under the assumption that the remaining services covered for these populations will not receive any TPL coverage.

Figure 19 below summarizes the adjustments for each Act 421 rate cell.

FIGURE 19: ACT 421 ADJUSTMENT FACTORS, BY RATE CELL

RATE CELL	PROXY RATE CELL	ACUITY ADJUSTMENT	TPL ADJUSTMENT	SBH ADJUSTMENT	FINAL ADJUSTMENT APPLIED
Act 421 - LaHIPP TPL - 0-2 Months	SSI 0-2 Months	0.5065	1.0000	0.0187	0.0095
Act 421 - LaHIPP TPL - 3-11 Months	SSI 3-11 Months	0.5065	1.0000	0.0052	0.0026
Act 421 - LaHIPP TPL - Child 1-18 Years	SSI Child 1-20 Years	0.9675	1.0000	0.2325	0.2249
Act 421 - Non-LaHIPP TPL - 0-2 Months	SSI 0-2 Months	0.5065	0.2566	1.0000	0.1299
Act 421 - Non-LaHIPP TPL - 3-11 Months	SSI 3-11 Months	0.5065	0.2777	1.0000	0.1406
Act 421 - Non-TPL - 0-2 Months	SSI 0-2 Months	0.3873	1.0000	1.0000	0.3873
Act 421 - Non-TPL - 3-11 Months	SSI 3-11 Months	0.3873	1.0000	1.0000	0.3873

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

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

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

- Incorporating enrollment and acuity adjustments to reflect expected enrollment shifts in line with the state's planned PHE unwinding due to the resumption of Medicaid redeterminations.

All material assumptions are documented in this rate certification report.

Overpayments to providers

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

iii. Projected benefit cost trends

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

(a) Required elements

(i) Data

We analyzed January 2020 through December 2023 non-pharmacy expenditure data from the encounter data to develop estimated prospective trend rates. For pharmacy, we analyzed expenditure data from January 2020 through January 2024 from the encounter data to develop estimated prospective trend rates. In addition, we evaluated observed trend rates against external data sources to determine the trend assumptions that would be applied to the base experience data. We referenced the Medicaid Pharmacy Trend Report™ 2023 Eighth Edition by Magellan Rx Management[10]. We also reviewed internal sources that are not publicly available, such as historical experience from other programs and trends used by other Milliman actuaries.

[10] https://www1.magellanrx.com/read-watch-listen/read/our-publications/medicaid-pharmacy-trend-report/

(ii) Methodology

Non-pharmacy utilization trends

To evaluate prospective non-pharmacy trend, we primarily focused on a mix of long-term and emerging trends, including data between January 2020 and December 2023. Prior to evaluation, encounter claims were adjusted for completion and changes in population acuity. We then stratified encounter claims experience by population and summarized by trend category of service. Trends were evaluated and applied on a statewide basis.

The resulting utilization per 1,000 and PMPM data points were compared to historical experience and internal sources from other managed care programs. Based on our review, we believe that during the SFY 2023 base period, utilization in all categories of service functioned at long-term steady state levels.

Non-pharmacy unit cost trends

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

Pharmacy trends

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

To evaluate prospective pharmacy utilization trend, we summarized historical scripts by population, brand/generic, and age group on a monthly basis. The data was normalized for changes in population acuity. Effective July 1, 2023, LDH implemented a pharmacy edit to require a diagnosis of Type-2 diabetes for the GLP-1 drugs to be covered.

To account for changes in underlying utilization patterns, we reviewed emerging data through March 2024. Rolling 12-month, 9-month, 6-month, and 3-month trends were calculated to identify changes in the underlying patterns over time. We applied the composite annualized utilization trend rates from the midpoint of the adjusted base period to the midpoint of the rating period.

To evaluate prospective pharmacy unit cost trend, we evaluated emerging experience from July 2023 through March 2024 by therapeutic class. We adjusted actual pharmacy reimbursement to reflect the single PBM contracted discounts since implementation on October 28, 2023.

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

High-cost drug risk pool

In SFY 2025, LDH will continue to operate a high-cost drug risk pool, which is described further in Section 1, Subsection 4.C. The estimated costs for drugs in this pool were developed separately from the pharmacy trend assumptions. Based on a review of members potentially eligible for these treatments, we projected total costs associated with these drugs in SFY 2025. To avoid double-counting in the overall capitation rate development, we removed high-cost claims from the base data and added the full value of expected costs in SFY 2025. This is shown in Appendix 2.

(iii) Comparisons

Historical trends should not be used in a simple, formulaic manner to determine future trends; a great deal of actuarial judgment is also needed.

We referred to the sources listed in the prior section as well as considered changing practice patterns and the impact of reimbursement changes on utilization in the managed care populations.

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

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

(iv) Documentation of Trends

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

(b) Required elements

Figure 20 illustrates the utilization component of the trend rate assumptions by population and category of service for non-pharmacy services from the base experience period to the rating period for all regions.

As directed by CMS in its rate setting guide, utilization trend assumptions also account for estimated future changes in the mix or intensity of services. The trend assumptions reflect projected utilization changes in the absence of managed care efficiency gains. Note, the trend values in Figure 20 reflect the average annualized trend rates.

FIGURE 20: ANNUALIZED UTILIZATION TREND ASSUMPTIONS, ALL REGIONS

POPULATION	F&C - ADULT	F&C - CHILD	F&C - INFANT	SSI - ADULT	SSI - CHILD	SSI - INFANT	EXPANSION	SBH	OTHER POPULATIONS
Ancillary	2.0%	2.0%	1.0%	1.0%	1.5%	2.5%	1.0%	3.0%	1.0%
Inpatient Hospital	0.0%	1.0%	1.0%	0.0%	0.0%	4.0%	0.0%	n/a	3.0%
Outpatient Other	3.0%	0.0%	0.0%	4.0%	0.0%	4.0%	3.0%	n/a	3.5%
Outpatient ER	0.0%	0.0%	0.0%	0.0%	0.0%	3.0%	0.0%	n/a	0.0%
Professional	2.0%	2.0%	1.0%	1.0%	1.5%	2.5%	1.0%	3.0%	1.0%
Professional ER	0.0%	0.0%	0.0%	0.0%	0.0%	3.0%	0.0%	n/a	0.0%
SBH Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SBH Inpatient	0.0%	1.0%	0.0%	4.0%	4.0%	0.0%	0.0%	0.0%	4.0%

Figure 21 illustrates the pharmacy unit cost and utilization trend rate assumptions by population rate group. Pharmacy trend rates were developed consistently across all regions. Note, the pharmacy trend assumptions illustrated in Figure 21 reflect the annualized trend from the base period to the rating period.

FIGURE 21: ANNUALIZED PHARMACY TREND ASSUMPTIONS

RATE GROUP	UTILIZATION	COST PER UNIT	COMPOSITE
F&C - Adult	3.5%	8.0%	11.8%
F&C - Child	4.0%	10.0%	14.4%
F&C - Infant	3.0%	0.0%	3.0%
SSI - Adult	5.0%	7.0%	12.4%
SSI - Child	4.5%	11.5%	16.5%
SSI - Infant	3.0%	0.0%	3.0%
Expansion	3.5%	8.0%	11.8%
SBH	n/a	n/a	n/a
All Other Populations	4.5%	9.0%	13.9%

*Pharmacy trends were rounded to the 0.5%

(c) Variation

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

(d) Material adjustments

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

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

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

(e) Any other adjustments

(i) Impact of managed care

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

(ii) Trend changes other than utilization and cost

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

iv. Mental Health Parity and Addiction Equity Act Service Adjustment

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

v. In Lieu of Services

(a) Description of ILOSs

The following provides a brief description of each ILOS in the managed care program and whether the ILOS was provided as benefit during the base data period. Additional detail on each of these services can be found in Attachment C of the Medicaid Managed Care Organization Contract.

IMD

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

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

Managed care enrollees aged 21 to 64 and residing in an IMD for more than fifteen days were identified using the encounter data. These beneficiaries and all associated enrollment and expenditures, both related to IMD stays and other services rendered, have been excluded from capitation rate development. Note that services covered by the state's 1115 waiver were not excluded as part of this adjustment.

Other ILOSs

Additional ILOSs are described below. For each ILOS, we have provided the original effective date of the service and the date provided in the current MCO contract if the dates are different. Please note that the current MCO contract was effective January 1, 2023. Therefore, the earliest service date provided in the MCO contract is January 1, 2023. The benefit expense included in the SFY 2025 capitation rates for these ILOS is consistent with state plan services unless specified elsewhere in the certification.

- Chiropractic services for adults age 21 and older: effective date 1/1/2022; contract date 1/1/2023
- Hospital-based care coordination for pregnant and postpartum individuals with substance use disorder and their newborns: effective date 1/1/2022; contract date 1/1/2023
- Doula services: effective date 1/1/2022; contract date 1/1/2023
- 23-Hour observation bed services for adults age 21 and older: effective date 12/1/2015; contract date 1/1/2023
- Freestanding psychiatric hospitals for adults ages 21-64: effective date 12/1/2015; contract date 1/1/2023
- Injection services provided by licensed nurses to adults age 21 and older: effective date 12/1/2015; contract date 1/1/2023
- Mental health intensive outpatient programs: effective date 9/14/2018; contract date 1/1/2023
- Population health management program: effective date 1/5/2022; contract date 1/1/2023
- Remote patient monitoring: effective date 7/1/2023
- Outpatient lactation support: effective date 1/1/2024
- Therapeutic day center for ages 5-20: effective date 7/1/2023
- Integrated behavioral health homes: effective date 7/1/2023
- Care at home: effective date 7/1/2024
- Visions of hope community service: effective date 7/1/2024

(b) ILOS Cost Percentages

ILOS cost percentages are shown below in Figure 22. The ILOS cost percentages were developed using ILOS paid amounts in the base period, included in the MCO survey submissions, as a percentage of the total paid amounts for all services. All ILOS other than IMD account for approximately 0.45% of the projected capitation rates, including directed payments. We are considering each of these ILOSs as immaterial on their own and are calculating only a composite ILOS percentage across all of them combined.

FIGURE 22: ESTIMATED ILOS PERCENTAGE, EXCLUDING IMD

IN-LIEU-OF-SERVICES/SETTINGS	TOTAL
Chiropractic services for adults age 21 and older	0.17%
Hospital-based care coordination for pregnant and postpartum individuals with substance use disorder and their newborns	0.01%
Doula services	0.00%
23-hour observation bed services for adults age 12 and older	0.00%
Injection services provided by licensed nurses for adults age 21 and older	0.00%
Mental health intensive outpatient services	0.05%
Population health management programs	0.03%
Remote patient monitoring	0.02%
Outpatient lactation support	0.00%
Therapeutic day center for age 5-20	0.00%
Integrated behavioral health homes	0.15%
Care at home for adults age 18 and older	0.01%
Visions of hope community services for adults age 18 and older	0.00%
Total	**0.45%**

Note: Values above shown as 0.00% are non-zero; however, these services are expected to account for less than 0.02% of SFY 2025 total expected payments.

(c) Incorporation into rate development

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

(d) Inclusion of IMD services

IMD services were adjusted to remove long-stay IMDs for individuals between 21 and 64 years old. Reimbursement for short stay IMDs in capitation rate development reflects unit costs that are comparable to the same services through providers included under the State Plan. We compared the average amount paid per day at IMDs and compared this to LDH's published inpatient psychiatric per diem rates for other hospitals. We determined that the average cost provided for the IMD short stays was comparable to what would have been had State Plan services been provided instead (i.e., non-IMD members). The resulting base experience reflects costs associated with the IMD stays of less than 15 days consistent with the standard inpatient psychiatric per diem rates.

vi. Retrospective Eligibility Periods

(a) MCO responsibility

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

(b) Claims treatment

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

(c) Enrollment treatment

Enrollment is treated consistently with claims.

(d) Adjustments

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

vii. Impact of Material Changes

This section relates to material changes to covered benefits or services since the last rate certification. The last rate certification was for the SFY 2024 rating period, with an amendment to rates effective January through June 2024.

(a) Change to covered benefits

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

(b) Recoveries of overpayments

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

(c) Change to payment requirements

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

(d) Change to waiver requirements

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

(e) Change due to litigation

There were no material changes due to litigation.

viii. Documentation of Material Changes

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

4. Special Contract Provisions Related to Payment

A. INCENTIVE ARRANGEMENTS

i. Rate development standards

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

ii. Appropriate documentation

(a) Managed Care Incentive Program (MCIP)

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

(i) Time period

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

(ii) Covered enrollees, services, and providers

The incentive arrangement covers enrollees in the Healthy Louisiana program.

(iii) Purpose

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

(iv) Payments will not exceed 105 percent

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

(v) Effect on capitation rates

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

B. WITHHOLD ARRANGEMENTS

i. Rate development standards

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

ii. Appropriate documentation

(a) Withhold description

(i) Time period

The withhold arrangement in the Healthy Louisiana program is for SFY 2025, consistent with the rate period.

(ii) Enrollees, services, and providers

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

(iii) Purpose

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

(iv) Percentage withheld

The withheld percentage will be 2.0% of the limited rate (i.e., excluding FMP and directed payments) for SFY 2025 for all rate cells except maternity kick payments.

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

(v) Not reasonably achievable percentage

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

(vi) Reasonability of total withhold arrangement

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

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

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

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

(vii) Effect on capitation rates

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

(b) Actuarial soundness of withhold

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

C. RISK SHARING MECHANISMS

i. Rate development standards

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

ii. Appropriate documentation

(a) Description of the risk-sharing mechanism

LDH has two risk-sharing mechanisms that will apply in SFY 2025: a Hepatitis C risk corridor and high-cost drug risk pool.

Hepatitis C risk corridor

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

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

High-cost drug risk pool

In SFY 2024, LDH maintained a risk pool for five high-cost drugs, all of which were one-time treatments exceeding $1 million per individual. In SFY 2025, the pool will expand to include FDA approved treatments meeting the following criteria. The individual drugs are not included in the rate certification because drugs meeting these criteria might be approved by the FDA during the rating period and added to the high-cost drug risk pool at LDH's discretion.

- FDA approved therapy
- Labeler participated in the Federal Rebate Program
- Durable and potentially curative cell and gene therapies (one-time use therapies)
- Estimated treatment cost of at least $2 million on a wholesale acquisition cost basis

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

To be counted toward the risk pool reconciliation, claims must have a valid National Drug Code (NDC) identifier corresponding to one of the drugs in the pool. Drugs delivered in an inpatient setting must be billed on a separate claim identifying the cost of the drug treatment (separately from any hospital per diem reimbursement) and must contain a valid NDC. Claims to be included in the risk pool must adhere to all standard LDH coverage and billing requirements. The risk pool is also limited to claims specifically for the delivery of the high-cost drug and does not include any other services that may be required as part of the course of treatment.

(b) Medical loss ratio

Description

For CY 2022, LDH required all MCOs participating in the Healthy Louisiana managed care program to maintain a minimum medical loss ratio (MLR) of 85%, separately for the Medicaid Expansion and all other populations combined. For each of the two MLR calculations, the MLR is defined as the ratio of the numerator, as defined in accordance with 42 CFR 438.8(e), to the denominator, as defined in accordance with 42 CFR 438.8(f), plus a credibility adjustment, as defined in accordance with 42 CFR 438.8(h). These items will be accrued on an incurred year basis for the MLR calculation. MLR will be measured on a SFY basis starting on July 1, 2024.

Financial consequences

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

(c) Reinsurance requirements and effect on capitation rates

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

D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

i. Rate development standards

This section provides information on directed payments for certain providers which are pertinent to the SFY 2025 capitation rates.

(a) Description of Managed Care Plan Requirement

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

Since July 1, 2023, LDH has made directed payments to licensed mental health professionals (LMHPs) and providers who are certified Evidence-Based Practice (EBP) practitioners. The EBP payments will be made as a lump sum payment to each provider. The LMHP payments will be made through a uniform fee schedule increase. These payments are incorporated into the capitation rates as separate payment term.

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

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

Since January 1, 2024, MCOs have paid qualifying licensed mental health professionals (LMHPs) an add-on when providing dialectical behavioral therapy (DBT) services. These payments are incorporated into the capitation rates as separate payment term.

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

(b) Approval by CMS and consistency with preprints

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

(c) Contract arrangements with MCOs

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

(d) Inclusion of Provider Payment Initiatives in Capitation Rates

Hospital directed payments

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

LMHP/EBP directed payments

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

Non-emergency transportation directed payments

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

Home health directed payments

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

DBT directed payments

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

Minimum fee schedules

The minimum fee schedule directed payments are incorporated into the capitation rates through the program change adjustments or managed care efficiencies, described in Section 1, subsection 2.B.iii.d . MCOs will be required to contract with providers at no less than the approved state plan rates for these services. The contracting managed care efficiency reprices the base claims to the appropriate fee schedule in effect when the service was rendered. Any changes subsequent changes to the fee schedules are reflected in the program change adjustments.

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

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

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

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

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

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

(iv) Changes from initial base rate certification

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

ii. Appropriate documentation

(a) Description of Delivery System and Provider Payment Initiatives

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

State directed payments incorporated in the capitation rates are listed in Figure 23 below.

FIGURE 23: SUMMARY OF DIRECTED PAYMENTS INCLUDED IN CERTIFICATION

CONTROL NAME OF THE STATE DIRECTED PAYMENT	TYPE OF PAYMENT	BRIEF DESCRIPTION	IS THE PAYMENT INCLUDED AS A RATE ADJUSTMENT OR SEPARATE PAYMENT TERM?
LA_Fee_IPH.OPH_Renewal_20240701-20250630	Add-on based on utilization	Add-on paid to acute hospitals based on utilization of inpatient and outpatient services	Separate payment term
LA_Fee_IPH.OPH1_Renewal_20240701-20250630	Add-on based on utilization	Add-on paid to non-acute hospitals based on utilization of inpatient and outpatient services	Separate payment term
LA_Fee_BHO_New_20240701-20250630[1]	Add-on based on utilization	Add-on paid to LMHPs and EBP-certified practitioners based on participation and retention in MCO networks	Separate payment term
LA_Fee_OTH1_Amend_20240701-20250630[1]	Add-on based on utilization	Add-on paid to NEMT providers based on the number of vehicles in use each month	Separate payment term
LA_Fee_HCBS2_New_20240701-20250630[1]	Add-on based on utilization	Add-on paid to home health providers based on the number of nurses providing services to enrollees under the age of 21	Separate payment term
LA_Fee_BHO2_New_20240101-20241231[2]	Add-on based on utilization	Add-on paid to LMHPs for each DBT service provided	Separate payment term
Minimum fee schedules[3]	Minimum fee schedule	List of applicable services provided below	Rate adjustment

Notes:

1. LDH intends to renew these preprints but they have not yet been submitted to CMS. We anticipate these will be the control names used for the renewals.
2. This preprint will be renewed on a calendar year basis as it also applies to the Coordinated System of Care program. We anticipate LDH will submit a renewal for this preprint for calendar year 2025, but this preprint has not yet been submitted to CMS.
3. LDH is not required to submit pre-prints for minimum fee schedules on an annual basis and therefore we do not have a current control name for these directed payments.

Separate payment term directed payments were established for the SFY2025 rating period:

- **LA_Fee_IPH.OPH_Renewal_20240701-20250630**

  The acute hospital directed payment is established as a uniform percentage increase for inpatient and outpatient hospital services provided by acute care providers. The estimated total payment was developed based on grouping eligible providers into five separate tiers with uniform percent rate increases calculated separately for each tier to target a defined amount of available funding, which equates to roughly 93% of an average commercial rate (ACR) for tiers 2 through 5 and 80% of ACR for tier 1.

- **LA_Fee_IPH.OPH1_Renewal_20240701-20250630**

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

- **LA_ Fee_OTH1_Amend_20240701-20250630**

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

- **LA_Fee_HCBS2_New_20240701-20250630**

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

- **LA_Fee_BHO_New_20230701-20240630**

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

- **LA_Fee_BHO2_New_20240101-20241231**

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

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

- Pharmacy prescriptions through the single PBM
- Services provided by Indian Health Service providers
- Services provided by an FQHC or RHC
- Outpatient hospital and other cost-based services
- Ground and air ambulance
- NEMT

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

State directed payments incorporated in the capitation rates as a rate adjustment are listed in Figure 24 below, with more description following the table.

FIGURE 24: DIRECTED PAYMENTS INCORPORATED AS RATE ADJUSTMENTS

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

The minimum fee schedule directed payments are incorporated into the capitation rates through the program change adjustments or managed care efficiencies, described in Section 1, subsection 2.B.iii.d . MCOs will be required to contract with providers at no less than the approved state plan rates for these services. The contracting managed care efficiency reprices the base claims to the appropriate fee schedule in effect when the service was rendered. Any changes subsequent changes to the fee schedules are reflected in the program change adjustments.

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

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

FIGURE 25: DIRECTED PAYMENTS INCORPORATED AS SEPARATE PAYMENT TERMS

CONTROL NAME OF THE STATE DIRECTED PAYMENT	AGGREGATE AMOUNT INCLUDED IN THE CERTIFICATION[1]	STATEMENT THE ACTUARY IS CERTIFYING THE SEPARATE PAYMENT TERM	MAGNITUDE ON A PMPM BASIS	CONFIRMATION THE RATES ARE CONSISTENT WITH PREPRINT	CONFIRMATION THE ACTUARY WILL SUBMIT REQUIRED DOCUMENTATION AT END OF RATING PERIOD
LA_Fee_IPH.OPH_Renewal_20240701-20250630	$ 2,806.8 million	Yes	$146.08	Yes	Yes
LA_Fee_IPH.OPH1_Renewal_20240701-20250630	$ 54.4 million	Yes	$2.83	Yes	Yes
LA_Fee_OTH1_Amend_20230701-20240630[2]	$ 2.8 million	Yes	$0.15	Yes	Yes
LA_Fee_HCBS2_New_20230701-20240630[2]	$3.3 million	Yes	$0.17	Yes	Yes
LA_Fee_BHO_New_20240701-20250630[2]	$ 18.4 million	Yes	$0.96	Yes	Yes
LA_Fee_BHO2_New_20240701-20250630[3]	$ 3.4 million	Yes	$0.18	Yes	Yes

Notes:

1. Values shown are net of premium tax.
2. These preprints have not yet been submitted to CMS. The amounts shown here are based on our review of the preprints that will be submitted to CMS.
3. This preprint will be renewed on a calendar year basis as it also applies to the Coordinated System of Care program. We anticipate LDH will submit a renewal for this preprint for calendar year 2025, but this preprint has not yet been submitted to CMS. The amount shown here assumes the amount of the calendar year 2025 preprint is equal to the calendar year 2024 preprint.

Actuarial certification of separate payment terms.

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

Provider types receiving the payment

Providers who are part of the acute hospital directed payment include in-state providers of inpatient and outpatient hospital services licensed and enrolled in Medicaid on or before December 31, 2023, excluding freestanding psychiatric hospitals, freestanding rehabilitation hospitals, and long-term acute care hospitals.

The non-acute directed payment includes in-state hospital providers of long-term acute care, psychiatric services, and rehabilitation services for both inpatient and outpatient hospital services licensed and enrolled in Medicaid on or before December 31, 2023. Notwithstanding the foregoing, all public state-operated hospitals and freestanding psychiatric hospitals participating in DSH are not included in the psychiatric provider class and are excluded from participating in the state directed payment program.

The LMHP/EBP directed payment will be made to LMHPs and other practitioners who are EBP-certified.

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

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

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

Distribution methodology

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

For the LMHP/EBP directed payment, LDH will employ a process to ensure EBP practitioners will only receive one-sixth of the total payment from each MCO so that each practitioner joins all networks to receive the entire signing bonus. MCOs will pay EBP practitioners based on the addition of the EBP to its network, submittal of paperwork or receipt of a claim six months after enrollment. LMHP providers will receive reimbursement from the managed care organization upon processing the initial claim that represents the current reimbursement plus the uniform percentage add-on. The managed care organization will then invoice LDH quarterly for the state directed payment add-on portion of the reimbursement. LDH will pay the managed care organizations based on the invoices. LDH has retained auditing rights to determine if payments have been paid to the correct practitioners.

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

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

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

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

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

Estimated PMPM payout by rate cell

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

Consistency with 438.6(c) preprint

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

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

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

(b) Additional directed payments not addressed in the certification

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

(c) Other requirements regarding reimbursement rates

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

E. PASS-THROUGH PAYMENTS

i. Rate development standards

There are no pass-through payments applicable to the Healthy Louisiana program in SFY 2025.

5. Projected Non-Benefit Costs

A. RATE DEVELOPMENT STANDARDS

i. Overview

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

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

ii. PMPM versus percentage

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

B. APPROPRIATE DOCUMENTATION

i. Development of non-benefit costs

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

Data

The 4Q CY 2023 FRGT contained reported administrative costs by MCO and population for CY 2022 and 2023. This was the primary data source used in the development of the SFY 2025 non-benefit costs. Non-benefit costs were established for each population as a percentage of the limited capitation rates (excluding directed payments and FMP amounts).

In addition, we reviewed average costs from the financial statements of Medicaid health plans nationally, as summarized by Palmer, Pettit, McCulla, and Kinnick. These reports date from 2012 through 2023, analyzing financial results from 2011 through 2022.

Assumptions and methodology

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

MCO reported administrative and HQI expenses were reconciled between the available data sources, such as the MCO survey, for the purpose of evaluating the quality of the data provided. Administrative and HQI expenses reported in the CY 2023 FRGTs were analyzed for reasonableness and completeness. In addition, we reviewed changes in the MCO-reported administrative expenses from CY 2019 through CY 2022 using prior financial reporting templates provided by LDH. Overall, values reported by the MCOs were consistent with values reported in the SFY 2025 MCO Survey for the SFY 2023 experience period.

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

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

1. SFY 2023 MCO reported administrative costs were summarized. Based upon information provided by the MCOs, we were able to isolate the administrative costs associated with state plan services. MCO penalties and administrative costs associated with providing non-state plan services were deducted from reported administrative costs. In addition, pharmacy administrative costs were separately identified. Administrative costs for Humana was excluded from the non-benefit cost analysis.

Humana only had six months of experience during SFY 2023 and had lower enrollment than other plans during this time. We do not believe their administrative costs PMPM during this period are reflective of steady state costs for an MCO in SFY 2025.

2. An efficient MCO should be able to operate between the 25th and 50th percentile of the national benchmark. We used the CY 2022 and CY 2023 NAIC reported administrative expense ratio for expansion states as the national benchmark for the HLA program. Based on our review, we selected the average of the CY 2022 and CY 2023 50th percentile administrative loss ratio net of taxes and fees for expansion states (net of taxes and fees) as the benchmark which was 8.0%. We then converted the administrative loss ratio to a $33.89 PMPM using the January 2023 amended HLA capitation rates. Two of the HLA MCOs reported an administrative PMPM at or below this amount during SFY 2023.

3. Individual MCO-reported administrative costs were then capped and floored at a 10% variance relative to the national (expansion states) benchmark, resulting in a 2.6% increase to the national benchmark. Note, after making this adjustment, 3 of the 5 historical MCOs' SFY 2023 normalized administrative costs were outside the capped and floored composite administrative cost PMPM.

4. LDH implemented a single PBM on October 28, 2023, and the pharmacy-related administrative costs during SFY 2025 will be set based on the contract with the MCOs and the single PBM vendor. The pharmacy-related administrative costs of approximately $2 PMPM as collectively reported by the MCOs was removed from the floored and capped administrative cost benchmark. All administrative adjustments discussed below were applied to the floored and capped national administrative benchmark net of pharmacy cost.

5. The adjusted SFY 2023 administrative cost PMPM was then trended for a 24-month period at an annualized 3.0% trend rate. This trend rate was chosen based on published inflationary values as of May 2024 and forecasts for the SFY 2025 rating period[11, 12].

6. In recognition of the resumption of Medicaid redeterminations in July 2023, we evaluated estimated changes in administrative economies of scale that may occur with changes in total Healthy Louisiana enrollment between the SFY 2023 experience period and SFY 2025 rating period. Based upon emerging enrollment data, the Family and Children and Medicaid Expansion populations are anticipated to be impacted the most from disenrollments. We anticipate that the enrollment in these two populations will be approximately 15% lower in SFY 2025 than SFY 2023. Therefore, we have applied an economies of scale adjustment to the Family and Children and Medicaid expansion population. Based our review of historical administrative PMPM costs, reported enrollment, and inflation from CY 2019 through CY 2022, we applied a 7.1% increase to the administrative costs for the Family and Children and Medicaid Expansion populations for SFY 2025.

7. As a result of an agreement between LDH and the Department of Justice, the MCOs participating in the HLA program were required to develop and implement a specialized community case management program using subcontractors who meet the qualifications established by LDH. The MCOs were required to execute a contract with the LDH-approved subcontractors by November 12, 2021, with community case management services provided to DOJ Agreement Target Population members beginning January 2022. Based on our review of LDH-approved subcontractor invoices, utilization of these case management services are anticipated to be higher during the rating period than were reported during the base period. We added $0.15 PMPM (in aggregate) to the estimated administrative expense PMPM to reflect additional utilization of these services in SFY 2025 relative to SFY 2023. The impact is concentrated in rate cells with members utilizing these services.

8. A $0.07 PMPM adjustment reflecting January 1, 2023 MCO contractual changes was added to the composite administrative cost for the managed care program, and then distributed across populations and rate cells based on historical medical cost relativities. An appropriate PMPM amount was determined based on a review of MCO-reported incremental staffing changes necessary to fulfill the contract changes, as well as LDH and the Office of Behavioral Health's (OBH) assessment of the reasonableness and necessity of

[11] https://www.philadelphiafed.org/-/media/frbp/assets/surveys-and-data/survey-of-professional-forecasters/2024/spfq224.pdf

[12] https://www.bls.gov/regions/southwest/summary/blssummary_neworleans.pdf

reported staffing changes. Finally, the amount was divided by two to reflect a January 1, 2023 implementation date.

9. The final step was to apply the contracted single PBM cost per script admin of $0.77 to the administrative expense PMPM.

Risk margin. Risk margin assumptions have been maintained from SFY 2024 and apply to all benefit expenses included in the limited rate (which excludes FMP and directed payments made as a separate payment term). As MCO's will have additional risk-based capital requirements related to reimbursement adjustments, we believe it is appropriate to apply the margin assumptions to all incremental benefit expense changes.

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

In addition, we reviewed the underwriting gain model released in June 2022 by the Society of Actuaries (SOA).[13] In evaluating the model's results and with consideration for investment income earned by health insurers, we believe the margin assumptions included in rates provide a reasonable allowance for capital requirements and experience fluctuation.

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

(b) Material changes since last rate certification

There were no material changes since the prior certification.

(c) Other material adjustments

No other material adjustments were made.

ii. Non-benefit costs, by cost category

The SFY 2025 non-benefit cost allowance was developed as a percentage of the limited rate (net of premium tax) for each rate cell on a statewide basis.

Figure 26 illustrates the individual components and percentages that comprise the non-benefit costs. The resulting values of these items on a PMPM basis can be reviewed by region and rate cell in Appendix 2.

FIGURE 26: NON-BENEFIT COSTS AS A PERCENTAGE OF LIMITED RATES, PRIOR TO PREMIUM TAX

	LIMITED RATE		
POPULATION	ADMIN	QUALITY	MARGIN
SSI	5.50%	1.50%	1.50%
F&C	7.25%	1.75%	1.50%
SBH	11.75%	3.00%	1.50%
Medicaid Expansion	6.00%	1.50%	1.50%
All Other Populations	6.00%	1.50%	1.50%
Maternity Kick	2.75%	0.75%	1.50%

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

iii. Historical non-benefit cost data

Figure 27 below summarizes the administrative and quality expenses incurred by the Healthy Louisiana MCOs on a PMPM basis for CY 2020, CY 2021, CY 2022, SFY 2022, and SFY 2023.

These values are based on MCO financial reporting contained in the FRRs for the CY 2020 and CY 2021, and the FRGTs for SFY 2022 and SFY 2023. For the administrative and quality expenses, we compared the historical actuals to the loads included in previous capitation rates to help assess the adequacy of the loads in the SFY 2025 capitation rates.

FIGURE 27: HISTORICAL NON-BENEFIT COSTS PMPM

TIME PERIOD	TOTAL NON-BENEFIT EXPENSE PMPM
CY 2020	$ 34.83
CY 2021	$ 34.23
SFY 2022	$ 34.66
CY 2022	$ 36.52
SFY 2023	$ 36.09

Note: Values exclude premium tax.

6. Risk adjustment and acuity adjustments

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

A. RATE DEVELOPMENT STANDARDS

i. Overview

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

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

ii. Risk adjustment model

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

iii. Acuity adjustments

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

B. APPROPRIATE DOCUMENTATION

i. Prospective risk adjustment

(a) Data

We anticipate that SFY 2025 capitation rates will be risk adjusted on a semi-annual basis. Risk adjustment for the first half of SFY 2025 will reflect MCO experience incurred during CY 2023 (January 1, 2023 through December 31, 2023), while risk adjustment for the second half of SFY 2025 will utilize SFY 2024 experience. Additional adjustments may be applied to the risk adjusted rates for enrollment changes resulting from the economic impact of COVID-19. We will monitor enrollment changes during the unwinding process and consider more frequent risk adjustment updates if appropriate.

(b) Risk adjustment model

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

We will recalibrate the weights between the diagnostic and pharmacy components of the CDPS+Rx model based on observed experience for the Healthy Louisiana population. Diagnosis code and NDC information from SFY 2022 will be utilized to train a model to explain MCO covered claims expenditures from CY 2023. The weights will be developed on a statewide basis. MCO expenditures incorporated as part of the Maternity kick payment will not be included in the training of the risk adjustment model.

(c) Risk adjustment methodology

We expect to perform risk adjustment for the 2H CY 2024 and 1H CY 2025 rating periods. In each period, risk scores will be calculated for each MCO by region and rate group. The rate groups for the purposes of risk adjustment are:

- SSI – Child 1-20 Years
- SSI – Adult 21+ Years
- Family and Children – Child 1-20 Years
- Family and Children – Adult 21+ Years
- Medicaid Expansion – Age 19-64

The following rate cells will not be risk-adjusted:

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

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

Prospective risk adjustment is expected to take place on a semi-annual basis for the July 2024 through June 2025 period:

- **July 2024 through December 2024 rates:** Prospective risk adjustment will be performed using the member risk scores weighted based on actual MCO enrollment from June 2024.
- **January 2025 through June 2025 rates:** Prospective risk adjustment will be performed using the member risk scores weighted based on actual MCO enrollment from December 2024.

Members with six or more months of full benefit Medicaid eligibility during the diagnosis capture period will be assigned a risk score. The average risk score for unscored members for each MCO plan will be modeled based on the distribution of unscored members by age/gender category and the proportion auto-assigned to the MCO. The average risk score across all MCOs by region, rate cell, and age/gender category will be weighted by each MCO's distribution of unscored members. This will then be adjusted to account for differences in the proportion of unscored members auto-assigned to the MCO. This adjustment will be developed based on a review of historical experience.

(d) Magnitude of the adjustment

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

(e) Assessment of predictive value

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

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

Currently, we have no concerns with the risk adjustment process.

ii. Retrospective risk adjustment

Hepatitis C Risk Corridor

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

High-Cost Drug Risk Pool

In SFY 2024, LDH maintained a risk pool for five high-cost drugs, all of which were one-time treatments exceeding $1 million per individual. In SFY 2025, the pool will expand to include FDA approved treatments meeting the following criteria. The individual drugs are not included in the rate certification because drugs meeting these criteria might be approved by the FDA during the rating period and added to the high-cost drug risk pool.

- FDA approved therapy
- Labeler participated in the Federal Rebate Program
- Durable and potentially curative cell and gene therapies (one-time use therapies)
- Estimated treatment cost of at least $2 million on a wholesale acquisition cost basis

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

To be counted toward the risk pool reconciliation, claims must have a valid National Drug Code (NDC) identifier corresponding to one of the drugs in the pool. Drugs delivered in an inpatient setting must be billed on a separate claim identifying the cost of the drug treatment (separately from any hospital per diem reimbursement) and must contain a valid NDC. Claims to be included in the risk pool must adhere to all standard LDH coverage and billing requirements. The risk pool is also limited to claims specifically for the delivery of the high-cost drug and does not include any other services that may be required as part of the course of treatment.

iii. Risk adjustment documentation

(a) Risk adjustment model

Since the last risk adjustment period, we have not made changes to the risk adjustment model.

(b) Budget neutrality

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

iv. Acuity adjustments

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

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

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

Section III. New Adult Group Capitation Rates

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

1. Data

A. DATA USED IN CERTIFICATION

Section I, subsection 2 of this report thoroughly describes the data used in developing actuarially sound SFY 2025 capitation rates for the Medicaid Expansion population.

B. 2021 EXPERIENCE VS. ASSUMPTIONS

Figure 28 illustrates a comparison of SFY 2024 estimated and actual member months for the Medicaid Expansion population. The actual SFY 2024 member months are based on observed member months from July 2023 through February 2024, adjusted to reflect enrollment changes through the remainder of the unwinding process. Using this method, actual member months were approximately 2% below estimated member months.

FIGURE 28: SFY 2024 PROJECTED VERSUS ACTUAL MEMBER MONTHS FOR THE MEDICAID EXPANSION POPULATION

POPULATION	ESTIMATED MEMBER MONTHS	ACTUAL MEMBER MONTHS	% DIFFERENCE
Medicaid Expansion	8,165,384	8,001,568	(2.0%)
Medicaid Expansion – Kick	13,996	14,837	6.0%
Composite	8,165,384	8,001,568	(2.0%)

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

Figure 29 illustrates a comparison of SFY 2024 estimated and actual benefit costs for the Medicaid Expansion population. On an aggregate basis, actual experience was approximately 4.6% below the estimated benefit expenses. Note that the actual benefit costs in the figure below are based on encounter data incurred from July to December 2023, paid through February 2024, and does not include any adjustments for encounter data completeness or IBNR.

FIGURE 29: SFY 2024 PROJECTED VERSUS ACTUAL BENEFIT COST PMPMS FOR THE MEDICAID EXPANSION POPULATION

POPULATION	ESTIMATED BENEFIT COST	ACTUAL BENEFIT COST	% DIFFERENCE
Medicaid Expansion	$ 491.66	$ 478.28	(2.7%)
Medicaid Expansion – Kick	$ 8,015.56	$ 7,476.32	(6.7%)
Composite	$ 515.75	$ 492.14	(4.6%)

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

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

2. Projected Benefit Costs

A. DESCRIPTION OF PROJECTED BENEFIT COSTS

i. Description of projected benefit costs

(a) Experience specific to newly eligible adults

SFY 2023 MCO experience for the Medicaid Expansion population comprised the underlying data used in the development of the SFY 2025 Medicaid Expansion capitation rates as outlined in Section I of this report.

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

The data sources, assumptions, and methodologies are consistent with the SFY 2024 certification with the exceptions outlined in Section I of this report.

(c) Assumption changes since last certification

SFY 2023 MCO experience was used as the underlying data source in the development of the SFY 2025 capitation rates. SFY 2022 MCO experience was used as the underlying data source for SFY 2024 capitation rates. Other assumptions are generally consistent with the SFY 2024 rate certification.

C. DESCRIPTION OF KEY ASSUMPTIONS

Adjustment for pent-up demand. Consistent with the SFY 2024 rate setting, it was assumed that the baseline experience data did not require these adjustments.

Adjustment for adverse selection. Consistent with the SFY 2024 rate setting, it was assumed that the baseline experience data did not require these adjustments.

*Adjustment for demographics of the new adult group***.** We believe the current rate cell structure of the Expansion population appropriately adjusts capitation payments to the extent the demographic mix of the Expansion population changes significantly during the SFY 2025 rate period.

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

D. CHANGES TO BENEFIT PLAN

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

E. OTHER MATERIAL CHANGES OR ADJUSTMENTS TO BENEFIT COSTS

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

3. Projected Non-Benefit Costs

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

MCO non-benefit costs were available for SFY 2024. We reviewed this information as we developed non-benefit cost assumptions as outlined in Section I, subsection 5 of this report. Figure 30 illustrates the non-benefit cost assumptions for the SFY 2024 and SFY 2025 Medicaid Expansion capitation rates. The quality values in this figure reflect the care management add-on in addition to the original quality allowance. Note the values here reflect a composite value across both the standard and kick payment rate cells for Medicaid Expansion.

FIGURE 30: NON-BENEFIT COSTS AS A PERCENTAGE OF LIMITED RATES FOR THE MEDICAID EXPANSION POPULATION

	ADMIN + QUALITY	PREMIUM TAX	RISK MARGIN	TOTAL NON-BENEFIT COSTS
SFY 2024 Rate	7.7%	5.5%	1.5%	14.7%
SFY 2025 Rate	7.0%	5.5%	1.5%	14.0%

B. ASSUMPTION DIFFERENCES RELATIVE TO OTHER MEDICAID POPULATIONS

Figure 31 provides the non-benefit expense assumptions for the Medicaid Expansion population and other Medicaid managed care populations for the SFY 2025 rates. The quality values in these figures reflect the care management add-on in addition to the original quality allowance.

FIGURE 31: NON-BENEFIT COSTS AS A PERCENTAGE OF LIMITED RATES

POPULATION	ADMINISTRATIVE EXPENSES	QUALITY	RISK MARGIN	TOTAL NON-BENEFIT COSTS
SSI	5.50%	1.50%	1.50%	8.50%
F&C	7.25%	1.75%	1.50%	10.50%
SBH	11.75%	3.00%	1.50%	16.25%
Medicaid Expansion	6.00%	1.50%	1.50%	9.00%
All Other Populations	6.00%	1.50%	1.50%	9.00%
Kick	2.75%	0.75%	1.50%	5.00%

4. Final Certified Rates

A. COMPARISON TO PREVIOUS CERTIFICATION

Figure 32 illustrates the changes in estimated member months and capitation rates from SFY 2024 to SFY 2025 rates. The SFY 2024 rates reflect the SFY 2024 capitation rate certification, dated June 23, 2023. All values reflect total expected payments, including directed payments and FMP payments. On an aggregate basis, the SFY 2024 rates are estimated to increase by approximately 9.6%.

FIGURE 32: COMPARISON OF SFY 2024 AND SFY 2025 MEMBERS AND RATES FOR THE MEDICAID POPULATION

POPULATION	ESTIMATED SFY 2024 MONTHLY MEMBERS	ESTIMATED SFY 2025 MONTHLY MEMBERS	% DIFFERENCE	SFY 2024 COMPOSITE STATEWIDE RATE	SFY 2025 COMPOSITE STATEWIDE RATE	% DIFFERENCE
Medicaid Expansion	8,165,384	6,906,512	(15.4%)	$ 752.20	$ 821.29	9.2%
Medicaid Expansion - Kick	13,996	14,841	6.0%	$ 19,879.90	$ 23,371.83	17.6%
Composite	**8,165,384**	**6,906,512**	**(15.4%)**	**$ 794.92**	$ 871.51	9.6%

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

B. DESCRIPTION OF OTHER MATERIAL CHANGES TO THE CAPITATION RATES

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

5. Risk Mitigation Strategies

A. DESCRIPTION OF RISK MITIGATION STRATEGY

The risk mitigation strategy for the Medicaid Expansion population is outlined in Section I, subsection 7 of this report. No additional risk mitigation strategies are in effect for the SFY 2025 rating period.

B. CHANGES TO RISK MITIGATION STRATEGY RELATIVE TO PRIOR YEARS

Consistent with the other Healthy Louisiana populations, the minimum medical loss ratio (MLR) requirement will remain at 85% for the SFY 2025 contract year. Other risk mitigation strategies are structurally consistent with the prior rating period, although LDH has made some adjustments to the drugs to be included in the high-cost drug risk pool. This is discussed further in Section 1, subsection 4.C.

Limitations

The information contained in this report has been prepared for the State of Louisiana, Department of Health (LDH) and their consultants and advisors to provide documentation of the development of the state fiscal year 2025 actuarially sound capitation rates for the populations served under the Healthy Louisiana Medicaid managed care program. The data and information presented may not be appropriate for any other purpose.

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

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

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to develop actuarially sound capitation rates for the state fiscal year 2025 rating period. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models rely on data and information as input to the models. We have relied upon certain data and information provided by LDH for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

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

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

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

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

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

APPENDIX 1: ACTUARIAL CERTIFICATION

State of Louisiana
Department of Health
Healthy Louisiana Medicaid Managed Care Program
State Fiscal Year 2025 Capitation Rates
Actuarial Certification

I, Anders Larson, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of Louisiana, Department of Health to perform an actuarial review and certification regarding the development of capitation rates for the Healthy Louisiana Medicaid managed care program effective July 1, 2024. I am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

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

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

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

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

The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with the State of Louisiana. The "actuarially sound" capitation rates that are associated with this certification are effective for state fiscal year 2025.

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

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

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

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

Anders Larson, FSA
Member, American Academy of Actuaries

June 21, 2024
Date

APPENDIX 2: RATE DEVELOPMENT (PROVIDED IN EXCEL)

APPENDIX 3: RATE CHANGE SUMMARIES (PROVIDED IN EXCEL)

APPENDIX 4: PARISH TO REGION MAPPING

State of Louisiana
Department of Health
Healthy Louisiana Medicaid Managed Care Program
State Fiscal Year 2025 Capitation Rate Certification
Appendix 4 - Parish Mapping

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

APPENDIX 5: COVERED POPULATIONS

State of Louisiana
Department of Health
Healthy Louisiana Medicaid Managed Care Program
State Fiscal Year 2025 Capitation Rate Certification
Appendix 5a - Covered Populations

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

State of Louisiana
Department of Health
Healthy Louisiana Medicaid Managed Care Program
State Fiscal Year 2025 Capitation Rate Certification
Appendix 5a - Covered Populations

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

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

State of Louisiana
Department of Health
Healthy Louisiana Medicaid Managed Care Program
State Fiscal Year 2025 Capitation Rate Certification
Appendix 5b - Excluded Populations

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

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Appendix 5b - Excluded Populations

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

APPENDIX 6: COVERED SERVICES

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Appendix 6 - Covered Services

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

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

APPENDIX 7: UNWINDING ACUITY (PROVIDED IN EXCEL)

APPENDIX 8: RETROSPECTIVE COST MODELS (PROVIDED IN EXCEL)

APPENDIX 9: PROSPECTIVE COST MODELS (PROVIDED IN EXCEL)

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

APPENDIX 11: ATTRIBUTION (PROVIDED IN EXCEL)

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