MILLIMAN CLIENT REPORT

January 2024 Healthy Louisiana Medicaid Managed Care Capitation Rate Amendment

State of Louisiana Department of Health

February 14, 2024

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

Paul Houchens, FSA, MAAA, Principal and Senior Consulting Actuary

Zach Fohl, FSA, MAAA, Senior Consulting Actuary

Amine Elmeghni, FSA, MAAA, Actuary

Jennifer Prather, Pharm D, Senior Pharmacy Management Consultant

Milliman

Milliman

Table of Contents

1. BACKGROUND 1
2. EXECUTIVE SUMMARY 2
   A. SUMMARY OF METHODOLOGY 2
   B. FISCAL IMPACT ESTIMATE 3
3. UNWINDING ACUITY ADJUSTMENT 5
4. OTHER PROGRAM CHANGE ADJUSTMENTS 8
LIMITATIONS 13
APPENDIX 1: ACTUARIAL CERTIFICATION
APPENDIX 2: RATE DEVELOPMENT (PROVIDED IN EXCEL)
APPENDIX 3: RATE CHANGE SUMMARIES (PROVIDED IN EXCEL)
APPENDIX 4: PROSPECTIVE COST MODELS (PROVIDED IN EXCEL)
APPENDIX 5: UNWINDING ACUITY ADJUSTMENT DETAIL (PROVIDED IN EXCEL)

1. Background

BACKGROUND

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

- *State Fiscal Year 2024 Healthy Louisiana Medicaid Managed Care Capitation Rate Certification*, dated June 23, 2023
- *State Fiscal Year 2024 Healthy Louisiana Medicaid Managed Care Capitation Rate Certification Amendment*, dated December 6, 2023

We have updated the January through June 2024 capitation rates that were provided in the amended SFY 2024 certification to incorporate updated acuity assumptions as a result of the public health emergency (PHE) unwinding process, hospital reimbursement changes, assertive community treatment (ACT) fee schedule increase, coverage of crisis services for children, single pharmacy benefit manager (PBM) updates, changes to the single preferred drug list (PDL), average manufacturer price cap removal, clotting factor reimbursement implementation delay, coverage of Paxlovid, increased community case management expenditures, and withhold documentation. The capitation rates in this amendment will be effective for the period January through June 2024. Unless otherwise stated, the methodology and assumptions utilized are consistent with the capitation rate documentation included in the amended SFY 2024 certification. The required actuarial certification is in Appendix 1.

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

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

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

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

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

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

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

2. Executive Summary

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

- *State Fiscal Year 2024 Healthy Louisiana Medicaid Managed Care Capitation Rate Certification Amendment*, dated December 6, 2023

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

- Updated acuity adjustments related to the PHE unwinding
- Out of state hospital reimbursement changes
- Assertive community treatment fee schedule update
- Coverage of crisis services for children
- Update single pharmacy benefit manager (PBM) pricing impact to reflect more recent drug mix
- Update single preferred drug list (PDL)
- Average manufacturer price cap removal
- Clotting factor reimbursement implementation delay
- Coverage of Paxlovid expenditures
- Increased community case management expenses
- Updated withhold documentation

In addition, we reviewed the impact of the following items and have determined that they have an immaterial impact to the January through June 2024 Healthy Louisiana (HLA) program capitation rates.

- American Indiana 638 facility rate update effective CY 2024
- Ambulatory surgical center reimbursement update effective March 20, 2024

Unless otherwise stated, the methodology and assumptions utilized are consistent with the capitation rate documentation included in the amended SFY 2024 certification.

A. SUMMARY OF METHODOLOGY

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

i. Step 1: Base experience

We used the projected claims data underlying the amended SFY 2022 capitation rates, as outlined in the amended SFY 2024 certification, as base experience for developing this capitation rate amendment. These projected claims costs are inclusive of all retrospective, prospective, trend, managed care efficiency, and other claims cost adjustments made to the data as outlined in the amended SFY 2024 certification.

ii. Step 2: Unwinding acuity adjustments

We adjusted the projected claims costs from January through June 2024 to reflect emerging enrollment data. Multiplicative adjustment factors were developed at the rate cell level and then applied consistently across regions and detailed service categories. The resulting values establish the adjusted claim costs by rate cell for January through June 2024. Documentation about the development of the multiplicative adjustment factors is provided in Section 3 of this report.

iii. Step 3: Other program change adjustments

We adjusted the projected claims costs from January through June 2024 to reflect other program and reimbursement changes that were not known at the time of the original certification or prior amendment. Multiplicative adjustment factors by rate cell, region, and detailed service category were developed for the changes. The resulting values establish the adjusted claim costs by rate cell for January through June 2024. Documentation about the development of the multiplicative adjustment factors is provided in Section 4 of this report. Multiplicative factors are used to reflect changes to existing covered services.

iv. Step 4: Incorporate non-claims items and adjustments

The amended capitation rates are modified to include the impact of certain non-benefit items, such as an administrative expense allowance, quality allowance, and risk margin. In particular, we have modified the administrative allowance for certain rate cells to account for higher community case management expenses resulting from a Department of Justice settlement. Aside from this adjustment, we have not modified the per member per month (PMPM) add-on for the administrative expense allowance and quality allowance due to the program changes discussed in Step 3. In addition, we have not modified the risk margin assumptions from the original certification (as a percent of the MCO limited capitation rate). The total non-benefit expenses are presented in Appendix 2 on a PMPM basis.

v. Step 5: Incorporate withhold documentation

The amended capitation rate certification is modified to include updated documentation of the withhold arrangement.

vi. Step 6: Issuance of actuarial certification

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

B. FISCAL IMPACT ESTIMATE

The amended capitation rates for the Medicaid managed care populations are illustrated in Figure 1. These rates are effective from January 1, 2024 through June 30, 2024. Figure 1 also provides a comparison to the amended effective capitation rates for July 1, 2023 through June 30, 2024. The rates are inclusive of directed payments and Full Medicaid Pricing (FMP) amounts. The composite rates illustrated for January 1, 2024 through June 30, 2024 have been developed based on an estimate of projected enrollment during that time period. This figure was developed using the rates including full risk for prescription drugs and does not reflect the pharmacy carve-out rates paid to Humana prior to the implementation of the single PBM in late October 2023.

FIGURE 1: COMPARISON WITH AMENDED JULY 2023 PMPM RATES

POPULATION	ESTIMATED JAN-JUN 2024 AVERAGE MONTHLY ENROLLMENT	COMPOSITE MCO EXPECTED PAYMENTS		
		AMENDED SFY 2024	AMENDED JAN 2024	% CHANGE
SSI	106,900	$1,976.03	$1,975.86	(0.0%)
F&C	784,900	381.88	386.81	1.3%
SBH	130,400	45.82	54.31	18.5%
Medicaid Expansion	628,200	748.88	755.50	0.9%
All Other Populations	27,200	1,234.84	1,225.18	(0.8%)
Maternity Kick – Expansion	1,200	19,921.28	19,653.09	(1.3%)
Maternity Kick – Non-Expansion	2,100	20,403.70	20,186.79	(1.1%)
Composite	**1,677,600**	**648.34**	**653.16**	**0.7%**

Notes: 1. Average monthly enrollment is rounded to the nearest hundred. Individual values are rounded and the composite row cannot be calculated precisely from the rounded values shown in this figure.

2. Amended SFY 2024 and amended January-June 2024 composite rates were developed based on the January through June 2024 projected monthly enrollment. This figure reflects capitation rates with full risk for prescription drugs and does not reflect the pharmacy carve-out rates paid to Humana prior to the implementation of the Single PBM in late October 2023.

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

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

	TOTAL MCO EXPECTED PAYMENTS		
POPULATION	**AMENDED SFY 2024**	**AMENDED JAN 2024**	**CHANGE**
SSI	$ 1,267.5	$ 1,267.4	($ 0.1)
F&C	1,798.5	1,821.7	23.2
SBH	35.8	42.5	6.6
Medicaid Expansion	2,822.6	2,847.6	25.0
All Other Populations	201.3	199.7	(1.6)
Maternity Kick – Expansion	139.5	137.6	(1.9)
Maternity Kick – Non-Expansion	260.6	257.8	(2.8)
Composite	**$ 6,525.8**	**$ 6,574.3**	**$ 48.5**
Federal	**$ 5,077.5**	**$ 5,115.4**	**$ 38.0**
State	**$ 1,448.4**	**$ 1,458.9**	**$ 10.5**

Notes:
1. Individual values are calculated using unrounded values. Therefore, the dollar amounts cannot be calculated precisely from the rounded values shown in Figure 1.
2. Amended SFY 2024 and amended January-June 2024 composite rates were developed based on the January through June 2024 projected monthly enrollment. This figure reflects capitation rates with full risk for prescription drugs and does not reflect the pharmacy carve-out rates paid to Humana prior to the implementation of the Single PBM in late October 2023.
2. State expenditures based on Federal Fiscal Year (FFY) 2024 FMAP of 67.67% 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.

3. Unwinding acuity adjustment

This section describes the methodology used to update the unwinding acuity adjustment.

The first disenrollments related to the PHE unwinding occurred on July 1, 2023. Based on discussions with LDH, the unwinding process is expected to be randomized over the 12-month review process. Since the development of the SFY 2024 HLA capitation rates, we received emerging data from LDH related to the specific members that have been reviewed for July, August, and September 2023 and the result of the redetermination for each member (renewal package not returned, death, does not meet Medicaid eligibility requirement, SSA disability denial, deemed eligible, etc.).

Based on the emerging unwinding data received, we assessed the enrollment changes for the rate cells that experienced the greatest membership decline during the unwinding process. Based upon our review of the data, we believe that the average acuity of the Medicaid Expansion 19-64, F&C Child 1-20 Years, and F&C Adult 21+ rate cells during SFY 2024 will be materially different from the assumptions in the amended SFY 2024 capitation rates. We believe that for all other rate cells the population morbidity will be relatively similar to the assumptions in the amended SFY 2024 capitation rates.

To estimate the unwinding acuity, we allocated the enrollment into the following cohorts: SFY 2022 enrollment, growth members, disenrolled members, returners, stayers, joiners. To estimate the number of members and the relative acuity of each cohort, we reviewed information provided by LDH that provided details on the members that were reviewed and the redetermination reason for the first three months of 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. To calculate the average acuity, we created a relativity for each cohort and rate cell combination based on the individual's redetermination reason and SFY 2022 experience for each member reviewed during the first three months of the unwinding process. These cohorts and their relative acuity level are described in more detail below. Additional detail on the factors and enrollment estimates are provided in Appendix 5.

- **SFY 2022 enrollment.** This cohort reflects the average monthly enrollment by rate cell during SFY 2022. We set the relative acuity for this cohort to 1.00 because this cohort aligns with the base data period.
- **Growth members:** This cohort reflects the members driving the enrollment increase from SFY 2022 to June 2023. These are members who *would have been disenrolled* during this period if the continuous provisions of the PHE had not been in effect. The relative acuity for this cohort is equal to the acuity of the members that are anticipated to disenroll during the unwinding process and not return to the Healthy Louisiana program during SFY 2024. We estimated that the relative acuity for this cohort will be 0.70 for F&C children 1-20, 0.61 for F&C adults 21+, and 0.74 for Medicaid Expansion 19-64.
- **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 disenroll from Medicaid because of death. We estimated that the relative acuity, based on SFY 2022 incurred claims experience, for this cohort will be 0.75 for F&C children 1-20, 0.65 for F&C adults 21+, and 0.75 for Medicaid Expansion 19-64.
- **Returners:** This cohort reflects members that have been or will be disenrolled during the unwinding process, but who will reenroll during SFY 2024. 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 we only had three months of unwinding data available, data for this cohort is limited, and therefore a great deal of actuarial judgement was required to set the average acuity for this cohort. We estimated that the relative acuity for this cohort will be 95% of the acuity of members that were not disenrolled during the unwinding process (the June 2024 stayer cohort) for each rate cell.
- **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). We estimated the relative acuity of this population by stratifying enrollment within each rate cell into members that joined during COVID-19 PHE and members that were enrolled prior to the COVID-19 PHE. Based on our review, we estimated that the relative acuity for this cohort will be equal to 90% of the acuity of members that were not disenrolled during the unwinding process (the June 2024 stayer cohort) for each rate cell.
- **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.

The key acuity assumptions described above are shown in Figure 3 by rate cell and cohort.

FIGURE 3: KEY ACUITY ASSUMPTIONS BY RATE CELL AND COHORT

RATE CELL	GROWTH MEMBERS	DISENROLLEES	JUNE 2024 STAYERS	RETURNERS	JOINERS
Formula	(a)	(b)	(c)	(d) = (c) x 95%	(e) = (c) x 90%
Medicaid Expansion 19-64	0.74	0.75	1.10	1.05	1.00
F&C Child 1-20 Years	0.70	0.75	1.05	1.00	0.95
F&C Adult 21+	0.61	0.65	1.15	1.10	1.05

Note: Values are rounded.

Step 1: Calculate the average relative acuity as of June 2023 by rate cell

To calculate the average relative acuity as of June 2023, we took a weighted average of the average acuity of the SFY 2022 enrollment cohort and the growth member cohort (the enrollment increase from SFY 2022 to June 2023). Since the average acuity of the SFY 2022 enrollment population was assumed to be 1.00 and the average acuity of the growth members was less than 1.00, the average acuity as of June 2023 for each of these three rate cells was less than 1.00.

Step 2: Estimate the monthly disenrollment by rate cell

To estimate the monthly unwinding-related disenrollment by rate cell, we reviewed the member ID and redetermination reason provided by LDH for the first three months of the unwinding process. In addition, we also reviewed the monthly unwinding review plan provided by LDH to determine the number of members by rate cell that were going to be reviewed in each month of the unwinding process. Based on the observed disenrollments in the first three months of the unwinding process, we developed an assumption for the percentage of reviewed members who would be disenrolled each month, which we assumed would be constant throughout SFY 2024. Additionally, we projected the number of monthly deaths based on historical mortality rates for each rate cell.

Step 3: Estimate the monthly acuity for members retaining Medicaid eligibility by rate cell

The average projected monthly acuity for members that retain Medicaid eligibility throughout the unwinding process can be calculated directly based on the number of members that are disenrolled and the average acuity of the members as of June 2023. Since the selection process for reviews was randomized by LDH, we have assumed that all members disenrolled during the unwinding process by rate cell would have the same relative acuity. Additionally, based on a review of actual experience, we anticipate the members that will be disenrolled during the unwinding process will be healthier than the members that retain coverage. Additional detail on the calculation of the monthly stayer acuity by rate cell can be found in Appendix 5.

Step 4: Project the monthly returner enrollment

To estimate the number of members that are anticipated to return to Medicaid after being initially disenrolled during SFY 2024, we reviewed the experience for each rate cell during the first three months of the unwinding process. We then compared the experience observed during the first three months of the unwinding process to the return pattern observed during CY 2019 for each rate cell. Using this information, we projected the percentage of individuals that would return to Medicaid by month and rate cell. 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. Therefore, the return percentage by rate cell for each month within the first 90 days of disenrollment was set to the same percentage, which reflects cumulative re-enrollment over that time period.

Step 5: Project the monthly joiners

To estimate the number of members that are anticipated to join Medicaid during the unwinding process, we reviewed recent experience. We identified the average monthly members in July through September 2023 who were new to Medicaid and did not have any eligibility during the COVID-19 public health emergency. We have assumed that individuals will continue to enroll at a similar rate during the unwinding process as they did during the end of the COVID-19 public health emergency.

Step 6: Calculate the average monthly acuity during SFY 2024

Based upon the information gathered in the previous steps, we compiled the estimated monthly enrollment and projected acuity for each cohort. The average SFY 2024 acuity for each rate cell was then calculated directly as weighted average of the monthly acuity factors in each cohort during SFY 2024.

Step 7: Calculating the unwinding acuity adjustment factor

The last step of the process is to calculate the unwinding acuity adjustment factor to be included in the amendment. The adjustment factor included in Appendix 5 accounts for the incremental capitation revenue that needs to be added to the January through June 2024 HLA capitation rates to reflect the changes in the SFY 2024 unwinding acuity adjustment factor between our original certification and this amendment. In aggregate, this adjustment increases the projected January through June 2024 projected expenditures by approximately $74 million, based on updated projected enrollment for this rating period. Figure 4 below provides the original SFY 2024 unwinding acuity factor, the updated SFY 2024 unwinding acuity factor, and the required January through June 2024 adjustment factor based upon emerging experience by rate cell.

FIGURE 4: COMPARISON WITH ORIGINAL AND UPDATED SFY 2024 UNWINDING ACUITY FACTORS

RATE CELL	ORIGINAL SFY 2024 ACUITY FACTORS	UPDATED SFY 2024 ACUITY FACTORS	JAN-JUNE 2024 ADJUSTMENT FACTOR
Medicaid Expansion 19-64	1.0139	1.0257	1.0251
F&C Child 1-20 Years	1.0083	1.0132	1.0099
F&C Adult 21+	1.0000	1.0532	1.1118

Note: Values are rounded.

4. Other program change adjustments

This section describes the other program and reimbursement changes that became effective during the rate period that were not known at the time of the amended SFY 2024 certification. The impact on the total capitation rate by rate cell (including the acuity adjustment) can be found in Appendix 3.

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 July 1, 2021 through June 30, 2022 (SFY 2022), which represented the base data time period for SFY 2024 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 2024. 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 $55 million.

We then multiplied the total SFY 2024 fiscal impact by approximately 0.78 to reflect that the reimbursement would be effective on September 20, 2023 (approximately $43 million) and applied to the January through June 2024 time period. Lastly, to account for the months prior to the effective date of this amendment during which these reimbursement changes were effective, we incorporated an adjustment such that the total SFY 2024 dollar value of the reimbursement changes relative to the original certifications is included in the capitation rates that will be paid from January through June 2024. This adjustment is reflected in the Inpatient Hospital service category of the prospective cost models.

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 two fee schedule effective dates. To account for the months prior to the effective date of this amendment during which these reimbursement changes were effective, we incorporated an adjustment such that the total SFY 2024 dollar value of the reimbursement change is included in the capitation rates that will be paid from January through June 2024. This adjustment is reflected in the Other SBH service category of the prospective cost models.

Coverage of crisis services for children

Effective April 1, 2024, LDH anticipates adding 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 from April 1, 2024 through June 30, 2024 will be approximately $0.6 million. The impact of this programmatic change is reflected in the Other SBH service category in the prospective cost models.

Update single PBM pricing impact to reflect more recent drug mix

As of October 28, 2023, the managed care organizations (MCOs) participating in the HLA program are required to use a single PBM. The single PBM was expected to affect drug reimbursement in several ways, including changes to contractual discounts (separately for local and non-local pharmacies), changes to the clotting factor reimbursement methodology, and shifts for certain drugs from the retail pharmacy benefit to the medical benefit. In our original certification, we modeled the impact of these items on our base period of SFY 2022. In that certification, we estimated these items would decrease benefit expenses by approximately $12 million.

Since the original certification, we have continued to monitor drug utilization and costs. We observed that the mix of drugs has changed since SFY 2022 such that the net impact of the single PBM contractual discounts will differ materially. For this amendment, we recalculated the impact of the single PBM contractual discounts using data from the October 2022 through September 2023 time period. Using this time period, the impact of the single PBM contractual discounts on SFY 2024 benefit expenses was an approximately $8 million increase to benefit expenses relative to our original certification. We incorporated an adjustment in the amended rates to reflect this incremental cost relative to the original certification.

Note that we separately modeled the impact of the delay in the clotting factor reimbursement change, which is discussed in a later sub-section of this amendment.

January 2024 single PDL updates

The single PBM uses a preferred drug list (PDL) maintained by LDH. We adjusted the benefit expenses underlying the SFY 2024 capitation rates to reflect the expected drug mix changes based upon the anticipated PDL updates effective January 1, 2024. 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 compared to the PDL effective January 1, 2024. For each product name, we estimated the projected January through June 2024 market share based upon the PDL changes effective January 1, 2024.

The net impact to pharmacy expenditures as a result of the January 2024 PDL changes is a decrease to the projected January through June 2024 expenditures of approximately $11 million, which is reflected in the Retail Pharmacy service category in the prospective cost models. The drug categories with the largest impact are summarized below.

- ***Stimulants and Related Agents –*** Lisdexamfetamine tabs and chew tabs (the generic for Vyvanse®) will move to preferred status with brand Vyvanse® also remaining as a preferred drug. We anticipate the utilization to begin to shift to the generic formulation while assuming most brand utilization will remain due to ongoing drug shortages and the brand formulation still being available as a preferred option.
- ***Glucocorticoids, Inhaled –*** Fluticasone HFA (the generic for Flovent HFA®) will move to preferred status. The brand Flovent HFA® has notified the FDA their intention to discontinue producing the product effective 12/31/2023. We anticipate the majority of the utilization will shift to the preferred generic fluticasone, with a small amount shifting to a different brand drug within the same class.
- ***Otic Agents, Antibiotics –*** Ciprofloxacin/dexamethasone otic suspension (the generic for Ciprodex®) will move to preferred status. The brand manufacturer has notified the FDA they have discontinued manufacturing Ciprodex® effective September 2023. We anticipate all utilization will move to the preferred generic formulation.
- ***Bronchodilators, Beta Agonist –*** The authorized generic albuterol HFA (the generic for Ventolin HFA®) will move to non-preferred status. We anticipate the majority of utilization will move to brand Ventolin HFA®.

Average manufacturer price cap removal

Effective January 1, 2024, provisions of the American Rescue Plan Act will no longer cap 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 price reduction of at least 15% between July 2023 and January 2024 based upon published prices as of January 3, 2024. We acknowledge that instead of reducing prices, some manufacturers may discontinue certain drugs as a result of these legislative changes. As discussed above, the impact of discontinued drugs is included in the single preferred drug 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 fiscal impact to pharmacy expenditures as a result of the AMP cap removal is decrease to the projected January through June 2024 expenditures of approximately $10 million, which is reflected in the Retail Pharmacy service category in the prospective cost models. The drugs with the largest impact are Advair, Symbicort, and Victoza.

Clotting factor reimbursement implementation delay

The original SFY 2024 HLA rate certification anticipated that clotting factor reimbursement methodology would change as a result of the single PBM implementation, which was expected to occur on October 1, 2023. This change in methodology was projected to reduce expenditures by approximately $8 million over the remaining nine months in SFY 2024. Based upon guidance provided by LDH, the clotting factor reimbursement methodology update is anticipated to be delayed until February 1, 2024. The fiscal impact to pharmacy expenditures as a result of the clotting factor reimbursement delay is to the projected January through June 2024 expenditures of approximately $3 million, which is reflected in the Retail Pharmacy service category in the prospective cost models.

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 effective November 2023. We estimated the fiscal impact based on utilization of Paxlovid in the period October 2022 through September 2023, with an assumed average treatment cost of approximately $1,396. The fiscal impact to pharmacy expenditures as a result of covering Paxlovid treatments in November 2023 is an increase to the projected January through June 2024 expenditures of approximately $7 million, which is reflected in the Retail Pharmacy service category in the prospective cost models.

Community case management expenses

As a result of an agreement between LDH and the Department of Justice[2], 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 have increased sharply in recent months and materially exceed the expectations in SFY 2024 capitation rate development. We estimate the cost of providing community case management to the DOJ Agreement Target Population during SFY 2024 will increase the HLA non-benefit expenses by approximately $4 million compared to original rating assumptions. This adjustment is reflected as a non-benefit expense add-on in Appendix 2.

Withhold documentation

This section describes changes to the withhold arrangement effective during SFY 2024. The information has been presented consistently with requirements in the managed care rate setting guide, similar to Section 1, subsection 4.B. of the original certification. Some information has been repeated from the original certification for completeness.

B. WITHHOLD ARRANGEMENTS

i. Rate development standards

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

[2] Department of Justice Agreement Compliance Guide, published by Louisiana Department of Healthy at https://ldh.la.gov/assets/medicaid/DOJ/DOJ_Agreement_Compliance_Guide_2023-07-26.pdf

ii. Appropriate documentation

(a) Withhold description

(i) Time period

LDH has suspended the withhold arrangement in the Healthy Louisiana program for the period of July 1, 2023 through December 31, 2023. LDH will restart the withhold program in the Healthy Louisiana program effective January 1, 2024.

(ii) Enrollees, services, and providers

The withhold arrangement when effective 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. The withhold was suspended for the period of July 1, 2023 through December 31, 2023 to mitigate concerns with reporting, enrollment, single PBM implementation, and other operational items. The MCOs were still required to comply with quality, value-based payments (VBP), and health equity reporting as outlined in the MCO contract.

(iv) Percentage withheld

Effective January 1, 2024 the withheld percentage will be 2.0% of the limited rate (i.e., excluding FMP and directed payments) for all rate cells except maternity kick payments.

Quality and health outcomes will account for 1.0% of the withhold, 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.

Limitations

The services provided for this project were performed under the contract between Milliman and LDH.

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

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

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

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

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

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

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

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

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

APPENDIX 1: ACTUARIAL CERTIFICATION

State of Louisiana
Department of Health
Healthy Louisiana Medicaid Managed Care Program
Amended January through June 2024 Capitation Rates
Actuarial Certification

I, Anders Larson, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of Louisiana, Department of Health to perform an actuarial review and certification regarding the development of capitation rates for the Healthy Louisiana Medicaid managed care program effective January 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 reflect an amendment to the state fiscal year 2024 capitation rates, originally certified on June 23, 2023 and a subsequent amendment dated December 6, 2023.

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

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

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

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

Anders Larson, FSA
Member, American Academy of Actuaries

February 14, 2024
Date

APPENDIX 2: RATE DEVELOPMENT (PROVIDED IN EXCEL)

APPENDIX 3: RATE CHANGE SUMMARIES (PROVIDED IN EXCEL)

APPENDIX 4: PROSPECTIVE COST MODELS (PROVIDED IN EXCEL)

APPENDIX 5: UNWINDING ACUITY ADJUSTMENT DETAIL (PROVIDED IN EXCEL)

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

milliman.com

© 2024 Milliman, Inc. All Rights Reserved. The materials in this document represent the opinion of the authors and are not representative of the views of Milliman, Inc. Milliman does not certify the information, nor does it guarantee the accuracy and completeness of such information. Use of such information is voluntary and should not be relied upon unless an independent review of its accuracy and completeness has been performed. Materials may not be reproduced without the express consent of Milliman.