Mercer

Louisiana Coordinated System of Care Rate Certification

Effective January 1, 2022 through December 31, 2022

Louisiana Department of Health
December 29, 2021

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

Subject: State of Louisiana's Coordinated System of Care — Rate Development and Actuarial Certification for the Period January 1, 2022 through December 31, 2022

December 29, 2021

Dear Mr. Cocran:

The State of Louisiana's (State) Department of Health (LDH) has contracted with Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, to develop actuarially sound[1] capitation rates for the period of January 1, 2022 through December 31, 2022, or calendar year 2022 (CY 2022), for behavioral health (BH) services provided to the coordinated system of care (CSoC) population through a pre-paid inpatient health plan (PIHP).

The State developed a CSoC to serve children and youth with significant BH needs who are in or at imminent risk of out-of-home placement. The CSoC is administered statewide on an at-risk basis by Magellan Health. CSoC individuals have been eligible for additional services under the 1915(c) or 1915(b)(3) waiver authorities since the program's inception.

This letter presents an overview of the methodology used in Mercer's managed care rate development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS). This rate development process primarily relied upon encounter data provided by LDH and submitted by Magellan Health. CSoC recipients are eligible to receive services covered under the Healthy Louisiana (HLA) program in addition to the CSoC covered services, including psychiatric residential treatment facility, therapeutic group home, and residential substance use disorder (SUD) services. Magellan Health continues to administer the remaining specialized BH services for this population.

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

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

Services covered under the HLA program are excluded from capitation rates. The capitation rate is summarized in Appendix A and represents payment in full for the covered services.

Rate Change Compared to CY 2021 Rate

There is no rate change from the January 2021 through December 2021 contracted rate to the January 2022 through December 2022 contracted rate. This is primarily driven by reduced prospective trend factors that are offset by the update of the wraparound agency per member per month (PMPM) add-on. The following report provides additional detail related to this rate change.

Contents

1

General Information

Overview

Capitation rates for the CSoC program were developed in accordance with rate-setting guidelines established by CMS. For rate range development, Mercer used CY 2019 encounter data provided by Magellan. All data was reported on an incurred basis and included payment dates through June 30, 2020. Restrictions were applied to the enrollment and claims data, ensuring it was appropriate for the populations and benefit package defined in the contract.

Mercer reviewed the data provided by LDH and Magellan for consistency and reasonableness and determined the data was appropriate for the purpose of setting capitation rates for the CSoC program.

Adjustments were made to the selected base data to match the covered populations and CSoC benefit packages for CY 2022. Additional adjustments were then applied to the base data to incorporate:

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

The resulting rates for the CSoC rate cell were developed net of graduate medical education (GME) payments to teaching hospitals provided in the Louisiana Medicaid State Plan.

CSoC Populations

This section describes the covered populations of the CSoC contract as they are reflected in the capitation rate development.

The CSoC brings together the LDH, the Department of Children & Family Services, the Department of Education, the Office of Juvenile Justice, and the Governor's Office, as well as family, youth, and advocate representatives, to establish a service delivery system that is better integrated, has enhanced service offerings, and achieves improved outcomes. Children and youth eligible for CSoC are those who have significant BH challenges and are in or at-risk of out-of-home placement.

Children and families enrolled in CSoC are eligible to receive services under 1915(c) and 1915(b)(3) waiver authorities as further described below. The CSoC program covers children and youth who meet the eligibility requirements and choose to enroll in the voluntary program.

The base data set is comprised of the CSoC Children Ages 5–20 rate cell.

The rate cell structure is summarized based on a combination of category of aid (COA), type case, and Medicare eligibility status from the Louisiana Medicaid data. CSoC eligible members have one of the below COA/type case combinations, plus Waiver Segment 200 (1915(c) waiver), 202 (1915(b)(3) waiver), or 214 (presumptive eligibility prior to (b)(3) or (c) waiver designation).

Table 1: Rate Cell Structure by COA, Type Case, and Medicare Eligibility Status from the Louisiana Medicaid Data

COA	COA Description	Type Case Codes
02	Blind	078
03	Families and Children	001, 007, 008, 013–015, 055, 134, 151, 210
04	Disabled	059, 065, 070, 076–078, 133, 211
06	Office of Community Services (OCS) Foster Care	014, 030, 078
08	IV-E OCS/Office of Youth Development (OYD)	029, 031, 078
13	Lower income families with children	001, 009
22	OCS/OYD (XIX)	014
40	CSoC Level of Need Individual	200
02	Blind	078
03	Families and Children	001, 007, 008, 013–015, 055, 134, 151, 210
04	Disabled	059, 065, 070, 076–078, 133, 211
06	OCS Foster Care	014, 030, 078
08	IV-E OCS/OYD	029, 031, 078

Note: Aid Category 04 with Type Cases 070, 076, or 077 and with Waiver Segment Code 200 are not allowed as these populations are eligible for other State waiver programs.

Covered Services

Services are classified based on the criteria outlined in Table 2. Please refer to the CSoC contract for the full scope of required services.

Claims Data

The paid claims for the specialized BH services are summarized by category of service (COS) using the criteria shown in Table 2.

Table 2: COS Definitions

COS	Criteria	Units
Inpatient	Revenue codes 0100–0214 (with BH provider types and specialties) or Provider Type 64 or 69 with Place of Service = 21 or 51 Note this includes acute detox services provided in a BH facility.	Days
Emergency Room (ER)	Provider Type 64, 69, or professional claims with Provider Specialty 26, 27 with Place of Service = 23, procedure codes 99281–99285 or revenue codes 450, 459, or 981	Visits
Outpatient	Revenue Codes 0510, 0905, 0906, 0912, 0914, 0915, 0916 (with BH provider types and specialties) or Provider Type 64 or 69 with Place of Service not 21, 23, 51	Claims
Crisis Intervention	Procedure Codes S9485, H2011	Units
Community Psychiatric Support	Procedure Code H0036	Units
Assertive Community Treatment (ACT)	Procedure Code H0039	Units
Addiction Services (excluding SUD Residential)	Procedure Codes H0001, H0004, H0005, H0010, H0011, H0012, H0015, H2034, H2036	Units
Medical Physician/ Psychiatrist/Nurse Practitioner	Provider Types 19, 20, 78, 93, 94 with Provider Specialty 26, 27	Claims
Psychosocial Rehabilitation	Procedure Code H2017	Units
Other Professional (Mental Health [MH] Providers and Clinics, Nurses and Other Licensed Providers)	Provider Types 12, 18, 31, 33, 38, 56, 68, 73, 74, 77, AG, AH, AJ, AK	Claims
Federally Qualified Health Center (FQHC)	Procedure Code T1015 or Provider Type 72 with any BH specialist servicing provider (Provider Types 19, 20, 78, 93, 94 with Provider Specialty 26, 27, or Provider Type 31 any specialty)	Claims

COS	Criteria	Units
Other	Unclassified provider types delivering MH services authorized by the PIHP	Claims
Services Delivered under 1915(c) or 1915(b)(3) Waiver Authority		
Parent Support	Procedure Code S5110	Units
Respite	Procedure Code S5150 or Provider Type 83	Units
Youth Support	Procedure Code H0038	Units
Independent Living Skills	Procedure Code H2014	Units

Additional services, such as SUD residential addiction services, psychiatric residential treatment facility, and therapeutic group home, are accessed by CSoC eligible members, but administered under the separate HLA program. Multi-systemic treatment is not a covered service for this program.

The PIHP will be required to provide additional administrative functions, such as treatment planning for the identified populations in the contract under regulatory authority 42 CFR 438.208(c). Separate consideration will be included as part of the final payment rate calculation.

Medicare Crossover Claims

For dually eligible individuals, Medicare crossover claims (claims that include primary payment from Medicare) for Inpatient, Outpatient, ER, and Professional services are excluded from the base data. These services were paid directly by the State after coordinating with Medicare and will be excluded from managed care payment rates under this program.

In order to exclude Medicare crossover claims from the data book, Mercer identified claims submitted to the State with a non-zero Medicare Paid field. This includes claims with a Medicare qualifying Electronic Media Claim submitter ID and claim format 837-I (Institutional) or 837-P (Professional), as well as hard copy claims with an Explanation of Benefits attached from Medicare.

2
Base Data Development

Overview

For the CSoC program rate development, Mercer used CY 2019 data from the following sources:

- The claims data was submitted by the PIHP, Magellan, who has been administering this CSoC program for the State.
  - CSoC recipients are eligible to receive certain services through the HLA program in addition to the CSoC covered services. Services covered under the HLA program are excluded from these rates.
- The eligibility information used in the claims data analysis is summarized from the State's eligibility file provided by LDH's fiscal agent, which outlines the PIHP enrollment segments for each member enrolled during a month.

All data was reported on an incurred basis and included payment dates through June 30, 2020. Restrictions were applied to the enrollment and claims data so it was appropriate for the populations and benefit package defined in the contract.

Mercer reviewed the data provided by LDH and Magellan for consistency and reasonableness and determined the data was appropriate for the purpose of setting capitation rates for the PIHP program.

IBNR

Capitation rates were developed using claims data for services incurred in CY 2019 and reflects payments processed through June 30, 2020. Mercer developed IBNR factors for encounters incurred in CY 2019 in order to incorporate consideration for any outstanding claims liability. This adjustment resulted in an overall aggregate increase of 0.38%.

Table 3: IBNR Factors

Completion COS	CY 2019
Inpatient	1.0031
Outpatient	1.0075
Parent Support	1.0004
Youth Support	1.0005
Independent Living Skills	1.0023
Total	**1.0038**

Non-Claims and Financial Reporting Adjustments

Non-claims and financial reporting adjustments were developed by comparing encounter data from the Medicaid Management Information System (MMIS) to financial information provided by Magellan. This adjustment resulted in an overall aggregate increase of 2.81% to the overall aggregate CY 2019 expenses.

Prescription Rebates

Prescription benefits are not a covered service for this CSoC program, so no adjustment was applied with respect to prescription rebates.

Third-Party Liabilities

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

Fraud and Abuse Recoveries

Magellan included fraud and abuse recoveries in the reported claims data within their financial reports. These recoveries were included in the development of the under-reporting adjustment. Therefore, no further adjustment was needed for CY 2019.

Member Cost Sharing

Member cost sharing is limited to co-payments for prescription drugs. Since pharmacy benefits were not included in this CSoC program, no additional adjustment is necessary.

Disproportionate Share Hospital Payments

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

3
Base Rating Adjustments

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

Program changes that occurred during the base data period are referred to as base rating adjustments.

Fee Schedule Changes

The capitation rates reflect changes in covered services' fee schedules and unit costs that became effective during the base period.

Licensed Mental Health Professionals/Outpatient Services

Effective July 1, 2019, Magellan increased payments for licensed mental health professionals (LMHP)/outpatient services.

In order to increase access and delivery of outpatient services provided by LMHP, reimbursement for all outpatient services was increased by 25.0% for all LMHP. This adjustment resulted in an overall aggregate increase of 0.5% to the overall projected costs. The impact varies from the 25.0% adjustment mentioned previously, as the adjustment is limited to LMHP services and is only applied for the first half of the CY 2019 base data time period.

Short-Term Respite

Effective July 1, 2019, Magellan increased payments for short-term respite. In order for children who are in or at imminent risk of out-of-home placement to successfully live at home, stay in school, and reduce involvement in the child welfare and juvenile justice systems, it is imperative to provide access to short-term respite services throughout the State.

To increase access for short-term respite and offset provider costs, Magellan increased the previous rate of $3.90 per 15 minutes to $6.50 per 15 minutes. This adjustment resulted in an overall aggregate increase of 23.5% to the Respite COS line, and 1.9% to overall projected costs. This adjustment is only applied for the first half of the CY 2019 base data year.

Efficiency Adjustments

Mercer distinguishes efficiency adjustments (which are applied to previously managed populations) from managed care savings adjustments (which are applied to previously unmanaged populations). Mercer reviewed the program for efficiency adjustments and found it to be consistent with LDH's goal

that the CSoC program must be operated in an efficient, high-quality manner. As such, no efficiency adjustments were applied.

In-Lieu of Services

The costs in the base data reflect costs for State Plan services delivered in a managed care environment. No in-lieu of services are currently provided to the CSoC population.

Institutions for Mental Diseases

No adjustments were applied to services delivered in freestanding psychiatric facilities because the CSoC population is limited to individuals between the ages of 5 years–20 years. This logic is consistent with Institutions for Mental Diseases exclusion criteria. Additionally, no adjustments were necessary for SUD residential services, as they are not covered under the CSoC program.

4

Prospective Rating Adjustments

Prospective rating adjustments recognize the impact of new benefits or other changes not reflected or not fully reflected in the base period. CMS requires the rate-setting methodology used to determine actuarially sound rates incorporate the results of any program changes that have taken place, or are anticipated to take place, between the start of the base data period and the conclusion of the contract period. The overall impact of all program changes (both prospective and historic) is further illustrated in Appendix B.

Inpatient Fee Schedule Change

Inpatient claims were adjusted to reflect changes in the fee schedule between the base period and the contract period, using the fee schedule effective January 1, 2021. The non-GME portion of the per diems were used in this fee adjustment process to be consistent with LDH's intention to continue paying GME amounts directly to the teaching hospitals. This adjustment resulted in an overall aggregate increase of 15.5% to the Inpatient COS line and an increase of 2.2% to overall projected costs.

Medication Assisted Treatment

Effective January 2020, CSoC covered medication assisted treatment (MAT) provided by credentialed opioid treatment program (OTP) providers. The benefit will include both MAT and non-emergency medical transportation for Medicaid beneficiaries. OTP provider reimbursement will be based on a daily/weekly all-inclusive rate, which includes drug dispensing and ingredient costs, counseling, evaluation and management visits, urine drug screening, and any other services required or provided.

Mercer leveraged projected costs and utilization provided by the State for Medicaid enrollees in the HLA program. Projected HLA expenses were distributed to detailed populations based on historic prevalence of opioid abuse diagnoses. As MAT is expected to be available to CSoC enrollees, Mercer leveraged the adjustment made to the HLA Supplemental Security Income Child population. The resulting add-on for the CSoC population is $0.16 PMPM, which is a 0.02% increase to the medical component of the capitation rate.

5
Projected Benefit Costs

COVID-19

The ongoing impact to CSoC utilization in CY 2022 is somewhat uncertain as a result of the COVID-19 public health emergency (PHE). While Mercer expects utilization of some services may decrease, there is also potential that severity of services utilized will increase. Given the overall uncertainty for this population, explicit adjustments related to the COVID-19 PHE were not considered in the CY 2022 base capitation rate development. Mercer did consider adjustments to the CSoC trend development for certain categories of service to reflect expectations of prolonged impacts due to the PHE.

Medical Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the cost of providing health care services in a future period. Mercer studied historical cost and utilization data based on encounter data. Trends were selected based on historic CSoC experience, financial reports provided by Magellan for 2020 Q2 year-to-date, and national trend information.

In developing the trend projections, Mercer reviewed historic utilization and unit cost trend patterns for CSoC eligible members. Trends were analyzed on a Statewide basis by inpatient, outpatient, and 1915(c) waiver services. Mercer observed the following trend patterns:

- Inpatient services have historically shown moderate upward utilization trend, which has continued through CY 2020.
- Outpatient services showed declines in utilization beginning in early CY 2020 which were accelerated due to the PHE and have not yet experienced a recovery to pre-PHE experience.
- Parent support and youth support services both showed significant growth during CY 2019 and early CY 2020, but have been impacted as a result of the PHE and have not fully returned to pre-PHE experience.
- Respite services experienced a large utilization increase throughout CY 2019, likely driven by the increase in the fee schedule for these services. Growth for respite services was slowed due to the PHE, but has since recovered and exceeded pre-PHE levels.
- Independent living skills show low to moderate trend increases due to higher utilization throughout the base period, with a large drop-off during the PHE period. The emerging experience is showing utilization of independent living skills still running beneath pre-PHE levels.

Trend assumptions include both a unit cost and utilization component. The unit cost trend component of the PMPM trends were informed through historic unit cost trend patterns and were reduced for services where separate fee schedule program changes were applied. Trends by service category are illustrated below:

Table 4: Projected Trend by Major COS

COS	Annualized PMPM Trend Factor
Inpatient	5.0%
Outpatient	−3.1%
Parent Support	0.0%
Respite	30.0%
Youth Support	−5.0%
Independent Living Skills	−5.0%
Total	**−0.1%**

Additional information on historic expense patterns and trend projections by COS are shown in Appendix C.

Wraparound Agencies Costs

CSoC services are provided through wraparound agencies (WAA) and the Family Support Organization (FSO), as well as through other network providers. Together with youth and families, the WAA and FSO work to develop and coordinate a plan of care which supports children and youth in returning to or remaining in the community.

A key component of that package is the wraparound facilitation, which includes an integrated system of care planning and management across multiple levels. The expenses for this component were reviewed in the submitted encounter records for CY 2020. Reported expenses were consistent with the current WAA PMPM add-on. As a result, Mercer utilized the CY 2020 encounters to refresh the WAA PMPM add-on for CY 2022. For reference, Mercer has included documentation of the development of the WAA fee add-on in the table below.

Table 5: WAA Add-On

Development of WAA PMPM	Amount	Notes
A. Total CY 2020 WAA Fees[2]	$26,850,391	Reflects total daily service payments, exclusive of Administrative Service Organization (ASO) payments.
B. Daily WAA Payment Rate	$36.16	Contract rate per recipient per day, exclusive of ASO fees, as provided by the State.
C. 2020 Unique WAA User Months[2]	24,419	Recipients participating for partial months are fully counted.

[2]Adjustment made to WAA fees and user months to reflect leap year occurrence in CY 2020.

Development of WAA PMPM	Amount	Notes
D. Average Number of WAA Fee Payments per Month	30.41	D = A / B / C Reflects mix of both full and partial month eligible members.
E. Daily WAA Service Rate	$36.16	Service rate per recipient per day (excludes ASO fees), as provided by the State.
F. Final WAA Service PMPM Add-on	$1,099.57	F = D * E

The final WAA PMPM of $1,099.57 is added to the total medical cost.

6

Special Contract Provisions Related to Payment

Minimum Medical Loss Ratio

The CSoC contractor shall provide an annual medical loss ratio (MLR) report following the end of the MLR reporting year, which shall be a CY. An MLR shall be reported in the aggregate, including all medical services covered under the contract. If the aggregate MLR (cost for health care benefits and services and specified quality expenditures) is less than 85.0%, the contractor shall refund LDH the difference.

Directed Payments

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

- Inpatient Services Fee Schedule
- Outpatient Respite Fee Schedule
- LMHP
- MAT

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Projected Non-Benefit Costs

Non-Medical Expense Load

The actuarially sound capitation rates developed include a provision for PIHP administration and other non-medical expenses. Mercer reviewed historical expense data provided, as well as changes in the CSoC program between the base year and contract period. The administration load incorporates care management and underwriting gain, as well as general PIHP expenses to operate the program. Mercer also considers MLR requirements as prescribed by CMS (no less than 85.0% for Medicaid program).

Final Administrative load expectation is shown by program in Table 6.

Table 6: Administration Load Percentage

Care Management	Underwriting Gain	Administrative Load	Total Administrative Percentage
1.0%	1.5%	12.5%	15.0%

Mercer also includes a premium tax of 5.5% into the non-medical expense load to incorporate into final capitation rates.

Federal Health Insurance Providers Fee

Mercer made no health insurance provider fee (HIPF) adjustment for these rates. Section 9010 of the Patient Protection and Affordable Care Act (ACA) imposes a fee on each covered entity engaged in the business of providing health insurance for United States health risks. In previous years, Mercer has recognized the costs associated with this fee as “reasonable, appropriate, and attainable costs” to be considered in actuarially sound payments to the plans. The Further Consolidated Appropriations Act, 2020, Division N, Subtitle E § 502, repealed this annual fee on health insurance providers, applicable to CYs beginning after December 31, 2020 (fee years after the 2020 fee year). As such, an allowance for liabilities associated with the ACA Section 9010 HIPF is no longer necessary for the periods beyond CY 2021.

8 Risk Mitigation

As only one PIHP is anticipated to be selected, Mercer did not apply any risk mitigation strategy to this CSoC rate apart from the MLR remittance noted in Section 6 of this report.

9

Certification of Final Rates

In preparing the contract rate shown in Appendix A, Mercer has used and relied upon enrollment, encounter data, reimbursement level, benefit design, and other information supplied by LDH and its fiscal agent. LDH, its fiscal agent, and Magellan are responsible for the validity and completeness of the data supplied. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion they are appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

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

Mercer certifies that the contract rate in Appendix A was developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the managed care contract. Rate estimates provided are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially wide, range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual PIHP costs will differ from these projections. Mercer has developed these rates on behalf of LDH to demonstrate compliance with the CMS requirements under 42 CFR § 438.6(c), and in accordance with applicable law and regulations. Use of these rates for any purpose beyond that stated may not be appropriate.

PIHPs are advised that the use of these rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rates by PIHPs for any purpose. Mercer recommends that any PIHP considering contracting with LDH should analyze its own projected

medical expense, administrative expense, and any other premium needs for comparison to these rates before deciding whether to contract with LDH.

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

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

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

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

Sincerely,

Adam Sery, FSA, MAAA
Principal

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Senior Associate

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Appendix A

Louisiana CSoC Capitation Rate Development

	A	B	C	D	E	F	G	H
	Base PMPM	Program Changes[3]	Selected Trend[4]	WAA PMPM	Total Service Rate[5]	Admin Rate[6]	Premium Tax	Contract Rate[7]
Statewide Total	$728.99	4.6%	0.3%	$1,099.57	$1,869.17	15.0%	5.5%	$2,328.00

[3] Includes LMHP, respite fee schedule changes, inpatient fee schedules, and MAT

[4] The selected trend shown is blended across COS and is annualized from the 36-month trending period (July 1, 2019 through July 1, 2022)

[5] Total Service Rate formula: E = [A*(1+B)*(1+C)^(36/12)+D]

[6] Shown as a percentage of total rate

[7] Rate development formula: Contract Rate= [E]/(1-G)/(1-H)

Appendix B

Louisiana CSoC Program Change Impact Summary

Region	Individual Program Changes — PMPM Impacts		
	LMHP/Respite Fee Schedule Changes	Inpatient Fee Schedule Changes	MAT
Statewide Total	$17.32	$16.24	$0.16
% Impact	2.38%	2.23%	0.02%

Appendix C

Louisiana CSoC Projected Medical Trends by COS

COS	Best Estimate Trend Factor
Inpatient	5.0%
ER	−3.1%
Outpatient	−3.1%
Crisis Intervention	−3.1%
Community Psychiatric Support	−3.1%
ACT	−3.1%
Addiction Services (excluding SUD Residential)	−3.1%
Medical Physician/Psychiatrist/Nurse Practitioner	−3.1%
Psychosocial Rehabilitation	−3.1%
Other Professional (MH Providers and Clinics, Nurses, and Other Licensed Providers)	−3.1%
FQHC	−3.1%
Other	−3.1%
Respite	30.0%
Parent Support	0.0%
Youth Support	−5.0%
Independent Living Skills	−5.0%
Total	**−0.1%**

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