Financial Reporting Guide

Dental Benefit Plan Manager

Healthy Louisiana

Effective Date: January 1, 2016

Revised May 31, 2016

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Introduction and general instructions

1.01 Introduction

The provisions and requirements of this Financial Reporting Guide (Guide) are effective July 1, 2014. The purpose of this Guide is to set forth quarterly and annual reporting requirements for the Dental Benefit Plan Contractors (Contractors) contracted with Louisiana (LA) Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF) for prepaid dental care. The Guide instructions and reports are supplementary to any Department of Insurance (DOI) financial reporting requirements. This Guide does not replace any DHH electronic data submission requirements or quality/compliance-oriented reporting requirements from Contractors.

The primary objective of the Guide is to establish consistency and uniformity in reporting. All reports shall be submitted as outlined in the general and report-specific instructions. The financial reports submitted based on the Guide will be used to monitor the operations for participating Contractors and as a potential data source in capitation rate setting. Only revenues and expenses related to a direct contract between the State and the Contractor should be included in the reports, with the exception of parent organization financial statements and audit information required on an annual basis.

All terms and conditions of the Contract apply to this financial reporting guide. Current contractual requirements can be found at makingmedicaidbetter.com. This reporting guide may be revised as deemed necessary by DHH. Sanctions may be enforced for the untimely filing of the financial reports. Monthly reporting of the financial statements may also be enforced upon the discretion of DHH. This reporting guide is supplemental to any reporting provisions required by DHH, state and federal law, or Department of Insurance.

1.02 Reporting time frames

Amendments and/or updates to this Guide may be issued by the DHH as deemed necessary. The following table depicts reporting requirements and scheduling. Due dates are based on calendar days.

Schedule	Report name	Frequency	Due date[1]	Format
A	Income statement	Quarterly	60 days after quarter end	Predetermined
B	Financial statement footnotes	Quarterly & annual	60 days after quarter end and 120 days after year end	Narrative
C	Total categorical profitability statement	Quarterly	60 days after quarter end	Predetermined
D	Dental liability summary	Quarterly	60 days after quarter end	Predetermined
E	Received but unpaid claims	Quarterly	60 days after quarter end	Predetermined
F	LAP lag	Quarterly	60 days after quarter end	Predetermined
G	Medicaid LaCHIP lag	Quarterly	60 days after quarter end	Predetermined
H	Medicaid adult lag	Quarterly	60 days after quarter end	Predetermined
I	Utilization	Quarterly	60 days after quarter end	Predetermined
J	Sub-capitated expenses detail	Quarterly	60 days after quarter end	Predetermined
K	FQHC/Rural health clinic expenses	Quarterly	60 days after quarter end	Predetermined
L	Third party resource payments	Quarterly	60 days after quarter end	Predetermined
M	TPL subrogation	Quarterly	60 days after quarter end	Predetermined
N	Fraud and abuse tracking	Quarterly	60 days after quarter end	Predetermined
O	Parent audited financial statements	Annual	120 days after year end	Embedded PDF
P	Contractor agreed upon procedures	Annual	120 days after year end	Embedded PDF
Q	Income statement reconciliation report	Draft and final annual	90 and 120 days after year end	Predetermined
R	Agreed upon procedures adjustments	Draft and final annual	90 and 120 days after year end	Predetermined
S	Supplemental working area	As needed	As needed	Narrative
T	LAP Utilization Detail	Quarterly	60 days after quarter end	Predetermined

Schedule	Report name	Frequency	Due date[1]	Format
U	Medicaid/LaCHIP Children Utilization Detail	Quarterly	60 days after quarter end	Predetermined
V	Medicaid Adult Utilization Detail	Quarterly	60 days after quarter end	Predetermined
Appendix A	Financial disclosure statement	Annual	90 and 120 days after year end, if adjustments are necessary	Predetermined

[1]If a due date falls on a weekend or State-recognized holiday, reports will be due the next business day.

1.03 General instructions

Generally accepted accounting principles (GAAP) are to be observed in the preparation of these reports. Specifically, all revenues and expenses must be reported using the accrual basis method of accounting.

Amounts reported to DHH under this Guide are to represent only **covered services** for recipients eligible for the Healthy Louisiana Program. Covered services are services that would be considered reimbursable under each Contractor's contract with DHH.

All quarterly and annual reports must be completed and submitted to DHH by the due dates outlined above. DHH may extend a report deadline if a request for an extension is communicated in writing and is received at least five business days prior to the report due date. Any request for extension must include the reason for delay and the date by which the report will be filed.

Most line and column descriptions within each report are self-explanatory and, therefore, constitute instructions. However, specific instructions are provided in instances when interpretation may vary. Any entry for which no specific instruction is provided should be made in accordance with sound accounting principles and in a manner consistent with related items for which instruction is provided.

The Contractor shall always utilize predefined categories or classifications before reporting an amount as "Other." For any material amount included as "Other," the Contractor is required to provide **a detailed explanation**. For this purpose, material is defined as comprising an amount greater than or equal to 5% of the total for each section. For example, if "Other Income" reported is less than 5% of Total Revenue, no disclosure is necessary. However, if "Other" miscellaneous dental expense is reported with a value that is equal to 5% or higher of Total Other Dental expenses, disclosure would be necessary. Such disclosure is to be documented on Schedule B – Footnotes, line item 3. Refer to the supplemental working area location if additional space is needed for disclosures.

Unanswered questions and blank lines or schedules will not be considered properly completed and may result in a resubmission request. Any resubmission must be clearly identified as such. If no answers or entries are to be made, write "None," not applicable (N/A) or "-0-" in the space provided.

Input areas for the spreadsheet are shaded in red. The Contractor should input amounts in whole dollars only. Amounts should be rounded up to or down to the nearest whole dollar. For example, $1.49 would be rounded down and input as $1; $1.50 would be rounded up and input as $2, the next whole number.

1.04 Format and delivery

The Contractor will submit these reports both in hard copy and electronically, using the Excel spreadsheets on the template and in the format specified in this Guide without alteration. Please submit the completed reports and required supplemental materials, such as narrative support for "Other" categories that are considered material in nature, to:

Brandon Bueche
Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
628 North 4th Street
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

Electronic copies should be submitted to LA DHHS and LA DOI using the following e-mail addresses:

- Brandon Bueche at DHHS: Brandon.Bueche@la.gov
- Stewart Guerin at DOI: sguerin@lsi.state.la.us

1.05 Certification statement

The purpose of the certification statement is to attest that the information submitted in the reports is current, complete and accurate. The statement should include the Contractor's name, date of the period end, preparer information and signatures. The certification statement must be signed by the Contractor's CFO or CEO.

1.06 Financial statement check figures and instructions

In addition to the schedules that must be completed by the Contractor, the Guide includes a "Financial Statement Instruction and Check Figures Report" worksheet that evaluates the consistency of the values entered by the Contractor. The financial statement reporting template instructions and check figures tab lists the instructions for completing the spreadsheet, as well as check figures that identify any differences within specific schedules. The check figures must match prior to the submission of the quarterly and annual financial statements. If the audit check figures do not match, data should be corrected or an explanation should be provided in writing and submitted with the quarterly financial statement reporting package.

1.07 Maintenance of records

The Contractor must maintain and make available to DHH upon request the data used to complete any reports contained within this Guide.

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Quarterly report specifications

2.01 Schedule A: Income statement

The Contractor shall report revenues and expenses using the full accrual method. The income statement, Schedule A, must agree with the total profitability by eligibility category report, Schedule C, for the quarterly reporting period.

Specification	Inclusion	Exclusion
Member months	A member month is equivalent to one member for whom the Contractor has received or accrued capitation-based revenue for the entire month.	
Capitation revenue	Revenue received and accrued on a prepaid basis for the provision of covered dental services.	
Investment income	All investment income earned during the period net of interest expense.	
Other income	Revenue from sources not identified in the other revenue categories. Describe amounts in the footnotes in Schedule B. Note: Material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.	

Dental expenses and recoveries – All dental expenses must be reported net of third party reimbursement and coordination of benefits (e.g. other commercial insurance) and in correspondence with the identified categories of service in Schedule A. Expenses should be reported as paid and should not include changes in incurred but not paid (IBNP) estimates. Record changes in IBNP estimates in the appropriately described lines, corresponding to the detail provided in the lag tables from schedules F and G.

Specification	Inclusion	Exclusion
Dental expenses –dental provider, other dental expenses	All contracted fee-for-service and sub-capitation expenses as identified in the categories of service groupings. Descriptions are self-explanatory.	
Dental expenses – other and miscellaneous	Dental expenses that do not fall within the categories of services as defined in the reporting format. Note: Material other amounts (greater than 5% of the individual sections of expense) and "other expenses" should be disclosed and fully explained in Schedule B.	
Reinsurance premiums, as applicable.	Reinsurance premium payments and stop loss payments should be separately reported as premium payments.	
Reinsurance recoveries, as applicable.	Reinsurance recoveries associated with the premiums paid in the line item above.	
Third party liability subrogation	Cost-sharing revenue, including third party sources received on a cash basis for subrogation recovery efforts that could not be directly associated with a claim.	Do not include coordination of benefit payments that are deducted from payments to providers in the normal course of claims processing.
Fraud and abuse recoveries	Payments to the Contractor as a result of DHH, Contractor, or Provider sponsored recovery efforts.	
Other recoveries	Other recoveries of dental claims previously paid not included in a category above.	

Administrative expenses – Administrative expenses are divided into activities that improve health and dental care quality and those that are other, general, and operational, to perform necessary business functions. Use the following guidance for reporting activities that meet the criteria for improving health and/or dental care quality.

Administration – Oral Health care Quality Improvement expenses

Activity requirements

Activities conducted by the Contractor to improve quality must meet the following requirements. The activity must be designed to:

- Improve oral health care quality.
- Increase the likelihood of desired oral health outcomes in ways that are capable of being objectively measured and producing verifiable results and achievements.
- Be directed toward individual enrollees, or incurred for the benefit of specified segments of enrollees, or provide oral health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.
- Be grounded in evidence-based dentistry, widely-accepted best clinical practice, or criteria issued by recognized professional dental associations, accreditation bodies, government agencies, or other nationally-recognized health or dental care quality organizations.

- Improve oral health outcomes, including increasing the likelihood of desired outcomes compared to a baseline and reduce oral health disparities among specified populations.

Some examples of quality improvement activities include the direct interaction of the Contractor (including those services delegated by subcontract) with providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve oral health outcomes, including activities such as:

- Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence-based medicine.
- Quality reporting and documentation of care in non-electronic format.
- Health information technology to support these activities.
- Accreditation fees directly related to quality of care activities.

Improve patient safety, reduce dental errors and lower infection rates – Examples of activities primarily designed to improve patient safety, reduce medical and dental errors and lower infection and mortality rates include:

- The appropriate identification and use of best clinical practices to avoid harm.
- Activities to identify and encourage evidence-based dentistry in addressing independently identified and documented clinical errors or safety concerns.
- Activities to lower the risk of facility-acquired infections.
- Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce dental errors.
- Health information technology to support these activities.

Implement, promote, and increase wellness and health activities – Examples of activities primarily designed to implement, promote and increase wellness and health activities include:

- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements.
- Coaching programs designed to educate oral health conditions.
- Actual rewards, incentives, bonuses, and reductions in copayments (excluding administration of such programs) that are not already reflected in payments or claims.
- Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities.
- Coaching or education programs and oral health promotion activities designed to change member behavior and conditions.
- Health information technology to support these activities.
- Enhancing the use of health care data to improve quality, transparency and outcomes, and support meaningful use of health information technology.

Exclusions

Expenditures and activities that **must not be included** in quality improving activities are:

- Those that are designed primarily to control or contain costs.
- The *pro rata* share of expenses that are for lines of business or products other than Louisiana Medicaid.
- Those which otherwise meet the definitions for quality improvement activities, but which were paid for with grant money or other funding separate from DHH capitation payments.
- Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services.

- Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims [for example, costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 USC 1320d-2, as amended, including the new ICD-10 requirements].
- That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality.
- All retrospective and concurrent utilization review.
- Fraud prevention activities, other than fraud detection/recovery expenses up to the amount recovered that reduces incurred claims.
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason.
- Provider credentialing.
- Costs associated with calculating and administering individual enrollee or employee incentives.
- That portion of prospective utilization that does not meet the definition of activities that improve health quality.
- State and federal taxes and regulatory fees.
- Any function or activity not expressly included in paragraph (c) of this section, unless otherwise approved by and within the discretion of DHH, upon adequate showing by the Healthy Louisiana Contractor that the activity's costs support the definitions and purposes described above or otherwise support monitoring, measuring or reporting health care quality improvement.

Other administrative expenses – The following expenses are designated as other administrative expenses:

Specification	Inclusion	Exclusion
Utilization management and concurrent review	Utilization management activities that manage medically-necessary covered services, as well as prospective and concurrent utilization review.	
Network development and credentialing costs	Contracting, provider credentialing, and provider education.	
Member services	Member service/support and grievance and appeals, including recipient enrollment.	
General and operational management	General and Operational Management – Senior operational management and general administrative support [e.g., administrative assistants, public relations (to the extent that it does not relate to marketing or member/enrollment services as described below), receptionist, etc.].	
Accounting and finance	Accounting and finance expenditures.	

Specification	Inclusion	Exclusion
Claims and referral/authorization processing	Processing of Provider Payments – Expenditures related to the processing and authorizing of provider payments.	
Information systems	Information systems and communications.	
Administrative services only (ASO) cost	Vendor-related expenditures for the processing of provider payments.	
Other direct costs	Administrative Business Expenditures – Rent, utilities, office supplies, printing and copier expenses, marketing materials, training and education, recruiting, relocation, travel, depreciation and amortization, and other miscellaneous administrative expenses. Payments to incent providers to submit encounter forms.	
Indirect costs – corporate overhead allocations	Corporate Overhead Allocations – Management fees, and other allocations of corporate expenses based on some methodology [e.g., per member per month (PMPM), percent of revenue, percent of head counts and/or full time equivalents (FTE), etc.].	
Sanctions and late payment interest penalties	Sanctions and other penalties paid or accrued by the Contractor.	
Other administrative costs	Those administrative expenses not specifically identified in the categories above. Note: Material amounts (greater than 5% of total administrative expenses) should be disclosed and fully explained in Schedule B.	Other administrative expenses indicated above.

Additional non-operating items are required to be reported within Schedule A. These items are described below:

Non-operating income/loss	Any amounts relating to the non-operating revenues and expenses.
Income taxes	Income tax expense paid or accrued for the period.
Premium tax assessments	Premium taxes paid or accrued for the period.
Other	Any other income/loss not included elsewhere in the income statement.. Note: Amounts should be disclosed and fully explained in Schedule B.

Allocation of expenses

General Requirements

Each expense must be reported under only one type of expense unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses. Expenditures that benefit lines of business other than Louisiana Medicaid must be reported on a pro rata share.

- Allocation to each category should be based on a generally-accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above generally will be the most accurate method. If a specific identification is not feasible, the Contractor must provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses.
- Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense.
- Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, capitation payment ratios or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

2.02 Schedule B: Financial statement footnotes

The financial statement footnotes are designed to present information regarding organizational structures and changes to reimbursement methodologies, as well as an area to explain other amounts not specified in the reporting package. The following list is not exclusive of explanations that may be useful to DHH. Additional lines for required explanations are provided beginning in line 27. Appendix A includes required annual financial disclosures. On a quarterly basis, only include narrative and applicable supporting schedules for material changes to items described in the following table:

	Footnote disclosure requirements	**Indicate as N/A if no reportable items**
1	Organizational structure	
2	Summary of significant accounting policies changes	
3	Other amounts included in the financial statements > 5% of the reporting category	
4	Pledges, assignments and guarantees	
5	Statutory deposits or performance bond changes	
6	Material adjustments to financial statements	
7	Changes to liability estimation methodologies or margin assumptions	

	Footnote disclosure requirements	Indicate as N/A if no reportable items
8	Claims payable RBUCs analysis	
9	Contingent liabilities	
10	Due from/to affiliates (current and non-current)	
11	Related party transaction activities	
12	Equity contributions or distributions/other activity	
13	Non-compliance with financial viability standards and performance guidelines	
14	Charitable contributions, penalties or sanctions included in the financial statements	
15	Interest on late claims	
16	Changes in provider reimbursement methodologies	
17	Changes to reinsurance or stop loss agreements	
18	Non-operating income/loss amounts observations	
19	Other Recovery amounts	
20	Claims payment fluctuations reported in the lag reports, schedules F-G	
21	Unpaid claim adjustment expenses and methodology	
22	Premium deficiency reserves and methodology	
23	Allocation methodologies used for categorical profitability statements	
24	Administrative expense allocation methodology changes	
25	Non-covered services and amounts paid	
26	Differences between premium assessment tax payments and capitated tax provision	

2.03 Schedules C: Quarterly profitability by population groups

These reports are meant to provide detailed information on revenues and expenses pertaining to the Contractor for the current quarter for the populations selected by DHH. Schedule C is automatically calculated from the county-based profitability reports (income statements). The table below lists the population groups and associated data elements that help define each group for reporting purposes.

Population category	Aid Category	Rate Code
LaCHIP Affordable Plan (LAP)	01	01C
Medicaid/CHIP Children (Ages 0-20)	02	02C
Medicaid Adults	03	03C

2.04 Schedule D: Dental liability summary

This schedule combines summary information from the following schedules:

- Received but unpaid claims report.
- Dental provider services lag schedule.
- Other dental lag schedule.

The amounts to include in the rows and columns are self-explanatory, with a description at the bottom of the table on the following page of how the table is calculated. Prepare this schedule for both quarterly and YTD amounts.

Dental cost grouping	Paid claims	RBUC	IBNR	Current period ending IBNP	Current period beginning IBNP	Total recognized incurred claims
Dental provider services	$ -	$ -	$ -	$ -	$ -	$ -
Other dental	$ -	$ -	$ -	$ -	$ -	$ -
Total	$ -	$ -	$ -	$ -	$ -	$ -
Notes and explanations:	A	B	C	D	E	F
	These dollars are produced by the lag schedules.	These amounts are produced by the RBUC schedule.	These amounts should be calculated using the following formula: C = D – B	These amounts are produced by the lag schedules.	These amounts are produced by the prior quarter lag schedules.	F = (A + D) – E

The Dental Liability Summary report IBNR claims should be reported in the IBNR column by the appropriate category (e.g., dental provider and other dental). The total payable for outpatient, dental provider and other dental should agree with the totals on the corresponding lag schedules.

2.05 Schedule E: Received but unpaid claims (RBUCs) report

RBUCs are to be reported by the appropriate expense (e.g., dental provider and other dental) and aging (e.g., 1–30 days, 31–60 days, 61–90 days, 91–120 days and greater than 120 days). Note that a claim becomes an RBUC the day it is received by the Contractor, not the day it is processed/adjudicated. For RBUC estimates, Contractors are encouraged to run reports close to the reporting deadline to determine a more accurate estimate of adjudicated and paid amounts for claims that were in process as of the reporting period. Claims that are still in process and not yet adjudicated require an estimation technique by the Contractor based on average payment amounts or historical payment-to-billed ratios. Any late payment interest penalty payments should be listed next to the vendor for which payments were made.

2.06 Schedules F – H: Lag reports

Schedules F through H request the same type of information, but for different populations – LAP, Medicaid/LaCHIP children and Medicaid adults. The tables are arranged with the month of service horizontally and the month of payment vertically. Therefore, payments made during the current month for services rendered during the current month would be reported in line 1, column C, while payments made during the current month for services rendered in prior months would be reported on line 1, columns D through AM. Lines 1 through 3 contain data for payments made in the current quarter. Earlier data on lines 4 through 37 shall match data on appropriate lines on the prior period's submission. If lines 4 through 37 change from the prior period's submission, include an explanation. The current month is the last month of the period that is being reported.

Analyzing the accuracy of historical dental claims liability estimates is helpful in assessing the adequacy of current liabilities. This schedule provides the necessary information to complete this analysis.

Dental costs must be reported net of third party liability (TPL) and coordination of benefits (COB). Claims liabilities should **not** include the administrative portion of claim settlement expenses. Any liability for future claim settlement expense **must be disclosed separately** from the unpaid claim liability in a footnote.

Line 39 – **Global/subcapitation payments**: The Contractor should report global subcapitation payments on this line, by month of payment, and should not include this amount in any lines above line 39. Global/Subcapitation payments include:

- Global Capitation payments: Payments made to fully-delegated risk entities contracted with the Contractor. These types of payments are expected to be broken out between the outpatient facility, dental provider services, and other dental service lag reports.
- Subcapitation payments: Those services paid through a normal provider capitation agreement. Examples would include PMPM payments to a dental provider for a specified list of services or to a laboratory for a specified list of tests.

Line 40 – **Settlements**: The Contractor should report payments/recoupments on lines 1 through 37 to the extent possible. If the Contractor makes a settlement or other payment that cannot be reported on lines 1 through 37 due to lack of data, the amount must be reported on line 40 with the payment month used as a substitute for the service month. The Contractor may use an alternative method of reporting settlements that restates prior period amounts to reflect an actual settlement for that month. **For all amounts reported on line 40, include a footnote explanation**. Do not include adjustments to IBNR amounts on this line.

Settlements should include payments to or refunds from providers that cannot be linked to a specific claim adjudicated through the payment system. For instance, fraud abuse recoupments, incentive payments and inaccurate payment settlement agreements with a provider that have not been captured through the claims payment system should be included.

Line 41 – This line is the total amount paid to date (including subcapitation) for services rendered and should equal the sum of lines 38 through 40. This line will calculate automatically.

Line 42 – **Incurred but not reported (IBNR):** Amounts on this line represent the current estimates for unpaid claims, by month of service, for the past 36 months and the aggregate amount for all prior months. The Contractor must determine a new IBNR amount for each service month and include this amount on line 42. The development of each IBNR should be based on the most recent paid claims data.

Line 43 – **Total incurred claims:** Total incurred claims is the sum of line 41 (amounts paid to date) and line 42 (IBNR). These amounts represent current estimated amounts ultimately to be paid for dental services by month of service for the past 36 months and for all months prior to the 36th month. Each amount represents the dental expense for a particular month, not including adjustments to prior month IBNR claims estimates. This amount is comprised of claims for the incurred month that are known to be paid by the end of the reporting quarter, plus claims for the incurred month estimated to be unpaid at the end of the reporting quarter. Also included are subcapitations and adjustments. This line will calculate automatically.

Do not include risk pool distributions as payments in these schedules.

Schedules F through G must provide data for the period beginning with the first month the Contractor is responsible for providing dental benefits to DHH recipients, and ending with the current month.

2.07 Schedule I: Utilization report

The Contractor shall submit a summary of utilization and unit cost information during the current quarter. Data must reconcile to the consolidated financial submissions. Input areas are highlighted in red where data should be entered, including the quarterly member months.

Admissions, days, visits, and quantities should be reported on an incurred basis for the quarter being reported upon, as counted from authorizations or claims adjudication data. Estimates for claims still not received as of the report due date should be estimated so that the utilization is representative of the actual occurrence of services performed for the reporting period.

Service measure	Measure	Type of utilization/ proxy	Definitions
Dental provider services	Visits	Quantity/services	A visit is defined as one or more professional contacts between a patient and a unique dental provider on a unique date of service. Include data for which the Contractor is both the primary payer and the secondary payer.

2.08 Schedule J: Sub-capitation expense report

This report is a summary of sub-capitation expenses, by population group, by individual expense line item. If other capitation agreements exist and are listed in the miscellaneous dental expense line item, please describe the capitation agreement in the financial statement footnotes.

2.09 Schedule K: FQHC and rural health clinic report

This report is a summary of Contractor payments to Federally Qualified Health Centers (FQHCs) and rural health clinics (RHCs) for dental services, and a comparison of those payments to each FQHC's or RHC's Prospective Payment System (PPS) rates. The Contractor is to reimburse FQHCs/RHCs the PPS rates in effect on the dates of service for all encounters.

As PPS rates may vary by provider and change periodically, the schedule is designed to capture information by provider by quarter. List quarterly aggregate payments and encounters by provider, as well as the PPS rates in effect for the effective dates of service. In order for the reported payments to reconcile with other schedules, this schedule is designed for reporting based upon dates of service. Amounts reported should be based upon the Contractor's anticipated (accrued) payments for services even if actual payments have not yet been paid.

However, as PPS rates may change within a reporting period, reporting payments by quarter allows for direct comparison to such rates. Although only one entry per provider will typically be necessary within any given quarter, if payments change within a quarter (e.g. scope of service change, etc.), report the aggregate amounts on different lines for the same quarter corresponding to the different PPS rates for their effective periods. For example, if a PPS rate changed on 9/1/12 for FQHC A, report the aggregate payments and encounters for 7/1/12-8/31/12 on one line, and the aggregate payments and encounters for 9/1/12-9/30/12 on another. Both lines can be referenced with the same quarterly identification, and a clarifying disclosure should be provided in Schedule R.

Quarterly references should coincide with the Contractor's fiscal year, with Q1 being the first quarter of the fiscal period, followed by Q2-Q4 respectively. Quarter months should always correspond to January-March, April-June, July-September, and October-December.

Encounters for FQHC/RHC providers are based upon the DHH definition of encounters for FQHC/RHC services, and is correlated to PPS rate determination. Report the number of encounters corresponding to the payments listed. Generally, in spite of the number of dental services provided on any given day (i.e. line detail), an enrollee receives one encounter per day.

The Contractor is responsible for reporting PPS rates in effect for the dates services were provided. PPS rates may be obtained from the provider or DHH, but should be the rates issued by DHH.

The Contractor's payments per encounter are automatically calculated within the report (Accrued Amounts divided by Encounters), as are the Equivalent PPS Payments (Encounters multiplied by the PPS Rates). Any variance between the Contractor's payments and the calculated PPS equivalents is also automatically calculated. Describe the reason for any variance, by provider, on Schedule R. Negative variances indicate the contractually required PPS rates have not been paid, and a complete explanation is required on Schedule R.

2.10 Schedule L: Third party resource payments

This schedule provides detail regarding total claims payments and claims paid that had other coverage.

- Count of total claims paid: report all claims paid by the Contractor during the reporting quarter. The count of total claims paid will only be entered within the “Commercial” section of the template. The “Medicare” and “Total” claims will populate automatically. **NOTE:** The count of total claims paid should be ALL claims paid by the Contractor and NOT only those claims that had commercial or Medicare as primary payor.
- Count of claims paid with other insurance indicated: report all claims paid by the Contractor during the reporting period where the member had other insurance coverage. This should include claims paid at $0 due to other insurance payments greater than Contractor allowed amounts. In addition, claims should be reported even if the other insurance paid $0.00 for the claim due to services not covered by other insurance. Please see below for examples. The count of claims reported here is a subset of the “count of total claims paid”.
- Contractor allowed amount: report the Contractor allowed amount associated with the claims reported in “count of claims paid with other insurance indicated”.
- Contractor paid amount: report the total Contractor paid amount associated with the claims reported in “count of claims paid with other insurance indicated”.
- Other insurance paid amount: report the total amount paid by other insurers associated with the claims reported in “count of claims paid with other insurance indicated”.

Examples are discussed below and illustrate how to report the information:

- The Contractor receives and pays a claim and the member has other coverage. The Contractor allowed amount for this service is $50. However, the other insurance does not cover the Medicaid allowed service so other insurance pays $0. For this report, the Contractor would report $50 as Contractor allowed amount, $50 as Contractor paid amount and $0 as other insurance paid amount. This claim would be counted in both the “count of total claims paid” and the “count of claims paid with other insurance indicated.”

Report the count of members with active TPL resources at the end of the quarter on line 4

2.11 Schedule M: Third party liability subrogation claims

List all new, active and closed subrogation cases for the quarter. Include the count of related subrogation claims for each case by the attorney name and/or case ID number. Indicate with a “Y” if the case is new, active or closed and whether the submitted encounter was adjusted for the recovery in the corresponding columns. Report any amount recorded as a public record lien for each case.

2.12 Schedule N: Fraud and abuse activity

List all new, active and closed fraud and abuse cases for the quarter. Include the count of related claims for each case by the provider name and/or case ID number. Indicate with a “Y” if the case is new, active or closed, and whether the submitted encounter was adjusted for the recovery in the corresponding columns. Do not include member-specific names or identification numbers on the schedule.

2.13 Schedule S: Supplemental working area

This schedule should be used by Contractors for working purposes or as a supplemental reference area for quarterly financial statement footnote disclosures.

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Annual audit reporting requirements

3.01 Schedule N: Parent company audited financial statements

Insert the final audited parent company financial statements within this tab within 120 days after year end. Preferably, this can be accomplished by embedding the final balance sheet in PDF format.

3.02 Schedule P: Contractor agreed upon procedures

The agreed upon procedures are in effect for the annual reporting period ending each December 31st, and shall be submitted by June 30th of the subsequent year. Preferably, this can be accomplished by embedding the final audited financial statements in PDF format.

3.03 Schedule Q: Income statement reconciliation report

Any changes from the fourth quarter YTD quarterly submission schedules based upon the agreed upon procedures should be reconciled within this report.

3.04 Schedule R: Agreed upon procedures adjustment entries

This schedule should list annual agreed upon procedures adjustment entries, if applicable, with an explanation of each entry. Materiality threshold: Any adjustment that exceeds $5,000, or all adjustments, if, in aggregate, they exceed 0.25% of capitation revenue must be reported as a line item. Adjustments that are $5,000 or less may be excluded if, in aggregate, the sum total of all adjustments is less than 0.25% of capitation revenue from line 2 of Schedule A.

3.05 Schedule S: Supplemental working area

This schedule should be used by Contractors for working purposes or as a supplemental reference area for annual financial statement footnote disclosures.

3.06 Schedules T-V: Utilization Detail Report

The Contractor shall submit utilization detail and payment amount information for the current year. Data must reconcile to the consolidated financial submissions. Input areas are highlighted in red where data should be entered, including the quarterly member months.

Populate the "CDT or Encounter Code" columns with the appropriate procedure codes from the Current Dental Terminology (CDT) published by the American Dental Association. For dental services provided on an encounter basis (FQHC/RHC), populate the "CDT or Encounter Code" columns with the dental encounter code. For each code, indicate whether the unit of service is defined as visit, day, quantity, or other.

Provide supplemental information or notes, if any, on the Supplemental Working Area tab.

Appendix A

Annual financial statement disclosures and supplemental information requests

Appendix A is a separate Word® document of financial disclosure requirements and information requests that must be reported by the Contractor at year end. The schedule is in three sections and includes financial disclosures, related party transactions and supplemental information requests. The supplemental information requests may be inserted in either Appendix A, the supplemental working area on Schedule R, or a clearly labeled separate attachment.

Appendix B

Health Insurance Provider Fee (HIPF) Reimbursement

If the DBPM is identified by the IRS as a covered entity and thereby subject to an assessed fee (Annual Fee) whose final calculation includes an applicable portion of the DBPM's net premiums written from DHH's Medicaid/Children's Health Insurance Program (CHIP) lines of business, DHH shall, upon the DBPM satisfying completion of the requirements below, make an annual payment to the DBPM in each calendar year to the IRS (the Fee Year). This annual payment will be calculated by DHH (and its contracted actuary) as an adjustment to each DBPM's capitation rates for the full amount of the Annual Fee allocable to LA Medicaid/CHIP with respect to premiums paid to the DBPM for the preceding calendar year (the Data Year). The adjustment will be to the capitation rates in effect during the Data Year.

The DBPM shall, at a minimum, be responsible for adhering to the following criteria and reporting requirements:

Provide DHH with a copy of the final Form 8963 submitted to the IRS by the deadline listed in the HIPF Deliverables and Deadlines, below. The DBPM shall provide DHH with any adjusted Form 8963 filings to the IRS within five business days of any amended filing.

Provide DHH LA-specific Medicaid and CHIP-specific premiums included in the premiums reported on Form 8963 (including any adjusted filings) by the deadline listed in the HIPF Deliverables and Deadlines, below (for the initial Form 8963 filing) of the Fee Year and within five business days of any amended filing.

If the DBPM's LA-specific Medicaid/CHIP premium revenue is not delineated on its Form 8963, the DBPM shall provide with its Form 8963 a supplemental delineation of LA-specific Medicaid/CHIP premium revenue that was listed on the DBPM's Form 8963 and a methodological description of how its LA-specific Medicaid/CHIP premium revenue (payments to the DBPM pursuant to this Contract) was determined. The DBPM will indicate for DHH the portion of the LA-specific Medicaid/CHIP premiums that were excluded from the Form 8963 premiums by the DBPM as Medicaid long-term care, if applicable, beginning with Data Year 2015.

The DBPM shall also submit a certification regarding the supplemental delineation consistent with 42 CFR 438.604 and 42 CFR 438.606.

If a portion of the LA-specific Medicaid/CHIP premiums were excluded from the Form 8963 premiums by the DBPM as Medicaid long-term care, the DBPM shall submit the calculations and methodology for the amount excluded.

Provide DHH with the preliminary calculation of the Annual Fee as determined by the IRS by the deadline listed in the HIPF Deliverables and Deadlines below.

Provide DHH with the final calculation of the Annual Fee as determined by the IRS by the deadline listed in the HIPF Deliverables and Deadlines below.

Provide DHH with the corporate income tax rates — federal and state (if applicable) — by the deadlines listed in the HIPF Deliverables and Deadlines, below, and include a certification regarding the corporate income tax rates consistent with 42 CFR 438.604 and 42 CFR 438.606

For covered entities subject to the HIPF, DHH will perform the following steps to evaluate and calculate the HIPF percentage based on the Contractor's notification of final fee calculation (that is, HIPF liability) and all premiums for the Contractor subject to Section 9010, as reported on the Contractor's Form 8963, and agreed reasonable by DHH.

Review each submitted document and notify the Contractor of any questions.

DHH will check the reasonableness of the DBPM's LA-specific Medicaid/CHIP premium revenue included on the DBPM's Form 8963/supplemental delineation. This reasonableness check will include, but may not be limited to, comparing the DBPM's reported LA-specific Medicaid/CHIP premium revenue to DHH's capitation payment records.

DHH and its actuary will calculate revised Data Year capitation rates and rate ranges to account for the LA portion (specific to this contract) of the Contractor's HIPF obligation per the IRS HIPF final fee calculation notice (as noted above). To calculate the capitation payment adjustment, the DHH will:

- Step 1: Calculate the HIPF percentage based on the HIPF liability and all premiums for each entity subject to Section 9010.
- Step 2: Determine the total capitation revenue for the coverage in the data year for the Louisiana lines of business. The amount reported by the DBPM to the IRS, excluding any HIPF payments and accruals, will be compared to the revenue paid to the DBPM for the reporting year. If DHH determines the amounts are reasonably consistent, the reported figures from Form 8963, excluding any HIPF payments and accruals, will be used in the calculations.
- Step 3: Calculate the portion of the Step 2 capitation revenue that is subject to Section 9010. For example, if long-term care is a component of capitation revenue and not subject to Section 9010, adjust the total capitation revenue from Step 2 by such amounts.
- Step 4: Calculate the adjusted capitation revenue incorporating coverage of the HIPF and related taxes. The adjusted capitation revenue will include the Step 3 capitation revenue, the HIPF and the federal corporate income tax and state premium taxes applicable to the additional HIPF revenue.

Calculate the adjusted revenue as follows, where:
Step 3 = Cap Rev Step 3 capitation revenue
PremTaxes% = State premium tax percentage
AvgFIT% = Entity's federal corporate income tax rate

$$\frac{\text{(Step 3 Cap Rev) x (1 − PremTaxes\%)}}{\text{1 − PremTaxes\% − (HIPF\% / (1 − AvgFIT\%))}}$$

- Step 5: Calculate the amount of the HIPF capitation adjustment as the Step 4 amount minus the Step 3 amount.
- Step 6: Calculate the HIPF percentage adjustment applicable to the data year per-member per-month (PMPM) capitation rates as the HIPF amount from Step 5 divided by the capitation revenue paid to the DBPM per Step 2.

DHH (and its contract actuary) will compute the change in capitation revenue that is due to the higher capitation rates by multiplying the adjusted capitation rates by the known member months to determine the total supplemental HIPF payment amount for the DBPM.

In accordance with the schedule provided in the HIPF Deliverables and Deadlines, below, DHH will make a payment to the DBPM that is based on the final Annual Fee amount provided by the IRS and calculated by DHH (and its contracted actuary) as an adjustment to the capitation rates in effect during the Data Year. This payment will only be made to the Contactor if DHH determines that the reporting requirements under this section have been satisfied.

The DBPM shall advise DHH if payment of the final fee payment is less than the amount invoiced by the IRS.

The DBPM shall reimburse DHH for any amount applicable to LA Medicaid/CHIP premiums that are not paid towards the fee and/or are reimbursed back to the DBPM, at any time and for any reason, by the IRS.

DHH reserves the right to update the calculation and method of payment for the Annual Fee based upon any new or revised requirements established by CMS in regards to this fee.

Payment by DHH is intended to put the DBPM in the same position as the DBPM would have been in had the DBPM's HIPF tax rate (the final Annual Fee as a portion of the covered entity's premiums filed on Form 8963) and corporate tax rates been known in advance and used in the determination of the Data Year capitation rates.

HIPF Deliverables and Deadlines

Plan Deliverables	Deadline
Form 8963	May 1st
Louisiana-specific premium revenue reported on Form 8963	May 1st
Supplemental Delineation of Louisiana-specific premium revenue, if not provided on Form 8963 – *must also include certification* and list of exclusion*	May 1st
Applicable Corporate Tax Rate for IRS Preliminary Calculation – *must include certification**	May 1st
Preliminary Calculation of Annual Fee as determined by IRS, including Louisiana allocation	Within 5 business days of receipt (expected from IRS in June)
Final Calculation of Annual Fee as determined by IRS, including Louisiana allocation	Within 5 business days of receipt (expected from IRS by August 31st)
Applicable Corporate Tax Rate for IRS Final Calculation – *must include certification**	Within 5 business days of August 31st

* Form 8453-R may be used for certification

DHH Payment Schedule	Deadline
HIPF Reimbursement from DHH	October 31st