Office of State Procurement
PROACT Contract Certification of Approval

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

Reference Number: 2000123594 (5)
Vendor: MCNA Insurance Company
Description: A-5 to Medicaid managed care dental services
Approved By: Pamela Rice
Approval Date: 6/21/2017

Your amendment that was submitted to OSP has been approved.

Rev 2017-01

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 5

LAGOV#: 2000123594

LDH #: 06060

MVA

(Regional/ Program/ Facility): Medical Vendor Administration

AND

MCNA Insurance Company d/b/a MCNA Dental Plans
Contractor Name

Original Contract Amt: 484,300,137

Original Contract Begin Date: 07-01-2014

Original Contract End Date: 06-30-2017

RFP Number: 305PUR-DHHRFP-DENT

AMENDMENT PROVISIONS

Change Contract From: From Maximum Amount: 495,042,713 Current Contract Term: 7/1/2014-6/30/2017

CF - 1 Block 11 Termination Date 6/30/2017
CF-1 Block 13 Maximum Contract Amount $495,042,713
See Attachment A-5
Attachments C & E

Change Contract To: To Maximum Amount: 844,522,063 Changed Contract Term: 7/1/2014-6/30/2019

CF - 1 Block 11 Termination Date 6/30/2019
CF - 1 Block 13 Maximum Contract Amount $844,522,063
See Attachment A-5
Attachments C & E - revised attached
Attachment G - new

Justifications for amendment:

MCNA Dental Plans provides dental services to eligible Medicaid enrollees. LDH is pleased with the performance of MCNA Dental Plans and seeks to extend the contract to avoid disruption to enrollees that could be caused by a change of contractors. The CMS Medicaid Managed Care Final rule includes an Medical Loss Ratio requirement for Prepaid Ambulatory Health Plans such as MCNA, so this requirement has been added to the contract.

This Amendment Becomes Effective: 07-01-2017

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

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

CONTRACTOR

MCNA Insurance Company d/b/a MCNA Dental Plans

CONTRACTOR SIGNATURE DATE 6/1/17

PRINT NAME: Carlos Lacasa

CONTRACTOR TITLE: Senior Vice President and General Counsel

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE DATE 6/7/17

NAME: Jen Steele

TITLE: Medicaid Director

OFFICE: Medical Vendor Administration

PROGRAM SIGNATURE DATE

NAME

MCNA Contract Amendment #5
Attachment A-5
Effective Date 7/1/2017

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Attachment C	Contract Maximum and Terms of Payment		Replace with updated contract maximum and terms of payment	Addition of contract years 4 and 5.
Attachment E	Rate Certification		Replace with updated rate certification letter.	The required annual rate certification has been added.
Attachment G	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Add new section	Attachment G – MLR (Medical Loss Ratio) Calculation Methodology	The CMS Medicaid Managed Care Final Rule requires a Medical Loss Ratio requirement for Prepaid Ambulatory Health Plans such as MCNA, so this requirement has been added to the contract.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Add to Glossary	**Medical Loss Ratio** – The percentage of PMPM payments received by the MCO from DHH used to pay medical claims from providers and approved quality improvement and IT costs. **Medical Loss Ratio Year** – The calendar year for which Medical Loss Ratio is being reported.	The CMS Medicaid Managed Care Final Rule requires a Medical Loss Ratio requirement for Prepaid Ambulatory Health Plans such as MCNA, so this requirement has been added to the contract.
Exhibit 3	RFP305PUR-DHHRFP-DENTAL-PAHP-MVA	Add new section	III.B. **Operations Requirements** 12. Medical Loss Ratio a) In accordance with the DBPM Financial Reporting Guide published by LDH, the DBPM shall provide an annual Medical	The CMS Medicaid Managed Care Final Rule requires a Medical Loss Ratio requirement for Prepaid Ambulatory Health Plans such as MCNA, so this requirement has been added to the contract.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			Loss Ratio (MLR) report following the end of the MLR reporting year, which shall be a calendar year. b) An MLR shall be reported in the aggregate, including all dental services covered under the contract. c) If the aggregate MLR (cost for dental benefits and services and specified quality expenditures) is less than eighty-five percent (85%), the DBPM shall refund LDH the difference. Any unpaid balances after the refund is due shall be subject to interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher. d) Neither the minimum MLR standard (85%) nor the refund applicable to the aggregate MLR shall apply to distinct MLRs reported.	

Contract Maximum Amounts and Terms of Payment

Maximum Contract Amounts:

The maximum contract amounts outlined below are based on projected enrollment into the DBP times projected Per Member Per Month capitation rate for each contract year. DBPM payments shall be made for actual enrollment in accordance with the monthly capitated rates specified in contract Attachment E – Mercer Certification, Rate Development Methodology and Rates.

Contract year 1 July 1, 2014 to June 30, 2015			
Rate Cell Description	**Projected Member Months**	**Projected Per Member Per Month Capitation Rate**	**Maximum Contract Amount**
LaCHIP Affordable Plan	38,192	$11.85	$452,575
Medicaid Children	7,903,166	$15.48	$122,341,011
CHIP	1,418,385	$15.48	$21,956,596
Medicaid Adult	3,614,180	$1.26	$4,553,866
		Year 1 Total	$149,304,048

Contract year 2 July 1, 2015 to June 30, 2016			
Rate Cell Description	**Projected Member Months**	**Projected Per Member Per Month Capitation Rate**	**Maximum Contract Amount**
LaCHIP Affordable Plan	40,674	$18.28	$563,320
Medicaid Children	8,416,872	$15.48	$131,170,146
CHIP	1,510,580	$15.48	$24,575,981
Medicaid Adult	3,849,101	$1.96	$4,983,508
HIPF			$2,327,089
		Year 2 Total	$163,620,044

Contract year 3 July 1, 2016 to June 30, 2017			
Rate Cell Description	**Projected Member Months**	**Projected Per Member Per Month Capitation Rate**	**Maximum Contract Amount**
LaCHIP Affordable Plan	~~37,631~~ **35,670**	~~$19.86~~ **$19.85**	~~$747,352~~ **$708,059**
Medicaid Children	~~8,552,387~~ **7,962,034**	$15.92	~~$136,154,001~~ **$126,755,574**
CHIP	~~1,558,205~~ **1,453,755**	$15.92	~~$24,806,624~~ **$23,143,774**
Medicaid Adult	~~4,074,138~~ **3,723,883**	~~$1.27~~ **$1.28**	~~$5,174,155~~ **$4,766,570**
Medicaid Expansion – Child	~~343,922~~ **366,275**	$15.92	~~$5,475,238~~ **$5,831,104**
Medicaid Expansion - Adult	~~3,949,943~~ **3,952,125**	~~$1.27~~ **$1.52**	~~$5,016,428~~ **$6,007,230**
HIPF			~~$3,904,023~~ **$4,342,896**
		Year 3 Total	~~$181,277,821~~ **$171,555,207**

Contract year 4 July 1, 2017 to June 30, 2018			
Rate Cell Description	**Projected Member Months**	**Projected Per Member Per Month Capitation Rate**	**Maximum Contract Amount**
LaCHIP Affordable Plan	**36,642**	**$20.46**	**$749,705**

Medicaid Children	**7,974,594**	**$16.40**	**$130,783,348**
CHIP	**1,436,362**	**$16.40**	**$23,556,336**
Medicaid Adult	**3,699,673**	**$1.31**	**$4,846,572**
Medicaid Expansion – Child	**443,887**	**$16.40**	**$7,279,740**
Medicaid Expansion - Adult	**4,753,892**	**$1.31**	**$6,227,599**
HIPF			**$0**
		Year 4 Total	**$173,443,300**
Contract year 5 July 1, 2018 to June 30, 2019			
Rate Cell Description	**Projected Member Months**	**Projected Per Member Per Month Capitation Rate**	**Maximum Contract Amount**
LaCHIP Affordable Plan	**37,017**	**$21.07**	**$779,953**
Medicaid Children	**8,055,661**	**$16.89**	**$136,060,108**
CHIP	**1,450,963**	**$16.89**	**$24,506,772**
Medicaid Adult	**3,734,902**	**$1.35**	**$5,042,118**
Medicaid Expansion – Child	**482,205**	**$16.89**	**$8,144,446**
Medicaid Expansion - Adult	**5,160,984**	**$1.35**	**$6,967,328**
HIPF			**$5,098,739**
		Year 5 Total	**$186,599,464**

	~~3 year~~ 5-year Maximum Contract Amount	**~~$495,042,713~~ $844,522,063**

DHH reserves the right to re-negotiate the PMPM rates:

a. If the rate floor is removed;

b. If a result of federal or state budget reductions or increases;

c. If due to the inclusion or removal of a Medicaid covered dental service(s) not incorporated in the monthly capitation rates; or

d. In order to comply with federal requirements.

Terms of Payment:

1. DHH shall make monthly capitated payments for each member enrolled into the DBPM in accordance with the capitation rates specified in contract Attachment E – Mercer Certification, Rate Development Methodology and Rates. Capitation rates will be developed in accordance with 42 CFR 438.6 and will include claims for retroactive coverage.

2. DBPM agrees to accept payment in full and shall not seek additional payment from a member for any unpaid costs, including costs incurred during the retroactive period of eligibility.

3. DHH reserves the right to defer remittance of the PMPM payment for June until the first Medicaid Management Information System (MMIS) payment cycle in July to comply with state fiscal policies and procedures.

4. The monthly capitated payment shall be based on Medicaid recipients eligible for DBPM participation during the month, as specified in III.B.3.B.11. i) ii. (p. 57, 2nd to last bullet), and paid in accordance with a schedule to be provided by DHH.

Effective Date of Enrollment

DBPM enrollment for members in a given month will be effective at 12:01AM on the first (1st) calendar day of the month of Medicaid eligibility.

Withhold of Capitation Rate

1. A withhold of the aggregate capitation rate payment shall be applied to provide an incentive for DBPM compliance with the requirements of this contract.
2. The withhold amount will be equivalent to two percent (2%) of the monthly capitation rate payment for all DBPM enrollees.
3. If DHH has not identified any DBPM deficiencies, DHH will pay to the DBPM the withhold of the DBPM's payments withheld in the month subsequent to the withhold.
4. If DHH has determined the DBPM is not in compliance with a requirement of this Contract in any given month, DHH may issue a written notice of non-compliance and DHH may retain the amount withheld for the month prior to DHH identifying the compliance deficiencies.
5. Monthly retention of the withhold amount may continue for each subsequent month so long as the identified deficiencies have not been corrected. If the same or similar deficiency(s) continues beyond timeframes specified for correction as determined by DHH and documented in a written notice of action to the DBPM. DHH may permanently retain the amount withheld for the period of non-compliance consistent with the administrative actions, monetary penalties, sanctions and liquidated damages provisions of this Contract. The timeframe specified in the written notice of action shall be considered the cure period not less than 30 days unless the deficiency reasonably requires resolution in a shorter time frame after which amounts retained may be permanently withheld.
6. Amounts withheld for failure to achieve established performance measurement goals, as defined in Section III.B.3.B.11.l.iii., may be permanently retained at DHH's discretion.
7. No interest shall be due to the DBPM on any sums withheld or retained under this Section.
8. The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this Contract.

Erik Axelsen, ASA, MAAA
Senior Associate

Kodzo Dekpe, ASA, MAAA
Associate

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MERCER
MAKE TOMORROW, TODAY

Ms. Pam Diez
Deputy Medicaid Director/Chief Financial Officer
Louisiana Department of Health
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821-0629

March 31, 2017

Subject: Louisiana Medicaid Dental Benefit Program Capitation Rate Certification for the Period July 1, 2017 through June 30, 2018

Dear Ms. Diez:

In partnership with the State of Louisiana (State), Mercer Government Human Services Consulting (Mercer) has developed statewide actuarially sound capitation rates for the Louisiana Medicaid Dental Benefit Program (DBP). These rates are applicable for the contract period July 1, 2017 through June 30, 2018.

This document presents an overview of the rate development, as well as a certification of its actuarial soundness, for the purpose of seeking rate approval from the Centers for Medicare & Medicaid Services (CMS) under 42 CFR 438.6(c). This rate development process was based on managed care encounter data and financial data provided by Managed Care of North America (MCNA) Dental, the current DBP contractor.

Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing, and administrative expenses, any government mandated assessments, fees, and taxes, and the cost of capital. Note: Please see page 2 of Actuarial Standard of Practice Number 49, Medicaid Managed Care Capitation Rate Development and Certification, issued March 2015 by the Actuarial Standards Board, http://www.actuarialstandardsboard.org/wp content/uploads/2015/03/asop049_179.pdf.

Dental Capitation Rates

The proposed actuarially sound rates for the DBP are shown in Table 1.

Table 1: Dental Capitation Rates

July 1, 2017 to June 30, 2018	
Rate Cell Description	**Monthly Capitation Rate Per Eligible**
LaCHIP Affordable Plan	$19.59
Medicaid Child/CHIP	$16.10
Medicaid Adult	$1.27

Managed Care Rate Development Methodology

Overview

Effective July 1, 2014, Louisiana implemented a managed DBP for Louisiana Children's Health Insurance Program (LaCHIP) Affordable Plan, Medicaid Children (including the primary LaCHIP program), and Medicaid Adult populations. The State's DBP has been in place since the 1990s providing dental services to Medicaid members in a fee-for-service (FFS) environment. The DBP covers preventive dental services for eligible members younger than age 21 and adult denture benefits for eligible members at age 21 and above. The managed DBP is expected to efficiently manage service costs and utilization, improve access to essential specialty dental services, and increase outreach and education to promote healthy dental behavior.

The capitation rates provided above have been developed consistent with guidance provided in the CMS Medicaid Managed Care Rate Development Guide. These actuarially sound dental capitation rates are based upon the State Plan-covered services only. Base period dental claims data were analyzed, completed, and trended. Adjustments were applied, as appropriate, to reflect programmatic changes to the State Plan that affect the base period data and the contract period. A Prepaid Ambulatory Health Plan (PAHP) administrative load assumption was developed and included. Each of these rating elements is discussed in detail below.

Base Period Data and Enrollment

For the period of July 1, 2017 through June 30, 2018 rate setting, Mercer relied on managed care encounter data from state fiscal years (SFYs) 2015 and 2016. Louisiana's SFY runs from July 1 of a given year through June 30 of the following year.

Mercer applied weights of 40.0% and 60.0% to the SFYs 2015 and 2016 data, respectively, to blend the data from the two fiscal years. The goal of the blending is to obtain a set of base data that has sufficient credibility and reasonableness to develop actuarially sound rates.

Mercer reviewed the data provided by the State for consistency and reasonableness and determined the data is appropriate for the purpose of setting capitation rates for the DBP. Mercer confirmed the services included in this historical experience are State Plan-covered services only.

Covered Populations

In general, the DBP covers most Medicaid eligible, LaCHIP, and the LaCHIP Affordable Plan populations including full dual eligibles. The LaCHIP population was included in the Medicaid Children category for the dental capitation rates.

Beginning July 1, 2016, the State began the Medicaid Expansion program [42 CFR 433.204 b(1)], which is an option for individuals who have a household income less than 138% of the Federal Poverty Level (FPL) and are not eligible for any other Medicaid program or Medicare. The individual must be aged 19 to 64 years old and meet citizenship requirements.

The DBP non-covered populations are shown in Appendix A.

Retroactive Eligibility

Per the State, membership and claims incurred for covered services rendered prior to enrollment and during any retroactive period up to 12 months of eligibility are covered in the DBP.

Under-Reporting Adjustment

The under-reporting adjustment was developed by comparing encounter data from the Medicaid Management Information System (MMIS) to financial information provided by MCNA. The adjustment was based on detailed quarterly reported financial data provided by MCNA. The year-end financial report is reviewed by the managed care organization's (MCO's) auditors using agreed upon procedures. The audit report accounts for any changes or recommendations recommended by the auditor. Additionally, the financial data is compared to the MCO's annual statutory filing using standards from the National Association of Insurance Commissioners, commonly known as the "Orange Blank," to check for accuracy and completeness.

The adjustment was developed and applied by Child versus Adult. The Child grouping combines Medicaid Child/CHIP and LaCHIP Affordable Plan. For SFY 2015, the adjustment resulted in an increase of the base per member per month (PMPM) by 1.57% and 9.60% for Child and Adult, respectively, totaling a 1.81% increase of the overall SFY 2015 base PMPM. For SFY 2016, the adjustment resulted in an increase of the base PMPM by 5.59% and 12.42% for Child and Adult, respectively, totaling a 5.77% increase of the overall SFY 2016 base PMPM.

Completion Factors

The encounter data include claims for dates of service from July 1, 2014 to June 30, 2016, and reflect payments through September 30, 2016. Mercer estimated and adjusted for the remaining liability associated with incurred-but-not-reported claims for SFY 2016. The overall adjustment using paid claims data through September 30, 2016 was 0.24% for SFY 2016 claims. The SFY 2015 claims were deemed complete as they reflect 15 months of runout.

Fraud and Abuse Adjustment

Fraud and abuse recoveries were included in the financial reports. These recoveries were included in the development of the under-reporting adjustment.

Trend Adjustments

Trend adjustments were based on analysis of Louisiana dental claims experience and review of dental trend benchmarks in other state Medicaid programs and commercial dental managed care programs. Mercer evaluated trend patterns to examine and project utilization trends for the rate period. The overall annualized PMPM trend assumption was 0.77%.

Co-Payments and Third Party Liability

An adjustment for co-payments was not necessary for this analysis because both the Legacy Medicaid program and the DBP are not subject to co-payments. Recoveries associated with third party liability and subrogation have been removed from claims by selecting only MCO paid amounts.

Programmatic Changes

Medicaid Expansion

Effective July 1, 2016, individuals who gained medical coverage through the Medicaid Expansion program became also eligible for the DBP. Mercer evaluated the impact of the program change and assumed the following based on a review of the current adult covered population's experience:

- *Expected lag between first month of enrollment and first month of service*: Mercer assumed a 1- to 2-month lag, given the time it would take new enrollees to familiarize themselves with the DBP, in general, and to obtain some services such as extractions and fillings (not covered by the DBP), which are a prerequisite for using the covered removable prosthodontics services in certain cases.
- *Expected penetration/pent-up demand factor*: Pent-up demand is expected to be met following 12 months of continuous enrollment. After accounting for new enrollment and disenrollment,

Mercer assumed a factor between 0.00% and 5.00% higher utilization per 1,000 for the Expansion population, compared to the DBP non-Expansion adult population.

After sensitivity testing the assumptions above, the resulting prospective program change adjustments applied to the projected PMPMs are shown in Table 2.

Table 2: Medicaid Expansion Impact Assumptions

Rate Cell Description	PMPM Adjustment
LaCHIP Affordable Plan	0.00%
Medicaid Children	0.00%
Medicaid Adult	2.00%

No adjustment was applied to the child rate cells as the child subgroup of the Medicaid expansion is small compared to the DBP non-Expansion child population. Moreover, most of the Medicaid Expansion child population has likely been eligible for Medicaid or LaCHIP and is aging out into the adult Expansion group.

Given the limited scope of services covered for adults, the adult Expansion and non-Expansion populations were grouped together as Mercer does not expect materially different risk profiles for the Expansion population compared to the non-Expansion population. Mercer will continue to monitor the experience of the two groups to determine whether it is necessary to rate them separately.

The Expansion programmatic change increased the overall PMPM by 0.19%.

Administrative Load

The proposed capitation rates shown above include provision for dental (PAHP) administration and profit. Mercer relied upon its professional experience in working with numerous commercial managed dental plans and state Medicaid programs in determining appropriate non-medical expenses. The loads for non-medical expenses and underwriting gain are calculated as percentages of the capitation rate net of premium tax. The load for premium tax is calculated as a percentage of the final capitation rate. The proposed capitation rate, as developed, assumes a 9.00% load for non-medical expenses, 2.00% underwriting gain, and 2.25% premium tax for this rate period. In total, the overall load applied to the rates for administration and profit/contingencies was 13.00%.

Federal Health Insurance Provider Fee

Section 9010 of the ACA established a health insurance provider fee (HIPF), which applies to certain for-profit/tax-paying health insurers. For-profit Medicaid health plans are not exempt from the HIPF, which will become a cost of doing business that is appropriate to recognize in actuarially sound capitation rates.

At the time of this certification, many aspects of the calculation and application of this fee are not yet determined. This fee is calculated on an annual basis. The fee will be calculated and become payable during the third quarter of 2018. As this fee is not yet defined by insurer and by marketplace, no adjustment has been made in the rate development for the DBP. An adjustment and supplemental certification will be issued, if necessary, when the fee amount and impacted entities applicable to this rate period are announced in 2018.

Actuarial Certification

In preparing the capitation rate for the contract period July 1, 2017 through June 30, 2018 , Mercer used and relied upon enrollment, eligibility, FFS and encounter data, fee schedule, and benefit design information supplied by the State. The State is responsible for the validity and completeness of this supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. If the data and information is incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies the rate was developed in accordance with generally accepted actuarial practices and principles, and is appropriate for the Medicaid and LaCHIP covered populations and services under the managed care contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Capitation rates developed by Mercer are actuarial projections of future contingent events. Actual dental claims costs will differ from these projections. Mercer has developed this rate on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and in accordance with applicable law and regulations. Use of the rates for any purpose beyond that stated may not be appropriate.

The health plans are advised that the use of the rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of the rates by the health plans for any purpose. Mercer recommends that any health plan considering contracting with the State should analyze its own projected dental expense, administrative expense, and any other premium needs for comparison to the rates before deciding whether to contract with the State.

This certification letter assumes the reader is familiar with the Louisiana DBP, DBP eligibility rules, and actuarial rating techniques. It is intended for the State 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. This document should only be reviewed in its entirety.

If you have any questions or comments on the assumptions or methodology, please contact Erik Axelsen at +1 404 442 3517 or Kodzo Dekpe at +1 404 442 3296.

Sincerely,

Erik Axelsen

Erik Axelsen, ASA, MAAA
Senior Associate

Kodzo Dekpe

Kodzo Dekpe, ASA, MAAA
Associate

Appendix A

Type Case	Type Case Description	Aid Category	Aid Category Description	Excluded non-Expansion populations?
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	11	Hurricane Evacuees	Yes
002	Deemed Eligible	11	Hurricane Evacuees	Yes
005	SSI/LTC	11	Hurricane Evacuees	Yes
007	LACHIP Phase 1	11	Hurricane Evacuees	Yes
008	PAP - Prohibited AFDC Provisions	11	Hurricane Evacuees	Yes
009	LIFC - Unemployed Parent / CHAMP	11	Hurricane Evacuees	Yes
013	CHAMP Pregnant Woman (to 133% of FPIG)	11	Hurricane Evacuees	Yes
014	CHAMP Child	11	Hurricane Evacuees	Yes
015	LACHIP Phase 2	11	Hurricane Evacuees	Yes
020	Regular MNP (Medically Needy Program)	11	Hurricane Evacuees	Yes
021	Spend-Down MNP	11	Hurricane Evacuees	Yes
025	LTC Spend-Down MNP	11	Hurricane Evacuees	Yes
027	EDA Waiver	11	Hurricane Evacuees	Yes
028	Tuberculosis (TB)	20	TB	Yes
040	SLMB (Specified Low-Income Medicare Beneficiary)	01	Aged	Yes
040	SLMB (Specified Low-Income Medicare Beneficiary)	02	Blind	Yes
040	SLMB (Specified Low-Income Medicare Beneficiary)	04	Disabled	Yes

Type Case	Type Case Description	Aid Category	Aid Category Description	Excluded non-Expansion populations?
047	Illegal/Ineligible Aliens Emergency Services	01	Aged	Yes
047	Illegal/Ineligible Aliens Emergency Services	03	Families and Children	Yes
047	Illegal/Ineligible Aliens Emergency Services	04	Disabled	Yes
047	Illegal/Ineligible Aliens Emergency Services	11	Hurricane Evacuees	Yes
048	QI-1 (Qualified Individual - 1)	01	Aged	Yes
048	QI-1 (Qualified Individual - 1)	02	Blind	Yes
048	QI-1 (Qualified Individual - 1)	04	Disabled	Yes
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	01	Aged	Yes
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	04	Disabled	Yes
050	PICKLE	11	Hurricane Evacuees	Yes
053	CHAMP Pregnant Woman Expansion (to 185% FPIG)	11	Hurricane Evacuees	Yes
055	LACHIP Phase 3	11	Hurricane Evacuees	Yes
059	Disabled Adult Child	11	Hurricane Evacuees	Yes
062	SSI/Public ICF/DD	01	Aged	Yes
062	SSI/Public ICF/DD	02	Blind	Yes
062	SSI/Public ICF/DD	04	Disabled	Yes
062	SSI/Public ICF/DD	06	OCS Foster Care	Yes
062	SSI/Public ICF/DD	08	IV-E OCS/OYD	Yes
062	SSI/Public ICF/DD	22	OCS/OYD (XIX)	Yes
063	LTC Co-Insurance	01	Aged	Yes

Type Case	Type Case Description	Aid Category	Aid Category Description	Excluded non-Expansion populations?
063	LTC Co-Insurance	02	Blind	Yes
063	LTC Co-Insurance	04	Disabled	Yes
063	LTC Co-Insurance	11	Hurricane Evacuees	Yes
064	SSI/Private ICF/DD	01	Aged	Yes
064	SSI/Private ICF/DD	02	Blind	Yes
064	SSI/Private ICF/DD	04	Disabled	Yes
064	SSI/Private ICF/DD	06	OCS Foster Care	Yes
064	SSI/Private ICF/DD	08	IV-E OCS/OYD	Yes
064	SSI/Private ICF/DD	22	OCS/OYD (XIX)	Yes
065	Private ICF/DD	01	Aged	Yes
065	Private ICF/DD	02	Blind	Yes
065	Private ICF/DD	04	Disabled	Yes
065	Private ICF/DD	06	OCS Foster Care	Yes
065	Private ICF/DD	08	IV-E OCS/OYD	Yes
065	Private ICF/DD	22	OCS/OYD (XIX)	Yes
083	Acute Care Hospitals (LOS > 30 days)	11	Hurricane Evacuees	Yes
088	Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	11	Hurricane Evacuees	Yes
090	LTC (Long Term Care)	11	Hurricane Evacuees	Yes
094	QDWI	04	Disabled	Yes
095	QMB (Qualified Medicare Beneficiary)	17	QMB	Yes

Type Case	Type Case Description	Aid Category	Aid Category Description	Excluded non-Expansion populations?
099	Public ICF/DD	01	Aged	Yes
099	Public ICF/DD	02	Blind	Yes
099	Public ICF/DD	03	Families and Children	Yes
099	Public ICF/DD	04	Disabled	Yes
099	Public ICF/DD	06	OCS Foster Care	Yes
099	Public ICF/DD	08	IV-E OCS/OYD	Yes
099	Public ICF/DD	22	OCS/OYD (XIX)	Yes
100	PACE SSI	01	Aged	Yes
100	PACE SSI	02	Blind	Yes
100	PACE SSI	04	Disabled	Yes
101	PACE SSI-related	02	Blind	Yes
101	PACE SSI-related	01	Aged	Yes
101	PACE SSI-related	04	Disabled	Yes
102	GNOCHC Adult Parent	30	Non Traditional	Yes
103	GNOCHC Childless Adult	30	Non Traditional	Yes
104	Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL	11	Hurricane Evacuees	Yes
115	Family Planning, Previous LAMOMS eligibility	40	Family Planning	Yes
115	HPE Family Planning	16	Presumptive Eligible	Yes
116	Family Planning, New eligibility / Non LA MOM	40	Family Planning	Yes

Type Case	Type Case Description	Aid Category	Aid Category Description	Excluded non-Expansion populations?
116	HPE Family Planning	16	Presumptive Eligible	Yes
132	Spend-Down Denial of Payment/Late Packet	01	Aged	Yes
132	Spend-Down Denial of Payment/Late Packet	02	Blind	Yes
132	Spend-Down Denial of Payment/Late Packet	04	Disabled	Yes
136	Private ICF/DD Spend-Down Medically Needy Program	01	Aged	Yes
136	Private ICF/DD Spend-Down Medically Needy Program	02	Blind	Yes
136	Private ICF/DD Spend-Down Medically Needy Program	04	Disabled	Yes
137	Public ICF/DD Spend-Down MNP	01	Aged	Yes
137	Public ICF/DD Spend-Down Medically Needy Program	02	Blind	Yes
137	Public ICF/DD Spend-Down Medically Needy Program	04	Disabled	Yes
138	Private ICF/DD Spend-Down MNP/Income Over Facility Fee	02	Blind	Yes
138	Private ICF/DD Spend-Down MNP/Income Over Facility Fee	04	Disabled	Yes
139	Public ICF/DD Spend-Down MNP/Income Over Facility Fee	02	Blind	Yes
139	Public ICF/DD Spend-Down MNP/Income Over Facility Fee	04	Disabled	Yes
140	SSI Private ICF/DD Transfer of Resources	02	Blind	Yes
140	SSI Private ICF/DD Transfer of Resources	04	Disabled	Yes
141	Private ICF/DD Transfer of Resources	02	Blind	Yes
141	Private ICF/DD Transfer of Resources	04	Disabled	Yes
142	SSI Public ICF/DD Transfer of Resources	02	Blind	Yes
142	SSI Public ICF/DD Transfer of Resources	04	Disabled	Yes

Type Case	Type Case Description	Aid Category	Aid Category Description	Excluded non-Expansion populations?
143	Public ICF/DD Transfer of Resources	02	Blind	Yes
143	Public ICF/DD Transfer of Resources	04	Disabled	Yes
144	Public ICF/DD MNP Transfer of Resources	02	Blind	Yes
144	Public ICF/DD MNP Transfer of Resources	04	Disabled	Yes
145	Private ICF/DD MNP Transfer of Resources	02	Blind	Yes
145	Private ICF/DD MNP Transfer of Resources	04	Disabled	Yes
178	Disabled Adults authorized for special hurricane Katrina assistance	11	Hurricane Evacuees	Yes
201	1915(i) Behavioral Health only - adults	40	Non Traditional	Yes
201	LBHP - Adult 1915(i)	01	LBHP	Yes
201	LBHP - Adult 1915(i)	02	LBHP	Yes
201	LBHP - Adult 1915(i)	03	LBHP	Yes
201	LBHP - Adult 1915(i)	04	LBHP	Yes
205	LBHP - Adult 1915(i)	01	LBHP	Yes
205	LBHP - Adult 1915(i)	02	LBHP	Yes
205	LBHP - Adult 1915(i)	03	LBHP	Yes
205	LBHP - Adult 1915(i)	04	LBHP	Yes
212	Family Planning/Take Charge Transition	03	Family Planning	Yes
212	HPE Family Planning Elig Options	16	Presumptive Eligible	Yes

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Appendix B: Dental Capitation Rate Development (July 2017 - June 2018)

Table 1a

	[A]	[B]	Base Data Adjustments [C]	[D]	[E]	[F]	[G]
Rate Cell Description	SFY 2015 MMs	SFY 2015 PMPM	Under-reporting	IBNR	Annual Trend	Trend Month	Trended PMPM
LaCHIP Affordable Plan	37,860	$ 16.89	1.57%	0.00%	0.77%	36	$ 17.55
Medicaid/CHIP Child	9,359,013	$ 13.36	1.57%	0.00%	0.77%	36	$ 13.89
Medicaid Adult	3,669,446	$ 1.06	9.60%	0.00%	0.77%	36	$ 1.19
Total	13,066,319	$ 9.92	1.81%				$ 10.33

Table 1b

	[A]	[B]	Base Data Adjustments [C]	[D]	[E]	[F]	[G]
Rate Cell Description	SFY 2016 MMs	SFY 2016 PMPM	Under-reporting	IBNR	Annual Trend	Trend Month	Trended PMPM
LaCHIP Affordable Plan	34,820	$ 15.55	5.59%	0.20%	0.77%	24	$ 16.70
Medicaid/CHIP Child	9,525,387	$ 13.12	5.59%	0.21%	0.77%	24	$ 14.09
Medicaid Adult	3,845,965	$ 0.88	12.42%	1.45%	0.77%	24	$ 1.02
Total	13,406,172	$ 9.61	5.77%	0.24%			$ 10.35

Notes:
[G] = [B] x (1 + [C]) x (1 + [D])x (1 + [E])^([F] / 12)

Table 2

	[A]	Other Rating Adjustment [B]	[C]	Retention Load [D]	[E]	[F]	[G]	[H]
Rate Cell Description	Blended PMPM	Medicaid Expansion	Projected Benefit Expense PMPM	Admin %	Underwriting Gain	Premium Tax	Total	Final Loaded Rate
LaCHIP Affordable Plan	$ 17.04		$ 17.04	9.00%	2.00%	2.25%	13.00%	$ 19.59
Medicaid/CHIP Child	$ 14.01		$ 14.01	9.00%	2.00%	2.25%	13.00%	$ 16.10
Medicaid Adult	$ 1.08	2.00%	$ 1.11	9.00%	2.00%	2.25%	13.00%	$ 1.27

Notes:
[A] = 0.40 X Table 1a [A] + 0.60 X Table 1b [A]
[C] = [A] x (1+[B])
[G] = 1 - (1 - ([D] + [E])) x (1 - [F])
[H] = [C] / (1 - [G])

Medical Loss Ratio (MLR) Requirements

A Dental Benefit Plan Manager (DBPM) that receives capitation payments to provide dental benefits and services to Louisiana Medicaid members is required to rebate a portion of the capitation payment to LDH in the event the DBPM does not meet the eighty five percentage (85%) MLR standard. This document describes requirements for 1) reporting MLR, 2) methodology for calculation of MLR, 3) record retention 4) payment of any rebate due LDH, and 4) monetary penalties that may be assessed against the DBPM for failure to meet requirements.

Definitions

Direct Paid Claims – claim payments before ceded reinsurance and excluding assumed reinsurance except as otherwise provided in this Appendix.

MLR Reporting Year – calendar year during which dental benefits and services are provided to Louisiana Medicaid members through contract with LDH.

Unpaid Claim Reserves – reserves and liabilities established to account for claims that were incurred during the MLR reporting year but had not been paid within three months of the end of the MLR reporting year.

Reporting Requirements

A. **General Requirements**
For each MLR reporting year, the DBPM must submit to LDH a report which complies with the requirements that follow concerning capitation payments received and expenses related to Louisiana Medicaid enrollees (referred to hereafter as MLR Report).

B. Timing and Form of Report
The report for each MLR reporting year must be submitted to LDH by December 31 of the year following the end of an MLR reporting year, on a form and in the manner prescribed by LDH. A claims run-out period of at least 90 days subsequent the end of the MLR reporting period is required for the final MLR report due December 31.

C. Capitation Payments
The DBPM must report to LDH the total capitation payments received from Louisiana Medicaid for each MLR reporting year. Total capitation payments means all monies paid by LDH to the DBPM for providing dental benefits and services as defined in the terms of the contract.

Reimbursement for Clinical Services Provided to Enrollees

A. General Requirements
The MLR Report must include direct claims paid to or received by providers, whose services are covered by the subcontract for clinical services or supplies covered by LDH's contract with the DBPM. In addition, the report must include claim reserves associated with claims incurred during the MLR reporting year, the change in contract reserves, reserves for contingent benefits and the claim portion of lawsuits, and any

experience rating refunds paid or received. Reimbursement for clinical services as defined in this section is referred to as “incurred claims.”

1. Incurred Claims must include changes in unpaid claims between the prior year's and the current year's unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to subcontracted providers, claims that are recoverable for anticipated coordination of benefits (COB), and claim recoveries received as a result of subrogation.

2. Incurred claims must include the change in claims incurred but not reported from the prior year to the current year. Except where inapplicable, the reserve should be based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.

3. Incurred claims must include changes in other claims-related reserves.

4. Incurred claims must exclude rebates paid to LDH based upon prior MLR reporting year experience.

B. Adjustments to incurred claims:

1. Adjustments that must be deducted from incurred claims:

    a. Overpayment recoveries received from providers not included in expense lines on Schedule A

2. Adjustments that may be included in incurred claims:

    a. The amount of incentive and bonus payments made to providers if not included in the expense lines on Schedule A

3. Adjustments that must not be included in incurred claims:

    a. Amounts paid to third party vendors for secondary network savings
    b. Amounts paid to third party vendors for network development administrative fees, claims processing, and utilization management
    c. Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for Covered services provided to an enrollee. For example, medical record copying costs, attorneys' fees, subrogation vendor fees, compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel and medical record clerks must not be included in incurred claims.

Activities that Improve Health Care Quality

A. General Requirements

The MLR may include expenditures for activities that improve health care quality, as described in this section.

B. Activity Requirements

Activities conducted by a DBPM to improve quality must meet one or more of the following requirements:

1. The activity must be primarily designed to:

    a. Improve health quality;
    b. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;
    c. Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees;
    d. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations;
    e. Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations:

        1. Examples include the direct interaction of the DBPM (including those services delegated by subcontract for which the DBPM retains ultimate responsibility under the terms of the contract with LDH) 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 health outcomes, including activities such as:

            (a) Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in the RFP and contract;
            (b) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;
            (c) Quality reporting and documentation of care in non-electronic format;
            (d) Health information technology to support these activities;

    f. Accreditation fees directly related to quality of care activities;

    g. Improve patient safety, reduce medical errors, and lower infection and mortality rates.

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

            (a) The appropriate identification and use of best clinical practices to avoid harm;
            (b) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or

safety concerns;
(c) Activities to lower the risk of facility-acquired infections;
(d) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and,
(e) Health information technology to support these activities.

h. Implement, promote, and increase wellness and health activities:

1. Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include:

(a) Wellness assessments;
(b) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
(c) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
(d) Public health education campaigns that are performed in conjunction with the Louisiana Office of Public Health ;
(e) Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in payments or claims;
(f) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;
(g) Coaching or education programs and health promotion activities designed to change member behavior and conditions; and,
(h) Health information technology to support these activities.
(i) Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology.

A. Exclusions

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

a. Those that are designed primarily to control or contain costs;
b. The pro rata share of expenses that are for lines of business or products other than Louisiana Medicaid;
c. Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from LDH capitation payments;
d. Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;
e. 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 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements);
f. That portion of the activities of health care professional hotlines that does not

meet the definition of activities that improve health quality;
g. All retrospective and concurrent utilization review;
h. Fraud prevention activities, other than fraud detection/recovery expenses up to the amount recovered that reduces incurred claims;
i. 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;
j. Provider credentialing;
k. Marketing expenses;
l. Costs associated with calculating and administering individual enrollee or employee incentives;
m. That portion of prospective utilization that does not meet the definition of activities that improve health quality;
n. State and federal taxes. licensing and regulatory fees; and,
o. Any function or activity not expressly included in paragraph (c) of this section, unless otherwise approved by and within the discretion of LDH, upon adequate showing by the DBPM that the activity's costs support the definitions and purposes described above or otherwise support monitoring, measuring or reporting health care quality improvement.

Expenditures Related to Health Information Technology and Meaningful Use Requirements

A. General Requirements

The DBPM may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities that are designed for use by theDBPM, DBPM providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with HHS meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

1. Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their “meaningful use” as defined by HHS to the extent such payments are not included in reimbursement for clinical services;
2. Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicaid incentive payments;
3. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;
4. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA, URAC, or Joint Commission on Accreditation of Healthcare Organizations, or costs for reporting to LDH on quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures);
5. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

6. Advancing the ability of enrollees, providers, DBPM or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history and to support care management;
7. Reformatting, transmitting or reporting data to national or international government-based health organizations, as may be required by LDH, for the purposes of identifying or treating specific conditions or controlling the spread of disease; and,
8. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

Other Non-Claims Costs

A. General Requirements

The MLR Report must include non-claims costs described in paragraph B of this section and must provide an explanation of how capitation payments are used, other than to provide reimbursement for clinical services included in core benefits and services, expenditures for activities that improve health care quality, and expenditures related to Health Information Technology and meaningful use requirements.

B. Non-Claims Costs Other

1. The MLR Report must include any expenses for administrative services that do not constitute adjustments to capitation for clinical services to enrollees, or expenditures on quality improvement activities as defined above.

2. Expenses for administrative services include the following:

    a. Cost-containment expenses not included as an expenditure related to a qualifying quality activity;
    b. Loss adjustment expenses not classified as a cost containment expense;
    c. Workforce salaries and benefits;
    d. General and administrative expenses; and,
    e. Community benefits expenditures.

Allocation of Expenses

A. 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 pro-rated between types of expenses. Expenditures that benefit lines of business other than Louisiana Medicaid must be reported on a pro rata share.

B. Description of the Methods Used to Allocate Expenses

The report required must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, and other non-claims costs resulting from DBPM activities in Louisiana. A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

1. 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 will generally be the most accurate method. If a specific identification is not feasible, the DBPM 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;
2. 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; and,
3. 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. Any profit margin included in costs for related party administrative agreements should be excluded.

C. Maintenance of Records

The DBPM must maintain and make available to LDH upon request the data used to allocate expenses reported, together with all supporting information required to determine that the methods identified and reported as required under paragraph (b) of this section were accurately implemented in preparing the MLR Report.

Formula for Calculating Medical Loss Ratio

A. Medical Loss Ratio

1. The DBPM MLR is the ratio of the numerator, as defined in paragraph “a” of this section, to the denominator, as defined in paragraph “b” of this section.

2. The DBPM MLR shall be rounded to three decimal places. For example, if an MLR is 0.7988, it shall be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it shall be rounded to 0.825 or 82.5 percent.

    a. The **numerator** of the DBPM MLR for an MLR reporting year must be the DBPM's incurred claims plus the DBPM's expenditures for activities that improve health care quality. The numerator of an MLR reporting year shall include Total medical Expenses defined as follows:
        i. Incurred Claims
        ii. Plus MLR Expense Addition Adjustments as applicable:
            1. State subsidized stop-loss payments
            2. Provider incentive or bonus payments
            3. Administrative expense activities that improve health care quality
            4. HIT meaningful use expenses
        iii. Other adjustments for non-claim costs
        iv. Minus MLR Expense Reduction Adjustments as applicable:
            1. Claims that are recoverable for anticipated COB
            2. Subrogation recoveries
            3. Amounts paid to third party vendors for secondary network savings

4. Amounts paid to providers for non-Covered services
5. Prior year MLR rebates paid to LDH
6. Provider overpayments recovered
7. Administrative expense exclusions

v. Enhanced Benefit expenses not covered by Medicaid. This does NOT include expenses provided in lieu of Covered Medicaid services

b. The **denominator** of a DBPM's MLR must equal the DBPM's capitation payments received from LDH. The denominator of an MLR reporting year shall include Total Capitation Revenue less premium taxes unless a deduction for community benefit expenditures is taken, less the HIPF. Premium taxes and HIPF are excluded because they are pass-through administrative costs and including reimbursement for them would adversely affect ratios.

Rebating Capitation Payments if the 85% Medical Loss Ratio Standard is Not Met

A. General Requirement

For each MLR reporting year, the DBPM must provide a rebate to LDH if the DBPM's MLR does not meet or exceed the eight five percentage (85%) requirement.

B. Amount of Rebate

For each MLR reporting year, the DBPM must rebate to LDH the difference between the total amount of capitation payments received by the DBPM from LDH multiplied by the required MLR of 85% and the DBPM's actual MLR.

C. Timing of Rebate

The DBPM must provide any rebate owing to LDH no later than February 1 following the end of the MLR reporting year.

D. Late Payment Interest

A DBPM that fails to pay any rebate owing to LDH in accordance with paragraph “B” of this section or to take other required action within the time periods set forth in this Part must, in addition to providing the required rebate to LDH, pay LDH interest at the current Federal Reserve Board lending rate or ten percent annually, whichever is higher, on the total amount of the rebate, accruing from August 1.