MCO Financial Reporting Guide

Revised December 17, 2021

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Introduction and General Instructions

1.01 Introduction

The provisions and requirements of this Financial Reporting Guide (Guide) are effective January 1, 2022. The purpose of this Guide is to set forth quarterly and annual reporting requirements for Healthy Louisiana Contractors (Contractors) contracted with the Louisiana Department of Health (LDH), Bureau of Health Services Financing for Managed Care Organization (MCO) care. The Guide instructions and reports are supplementary to any Louisiana Department of Insurance (LDI) financial reporting requirements. This Guide does not replace any LDH 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. Submit all reports as outlined in the general and report-specific instructions. The financial reports 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 Guide. Current contractual requirements can be found at makingmedicaidbetter.com. This reporting guide may be revised as deemed necessary by LDH. 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 LDH. This reporting guide is supplemental to any reporting provisions required by LDH, state, and federal law or LDI.

1.02 Reporting Time Frames

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

Schedule	Report Name	Frequency	Due Date1	Format
A	Balance Sheet	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
B	Revenue Accrual	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
C	Income Statement	Quarterly	May 31, August 31, November 30, and February 28 (February 28 version will be considered Draft Annual).	Predetermined
C1	SBH Income Statement	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
D	Footnote Disclosures	Quarterly and Annually	May 31, August 31, November 30, and February 28 for quarterly, and June 30 for annual.	Narrative
E	Total Profitability by Eligibility Category	Quarterly	This Schedule is a roll-up of F–I. Data is not entered on this Schedule.	Predetermined
F–I	Region Profitability	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
J	Total SBH Profitability by Eligibility Category	Quarterly	This schedule is a roll-up of K–N. Data is not entered on this schedule.	Predetermined
K–N	Regional SBH Profitability	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
O	Medical Liability Summary	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
P	Received But Unpaid Claims	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
Q	Enrollment Table	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
R	Inpatient Services Lag	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
S	Outpatient Facility Services Lag	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
T	Professional Services Lag	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined

Schedule	Report Name	Frequency	Due Date1	Format
U	SBH Lag	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
V	Other Medical Services Lag	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
W	Pharmaceutical Lag	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
X	Pharmaceutical Statistics	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
Y	Pharmaceutical Statistics Financial Disclosures	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
Z	Member Value-Added Services	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
AA	In Lieu of Services	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
AB	Delegated Vendors	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
AC	FQHC/RHC Payments	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
AD	Third Party Resource Payments	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
AE	TPL Subrogation	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
AF	Fraud and Abuse	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
AG	Maternity and Delivery	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
AH	Utilization Summary	Quarterly and Annually	This schedule is a roll-up of AH-AK. Data is not entered on this schedule.	Predetermined
AI–AL	Regional Utilization	Quarterly and Annually	May 31, August 31, November 30, and February 28 for Quarterly; and June 30 for Annual.	Predetermined
AM	SBH Utilization Summary	Quarterly and Annually	(This schedule is a roll-up of AM-AP. Data is not entered on this schedule.)	Predetermined
AN–AQ	Regional SBH Utilization	Quarterly and Annually	May 31, August 31, November 30, and February 28 for Quarterly; and June 30 for Annual.	Predetermined

Schedule	Report Name	Frequency	Due Date[1]	Format
AR	Hospital Settlements	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
AS	Retroactive Enrollment Lag	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
AT	HBR Calculation	Quarterly and Annually	May 31, August 31, November 30, and February 28 for Quarterly; and June 30 for Annual.	Predetermined
AU	Parent Company Audited Financial Statements	Annually	June 30.	Embedded PDF
AV	Louisiana Level Entity Audited Financial Statements	Annually	June 30.	Embedded PDF
AW	MCO Agreed Upon Procedures	Annually	June 30 (Final to be completed *before* Annual MLR Report).	Embedded PDF
AX	Annual Income Statement Reconciliation	Draft and Final Annually	February 28 (Draft) and June 30 (Final).	Predetermined
AY	Agreed Upon Procedures Adjustments	Annually	June 30.	Predetermined
AZ	Administration Summary	Annually	February 28 (Draft) and June 30 (Final).	Predetermined
BA	Supplemental working area	As needed	As needed.	Narrative
Appendix A	MLR Requirement	Quarterly	May 31, August 31, November 30, and February 28.	Predetermined
Appendix A	MLR Requirement	Annual	June 30.	Predetermined
Appendix B	COS Specification Guidance	As needed	As needed.	Narrative
Appendix C	Pharmaceutical Non-Drug List	As needed	As needed.	Narrative
Appendix D	COVID-19 Risk Corridor	As needed	As needed.	Narrative

[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 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 LDH under this Guide are to represent only **covered revenues and expenses** for recipients eligible for the Healthy Louisiana Program. Covered revenues and expenses are based on the Healthy Louisiana contract, which may include State Plan, waiver, in lieu of, member value-added, incentive, and other contractually covered activities. Certain contractually required activities may include non-Medicaid revenues and expenses, and specific fields are provided as needed to capture that information.

All quarterly and annual reports must be completed and submitted to LDH by the due dates outlined above. LDH 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.

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.

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 Medical Expense” is reported with a value that is equal to 5% or higher of “Total Other Medical Expenses,” disclosure would be necessary. Such disclosure is to be documented on Schedule D — Footnotes, line item 3. Refer to the Schedule BA — Supplemental Working Area 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 electronically, using Excel spreadsheets in the format, and on the template specified in this Guide without alteration.

Please submit the completed electronic copies of the reports and required supplemental materials, such as narrative support for “Other” categories that are considered material in nature, as required by LDH Reporting.

If a previously unaudited quarter is changed materially, that quarter’s report should be resubmitted with an explanation for the change.

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 Certification Statement should include the Contractor name, period ended, 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 an "Instructions & Check figures" 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 LDH upon request the data used to complete any reports contained within this Guide.

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Quarterly Report Specifications

Medicaid Metrics

The template includes a Medicaid Metrics worksheet that evaluates information contained within the reports and highlights key metrics monitored by LDH. The data fields are automatically calculated within this tab.

Metric	Definition
Current Ratio	Current assets divided by current liabilities with separate metrics for the current year to date (YTD) figures and prior year ending figures.
Defensive Interval Ratio	Cash and equivalents divided by the average expense per day.
Risk-Based Capital ratio	Equity or net assets divided by the average of one-half of one month's medical expenses covered under capitation.
Days of Service Expenses in IBNR	IBNR divided by the average daily medical expense.
Total Revenue	The total YTD revenue from the Income Statement.
Capitation Adjustments	Adjustments to remove investment income, other income, taxes, and the provision for full Medicaid pricing.
Adjusted Capitation	Total revenue plus the capitation adjustments.
Net Income (Loss) From Operations	Total revenue less total expenses.
Net Result of Fraud, Waste, and Abuse	Fraud, waste and abuse recoveries from the income statement.
Adjusted Net Medical/Adjusted Capitation	Total medical expenses less the provision for full Medicaid pricing and changes in prior period IBNR divided by adjusted capitation.
Total Administration/Adjusted Capitation	The sum of administrative expenses divided by adjusted capitation.
Operating Income/Adjusted Capitation	One minus the sum of the adjusted net medical and total administration ratios.
Total Cost of Care Per Member Per Month (PMPM)	YTD adjusted net medical expenses divided by member months.
Enrollment Growth	Annualized YTD member months divided by prior year member months.

Metric	Definition
PMPMs by Program and Category of Service (COS)	Net adjusted medical expenses PMPMs without the provision for full Medicaid pricing by program and major COS.

2.01 Schedule A: Balance Sheet

The template is separated into three sections. The first section is for Healthy Louisiana Medicaid, the second section is for all Other Lines of Business, and the third is the Total, which should tie to the entity's balance sheet. MCOs should report allocation methodologies for figures on this schedule within the footnotes. In total, figures within this report should be equal to the MCO general ledger as well as the audited financial reports.

Current assets are assets that are expected to be converted into cash, used, or consumed within one year from the date of the balance sheet. Statutory deposits, restricted assets for the general risk reserves, etc., are not to be included as current assets.

Specification	Inclusion	Exclusion
Cash and Cash Equivalents	Cash and cash equivalents available for current use. Cash equivalents are investments maturing 90 days or less from the date of purchase.	Restricted cash (and equivalents) and any investments pledged by the Contractor to satisfy minimum net worth requirements.
Short-Term Investments	Investments that are readily marketable and are expected to be redeemed or sold within one year of the balance sheet date.	Investments maturing 90 days or less than one year from the date of purchase and restricted securities.
Medicaid Capitation Receivable	Capitation payments earned, but not yet received from LDH.	Other receivables from LDH.
Investment Income Receivable	Income earned, but not yet received from cash equivalents, investments, performance bonds or short- and long-term investments.	
Reinsurance Receivable	Accrued reinsurance receivable amounts due to contractual agreements with reinsurance contractors.	
Withhold Receivable Current Year	Revenue expected to be received from withhold on capitation revenue for the current reporting year.	Withhold receivables from prior years.
Withhold Receivable Prior Years	Revenue expected to be received from withhold on capitation revenue from prior reporting years.	Withhold receivables from the current year.
Quality Incentive Receivables	Revenue expected to be received from earned quality incentives.	
Value-Based Purchasing (VBP) Receivables	Receivables for shared savings or risk sharing from providers in VBP arrangements that are linked to the LDH quality strategy and rooted in evidenced-based practices.	APMs not linked to the LDH quality strategy.
Alternative Payment Methodology (APM) Receivables	Receivables for alternative payment arrangements from providers that are not linked to the LDH quality strategy. For example, pay for reporting.	VBPs linked to the LDH quality strategy.

Specification	Inclusion	Exclusion
Due from Affiliates (Current)	Receivables from related-party organizations expected to be received within one year.	
Other Current Assets	The total current portion of other assets, which will include all other assets not accounted for elsewhere on the balance sheet. Any receivables from providers due to overpayments should be accounted for in this line item.	

Other assets are assets that are expected to be held for greater than one year of the balance sheet date.

Specification	Inclusion	Exclusion
Statutory Deposits	Amounts deposited under the LDI regulations that require the Contractor to maintain a minimum level of tangible net equity, if applicable.	
Restricted Cash and Other Assets	Cash, securities, receivables, etc., whose use is restricted, including performance bonds (if applicable).	Cash and/or investments pledged by the Contractor to satisfy LDI or LDH statutory deposit requirements.
Due from Affiliates (Non-Current)	Receivables from related-party organizations not expected to be received within one year.	
Long-Term Investments	Investments maturing 90 days or less than one year from the date of purchase and restricted securities.	Investments that are readily marketable and expected to be redeemed or sold within one year of the balance sheet date.
Other Non-Current Assets	Include all other non-current assets not accounted for elsewhere on the balance sheet. Any receivables from providers should be accounted for in this line item.	

Property and equipment consists of fixed assets, including land, buildings, leasehold improvements, furniture, equipment, etc.

Specification	Inclusion	Exclusion
Land	Real estate owned by the Contractor.	
Buildings	Buildings owned by the Contractor, including buildings under a capital lease, and improvements to buildings owned by the Contractor.	Improvements made to leased or rented buildings or offices.
Leasehold Improvements	Capitalized improvements to facilities not owned by the Contractor.	
Furniture and Equipment	Medical equipment, office equipment, data processing hardware, software (where permitted), and furniture owned by the Contractor, as well as similar assets held under capital leases.	

Specification	Inclusion	Exclusion
Other — Property and Equipment	All other fixed assets not falling under one of the other specific asset categories.	
Accumulated Depreciation/Amortization	The total of all depreciation and amortization accounts relating to the various fixed asset accounts.	

Current liabilities are obligations whose liquidation is reasonably expected to occur within one year from the balance sheet date.

Specification	Inclusion	Exclusion
Accounts Payable	Amounts due to creditors for the acquisition of goods and services on a credit basis.	Claims payable from providers.
Accrued Administrative Expenses	Accrued expenses, management fees, and any other amounts estimated as of the balance sheet date (e.g., payroll, taxes). Also, include accrued interest payable on debts.	
Sub-Capitation Payable	Net amounts owed to providers for monthly capitation.	Capitation amounts payable to LDH as a result of overpayment (this amount should be reported in the 'Other Current Liabilities' line).
Claims Payable	Adjudicated but unpaid claims.	Pended claims or claims received but not adjudicated. Estimates related to IBNR.
Provision for Adverse Deviation	Amounts on this line represent the additional liability estimate that is above and beyond the MCO's best estimate of unpaid claim liability.	Estimates related to IBNR.
IBNR	The respective IBNR amounts calculated on an accrual basis estimating the remaining liability of IBNR claims.	Adjudicated but unpaid claims, VBP payable, provision for adverse deviation, or other services payable.
VBP Payable	Payables for shared savings or risk sharing to providers in VBP arrangements with providers that are linked to the LDH quality strategy and rooted in evidenced-based practices.	Estimates related to IBNR.
APM Payable	Payables for alternative payment methodologies to providers that are not linked to the LDH quality strategy. For example, pay for reporting.	Estimates related to IBNR.
Other Services Payable	Medical services payable that are not part of the IBNR claims payable amount.	Estimates related to IBNR.
Due to Affiliates (Current)	Payables owed to related-party organizations expected to be paid within one year.	

Specification	Inclusion	Exclusion
Current Portion Long-Term Debt	The total current portion of long-term debt, which will include the principal amount on loans, notes, and capital lease obligations due within one year of the balance sheet date.	Long-term portion of, and accrued interest on loans, notes, and capital lease obligations.
MLR Payable to State	Accrued MLR rebate amounts and non-risk amounts payable to LDH as a result of overpayment from current year activity.	MLR accruals owed to LDH for prior years.
Other Current Liabilities	The total current portion of other liabilities, which will include those current liabilities not specifically identified elsewhere.	

Other liabilities are those obligations whose liquidation is not reasonably expected to occur within one year of the date of the balance sheet.

Specification	Inclusion	Exclusion
Non-Current Portion — Long-Term Debt	The total non-current portion of long-term debt, which will include the long-term portion of principal on loans, notes, and capital lease obligations.	Current portion of and accrued interest on loans, notes, and capital lease obligations.
MLR Payable (Non-Current)	Accrued MLR rebate amounts and non-risk amounts payable to LDH as a result of overpayment from prior year(s) activity.	
Due to Affiliates (Non-Current)	Payables owed to related-party organizations not expected to be paid within one year.	
Other Non-Current Liabilities	The total non-current portion of liabilities not specifically identified elsewhere.	

Equity or Net Assets include contributed capital, retained earnings, unrealized long-term gains, and are net of any dividends or distributions.

Specification	Inclusion	Exclusion
Preferred Stock/Restricted Funds	Should equal the par value or, in the case of no-par shares, the stated or liquidation value per share multiplied by the number of issued shares for for-profit entities; or the sum of fund balances with restricted use for non-profit entities.	
Common Stock/Unrestricted Funds	Should equal the par value or, in the case of no-par shares, the stated value, per share multiplied by the number of issued shares for for-profit entities; or the sum of fund balances without restrictions on use for non-profit entities.	
Treasury Stock	Include the amount of treasury stock reported using the par value or cost method.	

Specification	Inclusion	Exclusion
Unrealized Gain on Long-Term Investments	Include unrealized gain on long-term investments.	
Additional Paid-In Capital	Amounts paid and contributed in excess of the par or stated value of shares issued.	
Contributed Capital	Include capital donated to the Contractor. Describe the nature of the donation, as well as any restrictions on this capital in the footnote disclosures in Schedule D: Footnotes Disclosures.	
Retained Earnings Prior Years	Excess of revenues over expenses from prior years. Excess of expenses over revenues from prior years would be shown as a negative amount. Any amounts redirected to other funds should be described in detail in Schedule BA — Supplemental Working Area.	Current year earnings/loss amounts.
Increase (Decrease) YTD	Excess of revenues over expenses from current year. Excess of expenses over revenues from current year would be shown as a negative amount. Any amounts redirected to other funds should be described in detail in Schedule BA — Supplemental Working.	Prior year earnings/loss amounts.

2.02 Schedule B: Revenue Accrual

This Schedule is a summary of revenues accrued and the applicable adjustments experienced. All figures in the gross capitation section should reflect member months multiplied by risk-adjusted rates, including the provision for other contractual payments. The figures are to be reported by program (Non-Expansion Full Benefit, Non-Expansion SBH/Non-Emergent Medical Transportation [NEMT] Only, and Expansion Full Benefit and SBH/NEMT Only) for prior year revenue and current year revenue spans. The revenue accrual schedule must agree to the Income Statement, Schedule C, for the YTD reporting period, meaning the difference line should be zero before submitting this schedule.

Prior year should reflect revenue relating to eligibility spans from the prior year. Current year should reflect revenue relating to eligibility spans within the current year.

Possible adjustments include, but are not limited to, anticipated retrospective capitation payments and accrual adjustments.

Accruals for COVID-19, Hepatitis C, and Zolgensma risk corridors must be included as separate capitation adjustments within this schedule.

2.03 Schedule C: Income Statement

The Contractor shall report revenues and expenses using the full accrual method. The Income Statement, Schedule C must agree to the Total Profitability by Eligibility Category Report, Schedule E, for the YTD reporting period.

Select "Yes" in cell C6 if SBH services are subcontracted at-risk to a Behavioral Health Organization (BHO). If not, select "No." Indicate in C6 if the BHO is a related party by selecting "Yes" or "No," regardless of whether or not the BHO is at risk. Schedule C is inclusive of all Healthy Louisiana services and includes the revenue and expense detail reported on Schedule C1-SBH Income Statement QRTLY.

For enrollees receiving only SBH and NEMT services, no physical health (PH) services (other than any enhanced services) are part of the benefit package; therefore, there should be no Basic Behavioral Health services for the SBH/NEMT only enrollment. However, should the MCO pay for any non-covered services, such costs should be reported on the most appropriate line.

The following contract language defining Basic and SBH may be used as a reference to better understand differences between the services.

Basic behavioral health services shall include, but are not limited to, screening, prevention, early intervention, medication management, treatment, and referral services provided in the primary care setting and as defined in the Medicaid State Plan. Basic behavioral health services may further be defined as those provided in the member's primary care physician (PCP) or medical office by the member's (non-specialist) physician (i.e., DO, MD, APRN) as part of routine physician evaluation and management activities. These services shall be covered by the MCO for members with both PH and behavioral health coverage.

Specialized behavioral health services shall include, but are not limited to services specifically defined in the Medicaid State Plan. Specialized behavioral health services shall also include any other behavioral health service subsequently amended into the Medicaid state plan or waivers. Effective December 1, 2015, these services are covered by the MCO for all covered populations except for specialized behavioral health services covered by the Coordinated System of Care (CSoC) contractor for youth enrolled with the CSoC contractor.

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.	Do not count kick payments as member months.
Maternity Delivery Payment Count	Report the number of maternity payments received and/or accrued for from LDH.	

Specification	Inclusion	Exclusion
PH/Integrated SBH Capitation Revenue	Revenue received and accrued on a prepaid basis for the provision of Physical and Integrated Behavioral Health Covered services. For January 2016, report only PH capitation (which includes Basic Behavioral Health) in this category. For February 2016 forward report capitation for Integrated Physical and SBH capitation revenue. These amounts should reflect the full capitation rates for the MCO; i.e. do not incorporate any adjustment for the withhold provisions. Separate lines are provided for reporting the financial activities pertaining to the withholds.	Stand-alone NEMT and SBH capitation payments should be reported separately as noted below. For January 2016, these will be based on separate capitation payments for NEMT and SBH (including SBH services for those receiving PH services in the PH program). For February 2016, forward SBH/NEMT-only services are combined into the same rates, and SBH services for the PH population are integrated into the PH/Integrated SBH capitation.
Maternity Delivery Payments	Revenue received and/or accrued for all supplemental maternity delivery payments.	
Risk Corridor Accrual	Accruals for COVID-19, Hepatitis C, and Zolgensma risk corridors should be reported on this line.	
SBH/NEMT Only Capitation	Revenue received and accrued on a prepaid basis for members eligible for SBH and NEMT services only. This is for capitation for services dates on or after February 1, 2016.	
Investment Income	All investment income earned during the period net of interest expense.	
Withhold reserve, current year	Revenue not expected to be earned from 2% withhold on capitation revenue (must be entered as negative amount). Please include a comment in Schedule BA – Supplemental Working Area describing the withhold provisions that are not expected to be met and how the amount reported was determined.	
Withhold received, prior years	Withhold revenue accrued from prior years.	
Other Income	Revenue from sources not identified in the other revenue categories. Describe amounts in the footnotes in Schedule D. Note: Material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.	

Covered Services Expenses and Recoveries

All Covered Services expenses must be reported net of third party reimbursement and coordination of benefits (COB) (for example, Medicare and other commercial insurance) and in

correspondence to the identified COS in Schedule C. Claim expenses should include paid and adjudicated but unpaid amounts. Claim expenses should not include changes in IBNR amounts. Non-claim expenses should be reported using the full accrual method. For example, outpatient hospital claims should be reported as paid in line 25, but hospital settlement payments should report all paid and accrued expense in line 27. Additionally, accrued non-claim medical expenses should be reflected in line 42 of the appropriate lag tables in Schedules R-W. Record changes in incurred but not paid IBNP estimates in the appropriately described lines, corresponding to the detail provided in the lag tables from Schedules R-W. Guidance for COS specification can be found in Appendix B.

Specification	Inclusion	Exclusion
Medical Expenses — Inpatient, Outpatient, Professional, Other Medical Expenses, and Pharmaceuticals	All contracted fee-for-service (FFS) and sub-capitation expenses as identified in the COS groupings. SBH costs should be reported separately in their own category (see below) and not included here.	Pharmaceutical costs should be reported gross of MCO Retained Rebates, which should be reported within their respective line.
Maternity Expenses	Refer to the detail in section 2.20 (Schedule AG Maternity and Deliveries) for complete instructions regarding identification of maternity counts and expenses.	
Other Contractual Inpatient Requirements	Other contractually required payments for services delivered in an Inpatient setting.	Excluding change in IBNR related to this category, which should be reported on the change in IBNR lines by category of service.
Settlements	Hospital settlement payments for current and prior periods as required by receipt of the Medicaid Cost Reports in lieu of form CMS 2552-10.	
Other Contractual Professional Requirements	Pay for performance, professional provider incentives, and other contractually required payments.	Excluding change in IBNR related to this category, which should be reported on the change in IBNR lines by category of service.
SBH	Payments to a BHO for coverage of SBH services, or costs for SBH services. SBH services include, but are not limited to, services specifically defined in the Medicaid State Plan, and provided by psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, mental health clinics, and Mental Health Rehabilitation service providers (public or private).	Basic Behavioral Health, as defined by the contract. Basic Behavioral Health services include, but are not limited to, screening, prevention, early intervention, medication management, treatment, and referral services provided in the primary care setting and as defined in the Medicaid State Plan. Basic Behavioral Health should be reported within the appropriate PH service categories.
Other Contractual Transportation Requirements	Other contractually required Transportation payments.	Excluding change in IBNR related to this category, which should be reported on the change in IBNR lines by category of service.

Specification	Inclusion	Exclusion
Medical Expenses — Other and Miscellaneous	Medical expenses that do not fall within the COS as defined in the reporting format. Note: Material other amounts (greater than 5% of the individual sections of expense) should be disclosed and fully explained in Schedule D.	
Reinsurance Premiums	Reinsurance premium payments and stop-loss payments should be separately reported as premium payments.	
Reinsurance Recoveries	Reinsurance recoveries associated with the premiums paid in the line item above.	
MCO Retained Rebates	Rebates reported during the reporting time period that are retained by the Plan (enter as a positive number).	
TPL 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 COB 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 LDH, Contractor, or Provider-sponsored recovery efforts, which should be compared to the expenses incurred attempting to recuperate the fraud and abuse recoveries.	The amount of claim payments recovered through fraud reduction efforts shall not exceed the amount of fraud reduction expenses.
Other Recoveries	Other recoveries of medical claims previously paid not included in a category above.	

Administrative Expenses

Administrative expenses are divided into activities that improve health 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 care quality.

Administration — Health Care Quality Improvement (HCQI) Expenses

Activity Requirements (Adapted from the National Association of Insurance Commission Supplemental Health Care Exhibit)

Activities conducted by the Contractor that improve quality and qualify as HCQI expenses must meet the following requirements and be designed to:

- Improve health quality.
- Increase the likelihood of desired 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 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 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.

Qualifying HCQI activities are designed to achieve the following goals:

- Improve health outcomes, including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations.
- Prevent hospital readmissions.
- Improve patient safety; reduce medical errors, lower infection, and mortality rates.
- Increase wellness and promote health activities.
- Enhance the use of Contractor data to improve quality, transparency, and outcomes.

*Note regarding HCQI expenses: Expenses that otherwise meet the definition for HCQI, but were paid for with grant money or other funding separate from premium revenues shall **NOT** be included in HCQI expenses.*

The HCQI portion of Administrative expense is broken into seven reporting categories as defined below.

❖ **Health Outcome Improvement**

Expenses incurred by the Contractor to improve health outcomes, including increasing the likelihood of desired outcomes compared to a baseline, and reduce health disparities among specified populations. This category includes the direct interaction of the Contractor (including those services delegated by Contractor for which the Contractor retains ultimate responsibility), 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. Examples include:

- Effective case management, care coordination, chronic disease management, medication, and care compliance initiatives, including:
  - Patient-centered interventions, such as:
    - Making/verifying appointments.
    - Medication and care compliance initiatives.
    - Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center).
    - Programs to support shared decision-making with patients, their families, and the patient's representatives.
    - Reminding member of physician appointment, lab tests, or other appropriate contact with specific providers.
  - Incorporating feedback from the patient to effectively monitor compliance
  - Providing coaching or other support to encourage compliance with evidence-based medicine
  - Activities to identify and encourage evidence-based medicine
  - Use of the medical homes model
  - Activities to prevent avoidable hospital admissions
  - Education and participation in self-management programs
  - Medication and care compliance initiatives, such as checking that the patient is following a medically effective prescribed regimen for dealing with the specific disease/condition, and incorporating feedback from the patient in the management program to effectively monitor compliance
- 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
- Accreditation fees directly related to quality of care activities

HIT to support these activities should be reported in line 80, HIT expenses for HCQI.

❖ **Hospital Readmission Prevention**

Expenses incurred by the Contractor to prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:

- Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital
- Patient-centered education and counseling
- Personalized post-discharge reinforcement and counseling by an appropriate health care professional
- Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission

HIT to support these activities should be reported in line 80, HIT expenses for HCQI.

❖ **Patient Safety Improvement and Medical Error Reduction**

Expenses incurred by the Contractor to improve patient safety, reduce medical errors and lower infection and mortality rates. Examples include:

- The appropriate identification and use of best clinical practices to avoid harm
- Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns
- Activities to lower the risk of facility-acquired infections
- Prospective Prescription Drug Utilization Review aimed at identifying potential adverse drug interactions
- Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors

HIT to support these activities should be reported in line 80, HIT expenses for HCQI.

❖ **Wellness and Health Promotion**

Expenses incurred by the Contractor to implement, promote, and increase wellness and health activities. Examples include:

- Wellness assessments
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition
- Public health education campaigns that are performed in conjunction with State or local health departments

- Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities
- Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity)

HIT to support these activities should be reported in line 80, HIT expenses for HCQI.

❖ **HIT Expenses for HCQI**

Expenses incurred by the Contractor to enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of HIT. This includes expenses that are designed for use by Contractor, health care providers or patients for the electronic creation, maintenance, access or exchange of health information, as well as those consistent with Medicare and/or Medicaid Meaningful Use Requirements.

- 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.
- 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 Medicare, and Medicaid incentive payments.
- Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies.
- Monitoring, measuring or reporting clinical effectiveness, including reporting, and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as the National Committee for Quality Assurance or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, Consumer Assessment of Healthcare Providers, and Systems surveys or chart review of Healthcare Effectiveness Data, and Information Set (HEDIS) measures, and costs for public reporting mandated or encouraged by law).
- Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes.
- Advancing the ability of members, providers, Contractors 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.
- Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease.
- Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

❖ **Other HCQI Expenses**

Requests to include expenses for broadly excluded activities will be considered. Upon showing the activities costs' support the definitions and purposes as HCQI, the expenses can be included within this line. Provide detail of any expenditure included as Other HCQI expenses in Schedule BA.

❖ **Subcontracted HCQI Expenses**

Activities conducted by the Contractor that improve quality and qualify as HCQI expenses are designed to improve health outcomes. Examples include:

- Expenses incurred by the Contractor to prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:
- Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help ensure appropriate care that will avoid readmission to the hospital.
- Patient-centered education and counseling.

Specification	Inclusion	Exclusion
Health Outcome Improvement	Case management, care coordination, and chronic disease management. Also include accreditation fees by a nationally recognized accrediting entity, racial disparity prevention.	
Hospital Readmission Prevention	Comprehensive discharge planning and post-discharge counseling by a professional.	
Patient Safety Improvement and Medical Error Reduction	Expenses for implementing activities to improve patient safety and reduce medical errors.	
Wellness and Health Promotion	Expenses for programs that provide wellness and health promotion activities, including wellness assessments, coaching programs and public health education campaigns.	
HIT Expenses for HCQI	Expenses required to accomplish the activities reported in first four lines above for the electronic creation, maintenance, access or exchange of health information, consistent with Medicare/Medicaid Meaningful Use Requirement.	Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims.
Other HCQI Expenses (described in Schedule BA)	Expenses for broadly excluded activities and activities not described above, but requested for consideration as HCQI should be documented and explained in Schedule BA.	Other Administrative expenses indicated above.
Delegated Vendor HCQI Expenses	Expenses incurred by a subcontractor entity for services provided to improve health outcomes.	The categories are intended to be mutually exclusive. Please report all delegated vendor HCQI expenditures in this section and expenses the MCO directly pays in the above sections.

Pharmacy Administration Expenses

The following expenses are designated as Pharmacy Administration Expenses.

Specification	Inclusion	Exclusion
Pharmacy Benefit Manager (PBM) Spread Pricing	The difference between the amount the MCO pays the PBM and the amount the PBM pays the pharmacy.	
PBM Retained Rebates	The difference between the value of pharmaceutical rebates collected by the PBM and the value of the pharmaceutical rebates remitted to the MCO.	
PBM Administrative Fees	An administrative fee (usually paid by the MCO to a contracted PBM or claim administrator) for pharmacy claim adjudication and management. The fees should not include internal PBM costs associated with the administration of the pharmacy benefit that are not charged to the MCO, but should include all costs charged to the MCO beyond what is paid to the pharmacy providers for the prescriptions not already included in the PBM spread pricing or retained rebates categories.	
MCO Pharmacy Administrative Fees	Other administrative fees incurred by the MCO related to the pharmacy benefit not included in the designations listed above.	

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.	
Marketing	Sales and marketing expenditures.	
Member Services	Member service/support, grievance, and appeals, including recipient enrollment.	
General and Operational Management	Senior operational management and general administrative support (for example, 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.	
Claims and Referral/Authorization Processing	Processing of Provider Payments — Expenditures related to the processing and authorizing of provider payments.	

Specification	Inclusion	Exclusion
Information Systems	Information systems and communications.	
Administrative Services Only 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	Management fees and other allocations of corporate expenses based on some methodology (e.g., PMPM, percent of revenue, percent of head counts, and/or full time equivalents, etc.).	
Lobbying Costs	Contributions to political parties, candidates or lobbying groups.	
Charitable Contributions	Donations to non-profits and other 501(c)(3) charities.	
Travel and Entertainment	Expenses for traveling and entertainment including, but not limited to, airfare, hotel, car rental, mileage, meals, and event tickets.	
Sanctions and Late Payment Interest Penalties	Sanctions and other penalties paid or accrued by the Contractor.	
Royalties	Fees 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 D.	Other Administrative expenses indicated above.
Subcontracted Administrative Costs	Administration expenses incurred by a subcontracted entity as defined in Section 2.03.	

Other Reporting

Member value-added services are to be reported separately from Other Administrative expenses.

Specification	Inclusion
Encounter Member Value-Added Services	Encounterable services provided as value-added per the contracted benefit package.
Non-Encounter Member Value-Added Services	Non-encounterable services provided as value-added per the contracted benefit package.

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

Specification	Inclusion
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 including, but not limited to, MLR rebate accruals. Note: Amounts should be disclosed and fully explained in Schedule D.

As an internal check, the sum of the change in prior period IBNR for all quarters reported on the income statement should equal the change in prior period IBNR reported on the profitability statement. Please see the table below for further clarification on the reporting of IBNR between the balance sheet, income statement, and total profitability reports.

Balance Sheet	2018Q4	2019Q1	2019Q2	2019Q3	2019Q4	YTD Figure (Last Quarter)
Current Period IBNR	$ -	$ 30	$ 60	$ 85	$ 110	$ 110
Prior Period IBNR	$ 100	$ 80	$ 45	$ 25	$ -	$ -
Total IBNR (as reported)	$ 100	$ 110	$ 105	$ 110	$ 110	$ 110

Income Statement (Quarterly)	2018Q4	2019Q1	2019Q2	2019Q3	2019Q4	YTD Figure (Sum of Quarters)
Change in Current Period IBNR	$ -	$ 30	$ 30	$ 25	$ 25	$ 110
Change in Prior Period IBNR	$ 100	$ (20)	$ (35)	$ (20)	$ (25)	$ (100)
Total Change in IBNR	N/A	$ 10	$ (5)	$ 5	$ -	$ 10

Profitability (YTD)	2018Q4	2019Q1	2019Q2	2019Q3	2019Q4	YTD Figure (Last Quarter)
Change in Current Year IBNR	$ -	$ 30	$ 60	$ 85	$ 110	$ 110
Change in Prior Year IBNR	$ 100	$ (20)	$ (55)	$ (75)	$ (100)	$ (100)
Total Change in IBNR	N/A	$ 10	$ 5	$ 10	$ 10	$ 10

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 LA 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.

Lines 122–126 are reserved for revenues and expenses related to the Managed Care Incentive Payment Program (MCIP). The program receives authority through 42 CFR 438.6 and relates to special contract provisions related to payment. MCIP revenue and expenses are not included in the HBR calculations displayed within schedule AT — Health Benefit Ratio Calculation Report.

MCIP Activities

Specification	Inclusion
MCIP Revenue, current year	YTD earned revenue associated with the MCIP program.
MCIP Revenue, prior years	Prior year earned revenue associated with the MCIP program.
MCIP Expense, current year	YTD incentive payments, funded from the MCIP revenues, incurred for meeting specified performance targets.
MCIP Expense, prior years	Prior year incentive payments, funded from the MCIP revenues, incurred for meeting specified performance targets.

Lines 127–129 are for non-Medicaid expenses, including Room and Board charges. These lines are excluded from HBR calculations.

Non-Medicaid Activities

Specification	Inclusion
Non-Medicaid Revenue	Any revenue amounts for residential services for non-Medicaid covered service components, such as room and board for respite, crisis respite, group homes, and similar services.
Non-Medicaid Room and Board Expense	Any costs associated with the provision of residential services for non-Medicaid covered service components, such as room and board for respite, crisis respite, group homes, and similar services.

The Medicaid rate does not include costs for room and board. Other funding sources reimburse for room and board, including the family or legally responsible party (e.g., OJJ and DCFS).

2.04 Schedule C1: SBH Income Statement

The Contractor shall report all SBH revenues and expenses using the full accrual method. The SBH Income Statement, Schedule C1, must agree to the Total SBH Profitability by eligibility category report, Schedule J, for the YTD reporting period for all lines. Lines may be hidden or visible depending on the answer displayed in cell C6 (entered on Schedule C).

If SBH is sub-capitated to a BHO, line 2 is used to report SBH expenses in Schedule C, line 43. If SBH is not sub-capitated to a BHO, line 41 is used to report SBH expenses in Schedule C, line 43.

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.	Only include member months for the SBH population.
SBH Revenue from MCO	BHO revenue received and/or accrued from the MCO for the provision of Covered SBH capitation.	Basic Behavioral Health coverage should still be reported under the PH capitation revenue amount in Schedule C.
Other Income	MCO revenue from sources not identified in the other revenue categories. Describe amounts in the footnotes in Schedule D. Note: Material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.	

SBH Expenses and Recoveries

All SBH expenses must be reported net of third party reimbursement and COBs (e.g., Medicare and other commercial insurance) and in correspondence to the identified COS in Schedule C1. Expenses should be reported as paid and should not include changes IBNP estimates. Record changes in IBNP estimates in the appropriately described lines, corresponding to the detail provided in the lag tables from Schedule U. Guidance for COS specification can be found in Appendix B.

Specification	Inclusion	Exclusion
Medical Expenses – Inpatient, Outpatient, Professional, Addiction services and Other Medical Expenses	All contracted FFS and sub-capitation expenses as identified in the COS groupings.	All non-Medical expenses, including those related to non-Medicaid Room and Board, which should be reported separately under the appropriate line.
Other Expenses	Other expenses that do not fall within the COS as defined in the reporting format. Note: Material Other amounts (greater than 5% of the individual sections of expense) should be disclosed and fully explained in Schedule D.	
Reinsurance Premiums	Reinsurance premium payments and stop-loss payments should be separately reported as premium payments.	
Reinsurance Recoveries	Reinsurance recoveries associated with the premiums paid in the line item above.	

Specification	Inclusion	Exclusion
TPL 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 COB 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 LDH, Contractor, or Provider-sponsored recovery efforts.	
Other Recoveries	Other recoveries of SBH claims previously paid not included in a category above.	

Administrative Expenses

Administrative expenses are divided into activities that improve health care quality and those that are other, general and operational, to perform necessary business functions. Use the guidance above in Section 2.03 for reporting administrative activities that meet the criteria for improving health care quality. Only aggregate HCQI and Other Administrative Expenses are to be reported by the BHO. If the MCO is reporting its direct costs (i.e. Schedule C, cell C6 is marked "No"), these lines will not appear and all such costs should be reported in the detailed categories on Schedule C. Taxes and net income are not reported on Schedule C1. The template does not request the taxes or net income of the BHO. If there is no BHO, then all of the MCO's taxes and net income are included on Schedule C.

Other Reporting

Use the guidance above in Section 2.03 for other reporting expenses.

2.05 Schedule D: Footnote Disclosures

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 LDH. 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	Claims payable analysis, including IBNR	

	Footnote Disclosure Requirements	Indicate as N/A if No Reportable Items
8	Contingent liabilities	
9	Due from/to affiliates (current and non-current)	
10	Related party transaction activities, including pharmacy benefit manager (PBM) activities	
11	Equity contributions or distributions/other activity	
12	Non-compliance with financial viability standards and performance guidelines	
13	Charitable contributions, penalties or sanctions included in the financial statements	
14	Interest on late claims	
15	Changes in provider reimbursement methodologies	
16	Changes to reinsurance or stop-loss agreements	
17	Non-operating income/loss amount observations	
18	Other recovery amounts	
19	Claims payment fluctuations reported in the Lag Reports, Schedules R-W	
20	Unpaid claim adjustment expenses and methodology	
21	Premium deficiency reserves and methodology	
22	Allocation methodologies used for profitability statements	
23	Administrative expense allocation methodology changes	
24	Non-covered services and amounts paid	
25	Differences between premium assessment tax payments and capitated tax provision	
26	Any activity associated with a contracted PBM	
27	In Lieu of Services	

2.06 Schedules E–N: Total Profitability by Eligibility Category

These reports are meant to provide detailed information on YTD revenues and expenses pertaining to the Contractor through the current quarter for the populations selected by LDH. Schedule E is automatically calculated from the parish-based profitability reports (Income Statements). Schedules F through I report the results by region and should be reported based on the member's place of residence. The table below lists the population groups and associated data elements that help define each group for reporting purposes. All service definitions are included above in relation to Schedule C — Income Statement.

If SBH services are subcontracted (whether or not with a related party) the revenue lines will appear in Schedules C1 and J–N to report income to the BHO. The revenue lines will not appear if the MCO does **not** subcontract for these services. As payments to a BHO are classified as expenses irrespective of the BHO's expenses, SBH expenses reported on Line 43 of Schedules E–I will automatically populate from the total SBH expenses in Schedules J–N based on whether such arrangements exist.

Note: All rate cells not designated with "Expansion" are not affiliated with Medicaid Expansion and should be considered Non-Expansion.

Rate Cell Table:

Cap Category	Category of Aid Code	Category of Aid Description	Rate Cell Code	Rate Cell Description
1	1	Supplemental Security Income (SSI)	N01	Newborn, 0–2 Months, Male & Female
1	1	SSI	N02	Newborn, 3–11 Months, Male & Female
1	1	SSI	CHD	Child, 1–20 Years, Male & Female
1	1	SSI	ADT	Adult, 21+ Years, Male & Female
1	2	Family and Children	N01	Newborn, 0–2 Months, Male & Female
1	2	Family and Children	N02	Newborn, 3–11 Months, Male & Female
1	2	Family and Children	CHD	Child, 1–20 Years, Male & Female
1	2	Family and Children	ADT	Adult, 21+ Years, Male & Female
1	7	Foster Care Children	FLL	Foster Care, All Ages, Male & Female
1	3	Breast and Cervical Cancer	BLL	BCC, All Ages, Female
1	4	LaCHIP Affordable Plan	LLL	LAP, All Ages, Male & Female
1	9	ACT 421-CMO Non-TPL	A01	0 - 2 Months
1	9	ACT 421-CMO Non-TPL	A02	3 - 11 Months
1	9	ACT 421-CMO Non-TPL	ACHD	Child 1 - 20 Years
1	9	ACT 421-CMO Non-LaHIPP TPL	AT01	0 - 2 Months
1	9	ACT 421-CMO Non-LaHIPP TPL	AT02	3 - 11 Months
1	9	ACT 421-CMO Non-LaHIPP TPL	ATCHD	Child 1 - 20 Years
1	9	ACT 421-CMO LaHIPP TPL	AN01	0 - 2 Months
1	9	ACT 421-CMO LaHIPP TPL	AN02	3 - 11 Months
1	9	ACT 421-CMO LaHIPP TPL	ANCHD	Child 1 - 20 Years
1	5	Home and Community Based Services (HCBS) Waiver	CHD	Child, 0–20 Years, Male & Female
1	5	HCBS Waiver	ADT	Adult, 21+ Years, Male & Female
1	6	Chisholm Class Members	CCM	Chisholm, All Ages, Male & Female
3	1	Maternity Kick Payment	KLL	Maternity Kick Payment
3	1	Early Elective Delivery Kick Payment	KEE	Early Elective Delivery Kick Payment
5	1	SBH/NEMT Only Chisholm Class Members	CCM	SBH/NEMT — Chisholm, All Ages Male & Female
5, 1	2, 8	SBH/NEMT Only — Dually Eligible/LaHIPP	DE1, HIP	SBH/NEMT — Dual Eligible, All Ages, Male & Female
5	3	SBH/NEMT Only — HCBS Waiver	CHD	SBH/NEMT — 20 & Under, Male and Female

Cap Category	Category of Aid Code	Category of Aid Description	Rate Cell Code	Rate Cell Description
5	3	SBH/NEMT Only — HCBS Waiver	ADT	SBH/NEMT — 21+ Years, Male and Female
5	4	SBH/NEMT Only — Other	OT1	SBH/NEMT — Other, All Ages, Male & Female
9	0	Expansion	EXP	Ages 19–64, Male & Female
9	5, 8	Expansion SBH/NEMT Only — Dual Eligible/LaHIPP	XU5, HIP	SBH/NEMT Only — Dual Eligible/LaHIPP, All Ages, Male & Female
9	5	Expansion SBH/NEMT Only — Chisholm	CCM	SBH/NEMT Only — Chisholm Class, All Ages, Male & Female
9	5	Expansion SBH/NEMT Only — Other	OT1	SBH/NEMT Only — Other, All Ages, Male & Female
9	6	Expansion — Maternity Kick Payment	KLL	Maternity Kick Payment
9	6	Expansion — Early Elective Delivery Kick Payment	KEE	EED Kick Payment
9	7	Expansion — High Needs	XU7	High Needs, All Ages, Male & Female

2.07 Schedules J–N: Total Specialty Behavioral Health Profitability by Eligibility Category

These reports are meant to provide detailed information on YTD revenues and expenses pertaining to the Contractor through the current quarter for the SBH populations and services selected by LDH. Schedule J is automatically calculated from the region-based profitability reports (Income Statements). Schedules K–N report the results by each of the four regions and should be reported based on the member's place of residence. The table above lists the population groups and associated data elements that help define each group for reporting purposes. The total amounts for each section within Schedules J–N must also agree to the SBH line items within the overall profitability statements, Schedules E–I.

Note: All rate cells not designated with "Expansion" are not affiliated with Medicaid Expansion and should be considered non-Expansion.

2.08 Schedule O: Medical Liability Summary

This Schedule combines summary information from the following schedules:

- RBUC Report
- Inpatient Lag Report
- Outpatient Facility Lag Schedule
- Professional Services Lag Schedule

- SBH Lag Schedule
- Other Medical Lag Schedule
- Pharmaceutical Lag Schedule

Prepare this Schedule for both quarterly and YTD amounts.

Medical Cost Grouping	Paid Claims	RBUC	IBNR	Current Period Ending IBNP	Current Period Beginning IBNP	Total Recognized Incurred Claims
Inpatient	$ -	$ -	$ -	$ -	$ -	$ -
Outpatient Facility	$ -	$ -	$ -	$ -	$ -	$ -
Professional Services	$ -	$ -	$ -	$ -	$ -	$ -
Other Medical	$ -	$ -	$ -	$ -	$ -	$ -
Pharmaceutical	$ -	$ -	$ -	$ -	$ -	$ -
SBH	$ -	$ -	$ -	$ -	$ -	$ -
Total	$ -	$ -	$ -	$ -	$ -	$ -
Notes and Explanations	A	B	C	D	E	F
	These amounts are produced by the lag schedules	These amounts are produced by the RBUC schedule	These amounts are calculated by the Contractor (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 Medical Liability Summary report IBNR claims should be reported in the IBNR column by the appropriate category (for example, Inpatient, Outpatient, Professional, Other Medical, Pharmaceutical, and SBH). The total payable for Inpatient, Outpatient, Professional, Other Medical, Pharmaceutical, and SBH should agree with the totals on the corresponding lag schedules.

Please see the table below for further explanation regarding the categorization of claims:

Claim Category	Known, Adjudicated and Paid	Known, Adjudicated and Not Paid	Known, Pended and Not Paid	Unknown, Not Adjudicated and Not Paid
Paid Claims	•	•		
RBUC			•	
IBNR				•

Figures reported on this schedule are required to tie out with the expenses in Schedule C. Any variance must be explained in detail on Schedule BA.

2.09 Schedule P: RBUC Report

RBUCs are to be reported by the appropriate expense (for example, Inpatient, Outpatient, Professional, Other Medical, and Pharmaceutical), and aging (for example, 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. The RBUC report should include received but unprocessed claims and pended claims. 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.

2.10 Schedule Q: Enrollment Report

The Enrollment table is set up to report enrollment according to the 1/1/2021 enrollment categories. The enrollment table is structured to feed the enrollment found in the lag tables. Claims in the lag should be tied to the enrollment reported for the corresponding month and must be reported on a restated YTD basis.

The enrollment table must include retroactive enrollment.

2.11 Schedules R-W: Lag Reports

Schedules R through W request the same type of information, but for different consolidated services categories (Inpatient, Outpatient, Professional, Other Medical, Pharmaceutical, and SBH) by program (Non-Expansion Full Benefit, Non-Expansion SBH/NEMT Only and Expansion Full Benefit and SBH/NEMT Only). The tables are arranged with the month of service horizontally and the month of payment vertically. Payments made during the current month for services rendered during the current month would be reported in line 1, column D, while payments made during the current month for services rendered in prior months would be reported on line 1, columns E through AN. 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.

Paid claims listed in the lag reports shall include all adjudication service sequence payments and reversals by month of service and month of payment. Therefore, the amounts reported within this table are not expected to change from quarter to quarter. For example, if a payment for a service that occurred in March is incorrectly paid to a provider in March for $50.00, and the claim is correctly adjudicated in April for an additional $25.00 (-$50.00 reversal + $75.00 updated payment), the plan shall report both figures within the paid claim table for March dates of service. The records will include $50.00 payment in March for March dates of service and a $25.00 payment in April for March dates of service.

All programs cover SBH services and NEMT. Each enrollee should be mapped to PH or SBH in any given month. All claims for that individual in the given month should be reported in the same program according to the major COS. Any members in the Expansion population, such as the

consolidated age/gender rate cells, high needs, Expansion SBH/NEMT only members and Expansion maternity kick payments should be reported in the Expansion Full Benefit and SBH/NEMT Only lag tables. Additionally, due to the limited covered service package of the SBH program, LDH expects that many of the SBH schedules will have zero claims reported.

Analyzing the accuracy of historical medical claims liability estimates is helpful in assessing the adequacy of current liabilities. This Schedule provides the necessary information to make this analysis.

Member Value-Added Services should not be included in Lines 1 through 37. Medical and SBH costs must be reported net of TPL and COB. Claims liabilities should **not** include the administrative portion of claim settlement expenses. Adjudicated claims, which have not yet been paid should be included in the lag triangles. These claims payable amounts may cause the month of payment to shift between report submissions. This variance is known and acceptable. Any liability for future claim settlement expense **must be disclosed separately** from the unpaid claim liability in a footnote.

Note: Multiple-month Inpatient stays should be recorded in the admission month. Inpatient stays with a primary diagnosis requiring SBH services should be included on Schedule R — Inpatient Lag.

Line 39 — Global/Subcapitation Payments and Pharmacy Rebates

The Contractor should report global subcapitation payments on this line, by month of payment, which should not be included 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 Inpatient services, Outpatient facility, Professional services, and Other Medical service lag reports.
- Subcapitation Payments: Those services paid through a normal provider capitation agreement. Examples would include PMPM payments to a PCP for a specified list of services, or to a laboratory for a specified list of tests.

For the Pharmacy Lag Schedule, the Contractor should report Pharmacy rebates received as a negative number on this line. This will result in a reduction to Pharmaceutical expenses. This shall reconcile to the LDH *054 Pharmacy Benefits Management Report* (at https://ldh.la.gov/index.cfm/page/1700) line (d5), total dollar amount of the Medicaid drug rebates and manufacturer discounts retained by the PBM and/or the MCO.

Activities classified as pharmacy administration, such as spread pricing, and PBM retained rebates, should be reported in lines 84–87 of the Income Statement and line 77 of the Total Profitability Statements and not in the claims lag.

Line 40 — Value-Based Payments

The Contractor should report value-based payments on this line that are not reflected in encounter data. Value-based payments must meet evidenced based quality guidelines; expenses must reflect payments tied to quality programs. The at-risk portion of any program must not incentivize withholding of necessary care. These arrangements must be disclosed on Attachment E – APM

Strategic Plan Requirements Report (a separate report referenced in the Contract) and be approved by LDH. If the Contractor makes a value-based payment that cannot be reported on lines 1 through 37 due to lack of data or method of payment, the amount must be reported on line 40 with the payment month used as a substitute for the service month. Full Medicaid pricing or administrative costs should not be reported in this line. Provide any clarifying explanation on Schedule BA.

Line 41 — Alternative Payment Methodologies

The Contractor should report alternative payment methodology expenditures on this line that are not reflected in encounter data. Alternative payment methodology expenditures do not meet evidenced based quality guidelines. For example, pay for reporting arrangements. These arrangements must be disclosed on Attachment E – APM Strategic Plan Requirements Report; although, they have not been approved by LDH. If the Contractor makes an alternative payment methodology that cannot be reported on lines 1 through 37 due to lack of data or method of payment, the amount must be reported on line 41 with the payment month used as a substitute for the service month. Full Medicaid pricing or administrative costs should not be reported in this line. Provide any clarifying explanation on Schedule BA.

Line 42 — 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 42 with the payment month used as a substitute for the service month.

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 and abuse recoupment or inaccurate payment settlement agreements with a provider that have not been captured through the claims payment system should be included.

Line 43 — Other Contractual Payments

Full Medicaid pricing should be reported in this line. The Contractor may use an alternative method of reporting other contractual payments that restates prior period amounts to reflect actual other contractual payments for that month. Do not include adjustments to IBNR amounts on this line or administrative expenses, such as premium tax.

Line 44 — Sum of Claims, Capitation Payments, and Settlements

This line is the total amount paid to date (including subcapitation) for services rendered and should equal the sum of lines 38 through 43. This line will calculate automatically.

Line 45 — 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 45. The development of each IBNR should be based on the most recent paid claims data. The sum of estimated IBNR across all lag schedules should be equal to the IBNR listed within the Balance Sheet. Claims

payable, VBP payable, and other services payable amounts should not be included in the IBNR estimate.

Line 46 — Net Incurred Claims

Net incurred claims is the sum of lines 44 – Sum of Claims, Capitation Payments, and Settlements and 45 – IBNR. Member Value-Added Services should not be included in Net Incurred Claims. These amounts represent current estimated amounts ultimately to be paid for Medical and Behavioral Health services by month of service for the past 36 months, and for all months prior to the 36th month. Each amount represents the medical 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 in this amount are subcapitations and adjustments. This line will calculate automatically.

Line 47 — Member Value-Added Services Paid

Amounts on this line represent member value-added services by month of service for encounterable and non-encounterable services.

Line 48 — Member Value-Added Services Remaining Liability IBNR

Amounts on this line represent the current estimates for unpaid claims by month of service for member value-added services over 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 48. The development of IBNR should be based on the most recent paid claims data.

Line 49 — Total Incurred Claims

Total incurred claims is equal to line 46 (net incurred claims) plus lines 47 and 48 (non-covered expenses). This line will calculate automatically.

Line 50 — Provision for Adverse Deviation

Amounts on this line represent the additional liability estimate that is above and beyond the MCO's best estimate of unpaid claim liability. Do not include estimates related to IBNR.

Line 51 — Members

Count of members whose claims map to program and major COS combination for the given month on line 51 (membership). This line will calculate automatically.

Schedules R through W must provide data for the period beginning with the first month the Contractor is responsible for providing medical benefits to LDH recipients, and ending with the current month.

2.12 Schedule X: Pharmaceutical Statistics

This report provides data on key measures of price and utilization for Pharmaceutical services. Portions of the data are provided by recipient group. The Contractor will submit one report in each quarterly submission, which will reflect YTD values throughout the calendar year.

Data reported in the Pharmaceutical Statistics section shall include only Outpatient point-of-sale (POS) claim volume adjudicated through the contracted claims processor (e.g., contracted Pharmacy Benefits Manager [PBM]) or in-house claims processor. All activity with a contracted PBM should also be reported in the report's footnotes, Schedule D.

Physician-Administered Drugs billed through the medical benefit using Health Care Common Procedure Coding System (HCPCS) codes should not be reported in this section.

Note: All rate cells not designated with "Expansion" are not affiliated with Medicaid Expansion and should be considered non-Expansion.

Pharmaceutical POS Statistics Section

Prescription Claim: One fill of a prescription drug or other product that is obtained from a pharmacy, billed through the POS claims system.

Prescription Claims: Only legend and OTC products that meet the CMS definition of prescribed drugs as described in 42 CFR §440.120 should be included in calculations pertaining to prescription claims. Other products dispensed by pharmacies and billed through the POS claims system should be reported as either "vaccines" or "other non-drug POS claims" as appropriate. Any compounded prescriptions should be reported as prescription claims, even if they contain non-drug ingredients. For select measures, each category shall also be sorted and reported as a brand or a generic claim based on the status of the product on the date of service/adjudication.

Specialty Drug: A prescription drug which cannot be routinely dispensed at a majority of retail community pharmacies due to physical or administrative requirements that limit preparation and/or delivery in the retail community pharmacy environment. The drug may require special handling, storage, and/or have distribution or inventory limitations. These may include, but are not limited to chemotherapy drugs, radiation drugs, intravenous therapy drugs, biologic drugs, and/or drugs that require physical facilities not typically found in a retail community pharmacy, such as a ventilation hood for preparation.

Brand/Generic Drug: The Centers for Medicare & Medicaid Services (CMS) has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each National Drug Code along with sourcing status of each drug: S (Single Source), N (Non-Innovator Multiple-Source), or I (Innovator Multiple-Source).

(S) Single-Source: Drugs that have an FDA New Drug Application (NDA) approval for which there are no generic alternatives available on the market. Drugs with an (S) designation should be considered brand drugs for this report.

(N) Non-Innovator Multiple-Source: Drugs that have an FDA Abbreviated New Drug Application (ANDA) approval and for which there exists generic alternatives on the market. Drugs with an (N) designation should be considered generic for this report.

(I) Innovator Multiple-Source: Drugs which have an NDA and no longer have patent exclusivity. Drugs with an (I) designation should be considered brand name drugs for this report.

Brand and generic dispensing fees should be reported as the actual average paid per claim and not the contracted dispensing fee. The average dispensing fee = (total dispensing fee paid)/(total number of claims). Exclude specialty, 340b, usual and customary (U&C), and TPL claims when calculating the brand and generic dispensing fee for local and chain pharmacies. When calculating the dispensing fee, do not include any claims for medical supplies, such as diabetic test strips, or care supplies billed and paid for through the pharmacy benefit.

Vaccine Claims:

Vaccines should be identified using the American Hospital Formulary Service (AHFS) therapeutic class codes. Claims for products falling into the following codes should be reported on the vaccine line:

AHFS Therapeutic Class Code	AHFS Therapeutic Class Description
80120000	Vaccines
80080000	Toxoids

The per claim administration fee should include only those fees paid by the MCO to the Contractor's pharmacy vendor for administration of the Pharmacy benefit. Internal Contractor costs associated with administration of the Pharmacy benefit should not be included. All fee and rebate amounts should be reported in dollars with two decimal places represented. All discounts and percentages should be rounded to the nearest hundredth of a percent. All other line items detailed below should be input as whole numbers.

Category	Measure	Definitions
1	Brand Dispensing Fee – Local	Average fee paid to local pharmacies to dispense any brand name drug (e.g., legend and OTC products) for both single-source and multi-source products. Brand drugs are those designated as S or I in the CMS Drug Product File. Brand dispensing fee should be reported as the actual average paid per claim and not the contracted dispensing fee. Exclude specialty, 340b, U&C, and TPL claims. Local pharmacies are those independent pharmacies defined in Act 399 of the 2015 Louisiana Regular Session.
2	Brand Dispensing Fee – Chain	Average fee paid to pharmacies not defined as local pharmacies to dispense any brand name drug (e.g., legend or OTC products) for both single-source and multi-source products. Brand drugs are those designated as S or I in the CMS Drug Product File. Brand dispensing fee should be reported as the actual average paid per claim and not the contracted dispensing fee. Exclude specialty, 340b, U&C, and TPL claims. Chain pharmacies are defined as all pharmacies not meeting the definition of local pharmacies under Act 399 of the 2015 Louisiana Regular Session.
3	Generic Dispensing Fee – Local	Average fee paid to local pharmacies to dispense any generic drug (e.g., legend and OTC products). Generic drugs are those designated as N in the CMS Drug Product File. Generic dispensing fee should be reported as the actual average fee paid per claim and not the contracted dispensing fee. Exclude specialty, 340b, U&C, and TPL claims.
4	Generic Dispensing Fee – Chain	Average fee paid to pharmacies not classified as local pharmacies to dispense any generic drug (e.g., legend and OTC products). Generic drugs are those designated as N in the CMS Drug Product File. Generic dispensing fee should be reported as the actual average fee paid per claim and not the contracted dispensing fee. Exclude specialty, 340b, U&C, and TPL claims.
5	Specialty Dispensing Fee – Local	Average fee paid to local pharmacies to dispense any specialty drug, including brand and generic. The specialty drug dispensing fee should be reported as the actual average paid per claim and not the contracted specialty dispensing fee. Exclude specialty, 340b, U&C, and TPL claims.
6	Specialty Dispensing Fee – Chain	Average fee paid to pharmacies not classified as local pharmacies to dispense any specialty drug, including brand and generic. The specialty drug dispensing fee should be reported as the actual average paid per claim and not the contracted specialty dispensing fee. Exclude 340b, U&C, and TPL claims.
7	Average Rebate per Claim (Non-Specialty)	Defined as the total dollar amount of rebates expected to be received for POS prescriptions (excluding specialty drug claims) filled in the reporting period divided by total number of prescriptions (excluding specialty and 340b drug claims) filled in the reporting period, including brand and generic. This estimate should be reported on an accrual basis, net of any rebate splits, and should include any expected amounts even if the amounts are not guaranteed.

Category	Measure	Definitions
8	Average Specialty Rebate per Specialty Claim	Defined as the total dollar amount of specialty rebates expected to be received for specialty prescriptions filled in the reporting period divided by total number of specialty prescriptions filled in the reporting period, including brand and generic. Exclude 340b claims. Only rebates for specialty claims processed through the POS pharmacy benefit should be included in this estimate. This estimate should be reported on an accrual basis, net of any rebate splits, and should include any expected amounts even if the amounts are not guaranteed.
9	Administrative Fee per Claim	Administrative fee paid to the pharmacy outside of the dispensing fee and ingredient cost.
10	Generic Dispensing Rate	Divide the total number of generic prescriptions by the total number of prescriptions dispensed in a given period. Include both specialty and non-specialty drugs. Generic drugs are those designated as N in the CMS Drug Product File.
11	Multi-Source Brand Utilization	Brand drugs that, at the time of dispensing, were available from a brand name manufacturer and also from a generic manufacturer. Multi-source brand products are those designated as I in the CMS Drug Product File. (e.g., Zocor dispensed when generic Simvastatin was available).
12	Average Discount for Brand Prescriptions (Non-Specialty)	Defined as the average percentage amount below the published wholesale acquisition cost (WAC) benchmark paid as the ingredient cost component of reimbursement for all non-specialty brand name drugs. Brand products are those designated as S and I in the CMS Drug Product File. The average discount should be reported as the actual average percent below the WAC benchmark paid per claim and not the contracted WAC discount (excluding specialty, 340b, U&C, and TPL claims). For example, if the amount paid for the ingredient cost component of the prescriptions divided by the total value of the units dispensed at WAC basis is $0.99, the discount reported should be 1%. If, on average, the amount paid for the prescriptions exceeds WAC, the discount should be reported as a negative value. For example, a -2% discount would equate to an average payment of WAC plus 2%.
13	Average Discount for Generic Prescriptions (Non-Specialty)	Defined as the average percentage amount below the published WAC benchmark paid as the ingredient cost component of reimbursement for all non-specialty generic drugs. Generic products are those designated as N in the CMS Drug Product File. The average discount should be reported as the actual average percent below the WAC benchmark paid per claim and not the contracted WAC discount (excluding specialty, 340b, U&C, and TPL claims). For example, if the amount paid for the ingredient cost component of the generic prescriptions divided by the total value of the units dispensed at WAC basis is $0.55, the discount reported should be 45%.
14	Average Discount for Specialty Prescriptions	Defined as the average percentage amount below the published WAC benchmark paid as the ingredient cost component of reimbursement for all specialty drugs, both brand and generic. The average discount should be reported as the actual average percent below the WAC benchmark paid per claim and not the contracted WAC discount (excluding non-specialty, 340b, U&C, and TPL claims). For example, if the amount paid for the ingredient cost component of the specialty prescriptions divided by the total value of the units dispensed at WAC basis is $0.96, the discount reported should be 4%.
15	Specialty Utilizers as a Percent of Members	Defined as the number of members who received at least one prescription for a specialty drug during the quarter divided by the total number of distinct members in the plan during the quarter.
16	Total Number of 340b Pharmacy Claims	Defined as the total number of prescription claims filled with drug product purchased through the 340b program (including both traditional and specialty drug claims) reimbursed by the Contractor during the reporting period.

Category	Measure	Definitions
17	Total Reimbursed Amount for 340b Claims	Defined as the total dollar amount reimbursed by the Contractor to pharmacies for 340b pharmacy prescription claims (including brand, generic, and specialty drug claims) during the reporting period.
18	Percent Retail Prescriptions	Defined as the percentage of retail prescription claims reimbursed by the Contractor divided by the total prescription claims. Retail claims are defined as those filled by brick-and-mortar stores which are not considered mail order.
19	Percent Traditional Mail Prescriptions	Defined as the percentage of mail order prescription claims for traditional drugs reimbursed by the Contractor divided by the total traditional prescription claims. Mail order includes those prescriptions dispensed by pharmacies identified as Mail Order Pharmacies in the National Plan and Provider Enumeration System (NPPES) National Provider Index (NPI) registry.
20	Percent Specialty Mail Prescriptions	Defined as the percentage of mail order prescription claims for specialty drugs reimbursed by the Contractor divided by the total specialty prescription claims. Mail order includes those prescriptions dispensed by pharmacies identified as Mail Order Pharmacies in the NPPES NPI registry or dispensed by pharmacies outside of Louisiana that have a taxonomy of Specialty Pharmacy in the NPPES NPI registry.
21	Total Number of Vaccine Claims	Defined as the total number of vaccine claims billed through the pharmacy POS claims system and reimbursed by the Contractor.
22	Total Number of Other Non-Drug POS Claims	Defined as all products dispensed by pharmacies and billed through the POS claims system that are neither vaccines nor prescribed drugs as defined by CMS. Products contained in the AHFS therapeutic class codes listed in Appendix C are considered non-drugs and should be reported on the Non-Drug POS line.
23	Total Brand Number of Prescription Claims	Defined as the total number of non-specialty brand prescription claims reimbursed by the Contractor during the reporting period. Brand drugs are defined as those with a designation of S or I in the CMS Drug Product File.
24	Total Generic Number of Prescription Claims	Defined as the total number of non-specialty generic prescription claims reimbursed by the Contractor during the reporting period. Generic drugs are defined as those with a designation of N in the CMS Drug Product File.
25	Total Specialty Number of Prescription Claims	Defined as the total number of specialty prescription claims reimbursed by the Contractor during the reporting period, including both brand and generic specialty drugs.
26	Overall Total Number of POS Pharmacy Claims	Defined as the overall total number of claims reimbursed by the Contractor to pharmacies for total POS claims during the reporting period. Calculation includes brand, generic, and specialty drugs, as well as vaccine and non-drug POS claims. This field will populate automatically based on line items described above.
27	Total Vaccine Reimbursed Amount	Defined as the total dollar amount reimbursed by the Contractor to pharmacies for vaccines billed through the pharmacy POS claims system. Reported value should include both payment for the vaccine product and the administration if both components are billed and reimbursed through the pharmacy POS claims system. The amount reported on this line should reflect the total amount reimbursed for claims listed on line 21.
28	Total Other Non-Drug POS Reimbursed Amount	Defined as the total dollar amount reimbursed by the Contractor to pharmacies for all products billed through the pharmacy POS claims system that are neither vaccines nor prescribed drugs as defined by CMS. The amount reported on this line should reflect the total amount reimbursed for claims listed in line 22.
29	Total Brand Reimbursed Amount	Defined as the total dollar amount reimbursed by the Contractor to pharmacies for non-specialty brand prescription claims during the reporting period.

Category	Measure	Definitions
30	Total Generic Reimbursed Amount	Defined as the total dollar amount reimbursed by the Contractor to pharmacies for non-specialty generic prescription claims during the reporting period.
31	Total Specialty Reimbursed Amount	Defined as the total dollar amount reimbursed by the Contractor to pharmacies for specialty prescription claims, both brands and generics, during the reporting period.
32	Overall Total POS Reimbursed Amount	Defined as the overall total dollar amount reimbursed by the Contractor to pharmacies for pharmacy POS claims including brand, generic, and specialty drug claims, as well as vaccine and other non-drug claims during the reporting period. This field will populate automatically based on line items described above. This total must equal the YTD total pharmaceutical expenses included in the income statement.

2.13 Schedule Y: Pharmacy Benefit Manager Financial Disclosures Report

This report is designed to capture pharmacy benefit manager contractual arrangements consistent with the requirements outlined in Section 5.15 — Financial Disclosures for Pharmacy Services of the MCO Statement of Work with the LDH.

This report should be completed quarterly. A copy of the PBM agreement or contract with the MCO is not a substitute for completing the list of required disclosures. LDH does not expect the disclosures to change materially from quarter to quarter. Please highlight material changes, and note the reason for the change within Schedule BA — Supplemental Working Area. LDH agrees to maintain the confidentiality of information disclosed by the MCO pursuant to the contract, to the extent that such information is confidential under Louisiana or federal law.

The realized dollar value is an estimate of the implied value of the contract or agreement. For example, the vendor may have a service fee agreement with a drug manufacturer to share utilization data. The vendor is paid by the manufacturer based on a percentage of the drug's cost. If the service fee arrangement is 0.5% of the drugs cost, and the typical annual cost of the drug is $1,000,000, then the MCO should enter 0.5% administrative service fee based on WAC for disclosure description with a realized dollar value equal to $5,000.

2.14 Schedule Z: Member Value-Added Services Report

This report is a summary of Member Value-Added Services expenses reported on an YTD basis. Please reference Section 2.03 as guidance when reporting expenses. Detail regarding all Member Value-Added services, including those reported as administrative in addition to those reported as claims, is to be included in the value-added services table. Additionally, please indicate whether the reporting method for the service in the Encounter vs. Non-Encounter column using the drop down. The Preparer may need to insert additional rows to accommodate all services.

2.15 Schedule AA: In Lieu of Services Report

Schedule AA is designed to inform LDH of costs associated with approved alternative, or "In Lieu Of" services. Alternative or "In Lieu Of" services approved by LDH should be tracked and reported on an YTD basis. Enter each approved service on a separate line. Use column B to identify the

service description as it was approved by LDH. Use column C to record the applicable procedure codes and modifiers. Enter a method for identifying the service in the encounters in column D, the corresponding line in Schedule C into column E, and the description for the service replaced in column F. The implementation date listed in column G should not precede the approval date of the alternative service by LDH. Column H will calculate the rate paid to providers for the service by dividing column K by column J. If rates vary in meaningful ways, please use additional lines; otherwise the average will be deemed reasonable. Enter a unit description in column I. If more than one unit description exists, add a new row for each type. Enter the total number of units provided in column J and the total paid amount in column K. All figures should be reported based on standard COS logic, guidance for COS specification can be found in Appendix B.

2.16 Schedule AB: Delegated Vendors Expense Report

This report is a summary of delegated service expenses by vendor. The vendor will submit one YTD report in each quarterly submission. For each vendor, identify whether the vendor has full risk, shared risk, or no risk. Also, identify if the vendor is a related party and if the vendor provides Member Value-Added services. For Health Care Expense Mapping, use the prescribed drop down menu in column G and for Lag Report Mapping, use the drop down menu in column I. If a vendor provides services for more than one expense or lag report, use multiple lines.

Categorize expense as general administrative, HCQI, or health care expenses paid to vendors. For example, delegated pharmacy services may include costs incurred by the vendor's PBM. The cost of reimbursement paid to pharmacies would be considered health care expenses. The PBM fee would be general administrative and any services provided to improve health outcomes, under the definitions in section 2.01 page 13, classified as HCQI.

2.17 Schedule AC: FQHC and RHC Payments

This report is a summary of Contractor payments to FQHCs and RHCs for 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 (Section 9.2.3 of the RFP). The Contractor will submit one YTD report in each quarterly submission.

The Medicaid Provider ID number for each provider must be documented to properly identify the corresponding rate for each FQHC or RHC. As PPS rates may vary by provider and change periodically, the Schedule is designed to capture information by provider by quarter. Quarterly aggregate payments and encounters must be listed by provider, as well as the PPS rates in effect for the effective dates of service. Interest payments should be reported separately from the actual payments for services. 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 (for example, 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/xx for FQHC A, report the aggregate payments and encounters for 7/1/xx-8/31/xx on one line, and the aggregate payments and encounters for 9/1/xx–9/30/xx on another. Both lines can be referenced with the same quarterly identification, and a clarifying disclosure should be provided in Schedule BA.

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 LDH definition of encounters for FQHC/RHC services, and are correlated to PPS rate determination. Report the number of encounters corresponding to the payments listed. Generally, in spite of the number of Medical services provided on any given day (that is, 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 LDH, but must be the rates issued by LDH.

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 BA. Negative variances indicate the contractually required PPS rates have not been paid, and a complete explanation is required on Schedule AB.

2.18 Schedule AD: Third Party Resource Payments

This Schedule provides detail regarding total claims payments and claims paid that had other coverage. The Contractor will submit an YTD report in each quarter.

- 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 payer.
- 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 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”.

Two examples are discussed below and illustrate how to report the information:

- The Contractor receives and pays a claim and the member has Medicare coverage. The Contractor allowed amount for the service is $65 and Medicare paid $80. The Contractor paid amount for this should be $0, since Medicare paid more than the Contractor allowed amount. For this report, the Contractor would report $65 as Contractor allowed amount, $0 as Contractor paid amount and $65 as other insurance paid amount. Note: The Other Insurance Paid Amount should not be greater than the Contractor allowed amount. This claim would be counted in both the “Count of Total Claims Paid” and the “Count of Claims Paid with Other Insurance Indicated”.
- 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 lines 16 and 17. Report an unduplicated count of members with active TPL resources at the end of the quarter on line 18 (that is, a member could be included in both lines 16 and 17, but should only be reported once in line 18).

2.19 Schedule AE: TPL Subrogation Claims

Subrogation is defined as the pursuit of recoverable costs from a third party. This Schedule is intended to capture recoveries that have not been applied directly to claims or adjusted in the MCO’s claims processing system. List all new, active, and closed subrogation cases for the year. 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. Report all recoveries, including those recorded as a public record lien for each case. The Contractor will submit one YTD report in each quarterly submission.

2.20 Schedule AF: Fraud and Abuse Activity

List all new, active, and closed fraud and abuse cases for the year. 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 or active within the reporting quarter. Encounters that are pending may be entered with a “P”, otherwise flag with “Y” if they have been adjusted. Do not include member specific names or identification numbers on the Schedule. The Contractor will submit one YTD report in each quarterly submission. The total amount of recoveries should equal the recoveries listed within the income statement if the encounters are NOT updated. If the encounters are updated, recoveries should be reflected in claims expenses by COS.

2.21 Schedule AG: Maternity and Deliveries

This Schedule combines summary information from Maternity and Delivery revenue and expenses, identified as either early elective deliveries or non-early elective deliveries. The Contractor will submit one YTD report in each quarterly submission. Early elective deliveries are either induced or performed without medical necessity. Medical expenses to be included on this Schedule should be classified consistent with the major COS groupings on Schedule C – Income Statement.

General guidance on identifying maternity related costs and delivery events is included in this section even though most of the maternity related information (i.e. unrelated to elective deliveries) will be reported elsewhere in this report. Use the following parameters for identifying costs and delivery events:

Delivery counts should be determined using the following criteria:

Inpatient Acute	
Claim type	**01**
Billing provider type	**60, 55**
Approved Encounter claim status	**1 or 2**
Submitted on/after	**10/1/2015**
Recipient Sex	**Female**
Recipient Age	**> 10 Years**
Recipient linked to the plan	**From-DOS**
Date of Service	**>10/1/2015**
Diagnosis Codes (Live born)	**Z37.0, Z37.2, Z37.3, Z37.50, Z37.51, Z37.52, Z37.53, Z37.54, Z37.59, Z37.60, Z37.61, Z37.62, Z37.63, Z37.64, Z37.69, Z37.9**
Diagnosis Codes (Still-born)	**Z37.1, Z37.4, Z37.7**
No fetal demise code of	**O02.1**

Note: Look at the first 8 diagnosis codes submitted on encounter.

OR

Professional Claims	
Claim type	**04**
Billing provider type	**19, 20, 90 or (BC Birthing Center and Procedure Code= 59409)**
Claim Status (Normal)	**Approved Encounter, status 1 or 2**
Claim Status (Prior to 39 Weeks w/o Justification)	**Denied Encounter: 3; Deny Edit Code 134**
Submitted on/after	**10/1/2015**
Recipient Sex	**Female**
Recipient Age	**> 10 Years**
Recipient linked to the plan	**From - DOS**

Professional Claims	
Procedure Codes	**Vaginal: 59400, 59409, 59410, 59610, 59612, 59614** **Cesarean: 59510, 59514, 59515, 59618, 59620, 59622**
Modifier (1,2,3, or 4)	**GB, AT, GZ**

Or

- Date of Service on or after 1/1/16. Date of Service between 10/1/15 and 12/31/2015 should be used for retro enrollments only or maternity cases unaccounted for in in 2015. For dates prior to 10/1/15, please refer to previous versions of the FRR guidance for ICD-9 coding.
- After all encounters are identified, determine a single live-born delivery event for a given recipient within a 245-day period, plus or minus.
- Inpatient encounters for still-born events take precedence.
- Professional Encounters with GZ modifier for live-born events take precedence.
- If a kick payment has already been made within a 245-day period, plus or minus, then do not count as a separate delivery.

Maternity expenses should be calculated using the following criteria:

1. Use the first eight diagnosis codes submitted on the encounter.
2. Use the following logic to determine applicable expense.
3. Prenatal.
   a. CPT Codes: codes w/“TH” modifier, 59425, and 59426 or
   b. ICD-10 Codes or

Prenatal ICD-10 Codes								
O09.00	O09.01	O09.02	O09.03	O09.10	O09.11	O09.12	O09.13	O09.211
O09.212	O09.213	O09.219	O09.291	O09.292	O09.293	O09.299	O09.30	O09.31
O09.32	O09.33	O09.40	O09.41	O09.42	O09.43	O09.511	O09.512	O09.513
O09.519	O09.521	O09.522	O09.523	O09.529	O09.611	O09.612	O09.613	O09.619
O09.621	O09.622	O09.623	O09.629	O09.70	O09.71	O09.72	O09.73	O09.811
O09.812	O09.813	O09.819	O09.821	O09.822	O09.823	O09.829	O09.891	O09.892
O09.893	O09.899	O09.90	O09.91	O09.92	O09.93	O09.A0	O09.A1	O09.A2
O09.A3	O10.011	O10.012	O10.013	O10.019	O10.111	O10.112	O10.113	O10.119
O10.211	O10.212	O10.213	O10.219	O10.311	O10.312	O10.313	O10.319	O10.411
O10.412	O10.413	O10.419	O10.911	O10.912	O10.913	O10.919	O11.1	O11.2
O11.3	O11.9	O12.00	O12.01	O12.02	O12.03	O12.10	O12.11	O12.12
O12.13	O12.20	O12.21	O12.22	O12.23	O13.1	O13.2	O13.3	O13.9
O14.00	O14.02	O14.03	O14.10	O14.12	O14.13	O14.20	O14.22	O14.23
O14.90	O14.92	O14.93	O15.00	O15.02	O15.03	O15.9	O16.1	O16.2
O16.3	O16.9	O20.0	O20.8	O20.9	O21.0	O21.1	O21.2	O21.8
O21.9	O22.00	O22.01	O22.02	O22.03	O22.10	O22.11	O22.12	O22.13
O22.20	O22.21	O22.22	O22.23	O22.30	O22.31	O22.32	O22.33	O22.40
O22.41	O22.42	O22.43	O22.50	O22.51	O22.52	O22.53	O22.8X1	O22.8X2
O22.8X3	O22.8X9	O22.90	O22.91	O22.92	O22.93	O23.00	O23.01	O23.02
O23.03	O23.10	O23.11	O23.12	O23.13	O23.20	O23.21	O23.22	O23.23

Prenatal ICD-10 Codes								
O23.30	O23.31	O23.32	O23.33	O23.40	O23.41	O23.42	O23.43	O23.511
O23.512	O23.513	O23.519	O23.521	O23.522	O23.523	O23.529	O23.591	O23.592
O23.593	O23.599	O23.90	O23.91	O23.92	O23.93	O24.011	O24.012	O24.013
O24.019	O24.111	O24.112	O24.113	O24.119	O24.311	O24.312	O24.313	O24.319
O24.410	O24.414	O24.415	O24.419	O24.811	O24.812	O24.813	O24.819	O24.911
O24.912	O24.913	O24.919	O25.10	O25.11	O25.12	O25.13	O26.00	O26.01
O26.02	O26.03	O26.10	O26.11	O26.12	O26.13	O26.20	O26.21	O26.22
O26.23	O26.30	O26.31	O26.32	O26.33	O26.40	O26.41	O26.42	O26.43
O26.50	O26.51	O26.52	O26.53	O26.611	O26.612	O26.613	O26.619	O26.711
O26.712	O26.713	O26.719	O26.811	O26.812	O26.813	O26.819	O26.821	O26.822
O26.823	O26.829	O26.831	O26.832	O26.833	O26.839	O26.841	O26.842	O26.843
O26.849	O26.851	O26.852	O26.853	O26.859	O26.86	O26.872	O26.873	O26.879
O26.891	O26.892	O26.893	O26.899	O26.90	O26.91	O26.92	O26.93	O28.0
O28.1	O28.2	O28.3	O28.4	O28.5	O28.8	O28.9	O29.011	O29.012
O29.013	O29.019	O29.021	O29.022	O29.023	O29.029	O29.091	O29.092	O29.093
O29.099	O29.111	O29.112	O29.113	O29.119	O29.121	O29.122	O29.123	O29.129
O29.191	O29.192	O29.193	O29.199	O29.211	O29.212	O29.213	O29.219	O29.291
O29.292	O29.293	O29.299	O29.3X1	O29.3X2	O29.3X3	O29.3X9	O29.40	O29.41
O29.42	O29.43	O29.5X1	O29.5X2	O29.5X3	O29.5X9	O29.60	O29.61	O29.62
O29.63	O29.8X1	O29.8X2	O29.8X3	O29.8X9	O29.90	O29.91	O29.92	O29.93
O30.001	O30.002	O30.003	O30.009	O30.011	O30.012	O30.013	O30.019	O30.021
O30.022	O30.023	O30.029	O30.031	O30.032	O30.033	O30.039	O30.041	O30.042
O30.043	O30.049	O30.091	O30.092	O30.093	O30.099	O30.101	O30.102	O30.103
O30.109	O30.111	O30.112	O30.113	O30.119	O30.121	O30.122	O30.123	O30.129
O30.131	O30.132	O30.133	O30.139	O30.191	O30.192	O30.193	O30.199	O30.201
O30.202	O30.203	O30.209	O30.211	O30.212	O30.213	O30.219	O30.221	O30.222
O30.223	O30.229	O30.231	O30.232	O30.233	O30.239	O30.291	O30.292	O30.293
O30.299	O30.801	O30.802	O30.803	O30.809	O30.811	O30.812	O30.813	O30.819
O30.821	O30.822	O30.823	O30.829	O30.831	O30.832	O30.833	O30.839	O30.891
O30.892	O30.893	O30.899	O30.90	O30.91	O30.92	O30.93	O31.00X0	O31.00X1
O31.00X2	O31.00X3	O31.00X4	O31.00X5	O31.00X9	O31.01X0	O31.01X1	O31.01X2	O31.01X3
O31.01X4	O31.01X5	O31.01X9	O31.02X0	O31.02X1	O31.02X2	O31.02X3	O31.02X4	O31.02X5
O31.02X9	O31.03X0	O31.03X1	O31.03X2	O31.03X3	O31.03X4	O31.03X5	O31.03X9	O31.10X0
O31.10X1	O31.10X2	O31.10X3	O31.10X4	O31.10X5	O31.10X9	O31.11X0	O31.11X1	O31.11X2
O31.11X3	O31.11X4	O31.11X5	O31.11X9	O31.12X0	O31.12X1	O31.12X2	O31.12X3	O31.12X4
O31.12X5	O31.12X9	O31.13X0	O31.13X1	O31.13X2	O31.13X3	O31.13X4	O31.13X5	O31.13X9
O31.20X0	O31.20X1	O31.20X2	O31.20X3	O31.20X4	O31.20X5	O31.20X9	O31.21X0	O31.21X1
O31.21X2	O31.21X3	O31.21X4	O31.21X5	O31.21X9	O31.22X0	O31.22X1	O31.22X2	O31.22X3
O31.22X4	O31.22X5	O31.22X9	O31.23X0	O31.23X1	O31.23X2	O31.23X3	O31.23X4	O31.23X5
O31.23X9	O31.30X0	O31.30X1	O31.30X2	O31.30X3	O31.30X4	O31.30X5	O31.30X9	O31.31X0
O31.31X1	O31.31X2	O31.31X3	O31.31X4	O31.31X5	O31.31X9	O31.32X0	O31.32X1	O31.32X2
O31.32X3	O31.32X4	O31.32X5	O31.32X9	O31.33X0	O31.33X1	O31.33X2	O31.33X3	O31.33X4
O31.33X5	O31.33X9	O31.8X10	O31.8X11	O31.8X12	O31.8X13	O31.8X14	O31.8X15	O31.8X19

Prenatal ICD-10 Codes								
O31.8X20	O31.8X21	O31.8X22	O31.8X23	O31.8X24	O31.8X25	O31.8X29	O31.8X30	O31.8X31
O31.8X32	O31.8X33	O31.8X34	O31.8X35	O31.8X39	O31.8X90	O31.8X91	O31.8X92	O31.8X93
O31.8X94	O31.8X95	O31.8X99	O32.0XX0	O32.0XX1	O32.0XX2	O32.0XX3	O32.0XX4	O32.0XX5
O32.0XX9	O32.1XX0	O32.1XX1	O32.1XX2	O32.1XX3	O32.1XX4	O32.1XX5	O32.1XX9	O32.2XX0
O32.2XX1	O32.2XX2	O32.2XX3	O32.2XX4	O32.2XX5	O32.2XX9	O32.3XX0	O32.3XX1	O32.3XX2
O32.3XX3	O32.3XX4	O32.3XX5	O32.3XX9	O32.4XX0	O32.4XX1	O32.4XX2	O32.4XX3	O32.4XX4
O32.4XX5	O32.4XX9	O32.6XX0	O32.6XX1	O32.6XX2	O32.6XX3	O32.6XX4	O32.6XX5	O32.6XX9
O32.8XX0	O32.8XX1	O32.8XX2	O32.8XX3	O32.8XX4	O32.8XX5	O32.8XX9	O32.9XX0	O32.9XX1
O32.9XX2	O32.9XX3	O32.9XX4	O32.9XX5	O32.9XX9	O33.0	O33.1	O33.2	O33.3XX0
O33.3XX1	O33.3XX2	O33.3XX3	O33.3XX4	O33.3XX5	O33.3XX9	O33.4XX0	O33.4XX1	O33.4XX2
O33.4XX3	O33.4XX4	O33.4XX5	O33.4XX9	O33.5XX0	O33.5XX1	O33.5XX2	O33.5XX3	O33.5XX4
O33.5XX5	O33.5XX9	O33.6XX0	O33.6XX1	O33.6XX2	O33.6XX3	O33.6XX4	O33.6XX5	O33.6XX9
O33.7XX0	O33.7XX1	O33.7XX2	O33.7XX3	O33.7XX4	O33.7XX5	O33.7XX9	O33.8	O33.9
O34.00	O34.01	O34.02	O34.03	O34.10	O34.11	O34.12	O34.13	O34.211
O34.212	O34.218	O34.219	O34.22	O34.29	O34.30	O34.31	O34.32	O34.33
O34.40	O34.41	O34.42	O34.43	O34.511	O34.512	O34.513	O34.519	O34.521
O34.522	O34.523	O34.529	O34.531	O34.532	O34.533	O34.539	O34.591	O34.592
O34.593	O34.599	O34.60	O34.61	O34.62	O34.63	O34.70	O34.71	O34.72
O34.73	O34.80	O34.81	O34.82	O34.83	O34.90	O34.91	O34.92	O34.93
O35.0XX0	O35.0XX1	O35.0XX2	O35.0XX3	O35.0XX4	O35.0XX5	O35.0XX9	O35.1XX0	O35.1XX1
O35.1XX2	O35.1XX3	O35.1XX4	O35.1XX5	O35.1XX9	O35.2XX0	O35.2XX1	O35.2XX2	O35.2XX3
O35.2XX4	O35.2XX5	O35.2XX9	O35.3XX0	O35.3XX1	O35.3XX2	O35.3XX3	O35.3XX4	O35.3XX5
O35.3XX9	O35.4XX0	O35.4XX1	O35.4XX2	O35.4XX3	O35.4XX4	O35.4XX5	O35.4XX9	O35.5XX0
O35.5XX1	O35.5XX2	O35.5XX3	O35.5XX4	O35.5XX5	O35.5XX9	O35.6XX0	O35.6XX1	O35.6XX2
O35.6XX3	O35.6XX4	O35.6XX5	O35.6XX9	O35.7XX0	O35.7XX1	O35.7XX2	O35.7XX3	O35.7XX4
O35.7XX5	O35.7XX9	O35.8XX0	O35.8XX1	O35.8XX2	O35.8XX3	O35.8XX4	O35.8XX5	O35.8XX9
O35.9XX0	O35.9XX1	O35.9XX2	O35.9XX3	O35.9XX4	O35.9XX5	O35.9XX9	O36.0110	O36.0111
O36.0112	O36.0113	O36.0114	O36.0115	O36.0119	O36.0120	O36.0121	O36.0122	O36.0123
O36.0124	O36.0125	O36.0129	O36.0130	O36.0131	O36.0132	O36.0133	O36.0134	O36.0135
O36.0139	O36.0190	O36.0191	O36.0192	O36.0193	O36.0194	O36.0195	O36.0199	O36.0910
O36.0911	O36.0912	O36.0913	O36.0914	O36.0915	O36.0919	O36.0920	O36.0921	O36.0922
O36.0923	O36.0924	O36.0925	O36.0929	O36.0930	O36.0931	O36.0932	O36.0933	O36.0934
O36.0935	O36.0939	O36.0990	O36.0991	O36.0992	O36.0993	O36.0994	O36.0995	O36.0999
O36.1110	O36.1111	O36.1112	O36.1113	O36.1114	O36.1115	O36.1119	O36.1120	O36.1121
O36.1122	O36.1123	O36.1124	O36.1125	O36.1129	O36.1130	O36.1131	O36.1132	O36.1133
O36.1134	O36.1135	O36.1139	O36.1190	O36.1191	O36.1192	O36.1193	O36.1194	O36.1195
O36.1199	O36.1910	O36.1911	O36.1912	O36.1913	O36.1914	O36.1915	O36.1919	O36.1920
O36.1921	O36.1922	O36.1923	O36.1924	O36.1925	O36.1929	O36.1930	O36.1931	O36.1932
O36.1933	O36.1934	O36.1935	O36.1939	O36.1990	O36.1991	O36.1992	O36.1993	O36.1994
O36.1995	O36.1999	O36.20X0	O36.20X1	O36.20X2	O36.20X3	O36.20X4	O36.20X5	O36.20X9
O36.21X0	O36.21X1	O36.21X2	O36.21X3	O36.21X4	O36.21X5	O36.21X9	O36.22X0	O36.22X1
O36.22X2	O36.22X3	O36.22X4	O36.22X5	O36.22X9	O36.23X0	O36.23X1	O36.23X2	O36.23X3
O36.23X4	O36.23X5	O36.23X9	O36.4XX0	O36.4XX1	O36.4XX2	O36.4XX3	O36.4XX4	O36.4XX5

Prenatal ICD-10 Codes								
O36.4XX9	O36.5110	O36.5111	O36.5112	O36.5113	O36.5114	O36.5115	O36.5119	O36.5120
O36.5121	O36.5122	O36.5123	O36.5124	O36.5125	O36.5129	O36.5130	O36.5131	O36.5132
O36.5133	O36.5134	O36.5135	O36.5139	O36.5190	O36.5191	O36.5192	O36.5193	O36.5194
O36.5195	O36.5199	O36.5910	O36.5911	O36.5912	O36.5913	O36.5914	O36.5915	O36.5919
O36.5920	O36.5921	O36.5922	O36.5923	O36.5924	O36.5925	O36.5929	O36.5930	O36.5931
O36.5932	O36.5933	O36.5934	O36.5935	O36.5939	O36.5990	O36.5991	O36.5992	O36.5993
O36.5994	O36.5995	O36.5999	O36.60X0	O36.60X1	O36.60X2	O36.60X3	O36.60X4	O36.60X5
O36.60X9	O36.61X0	O36.61X1	O36.61X2	O36.61X3	O36.61X4	O36.61X5	O36.61X9	O36.62X0
O36.62X1	O36.62X2	O36.62X3	O36.62X4	O36.62X5	O36.62X9	O36.63X0	O36.63X1	O36.63X2
O36.63X3	O36.63X4	O36.63X5	O36.63X9	O36.70X0	O36.70X1	O36.70X2	O36.70X3	O36.70X4
O36.70X5	O36.70X9	O36.71X0	O36.71X1	O36.71X2	O36.71X3	O36.71X4	O36.71X5	O36.71X9
O36.72X0	O36.72X1	O36.72X2	O36.72X3	O36.72X4	O36.72X5	O36.72X9	O36.73X0	O36.73X1
O36.73X2	O36.73X3	O36.73X4	O36.73X5	O36.73X9	O36.80X0	O36.80X1	O36.80X2	O36.80X3
O36.80X4	O36.80X5	O36.80X9	O36.8120	O36.8121	O36.8122	O36.8123	O36.8124	O36.8125
O36.8129	O36.8130	O36.8131	O36.8132	O36.8133	O36.8134	O36.8135	O36.8139	O36.8190
O36.8191	O36.8192	O36.8193	O36.8194	O36.8195	O36.8199	O36.8210	O36.8211	O36.8212
O36.8213	O36.8214	O36.8215	O36.8219	O36.8220	O36.8221	O36.8222	O36.8223	O36.8224
O36.8225	O36.8229	O36.8230	O36.8231	O36.8232	O36.8233	O36.8234	O36.8235	O36.8239
O36.8290	O36.8291	O36.8292	O36.8293	O36.8294	O36.8295	O36.8299	O36.8310	O36.8311
O36.8312	O36.8313	O36.8314	O36.8315	O36.8319	O36.8320	O36.8321	O36.8322	O36.8323
O36.8324	O36.8325	O36.8329	O36.8330	O36.8331	O36.8332	O36.8333	O36.8334	O36.8335
O36.8339	O36.8390	O36.8391	O36.8392	O36.8393	O36.8394	O36.8395	O36.8399	O36.8910
O36.8911	O36.8912	O36.8913	O36.8914	O36.8915	O36.8919	O36.8920	O36.8921	O36.8922
O36.8923	O36.8924	O36.8925	O36.8929	O36.8930	O36.8931	O36.8932	O36.8933	O36.8934
O36.8935	O36.8939	O36.8990	O36.8991	O36.8992	O36.8993	O36.8994	O36.8995	O36.8999
O36.90X0	O36.90X1	O36.90X2	O36.90X3	O36.90X4	O36.90X5	O36.90X9	O36.91X0	O36.91X1
O36.91X2	O36.91X3	O36.91X4	O36.91X5	O36.91X9	O36.92X0	O36.92X1	O36.92X2	O36.92X3
O36.92X4	O36.92X5	O36.92X9	O36.93X0	O36.93X1	O36.93X2	O36.93X3	O36.93X4	O36.93X5
O36.93X9	O40.1XX0	O40.1XX1	O40.1XX2	O40.1XX3	O40.1XX4	O40.1XX5	O40.1XX9	O40.2XX0
O40.2XX1	O40.2XX2	O40.2XX3	O40.2XX4	O40.2XX5	O40.2XX9	O40.3XX0	O40.3XX1	O40.3XX2
O40.3XX3	O40.3XX4	O40.3XX5	O40.3XX9	O40.9XX0	O40.9XX1	O40.9XX2	O40.9XX3	O40.9XX4
O40.9XX5	O40.9XX9	O41.00X0	O41.00X1	O41.00X2	O41.00X3	O41.00X4	O41.00X5	O41.00X9
O41.01X0	O41.01X1	O41.01X2	O41.01X3	O41.01X4	O41.01X5	O41.01X9	O41.02X0	O41.02X1
O41.02X2	O41.02X3	O41.02X4	O41.02X5	O41.02X9	O41.03X0	O41.03X1	O41.03X2	O41.03X3
O41.03X4	O41.03X5	O41.03X9	O41.1010	O41.1011	O41.1012	O41.1013	O41.1014	O41.1015
O41.1019	O41.1020	O41.1021	O41.1022	O41.1023	O41.1024	O41.1025	O41.1029	O41.1030
O41.1031	O41.1032	O41.1033	O41.1034	O41.1035	O41.1039	O41.1090	O41.1091	O41.1092
O41.1093	O41.1094	O41.1095	O41.1099	O41.1210	O41.1211	O41.1212	O41.1213	O41.1214
O41.1215	O41.1219	O41.1220	O41.1221	O41.1222	O41.1223	O41.1224	O41.1225	O41.1229
O41.1230	O41.1231	O41.1232	O41.1233	O41.1234	O41.1235	O41.1239	O41.1290	O41.1291
O41.1292	O41.1293	O41.1294	O41.1295	O41.1299	O41.1410	O41.1411	O41.1412	O41.1413
O41.1414	O41.1415	O41.1419	O41.1420	O41.1421	O41.1422	O41.1423	O41.1424	O41.1425
O41.1429	O41.1430	O41.1431	O41.1432	O41.1433	O41.1434	O41.1435	O41.1439	O41.1490

Prenatal ICD-10 Codes								
O41.1491	O41.1492	O41.1493	O41.1494	O41.1495	O41.1499	O41.8X10	O41.8X11	O41.8X12
O41.8X13	O41.8X14	O41.8X15	O41.8X19	O41.8X20	O41.8X21	O41.8X22	O41.8X23	O41.8X24
O41.8X25	O41.8X29	O41.8X30	O41.8X31	O41.8X32	O41.8X33	O41.8X34	O41.8X35	O41.8X39
O41.8X90	O41.8X91	O41.8X92	O41.8X93	O41.8X94	O41.8X95	O41.8X99	O41.90X0	O41.90X1
O41.90X2	O41.90X3	O41.90X4	O41.90X5	O41.90X9	O41.91X0	O41.91X1	O41.91X2	O41.91X3
O41.91X4	O41.91X5	O41.91X9	O41.92X0	O41.92X1	O41.92X2	O41.92X3	O41.92X4	O41.92X5
O41.92X9	O41.93X0	O41.93X1	O41.93X2	O41.93X3	O41.93X4	O41.93X5	O41.93X9	O42.00
O42.011	O42.012	O42.013	O42.019	O42.02	O42.10	O42.111	O42.112	O42.113
O42.119	O42.12	O42.90	O42.911	O42.912	O42.913	O42.919	O42.92	O43.011
O43.012	O43.013	O43.019	O43.021	O43.022	O43.023	O43.029	O43.101	O43.102
O43.103	O43.109	O43.111	O43.112	O43.113	O43.119	O43.121	O43.122	O43.123
O43.129	O43.191	O43.192	O43.193	O43.199	O43.211	O43.212	O43.213	O43.219
O43.221	O43.222	O43.223	O43.229	O43.231	O43.232	O43.233	O43.239	O43.811
O43.812	O43.813	O43.819	O43.891	O43.892	O43.893	O43.899	O43.90	O43.91
O43.92	O43.93	O44.00	O44.01	O44.02	O44.03	O44.10	O44.11	O44.12
O44.13	O44.20	O44.21	O44.22	O44.23	O44.30	O44.31	O44.32	O44.33
O44.40	O44.41	O44.42	O44.43	O44.50	O44.51	O44.52	O44.53	O45.001
O45.002	O45.003	O45.009	O45.011	O45.012	O45.013	O45.019	O45.021	O45.022
O45.023	O45.029	O45.091	O45.092	O45.093	O45.099	O45.8X1	O45.8X2	O45.8X3
O45.8X9	O45.90	O45.91	O45.92	O45.93	O46.001	O46.002	O46.003	O46.009
O46.011	O46.012	O46.013	O46.019	O46.021	O46.022	O46.023	O46.029	O46.091
O46.092	O46.093	O46.099	O46.8X1	O46.8X2	O46.8X3	O46.8X9	O46.90	O46.91
O46.92	O46.93	O47.00	O47.02	O47.03	O47.1	O47.9	O48.0	O48.1
O60.00	O60.02	O60.03	O71.00	O71.02	O71.03	O88.011	O88.012	O88.013
O88.019	O88.111	O88.112	O88.113	O88.119	O88.211	O88.212	O88.213	O88.219
O88.311	O88.312	O88.313	O88.319	O88.811	O88.812	O88.813	O88.819	O91.011
O91.012	O91.013	O91.019	O91.111	O91.112	O91.113	O91.119	O91.211	O91.212
O91.213	O91.219	O92.011	O92.012	O92.013	O92.019	O92.111	O92.112	O92.113
O92.119	O98.011	O98.012	O98.013	O98.019	O98.111	O98.112	O98.113	O98.119
O98.211	O98.212	O98.213	O98.219	O98.311	O98.312	O98.313	O98.319	O98.411
O98.412	O98.413	O98.419	O98.511	O98.512	O98.513	O98.519	O98.611	O98.612
O98.613	O98.619	O98.711	O98.712	O98.713	O98.719	O98.811	O98.812	O98.813
O98.819	O98.911	O98.912	O98.913	O98.919	O99.011	O99.012	O99.013	O99.019
O99.111	O99.112	O99.113	O99.119	O99.210	O99.211	O99.212	O99.213	O99.280
O99.281	O99.282	O99.283	O99.310	O99.311	O99.312	O99.313	O99.320	O99.321
O99.322	O99.323	O99.330	O99.331	O99.332	O99.333	O99.340	O99.341	O99.342
O99.343	O99.350	O99.351	O99.352	O99.353	O99.411	O99.412	O99.413	O99.419
O99.511	O99.512	O99.513	O99.519	O99.611	O99.612	O99.613	O99.619	O99.711
O99.712	O99.713	O99.719	O99.810	O99.820	O99.830	O99.840	O99.841	O99.842
O99.843	O99.891	O9A.111	O9A.112	O9A.113	O9A.119	O9A.211	O9A.212	O9A.213
O9A.219	O9A.311	O9A.312	O9A.313	O9A.319	O9A.411	O9A.412	O9A.413	O9A.419
O9A.511	O9A.512	O9A.513	O9A.519	Z32.00	Z32.01	Z32.02	Z34.00	Z34.01
Z34.02	Z34.03	Z34.80	Z34.81	Z34.82	Z34.83	Z34.90	Z34.91	Z34.92

Prenatal ICD-10 Codes								
Z34.93	Z36.0	Z36.1	Z36.2	Z36.3	Z36.4	Z36.5	Z36.81	Z36.82
Z36.83	Z36.84	Z36.85	Z36.86	Z36.87	Z36.88	Z36.89	Z36.8A	Z36.9

c. Surgical Procedure Codes

Prenatal Surgical Procedure ICD-10 Codes							
10903ZU	10900ZC	10900ZU	10907ZU	10908ZU	30273H1	30273J1	30273K1
30273L1	30273M1	30273N1	30273P1	30273Q1	30273R1	30273S1	30273T1
30273V1	30273W1	30277H1	30277J1	30277K1	30277L1	30277M1	30277N1
30277P1	30277Q1	30277R1	30277S1	30277T1	30277V1	30277W1	10J08ZZ

d. Weeks of Gestation Codes

Weeks of Gestation Codes								
Z3A.00	Z3A.01	Z3A.08	Z3A.09	Z3A.10	Z3A.11	Z3A.12	Z3A.13	Z3A.14
Z3A.15	Z3A.16	Z3A.17	Z3A.18	Z3A.19	Z3A.20	Z3A.21	Z3A.22	Z3A.23
Z3A.24	Z3A.25	Z3A.26	Z3A.27	Z3A.28	Z3A.29	Z3A.30	Z3A.31	Z3A.32
Z3A.33	Z3A.34	Z3A.35	Z3A.36	Z3A.37	Z3A.38	Z3A.39	Z3A.40	Z3A.41
Z3A.42	Z3A.49							

4. Delivery
    a. Revenue Codes: 0720, 0721, 0722, 0724, 0729, 0112, 0122, 0132, 0142, 0152, 0232 or
    b. CPT Codes (Vaginal and Cesarean Groupings) or

Delivery Type	CPT Codes
Vaginal	59400, 59409, 59410, 59610, 59612, 59614, 59899, 01960
Cesarean	59510, 59514, 59515, 59618, 59620, 59622, 01961

c. ICD-10 Codes or

Delivery ICD-10 Codes								
O60.10X0	O60.10X1	O60.10X2	O60.10X3	O60.10X4	O60.10X5	O60.10X9	O60.12X0	O60.12X1
O60.12X2	O60.12X3	O60.12X4	O60.12X5	O60.12X9	O60.13X0	O60.13X1	O60.13X2	O60.13X3
O60.13X4	O60.13X5	O60.13X9	O60.14X0	O60.14X1	O60.14X2	O60.14X3	O60.14X4	O60.14X5
O60.14X9	O60.20X0	O60.20X1	O60.20X2	O60.20X3	O60.20X4	O60.20X5	O60.20X9	O60.22X0
O60.22X1	O60.22X2	O60.22X3	O60.22X4	O60.22X5	O60.22X9	O60.23X0	O60.23X1	O60.23X2
O60.23X3	O60.23X4	O60.23X5	O60.23X9	O67.0	O67.8	O67.9	O68	O69.0XX0
O69.0XX1	O69.0XX2	O69.0XX3	O69.0XX4	O69.0XX5	O69.0XX9	O69.1XX0	O69.1XX1	O69.1XX2
O69.1XX3	O69.1XX4	O69.1XX5	O69.1XX9	O69.2XX0	O69.2XX1	O69.2XX2	O69.2XX3	O69.2XX4
O69.2XX5	O69.2XX9	O69.3XX0	O69.3XX1	O69.3XX2	O69.3XX3	O69.3XX4	O69.3XX5	O69.3XX9
O69.4XX0	O69.4XX1	O69.4XX2	O69.4XX3	O69.4XX4	O69.4XX5	O69.4XX9	O69.5XX0	O69.5XX1
O69.5XX2	O69.5XX3	O69.5XX4	O69.5XX5	O69.5XX9	O69.81X0	O69.81X1	O69.81X2	O69.81X3
O69.81X4	O69.81X5	O69.81X9	O69.82X0	O69.82X1	O69.82X2	O69.82X3	O69.82X4	O69.82X5
O69.82X9	O69.89X0	O69.89X1	O69.89X2	O69.89X3	O69.89X4	O69.89X5	O69.89X9	O69.9XX0
O69.9XX1	O69.9XX2	O69.9XX3	O69.9XX4	O69.9XX5	O69.9XX9	O70.0	O70.1	O70.20

Delivery ICD-10 Codes								
O70.21	O70.22	O70.23	O70.3	O70.4	O70.9	O72.0	O72.1	O72.2
O72.3	O73.0	O73.1	O74.0	O74.1	O74.2	O74.3	O74.4	O74.5
O74.6	O74.7	O74.8	O74.9	O75.0	O75.1	O75.2	O75.3	O75.4
O75.5	O75.81	O75.82	O75.89	O75.9	O76	O77.0	O77.1	O77.8
O77.9	O80	O82	O01.0	O01.1	O01.9	O02.0	O02.81	O02.89
O02.9	O10.02	O10.12	O10.22	O10.32	O10.42	O10.92	O15.1	O24.02
O24.12	O24.32	O24.420	O24.424	O24.429	O24.82	O24.92	O25.2	O26.62
O26.72	O61.0	O61.1	O61.8	O61.9	O62.0	O62.1	O62.2	O62.3
O62.4	O62.8	O62.9	O63.0	O63.1	O63.2	O63.9	O64.0XX0	O64.0XX1
O64.0XX2	O64.0XX3	O64.0XX4	O64.0XX5	O64.0XX9	O64.1XX0	O64.1XX1	O64.1XX2	O64.1XX3
O64.1XX4	O64.1XX5	O64.1XX9	O64.2XX0	O64.2XX1	O64.2XX2	O64.2XX3	O64.2XX4	O64.2XX5
O64.2XX9	O64.3XX0	O64.3XX1	O64.3XX2	O64.3XX3	O64.3XX4	O64.3XX5	O64.3XX9	O64.4XX0
O64.4XX1	O64.4XX2	O64.4XX3	O64.4XX4	O64.4XX5	O64.4XX9	O64.5XX0	O64.5XX1	O64.5XX2
O64.5XX3	O64.5XX4	O64.5XX5	O64.5XX9	O64.8XX0	O64.8XX1	O64.8XX2	O64.8XX3	O64.8XX4
O64.8XX5	O64.8XX9	O64.9XX0	O64.9XX1	O64.9XX2	O64.9XX3	O64.9XX4	O64.9XX5	O64.9XX9
O65.0	O65.1	O65.2	O65.3	O65.4	O65.5	O65.8	O65.9	O66.0
O66.1	O66.2	O66.3	O66.40	O66.41	O66.5	O66.6	O66.8	O66.9
O71.1	O71.3	O71.4	O71.5	O71.6	O71.7	O71.81	O71.82	O71.89
O71.9	O88.02	O88.12	O88.22	O88.32	O88.82	O90.0	O90.1	O90.2
O98.02	O98.12	O98.22	O98.32	O98.42	O98.52	O98.62	O98.72	O98.82
O98.92	O99.02	O99.12	O99.214	O99.284	O99.314	O99.324	O99.334	O99.344
O99.354	O99.42	O99.52	O99.62	O99.72	O99.814	O99.824	O99.834	O99.844
O99.892	O9A.12	O9A.22	O9A.32	O9A.42	O9A.52			

d. Surgical Procedure Codes

Delivery Surgical Procedure ICD-10 Codes								
0DQP0ZZ	0DQP3ZZ	0DQP4ZZ	0DQP7ZZ	0DQP8ZZ	0DQR0ZZ	0DQR3ZZ	0DQR4ZZ	0JCB0ZZ
0JCB3ZZ	0Q820ZZ	0Q823ZZ	0Q824ZZ	0Q830ZZ	0Q833ZZ	0Q834ZZ	0TQB0ZZ	0TQB3ZZ
0TQB4ZZ	0TQB7ZZ	0TQB8ZZ	0TQD0ZZ	0TQD3ZZ	0TQD4ZZ	0TQD7ZZ	0TQD8ZZ	0TQDXZZ
0U7C7ZZ	0UCG0ZZ	0UCG3ZZ	0UCG4ZZ	0UCM0ZZ	0UJD0ZZ	0UJD3ZZ	0UJD4ZZ	0UJD7ZZ
0UQ90ZZ	0UQ93ZZ	0UQ94ZZ	0UQ97ZZ	0UQ98ZZ	0UQC0ZZ	0UQC3ZZ	0UQC4ZZ	0UQC7ZZ
0UQC8ZZ	0UQG0ZZ	0UQG3ZZ	0UQG4ZZ	0UQG7ZZ	0UQG8ZZ	0UQGXZZ	0UQM0ZZ	0UQMXZZ
0US90ZZ	0US94ZZ	0US97ZZ	0US98ZZ	0US9XZZ	0USC0ZZ	0USC4ZZ	0USC8ZZ	0W3R0ZZ
0W3R3ZZ	0W3R4ZZ	0W3R7ZZ	0W3R8ZZ	0W8NXZZ	0WQN0ZZ	0WQN3ZZ	0WQN4ZZ	0WQNXZZ
10900ZA	10900ZC	10903ZA	10903ZC	10904ZA	10904ZC	10907ZA	10907ZC	10908ZA
10908ZC	10A00ZZ	10A03ZZ	10A04ZZ	10A07Z6	10A07ZW	10A07ZX	10A07ZZ	10A08ZZ
10D00Z0	10D00Z1	10D00Z2	10D07Z3	10D07Z4	10D07Z5	10D07Z6	10D07Z7	10D07Z8
10D17Z9	10D17ZZ	10D18Z9	10D18ZZ	10E0XZZ	10H003Z	10H00YZ	10H073Z	10H07YZ
10J00ZZ	10J03ZZ	10J04ZZ	10J07ZZ	10J08ZZ	10J0XZZ	10P003Z	10P00YZ	10P073Z
10P07YZ	10S07ZZ	10S0XZZ	10T20ZZ	10T23ZZ	10T24ZZ	10T27ZZ	10T28ZZ	2Y44X5Z
3E030VJ	3E033VJ	3E040VJ	3E043VJ	3E050VJ	3E053VJ	3E060VJ	3E063VJ	3E0DXGC

5. Post-Partum
    a. CPT Codes: 59430 or

b. ICD-10 Codes or

Post-Partum ICD 10 Codes								
O08.0	O08.1	O08.2	O08.3	O08.4	O08.5	O08.6	O08.7	O08.81
O08.82	O08.83	O08.89	O08.9	O10.03	O10.13	O10.23	O10.33	O10.43
O10.93	O15.2	O24.03	O24.13	O24.33	O24.430	O24.434	O24.439	O24.83
O24.93	O25.3	O26.63	O26.73	O71.2	O85	O86.00	O86.01	O86.02
O86.03	O86.04	O86.09	O86.11	O86.12	O86.13	O86.19	O86.20	O86.21
O86.22	O86.29	O86.4	O86.81	O86.89	O87.0	O87.1	O87.2	O87.3
O87.4	O87.8	O87.9	O88.03	O88.13	O88.23	O88.33	O88.83	O89.01
O89.09	O89.1	O89.2	O89.3	O89.4	O89.5	O89.6	O89.8	O89.9
O90.3	O90.4	O90.5	O90.6	O90.81	O90.89	O90.9	O91.02	O91.03
O91.12	O91.13	O91.22	O91.23	O92.02	O92.03	O92.12	O92.13	O92.20
O92.29	O92.3	O92.4	O92.5	O92.6	O92.70	O92.79	O98.03	O98.13
O98.23	O98.33	O98.43	O98.53	O98.63	O98.73	O98.83	O98.93	O99.03
O99.13	O99.215	O99.285	O99.315	O99.325	O99.335	O99.345	O99.355	O99.43
O99.53	O99.63	O99.73	O99.815	O99.825	O99.835	O99.845	O99.893	O9A.13
O9A.23	O9A.33	O9A.43	O9A.53	Z39.0	Z39.1	Z39.2		

c. Surgical Procedure Codes

Post-Partum Surgical Procedure Codes								
0JCB0ZZ	0JCB3ZZ	0UCG0ZZ	0UCG3ZZ	0UCG4ZZ	0UCG7ZZ	0UCG8ZZ	0UCGXZZ	0UCM0ZZ
0UCMXZZ	0UJD0ZZ	0UJD3ZZ	0UJD4ZZ	0UJD7ZZ	0UJD8ZZ	0UJDXZZ	0US90ZZ	0US94ZZ
0US97ZZ	0US98ZZ	0US9XZZ	0W3R0ZZ	0W3R3ZZ	0W3R4ZZ	0W3R7ZZ	0W3R8ZZ	2Y44X5Z

6. Abortions
   a. CPT Codes or

Abortion CPT Codes								
59812	59820	59821	59830	59840	59841	59850	59851	59852
59855	59856	59857						

b. ICD-10 Codes or

Abortion ICD-10 Codes								
O02.1	O03.0	O03.1	O03.2	O03.30	O03.31	O03.32	O03.33	O03.34
O03.35	O03.36	O03.37	O03.38	O03.39	O03.4	O03.5	O03.6	O03.7
O03.80	O03.81	O03.82	O03.83	O03.84	O03.85	O03.86	O03.87	O03.88
O03.89	O03.9	O04.5	O04.6	O04.7	O04.80	O04.81	O04.82	O04.83
O04.84	O04.85	O04.86	O04.87	O04.88	O04.89	O07.0	O07.1	O07.2
O07.30	O07.31	O07.32	O07.33	O07.34	O07.35	O07.36	O07.37	O07.38
O07.39	O07.4	Z33.2	10A00ZZ	10A03ZZ	10A04ZZ	10A07Z6	10A07ZW	10A07ZX
10A07ZZ	10A08ZZ							

c. HCPC Codes: S0199, S2260

7. Ectopic Pregnancy
    a. CPT Codes: 59120, 59121, 59130, 59135, 59136, 59140, 59150, 59151
    b. ICD-10 Codes

Ectopic Pregnancy ICD-10 Codes								
O00.00	O00.01	O00.101	O00.102	O00.109	O00.111	O00.112	O00.119	O00.201
O00.202	O00.209	O00.211	O00.212	O00.219	O00.80	O00.81	O00.90	O00.91

Use the following logic for COS splits:

- Inpatient: Bill type 011x and 012x
- Outpatient: Bill type 013x, 083x, or 084x
- Professional: CLC_Claim_Cat_Serv = 07
- Pharmaceuticals: CLQ_Claim_Type =12
- Other Medical: All other expenses not described above

2.22 Schedules AH-AL: Utilization Reports

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

Admission, day, visit, assessment, script, unit, and claim quantities should be reported on an incurred basis for the year being reported as counted from authorizations or claims adjudication data. Estimates for claims still not received as of the report due date should be estimated so the utilization is representative of the actual occurrence of services performed for the reporting period.

Service Measure	Measure	Type of Utilization/ Proxy	Definitions
Inpatient	Days	Quantity/Days	Days are calculated as follows: ▪ Number of days between admission and discharge date. (Exclude discharge date and denied days. Include admission day.) If dates are equal, Inpatient day is counted as one. ▪ Days counted should be all paid days of service for each admission that occurred in the period. If the admission and discharge dates do not occur in the same period, all days are counted as occurring in the period in which the admission occurs. ▪ Include data for which the Contractor is both the primary payer and the secondary payer.
Inpatient	Admissions	Quantity/Admissions	This measure summarizes utilization of Inpatient services and observation room stays that result in admission requiring stays greater than or equal to 24 hours before discharge.

Service Measure	Measure	Type of Utilization/ Proxy	Definitions
Outpatient	Visits	Quantity/Services	▪ This measure summarizes utilization of Outpatient services and observation room stays that result in discharge. ▪ Each visit to an emergency room that does not result in an admission should be counted once, regardless of the intensity of care required during the stay or the length of stay. Patients admitted to the hospital from the emergency room should not be included in counts of visits. Visits to urgent care centers should be counted. ▪ Include data for which the Contractor is both the primary payer and the secondary payer.
Outpatient	Claims	Quantity/Claims	This measure summarizes the count of paid or payable claims at the header level. Claims with any lines paid greater than $0 are considered paid. Claims paid $0 because of COB are also considered paid.
Professional	Visits	Quantity/Services	Visits are calculated as follows: ▪ A visit is defined as one or more professional contacts between a patient and a unique service provider on a unique date of service. ▪ Include data for which the Contractor is both the primary payer and the secondary payer.
Clinical	Claims	Quantity/Claims	This measure summarizes the count of paid or payable claims at the header level. Claims with any lines paid greater than $0 are considered paid. Claims paid $0 because of COB are also considered paid.
SBH	Days	Quantity/Days	Days are calculated as follows: ▪ Number of days between admission and discharge date. (Exclude discharge date and denied days. Include admission day.) If dates are equal, SBH day is counted as one. ▪ Days counted should be all paid days of service for each admission that occurred in the period. If the admission and discharge dates do not occur in the same period, all days are counted as occurring in the period in which the admission occurs. ▪ Include data for which the Contractor is both the primary payer and the secondary payer.
SBH	Admissions	Quantity/Admissions	This measure summarizes utilization of SBH service stays that result in admission requiring stays greater than or equal to 24 hours before discharge.
SBH	Claims	Quantity/Claims	This measure summarizes the count of paid or payable claims at the header level. Claims with any lines paid greater than $0 are considered paid. Claims paid $0 because of COB are also considered paid.

Service Measure	Measure	Type of Utilization/ Proxy	Definitions
SBH	Visits	Quantity/Services	▪ A visit is defined as one or more professional contacts between a patient and a unique service provider on a unique date of service. ▪ Include data for which the Contractor is both the primary payer and the secondary payer.
Other	Visits	Quantity/Services	▪ A visit or service is defined as one or more professional contacts between a patient and a unique service provider on a unique date of service. For Nursing Facility stays, count the days as consistent with the hospitalization service measure. ▪ Include data for which the Contractor is both the primary payer and the secondary payer.
Other	Claims	Quantity/Claims	This measure summarizes the count of paid or payable claims at the header level. Claims with any lines paid greater than $0 are considered paid. Claims paid $0 because of COB are also considered paid.
Other	Units	Quantity/Services	This measure summarizes the unit count of paid or payable claims.
Other	Days	Quantity/Days	Days are calculated as follows: ▪ Number of days between admission and discharge date. (Exclude discharge date and denied days. Include admission day.) If dates are equal, Inpatient day is counted as one. ▪ Days counted should be all paid days of service for each admission that occurred in the period. If the admission and discharge dates do not occur in the same period, all days are counted as occurring in the period in which the admission occurs. ▪ Include data for which the Contractor is both the primary payer and the secondary payer.
Member Value-Added Services	Units	Quantity/Services	This measure summarizes the unit count of paid or payable claims.
Pharmacy	Scripts	Quantity/Scripts	Scripts count the number of prescriptions filled.

2.23 Schedules AM–AQ: SBH Utilization Reports

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

Admission, visit, day, unit, and claim quantities should be reported on an incurred basis for the year being reported as counted from authorizations or claims adjudication data. Estimates for claims still not received as of the report due date should be estimated so the utilization is representative of the actual occurrence of services performed for the reporting period.

Service Measure	Measure	Type of Utilization/ Proxy	Definitions
Inpatient	Days	Quantity of Days	Days are calculated as follows: ▪ Number of days between admission and discharge date. (Exclude discharge date and denied days. Include admission day.) If dates are equal, Inpatient day is counted as one. ▪ Days counted should be all paid days of service for each admission that occurred in the period. If the admission and discharge dates do not occur in the same period, all days are counted as occurring in the period in which the admission occurs. ▪ Include data for which the Contractor is both the primary payer and the secondary payer.
Inpatient	Admissions	Quantity of Admissions	This measure summarizes utilization of Inpatient services and observation room stays that result in admission requiring stays greater than or equal to 24 hours before discharge.
Outpatient	Visits	Quantity of Services	▪ This measure summarizes utilization of Outpatient services and observation room stays that result in discharge. ▪ Each visit to an emergency room that does not result in an admission should be counted once, regardless of the intensity of care required during the stay or the length of stay. Patients admitted to the hospital from the emergency room should not be included in counts of visits. Visits to urgent care centers should be counted. ▪ Include data for which the Contractor is both the primary payer and the secondary payer.
Professional	Visits	Quantity of Services	▪ A visit is defined as one or more professional contacts between a patient and a unique service provider on a unique date of service. ▪ Include data for which the Contractor is both the primary payer and the secondary payer.
Professional Services	Units	Quantity of Units	This measure summarizes the unit count of paid or payable claims.

Service Measure	Measure	Type of Utilization/ Proxy	Definitions
Addiction Services	Days	Quantity of Days	Days are calculated as follows: ▪ Number of days between admission and discharge date. (Exclude discharge date and denied days. Include admission day.) If dates are equal, Inpatient day is counted as one. ▪ Days counted should be all paid days of service for each admission that occurred in the period. If the admission and discharge dates do not occur in the same period, all days are counted as occurring in the period in which the admission occurs. ▪ Include data for which the Contractor is both the primary payer and the secondary payer.
Addiction Services	Admissions	Quantity of Admissions	This measure summarizes utilization of Addiction services and observation room stays that result in admission requiring stays greater than or equal to 24 hours before discharge.
Addiction Services	Visits	Quantity of Services	▪ This measure summarizes utilization of Outpatient and Intensive Outpatient services and observation room stays that result in discharge. ▪ Include data for which the Contractor is both the primary payer and the secondary payer.
Addiction Services	Units	Quantity/Services	This measure summarizes the unit count of paid or payable claims.
Other Services	Units	Quantity/Services	This measure summarizes the unit count of paid or payable claims.
Other Services	Days	Quantity of Days	Days are calculated as follows: ▪ Number of days between admission and discharge date. (Exclude discharge date and denied days. Include admission day.) If dates are equal, Inpatient day is counted as one. ▪ Days counted should be all paid days of service for each admission that occurred in the period. If the admission and discharge dates do not occur in the same period, all days are counted as occurring in the period in which the admission occurs. ▪ Include data for which the Contractor is both the primary payer and the secondary payer.
Other Services	Admissions	Quantity of Admissions	This measure summarizes utilization of Other services and observation room stays that result in admission requiring stays greater than or equal to 24 hours before discharge.
Member Value-Added Services	Units	Quantity/Services	This measure summarizes the unit count of paid or payable claims.

2.24 Schedule AR: Settlement Payments

This Schedule is a summary of hospital settlement payments not reflected in encounter data, and should include Hospital Inpatient and Outpatient cost settlement only. This includes recoupments from cost settlements in cases where the hospital facility owed the Contractor any amount. Payments or recoupments should be detailed by state vendor identification number and provider identification number. The state vendor number and provider number should correspond to those reported to the contractor on the Medicaid cost reports in lieu of form CMS 2552-10 and the accompanying cover letters, if available. Please identify the facility fiscal year end (FYE). Payments to the same facility should have a separate line for each FYE. Please indicate whether the payment is to satisfy the Medicaid cost report obligation by selecting "yes" or "no" from the drop down in column F. In columns J and K, please indicate the status of the cost report settlement by selecting "Final" or "Interim" from the designated drop down and subsequently the percentage of the cost settlement paid to date.

Specification	Inclusion
Amount Identified for Payment	The total obligation identified for the provider on a YTD basis
Amount Payable	The unpaid portion of the Amount Identified for Payment
Amount Paid	The paid portion of the Amount Identified for Payment

The Amount Paid and the Amount Payable should be equal to the Amount Identified for Payment.

Cost report letters may include zero balance settlements as well as cost settlements under $1,000. Due to concerns regarding materiality of the cost settlements reported, the Contractor has the option of excluding cost settlement payments and recoupments under $1,000. Any amounts not reported will be omitted from the rate-setting process. Please take this into consideration when completing this Schedule.

2.25 Schedule AS: Retroactive Enrollment Claims Lag Report

Schedule AR requests the same type of information as the lags reported in Schedules R through W, but only for retroactive enrollment payments/claims associated with member reimbursement prior to the initial prospective month of enrollment. The retroactive enrollment claims prior to the initial prospective month of enrollment should be reported in aggregate. The table is arranged with the month of service horizontally and the month of payment vertically. All payments made during the current month for services rendered during the current month would be reported in the appropriate column and row, similar to how information is reported in Schedules R-W. Payments made during the current month for services rendered in prior months would be reported in a similar manner. All retroactive enrollment costs should be reported on these tables, and also reported in the service-specific lag tables in Schedules R–W. If any data changes between quarterly submissions, please provide an explanation. Please report all available data for the time period shown in this table.

Member Value-Added Services should not be included in Lines 1 through 37. Medical and SBH costs must be reported net of TPL and COB. Claims liabilities should **not** include the administrative portion of claim settlement expenses. Adjudicated claims, which have not yet been paid should be included in the lag triangles. These claims payable amounts may cause the month

of payment to shift between report submissions. This variance is known and acceptable. Any liability for future claim settlement expense **must be disclosed separately** from the unpaid claim liability in a footnote.

Note: Multiple-month Inpatient stays should be recorded in the admission month. Inpatient stays with a primary diagnosis requiring SBH services should be included on Schedule R — Inpatient Lag.

Line 39 — Global/Subcapitation Payments

The Contractor should report global subcapitation payments on this line, by month of payment, which should not be included 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 Inpatient services, Outpatient facility, Professional services, and Other Medical service lag reports.
- Subcapitation Payments: Those services paid through a normal provider capitation agreement. Examples would include PMPM payments to a PCP for a specified list of services, or to a laboratory for a specified list of tests.

Line 40 — Value-Based Payments

The Contractor should report value-based payments on this line that are not reflected in encounter data. Value-based payments must meet evidenced based quality guidelines; expenses must reflect payments tied to quality programs. The at-risk portion of any program must not incentivize withholding of necessary care. These arrangements must be disclosed on Attachment E – APM Strategic Plan Requirements Report (a separate report referenced in the Contract) and be approved by LDH. If the Contractor makes a value-based payment that cannot be reported on lines 1 through 37 due to lack of data or method of payment, the amount must be reported on line 40 with the payment month used as a substitute for the service month. Full Medicaid pricing should not be reported in this line. Provide any clarifying explanation on Schedule BA.

Line 41 — Alternative Payment Methodologies

The Contractor should report alternative payment methodology expenditures on this line that are not reflected in encounter data. Alternative payment methodology expenditures do not meet evidenced based quality guidelines. For example, pay for reporting arrangements. These arrangements must be disclosed on the Attachment E – APM Strategic Plan Requirement Report; although, they have not been approved by LDH. If the Contractor makes an alternative payment methodology that cannot be reported on lines 1 through 37 due to lack of data or method of payment, the amount must be reported on line 41 with the payment month used as a substitute for the service month. Full Medicaid pricing should not be reported in this line. Provide any clarifying explanation on Schedule BA.

Line 42 — 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 42 with the payment month used as a substitute for the service month.

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 and abuse recoupment or inaccurate payment settlement agreements with a provider that have not been captured through the claims payment system should be included.

Line 43 — Other Contractual Payments

Full Medicaid pricing should be reported in this line. The Contractor may use an alternative method of reporting other contractual payments that restates prior period amounts to reflect actual other contractual payments for that month. Do not include adjustments to IBNR amounts on this line.

Line 44 — Sum of Claims, Capitation Payments, and Settlements

This line is the total amount paid to date (including subcapitation) for services rendered and should equal the sum of lines 38 through 43. This line will calculate automatically.

Line 45 — 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 45. The development of each IBNR should be based on the most recent paid claims data. The sum of estimated IBNR across all lag schedules should be equal to the IBNR listed within the Balance Sheet. Claims payable, VBP payable, and other services payable amounts should not be included in the IBNR estimate.

Line 46 — Net Incurred Claims

Net incurred claims is the sum of lines 44 – Sum of Claims, Capitation Payments, and Settlements and 45 – IBNR. Member Value-Added Services should not be included in Net Incurred Claims. These amounts represent current estimated amounts ultimately to be paid for Medical and Behavioral Health services by month of service for the past 36 months, and for all months prior to the 36th month. Each amount represents the medical 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 in this amount are subcapitations and adjustments. This line will calculate automatically.

Line 47 — Member Value-Added Services Paid

Amounts on this line represent member value-added services by month of service for encounterable and non-encounterable services.

Line 48 — Member Value-Added Services Remaining Liability IBNR

Amounts on this line represent the current estimates for unpaid claims by month of service for member value-added services over 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 48. The development of IBNR should be based on the most recent paid claims data.

Line 49 — Total Incurred Claims

Total incurred claims is comprised of line 46 (net incurred claims) plus lines 47 and 48 (non-covered expenses). This line will calculate automatically.

Line 50 — Provision for Adverse Deviation

Amounts on this line represent the additional liability estimate that is above and beyond the MCO's best estimate of unpaid claim liability. Do not include estimates related to IBNR.

Line 51 — Members

Count of members whose claims map to program and major COS combination for the given month on line 51 (membership). This line will calculate automatically.

Schedules R through W must provide data for the period beginning with the first month the Contractor is responsible for providing medical benefits to LDH recipients, and ending with the current month.

2.25 Schedule AT: HBR Calculation

Schedule AS is automatically calculated from Schedule C, Income Statement. Please note that the quarterly HBR calculation will be used for informational purposes only by LDH. The quarterly schedule will not be utilized for determination of payments from the Contractor to LDH, nor for determination of any payments from LDH to the Contractor pertaining to Expansion risk corridors. The information reported should be on a YTD basis. Therefore, the quarterly report for June 30, 20XX will include financial data from January 1, 20XX through June 30, 20XX, and would be due on August 31, 20XX.

Significant parts of the MLR calculation come directly from the income statements completed in Schedule C.

2.26 Schedule BA: 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.

3

Annual Reporting Requirements

3.01 Schedule AU: 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 statements in PDF format.

3.02 Schedule AV: Louisiana Entity Level Audited Financial Statements

Insert the final audited company financial statements for the entity contracted with LDH within this tab within 120 days after year end. Preferably, this can be accomplished by embedding the final statements in PDF format.

3.03 Schedule AW: 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. The agreed upon procedures should be finalized before completing the Annual MLR.

3.04 Schedule AX: 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.

3.05 Schedule AY: 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 3 of Schedule C.

3.06 Schedule AZ: Administration Summary Report

The provider must annually submit administrative cost detail by the requested expense categories and classifications, and also include general ledger accounts (number or code) and names with the associated expenditures. The provider may also embed an Excel document which details all individual general ledger accounts by expense category with the associated expenditures within the report. The excel document should tie to the amounts included within the schedule. Totals from this report must tie to the audited schedules at year end. A reconciliation calculation is performed at the bottom of Table A. Any differences between Table A and A-Income Statement QTRLY should be reconciled using Schedule BA provided within this template.

Detailed instructions for each of the requested categories and classifications are included below:

Expense Classifications Administrative Expense Detail tab columns F-H:	
Health Plan Direct Charge (Column F)	Expenses directly incurred and expensed by the Healthy Louisiana Health Plan and recorded directly in the general ledger of the Healthy Louisiana Health Plan.
Corporate Allocation (Column G)	Expenses allocated to the Healthy Louisiana Health Plan through a corporate allocation arrangement with a related or affiliated entity. Methodologies for allocated expenses may include PMPM, percent of revenue, percent of head counts and/or full-time equivalents, etc. Include/submit an explanation of the expenses included and the basis of the methodology. This includes allocations to the Healthy Louisiana Health Plan when the allocation is to the health plan's multiple lines of business.
Management Service Agreement (Column H)	Expenses incurred by the Healthy Louisiana Health Plan through a management service agreement.

Category	Administrative Category Descriptions	Definitions
1.0	Compensation	
1.1	Compensation and Benefits - Based in Louisiana	All forms of compensation, including employee benefits and taxes to administrative personnel based in Louisiana. Also include medical director compensation, whether on salary or contract. Include case management compensation below.
1.2	Compensation - Corporate Allocation for Direct Support	All forms of corporate-allocated compensation, including employee benefits and taxes to administrative personnel in direct support of the Healthy Louisiana Health Plan. Include case management compensation below.
1.3	Compensation - Executive Officers - Board of Directors' Fees	Corporate Executive Officers' Salaries and Board of Director's Fees charged or allocated to the Louisiana Medicaid line of business.
1.4	Share/Stock/Incentive Based Compensation	To the extent not included elsewhere within this report, expenses associated with share/stock based compensation and/or stock-option expenses.

Category	Administrative Category Descriptions	Definitions
1.5	Compensation - Case Management - Non-Expansion	All forms of compensation, including employee benefits and taxes, for services related to enrollee social and medical case management and coordination, including assessment, planning, monitoring, and evaluation. The information in this category should be specific to Non-Expansion rate cell populations only. The information for the Non-Expansion rate cell populations should not be included in category 1.6, which is specific to Expansion rate cell populations only.
1.6	Compensation - Case Management - Expansion	All forms of compensation, including employee benefits and taxes, for services related to enrollee social and medical case management and coordination, including assessment, planning, monitoring, and evaluation. The information in this category should be specific to the Expansion rate cell populations only. The information for the Expansion rate cell populations should not be included in category 1.5, which is specific to Non-Expansion rate cell populations only.
1.7	Compensation – Fraud Reduction	Expenses for activities that focus on reducing fraud both before and after it occurs. These expenses may count toward HCQI and included in calculating MLR, since they are grounded in evidenced-based medicine, increase the likelihood of positive health outcomes, and can be objectively measured. Examples include post-payment recovery efforts and costs for maintaining a tip line.
1.8	Compensation – Fraud Prevention	Expenses for activities that focus on preventing fraud and/or are designed primarily to eliminate opportunities for fraud before it occurs. These expenses would not count toward HCQI, and would be considered general administrative expenses for the purposes of calculating MLR. Examples include costs for establishing claim system edits to monitor for duplicate payments.
2.0	Occupancy/Depreciation/Amortization	
2.1	Occupancy	Occupancy expenses incurred, such as rent, utilities, security, and facility management on facilities not used to deliver health care services to the health plan's members.
2.2	Depreciation	Depreciation on those assets not used to deliver health care services to the health plan's members.
2.3	Amortization (non-Goodwill)	Amortization expense of certain assets not used to deliver health care services to the health plan's members (i.e., leasehold improvements).
2.4	Amortization Goodwill and Other Intangibles	The amortization expense or impairment charges related to goodwill and intangible assets.
3.0	Interest Expense	
3.1	Long-Term Borrowing and Debt Costs	Interest expense, debt financing and issuance costs, debt restructuring and cancellation costs, and amortization of any such costs when the cost is incurred on borrowed capital that is not a specific requirement of the State of Louisiana.

Category	Administrative Category Descriptions	Definitions
3.2	Interest Expense for Late Payment of Claims	Interest expense or penalties on late payment of claims.
4.0	Education/Outreach/Marketing	
4.1	General Education/Outreach/Marketing	Expenses incurred for education and outreach activities related to the health plan's enrollees efficiently obtaining Healthy Louisiana services and benefits. Expenses for communications with enrollees through newsletters or special mailings. Expenses directly related to marketing activities which are designed to persuade potential enrollees to become enrolled in the health plan. This includes activities such as the use of direct sales or brokers. Marketing expenses related to items such as pamphlets on health, welfare and educational subjects required by regulation.
4.2	Printing and Postage	Expenses for printing, postage, express mail and courier service that do not meet the criteria described in Category 4.1. For example, annual reports to policyholders and stockholders.
4.3	Advertising	All advertising and public relations costs that do not meet the criteria described in Category 4.1. Examples of such costs may include expenses for: ▪ Marketing related to design and advertising campaigns to increase a health plan's visibility and advertising agency fees related to such advertising. ▪ Newspaper, magazine and trade journal advertising for the purpose of soliciting and maintaining business. ▪ Other advertising mediums such as signs, billboards, television, radio and movie theater advertising.
4.4	Direct Mailings	Expenses for direct mailings that do not meet the criteria described in category 4.1.
4.5	Telemarketing and Surveys	Expenses for telemarketing and surveys that do not meet the criteria described in category 4.1.
4.6	Community Relations and Giveaways	Expenses related to establishing and maintaining relationships with the communities in which the Healthy Louisiana Health Plan operates, which are not specifically required by the Healthy Louisiana contract.
4.7	Charitable Contributions and Donations	Expenses related to donations or gifts to charitable, civic, educational, medical, or political entities.
4.8	Contributions and Donations to Affiliated Parties of the Health Plan or its Board Members	Expenses related to donations or gifts to charitable, civic, educational, medical, or political entities with direct connections to the health plan or its board members.
4.9	Sponsorships	Expenses related to sponsorship of events, properties, groups, activities or employee, and/or local athletic programs.
4.10	Sales and Promotion	All sales, marketing, and promotion costs, including commissions and the costs of promotional items and memorabilia, gifts, and souvenirs not specifically required by the Healthy Louisiana contract.

Category	Administrative Category Descriptions	Definitions
4.11	Royalties	Fees accrued by the Contractor as defined in the "Royalty License Agreement" which should not exceed 3% of the Contractors premium revenue
5.0	Sanctions/Fines/Penalties	
5.1	Sanctions - Imposed and collected by Healthy Louisiana	Expenses related to events where Healthy Louisiana finds the health plan to be out of compliance with the program standards, performance standards, or the terms and conditions of the Healthy Louisiana contract.
5.2	Sanctions/Fines/Penalties - Other	Fines, penalties, sanctions, damages, and other settlements resulting from violations (or alleged violations) of, or failure of the health plan to comply with Federal, State, or local laws and regulations not otherwise reported as sanctions imposed and collected by Healthy Louisiana.
6.0	Corporate Overhead Allocations and Charges	
6.1	Corporate Overhead Allocations	Expenses allocated to the Healthy Louisiana Health Plan through a corporate allocation arrangement with a related or affiliated entity.
6.2	Cost Plus Administrative Charges	The portion of all cost plus corporate allocations and management service arrangements that are above the actual cost of the services performed.
6.3	Information Systems	Corporate allocations related to shared systems and technology infrastructure.
7.0	Management Fees	
7.1	Pharmacy Benefit Manager (PBM) Spread Pricing	The difference between the amount the MCO pays the PBM and the amount the PBM pays the pharmacy.
7.2	PBM Retained Rebates	The difference between the value of pharmaceutical rebates collected by the PBM and the value of the pharmaceutical rebates remitted to the MCO.
7.3	PBM Administrative Fees	An administrative fee (usually paid by the MCO to a contracted PBM or claim administrator) for pharmacy claim adjudication and management. The fees should not include internal PBM costs associated with the administration of the pharmacy benefit that are not charged to the MCO, but should include all costs charged to the MCO beyond what is paid to the pharmacy providers for the prescriptions not already included in the PBM spread pricing or retained rebates categories.
7.4	MCO Pharmacy Administrative Fees	Other administrative fees incurred by the MCO related to the pharmacy benefit not included in the designations listed above.
7.5	Claims Processing	Direct or vendor-related costs related to the processing of provider claims.
7.3	Other Administrative Management Fees	If necessary, add lines and provide details of services.
8.0	Other Administration	

Category	Administrative Category Descriptions	Definitions
8.1	Lobbying Expenses	The cost of influencing activities associated with obtaining grants, contracts, cooperative agreements, loans, and the cost to influence (directly or indirectly) governmental employees, elected officials, and/or political parties.
8.2	Dues/Fees	Expenses related to boards, bureaus, and association fees. This should include all dues and assessments of organizations of which the Healthy Louisiana Health Plan is a member, as well as all dues for employees' and agents' memberships on the health plan's behalf.
8.3	Professional Fees (Audit, Tax, Actuarial, etc.)	Expenses related to activities associated with the accounting functions of the health plan, including financial reporting and rate setting.
8.4	Legal - Litigation and Settlements	Costs incurred in defense or settlement of any civil or criminal proceeding where the health plan is found liable or has settled out of court. In addition, all legal, litigation and settlement expenses, charges or allocations (even if not found liable) not associated with the Louisiana Medicaid line of business.
8.5	Legal - Other	All other legal expenses not included above, e.g. contracts or legal expenses in connection with investigation, litigation, and settlement of policy claims.
8.6	Bad Debt and Allowance for Uncollected Premiums	Bad debts and allowance for uncollected premiums, including losses (actual or estimated) arising from uncollectible accounts and other claims.
8.7	Travel, Conferences, Conventions, etc.	All costs for transportation, lodging, subsistence, and conferences in direct support of the Healthy Louisiana Health Plan and its Medicaid members.
8.8	Other Travel, Conferences, Conventions, etc.	
	a) Non-Louisiana Medicaid Required Travel, Food, Conferences, and Entertainment	All costs for transportation, lodging, subsistence, conferences, and entertainment not directly related to a meeting or conference with the State of Louisiana. Such costs might include tickets to sporting or other events, golf outings, ski trips, cruises, or professional entertainers.
	b) First Class Travel	Airfare costs in excess of the standard commercial airfare (coach or equivalent) rate.
	c) Alcoholic Beverages	All costs associated with the purchase and expense of alcoholic beverages.
	d) Corporate Jet Expenses/Allocations	All costs associated with the purchase, expense (direct or depreciation) or allocation of corporate jets or aircraft.
8.9	Employee Recruitment and Retention	Costs incurred for purposes of employee morale such as an annual employee picnic or holiday party, or annual employee awards.
8.10	Royalties	Royalties on a patent, copyright, or amortization of the costs of acquiring by purchase a patent or copyright.

Category	Administrative Category Descriptions	Definitions
8.11	Contingencies	Contributions and expenses associated with a contingency reserve or similar provision made for events the occurrence of which cannot be foretold. Include loss contingency reserves. Exclude self-insurance reserves, pension plan reserves, and post-retirement health and other benefit reserves computed using acceptable actuarial cost methods.
8.12	Medical Liability Insurance	Expenses related to medical liability insurance for the Healthy Louisiana Health Plan.
8.13	Start-Up, Acquisition, Restructuring, and Discontinued Operations	All expenses, including amortization or depreciation, associated with business startup, business acquisition and purchases, business restructuring and reorganization, and discontinuance of operation costs.
8.14	One-Time Charges for Systems Upgrades and/or Conversions	Expenses for one-time charges for systems upgrades and/or conversions as they relate to equipment and systems required for the administration of the Healthy Louisiana program.
8.15	Quality Improvement Fees	Costs associated with the Healthy Louisiana Health Plan's quality improvement program.
8.16	State and Federal Income Taxes	Any State and Federal income taxes, current or deferred, expensed, charged, or allocated to the Louisiana Medicaid line of business that was not reported as "Income Tax" in line 116 of the Income Statement.
8.17	Intercompany Eliminations	Profitability elimination entries between related party entities. Provide GL detail for both related parties.
8.18	All Other Expenses**	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 a separate sheet.
8.19	Delegated Vendor Administration	Administration related to delegated risk entities contracted with the Contractor.
9.0	HCQI	
9.1	Health Outcome Improvement	Expenses incurred by the Healthy Louisiana Health Plan to improve health outcomes, including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations. This category includes the direct interaction of the Healthy Louisiana Health Plan (not including those services delegated by the Healthy Louisiana Health Plan for which the Healthy Louisiana Health Plan retains ultimate responsibility), providers and the enrollee or the enrollee's representative (e.g., face-to-face, telephonic, web-based interactions, or other means of communication) to improve health outcomes. This category should not include any expenses related to compensation that have already been captured in other categories.

Category	Administrative Category Descriptions	Definitions
9.2	Hospital Readmission Prevention	Expenses incurred by the Healthy Louisiana Health Plan to prevent hospital readmissions through a comprehensive program for hospital discharge. This category should not include any expenses related to compensation that have already been captured in other categories.
9.3	Patient Safety Improvement and Medical Error Reduction	Expenses incurred by the Healthy Louisiana Health Plan to improve patient safety, reduce medical errors, and lower infection and mortality rates. This category should not include any expenses related to compensation that have already been captured in other categories.
9.4	Wellness and Health Promotion	Expenses incurred by the Healthy Louisiana Health Plan to implement, promote, and increase wellness and health activities. This category should not include any expenses related to compensation that have already been captured in other categories.
9.5	HIT Expenses for Health Quality Improvement	Expenses incurred by the Healthy Louisiana Health Plan to enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of HIT. This includes expenses that are designed for use by Healthy Louisiana Health Plan, health care providers, or patients for the electronic creation, maintenance, access or exchange of health information, as well as those consistent with Medicare and/or Medicaid Meaningful Use Requirements. This category should not include any expenses related to compensation that have already been captured in other categories.
9.6	Other HCQI Adjustments	Expenses for broadly excluded activities from other administrative categories. These expenses must support the definitions and purposes as HCQI. Please reference the Other HCQI Expenses table at the end of page 14 and the beginning of page 15 of the Healthy Louisiana FRR instructions for clarification as to what can/should be included in this category.
9.7	Delegated Vendor HQCI	Delegated vendor expenses incurred by the Healthy Louisiana Health Plan to improve health outcomes, including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.

3.07 Schedule BA: 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. Please include an outline of the methodology used to calculate the COVID-19, Hepatitis C, and Zolgensma risk corridor payments, as well as any supporting documentation related to the figures included in Schedule B: Revenue Accrual worksheet.

Appendix A

Appendix A: MLR Reporting

MLR Requirements

This MLR Reporting Guide (Guide) is adapted from 42 CFR Part 438 Federal Register, including requirements incorporated into the Medicaid and Children's Health Insurance Program Managed Care Final Rule published May 6, 2016 and effective July 5, 2016. Requirements for calculating any rebate amounts that may be due the Louisiana Department of Health (LDH) in the event the Healthy Louisiana Medicaid Managed Care Organization (MCO) minimum MLR is not equal to or higher than 85 percent are described in this Guide [42 CFR 438.8(c)].

Definitions

- **Direct Paid Claims —** Claim payments before ceded reinsurance and excluding assumed reinsurance, except as otherwise provided in this Guide.

- **Fraud Prevention Expense —** Expenses incurred prior to the payment of a claim to prevent fraudulent claim payments. These expenses are considered routine program integrity activities that the MCO should be performing and are to be classified as non-claims cost.

- **Fraud Reduction Expense —** Expenses incurred subsequent to the payment of a claim to specifically identify and detect fraudulent claims for recoupment. (Note: all other post payment claim review activities ensuring proper claim payment performed by the MCO as part of their program integrity duties are to be considered non-claims cost.)

- **Material Change —** A change that would reduce the MLR below 85%, change the rebate amount, or cause a change in the reported MLR of 1% or more.

- **Medicaid Managed Care Incentive Payments (MCIP) —** A program that is designed to provide incentive payments to Medicaid Managed Care Organizations for achieving quality objectives that increase access to healthcare, improve quality of care, and/or enhance the health of members the MCO serves.

- **Member Months —** the number of months an enrollee or a group of enrollees is covered by an MCO for the MLR reporting year.

- **MLR Reporting Year —** Calendar year during which core benefits and services are provided to LA Medicaid members through contract with LDH.

- **Non-Claims Costs —** expenses for administrative services that are not: Incurred claims as defined in 42 CFR 438.8(e)(2); expenditures on activities that improve health care quality as defined in 42 CFR 438.8(e)(3); or licensing and regulatory fees, or Federal and State taxes as defined in 438.8(f)(3). These definitions apply unless otherwise stated in this Guide.

- **Run-out Period –** the time period given to MCOs prior to the report deadline in order to ensure the experience reported for revenue and expenses on the MLR contains more accurate data than can be complied during year end reporting.

- **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.

- **Value-Added Services —** The additional member services outside of the core benefits and services that are delivered at the MCO's discretion and are not included in capitation rate calculations. Incentive and bonus payments made to providers must be excluded from this amount as Value-Added Services are for members only.

Reporting Requirements

General Requirements

For each MLR reporting year, the MCO must submit to LDH a report which complies with the requirements that follow concerning premium revenue (total capitation payments) received and expenses related to LA Medicaid enrollees [42 CFR 438.8(a)]. A run-out period of 120 days is required for the final annual MLR report. For the quarterly report, use YTD information with a 30-day run-out period.

MCOs must attest to the accuracy of the calculation of the MLR in accordance with requirements of these instructions when submitting the required report [42 CFR 438.8(n)].

Effective January 1, 2021, LDH requires the individual Non-Expansion and Expansion populations to meet the minimum MLR standard. Section 4001 of the SUPPORT for Patients and Communities Act, enacted October 24, 2018, amended section 1903(m) of the Act to add a new paragraph (m)(9). Section 1903(m)(9) provides a time-limited authorization for states that collect an MLR remittance from their Medicaid managed care plans for the eligibility group described in section 1902(a)(10)(A)(i)(VIII) (referred to here as "the Expansion Group"). Section 4001 allows states to apply the state's regular federal medical assistance percentage (FMAP) match rate (calculated pursuant to section 1905(b) of the Act) for the purposes of determining the federal share of the remittance instead of the higher FMAP match rate specified under 1905(y) for use in connection with the Expansion Group.

Timing and Form of Report

The annual report for each MLR reporting year must be submitted to LDH by June 30 following the end of an MLR reporting year, using the form and in the manner prescribed by LDH. A link to the form including the reporting template required by LDH can be found at http://new.dhh.louisiana.gov/index.cfm/page/278

In addition to the report at the link above the MCO must:

- Provide the MCIP amounts in the numerator and denominator; and
- Require any third party vendor providing services to enrollees to supply all underlying data to that MCO within 180 days of the end of the MLR reporting year or within 30 days of being requested by the MCO, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

Recalculation of MLR. In an instance where LDH makes a retroactive change to the capitation payments for a MLR reporting year where the report has already been submitted to the State, and this change causes the MCO to fall below the 85% MLR requirement, the MCO must re-calculate the MLR for all MLR reporting years affected by the change and submit a new report [42 CFR 438.8(m)].

Newer Experience

LDH, in its discretion, may exclude an MCO that is newly contracted with the State from certain requirements in this Guide for the first year of the MCO's operation. Such MCOs must be required to comply with the requirements in this Guide during the next MLR reporting year in which the MCO is in business with the State, even if the first year was not a full 12 months [42 CFR 438.8(l)].

If 50% or more of the total capitation payment received in an MLR reporting year is attributable to new Medicaid enrollees with less than 12 months of experience with the reporting entity in that MLR reporting year, then the experience of these enrollees may be excluded from the MLR report. If the MCO chooses to defer reporting of newer business, then the excluded experience must be added to the experience reported in the following MLR reporting year.

For MLR rebate calculation purposes, new enrollees assigned to a MCO within a calendar year are identified as those that have not been continuously enrolled with the plan. Continuous enrollment is defined, for this purpose, as being enrolled for a minimum of 11 months in a calendar year, including enrollment months prior to the current calendar year. Enrollment spans must be separated by 63 days or more to qualify as separate enrollment spans; intervening months shall be included in the monthly count in determining the total months of continuous eligibility if comprised of 62 days or less. HEDIS rules for continuous enrollment do not apply for MLR rebate calculation purposes.

Continuous enrollment shall be determined on plan enrollment, and shall not consider changes in category of eligibility, region or age/gender classification as changes to enrollment spans.

To quantify the impact of new enrollees:

- List all plan enrollees during the MLR period (total population).
- Using continuous membership spans from initial enrollment (including months prior to the MLR period), identify members from the population that have NOT had continuous enrollment for a minimum of 11 months (this subgroup represents the potential new enrollees).
- Review the potential new enrollees, identifying those members that had initial enrollment (no enrollment prior to MLR period) and those with intermittent membership spans. Review the intermittent membership spans to determine if any breaks in membership were for periods of 62 days or less; if so, combine the spans and include the months between spans to determine if they meet the 11 month continuous enrollment threshold. The potential new enrollees should

now be able to be separated between defined new enrollees (those with less than 11 months of continuous enrollment including intermittent membership spans) and the non-new enrollees (those with 11 months or more continuous enrollment including intermittent membership spans).

- Determine the total capitation for the total population and the total capitation for the defined new enrollees. If the defined new enrollee capitation is greater than 50% of the Total Population Capitation, the defined new enrollees capitation and expenses may be deferred to the next MLR period. If the percentage is less than 50%, all of the membership should be included in the current MRL period.
- Review the prior MLR period to determine if the defined new enrollees revenue and expenses from the prior MLR period was deferred to the current period. If it was deferred, include the capitation and expense from the prior period defined new enrollees in the current period.

Premium Revenue

Each MCO must report to LDH the premium revenue received from LDH for each MLR reporting year, prior to reinsurance. Premium revenue means all monies paid by LDH to the MCO for providing core benefits and services as defined in the terms of the contract including Medicaid Managed Care Incentive Program (MCIP) revenues earned. This should include any retroactive payments received during the runout period for dates of service in the MLR reporting year and should reflect a proper matching with the expenses reported. Premium revenue includes all capitation and maternity kick payments with deductions (as calculated by the MLR reporting template) for premium tax, less all other applicable taxes/fees. The MCO's Federal, State, and local taxes and licensing and regulatory fees (as defined in [42 CFR 438.8(f)(3)]) may be deducted from premium revenue on the applicable line in the MLR reporting template.

For COVID-19 Risk Corridor Specifications, the anticipated net settlement should be accrued at the time of the MLR filing. The variance between the accrual and the actual final settlement should be reported in the subsequent reporting year, unless it would cause a material change to a prior submitted MLR.

For Hepatitis C Risk Corridor Specifications, the anticipated net settlement should be accrued at the time of the MLR filing. The variance between the accrual and the actual final settlement should be reported in the subsequent reporting year, unless it would cause a material change to a prior submitted MLR.

Reimbursement for Clinical Services Provided to Enrollees

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 MCO. The MCO may only include reimbursement for incurred claims, the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees. Where the third party vendor is performing an administrative function such as eligibility and coverage verification, claims processing, utilization review, or network development, expenditures, and profits on these functions would be considered non-claims costs. 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.”

Incurred Claims

Incurred claims must include:

- Direct claims that the MCO paid to providers (including under capitated contracts with network providers) for services or supplies covered under the contract;
- Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported;
- Withholds from payments made to network providers;
- Claims that are recoverable for anticipated coordination of benefits;
- Claims payments recoveries received as a result of subrogation;
- Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity;
- Changes in other claims-related reserves; and
- Reserves for contingent benefits and the medical claim portion of lawsuits.

Note: Incurred claims should <u>not</u> include the entire capitation payment amounts made to delegated vendors, but rather the portion identified as medical expense paid by the delegated vendor to the medical provider or servicer.

Adjustments to Incurred Claims

Adjustments that **must be deducted** from incurred claims:

- Prescription drug rebates available to the MCO, regardless of whether the MCO acts on collection process;
- Other prompt pay discounts available to the MCO, regardless of whether the MCO takes advantage of these discounts; and
- Overpayment recoveries received from providers.

Adjustments that **must be included** in incurred claims:

- The amount of incentive and bonus payments made to providers including payments related to MCIP, if not reported elsewhere.
- The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses.

Note: LDH will not consider allowing fraud prevention expenses (previously defined) in the MLR calculation until expenditures for program integrity activities are aligned with a future standard adopted in the private market rules. In addition, claim payment recoveries must be separately distinguishable as a result of fraud reduction efforts (previously defined) versus other types of claim payment recoveries.

Adjustments that **may be included** in incurred claims:

- The amount of incurred claims paid to providers for Member Value-Added Services, if not reported elsewhere. MCO encounter data with Member Value-Added Services prefixes as stated in the MCO Systems Companion Guide is a minimum requirement.

Adjustments that **must not be included** in incurred claims:

- Non-Claims Costs, as previously defined, which include: 1) amounts paid to third party vendors for secondary network savings; 2) amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management; 3) amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or 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); and 4) fines and penalties assessed by regulatory authorities;
- Prior year MLR rebates paid to LDH;
- The portion of the per-member per-month capitation payments to delegated vendors providing clinical services that exceed the amounts paid by the delegated vendor to their servicing providers (For a related party, this excess up to the actual costs incurred by the related party, may be considered non-claims costs. For non-related parties, this excess should be considered non-claims costs. For MLR reporting template, include amounts not already in Non-Claims Costs above);
- Spread Pricing amounts paid to a pharmacy benefit manager (PBM); and
- The amount of reinsurance premiums that exceed the reinsurance recoveries, as these are non-claims costs.

Adjustment to incurred claims – Other:

- Incurred claims paid by one MCO that is later assumed by another entity must be reported by the assuming MCO for the entire MLR reporting year and no incurred claims for that MLR reporting year may be reported by the ceding MCO.

Activities that Improve Health Care Quality

General Requirements

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

Activity Requirements

Activities conducted by an MCO to improve quality must meet the following requirements:

The activity must be primarily designed to:

- Improve health quality;
- Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;

- 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;
- 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;
- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations:
    - Examples include the direct interaction of the MCO (including those services delegated by subcontract for which the MCO 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:
        - 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 MCO RFP and contract;
        - 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;
        - HIT to support these activities;
        - Accreditation fees directly related to quality of care activities;
- Prevent hospital readmissions through a comprehensive program for hospital discharge:
    - Examples include:
        - Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
        - Patient-centered education and counseling;
        - Personalized post-discharge reinforcement and counseling by an appropriate health care professional;
        - Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission;
        - HIT to support these activities;
- Improve patient safety, reduce medical error, and lower infection and mortality rates:
    - Examples of activities primarily designed to improve patient safety, reduce medical errors and lower infection and mortality rates include:
        - Appropriate identification and use of best clinical practices to avoid harm;
        - Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns;
        - Activities to lower the risk of facility-acquired infections;
        - Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions;
        - Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors;

        - HIT to support these activities;
- Increase wellness and promote health activities:
    - Examples of activities primarily designed to promote and increase wellness and health activities include:
        - Wellness assessments;
        - Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
        - Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
        - Public health education campaigns that are performed in conjunction with the LA Office of Public Health;
        - 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 health promotion activities designed to change member behavior and conditions (for example, smoking or obesity);
        - HIT to support these activities; and
- Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of HIT.

Exclusions

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

- Those that are designed primarily to control or contain costs (e.g. reinsurance premiums exceeding reinsurance recoveries);
- The pro rata share of expenses that are for lines of business or products other than LA Medicaid;
- 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;
- 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 HIT 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 HIPAA, 42 U.S.C. 1320d-2, as amended, including 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;

- 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;
- Marketing expenses;
- 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;
- Any cost that is not directly applicable to providing measurable quality improving activities such as corporate administrative allocations, amounts exceeding actual cost of providing service, or other overhead expenses that do not directly support the healthcare quality initiative;
- State and federal taxes, licensing and regulatory fees; and
- Any function or activity not expressly included in the functions or activities paid for with grant money or other funding separate from LDH capitation payments, unless otherwise approved by and within the discretion of LDH, upon adequate showing by the MCO that the activity's costs support the definitions and purposes described above or otherwise support monitoring, measuring or reporting HCQI.

  Note: The MCO must also possess documentation for the source expense, methodology for determining how the expense meets the above definition of an expense that improves healthcare quality improvement, the allocation methodology, and statistics utilized for any allocation.

Expenditures Related to HIT and Meaningful Use Requirements

General Requirements

An MCO may include as activities that improve health care quality such HIT expenses as are required to accomplish the activities that are designed for use by the MCO, MCO providers or enrollees for the electronic creation, maintenance, access or exchange of health information, as well as those consistent with the U.S. Department of Health and Human Services' (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:

- 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;
- 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;
- Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;

- Monitoring, measuring or reporting clinical effectiveness, including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as the National Committee for Quality Assurance, URAC or the 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, Consumer Assessment of Healthcare Providers and Systems surveys or chart review of HEDIS measures);
- Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;
- Advancing the ability of enrollees, providers, MCOs 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;
- 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
- Provision of electronic health records, patient portals and tools to facilitate patient self-management.

Activities Related To External Quality Review (EQR)

General Requirements

An MCO may include activity related to any EQR-related activity as described in §438.358(b) and (c).

Non-Claims Cost

General Requirements

All other expenses that are not classified as incurred claims, activities that improve health care quality (HCQI and HIT), or licensing and regulatory fees or Federal and State taxes can be reported as Non-Claims Costs. For MLR reporting form purposes, Non-Claims Costs, irrespective of their allowability determination, are excludable from the MLR calculations and are informational only.

Non-Claims Cost is defined in 45 CFR § 158.160 as:

- Cost-containment expenses not included as an expenditure related to an activity at 45 CFR § 158.150 of this subpart;
- Loss adjustment expenses not classified as a cost containment expense;
- Direct sales salaries, workforce salaries and benefits;
- Agents and brokers fees and commissions; and
- General and administrative expenses.

Per 42 CFR § 438.8(e), non-claims costs include the following:

- Amounts paid to third party vendors for secondary network savings;
- Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management;
- Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for state plan services or services meeting the definition in 42 CFR § 438.3(e) and provided to an enrollee; and
- Fines and penalties assessed by regulatory authorities.

Any licensing and regulatory fees such as fines and penalties of regulatory authorities and fees for examinations by any state or federal departments other than those specified as includable licensing and regulatory fees [45 CFR § 158.161 (a) and (b)] must be included with Non-Claims Costs and should not be considered an adjustment to premium revenue.

Note: Be sure to review any adjustments or exclusions made when determining the incurred claims and HCQI amounts for potential inclusion (reclassification) as Non-Claims costs.

Expenditures related to Program Integrity Requirements

General Requirements

Federal reporting requirements mandate that Program Integrity costs be segregated and reported separately as a subset of the Non-Claims costs.

42 CFR § 438.608 defines program integrity expenditures as costs related to administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse and costs to ensure Provider screening and enrollment requirements.

Costs associated with the mandated Program Integrity Requirements would fall under this classification:

- A compliance program that includes, at a minimum, all of the following elements:
  - Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements;
  - The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors;
  - The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract;
  - A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract;

- Effective lines of communication between the compliance officer and the organization's employees;
- Enforcement of standards through well-publicized disciplinary guidelines; and
- Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State.
- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including all of the following:
  - Changes in the enrollee's residence; and
  - The death of an enrollee.
- Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP.
- Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.
- Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.
- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with § 455.23 of this chapter.
- The State, through its contracts with a MCO, PIHP, PAHP, PCCM, or PCCM entity must ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of part 455, subparts B and E of this chapter. This provision does not require the network provider to render services to FFS beneficiaries.

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

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 MCO activities in LA. 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.

- 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 MCO 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. Any profit margin included in costs for related party administrative agreements should be excluded.

Note: The MCO must also possess documentation for the source expense, the allocation methodology, and statistics utilized for any allocation.

Credibility Adjustment

General Requirements

The MCO may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible. The credibility adjustment is added to the reported MLR calculation before calculating any remittances.

- The MCO may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible;
- If the MCO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards; and
- CMS will publish base credibility factors for MCOs on an annual basis.

Calculation of the MLR

The MLR for the MLR reporting year is the ratio of the numerator to the denominator as calculated by the MLR reporting template using this Guide as instructions.

The MCO's 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%. If an MLR is 0.8253, or 82.53%, it shall be rounded to 0.825, or 82.5%.

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

General Requirement

For each MLR reporting year, a MCO must provide a rebate to LDH if the MCO's MLR does not meet or exceed the 85% requirement.

LDH will determine the final MLR percentage used to calculate rebates using an examination of the final annual MLR report conducted by LDH or its agent. Authoritative guidance for the examination may include state and federal policies other than 42 CFR Part 438.

Amount of Rebate

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

Timing of Rebate

MCOs must provide any rebate owing to LDH no later than August 1 following the end of the MLR reporting year.

Late Payment Interest

An MCO that fails to pay any rebate owing to LDH in accordance with the *Amount of Rebate* paragraph of this section or to take other required action within the time periods set forth in this Guide must, in addition to providing the required rebate to LDH, pay LDH interest at the current Federal Reserve Board lending rate or 10% annually, whichever is higher, on the total amount of the rebate, accruing from August 1.

Appendix B

Appendix B: COS Specification Guidance

The following table was designed to promote consistency in classification of expenses. Not all expenses are defined with exact specifications. Reasonable judgment of categorization may be used in the absence of guidance.

Some procedures may be classified in multiple categories; therefore, to ensure each expenditure is classified only once, please follow this coding hierarchy:

- Maternity kick payment expenses, including Inpatient, Outpatient, Professional, and Early and Periodic Screening, Diagnostic & Treatment (EPSDT)
- Inpatient Neonatal Intensive Care Unit (NICU), Emergency Room, Skilled Nursing Facility, Prescribed Drugs
- SBH (excluding ABA services)
- PCP
- Specialty Care Physician
- Other defined Professional services
- Inpatient Hospital, Outpatient Hospital
- Other (if equal to 5% or higher of Total Other Medical expenses, disclose in Schedule D, number 3)

The following definitions are provided to help classify expenses:

- Claim COS: A service rendered by the provider for use in the MARS, SURS, and FACS (ISIS) reporting and accounting subsystems. The designation is equal to the COS cost center assignment provided by Molina Medicaid Solutions within the Louisiana Medicaid Management Information System.
- Treatment Place: The HIPAA standard code indicating where service was rendered by a provider. Only applicable to Professional services, Cross-Over Professional services, and Dental claims (CT=04, 05, 06, 07, 09, 10, 11 and 15). This column will always contain the HIPAA standard (NUBC) value.
- Provider Type: A code which designates the classification of a provider per the State Plan (for example, dentist, pharmacy).
- Provider Specialty: The provider's indicated specialty from the PE 50 (Provider Enrollment form).

Physical Health Identifiers

Expense Category	Classification Details
Inpatient Hospital	Claim Category of Service = 01 or (Claim Type = 01 and Claim Category of Service 31) and Not a claim included in the Inpatient Maternity or Inpatient NICU Categories
Inpatient Maternity*	Using the first five diagnosis codes submitted on the encounter, apply the kick payment logic found in 2.20 Schedule AG: Maternity and Delivery
Inpatient NICU	Claim Category of Service = 01 and Revenue Codes in ('171','172','173','174')
Hospice	Claim Category of Service = 66 and Billing Provider type = 09
Skilled Nursing Facilities	Billing Provider Type = 80
Other Contractual Inpatient Requirements	Other non-claim Inpatient payments
Outpatient Emergency Room	Treatment Place = 23 or Procedure Code = 99281-99285 or Revenue Codes = 450, 459, or 981 Expense category is applied by claim. If one line of the claim satisfies the above criteria, then the entire claim is flagged as Emergency Room A unique claim can be identified by using the first 11 digits of the claim ICN
Outpatient Hospital	Claim Category of Service = 08 or (Claim Type 03 and Claim Category of Service = 31)
Outpatient Maternity*	Using the first five diagnosis codes submitted on the encounter, apply the kick payment logic found in 2.20 Schedule AG: Maternity and Delivery
Hospital Settlements	Non-claim settlements paid to hospitals
Primary Care Provider	Claim Category of Service = 07 or 54 and Servicing Provider Specialty = 01, 08, 16, 37, 41 or 79
Physician EPSDT	Claim Category of Service = 26, 28 34 or 46
Physician Maternity	Using the first five diagnosis codes submitted on the encounter, apply the kick payment logic found in 2.20 Schedule AG: Maternity and Delivery
Clinical	Claim Category of Service = 09 or 12
Specialty Care Physician	Claim Category of Service = 07 or 54 and Servicing Provider Specialty ≠ 01, 08, 16, 37, 41 or 79
Family Planning	Claim Category of Service = 22
FQHC/RHC	Claim Category of Service = 21 or 38
Other Professional Contractual Requirements	Non-claims expenses paid for settlement of shared-risk arrangements, including shared savings or quality incentives due for the delivery of care to Medicaid members
ACA 1202	Supplemental payments to providers not included in paid claims used to meet rate minimums as described in ACA 1202
SBH	See SBH Service Identifiers table below Excluding Procedure Codes = 0359T through 0361T or 0364T through 0372T

Expense Category	Classification Details
Applied Behavioral Analysis	Procedure Codes = 97151, 97151 TF, 97152, 97153, 97153 HN, 97154, 97155, 97155 TF, 97156, 97156 TF, 97157, 97517 TF, 97158, 97158 TF, 0362T, 0373T
Dental	Claim Category of Service = 25 or 27 or 45
DME, incl. Prosthetics/Orthotics	Claim Category of Service = 20
Home Health	Claim Category of Service = 17
Lab & Radiology	Claim Category of Service = 15
Pediatric Day Health	Claim Category of Service = 82 (for children Only)
Personal Care Services	Claim Category of Service = 44, 71 or 72 (for children Only)
Rehabilitation Services (PT, ST, OT)	Claim Category of Service = 13, 52 or 56
Vision	Servicing Provider Type = 28 or (Servicing Provider Type = 20 and Servicing Provider Specialty in (18, 88))
Transportation – Emergency	Claim Category of Service = 24
Transportation – Non-Emergency	Claim Category of Service = 23 or 92
Other Medical Expenses	All other paid claims expenses not described elsewhere allowable under Medicaid in Louisiana
Pharmaceuticals – POS	Claim Type = 12 or Claim Category of Service = 18 and Not included in Pharmaceuticals - POS Vaccines and Not included in Non-Drug POS
POS Vaccines	Claim Type = 12 or Claim Category of Service = 18 and Claims for any product with AHFS codes = 80120000 or 80080000
Non-Drug POS	Claim Type = 12 or Claim Category of Service = 18 and AHFS Codes included in Appendix C
Encounter Member Value-Added Services and Non-Encounter Member Value-Added Services	Member value-added services provided in addition to the contracted benefit package. Services should be documented within Schedule Z – Member Value-Added Services and categorized whether the service is encounterable or not.
In Lieu Of Services	Services or Provider Types outside those listed above related to the provision of services authorized by the MCO, whether a State Plan service or a service provided in lieu of an existing State Plan service. Services should be documented within Schedule AA – In Lieu of Services Report and included in the appropriate expense category within the Income Statement and Total Profitability Statements.

SBH Service Identifiers

Expense Category	Classification Details
Distinct Part Psychiatric (DPP) Inpatient Hospital	Distinct Part Psychiatric Unit = Billing Provider Type 69 and Claim Type = 01
	Note this includes Acute Detox services provided in a Behavioral Health Facility
Freestanding Psychiatric Hospital (IMD)	Free Standing Psychiatric Hospital = Billing Provider Type 64 and Claim Type = 01
	This includes Acute Detox services provided in a Behavioral Health Facility
Psychiatric Residential Treatment Facility	Procedure code H2013 or Billing Provider Type 96 (Recipients under age 21 only)
Outpatient Hospital	Billing Provider Type 64 or 69 and Claim Type = 03
Psychiatrist	Billing Provider Type 19 with Provider Specialty 26, 27, 2W with procedure codes not in H0001, H0004, H0005, 90791, 90792
	Billing Provider Type 20 with Provider Specialty 26 or 2W with procedure codes not in H0001, H0004, H0005, 90791, 90792
FQHC or RHC	Procedure Code T1015 and: Billing Provider Type 72, 79 or 87 **AND** Behavioral Health Service Provider Type 78, 93, 94 with Provider Specialty 26 **OR** Service Provider Type 19 with Provider Specialty 26, 27, 2W **OR** Provider Type 20 with Provider Specialty 26, 2W; **OR** Service Provider Type 31 with any specialty
Medical or Licensed Psychologists	Billing Provider Type 31 with procedure codes not in H0001, H0004, H0005, 90791, 90792
Licensed Clinical Social Worker	Billing Provider Type 73 with procedure codes not in H0001, H0004, H0005, 90791, 90792
Licensed Professional Counselors	Billing Provider Type AK with procedure codes not in H0001, H0004, H0005, 90791, 90792
Licensed Marriage and Family Therapist	Billing Provider Type AH with procedure codes not in H0001, H0004, H0005, 90791, 90792
Advanced Practice Registered Nurse, Clinical Nurse Specialist, Physician Assistant	Billing Provider Types 78, 93, 94 with Provider Specialty 26 with procedure codes not in H0001, H0004, H0005, 90791, 90792
Substance Use Disorder Services	Residential: Procedure Codes H0011, H0012, H0019, H2034, H2036
	Outpatient: Procedure Codes H0001, H0004, H0005, H0014
	Intensive Outpatient: Procedure Code H0015
	Licensed Addiction Counselor: Billing Provider Type = AJ
Lab Services	Only Lab Services associated with SBH that are not provided in an inpatient or independent lab setting.
Crisis Intervention	Procedure Codes S9485, H2011
Crisis Stabilization	Procedure Code H0045 (Recipients under the age of 21 only)
Diagnostic Services (Psych)	Procedure Codes 90791, 90792
Community Psychiatric Supportive Treatment	Procedure Code H0036 (excluding Modifiers HE and HK)

Expense Category	Classification Details
Multi-Systemic Therapy	Procedure Code H2033 (Recipients under the age of 21 only)
Functional Family Therapy	Procedure Code H0036, Modifier HE only (Recipients under the age of 21 only)
Therapeutic Group Home	Procedure Code H0018 (Recipients under the age of 21 only)
Homebuilders	Procedure Code H0036, Modifier HK only
Assertive Community Treatment	Procedure Code H0039
Psychosocial Rehabilitation	Procedure Code H2017
Other Expenses	All other SBH paid claims expenses not described elsewhere allowable under Medicaid in Louisiana. Please provide additional documentation regarding these expenses within Schedule BA – Supplemental Working Area
Encounter Member Value-Added Services and Non-Encounter Member Value-Added Services	Member value-added SBH services provided in addition to the contracted benefit package. Services should be documented within Schedule A – Member Value-Added Services and categorized whether the service is encounterable or not.
In Lieu of Services	Services or Provider Types outside of those listed above related to the provision of Behavioral Health services authorized by the MCO, whether a State Plan service or a service provided in lieu of an existing State Plan service. Services should be documented within Schedule AA – In Lieu of Services Report and included in the appropriate expense category within the SBH Income Statement and SBH Total Profitability Statements

Appendix C

Appendix C: Pharmaceutical Non-Drug List

The following table was designed to reflect products billed through the pharmacy POS claims system that are neither vaccines nor prescribed drugs as defined by CMS. The list is current as of the revised date of this publication; however, it may be revised as new AHFS non-drug codes are introduced.

AHFS	AHFS_DESC
32000000	CONTRACEPTIVES (E.G. FOAMS, DEVICES)
34000000	DENTAL AGENTS
36000000	DIAGNOSTIC AGENTS
36180000	CARDIAC FUNCTION
36260000	DIABETES MELLITUS
36300000	DRUG HYPERSENSITIVITY
36320000	FUNGI
36340000	GALLBLADDER FUNCTION
36400000	KIDNEY FUNCTION
36440000	LIVER FUNCTION
36460000	LYMPHATIC SYSTEM
36580000	OCULAR DISORDERS
36610000	PANCREATIC FUNCTION
36640000	PHEOCHROMOCYTOMA
36660000	PITUITARY FUNCTION
36680000	ROENTGENOGRAPHY
36700000	RESPIRATORY FUNCTION
36840000	TUBERCULOSIS
36880000	URINE AND FECES CONTENTS
36881200	KETONES
36882000	OCCULT BLOOD
36882400	PH
36882800	PROTEIN
36884000	SUGAR
52120000	CONTACT LENS SOLUTIONS
84200000	DETERGENTS
94000000	DEVICES
96000000	PHARMACEUTICAL AIDS

Appendix D

Appendix D: COVID-19 Risk Corridor

For the contract period covering January 1, 2020 through December 31, 2020, or rate year 2020 (RY20), the LDH will implement a risk corridor for the total medical costs incurred by the Healthy Louisiana (HLA) MCOs, not including the Hepatitis C virus (HCV) direct acting antivirals (DAAs) and certain related costs already covered by the Hepatitis C risk corridor, nor the costs for Zolgensma® separately covered through a risk pool arrangement. This document describes the structure of the risk corridor and outlines the specifications that will be followed in the evaluation and settlement calculation phases of this process.

Given the greater than normal uncertainty that exists during RY20, the Centers for Medicare & Medicaid Services (CMS) has encouraged states to consider the use of a risk corridor around the full year of capitation rates to reduce the risk to the MCOs and the State. In guidance issued from CMS on May 14, 2020, they stated, “In addition to the options described in this guidance, CMS will consider where appropriate, state requests to retroactively amend or implement risk mitigation strategies only for the purposes of responding to the COVID 19 pandemic. In the Notice of Proposed Rulemaking (NPRM), Medicaid Program: Medicaid and CHIP Managed Care (CMS 2408 P) published in November 2018, CMS proposed to prohibit states from implementing retroactive risk mitigation strategies. CMS continues to support the identification of all risk mitigation strategies in contracts prospectively. However, given that this NPRM has not been finalized, CMS recognizes that these are unique and unanticipated circumstances under which approving retroactive risk mitigation strategies may be appropriate when other methods or making retroactive rate adjustments to capitation rates may be extraordinarily difficult for states to implement at this time. Such risk mitigation strategies could include a 2-sided risk corridor on all medical costs.”

Instituting a risk corridor retroactive to January 1, 2020 would ultimately provide some protection to the MCOs to the extent utilization and costs rebound more quickly than anticipated in the remainder of RY20. At the same time, if the utilization reductions are even more severe, the risk corridor would provide LDH with additional protections against overpayment to the HLA MCOs.

Risk Corridor Structure

The utilization of all medical claims aside from HCV DAAs (both preferred and non-preferred products) and certain non-pharmacy costs related to screening, evaluation and treatment of HCV, which are included in the Hepatitis C risk corridor, will be subject to this risk corridor. Zolgensma claims are also excluded from this risk corridor, as they are covered separately by a risk pool. Separate risk corridors will be developed for the Expansion and Non-Expansion rate cells.

For the medical costs subject to the risk corridor, the MCOs and LDH will share the risk as follows:

Risk Band	MCO Responsibility	LDH Responsibility
Outside of +5% of Benchmark	0%	100%
+2% to +5% of Benchmark	50%	50%
0% to ±2% of Benchmark	0%	100%
-2% to -5% of Benchmark	50%	50%
Outside of -5% of Benchmark	0%	100%

Risk Corridor Benchmark

In the first exhibit accompanying this document, Mercer has detailed the build-up of the COVID-19 Risk Corridor Benchmarks for each region and rate cell on a PMPM basis. These PMPMs represent the projected total medical cost less the HCV DAAs and qualifying non-pharmacy costs in the RY20 rates. All rate cells, including maternity kick payments, will be included and each will have its own benchmark. The benchmark will utilize RY20 rates effective January 1, 2020, certified on December 23, 2019 for the first six months of RY20, and the rates effective July 1, 2020 (pending final certification) for the second half of the calendar year.

The "1.0 Risk Corridor Benchmark" will be identical for all MCOs. MCO-specific Risk Corridor Benchmarks will be generated by applying each MCO's risk score to the 1.0 Risk Corridor Benchmark, where applicable. Rate cells not subject to risk adjustment will reflect a value of 1.0000 in the risk score column.

Risk Corridor Settlement

The risk corridor will be settled using actual MCO experience from the RY20 period, making it imperative that MCOs submit encounters prior to the cutoff dates described later in this section. For each MCO, Mercer will extract and summarize member months (MMs) and total encounter utilization and paid amounts for each region and rate cell. Adjustments will be made for the following factors:

- IBNR Claims: Please refer to the descriptions of the interim and final settlement calculations, below, for the detail related to this adjustment.
- Value-Added Services: Although costs for value-added services are not permissible to include in rate development, encounters for these services will be included in the risk corridor settlement. Mercer and LDH will refer to additional details on value-added services submitted in the financial reporting requirements (FRR).
- Subcapitation Costs: Subcapitated arrangements covering State Plan services for the HLA population will be included. An adjustment from the FRRs will be made for any subcapitated costs not included in the encounter data.
- Value-Based Payments: Additional costs for value-based payments, such as provider quality bonuses, will be considered in the settlement calculations. To the extent such payments are not reflected in the encounter submissions, Mercer and LDH will consider costs reported as value-based payments in the FRRs.

LDH will work with its actuaries to validate the encounters and review the reasonability of unit costs, if needed. Mercer does not anticipate repricing encounters for qualifying costs unless significant discrepancies in the reported unit cost for these services are observed across MCOs. LDH and its actuaries plan to review any significant unit cost discrepancies, as compared to

anticipated network access requirements, and may follow up with MCOs. LDH intends to perform an initial settlement calculation, as well as a final settlement, as described below.

Initial Settlement Calculations

LDH will perform initial settlement calculations based on encounters paid and submitted through February 28, 2021. For encounters to be considered for inclusion in the risk corridor settlement calculations, they must be submitted to and accepted by LDH's Medicaid Management Information System (MMIS) by February 28, 2021. These calculations will be performed by region and rate cell and will be aggregated for Non-Expansion and Expansion populations, separately. Because of the limited claims runout, particularly for the latter months of RY20, adjustments will be made for IBNR claims. Upon completion of the initial calculations, it will be at the discretion of LDH whether payouts or recoupments are made. It is anticipated that any payouts or recoupments based on the initial calculations will be completed by June 30, 2021.

Final Settlement Calculations

LDH will perform final settlement calculations based on encounters paid and submitted through December 31, 2021. For encounters to be considered for inclusion in the risk corridor settlement calculations, they must be submitted to and accepted by LDH's MMIS by December 31, 2021. Similar to the initial calculations, they will be performed by region and rate cell and aggregated for Non-Expansion and Expansion populations, separately. LDH and Mercer do not anticipate making adjustments for IBNR claims in the final settlement calculations. The final settlement calculations will also include consideration for any initial payouts or recoupments in 2021. LDH anticipates timing of the final settlement payouts or recoupments would be completed around June 2022.

MLR Reporting

Each MCO will still be required to submit MLR reports on the same timeline required by the HLA contracts. By the time of submission, any initial settlements should be processed. However, MCOs will need to assess whether additional consideration should be made in the MLR reports for additional anticipated recoupments or payments from the risk corridor. Settlements, whether resulting in a recoupment or payment, should be included in the revenue section of the MLR reports as additional or contra revenue. As a result, the actual or expected risk corridor settlement would impact the MLR report prior to calculation of any additional MLR remittance. It is unlikely there will need to be a minimum MLR remittance after the final risk corridor reconciliations, but in the event that it occurs, it will be paid back as a net amount after the final risk corridor reconciliations have been determined.