MCO Financial Reporting Guide

Revised July 22, 2015 v3

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Introduction and general instructions

1.01 Introduction

The provisions and requirements of this Financial Reporting Guide (Guide) are effective February 1, 2015. The purpose of this Guide is to set forth quarterly and annual reporting requirements for Bayou Health Contractors (Contractors) contracted with Louisiana (LA) Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF) for MCO care. The Guide instructions and reports are supplementary to any Department of Insurance (DOI) financial reporting requirements. This Guide does not replace any DHH electronic data submission requirements or quality/compliance-oriented reporting requirements from Contractors.

The primary objective of the Guide is to establish consistency and uniformity in reporting. 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 financial reporting guide. Current contractual requirements can be found at makingmedicaidbetter.com. This reporting guide may be revised as deemed necessary by DHH. Sanctions may be enforced for the untimely filing of the financial reports. Monthly reporting of the financial statements may also be enforced upon the discretion of DHH. This reporting guide is supplemental to any reporting provisions required by DHH, state and federal law, or DOI.

1.02 Reporting time frames

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

Schedule	Report name	Frequency	Due date[1]	Format
A	Income Statement	Quarterly	May 31, August 31, November 30, and February 28 (February 28 version will be considered Draft Annual)	Predetermined
B	Footnote Disclosures	Quarterly and annually	May 31, August 31, November 30, and February 28 for quarterly, and June 30 for annual	Narrative
C	Total Profitability by Eligibility Category	Quarterly	(This schedule is a roll-up of D-G. Data is not entered on this schedule)	Predetermined
D-G	Region Profitability	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
H	Medical Liability Summary	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
I	Received But Unpaid Claims	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
J	Hospitalization Services Lag	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
K	Outpatient Facility Services Lag	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
L	Physician Services Lag	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
M	Other Medical Services Lag	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
N	Pharmaceutical Lag	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
O	Utilization Report	Annually	(This schedule is a roll-up of P-S. Data is not entered on this schedule)	Predetermined
P-S	Region Utilization	Annually	February 28 (Draft) and June 30 (Final)	Predetermined
T	Pharmaceutical Statistics	Quarterly	May 31, August 31, November 30, and February 28	Predetermined

Schedule	Report name	Frequency	Due date[1]	Format
U	Sub-Capitated Expenses detail	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
V	FQHC/Rural Health Clinic Payments	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
W	Third party resource Payments	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
X	TPL subrogation	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
Y	Fraud and Abuse	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
Z	Maternity and Delivery	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
AA	Parent Company Audited Financial Statements	Annually	June 30	Embedded PDF
AB	Louisiana Level Entity Audited Financial Statements	Annually	June 30	Embedded PDF
AC	MCO Agreed Upon Procedures	Annually	June 30 (Final to be completed *before* Annual MLR Rebate Calculation)	Embedded PDF
AD	Annual Income Statement Reconciliation	Annually	June 30	Predetermined
AE	Agreed Upon Procedures Adjustments	Draft and final annually	June 30	Predetermined
AF	Hospital Settlements	Quarterly	May 31, August 31, November 30, and February 28	Predetermined
AG	MLR Rebate Calculation	Quarterly and Annually	May 31, August 31, November 30, and February 28 for quarterly, and June 30 for annual	Predetermined
AH	Supplemental working area	As needed	As needed	Narrative
AI	Retroactive Enrollment Lag	Quarterly	August 31, November 30, and February 28	Predetermined

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

1.03 General instructions

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

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

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

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

Always utilize predefined categories or classifications before reporting an amount as "Other." For any material amount included as "Other", the Contractor is required to provide **a detailed explanation**. For this purpose, material is defined as comprising an amount greater than or equal to 5% of the total for each section. For example, if "Other Income" reported is less than 5% of Total Revenue, no disclosure is necessary. However, if "Other" miscellaneous 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 B – Footnotes, line item 3. Refer to the Schedule AH – 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. A hard copy original of the attestation is required. Please submit the original signed attestation page to:

Steve Annison
Louisiana Department of Health and Hospitals

Bureau of Health Services Financing

(courier address)
628 North 4th Street
Baton Rouge, LA 70802

(US Mail address)
Post Office Box 91030
Baton Rouge, LA 70821-9030

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, to:

- Steve Annison at DHH: Steve.Annison@la.gov
- Stewart Guerin at DOI: sguerin@ldi.la.gov

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

1.05 Certification statement

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

1.07 Maintenance of records

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

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Quarterly report specifications

2.01 Schedule A: Income Statement

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

Specification	Inclusion	Exclusion
Member months	A member month is equivalent to one member for whom the Contractor has received or accrued capitation-based revenue for the entire month.	Do not count kick payments as member months.
Maternity delivery payment count	Report the number of maternity payments received and/or accrued for from DHH.	
Capitation revenue	Revenue received and accrued on a prepaid basis for the provision of covered services.	
Maternity delivery payments	Revenue received and/or accrued for all supplemental maternity delivery payments.	
Investment income	All investment income earned during the period net of interest expense.	
ACA 1202 Revenue	Prospective capitation and proceeds or payments for final settlement of ACA 1202 payments for physician services.	
HIPF Received for premiums written in the Prior Year	Health Insurer's Provider Fee revenue paid in the current year calculated based on prior year premiums. This amount should reflect the difference between amounts accrued in the prior year and the amount paid in the current year.	
HIPF Adjustments for prior years	Adjustments to Health Insurer's Provider Fee receivable from prior years.	

Specification	Inclusion	Exclusion
Other income	Revenue from sources not identified in the other revenue categories. Describe amounts in the footnotes in Schedule B. Note: Material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.	

Medical expenses and recoveries – All medical expenses must be reported net of third party reimbursement and coordination of benefits (for example, Medicare and other commercial insurance) and in correspondence to the identified categories of service in Schedule A. Expenses should be reported as paid and should not include changes in Incurred-But-Not-Paid (IBNP) estimates. Record changes in IBNP estimates in the appropriately described lines, corresponding to the detail provided in the lag tables from schedules J-N. Guidance for category of service specification can be found in Appendix C.

Specification	Inclusion	Exclusion
Medical expenses – hospitalization, outpatient, physician, other medical expenses and pharmaceuticals	All contracted fee-for-service and sub-capitation expenses as identified in the categories of service groupings. Descriptions are self-explanatory.	
Hospital Settlements	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 Hospital Requirements	Other contractually required hospital payments.	
Other Contractual Physician Requirements	Pay for performance, physician incentives, and other contractually required payments.	
Other Contractual Transportation Requirements	Other contractually required transportation payments.	
Medical expenses – other and miscellaneous	Medical expenses that do not fall within the categories of services as defined in the reporting format. Note: Material other amounts (greater than 5% of the individual sections of expense) should be disclosed and fully explained in Schedule B.	
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
Third party liability subrogation	Cost-sharing revenue, including third party sources received on a cash basis for subrogation recovery efforts that could not be directly associated with a claim.	Do not include coordination of benefit payments that are deducted from payments to providers in the normal course of claims processing.
Fraud and abuse recoveries	Payments to the Contractor as a result of DHH, Contractor or Provider sponsored recovery efforts.	
Other recoveries	Other recoveries of 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 expenses

Activity requirements

Activities conducted by the Contractor to improve quality must meet the following requirements. The activity must 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.
- Improve health outcomes, including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations.

  Examples include the direct interaction of the Contractor (including those services delegated by subcontract for which the Contractor retains ultimate responsibility under the terms of the contract with DHH) 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 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.
  - Health information technology 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.
- Health information technology to support these activities.

Improve patient safety, reduce medical errors 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:

- 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.
- Health information technology to support these activities.

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

- Wellness 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 DPH.
- 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).
- Health information technology to support these activities.
- Enhancing the use of health care data to improve quality, transparency and outcomes, and support meaningful use of health information technology.

Exclusions

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

- Those that are designed primarily to control or contain costs.

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

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

Specification	Inclusion	Exclusion
Utilization management and concurrent review	Utilization management activities that manage medically-necessary covered services, as well as prospective and concurrent utilization review.	
Network development and credentialing costs	Contracting, provider credentialing, and provider education.	
Marketing	Sales and marketing expenditures.	
Member services	Member service/support and grievance and appeals, including recipient enrollment.	

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

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

Non-operating income/loss	Any amounts relating to the non-operating revenues and expenses.	
Income taxes	Income tax expense paid or accrued for the period.	
Premium tax assessments	Premium taxes paid or accrued for the period.	

HIPF assessments paid based on premiums for prior years	IRS assessed HIPF paid in the current year based on premiums written in prior years. This amount should reflect the difference between amounts accrued in the prior year and the amount paid in the current year.	
HIPF Adjustments for prior years	Adjustments to Health Insurer's Provider Fee receivable from prior years.	
Other	Any other income/loss not included elsewhere in the income statement. Note: Amounts should be disclosed and fully explained in Schedule B.	

Allocation of expenses

General Requirements

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

2.02 Schedule B: 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 DHH. 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

	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 incurred but not reported	
8	Contingent liabilities	
9	Due from/to affiliates (current and non-current)	
10	Related party transaction activities, including 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 J–N	
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	

2.03 Schedules C – G: Total Profitability by Eligibility Category

These reports are meant to provide detailed information on revenues and expenses pertaining to the Contractor for the current quarter for the populations selected by DHH. Schedule C is automatically calculated from the parish-based profitability reports (income statements). Schedules D through G 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.

Region Code Table:

Old Region ID	Old Geographic Region	Geo Group	Geographic Region Grouping Description	New Geo Group Description

01	New Orleans	01	New Orleans-Thibodaux	Gulf
02	Baton Rouge	02	Baton Rouge-North Shore	Capital
03	Thibodaux	01	New Orleans-Thibodaux	Gulf
04	Lafayette	03	Lafayette-Lake Charles-Alexandria	South Central
05	Lake Charles	03	Lafayette-Lake Charles-Alexandria	South Central
06	Alexandria	03	Lafayette-Lake Charles-Alexandria	South Central
07	Shreveport	04	Shreveport-Monroe	North
08	Monroe	04	Shreveport-Monroe	North
09	North Shore	02	Baton Rouge-North Shore	Capital

Rate Cell Table:

Category of Aid Code	Category of Aid Description	Rate Cell Code	Rate Cell Description
01	SSI	N01	Newborn, 0-2 Months
01	SSI	N02	Newborn, 3-11 Months
01	SSI	CHD	Child, 1-18 Years
01	SSI	ADT	Adult, 19+ Years
02	Family and Children	N01	Newborn, 0-2 Months
02	Family and Children	N02	Newborn, 3-11 Months
02	Family and Children	CHD	Child, 1-18 Years
02	Family and Children	ADT	Adult, 19+ Years
03	Breast and Cervical Cancer	BLL	BCC, All Ages Female
04	LaCHIP Affordable Plan	LLL	All Ages
05	HCBS Waiver	H01	18 & Under, M&F
05	HCBS Waiver	H02	19+ Years, M&F
06	Chisholm Class Members	CCM	Chisholm, All Ages M&F
KI	Maternity Kick Payment	KLL	Maternity Kick Payment, All ages
ED	Early Elective Delivery Kick Payment	EED	Early Elective Delivery Kick Payment, All ages

2.04 Schedule H: Medical Liability Summary

This schedule combines summary information from the following schedules:

- Received but unpaid claims (RBUC) report
- Hospital Inpatient Lag report
- Outpatient Facility Lag schedule
- Physician Services Lag schedule
- Other Medical Lag schedule
- Pharmaceutical Lag schedule

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

Medical cost grouping	Paid claims	RBUC	IBNR	Current period ending IBNP	Current period beginning IBNP	Total recognized incurred claims

Medical cost grouping	Paid claims	RBUC	IBNR	Current period ending IBNP	Current period beginning IBNP	Total recognized incurred claims
Hospitalization	$ -	$ -	$ -	$ -	$ -	$ -
Outpatient facility	$ -	$ -	$ -	$ -	$ -	$ -
Physician services	$ -	$ -	$ -	$ -	$ -	$ -
Other medical	$ -	$ -	$ -	$ -	$ -	$ -
Pharmaceutical	$ -	$ -	$ -	$ -	$ -	$ -
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 incurred but not reported (IBNR) claims should be reported in the IBNR column by the appropriate category (for example, hospitalization, outpatient, physician, other medical, and pharmaceutical). The total payable for hospitalization, outpatient, physician, other medical, and pharmaceutical should agree with the totals on the corresponding lag schedules.

2.05 Schedule I: Received But Unpaid Claims (RBUCs) Report

RBUCs are to be reported by the appropriate expense (for example, hospitalization, outpatient, physician, 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. For RBUC estimates, Contractors are encouraged to run reports close to the reporting deadline to determine a more accurate estimate of adjudicated and paid amounts for claims that were in process as of the reporting period. Claims that are still in process and not yet adjudicated require an estimation technique by the Contractor based on average payment amounts or historical payment-to-billed ratios. Any late payment interest penalty payments should be listed next to the vendor for which payments were made.

2.06 Schedules J – N: Lag reports

Schedules J through N request the same type of information, but for different consolidated services categories (hospitalization, outpatient, physician, other medical, and pharmaceutical). The tables are arranged with the month of service horizontally and the month of payment vertically. Therefore, payments made during the current month for services rendered during the current month would be reported in line 1, column C, while payments made during the current month for services rendered in prior months would be reported on line 1, columns D through

AM. Lines 1 through 3 contain data for payments made in the current quarter. Earlier data on lines 4 through 37 shall match data on appropriate lines on the prior period's submission. If lines 4 through 37 change from the prior period's submission, include an explanation. The current month is the last month of the period that is being reported.

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

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

Note: Multiple-month inpatient stays should be recorded in the admission month.

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 hospitalization, outpatient facility, physician 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 primary care physician for a specified list of services or to a laboratory for a specified list of tests.

In addition, 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.

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

Settlements should include payments to or refunds from providers that cannot be linked to a specific claim adjudicated through the payment system. For instance, fraud and abuse recoupment, incentive payments, and inaccurate payment settlement agreements with a provider that have not been captured through the claims payment system should be included. All other contractually required payments not included in the encounter data should also be reported in this line.

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

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

Line 43 – **Total incurred claims:** Total incurred claims is the sum of line 41 (amounts paid to date) and line 42 (IBNR). These amounts represent current estimated amounts ultimately to be paid for medical 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.

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

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

2.07 Schedule T: 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 for the most recent service quarter.

With the exception of specialty drugs, data presented in this report shall include only outpatient prescription volume adjudicated through the contracted claims processor (for example, contracted Pharmacy Benefit Manager [PBM]) or in-house claims processor.

- A prescription is defined as one fill of a prescription that is obtained from a pharmacy based on a written order to supply a particular medication for a specific patient with instruction for its use. For specialty drugs, include all pharmacy and medical claims for both prescriptions dispensed by outpatient pharmacies and medical claims for specialty drugs administered and billed through physician offices, with the exception of reporting the discounts (lines 12 and 13), in which only the prescriptions dispensed through outpatient pharmacies should be included. Specialty medications associated with an inpatient prescription are not to be included in this report.
- 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 drugs are defined as all prescriptions dispensed from outpatient pharmacies and physician offices.
- Brand/generic definition: The recommended methodology to classify brand/generic status is based upon a combination of generic indicators provided by First Data Bank (FDB); the Innovator (INNOV), the New Drug Application (NDA), the Generic Therapeutic Indicator (GTI), and the Generic Manufacturer Indicator (GMI).
  - A Brand is defined by the following hierarchy of indicators:
    (1) NDC with an INNOV value of “1”
    (2) NDC with a NDA value of “1”

(3) NDC with a GTI of "2"
(4) NDC with a GTI of "4" and a GMI of "2"

- All other values and combination of values defined a generic drug.

- Brand and generic dispensing fee 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).
- The per claim administration fee should include only those fees paid 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.

Category	Measure	Definitions
1	Brand dispensing fee	Average fee paid to pharmacies to dispense any brand name drug (e.g. legend, over the counter [OTC], and non-drug) for both single-source and multi-source products. Brand dispensing fee should be reported as the actual average paid per claim and not the contracted dispensing fee (excluding specialty, usual and customary [U&C] and TPL claims).
2	Generic dispensing fee	Average fee paid to pharmacies to dispense any generic drug (e.g. legend, OTC, and non-drug). Generic dispensing fee should be reported as the actual average paid per claim and not the contracted and dispensing fee (excluding specialty, U&C and TPL claims).
3	Specialty brand dispensing fee	Average fee paid to pharmacies to dispense any brand name specialty drug for both single-source and multi-source products. Brand dispensing fee should be reported as the actual average paid per claim and not the contracted specialty dispensing fee.
4	Specialty generic dispensing fee	Average fee paid to pharmacies to dispense any generic specialty drug. Generic dispensing fee should be reported as the actual average paid per claim and not the contracted specialty dispensing fee.
5	Average rebate per claim (non-specialty)	Average dollar amount of rebates expected to be received for prescriptions (excluding specialty drug claims) filled in the reporting period divided by total number of prescriptions (excluding specialty drug claims) filled in the reporting period – brand and generic. This estimate should be reported on an accrual basis, net of any rebate splits, and should include any expected amounts that are not guaranteed.
6	Average specialty rebate per specialty claim	Average 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 – brand and generic. This estimate should be reported on an accrual basis, net of any rebate splits, and should include any expected amounts that are not guaranteed.
7	Administrative fee per claim	Administrative fee (usually paid by the Contractor to a contracted PBM or claim administrator) on a per claim basis for pharmacy claim adjudication and management. Do not include internal Contractor costs associated with the administration of the pharmacy benefit.
8	Generic dispensing rate (GDR)	Divide the total number of generic prescription by the total number of prescription dispensed in a given period.
9	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.

Category	Measure	Definitions
		(e.g. Zocor dispensed when generic Simvastatin was available)
10	Average discount for brand prescriptions (non-specialty)	Defined as 1 – (discounted amount paid for all brand name drugs [e.g., legend, OTC and non-drug] dispensed [excluding specialty, U&C and TPL claims] / 100% amount of brand name drugs dispensed).
11	Average discount for generic prescriptions (non-specialty)	Defined as 1 – (discounted amount paid for all generic drugs [e.g., legend, OTC and non-drug] dispensed [excluding specialty, U&C and TPL claims] / 100% amount of generic name drugs dispensed).
12	Average discount for specialty brand prescriptions	Defined as 1 – (discounted amount paid for all specialty brand name drugs dispensed [excluding U&C, TPL, and specialty claims dispensed through the physician's office] / 100% amount of specialty brand name drugs dispensed).
13	Average discount for specialty generic prescriptions	Defined as 1 – (discounted amount paid for all specialty generic drugs dispensed [excluding U&C, TPL, and specialty claims dispensed through the physician's office] / 100% amount of specialty generic drugs dispensed).
14	Specialty Utilizers as a percent of members	Defined as number of members on specialty drugs for the quarter over the total member months for the quarter for each rate cell.
15	Total number of 340b pharmacy claims	Defined as total number of 340b pharmacy prescription claims (including specialty drug claims) reimbursed by the Contractor during the reporting period.
16	Total reimbursed amount for 340b claims	Defined as total dollar amount reimbursed by the Contractor to pharmacies for 340 pharmacy prescription claims (including specialty drug claims) during the reporting period.
17	Percent retail prescriptions	Defined as percentage of retail prescription claims reimbursed by the Contractor over the total prescription claims.
18	Percent mail prescriptions	Defined as percentage of mail prescription claims reimbursed by the Contractor over the total prescription claims.
19	Total brand number of prescription claims	Defined as total number of brand prescription claims reimbursed by the Contractor during the reporting period.
20	Total generic number of prescription claims	Defined as total number of generic prescription claims reimbursed by the Contractor during the reporting period.
21	Total specialty number of prescription claims	Defined as total number of specialty prescription claims reimbursed by the Contractor during the reporting period.
22	Overall total number of prescription claims	Defined as overall total number of claims reimbursed by the Contractor to pharmacies for total prescription claims (including brand, generic and specialty drug claims) during the reporting period.
23	Total brand reimbursed amount	Defined as total dollar amount reimbursed by the Contractor to pharmacies for brand prescription claims during the reporting period.
24	Total generic reimbursed amount	Defined as total dollar amount reimbursed by the Contractor to pharmacies for generic prescription claims during the reporting period.
25	Total specialty reimbursed amount	Defined as total dollar amount reimbursed by the Contractor to pharmacies for specialty prescription claims during the reporting period.
26	Overall total reimbursed amount	Defined as overall total dollar amount reimbursed by the Contractor to pharmacies for prescription claims (including brand, generic and specialty drug claims) during the reporting period.

2.08 Schedule U: Sub-Capitated Expense report

This report is a summary of sub-capitation expenses, by population group, by individual expense line item. The Contractor will submit one year-to-date report in each quarterly submission. If other capitation agreements exist and are listed in the miscellaneous medical expense line item, please describe the capitation agreement in the financial statement footnotes. Please use the prescribed drop downs in columns C through F. Also, if the sub-capitation payment is for enhanced benefits not normally covered under Medicaid, please indicate with "yes" in the Enhanced Benefits column using the drop down.

2.09 Schedule V: FQHC and Rural Health Clinic Payments

This report is a summary of Contractor payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (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 year-to-date report in each quarterly submission.

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

However, as PPS rates may change within a reporting period, reporting payments by quarter allows for direct comparison to such rates. Although only one entry per provider will typically be necessary within any given quarter, if payments change within a quarter (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 AH.

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

Encounters for FQHC/RHC providers are based upon the DHH definition of encounters for FQHC/RHC services, and is correlated to PPS rate determination. Report the number of encounters corresponding to the payments listed. Generally, in spite of the number of 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 DHH, but should be the rates issued by DHH.

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

2.10 Schedule W: Third Party Resource Payments

This schedule provides detail regarding total claims payments and claims paid that had other coverage. The Contractor will submit one report in each quarterly submission for the most recent service 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 14 and 15. Report an unduplicated count of members with active TPL resources at the end of the

quarter on line 16 (that is, a member could be included in both lines 14 and 15 but should only be reported once in line 16).

2.11 Schedule X: Third Party Liability 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 any amount recorded as a public record lien for each case. The Contractor will submit one year-to-date report in each quarterly submission.

2.12 Schedule Y: 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, active or closed. Do not include member-specific names or identification numbers on the schedule. The Contractor will submit one year-to-date report in each quarterly submission.

2.13 Schedule Z: 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 year-to-date 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 category of service groupings on Schedule A – Income Statement.

Delivery counts should be determined using the following criteria:

1. Inpatient Acute Care encounters (live-born deliveries):
    a. Claim Type 01.
    b. Billing Provider Type 60.
    c. Approved Encounter, claim status=1 or 2.
    d. Encounter submitted to Molina on/after 2/1/2015.
    e. Recipient Sex is Female.
    f. Recipient Age>10 years.
    g. Recipient is linked to the plan on the From-DOS.
    h. Diagnosis codes:
        i. 640-649 and 5th digit must be 1 or 2
        ii. 650-659 and 5th digit must be 1 or 2
        iii. 660-669 and 5th digit must be 1 or 2.
    i. Look at the first 8 diagnosis codes submitted on the encounter (these are what Molina capture on inpatient encounters).
    j. Does not have a stillborn diagnosis: V271, V273, V274, V276, or V277.
    k. Does not have a fetal demise diagnosis: 632.
2. Inpatient Acute Care encounters (still-born):
    a. Claim Type 01.
    b. Billing Provider Type 60.

c. Approved Encounter, claim status=1 or 2.
d. Encounter submitted to Molina on/after 2/1/2015.
e. Recipient Sex is Female.
f. Recipient Age>10 years.
g. Recipient is linked to the plan on the From-DOS.
h. Diagnosis codes:
    i. V271, V273, V274, V276, or V277.
i. Look at the first 8 diagnosis codes submitted on the encounter.
j. Does not have a fetal demise diagnosis: 632.

3. Professional encounters:
    a. Claim Type 04.
    b. Billing Provider Types 19, 20, 90.
    c. Approved Encounter, claim status=1 or 2.
    d. Encounter submitted to Molina on/after 2/1/2015.
    e. Recipient Sex is Female.
    f. Recipient Age>10 years.
    g. Recipient is linked to the plan on the From-DOS.
    h. Procedure codes:
        i. 59510, 59400, 59610, 59618, 59515, 59514, 59410, 59409, 59612, 59614, 59620 or 59622.
    i. Modifier (1, 2, 3 or 4): GB, AT, or GZ.
4. Professional encounters (looking for deliveries before 39 weeks without medical justification)
    a. Claim Type 04.
    b. Billing Provider Types 19, 20, 90.
    c. Denied encounter, claim status=3, deny edit code=134 (denied by plan).
    d. Encounter submitted to Molina on/after 2/1/2015.
    e. Recipient Sex is Female.
    f. Recipient Age>10 years.
    g. Recipient is linked to the plan on the From-DOS.
    h. Procedure codes:
        i. 59510, 59400, 59610, 59618, 59515, 59514, 59410, 59409, 59612, 59614, 59620 or 59622.
    i. Modifier (1, 2, 3 or 4): GZ.
5. After all encounters are identified, determine a single live-born delivery event for a given recipient within a 245-day period, plus or minus.
6. Inpatient Encounters for still-born events take precedence.
7. Professional Encounters with GZ modifier for live-born events take precedence (will set the 07KEE code).
8. 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 2 diagnosis codes submitted on the encounter.
2. Use the following logic to determine applicable expense.

Category of Service	Identification Logic
Maternity Kick Payment	CPT codes 99201-99215 with the "TH" modifier.
	CPT 59425, 59426.

(Prenatal)	ICD 9 Dx Codes: V22.0, V22.1, V22.2, V23.0, V23.1, V23.2, V23.3, V23.41, V23.49, V23.5, V23.7, V23.81, V23.82, V23.83, V23.84, V23.89, V28.0, V28.1, V28.2, V28.3, V28.4, V28.5, V28.6, V28.8, V28.9
	ICD9 Surgical Procedure Codes: 75.1, 75.2, 75.31
	ICD9 Diagnosis used in conjunction with one of the following CPT codes 59425, 59426: 671.31 (Note: claims with this Dx code without one of the accompanying CPT codes would be grouped to Delivery)
Maternity Kick Payment (Delivery)	CPT Codes: 59400-59414, 59510-59622
	ICD9 VCodes: V27.x
	ICD9 Procedure: 72.x – 75.x except 75.0x – 75.3x because these are fetal procedures.
	Revenue: 720, 721, 722, 724, 729, 0112, 0122, 0132, 0142, 0152, 0232; these include both Labor & Delivery codes as well as Room & Board with OB designation.
	C-Section: 669.71
	Vaginal: 640.01, 640.81, 640.91 641.01, 641.11, 641.21, 641.31, 641.81, 641.91, 642.01, 642.11, 642.21, 642.31, 642.41, 642.51, 642.61, 642.71, 642.91, 642.02, 642.12, 642.22, 642.32, 642.42, 642.52, 642.62, 642.72, 642.92 643.01, 643.11, 643.21, 643.81, 643.91, 644.20, 644.21, 644.22 645.11, 645.21 646.01, 646.11, 646.12, 646.21, 646.22, 646.31, 646.41, 646.42, 646.51, 646.52, 646.61, 646.62, 646.71, 646.81, 646.82, 646.91 647.01, 647.11, 647.21, 647.31, 647.41, 647.51, 647.61, 647.81, 647.91, 647.02, 647.12, 647.22, 647.32, 647.42, 647.52, 647.62, 647.82, 647.92 648.01, 648.11, 648.21, 648.31, 648.41, 648.51, 648.61, 648.71, 648.81, 648.91, 648.02, 648.12, 648.22, 648.32, 648.42, 648.52, 648.62, 648.72, 648.82, 648.92 649.01, 649.02, 649.11, 649.12, 649.21, 649.22, 649.31, 649.32, 649.41, 649.42, 649.51, 649.61, 649.62 (These are codes for complications affecting the mother during pregnancy that resulted in deliveries, i.e. tobacco use, obesity, epilepsy, etc.) 650 (and any or no trailing characters) 651.01, 651.11, 651.21, 651.31, 651.41, 651.51, 651.61, 651.81, 651.91 652.01, 652.11, 652.21, 652.31, 652.41, 652.51, 652.61, 652.71, 652.81, 652.91 653.01, 653.11, 653.21, 653.31, 653.41, 653.51, 653.61, 653.71, 653.81, 653.91 654.01, 654.11, 654.21, 654.31, 654.41, 654.51, 654.61, 654.71, 654.81, 654.91, 654.02, 654.12, 654.32, 654.42, 654.52, 654.62, 654.72, 654.82, 654.92 655.01, 655.11, 655.21, 655.31, 655.41, 655.51, 655.61, 655.71, 655.81, 655.91 656.01, 656.11, 656.21, 656.31, 656.41, 656.51, 656.61, 656.71, 656.81, 656.91

	657.01 658.01, 658.11, 658.21, 658.31, 658.41, 658.81, 658.91 659.01, 659.11, 659.21, 659.31, 659.41, 659.51, 659.61, 659.71, 659.81, 659.91 660.01, 660.11, 660.21, 660.31, 660.41, 660.51, 660.61, 660.71, 660.81, 660.91 661.01, 661.11, 661.21, 661.31, 661.41, 661.91 662.01, 662.11, 662.21, 662.31 663.01, 663.11, 663.21, 663.31, 663.41, 663.51, 663.61, 663.81, 663.91 664.01, 664.11, 664.21, 664.31, 664.41, 664.51, 664.61, 664.81, 664.91 (These previously were 664.x as there were no subdivisions for 664).665.01, 665.11, 665.31, 665.41, 665.51, 665.61, 665.71, 665.81, 665.91, 665.22, 665.72, 665.82, 665.92 666.02, 666.12, 666.22, 667.02, 667.12 668.01, 668.11, 668.21, 668.81, 668.02, 668.12, 668.22, 668.82, 668.91, 668.92 (These have been added: Unspec. complications of anesthesia during labor & delivery).669.01, 669.11, 669.21, 669.31, 669.41, 669.51, 669.61, 669.71, 669.81, 669.91, 669.02, 669.12, 669.22, 669.32, 669.42, 669.82, 669.92 670.02 671.01, 671.11, 671.21, 671.31, 671.42, 671.51, 671.81, 671.91, 671.02, 671.12, 671.22, 671.52, 671.82, 671.92 672.02 673.01, 673.11, 673.21, 673.31, 673.81, 673.02, 673.12, 673.22, 673.32, 673.82 674.01, 674.02 674.12, 674.22, 674.32, 674.42, 674.51, 674.52, 674.82, 674.92 675.01, 675.11, 675.21, 675.81, 675.91, 675.02, 675.12, 675.22, 675.82, 675.92 676.01, 676.11, 676.21, 676.31, 676.41, 676.51, 676.61, 676.81, 676.91, 676.02, 676.12, 676.22, 676.32, 676.42, 676.52, 676.62, 676.82, 676.92, 677 (no other characters) V27, V27.0, V27.1, V27.2, V27.3, V27.4, V27.5, V27.6, V27.7, V27.9
Maternity Kick Payment (Post-Partum)	CPT Codes: 59430
	ICD9 Diagnosis used in conjunction with CPT code 59430: 642.02, 642.12, 642.22, 642.32, 642.42, 642.52, 642.62, 642.72, 642.92, 646.12, 646.22, 646.42, 646.52, 646.62, 646.82, 647.02, 647.12, 647.22, 647.32, 647.42, 647.52, 647.62, 647.82, 647.92, 648.02, 648.12, 648.22, 648.32, 648.42, 648.52, 648.62, 648.72, 648.82, 648.92, 649.02, 649.12, 649.22, 649.32, 649.42, 649.52, 649.62, 654.02, 654.12, 654.22, 654.32, 654.42, 654.52, 654.62, 654.72, 654.82, 654.92, 665.72, 665.82, 665.92, 666.02, 666.12, 666.22, 666.32, 667.02, 667.12, 668.02, 668.12, 668.22, 668.82, 668.92, 669.02, 669.12, 669.22, 669.32, 669.42, 669.82, 669.92, 670.02, 671.02, 671.12, 671.22, 671.42, 671.52, 671.82, 671.92, 672.02, 673.02, 673.12, 673.22, 673.32, 673.82, 674.01, 674.02, 674.12, 674.22, 674.32, 674.42, 674.51, 674.52, 674.82, 674.92, 675.01, 675.02, 675.11, 675.12, 675.21, 675.22, 675.81, 675.82, 675.91, 675.92, 676.01, 676.02, 676.11, 676.12, 676.21, 676.22, 676.31, 676.32, 676.41, 676.42, 676.51, 676.52, 676.61, 676.62, 676.81, 676.82, 676.91, 676.92, 677, V24.0, V24.1, V24.2, (Note: claims with this Dx code without one of the accompanying CPT codes would be grouped to Delivery)
	ICD9 Surgical Procedure Codes used in conjunction with CPT code 59430: 75.7, 75.8, 75.91, 75.92, 75.93, 75.94

Use the following logic for category of service splits:
Hospitalization: Bill type 011x and 012x
Outpatient: Bill type 013x or 083x
Physician: CLC_Claim_Cat_Serv=07
Pharmaceuticals: CLQ_Claim_Type=12
Other Medical: All other expenses not described above.

2.14 Schedule AF: Hospital Settlements

This report 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 year-to-date 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.

2.15 Schedule AG: Medical Loss Rebate (MLR) calculation

This schedule should be completed for the quarterly MLR calculation. Please note that the quarterly MLR calculation will be used for informational purposes only by DHH. The quarterly schedule will not be utilized for determination of payments from the Contractor to DHH. The information reported should be on a year-to-date 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.

2.16 Schedule AH: 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.

2.17 Schedule AI: Retroactive Enrollment Claims Lag Report

Schedule AI requests the same type of information as the lags reported in Schedules J through N, but only for retroactive enrollment claims for the period January 2014 through December 2015. The retroactive enrollment claims prior to January 2014 should be reported in aggregate. The time period will be updated in future years' templates. The table is arranged with the month

of service horizontally and the month of payment vertically for the months starting January 2014. Therefore, all payments made during the current month for services rendered during the current month would be reported in the appropriate column and row using columns C through AA and rows 7 through 31 (e.g. For a claim paid during December 2015 for a service rendered in December 2015, the payments would be reported in Column C and Line 1). Payments made during the current month for services rendered in prior months would be reported in a similar manner (e.g. For a claim paid during December 2015 for a service rendered in September 2015, the payments would be reported in Column F and Line 1). If any data changes between quarterly submissions, please provide an explanation. Please report all available data for the time period shown in this table.

Analyzing the accuracy of retroactive enrollment claims liability estimates is helpful in assessing the adequacy of current liabilities. This schedule provides the necessary information to make this analysis.

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

Line 27 – 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 27. 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 hospitalization, outpatient facility, physician 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 primary care physician for a specified list of services or to a laboratory for a specified list of tests.

Line 28 – Settlements and other payments: The Contractor should report payments/recoupments on lines 1 through 25 to the extent possible. If the Contractor makes a settlement or other payment that cannot be reported on lines 1 through 25 due to lack of data, the amount must be reported on line 28 with the payment month used as a substitute for the service month. The Contractor may use an alternative method of reporting settlements that restates prior period amounts to reflect an actual settlement for that month. **For all amounts reported on line 28, include a footnote explanation**. Do not include adjustments to IBNR amounts on this line.

Settlements should include payments to or refunds from providers that cannot be linked to a specific claim adjudicated through the payment system. For instance, fraud and abuse recoupment, incentive payments, and inaccurate payment settlement agreements with a provider that have not been captured through the claims payment system should be included. All other contractually required payments not included in the encounter data should also be reported in this line.

Line 29 – This line is the total amount paid to date (including subcapitation) for services rendered and should equal the sum of lines 26 through 28. This line will calculate automatically.

Line 30 – **Incurred but not reported (IBNR):** Amounts on this line represent the current estimates for unpaid claims, by month of service, for the period of January 2014 to December 2015 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 30. The development of each IBNR should be based on the most recent paid claims data.

Line 43 – **Total incurred claims:** Total incurred claims is the sum of line 29 (amounts paid to date) and line 30 (IBNR). These amounts represent current estimated amounts ultimately to be paid for retroactive enrollment claims by month of service for the period from January 2015 to current date and for all months prior to January 2014. Each amount represents the retroactive enrollment 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 subcapitation payments and adjustments. This line will calculate automatically. Do not include risk pool distributions as payments in these schedules.

3

Annual reporting requirements

3.01 Schedule O-S: Utilization reports

The Contractor shall submit a summary of utilization and unit cost information annually 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.

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

Service measure	Measure	Type of utilization/ proxy	Definitions
Hospitalization	Days	Quantity/days	Days are calculated as follows: Number of days between admit and discharge date. (Exclude discharge date and denied days. Include admit 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 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.
Hospitalization	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 services	Visits	Quantity/services	This measure summarizes utilization of outpatient services and observation room stays that result in discharge. Each visit to an emergency department 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 department 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 services	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 coordination of benefits are also considered paid.
Physician services	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.
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 coordination of benefits are also considered paid.
Other services	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 Services	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 coordination of benefits are also considered paid.
Other Services	Units	Quantity/services	This measure summarizes the unit count of paid or payable claims.

Service measure	Measure	Type of utilization/ proxy	Definitions
Other Services	Assessments	Quantity/services	This measure summarizes the number of foster care assessments completed.
Other Services	Days	Quantity/days	Days are calculated as follows: Number of days between admit and discharge date. (Exclude discharge date and denied days. Include admit 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 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.
Pharmacy	Scripts	Quantity/scripts	Scripts count the number of prescriptions filled.

3.02 Schedule AA: 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.

3.03 Schedule AB: Louisiana entity level audited financial statements

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

3.04 Schedule AC: 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.

3.05 Schedule AD: 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.

3.06 Schedule AE: 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 .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 .25% of capitation revenue from line 3 of Schedule A.

3.07 Schedule AG: Medical Loss Rebate (MLR) calculation

This schedule provides the calculations necessary at year end to determine any rebates payable to DHH based on adjusted adjustments to revenue and expenses as defined in Appendix B of this Financial Reporting Guide. The schedule should only be completed after the agreed upon procedures have been finalized. The annual report is due June 30, 20xx.

3.08 Schedule AH: 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.

Appendix A

Medical Loss Ratio (MLR) Rebate Calculation

Appendix A includes the instructions and guidance for calculating any rebate amounts due to DHH. The document is adapted from 45 CFR Part 158 Federal Register, December 1, 2010. Requirements for calculating any rebate amounts that may be due the DHH in the event the Bayou Health Contractor does not meet the 85% MLR standard are described in this appendix.

Medical Loss Ratio (MLR) Requirements

Managed Care Organizations (MCOs) that receive capitation payments to provide core benefits and services to Louisiana Medicaid members are required to rebate a portion of the capitation payment to DHH in the event the MCO does not meet the eighty five percentage (85%) MLR requirement. This document describes requirements for 1) reporting MLR, 2) methodology for calculation of MLR, 3) record retention, 4) payment of any rebate due DHH, and 5) monetary penalties that may be assessed against the MCO for failure to meet requirements.

Definitions

- **Direct Paid Claims** – claim payments before ceded reinsurance and excluding assumed reinsurance except as otherwise provided in this Appendix.
- **MLR Reporting Year** – calendar year during which core benefits and services are provided to Louisiana Medicaid members through contract with DHH.
- **Unpaid Claim Reserves** – reserves and liabilities established to account for claims that were incurred during the MLR reporting year but had not been paid within three months of the end of the MLR reporting year.

Reporting Requirements

A. **General Requirements**

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

B. **Timing and Form of Report**

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

C. **Newer Experience**

If 50 percent 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 an 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:

1. List all plan enrollees during the MLR period (total population).
2. 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).
3. 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 months 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).
4. 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.

5. 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.

D. **Capitation Payments**

A MCO must report to DHH the total capitation payments received from Louisiana Medicaid for each MLR reporting year. Total capitation payments means all monies paid by DHH to the MCO for providing core benefits and services as defined in the terms of the contract.

Reimbursement for Clinical Services Provided to Enrollees

A. **General Requirements**

The MLR Report must include direct claims paid to or received by providers whose services are covered by the subcontract for clinical services or supplies covered by DHH's contract with the MCO. In addition, the report must include claim reserves associated with claims incurred during the MLR reporting year, the change in contract reserves, reserves for contingent benefits and the claim portion of lawsuits, and any experience rating refunds paid or received. Reimbursement for clinical services as defined in this section is referred to as "incurred claims".

1. Incurred Claims must include changes in unpaid claims between the prior year's and the current year's unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to subcontracted providers, claims that are recoverable for anticipated coordination of benefits (COB), and claim recoveries received as a result of subrogation.
2. Incurred claims must include the change in claims incurred but not reported from the prior year to the current year. Except where inapplicable, the reserve should be based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency, or severity.
3. Incurred claims must include changes in other claims-related reserves.
4. Incurred claims must exclude rebates paid to DHH based upon prior MLR reporting year experience.

B. **Adjustments to incurred claims:**

1. Adjustments that must be deducted from incurred claims:
   a. Prescription drug rebates received by the MCO.
   b. Overpayment recoveries received from providers.
2. Adjustments that may be **included** in incurred claims:
   a. The amount of incentive and bonus payments made to providers.
3. Adjustments that must not be included in incurred claims:
   a. Amounts paid to third party vendors for secondary network savings.
   b. Amounts paid to third party vendors for network development administrative fees, claims processing, and utilization management.
   c. Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee. For example, medical record copying costs, attorneys' fees, subrogation vendor fees, compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel, and medical record clerks must not be included in incurred claims.

Activities that Improve Health Care Quality

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

B. **Activity Requirements**
Activities conducted by a MCO to improve quality must meet the following requirements:

1. The activity must be primarily designed to:
    a. Improve health quality;
    b. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;
    c. Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage, as long as no additional costs are incurred due to the non-enrollees;
    d. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations;
    e. Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations:
        - 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 DHH) with providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:
            (a) Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in the RFP and contract;
            (b) Identifying and addressing ethnic, cultural, or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;
            (c) Quality reporting and documentation of care in non-electronic format;
            (d) Health information technology to support these activities.

    f. Accreditation fees directly related to quality of care activities;
    g. Prevent hospital readmissions through a comprehensive program for hospital discharge;
        - Examples include:
            (a) 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;
            (b) Patient-centered education and counseling;

(c) Personalized post-discharge reinforcement and counseling by an appropriate health care professional;
(d) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and,
(e) Health information technology to support these activities.

h. Improve patient safety, reduce medical errors, 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:
     (a) The appropriate identification and use of best clinical practices to avoid harm;
     (b) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns;
     (c) Activities to lower the risk of facility-acquired infections;
     (d) Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions;
     (e) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and,
     (f) Health information technology to support these activities.

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

A. **Exclusions**

1. Expenditures and activities that **must not be included** in quality improving activities are:
   a. Those that are designed primarily to control or contain costs;
   b. The *pro rata* share of expenses that are for lines of business or products other than Louisiana Medicaid;
   c. Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from DHH capitation payments;

d. Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;
e. Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (for example, costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements);
f. That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;
g. All retrospective and concurrent utilization review;
h. Fraud prevention activities, other than fraud detection/recovery expenses up to the amount recovered that reduces incurred claims;
i. The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;
j. Provider credentialing;
k. Marketing expenses;
l. Costs associated with calculating and administering individual enrollee or employee incentives;
m. That portion of prospective utilization that does not meet the definition of activities that improve health quality;
n. State and federal taxes. licensing and regulatory fees; and,
o. Any function or activity not expressly included in paragraph (c) of this section, unless otherwise approved by and within the discretion of DHH, 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 health care quality improvement.

Expenditures Related to Health Information Technology and Meaningful Use Requirements

A. **General Requirements**

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

1. Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their “meaningful use” as defined by HHS to the extent such payments are not included in reimbursement for clinical services;
2. Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicaid incentive payments;
3. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;
4. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized

accrediting organizations such as NCQA, URAC, or JHACO, or costs for reporting to DHH on quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures);

5. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;
6. Advancing the ability of enrollees, providers, 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;
7. Reformatting, transmitting, or reporting data to national or international government-based health organizations, as may be required by DHH, for the purposes of identifying or treating specific conditions or controlling the spread of disease; and,
8. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

Other Non-Claims Costs

A. **General Requirements**

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

B. **Non-Claims Costs Other**

1. The MLR Report must include any expenses for administrative services that do not constitute adjustments to capitation for clinical services to enrollees, or expenditures on quality improvement activities as defined above.
2. Expenses for administrative services include the following:
   a. Cost-containment expenses not included as an expenditure related to a qualifying quality activity;
   b. Loss adjustment expenses not classified as a cost containment expense;
   c. Workforce salaries and benefits;
   d. General and administrative expenses; and,
   e. Community benefits expenditures.

Allocation of Expenses

A. **General Requirements**

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

B. **Description of the Methods Used to Allocate Expenses**

The report required must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, and other non-claims costs resulting from MCO activities in Louisiana. A detailed description of each

expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

1. Allocation to each category should be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, the 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;
2. Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned *pro rata* to the entities incurring the expense; and,
3. Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, capitation payment ratios, or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group. Any profit margin included in costs for related party administrative agreements should be excluded.

C. **Maintenance of Records**

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

Formula for Calculating Medical Loss Ratio

A. **Medical Loss Ratio**

1. A MCO's MLR is the ratio of the numerator, as defined in paragraph “a” of this section, to the denominator, as defined in paragraph “b” of this section.
2. A 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 percent. If an MLR is 0.8253 or 82.53 percent, it shall be rounded to 0.825 or 82.5 percent.
    a. The **numerator** of a MCO's MLR for an MLR reporting year must be the MCO's incurred claims plus the MCO's expenditures for activities that improve health care quality. The numerator of an MLR reporting year shall include Total Medical Expenses defined as follows:
        a. Incurred claims
        b. Plus MLR Expense Addition Adjustments as applicable:
            i. State subsidized stop loss payments.
            ii. Provider incentive or bonus payments.
            iii. Administrative expense activities that improve health care quality.
            iv. Health Information Technology meaningful use expenses.
            v. Add the New Enrollee expenses deferred from the prior MLR reporting year as defined on page 28 of this guide.
            vi. Other adjustments for non-claim costs.
        c. Minus MLR Expense Reduction Adjustments as applicable:
            i. Claims that are recoverable for anticipated COB.
            ii. Subrogation recoveries.
            iii. Amounts paid to third party vendors for secondary network savings.
            iv. Amounts paid to providers for non-covered services.

v. Prior year rebates paid to DHH.
vi. Pharmacy rebates.
vii. Provider overpayments recovered.
viii. Administrative expense exclusions.

b. The denominator of a MCO's MLR must equal the MCO's capitation payments received from DHH. The denominator of an MLR reporting year shall include Total Capitation Revenue less premium taxes unless a deduction for community benefit expenditures is taken, less the Health Insurance Provider Fee (HIPF). Premium taxes and HIPF are excluded because they are all considered pass-through administrative costs and including reimbursement for them would adversely affect ratios. The following adjustments may apply:
   a. Subtract the New Enrollee capitation and expense impact for the current MLR reporting year as defined on page 28 of this guide.
   b. Add the New Enrollee capitation deferred from the prior MLR reporting year as defined on page 28 of this guide.

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

A. **General Requirement**
For each MLR reporting year, a MCO must provide a rebate to DHH if the MCO's MLR does not meet or exceed the eighty-five percentage (85%) requirement.

B. **Amount of Rebate**
For each MLR reporting year, a MCO must rebate to DHH the difference between the total amount of capitation payments received by the MCO from DHH multiplied by the required MLR of 85% and the MCO's actual MLR.

C. **Timing of Rebate**
A MCO must provide any rebate owing to DHH no later than August 1 following the end of the MLR reporting year.

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

Appendix B

Category of Service 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, physician, and EPSDT.
- Inpatient NICU, Emergency Room, Skilled Nursing Facility, Prescribed Drugs.
- Behavioral Health.
- Primary Care Physician.
- Specialty Care Physician.
- Other defined physician services.
- Inpatient Hospital, Outpatient Hospital.
- Other (if equal to 5% or higher of Total Other Medical expenses, disclose in Schedule B, no.3).

The following definitions are provided to help classify expenses:

- Claim category of service – CLC_CLAIM_CAT_SERV: A service rendered by the provider for use in the MARS, SURS and FACS (ISIS) reporting and accounting subsystems.
- Place of treatment – CLH_TREAT_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.
- Service Provider type – CLP_SERV_PROV_TYPE: A code which designates the classification of a provider per the state plan (i.e., dentist, pharmacy).
- Service Provider Specialty – CLP_SERV_PROV_SPEC1: The provider's indicated specialty from the PE 50 (Provider Enrollment form).

Category of Service	Lag Table	Specification
Inpatient Hospital	Inpat	All hospital stays greater than 24 hours that are not included in a category below.
Inpatient Maternity*	Inpat	Using the first two diagnosis codes submitted on the encounter, apply the kick payment logic found in 2.13 Schedule Z: Maternity and Delivery.
Inpatient NICU	Inpat	Inpatient Hospitals for age 0-2 months.
Hospital Settlements	Inpat	Non-Claim Settlements paid to hospitals.
Other Contractual Hospital Requirements	Inpat	Other non-claims hospital payments
Skilled Nursing Facilities	Inpat	CLC_Claim_Cat_Serv=66 and CLP_Serv_Prov_Type<>09
Emergency Room	Outpat	CLH_TREAT_PLACE=23 (Place of Service = Emergency Room), CLC_Procedure_Code 99281-99285 , Revenue Codes 450, 459 or 981
Outpatient Hospital	Outpat	CLC_Claim_Cat_Serv=08 (Category of Service = Outpatient Hospital)
Outpatient Maternity*	Outpat	Using the first two diagnosis codes submitted on the encounter, apply the kick payment logic found in 2.13 Schedule Z: Maternity and Delivery.
Clinic	Phys	CLC_Claim_Cat_Serv=09 or 12
EPSDT*	Phys	CLC_Claim_Cat_Serv=28 or 34
Physician Maternity*	Phys	Using the first two diagnosis codes submitted on the encounter, apply the kick payment logic found in 2.13 Schedule Z: Maternity and Delivery.
Primary Care Physician	Phys	CLC_Claim_Cat_Serv=07 (Category of Service = Physician services) and CLP_Serv_Prov_Spec1 = 01, 08, 16, 37, 41, or 79 (Provider specialty = General Practice, Family Practice, OB/GYN, Pediatrics, Internal Medicine, or Nurse Practitioner).
Other Physician Contractual Requirements	Phys	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.
Specialty Care Physician	Phys	CLC_Claim_Cat_Serv=07 and CLP_Serv_Prov_Spec1 NOT=01, 08, 16, 37, 41, AND 79.
ACA 1202	Phys	Supplemental payments to providers not included in paid claims used to meet rate minimums as described in ACA 1202.
Basic Behavioral Health	Other	CLC_Claim_Cat_Serv = 02, 10, 11, 42, 50, 74, or 79 or CLP_Serv_Prov_Type = 69, 96, 18, 31, 64, 68, 74, or 77 or CLP_Serv_Prov_Spec1 = 26, 27, 62, 78, 95, 96, 4D, 5H, 5M, 6A, 6B, 6C, 6D, 6E, 6F, or 9B or CLH_Treat_Place = 51, 52, 53, 55, 56, or 57.
Dental	Other	CLC_Claim_Cat_Serv=25 or 27 or 45

Category of Service	Lag Table	Specification
DME	Other	CLC_Claim_Cat_Serv=20
Family Planning	Other	CLC_Claim_Cat_Serv=22
Foster Care Assessments	Other	Self-Explanatory
FQHC/RHC	Other	CLC_Claim_Cat_Serv = 21 or 38
Home Health	Other	CLC_Claim_Cat_Serv=17
Hospice	Other	CLC_Claim_Cat_Serv=66 and CLP_Serv_Prov_Type=09
Lab/Radiology	Other	CLC_Claim_Cat_Serv=15
Other	Other	All other paid claims expenses not described elsewhere allowable under Medicaid in Louisiana.
Pediatric Day Health	Other	CLC_Claim_Cat_Serv=82
Personal Care Services	Other	CLC_Claim_Cat_Serv= 44 or 71 or 72
Rehabilitation Services (OT, PT, ST)	Other	CLC_Claim_Cat_Serv= 13 or 52 or 56
Vision	Other	Self-Explanatory
Enhanced Benefits	Other	All medical expense, including claims, not covered by traditional Medicaid.
Emergency Transportation	Other	CLC_Claim_Cat_Serv=24
Non-Emergency Transportation	Other	CLC_Claim_Cat_Serv=23
Other Contractual Transportation Requirements	Other	Other non-claims transportation payments
Prescribed drugs	Rx	CLQ_Claim_Type=12

Appendix C

Health Insurance Provider Fee (HIPF) Reimbursement

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

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

Provide DHH with a copy of the final Form 8963 submitted to the IRS by the deadline listed in the HIPF Deliverables and Deadlines below. The MCO shall provide DHH with any adjusted Form 8963 filings to the IRS within 5 business days of any amended filing.

Provide DHH Louisiana-specific Medicaid and CHIP-specific premiums included in the premiums reported on Form 8963 (including any adjusted filings) by the deadline listed in the HIPF Deliverables and Deadlines below (for the initial Form 8963 filing) of the Fee Year and within 5 business days of any amended filing.

If the MCO's Louisiana-specific Medicaid/CHIP premium revenue is not delineated on its Form 8963, the MCO shall provide with its Form 8963 a supplemental delineation of Louisiana-specific Medicaid/CHIP premium revenue that was listed on the MCO's Form 8963 and a methodological description of how its Louisiana-specific Medicaid/CHIP premium revenue (payments to the MCO pursuant to this Contract) was determined. The MCO will indicate for DHH the portion of the Louisiana-specific Medicaid/CHIP premiums that were excluded from the Form 8963 premiums by the MCO as Medicaid long-term care, if applicable, beginning with Data Year 2014.

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

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

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

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

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

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

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

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

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

Calculate the HIPF obligation as a percentage of the total data year premiums subject to the HIPF (this total will include all of the first $25 million and 50% of the next $25 million of premium deducted by the IRS). This is the "HIPF%", which is unique to each MCO that is subject to the HIPF.

Calculate Figure A. Figure A is the total premium revenue for coverage in the Data Year. The Figure A amount has no provision for the HIPF obligation.

Calculate Figure B. Figure B is the portion of Figure A that is for services subject to the HIPF. Capitation revenue for services that are excludable under Section 9010 of the Patient Protection and Affordable Care Act of 2010, such as long-term care services, will not be included in Figure B. The Figure B amount has no provision for the HIPF obligation.

Calculate Figure C. Figure C is the calculation of total revenue that incorporates provision for the HIPF and applicable taxes. DHH will use the following formula to calculate Figure C. If the Contractor has not provided satisfactory documentation of federal income tax obligations, then the Average Federal Income Tax Rate (AvgFIT%) in the formula will be zero. If the Contractor has not provided satisfactory documentation of corporate net income tax obligations or if state income taxes are not applicable, then the Average State Income Tax Rate (AvgSIT%) in the formula will be zero. The Louisiana Department of Insurance has determined that state premium tax is not applicable to the HIPF payment; as such, no consideration for premium tax will be made. If in the future, however, the applicability of premium tax to the HIPF payments changes, the formula will be modified accordingly.

Figure B

$$1 - (HIPF\% / (1 - AvgSIT\% - AvgFIT\% \times (1 - AvgSIT\%)))$$

Calculate Figure D. DHH will calculate Figure D by subtracting Figure B from Figure C. This is the final HIPF adjustment amount that will serve as the basis for DHH payment to the impacted contractors.

DHH will compare Figure D with Figure B to calculate the percentage adjustment to the Data Year capitation rates and rate ranges for submission to CMS for approval.

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

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

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

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

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

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

HIPF Deliverables and Deadlines

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

* Form 8453-R may be used for certification

DHH Payment Schedule	Deadline
HIPF Reimbursement from DHH	October 31st