Louisiana Behavioral Health Partnership
Medical Loss Ratio (MLR) Rebate Calculation
Effective 3.1.2015

This guidance includes the requirements for calculating any rebate amounts that may be due the Department of Health & Hospitals (DHH) Office of Behavioral Health (OBH) in the event the Statewide Management Organization (SMO) does not meet the 85% MLR standard, effective January 1, 2015. This guidance also includes the requirements for SMO to maintain records and civil monetary penalties that may be assessed against SMO who violate the requirements of this Part.

Applicability

The requirements apply to all SMOs who receive a capitation payment to provide Medicaid services.

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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 LBHP enrollees through SMO.

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 3 months of the end of the MLR reporting year. The intent is to clarify that claims paid within three months following the reporting period should not be included in unpaid claims reserves. Paid claims experience could be determined if paid more than 3 months after the end of the period, but should not be determined on less than 3 months. In other words, IBNP is calculated on or later than the beginning of the 4th month following the end of the reporting period

Reporting requirements related to capitation payments and expenditures

(a) **General requirements –** For each MLR reporting year, SMO must submit to OBH a report which complies with the requirements that follow, concerning premium revenue and expenses related to Louisiana Medicaid enrollees (referred to hereafter as MLR Report).

(b) **Timing and form of report –** The report for each MLR reporting year must be submitted to OBH by June 1 of the year following the end of an MLR reporting year.

Newer Experience

For Medical Loss Ratio rebate calculation purposes, new enrollees assigned to a prepaid plan within a calendar year is identified as those that have **not** been continuously enrolled in 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 SMO 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 MLR 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 New Enrollees in the current period.

(c) **Capitation Payments –** SMO must report to the DHH - OBH total capitation payments received for Louisiana Medicaid enrollees for each MLR reporting year. Total capitation payments means all monies paid by OBH to SMO as a condition of receiving coverage for providing core benefits and services as defined in the terms of the contract for Medicaid enrollees.

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 contract for clinical services or supplies. 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 are 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 contracted 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 with the exception of the first contract 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 OBH based upon prior MLR reporting year experience.

Adjustments to incurred claims

(a) Adjustments that may be **included** in incurred claims, if not already added to the total:

(i) State subsidies based on a stop-loss payment methodology.
(ii) The amount of incentive and bonus payments made to providers.
(iii) Administrative expense activities that improve health care.
(iv) Health Information Technology meaningful use expenses.
(v) Other adjustments for non-claim costs.
(vi) Adjustments due to underaccrual of IBNR during the three-month run-out period.

(b) Adjustments that must be **excluded** in incurred claims:

(i) Amounts paid to third party vendors for secondary network savings.
(ii) Amounts paid to third party vendors for network development administrative fees, claims processing, and utilization management.
(iii) 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.
(iv) Prescription drug rebates received by SMO.
(v) Overpayment recoveries received from providers.
(vi) Prior year rebates paid to DHH.
(vii) Adjustments due to overaccrual of IBNR during the three-month run-out period.

Activities that improve Healthcare Quality

(a) **General requirements**. The MLR must include expenditures for activities that improve health care quality, as described in this section.

(b) **Activity requirements**. Activities conducted by SMO to improve quality must meet the following requirements:

(1) The activity must be designed to:
- (i) Improve health quality.
- (ii) Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.
- (iii) 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.
- (iv) 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

(2) The activity must be primarily designed to:
- (i) Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.
  - (A) Examples include the direct interaction of SMO (including those services delegated by contract for which SMO retains ultimate responsibility under the terms of the contract with OBH) 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:
    - (1) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.
    - (2) Quality reporting and documentation of care in non-electronic format.
    - (3) Health information technology to support these activities.
    - (4) Accreditation fees directly related to quality of care activities.
- (ii) 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.
  - (E) Health information technology to support these activities.
  - (F) Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology.

(c) **Exclusions**. Expenditures and activities that **must not be included** in quality improving activities are:

(1) Those that are designed primarily to control or contain costs.
(2) The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans.
(3) Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from premium revenue.
(4) Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services.
(5) 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.)
(6) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality.
(7) All retrospective and concurrent utilization review.
(8) Fraud prevention activities, other than fraud detection/recovery expenses up to the amount recovered that reduces incurred claims.
(9) 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.
(10) Provider credentialing.
(11) Marketing expenses.
(12) Costs associated with calculating and administering individual enrollee or employee incentives.
(13) That portion of prospective utilization that does not meet the definition of activities that improve health quality.
(14) State and federal taxes and regulatory fees; and
(15) Any function or activity not expressly included in paragraph (c) of this section, unless otherwise approved by and within the discretion of OBH, upon adequate showing by SMO that the activity's costs support the definitions and purposes in this Part or otherwise support monitoring, measuring or reporting health care quality improvement.

Expenditures related to Health Information Technology (HIT) and meaningful use requirements

(a) **General requirements**. SMO 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 SMO, SMO providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with Medicaid 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 the Department of Health and Human Services (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 or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law.
(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, SMO 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, for the purposes of identifying or treating specific conditions or controlling the spread of disease.
(8) Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

Other non-claims costs

(a) **General requirements**. The MLR Report must include non-claims costs described in paragraph (b) of this section and must provide an explanation of how capitation payments are used, other than to provide reimbursement for clinical services included in core benefits and services, expenditures for activities that improve health care quality, and expenditures related to Health Information Technology and meaningful use requirements.
(b) **Non-claim 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 in this Section.
(2) Expenses for administrative services include the following:
(i) Cost-containment expenses not included as expenditure related to a qualifying quality activity.
(ii) Loss adjustment expenses not classified as a cost containment expense.
(iii) Workforce salaries and benefits.
(iv) General and administrative expenses.

(vi) Community benefits expenditures in lieu of the deduction for state premium taxes.

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 or products other than those being reported, including but not limited to those that are for or benefit self-funded plans, must be reported on a pro rata share.

(b) **Description of the methods used to allocate expenses**. The report required in Sec. 158.110 of this subpart 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 SMO 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 methodology**. All direct administrative costs provided to a specific population or eligibility group must be allocated at 100% to that population, or pro-rated amongst only applicable sub-populations within the population. For example, if expenses tie only to the 1915i population, those expenses may only be booked to persons within that population; or if expenses tie only to youth, then those expenses may not be allocated to an adult population for which SMO is at risk.

Once the direct administrative costs have been applied to their respective populations, remaining administrative costs that impact all persons served by SMO, may be prorated based upon the number of recipients in the CAPS system each month that belong to each eligibility group.

With respect to the MLR, costs that directly impact the at-risk population may be considered. Costs that partially impact the at-risk population may be considered based upon utilization of the HCQI as can be evidenced by persons served. Costs that do not have an impact on the at-risk population may not be considered at all for the purposes of MLR, either directly or via any allocation methodology.

(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.

(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, premium 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.

(c) **Maintenance of records**. SMO must maintain and make available to OBH upon request the data used to allocate expenses reported under this Part 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 the Medical Loss Ratio

(a) **Medical loss ratio**. The MLR is the ratio of the numerator, as defined in paragraph (b) of this section, to the denominator, as defined in paragraph (c) of this section. The 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.
(b) **Numerator**. The numerator of an MLR reporting year shall include Total Medical Expenses defined as follows:

1. Incurred claims
2. Plus MLR Expense Addition Adjustments as applicable:
    a. State subsidized stop loss payments.
    b. Provider incentive or bonus payments.
    c. Administrative expense activities that improve health care quality.
    d. Health Information Technology meaningful use expenses.
    e. Add the New Enrollee expenses deferred from the prior MLR reporting year as defined on page 2 of this guide.
    f. Other adjustments for non-claim costs.
3. Minus MLR Expense Reduction Adjustments as applicable:
    a. Claims that are recoverable for anticipated COB.
    b. Subrogation recoveries.
    c. Amounts paid to third party vendors for secondary network savings.
    d. Amounts paid to providers for non-covered services.
    e. Prior year rebates paid to DHH.
    f. Pharmacy rebates.
    g. Provider overpayments recovered.
    h. Administrative expense exclusions.

(c) **Denominator**. 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), less the CSoC Wrap-around payment. Premium taxes, HIPF, and the CSoC wrap-around payment 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:

1. Subtract the New Enrollee capitation and expense impact for the current MLR reporting year as defined on page 2 of this guide
2. Add the New Enrollee capitation deferred from the prior MLR reporting year as defined on page 2 of this guide.

Sec. 158.240 Rebating capitation payments if the 85% Medical Loss Ratio standard is not met

(a) **General requirement**. For each MLR reporting year, SMO must provide a rebate to OBH if SMO does not meet or exceed 85 percentage requirements.
(c) **Amount of rebate**. (1) For each MLR reporting year, SMO must rebate to OBH the difference between the total amounts of capitation payments received by SMO from OBH multiplied by the required MLR of 85% and SMO's actual MLR.

(d) **Timing of rebate**. SMO must provide any rebate owing to OBH no later than August 1 following the end of the MLR reporting year.
(e) **Late payment interest**. Should SMO fail to pay any rebate owing to OBH in accordance with paragraph (c) of this section or to take other required action within the time periods set forth in this Part, it must, in addition to providing the required rebate, pay OBH 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.