Financial Reporting Guide – Louisiana Statewide Management Organization

November 2014

V1.0

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Introduction and general instructions

1.01 Introduction

The revised provisions and requirements of this Financial Reporting Guide (Guide) are effective November 1, 2014. The purpose of this Guide is to set forth quarterly and annual reporting requirements for the Statewide Management Organization (SMO) contracted with the State of Louisiana (LA). The Guide instructions and reports are supplementary to any Department of Insurance (DOI) financial reporting requirements. This Guide does not replace any Department of Health and Hospitals (DHH) electronic data submission requirements or quality/compliance-oriented reporting requirements from SMOs.

All reports shall be submitted as outlined in the general and report-specific instructions. The financial reports submitted based on the Guide will be used to monitor the operations of the SMO and as a potential data source in capitation rate setting. Only revenues and expenses related to a direct contract between the State and the SMO should be included in the reports, with the exception of DOI filings and other company-wide financial statement information and audit information required on an annual basis.

All terms and conditions of the LA SMO Contract apply to the Guide. The Guide may be revised as deemed necessary by the State. 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 the State. The Guide is supplemental to any reporting provisions required by DHH, State or federal law, DOI, other state agencies, or the Department of Public Health (DPH).

1.02 Reporting time frames

Amendments and/or updates to this Guide may be issued by the State 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	Balance sheet	Quarterly	60 days after quarter end	Predetermined
B	Income statement	Quarterly	60 days after quarter end	Predetermined
C	Footnote disclosures	Quarterly	60 days after quarter end	Narrative
D1	Medicaid at-risk profitability by eligibility category, quarterly	Quarterly	60 days after quarter end	Predetermined
D2	Medicaid at-risk profitability by eligibility category, year-to-date	Quarterly	60 days after quarter end	Predetermined
E	Non-Medicaid claim payments by eligibility category/ fund source	Quarterly	60 days after quarter end	Predetermined
F1	Inpatient services lag report	Quarterly	60 days after quarter end	Predetermined
F2	HCBS lag report	Quarterly	60 days after quarter end	Predetermined
F3	Other services lag report	Quarterly	60 days after quarter end	Predetermined
F4	Pharmacy lag report	Quarterly	60 days after quarter end	Predetermined
H	Medicaid utilization report	Quarterly	60 days after quarter end	Predetermined
I	Claim processing/ inventory report	Quarterly	60 days after quarter end	Predetermined
J	Third party liability and coordination of benefits report	Quarterly	60 days after quarter end	Predetermined
K	Fraud and abuse report	Quarterly	60 days after quarter end	Predetermined
L	Quarterly Department of Insurance statement filings	Quarterly	60 days after quarter end or upon submission to LA DOI	Embedded PDF
M	Supplemental working area	Quarterly	As needed	Narrative
N	OBH, Non-Medicaid Utilization- Monthly	Monthly	5 days after month end	Predetermined
O	School-Based Services, Non-Medicaid	Quarterly	60 days after quarter end	Predetermined

Schedule	Report name	Frequency	Due date[1]	Format
AA	Parent company audited financial statements	Annually	120 days after year end	Embedded PDF
BB	Statewide Management Organization audited financial statements	Annually	120 days after year end	Embedded PDF
CC	Audited balance sheet reconciliation	Annually	90 (draft) and 120 (final) days after year end	Predetermined
DD	Audited income statement reconciliation	Annually	90 (draft) and 120 (final) days after year end	Predetermined
EE	Audit adjustment entries	Annually	90 (draft) and 120 (final) days after year end	Predetermined
FF	Footnote disclosures	Annually	120 days after year end	Narrative
GG	Annual Department of Insurance statement filings	Annually	120 days after year end or upon submission to LA DOI	Embedded PDF
HH	Medicaid at-risk profitability by eligibility category (incurred basis)	Annually	60 days after year end	Predetermined
II	OBH, Non-Medicaid Utilization-Annual	Annually	60 days after year end	Predetermined
JJ	Medical Loss Ratio (MLR) report		June 1 of the year following the end of an MLR reporting year	Predetermined
KK	Supplemental working area	Annually	As needed	Narrative
Appendix A	Financial disclosure statement	Annually	120 days after year end	Predetermined
Appendix B	Medical Loss Ratio (MLR) guidelines	Annually	June 1 following year end	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 – with the exception of the Department of Insurance statement filings. Specifically, all revenues and expenses must be reported using the accrual basis method of accounting.

All monthly, quarterly, and annual reports must be completed and submitted to the State by the due dates outlined above. The State 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 SMO 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 Income” is reported with a value that is equal to 5% or higher of Total Revenue, disclosure would be necessary. Such disclosure is to be documented on Schedule C or FF – Footnotes, line item 3. Refer to the supplemental working area location if additional space is needed for disclosures.

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

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

Cindy Rives
Louisiana Department of Health and Hospitals
Office of Behavioral Health – Administration
628 North 4th Street
PO Box
Baton Rouge LA 70804

Send electronic copy to at DHH-OBH: cindy.rives@la.gov
Send electronic copy to Stewart Guerin at DOI: sguerin@lsi.state.la.us

1.05 Certification statement

The purpose of the certification statement is to attest that the information submitted in the reports is current, complete and accurate. The statement should include the SMO name, period

ended, preparer information and signatures. The certification statement must be signed by the SMO's CFO or CEO.

1.06 Financial statement check figures and instructions

In addition to the schedules that must be completed by the SMO, the Guide includes a "Financial Statement Instruction and Check Figures Report" worksheet that evaluates the consistency of the values entered by the SMO. 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 SMO must maintain and make available to the State, and others determined necessary by the State, upon request the data used to complete any reports contained within this Guide.

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Quarterly and monthly report specifications

2.01 Schedule A: Balance sheet

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

Specification	Inclusion	Exclusion
Cash and cash equivalents	Cash and cash equivalents available for current use. Cash equivalents are investments maturing 90 days or less from the date of purchase.	Restricted cash (and equivalents) and any investments pledged by the SMO to satisfy minimum net worth requirements.
Short-term investments	Investments that are readily marketable and that are expected to be redeemed or sold within one year of the balance sheet date. Note: Material amounts (greater than 5% of total assets) should be disclosed and fully explained in Schedule C, footnote disclosures.	Investments maturing 90 days or less than one year from the date of purchase and restricted securities. Also exclude investments pledged by the SMO to satisfy statutory deposit requirements, if applicable.
Capitation receivable	Capitation payments earned, but not yet received from the State of Louisiana.	Receivable from State amounts for non-risk payment of claims as described below.
Reinsurance receivable	Accrued reinsurance receivable amounts due to contractual agreements with reinsurance contractors, if applicable.	
Investment income receivable	Income earned, but not yet received, from cash equivalents, investments, performance bonds and short- and long-term investments.	
Current due from affiliates	Current amounts due from parent or subsidiary affiliate entities.	Amounts due to parent or subsidiary affiliate entities.
Risk pool/share receivable	Amounts due from provider organization entities because of a contractual incentive or shared risk relationship with the SMO. Also include “risk share” for 1915i only members.	Risk-pool payable amounts.

Specification	Inclusion	Exclusion
HIPF Receivable from State	Amounts due from the State for the payment of the Health Insurance Provider Fee (HIPF) for which the payment has not been received.	Capitation receivable amounts.
Other current assets	The total current portion of Other Assets, which will include all other assets (e.g., income tax refunds receivable) not accounted for elsewhere on the balance sheet. Any receivables from providers due to overpayments should be accounted for in this line item. See Other Assets, Schedule P, for required detail on this item. In addition, report the current portions of goodwill and other intangible assets here.	

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

Specification	Inclusion	Exclusion
Statutory deposits	Amounts deposited that require the SMO to maintain a minimum level of tangible net equity, if applicable.	Performance Bonds that would not be recognized for GAAP purposes.
Restricted cash and other assets	Cash, securities, receivables, etc. whose use is restricted.	Cash and/or investments pledged by the SMO.
Long-term investments	Investments that are expected to be held longer than one year.	Investments or Statutory deposit requirements to satisfy regulatory requirements.
Non-current due from affiliates	Non-current amounts due from parent or subsidiary affiliate entities.	Amounts due to parent or subsidiary affiliate entities.
Other non-current assets	Include all other non-current assets (e.g., income taxes receivable) not accounted for elsewhere on the balance sheet. Any receivables from providers should be accounted for in this line item. Note: material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.	

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

Specification	Inclusion	Exclusion
Land	Real estate owned by the SMO.	

Specification	Inclusion	Exclusion
Buildings	Buildings owned by the SMO, including buildings under a capital lease and improvements to buildings owned by the SMO.	Improvements made to leased or rented buildings or offices.
Leasehold improvements	Capitalized improvements to facilities not owned by the SMO.	
Furniture and equipment	Medical equipment, office equipment, data processing hardware and software (where permitted) and furniture owned by the SMO, as well as similar assets held under capital leases.	
Other – property and equipment	All other fixed assets not falling under one of the other specific asset categories.	
Accumulated depreciation and amortization	The total of all depreciation and amortization accounts relating to the various fixed asset accounts.	

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

Specification	Inclusion	Exclusion
Accounts payable	Amounts due to creditors for the acquisition of goods and services (provider and administrative vendors) on a credit basis.	
Accrued administrative expenses	Accrued expenses and management fees and any other amounts estimated as of the balance sheet date (i.e., payroll, taxes). Also include accrued interest payable on debts.	
Sub-capitation payable	Net amounts owed to providers for monthly capitation.	Capitation amounts payable to the State as a result of overpayment. (This amount should be reported in the 'Payable to State' line.)
Inpatient services incurred but not reported (IBNR) claims payable	The respective IBNR amounts listed in Schedule F1 – Inpatient services lag report, within the Current Estimate of Remaining Liability (Claims Incurred But Not Reported) column.	
HCBS IBNR claims payable	The respective IBNR amounts listed in Schedule F2 – HCBS lag report, within the Current Estimate of Remaining Liability (Claims Incurred But Not Reported) column.	

Specification	Inclusion	Exclusion
Other services IBNR claims payable	The respective IBNR amounts listed in Schedule F3 – Other services lag report, within the Current Estimate of Remaining Liability (Claims Incurred But Not Reported) column.	
Pharmacy IBNR claims payable	The respective IBNR amounts listed in Schedule F4 – Pharmacy lag report, within the Current Estimate of Remaining Liability (Claims Incurred But Not Reported) column.	
Risk pool and Medical Loss Ratio (MLR) payable	Amounts due to provider organization entities because of a contractual incentive or shared risk relationship with the SMO. Also include MLR rebates payable to the State.	Risk-pool receivable amounts.
Current portion – Long-term debt	The total current portion of long-term debt, which will include the principal amount on loans, notes, and capital lease obligations due within one year of the balance sheet date.	Long-term portion of and accrued interest on loans, notes, and capital lease obligations.
Due to affiliates	Current amounts due to parent or subsidiary affiliate entities.	Amounts due from parent or subsidiary affiliate entities.
HIPF Payable	HIPF due to the Internal Revenue Service (IRS).	
Other current liabilities	The total current portion of other liabilities, which will include those current liabilities not specifically identified elsewhere (i.e., income taxes payable).	

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

Specification	Inclusion	Exclusion
Non-current portion – long-term debt	The total non-current portion of long-term debt, which will include the long-term portion of principal on loans, notes and capital lease obligations.	Current portion of and accrued interest on loans, notes, and capital lease obligations.
Non-current due to affiliates	Non-current amounts due to parent of subsidiary affiliate entities.	Current amounts due to parent or subsidiary affiliate entities.
Other non-current liabilities	The total non-current portion of liabilities not specifically identified elsewhere.	

Equity includes preferred stock, common stock, treasury stock, additional paid-in capital, contributed capital and retained earnings/fund balance.

Specification	Inclusion	Exclusion
Preferred stock	Should equal the par value or, in the case of no-par shares, the stated or liquidation value per share multiplied by the number of issued shares.	
Common stock	Should equal the par value or, in the case of no-par shares, the stated value per share multiplied by the number of issued shares.	
Treasury stock	Include the amount of treasury stock reported using the par value or cost method.	
Additional paid-in capital	Amounts paid and contributed in excess of the par or stated value of shares issued.	
Contributed capital	Include capital donated to the SMO.	
Retained earnings/net assets (liabilities)	Include the undistributed and unappropriated amount of earned surplus. Beginning retained earnings for a new fiscal year should remain constant during the fiscal year.	
Increase (decrease) YTD	The change in income or loss from the retained earnings for the beginning of the fiscal year.	

2.02 Schedule B: Income Statement

The SMO shall report revenues and expenses using the full accrual method. The Income Statement (Schedule A), must agree to the Total Profitability Report (Schedule C) for the quarterly reporting period.

Specification	Inclusion	Exclusion
Member months	A member month is equivalent to one member for whom the SMO has received and/or accrued capitation-based revenue for the entire month.	Non-Medicaid payments for administrative services.
Capitated revenue	Revenue received and/or accrued on a prepaid basis for the provision of administrative and covered medical services.	
Other administrative revenue	Revenue received and/or accrued based upon a percentage of medical services paid and approved by a State agency, upon a 1/12 distribution to the SMO from a State agency or for any other non-risk member provided within the terms of the Contract.	
Investment income	All investment income earned during the period net of interest expense.	

Specification	Inclusion	Exclusion
Other income	Revenue from sources not identified in the other revenue categories. Note: Material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.	
Prior year HIPF settlement	Revenue received to cover HIPF expenses for the prior year.	

Medical expenses and recoveries – All medical expenses must be reported net of third party reimbursement and coordination of benefits (e.g., Medicare and other commercial insurance) and in correspondence to the identified categories of service in Schedule B. Expenses should be reported as paid and incurred for each line item to include IBNR estimates.

Specification	Identification
Inpatient Psych Facilities	Provider Type 64 or 69 - Freestanding or Distinct Part Psych - Revenue Codes 0100-0214 and Place of Service 21 or 51; OR Professional Claims with Provider Specialty 26 or 27 and POS 21 or 51
Addiction Services – Residential Facility	H0010, H0011, H0012, H0019, H2034, H2036
Addiction Services - Outpatient	H0001, H0004, H0005 and H0015
Crisis Intervention and Non CSoC Crisis Stabilization	90839, 90840, S9485 and H2011
Psychosocial Rehabilitation	H2017
Community Psychiatric Support and Treatment	H0036
Multi-Systemic Treatment (MST) (Children Only)	H2033 (Children only)
Assertive Community Treatment	H0039, H0040
Crisis Stabilization	H0045, Modifier HA (Children Only)
Respite	S5150 or PT 83, (CSoC children only)
Parent Support and Training	S5110 (CSoC children only)
Youth Support and Training	H0038 (CSoC children only)
Independent Living Skills	H2014 (CSoC children only)
Licensed Professional Counselor	PT-AK
Licensed Clinical Social Worker	PT 73
Psychologist	PT 31
Licensed Marriage and Family Therapist	PT-AH
Physician/Professionals (MD, DO, Med PHD, APRN, PA)	Provider Types 19, 20, 78, 93, 94 with Provider Specialty 26, 27.
Outpatient Hospital - Psychiatric Services, including ER	Provider Type 64 or 69 Place of Service not in 21 or 51 OR Professional Claims with Provider Specialty 26, 27 with Place of Service not in 21 or 51 and Revenue Codes in 0510, 0905, 0906, 0912, 0914, 0915, 0916, 450, 459, or 981.

Specification	Identification
FQHC Services	Procedure Code T1015 or Provider Type 72 with any BH specialist servicing provider from a designated Federally Qualified Health Center
RHC Services	Procedure Code T1015 or Provider Type 79 with any BH specialist servicing provider from a designated Rural Health Center
Psychiatric Residential Treatment Facility (PRTF)	H2013 and PT-96 (Children only)
Therapeutic Group Home (TGH)	H0018 (Children only)
1915(b)(3) Services - Case Conference	99367 and 99368
Other Non-defined Services (describe)	Provide detail of reported services that are not otherwise captured above
Pharmacy	Any drugs prescribed by Provider Types 19, 20, 33, 56, 78, 93 with Provider Specialty 26, 27 or Provider Type 31 any specialty.

Reinsurance and recoveries should be input as adjustments to calculate the net medical costs of the SMO. The categories and descriptions for reinsurance and recoveries are listed in the table below.

Specification	Inclusion	Exclusion
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.	
Third party liability and coordination of benefits recoveries	Cost recoveries subsequent to the payment of a claim that has not been adjusted to the original claim for recoveries associated with third-party resources.	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 SMO as a result of State, SMO 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. The administrative expenses that improve health care quality for the at-risk population will be identified and reported for the MLR requirements in Schedule HH. This schedule should report all administrative expenses and should use the following guidance for reporting administrative activities.

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 reduce 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.
  - 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, 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 paragraph (c) of this section, unless otherwise approved by and within the discretion of DHH, upon adequate showing by the SMO 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.	
General and operational management	General and Operational Management – Senior operational management and general administrative support (e.g., administrative assistants, public relations [to the extent that it does not relate to marketing or member/enrollment services as described below], receptionist, etc.).	
Accounting and finance	Accounting and finance expenditures.	
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.	
CSoC wraparound payments	Wraparound payments made to providers for facilitation of the CSoC program.	
Administrative services only (ASO) cost	Vendor-related expenditures for the processing of provider payments.	

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

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

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

Allocation of expenses

General Requirements

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

- Allocation to each category should be based on a generally accepted allocation 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 SMO 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.

2.03 Schedule C: 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 all-inclusive of explanations that may be useful to the State. On a quarterly basis, only include narrative and applicable supporting schedules for material changes to items described in the following table:

	Footnote disclosure requirements	Indicate as N/A if no reportable items
1	Organizational structure	
2	Summary of significant accounting policies changes	
3	Other amounts included in the financial statements > 5% of the reporting category	
4	Pledges, assignments and guarantees	
5	Statutory deposits or performance bonds	
6	Material adjustments	
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	
11	Equity 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	Significant changes in provider reimbursement methodologies	
16	Changes to reinsurance or stop loss agreements	

	Footnote disclosure requirements	Indicate as N/A if no reportable items
17	Non-operating income/loss amounts	
18	Other Recovery amounts reported on line 52	
19	Claims payment fluctuations reported in the lag reports, schedules F	
20	Unpaid claim adjustment expenses and methodology	
21	Premium deficiency reserves and methodology	
22	Allocation methodologies used for categorical profitability statements	
23	All in-kind contributions included or not included in an income or expense line item within the financial reports. If included, provide the line item containing the in-kind contribution and the dollar amount(s) reported	

2.04 Schedules D1 & D2: Medicaid Profitability by Eligibility Category

Schedules D1 and D2 report the results of operations by Medicaid eligibility category. The table below lists the population groups and associated data elements that help define each group for reporting purposes.

Use a hierarchical approach to determine eligibility. First, identify members with 1915(i) eligibility. From remaining members, classify as Medicaid recipients next, then, lastly, as dual eligible. All members should be classified into one category only. No members should be unclassified.

Description	Aid Category	Type Case Codes
Adults Non-disabled, Ages 21+	01	001, 003, 005, 018, 019, 023, 024, 043, 050, 056, 059, 070, 078, 079, 080, 081, 083, 086, 090, 117, 118, 119, 120, 121, 122, 130, 131, 149, 150, 153, 154, 211
	03	001, 008, 013, 052, 053, 086, 104,127, 210
	13	001, 009, 071, 085
	16	001, 052, 210
Adults Disabled, Ages 21+	02	001, 003, 005, 018, 019, 023, 024, 043, 050, 056, 057, 059, 060, 061, 070, 078, 079, 080, 081, 082, 083, 086, 088, 090, 117, 118, 119, 120, 121, 122, 130, 131, 149, 150, 153, 154, 211
	03	090
	04	001, 003, 005, 018, 019, 023, 024, 043, 050, 056, 057, 059, 060, 061, 070, 078, 079, 080, 081, 082, 083, 086, 088, 090, 117, 118, 119, 120, 121, 122, 130, 131, 149, 150, 153, 154, 211
1915(i) Adult Non-Disabled	One of the above Non-Disabled AC	Waiver Segment 201 or 203

Description	Aid Category	Type Case Codes
1915(i) Adult Disabled	One of the above Disabled AC	Waiver Segment 201 or 203
1915(i) only, Adult Ages 19 +	ALL	201 or 205
Child Non-Disabled, Ages 0-20	03	001, 002, 007, 008, 013-015, 052, 053, 055, 086, 090, 093, 099, 104, 127, 134, 148, 151, 210
	13	001, 009, 071, 085
	16	001, 014, 052, 055, 210
Child, Foster Care and/or Disabled, Ages 0-20	02	001, 003, 005, 018, 019, 023, 024, 043, 050, 057, 058, 059, 060-062, 064, 065, 070, 076, 077, 078, 081, 083, 086, 088, 090, 099, 117, 118, 119, 120, 130-132, 136-145, 149, 150
	04	001, 003, 005, 018, 019, 023, 024 043, 050, 057-062, 064, 065, 070, 076-078, 081, 083, 086, 088, 090, 099, 117, 118, 119, 120, 125, 130-133, 136-145, 149, 150, 211
	06	005, 007, 013, 014, 030, 034, 043, 053, 062, 064, 065, 070, 076-078, 081, 090, 099, 119, 120, 149, 150
	08	005, 031, 043, 062, 064, 065, 070, 076-078, 081, 086, 090, 099, 119, 120, 149, 150
	22	005, 007, 013, 014, 033, 035, 043, 053, 062, 064, 065, 070, 076-078, 081, 086, 090, 099, 119, 120, 149, 150
Child MCHIP	All	007, 015, 055
Child SCHIP	All	127, 134
1915(b)3 Child CSoC, Ages 0-21	One of the above AC/TC	Waiver Segment 202
1915(c) Child CSoC Ages 0-21	One of the above type cases	Waiver Segment 200
1915(c) Child CSoC Ages 0-21 (.217)	40	200
Dual Eligible Adults, Non-Disabled (Recipients with Medicare as Primary in addition to full Medicaid coverage) 21+	One of the above Non-Disabled AC	One of the above TC, and *Dual Status Code 02, 04 or 08
Dual Eligible Adults, Disabled 21+	One of the above Disabled AC	One of the above TC, and *Dual Status Code 02, 04 or 08

Description	Aid Category	Type Case Codes
Dual Eligible Children, Disabled 0-20	One of the above Disabled AC	One of the above TC, and *Dual Status Code 02, 04 or 08

*The identifying indicator for Dual Eligibles may be revised prior to Program Implementation, and this document will be revised as needed.

For dual eligible members with Medicare as their primary coverage, only specific HCPC codes considered non-Medicare covered services should be included and covered by the SMO. Those HCPC codes are listed in Appendix D.

2.05 Schedule E: Non-Medicaid Claim Payments

This schedule provides claim payments for the non-risk populations for the Department of Children & Family Services (DCFS) and Office of Juvenile Justice (OJJ) by eligibility category/fund source. This schedule should contain actual claim payments only and SHOULD NOT contain any estimation for incurred but not reported claims. Utilize definitions for the medical expense categories from Schedule D1 (Total Profitability).

The non-Medicaid membership categories are identified through the following methods:

Population category	Aid Category	Other Identification Method
DCFS Only All ages	NA	As identified by responsible Agency
Child OJJ Only 0-18	NA	As identified by responsible Agency

The definitions associated with the specific revenue and administrative expense lines detailed in Schedule D (Total Profitability) are applicable for this schedule as well.

2.06 Schedules F1 thru F4: Lag reports

Schedules F and G request the same type of information, but for different consolidated services categories (inpatient services and other services). 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 and coordination of benefits. 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 – **Sub capitation and other non-claim payments**: Global/sub capitation payments should be reported on this line, by month of payment, and should not be included in any lines above line 39. Also include other payment for medical expenses not paid through the claims system, for example, ACT payments. **For all amounts reported on line 39, include a footnote explanation**. Global/Sub capitation payments include:

- Global Capitation payments: Payments made to fully-delegated risk entities contracted with the SMO. These types of payments are expected to be broken out between the hospitalization, outpatient facility, physician services, and other medical service lag reports.
- Sub capitation 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 40 – **Settlements**: The SMO should report payments/recoupments on lines 1 through 37 to the extent possible. If the SMO 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 SMO may use an alternative method of reporting settlements that restates prior period amounts to reflect an actual settlement for that month. **For all amounts reported on line 40, include a footnote explanation**. Do not include adjustments to IBNR amounts on this line.

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

For schedule F4 (Pharmacy Lag), line 40 is designated for pharmacy rebates. The rebates listed should be accrued to match the expenses reported in line 39 of schedule B (Income Statement).

Line 41 – This line is the total amount paid to date (including sub capitation) 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 SMO 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). This line will calculate automatically.

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 are sub capitation and adjustments.

Do not include risk pool distributions as payments in the lag schedules.

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

2.07 Schedule H: Medicaid At-risk Utilization report

The SMO shall submit a summary of utilization and unit cost information during the current quarter. Data is reported on claims paid during the quarter and is not restated. Input areas are highlighted in red where data should be entered, including the quarterly member months. Members Serviced, days, visits, and quantities should be reported on a paid basis for the quarter being reported. Utilize category of service definitions consistent with Schedule D (Total Profitability).

Service measure	Measure	Type of utilization/ proxy	Definitions
Residential/Inpatient 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 discharge that occurred in the period and resulted in a paid claim. If the admission and discharge do not occur in the same period, all days are counted as occurring in the period in which the discharge occurs. Include data for which the SMO is both the primary payer and the secondary payer.
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. Include data for which the SMO is both the primary payer and the secondary payer.

2.08 Schedule I: Claim Processing/Inventory Report

The four sections of this report provide information on claims received during the reporting period, including outstanding claims at the end of a reporting period and the total claims processed during the reporting period. The top two sections are to account for all of the claims

received and processed during the current month, prior month, and second prior month. The top section is for claim counts. The second section is to account for actual dollars paid or payable on accepted claims, or the billed amount on pended or denied claims.

The third section is to account for remaining inventory of claims. The claim inventory counts are to be reported by the appropriate expense (i.e., inpatient, HCBS, other, and pharmacy) and aging (i.e., 1-30 days, 31-60 days, 61-90 days, 91-120 days and greater than 120 days). Note the aging of a claim starts the day it is received by the SMO. The SMO is encouraged to run reports close to reporting deadline to determine a more accurate estimate of outstanding and adjudicated claims that were in process as of the reporting period. If more information is needed to process a claim, the aging should re-start on the day additional information is received. In addition, include a count of total claims adjudicated during the reporting period by appropriate expense category.

For claims greater than 60 days old, please provide the top ten reasons for the delay, based on billed amount.

2.09 Schedule J: Third Party Liability and Coordination of Benefits Report

List all third party liability (TPL) resource payments made for members with active commercial or Medicare coverage on the date of claim service during the quarter. Provide the count of claims, count of claims cost avoided, amount billed, amount paid, and the total resource payments paid by other insurance for commercial and Medicare recipients. All claim counts and amounts should be reflected even if no coordination of benefits took place when adjudicating the claim. Claims cost avoided are those denied in the period for lack of evidence of coordination of benefits by the provider for a member with a known TPL resource on the date of service. For claims cost avoided, the amount billed should be reported. For claims that are adjusted in the period or for prior periods in the reporting quarter, each re-adjudication should be counted along with amounts reported. Report the count of members with active TPL resources at the end of the quarter on lines 9 and 10. Do not include counts or amounts for members where TPL subrogation is being pursued.

2.10 Schedule K: Fraud and Abuse Report

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

2.11 Schedule L: Quarterly Department of Insurance Statement Filings

Insert the Quarterly DOI Statement Filings within this tab; preferably, this can be accomplished by embedding the statement in PDF format.

2.12 Schedule M: Supplemental Working Area

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

2.13 Schedule N OBH Monthly Utilization Report

This report should be completed on a **MONTHLY basis** and must be submitted by the fifth day of the month following the end of the reporting month. Please use categories of service definitions determined in Schedule D (Total Profitability) and Schedule D2 (Non-Risk Profitability by Eligibility Category/Fund Source) for completion of this schedule. The utilization measures should only include the current month being reported. Annual utilization measurements are reported in schedule II: OBH Annual.

A separate schedule is completed for OBH (N), and School-based services (O), described below. Report total utilization measures with the guidelines from the following table for both reports.

Service measure	Measure	Type of utilization/ proxy	Definitions
Inpatient or Residential services	Admits	Quantity/count	Admits are calculated by counting the number of formal admissions to the hospital or treatment facility.
Inpatient or Residential 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 SMO is both the primary payer and the secondary payer.
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. Include data for which the SMO is both the primary payer and the secondary payer.

Region definitions for schedule N1 are defined in the following table:

DHH Region	Local Governing Entity (LGE)	Acronym	Parishes within LGE
1	Metropolitan Human Services District	MHSD	Orleans, St. Bernard and Plaquemines
2	Capital Area Human Services District	CAHSD	Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge and West Feliciana
3	South Central Louisiana Human Services Authority	SCLHSA	Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne
4	Acadiana Human Services District	AAHSD	Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin and Vermilion
5	Imperial Calcasieu Human Services Authority	ImCal	Allen, Beauregard, Calcasieu, Jefferson Davis and Cameron
6	Central Louisiana Human Services District	CLSHD	Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon and Winn
7	Northwest Louisiana Human Services District	NLHSD	Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine and Webster
8	Northeast Delta Human Services Authority	NEDHSA	Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union and West Carroll
9	Florida Parishes Human Services Authority	FPHSA	Livingston, St. Helena, St. Tammany, Tangipahoa and Washington
10	Jefferson Parish Human Services Authority	JPHSA	Jefferson

2.14 Schedule O School Based Services Monthly Report

This report should be completed on a **Quarterly basis** and must be submitted by the fifth day of the month following the end of the reporting month. Please use categories of service definitions determined in Schedule D (Total Profitability) and Schedule D2 (Non-Risk Profitability by Eligibility Category/Fund Source) for completion of this schedule.

Report total utilization measures with the guidelines from the table provided in section 2.13.

3

Annual audit reporting requirements

3.01 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 Form 10-K and SSAE-16 reports in PDF format.

3.02 Schedule BB: SMO Audited Financial Statements

Insert the draft agreed upon procedures report, including final management letter and report of internal controls, within this tab within 90 days after year end. Insert the final agreed upon procedures 120 days after year end. Preferably, this can be accomplished by embedding the final audited financial statements in PDF format.

3.03 Schedule CC: Audited Balance Sheet Reconciliation

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

3.04 Schedule DD: Audited Income Statement Reconciliation

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

3.05 Schedule EE: Audit Adjustment Entries

This schedule should list annual audit adjustment entries, if applicable, with an explanation of each entry.

3.06 Schedule FF: Annual 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 all-inclusive of explanations that may be useful to the State. Include narrative and applicable supporting schedules for material changes to items described in the following table:

	Footnote disclosure requirements	Indicate as N/A if no reportable items
1	Organizational structure	
2	Summary of significant accounting policies changes	
3	Other amounts included in the financial statements > 5% of the reporting category	
4	Pledges, assignments and guarantees	
5	Statutory deposits or performance bonds	
6	Material adjustments	
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	
11	Equity 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	Significant changes in provider reimbursement methodologies	
16	Changes to reinsurance or stop loss agreements	
17	Non-operating income/loss amounts	
18	Other Recovery amounts reported on line 52	
19	Claims payment fluctuations reported in the lag reports, schedules F	
20	Unpaid claim adjustment expenses and methodology	
21	Premium deficiency reserves and methodology	
22	Allocation methodologies used for categorical profitability statements	
23	All in-kind contributions included or not included in an income or expense line item within the financial reports. If included, provide the line item containing the in-kind contribution and the dollar amount(s) reported	

3.07 Schedule GG: Annual Department of Insurance Statement Filings

Insert the Annual DOI Statement Filings within this tab; preferably, this can be accomplished by embedding the statement in PDF format.

3.08 Schedule HH: Profitability by Eligibility Category (Incurred)

Complete the schedule using instructions from schedules D1 & D2, but on an incurred basis. Expenses should reasonably tie to the lag tables by incurred date.

3.09 Schedule II: OBH Year to Date

Complete the schedule using instructions from schedule N, but on an annual basis.

3.10 Schedule JJ: Medical Loss Rebate (MLR) calculation

This schedule provides the calculations necessary at year end to determine any rebates payable to the State based on adjusted adjustments to revenue and expenses as defined in Appendix B of this Guide. The schedule should only be completed after the audit has been finalized. Capitation revenue and medical expenses are inputted from Schedule DD – Audited Income Statement Reconciliation report.

3.11 Schedule KK: Supplemental Working Area

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

Appendix A

Annual financial statement disclosures and supplemental information requests

Appendix A is a separate word document of financial disclosure requirements and information requests that must be reported by the SMO at year end. The schedule is in three sections and includes financial disclosures, related party transactions and supplemental information requests. This information may be inserted in Schedule II (Supplemental Working Area) or a clearly labeled separate attachment.

Appendix B

Louisiana SMO Medical Loss Ratio (MLR) Rebate Calculation

Appendix B includes the instructions and guidance for calculating any rebate amounts due to the State. Requirements for calculating any rebate amounts that may be due the State in the event the SMO does not meet the 85% MLR standard are described in this appendix.

Appendix C

Provider Type and Provider Specialty Code Reference

Louisiana Medicaid Provider Type Codes

Provider Type Code	Description
01	Fiscal Agent - Waiver
02	Transitional Support - Waiver
03	Children's Choice - Waiver (in-state only)
04	Pediatric Day Health Care (PDHC) facility
05	CCN-P Organization (Coordinated Care Network, Pre-Paid)
06	NOW Professional (Registered Dietician, Psychologist, Social Worker)
07	Case Mgmt. - Infants & Toddlers (in-state only)
08	OAAS Case Management
09	Hospice Services (in-state only)
10	Comprehensive Community Support Services
11	Shared Living - Waiver (in-state only)
12	Multi-Systemic Therapy (in-state only)
13	Pre-Vocational Habilitation (in-state only)
14	Adult Day Habilitation - Waiver (in-state only)
15	Environmental Accessibility Adaptation - Waiver (in-state only)
16	Personal Emergency Response Systems - Waiver
17	Assistive Devices - Waiver
18	Community Mental Health Center/Magellan Registration
19	Doctor of Osteopathic Medicine (DO) and Doctors of Osteopathic Medicine(DO) Group
20	Physician (MD) and Physician (MD) Group
21	Third Party Submitter
22	Waiver Personal Care Attendant
23	Independent Lab
24	Personal Care Services (LTC/PCS/PAS) (in-state only)
25	Mobile X-Ray/Radiation Therapy Center
26	Pharmacy (out-of-state for crossovers only)
27	Dentist and Dental Group

Provider Type Code	Description
28	Optometrist and Optometrist Group
29	EarlySteps and EarlySteps Group (in-state only)
30	Chiropractor and Chiropractor Group
31	Medical or Licensed Psychologist
32	Podiatrist and Podiatrist Group
33	Prescribing Only Provider
34	Audiologist
35	Physical Therapist
36	Not assigned
37	Occupational Therapist
38	School-Based Health Center (in-state only)
39	Speech/Language Therapist
40	DME Provider (out-of-state for crossovers only)
41	Registered Dietician
42	Non-Emergency Medical Transportation (in-state only)
43	Case Mgmt. - Nurse Home Visit - 1st Time Mother (in-state only)
44	Home Health Agency (in-state only)
45	Case Mgmt. - Contractor (in-state only)
46	Case Mgmt. - HIV (in-state only)
47	Case Mgmt. - CMI
48	Case Mgmt. - Pregnant Woman
49	Case Mgmt. - DD
50	PACE Provider
51	Ambulance Transportation
52	CCN-S Organization (Coordinated Care Network, Shared Savings)
53	Self-Directed/Direct Support
54	Ambulatory Surgical Center (in-state only)
55	Emergency Access Hospital
56	Prescriber Only for MCO’s
57	OPH RN
58	Not in Use: to-be used for LPN
59	Neurological Rehabilitation Unit (Hops)
60	Hospital
61	Venereal Disease Clinic
62	Tuberculosis Clinic
63	Tuberculosis Inpatient Hospital
64	Mental Health Hospital (Free-Standing)
65	Rehabilitation Center (in-state only)
66	KIDMED Screening Clinic (in-state only)

Provider Type Code	Description
67	Prenatal Health Care Clinic
68	Substance Abuse and Alcohol Abuse Center
69	Hospital - Distinct Part Psychiatric Unit (in-state only)
70	EPSDT Health Services (in-state only)
71	Family Planning Clinic
72	Federally Qualified Health Center (in-state only)
73	Licensed Clinical Social Worker (LCSW)
74	Mental Health Clinic
75	Optical Supplier (in-state only)
76	Hemodialysis Center (in-state only)
77	Mental Health Rehabilitation (in-state only)
78	Nurse Practitioner and Nurse Practitioner Group
79	Rural Health Clinic (Provider Based) (in-state only)
80	Nursing Facility (in-state only)
81	Case Mgmt. - Ventilator Assisted Care Program
82	Personal Care Attendant - Waiver (in-state only)
83	Respite Care (Center Based)- Waiver (in-state only)
84	Substitute Family Care - Waiver (in-state only)
85	ADHC Home and Community Based Services - Waiver (in-state only)
86	ICF/DD Rehabilitation
87	Rural Health Clinic (Independent) (in-state only)
88	ICF/DD - Group Home (in-state only)
89	Supervised Independent Living - Waiver (in-state only)
90	Nurse-Midwife
91	CRNA or CRNA Group
92	Private Duty Nurse
93	Clinical Nurse Specialist
94	Physician Assistant
95	American Indian / Native Alaskan "638" Facilities
96	Psychiatric Residential Treatment Facility
97	Adult Residential Care
98	Supported Employment
99	Greater New Orleans Community Health Connection (in-state only)
AA	Assertive Community Treatment Team (ACT)
AB	Prepaid Inpatient Health Plan (PIHP)
AC	Family Support Organization
AD	Transition Coordination (Skills Building)
AE	Respite Care Service Agency
AF	Crisis Receiving Center

Provider Type Code	Description
AG	Behavioral Health Rehabilitation Provider Agency
AH	Licensed Marriage & Family Therapist (LMFT)
AJ	Licensed Addiction Counselors (LAC)
AK	Licensed Professional Counselors (LPC)
AL	Community Choices Waiver Nursing
AM	Home Delivered Meals
AN	Caregiver Temporary Support
AQ	Non-Medical Group Home (NMGH)
AR	Therapeutic Foster Care (TFC) Caregiver Temporary Support
AS	OPH Clinic
AU	OPH Registered Dietitian
AV	Extended Duty Dental Assistant
AW	Permanent Supportive Housing Agency
AX	Certified Behavior Analyst
BI	Behavior Intervention
IP	EHR Incentive Program
MI	Monitored In-Home Caregiving (MIHC)
SP	Super Provider/Organized Health Care Delivery System
XX	Error Provider

Louisiana Medicaid Provider Specialty Codes

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty	Related Provider Types
00	All Specialties	1		n/a
01	General Practice	1		19,20
02	General Surgery	1		19, 20, 93
03	Allergy	1		19,20
04	Otology, Laryngology, Rhinology	1		19,20
05	Anesthesiology	1		19, 20, 91
06	Cardiovascular Disease	1		19,20
07	Dermatology	1		19,20
08	Family Practice	1		19, 20, 78
09	Gynecology (DO only)	1		19
10	Gastroenterology	1		19,20
11	Not in Use	n/a		n/a
12	Manipulative Therapy (DO only)	1		19
13	Neurology	1		19,20
14	Neurological Surgery	1		19,20
15	Obstetrics (DO only)	1		19
16	OB/GYN	1		19, 20, 78, 90
17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	1		19
18	Ophthalmology	1		20
19	Orthodontist	1		19,20
20	Orthopedic Surgery	1		19,20
21	Pathologic Anatomy; Clinical Pathology (DO only)	1		19
22	Pathology	1		20
23	Peripheral Vascular Disease or Surgery (DO only)	1		19
24	Plastic Surgery	1		19,20
25	Physical Medicine Rehabilitation	1		19,20
26	Psychiatry	1		19, 20, 93
27	Psychiatry; Neurology (DO only)	1		19
28	Proctology	1		19,20
29	Pulmonary Diseases	1		19,20
30	Radiology	1		19,20
31	Roentgenology, Radiology (DO only)	1		19
32	Radiation Therapy (DO only)	1		19
33	Thoracic Surgery	1		19,20
34	Urology	1		19,20

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty	Related Provider Types
35	Chiropractor	1		30,35
36	Pre-Vocational Habilitation	1		13
37	Pediatrics	1		19, 20, 78
38	Geriatrics	1		19,20
39	Nephrology	1		19,20
40	Hand Surgery	1		19,20
41	Internal Medicine	1		19,20
42	Federally Qualified Health Centers	1		72
43	Not in Use	n/a		n/a
44	Public Health/EPSDT	1		66,70
45	NEMT - Non-profit	1		42
46	NEMT - Profit	1		42
47	NEMT - F+F	1		42
48	Podiatry - Surgical Chiropody	1		20, 32
49	Miscellaneous (Admin. Medicine)	1		20
50	Day Habilitation	1		14
51	Med Supply / Certified Orthotist	1		40
52	Med Supply / Certified Prosthetist	1		40
53	Direct Care Worker	1		40
54	Med Supply / Not Included in 51, 52, 53	1		40
55	Indiv Certified Orthotist	1		40
56	Indiv Certified Prosthetist	1		40
57	Indiv Certified Prosthetist - Orthotist	1		40
58	Indiv Not Included in 55, 56, 57	1		40
59	Ambulance Service Supplier, Private	1		51
60	Public Health or Welfare Agencies & Clinics	1		61, 62, 66, 67
61	Voluntary Health or Charitable Agencies	1		unknown
62	Psychologist Crossovers only	1		29, 31
63	Portable X-Ray Supplier (Billing Independently)	1		25
64	Audiologist (Billing Independently)	1		29,34
65	Indiv Physical Therapist	1		29,35
66	Dentist, DDS, DMS	1		27
67	Oral Surgeon - Dental	1		27
68	Pedodontist	1		27
69	Independent Laboratory (Billing Independently)	1		23

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty	Related Provider Types
70	Clinic or Other Group Practice	1		19, 20, 68, 74, 76, 91
71	Speech Therapy	1		29
72	Diagnostic Laboratory	1		23
73	Social Worker Enrollment	1		73
74	Occupational Therapy	1		29,37
75	Other Medical Care	1		65
76	Adult Day Care	1		85
77	Habilitation	1		85
78	Mental Health Rehab	1		77
79	Nurse Practitioner	1		78
80	Environmental Accessibility Adaptations	1		15
81	Case Management	1		07, 08, 43, 46, 81
82	Personal Care Attendant	1		82
83	Respite Care	1		83
84	Substitute Family Care	1		84
85	Extended Care Hospital	1		60
86	Hospitals and Nursing Homes	1		55, 59, 60, 64, 69, 80, 88
87	All Other	1		26,40,44, 60
88	Optician / Optometrist	1		28,75
89	Supervised Independent Living	1		89
90	Personal Emergency Response Sys (Waiver)	1		16
91	Assistive Devices	1		17
92	Prescribing Only Providers/Providers Not Authorized to Bill Medicaid	1		33
93	Hospice Service for Dual Elig.	1		09
94	Rural Health Clinic	1		79,87
95	Psychologist (PBS Program Only)	1		31
96	Psychologist (PBS Program and X-Overs)	1		31
97	Family Planning Clinic	1		71
98	Supported Employment	1		98
99	Provider Pending Enrollment	1		n/a
1A	Adolescent Medicine	2	37	19,20
1B	Diagnostic Lab Immunology	2	37	19,20
1C	Neonatal Perinatal Medicine	2	37	19,20
1D	Pediatric Cardiology	2	37	19,20
1E	Pediatric Critical Care Medicine	2	37	19,20

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty	Related Provider Types
1F	Pediatric Emergency Medicine	2	37	19,20
1G	Pediatric Endocrinology	2	37	19,20
1H	Pediatric Gastroenterology	2	37	19,20
1I	Pediatric Hematology - Oncology	2	37	19,20
1J	Pediatric Infectious Disease	2	37	19,20
1K	Pediatric Nephrology	2	37	19,20
1L	Pediatric Pulmonology	2	37	19,20
1M	Pediatric Rheumatology	2	37	19,20
1N	Pediatric Sports Medicine	2	37	19,20
1P	Pediatric Surgery	2	37	19,20
1Q	Pediatric Neurology	2	37	19,20
1R	Pediatric Genetics	2	37	19,20
1S	BRG - Med School	2		19,20
1T	Emergency Medicine	1		19,20
1U	Pediatric Developmental Behavioral Health	2	37	19,20
1Z	Pediatric Day Health Care	1		04
2A	Cardiac Electrophysiology	2	41	19,20
2B	Cardiovascular Disease	2	41	19,20
2C	Critical Care Medicine	2	41	19,20
2D	Diagnostic Laboratory Immunology	2	41	19,20
2E	Endocrinology & Metabolism	2	41	19,20
2F	Gastroenterology	2	41	19,20
2G	Geriatric Medicine	2	41	19,20
2H	Hematology	2	41	19,20
2I	Infectious Disease	2	41	19,20
2J	Medical Oncology	2	41	19,20
2K	Nephrology	2	41	19,20
2L	Pulmonary Disease	2	41	19,20
2M	Rheumatology	2	41	19,20
2N	Surgery - Critical Care	2	41	19,20
2P	Surgery - General Vascular	2	41	19,20
2Q	Nuclear Medicine	1		19,20
2R	Physician Assistant	1		94
2S	LSU Medical Center New Orleans	2		19,20
2T	American Indian / Native Alaskan	2		95
2Y	OPH Genetic Disease Program	1		40
3A	Critical Care Medicine	2	16	19,20
3B	Gynecologic Oncology	2	16	19,20

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty	Related Provider Types
3C	Maternal & Fetal Medicine	2	16	19,20
3D	Community Choices Waiver - Respiratory Therapy	2	87, 75	44, 65
3E	Community Choices Waiver - PT and OT	2	87, 75	44, 66
3F	Community Choices Waiver - PT and S/L T	2	87, 75	44, 67
3G	Community Choices Waiver - PT and RT	2	87, 75	44, 68
3H	Community Choices Waiver - OT and S/L T	2	87, 75	44, 69
3J	Community Choices Waiver - OT and RT	2	87, 75	44, 70
3K	Community Choices Waiver - S/L T and RT	2	87, 75	44, 71
3L	Community Choices Waiver - PT, OT & S/L T	2	87, 75	44, 72
3M	Community Choices Waiver - PT, OT & RT	2	87, 75	44, 73
3N	Community Choices Waiver - PT, S/L T & RT	2	87, 75	44, 74
3P	Organized Health Care Delivery System (OHCDS)	1		
3Q	Community Choices Waiver - OT, S/L T & RT	2	87, 75	44, 75
3R	Community Choices Waiver - All Skilled Maintenance Therapies (PT, OT, S/L T, RT)	2	87, 75	44, 76
3S	LSU Medical Center Shreveport	2		19,20
3U	Community Choices Waiver – Assistive Devices – Home Health	2		
3W	Supportive Housing Agency	1		AW
3X	Extended Duty Dental Assistant	1		AV
4A	Home and Community-Based Services	1		01,02
4B	NOW RN	1		06
4C	NOW LPN	1		06
4D	NOW Psychologist	1		06
4E	NOW Social Worker	1		06
4G	New, Provider Domain	1		
4H	Conversion, Participant Domain	1		
4J	Conversion, Provider Domain	1		
4K	Home and Community-Based Services (HCBS)	1		
4L	New, Participant Domain	1		
4M	EHR Managed Care (Behavior Health)	2		IP
4P	OAAS	1		
4R	Registered Dietician	1		41
4S	Ochsner Med School	2		19,20

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty	Related Provider Types
4U	OPH Registered Dietitian	1		AU
4W	Waiver Services	1		42
4X	Waiver-Only Transportation	1		42
4Y	EHR Managed Care (Medical)	2		IP
5A	PCS-LTC	1		24
5B	PCS-EPSDT	1		24
5C	PAS	1		24
5D	PCS-LTC, PCS-EPSDT	1		24
5E	PCS-LTC, PAS	1		24
5F	PCS-EPSDT, PAS	1		24
5G	OCS-LTC, PCS-EPSDT, PAS	1		24
5H	Community Mental Health Center			18
5I	Statewide Management Organization (SMO)	1		AB
5J	Youth Support	1		AC
5K	Family Support	1		AC
5L	Both Youth and Family Support	1		AC
5M	Multi-Systemic Therapy			12
5N	Substance Abuse and Alcohol Abuse Center	1		68
5P	PACE	1		50
5Q	CCN-P (Coordinated Care Network, Pre-paid)	1		05
5R	CCN-S (Coordinated Care Network, Shared Savings)	1		52
5S	Tulane Med School	2		19,20
5T	Community Choices Waiver (CCW)	1		
5U	Individual	1		AD
5V	Agency/Business	1		AD
5W	Community Choices Waiver - Personal Assistance Service	2	87	44
5X	Therapeutic Group Homes	1		
5Y	PRCS Addiction Disorder	1		
5Z	Therapeutic Group Home Disorder	1		
6A	Psychologist -Clinical	1		31
6B	Psychologist-Counseling	1		31
6C	Psychologist - School	1		31
6D	Psychologist - Developmental	1		31
6E	Psychologist - Non-Declared	1		31
6F	Psychologist - All Other	1		31

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty	Related Provider Types
6H	LaPOP	1		01
6N	Endodontist	1		27
6P	Periodontist	1		27
6S	E Jefferson Fam Practice Ctr - Residency Program	2		19,20
6T	Community Choices Waiver - Physical Therapy	2	65, 87, 75	35, 44, 65
6U	Applied Behavioral Analyst	1		AX
7A	SBHC - NP - Part Time - less than 20 hrs week	1		38
7B	SBHC - NP - Full Time - 20 or more hrs week	1		38
7C	SBHC - MD - Part Time - less than 20 hrs week	1		38
7D	SBHC - MD - Full Time - 20 or more hrs week	1		38
7E	SBHC - NP + MD - Part Time - combined less than 20 hrs week	1		38
7F	SBHC - NP + MD - Full Time - combined less than 20 hrs week	1		38
7G	Community Choices Waiver - Speech/Language Therapy	2	71, 87, 75	39, 44, 65
7H	Community Choices Waiver - Occupational Therapy	2	74, 87, 75	37, 44, 65
7M	Retail Convenience Clinics	2	70	19,20,78
7N	Urgent Care Clinics	2	70	19,20,79
7S	Leonard J Chabert Medical Center - Houma	2		19,20
8A	Elderly, Community Choices Waiver, DD	2	82	82
8B	Elderly, Community Choices Waiver	2	82	82
8C	DD services	2	82	82
8D	Community Choices Waiver - Caregiver Temporary Support	1	82, 83	82, 83
8E	CSoC/Behavioral Health	1, 2		AB, AC, AD, AE, AF, AG, AH, AJ, AK, 82, 31, 68, 70, 73, 83, 53
8F	Community Choices Waiver - Caregiver Temporary Support - Home Health	2	8D	AN
8G	Community Choices Waiver - Caregiver Temporary Support - Assisted Living	2	8D	AN
8H	Community Choices Waiver - Caregiver Temporary Support - ADHC	2	8D	AN

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty	Related Provider Types
8J	Community Choices Waiver - Caregiver Temporary Support - Nursing Facility	2	8D	AN
8K	ADHC HCBS	1		AL
8L	Hospital-based PRTF	1		96
8M	Community Choices Waiver - Home-Delivered Meals	1		AM
8N	Community Choices Waiver - Nursing	2		44, 78
8O	IP - Doctor of Osteopathic Medicine	1		IP
8P	IP - Physician - MD	1		IP
8Q	Community Choices Waiver - EAA Assessor, Inspector, Approver	2		15
8S	OLOL Med School	2		
9A	Community Choices Waiver - Nursing and Personal Assistance Services	2		
9B	Psychiatric Residential Treatment Facility	1		96
9D	Residential Care	1		97
9E	Children's Choice Waiver	1		03
9F	Therapeutic Foster Care (TFC)	1		AR
9G	Non-Medical Group Home (NMGH)	1		AQ
9L	RHC/FQHC OPH Certified SBHC	1		72
9M	Monitored In-Home Caregiving (MIHC)	1		
9P	GNOCHC - Greater New Orleans Community Health Connection	1		99
9Q	PT 21 - EDI Independent Billing Company	2		21
9S	IP - Optical Supplier	1		IP
9U	Medicare Advantage Plans	1		21
9V	OCDD - Point of Entry	1		21
9W	OAAS - Point of Entry	1		21
9X	OAD - Point of Entry	1		21
9Y	Juvenile Court/Drug Treatment Center	1		21
9Z	Other Contract with a State Agency	1		21
XX	Error Provider	1		XX

Appendix D

Dual Eligible Covered Services Reference

Claims payment for Dual Eligible covered services including CSoC Waiver Services, Community Psychiatric Support and Treatment (including the evidence-based practices), Psychosocial Rehabilitation, Crisis Intervention, and Substance Use Treatments is the responsibility of the SMO. These claims are considered non-crossovers, as the services are not covered by Medicare.

The services include the following HCPCS:

S5110, H0038, H2014, S5150, H0045, H2017, S9485, H2011, H0036, H0039, H2033, H0018, T2048, S5145, H0001, H0004, H0005, H0011, H0012, H0015, H0019, H2034, H2036, H2013, H0049, and H0050