Medical Loss Ratio (MLR) Requirements

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

Definitions

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

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

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

Reporting Requirements

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

B. **Timing and Form of Report**
The report for each MLR reporting year must be submitted to DHH prior to July 1 of the year following the end of an MLR reporting year, on a form and in the manner prescribed by DHH.

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

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

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

To quantify the impact of New Enrollees:

1. List all plan enrollees during the MLR period (total population)
2. Using continuous membership spans from initial enrollment (including months prior to the MLR period), identify members from the population that have NOT had continuous enrollment for a minimum of 11 months (this subgroup represents the potential New Enrollees).
3. Review the potential New Enrollees, identifying those members that had initial enrollment (no enrollment prior to MLR period), and those with intermittent membership spans. Review the intermittent membership spans to determine if any breaks in membership were for periods of 62 days or less; if so, combine the spans and include the months between spans to determine if they meet the 11 months continuous enrollment threshold. The potential New Enrollees should now be able to be separated between defined New Enrollees (those with less than 11 months of continuous enrollment including intermittent membership spans) and the non-New Enrollees (those with 11 months or more continuous enrollment including intermittent membership spans).
4. Determine the total capitation for the total population and the total capitation for the defined New Enrollees. If the defined New Enrollee Capitation is greater than 50% of the Total Population Capitation, the defined New Enrollees capitation and expenses may be deferred to the next MLR period. If the percentage is less than 50%, all of the membership should be included in the current MRL period.
5. Review the prior MLR period to determine if the defined New Enrollees revenue and expenses from the prior MLR period was deferred to the current period. If it was deferred, include the capitation and expense from the prior period *defined* New Enrollees in the current period.

D. **Capitation Payments**

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

Reimbursement for Clinical Services Provided to Enrollees

A. **General Requirements**

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

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

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

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

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

B. **Adjustments to incurred claims:**

1. Adjustments that must be deducted from incurred claims:

    a. Prescription drug rebates received by the MCO
    b. Overpayment recoveries received from providers

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

    a. The amount of incentive and bonus payments made to providers

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

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

Activities that Improve Health Care Quality

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

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

1. The activity must be primarily designed to:

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

      1. Examples include the direct interaction of the MCO (including those services delegated by subcontract for which the MCO retains ultimate responsibility under the terms of the contract with DHH) with providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:

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

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

   g. Prevent hospital readmissions through a comprehensive program for hospital discharge;

1. Examples include:

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

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

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

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

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

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

      (a) Wellness assessments;
      (b) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
      (c) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
      (d) Public health education campaigns that are performed in conjunction with the Louisiana Office of Public Health ;
      (e) Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in payments or claims;
      (f) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

(g) Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity); and,
(h) Health information technology to support these activities.
(i) Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology.

A. **Exclusions**

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

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

Expenditures Related to Health Information Technology and Meaningful Use Requirements

A. **General Requirements**

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

1. Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their "meaningful use" as defined by HHS to the extent such payments are not included in reimbursement for clinical services;
2. Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicaid incentive payments;
3. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;
4. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA, URAC, or JHACO, or costs for reporting to DHH on quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures);
5. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes.;
6. Advancing the ability of enrollees, providers, MCOs or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history and to support care management;
7. Reformatting, transmitting or reporting data to national or international government-based health organizations, as may be required by DHH, for the purposes of identifying or treating specific conditions or controlling the spread of disease; and,
8. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

Other Non-Claims Costs

A. **General Requirements**

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

B. **Non-Claims Costs Other**

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

2. Expenses for administrative services include the following:

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

Allocation of Expenses

A. **General Requirements**

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

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

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

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

other entities within a group. Any profit margin included in costs for related party administrative agreements should be excluded.

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

Formula for Calculating Medical Loss Ratio

A. **Medical Loss Ratio**

1. A MCO's MLR is the ratio of the numerator, as defined in paragraph “a” of this section, to the denominator, as defined in paragraph “b” of this section.

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

    a. The **numerator** of a MCO's MLR for an MLR reporting year must be the MCO's incurred claims plus the MCO's expenditures for activities that improve health care quality.

    b. The **denominator** of a MCO's MLR must equal the MCO's capitation payments received from DHH.

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

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

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

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

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