§2111. Payment Methodology

A. Payments to the Dental Benefit Plan. The department, or its fiscal intermediary, shall make monthly capitation

payments to the dental benefit plan based on a per member, per month (PMPM) rate.

1. The department reserves the right to re-negotiate the PMPM rates:

a. if the rate floor is removed;

b. as a result of federal or state budget reductions or increases;

c. due to the inclusion or removal of a Medicaid covered dental service(s) not incorporated into the monthly capitation rates; or

d. in order to comply with federal requirements.

2. The rates may also be adjusted based on legislative appropriations and budgetary constraints. Any adjusted rates must continue to be actuarially sound as determined by the department's actuarial contractor and will require an amendment to the contract that is mutually agreed upon by both parties.

3. The department or its fiscal intermediary, may reimburse a DBPM's monthly capitation payments in the aggregate on a lump sum basis when administratively necessary.

B. The DBPM must agree to accept the PMPM rate as payment-in-full from the department and agree not to seek additional payment from a member for any unpaid cost.

C. A DBPM shall assume 100 percent liability for any expenditure above the prepaid premium.

D. A DBPM shall meet all financial reporting requirements specified in the terms of the contract.

E. Any cost sharing imposed on Medicaid members must be in accordance with the federal regulations governing cost sharing and cannot exceed the amounts reflected in the Medicaid state plan, but the amounts can be less than the cost sharing levels in the state plan.

F. The DBPM shall not assign its rights to receive the PMPM payment, or it obligation to pay, to any other entity.

G. In the event that an incorrect payment is made to the DBPM, all parties agree that reconciliation will occur. If an error or overcharge is discovered by the department, it will be handled in accordance with the terms and conditions of the DBPM's contract.

H. Network Provider Reimbursement

1. The DBPM shall provide reimbursement for defined core dental benefits and services provided by an in-network provider pursuant to the terms of its contract with the department.

2. The network provider may enter into alternative reimbursement arrangements with the DBPM if the network provider initiates the request and it is approved in advance by the department.

I. Emergency or Out-of-Network Provider Reimbursement. The DBPM shall make prompt payment for covered emergency dental services that are furnished by providers that have no arrangements with the DBPM for the provision of such services. Reimbursement by the DBPM to out-of-network providers for the provision of emergency dental services shall be no more than what would be paid under Medicaid FFS.

J. A DBPM shall have a medical loss ratio (MLR) for each MLR reporting year, which shall be a calendar year, except in circumstances in which the reporting period must be revised to align to a CMS-approved capitation rating period.

1. Following the end of the MLR reporting year, a DBPM shall provide an annual MLR report, in accordance with the financial reporting guide issued by the department.

2. The annual MLR report shall be limited to the DBPM's MLR for services provided to Medicaid enrollees and payment received under the contract with the department, separate from any other products the DBPM may offer in the state of Louisiana.

3. An MLR shall be reported in the aggregate, including all services provided under the contract, unless the department requires separate reporting and a separate MLR calculation for specific populations.

a. The MLR shall not be less than 85 percent using definitions for health care services, quality initiatives and administrative cost as specified in 42 CFR 438.8. If the MLR is less than 85 percent, the DBPM will be subject to refund the difference, within the timeframe specified, to the department. The portion of any refund due the department that has not been paid, within the timeframe specified, will be subject to interest at the current Federal Reserve Board lending rate or in the amount of 10 percent per annum, whichever is higher.

4. The department shall provide for an audit of the DBPM's annual MLR report and make public the results within 60 calendar days of finalization of the audit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:788 (April 2014), amended LR 46:953 (July 2020), LR 47:369 (March 2021).

§3509. Reimbursement Methodology

A. Payments to an MCO. The department, or its fiscal intermediary, shall make monthly capitation payments to the MCO based on a per member, per month (PMPM) rate.

1. The department will establish monthly capitation rates within an actuarially sound rate range certified by its actuaries. Consistent with all applicable federal rules and regulations, the rate range will initially be developed using fee-for-service claims data, Bayou Health shared savings claims data, Bayou Health managed care organization encounter data, Louisiana Behavioral Health Partnership (LBHP) encounter data, financial data reported by Bayou Health managed care organizations and the LBHP statewide management organization, supplemental ad hoc data, and actuarial analyses with appropriate adjustments.

2. As the Bayou Health managed care program matures and fee-for-service, shared savings and LBHP data are no longer available, there will be increasing reliance on Bayou Health managed care organization encounter data and/or financial data to set future rates, subject to comparable adjustments.

3. Capitation rates will be set for all MCOs at the beginning of each contract period and will be periodically reviewed and adjusted as deemed necessary by the department.

4. Capitation rates will be risk-adjusted for the health of Medicaid enrollees enrolled in the MCO as appropriate.

a. The health risk of the Medicaid enrollees enrolled in the MCO will be measured using a national-recognized risk-assessment model.

b. Utilizing this information, the capitation rates will be adjusted to account for the health risk of the enrollees in each MCO relative to the overall population being measured.

c. The health risk of the members and associated MCO risk scores will be updated periodically to reflect changes in risk over time.

d. The department will provide the MCO with advance notice of any major revision to the risk-adjustment methodology.

5. Kick Payments. MCOs may be reimbursed a one-time supplemental lump sum payment, hereafter referred to as a "kick payment", for the provision of certain services that meet specific conditions, in an amount determined by the department's actuaries.

a. The kick payment is intended to cover the cost of a specific care event or treatment. Payment will be made to the MCO upon submission of satisfactory evidence of the event or treatment.

b. Only one kick payment will be made per event or treatment.

6. Capitation rates related to pharmacy services will be adjusted to account for pharmacy rebates.

7. The department, or its fiscal intermediary, may reimburse an MCO's monthly capitation payments or kick payments in the aggregate on a lump sum basis when administratively necessary.

B. As Medicaid is the payor of last resort, an MCO must agree to accept the PMPM rate as payment-in-full from the department and agree not to seek additional payment from a member for any unpaid cost.

C. The MCO rate does not include graduate medical education payments or disproportionate share hospital payments. These supplemental payments will be made to applicable providers outside the PMPM rate by the department according to methodology consistent with existing Rules.

D. An MCO shall assume 100 percent liability for any expenditure above the PMPM rate.

E. The MCO shall meet all financial reporting requirements specified in the terms of the contract.

F. An MCO shall have a medical loss ratio (MLR) for each MLR reporting year, which shall be a calendar year.

1. Following the end of the MLR reporting year, an MCO shall provide an annual MLR report, in accordance with the financial reporting guide issued by the department.

2. The annual MLR report shall be limited to the MCO's medical loss ratio for services provided to Medicaid enrollees and payment received under the contract with the department, separate from any other products the MCO may offer in the state of Louisiana.

3. An MLR shall be reported in the aggregate, including all services provided under the contract.

a. The aggregate MLR shall not be less than 85 percent using definitions for health care services, quality initiatives and administrative cost as specified in 45 CFR Part 158. If the aggregate MLR is less than 85 percent, the MCO will be subject to refund the difference, within the timeframe specified, to the department. The portion of any refund due the department that has not been paid, within the timeframe specified, will be subject to interest at the current Federal Reserve Board lending rate or in the amount of 10 percent per annum, whichever is higher.

b. The department may request MLR reporting that distinguishes physical and basic behavioral health from specialized behavioral health. Neither the 85 percent minimum nor the refund applicable to the aggregate shall apply to distinct MLRs reported.

4. The department shall provide for an audit of the MCO's annual MLR report and make public the results within 60 calendar days of finalization of the audit.

G. Any cost sharing imposed on Medicaid members must be in accordance with the federal regulations governing cost sharing and cannot exceed the amounts reflected in the Louisiana Medicaid State Plan, but the amounts can be less than the cost sharing levels in the State Plan.

H. The department may adjust the PMPM rate, during the term of the contract, based on:

1. changes to core benefits and services included in the capitation rate;

2. changes to Medicaid population groups eligible to enroll in an MCO;

3. changes in federal requirements; and/or

4. legislative appropriations and budgetary constraints.

I. Any adjusted rates must continue to be actuarially sound and will require an amendment to the contract.

J. The MCO shall not assign its rights to receive the PMPM payment, or its obligation to pay, to any other entity.

1. At its option, the department may, at the request of the MCO, make payment to a third party administrator.

2. - 3.a. Reserved.

K. In the event that an incorrect payment is made to the MCO, all parties agree that reconciliation will occur.

1. If an error or overcharge is discovered by the department, it will be handled in accordance with the terms and conditions of the contract.

L. Network Provider Reimbursement

1. Reimbursement for covered services shall be equal to or greater than the published Medicaid fee-for-service rate in effect on the date of service, unless mutually agreed by both the plan and the provider in the provider contract to pay otherwise.

a. The MCO shall pay a pharmacy dispensing fee, as defined in the contract, at a rate no less than the minimum rate specified in the terms of the contract.

2. The MCO's subcontract with the network provider shall specify that the provider shall accept payment made by the MCO as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from the department or the member.

a. The term "member" shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the member being served.

3. The MCO shall not enter into alternative payment arrangements with federally qualified health centers (FQHCs) or rural health clinics (RHCs) as the MCO is required to reimburse these providers according to the published FQHC/RHC Medicaid prospective payment schedule rate in effect on the date of service, whichever is applicable.

M. Out-of-Network Provider Reimbursement

1. The MCO is not required to reimburse more than 90 percent of the published Medicaid fee-for-service rate in effect on the date of service to out-of-network providers to whom they have made at least three documented attempts to include the provider in their network as per the terms of the contract.

2. If three attempts to contract with the provider prior to the delivery of the medically necessary service have not been documented, the MCO shall reimburse the provider the published Medicaid fee-for-service rate in effect on the date of service.

3. The MCO is not required to reimburse pharmacy services delivered by out-of-network providers. The MCO shall maintain a system that denies the claim at the point-of-sale for providers not contracted in the network.

N. Reimbursement for Emergency Services for In-Network or Out-of-Network Providers

1. The MCO is financially responsible for ambulance services, emergency and urgently needed services and maintenance, and post-stabilization care services in accordance with the provisions set forth in 42 CFR §422.113.

2. The reimbursement rate for medically necessary emergency services shall be no less than the published Medicaid fee-for-service rate in effect on the date of service, regardless of whether the provider that furnished the services has a contract with the MCO.

a. The MCO may not concurrently or retrospectively reduce a provider's reimbursement rate for these emergency services, including ancillary and diagnostic services, provided during an episode of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1587 (June 2011), amended LR 39:92 (January 2013), LR 41:937 (May 2015), LR 41:2367 (November 2015), LR 42:755 (May 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1771 (December 2019).