FINANCIAL REPORTING REQUIREMENTS

HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

Southeast Zone
Southwest Zone
Lehigh Capital Zone
Northeast Zone
North Central Zone
North Central County Option Zone

Reporting Period 01/01/26 through 12/31/26

May 27, 2026

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1.0 GLOSSARY OF TERMS

Adjudicate. To pay or reject a claim.

ASO. Administrative Services Organization.

BH-MCO. Behavioral Health Managed Care Organization. An entity directly operated by county government or licensed by the Commonwealth as a Health Maintenance Organization or risk assuming Preferred Provider Organization, which manages the purchase and provision of behavioral health services.

CBCM. Community Based Care Management.

CBO. Community Based Organization.

C & Y. Office of Children & Youth.

DHS. Pennsylvania Department of Human Services.

DOI. Pennsylvania Insurance Department.

EPSDT. (now referred to as Behavioral Health Rehabilitation Services for Children and Adolescents). The Early and Periodic Screening, Diagnosis, and Treatment Program for persons under age 21.

Freestanding Psychiatric Facility. A freestanding hospital that provides inpatient psychiatric services.

FYE. Fiscal Year End.

GA. General Assistance.

GAAP. Generally Accepted Accounting Principles.

HCE - NE. HealthChoices Expansion – Newly Eligible.

HIPF. Health Insurer Provider Fee.

HMO. Health Maintenance Organization. A public or private entity organized under state law that is a federally qualified HMO; or meets the Medicaid state plan definition of an HMO.

IBHS. Intensive Behavioral Health Services.

IMD. Institution for Mental Disease. A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

IBNRs. Incurred But Not Reported Claims. Costs associated with health care services incurred prior to a financial reporting date but not reported to the health care organization until after the financial reporting date.

JCAHO. Joint Commission on Accreditation of Healthcare Organizations.

MA. Medicaid or Medical Assistance.

MAGI. Modified Adjusted Gross Income.

PCP. Primary Care Practitioner. A specific physician, physician group, or health center operating under the scope of individual licensure responsible for providing primary care services and locating, coordinating, and monitoring other medical care and rehabilitation services on behalf of a recipient.

PMPM. Per Member Per Month.

PSR. Program Standards and Requirements Document.

RBUCs. Received but Unpaid Claims. A claim is considered received the day it is physically received.

RTF. Residential Treatment Facility.

SAP. Statutory Accounting Principles.

SSI. Supplemental Security Income. Income under Title XVI of the Social Security Act, as amended.

TANF. Temporary Assistance to Needy Families.

2.0 FINANCIAL REPORTING REQUIREMENTS TABLE

Frequency	Due Date	Title	Report #
Q	15th of the second month after period end i.e. – period ending 03/31/XX reports are due 5/15/XX **December Monthly & Quarterly Reports will be due the same time as the Annual Counterpart Reports – March 1st**	Enrollment Table	1
Q		Primary Contractor Summary of Transactions	2
Q		Subcontractor Summary of Transactions	3
Q		Related Party Transactions and Obligations	4
Q		Risk Pool Analysis	5
M		Claims Payable (RBUCs and IBNRs)	6
M		Lag Reports	7
M		Claims Processing Report	8
Q		Analysis of Revenues and Expenses	9
M		Coordination of Benefits Report	11
M		Reinvestment Report	12
M, Q, or A		Balance Sheet	13
M, Q, or A		Statement of Revenues, Expenses, and Changes in Retained Earnings (Deficit)/Fund Balance	14
M, Q, or A		Statement of Cash Flows	15
Q		Contract Reserves Compliance Report	17
Q		Insurance Department Quarterly Filing	18
A	March 1st	Annual Counterpart Reports	20
M, Q	March 1st	December Monthly & Quarterly Reports	1,2,3,4,5, 6,7,8,9,12 , 29
A	May 15th	Annual HealthChoices Behavioral Health Contract Audit	21
A	9 months after the County's audit year end	Audited General Purpose Financial Statements	22
A	180 days after FYE	Annual Entity-Wide Audit	23
A	March 1st	Insurance Department Annual Filing	24
A	June 30th	Insurance Department Annual Audited Financial Statements	26
Q	15th of the second month after period end	CBCM Expenditures Report	29
A	Last date of the contract year	Physician Incentive Arrangement	
A	November 15th	Equity Requirement	
A	November 1st	Insolvency Protection Arrangement	
A	November 1st	Risk Protection (Stop-Loss Reinsurance)	
A	April 1st	Reinsurance Experience - Estimated	
A	January 2nd	Reinsurance Experience - Actual	
A	November 15th	Medical Loss Ratio (MLR)	42
A	November 15th	Reinvestment Sharing Calculations	43

Please refer to Attachment D for more information on which entities are required to submit the above reports.

If a due date falls on a weekend or state holiday, reports will be due the next state business day.

The Pennsylvania Department of Human Services may issue amendments and/or updates to the financial reporting requirements from time to time as deemed necessary by DHS.

Frequency Key: M = Monthly
Q = Quarterly
A = Annually

3.0 INSTRUCTIONS FOR THE COMPLETION OF REPORTING FORMS

This section contains the instructions for completing the required monthly, quarterly, and annual reports.

3.1 General Instructions

HOW TO REPORT:

The following are general instructions for completing the monthly, quarterly, and annual reports required to be submitted by the Primary Contractor and Subcontractors (as applicable, refer to Attachment D) to DHS. The primary objectives of these instructions are to promote uniformity in reporting and to ensure that the financial statements are prepared in accordance with Generally Accepted Accounting Principles (GAAP), except as otherwise noted in the instructions.

The heading of each report should contain the following fields:

Statement as of: This should be the month, quarter, or year-end date for the report.
County: This should be the name of the County for which the report is applicable.
Reported By: This should be the entity that collected the data and compiled the report. In instances where a report contains data from more than one entity, this field should name the primary contractor.

Line titles and columnar headings of the reports are, in general, self-explanatory and therefore constitute instructions. Specific instructions are provided for items about which there may be some question as to content. Any entry for which no specific instructions are included should be made in accordance with sound accounting principles and in a manner consistent with related items covered by specific instructions.

Always utilize predefined categories or classifications before reporting an amount as "Other". Provide detail for “Other Administrative Expenses” if the total amount reported is >5% of total administrative expense. At a minimum, the detail should list any item that composes an amount ≥1% of total administrative expense. Items that are <1% of total administrative expense can be consolidated. For example: “Total Administrative Expenses is $100,000 and total “Other Administrative Expenses” is $5,500, which consists of Consulting Fees $3,000; Legal Fees $1,000; Telephone $900; and Equipment $600. The detail would include Consulting Fees $3,000; Legal Fees $1,000; and Other $1,500. ALL “Other Medical Services” reported must be disclosed by local code and by national code and modifier combination, as well as a detailed description, regardless of materiality. ALL “Other Revenue”, “Other Distributions to Subcontractors” and “Other Distributions” reported must be disclosed by source, regardless of materiality.

Only contract-related income and expenses should be reported in these reports. Charitable contributions, Federal Income taxes, State Income taxes and non-HC Program interest expense allocations are examples of expenses not directly related to the HC Program and therefore, should not be reported in these reports. Expenditures included in the financial reports that are not directly related to the operation of the program, as well as expenditures that are considered one-time administrative costs or one-time provider rate increases not created by a recurring liability will be removed from the base data for rate setting purposes. To clarify, one-time provider payments from recurring liabilities, such as value-based purchasing arrangements, will be included in the base data used for rate setting.

Premium Deficiency Reserves (PDR) should **not** be included in reports that are prepared to

comply with HealthChoices Financial Reporting Requirements. The primary focus of Statutory Accounting Principles is the solvency of a company and its ability to meet long-term contractual obligations. Requiring adequate statutory reserves (including PDRs) is the principle means of ensuring financial soundness. Although DHS is concerned with the solvency of HealthChoices contractors, the HealthChoices reports are used to understand the current medical costs and administrative expenses of the HealthChoices program. Since the PDR concerns projected losses for future periods, recording it in a current period distorts the true picture for the current period.

Any interest or penalties paid to providers as a result of not paying claims timely should not be included in these reports. For electronic filing, include disclosure information in the common text area.

Any adjustments to amounts already reported for any current year prior period should be made to the reports for the current period being reported. If an adjustment affects a line item amount being reported for the current period by >5%, provide an explanation of the amount and reason for the adjustment (i.e., if an expense for the current period would be $100,000 without any adjustment and the adjustment causes the amount to be less than $95,000 or greater than $105,000, disclosure is necessary). The disclosure should indicate how the adjustment(s) should be applied over the prior periods(s), various categories of assistance, and/or various rating groups, if applicable. For purposes of these financial reports, the Department considers adjustments to be changes to estimated amounts **previously reported** due to the determination that the estimate was over/understated. The Department retains the right to impose sanctions if material adjustments are made after year-end, if Department staff raised concerns related to the adjusted items throughout the course of the contract year. Errors in the calculation of amounts previously reported are not considered adjustments. The Department reserves the right to require resubmission of reports that include incorrect amounts, depending on the materiality of the error. **The revision date must be indicated on all revised reports.**

Current year prior period information should be reported using the same criteria established for completing the current period information. Where the necessary detail does not exist to adequately report current year prior period information, this fact should be disclosed. Include the disclosure on paper when submitting paper copy reports. When reporting electronically, include the disclosure in the common text area. Ending balances from the last month of a contract year should not be carried over as the beginning balance of the next contract year, except for Reports 5A, 6, 7, 8, 12, 13, 14, and 15 (if applicable). **The financial reports should be prepared to reflect transactions related to the current contract year ONLY, except as otherwise noted in the instructions.**

Unanswered questions and blank lines or reports will not be considered properly completed. If no answers or entries are to be made, write "None", "Not Applicable" (N/A), or "-0-" in the space provided. For specific instructions on how to report blank lines or blank reports when filing electronically, please refer to Attachment L HCBH Financial Reporting Instructions for Primary Contractors.

Amounts should be reported to the nearest dollar and should not include decimal places, except for per member per month (PMPM) amounts which should include two decimal places. **IMPORTANT:** When rounding or truncating numbers do not perform rounding or truncation until arriving at the final amount. (Example: If calculation is 1.5892 x 2.059 = 3.272163, report final

amount as 3.27; not 1.59 x 2.06 = 3.28.)

Sanctions imposed by DHS on the Primary Contractor must be reported as follows: Report #2, Capitation Revenue (Line 2a), should disclose the gross amount of capitation revenue. Other Revenue (Line 2c) should include an offsetting negative number in the amount of the sanction. Report #9, Other Revenue (Line 3), should also include the offsetting negative number in the amount of the sanction. If the Primary Contractor passes part or all of the sanctions on to the Subcontractor, follow the reporting instructions below for Sanctions imposed by the Primary Contractor. Sanctions must be disclosed in the footnotes to the reports.

Sanctions imposed by the Primary Contractor on the Subcontractor must be reported as follows: Report #2, Distributions to Subcontractor, Other (Line 3e), should disclose a negative number in the amount of the sanction. Report #3, Capitation Revenue (Line 2a), should disclose the gross amount of capitation revenue. This amount should equal the sum of Report #2, Distributions to Subcontractor for Medical Services and Administration (Lines 3a and 3b). Also, on Report #3, Other Revenue (Line 2c), should include an offsetting negative number in the amount of the sanction. Sanctions imposed by the Primary Contractor should not be disclosed on Report #9. Sanctions must be disclosed in the footnotes to the reports.

Sanctions imposed by the Primary Contractor on an ASO must be reported on Report #2 as an offset to Other Administrative Expenses (Line 9g). Contact DHS for further reporting instructions if a different situation exists other than described in the preceding instructions.

All reports must be submitted via electronic files consistent with specifications provided by DHS. Excel-based financial reporting templates are to be used for Reports #1–4, 6–9, 12 and 29; all other reports should be submitted in pdf format. These files should be submitted to the financial reporting website: **https://ereporting.mercer.com/OMHSAS/Login.aspx**. See Attachment L for more information about submitting reports.

WHERE TO SEND REPORTS:

These reports require accounting of all capitation funds paid under a HealthChoices Behavioral Health contract. All reports are deemed received when they are actually received by the Department. Paper reports should be sent in one package via;

Regular mail to:

Department of Human Services
Office of Mental Health & Substance Abuse Services
Ms. Kimberly Butsch
Commonwealth Tower
303 Walnut Street, 12th Floor
P.O. Box 2675
Harrisburg, PA 17105

Or overnight courier to:

Ms. Kimberly Butsch
Department of Human Services
Bureau of Financial Management and Administration
Division of Medicaid Finance
Commonwealth Tower

303 Walnut Street, 12th Floor
Harrisburg, PA 17101

LATE REPORTING:

The Department has the right to impose sanctions, as defined in the contract with the Department of Human Services, for failure to submit, or late submission of, reports as contractually obligated. The Department may extend a report deadline if a request for an extension is communicated, in writing, and is received at least five (5) business days prior to the report deadlines as set forth in this document. Requests for extension must include the reason for the requested extension and the date by which the report will be filed. Requests for extensions will be reviewed and the requestor will be notified of the decision in writing.

REPORTING OF HEALTHCHOICES REVENUES AND EXPENSES:

For reference purposes, the eleven Behavioral Health Major Rate Code Service Groupings referred to throughout the financial reporting package are:

- Inpatient Psychiatric
- Inpatient D & A
- Non-Hospital D & A
- Outpatient Psychiatric
- Outpatient D & A
- Intensive Behavioral Health Services (IBHS)
- RTF - Accredited
- RTF - Non-Accredited
- Ancillary Support
- Community Support
- Other

For reference purposes, the six Behavioral Health Rating Groups referred to throughout the financial reporting package are summarized below. See Section 4 of Attachment L for changes, guidance and timing associated with the rating group structure changes resulting from the HealthChoices Expansion initiative.

- Temporary Aid to Needy Families (TANF)/MAGI – Child
- Temporary Aid to Needy Families (TANF)/MAGI – Adult
- SSI & Healthy Horizons w/ Medicare
- SSI & Healthy Horizons w/o Medicare – Child
- SSI & Healthy Horizons w/o Medicare – Adult
- HealthChoices Expansion – Newly Eligible (HCE – NE)

The financial reports (Reports #2, #3, and #9, in particular) were modeled after the Capitation Rate Calculation Sheets (CRCS) and are to reflect costs in the same way.

For purposes of these financial reports, "medical" expenses should reflect only those costs that represent claims or service costs, with the addition of individual stop loss reinsurance premiums and recoveries. All other costs, including those incurred for

Utilization Review, Quality Assurance, Medical Director, Member Services, aggregate reinsurance premiums and recoveries, and all other non-medical claim costs, are to be reported under the "Administrative Expense" sections of applicable reports. This will enable DHS and its contractors to compare costs actually being incurred to the costs included in each service group in the existing capitation rates. In addition, the Department and its contractors will also be utilizing these financial reports, along with the contractors' encounter data, to develop future capitation rates.

Exception: If a contractor/subcontractor is a staff model HMO (an HMO that directly employs physicians and other providers on its staff for the purpose of the direct delivery of services, as opposed to contracting with providers through a network), the above requirement may be waived. Each contractor will be evaluated on a case-by-case basis, and the decision of the Department will be final.

GENERAL NOTES REGARDING CBCM EXPENDITURES

Revenues and expenses for CBCM initiatives are included in Reports #2, #3 and #9. The revenue is a component of the capitation rate and is consequently reported in “Capitation” (Line 1 in Report #9). Expenditures for approved CBCM initiatives are reported in “Clinical Care/Medical Management” (Line 16f in Report #9). The accompanying report notes must also list the CBCM expenditure amounts reflected in the report. The expenditures included in Report #9 should match the amount submitted in Report #29.

GENERAL NOTES REGARDING CBO EXPENDITURES

Reports #2, #3 and #9 must include CBO payments made with capitation funding. CBO reimbursements that are made using reinvestment funds should be excluded and only reflected in Report #12.

CBO arrangements in which the Primary Contractor only reimburses a Medicaid provider directly should be reported in a manner consistent with other Medicaid provider payments. This includes the scenario where the Primary Contractor reimburses a Medicaid provider who independently sub-contracts with a CBO for additional services. CBO arrangements where the Primary Contractor directly reimburses a CBO that is not a Medicaid provider must be reported under administrative expenses. If the service constitutes care management then it is reported in “Clinical Care/Medical Management”, otherwise it is reported in “Other Administrative Expenses”. In both cases, the amounts must be identified in the report notes.

Additional instructions on the classification and allocation of revenues and expenses can be found in the specific instructions for the financial reports.

3.2 Report #1 – Enrollment Table

A member is a person who has been enrolled consistent with the DHS contract. This report discloses member month equivalents per month by behavioral health rating group.

Count of Members Enrolled on Last Day of Current Period – Report the number of people enrolled on the last day of the month for which the report is being prepared.

Member Month Equivalents – These columns disclose member month equivalents per month by behavioral health rating group. The member month equivalents should be reported by the behavioral health rating group as shown on the report. A member month is equivalent to one member for one entire month. Where eligibility is recognized for only part of a month for a given individual, a partial, pro-rated member month should be counted. A partial member month is pro-rated based on the actual number of days in a particular month.

Year-to-Date – The year-to-date column should equal the sum of as many months as have been completed through the month being reported. For example, after the first month, the year-to-date column will equal the first month's numbers, but after the second month, the year-to-date column will equal the sum of the first and each subsequent month columns.

Do not update member month counts provided for a prior month on a previous report. Adjustments to costs and populations reported for a previous month within the current year should be applied to current month information.

3.3 Report #2 – Primary Contractor Summary of Transactions

The Primary Contractor must report all capitation revenue received applicable to the current period, as well as the disposition of those funds, in this report. Consistent with GAAP, capitation revenue is reported on an accrual basis.

All earned interest from the risk and contingency and restricted reserve account that is included on Line 2b, Investment Revenue should be shown separately in the report notes.

Any funds being held by the Primary Contractor for future incentive payments to a subcontractor should be reported on Line 6, Incentive/Risk Pools. However, investment income earned on these funds should be reported on Line 2)b, Investment Revenue.

Incentive/Risk Pools: This line should include funds retained by the Primary Contractor for potential payment to the Subcontractor for excess medical expenses or incentives. Incentive payments made by the Primary Contractor to Providers should be reported as an Administrative Expense under “Other” and disclosed in the notes to the report.

Payment or accrual of Excess Medical/Incentive Funds and applicable interest:

If excess medical expense or incentive to be paid from funds reserved on Line 6, Incentive/Risk Pools, is known or can be reasonably estimated during the year in which they were earned or prior to submission of the annual contract audit, this amount should be reported on either Line 3a, Distributions to Subcontractor for Medical Services or Line 3e, Other, and an offsetting entry in the amount of the payment or accrual should be made to Line 6. If the payment or accrual includes interest earned on this account, an offsetting entry in the amount of the interest payment should be made to Line 2)b, Investment Revenue. If the amount to be paid for excess medical expenses or incentive funds is not known until after the annual counterpart report and/or contract audit have been submitted, that information should **not** be reflected on the current year’s reports. Information pertaining to distributions from funds reserved on Line 6 not reported on either the annual counterpart report or contract audit should be supplied to the Department as soon as it is available for adjustments to the prior year database.

Primary Contractor Medical Expenses: This line should be used to report medical claims expense incurred for the reporting period by the primary contractor. This does not include medical expenses incurred by any subcontractors.

Distributions to Management Corp/ASO: This line should be used to report the expense incurred for the reporting period as a result of a subcontract or management agreement with a Management Corporation or ASO. The amount should only reflect that portion of the expense that directly relates to the performance of administrative functions.

Distributions to a Joinder: Report these distributions as County Administrative Expenses under "Other." The amount of the distribution to the joinder must be specified in the footnotes to the report.

Clinical Care/Medical Management: All Clinical Care/Medical Management expenses should be reported on this line. The amounts reported on this line should not be duplicated in any other administrative expense line on this report. Compensation, interest expense, occupancy, depreciation, and amortization, and other administrative expense lines should include Administrative Overhead costs only. Refer to Attachment F to assist in the task of determining which costs are clinical care/medical management or administrative overhead for DHS reporting purposes.

In the event a primary contractor reports a medical loss that requires coverage from its Managed Care Organization, this amount should be shown in the report notes.

IMPORTANT: For the purpose of allocating administrative expense amounts, use the following guidelines: 1) if the entire expense can be directly attributed to each behavioral health rating group, report exact dollar amounts for each behavioral health rating group; 2) if a portion of the expense can be directly attributed to one or more of the behavioral health rating groups, distribute only the remaining amounts based on the applicable percentage of capitation revenue; and 3) if no portion of the expense can be directly attributed to one or more of the behavioral health rating groups, distribute the entire expense amount proportionately based on the applicable percentage of capitation revenue. Include an explanation of the amount being allocated in the common text area.

3.4 Report #3 – Subcontractor Summary of Transactions

If the Department's primary contractor has subcontracted with an entity who will be subcapitated and whose subcapitation payment includes a medical claims cost component, the subcontracted entity must report all capitation revenue received during the period, as well as the disposition of those funds, in this report. If the Department's primary contractor has subcontracted with an entity for administrative services only, regardless of the type of payment arrangements, this report should not be filed.

Distribution at Subcontractor Level – These lines are for the subcontractor to report amounts that they paid directly from their capitation revenues for medical services, profit, reinvestment and other.

Clinical Care/Medical Management: All Clinical Care/Medical Management expenses should be reported on this line. The amounts reported on this line should not be duplicated in any other administrative expense line on this report. Compensation, interest expense, occupancy,

depreciation, and amortization and other administrative expense lines should include Administrative Overhead costs only. Refer to Attachment F to assist in the task of determining which costs are clinical care/medical management or administrative overhead for DHS reporting purposes.

Incentive/Risk Pools: This line should include funds received from the Primary Contractor and reserved for potential payment to the Subcontractor for excess medical expenses or incentives. Incentive payments made by the Subcontractor to Providers should be reported as an Administrative Expense under "Other" and disclosed in the notes to the report.

IMPORTANT: For the purpose of allocating administrative expense amounts, use the following guidelines: 1) if the entire expense can be directly attributed to each behavioral health rating group, report exact dollar amounts for each behavioral health rating group; 2) if a portion of the expense can be directly attributed to one or more of the behavioral health rating groups, distribute only the remaining amounts based on the applicable percentage of capitation revenue; and 3) if no portion of the expense can be directly attributed to one or more of the behavioral health rating groups, distribute the entire expense amount proportionately based on the applicable percentage of capitation revenue. Include an explanation of the amount being allocated in the common text area.

3.5 Report #4 – Related Party Transactions and Obligations

Transactions with related parties/affiliates (as defined in the HealthChoices contract) may or may not be in the normal course of business. In the normal course of business, there may be numerous routine and recurring transactions with parties who meet the definition of a related party. Although each party may be appropriately pursuing its respective best interest, transactions between them must be disclosed to the Department.

Description of Relationship or Affiliation, Transaction Code, Income or Receipts, and Expense or Distributions – Report the total amount of each transaction code on a separate line for the current reporting period involving any individual or entity that meets the definition/description of a related party/affiliate as defined in the contract. For example, report all Inpatient Psychiatric Hospital expenses at an affiliated facility for the period, or all medical compensation expenses, including risk pool activity, to owners, medical directors, and/or board members. Other non-medical service transactions should also be reported on this schedule, such as allocation of overhead, rent or management fees to related parties, as well as any loans and/or distribution between related parties.

The transaction codes for this report are as follows:

01) Shareholder Dividends

02) Capital Contributions

03) Purchases, Sales or Exchanges of Loan Securities, Real Estate Mortgage Loans or Other Investments

04) Income/(Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)

05) Management Agreements, Service Contracts, including Contract for Services Provided by the primary contractor, or Purchased by the primary contractor (for the HealthChoices Program) from Other Affiliates, and Non-GAAP Cost Sharing Agreements

06) Income/(Disbursements) Incurred Under Reinsurance Agreements

07) Reinsurance Recoverable/(Payable) on Losses and/or Reserve Credit Taken/(Liability)

98) Other – include explanation in footnote or common text area

Include transactions and obligations that are related to administrative costs associated with the HealthChoices contract. Transactions or obligations that are related to medical costs may be limited to those that are associated with the HealthChoices contract. It is acceptable to provide comprehensive information on qualifying transactions or obligations, without regard to whether they are related to this contract. If the latter option is selected, the reports must specify this in accompanying text.

Amount Due From/(To) Current & Amount Due From/(To) Noncurrent – List current and non-current amounts due from (to) related parties or affiliates. If a due from and due to exists for the same affiliate, the amounts should be netted together and reported as one net amount. However, current amounts should not be netted with non-current amounts.

Current assets or obligations are those expected to be used or satisfied within one year of the last day of the period being reported.

A separate report must be prepared for all entities identified in Attachment D.

3.6 Report #5 – Part A: Risk Pool Analysis

The purpose of this report is to monitor risk pool activity. All revenues and expenses allocated to the risk pool(s) are shown on this report along with risk pool adjustments and distributions.

Line 1 – Revenues Allocated to Risk Pool(s) – All amounts allocated to the risk pool(s) from which claims are to be paid should be reported (capitation, reinsurance, deferred liability and other revenue sources).

Lines 2 through 13 – Expenses Allocated to Risk Pool(s) – The expenses recognized in the risk pool(s) should be reported by expense category. Include provider capitation paid out of the pool(s).

Line 15 – Risk Pool Expense Adjustment(s) for the Period – The difference between the total revenue allocated to the risk pool less the total expenses allocated to the risk pool results in the net adjustment from the current period activity.

Line 16 – Risk Pool Balance(s) at the Beginning of the Period – The beginning risk pool balance should be the accrued risk pool payable from the prior period.

Line 18 – Risk Pool Distribution(s) – All risk pool distribution(s) during the period are to be recorded on Line 18. This amount should equal the ending balance in the Distributions/Contributions column on Report #5 – Part B.

Line 19 – Risk Pool Payable/(Receivable) – If a negative amount is not receivable in full, please provide an explanation on paper, when filing paper copy reports, and in common text area when filing electronically.

If a risk pool arrangement covers multiple levels of care, a proposal for the allocation of amounts across service groupings must be submitted BEFORE submission of the first monthly report. All risk pool arrangements should be reviewed for compliance with the federal requirements concerning physician incentive arrangements.

Part B: Risk Pool Listing by Participant – List all participants in the risk pool(s) on this schedule. Include all prior period risk pool balances along with any distributions to or contributions from these participants during the period. The ending balance for the total of all participants should tie to the last line on Report #5 – Part A.

Risk Pool Accounting – Risk pool contracting passes on some element of risk for members' medical expenses to the subcontracted providers participating in the risk pool. This contracting arrangement is useful as an incentive to maintain proper utilization of medical services. Many of the Counties and subcontractors may have risk sharing arrangements with some or all of their health care providers. For consistency in reporting among the Counties and MCO subcontractors, DHS has established the following suggested guidelines for risk pool accounting. The goal of accounting for risk pools is to identify revenues and expenses relating to providers who are part of a risk pool so that the net results of that activity can be reported in the risk pool expense adjustment accounts and the risk pool payable/receivable account on the financial statements. It is important to note that while only the net results are being reported in these accounts, the total of all revenues and expenditures must be accounted for on the financial statements. Specifically, all revenues and expenses are to be reported gross, not net, of risk pool activity.

As revenues are realized relating to members assigned to a risk pool, they are accounted for as any other revenues, crediting the appropriate account such as capitation, reinsurance, etc. while debiting either cash or receivables. After this accounting is done, the proper allocations are made to the risk pool accounts by debiting the risk pool expense adjustment account and crediting the risk pool payable/receivable account. Likewise, all expenses relating to members assigned to a risk pool are to be reported as debits to the appropriate expense category and credits to cash or claims liabilities. After these entries are made they should be reflected in the risk pool accounts by crediting risk pool expense adjustment and debiting risk pool payable/receivable.

Risk Pool Accounting Example – The following example will illustrate the accounting discussed above. Assume this County/BH-MCO has a risk pool arrangement with a group of primary care physicians whereby they are capitated for their services and all medical expenses relating to the risk pool members are paid out of the pool.

A. The County/BH-MCO receives $100,000 of capitation revenue from DHS that relates to members in the risk pool. The County/BH-MCO allocates 90% of all revenues to risk pools

($100,000 x 90% = $90,000).

B. The County/BH-MCO capitates a group of PCPs $20,000 for their services relating to the risk pool members for the period.
C. During the period, the County/BH-MCO pays $15,000 for hospitalization, $5,000 for medical compensation, and $5,000 for other medical services for members in the risk pool.
D. During the period, the County/BH-MCO receives $10,000 in supplemental revenue (risk pool allocation, $10,000 x 90% = $9,000) and recognizes $5,000 in reinsurance revenue (risk pool allocation, $5,000 x 90% = $4,500) related to risk pool members.
E. At the end of the period, the County/BH-MCO estimates unpaid liabilities relating to the risk pool members as follows: $30,000 hospitalization, $10,000 medical compensation, and $10,000 other medical.
F. The County/BH-MCO pays out the resulting risk pool payable of $8,500.

3.7 Report #6 – Claims Payable (RBUCs and IBNRs)

A claim becomes a Received But Unpaid Claim (RBUC) the day it is received. Incurred But Not Reported (IBNR) claims should be reported in the second to last column by the appropriate Behavioral Health major service grouping.

This is a point-in-time report as of the last day of the month. There is no relationship between the report and service dates.

Show amounts for each Behavioral Health Major Rate Code Service Grouping, net of third party resources.

Claims Liability (Including Claim Estimations, RBUCs & IBNRs) – There are three primary components of claims expense:

- Paid claims.
- RBUCs. Note that a claim is considered an RBUC immediately upon receipt and should be tracked as such. Include, in the footnote to Report #6, the amount of RBUCs that is estimated (i.e., claims in-house but not yet entered on the system).
- IBNRs. **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. This may require a qualification to the actuarial certification.**

The first two components of claims expense are readily identifiable as part of the basic accounting systems being utilized. Since these components, along with a well-established prior authorization and referral system, form the basis for estimation of IBNRs, it is important to have adequate claims accrual and payment systems. These systems must be capable of reporting claims, by major rate code service groupings and by rating group on an incurred or date of service basis, have the capacity to highlight large outlier cases, possess sufficient internal controls to prevent and detect payment errors, and conform to regular payment patterns. Once IBNR estimates have been established, it is imperative that they be continually monitored with reference to reported and paid claims.

Claims expense cannot be properly evaluated without adequate consideration of current trends

and conditions. The following summarizes claims environment factors that should be considered.

- Changes in policy, practice or coverage.
- Fluctuations in enrollment by behavioral health rating group.
- Expected inflationary trends.
- Trends in claims lag time.
- Trends in the length of hospital inpatient stay by behavioral health rating group.
- Changes in behavioral health rating group case mix.
- Changes in contractual agreements.

Elements of an IBNR System – IBNRs are difficult to estimate because the quantity of service and exact service cost are not always known until claims are actually received. Since medical claims are the major expenses incurred, it is extremely important to accurately identify costs for outstanding unbilled services. To accomplish this, a reliable claims system and logical IBNR methodology is required.

Selection of the most appropriate system for estimating IBNR claims expense requires judgement based on the circumstances, characteristics, and the availability and reliability of various data sources. Using a primary estimation methodology, along with supplementary analysis, usually produces the most accurate IBNR estimates. Other common elements needed for a successful IBNR system are:

1. IBNR systems must function as part of the overall financial management and claims system. These systems combine to collect, analyze and share claims data. They require effective referral, prior authorization, utilization review and discharge planning functions. In addition, a full accrual accounting system is necessary. Full accrual systems help properly identify and record the expense, together with the related liability, for all unpaid and unbilled medical services provided to members.

2. An effective IBNR system requires the development of reliable lag tables that identify length of time between provision of service, receipt of claims, and processing and payment of claims by behavioral health major service grouping. Reliable claims/cash disbursement systems generally produce most of the necessary data. Lag tables, and the projections developed from them, are most useful when there is sufficiently accurate claims history which shows stable claims lag patterns. Otherwise, the tables will need modification on a proforma basis to reflect corrections for known errors or skewed payment patterns. The data included in the lag schedules should include all information received to date in order to take advantage of all known amounts (i.e. RBUCs).

3. Accurate, complete and timely claims data should be monitored, collected, compiled and evaluated as early as possible. Whenever practical, claims data collection and analysis should begin before the service is provided (i.e. prior authorization records). This prospective claims data, together with claims data collected as the services are provided, should be used to identify claims liabilities.

4. **Claims data should also be segregated to permit analysis by behavioral health rating group, behavioral health major service grouping, major provider, and county, if more than one county's membership is maintained on the system.**

5. Subcontractor agreements should clearly state each party's responsibility for claims/encounter submission, prior notification, authorization and reimbursement rates. These agreements should be in writing, clearly understood and followed consistently by each party.

6. The individual IBNR amounts, once established, should be monitored for adequacy and adjusted as needed. If IBNR estimates are subsequently found to be significantly inaccurate, analysis should be performed to determine the reasons for the inaccuracy. Such an analysis should be used to refine an IBNR methodology, if applicable. **Material changes in estimates to an IBNR methodology must be reported to DHS in the period during which it occurs.**

IMPORTANT: There are several different methods that can be used to determine the amount of IBNRs. Employ the one that best meets your needs and accurately estimates the IBNRs. The IBNR methodology being utilized must be submitted to the Department. The IBNR methodology used must be evaluated by an independent accountant or actuary for reasonableness. An actuarial certification of claims liabilities shown on the Balance Sheet must accompany the Balance Sheet as required in the instructions for Report #13.

For further information concerning lag tables refer to the instructions for Report #7.

3.8 Report #7 - Lag Reports

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

A separate form must be completed for each of the eleven behavioral health major service groupings, as well as a total page.

Expenditures for CBCM and payments made by the Primary Contractor to non-Medicaid providers, including CBOs, are not considered medical expenses and are excluded from Report #7.

The schedules are arranged with dates of service horizontally and 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 3, while payments made during the current month for services rendered in prior months would be reported on Line 1, Columns 4 through 27. Do not include risk pool distributions as payments in this schedule.

Line 27 – The expense reported to DHS on Report #9 for each behavioral health major service grouping in the current and previous months should be recorded, on Line 27 in the appropriate column.

Line 28 – "Remaining Liability", represents any remaining liability estimated for each month.

Only data applicable to the HealthChoices program is to be included in this report. The Lag Report should not be adjusted for Reinsurance Recoveries.

Lag Tables – Lag tables are used to track historical payment patterns. When a sufficient history

exists and a regular claims submission pattern has been established, this methodology can be employed. Lag information should be used as a validation test for accruals calculated using other methods if it is not the primary methodology employed. Typically, the information on the schedules is organized according to the month claims are incurred on one axis (horizontal) and the month claims are paid on the other axis (vertical). Specific information by Behavioral Health rating group, and by Behavioral Health major service grouping, must be tracked, as each population may have different characteristics.

Once a number of months become "fully developed" (i.e. claims submissions are thought to be complete for the month of service), the information can be utilized to effectively estimate IBNRs. This is done by computing the average period over which claims are submitted historically and applying this information to months that are not yet fully developed.
Lag Table Example – The following simple example demonstrates the lag table approach discussed above.

Fully Developed Table
Month Incurred (Date of Service)

Month Paid	January	February	March	Total	Percent of Total	Cumulative Percent
Current	$1,400	$800	$2,000	$4,200	10.0%	10.0%
1st Subsequent	$8,200	$8,750	$8,500	$25,450	60.6%	70.6%
2nd Subsequent	$3,700	$2,800	$3,750	$10,250	24.4%	95.0%
3rd Subsequent	$700	$650	$750	$2,100	5.0%	100.0%
TOTAL	**$14,000**	**$13,000**	**$15,000**	**$42,000**	**100.0%**	

This table indicates that 10% of all claims are reported and paid in the month services are rendered; in the next month, 60.6% of the claims are paid; and so on. In this example, all claims are shown to be paid within four months from the date of service (i.e. fully developed). This may be unrealistic but it satisfies the needs of this example. The above information can be used to calculate IBNRs by looking at claims payment experience for the three months prior to the balance sheet date.

By dividing claim payments to date by the decimal form of the cumulative percent developed from the fully developed table for the applicable month, an estimate is made of each month's total claims to be experienced for the period. Subtracting the total claims paid to date from this estimate yields the estimated claims accrual.

The following steps must be taken:

In order to estimate the total claims expense as of the end of June:

1. For each month not yet fully developed, the cumulative percentage (obtained from the fully developed table) should be divided into the total amount of claims paid to date for each month. The result will be the estimated total claims expense for each month.

2. Subtract all claims already paid or received (RBUCs) for that month from the estimated total claims expense for each month. The remainder represents your IBNR estimates.

Month Paid	April	May	June	Total
Current	$1,600	$1,900	$1,600	$5,100

1st Subsequent	$9,700	$10,600	$-------	$20,300
2nd Subsequent	$3,800	$--------	$-------	$3,800
3rd Subsequent	$--------	$--------	$-------	$--------
TOTAL	**$15,100**	**$12,500**	**$1,600**	**$29,200**
Divided by Cumulative				
Percent Paid	95.0%	70.6%	10.0%	N/A
Estimated Total				
Claims Expense	$15,895	$17,705	$16,000	$49,600
Less: Amount				
Paid to Date	($15,100)	($12,500)	($1,600)	($29,200)
Less RBUCs	($100)	($200)	($1,100)	($1,400)
Estimated Claims				
Accrual (IBNR)	$695	$ 5,005	$13,300	$19,000

It should be noted that the estimates developed by this lag technique should be monitored for reasonableness. This is especially true for the most recent months where the information is less developed than the older months. If the calculation is producing an unusually low or high total claims accrual for any particular month, it should be investigated for validity. An example of a possible solution is to override the skewed portion of the IBNR with an average monthly cost less the amount paid to date for that month.

3.9 Report #8 – Claims Processing Report

Refer to Attachment E for additional information on claims processing requirements.

This report should reflect the status of claims entered into the claims processing system as of the end of the month being reported.

Part A should reflect the number of claims. For purposes of this report, each claim line is counted as 1 claim.

Part B should reflect the dollar amount of claims.

- "#/$ Amount of Claims Received" column includes all claims entered into the claims processing system with a receipt date prior to the end of the month being reported. Report the dollar amount of the claim that is allowable/authorized by the County/BH-MCO. If the dollar amount cannot be determined, include the claim on Part A and report as $0 dollars on Part B. However, if the claim is included as part of the RBUC estimate on Report #6, Claims Payable (RBUCs and IBNRs), the estimate must be included on Part B and adjusted when the dollar amount can be determined.

- "#/$ Amount of Clean Claims" column should include the number or dollar amount of clean claims received. If efforts are made internally to procure the necessary information to adjudicate a pended claim, the claim should be moved from the "#/$ Amount of Claims Not Adjudicated" column to the "#/$ Amount of Clean Claims" column and either "Paid" or "Rejected" for the month received. However, if the claim is pended and later returned to the provider for further information, it should be removed from the "#/$ Amount of Claims Not Adjudicated" column and shown as "Rejected" only.

– Clean Claim – A claim that can be processed without obtaining additional information from the

Provider of the service or from a third party. It includes a claim with errors originating in the Primary Contractor's claims processing computer system, and those originating from human errors. It does not include a claim under review for Medical Necessity, or a claim that is from a Provider who is under investigation by a governmental agency or the Primary Contractor or BH-MCO for fraud or abuse. However, if under investigation by the Primary Contractor or BH-MCO, the Department must have prior notification of the investigation.

  - A clean claim does not include claims pended or rejected because they require additional information either from a provider or from internal sources (i.e. claims pended for an authorization number, etc.), a claim under review for medical necessity; or a claim submitted by a provider or contractor reported as being under investigation by a governmental agency.

- "#/$ Amount of Claims Not Adjudicated" column should include **all** claims that have not been adjudicated. This includes approved but unpaid claims, as well as claims requiring additional information from the provider of the service and or from a third party.

- "Paid" column includes all claims for which a check has been created or an electronic payment has been transferred to the provider.

- "Clean Rejected" column includes all clean claims that have been returned to the provider or third party.

  - Clean Rejected Claim – A claim that is returned to the provider or third party due to ineligible recipient or service.

- "Unclean Rejected" column includes all unclean claims that have been returned to the provider or third party.

  - Unclean Rejected Claim – A claim that is returned to the provider or third party for additional information.

As claims are adjudicated, they should be reflected in the aging columns as either paid or rejected.

Part C – The Contractor must also include a listing of all clean claims currently in-house that have not yet been adjudicated within 45 days separated by the three categories of service below:

1. Inpatient Claims – Includes claims received for inpatient admissions (Psych and D&A) and RTFs;

2. Practitioner and Outpatient Claims – Includes claims for all outpatient services (Psych, D&A and Partial), Non-hospital D&A, Non-Accredited RTFs and IBHS for children.

3. Other Claims – Includes claims for Ancillary or Community Support services, or claims received from any providers not included in category 1. or 2. (above).

The listing should include both number of claims and dollar amount of claims. When the claim is adjudicated, it should no longer appear on this report.

Beginning with the first month of the second contract year, this report should reflect data for the 12 most recent months of the HealthChoices program. In the event that claims from 13 months prior

or before are still not adjudicated, two versions of this report should be filed; one for the most recent 12 months; and one for the prior 12-month period.

Any interest or penalties paid to providers should not be included in this report.

3.10 Report #9 – Analysis of Revenues and Expenses

This report is meant to be an analysis of revenues and expenses. In Part A, information should be completed for each behavioral health rating group. Part B will sum the information shown on Part A. Consistent with GAAP, capitation revenue is reported on an accrual basis.

Line 3 – Other Revenues – All "Other" revenue reported must be disclosed by source, regardless of materiality. Only contract-related revenue should be reported. "Other" Revenue reported on Report #2 and Report #3 that represents a transfer of funds between entities should **not** be included on Report #9 (i.e., sanctions imposed by the County on the BH-MCO or a transfer of medical management funds.)

Line 5 – Inpatient Psychiatric must be reported on Part A and Part B of the report by Freestanding Psychiatric Facility or Other. The Freestanding Psychiatric Facility line is only to be used for expenses related to persons between the ages of 22–64. Expenses for Freestanding Psychiatric Facilities that are related to persons not between the ages of 22–64 should be included in the Other line as well as all inpatient psychiatric expenses for facilities that are not Freestanding Psychiatric Facilities.

Lines 6, 7, 9, and 12 – Refer to the OMHSAS and DDAP Medical Necessity Criteria Appendix of the HealthChoices Behavioral Health PSR for details of items that should be included on these lines.

Line 7)b – Non-Hospital D&A Non-Accredited Room and Board (CISC) should include room and board expenses for children who are in substitute care placed in a non-accredited non-hospital D&A facility. These expenses are not MA reimbursable and are not included in the HealthChoices capitation rate base. Expenses related to the treatment component should be reported on Line 7)a.

Line 10)b – CRR Host Homes Room and Board should include room and board expenses for children who are **not** in substitute care placed in CRR Host Homes. These expenses are not MA reimbursable and are not included in the HealthChoices capitation rate base. Expenses related to the treatment component should be reported on Line 10)a.

Line 12)b – RTF Non-Accredited Room & Board should include room and board paid to Children and Youth Licensed Group Homes with a Mental Health Treatment Component (formerly known as CRR Group Homes), as well as other Non-JCAHO RTF room & board paid for children who are **not** in substitute care. Expenses related to the treatment component should be reported on Line 12)a. Non-Accredited RTF room and board funded by Children and Youth should be reported on Line 19.

Line 15)a – Individual stop loss reinsurance premiums should be reported on this line as Medical Expense "Other". Aggregate reinsurance premiums should be reported as Administrative "Other". Reinsurance Recoveries should be reported in the appropriate category of service and rating group.

Line 15)b – “Other Medical Services” reported must be disclosed by local code and by national code and modifier combination, as well as a detailed description, regardless of materiality.
Line 16)f – Clinical Care/Medical Management: All Clinical Care/Medical Management expenses should be reported on this line. The amounts reported on this line should not be duplicated in any other administrative expense line on this report. Compensation, interest expense, occupancy, depreciation and amortization and other administrative expense lines should include Administrative Overhead costs only. Refer to Attachment F to assist in the task of determining which costs are clinical care/medical management or administrative overhead for DHS reporting purposes.

Line 19 – Both parts of the report also include Line 19 for the reporting of Non-Accredited, Room & Board expenses, Children and Youth Secondary Funding Sources. Information provided on this line must NOT include any funding included as part of the capitation. Funding is to include only other funding sources, such as from Children and Youth or other secondary sources. Amounts reported in this row must NOT be included within any of the capitation rows (1–15).

No Incentive Payment transactions to subcontractors (reserves or distributions) should be included in this report.

This report must be provided in two versions: Current period dollar amounts (Part A) and per member per month (PMPM) amounts (Part B). Part A should reflect dollar amounts for the current period. Part B should reflect the sum of all dollar amounts listed on Part A, YTD dollar amount, and PMPM amounts for both the current month and YTD dollar amounts.

Amounts should be net of third party resources collected.

IMPORTANT: For the purpose of allocating administrative expense amounts, use the following guidelines: 1) if the entire expense can be directly attributed to each behavioral health rating group, report exact dollar amounts for each behavioral health rating group; 2) if a portion of the expense can be directly attributed to one or more of the behavioral health rating groups, distribute only the remaining amounts based on the applicable percentage of capitation revenue; and 3) if no portion of the expense can be directly attributed to one or more of the behavioral health rating groups, distribute the entire expense amount proportionately based on the applicable percentage of capitation revenue. Include an explanation of the amount being allocated in the common text area.

3.11 Report # 11 (Behavioral Health) - Coordination of Benefits Reports

This report is used to capture the MCO’s activities involving third party resources. The reporting is compiled using quarterly data. These reports will be submitted quarterly, however, each report contains three months of accumulated history. Each report is separated into the types of claims that the service represents. Each report is also divided by resource type, Commercial and Medicare. On each report, there are fields for the **Commercial Subtotal** and the **Medicare Subtotal.** The figures within each column should equal the resource subtotal. On each report, the final line is the combination of both the **Commercial** and **Medicare Subtotals** for all claim types.

- Commercial is defined by carrier codes beginning with numbers 2 (200's), 3 (300's), 4 (400's), 5 (500's) and 7 (700's).

- Medicare is defined by carrier codes beginning with numbers 1 (100's) and 6 (600's).

NOTE: Report Hospital stay charges (i.e. the Room and Board) in the "Inpatient" fields. Report physician, lab and any procedure charges associated with an inpatient stay in the "Outpatient/Professional" fields.

REPORT 11A – CLAIMS COST AVOIDED: These are claims that the MCO **DENIES**, because a third party health insurance-related resource exists that may cover the service. A "cost avoidance" occurs when a provider submits a claim that has an identified third party liability (TPL) resource, and the provider did not attach an Explanation of Benefits (EOB) indicating that Coordination of Benefits (COB) with the primary insurance carrier occurred and the amount paid by the other insurance.

NOTE: Total number of claims processed (Column D) as identified below is the "Total" number of claims processed that had a TPL resource (either coordinated or denied) whether it was an initial submission, a corrected claim, or a resubmitted claim.

Complete Report **11A** as follows:

Step 1: The MCO must first identify whether this is a **COMMERCIAL** or a **MEDICARE** resource and the type of claim (Inpatient, Outpatient/Professional) as indicated in column A.

Step 2: Identify the total number of claims with COB processed with a known TPL resource: 1) at initial claim submission, 2) when a provider resubmits a claim that was previously denied due to a TPL resource without an EOB attached, and 3) when the provider re-submits a claim with an EOB attached after an unknown TPL resource has been discovered, and enter the number in the appropriate row in column B.

Step 3: Identify the total number of claims denied due to a known TPL resource submitted without an EOB attached, and enter the number in the appropriate row in column C. Identify the total dollar amount of claims denied due to a known TPL resource submitted without an Explanation of Benefits (EOB) attached, and enter the number in the appropriate row in column F.

*NOTE: A claim is considered denied if the entire claim is denie*d. *Partial coordination with another resource should be considered coordinated.*

The total number of claims with a TPL resource coordinated or denied is the summation of the totals found in columns B and C. This total amount is displayed in column D. The percent of claims denied with a known TPL resource without an EOB attachment is calculated by dividing column C by column D. These figures are displayed in column E.

Step 4. Identify the total dollar amount of claims with coordination of benefits processed with a known TPL resource, and enter the amount in the appropriate row in column F. This dollar amount will correspond to the claims reported in column B. Also, identify the total dollar

amount of claims denied due to a known TPL resource submitted without an Explanation of Benefits (EOB) attached and enter the number in the appropriate row in column G. This dollar amount will correspond to the claims reported in column C.

Step 5: Identify the total number of unique members active with a TPL resource at the end of the quarter being reported for Commercial and Medicare in the appropriate row in column H. If a member has BOTH Commercial and Medicare, report the member as having Medicare.

NOTE: This is the total number of active members (count ONLY once) that have an identified TPL resource regardless if a claim was processed or not for the member.

Report #11A

Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H
Type of Resource by Type of Claim	Total Number of Claims with Coordination of Benefits Processed with a Known TPL Resource	Total Number of Claims Denied Due to a Known TPL Resource without an EOB Attachment	Total Number of Claims with a TPL Resource Coordinated or Denied (Column B + Column C)	Percent of Claims Denied with a Known TPL Resource without an EOB Attachment (Column C Divided by Column D)	Total Dollar Amount of Claims with Coordination of Benefits Processed with a Known TPL Resource (Dollar amount corresponding to Column B)	Total Dollar amount of Claims Denied Due to a Known TPL Resource without an EOB Attachment (Dollar amount corresponding to Column C)	Total Number of Members Active with a TPL Resource at the End of the Quarter (Commercial, Medicare, Total Commercial and Medicare)

Step 6: In the comment box, at the end of the report, describe any changes in cost avoidance or COB processing methodologies.

REPORT #11B(1) - PROVIDER REPORTED: These are the **REPORTED** payments received by the provider from third party insurers when coordination of benefits has occurred: 1) at initial claim submission, and 2) when a provider resubmits a claim that was previously denied due to a known TPL resource without an EOB attached. These amounts are reported by the provider in the **Other Insurance** Paid and the **Medicare Paid** fields on encounter data.

Complete Report #**11B(1)** as follows:

Step 1: The MCO must first identify whether it is a **COMMERCIAL** or a **MEDICARE** resource and the type of claim (Inpatient, Outpatient/Professional) as indicated in column A.

Step 2: Identify the number of claims reported by a provider as paid by the third party insurer and enter that number in the appropriate **NUMBER OF CLAIMS** field in column B.

Step 3: Identify the amount the provider billed the MCO and enter the amount in the appropriate row in column C, **AMOUNT BILLED** field.

Step 4: Identify the amount the provider received from the third party insurer noted/documented on the EOB and enter the amount in the appropriate row in column D, the **AMOUNT REPORTED** field.

Report #11B(1)

Column A	Column B	Column C	Column D
Type of Resource by Type of Claim	Number of Claims	Amount Billed	Amount Reported

*Note: If BOTH Medicare and Commercial Medicare Supplemental insurance is available to pay for an encounter/service, the **claim is counted as Medicare**, because **Medicare is always the primary payer over a Commercial Medicare Supplemental insurance**. However, each of the two payments should be reported separately under the two types of resource.*

Example:

The Provider bills the MCO **$15,000** for **1** inpatient claim and **received a payment of $1,500** from Medicare. The claim also shows that the provider **received $500** from the Commercial Medicare Supplemental insurance.

Report #11B(1)

Column A	Column B	Column C	Column D
Type of Resource by Type of Claim	Number of Claims	Amount Billed	Amount Reported
Commercial			
Inpatient			
Medicare			
Inpatient	1	15,000	1,500

REPORT #11B(2)- : MCO Recovered: These are the amounts collected from a Provider or a third party insurer **after** the MCO has already paid the Provider for the encounter/service. The MCO should have an established process for collecting payments from third party insurers to effectively process a retroactive TPL resource or discovery of a missed coordination of benefits opportunity.

If the MCO initially pays a claim, then later discovers there is a liable third party insurer, or newly acquired coverage retroactive to the date of service, the MCO should retrospectively review the claims previously paid, within the allowable recovery "Window of Opportunity" (6 months from the date of adjudication or 9 months from the date of service) determine if any fall within the effective date of eligibility, and attempt to collect the money from the provider or the third party insurer. In order for the provider to resubmit a retroactive TPL resource claim for payment, they would need to attach the appropriate EOB with the dollar amount paid by the other insurance (Provider Reported). The amount collected when a provider resubmits a claim that was previously denied due to a TPL resource without an EOB attached should be recorded as Provider Reported and captured as part of the claims payment process.

Complete Report #**11B(2)** as follows:

Step 1: The MCO must first identify whether it is a **COMMERCIAL** or a **MEDICARE** resource and the type of claim (Inpatient, Outpatient/Professional) as indicated in column A.

Step 2: Identify the number of claims reported by a provider as paid by the third party insurer and enter that number in the appropriate **NUMBER OF CLAIMS** field in column B.

Step 3: Identify the amount the provider billed the MCO and enter the amount in the appropriate row in column C, **AMOUNT BILLED** field.

Step 4: Identify the amount the provider received from the third party insurer noted/documented on the EOB and enter the amount in the appropriate row in column D, the **AMOUNT REPORTED** field

Report #11B(2)

Column A	Column B	Column C	Column D
Type of Resource by Type of Claim	Number of Claims	Amount Billed	Amount Reported

*Note: If BOTH Medicare and Commercial Medicare Supplemental insurance is available to pay for an encounter/service, the **claim is counted as Medicare**, because **Medicare is always the primary payer over a Commercial Medicare Supplemental insurance**. However, each of the two payments should be reported separately under the two types of resource.*

Example:

The Provider bills the MCO **$15,000** for **1** inpatient claim and **received a payment of $1,500** from Medicare. The claim also shows that the provider **received $500** from the Commercial Medicare Supplemental insurance.

Report #11B(2)

Column A	Column B	Column C	Column D
Type of Resource by Type of Claim	Number of Claims	Amount Billed	Amount Reported
Commercial			
Inpatient			500
Medicare			
Inpatient	1	15,000	1,500

REPORT #11C -THIRD PATY DIRECT OR VENDOR RECOVERED: : These are the RECOVERED amounts regarding a TPL resource that has **not been captured in the claims processing** system as Other Insurance, and not reported as Provider Reported on Report 11B(1). An example of a RECOVERED amount would be direct recoveries from the third party insurer or if the MCO uses a third-party recovery vendor and the vendor reports recoveries based on discovering a TPL resource or other TPL-related missed opportunity. The vendor recovery dollars, if not recorded in the claims system on individual claims as other insurance paid

(Provider Reported), would be reported as Third Party Direct or Vendor Recovered.

Complete Report #**11C** as follows:

Step 1: The MCO must first identify whether it is a **COMMERCIAL** or a **MEDICARE** resource and the type of claim (Inpatient, Outpatient/Professional)

Step 2: Identify the number of claims associated with the recovered amount (as defined above) and enter that number in the appropriate **NUMBER OF CLAIMS** field in column B.

Step 3: Enter the Total Amount Recovered in the **GROSS AMOUNT RECOVERED** field.

Step 4: If some of the recovered dollars is paid to a contractor (e.g. recovery vendor), enter the Portion Received by the MCO in the **NET AMOUNT RECOVERED** field and DO NOT report any third party payment with the Provider Reported data if the MCO bills the third party insurer directly.

Example:

The MCO has a contract with a recovery vendor. The vendor recovers **$1,000** for the MCO for **1** commercial inpatient claim. The vendor charges a fee of 25% or $250. **The Gross amount of $1,000** is reported in Column C. **The Net Dollar Amount recovered is $750** ($1,000 less $250) and is reported in Column D.

Report #11C

Column A	Column B	Column C	Column D
Type of Resource by Type of Claim	Number of Claims	Gross Amount Recovered	Net Dollar Amount Recovered by the MCO
Commercial			
Inpatient	1	1,000	750

NOTE: If an amount is recovered due to a TPL resource and not captured as "Provider Reported" in the claims system as other insurance paid, the amount should be reported on Part C as Recovered and mapped to the type of resource and type of claim. A description of the recovered amounts should be provided in the comment box if the detail by type of claim is not available.

The Gross Amount Recovered should be offset to medical expense, and the Vendor fee would be an Administrative Expense. If the recovery vendor pays interest on any funds they hold for a period of time, the interest would be reported as Interest Income.

Step 5: In the comment box, describe any significant recovery efforts the MCO or recovery vendor have undertaken that would be useful to DHS in understanding amounts reported and time periods affected.

This report is to be submitted electronically to the TPL RA mailbox. The excel template for this report will be provided to all MCOs and is available, by request, through DHS/BPI Contract Management. This report is due 45 days after the end of the program quarter and should be emailed to RA-PWBHCostAvoidance@pa.gov.

Please Note: When submitting Financial Report 11 to the TPL RA mailbox, use the below format for the email subject line:

"[BH-MCO Name] – [County Name] – [Reporting Quarter]"

The excel file template should follow the naming convention as outlined in Attachment L, Appendix B. An example of the file name is:

FIN_2022_BU_Q1_31.xls

3.12 Report #12 - Reinvestment Report

The purpose of this report is to monitor reinvestment activity. All approved allocations to and distributions from the reinvestment account are to be shown on this report. This report must be prepared on a cash-basis (report deposits and payments in the month in which they occur). No accruals for services should be reflected on this report.

Reinvestment funds can be deposited when identified, but **must** be placed in a restricted account within 30 days of the OMHSAS written approval of the County's reinvestment plan(s).

IMPORTANT NOTE: The services reported on this report should NOT be reported on Report #9. Report #9 should only reflect those medical services being provided under the current year's capitation revenue.

A separate report must be provided for each of the following groups:

1. All HealthChoices (all HealthChoices eligible recipients)
2. Other (non-HealthChoices recipients or non-identifiable recipients)
3. Total (total of the two categories above)

A methodology for allocating costs that are not attributable to a specific rating group must be submitted and approved by DHS prior to implementation.

In addition, if reinvestment funds from more than one contract year are being utilized, a separate set of reports must be filed for each contract year's reinvestment funds.

The Prior Period Balance is the reinvestment account balance as of the last day of the prior calendar month for the "Current Period" column; the reinvestment account balance as of the last day of the prior year for the "Year to Date" column; and $0 for the "Contract to Date" column.

Allocations/contributions are funds transferred into the reinvestment account.

Investment Revenue is income generated by the undistributed funds retained in the reinvestment account. Reinvestment revenue represents earnings on prior year funds and should appear on Report #12 only.

Approved Distributions are funds withdrawn from the reinvestment account in accordance with the DHS-approved Reinvestment Plan. A written plan for reinvestment must be submitted to and approved by DHS prior to making any distribution. Administrative costs, such as bank fees, should be reported on a separate line. Any administrative costs reported **must** be disclosed in detail in the footnotes to these reports.

Ending Balance is the reinvestment account balance as of the end of the last day of the calendar month.

The Budgeted Amount column should reflect the amounts and services contained in the DHS-approved reinvestment plan. Budgeted Investment/Interest Income should reflect either estimated interest to be earned on HealthChoices funds deposited in the reinvestment bank account and included in the Budget Forms submitted with your reinvestment plans to DHS for approval or interest earned on funds deposited in the reinvestment bank account and allocated to approved reinvestment plans. Budgeted Amounts are not required to be allocated by rating group and can be reported only on the Total page. For electronic reporting, Budgeted Amounts may be reported in total as "Other".

The HealthChoices Behavioral Health Program Requirements for County Reinvestment Plans requires that revisions to an individual reinvestment plan priority, which are the greater of twenty-five percent (25%) or $50,000 for the priority being revised, be approved by OMHSAS in advance. Revisions less than the preceding requirements can be made without OMHSAS approval. All revisions to budget amounts made without OMHSAS approval must be included in the footnotes to the reports.

The bank statements for the reinvestment account must be submitted with each month's report. The Department reserves the right to request additional documentation.

Columns are provided for reporting the number of unduplicated recipients served, current month units of service provided and dollar amount paid for those services, as well as cumulative year to date and contract to date units of service provided and dollar amount paid. Effective January 1, 2019 this information should be reported.

3.13 Report #13 - Balance Sheet/Statement of Net Assets

This report should include all HealthChoices Behavioral Health contract assets and liabilities. IBNRs and RBUCs should be reported separately. The Balance Sheet should be broken out, at a minimum, into current and noncurrent assets and liabilities. Claims liability on the balance sheet must agree with Report #6 and Report #7. If any single balance sheet item classified under "Other" Current Asset/Liability or Noncurrent Asset/Liability is $\geq$ 5 percent (5%) of the total for that section, please provide an itemized list and dollar amount for that item.

Any Risk and Contingency Fund must be reported as a separate line item on the Balance Sheet.

County operated BH-MCOs as primary contractors must submit the balance sheet for the Special Revenue/Enterprise Fund containing the HealthChoices Behavioral Health contract transactions monthly. An actuarial certification of the claims liabilities shown on the balance sheet must be submitted **quarterly**. All others should file the balance sheet as indicated in Attachment D and submit an actuarial certification of the claims liabilities shown on the balance sheet **annually**.

NO FORM IS PROVIDED FOR THIS REPORT.

3.14 Report #14 - Statement of Revenues, Expenses and Changes in Retained Earnings (Deficit)/Fund Balance

County operated BH-MCOs as primary contractors must provide the Statement of Revenues, Expenses and Changes in Retained Earnings (Deficit)/Fund Balance for the Special Revenue/Enterprise Fund containing the HealthChoices Behavioral Health contract transactions when Reports #2, 3 and #9 are due. All others should file this report as indicated in Attachment D. This report must include a current period and a year to date column. The revenue and expense line items should include, at a minimum, the line items listed in Report #9. If any revenue or expense item classified as "Other" is $\geq$ 5 percent (5%) of the total for that account classification, please provide an itemized list and dollar amount for that item.

NO FORM IS PROVIDED FOR THIS REPORT.

3.15 Report #15 - Statement of Cash Flows

County operated BH-MCOs as primary contractors must provide the Statement of Cash Flows for the Special Revenue/Enterprise Fund containing the HealthChoices Behavioral Health contract transactions when Reports #2, #3 and #9 are due. All others should file this report as indicated in Attachment D.

NO FORM IS PROVIDED FOR THIS REPORT.

3.17 Report #17 - Contract Reserves Compliance Report

The HealthChoices Behavioral Health PSR effective January 1, 2008 specifies equity requirement: This report states whether or not the overall reserve requirement has been met. The report should include the detailed calculation used to determine compliance. If there is a lack of compliance, the report must include an analysis of the fiscal status of the contract and a corrective action plan for fiscal improvement that management plans to take to ensure compliance. All HealthChoices capitation revenues, for all contracts, must be included in the calculation of the reserve requirement for entities responsible for meeting this requirement.

The Report for the quarter ending December 31 is due March 1 to coincide with the due date for Report #24, Insurance Department Annual Filing.

A FORM IS PROVIDED FOR THIS REPORT.

3.18 Report #18 - Insurance Department Quarterly Filings

These reports must be filed with DOI by any licensed, risk-bearing MCO. These reports should be provided on the forms created for DOI. Provide a copy of the reports as submitted to DOI, including any and all amendments to these reports.

NO FORM IS PROVIDED FOR THIS REPORT.

3.19 Reserved

3.20 Report #20 - Annual Counterpart Reports

Annual counterparts to Monthly Reports #2, #3, #4 and #9A must be filed. The annual counterparts should reflect the sum of the reports submitted for the year to DHS. The amounts reported will be verified against the monthly reports by DHS. The annual counterparts should be submitted in the same formats as the monthly reports, and should include the annual certification statement, included in this package. No revisions will be accepted for either the annual counterpart reports or the last quarter of the fiscal year's financial reports unless requested by DHS.

If requested, the Individual County Annual Reports for Multi-County contracts should be available for Reports #1, #2, #3, #7,#9, #12 & #29.

THE ANNUAL CERTIFICATION STATEMENT IS PROVIDED FOR THIS REPORT.

3.21 Report #21 – Annual HealthChoices Behavioral Health Contract Audit

The annual contract audit shall be performed in accordance with the HealthChoices Behavioral Health Contract Audit Guide for the applicable contract year, and the HealthChoices Behavioral Health Contract Audit Clause.

NO FORM IS PROVIDED FOR THIS REPORT.

3.22 Report #22 – Audited General Purpose Financial Statements

NO FORM IS PROVIDED FOR THIS REPORT.

3.23 Report #23 – Annual Subcontractor Entity-Wide Audit

This report should be the annual entity-wide audit complete with independent auditor's opinion, notes to the financial statements, and management letters. Please refer to Attachment D for additional information on which entities are required to submit this audit.

NO FORM IS PROVIDED FOR THIS REPORT.

3.24 Report #24 – Insurance Department Annual Filing

These reports must be filed with DOI by any licensed, risk-bearing BH MCO. These reports should be provided on the forms created for DOI. Provide a copy of the reports as submitted to DOI, including any and all amendments.

NO FORM IS PROVIDED FOR THIS REPORT.

3.25 Report #26 – Insurance Department Annual Audited Financial Statements

These reports must be filed with DOI by any licensed, risk-bearing MCO. Provide a copy of the

reports as submitted to DOI, including a copy of the management letter. Any revisions to these financial statements must also be submitted to DHS.

NO FORM IS PROVIDED FOR THIS REPORT.

3.26 Report #29 – CBCM Expenditures Report

This report includes all HealthChoices funded CBCM program expenditure activities, whether operated by the Primary Contractor or contracted through a vendor and/or provider. The report must include CBCM expenditures for every approved, HealthChoices funded CBCM initiative to show spending of CBCM funds for each initiative.

One quarterly submission using the supplied template is required for each reporting period. Additionally, an annual submission is required using the supplied Annual template and must include reporting on all HealthChoices funded CBCM initiatives undertaken during the calendar year.

The report submissions are required to include the name of each CBCM initiative approved on a separate row of the report template. Expenditures are reported by month for each individual initiative, which are used to calculate the "Year to Date Total". Contractors are also required to include the "Proposed Total Cost" for each initiative that reflects the approved distribution of CBCM funding by initiative. The total expenditures across all initiatives are shown in Row 57. The total amounts shown in this row should be consistent with the CBCM expenditures identified in the notes for Report #9.

A text box is included below the table. This should be used to provide an explanation for any discrepancy in spending, including over-spending, under-spending or any delay in implementation.

3.27 Report #42 – Medical Loss Ratio (MLR Report)
See Appendix O

3.28 Report #43 – Reinvestment Sharing Calculations
This report is used to calculate any reinvestment sharing recoupments owed back to the Commonwealth. The report is included the same Excel-based template as the MLR Report, or Report #42, and the data entered in the MLR template is used in the Report #43 calculations.

The report is to be submitted to the web-based financial reporting system by November 15th of the year following the agreement period that is being reported. For example, the MLR report for the CY 2024 agreement period will be due to the Department on November 15th, 2025.

The report is arranged into five different sections. The first three sections are used to calculate Net Capitation Revenue, Administrative Expense and Medical Expense that are all used in the recoupment calculation. The fourth section is used to collect information on any OMHSAS-approved adjustments that should be applied when calculating the reporting year's savings. Finally, the "Recoupment Calculation" combines the information from the previous sections to calculate any recoupment amount owed back to DHS.

Information in Report #43 that is automatically populated is identified using black font and white background. Rows in the report that are populated using data from the MLR Report include a

reference to the Line(s) where this data is entered in Report #42. Rows that are automatically calculated using a formula also describe the calculation.

The reinvestment sharing calculations also require Primary Contractors to provide additional financial data identified in cells with blue font and yellow background. Financial data inputs that DHS expect to reflect amounts already reported in the audited annual Report #2 are identified. For the other financial data inputs:

Line II.8 – This line should be used to report any program administrative expenses that are not already reported in Lines II.I through II.7. This line can be used to capture any BH-MCO incentive payments or CBCM expenditures not included in Line II.5 Clinical Care/Medical Management (if the CBCM expenditure is not in Line 9f of Report #2).

Line III.5 – One-time lump sum payments (retroactive payments and retroactive rate adjustments) must be submitted to OMHSAS prior to September 30th of the agreement period to be included in the reinvestment sharing calculations. Include any amounts for one-time lump sum payments made to providers after September 30th of the reporting year so they may be excluded from the reinvestment sharing calculations. Note that supporting documentation must be provided to and approval granted by OMHSAS, and that any retroactive payment rate adjustments must be tied to quality and/or performance measure improvements.

Lines IV.1 and IV.2 – These lines should be used to report any adjustments for risk and contingency transfers or restricted reserves. This would include any interest retained in either account and this would not include any approved transfers from either the risk and contingency and/or restricted reserved account. Amounts entered in these lines must be submitted to and approved by DHS for the reduction to be included in the reinvestment calculations.

Line IV.3 – This line should be used to report any adjustments made to the reported medical expenditures for a medical loss that requires coverage from its BH-MCO. Amounts entered in Report #43 should also be reflected in the notes for Report #2.

Following the Report #43 submission by the Primary Contractor, the Department will review and approve or provide feedback and request a resubmission within 60 days.

3.29 Other Financial Requirements

1. Physician Incentive Arrangement

   To ensure that each managed care contractor is in compliance with the Physician Incentive Arrangement requirements issued by HCFA (61 Fed. Reg. 13430), the County must notify DHS in writing whether any reporting by the County or BH-MCO is required.

2. Equity Requirement

   Submit documentation to support the ability to meet the equity requirement for the subsequent year if anything other than the DOI filings reflecting SAP based equity is being used to meet the requirement.

3. Insolvency Protection Arrangement

Submit documentation to support the ability to meet the insolvency protection arrangement for the subsequent contract year.

4. Risk Protection Arrangements (Stop-Loss Reinsurance)

Submit a copy of the Individual Stop-Loss Reinsurance policy for the subsequent contract year.

5. Reinsurance Experience - Estimated

The estimate of reinsurance experience should include information on high utilizers whose costs exceeded the reinsurance threshold throughout the year. The estimate should be provided by rating group and category of service. This report should also include the current estimate of reinsurance collections.

6. Reinsurance Experience - Actual

The actual reinsurance experience should include information on high utilizers whose costs exceeded the reinsurance threshold throughout the preceding year. Actual experience should be provided by rating group and category of service. This report should also include actual reinsurance collections for the preceding year.

3.30 Financial Data Certification Form

Reports submitted to the Division of Medicaid and Financial Review (DMFR) by HealthChoices Behavioral Health Contractors require certification by authorized signatories on file with DMFR. All reports submitted electronically that are used in rate-setting require concurrent certification per Federal BBA Regulations. The following chart identifies which reports require submission of the Financial Data Certification Form, as well as those that require concurrent submission if submitted electronically:

Submitted Concurrently	Certification Required	#	Report Description
	X	1	Enrollment Table
X	X	2	Primary Contractor Summary of Transactions
X	X	3	Subcontractor Summary of Transactions
	X	4	Related Party Transactions and Obligations
	X	5	Risk Pool Analysis
	X	6	Claims Payable (RBUCs and IBNRs)
X	X	7	Lag Reports
	X	8	Claims Processing Report
X	X	9	Analysis of Revenues and Expenses
	X	11	Coordination of Benefits Report
X	X	12	Reinvestment Report
		13	Balance Sheet
		14	Stmt of Rev, Exp, and Changes in RE (Deficit)/Fund Balance
		15	Statement of Cash Flows
	X	17	Contract Reserves Compliance Report

Submitted Concurrently	Certification Required	#	Report Description
		18	Insurance Department Qtrly Filing
X	X	20	Annual Counterpart Reports
	X	21	Annual HealthChoices Behavioral Health Contract Audit
		22	General Purpose Financial Statements (CAFR)
		23	Annual Subcontract-or Entity-Wide Audit
		24	Insurance Department Annual Filing
		26	Insurance Dept Annual Audited Fin'l Stmts (Audited SAP-based Financials)
X	X	29	CBCM Expenditures Report
			Physician Incentive Arrangement
			Equity Requirement
			Insolvency Protection Arrangement
			Risk Protection (Stop-Loss Reinsurance)
X	X		Estimated Reinsurance Experience
X	X		Actual Reinsurance Experience
			Actuarial Certification of Claims Liabilities
X	X	42	Medical Loss Ratio (MLR Report)
X	X	43	Reinvestment Sharing Calculations

All reports listed in the report grid on the Certification Statement must have a Certification Statement sent concurrently at the time of submission (both original and revised submissions). Certification Statements must be faxed concurrent with electronic and/or email report submissions. Original hard copy Certification Statements must accompany hard copy reports sent in the mail. Reports not listed in the report grid on the Certification Statement but listed above as requiring certification do not need to be faxed concurrently. The certification can be mailed following the submission of electronic or email submissions.

The Date of Submission must be completed on all Certification Statements. The Time of Submission is required on all reports being submitted electronically or via email. It is not required if only submitting hard copy reports.

4.0 REPORTING FORMS

This section includes most of the forms to be completed by the County and the subcontractor. Instructions on the completion of these reporting forms are included in Section 3.

FINANCIAL DATA CERTIFICATION FORM

MONTHLY/QUARTERLY/ANNUAL CERTIFICATION STATEMENT OF

_____
Name of Primary Contractor and Subcontractor

TO THE

PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES

FOR THE PERIOD ENDED

_____, 20_____
(Month & Day) (Yr.)

Name of Preparer _____

Title _____

Phone Number _____

Please check which reports are included with this submission:

Report #	Name of Report	
2	Analysis of Revenues & Expenses – Primary Contractor	
3	Analysis of Revenues & Expenses – Subcontractor	
4	Related Party Transactions and Obligations	
7	Lag Report	
9	Analysis of Revenues & Expenses	
12	Reinvestment Report	
17	Contract Reserves Compliance Report	
20	Annual Counterpart Reports	
21	HealthChoices Contract Audit	
29	CBCM Expenditures Report	
31	Estimated Reinsurance Experience	
32	Actual Reinsurance Experience	

This form is to be executed by the Chief Executive Officer or the Chief Financial Officer of the Entity, or by an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Office or Chief Financial Officer is ultimately responsible for the certification.

I_____(Name),_____(Title) of _____(Entity Name), attest that the information submitted herein is complete, truthful and accurate to the best of my knowledge, information and belief. I understand that any knowing and willful false statement or representation in the information submitted may be subject to prosecution under applicable state laws. In addition, any knowing and willful failure to fully and accurately disclose the requested information may result in termination of the agreement between the Department of Human Services and _____ (Entity Name).

☐ In addition, I hereby attest that the information submitted in the reports herein is considered proprietary and confidential information. I understand that should this information be appealed based on the nature of being proprietary or confidential, the named MCO will defend that decision before the Office of Open Records (OOR), the Bureau of Hearings and Appeals (BHA) or any other forum.

Date of Submission _____ Time of Submission_____

Original Submission? Y N

Revised Submission? Y N

Data Certification forms MUST be converted to PDF and uploaded to the OMHSAS Financial Report Website concurrent with the upload of selected financial reports.

_____	_____	_____
Date	Primary Contractor Authorized Signatory (Name & Title Typewritten)	Signature

_____	_____	_____
Date	Chief Financial Officer/ Subcontractor (Name & Title Typewritten)	Signature

REPORTING ENTITIES

The Department's primary contractor is responsible for the timely filing and accuracy of all financial reports. The following tables are provided as a guideline to assist in determining which entity(s) must file the necessary financial reports. Report #s and titles are found in Section 2.00.

Zone 1 Contractors

Bucks and Montgomery Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
County		Q		Q**	Q**				Q*		M	A	A	A	Q		N/A	A*	A*	A				Q	A	A
MBH-PA	Q		Q	Q**	Q**	M	M	M		Q		Q	Q	Q	Q	Q					A	A	A			

Chester and Delaware Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
County		Q		Q**	Q**				Q*		M	A	A	A	Q		Q	A*	A*	A				Q	A	A
CCBHO	Q		Q	Q**	Q**	M	M	M		Q		Q	Q	Q	Q	Q					A	A	A			

Philadelphia County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
County		Q		Q**	Q**				Q*		M	M	Q	Q	Q	N/A	Q	A*	A*	A		N/A	N/A	Q	A	A
CBH	Q		Q	Q**	Q**	M	M	M		Q											A					

*These reports will be a combination of data from several reporting entities.
** Each entity must file a separate report.

Attachment D

Zone 2 Contractors

Allegheny County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
County	Q	Q*		Q**	Q**				Q*		M	A	A	A	Q		**Q**	A*	A*	A				Q	A	A
CCBHO			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	Q	Q					A	A	A			
UPMC												Q	Q	Q							A					

Beaver County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
County	Q	Q	N/A	Q**	Q**	M	M	M	Q*	Q	M	M	Q	Q	Q	N/A	Q	A	A*	A	N/A	N/A	N/A	Q	A	A
Carelon				Q**	Q**							Q	Q	Q												

Fayette County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
County	Q	Q	N/A	Q**	Q**	M	M	M	Q*	Q	M	M	Q	Q	Q	N/A	N/A	A	A*	A	N/A	N/A	N/A	Q	A	A
Carelon				Q**	Q**							Q	Q	Q												

*These reports will be a combination of data from several reporting entities.
**Each entity must file a separate report

Zone 2 Contractors – (continued)

SBHM of behalf of Armstrong-Indiana, Butler, Lawrence, Washington, and Westmoreland Counties****

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
Carelon			N/A	Q**	Q**							Q	Q	Q		N/A						N/A	N/A			
SBHM	Q	Q		Q**	Q**	M	M	M	Q*	Q	M	M/Q	Q	Q	Q		Q(1)	A*	A*	A	A			Q	A	A

(1)Armstrong-Indiana, Butler, Lawrence, Washington, Westmoreland

* These reports will be a combination of data from several reporting entities.
** Each entity must file a separate report.
***

Zone 3 Contractors

CABHC on behalf of Cumberland, Dauphin, Lancaster, Lebanon and Perry Counties***

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
PerformCare			N/A	Q**	Q**							Q	Q	Q							A					
CABHC	Q	Q*		Q**	Q**	M	M	M	Q*	Q	M	M	Q	Q	Q	N/A	N/A	A*	A*	A	A	N/A	N/A	Q	A	A

*** Cumberland, Dauphin, Lancaster, Lebanon and Perry Counties all reporting under one entity (Capital Area Behavioral Health Collaborative; CABHC) for reports beginning July 1, 2019.

*** **County specific Annual reports must be submitted upon request.**
If requested, the Individual County Annual Reports for Multi-County contracts should be available

Adams/York Joinder Board, and Berks County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
County	Q	Q		Q**	Q**				Q*		M	A	A	A			N/A	A*	A*	A				Q	A	A
CCBHO			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	Q	Q					A	A	A			
UPMC												Q	Q	Q							A					

Lehigh and Northampton Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
County	Q	Q		Q**	Q**				Q*		M	A	A	A			Q (1)	A*	A*	A				Q	A	A
MBH-PA			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	Q	Q					A	A	A			

(1) Northampton Only

* These reports will be a combination of data from several reporting entities.
** Each entity must file a separate report.

Zone 4 Contractors

NBHCC on behalf of Lackawanna, Luzerne, Susquehanna and Wyoming Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
NBHCC	Q	Q*		Q**	Q				Q*		M	A	A	A			N/A	A	A	N/A					A	A
CCBHO			Q	Q**	Q	M	M	M		Q		Q	Q	Q	Q	Q					A	A	A	Q		
UPMC												Q	Q	Q							A					

* These reports will be a combination of data from several reporting entities.
** Each entity must file a separate report.
*** **County specific Annual reports must be submitted upon request**.
If requested, the Individual County Annual Reports for Multi-County contracts submitted upon request

Zone 5 Contractors

Behavioral Health Alliance of Rural Pennsylvania (BHARP) on behalf of Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Greene, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
BHARP	Q	Q		Q**	Q**				Q		M	A	A	A			N/A	A*	A*	A					A	A
CCBHO			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	Q	Q					A	A	A	Q		
UPMC												Q	Q	Q							A					

* These reports will be a combination of data from several reporting entities.
** Each entity must file a separate report.

Zone 6 Contractors

Carbon, Monroe, Pike Joinder Board

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
CMP Joinder	Q	Q		Q**	Q**				Q*		M	A	A	A			N/A	A*	A*		A			Q	A	A
CCBHO			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	Q	Q					A	A	A			
UPMC												Q	Q	Q							A					

Cambria County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
Cambria County	Q	Q*		Q**	Q**				Q*		M	A	A	A			N/A	A*	A*	A				Q	A	A
MBH-PA			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	Q	Q					A	A	A			

Erie County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
Erie County	Q	Q		Q**	Q**				Q*		M	A	A	A			N/A	A*	A*	A				Q	A	A
CCBHO			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	Q	Q					A	A	A			
UPMC												Q	Q	Q							A					

Zone 6 Contractors (continued)

Northwest Behavioral Health Partnership - Crawford, Mercer, Venango

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
NWBHP	Q	Q		Q**	Q**				Q*		M	A	A	A			Q	A*	A*		A			Q	A	A
Carelon			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	Q	Q					A	A	A			

Blair County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
Blair HealthChoices	Q	Q*		Q**	Q**				Q*		M	A	A	A			N/A	A*	A*		A			Q	A	A
CCBHO			Q*	Q**	Q**	M	M	M		Q		Q	Q	Q	Q	Q					A	A	A			

Behavioral Health Services of Somerset and Bedford Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
BHSSBC	Q	Q		Q**	Q**				Q*		M	A	A	A			N/A	A*	A*					Q	A	A
MBH-PA				Q**	Q**	M	M	M		Q		Q	Q	Q	Q	Q					A	A	A			

Tuscarora Managed Care Alliance - Franklin and Fulton

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
TMCA	Q	Q		Q**	Q**				Q*	Q	M	M	Q	Q	Q	N/A	N/A	A*	A*		A	N/A	N/A	Q	A	A
PerformCare			N/A	Q**	Q**	M	M	M				Q	Q	Q							A					

Zone 6 Contractors (continued)

Lycoming and Clinton Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	17	18	19	20	21	22	23	24	26	29	42	43
Lycoming/Clinton Joinder	Q	Q		Q**	Q**				Q*		M	A	A	A			N/A	A*	A*		A			Q	A	A
CCBHO			Q*	Q**	Q**	M	M	M		Q		Q	Q	Q	Q	Q					A	A	A			

*These reports will be a combination of data from several reporting entities.
**Each entity must file a separate report.

Last updated 3/2/2026

HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

CLAIMS PROCESSING REQUIREMENTS

This appendix describes the claims processing requirements for Primary Contractors and BH-MCO Subcontractors. This appendix also contains the timeliness standards which must be met, and instructions for determining compliance with these standards. A monthly report of summary claims processing information is also required. The HealthChoices (HC) Behavioral Health (BH) Financial Reporting Requirements contain additional detail and instructions for the monthly (Report #8) report.

A. Claims Processing Standards

The Contractor must make timely payments to its providers. In addition to any Federal and state requirements, or standards included in the Contractor's provider agreements or subcontracts, the Contractor will adjudicate fee for service (FFS) claims consistent with the adjudication timeliness standards below.

Adjudication Timeliness Standards:

A. 90% of **clean** claims must be adjudicated within **30** days.

B. 100% of **clean** claims must be adjudicated within **45** days.

C. 100% of **all** claims must be adjudicated within **90** days.

"Adjudicate" means to pay or reject a claim. A "clean claim" is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the Contractor's claims processing computer system, and those originating from human errors. It does not include a claim under review for medical necessity, or a claim that is from a provider who is under investigation by a governmental agency or the Contractor for fraud or abuse. However, if under investigation by the Contractor, the Department must have prior notification of the investigation.

Capitation claims must also be paid timely and in accordance with any Federal requirements and/or standards included in the Contractor's provider agreements or subcontracts, and must be included in Report #8, Claims Processing, found in the HC Behavioral Health Financial Reporting Requirements.

The Contractor must identify, on every claim processed, the date the claim was received. This date must be carried on claims records in the claims processing computer system. Each hard-copy claim received by the Contractor must be date-stamped with the date of receipt not later than the first workday after the date of receipt.

Every claim entered into the Contractor's claims processing computer system must be adjudicated. The Contractor must maintain an electronic file of rejected claims, inclusive of the dollar amount of the rejected claim and a reason or reason code for rejection.

The amount of time required to adjudicate a paid claim is computed by comparing the date the claim was received, either in the mail or via an electronic filing, with the date the check was created, or electronic funds transfer date. The amount of time required to adjudicate a rejected claim is computed by comparing the date the claim was received with the date the denial notice was created, or the transmission date of an electronic denial notice. If claims processing is the responsibility of a subcontractor, the date of initial receipt, either at the Contractor or at the claims processing subcontractor, is the date of receipt applicable to these requirements.

B. Claims Processing Reports

Monthly Claims Processing Report – The Contractor will provide the Department with summary information on the number and amount of claims received, pended, rejected and paid, by aging category, each month, including payments to capitated providers. Detailed instructions, report formats and due dates can be found in the HC BH Financial Reporting Requirements, Report #8, Claims Processing Report.

ADMINISTRATIVE OVERHEAD AND CLINICAL CARE / MEDICAL MANAGEMENT COST DEFINITIONS

Administrative Overhead costs are expenditures associated with the overall management and operation of a BH-MCO, agreeing to contract with OMHSAS for the provision of behavioral health services. For DHS reporting purposes, Clinical Care/Medical Management services are part of medical services and are distinguished from provider payments as services necessary to ensure the continuity of a member's behavioral health care treatment; these services do not constitute treatment, but are considered indirect costs associated with direct care. The following describes proposed definitions for various administrative categories. Note that County and subcontracted or parent company allocations should also be categorized as follows.

ADMINISTRATIVE OVERHEAD *	CLINICAL CARE / MEDICAL MANAGEMENT *
1. General and Administrative • Senior operational management • General administrative support staff (i.e., Administrative Assistants, Data Entry, Medical Records, Public Relations, Receptionist, etc.) • Accounting and Finance • Consultants/Actuaries (See #8 under Clinical Care/Medical Management for exceptions) • Depreciation and Amortization • Malpractice, General, and Liability Insurance • Marketing • Office Supplies • Postage • Printing and Copier expenses • Recruiting • Relocation • Rent • Training and Education (See #15 under Clinical Care/Medical Management for exceptions) • Travel (See #16 under Clinical Care/Medical Management for exceptions) • Utilities • Other miscellaneous administrative expenses 2. Claims Processing – Direct or vendor related expenditures related to the processing of provider claims 3. Information Systems – Information systems and communications 4. Provider Services/Network • Contracting • Provider credentialing • Provider education 5 Member Services	1. Clinical staff salaries 2. Community Relations staff salaries 3. Medical Affairs staff salaries 4. Intake staff salaries 5. Quality Management staff salaries 6. Service Management staff salaries 7. Case Management 8. Consultants (i.e. Language and Deaf Interpreter services, Psychological testing, etc.) 9. Consulting Physician services (Peer to peer physician review of cases) 10. Intake/Member Services Coordinator 11. Medical Director services 12. Other Appropriate Clinical Staff services 13. Outreach/Consumer and Public Education 14. Quality Improvement and Management programs 15. Training for certification and licensing purposes (Clinical staff only) 16. Travel (Interagency team meetings and medical director/provider meetings) 17. 24-hour telephone accessibility for crisis response, screening, referral and authorization 18. 24-hour accessibility to physician and/or board certified addictionologist physician for consultation and review 19. Utilization Management 20. Utilization Review

ADMINISTRATIVE OVERHEAD *	CLINICAL CARE / MEDICAL MANAGEMENT *
• Customer service/support • Grievance and Appeals 6. Patient Transportation 7. Sanctions 8. Member Handbooks	

* Costs which can be directly or indirectly attributed to the HealthChoices Behavioral Health Program only.

HEALTHCHOICES BEHAVIORAL HEALTH FINANCIAL REPORTING INSTRUCTIONS FOR PRIMARY CONTRACTORS

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF MENTAL HEALTH &
SUBSTANCE ABUSE SERVICES

JANUARY 23, 2018

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1

Introduction

The Commonwealth of Pennsylvania, Department of Human Services (DHS), Office of Mental Health and Substance Abuse Services (OMHSAS) has implemented a new web-based financial reporting system (Financial System). The Financial System is a secure, web-based application which Behavioral Health HealthChoices Contractors and Behavioral Health Managed Care Organizations (BH-MCOs) will use to submit required financial and utilization data periodically. The automated system will include the following key features:

- Provides the ability for Contractors to upload Financial Reporting templates via an online submission process on a monthly, quarterly and annual basis.
- Allows Contractors to view and save actual reports previously submitted to the system.
- Allows Contractors to generate output reports based on the previous financial report submissions.
- Maintains a history of all file submissions and tracks all file uploads and upload attempts. Contractors will be able to view the status of each uploaded file.
- Validates various financial reporting data in real time and immediately notifies Contractors of receipt or rejection of Financial Reporting submissions. These will also be referred to as “edits” throughout this document.
- Provides a detailed error report for failed and successfully submitted reports for Contractors to keep for their records. The error reports also allow Contractors to understand the items that need to be corrected to achieve a successful submission, in the case of erroneous submissions.

This document outlines the general instructions for submitting Portable Document Format (PDF) and Excel-based monthly, quarterly and annual reports to the new Financial System. Unless specific instructions are provided, please follow the instructions set forth in the HealthChoices Behavioral Health Program Financial Reporting Requirements (FRR) for completing the required monthly, quarterly and annual reports, where applicable.
The Financial System website address is:
https://ereporting.mercer.com/OMHSAS/Login.aspx

2

General Overview and Requirements

The following section outlines the instructions for completing the required Excel-based Financial Reports 1–4, 6–9 and 12 and the timelines for submitting these reports.

Guidelines for Reporting

Excel-based Financial Reporting templates containing the raw data that DHS requires will be used to produce the financial reports. When uploading completed financial reports to the Financial System, each completed report template must be transmitted within the requested submission time period. Please refer to the Financial Reporting Requirements table in Section 2.0 of the FRR for the established time periods for submitting financial reports.

Note that the categories of aid or rating groups in the Excel-based quarterly report #s 1–4, 9, and annual report #2–4, 9 templates changed due to the implementation of Medicaid enrollment according to the HealthChoices Expansion initiative. See Section 4 for more information.

The heading of each report should contain the following fields:

Statement as of: This should be the month-, quarter- or year-end date for the report and should be entered using the MM/DD/YYYY format.

Primary Contractor: This should be the name of the Contractor for which the report is applicable and can be selected from the drop down box in each Financial Reporting template.

Reported By: This should be the entity that collected the data and compiled the report. In instances where a report contains data from more than one entity, this field should name the primary contractor. Refer to Appendix A for a list of Financial Reporting Entity ID numbers required for each report. Contractors are to enter the Financial Reporting ID, including the leading zeros, followed by the organization name.

Line titles and columnar headings of the reports are, in general, self-explanatory and therefore do not constitute instructions. Specific instructions are provided for items about which there may be some question as to the content. Any entry for which no specific instructions are included should be made in accordance with sound accounting principles and in a manner consistent with related items covered by specific instructions.

To ensure values tie across reports, OMHSAS has designed the Financial Reporting templates to automatically populate certain cells. Contractors will see several cells with

blue shading throughout the templates. This shading is applied to cells that contain formulas and will be automatically populated based on data reported in non-highlighted cells of each report. Column headers and standard fields in each template have also been locked and protected to ensure consistent reporting by all Contractors. Other than the white cells within the body of the report for each template, the following sections are unprotected for Contractors to use at their discretion, shown in Excel coordinates:

Monthly
- Report #6 – Columns I:GG
- Report #7 – Columns AC:GG and all gray cells between columns C:Z
- Reports #6, 7 Notes – Columns D:GG
- Reports #8A and 8B – Columns Q:GG
- Report #8C – Columns G:GG
- Reports #8, 12 Notes – Columns E:GG
- Report #12 Year Tabs – Columns AA:GG

Quarterly
- Report #1 – Columns P:GG
- Report #1 Notes – Columns D:GG
- Reports #2, 3, 9 Notes – Columns H:GG

Quarterly and Annual
- Report #2 – Columns J:GG and all gray cells between columns B:H
- Report #3 – Columns J:GG and all gray cells between columns B:H
- Report #4 (Entity #1 – 3) – Columns H:GG
- Report #4 (Entity #1 – 3) Notes – Columns D:GG
- Report #9A – Columns J:GG and all gray cells between columns B:H
- Report #9B – Columns F:GG and all gray cells between columns B:D

Annual
- Reports #2, 3, 9 Notes – Columns D:GG

NOTE: If data are present in the unprotected cells of a submitted report, they will transfer to the user generated output report. Ideally, it is preferred that users delete this information prior to report submission, but it is understood that cells in the actual report range may depend on it. However, since this information is outside the print range, it will not be visible on printed output reports.

Rounding
The report templates are formatted to round non-per member per month (PMPM) values. Therefore, amounts can be entered with decimals or rounded to the nearest dollar, except for PMPM amounts which should include two decimal places. **IMPORTANT**: When rounding or truncating numbers, do not perform rounding or truncation until arriving at the final amount. (Example: If calculation is 1.5892 x 2.059 = 3.272163, report final amount as 3.27; not 1.59 x 2.06 = 3.28.)

Other Supporting Information

Below are additional features and requirements of the Excel-based financial reports. This information will assist in Contractors achieving successful submission to the Financial System.

Features

- Report magnification can be adjusted by selecting View > Zoom from the Excel menu.
- Cells are formatted to autofit and wrap text within each cell, but users have the ability to manually adjust row and column sizes as necessary.
- The font and text size are pre-defined, so there is no need for user adjustments.
- The “Freeze panes” feature is enabled in every report.
- Report templates can be saved and uploaded in .xls and .xlsx versions of Excel. Refer to Section 4 for more information.
- Users can link and formulate unprotected cells within the templates at their discretion for ease of reporting. For example, Report #1 can be referenced within the Quarterly report template to populate Member Months in Report #9.

*NOTE: Linked data in completed reports **do not** have to be value pasted prior to submitting to the system. Enhancements have been made to allow data to be linked between tabs in the templates, outside the body of the report or from external files. In addition, calculations within the body of the report can remain as formulated and **do not** need to be value pasted prior to submission*.

Requirements

- All cells within the report templates need to be populated with the appropriate values outlined in Section 3 below and no cells can be left blank (except Report #12).
- If a Contractor chooses to paste data directly into the report templates, this data needs to be value pasted to maintain consistent formatting between the reports. For example, after copying a value, select the destination in the template and go to Edit > Paste Special > Values from the Excel menu.
- Additional rows, columns and tabs should not be added to the report templates.

3

Overview of the Financial Reports

Below is a summary of the monthly, quarterly and annual Excel-based and PDF files Contractors are required to complete and submit to the Financial System. Each report in the Excel-based template below has its own tab followed by its respective Notes Tab.

Quarterly
- Report #1

Quarterly and Annual
- Report #2
- Report #3
- Report #4 (Entity #1)
- Report #4 (Entity #2)
- Report #4 (Entity #3)
- Report #9A
- Report #9B
- Report #29

Monthly
- Report #6
- Report #7 (one for each Category of Service and Total)
- Report #8A
- Report #8B
- Report #8C
- Report #12

Annual
- Report #42
- Report #43

*See Section 4 for the rating group changes impacting the Report #s: 1–3, 9 templates. In addition, the information provided for each report below will apply to the existing and new templates, where applicable.

Additional Financial Reports
Some Contractors are required to submit Additional Financial Reports (Additional reports) electronically. These reports are not required to be completed using a standard template; however, they must be submitted to the Financial System in PDF format using the correct file naming convention (see Section 5 for more information on file naming conventions).

Please refer to the Financial Reporting Requirements (FRR) table in Section 2.0 and

Attachment D in the FRR for further details. The Additional reports include, but are not limited to those listed below. A complete listing of the Additional reports to date and their corresponding Report Group Designations for the file name can be found in Table 3 of Appendix B:

- Actual Reinsurance Experience
- Actuarial Certification of Claims Liability (CY Counties)
- Actuarial Certification of Claims Liability (SFY Counties)
- Balance Sheet
- Report #17 - Contract Reserves Compliance Report
- Equity Reserve Bank Statement
- Estimated Reinsurance Experience
- General Account Bank Statement
- Parental Guaranty Quarterly Monitoring Report
- Physician Incentive Arrangement
- Reinsurance Waiver Report > $75,000
- Reinvestment Bank Statement
- Risk & Contingency Bank Statement
- Reports #13, #14, #15 (Primary Contractor)
- Reports #13, #14, #15 (Subcontractor)
- Annual Audited Financial Statements (DOI) - Statutory Basis
- Audited County General Purpose Financial Statements (CAFR)
- Entity Wide Audit (Primary Contractor)
- Entity Wide Audit (Subcontractor)
- Insurance Department Annual Filing
- Insurance Department Quarterly Filing

Instructions for Completing the Financial Reports
The remainder of this section contains detailed instructions for completing the above reports, where applicable.

Report #1 – Enrollment Table
This tab is pre-populated with zero values in the financial reporting template. Contractors are to update this report for all months through the current reporting period with numeric values, leaving all other cells populated with zeros.

Note that Month #1 in this tab corresponds to January and Month #12 corresponds to December for all Contractors for the same calendar year. This means the first month of the Agreement year, January, will be Month #1 and the last month of the Agreement year, December, will be Month #12.

For additional descriptions and instruction, please consult the FRR.

Report #2 – Primary Contractor Summary of Transactions
All fields in this report are required and should be completed using numeric values. For

additional descriptions and instruction, please consult the FRR.

Report #3 – Subcontractor Summary of Transactions
All fields in this report are required and should be completed using numeric values. For additional descriptions and instruction, please consult the FRR.

Report #4 (Entity 1 – 3) – Related Party Transactions and Obligations
These tabs are pre-populated with “N/A” and zero values, where applicable. Contractors are to overwrite these values as necessary, leaving all other cells with their pre-populated values. This report is to be completed assuming Entity #1 is the Primary Contractor, Entity #2 is the Subcontractor and Entity #3 is the Management Corporation.

The “Name & Address of Related Party/Affiliate”, “Description of Relationship or Affiliation” and “Tran. Code” fields should be completed in text format. When completing the “Name & Address of Related Party/Affiliate” field, please enter the name, street address, city, state and zip code in one cell separated by commas.

The remaining fields should be completed using numeric values. For additional descriptions and instruction, please consult the FRR.

Report #6 – Claims Payable (RBUCs and IBNRs)
All fields in this report are required and should be completed using numeric values. For additional descriptions and instruction, please consult the FRR.

Report #7 – Lag Reports
All COS tabs are pre-populated with zero values. Contractors are only required to update the values for the month(s) that are being reported with numeric values, leaving all other cells populated with zeros. Although not required, the Contractors may complete the report in its entirety. A user generated Report #7 output report will be available for print or download (See “Output Reports” below for more information). For additional descriptions and instruction, please consult the FRR.

Reports #8A, #8B and #8C – Claims Processing Report
Part A and B
All fields in this report are required and should be completed using numeric values. Note that "Month #1" in column A should tie to the month for the reporting period in the "Statement as of:" date. Months #2 - #12 should reflect the previous 11 months from the "Statement as of:" date. For additional descriptions and instruction, please consult the FRR.

Part C
These tabs are pre-populated with “N/A” and zero values, where applicable. Contractors are to overwrite these values as necessary, leaving all other cells with their pre-populated values.

Complete the “Date Claim Received” field using the MM/DD/YYYY date format. The “Claim Reference #”, “Provider #” and “Provider Name” fields should be completed in text format.

The “Service Type” and “Amount” fields should be completed using numeric values.

Rows 207 – 806, 1009 – 1608 and 1811 – 2410 are hidden in the 8C Tab. If there are not enough rows to fully complete the report, users can unhide these rows at their discretion.

Reports #9A and #9B – Analysis of Revenues and Expenses

Part A
All fields in this report are required and should be completed using numeric values. For additional descriptions and instruction, please consult the FRR.

Part B
This tab is for Contractors’ internal documentation. Users should feel free to submit their Quarterly and Annual reports with or without completing this report. A user generated Report #9B output report will be available for print or download (See “Output Reports” below for more information).

Report #12 – Reinvestment Report

This template includes a tab for each Reinvestment Fund Year. Within each tab are separate reports for each of the following rating groups:

1. ALL HEALTHCHOICES
2. OTHER
3. TOTAL

Note that the “Statement as of:”, “Primary Contractor:” and “Reported By:” Lines at the top of each tab will be populated based on what is entered in the most current year’s tab.

Rows 40–74 in each Reinvestment Fund Year tab are hidden and can be expanded if more lines are needed to complete the report. In addition, the Report #12 template includes an “Input” Tab for the Contractors to use at their discretion for completing the report. For example, Contractors can use the “Input” Tab as a data entry sheet to link to the other tabs.

Where applicable, please complete the “Unduplicated Recipients”, “Current Period” units and dollars and “Budget Amount” dollars for the “Allocations/contributions” (Line 2), “Investment/interest income” (Line 3) and “Approved distributions for Reinvestment Services” being reported for each applicable year and rating group. For additional descriptions and instruction, please consult the FRR.

The Approved Reinvestment Services being reported should be in text format. All other fields should be numeric values. A user generated Report #12 output report will be available for print or download (See “Output Reports” below for more information). For additional descriptions and instruction, please consult the FRR.

Notes Tabs

Each report above has a corresponding “Notes” Tab. Rows are hidden in the following reports and Contractors can expand these rows at their discretion:

Monthly
- Reports #6, 7 – Rows 28–60
- Report #8 – Rows 44–60

Quarterly and Annual
- Reports #1, 4 (Entity #1–3) – Rows 28–60
- Reports #2, 3 – Rows 28–49, 71–80

NOTE: Please complete the Notes Tabs as you normally would. Keep in mind the following guidelines:

- ”Other Admin” only needs to be reported for Reports #2 and 3.
- Additional notes for Reports #2 and 3 can be entered in rows 51–80 below the “Other Admin Total”.
- Excel rows 3–39 in the Report #9 Notes Tab are pre-populated with common Other Medical procedure codes. Contractors should input the corresponding values, where applicable. Rows 40–49 are placeholders for Contractors to enter additional Other Medical procedure codes as necessary. Additional notes should be entered beneath the total line in Excel row 50.
- The list of common procedure codes in the Report #9 Notes tab were modified to remove the codes that were end-dated on June 23, 2013 and replaced with the corresponding codes that became effective June 24, 2013, per the July 2013 version of the Behavioral Health Services Reporting Classification Chart (BHSRCC).
- Quarterly Reports #2, 3 and 9 Notes Tabs should include values for all quarters leading up to the reporting period. For example, if submitting the Q3 2012 reports, the Reports #2, 3 and 9 Notes Tabs should include values in the “1st Qtr”, “2nd Qtr”, and “3rd Qtr” columns.

4

HealthChoices Expansion Impacts on the Financial Reports

As a result of the implementation of the HealthChoices Expansion initiative, 21 year olds in TANF/MAGI - Child and SSI & Healthy Horizons without Medicare - Child rating groups will shift into TANF/MAGI - Adult and SSI and Healthy Horizons without Medicare - Adult rating groups. There will be newly eligible 19–20 year olds joining the TANF/MAGI - Child rating group as the Federal Poverty Level increases to 133%. Additionally, the State-Only GA rating groups were eliminated, and a new rating group was created, labeled as HealthChoices Expansion – Newly Eligible. For guidance on payments, claims and eligibility with respect to the rating groups please see the November 2014 version of the Managed Care Payment System Table.

During the SFY 2016/2017 and CY 2017 time periods, all contractors will submit Quarterly Report #1–4, 9 and Annual Report #2–4, 9 templates with HCE – NE rating group names and HCE – NE eligibility rules.

It is very important to be aware that adjusted Quarterly, Annual and Monthly Report #12 reports need to be submitted in the versions of the templates that have been submitted to the financial system to date. In other words, prior year adjustments to any Quarterly, Annual and Monthly Report #12 reports should be uploaded in the same version of the template as the original submission.

Financial Reporting Rating Group IDs:
The tables below assign the latest rating group names with a two-digit ID. This ID can take the place of the full name when referencing a specific rating group. Most notably, this ID can be used as a key to understanding the Submission Edit Results received after uploading financial reports to the Financial System. See Section 5 in Attachment L of the FRR for more information regarding critical, non-critical and structural edits.

Rating Group	Rating Group Name
01	TANF/MAGI – Child
02	TANF/MAGI – Adult
03	SSI & Healthy Horizons with Medicare
04	SSI & Healthy Horizons without Medicare – Child
05	SSI & Healthy Horizons without Medicare – Adult
06	HealthChoices Expansion – Newly Eligible

Note: Children are under age 21, adults are ages 21 and above.

5

Web-based Access

This section includes information on how to access the financial report templates and website along with considerations for users with different versions of Excel. This section also includes technical advice to make it easier for users to navigate the Financial System website.

The website address where completed submissions are uploaded were provided during the web-based training on February 16, 2012.(https://ereporting.mercer.com/OMHSAS/Login.aspx). OMHSAS sent User Name and Password information to Contractors via email, please contact Kimberly Butsch with questions regarding your log-in credentials.

Accessing the Financial Report Templates and Website

OMHSAS will send the Microsoft Excel-based Financial Report templates to the Contractors via email. Users with Excel 2003, 2007 or 2010 will be able to access and use the Financial Report templates.

Contractors can verify their version of Excel by clicking on the “Help” button and then the “About Microsoft Office Excel” selection. This shows the version that is currently installed on the computer. If you need the Financial Report templates in a version of Excel prior to 2003, please submit a request to Kimberly Butsch at kbutsch@pa.gov.

Considerations for Excel 2007 or 2010 Users

There have been interaction issues between Excel 2003 and Excel 2007/2010. If the Contractor repeatedly switches back and forth between using Excel 2003 and Excel 2007/2010, the Contractor may experience file corruption issues. If possible, OMHSAS recommends the Contractor only use Excel 2003 when completing the Financial Reports. In cases where the Contractor only has access to Excel 2007 or Excel 2010, OMHSAS recommends the Contractor work in one of those versions the entire time. Contractors who do switch back and forth between Excel 2003 and Excel 2007/2010 may see that Excel adds an extra tab to the Financial Report template files listing potential errors that occurred in the conversion. In this case, the Contractor will need to delete the extra tab prior to uploading the file to the automated website or the Financial Report file will be rejected.

Lastly, Excel 2007 and Excel 2010 may cause the Financial Report file size to grow. This increased file size will contribute to longer upload times.

Additional IT Tips for Using the Financial Report Website

Internet Connectivity

A high-speed internet connection is required to download or upload the Financial Report templates. Using a dial-up modem will likely result in the action timing out before the entire file has been downloaded to your computer or before the entire file is uploaded to the website. Contractors that have a dial-up modem should submit an email to Kimberly Butsch (kbutsch@pa.gov) indicating that they have dial-up internet connectivity and need assistance in obtaining the Financial Report templates and in submitting their completed Financial Reports.

Internet Browser

It is highly recommended that you use a current version of an internet browser to upload your completed Financial Reports. The most commonly used browsers include Internet Explorer and Firefox. It is recommended that you use Internet Explorer Version 6.0 or higher and Firefox Version 2.3 or higher.

Pop-up Windows

Pop-up windows must be enabled to see error messages or submission confirmation reports. If you are not seeing these types of items upon upload, then pop-ups may be blocked on your computer. Please follow these steps to enable them:

- Internet Explorer
  - Open Internet Explorer
  - Click on Tools
  - Click on the Internet Options
  - Click on Pop-up Blocker
  - Click on Turn Off Pop-up Blocker
  - Click on Yes when prompted to turn off Internet Explorer's pop-up blocker
- Firefox
  - Open Firefox
  - Click on Tools
  - Select Options
  - Select Content
  - Uncheck Block Pop-up Windows

Internet Cookies

Internet Cookies must be accepted in order for the Financial Report upload processes to work correctly. To enable Internet Cookies please follow these steps:

- Internet Explorer
  - Open Internet Explorer
  - Click on Tools
  - Click on Privacy
  - Click Settings bar level to Low
  - Click on Apply
- Firefox

- Open Firefox
- Click on Tools
- Select Options
- Select Privacy
- Check Accept Cookies from Sites
- Click on OK

Macintosh Computers

There may be issues with the Excel Financial Report templates not being fully functional on a Macintosh computer. OMHSAS recommends Macintosh computers not be used for work related to the Financial Report templates.

6

Submission Process

This section provides detailed information regarding the process Contractors should follow to successfully complete and upload the Financial Reports. Topics covered include: file naming conventions that must be used to ensure that submissions are not rejected upon upload, submission process, erroneous submissions, prior year adjustments, generic submission, generating output reports, generating trend charts, and downloading previously submitted files.

File Naming Conventions

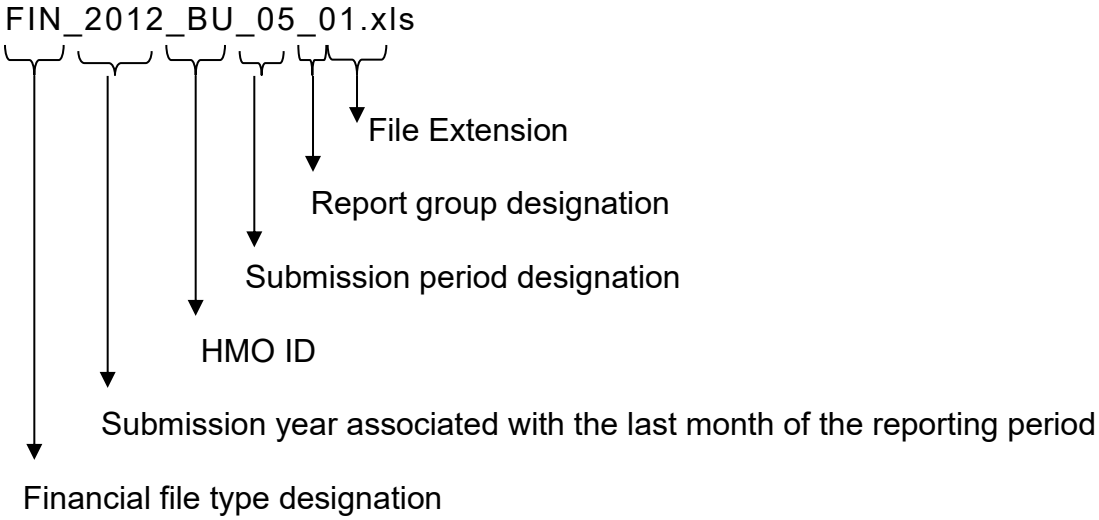
Each file that a Contractor uploads to the Financial System must conform to specific naming conventions. Any files that do not exactly follow the naming conventions will be rejected in the real-time edit process and will require resubmission. See below for information on a File Naming Convention tool available on the website that is designed to automatically generate file names based on criteria entered by the Contractor. The components of the Financial System file naming conventions are as follows:

Character #	Description
1–3	File type designation (e.g., FIN = Financial and Additional Reports or CER = Data Certification)
4	_ (underscore)
5–8	Four-digit submission year (year associated with the final month of the submission period
9	_ (underscore)
10–11	Two-character HMO ID (see Appendix B Table 1)
12	_ (underscore)
13–14	Two-character submission period designation (see Appendix B Table 2a and 2b)
15	_ (underscore)
16–17	Two- or three-character upload report group designation (see Appendix B Table 3)
Suffix	Standard Excel file suffix for financial and PDF suffix for data certification and Additional Reports

Example: Bucks County May 2012 submission of financial Reports # 6–8C

File name example: FIN_2012_BU_05_01.xls

NOTE: This example is also located in Appendix B.



All Financial Report submissions must be based on the **OMHSAS Excel-based financial report templates** and must contain "FIN" at the beginning of the file name to be recognized as a valid and successful submission. The **Additional reports**, submitted in PDF format, must also contain "FIN" at the beginning of the file, but do not need to be based on a standard template. The Additional reports are not subject to critical or non-critical edits (see "Instructions for Uploading Files" below), but do need to follow the proper file naming conventions.

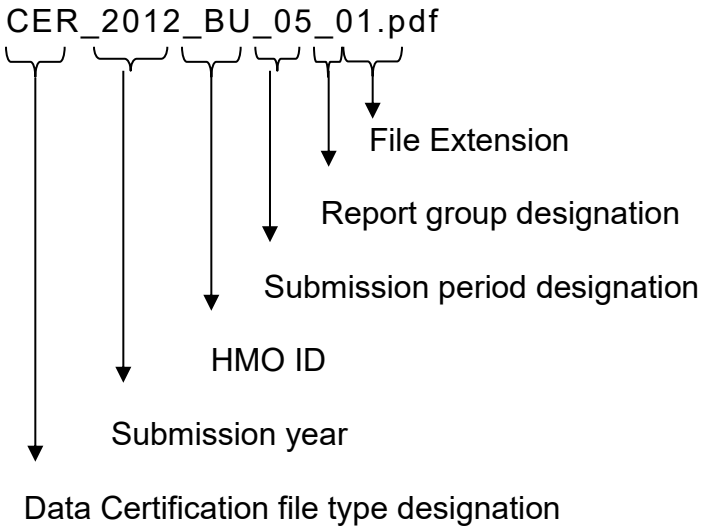
In addition, Financial and Additional report files cannot be zipped prior to upload. If these reports are uploaded as a zip file (file extension is .zip), the file will be rejected. If the Contractor's completed Financial and Additional report files are very large in size, and the Contractor is experiencing significantly slow upload durations, the Contractor should submit a question to Kimberly Butsch at kbutsch@pa.gov.

File names for submitting resubmissions due to failed edits must match the file name of the original submission. For example: a Contractor originally submits its May 2012 Monthly Reports # 6–8C and the file is rejected because it did not pass the real-time edits process. Upon fixing the errors, the Contractor would upload its resubmission with the same naming convention that was originally used. The electronic date stamp will be used to identify the most current version when multiple versions are submitted by the same Contractor.

Signed non-actuarial **Data Certifications of Reports 1–4, 6–9 and 12** should be uploaded through the financial submission process as PDF documents after the financial reports have been successfully submitted. As with Additional reports, these documents are not subject to critical or non-critical edits, but do need to follow the proper naming conventions. The data certification file name should mirror the Financial Report submission for which it is being submitted with "CER" instead of "FIN" as the file type designation.

Example: Data Certification for the Bucks County May 2012 submission of financial report # 6 –8C

File name example: CER_2012_BU_05_01.pdf



File Naming Conventions Tool

To ensure that all financial files submitted to the Financial System adhere to the correct naming convention, a file naming convention tool is available for download on the Financial System website. This tool is located the *Financial File Submission* screen of the Financial System, and will allow Contractors to select HMO ID, Submission Type, Final Month of the Year, Report Type, and Financial Report from **drop-down boxes** and **manually enter the Reporting Year** to aid in generating the appropriate file name for a successful financial report submission.

Once all six lines are completed, the Contractor will push the button on Line 7 (“Press Button to Generate File Name”) to run the macro that will output the final file naming convention on Line 8 (“File Name to Export”). The file name generated on Line 8 can be used to name the Contractor’s file prior to submission. **Please note that the file extension .xls and .pdf are included in the file name to indicate if the file needs to be submitted as a valid Excel file or as a PDF file.**

NOTE: If you do not use this as a resource, it is still important to check your file name against this tool since the Financial System naming convention is programmed on a CY basis. That is, if a SFY Contractor, Perry County for example, submits Quarterly Report #1 – 4 and 9A for October – December 2012 (Q2 of SFY 2012-2013), the file name is FIN_2012_PE_Q4_03.xls, not FIN_2012_PE_Q2_03.xls.

Instructions for Uploading Files

Upon naming all files in accordance with the file-naming conventions, Contractors should complete the following steps to successfully upload the Financial Reports templates to the website:

Step 1: OMHSAS will send User Name and Password information to Contractors via email. Upon arriving at the website's home page, the Contractor should use their user account information to log into the website (https://ereporting.mercer.com/OMHSAS/Login.aspx).

Step 2: Once logged in, the user will arrive at the Contractor's Home page. It is optional for the user to change their password. To do so click on the "Change Password" link under "Help" on the left side of the screen.

Step 3: Click the "*Financial File Submission*" link on the left side of the screen to proceed to the file submissions page. This is the screen where Contractors submit their Financial Reports. Included in the Welcome section are step by step instructions for submitting Financial Reports. These instructions can be viewed or hidden using the +/- button next to Welcome.

Step 4: Upon arriving at the *Financial File Submission* screen, click "Browse" to locate the financial report to upload. Once located, select the file from your computer's directory and click "Open".

Step 5: Upon opening the file, click "Submit File" to initiate the upload process. A Submission Confirmation dialogue box will appear, prompting the user to confirm that if the file is a prior year audit adjustment, that the Prior Year Adjustment check box was marked.

A. If the user selects "OK", the file will proceed to be uploaded to the Financial System and the user can continue with Steps 6–7.
B. If the user selects "Cancel", they will go back to Step 1 to submit the file. Please note the reasons a user would select "Cancel" include:
    1. The wrong file was chosen in Step 4.
    2. The Prior Year Adjustments box was not appropriately selected.
    3. The user is attempting to upload a standard submission, but the Prior Year Adjustments box was erroneously selected.

NOTE: After the file is uploaded, the user will receive one of four results:

1. The report has passed the real-time edit process and the file has uploaded successfully (see Steps 6 and 7).
2. The report has encountered **Non-Critical Errors**, but can still be uploaded successfully.
3. The report contains **Structural Errors** and needs to be fixed for a successful upload.
4. The report contains **Critical Errors** and needs to be fixed for a successful upload.

For more details regarding the errors in 2–4 above, please see the "Erroneous

Submissions" section below.

Step 6: For result #s 1 and 2 noted above, the user can choose to view the list of Edit Results, or submit a file. This means the submitted file is either free from errors or contains Non-Critical errors.

Step 7: Prior to submitting for result #s 1 and 2 noted above, or for result #s 3 and 4 noted above, the user can choose the "Click here to view/print a submission upload report" link. Contractors have the option to print the Submission Edit Results and are urged to review this report for accuracy of the submission. **Note that the file has been uploaded, but not yet submitted to the system.**

To complete the submission process, Contractors must confirm they would like to submit the successfully uploaded file. Once submitted, the Submission Edits Results indicate that the file has been submitted to the system.

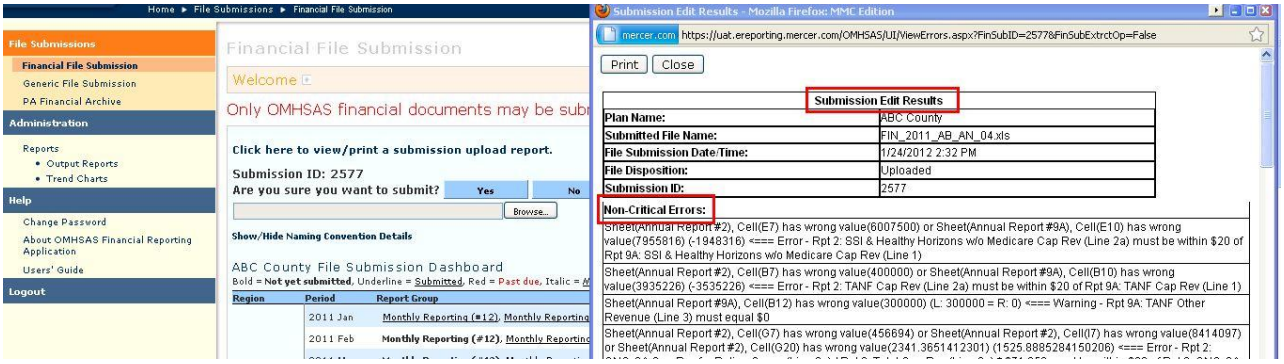
Erroneous Submissions – Non-Critical Errors

Non-Critical Errors occur when a user submits a financial report containing values that disagree with formulas or relationships based on the DHS's Math Edits. Reports containing Non-Critical Errors will not cause a report submission to be rejected. However, Contractors are urged to review Non-Critical error reports before submitting a file containing these errors. Below are the two types of Edits that would trigger Non-Critical Errors.

Non-Critical Edits:

- Math Warnings — Some cells are expected to be greater than, less than, or equal to zero (e.g., Report #2, Reinvestment (Line 5), must be zero).
- Comparison Errors — The relationship between certain cells must be appropriate (e.g., Report #9 Capitation Revenue (Line 1) must be within $20 of Report #2: Capitation Revenue (Line 2a))

Below are the Submission Edit Results for a submitted financial report containing Non-Critical errors. The edit results identify the report number, cell coordinates, cell values and a description of the edits that are failing. This allows the user to quickly locate and correct the errors.



If the Contractor determines the data is correct, the user can proceed to upload the report

by clicking “Yes” after the “Are you sure you want to submit?” or click “No” to reject the submission and go to Step 4 to resubmit a revised report.

Erroneous Submissions – Structural and Critical Errors

Structural and **Critical Errors** will cause a submitted report to be rejected. The user will need to fix reports with these types of errors in order to successfully upload a file. Below are the types of Edits that would trigger Structural or Critical Errors (see below for examples).

Structural Edits:

- If a file does not follow the file naming conventions, it will be rejected immediately. The error message will indicate the improper name used.
- Tab names cannot be changed, and tabs cannot be added or deleted, as these items will cause the submission to be rejected.
- Each cell in the financial template has been programmed to only accept specific data types: text, decimal, whole number, or date.
  - Note: if the data type is decimal, a decimal point is not required but is allowed.

Structural error messages provide the tab, row and column of the Excel spreadsheet where the data type error is present; detailed descriptions are provided for the remaining Structural errors. These errors need to be corrected for the file to pass all edits and be successfully uploaded to the site.

Once the user corrects the errors identified in the detailed error report, they will need to resubmit the report until all Structural edits have passed (starting from Step 4).

Critical Edits:

- Incomplete Cells — All cells must be populated.

NOTE: Non-Critical and Critical Edit messages have two parts:

- The first part provides the Excel coordinates of the cell and the value in the spreadsheet that is in error.
- The second part gives a description of the column and line number on the financial report, as described in the Hard Edits Excel file received from OMHSAS.

These errors need to be corrected for the file to pass all edits and be successfully uploaded to the site.

Once the user corrects the errors identified in the detailed error report, they will need to continue to resubmit the report until all Critical edits have passed (starting from Step 4).

Instructions for Downloading Submitted Reports

Contractors can download their submitted financial reports at any time. To do this, go to the “*Financial File Submission*” screen and click the underlined file in the **File Submission**

Dashboard at the bottom of the page. From here user will have the option to open or save the document.

Prior Year Adjustments

The information below describes the process for submitting prior year adjusted financial reports. Adjusted reports are to be submitted to the appropriate Financial System depending on the year of the original financial report submission.

CY 2012 and SFY 2012-2013 and Beyond

To reflect prior year adjustments, contractors are required to incorporate the value of the adjustment into the originally submitted Excel-based financial report file and then submit the restated report to the new system. Following is an example of how to complete the Excel-based financial report template to reflect prior year adjustments in the new Financial System.

Example: A Contractor is submitting a $200,000 downward adjustment to the Report #9A OP Psych line for the TANF rating group in their December 2013 quarterly report following an audit adjustment. The original value in that cell is $1.8M.

I. The Contractor accesses the **most recent** Excel-based Quarterly Report #1–4 and 9A financial report that was **successfully submitted** for the year ending December 2013. *Note that this report can be downloaded from the Contractor's Dashboard in the Financial System.*
II. The Contractor opens the file and adjusts the OP Psych line for TANF to $1.6 million and leaves all other values in the file as is, unless further adjustments are necessary.
III. The file is then saved with the **same file naming convention that was originally used** and then the process outlined in the steps 1–7 below is followed.

Steps 1–3: Follow Steps 1 through 3 under the "Instructions for Uploading Files" section starting on page 19.

Step 4: Upon arriving at the *Financial File Submission* screen, click the box next to "Please select the check box if this financial file submission is related to **Prior Year Adjustments**, including audit adjustments". Next click "Browse" to locate the financial report to upload. Once located, select the file from your computer's directory and click "Open". Upon opening the file, click "Submit File" to initiate the upload process.

Steps 5–7: Follow steps 5 through 7 on pages 19–20 under the section "Instructions for Uploading Files" to complete the adjusted financial report uploading process.

NOTE: When submitting prior year adjustments to the new Financial System (CY 2012 and SFY 2012–2013 and beyond), please keep in mind the following guidelines:

- Adjustments to prior year reports must be submitted using the Excel-based financial templates.

- The value of the adjustment must be reported in addition to the originally submitted values prior to submission. Meaning, when submitting reports that include prior year adjustments following steps 1–7 above, the financial report must contain the original amount plus or minus the adjustment amount.
- It is recommended that Contractors download originally submitted reports from the County/MCE Dashboard (see Instructions for Downloading Submitted Reports above) as the starting point for populating the prior year adjusted financial reports.
- The file name of the adjusted financial report that is being submitted must exactly match the name of the originally submitted financial file.
- **In addition to monthly and quarterly reports, prior year adjustments to the Annual Counterpart reports are required to be submitted to the Financial System.**
- Adjustments to the Quarterly, Annual and Monthly Report #12 reports need to be submitted in the versions of the templates that have been submitted to the financial system to date. In other words, prior year adjustments to any Quarterly, Annual and Monthly Report #12 reports should be uploaded in the same version of the template as the original submission.

Generic File Submissions

The generic file submission interface will allow the user to browse and find any file (supporting documentation, voluntary submissions, etc.) and then upload it to the Financial System.

The user will click on the Browse button to select the file to upload, include a text description of the file in the "File description" box, choose the submission period that the file pertains to and click on the Submit File button. The file will be uploaded but no edits will be performed. Files can be uploaded in multiple formats, including: Excel, Word, PDF, zipped, etc. **Note that only OMHSAS can access generic files once they are submitted.**

For Contractors submitting on behalf of multiple entities, please use the drop-down box to select the appropriate Zone/County/MCE prior to submitting generic files.

Instructions for Generating Output Reports

Users can generate output reports for any successfully submitted report, except Additional reports. Additional reports submitted to the Financial System can be accessed from the File Submission Dashboard (see Instructions for Downloading Submitted Reports above). To create an output report for all other successfully submitted reports, go to the "*Output Reports*" screen from the link on the left side of the screen.

Step A: Note that files will only display in the "Active Reports" box for Report Cycles and Periods in which a report was submitted.

Step B: Reports #1–4, 6–8 and 9A–9B can be viewed and saved as Excel spreadsheets. To generate one of these reports, select the Year (Report Cycle), Time Period/Report Cycle (Period) and Report Type (Active Reports) you would like to review, and then click

Submit.

Step C: Report #98 can be viewed in three different formats. The first option is the on-screen view from the bottom of the *Output Reports* screen. For this view, follow the instructions in Step B and choose “F98–Common Text” in the Active Reports box and press the “Submit” button.

Step D: The second and third formats are in Excel or PDF file types. The user has the option to export these formats from the “Select a format” drop-down box on the bottom half of the screen.

Instructions for Generating Trend Charts

To create a trend chart, go to the “*Trend Charts*” screen from the link on the left side of the screen, choose the trend time period from the “Start Period” and “End Period” boxes, check the applicable service category boxes under “Service Group” and click the “Submit” button.

APPENDIX A

Financial Reporting Entity ID Numbers

The following section provides information regarding the entity that should be entered in the "Reported By" field at the heading of each Financial Report template. In instances where a report contains data from more than one entity, this field should name the primary contractor.

Entity IDs by Report and Organization

Report 1

Financial Reporting ID	Organization		Financial Reporting ID	Organization		Financial Reporting ID	Organization
01840917	Adams		01846376	Cumberland		00000045	Monroe
01703981	Allegheny		01847346	Dauphin		00000003	Montgomery
00000076	Armstrong/Indiana MH/MR		00000003	Delaware		00000047	Montour
01704002	Armstrong		00000024	Elk		01848441	Northampton
01704011	Beaver		00000025	Erie		00000005	North Central State Option / CCBH
00000105	Bedford		01704030	Fayette		00000015	Northeast Behavioral Health Care Consortium
00000070	Bedford/Somerset (BHSSBC)		00000027	Forest		00000049	Northumberland
01841576	Berks		00000028	Franklin		01846385	Perry
01703981	BHARP		00000073	Franklin/Fulton (TMCA)		00000004	Philadelphia
00000107	Blair		00000029	Fulton		00000052	Pike
00000108	Bradford		00000006	Greene / VBH-PA		00000053	Potter
00000003	Bucks		00000031	Huntington		00000054	Schuylkill
01704020	Butler		01704058	Indiana		00000055	Snyder
00000012	CABHC		00000033	Jefferson		00000056	Somerset
00000111	Cambria		00000034	Juniata		00000057	Sullivan
00000112	Cameron		00000013	Lackawanna		00000016	Susquehanna
00000113	Carbon		01847050	Lancaster		00000059	Tioga
00000071	Carbon/Monroe/Pike		01704067	Lawrence		00000060	Union
00000114	Centre		01841567	Lebanon		00000061	Venango
01608946	Chester		01847364	Lehigh		00000062	Warren
00000116	Clarion		00000014	Luzerne		01704076	Washington
00000117	Clearfield		00000041	Lycoming		00000017	Wayne
00000018	Clinton		00000072	Lycoming/Clinton		01704085	Westmoreland
00000019	Columbia		00000042	McKean		00000017	Wyoming
00000020	Crawford		00000043	Mercer		01840935	York
00000074	Crawford/Mercer/Venango (NWBHP)		00000044	Mifflin			

Report 2 and Report 9

Financial Reporting ID	Organization		Financial Reporting ID	Organization		Financial Reporting ID	Organization
01840917	Adams		01846376	Cumberland		00000045	Monroe
01703981	Allegheny		01847346	Dauphin		01608973	Montgomery
00000076	Armstrong/Indiana MH/MR		01608955	Delaware		00000047	Montour
01704002	Armstrong		00000024	Elk		01848441	Northampton
01704011	Beaver		00000025	Erie		00000005	North Central State Option / CCBH
00000105	Bedford		01704030	Fayette		00000015	Northeast Behavioral Health Care Consortium
00000070	Bedford/Somerset (BHSSBC)		00000027	Forest		00000049	Northumberland
01841576	Berks		00000028	Franklin		01846385	Perry
01703981	BHARP		00000073	Franklin/Fulton (TMCA)		01608964	Philadelphia
00000107	Blair		00000029	Fulton		00000052	Pike
00000108	Bradford		00000006	Greene / VBH-PA		00000053	Potter
01608937	Bucks		00000031	Huntington		00000054	Schuylkill
01704020	Butler		01704058	Indiana		00000055	Snyder
00000012	CABHC		00000033	Jefferson		00000056	Somerset
00000111	Cambria		00000034	Juniata		00000057	Sullivan
00000112	Cameron		00000013	Lackawanna		00000016	Susquehanna
00000113	Carbon		01847050	Lancaster		00000059	Tioga
00000071	Carbon/Monroe/Pike		01704067	Lawrence		00000060	Union
00000114	Centre		01841567	Lebanon		00000061	Venango
01608946	Chester		01847364	Lehigh		00000062	Warren
00000116	Clarion		00000014	Luzerne		01704076	Washington
00000117	Clearfield		00000041	Lycoming		00000017	Wayne
00000018	Clinton		00000072	Lycoming/Clinton		01704085	Westmoreland
00000019	Columbia		00000042	McKean		00000017	Wyoming
00000020	Crawford		00000043	Mercer		01840935	York
00000074	Crawford/Mercer/Venango (NWBHP)		00000044	Mifflin			

Report 3

Financial Reporting ID	Organization
00000003	MBH of PA - Magellan Behavioral Health of PA
00000004	CBH - Community Behavioral Health
00000005	CCBH - Community Care Behavioral Health
00000006	VBH of PA - Value Behavioral Health of PA
00000077	CSI - CBHNP Services Inc.

Report 6, Report 7 and Report 8

Financial Reporting ID	Organization
00000003	MBH of PA - Magellan Behavioral Health of PA
00000004	CBH - Community Behavioral Health
00000005	CCBH - Community Care Behavioral Health
00000006	VBH of PA - Value Behavioral Health of PA
00000077	CSI - CBHNP Services Inc.
01704011	Beaver
01703981	BHARP
01704030	Fayette

Report 4

Financial Reporting ID	Organization		Financial Reporting ID	Organization		Financial Reporting ID	Organization
01840917	Adams		01846376	Cumberland		01846385	Perry
01703981	Allegheny		01847346	Dauphin		01608964	Philadelphia
00000076	Armstrong/Indiana MH/MR		01608955	Delaware		01704076	Washington
01704011	Beaver		00000025	Erie		01704085	Westmoreland
00000070	Bedford/Somerset (BHSSBC)		01704030	Fayette		01840935	York
01841576	Berks		00000073	Franklin/Fulton (TMCA)		00000003	MBH of PA - Magellan Behavioral Health of PA
01703981	BHARP		00000006	Greene / VBH-PA		00000004	CBH - Community Behavioral Health
00000107	Blair		01847050	Lancaster		00000005	CCBH - Community Care Behavioral Health
01608937	Bucks		01704067	Lawrence		00000006	VBH of PA - Value Behavioral Health of PA
01704020	Butler		01841567	Lebanon		00000008	SBHM
00000012	CABHC		01847364	Lehigh		00000009	AHCI
00000111	Cambria		00000072	Lycoming/Clinton		00000010	CBHNP
00000071	Carbon/Monroe/Pike		01608973	Montgomery		00000077	CSI - CBHNP Services Inc.
01608946	Chester		01848441	Northampton			
00000074	Crawford/Mercer/Venango (NWBHP)		00000015	Northeast Behavioral Health Care Consortium			

Report 12

Financial Reporting ID	Organization		Financial Reporting ID	Organization		Financial Reporting ID	Organization
01840917	Adams		00000074	Crawford/Mercer/Venango (NWBHP)		01848441	Northampton
01703981	Allegheny		01846376	Cumberland		00000015	Northeast Behavioral Health Care Consortium
00000076	Armstrong/Indiana MH/MR		01847346	Dauphin		01846385	Perry
01704011	Beaver		01608955	Delaware		01608964	Philadelphia
00000070	Bedford/Somerset (BHSSBC)		00000025	Erie		01704076	Washington
01841576	Berks		01704030	Fayette		01704085	Westmoreland
01703981	BHARP		00000073	Franklin/Fulton (TMCA)		01840935	York
00000107	Blair		00000006	Greene / VBH-PA			
01608937	Bucks		01847050	Lancaster			
01704020	Butler		01704067	Lawrence			
00000012	CABHC		01841567	Lebanon			
00000111	Cambria		01847364	Lehigh			
00000071	Carbon/Monroe/Pike		00000072	Lycoming/Clinton			
01608946	Chester		01608973	Montgomery			

APPENDIX B

File Naming Conventions

This section provides information regarding the naming convention the Contractors should use on files they upload to the Financial System website. Any files that do not exactly follow the naming conventions will be rejected in real-time and will require resubmission.

File Naming Key

The tables following the descriptions below define the two-character codes identified under the "File Naming Conventions" in Section 5.

Table 1 – DHS Assigned HMO ID
Includes the two-character HMO ID that maps to each County/Multi-County Entity/Zone.

Table 2a – Monthly Submission Period Designation
Includes the two-character code associated with the month that a report is submitted. This only applies to the Reports # 6 – 8C and 12 monthly submissions.

Table 2b – Quarterly and Annual Submission Period Designation
Includes the two-character code associated with the last month that a report is submitted (quarterly submission only). Note that the quarterly codes vary by the "Zone Year" defined in Table 1. The quarterly codes apply to the Reports # 1 – 4 and 9A quarterly submissions. The annual code, "AN", applies to the Reports # 2 – 4 and 9A annual submissions.

Table 3 – Quarterly, Annual and Additional Report Group Designation
Includes the two-character code assigned to each report template.

Example: Bucks County May 2012 submission of financial Reports # 6 – 8C

File Name Example: FIN_2012_BU_05_01.xls

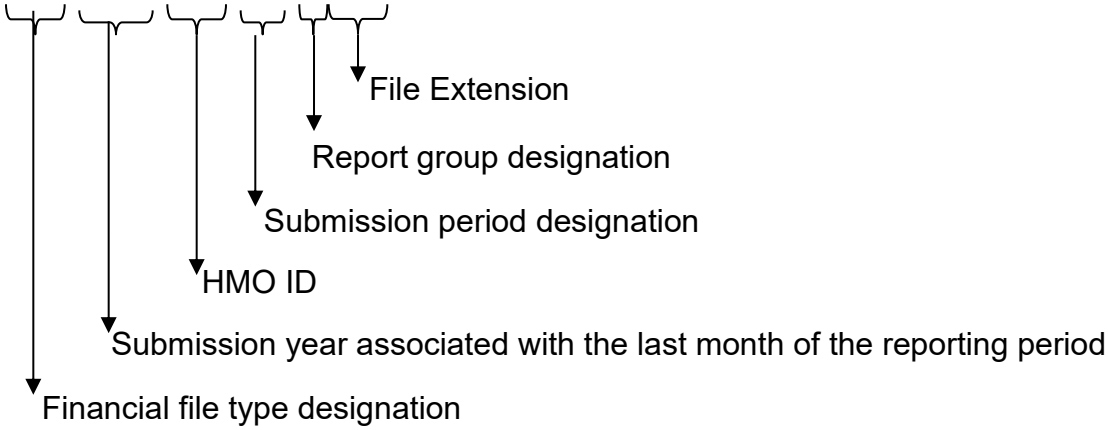


TABLE 1 - DPW Assigned HMO ID, Subcontractors and Management Corporations

Zone Year	ID	
SFY	AI	Armstrong/Indiana MCE Behavioral Health
CY	AL	Allegheny County Behavioral Health
CY	BE	Beaver County Behavioral Health
SFY	BT	Butler County Behavioral Health
CY	FA	Fayette County Behavioral Health
CY	GR	Greene County Behavioral Health
SFY	LW	Lawrence County Behavioral Health
SFY	WS	Washington County Behavioral Health
SFY	WE	Westmoreland County Behavioral Health
CY	SB	Southwest Behavioral Health Management, Inc. (SBHM)
CY	BU	Bucks County BH
CY	CH	Chester County BH
CY	DE	Delaware County BH
CY	MO	Montgomery County BH
CY	PH	Philadelphia County BH
SFY	AD	Adams County Behavioral Health
CY	BK	Berks County Behavioral Health
CY	CF	Capital Area Behavioral Health Collaborative, Inc. (CABHC)
SFY	CU	Cumberland County Behavioral Health
SFY	DA	Dauphin County Behavioral Health
SFY	LA	Lancaster County Behavioral Health
SFY	LB	Lebanon County Behavioral Health
CY	LE	Lehigh County Behavioral Health
CY	NH	Northampton County Behavioral Health
SFY	PE	Perry County Behavioral Health
SFY	YO	York County Behavioral Health
CY	YY	York/Adams
CY	NB	Northeast Behavioral Health Care Consortium
CY	BI	Blair HealthChoices
CY	BS	Behavioral Health Services of Somerset And Bedford Counties
CY	CK	Carbon, Monroe, Pike Counties
CY	CM	Behavioral Health of Cambria County
CY	CV	Northwest Behavioral Health (Crawford, Mercer, Venango)
CY	ER	Erie County
CY	FF	Tuscarora Managed Care Alliance (Franklin & Fulton Counties)
CY	LC	Lycoming Clinton Joinder Board
CY	NC	State Option - Community Care Behavioral Health Organization, Inc. (NC SO)
CY	NS	Behavioral Health Alliance of Rural Pennsylvania (BHARP)
	CC	Community Care Behavioral Health Organization (Community Care)
	CS	Community Behavioral HealthCare Network of Pennsylvania Services, Inc. (CSI)
	MB	Magellan Behavioral Health of Pennsylvania (MBH-PA)
	SB	Southwest Behavioral Health Management, Inc. (SBHM)
	VB	Value Behavioral Health of Pennsylvania, Inc. (VBH-PA)

TABLE 2a - Monthly Submission Period Designation

Monthly Submission Period	2-character Submission Period Designation
January	01
February	02
March	03
April	04
May	05
June	06
July	07
August	08
September	09
October	10
November	11
December	12

TABLE 2b - Quarterly and Annual Submission Period Designation

Zone Year[1]	Submission Period (Last month in submission period)	2-Character Submission Period Designation
CY	March	Q1
CY	June	Q2
CY	September	Q3
CY	December	Q4
CY	**Annual**	**AN**

[1] Refer to Table 1 for Zone Year assignments.

TABLE 3 – Report Group Designation (as of March 2021)

Submission Period	Financial Report #	Report Group Designation
Monthly	6 – 8C	01
Monthly	12 – MAGI	28
Quarterly	1 – 4 and 9A	03
Annual	2 – 4 and 9A	04
Quarterly	29	29
Annual	29	30
Quarterly	11	31
Annual	42 – 43	42
Additional Reports		
Actual Reinsurance Experience		05
Actuarial Certification of Claims Liability (CY)		06
Balance Sheet		07
Contract Reserves Compliance Report		08
ELTSR Reinvestment Bank Statement		09
ELTSR Reinvestment Report #12		10
Equity Reserve Bank Statement		11
Estimated Reinsurance Experience		12
General Account Bank Statement		13
Parental Guaranty Quarterly Monitoring Report		14
Physician Incentive Arrangement		15
Reinsurance Waiver Report > $75,000		16
Reinvestment Bank Statement		17
Risk & Contingency Bank Statement		18
Reports #13, #14, #15 (Primary Contractor)		19
Reports #13, #14, #15 (Subcontractor)		20
Actuarial Certification of Claims Liability (SFY)		21
Annual Audited Financial Statements (DOI) - Statutory Basis		22
Audited County General Purpose Financial Statements (CAFR)		23
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Entity Wide Audit (Subcontractor)		25
Insurance Department Annual Filing		26
Insurance Department Quarterly Filing		27

APPENDIX C

Financial Reporting Templates

The Excel-based financial reporting templates are included as separate attachments with these instructions.

Excel-based Templates
Below are the names of the Excel-based financial reporting templates and Financial Data Certification form. When submitting these completed files to the website, please follow the file naming conventions discussed in Section 5 and Appendix B.

- Annual Reporting Template (#2-#4 & #9)_HCE eligibility.xls
- Monthly Reporting Template Part 1 (#6-#8).xls
- Monthly Reporting Template Part 2 (#12)_HCE eligibility.xls
- Quarterly Reporting Template (#1-#4 & #9)_HCE eligibility.xls
- Quarterly Reporting Template (#29).xlsx
- Annual Reporting Template (#29).xlsx
- Annual Reporting Template (#42-#43).xlsx
- Financial Data Certification.doc

Instructions for Completing the Primary Contractor MCO Assessment Report Form for Behavioral Health Medicaid Managed Care Organizations

This report must be completed by any Primary Contractor who has members enrolled in a Medicaid managed care plan for the HealthChoices Behavioral Health Program, for the purpose of the MCO Assessment for any year during which the assessment is imposed.

For purposes of this report, members shall mean an individual who is enrolled to receive health care services from a Behavioral Health managed care plan during each month of the reporting period for any period of time. Monthly unduplicated members are subject to the MCO Assessment. Payments will be assessed for members enrolled during the quarter for any time period for which the Assessment applies.

Certification Form:

This form must be completed and submitted with each quarterly report.

Specific Instructions:

PART 1: CURRENT QUARTER

Section 1 – Unduplicated Members per DHS (to be completed by DHS)

DHS will obtain membership information from its information systems for all members enrolled during the quarter being assessed for any time period within the effective period of the assessment (beginning July 1, 2016). The member amounts that DHS obtains will be provided to the Primary Contractor or it's designee approximately 20 days prior to the report and payment due date.

Section 2 – Unduplicated Members per the Primary Contractor (to be completed by the Primary Contractor)

DHS anticipates that the amounts in this section should be the same as the amounts provided by DHS in Section 1. However, if the Primary Contractor believes that the amounts provided by DHS are in error, the Primary Contractor should use this section to report the amounts that they have in their records. Otherwise, the amounts in this section will be the same as the amounts in Section **1**.

Section 3 – Difference (to be completed by the Primary Contractor)

If Section 2 reflects differences from Section 1, this section should be used to report the amount of those differences.

Members to Be Assessed – Report the total amount of unduplicated members reported in Section 2.

Assessment Rate for Current Year– Effective July 1, 2016, Act 92 of 2015 imposes an assessment fee for each unduplicated member for each month the member is enrolled for any period of time with the managed care organization. 62 P.S. § 803-I(b). This rate may be adjusted and notice of the adjustment will be published in the Pennsylvania Bulletin.

Assessment Rate for Prior Year – In the event the rate changes between reporting years, include the prior period assessment rate on this line and apply it to any retroactively enrolled members.

Assessment Amount Due for the Current Quarter – For members enrolled during the current reporting quarter, calculate using the current rate.

Correction of Prior Period Assessment – If, for any reason, a previous period's assessment amount has been determined to be incorrect, any balance due or credit due should be reflected on this line. An explanation must be provided for any correction reported.

Restatement of Prior Quarter to actual – This amount is calculated in Part 2 as the difference between the estimated amount and the actual amount due for a prior quarter.

Total Assessment Being Remitted – Report the total of the Assessment Amount Due for Current period plus any Correction of Prior Period Assessment amount.

PART 2: RESTATEMENT OF PRIOR QUARTER

For quarters where an estimated amount was paid in the previous quarter, this section should be completed to restate the estimated membership to actual enrollment amounts. This part will compare what was paid based on the estimated member count to the actual amount due based on the actual member count. The total on the "Adjustment due to Restatement" line should be added to Part 1 and paid with the current quarter assessment.

Quarterly Assessment Report Form and Payment

The Primary Contractor shall email completed MCO Assessment Report forms, along with the Certification, to RA-PWMCOASSMNTRPT@pa.gov, as specified in the payment schedule below.

Assessment Quarter	Due Date
Quarter 1: July 1 – September 30	**October 31**
Quarter 2: October 1 – December 31	**January 31**
Quarter 3: January 1 – March 31	**April 30**
Quarter 4: April 1 – June 30	**June 20**

The Primary Contractor shall remit the assessment electronically. If the due date falls on a banking holiday, the payment is due the next banking business day after the due date.

Payments due must be transmitted through the Budget Payment Center at https://www.bpp.ob.pa.gov/Customer. Please save this link to your browser. When you go to the site select the 3rd option, which is indicated in red box below. Once you select that option, on the next screen fill out the relevant data and then select "Human Services" from the Agency Drop Down and then select "298-OHMSAS MCO ASSESSMENT" from the Program ID Drop Down. Please also make sure to include entity name in the Payment Reference Box. If you are making an ACH/Intellicheck payment from a corporate account, please ensure you have notified your banking institution to add the Commonwealth of Pennsylvania, ACH ID#9049039603 to allow for ACH/Intellicheck payments.

These instructions and the report format are subject to change periodically based on current legislation and the needs of DHS.

Remedies, Liens and Appeal Rights

Remedies, Liens and Appeal Rights provisions are specified in Sections 807-I, 808-I, and 809-I of the Act. 62 P.S. §§ 807-I; 808-I; 809-I.

Instructions for MLR Report

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Introduction

These instructions are for the Excel-based MLR Reporting. The Excel workbook is designed to collect all information needed for MLRs as required by the HealthChoices Behavioral Health Agreement. Per the CMS Medicaid Managed Care Final Rule, § 438.5(b)(5), the past medical loss ratio must be taken into account while setting actuarially sound capitation rates.

This report is to be completed and submitted to the web-based financial reporting system by November 15th following the MLR reporting year. For example, the MLR report for CY 2022 experience would be due to the Department on November 15th, 2023.

Throughout these instructions there will be references to the 2016 Medicaid/CHIP Managed Care Final Rule and other regulations. The text of the regulations cited are included in this document. All regulations are parts of 42 CFR unless cited otherwise.

The information requested by the report follow regulation § 438.8(k):

(1) The State, through its contracts, must require each MCO, PIHP, or PAHP to submit a report to the State that includes at least the following information for each MLR reporting year:
   (i) Total incurred claims.
   (ii) Expenditures on quality improving activities.
   (iii) Expenditures related to activities compliant with § 438.608(a)(1) through (5), (7), (8) and (b).
   (iv) Non-claims costs.
   (v) Premium revenue.
   (vi) Taxes, licensing and regulatory fees.
   (vii) Methodology(ies) for allocation of expenditures which must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, Federal and State taxes and licensing or regulatory fees, and other non-claims costs, as described in 45 CFR 158.170(b).
   (viii) Any credibility adjustment applied.
   (ix) The calculated MLR.
   (x) A comparison of the information reported in this paragraph with the audited financial report required under § 438.3(m).
   (xi) A description of the aggregation method used under paragraph (i) of this section.
   (xii) The number of member months.

(2) A MCO, PIHP, or PAHP must submit the report required in paragraph (k)(1) of this section in a timeframe and manner determined by the State, which must be within 12 months of the end of the MLR reporting year.

(3) MCOs, PIHPs, or PAHPs must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to that MCO, PIHP, or PAHP within 180 days of the end of the MLR reporting year or within 30 days of being requested by the MCO, PIHP, or PAHP, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

1. Plan Information

Please fill out the contact information of your County/MCE.

2. Numerator

This worksheet collects information for items that are included or deducted from the numerator. Note that incurred claims by one County/MCE that are later assumed by another entity must be reported by the assuming County/MCE for the entire MLR reporting year, and no incurred claims for the MLR reporting year may be reported by the ceding County/MCE.

Please fill in the cells that are formatted with blue font.

Detail for each line can be found here:

Line 1.0 Incurred claims, including unpaid claim liabilities for the MLR reporting year: Note that this amount should be net of all fraud recoveries, including what is reported in or out of the claims system. See §§ 438.8(e)(2)(i)(A) and 438.8(e)(2)(i)(B):

(A) Direct claims that the MCO, PIHP, or PAHP paid to providers for services or supplies covered under the contract and services meeting the requirements of § 438.3(e) provided to enrollees. This includes:
   a. Claims for State Plan and OMHSAS-approved In Lieu of Services
   b. Retroactive provider fee increases that are permanent
   c. The amount of payments made to providers under State directed payments described in § 438.6(c).
   d. Do NOT include reinvestment plan expenditures.

(B) Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted.

§ 438.3(e) Services that may be covered by an MCO, PIHP, or PAHP:

(1) An MCO, PIHP, or PAHP may cover, for enrollees, services that are in addition to those covered under the State plan as follows:
   (i) Any services that the MCO, PIHP or PAHP voluntarily agree to provide, although the cost of these services cannot be included when determining the payment rates under paragraph (c) of this section.
   (ii) Any services necessary for compliance by the MCO, PIHP, or PAHP with the requirements of subpart K of this part and only to the extent such services are necessary for the MCO, PIHP, or PAHP to comply with § 438.910.

(2) An MCO, PIHP, or PAHP may cover, for enrollees, services or settings that are in lieu of services or settings covered under the State plan (includes Non-Hospital D&A services, Psychiatric Rehabilitation Services and transportation, Assertive Community Treatment, etc.) as follows:
   (i) The State determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State plan;
   (ii) The enrollee is not required by the MCO, PIHP, or PAHP to use the alternative service or setting;

(iii) The approved in lieu of services are authorized and identified in the MCO, PIHP, or PAHP contract, and will be offered to enrollees at the option of the MCO, PIHP, or PAHP; and
(iv) The utilization and actual cost of in lieu of services is taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.

Line 1.1 Incurred claims for Value-Based Purchasing (VBP) arrangements. Report payments for VBP arrangements approved by and reported to DHS.

Line 1.2 Incurred claims for Alternative Payment Arrangements (APAs) NOT identified as a VBP in line 1.2. Report payments for APAs approved by and reported to DHS that are not captured in line 1.1.

Line 1.3 Incurred claims not considered a VBP arrangement or APA (as reported in lines 1.1 or 1.2). Report all other paid claims for services as described above in Line 1.0.

Line 1.4 IBNR for claims incurred in the period expected to be paid in months after the known runout: See § 438.8(e)(2)(i)(F)

Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.

Line 1.5 Withholds from payments made to network providers: See § 438.8(e)(2)(i)(C)

Withholds from payments made to network providers.

Line 1.6 Amount of incentive and bonus payments made, or expected to be made, to network providers: See § 438.8(e)(2)(iii)(A)

The amount of incentive and bonus payments made, or expected to be made, to network providers, that are tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers, including Pay for Performance (P4P). This includes retroactive one-time provider fee increases.

Line 1.7 Changes in other claims-related reserves: See § 438.8(e)(2)(i)(G)

Changes in other claims-related reserves.

Line 1.8 Reserves for contingent benefits and the medical claim portion of lawsuits: See § 438.8(e)(2)(i)(H)

Reserves for contingent benefits and the medical claim portion of lawsuits.

Line 1.9 Reinsurance premiums

Reinsurance premiums paid as part of HealthChoices solvency requirements.

Line 1.10a Amount spent on fraud reduction: See § 438.8(e)(2)(iii)(B)

The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include activities specified in paragraph (e)(4) of this section.

§ 438.8(e)(4):
Fraud prevention activities. MCO, PIHP, or PAHP expenditures on activities related to fraud prevention as adopted for the private market at 45 CFR part 158. Expenditures under this

paragraph must not include expenses for fraud reduction efforts in paragraph (e)(2)(iii)(B) of this section.

Note that the private market at this time has not adopted fraud prevention, so amounts for fraud prevention should not be in any part of this MLR report.

Line 1.10b Amount of claims payments recovered through fraud reduction: Note that lines 1.1 – 1.3 should be net of all fraud recoveries, including what is reported in and out of the claims system. That same recoveries amount is then reported here as a positive amount. Also, see line 1.10a.

Line 1.11 Claims that are recoverable for anticipated coordination of benefits: See § 438.8(e)(2)(i)(D)
Claims that are recoverable for anticipated coordination of benefits, such as Medicare or commercial insurance payments.

Line 1.12 Claims payments recoveries received as a result of subrogation: See § 438.8(e)(2)(i)(E)
Claims payments recoveries received as a result of subrogation.

Line 1.13 Overpayment recoveries received from network providers: The Department expects this to include any anticipated settlements for claims incurred during the MLR reporting year, including those outside of the claims system. See § 438.8(e)(2)(ii)(A)
Overpayment recoveries received from network providers.

Line 1.14 Reinsurance recoveries
Reinsurance recoveries received through reinsurance purchased as part of HealthChoices solvency requirements.

Line 1.15 Claims payments for Inpatient Psychiatric IMD Long Stays: Unallowable inpatient psychiatric IMD medical expenses for adults aged 21-64 with stays in excess of 15 days in a calendar month.
Medical expenses will be eligible for adults aged 21–64 receiving inpatient treatment in an IMD so long as the facility is a hospital providing psychiatric or substance use disorder (SUD) inpatient care or a sub-acute facility providing psychiatric or SUD crisis residential services, AND length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment. The Commonwealth has an 1115 waiver covering residential SUD IMD providers which exempts these facilities from the 15-day limitation.

Line 2.1 County/MCE activity that meets 45 CFR § 158.150(a) and § 158.150(b) and is NOT EXCLUDED under 45 CFR § 158.150(c): See § 438.8(e)(3)(i)
An MCO, PIHP, or PAHP activity that meets the requirements of 45 CFR 158.150(a) and (b) and is not excluded under 45 CFR 158.150(c).

This includes Joint Planning Treatment teams, Integrated Care Plan programs and approved Community Based Care Management initiatives that meet the definition of activities that improve health care quality.

45 CFR § 158.150 – Activities that improve health care quality
(b) Activity requirements. Activities conducted by an issuer to improve quality must meet the following requirements:

(1) The activity must be designed to:
  (i) Improve health quality.
  (ii) Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.
  (iii) Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.
  (iv) Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.
(2) The activity must be primarily designed to:
  (i) Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.
    (A) Examples include the direct interaction of the issuer (including those services delegated by contract for which the issuer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:
      (1) 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 section 3502 of the Affordable Care Act.
      (2) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.
      (3) Quality reporting and documentation of care in non-electronic format.
      (4) Health information technology to support these activities.
      (5) Accreditation fees directly related to quality of care activities.
      (6) Commencing with the 2012 reporting year and extending through the first reporting year in which the Secretary requires ICD-10 as the standard medical data code set, implementing ICD-10 code sets that are designed to improve quality and are adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, limited to 0.3 percent of an issuer's earned premium as defined in § 158.130.
    (B) [Reserved]
  (ii) Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:
    (A) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
    (B) Patient-centered education and counseling.
    (C) Personalized post-discharge reinforcement and counseling by an appropriate health care professional.
    (D) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.
    (E) Health information technology to support these activities.
  (iii) Improve patient safety, reduce medical errors, and lower infection and mortality rates.
    (A) Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:
      (1) The appropriate identification and use of best clinical practices to avoid harm.

(2) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns.
(3) Activities to lower the risk of facility-acquired infections.
(4) Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions.
(5) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.
(6) Health information technology to support these activities.

(B) [Reserved]

(iv) Implement, promote, and increase wellness and health activities:

(A) Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include -
(1) Wellness assessments;
(2) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
(3) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
(4) Public health education campaigns that are performed in conjunction with State or local health departments;
(5) Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in premiums or claims should be allowed as a quality improvement activity for the group market to the extent permitted by section 2705 of the PHS Act;
(6) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;
(7) Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity); and
(8) Health information technology to support these activities.

(B) [Reserved]

(v) Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with § 158.151 of this subpart.

(c) Exclusions. Expenditures and activities that must not be included in quality improving activities are:
(1) Those that are designed primarily to control or contain costs;
(2) The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;
(3) Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from premium revenue;
(4) Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;
(5) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended.
(6) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;
(7) All retrospective and concurrent utilization review;

(8) Fraud prevention activities;
(9) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;
(10) Provider Credentialing;
(11) Marketing expense
(12) Cost associated with calculating and administering individual enrollee or employee incentives;
(13) That portion of prospective utilization that does not meet the definition of activities that improve health quality; and
(14) Any function or activity not expressly included in paragraph (a) or (b) of this section, unless otherwise approved by and within the discretion of the Secretary, upon adequate showing by the issuer that the activity's costs support the definitions and purposes in this part or otherwise support monitoring, measuring or reporting health care quality improvement.

Line 2.2 County/MCE activity related to any EQR-related activity as described in § 438.358(b) and § 438.358(c): See § 438.8(e)(3)(ii)

An MCO, PIHP, or PAHP activity related to any EQR-related activity as described in § 438.358(b) and (c)

§ 438.358 – Activities related to external quality review
(b) Mandatory activities.
(1) For each MCO, PIHP, or PAHP the following EQR-related activities must be performed:
(i) Validation of performance improvement projects required in accordance with § 438.330(b)(1) that were underway during the preceding 12 months.
(ii) Validation of MCO, PIHP, or PAHP performance measures required in accordance with § 438.330(b)(2) or MCO, PIHP, or PAHP performance measures calculated by the State during the preceding 12 months.
(iii) A review, conducted within the previous 3-year period, to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in subpart D of this part and the quality assessment and performance improvement requirements described in § 438.330.
(iv) Validation of MCO, PIHP, or PAHP network adequacy during the preceding 12 months to comply with requirements set forth in § 438.68 and, if the State enrolls Indians in the MCO, PIHP, or PAHP, § 438.14(b)(1).
(2) For each PCCM entity (described in § 438.310(c)(2)), the EQR-related activities in paragraphs (b)(1)(ii) and (iii) of this section must be performed.
(c) Optional activities. For each MCO, PIHP, PAHP, and PCCM entity (described in § 438.310(c)(2)), the following activities may be performed by using information derived during the preceding 12 months:
(1) Validation of encounter data reported by an MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)).
(2) Administration or validation of consumer or provider surveys of quality of care.
(3) Calculation of performance measures in addition to those reported by an MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)) and validated by an EQRO in accordance with (b)(2) of this section.
(4) Conduct of performance improvement projects in addition to those conducted by an MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)) and validated by an EQRO in accordance with (b)(1) of this section.
(5) Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.
(6) Assist with the quality rating of MCOs, PIHPs, and PAHPs consistent with § 438.334.

Line 2.3 County/MCE expenditure that is related to Health Information Technology and meaningful use: See § 438.8(e)(3)(iii)

Any MCO, PIHP, or PAHP expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 CFR 158.151, and is not considered incurred claims, as defined in paragraph (e)(2) of this section.

45 CFR § 158.151

(a) General requirements. An issuer may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities allowed in § 158.150 of this subpart and that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with Medicare and/or Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

(1) Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their “meaningful use” as defined by HHS to the extent such payments are not included in reimbursement for clinical services as defined in § 158.140 of this subpart;

(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 Medicare and Medicaid incentive payments;

(3) Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;

(4) Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law.

(5) Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes.

(6) Advancing the ability of enrollees, providers, issuers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history and to support care management.

(7) Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease.

(8) Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

(b) [Reserved]

3. Excluded Amounts

This worksheet collects information for items excluded from the numerator, but required to be reported. Note that incurred claims by one County/MCE that are later assumed by another entity must

be reported by the assuming County/MCE for the entire MLR reporting year, and no incurred claims for the MLR reporting year may be reported by the ceding County/MCE.

Please fill in the cells that are formatted with blue font.

Line 3.1 Amounts paid to third party vendors for secondary network savings: See § 438.8(e)(2)(v)(A)(1)

Amounts paid to third party vendors for secondary network savings.

Line 3.2 Amounts paid to third party vendors for network development, admin fees, claims: processing, and utilization management: See § 438.8(e)(2)(v)(A)(2)

Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.

Line 3.3 Amounts paid to a provider for professional or administrative services outside of providing services to enrollees: See § 438.8(e)(2)(v)(A)(3)

Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee.

§ 438.3(e): See Line 1.1

Line 3.4 Fines and penalties assessed by regulatory authorities: See § 438.8(e)(2)(v)(A)(4)

Fines and penalties assessed by regulatory authorities.

Line 3.5 Amounts for pass-through payments under § 438.6(d): See § 438.8(e)(2)(v)(C)

Amounts paid to network providers under § 438.6(d).

§ 438.6: Special contract provisions related to payment

(a) Definitions. As used in this part, the following terms have the indicated meanings:

Pass-through payment is any amount required by the State to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between the MCO, PIHP, or PAHP and hospitals, physicians, or nursing facilities that is not for the following purposes: A specific service or benefit provided to a specific enrollee covered under the contract; a provider payment methodology permitted under paragraphs (c)(1)(i) through (iii) of this section for services and enrollees covered under the contract; a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract; GME payments; or FQHC or RHC wrap around payments.

(d) Pass-through payments under MCO, PIHP, and PAHP contracts.

(1) States may require MCOs, PIHPs, and PAHPs to make pass-through payments (as defined in paragraph (a) of this section) to network providers that are hospitals, physicians, and nursing facilities under the contract subject to the requirements of this paragraph (d). States may not require MCOs, PIHPs, and PAHPs to make pass-through payments other than those permitted under this paragraph.

(2) Calculation of the base amount. The base amount of pass-through payments is the sum of the results of paragraphs (d)(2)(i) and (ii) of this section.

(i) For inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period that includes pass-through

payments and that were provided to the eligible populations under MCO, PIHP, or PAHP contracts two years prior to the rating period, the State must determine reasonable estimates of the aggregate difference between:

(A) The amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under the MCO, PIHP, or PAHP contracts for the 12-month period immediately two years prior to the rating period that will include pass-through payments; and

(B) The amount the MCOs, PIHPs, or PAHPs paid (not including pass through payments) for those inpatient and outpatient hospital services utilized by the eligible populations under MCO, PIHP, or PAHP contracts for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments.

(ii) For inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period that includes pass-through payments and that were provided to the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period, the State must determine reasonable estimates of the aggregate difference between:

(A) The amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments; and

(B) The amount the State paid under Medicaid FFS (not including pass through payments) for those inpatient and outpatient hospital services utilized by the eligible populations for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments.

(iii) The base amount must be calculated on an annual basis and is recalculated annually.

(iv) States may calculate reasonable estimates of the aggregate differences in paragraphs (d)(2)(i) and (ii) of this section in accordance with the upper payment limit requirements in 42 CFR part 447.

(3) Schedule for the reduction of the base amount of pass-through payments for hospitals under the MCO, PIHP, or PAHP contract. Pass-through payments for hospitals may be required under the contract but must be phased out no longer than on the 10-year schedule, beginning with contracts that start on or after July 1, 2017. Pass-through payments may not exceed a percentage of the base amount, beginning with 100 percent for contracts starting on or after July 1, 2017, and decreasing by 10 percentage points each successive year. For contracts beginning on or after July 1, 2027, the State cannot require pass-through payments for hospitals under a MCO, PIHP, or PAHP contract.

(4) Documentation of the base amount for pass-through payments to hospitals. All contract arrangements that direct pass-through payments under the MCO's, PIHP's or PAHP's contract for hospitals must document the calculation of the base amount in the rate certification required in § 438.7. The documentation must include the following:

(i) The data, methodologies, and assumptions used to calculate the base amount;

(ii) The aggregate amounts calculated for paragraphs (d)(2)(i)(A), (d)(2)(i)(B), (d)(2)(ii)(A), (d)(2)(ii)(B) of this section; and

(iii) The calculation of the applicable percentage of the base amount available for pass-through payments under the schedule in paragraph (d)(3) of this section.

(5) Pass-through payments to physicians or nursing facilities. For contracts starting on or after July 1, 2017 through contracts beginning on or after July 1, 2021, the State may require pass-through payments to physicians and nursing facilities under the MCO, PIHP, or PAHP contract.

For contracts beginning on or after July 1, 2022, the State cannot require pass-through payments for physicians or nursing facilities under a MCO, PIHP, or PAHP contract.

4. Denominator

This worksheet collects information for the denominator. Note that the total amount of the denominator for a County/MCE, which is later assumed by another entity, must be reported by the assuming County/MCE for the entire MLR reporting year, and no amount for that year may be reported by the ceding County/MCE.

Please fill in the cells that are formatted with blue font.

Line 4.1 State capitation payments, including adjustments, and net of any known IMD recoveries (if applicable): See § 438.8(f)(2)(i) and § 438.8(f)(2)(vii)

State capitation payments, developed in accordance with § 438.4, to the MCO, PIHP, or PAHP for all enrollees under a risk contract approved under § 438.3(a), excluding payments made under to § 438.6(d).

- Report the total capitation payments, including the MCO assessment. Do NOT include any investment income.
- Capitation should be net of IMD capitation recoveries.
- Capitation should include payments to the MCO, PIHP, or PAHP for expenditures under State directed payments described in § 438.6(c).

§ 438.4 Actuarial Soundness:

(a) Actuarially sound capitation rates defined. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.

(b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:

(1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.

(2) Be appropriate for the populations to be covered and the services to be furnished under the contract.

(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§ 438.206, 438.207, and 438.208.

(4) Be specific to payments for each rate cell under the contract.

(5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.

(6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).

(7) Meet any applicable special contract provisions as specified in § 438.6.

(8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.

(9) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under § 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

§ 438.3(a) Standard Contract Requirements:
CMS review. The CMS must review and approve all MCO, PIHP, and PAHP contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirement in § 438.806. Proposed final contracts must be submitted in the form and manner established by CMS. For States seeking approval of contracts prior to a specific effective date, proposed final contracts must be submitted to CMS for review no later than 90 days prior to the effective date of the contract.

§ 438.6(d): See Line 3.6

Line 4.2 Earned premium withholds approved under § 438.6(b)(3): See § 438.8(f)(2)(iii)
Other payments to the MCO, PIHP, or PAHP approved under § 438.6(b)(3)

§ 438.6(b)(3):
Contracts that provide for a withhold arrangement must ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound as determined by an actuary. The total amount of the withhold, achievable or not, must be reasonable and take into consideration the MCO's, PIHP's or PAHP's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the MCO's, PIHP's or PAHP's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves. The data, assumptions, and methodologies used to determine the portion of the withhold that is reasonably achievable must be submitted as part of the documentation required under § 438.7(b)(6). For all withhold arrangements, the contract must provide that the arrangement is -

(i) For a fixed period of time and performance is measured during the rating period under the contract in which the withhold arrangement is applied.
(ii) Not to be renewed automatically.
(iii) Made available to both public and private contractors under the same terms of performance.
(iv) Does not condition MCO, PIHP, or PAHP participation in the withhold arrangement on the MCO, PIHP, or PAHP entering into or adhering to intergovernmental transfer agreements.
(v) Necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy under § 438.340.

§ 438.6(a)
Withhold arrangement means any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract. Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement.

Line 4.3 Unpaid cost-sharing amount that the health plan could have collected from enrollees under the contract: See § 438.8(f)(2)(iv)

Unpaid cost-sharing amounts that the MCO, PIHP, or PAHP could have collected from enrollees under the contract, except those amounts the MCO, PIHP, or PAHP can show it made a reasonable, but unsuccessful, effort to collect.

Line 4.4 All changes to unearned premium reserves: See § 438.8(f)(2)(v)

All changes to unearned premium reserves.

Line 4.5a Reinvestment Sharing remittances to DHS

Reinvestment Sharing remittances are a profit experience rebate considered a risk mitigation strategy. As such they are a premium revenue reduction. Reported remittances must be specific to revenue from the year the capitation was **earned**.

Line 4.5b Other net payments/receipts related to risk sharing mechanisms: The risk-sharing mechanisms referenced in § 438.5 and § 438.6 are risk adjustment, risk corridors, reinsurance, and stop loss limits: See § 438.8(f)(2)(vi)
Net payments or receipts related to risk sharing mechanisms developed in accordance with § 438.5 or § 438.6.

§ 438.5(a) and (g): Rate Development Standards

(a) Definitions. As used in this section and § 438.7(b), the following terms have the indicated meanings:

Budget neutral means a standard for any risk sharing mechanism that recognizes both higher and lower expected costs among contracted MCOs, PIHPs, or PAHPs under a managed care program and does not create a net aggregate gain or loss across all payments under that managed care program.

Prospective risk adjustment means a methodology to account for anticipated variation in risk levels among contracted MCOs, PIHPs, or PAHPs that is derived from historical experience of the contracted MCOs, PIHPs, or PAHPs and applied to rates for the rating period for which the certification is submitted.

Retrospective risk adjustment means a methodology to account for variation in risk levels among contracted MCOs, PIHPs, or PAHPs that is derived from experience concurrent with the rating period of the contracted MCOs, PIHPs, or PAHPs subject to the adjustment and calculated at the expiration of the rating period.

Risk adjustment is a methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of MCOs, PIHPs, or PAHPs contracted with the State.

…

(g) Risk adjustment. Prospective or retrospective risk adjustment methodologies must be developed in a budget neutral manner consistent with generally accepted actuarial principles and practices.

§ 438.6(a) and (b)(1): Special contract provisions related to payment

(a) Definitions. As used in this part, the following terms have the indicated meanings:

Risk corridor means a risk sharing mechanism in which States and MCOs, PIHPs, or PAHPs may share in profits and losses under the contract outside of a predetermined threshold amount.

(b) Basic requirements.
(1) If used in the payment arrangement between the State and the MCO, PIHP, or PAHP, all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be described in the contract, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices.

Line 5.1 Statutory assessments to defray the operating expense of any state or federal department: See § 438.8(f)(3)(i)
Statutory assessments to defray the operating expenses of any State or Federal department.

Line 5.2 Examination fees in lieu of premium taxes as specified by state law: See § 438.8(f)(3)(ii)
Examination fees in lieu of premium taxes as specified by State law.

Line 5.3 Federal taxes and assessments allocated to MCOs: See § 438.8(f)(3)(iii)
Federal taxes and assessments allocated to MCOs, PIHPs, and PAHPs, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

Line 5.4 State and local taxes and assessments: See § 438.8(f)(3)(iv).
(iv) State and local taxes and assessments including:
(A) The MCO Assessment.
(B) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.
(C) Guaranty fund assessments.
(D) Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.
(E) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.
(F) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

Line 5.5 Amounts otherwise exempt from Federal income taxes for community benefit expenditures: See § 438.8(f)(3)(v)
(v) Payments made by an MCO, PIHP, or PAHP that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 CFR 158.162(c), limited to the highest of either:
(A) Three percent of earned premium; or
(B) The highest premium tax rate in the State for which the report is being submitted, multiplied by the MCO's, PIHP's, or PAHP's earned premium in the State.

45 CFR § 158.162(c)
(c) Community benefit expenditures. Community benefit expenditures means expenditures for activities or programs that seek to achieve the objectives of improving access to health services,

enhancing public health and relief of government burden. This includes any of the following activities that:
(1) Are available broadly to the public and serve low-income consumers;
(2) Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (for example, longer wait times or increased travel distances);
(3) Address Federal, State or local public health priorities such as advancing health care knowledge through education or research that benefits the public;
(4) Leverage or enhance public health department activities such as childhood immunization efforts; and
(5) Otherwise would become the responsibility of government or another tax-exempt organization.

5. Credibility Adjustment

On July 31, 2017, CMS published an Informational Bulletin documenting the MLR credibility adjustment for rating periods beginning July 1, 2017 or later for Medicaid and CHIP managed care contracts. The specifics of the bulletin are available here:
https://www.medicaid.gov/federal-policy-guidance/downloads/cib073117.pdf

The CMS OACT calculated:
(1) The minimum number of member months for a managed care plans' MLR to be fully credible;
(2) The maximum number of member months for a managed care plans' MLR to be non-credible;
(3) The number of member months for several partial credibility adjustment factors.

Credibility adjustment factors were developed for two types of Medicaid and CHIP managed care plans that may operate in each state:
(1) All managed care plans that provide health care services, except managed care plans that only provide long-term services and supports (referenced as "Standard Plans"); and
(2) Managed care plans that only provide long-term services and supports.

The credibility adjustment factors for the Standard Plan are included in the MLR template for the HealthChoices Behavioral Health program.

Please fill in the **Annual Member Months** for the County/MCE in the cell that is formatted with blue font. The far right column of Table 1 will indicate whether the County/MCE is deemed non-credible, fully credible or partially credible. If the County/MCE meets the member month thresholds to achieve partial credibility, the Credibility Adjustment will be calculated consistent with the methodology and formula prescribed by CMS.

6. MLR Calculation

This worksheet takes the prior amounts and summarizes them into subtotals and calculates the unadjusted MLR. The member months and credibility adjustment from the prior tab are summarized to calculate the credibility-adjusted MLR.

If the member months indicate the County/MCE's size is eligible for a partial credibility adjustment but the County/MCE declines the adjustment, please leave the cell as 0.

7. Expense Allocation

Certain expenses may not be attributable to one line of business. Describe methods used to allocate these expenses and how they factor into the MLR calculated for this report. A description can be included in the workbook or a reference can be made to an attached document: See § 438.8(g)

§ 438.8(g)
(g) Allocation of expense -
- (1) General requirements.
  - (i) Each expense must be included 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.
  - (ii) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.
- (2) Methods used to allocate expenses.
  - (i) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results.
  - (ii) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
  - (iii) Expenses that relate solely to the operation 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 the other entities.

8. Financial Comparison

Per § 438.8(k)(1)(xi) (see intro for text), a comparison of the financial amounts included in this report and what is reported in audited financials is required. Show the comparison in this worksheet or reference an attached document with the comparison.

9. Aggregation Method

The Department requires the County/MCE's MLR and MLR report to be calculated as one aggregate value representing all HealthChoices Medicaid/Title XIX rate cells/populations that are covered under the HealthChoices physical health Agreements. The Department reserves the right to modify this requirement and obtain MLR information on a rate cell and/or region-specific basis.

A description can be included in the workbook or a reference can be made to an attached document to explain the aggregation method.

10. MLR Report Summary

This worksheet summarizes the information requested by the Agreement and meets § 438.8(k) (see intro for regulation text).

11. Attestation

An attestation to the accuracy of this MLR report is required per § 438.8(n), § 438.604(a)(3), and § 438.606.

§ 438.8(n):

> Attestation. MCOs, PIHPs, and PAHPs must attest to the accuracy of the calculation of the MLR in accordance with requirements of this section when submitting the report required under paragraph (k) of this section.

§ 438.604(a)(3) Data, information, and documentation that must be submitted.

> Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in § 438.8.

§ 438.606 Source, content, and timing of certification:

(a) Source of certification. For the data, documentation, or information specified in § 438.604, the State must require that the data, documentation or information the MCO, PIHP, PAHP, PCCM or PCCM entity submits to the State be certified by either the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

(b) Content of certification. The certification provided by the individual in paragraph (a) of this section must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in § 438.604 is accurate, complete, and truthful.

(c) Timing of certification. The State must require the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in § 438.604(a) and (b).

Please contact Kimberly Butsch (OMHSAS) at (717) 346-1097 if there are any questions about the requirements for this MLR report.

FINANCIAL DATA CERTIFICATION FORM

MEDICAL LOSS RATIO CERTIFICATION STATEMENT OF

_____
Name of Primary Contractor and Subcontractor

TO THE

PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES

FOR THE PERIOD ENDED

_____, 20_____
(Month & Day) (Yr.)

Name of Preparer _____

Title _____

Phone Number _____

This form is to be executed by the Chief Executive Officer or the Chief Financial Officer of the Entity, or by an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Office or Chief Financial Officer is ultimately responsible for the certification.

I_____(Name),_____(Title) of _____(Entity Name), attest that the information submitted herein is complete, truthful and accurate to the best of my knowledge, information and belief. I understand that any knowing and willful false statement or representation in the information submitted may be subject to prosecution under applicable state laws. In addition, any knowing and willful failure to fully and accurately disclose the requested information may result in termination of the agreement between the Department of Human Services and _____ (Entity Name).

☐ In addition, I hereby attest that the information submitted in the reports herein is considered proprietary and confidential information. I understand that should this information be appealed based on the nature of being proprietary or confidential, the named MCO will defend that decision before the Office of Open Records (OOR), the Bureau of Hearings and Appeals (BHA) or any other forum.

Date of Submission _____ Time of Submission_____

Original Submission? Y N

Revised Submission? Y N

Data Certification forms MUST be converted to PDF and uploaded to the OMHSAS Financial Report Website concurrent with the upload of selected financial reports.

_____	_____	_____
Date	Primary Contractor Authorized Signatory (Name & Title Typewritten)	Signature
_____	_____	_____
Date	Chief Financial Officer/ Subcontractor (Name & Title Typewritten	Signature