

# UNIFORM MANAGED CARE MANUAL 5.3.1.100 STAR Financial Statistical Report (FSR) Instructions Version 2.1

## DOCUMENT HISTORY LOG

STATUS 1	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
<b>Baseline</b>	<b>2.0</b>	<b>November 28, 2022</b>	<p><b>Initial version Uniform Managed Care Manual Chapter 5.3.1.100, STAR Financial Statistical Report (FSR) Instructions.</b></p> <p><b>This chapter applies to contracts issued as a result of HHSC RFP number 529-12-0002 and replaces Chapter 5.3.1.90 for reporting dates of service on or after September 1, 2021.</b></p>
<b>Revision</b>	<b>2.1</b>	<b>March 27, 2023</b>	<b>Accessibility Version</b>

<sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.

<sup>2</sup> Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.

<sup>3</sup> Brief description of the changes to the document made in the revision.

## **Objective**

All MCOs contracting with the State of Texas to arrange for or to provide healthcare to Members in the STAR Program must submit STAR MCO FSRs for each Service Area (SA) in accordance with the Contract between HHSC and MCO and in accordance with the instructions below.

## **General**

MCOs must use this template to report financial transactions for dates of service on and after September 1, 2021. The first submissions using this template are due with the State Fiscal Year 2022 Quarter 4 filings. MCOs must complete all STAR MCO FSRs using the locked Microsoft Excel template provided by HHSC. Data integrity is critical to the automated compilation of the data. Do not alter the file name, sheet names, existing cell locations, or formatting of the data in the file and sheets. Do not add or delete any columns or rows. **Any deviations from the locked template will render the FSR unreadable by the software application and therefore unacceptable to HHSC.**

All shaded data fields in the FSR represent fields where data input is required. In order to maintain consistency, please ensure that the data input is in black. All data fields not shaded represent referenced data or calculations. All line numbers in these instructions refer to the line numbers in column B on each worksheet.

Cells can be linked within the template, but there can be no outside links to the MCO Accounting Systems or other sources.

The following note is included on all FSR pages **“Note: Except where stated otherwise, reporting is on an incurred basis (that is, reported in the period corresponding to dates of service, rather than to date paid). All prior quarters’ data must be updated to reflect the most recent revised IBNR estimates.”** The MCO must update member months’ data in accordance with information provided by the enrollment broker.

**Before completing the STAR FSR, complete the Admin and QI FSR.**

## **FSR Page Headers**

Header information entered on Part 1 populates header data for all the other sheets; please make sure Part 1 is entered correctly. Enter the following on Part 1:

**MCO Name:** Select the MCO’s name from the drop-down menu.

**State Fiscal Year:** Select the State Fiscal Year (SFY) from the drop-down menu.

**Submission Date:** Enter the month, day, and year, e.g., 6/30/2022.

**Submission Type:** Select the type of FSR, (e.g., Q1; Q2; Q3; Q4; Year-End 90-Day; Year-End 33-Day) from the drop-down menu.

**Service Area:** Select the Service Area from the drop-down menu.

**Rptg Period End Date:** Enter the month, day, and year, e.g., 5/31/2022, of the last date of service included in the reporting period.

### **Part 1: Summary Income Statement**

Line 1: Member Months: Referenced from Part 3, Line 27, "Total Member Months."

Line 2: Average Monthly Member Months: Calculated as Line 1, "Member Months," divided by the number of months of membership data.

#### **Revenues**

Line 3: Medical Premiums: Referenced from Part 3, Line 9, "Total Medical Premiums."

Line 4: Delivery Supplemental Payments: Referenced from Part 7, Line 4, "Total DSPs (\$) Aggregate."

Line 5: Pharmacy Premiums: Referenced from Part 3, Line 36, "Total Pharmacy Premiums."

Line 6: Investment Income: Enter all interest and dividend income resulting from investment of funds received from the state and federal governments under the Contract.

Line 7: Other Revenue: Enter all income generated from the STAR Medicaid Program for the Contract Service Area other than premiums (HHSC Capitation), Delivery Supplemental Payments (DSPs), and Investment Income. Do not include direct claim reimbursements received from HHSC.

Line 8: Total Gross Revenues: Calculated sum of Lines 3 through 7.

Line 9: Premium Taxes: Enter the premium taxes incurred for premiums applicable to the reporting period.

Line 10: Maintenance Taxes: Enter the maintenance taxes incurred for premiums applicable to the reporting period.

Line 11: Net Revenues: Calculated as Line 8, "Total Gross Revenues," less the sum of Line 9, "Premium Taxes," and Line 10, "Maintenance Taxes."

### **Medical Expenses**

Line 12: Fee-For-Service: Calculated as Line 20, "Total Medical Expenses," minus the sum of Line 13, "Capitated Services," Line 14, "Patient Centered Medical Home Services," Line 15, "Net Reinsurance Cost," Line 16, "IBNR Accrual-Medical, Line 17, "Quality Improvement," and Line 18, "NEMT Expense. "Line 13: Capitated Services: Calculated as sum of Part 5, Line 23, "Capitated Services: PCPs, Hospitals, and Other Providers" and Part 5, Line 24, "Capitated Services: BH, Vision, etc."

Line 14: Patient Centered Medical Home Services: Referenced from Part 5, Line 12, "Patient Centered Medical Home Services."

Line 15: Net Reinsurance Cost: Calculated as sum of Part 5, Line 13, "Reinsurance Premiums," and Part 5, Line 14, "Reinsurance Recoveries."

Line 16: IBNR Accrual – Medical: Referenced from Part 5, Line 15, "Incurred But Not Reported (IBNR)."

Line 17: Quality Improvement: Referenced from Part 5, Line 17, Quality Improvement.

Line 18: NEMT Expenses: Referenced from Part 5, Line 18, "NEMT Services."

Line 19: Directed Payment Programs (DPP) including NAIP: Referenced from Part 5, Line 19, "Directed Payment Programs (DDP) including NAIP."

Line 20: Total Medical Expenses: Referenced from Part 5, Line 20, "Total Medical Expenses."

Line 21: Prescription Expenses (excluding PBM Admin): Referenced from Part 6, Line 12, "Prescription Expense (excluding PBM Admin)."

Line 22: Total Medical and Prescription Expenses: Calculated as sum of Line 20, "Total Medical Expenses," and Line 21, "Prescription Expenses (excluding PBM Admin)."

Line 23: Administrative Expenses: Enter the allocated "Administrative Expenses" from the Admin and QI FSR, Admin - Part 4tab, by the applicable Program/Service Area.

Line 24: Total Expenses: Calculated as sum of Line 22, "Total Medical and Prescription Expenses," and Line 23, "Administrative Expenses."

Line 25: Net Income Before Taxes: Calculated as Line 11, "Net Revenues," minus Line 24, "Total Expenses."

Line 26: % Medical Exp to Net Revenues: Calculated as Line 20, "Total Medical Expenses," divided by Line 11, "Net Revenues."

Line 27: % Prescription Exp to Net Revenues: Calculated as Line 21, "Prescription Expenses (excluding PBM Admin)," divided by Line 11, "Net Revenues."

Line 28: % Total Medical and Prescription to Net Rev. (MLR): Calculated as the sum of Line 26 "% Medical Exp to Net Revenues" and Line 27 "% Prescription Exp to Net Revenues."

Line 29: % Admin Exp to Net Revenues: Calculated as Line 23, "Administrative Expenses," divided by Line 11, "Net Revenues."

Line 30: % Net Income to Net Revenues: Calculated as Line 25, "Net Income Before Taxes," divided by Line 11, "Net Revenues."

Line 31: % Adj. Admin to Net Revenues (excludes taxes and Prescription pass through): Calculated as Line 23, "Administrative Expenses," divided by the difference of Line 11, "Net Revenues," less Line 5, "Pharmacy Premiums."

### **Post-income items**

Line 32: Performance Assessment: Enter in the YTD cell the amount of the Pay for Quality (P4Q) performance assessment.

### **Part 2: Statistics**

Line 1: Paid Medical Expenses Completion Factor: Calculated as the difference between Part 5, Line 20, "Total Medical Expenses," and Part 5, Line 15, "Incurred But Not Reported (IBNR)," divided by Part 5, Line 20, "Total Medical Expenses."

### **Total Cost \$PMPM**

Line 2: MCO Admin Cost (including PBM Admin): Calculated as Part 1, Line 23, "Administrative Expenses," divided by Part 1, Line 1, "Member Months."

Line 3: Premium & Maintenance Taxes: Calculated as sum of Part 1, Line 9, "Premium Taxes," and Part 1, Line 10, "Maintenance Taxes," divided by Part 1, Line 1, "Member Months."

Line 4: Medical Expenses, excl Net Reinsurance and Quality Improvement: Calculated as difference between Part 1, Line 20, "Total Medical Expenses," and the sum of Part 1, Line 15, "Net Reinsurance Cost," and Part 1, Line 17, "Quality Improvement" divided by Part 1, Line 1, "Member Months."

Line 5: Net Reinsurance: Calculated as sum of Part 5, Line 13, "Reinsurance Premiums," and Part 5, Line 14, "Reinsurance Recoveries," divided by Part 1, Line 1, "Member Months."

Line 6: Quality Improvement: Calculated as Part 5, Line 17, "Quality Improvement," divided by Part 1, Line 1, "Member Months."

Line 7: Prescription Expenses (excluding PBM Admin): Calculated as Part 6, Line 12, "Prescription Expense (excluding PBM Admin)," divided by Part 1, Line 1, "Member Months."

Line 8: Subtotal: Calculated as sum of Lines 2 through 7.

Line 9: Profit/(Loss) before Experience Rebate: Calculated as Part 1, Line 25, "Net Income Before Taxes," divided by Part 1, Line 1, "Member Months."

Line 10: Total Cost \$PMPM to HHSC: Calculated as sum of Line 8 and Line 9.

### **Part 3: Medical and Pharmacy Premiums**

#### **Medical Premiums (HHSC Capitation)**

Lines 1 through 8: Medical Premiums (HHSC Capitation): Each cell in this matrix is calculated and is the product of the corresponding capitation rate in the matrix of Lines 10 through 17 and the corresponding member months in the matrix of Lines 19 through 26.

Line 9: Total Medical Premiums: Calculated as sum of Lines 1 through 8.

#### **Medical Premium \$PMPM**

Lines 10 through 17: Medical Premium \$PMPM: Enter each risk group's medical capitation rate including any applicable amounts for the Network Access Improvement Program (NAIP).

Line 18: Total Medical Premium \$PMPM: Calculated as Line 9, "Total Medical Premiums," divided by Line 27, "Total Member Months."

#### **Member Months**

Lines 19 through 26: Member Months: Enter the member months based on the supplemental files supporting HHSC's monthly capitation payments to the MCO.

Line 27: Total Member Months: Calculated as sum of Lines 19 through 26.

#### **Pharmacy Premiums (HHSC Capitation)**

Lines 28 through 35: Pharmacy Premiums (HHSC Capitation): Each cell in this matrix is calculated and is the product of the corresponding capitation rate in the matrix of Lines 37 through 44 and the corresponding member months in the matrix of Lines 19 through 26.

Line 36: Total Pharmacy Premiums: Calculated as sum of Lines 28 through 35.

**Pharmacy Premium \$PMPM**

Lines 37 through 44: Pharmacy Premium \$PMPM: Enter each risk group's pharmacy capitation rate applicable to each month.

Line 45: Total Pharmacy Premium \$PMPM: Calculated as Line 36, "Total Pharmacy Premiums," divided by Line 27, "Total Member Months."

**Part 4a: Medical Expense by Expense Class**

**Paid Claims**

Lines 1 through 8: Paid Claims: Enter monthly paid claims by risk groups as incurred. Adjust to exclude amounts reported on Part 4c Medical Expenses by Expense Class Directed Payment Programs (DPPs).

Line 9: Total Paid Claims: Calculated as sum of Lines 1 through 8.

**Paid Capitation**

Lines 10 through 17: Paid Capitation: Enter the total provider and subcontractor capitation payments by risk groups covered by the capitation payments.

Line 18: Total Paid Capitation: Calculated as sum of Lines 10 through 17.

**Paid Reinsurance Premiums, Net of Reinsurance Recoveries**

Lines 19 through 26: Paid Reinsurance Premiums, Net of Reinsurance Recoveries: Enter the paid reinsurance premiums net of collected reinsurance recoveries specific to each risk group the reinsurance coverage was effective. Report collected Reinsurance Recoveries by the appropriate risk group and by the incurred month of the services to which the recoveries relate.

Line 27: Total Net Reinsurance: Calculated as sum of Lines 19 through 26.

Section Beneath Line 27: No action necessary. These lines populate with the member months' data entered in Part 3.

**Part 4b: Medical Expense by Expense Class**

**Medical IBNR**

Lines 28 through 35: IBNR: Enter Incurred-But-Not-Reported (IBNR) estimate by risk group.

Line 36: Total Medical IBNR: Calculated as sum of Lines 28 through 35.

**Patient Centered Medical Home Services**

Lines 37 through 44: Patient Centered Medical Home Services: Enter medical expenses by risk group as incurred at a PCMH-approved facility.

Line 45: Total PCMH: Calculated as the sum of Lines 37 through 44.

**Quality Improvement Cost**

Line 46: Quality Improvement: From Part 5, Line 17.

**Directed Payment Programs Expense including NAIP:**

Line 47: Network Access Improvement Program (NAIP): Amount from Part 4c, Line 79, "Total NAIP Expense."

Line 48: Directed Payment Program for Behavioral Health Services (DPP BHS): Sum of amounts from Part 4c, Line 88, "Total DPP BHS Expense Paid Outside the Claims System," and Line 97, "Total DPP BHS Expense Based on Encounter Data."

Line 49: Texas Incentives for Physician and Professional Services (TIPPS): Sum of amounts from Part 4c, Line 106, "Total TIPPS Expense Paid Outside the Claims System," and Line 115, "Total TIPPS Expense Based on Encounter Data."

Line 50: Rural Access to Primary and Preventive Services (RAPPS): Sum of amounts from Part 4c, Line 124, "Total RAPPS Expense Paid Outside the Claims System," and Line 133, "Total RAPPS Expense Based on Encounter Data."

Line 51: Comprehensive Hospital Increase Reimbursement Program (CHIRP): Amount from Part 4c, Line 142, "Total CHIRP Expense."

Line 52: Total Directed Payment Programs Expense: Calculated as the sum of Lines 47, 48, 49, 50 and 51 above.

**NEMT Expenses**

Lines 53 through 60: NEMT Expense: Enter all paid NEMT expenses for services rendered to a Member by risk group.

Line 61: Total NEMT Expenses: Calculated as the sum of Lines 53 through 60.

**Other Medical Expenses**

Lines 62 through 69: Other Medical Expenses: Enter any other medical expenses or adjustments to medical expenses not captured by "Paid Claims," "Paid Capitation," "Reinsurance Premiums net of Recoveries," "IBNR," "Patient Centered Medical Home Services," "Quality Improvement," "Directed Payment Programs," or "NEMT Expenses" for each risk group. Examples of these expenses include, but are not limited to: incentives paid directly to physicians; third party recoveries, other recoveries, or settlements that have not been captured through claims adjustments in the claims processing system, FQHC reimbursement received from HHSC, and refunds. Please note third party recoveries should be reported in the month in which cash is received. Do not enter recoveries in the month in which services were provided unless the collection occurred in that same month.



Also include certain pharmacy-related expenses that are not included in Part 6, "Prescription Expenses," that cannot be processed as pharmacy encounters. Pharmacy-related items that should be reported on the FSR under Part 4, "Other Medical," should be limited to covered benefits that are either:

- pharmacy Durable Medical Equipment (DME) (certain Home Health Supplies) that are not on HHSC's formulary, such as diabetic strips, meters, lancets, aero chamber devices, diaphragms; or
- drugs that are billed directly by the physician/clinic (not picked up at the pharmacy by the client).

When certain pharmacy DME gets added to the formulary, it should be processed as a pharmacy encounter, and at that point be reported under "Prescription Expenses" instead of "Other Medical."

Amounts reported in "Other Medical" for appropriate pharmacy DME should not have any PBM administrative expense included. All PBM Admin is to be reported in the Admin FSR.

Line 70: Total Other Medical Expenses: Calculated as sum of Lines 62 through 69.

Beneath Line 70, there is a calculation which sums Part 4a, Line 9 "Total Paid Claims," Part 4a, Line 18 "Total Paid Capitation," Part 4a, Line 27 "Total Net Reinsurance," Part 4b, Line 36, "Total Medical IBNR," Part 4b, Line 45 "Total PCMH," Part 4b, Line 46 "Quality Improvement", Part 4b, Line 52, "Total Directed Payment Programs", Part 4b, Line 61 "Total NEMT Expenses", and Part 4b, Line 70, "Total Other Medical Expenses."

Line 70: Other Medical Expenses: Identify each category of expense included in Lines 61 through 68, "Other Medical Expenses." Identify the YTD dollar amount associated with each category of expense if more than one.

Beneath Line 70, there are lines which bring over the member months detail entered in Part 3.

**Part 4c: Medical Expenses by Expense Class – Directed Payment Programs (DPPs) including NAIP**

**Network Access Improvement Program (NAIP) Expense**

Lines 71 through 78: NAIP Expense: Enter Network Access Improvement Program amounts paid out to the Public Hospital or Health Related Institution (HRI) by risk group.

Line 79: Total NAIP Expense: Calculated as the sum of Lines 71 through 78.

**Directed Payment Program for Behavioral Health Services (DPP BHS) Expense Processed Outside Claims System**

Lines 80 through 87: DPP BHS Expense Processed Outside the Claims System: Enter the increased Medicaid Payments paid monthly to qualified Community Mental Health Centers (CMHCs) based on allocating by caseload, for the appropriate risk groups.

Line 88: Total DPP BHS Expense Paid Outside the Claims System: Calculated as the sum of Lines 80 through 87.

**Directed Payment Program for Behavioral Health Services (DPP BHS) Expense Based on Encounters**

Lines 89 through 96: DPP BHS Expense Based on Encounters: Enter the increased Medicaid Payments paid monthly to qualified Community Mental Health Centers (CMHCs) by risk group.

Line 97: Total DPP BHS Expense Paid Based on Encounter Data: Calculated as the sum of Lines 89 through 96.

**Texas Incentives for Physician and Professional Services (TIPPS) Expense Processed Outside Claims System**

Lines 98 through 105: TIPPS Expense: Enter increased Medicaid Payments paid monthly to qualified providers based on allocating by caseload, for the appropriate risk groups.

Line 106: Total TIPPS Expense Paid Outside the Claims System: Calculated as the sum of Lines 98 through 105.

**Texas Incentives for Physician and Professional Services (TIPPS) Expense Based on Encounters**

Lines 107 through 114: TIPPS Expense: Enter increased Medicaid Payments paid monthly to qualified providers by risk group.

Line 115: Total TIPPS Expense Based on Encounter Data: Calculated as the sum of Lines 107 through 114.

**Rural Access to Primary and Preventive Services (RAPPS) Expense Processed Outside Claims System**

Lines 116 through 123: RAPPS Expense: Enter increased Medicaid Payments paid monthly to qualified rural health clinics (RHCs) based on allocating by caseload, for the appropriate risk groups.

Line 124: Total RAPPS Expense Paid Outside the Claims System: Calculated as the sum of Lines 116 through 123.

**Rural Access to Primary and Preventive Services (RAPPS) Expense Based on Encounters**

Lines 125 through 132: RAPPS Expense: Enter increased Medicaid Payments paid monthly to qualified rural health clinics (RHCs) by risk group.

Line 133: Total RAPPS Expense Based on Encounter Data: Calculated as the sum of Lines 125 through 132.

**Comprehensive Hospital Increase Reimbursement Program (CHIRP) Expense Based on Encounters**

Line 134 through 141: Enter increased Medicaid Payments paid monthly to qualified providers by risk group.

Line 142: Total CHIRP Expense Based on Encounter Data: Calculated as the sum of Lines 134 through 141.

**Sum of All Directed Payment Programs Expense above including NAIP:**

Lines 143 through 150: Calculated as the sum of NAIP, DPP BHS, TIPPS, RAPPS, and CHIRP expenses by risk group per month.

Line 151: Total Directed Payment Programs Expense: Calculated as the sum of Lines 143 through 150.

**Part 5: Medical Expenses by Service Type**

Line 1: Physician Services: Primary Care: Enter all paid expenses related to the medical care provided to a Member by a primary care physician (PCP) upon first contact with the health care system for treatment of an illness or injury before referral. The PCP performs or directs the performance of primary care services that include, but are not limited to, case management, consultations, family planning, emergency room visits, inpatient visits, maternity care services, office visits, preventive care services, dispensing or prescribing medical supplies and pharmaceuticals, authorizing referrals to specialists, etc.

Under the Texas Medicaid Managed Care Program, all Members are required to have a primary care physician (PCP) when enrolling in a MCO. For expenses to be classified as PCP services, the performing provider at 24J on a CMS-1500 claim must be the Member's assigned PCP, and the services cannot represent "Deliveries - Professional Component." The amount paid covering all charges on a CMS-1500 claim is classified as PCP expense when the performing provider is the Member's PCP.

Line 2: Physician Services: Specialist: Enter all paid expenses related to the medical care provided to a patient by a physician whose practice is limited to a particular

branch of medicine or surgery, e.g., cardiology or radiology, in which a physician specializes or is certified by a board of physicians. Generally, a Member must have a referral authorized by his/her assigned PCP to receive services from a specialist.

For expenses to be classified as "Specialist Physician Services," the performing provider identified at 24J on a CMS-1500 claim must be a physician, who is not the Member's assigned PCP, and the services cannot represent "Deliveries - Professional Component." The amount paid covering all charges on a CMS-1500 claim is classified as "Specialist Physician Services" when the performing provider is a physician who is not the Member's PCP.

Line 3: Physician Services: Deliveries – Prof. Component: Enter paid expenses for the services of the delivering physician and the anesthesiologist, unless they are billed as part of the facility charge. Only the delivering physician and the anesthesiologist charges are included on Line 3, as they are the only charges included in the professional component of the DSP. Only those amounts paid for charges on a CMS- 1500 claim identified with "Delivery CPT Codes" (and the HCPCS Codes with Modifiers for the FQHCs and RHCs) are classified as "Delivery – Professional Component." All other amounts paid for charges on the same CMS-1500 claim that are not identified with Delivery Procedure Codes are classified as PCP or specialist based on the criteria at Lines 1 and 2, respectively.

Line 4: Non-Physician Professional Services: Enter all paid expenses for medical care provided by non-physician, healthcare services providers. These include, but are not limited to, audiologists, chiropractors, counselors, dentists, home health aides, licensed vocational nurses, occupational therapists, opticians, optometrists, physical therapists, psychologists, registered nurses, respiratory therapists, social workers, speech therapists, etc.

The total amount paid covering all charges on a CMS-1500 claim is classified as "Non- Physician Professional Services" when the performing provider at 24J is a non- physician healthcare services provider.

Line 5: Emergency Room Services: Enter all paid expenses incurred during an encounter in an emergency room, i.e., the section of a healthcare facility intended to provide rapid treatment for victims of sudden illness or trauma. Include the cost of emergency room equipment, facility usage, staff, and supplies.

The costs of emergency department ancillary services including laboratory services, radiology services, respiratory therapy services, and diagnostic studies, such as EKGs, CT scans, and supplies are also included on Line 5. Exclude non-staff attending or consulting physician billed separately as PCP or specialist services. The total amount paid by the MCO covering all charges on a UB04 claim that are incurred during an emergency room encounter are classified as "Emergency Room Services." Any amounts paid for any charges on a UB04 claim that include emergency room services that were incurred on a different service date than the

emergency room encounter are classified as "Outpatient Facility Services" unless they represent additional emergency room encounters.

Line 6: Outpatient Facility Services: Enter all paid expenses for services rendered to a Member that remains in a hospital based or freestanding facility, such as an ambulatory surgical center, for less than 24 consecutive hours and the Member-patient is discharged from an outpatient status, except for emergency room services.

Outpatient facility services include, but are not limited to, the following items and services performed on an outpatient basis in a hospital based or freestanding facility:

- Observation, operating, and recovery room charges;
- Surgical operations or procedures, day surgery;
- Laboratory, nuclear medicine, pathology, and radiological services;
- Diagnostic, therapeutic, and rehabilitative clinic or treatment services;
- Injections, drugs, and medical supplies; and
- All medically necessary services and supplies ordered by a physician.

Exclude non-staff attending or consulting physician billed separately as PCP or specialist services. The amount paid covering all charges on a UB04 claim is classified as "Outpatient Facility Services" if the Type of Bill indicates the claim is for outpatient facility services, and there are no emergency room charges included.

Line 7: Inpatient Facility Svcs: Medical/Surgical: Enter all paid expenses for acute care facilities covering inpatient services for medical/surgical stays, intensive care units (ICUs), cardiac/coronary care units (CCUs), burn units, cancer treatment centers, etc. Also includes the expenses of non-acute care inpatient services rendered at extended care/skilled nursing facilities.

Inpatient medical/surgical services include, but are not limited to, the following items and services performed on an inpatient basis:

- Bed and board in semiprivate accommodations or in an intensive care or coronary care unit including meals, special diets, and general nursing services; and an allowance for bed and board in private accommodations including meals, special diets, and general nursing services up to the hospital's charge for its most prevalent semiprivate accommodations;

- Whole blood and packed red cells reasonable and necessary for treatment of illness or injury;
- Newborn care including routine care and specialized nursery care for newborns with specific problems;
- Other inpatient services including organ/tissue transplant services and rehabilitation services; and
- All medically necessary services and supplies ordered by a physician.

The total amount paid covering all charges on a UB04 claim is classified as "Inpatient Facility Services" if the Type of Bill indicates the claim is for inpatient facility services, and there are no delivery charges included.

Line 8: Inpatient Facility Svcs: Deliveries – Facility Component: Enter paid expenses of all delivery services and supplies provided by the facility where the birth takes place, except for the "Professional Component." Only those amount(s) paid for charges on a UB04 claim identified with Delivery ICD-10 Codes are classified as "Delivery – Facility Component." Any amount(s) paid for any charges on the same UB04 inpatient claim that are not identified with Delivery ICD-10 Codes are classified as "Inpatient Facility Services – Medical/Surgical."

Line 9: Behavioral Health Services: Enter all paid expenses incurred for inpatient and outpatient mental health services and inpatient and outpatient chemical dependency services including both treatment and detoxification of alcohol and substance abuse. Only those amount(s) paid for charges on a CMS-1500 or UB04 claim identified with Behavioral Health Services ICD-10 or Revenue Codes are classified as "Behavioral Health Services." Any amount(s) paid for any charges on the same CMS-1500 or UB04 claim that are not identified with Behavioral Health Services ICD-10 or Revenue Codes should be classified in the appropriate medical expense classification.

Line 10: Vision Services: Enter all paid expenses incurred for vision services. This includes, but is not limited to, optometry and glasses.

Line 11: Miscellaneous Other: Enter all paid expenses of all medical services and supplies rendered that are not classified in any of the medical expense classifications in Lines 1 through 10 or Line 12. "Miscellaneous Other" includes, but is not limited to, ambulance services and durable medical equipment (DME), oxygen, and other medical supplies obtained directly from these suppliers, i.e., not obtained incidental to physician, non-physician professional, or facility encounters. The total amount paid covering all charges on a CMS-1500 claim is classified as "Miscellaneous Other."

Line 12: Patient Centered Medical Home Services: Enter paid expenses of all medical services incurred at a PCMH-approved facility.

Line 13: Reinsurance Premiums: Enter paid expenses to obtain reinsurance coverage from reinsurance companies that assume all or part of the financial risks associated with catastrophic medical expenses that could, otherwise, be ruinous to the MCO. Offset any reinsurance premiums collected for any reinsurance risks assumed.

Line 14: Reinsurance Recoveries: Enter any and all return of funds or recovery of paid losses that have been collected from reinsurers associated with a particular case where catastrophic medical expenses have been incurred. Offset any reinsurance recoveries paid for reinsurance risks assumed. Record "Reinsurance Recoveries" in the month(s) in which the healthcare services were rendered to which the recoveries relate.

Line 15: Incurred-But-Not-Reported (IBNR): Enter the total medical expenses accrual, which includes:

- Reported claims in process for adjudication;
- An estimated expense of the incurred but not reported healthcare services;
- Amounts withheld from paid claims and capitations;
- Any capitation payable to providers; and
- Any reinsurance payable to reinsurers for ceded risk, net of any reinsurance receivable for assumed risk.

The IBNR medical expenses accrual is an estimate of the expected healthcare expenses incurred but not paid based on claims lag schedules and completion factors, as well as, any counts of services rendered but not billed, e.g., pre-authorized hospital days. Any major change in the claims processing function that was not in effect during the period of time covered by the lag schedules could materially impact the estimated IBNR accrual; hence, actuarial judgment and adjustment may sometimes be needed.

**Note: No IBNR should be reported on the second final FSR reflecting expenses paid through the 334<sup>th</sup> day after the end of the contract period.**

Line 16: Incentives or Network Risk Retention: Enter any incentives paid directly to physicians, i.e., bonuses paid based on quality compliance measures.

Line 17: Quality Improvement: Enter the allocated "Quality Improvement Expenses" From the Admin and QI FSR, QI - Part 4 tab, by Service Delivery Area.

Line 18: NEMT Services: Enter all paid expenses for Nonemergency Medical Transportation Services rendered to a Member. Do not include ambulance services reported in Line 11, or administrative costs to arrange, re-schedule, or coordinate transport.

Line 19: Directed Payment Programs (DPP) including NAIP: Enter the sum of NAIP, DPP BHS, TIPPS, RAPPS, and CHIRP expenses.

Line 20: Total Medical Expenses: Calculated as sum of Lines 1 through 19.

Beneath Line 20, there are balancing lines which compare "Total Medical Expenses" on Part 5, Line 20 to the Sum of Part 4a + Part 4b on Row 57 of Part 4b. If it does not balance the "Check" line will show "Not balanced" and a rounding adjustment may be entered in the shaded area labeled "Balance."

**Included in Total Medical Above:**

Line 21: Total Related Party Expenses: Enter the total medical expenses paid to any companies affiliated with the MCO through common ownership for providing healthcare services in support of the Texas Medicaid operations of the MCO.

Line 22: % of Medical Expenses that are Related Party: Calculated as Line 21, "Total Related Party Expenses," divided by Line 20, "Total Medical Expenses."

Line 23: Capitated Services: PCPs, Hospitals, and Other Providers: Enter the total capitation paid to providers that do not pay claims to other providers from the capitation payments received.

Line 24: Capitated Services: BH, Vision, etc.: Enter the total capitation paid to subcontractors in which the capitation is the funding source for paying claims for healthcare services performed in each Texas service area.

**Not Included in Total Medical Above**

Line 25: Total Medical Value Added Services: Enter the expenses approved by HHSC and paid by the MCO for Medicaid Members' services that are not covered under the HHSC Capitation nor reimbursed by HHSC. These expenses are the financial responsibility of the MCO. They are not included in "Total Medical Expenses" in the MCO FSR. The specific Value Added Services are included in the Contract for Services between HHSC and MCO.

Line 26: Total Case-by-Case Services: Enter the expenses paid by the MCO for Medicaid Members' additional benefits that are outside the scope of services covered under the Contract, and are not Value-Added Services. These expenses are the financial responsibility of the MCO. They are not included in "Total Medical Expenses" in the MCO FSR. Services may be based on Medical Necessity, cost-effectiveness, the wishes of the Member or the Member's Legally Authorized Representative (LAR), or the potential for improved health status of the Member.



The MCO must maintain documentation of each authorized service provided to each Member.

**Other**

Line 27: Behavioral Health Services \$PMPM: Calculated as Line 9, "Behavioral Health Services," divided by Part 1, Line 1, "Member Months."

Line 28: Vision Services \$PMPM: Calculated as Line 10, "Vision Services," divided by Part 1, Line 1, "Member Months."

Line 29: Emergency Room as a % of Medical Expenses: Calculated as Line 5, "Emergency Room Services," divided by Line 20, "Total Medical Expenses," excluding the sum of Lines 13 through 16, which are "Reinsurance Premiums," "Reinsurance Recoveries," "IBNR," and "Incentives/Network Risk Retention."

**Part 6: Prescription Expense by Risk Group**

**Prescription Expense (excluding PBM Admin)**

Lines 1 through 8: Prescription Expense (excluding PBM Admin): Enter the prescription expense by risk group based on Pharmacy Encounters. Exclude PBM admin fees.

Line 9: Prescription Paid Claims Expense: Calculated as sum of Lines 1 through 8.

Line 10: IBNR related to Prescriptions: Enter the estimated dollar amount of pharmacy prescriptions incurred for which claims have not been received.

Line 11: TPL pay & chase collected (related to Pharmacy only): Enter the dollars collected from third parties in the month in which cash is received. Do not enter recoveries in the month in which services were provided unless the collection occurred in that same month.

Line 12: Prescription Expense (excluding PBM Admin): Calculated as the sum of Lines 9 and 10, less Line 11.

**Prescription Expense \$PMPM**

Lines 13 through 20: Prescription Expense \$PMPM: Calculated as "Prescription Expense" for each risk group as reported on Lines 1 through 8, divided by the corresponding "Member Months" for each risk group as reported on Part 3, Lines 19 through 26.

Line 21: Prescription Paid Claims Expense \$PMPM: Calculated as Line 9, "Prescription Paid Claims Expense," divided by Part 3, Line 27, "Total Member Months."

Line 22: Prescription Expense including IBNR \$PMPM: Calculated as the sum of Line 9, "Prescription Paid Claims Expense," and Line 10, "IBNR related to Prescriptions," divided by Part 3, Line 27, "Total Member Months."

**# of Prescriptions**

Lines 23 through 30: # of Prescriptions: Enter the number of prescriptions filled by each risk group by month.

Line 31: # of Prescriptions in IBNR (Line 10 above): Enter the estimated number of prescriptions incurred for which claims have not been received.

Line 32: Total # of Prescriptions: Calculated as sum of Lines 23 through 31.

**Cost per Prescription (excluding PBM Admin)**

Line 33 through 40: Cost per Prescription (excluding PBM Admin): Calculated as "Total Prescription Expense" for each risk group as reported in Lines 1 through 8, divided by the corresponding "# of Prescriptions" for each risk group as reported on Lines 23 through 30.

Line 41: Average Cost of Paid Claims per Prescription: Calculated by dividing Line 9, "Prescription Paid Claims Expense," by the total "# of Prescriptions" in Lines 23 through 30.

Line 42: IBNR related to Prescriptions: Calculated by dividing Line 10, "IBNR related to Prescriptions," by Line 31, "# of Prescriptions in IBNR."

Line 43: Average Cost per Prescription (excluding PBM Admin): Calculated as Line 12, "Prescription Expense (excluding PBM Admin)," divided by Line 32, "Total # of Prescriptions."

Line 44: % Prescription Cost to Rx Premium: Calculated as Line 12, "Prescription Expense (excluding PBM Admin)," divided by Part 1, Line 5, "Pharmacy Premiums."

**# of Prescriptions per Member-Month**

Lines 45 through 52: # of Prescriptions per Member-Month: Calculated as "# of Prescriptions" for each risk group as reported on Lines 23 through 30, divided by the corresponding "Member Months" for each risk group as reported on Part 3, Lines 19 through 26.

Line 53: Average # of Paid Prescriptions per Member-Month: Calculated as the sum of Lines 23 through 30, divided by Part 3, Line 27, "Total Member Months."

Line 54: Average # of Prescriptions per Member-Month including IBNR: Calculated as Line 32, "Total # of Prescriptions" divided by Part 3, Line 27, "Total Member Months."

**Generic Split for Paid Prescriptions**

Line 55: % Generic, by # of Prescriptions: Enter the % of prescriptions filled with generic brands.

Line 56: % Generic, by Aggregate \$ Gross Cost: Enter the % of gross cost associated with generic prescriptions.

**Other**

Line 57: Included in Line 9 above: Non-PBM expenditures: Input the portion, if any, of Line 9, "Prescription Paid Claims Expense," above that was not processed by the MCO's PBM (i.e., not billed to the MCO by the PBM).

Line 58: Included in Line 32 above: Non-PBM # of Rx (Prescriptions): Input the portion, if any, of Line 32, "Total # of Prescriptions," above that would correspond to the dollars in the Line 57.

Line 59: Excluded from Line 9: PBM \$ in Part 4 Other Med Exp: Input the portion, if any, of total PBM billings not processed as Encounters but reported in Part 4, "Other Medical Expenses." Include non-formulary Rx (Prescriptions) DME; do not include any admin expense.

Line 60: Excluded from Line 32: PBM # of Rx (Prescriptions) related to Line 59: Input the quantity that corresponds to the dollars in Line 59.

Line 61: Total PBM \$ billed to MCO (excl PBM Admin): Calculated as Line 57, subtracted from Line 9, "Prescription Paid Claims Expense," plus Line 59.

Line 62: Total PBM Qty of Rx (Prescriptions): Calculated as Line 58, subtracted from Line 32, "Total # of Prescriptions," plus Line 60.

Line 63: Enter the last NCPDP (National Council for Prescription Drug Programs) adjudication date of actual pharmacy payments (Pharmacy Benefit Manager/PBM invoiced date range) included in "Prescription Paid Claims Expense" Line 9 above.

Line 64: Pharmacy administered vaccines: Enter the dollar amount included within the Line 12 total for "Prescription Expense (excluding PBM Admin)," which is associated with vaccines administered at a pharmacy.

**Part 7: DSPs and Delivery Expenses**

Line 1: Contracted DSP Amount: Enter the DSP rate applicable to each month.

**Delivery Supplemental Payments – DSPs (\$)**

Line 2: DSPs Received by MCO: Calculated as sum of Lines 5 through 10, "Number of Deliveries," by risk group, multiplied by Line 1, "Contracted DSP Amount."

Line 3: Incurred But DSP Not Received: Calculated as the product of Line 1, "Contracted DSP Amount," and Line 11, "Incurred But DSP Not Received."

Line 4: Total DSPs (\$) Aggregate: Calculated as sum of Line 2 and Line 3.

Lines 5 through 10: Number of Deliveries: Enter the sum of the delivery counts from (1) the accepted DSP records in the monthly DSP submission files, (2) the accepted DSP records that were previously rejected by file edit 102, and (3) the accepted appealed DSP records; reported by risk groups and incurred months.

Line 11: Incurred But DSP Not Received: Enter the difference between the total number of facility delivery discharges and the sum of Lines 5 through 10.

Line 12: Total Number of Deliveries Incurred: Calculated as sum of Lines 5 through 11.

### **MCO Delivery Expenses (\$)**

Line 13: Paid Claims: Referenced from Part 5, Line 3, "Physician Services: Deliveries - Prof Component," and Part 5, Line 8, "Inpatient Facility Svcs: Deliveries - Facility Component."

Line 14: Incurred But Not Paid: Enter the unpaid expenses for incurred delivery services based on the number of incurred deliveries reported on Line 11.

Line 15: Total Delivery Expenses: Calculated as sum of Line 13 and Line 14.

### **Average Cost Per Delivery (\$)**

Line 16: Paid Claims: Calculated as Line 13, "Paid Claims," divided by Line 12, "Total Number of Deliveries Incurred," excluding Line 11, "Incurred But DSP Not Received."

Line 17: Incurred But Not Paid: Calculated as Line 14, "Incurred But Not Paid," divided by Line 11, "Incurred But DSP Not Received."

Line 18: Average Cost per Delivery: Calculated as Line 15, "Total Delivery Expenses," divided by Line 12, "Total Number of Deliveries Incurred."

## **Data Certification Form**

### **General Instructions**

1. The Data Certification Form must be submitted with the FSR Reports, and it must be signed by the CEO, CFO, or equivalent.
2. Certification of certain financial data is a Federal requirement.

3. It is acceptable to include the Data Certification Form pasted into the Certification tab as a PDF.

**Instructions for Completing Specific Data Fields**

The name of the MCO, document name, date of submission, State Fiscal Year (SFY), FSR Period, Program and service area will populate from header information entered in Part 1.

Data Field 7 – Type or print the name and title of the person signing the Certification. Data Field 9 – Sign the Certification.

Data Field 10 – Enter the date the form is signed without using a formula.