DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	2.0	February 28 2015	Initial version of Uniform Managed Care Manual Chapter 5.3.1.48, "Medicare-Medicaid Plan (MMP) Dual Demonstration Program Financial Statistical Report (FSR) Instructions." This chapter applies only to MMPs in the Dual Demonstration, also known as the Integrated Care Pilot Project. While this Program combines STAR+PLUS plus Medicare, these FSR instructions do not apply to the regular STAR+PLUS Program.
Revision	2.1	August 30, 2015	Part 4 modified to add new Line items, to calculate total aggregate medical costs by Risk Group, and corresponding instructions. Added a new tab, Part 4b, to calculate medical rates, expense, and margin by Risk Group, and corresponding instructions. Part 5 modified to change the definition/instructions for what to include as Medicare vs Medicaid; this impacts the reporting of "blended" services and cross-over claims. Added Part 5, Line 18, to show the estimated amount of Medicaid cross-over, etc, dollars that are included within the Medicare cost Lines. (Re-numbered the subsequent Line numbers in Part 5.) Changed/clarified that Part 5 Lines 25 and 56 should only show the amounts allocated between Medicare vs Medicaid (and do not include amounts allocated between acute vs long-term care). Clarified Part 5, Line 19, removing the phrase "1st 100 days," and further clarified that Medicare-covered Nursing Facility services may not be universally considered to be "Long Term" care, but nevertheless should be grouped here at this time. Added additional examples of related party medical expenses in Part 5, Line 66. Part 7 row heading descriptions for Lines 25 and 28 modified to clarify that these amounts do not pertain to Duals in the STAR+PLUS Program, and must be limited to the HHSC MMP Program only. Corrected several erroneous Line number references. Other minor changes / clarifications.
Revision	2.2	September 1, 2016	Part 1, Line 29 "Medicare Rx Rebates" is added and subsequent lines are renumbered. Part 1, Line 35 "Minimum Payment Amount Program (MPAP)" is added. Part 5, Line 49 is modified to remove the parenthetical regarding contracted services. This change applies for transactions occurring on or after September 1, 2015.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Version 2.2 applies only to MMPs in the Dual Demonstration, also known as the Integrated Care Pilot Project for reporting transactions occurring prior to September 1, 2016.

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.
[2] 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.
[3] Brief description of the changes to the document made in the revision.

Objective

All MMPs contracting with the State of Texas to arrange for or to provide healthcare to enrollees in the Medicare-Medicaid Dual Demonstration Program (herein, the "Dual Program," and also known as the Integrated Care Pilot Project, and as the Texas Financial Alignment Demonstration) must submit STAR+PLUS MMP FSRs ("Dual FSRs") for each Service Area (SA) in accordance with the three-way Contract between HHSC, CMS, and the MCO referred to as a Medicare-Medicaid Plan (MMP), and in accordance with the instructions below. Service Areas are, at least initially, limited to a single county.

General

MMPs must complete all Dual 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. If it appears that the FSR xls file has been unprotected or had the password or protection defeated, the MMP may be subject to Liquidated Damages.**

All gray-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 represents referenced data or calculations. All line numbers in these instructions refer to the line numbers in column A on each worksheet (not to the row numbers of the spreadsheet).

Cells can be linked within the template, but there can be no outside links to the MMP's accounting systems or other sources. (See the "free tab" at the end for a place to dump data which can then be linked to.)

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). With each new FSR submission, all prior quarters' data must be updated to reflect, in the column pertaining to the appropriate past month, the most recent revised IBNR estimates, the most recent Medicare capitation premium adjustments, and the most recent Medicare and Medicaid payment file data."** The MMP must update member months' data in accordance with information provided by the enrollment broker.

All costs and amounts submitted herein must be in compliance with the Cost Principles for Expenses, and other relevant Contract language.

Note that some cells within the spreadsheet have embedded comments, which may provide additional description, etc.

This Dual FSR should include no expenses incurred prior to 3/1/2015. For the very first submission for this new Program, for the Quarter commencing 3/1/2015, the first six months of the FSR (9/1/2014 through 2/28/2015) have been pre-populated with zeroes. [Note: Any Pre-implementation Expenses will be addressed in a separate FSR file.]

Contents / Quick Links

By clicking on items, you may jump to that topic within this document.

- Medicaid Rx spend, quantities, $/Rx, $/Mbr, Rx's/Mbr, & generic split
- Medicaid Rx Premiums vs Costs
- Medicare & Medicaid Combined - Rx

Part 7: Dual Demo Program Administrative Expenses

Data Certification Form

"Free tab"

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 in the top left corner on Part 1:

MMP Name: Select the MMP'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., 6/30/2015. This should correspond to the date that the spreadsheet file is submitted to HHSC. Note that, if a given FSR is re-submitted (due to error correction, or whatever), then this date should be updated with the date that the revised version was submitted.

Revision?: To the right of the Submission Date, in cell D5, enter the word REVISED if this is not the first submission for a given Quarter, etc.

Submission Type: Select the type of FSR (e.g., Quarterly; Year End + 90 Days; Year End + 334 Days; Other) from the drop down menu. If "Other" is selected, add description in Cell D6.

County: Select the county (Service Area) from the drop-down menu. Note: Each Service Area requires a separate FSR. At present, there is only a single county per Service Area.

Rptg Period End Date: Enter the month, day, and year (e.g., 5/31/2015) from the drop-down menu. This reporting period date usually corresponds to the last day of the Quarter, and is irrespective of when the submission is sent.

Part 1: Summary Income Statement

Part 1: Summary Income Statement modified by Version 2.2

Line 1: Member Months (per Medicaid): Populated from Part 3, Line 24, "Total Member Months (per Medicaid)." This amount should correspond to the Medicaid eligibility file.

Line 2: additional / (fewer) Mbr-Mos in Medicare: Calculated by subtracting Line 1 above from Part 3, Line 4, Total Member Months (per Medicare). [Note: This line shows the difference in the Medicaid eligibility files vs the Medicare files. Ideally, this would be zero, and should primarily reflect timing differences. The amount may be positive or negative, but should be small in comparison to Line 1, and should approach zero after retroactive adjustments are made in subsequent FSR submissions.]

Line 3: Average Monthly Member Months: Calculated as a Year-to-Date amount in column Q, from Line 1, "Member Months (per Medicaid)," divided by the number of months of membership data. This is based on the Medicaid member-months, and does not take into account any differences with the Medicare number.

Revenues:

- **CMS Medicare Premiums**

Line 4: Monthly Capitation Received - Medical: enter the amount here that the MMP actually received (that are applicable to services rendered in the given month) from CMS for the Medicare Part A/B premium payment.

- Any retroactive adjustments received should be entered into the prior month(s) to which they pertain. For example, if in April the MMP receives $110,000 in Part A/B premiums, and $100,000 of it is the prospective payment for April services, and the other $10,000 is a retroactive adjustment to March's payment, then enter $100,000 in the column for April, and $10,000 in the column for March.
- Amounts entered here should be the actual amounts received. For example, if the MMP was due to receive a total of $100,000 for April, but 1% was withheld due to the Quality Withhold Policy ("QWP"), as outlined in the Contract, section 4.4.5), then only the $99,000 actually received should be entered here.

Line 5: Monthly Capitation Withheld – Medical: this is calculated by subtracting Line 4 above from Line 6, below. This amount represents what was withheld for QWP with respect to Medicare Medical. (Note that this Line does not get adjusted by any amounts that are later paid to reimburse for withholdings under QWP; the net amount still outstanding due to QWP withholdings is tracked elsewhere.)

Line 6: Gross Total (Before Withhold) – Medical: this is populated from Part 3, Line 12, Total Medicare Medical Premiums. This amount represents the total of Medicare Part A/B premiums corresponding to services for this month, before any QWP.

- Any 2% sequestration adjustments, Federal plan user fees, or other similar amounts that have been netted out and will not be paid, would not be included here. For example, if the MMP Medicare rates indicated that $102,000 should have been paid prior to the Federal sequestration, and this was reduced by sequestration to $100,000, and then 1% was withheld due to QWP, leaving a net receipt of $99,000, then the $100,000 would be entered here.
- This amount should be adjusted due to retroactive risk adjustments, etc., as such adjustments are made. Such adjustments should be entered into the column for the month to which they apply, which is generally not the month in which the adjustments are received.

Line 7: Gross Total (No Withholding) - Pharmacy: Populated from Part 3, Line 20, "Total Medicare Pharmacy Premiums." Note that there is no QWP withholding for pharmacy. Also note that any sequestration adjustments would be handled as described in Line 6 above. Any retrospective risk corridor adjustments to Medicare, including subsequent supplementary payments, should be added to the Pharmacy premiums here (via Part 3, Lines 17 through 19).

Line 8: Sub-total: Medicare Capitation: Calculated by adding Lines 6 and 7 above. This represents the total effective Medicare Capitation, as if there were no QWP (i.e., this does *not* represent the net amount received after amounts were withheld). For a given month, this amount will fluctuate in subsequent FSR submissions, as retroactive risk adjustments, etc., are applied. (Note how the Federal 2% sequestration is taken out, as described under Line 6 above.)

- **Medicaid Premiums:**

Line 9: monthly capitation received - Medical: Enter the amount here that the MMP actually received (that are applicable to services rendered in the given month) from HHSC for the medical portion (i.e., excluding pharmacy) of the Medicaid premium payment. Any prior month adjustments included should be put into those corresponding prior month columns.

- Amounts entered here should be the actual amounts received. For example, if the MMP was due to receive a total of $100,000 for April, but 1% was withheld due to the Quality Withhold Policy ("QWP"), as outlined in the Contract, section 4.4.5), then only the $99,000 actually received should be entered here.

- If funds are recouped afterwards, instead of withheld upfront, then go back and adjust the original amount received downwards, to the actual final net received.

Line 10: Monthly Capitation Received - Pharmacy: Enter the amount here that the MMP actually received (that are applicable to services rendered in the given month) from HHSC for the pharmacy portion of the Medicaid premium payment. Any prior month adjustments included should be put into those corresponding prior month columns. As with the Line above, this would be the amounts actually received. If no QWP was withheld upfront from the Medicaid premium, then this amount should be the same as Line 14 below. If funds are recouped afterwards, instead of withheld upfront, then go back and adjust the original amount received downwards, to the actual final net received.

Line 11: Monthly Capitation Withheld – Medical: Calculated by subtracting Line 9 above from Line 13 below. This amount represents the difference between what would have been paid for the Medicaid medical portion without the QWP, and what was actually received. If no QWP was withheld upfront from the Medicaid premium, then this amount should be zero.

Line 12: Monthly Capitation Withheld – Pharmacy: Calculated by subtracting Line 10 above from Line 14 below. This amount represents the difference between what would have been paid for the Medicaid pharmacy portion without the QWP, and what was actually received. If no QWP was withheld upfront from the Medicaid premium, then this amount should be zero.

Line 13: Gross Total (Before Withhold) – Medical: Populated from Part 3, Line 32, Total Medicaid Medical Premiums. This amount represents the total of Medicaid medical premiums corresponding to services for this month, before any QWP. It is calculated in Part 3 by multiplying the # of beneficiaries by the medical portion of the Medicaid cap rate, PMPM. If no QWP was withheld upfront from the Medicaid premium, then this amount should be the same as Line 9 above.

Line 14: Gross Total (Before Withhold) – Pharmacy: Populated from Part 3, Line 40, Total Medicaid Pharmacy Premiums. This amount represents the total of Medicaid pharmacy premiums corresponding to services for this month, before any QWP. It is calculated in Part 3 by multiplying the # of beneficiaries by the pharmacy portion of the Medicaid cap rate, PMPM. If no QWP was withheld upfront from the Medicaid premium, then this amount should be the same as Line 10 above.

Line 15: Sub-total: Medicaid Capitation: Calculated by adding Lines 13 and 14 above. This represents the total Medicaid Capitation as if there were no QWP (i.e., this does *not* represent the net amount received after any QWP amounts were withheld).

- Other adjustments to Revenues:

Line 16: Investment Income: Enter all interest and dividend income resulting from investment of funds received from the state and federal governments under the Contract. This does not have to be differentiated between Medicare and Medicaid.

Line 17: Other Revenue: Enter all income generated from the Dual Program for the Service Area other than premiums (HHSC and CMS Capitation), and Investment Income. This does not have to be differentiated between Medicare and Medicaid.

Line 18: Total Gross Revenues: Calculated as the sum of Lines 8, 15, 16, and 17.

Line 19: Premium Taxes (on Medicaid): Enter all premium taxes incurred for Medicaid premiums applicable to the reporting period.

Line 20: Maintenance Taxes: Enter the maintenance taxes incurred for Medicaid premiums (number of beneficiaries) applicable to the reporting period.

Line 21: **Net Revenues**: Calculated as Line 18, "Total Gross Revenues," less the sum of Lines 19 and 20. The amount represents the effective revenues for the Program, after adjusting for the pass-through items of Premium Taxes and Maintenance Taxes, and adding-in interest earned on the cash-flow float from prospective payment of Program premiums. It is calculated as though there was no Quality Withhold. Any eventual forfeiture of premiums under QWP does not result in an adjustment to reported Net Revenues hereunder. Net Revenues should include retroactive payments to the MMP in Medicare, including risk adjustments, etc.

Expenses:

- ### Medicare Expenses:

Line 22: Fee-For-Service: Amounts paid to providers on a FFS basis, for Medicare medical expenses. Populated from Part 4, Line 4, "Total Medicare Paid Claims (FFS)."

Line 23: Capitated Services: Amounts paid to providers on a capitated basis, for Medicare medical expenses. Populated from Part 4, Line 8, "Total Medicare Paid Capitation."

Line 24: Net Reinsurance Cost: Gross reinsurance premiums paid with respect to Medicare (if any), less recoveries received from reinsurers. Populated from Part 4, Line 12, "Total Medicare Net Reinsurance." This may be zero for this Program. Note that amounts here may be subtracted from expenses for calculation of adjusted income for the Experience Rebate (reference the Reinsurance Cap in the Contract).

Line 25: IBNR Accrual – Medical: Incurred-But-Not-Reported. Populated from Part 4, Line 16, "Total Medicare Medical IBNR." This Line must be zero for the 334-day FSR.

Line 26: Other Medical Expenses: Populated from Part 4, Line 20, "Total Other Medical Expenses." Other here captures those Allowable Medicare medical expenses (excluding pharmacy) that do not fit in Lines 22 through 25 above. Examples 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; and, refunds.

Line 27: Total Medicare Medical Expenses: total Medicare medical expenses (excluding pharmacy). Calculated as the sum of Lines 22 through 26 above.

Line 28: Medicare Prescription Exp. (excl. PBM Admin): Populated from Part 6, Line 6, "Medicare Prescription Expense (excl. PBM Admin)." This Line includes IBNR related to pharmacy/prescriptions. (Note that Pharmacy Benefit Manager (PBM) Administrative expenses are reported in the Admin section.)

Line 29: Medicare Rx Rebates: Populated from Part 6, Line 7,"Medicare Prescription Rebates."

Line 30: Sub-total: Medicare Medical & Rx Expenses: Calculated as the sum of Line 27, "Total Medicare Medical Expenses," and Line 28, "Medicare Prescription Exp. (excl. PBM Admin)," above.

- ### Medicaid Expenses:

Line 31: Fee-For-Service: Amounts paid to providers on a FFS basis, for Medicaid medical expenses. Populated from Part 4, Line 24, "Total Medicaid Paid Claims (FFS)."

Line 32: Capitated Services: Amounts paid to providers on a capitated basis, for Medicaid medical expenses. Populated from Part 4, Line 28, "Total Medicaid Paid Capitation."

Line 33: Net Reinsurance Cost: Gross reinsurance premiums paid with respect to Medicaid (if any), less recoveries received from reinsurers. Populated from Part 4, Line 32, "Total Medicaid Net Reinsurance." This may be zero for this Program. Note that amounts here may be subtracted from expenses for calculation of adjusted income for the Experience Rebate (reference the Reinsurance Cap in the Contract).

Line 34: IBNR Accrual – Medical: Incurred-But-Not-Reported. Populated from Part 4, Line 36, "Total Medicaid Medical IBNR." This Line must be zero for the 334-day FSR.

Line 35: Minimum Payment Amount Program (MPAP): Populated from Part 4, Line 37.

Line 36: Other Medical Expenses: Populated from Part 4, Line 40, "Total Other Medical Expenses." Other here captures those allowable Medicaid medical expenses (excluding pharmacy) that do not fit in Lines 31 through 35 above. Examples 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; and, refunds.

Line 37: Total Medicaid Medical Expenses: Total Medicaid medical expenses (excluding pharmacy). Calculated as the sum of Lines 31 through 35 above.

Line 38: Medicaid Prescription Exp. (excl. PBM Admin): Populated from Part 6, Line 42, "Medicaid Prescription Expense (excl. PBM Admin)." This Line includes IBNR related to pharmacy/prescriptions. (Note that Pharmacy Benefit Manager (PBM) Administrative expenses are reported in the Admin section.)

Line 39: Sub-total: Medicaid Medical & Rx Expenses: Calculated as the sum of Line 37, "Total Medicaid Medical Expenses," and Line 38, "Medicaid Prescription Exp. (excl. PBM Admin)," above.

- **Total Expenses, and Net Income:**

Line 40: Total Medical & Prescription Expenses: Calculated as the sum of Line 30, "Sub-total: Medicare Medical & Rx Expenses," and Line 39, "Sub-total: Medicaid Medical & Rx Expenses," above.

Line 41: Administrative Expenses: populated from Part 7, Line 25, "Total Dual Demo Administrative Expenses." Note that this is *not* from the Consolidated Admin FSR that is used for other MCO Programs. All amounts entered into Admin Expenses here must be excluded from the Consolidated Admin FSR. Any amounts determined to have been included in both the Consolidated Admin FSR and also the Dual FSR (Part 7 and Part 1) will be deemed as double-counted and misreported.

Line 42: Total Expenses: Calculated as the sum of Line 40, "Total Medical and Prescription Expenses," and Line 41, "Administrative Expenses," above.

Line 43: **Total Net Income Before Taxes**: Calculated as Line 21, "Net Revenues," minus Line 42, "Total Expenses," above. This is the total Net Income attributable to the Program.

Line 44: **Net Income EXCL. Medicare Rx**: This Line 44 amount is used (as may be further adjusted by the Admin Cap, Reinsurance Cap, Loss Carry-forward, etc.) in calculating the adjusted income that is the basis for the Experience Rebate determination. This is Line 43, Total Net Income, adjusted to exclude the impact of Medicare Part D (Pharmacy). This removes both the Medicare pharmacy premiums and also the Medicare pharmacy costs (including a pro rata portion of pharmacy Admin).

- Line 44 is calculated as Line 43, "Net Income," minus the P&L impact of Medicare pharmacy.

- The P&L impact of Medicare pharmacy is calculated as Line 7, "CMS Medicare premiums - gross total (no withholding) - Pharmacy," minus Line 28, "Medicare Prescription Expense (excl. PBM)," minus a calculated pro rata share of PBM Admin expenses.
- The pro rata share representing Medicare PBM admin expenses is calculated as Part 2, Line 5, "Medicare PBM Admin Cost $-PMPM" times the sum of Part 1, Line1, "Member Months (per Medicaid)" plus Part 1, Line 2, "additional / (fewer) Mbr-Mos in Medicare."

- **Key Ratios:**

Line 45: % Total Medical Exp. to Net Revenues: Calculated as the sum of Line 27, "Total Medicare Medical Expenses," and Line 37, "Total Medicaid Medical Expenses," divided by Line 21, "Net Revenues." This is what the MLR would be without impact of the pharmacy carve-in.

Line 46: % Total Prescription Exp. to Net Revenues: Calculated as the sum of Line 28, "Total Medicare Pharmacy Expenses," and Line 36, "Total Medicaid Pharmacy Expenses," divided by Line 21, "Net Revenues."

Line 47: % Total Medical & Rx to Net Rev. (MLR): Calculated as Line 40, "Total Medical & Prescription Expenses" divided by Line 21, "Net Revenues." This is the **Medical Loss Ratio (MLR)** for the Program.

Line 48: % Admin Exp. to Net Revenues: Calculated as Line 41, "Administrative Expenses," divided by Line 21, "Net Revenues." This is the overall Admin Rate for the Program. (See also Line 48 below.)

Line 49: **% Total Net Income to Net Revenues**: Calculated as Line 43, "Net Income Before Taxes," divided by Line 21, "Net Revenues." This is the overall pre-tax profitability rate for the Program, before any impact from the Experience Rebate.

Line 50: % Adj. Admin to Adj. Net Revenues (excludes Taxes & Prescription pass through): This provides an adjusted Admin Rate that is not diluted by the pharmacy carve-in. It is Admin without Rx, divided by Revenues without Rx. This is calculated here by taking the Administrative Expenses from Line 41 and making adjustments to it, and then dividing that adjusted Admin by an adjusted version of Line 21, Net Revenues. The Line 50 Admin Expenses are adjusted by subtracting out the total PBM Admin Fees from Part 7, Lines 21 through 23. The Line 21 Net Revenues are adjusted by subtracting out Medicare and Medicaid pharmacy capitation (Part 1, Lines 7 and 14). Maintenance Taxes and Premium Taxes are not considered Admin expenses here, and are also removed from the calculation (showing up in neither the Revenue nor the Expense side of the equation).

Line 51: **% Net Income EXCL. Medicare Rx**: Calculated as Line 44, "Net Income EXCL. Medicare Rx," divided by the sum of [Line 21, "Net Revenues," minus Line 7, "CMS Medicare premiums - gross total (no withholding) – Pharmacy"]. This is the profitability percentage that is looked at with respect to determining the Experience Rebate (as may be further adjusted by the Admin Cap, Reinsurance Cap, etc.).

- **Memo: QWP withholdings and recoupments:**

Line 52: Total Medicare Capitation Withheld: Populated from Line 5 above, "CMS Medicare Premiums - monthly capitation withheld – Medical."

Line 53: Total Medicaid Capitation Withheld: Calculated from the sum of Lines 11 and 12 above, "Medicaid Premiums - monthly capitation withheld – Medical," and "- monthly capitation withheld – Pharmacy." This should also show any amounts recouped afterwards, if it is done that way instead of as an upfront withhold.

Line 54: Medicare Payments against Withholding: Input into the last month of the SFY (August, in column P), any year-to-date amounts that CMS has paid to the MMP in the SFY that represents a recovery of premium dollars withheld by CMS under the Quality Withhold Policy (QWP). Input as a positive number. *Be sure to update this in the 334-day FSR*. If you receive an amount pertaining to a prior State Fiscal Year, do not enter it in this FSR.

Line 55: Medicaid Payments against Withholding: Input into the last month of the SFY (August, in column P), any year-to-date amounts that HHSC has paid to the MMP in the SFY that represents a recovery of premium dollars withheld by HHSC under the QWP. Input as a positive number. *Be sure to update this in the 334-day FSR*. If you receive an amount pertaining to a prior State Fiscal Year, do not enter it in this FSR.

Line 56: Net Amount Not Received by MMP: Calculated by adding Lines 52 and 53 above (representing the total withheld under the QWP), and then subtracting from that Lines 54 and 55 (representing the total withholdings that have been remitted to the MMP). This Net Amount Not Received represents the combination of any amounts yet to be earned and remitted to the MMP, plus any amounts that may have been forfeited under the QWP. (Note that, until such time as final assessments have been made, along with final remittances to the MMP, the ultimate net amount forfeited will not be known on this template.)

Additional "memo" items: *(these are all calculated amounts, which are used elsewhere)*

Line 57: total Net Revenues (from Line 21): Populates from Line 21 above.

Line 58: Medicare portion (includes interest income): Calculates the portion of Net Revenues attributable to Medicare. Calculates as Line 8, Medicare Capitation, plus the Medicare pro-rata share of Interest and Other Income.

Line 59: Medicaid portion (excludes Premium Tax; includes interest income): Calculates the portion of Net Revenues attributable to Medicaid. Calculates as Line 15, Medicaid Capitation, plus the Medicaid pro-rata share of Interest and Other Income, less all the Premium Taxes and Maintenance Taxes.

Line 60: add-check: checks to see if the calculations in Lines 58 and 59 add up to the total in Line 57.

Line 61: total Net Income (from Line 43): Populates from Line 43 above.

Line 62: Medicare portion: Calculates the portion of Net Income attributable to Medicare. Calculated from Part 2, Line 37, Medicare Net Income % to Medicare Revenues, times Medicare Net Revenues in Line 58 above.

Line 63: Medicaid portion: Calculates the portion of Net Income attributable to Medicaid. Calculated from Part 2, Line 43, Medicaid Net Income % to Medicaid Net Revenues, times Medicaid Net Revenues in Line 59 above.

Line 64: add-check: checks to see if the calculations in Lines 62 and 63 add up to the total in Line 61.

Part 2: Ratios

Note: There is no input required for this tab; all amounts are populated from other lines, or are calculated.

Paid Medical Expenses Completion Factor:

Part 2: Ratios modified by Version 2.1

This is used to show to what degree the Medical Expenses reported are still represented by estimates used in IBNR (Incurred But Not Reported). It is effectively the ratio of paid medical expenses to total estimated medical expenses (including IBNR). 100% means that there is no IBNR remaining (i.e., all expenses are represented by received and processed invoices, etc.), and 0% would mean that all of it is estimated IBNR. All of the calculations for these completion factors are done from FSR Part 5 data (Medical Expenses).

Line 1: Medicare: This takes the Medicare Acute total and Long Term Care total and removes the IBNR from each, and then divides that by the total Medicare medical expenses (which total includes the IBNR). You can see the formula in the spreadsheet cell.

Line 2: Medicaid: This is exactly as above, only for the Medicaid numbers in Part 5.

Line 3: Total: This starts with the grand total medical expenses, removes the four IBNR lines, and divides that by the grand total medical expenses (i.e., [expenses less IBNR], divided by [expenses including IBNR]). This Line combines Medicare and Medicaid.

Medicare Costs $PMPM:

The dollar cost per Member per month for Medicare costs. This includes estimates used to allocate an appropriate portion of costs such as administrative expenses that may not be discretely identifiable as being strictly for Medicare. These calculations are primarily done from Part 1 data, and generally take the aggregate dollars for the item and divide that by the number of Medicare Member-Months.

Line 4: MMP Admin Cost (excluding PBM Admin costs): The estimated pro rata share of MMP Admin (excluding PBM Admin) attributed (by the FSR spreadsheet) to Medicare, divided by the number of Medicare member-months. MMP Dual Admin, from Part 7, has the PBM portion backed out, and is then prorated between Medicaid and Medicare based on the dollar volume of medical expenses.

Line 5: PBM Admin Cost: As in the Line above, only just for the PBM Admin portion (which is in Line items #21 through 23 in Part 7). These costs are prorated between Medicaid and Medicare based on the dollar volume of prescription expenses.

Line 6: Medical Expenses, excluding Net Reinsurance: This takes Medicare Medical expenses, subtracts Net Reinsurance attributed by the MMP to Medicare, and divides the result by the number of Medicare Member-Months.

Line 7: Net Reinsurance: This is as in the Line immediately above, only it is just the measurement for the Net Reinsurance piece. Net Reinsurance is as provided in Part 4, Line item # 12. Net Reinsurance is reinsurance premiums paid by the MMP, less reinsurance recoveries received from the reinsurer.

Line 8: Prescription Expenses (excluding PBM Admin costs): Medicare prescription expenses (excluding PBM Admin) divided by the number of Medicare Member-Months.

Line 9: less: Medicare share of interest & other income: This is the Investment Income and "Other Revenue" from Lines #16 and 17 from Part 1, as prorated to Medicare (by the FSR, according to relative Medical premiums), divided by the number of Medicare Member-Months.

Line 10: Subtotal - MMP Medicare costs: This is the sum of the PMPM's in Lines 4 through 9 above, and as such, represents the total cost per Member per month for Medicare expenses, including an allocated portion

of Admin expenses. This is the cost to the MMP; it is not the total cost to HHSC/CMS, as it does not include any MMP profit/(loss). It should be the same as adding all the aggregate Medicare costs (including FSR-allocated Admin, etc.), and dividing that by the number of Medicare Member-Months.

Line 11: Medicare Profit/(Loss) before Experience Rebate: This is the difference between the Medicare cost to Program (HHSC/CMS, as in Line 12 below), and the MMP cost (as in Line 10 above).

Line 12: Medicare Cost to Program, $PMPM: This is the aggregate of all Medicare premiums paid to the MMP, irrespective of any QWP Withholding, divided by the number of Medicare Member-Months.

Medicaid Costs $PMPM:

As above, only for Medicaid, rather than Medicare.

Line 13: MMP Admin Cost (excluding PBM Admin): As in Line 4 above, only for the Medicaid portion (and divided by the number of Medicaid Member-Months, which may vary slightly from the number of Medicare Member-Months (primarily due to timing differences between the two enrollment files, etc.).

Line 14: PBM Admin Cost: As in Line 5 above, only for the Medicaid portion.

Line 15: Premium & Maintenance Taxes: Premium Taxes and Maintenance Taxes are only assessed on Medicaid premiums (i.e., not on Medicare premiums), and so they are applied entirely to the Medicaid side of the costs. Total of these taxes, as reported in Part 1 Lines # 19 and 20, divided by the total number of Medicaid Member-Months.

Line 16: Medical Expenses, excluding Net Reinsurance: As in Line 6 above, only for the Medicaid portion.

Line 17: Net Reinsurance: As in Line 7 above, only for the Medicaid portion.

Line 18: Prescription Expenses (excluding PBM Admin): As in Line 8 above, only for the Medicaid portion.

Line 19: less: Medicaid share of interest & other income: As in Line 9 above, only for the Medicaid portion.

Line 20: Subtotal - MMP Medicaid costs: As in Line 10 above, only for the Medicaid portion.

Line 21: Medicaid Profit/(Loss) before Experience Rebate: As in Line 11 above, only for the Medicaid portion.

Line 22: Medicaid Cost to Program, $PMPM: As in Line 12 above, only for the Medicaid portion.

Dual Program Total Costs $PMPM:

As above, only jointly for both Medicare and Medicaid.

Line 23: MCO Admin Cost (including PBM Admin costs): The sum of Lines 4, 5, 13, and 14 above, combining all Admin per member, per month. This should be very close to the same as taking Part 1, Line 39, “Administrative Expenses,” and dividing by Part 1, Line 1, “Member Months (per Medicaid),” if the number of Member-Months for Medicare and Medicaid are very close to the same amount. In this total version (i.e., combining Medicare and Medicaid), we combine the PBM Admin in with all the Admin costs to get a total Admin rate, in PMPM terms.

Line 24: Premium & Maintenance Taxes: This is taken from Line 15 above, which is the same as calculating the sum of Part 1, Line 19, “Premium Taxes,” and Part 1, Line 20, “Maintenance Taxes,” divided by Part 1, Line 1, “Member Months.”

Line 25: Medical Expenses, excluding Net Reinsurance: The sum of Lines 6 and 16 above. This would be the same as taking the total Medicare and Medicaid medical expenses (excluding pharmacy), and subtracting the respective Net Reinsurance amounts, and then dividing that amount by the

number of Member-Months (again, assuming the number of Member-Months is close to the same for Medicare and Medicaid).

Line 26: Net Reinsurance: The sum of Lines 7 and 17 above. This would be the same as taking the total Medicare and Medicaid Net Reinsurance, and dividing it by the number of Member-Months (again, assuming the number of Member-Months is close to the same for Medicare and Medicaid).

Line 27: Prescription Expenses (excluding PBM Admin costs): The sum of Lines 8 and 18 above. This would be the same as taking the total Medicare and Medicaid prescription expenses (pharmacy excluding PBM admin), and dividing it by the number of Member-Months (again, assuming the number of Member-Months is close to the same for Medicare and Medicaid).

Line 28: less: interest & other income: The sum of Lines 9 and 19 above.

Line 29: Subtotal - MMP total costs: Calculated as sum of Lines 23 through 28 above. This represents the total cost per Member per month for Medicaid and Medicare expenses, including Admin expenses. This is the cost to the MMP; it is not the total cost to HHSC/CMS, as it does not include any MMP profit/(loss). It should be very close to the same as adding all the aggregate Medicare and Medicaid costs (including total Admin), and dividing that by the number of Member-Months.

Line 30: Profit/(Loss) before Experience Rebate: This is the difference between the total (Medicare and Medicaid) cost to Program (HHSC/CMS, as in Line 31 below), and the total MMP cost (as in Line 29 above). It should be very close to the same as Part 1, Line 21, "Net Income Before Taxes," divided by Part 1, Line 1, "Member Months" (except for any differences in number of Member-Months between Medicare and Medicaid).

Line 31: Total Cost $PMPM to Program: Calculated as sum of Lines 12 and Line 22, above. This represents the combined premiums (Medicare and Medicaid), per member, per month.

Medicare % to (Medicare) Revenues:

This represents Medicare expenses and income as percentages of Medicare premium revenues (plus a share of interest income). "Medicare revenues" in these Lines are Medicare premiums (i.e., both Part A/B Medical and Part D Pharmacy) paid by CMS (including any later retroactive adjustments), plus a pro-rata share of interest income (as input in Part 1, Lines 16 and 17). Medicare revenues here are not reduced by any Quality Withhold Program (QWP) withholding or forfeitures, or, likewise, by any Liquidated Damages (LDs) or Experience Rebates. Similarly, cost items in these lines are not increased for any QWP, LDs, or Experience Rebates.

Line 32: % Medical Expenses to Revenues: This represents Medicare medical expenses, excluding prescription expenses, divided by total Medicare revenues.

Line 33: % Prescription Expenses to Revenues: This represents Medicare prescription expenses (excluding PBM Admin costs), divided by total Medicare revenues (i.e., both Part A/B Medical and Part D Pharmacy, plus interest income).

Line 34: % Total Medical & Rx to Revenues (**Medicare MLR**): This is the Medical Loss Ratio (MLR) pertaining just to Medicare. It is Medicare medical and pharmacy, excluding PBM Admin, divided by total Medicare revenues. It is also the sum of Lines 32 and 33 above.

Line 35: % allocated Admin Expenses to Revenues: This represents the portion of Admin costs (including PBM Admin) that the FSR allocates to Medicare, divided by total Medicare revenues. The allocation of MMP Admin is prorated between Medicaid and Medicare based on dollar volume of Medical expenses.

Line 36: % Interest Income to Revenues: This is the portion of Investment Income and Other Revenues, as input in Part 1, Lines 16 and 17, which is prorated to Medicare (by the FSR), divided by Medicare revenues. The proration between Medicaid and Medicare for interest income is based on dollar volume of premiums.

Line 37: % Medicare Net Income to Revenues: This represents the pretax income attributable to Medicare under this Program, divided by the Medicare revenues (which are primarily the premiums paid to the MMP by CMS). It is before the impact of any Experience Rebate, and excludes the impact of any premiums forfeited under the Quality Withhold Program. It also excludes any Liquidated Damages. It should include any subsequent risk adjustment payments or other amounts paid by CMS. Costs counted are as allowed under the Cost Principles. In determining this number, MMP Admin costs were prorated between Medicaid and Medicare. This number is also equivalent to 100%, less Lines 34 and 35, as above. As with all numbers herein, these amounts are initially self-reported by the MMPs, are subject to quarterly updates as run-out occurs and CMS retroactive payments are made for risk adjustment, etc., and are subject to HHSC quarterly desk review and to annual audit by an external audit firm.

Medicaid % to Medicaid Net Revenues:

Medicaid expenses and income as percentages of net Medicaid revenues. Premium taxes and Maintenance taxes are netted out to get to net revenues. Except for dividing by net Medicaid Revenues (i.e., with Premium Taxes and Maintenance Taxes backed out of the Medicaid premiums paid), this section is largely the same as the *Medicare % to Revenues* section above, except using the corresponding Medicaid numbers. (Note that in Medicare, there are no Premium taxes and Maintenance taxes to back out, as these pertain only to Medicaid).

Line 38: % Medical Exp. to Net Revenues: This represents Medicaid medical expenses, excluding prescription expenses, divided by total net Medicaid revenues. "Net Medicaid revenues" in this Line and those below are Medicaid premiums (as paid by HHSC), less Premium Taxes and Maintenance Taxes, plus a pro-rata share of interest income (as input in Part 1, Lines 16 and 17).

Line 39: % Prescription Exp. to Net Revenues: This represents Medicaid prescription expenses (excluding PBM Admin), divided by total net Medicaid revenues.

Line 40: % Total Medical & Rx to Net Rev. (**Medicaid MLR**): This is the Medical Loss Ratio (MLR) pertaining just to Medicaid. It is Medicaid medical and pharmacy, excluding PBM Admin, divided by total net Medicaid revenues. It is also the sum of Lines 38 and 39 above.

Line 41: % allocated Admin Exp. to Net Revenues: This represents the portion of Admin costs (including PBM Admin) that the FSR allocates to Medicaid, divided by total net Medicaid revenues. The allocation of MMP Admin is prorated between Medicaid and Medicare based on dollar volume of Medical expenses.

Line 42: % Interest Income to Net Revenues: This is the portion of Investment Income and Other Revenues, as input in Part 1, Lines 16 and 17, which is prorated (by the FSR) to Medicaid, divided by net Medicaid revenues. The proration between Medicaid and Medicare for interest income is based on dollar volume of premiums.

Line 43: % Medicaid Net Income to Net Revenues: This represents the pretax income attributable to Medicaid under this Program, divided by the net Medicaid revenues (which net revenues are the premiums paid to the MMP by HHSC, less Premium Taxes and Maintenance Taxes, plus pro-rated interest income). It is before the impact of any Experience Rebate, and excludes the impact of any premiums forfeited under the Quality Withhold Program. It also excludes the impact of any Liquidated

Damages. Costs counted are as allowed under the Cost Principles. In determining this number, MMP Admin costs were prorated between Medicaid and Medicare. This number is also equivalent to 100%, less Lines 40 and 41, as above. As with all numbers herein, these amounts are initially self-reported by the MMPs, are subject to quarterly updates as run-out occurs, and are subject to HHSC quarterly desk review and to annual audit by an external audit firm.

Part 3: Premiums, Member-Months, & Rates, by Risk Group

Member Months (per Medicare):

Lines 1 through 3: Enter the member months based on the CMS payment file that supports the monthly CMS capitation payments to the MMP. While the CMS eligibility and payment files do not categorize members into these three risk groups, all these members are in one of these three risk groups with respect to Medicaid, so a given Member's risk group should be attributable.

A few beneficiaries may appear on the MMR but not appear on the Medicaid enrollment or capitation files; these should largely be resolved later with retroactive adjustments. In the interim, temporarily include them as part of the "Dual Eligible – Community (OCC)" risk group. Later, move these beneficiaries to the correct risk group, if it is not OCC. (Note: Include their premiums in the same risk group, as well as any corresponding claims costs. As above, move these premiums and claims costs to the correct risk group as the risk group becomes known.) Notify HHSC if these amounts appear to be significant and not transitory.

Line 4: Total Medicare Member Months: Calculated as the sum of Lines 1 through 3. This should tie out to the Medicare Monthly Membership Report (MMR). It is anticipated that this total should be very close to, but not always match exactly, the Total Member Months per Medicaid, as shown in Line 24 below. Most differences should be timing differences between the two systems, which should be resolved retrospectively after several months.

Medicare Medical Premium $PMPM average, adjusted:

Lines 5 through 8: Each cell in this matrix is calculated and is the result of the corresponding aggregate Medicare medical capitation dollars (Parts A/B) in the matrix of Lines 9 through 12 below, divided by the corresponding number of member months in the matrix of Lines 1 through 4 above. For Medicare this is calculated as a risk group average, rather than input as a set rate, due to 1) individual rates by Member, and 2) significant retroactive adjustments.

Medicare Medical Premiums:

Lines 9 through 11: Enter each risk group's aggregate medical capitation dollars (Medicare Part A/B), as paid to the MMP by CMS. As above with Lines 1 through 3, the CMS payment files do not categorize members into these three risk groups, but all these members are in one of these three risk groups with respect to Medicaid, so a given Member's risk group should be attributable. This should include all Part A/B payments, including any and all adjustments (retroactive adjustments, risk adjustments, etc.). (Note: See comments in Lines 1 through 3 above with respect to Medicare medical premiums received for any beneficiaries that do not show up on the Medicaid enrollment or capitation files.)

Line 12: Total Medicare Medical Premiums: Calculated as the sum of Lines 9 through 11 above. This should tie out to the CMS Plan Payment Report (PPR). Amounts paid as retroactive adjust-

ments should be added to the column pertaining to the prior month which the adjustment is for, rather than the month in which the adjustment is received. Amounts here should be the amounts that would be paid if there were no Quality Withhold Program (QWP). In other words, do not decrease premiums here due to any amounts withheld or forfeited. (There is another place in the FSR, in Part 1 Line 5, where QWP amounts withheld will be documented.) Do not reduce these amounts for any Liquidated Damages or Experience Rebates.

Any 2% sequestration adjustments, Federal plan user fees, or other similar amounts that have been netted out and will not be paid, would not be included here. For example, if the MMP Medicare rates indicated that $102,000 should have been paid prior to the Federal sequestration, and this was reduced by sequestration to $100,000, and then 1% was withheld due to QWP, leaving a net receipt of $99,000, then the $100,000 would be entered here.

Medicare Pharmacy Premium $PMPM average, adjusted:

Lines 13 through 16: Each cell in this matrix is calculated and is the result of the corresponding aggregate pharmacy capitation dollars (Medicare Part D) in the matrix of Lines 17 through 20 below, divided by the corresponding number of member months in the matrix of Lines 1 through 4 above. For Medicare this is calculated as a risk group average, rather than input as a set rate, due to 1) individual rates by Member, and 2) significant retroactive adjustments. As with Medicare medical, these Medicare pharmacy PMPM's are calculated rather than input as fixed rates, for the same reasons as discussed above.

Medicare Pharmacy Premiums:

Lines 17 through 19: Enter each risk group's aggregate Medicare pharmacy capitation dollars (Medicare Part D). As above with Lines 1 through 3, the CMS payment files do not categorize members into these three risk groups, but all these members are in one of these three risk groups with respect to Medicaid, so a given Member's risk group should be attributable. These Lines must include the full capitation amount, plus any and all subsequent adjustments (including risk adjustments, retroactive adjustments, etc.). Any later adjustments should be applied to the month(s) it pertains to, not the month in which it is received. (Note: See comments in Lines 1 through 3 above with respect to Medicare pharmacy premiums received for any beneficiaries that do not show up on the Medicaid enrollment or capitation files.)

Line 20: Total Medicare Pharmacy Premiums: Calculated as the sum of Lines 17 through 19. This should be done similarly to the instructions for Line 12, Medicare Medical Premiums, above.

Member Months (per Medicaid):

Lines 21 through 23: Enter the member months based on the Purchase Voucher supplemental files that support the monthly HHSC Medicaid capitation payments to the MMP.

Line 24: Total Medicaid Member Months: Calculated as the sum of Lines 21 through 23. It is anticipated that this total should be very close to, but not always match exactly, the Total Member Months per Medicare, as shown in Line 4 above. Most differences should be timing differences between the two systems, which should be resolved retrospectively after several months.

Medicaid Medical Premium $PMPM rates:

Lines 25 through 27: Enter each risk group's Medicaid medical capitation rate. This is as set by HHSC Rate Setting, and generally does not change from month-to-month.

Line 28: Total Medicaid Medical Premium $PMPM: This is calculated as Line 32, "Total Medicaid Medical Premiums," divided by Line 24, "Total Medicaid Member Months."

Medicaid Medical Premiums (HHSC Capitation):

Lines 29 through 31: Each cell in this matrix is calculated, and is the product of the Medicaid member months in the matrix of Lines 21 through 23 above, multiplied by the corresponding Medicaid medical capitation rate in the matrix of Lines 25 through 27 above.

Line 32: Total Medicaid Medical Premiums: Calculated as the sum of Lines 29 through 31.

Medicaid Pharmacy Premium $PMPM rates:

Lines 33 through 35: Enter each risk group's Medicaid pharmacy capitation rate applicable to each month. This is as set by HHSC Rate Setting, and generally does not change from month-to-month.

Line 36: Total Medicaid Pharmacy Premium $PMPM: Calculated as Line 40, "Total Medicaid Pharmacy Premiums," divided by Line 24, "Total Medicaid Member Months."

Medicaid Pharmacy Premiums (HHSC Capitation):

Lines 37 through 39: Each cell in this matrix is calculated, and is the product of the Medicaid member months in the matrix of Lines 21 through 23 above, multiplied by the corresponding Medicaid pharmacy capitation rate in the matrix of Lines 33 through 35 above.

Line 40: Total Medicaid Pharmacy Premiums: Calculated as the sum of Lines 37 through 39.

Part 4: Medical Expense by Expense Class, by Risk Group

Note: this section excludes pharmacy expenses.

Medicare:

See description in Part 5 for information regarding treatment of blended and cross-over claims.

Paid Claims by risk group:

Part 4: Medical Expense by Expense Class, Risk Group modified by Version 2.1

Lines 1 through 3: Paid Claims: Enter paid claims by risk groups as incurred by the MMP. These are the amounts that the MMP pays its providers for Medicare medical expenses (excluding pharmacy) hereunder, on a fee-for-service payment basis. See instructions under Part 3, Lines 1 through 3, for comments regarding risk groups under Medicare.

If, due to Federal sequestration, the MMP is paying the provider approximately 2% less than the amount that would have been paid had there been no sequestration, and there is no future obligation to pay this unpaid 2% on already incurred claims, then *the amount actually paid* (i.e., 98% of the amount that would have been paid without sequestration) *would be the amount recorded on the FSR*. In other words, the MMP would not record claims cost for the entire amount when that is not the amount paid, and when the difference is due to sequestration.

If there are paid claims for beneficiaries that appear on the MMR but do not appear on the Medicaid enrollment or capitation files, and thus no risk group is immediately identifiable, then tempo-

rarily include such expenses under the "Dual Eligible – Community (OCC)" risk group. Later, move these expenses to the correct risk group, if it is not OCC. Notify HHSC if these amounts appear to be significant and not transitory. Follow this same procedure for other sections below.

Line 4: Total Medicare Paid Claims (FFS): Calculated as the sum of Lines 1 through 3.

Paid Capitation by risk group:

Lines 5 through 7: Paid Capitation: Enter the total provider and subcontractor capitation payments, by risk groups, as incurred by the MMP. These are the amounts that the MMP pays its providers for Medicare medical expenses (excluding pharmacy) hereunder, on a capitated payment basis. [Note that any amount not paid due to Federal sequestration would not be added to the FSR; this issue is treated the same as for Lines 1 through 3 above.]

Line 8: Total Medicare Paid Capitation: Calculated as the sum of Lines 5 through 7.

Paid Reinsurance Premiums, Net of Reinsurance Recoveries, by risk group:

Lines 9 through 11: Paid Reinsurance Premiums, Net of Reinsurance Recoveries: Enter the paid reinsurance premiums net of collected reinsurance recoveries specific to each risk group by the months the reinsurance coverage was effective. Collected Reinsurance Recoveries are reported by the appropriate risk group and by the incurred month of the services to which the recoveries relate. These amounts may be zero.

Line 12: Total Medicare Net Reinsurance: Calculated as the sum of Lines 9 through 11.

Medical IBNR by risk group:

Estimated accruals for Incurred-But-Not-Reported. Should correspond to the total of IBNR amounts input in Part 5, Lines 15 and 21; see description there. Amounts on these lines are generally largest for the last month of the Quarter submitted, less for the next-to-last month, and trailing down to zero for months in prior Quarters. Upon submission of the subsequent Quarterly FSR, amounts for the prior Quarter would generally be reduced downwards, as outstanding invoices come in for older months. These Lines must be zero for the 334-day FSR.

Lines 13 through 15: IBNR: Enter Incurred-But-Not-Reported (IBNR) estimate by risk group.

Line 16: Total Medicare Medical IBNR: Calculated as the sum of Lines 13 through 15.

Other Medical Expenses by risk group:

Lines 17 through 19: Other Medical Expenses: Enter any other Medicare medical expenses not captured by "Paid Claims," "Paid Capitation," "Reinsurance Premiums, Net of Reinsurance Recoveries," or "IBNR," 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; and refunds.

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 here 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, aerochamber 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 section under Part 7 (Lines 21 through 23) of this FSR.

Line 20: Total Medicare Other Medical Expenses: Calculated as the sum of Lines 17 through 19.

Medicaid:

Paid Claims:

Lines 21 through 23: Paid Claims: Enter paid claims by risk groups as incurred by the MMP. These are the amounts that the MMP pays its providers for Medicaid medical expenses (excluding pharmacy) hereunder, on a fee-for-service payment basis. Note that any incremental amounts paid due to MPAP (i.e., the MPAP increases in payment rate) would not be captured here, but would instead be in Line 37 below.

Line 24: Total Medicaid Paid Claims (FFS): Calculated as the sum of Lines 21 through 23.

Paid Capitation:

Lines 25 through 27: Paid Capitation: Enter the total provider and subcontractor capitation payments, by risk groups, as incurred by the MMP. These are the amounts that the MMP pays its providers for Medicaid medical expenses (excluding pharmacy) hereunder, on a capitated payment basis. Note that any *incrementa*l amounts paid due to MPAP (i.e., the MPAP *increases* in payment rate) would not be captured here, but would instead be in Line 37 below.

Line 28: Total Medicaid Paid Capitation: Calculated as the sum of Lines 25 through 27.

Paid Reinsurance Premiums, Net of Reinsurance Recoveries:

Lines 29 through 31: Paid Reinsurance Premiums, Net of Reinsurance Recoveries: Enter the paid reinsurance premiums net of collected reinsurance recoveries specific to each risk group by the months the reinsurance coverage was effective. Collected Reinsurance Recoveries are reported by the appropriate risk group and by the incurred month of the services to which the recoveries relate. These amounts may be zero.

Line 32: Total Medicaid Net Reinsurance: Calculated as the sum of Lines 9 through 11.

Medical IBNR:

Estimated accruals for Incurred-But-Not-Reported. Should correspond to the total of IBNR amounts input in Part 5, Lines 40 and 52; see description there. Amounts on these lines are generally largest for the last month of the Quarter submitted, less for the next-to-last month, and

trailing down to zero for months in prior Quarters. Upon submission of the subsequent Quarterly FSR, amounts for the prior Quarter would generally be reduced downwards, as outstanding invoices come in for older months. These Lines must be zero for the 334-day FSR.

Lines 33 through 35: IBNR: Enter Incurred-But-Not-Reported (IBNR) estimate by risk group.

Line 36: Total Medicaid Medical IBNR: Calculated as the sum of Lines 33 through 35.

Minimum Payment Amount Program (MPAP):

Lines 37: Dual Eligible - Nursing Facility: Enter incremental Medicaid amounts paid by the MMP to governmental nursing facilities that are not owned (directly or indirectly) by the state government, under the MPAP program, attributed to Dual Eligibles in nursing facilities who are enrolled hereunder. This should correspond to the MPAP amounts which HHSC tells the MMP to pay to various facilities, assuming such payments are made. The "base" amounts paid to these specific nursing facilities (i.e., the amounts paid, excluding the MPAP incremental piece), should be captured in the sections above (Paid Claims, Paid Capitation, IBNR, etc.). Note that these MPAP amounts do not apply to either of the other two Risk Groups under this Program. Further note that this does not apply to Medicare medical expenses.

Other Medical Expenses:

Lines 38 through 40: Other Medical Expenses: Enter any other Medicaid medical expenses not captured by "Paid Claims," "Paid Capitation," "Reinsurance Premiums, Net of Reinsurance Recoveries," "IBNR," or "Minimum Payment Amount Program" 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; and refunds.

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 here 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, aerochamber 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 section under Part 7 (Lines 21 through 23) of this FSR.

Line 41: Total Medicaid Other Medical Expenses: Calculated as the sum of Lines 38 through 40.

Indicate categories of expenses included in each of the two Other Medical Expenses sections:

Line 42: Indicate categories of Other Medical Expenses: Identify each category of expense included in Lines 17 through 20, and 38 through 41, "Other Medical Expenses," as above, for both Medicare and Medicaid. Identify the YTD dollar amount associated with each category of expense if more than one. This is input in text form, with a fresh (updated) entry each quarter (which takes the place of the prior entry). This is not meant to be by month. Amounts in the description may be abbreviated to the nearest thousand dollars, if so indicated (e.g. $4K).

Allocations in Paid Capitation:

Line 43: Allocations used in splitting Paid Capitation between Medicare and Medicaid, above: From the total of Lines 8 & 28 above, enter the amount (in dollars) of the Paid Capitation to Providers that is allocated between Medicaid vs Medicare. (This is as opposed to being discretely identifiable by Medicaid or Medicare, without allocation.)

For example, if Line 8 (Medicare Paid Capitation) in a given month is $56,000 and Line 28 (Medicaid Paid Capitation) is $44,000 in that month, then Paid Capitation totaled $100,000. If an MMP can discretely identify, say, $35,000 as being Medicare without needing to allocate, and can likewise discretely identify, say, $40,000 as being Medicaid without needing to allocate, then $75,000 was determined without allocation, and the MMP would enter $25,000 here as the amount that was allocated between Medicare and Medicaid within the Paid Capitation amount for that month.

Line 44: Allocations used in splitting Paid Capitation between Risk Groups, above: From the total of Lines 8 & 28 above, enter the amount (in dollars) of the Paid Capitation to Providers that is allocated between Risk Groups. (This is as opposed to being discretely identifiable by Risk Group, without allocation.)

For example, if Line 8 (Medicare Paid Capitation) in a given month is $56,000 and Line 28 (Medicaid Paid Capitation) is $44,000 in that month, then Paid Capitation totaled $100,000. If an MMP can discretely identify, say, $35,000 as being in specific Risk Groups without needing to allocate, then $35,000 was determined without allocation, and the MMP would enter $65,000 here as the amount that was allocated amongst Risk Groups within the Paid Capitation amount for that month.

Total Aggregate Medical Cost by Risk Group: *(Note: There is no input required for this section.)*

This section calculates the aggregate cost to the MMP of all medical expenses, by risk group; first, just for Medicare, then for Medicaid, and then combined. (Excludes pharmacy and administrative expenses.) Note that Medicare does not use the same risk groups as Medicaid; all Medicare costs in the FSR are attributed to the risk group that the beneficiary is in with respect to Medicaid.

Medicare

Line 45: Dual Eligible - Community (OCC): Calculated as the sum of Paid Claims, Paid Capitation, Net Reinsurance, IBNR, and Other Medical, for Medicare, under this risk group (Community / OCC), expressed in aggregate dollars.

Line 46: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated as the sum of Paid Claims, Paid Capitation, Net Reinsurance, IBNR, and Other Medical, for Medicare, under this risk group (HCBS Waiver), expressed in aggregate dollars.

Line 47: Dual Eligible - Nursing Facility: Calculated as the sum of Paid Claims, Paid Capitation, Net Reinsurance, IBNR, and Other Medical, for Medicare, under this risk group (Nursing Facility), expressed in aggregate dollars.

Line 48: Total Medicare Medical Cost: Calculated as the sum of Lines 45 through 47 above.

Medicaid

Line 49: Dual Eligible - Community (OCC): Calculated as the sum of Paid Claims, Paid Capitation, Net Reinsurance, IBNR, and Other Medical, for Medicaid, under this risk group (Community / OCC), expressed in aggregate dollars.

Line 50: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated as the sum of Paid Claims, Paid Capitation, Net Reinsurance, IBNR, and Other Medical, for Medicaid, under this risk group (HCBS Waiver), expressed in aggregate dollars.

Line 51: Dual Eligible - Nursing Facility: Calculated as the sum of Paid Claims, Paid Capitation, Net Reinsurance, IBNR, and Other Medical, for Medicaid, under this risk group (Nursing Facility), expressed in aggregate dollars.

Line 52: Total Medicaid Medical Cost: Calculated as the sum of Lines 49 through 51 above.

Combined Medicare & Medicaid

Line 53: Dual Eligible - Community (OCC): Calculated as the sum of Lines 45 through 49 above.

Line 54: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated as the sum of Lines 46 through 50 above.

Line 55: Dual Eligible - Nursing Facility: Calculated as the sum of Lines 47 through 51 above.

Line 56: Total Medicaid Medical Cost: Calculated as the sum of Lines 53 through 55 above.

Part 4b: Medical Rates, Expense, & Margin by Risk Group

Part 4b: Medical Rates, Expense, & Margin by Risk Group added by Version 2.1

Note: There is no input required for this tab; all amounts are populated from other lines, or are calculated. Note that Medicare does not use the same risk groups as Medicaid; all Medicare costs in the FSR are attributed to the risk group that the beneficiary is in with respect to Medicaid.

Effective Medical Premium Rates PMPM by Risk Group:

This section calculates the average amount paid, per member, per month (PMPM) to the MMP, excluding pharmacy, by risk group. First, a calculation for Medicare, then the rates that were set by HHSC for Medicaid, and then a calculation of a combined amount. Medical premiums contain amounts for administrative operations as well.

Medicare Medical Premium $PMPM average, adjusted:

Medicare rates are not set discretely for each of the three Medicaid risk groups; additionally, they change retrospectively. To accommodate this in these reports, we calculate average effective Medicare rates, which is done by dividing aggregate Medicare premiums by the number of Medicare member months. These Medicare average $PMPM amounts here reflect the effective aver-

age rate for a Medicaid risk group, as data here is grouped by Medicaid risk group, not by Medicare rate cell. There are effectively multiple Medicare rate cells within a single Medicaid risk group. Average rates calculated for any given month may change for that same month in future submissions, reflecting the impact of subsequent CMS retroactive risk adjustment payments, etc. The average Medicare amount for a given Medicaid risk group can also fluctuate from one month to the next month due to shifting mix.

Line 1: Dual Eligible - Community (OCC): From Part 3, Line 5 [which is turn derived from Part 3 Line 9 (Medicare Medical Premiums) divided by Part 3 Line 1 (Member Months, per Medicare), for Medicare, with respect to this risk group].

Line 2: Dual Eligible - HCBS STAR+PLUS Waiver: From Part 3, Line 6 [which is turn derived from Part 3 Line 10 (Medicare Medical Premiums) divided by Part 3 Line 2 (Member Months, per Medicare), for Medicare, with respect to this risk group].

Line 3: Dual Eligible - Nursing Facility: From Part 3, Line 7 [which is turn derived from Part 3 Line 11 (Medicare Medical Premiums) divided by Part 3 Line 3 (Member Months, per Medicare), for Medicare, with respect to this risk group].

Line 4: Total Medicare Medical Premium $PMPM: From Part 3, Line 8 [which is turn derived from Part 3 Line 12 (Total Medicare Medical Premiums) divided by Part 3 Line 4 (Member Months, per Medicare)].

Medicaid Medical Premium $PMPM rates:

Line 5: Dual Eligible - Community (OCC): From Part 3, Line 25 [which is the Medicaid rate, excluding pharmacy, which has been set for this risk group by HHSC].

Line 6: Dual Eligible - HCBS STAR+PLUS Waiver: From Part 3, Line 26 [which is the Medicaid rate, excluding pharmacy, which has been set for this risk group by HHSC].

Line 7: Dual Eligible - Nursing Facility: Line 27 [which is the Medicaid rate, excluding pharmacy, which has been set for this risk group by HHSC].

Line 8: Total Medicaid Medical Premium $PMPM: From Part 3, Line 28 [which is the weighted average of the above three rates, as calculated from Part 3 Line 32 (Total Medicaid Medical Premiums) divided by Part 3 Line 24 (Total Medicaid Member Months)].

Combined Medicare & Medicaid Medical Premium $PMPM rates:

Line 9: Dual Eligible - Community (OCC): Calculated from the sum of Part 3, Line 9 (Medicare Medical Premiums for this risk group) plus Part 3, Line 29 (Medicaid Medical Premiums for this risk group), divided by Part 3, Line 21 (number of Member Months for this risk group).

Line 10: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated from the sum of Part 3, Line 10 (Medicare Medical Premiums for this risk group) plus Part 3, Line 30 (Medicaid Medical Premiums for this risk group), divided by Part 3, Line 22 (number of Member Months for this risk group).

Line 11: Dual Eligible - Nursing Facility: Calculated from the sum of Part 3, Line 11 (Medicare Medical Premiums for this risk group) plus Part 3, Line 31 (Medicaid Medical Premiums for this risk group), divided by Part 3, Line 23 (number of Member Months for this risk group).

Line 12: Combined Medicare & Medicaid Medical Premium $PMPM: Calculated from the sum of Part 3, Line 12 (total Medicare Medical Premiums) plus Part 3, Line 32 (total Medicaid Medical Premiums), divided by Part 3, Line 24 (total number of Member Months).

Total Medical Cost PMPM by Risk Group:

This section calculates the average total medical cost incurred, per member, per month (PMPM), by the MMP, excluding pharmacy, by risk group; first, for Medicare, then for Medicaid, and then combined.

Medicare Medical Costs PMPM:

Line 13: Dual Eligible - Community (OCC): Calculated from Part 4, Line 45 (aggregate Medicare Medical costs incurred for this risk group) divided by Part 3, Line 1 (number of Member Months, per Medicare, for this risk group). The aggregate Medicare Medical costs are in turn calculated from the amounts input for each expense class under Medicare Medical in Part 4 for this risk group.

Line 14: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated from Part 4, Line 46 (aggregate Medicare Medical costs incurred for this risk group) divided by Part 3, Line 2 (number of Member Months, per Medicare, for this risk group).

Line 15: Dual Eligible - Nursing Facility: Calculated from Part 4, Line 47 (aggregate Medicare Medical costs incurred for this risk group) divided by Part 3, Line 3 (number of Member Months, per Medicare, for this risk group).

Line 16: Total Medicare Medical Cost: Calculated from Part 4, Line 47 (total aggregate Medicare Medical costs incurred for all risk groups) divided by Part 3, Line 3 (number of Member Months, per Medicare, for all risk groups).

Medicaid Medical Costs PMPM:

Line 17: Dual Eligible - Community (OCC): Calculated from Part 4, Line 49 (aggregate Medicaid Medical costs incurred for this risk group) divided by Part 3, Line 21 (number of Member Months, per Medicaid, for this risk group). The aggregate Medicaid Medical costs are in turn calculated from the amounts input for each expense class under Medicaid Medical in Part 4 for this risk group.

Line 18: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated from Part 4, Line 50 (aggregate Medicaid Medical costs incurred for this risk group) divided by Part 3, Line 22 (number of Member Months for this risk group).

Line 19: Dual Eligible - Nursing Facility: Calculated from Part 4, Line 51 (aggregate Medicaid Medical costs incurred for this risk group) divided by Part 3, Line 23 (number of Member Months for this risk group).

Line 20: Total Medicaid Medical Cost: Calculated from Part 4, Line 52 (total aggregate Medicaid Medical costs incurred for all risk groups) divided by Part 3, Line 24 (total number of Member Months for all risk groups).

Combined Medicare & Medicaid Medical Costs PMPM:

These Lines represent the cost per member, per month, for all medical expenses (Medicare and Medicaid), excluding pharmacy and administrative costs.

Line 21: Dual Eligible - Community (OCC): Calculated from Part 4, Line 53 (aggregate combined Medicare and Medicaid Medical costs incurred for this risk group) divided by Part 3, Line 21 (number of Member Months, per Medicaid, for this risk group). The aggregate combined Medicare and Medicaid Medical costs are in turn calculated from adding the Medicare and Medicaid subtotals.

Line 22: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated from Part 4, Line 54 (aggregate combined Medicare and Medicaid Medical costs incurred for this risk group) divided by Part 3, Line 22 (number of Member Months, for this risk group).

Line 23: Dual Eligible - Nursing Facility: Calculated from Part 4, Line 55 (aggregate combined Medicare and Medicaid Medical costs incurred for this risk group) divided by Part 3, Line 23 (number of Member Months, for this risk group).

Line 24: Total Medicare & Medicaid Medical Cost: Calculated from Part 4, Line 56 (aggregate combined Medicare and Medicaid Medical costs incurred for all risk groups) divided by Part 3, Line 24 (total number of Member Months, for all risk groups). This represents the weighted average cost per member, per month, across all Risk Groups, for all medical expenses (Medicare and Medicaid), excluding pharmacy.

Medical Margin by Risk Group - $PMPM:

This section calculates the average margin experienced, per member, per month (PMPM), by the MMP, excluding pharmacy, by risk group; first, by Medicare, then by Medicaid, and then combined. Margin can be either positive or negative. Margin here is the difference between the medical premiums paid to the MMP and the medical costs incurred by the MMP. The margin must cover administrative costs; to the extent the margin is in excess of the administrative costs, that would yield a pre-tax profit. (Medical margin $PMPM is equal to the aggregate medical margin dollars divided by the number of member months; aggregate medical margin dollars is in turn equal to the aggregate medical premiums less the aggregate medical costs.) In the Lines below, the calculation is achieved by subtracting medical cost pmpm amounts from medical premium pmpm amounts.

Medicare Medical Margin $PMPM:

Line 25: Dual Eligible - Community (OCC): Calculated here by subtracting Line 13 (medical cost PMPM) from Line 1 (medical premium PMPM) with respect to Medicare, for this Risk Group.

Line 26: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated here by subtracting Line 14 (medical cost PMPM) from Line 2 (medical premium PMPM) with respect to Medicare, for this Risk Group.

Line 27: Dual Eligible - Nursing Facility: Calculated here by subtracting Line 15 (medical cost PMPM) from Line 3 (medical premium PMPM) with respect to Medicare, for this Risk Group.

Line 28: Total Medicare Medical Margin $PMPM: Calculated here by subtracting Line 16 (medical cost PMPM) from Line 4 (medical premium PMPM) with respect to Medicare, for all Risk Groups.

Medicaid Medical Margin $PMPM:

Line 29: Dual Eligible - Community (OCC): Calculated here by subtracting Line 17 (medical cost PMPM) from Line 5 (medical premium PMPM) with respect to Medicaid, for this Risk Group.

Line 30: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated here by subtracting Line 18 (medical cost PMPM) from Line 6 (medical premium PMPM) with respect to Medicaid, for this Risk Group.

Line 31: Dual Eligible - Nursing Facility: Calculated here by subtracting Line 19 (medical cost PMPM) from Line 7 (medical premium PMPM) with respect to Medicaid, for this Risk Group.

Line 32: Total Medicaid Medical Margin $PMPM: Calculated here by subtracting Line 20 (medical cost PMPM) from Line 8 (medical premium PMPM) with respect to Medicaid, for all Risk Groups.

Combined Medicare & Medicaid Medical Margin $PMPM:

Line 33: Dual Eligible - Community (OCC): Calculated here by subtracting Line 21 (medical cost PMPM) from Line 9 (medical premium PMPM) with respect to the combined Medicare and Medicaid, for this Risk Group.

Line 34: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated here by subtracting Line 22 (medical cost PMPM) from Line 10 (medical premium PMPM) with respect to the combined Medicare and Medicaid, for this Risk Group.

Line 35: Dual Eligible - Nursing Facility: Calculated here by subtracting Line 23 (medical cost PMPM) from Line 11 (medical premium PMPM) with respect to the combined Medicare and Medicaid, for this Risk Group.

Line 36: Combined Medicare & Medicaid Medical Margin $PMPM: Calculated here by subtracting Line 24 (medical cost PMPM) from Line 12 (medical premium PMPM) with respect to the combined Medicare and Medicaid, for all Risk Groups.

Medical Margin by Risk Group - %:

This section is the same as the one preceding, except that, instead of measuring the medical margin in terms of per member per month, this measures the medical margin as a percent of premiums paid. (Margin % is equal to aggregate medical margin dollars divided by aggregate medical premium dollars; aggregate medical margin dollars is in turn equal to the aggregate medical premiums less the aggregate medical costs.) Excludes pharmacy. In the Lines below, the calculations are done by dividing the margin PMPM amounts by the premium PMPM amounts.

Medicare Medical Margin %:

Line 37: Dual Eligible - Community (OCC): Calculated here by dividing Line 25 (medical margin PMPM) by Line 1 (medical premiums PMPM), under Medicare, for this Risk Group.

Line 38: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated here by dividing Line 26 (medical margin PMPM) by Line 2 (medical premiums PMPM), under Medicare, for this Risk Group.

Line 39: Dual Eligible - Nursing Facility: Calculated here by dividing Line 27 (medical margin PMPM) by Line 3 (medical premiums PMPM), under Medicare, for this Risk Group.

Line 40: Total Medicare Medical Margin %: Calculated here by dividing Line 28 (medical margin PMPM) by Line 4 (medical premiums PMPM), under Medicare, for all Risk Groups.

Medicaid Medical Margin %:

Line 41: Dual Eligible - Community (OCC): Calculated here by dividing Line 29 (medical margin PMPM) by Line 5 (medical premiums PMPM), under Medicaid, for this Risk Group.

Line 42: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated here by dividing Line 30 (medical margin PMPM) by Line 6 (medical premiums PMPM), under Medicaid, for this Risk Group.

Line 43: Dual Eligible - Nursing Facility: Calculated here by dividing Line 31 (medical margin PMPM) by Line 7 (medical premiums PMPM), under Medicaid, for this Risk Group.

Line 44: Total Medicaid Medical Margin %: Calculated here by dividing Line 32 (medical margin PMPM) by Line 8 (medical premiums PMPM), under Medicaid, for all Risk Groups.

Combined Medicare & Medicaid Medical Margin %:

Line 45: Dual Eligible - Community (OCC): Calculated here by dividing Line 33 (medical margin PMPM) by Line 9 (medical premiums PMPM), for combined Medicare and Medicaid, for this Risk Group.

Line 46: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated here by dividing Line 34 (medical margin PMPM) by Line 10 (medical premiums PMPM), for combined Medicare and Medicaid, for this Risk Group.

Line 47: Dual Eligible - Nursing Facility: Calculated here by dividing Line 35 (medical margin PMPM) by Line 11 (medical premiums PMPM), for combined Medicare and Medicaid, for this Risk Group.

Line 48: Combined Medicare & Medicaid Medical Margin %: Calculated here by dividing Line 36 (medical margin PMPM) by Line 12 (medical premiums PMPM), for combined Medicare and Medicaid, for all Risk Groups.

Medical Margin by Risk Group - aggregate $:

This section is the same as the one preceding, except that, instead of measuring the medical margin in terms of a percentage of premiums paid, this measures the medical margin as an aggregate amount of total dollars. (Aggregate medical margin dollars is equal to the aggregate medical premiums less aggregate medical costs.) Excludes pharmacy. The Lines below are calculated by multiplying margin PMPM amounts by the number of Member-Months.

Medicare Medical Margin $:

Line 49: Dual Eligible - Community (OCC): Calculated here by multiplying Line 25 (Medicare medical margin PMPM) by Part 3, Line 1 (number of Member-Months, per Medicare), for this Risk Group.

Line 50: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated here by multiplying Line 26 (Medicare medical margin PMPM) by Part 3, Line 2 (number of Member-Months, per Medicare), for this Risk Group.

Line 51: Dual Eligible - Nursing Facility: Calculated here by multiplying Line 27 (Medicare medical margin PMPM) by Part 3, Line 3 (number of Member-Months, per Medicare), for this Risk Group.

Line 52: Total Medicare Medical Margin $: Calculated here by summing the above three Lines, for all Risk Groups under Medicare.

Medicaid Medical Margin $:

Line 53: Dual Eligible - Community (OCC): Calculated here by multiplying Line 29 (Medicaid medical margin PMPM) by Part 3, Line 21 (number of Member-Months, per Medicaid), for this Risk Group.

Line 54: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated here by multiplying Line 30 (Medicaid medical margin PMPM) by Part 3, Line 22 (number of Member-Months, per Medicaid), for this Risk Group.

Line 55: Dual Eligible - Nursing Facility: Calculated here by multiplying Line 31 (Medicaid medical margin PMPM) by Part 3, Line 23 (number of Member-Months, per Medicaid), for this Risk Group.

Line 56: Total Medicaid Medical Margin $: Calculated here by summing the above three Lines, for all Risk Groups under Medicaid.

Combined Medicare & Medicaid Medical Margin $:

Line 57: Dual Eligible - Community (OCC): Calculated here by summing Lines 49 and 53 above, for this Risk Group, for both Medicare and Medicaid.

Line 58: Dual Eligible - HCBS STAR+PLUS Waiver: Calculated here by summing Lines 50 and 54 above, for this Risk Group, for both Medicare and Medicaid.

Line 59: Dual Eligible - Nursing Facility: Calculated here by summing Lines 51 and 55 above, for this Risk Group, for both Medicare and Medicaid.

Line 60: Combined Medicare & Medicaid Medical Margin $: Calculated here by summing the above three Lines, for all Risk Groups, for both Medicare and Medicaid.

Part 5: Medical Expenses by Service Type

Medicare:

Part 5: Medical Expenses by Service Type modified by Versions 2.1 and 2.2

Note that any service that is “Medicare-covered” is also “Medicare primary.” Anything that is “Medicare-covered” has to be either 1) entirely Medicare, or 2) first Medicare, with Medicaid being secondary. This is because Medicaid is always the payment of last resort. Anything that is a “Medicare-covered service”

should have all its allowable costs entered into the FSR in the Medicare Lines. This would include those costs where Medicaid is secondary.

Acute Care Services:

Enter in this section the dollars for all Medicare-covered acute care services. This includes all payments for "blended" Medicare-Medicaid services, including "cross-over claims." Thus, there will be a proportionately small amount of what would otherwise be classified as Medicaid dollars in some of these amounts. This is to accommodate "one touch" claims processing, wherein providers are paid a single amount for a service which has both Medicare and Medicaid cost components, and the segregation of the Medicare vs. Medicaid cost components is not available to the MMP through its claims processing system. The amount of these dollars included in Lines 1 through 17 that would have been attributable to Medicaid may be estimated in Line 18, below, as an informational line item. Phrases referring to "expenses related to Medicare medical care" in the descriptions of Lines 1 through 17 below should be interpreted to include, where appropriate, the Medicaid cross-over portion of blended claims. This would include co-pays and deductibles covered by Medicaid for Medicare-covered services.

Line 1: Physician Services: Primary Care: Enter all paid expenses related to the Medicare 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 which 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 managed care program, all members are required to have a primary care physician (PCP) when enrolling in a MMP. 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 Medicare 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 – Professional Component: Enter paid expenses for the Medicare services of the delivering physician and the anesthesiologist, unless they are billed as part of the facility charge. 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 Medicare 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 Medicare 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 and/or specialist services. The total amount paid by the MMP 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 Medicare 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
- 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 Services: Medical/Surgical: Enter all Medicare 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.
- 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 Services: Deliveries – Facility Component: Enter Medicare 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 Medicare 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 Medicare paid expenses incurred for vision services. This includes, but is not limited to, optometry and glasses.

Line 11: Miscellaneous Other Covered Services (Acute): Enter all Medicare paid expenses of all medical services and supplies rendered that are not classified in any of the medical expense classifications above. "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: approved Dual Flexible Benefits (Acute) - allocated from Line 58: This is the amount input into Line 58 for Acute Care health services, allocated between Medicaid and Medicaid by the FSR.

Line 13: Reinsurance Premiums: Enter Medicare paid expenses to obtain acute care 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 MMP. Offset any re-insurance premiums collected for any reinsurance risks assumed.

Line 14: Reinsurance Recoveries: Enter any and all return of funds, or recovery of paid losses (against the premiums paid in Line 13 above), that have been collected from reinsurers associated with a particular case where catastrophic medical expenses have been incurred. Offset any re-insurance 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. Enter such recoveries / return of funds here as a negative amount.

Line 15: Incurred-But-Not-Reported (IBNR): Enter the total Medicare acute care medical expenses accrual based on the MMP's IBNR Plan, 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. [See also Part 4, Lines 13 through 16.]

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

Line 16: Provider Incentives or Network Risk Retention: Enter any incentives paid directly to physicians for Medicare acute care services, e.g., bonuses paid based on quality compliance measures.

Line 17: Total Medicare Acute Care Expenses (includes the Medicaid portion of blended claims): Calculated as the sum of Lines 1 through 16. Note that this total includes cross-over claims and the Medicaid portion of blended claims, as described above before the description of Line 1.

Line 18: est. $ in above that are cross-over claims and the Medicaid portion of blended claims, etc.: Enter here the estimated amount that is included in Line 17, which represents what would have been attributed to Medicaid (e.g., under STAR+PLUS), with respect to "blended," or cross-over claims, This would include co-pays and deductibles covered by Medicaid for Medicare-covered services.

Long-Term Care Services:

The Line items in this section may not be universally considered to be truly "long term" care, but are grouped under this heading for now. Approach this section primarily in terms of the descriptions listed under Lines 19 and 20 below.

Line 19: Nursing Facility Services - 1st 100 days, daily rate: Enter all paid expenses related to Nursing Facility Services provided to a member-patient which are covered by Medicare, and which are included in the facility's set per-day rate. Nursing facility expenses covered by Medicare are generally 100% for the first 20 days, and then 80% for days 21 through 100 (with the remaining 20% during that time being picked-up by Medicaid).

Line 20: Nursing Facility Services - Add Ons: Enter all paid expenses related to Nursing Facility Add Ons which are covered by Medicare, and which are excluded from the facility's set per-day rate. These are billed by the nursing facility outside of any daily rate. This would include services such as therapy normally billed under Medicare Part B, and physician-ordered supplies that require pre-authorization and are billable to Part B.

Line-21: approved Dual Flexible Benefits (LTC) - allocated from Ln 60: This is the amount input into Line 60 that may correspond to Lines 19 and 20 above, allocated between Medicaid and Medicaid by the FSR.

Line 22: Incurred-But-Not-Reported (IBNR): Enter the total expense accrual corresponding to Lines 19 and 20 above, based on the IBNR Plan, 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. [See also Part 4, Lines 13 through 16.]

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

Line 23: Total Medicare Long-Term Care Expenses: Calculated as the sum of Lines 19 through 22.

Line 24: **Total Medicare Medical Expenses**: Calculated as the sum of Lines 17 and 23, combining Medicare Acute Care and Long-Term Care (but excluding pharmacy).

Line 25: Portion of above total which is allocated (show as $): Enter the total of all amounts that you allocated within Line 24, Total Medicare Medical Expenses, above, with the exception of any Flexible Benefits (all of which are allocated herein by the FSR). For example, if Line 24 totals $100,000, and, excluding Flexible Benefits, you had to allocate $17,000 of that (to split between Medicare and Medicaid), in determining the specific amounts to input above, then enter $17,000 here. These would primarily be amounts that you could not distinctly identify as being solely for Medicare (blended claims, etc.).

Line 26: Line Item #s above which contain such allocations: Enter the identifying Line item numbers (other than Flexible Benefits) from above that contain allocated amounts. List each applicable Line # from above. For example: #1, 2, 7, 9, & 11.

Medicaid:

Note that any service that is not "Medicare-covered" is by definition all Medicaid, and thus is "Medicaid primary." All allowable costs for medical services that are not "Medicare-covered services" should go entirely in the Medicaid Lines in the FSR.

Acute Care Services:

Some dollars that would be otherwise be attributable to Medicaid acute care services (such as under STAR+PLUS), which are part of a "blended" Medicaid/Medicare service or cross-over claim, are instead to be included under Medicare acute care services, as described above prior to the description of Line 1. These dollars should not be double-counted, and thus should not be included in this Medicaid acute care services section. Phrases that refer to "expenses related to Medicaid medical care" in the descriptions of Lines 27 through 43 below should be interpreted to exclude, where appropriate, cross-over claims and the Medicaid portion of blended claims. This would apply to co-pays and deductibles covered by Medicaid for Medicare-covered services.

Primarily what is included in the Lines in this section below are "Medicaid-only" services and their respective costs.

Line 27: Physician Services: Primary Care: Enter all paid expenses related to the Medicaid 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 which 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 managed care program, all members are required to have a primary care physician (PCP) when enrolling in a MMP. 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 28: Physician Services: Specialist: Enter all paid expenses related to the Medicaid 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 29: Physician Services: Deliveries – Professional Component: Enter paid expenses for the Medicaid services of the delivering physician and the anesthesiologist, unless they are billed as

part of the facility charge. 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 27 and 28, respectively.

Line 30: Non-Physician Professional Services: Enter all paid expenses for Medicaid 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 31: Emergency Room Services: Enter all paid Medicaid 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 31. Exclude non-staff attending or consulting physician billed separately as PCP and/or specialist services. The total amount paid by the MMP 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 32: Outpatient Facility Services: Enter all Medicaid 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
- 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 33: Inpatient Facility Services: Medical/Surgical: Enter all Medicaid 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.
- 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 34: Inpatient Facility Services: Deliveries – Facility Component: Enter Medicaid 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 35: Behavioral Health Services: Enter all Medicaid 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 36: Vision Services: Enter all Medicaid paid expenses incurred for vision services. This includes, but is not limited to, optometry and glasses.

Line 37: Miscellaneous Other Covered Services (Acute): Enter all Medicaid paid expenses of all medical services and supplies rendered that are not classified in any of the medical expense classifications above. "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 38: approved Dual Flexible Benefits (Acute) - allocated from Line 59: This is the amount input into Line 59 for Acute Care health services, allocated between Medicaid and Medicaid by the FSR.

Line 39: Reinsurance Premiums: Enter Medicaid paid expenses to obtain acute care 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 MMP. Offset any reinsurance premiums collected for any reinsurance risks assumed.

Line 40: Reinsurance Recoveries: Enter any and all return of funds or recovery of paid losses (against the premiums paid in Line 39 above) 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. Enter such recoveries / return of funds here as a negative amount.

Line 41: Incurred-But-Not-Reported (IBNR): Enter the total Medicaid acute care medical expenses accrual based on the MMP's IBNR Plan, 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. [See also Part 4, Lines 33 through 36.]

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

Line 42: Provider Incentives or Network Risk Retention: Enter any incentives paid directly to physicians for Medicaid acute care services, e.g., bonuses paid based on quality compliance measures.

Line 43: Total Medicaid Acute Care Expenses (excluding the Medicaid portion of blended claims): Calculated as the sum of Lines 27 through 42. As referenced in the description above prior to Line 27, this total does not include the Medicaid portion of Medicare-covered services, such as Medicaid-covered copays and deductibles for Medicare-covered services. An estimate for this "missing" piece of Medicaid costs (for the Medicaid portion of "blended services," and cross-over claims) is estimated above in Line 18.

Long-Term Care Services:

Line 44: Personal Attendant Services (non-HCBS STAR+PLUS Waiver): Enter all paid expenses related to the delivery of personal attendant services in the member's home for members that are not receiving HCBS STAR+PLUS Waiver services.

Line 45: DAHS – Adult Day Care Services: Enter all paid expenses related to Adult Day Care Services provided to a member-patient.

Line 46: Nursing Facility Services - daily rate: Enter all paid expenses related to Nursing Facility Services provided to a member-patient which are covered by Medicaid, and which are included in the facility's set per-day rate. (Exclude incremental amounts paid under MPAP; see Line 48 below.) Nursing facility expenses covered by Medicaid are generally 20% for days 21 through 100 (with the remaining 80% during that time being picked-up by Medicare), and then all eligible Covered Services expenses after 100 days.

Line 47: Nursing Facility Services – Add Ons: Enter all paid expenses related to Nursing Facility Add Ons which are covered by Medicaid, and which are excluded in the facility's set per-day rate. These are billed by the nursing facility in addition to the daily rate. Exclude incremental amounts paid under MPAP; see Line 48 below.

Line 48: Nursing Facility Services - MPAP only: Enter the incremental amounts paid to certain governmental nursing facilities, due to the MPAP program, which amounts are over and above what the Daily Rate and Add-Ons would have otherwise been. See also the information for Part 4, Line 37. Include the "base" amount (i.e., the amounts paid, excluding the MPAP incremental piece) paid to these facilities in Lines 46 and/or 47 above.

Line 49: Service Coordinator Direct Staff Services: Enter all salaries, fringe benefits and travel expenses associated with Service Coordinators who serve as Service Coordinators 100% of the time.

Line 50: HCBS STAR+PLUS Waiver Long-Term Care Services: Enter all paid expenses related to Home and Community-Based Services (HCBS) STAR+PLUS Waiver Long-Term Services provided to a member-patient. Services that are included in the Individual Service Plan for members who have qualified for the HCBS STAR+PLUS Waiver services should be reported on this line.

Line 51: approved Dual Flexible Benefits (LTC) - allocated from Ln 60: This is the amount input into Line 60 for Long-Term Care health services, allocated between Medicaid and Medicaid by the FSR.

Line 52: Provider Incentives or Network Risk Retention: Enter any incentives paid directly to LTSS providers, e.g., bonuses paid based on quality compliance measures.

Line 53: Incurred-But-Not-Reported (IBNR): Enter the total Medicaid LTSS expense accrual based on the IBNR Plan, 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. [See also Part 4, Lines 33 through 36.]

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

Line 54: Total Medicaid Long-Term Care Expenses: Calculated as the sum of Lines 44 through 53.

Line 55: **Total Medicaid Medical Expenses**: Calculated as the sum of Lines 43 and 54, combining Medicaid Acute Care and Long-Term Care (but excluding pharmacy).

Line 56: est. $ in above Medicaid total that are allocated between Medicare vs Medicaid: Enter the total of all amounts that you allocated within Line 55, Total Medicaid Medical Expenses, above, with the exception of any Flexible Benefits (all of which are allocated herein by the FSR). For example, if Line 55 totals $100,000, and, excluding Flexible Benefits, you had to allocate $17,000 of that (to split between Medicare and Medicaid), in determining the specific amounts to input above, then enter $17,000 here. These would primarily be amounts that you could not distinctly identify as being solely for Medicaid (nursing facility blended claims, etc.).

Line 57: Line Item #s above which contain such allocations: Enter the identifying Line item numbers (other than Flexible Benefits) from above that contain allocated amounts. List each applicable Line # from above. For example: #27, 32, 35, & 36.

Line 58: **Total Medicare and Medicaid Medical Expenses**: Calculated as the sum of Lines 24 and 55, combining all Dual Demo program Medical Expenses (excluding pharmacy).

For Medicare & Medicaid combined:

Line 59: approved Dual Flexible Benefits (Acute): Enter the expenses paid by the MMP for enrollee Acute Care healthcare services that are not Covered Services, and which have been approved in writing by HHSC/CMS as Dual Flexible Benefits under the Dual program. These expenses may not be discretely identifiable as Medicare vs Medicaid. Note: Do not include any costs here that are for items or services that are deemed to be “Incentives & Rewards” or “Value-Added Services” hereunder. See Line 78 below for Rewards & Incentives.

Line 60: approved Dual Flexible Benefits (LTC): Enter the expenses paid by the MMP for enrollee Long-Term Care healthcare services that are not Covered Services, and which have been approved in writing by HHSC/CMS as Dual Flexible Benefits under the Dual program. These expenses may not be discretely identifiable as Medicare vs Medicaid. Note: Do not include any costs here that are for items or services that are deemed to be “Incentives & Rewards” or “Value-Added Services” hereunder. See Line 78 below for Rewards & Incentives.

Line 61: total Flexible Benefits: Calculated as the sum of Lines 59 and 60 above.

Line 62: total Flexible Benefits, $-PMPM: Calculated as Line 61 above, divided by the total number of Member-Months, as found in Part 1, Line 1.

Line 63: total Flexible Benefits, as % of Revenues: Calculated as Line 61, divided by the total program net Revenues, as found in Part 1, Line 21.

Line 64: portion of Lines 59 & 60 that are allocated ($): If the MMP cannot discreetly identify all or some portion of the Flexible Benefits entered above in Lines 59 and 60 as either specifically for Acute, vs specifically for Long-Term Care, enter the amount out of the total that was allocated between Acute vs LTC. Enter the amount in dollars. If all of it is discretely identified, with no allocation between Acute and LTC, enter zero.

Included in Total Medical Above:

Line 65: Attendant Care Enhancement Payments: Enter the total amount paid to providers for attendant care enhancement payments (Medicare and Medicaid).

Line 66: Total Related Party Expenses: Enter the total amounts paid to any and all Affiliates of the MMP (as defined in the HHSC Cost Principles) wherein such costs are included, directly or indirectly, in Line 58, Total Medicare and Medicaid Medical Expenses, above. This would include hospitals under common ownership with the MMP, affiliated vision services or behavioral health services, affiliated reinsurance, coordination of care, health clinics, emergency centers, nursing facilities, physician groups, and diagnostic or specialty services (such as x-ray, blood work, colonoscopy, labs, chemotherapy, physical therapy, counseling, rehabilitation, DME supplies, and similar), etc.

Line 67: % of Medical Expenses that are Related Party: Calculated as Line 66, “Total Related Party Expenses,” divided by Line 58, “Total Medicare and Medicaid Medical Expenses.”

Line 68: Capitated Services: PCPs & Hospitals: Enter the total capitation paid to providers that do not pay claims to other providers from the capitation payments received.

Line 69: 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.

Line 70: difference (error) between Part 4 & Part 5: Calculated by summing the total paid capitation (MMP payments to certain providers which are subcontracted on a capitated, rather than fee-for-service, basis) from Part 4, Lines 8 and 28 (both Medicaid and Medicare), as input by risk group by the MMP in Part 4, and then subtracting from that the total paid capitation as input by service type by the MMP in Part 5 (Lines 68 and 69). If there is a non-trivial amount here, it means that what the MMP has input with respect to paid capitation payments to providers is internally inconsistent. The MMP should fix any material difference on this line before submitting the FSR.

Line 71: Total Capitated Services (per Part 4): Populated from Part 4 (adding Lines 8 and 28).

Other:

Line 72: Behavioral Health Services $PMPM: Calculated as the sum of Lines 9 and 35, “Behavioral Health Services,” for Medicare and Medicaid, respectively, divided by Part 1, Line 1, “# of Member Months (per Medicaid).”

Line 73: Vision Services $PMPM: Calculated as the sum of Lines 10 and 36, "Vision Services," for Medicare and Medicaid, respectively, divided by Part 1, Line 1, "# of Member Months (per Medicaid)."

Line 74: Emergency Room as a % of Acute Care Medical Expenses: Calculated as the sum of Lines 5 and 31, "Emergency Room Services" (for Medicare and Medicaid, respectively), divided by the sum of Lines 17 and 43, "Total Acute Care Expenses," (for Medicare and Medicaid, respectively), excluding the sum of Lines 12 through 16 on the Medicare side, and Lines 38 through 42 on the Medicaid side. This denominator takes total Medicaid and Medicare Acute Care medical expenses (excluding pharmacy) and removes Reinsurance Premiums, Reinsurance Recoveries, IBNR, Provider Incentives/Network Risk Retention, and Flexible Benefits.

Line 75: IBNR as % of total Medical Expenses: Calculated by summing the IBNR for each of Acute Care and Long-Term Care, for both Medicare and Medicaid, and dividing this total Program IBNR by total Program Medicare and Medicaid Medical Expenses (excluding pharmacy). This is the sum of Lines 15, 22, 40, and 53, divided by Line 58.

Line 76: % of Medical Expenses allocated between Medicare & Medicaid: Calculated as the sum of Lines 25 and 56, divided by Line 58. This sums the amounts input by the MMP as "Portion of above total which is allocated" (between Medicare and Medicaid), for each of Medicare and Medicaid, and divides it by the total Program Medical Expenses (excluding pharmacy).

Line 77: Provider Incentives / Network Risk Retention - $ allocated: From the total of Lines 16, 42, & 52 above, enter the portion (in dollars) that had to be allocated between Medicare vs Medicaid (as opposed to being discretely identifiable to these classifications). If the MMP allocated none of it, enter zero; if the MMP allocated all of it (in order to obtain the split between Medicare vs Medicaid, etc.), enter the total of those three Lines; otherwise, enter the portion of that total for which it was necessary to utilize allocations in order to make this split out.

Not Included in Total Medical Above:

Line 78: Rewards & Incentives: Enter the expenses paid by the MMP for certain services, gift cards, and items provided to enrollees that are not Covered Services, and which are not approved as Flexible Benefits, but which have been approved in writing as official "Rewards and Incentives" by HHSC/CMS. These items are not covered by Capitation payments nor reimbursed by HHSC or CMS. These expenses are the financial responsibility of the MMP. They are not included in "Total Medical Expenses" or Administrative Expenses in the MCO FSR, and are not deemed to be Allowable Costs under the Cost Principles.

Balancing Parts 4 & 5 Medical Expense input:

Lines 79 and 80: Beneath Line 78, in the non-printed area of the spreadsheet, there are balancing lines which compare "Total Medical Expenses," separately for each of Medicare and Medicaid, as entered in Part 4 (which is the sum of Lines 4, 8, 12, 16 and 20 for Medicare, and, Lines 24, 28, 32, 36, 37, and 41 for Medicaid), to the Medicare and Medicaid subtotals on Part 5 (which is Line 24 for Medicare, and Line 55 for Medicaid).

If, for Medicare, the Part 4 amounts do not tie to the Medicare amount in Part 5, then the two parts do not balance for what the MMP has input for Medicare. Likewise, if for Medicaid, the Part 4 amounts do not tie to the Medicaid amount on Part 5, then the two parts do not balance for what the MMP has input for Medicaid.

Part 4 has what the MMP input for medical expenses by risk group by "expense class" (e.g., FFS vs capitated, etc.), while Part 5 has what the MMP input for medical expenses by service type (e.g., physician

services, ER, outpatient, etc.). These Part 4 and Part 5 amounts, which are different slices of the same data, have to add up to the same total. If they do not, for either Medicare or Medicaid, the "Check" line will show "Not balanced" and a rounding adjustment may be entered in the shaded area labeled "Balance" (Line 79 for Medicaid, or Line 80 for Medicare). Any rounding adjustment entered should be a trivial amount; otherwise, Parts 4 and 5 are not in balance, which needs to be fixed by the MMP before the FSR is submitted.

Part 6: Prescription Expense by Risk Group

Medicare Prescription Data

Prescription Expense (excluding PBM Admin):

Lines 1 through 3: Medicare Prescription Paid Claims Expense (by risk group): Enter the Medicare prescription expense by risk group, as incurred by the MMP, based on Pharmacy Encounters. Exclude PBM admin fees. While the CMS payment files do not categorize members into these three risk groups with respect to Medicare expenditures, nevertheless, all these members are in one of these three risk groups with respect to Medicaid, so a given Member's risk group should be attributable.

Line 4: Total Medicare Prescription Paid Claims Expense: Calculated as the sum of Lines 1 through 3. Excludes the impact of IBNR and TPL, and excludes PBM Admin costs.

Line 5: IBNR related to Medicare Prescriptions: Enter the estimated dollar amount of Medicare pharmacy prescriptions incurred for which claims have not been received.

Note: "TPL pay & chase collected" does not apply to the Dual Program. Anyone with any sort of third-party insurance is not eligible to be in the Dual Demo Program, so there could be no third party recoveries.

Line 6: Total Medicare Prescription Expense (excluding PBM Admin): Calculated as the sum of Lines 4 and 5. Includes the impact of IBNR.

Medicare Prescription Expense $PMPM:

Lines 7 through 9: Medicare Prescription Expense $PMPM (by risk group): Calculated as Medicare Prescription Expense for each risk group as reported on Lines 1 through 3, divided by the corresponding "Member Months (per Medicare)" for each risk group as reported on Part 3, Lines 1 through 3.

Line 10: Medicare Prescription Paid Claims Expense $PMPM: Calculated as Line 4, "Total Medicare Prescription Paid Claims Expense," divided by Part 3, Line 4, "Total Member Months (per Medicare)."

Line 11: Medicare Prescription Expense including IBNR $PMPM: Calculated as the sum of Line 4, "Total Medicare Prescription Paid Claims Expense," and Line 5, "IBNR related to Medicare Prescriptions," divided by Part 3, Line 4, "Total Member Months (per Medicare)."

Medicare # of Prescriptions:

Lines 12 through 14: # of Prescriptions (by risk group): Enter the number of Medicare prescriptions filled for each risk group per month, corresponding to the paid claims dollars entered in Lines 1 through 3 above.

Line 15: # of Medicare Prescriptions in IBNR (Line 5 above): Enter the estimated number of Medicare prescriptions incurred for which claims have not been received. This should correspond to the dollar amount of IBNR entered in Line 5 above.

Line 16: Total # of Medicare Prescriptions: Calculated as the sum of Lines 12 through 15. Includes the estimated quantity of Rx's in IBNR.

Cost per Medicare Prescription (excluding PBM Admin):

Lines 17 through 19: Cost per Medicare Prescription (excluding PBM Admin) (by risk group): Calculated as Medicare paid claims Prescription Expense for each risk group as reported in Lines 1 through 3, divided by the corresponding "Medicare # of Prescriptions" for each risk group as reported on Lines 12 through 14. Excludes IBNR.

Line 20: Average Cost of Paid Claims per Medicare Prescription: Calculated by dividing Line 4, "Medicare Prescription Paid Claims Expense," by the sum of the total "# of Medicare Prescriptions" in Lines 12 through 14. (Paid claims exclude IBNR.)

Line 21: IBNR related to Medicare Prescriptions: Calculated by dividing Line 5, "IBNR related to Medicare Prescriptions," by Line 15, "# of Medicare Prescriptions in IBNR."

Line 22: Average Cost per Medicare Prescription (excluding PBM Admin): Calculated as Line 7, "Medicare Prescription Expense (excluding PBM Admin)," divided by Line 17, "Total # of Medicare Prescriptions." This average includes the impact of IBNR.

# of Medicare Prescriptions per Member-Month:

Lines 23 through 25: # of Medicare Prescriptions per Member-Month (by risk group): Calculated as "# of Medicare Prescriptions" for each risk group as reported on Lines 12 through 14: divided by the corresponding number of "Member Months" for each risk group as reported on Part 3, Lines 1 through 3.

Line 26: Average # of Paid Prescriptions per Member-Month: Calculated as the sum of Lines 12 through 14 (# of Medicare Prescriptions), divided by Part 3, Line 4, "Total Member Months." This excludes IBNR.

Line 27: Average # of Prescriptions per Member-Month including IBNR: Calculated as Line 16, "Total # of Medicare Prescriptions," divided by Part 3, Line 4, "Total Member Months."

Medicare Generic Split for Paid Prescriptions:

Line 28: % Generic, by # of Prescriptions: Enter the % of Medicare prescriptions (percentage as calculated by quantity of Rx's, not dollars) filled with generic (i.e., not brand) prescriptions. This should be determined by dividing the quantity of generic Medicare Rx's by the total quantity of Medicare Rx's (where the total quantity is as represented by the sum of Lines 12 through 14 above).

Line 29: % Generic, by Aggregate $ Paid Claims Cost: This is as in Line 28 above, only using aggregate dollars rather than quantities. Enter the % of the Medicare Rx paid claims expense

shown in Line 4 above that is associated with generic prescriptions. (This percentage would not take into account any subsequent rebates received directly by the government from drug companies, etc.)

Medicare Rx Premiums vs Costs:

Line 30: Medicare Rx Premiums (aggregate $): This is populated from Part 1, Line 7, and represents all Medicare Part D premiums and adjustments paid by CMS to the MMP.

Line 31: Medicare Rx Costs, excluding PBM Admin: This is populated from Line 6 above; it includes IBNR.

Line 32: Medicare pro rata share of PBM Admin: PBM Admin costs are allocated by the FSR between Medicare and Medicaid, according to proportional dollars of drug spend by Medicare vs Medicaid. PBM Admin is entered by the MMP in Part 7, Lines 21 through 23.

Line 33: Income / (Loss) on Medicare Rx - aggregate $: Medicare Part D pharmacy premiums paid to the MMP by CMS (including retroactive adjustments), less Medicare prescription costs incurred by the MMP, less pro rata PBM Admin costs. Calculated as Line 30 minus Lines 31 and 32.

Line 34: Income / (Loss) on Medicare Rx - %: The Medicare prescription Income/(Loss) to the MMP as above, as a percentage of the total net Medicare Part D premiums paid to the MMP. Calculated as Line 33 divided by Line 30.

Line 35: Income / (Loss) on Medicare Rx - $PMPM: The aggregate Medicare prescription Income/(Loss) to the MMP as above, divided by the total number of Medicare Member-Months; this represents the Income/(Loss) per Member-Month. Calculated as Line 33 divided by Part 3, Line 4.

Line 36: Medicare % Prescription Cost (including PBM Admin) to Rx (Prescription) Premium: This measure includes PBM Admin costs, and is an indication of the adequacy of the rates paid for Medicare pharmacy (or, alternately, an indication of an MMP's ability to provide appropriate pharmacy within the rates established). It is effectively all Medicare pharmacy costs incurred by the MMP, divided by all Medicare pharmacy premiums paid by CMS. A ratio under 100% implies that premiums covered costs, with some funds leftover for profit; a ratio above 100% implies that premiums did not cover costs. Calculated as the sum of Line 31 "Medicare Rx Costs, excluding PBM Admin" and Line 32 "Medicare pro rata share of PBM Admin," divided by Line 30, "Medicare Rx Premiums." Note that the Medicare Pharmacy premiums paid by CMS to the MMP included in this calculation should include all Medicare Part D payments, including risk adjustments, retroactive payments, etc. While this number is initially based on MMP self-reported data, it is subject to audit.

Medicaid Prescription Data

Prescription Expense (excluding PBM Admin):

Lines 37 through 39: Medicaid Prescription Paid Claims Expense (by risk group): Enter the Medicaid prescription expense by risk group, as incurred by the MMP, based on Pharmacy Encounters. Exclude PBM admin fees.

Line 40: Total Medicaid Prescription Paid Claims Expense: Calculated as the sum of Lines 37 through 39. Excludes the impact of IBNR and TPL, and excludes PBM Admin costs.

Line 41: IBNR related to Medicaid Prescriptions: Enter the estimated dollar amount of Medicaid pharmacy prescriptions incurred for which claims have not been received.

Note: "TPL pay & chase collected" does not apply to the Dual Program. Anyone with any sort of third-party insurance is not eligible to be in the Dual Demo Program, so there could be no third party recoveries.

Line 42: Total Medicaid Prescription Expense (excluding PBM Admin): Calculated as the sum of Lines 40 and 41. Includes the impact of IBNR.

Medicaid Prescription Expense $PMPM:

Lines 43 through 45: Medicaid Prescription Expense $PMPM (by risk group): Calculated as Medicaid Prescription Expense for each risk group as reported on Lines 37 through 39, divided by the corresponding "Member Months (per Medicaid)" for each risk group as reported on Part 3, Lines 21 through 23.

Line 46: Medicaid Prescription Paid Claims Expense $PMPM: Calculated as Line 40, "Total Medicaid Prescription Paid Claims Expense," divided by Part 3, Line 24, "Total Member Months (per Medicaid)." "Paid Claims" excludes IBNR.

Line 47: Medicaid Prescription Expense including IBNR, $PMPM: Calculated as the sum of Line 40, "Total Medicaid Prescription Paid Claims Expense," and Line 41, "IBNR related to Medicaid Prescriptions," divided by Part 3, Line 24, "Total Member Months (per Medicaid)."

Medicaid # of Prescriptions:

Lines 48 through 50: # of Prescriptions (by risk group): Enter the number of Medicaid prescriptions filled for each risk group per month, corresponding to the paid claims dollars entered in Lines 37 through 39 above.

Line 51: # of Medicaid Prescriptions in IBNR (Line 5 above): Enter the estimated number of Medicaid prescriptions incurred for which claims have not been received. This should correspond to the dollar amount of IBNR entered in Line 41 above.

Line 52: Total # of Medicaid Prescriptions: Calculated as the sum of Lines 48 through 51. Includes the estimated quantity of Rx's in IBNR.

Cost per Medicaid Prescription (excluding PBM Admin):

Lines 53 through 55: Cost per Medicaid Prescription (excluding PBM Admin) (by risk group): Calculated as Medicaid paid claims Prescription Expense for each risk group as reported in Lines 37 through 39, divided by the corresponding "Medicaid # of Prescriptions" for each risk group as reported on Lines 48 through 50.

Line 56: Average Cost of Paid Claims per Medicaid Prescription: Calculated by dividing Line 40, "Medicaid Prescription Paid Claims Expense," by the sum of the total "# of Medicaid Prescriptions" in Lines 48 through 50.

Line 57: IBNR related to Medicaid Prescriptions: Calculated by dividing Line 41, "IBNR related to Medicaid Prescriptions," by Line 52, "# of Medicaid Prescriptions in IBNR."

Line 58: Average Cost per Medicaid Prescription (excluding PBM Admin): Calculated as Line 42, "Medicaid Prescription Expense (excluding PBM Admin)," divided by Line 52, "Total # of Medicaid Prescriptions." This average includes the impact of IBNR.

# of Medicaid Prescriptions per Member-Month:

Lines 59 through 61: # of Medicaid Prescriptions per Member-Month (by risk group): Calculated as "# of Medicaid Prescriptions" for each risk group as reported on Lines 48 through 50: divided by the corresponding number of "Member Months" for each risk group as reported on Part 3, Lines 21 through 23.

Line 62: Average # of Paid Prescriptions per Member-Month: Calculated as the sum of Lines 48 through 50 (# of Medicaid Prescriptions), divided by Part 3, Line 24, "Total Member Months." This excludes IBNR.

Line 63: Average # of Prescriptions per Member-Month including IBNR: Calculated as Line 52, "Total # of Medicaid Prescriptions," divided by Part 3, Line 24, "Total Member Months."

Medicaid Generic Split for Paid Prescriptions:

Line 64: % Generic, by # of Prescriptions: Enter the percentage of Medicaid prescriptions (by quantity, not dollars) filled with generic (i.e., not brand) prescriptions. This should be determined by dividing the quantity of generic Medicaid Rx's by the total quantity of Medicaid Rx's (where the total quantity is as represented by the sum of Lines 48 through 50 above).

Line 65: % Generic, by Aggregate $ Paid Claims Cost: This is as in Line 64 above, only using aggregate dollars rather than quantities. Enter the percentage of the Medicaid Rx paid claims expense shown in Line 40 above that is associated with generic prescriptions. (This percentage would not take into account any subsequent rebates received directly by the government from drug companies, etc.)

Medicaid Rx Premiums vs Costs:

Line 66: Medicaid Rx Premiums (aggregate $): This is populated from Part 1, Line 14, and represents all Medicaid pharmacy premiums that would be paid by HHSC to the MMP, without any adjustment due to any withholding or recoupment under the Quality Withhold Program (QWP).

Line 67: Medicaid Rx Costs, excluding PBM Admin: This is populated from Line 42 above; it includes IBNR.

Line 68: Medicaid pro rata share of PBM Admin: PBM Admin costs are allocated by the FSR between Medicare and Medicaid, according to proportional dollars of drug-spend by Medicare vs Medicaid. PBM Admin is entered by the MMP in Part 7, Lines 21 through 23.

Line 69: Income / (Loss) on Medicaid Rx - aggregate $: Medicaid pharmacy premiums paid to the MMP by HHSC (excluding any QWP impact), less Medicaid prescription costs incurred by the MMP, less pro rata PBM Admin costs. Calculated as Line 66 minus Lines 67 and 68.

Line 70: Income / (Loss) on Medicaid Rx - %: The Medicaid prescription Income/(Loss) to the MMP as above, as a percentage of the total Medicaid pharmacy premiums as would be paid to the MMP before any QWP adjustment. Calculated as Line 69 divided by Line 66.

Line 71: Income / (Loss) on Medicaid Rx - $PMPM: The aggregate Medicaid prescription Income/(Loss) to the MMP as above, divided by the total number of Medicaid Member-Months; this

represents the Income/(Loss) per Member-Month. Calculated as Line 69 divided by Part 3, Line 24.

Line 72: Medicaid % Prescription Cost (including PBM Admin) to Rx (Prescription) Premium: This measure includes PBM Admin costs, and is an indication of the adequacy of the rates paid for Medicaid pharmacy (or, alternately, an indication of an MMP's ability to provide appropriate pharmacy within the rates established). It is effectively all Medicaid pharmacy costs incurred by the MMP, divided by the Medicaid pharmacy premiums that would paid by HHSC before any QWP adjustments. A ratio under 100% implies that premiums covered costs, with some funds leftover for profit; a ratio above 100% implies that premiums did not cover costs. Calculated as the sum of Line 67 "Medicaid Rx Costs, excluding PBM Admin" and Line 68 "Medicaid pro rata share of PBM Admin," divided by Line 66, "Medicaid Rx Premiums." While this number is initially based on MMP self-reported data, it is subject to audit.

Medicare & Medicaid combined:

Line 73: Income / (Loss) on all Rx - aggregate $: This combines Medicare and Medicaid prescription premiums, and subtracts combined pharmacy costs, including PBM Admin. This is the total Program pre-tax income, or loss, on pharmacy. Calculated here as Line 33, Income / (Loss) on Medicare Rx - aggreg $, plus Line 69, Income / (Loss) on Medicaid Rx - aggreg $.

Line 74: Income / (Loss) on all Rx - %: This is the above total Program pharmacy income/(loss), expressed as a percentage of total Program pharmacy premiums paid to the MMP by CMS and HHSC. Calculated here as Line 73 divided by the sum of Line 30, Medicare Rx Premiums, and Line 66, Medicaid Rx Premiums, above.

Line 75: Income / (Loss) on all Rx - $PMPM: This is the above total Program pharmacy income/(loss), expressed as a dollars per Member per month amount. Calculated here as Line 73 divided by Part 3, Line 24, Total Member Months.

Line 76: Pharmacy-administered vaccines: Enter the dollar amount included within Lines 4 and 40 "Prescription Paid Claims Expense" which is associated with vaccines administered at a pharmacy.

Line 77: last date of actual pharmacy payments: Please 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" Lines 4 and 40 above. This date will be used in the Pharmacy Reconciliation Report. This date entry will be replaced each time the FSR is re-submitted (for each Quarterly version, etc.).

Part 7: Dual Demo Program Administrative Expenses

Part 7: Dual Demo Program Administrative Expenses modified by Version 2.1

See **Cost Principles for Expenses**, Chapter 6.1 of the Uniform Managed Care Manual, for Allowable administrative expenses. Include only administrative expenses that are directly or indirectly in support of the Texas Medicaid service delivery area operations of the MMP. For all expenses other than depreciation, include only paid administrative expenses in the final FSR.

Note: All expenses included in Part 7 of this FSR must be excluded from the Consolidated Admin FSR that is for other Programs. Only input those Admin expenses in this FSR that are attributable to the Dual Demo Program. Make sure that no Admin expenses that are attributable to the Dual Demo Pro-

gram are included in the separate FSR that represents the Consolidate Admin FSR for all other HHSC managed care Programs. Also note that this is *not* simply the Admin expenses for handling all beneficiaries that are dually-eligible; the "duals" that are in the STAR+PLUS Program (as opposed to being in the MMP Duals Demo) would not be included here or in this FSR in general.

This Dual FSR should include no expenses incurred prior to 3/1/2015, and no pre-implementation expenses.

There are many types of costs recognized as legitimate by the IRS and by Generally Acceptable Accounting Principles (GAAP) that are unallowable for inclusion in this Financial Statistical Report (FSR); details are in the Cost Principles. Such costs are not allowed for inclusion either directly, or indirectly via blended amounts in Affiliate assessments, etc.

Some of the common types of costs that are not allowed to be reported in the FSR include (but are not limited to): interest expense; income taxes (federal, state, or local), including state franchise taxes; bad debt expense; contributions and donations; lobbying; royalty fees and franchise fees; Liquidated Damages and Experience Rebates; markups, add-ons, margin, or profits by Affiliates; entertainment; alcoholic beverages; fines, penalties, damages, and settlements; bond issuance cost amortization, and bond discounts; provision for contingent reserves; cost of capital; defense or prosecution of criminal proceedings, civil proceedings, and claims; investment management costs; loss on disposition of property; costs of memberships, dues and expenses associated with country club and fraternal organizations; political contributions; proposal preparation costs; and, airfare costs in excess of standard coach class. See the Cost Principles for more complete information.

Enter the appropriate amounts of contract-defined Allowable Costs on the following lines.

Line 1: Salaries, wages, and benefits, excl. bonuses: Enter amounts incurred as salary, wages, or benefits to employees and other staff. Include Temps, Part-time staff, and non-employee staff that are paid as independent contractors. Include payroll taxes and overtime. Also include reimbursement of employee relocation expenses and professional licensing fees such as RNs and CPAs. Exclude bonuses, and the payroll taxes on bonuses.

Line 2: Bonuses: Include bonuses and the payroll taxes on bonuses, and any associated gross-ups.

Line 3: Rent, Lease, or Mortgage Payment for Office Space: Enter rent paid for space used by the MMP.

Line 4: Utilities (if not incl. in rent), excluding Phone/Telecom: Enter payments for utility services used by the MMP.

Line 5: Phone / Telecom / Cell phones / T1 / Broadband: Enter the monthly operating expense, but do not include hardware purchases, or software.

Line 6: Equipment Lease or Rent, excluding Phone/Telecom: Enter monthly operating leases or rental payments.

Line 7: Computer Hardware/Software purchased, un-capitalized: Enter computer hardware and software purchases (including licenses) which by their nature or amount were not eligible for depreciation. See HHSC's Cost Principles for rules regarding capitalized items.

Line 8: Furniture, Fixtures, and other Equipment purchased, un-capitalized: Enter furniture, fixture or equipment purchases that by their nature or amount were not eligible for depreciation.

Line 9: Maintenance, Repairs, Custodial, and Security: Enter expenses paid for maintenance, repairs, custodial and security services. Exclude salaries, wages, etc., that would otherwise be included in Line 1 above.

Line 10: Supplies, Postage, Freight, Printing: Enter amounts paid for supplies, postage, freight, and printing services.

Line 11: Legal & Professional Services, including External Audit, Tax, Consulting: Enter the cost of professional or consulting services rendered by persons or organizations that are members of a particular profession or possess a special skill.

Line 12: Travel Expenses: Enter the direct cost for transportation, lodging, subsistence, etc. incurred by employees traveling on official business specifically related to an HHSC program.

Line 13: Marketing, PR, and Outreach (excluding Salaries): Enter paid cost of marketing, public relations, and outreach. Exclude any salaries, wages, etc., that would otherwise be included in Line 1 above.

Line 14: Taxes (excluding income taxes & premium taxes) & Licensing: Enter all applicable taxes and licensing expenses; exclude Income Taxes, Premium Taxes, and Maintenance Taxes.

Line 15: Insurance: Enter paid insurance premiums; exclude any reinsurance premiums.

Line 16: Depreciation & Amortization: Enter applicable depreciation and amortization charges for the period.

Line 17: Other Administrative Expenses: Enter all other expenses not specifically identified in the above administrative expense classifications. These (along with all costs herein) must be Allowable Costs, per the Cost Principles.

Line 18: Subtotal (specified in-house services): Calculated as sum of lines 1 through 17.

Line 19: Outsourced Services (Non-Capitated Arrangements): Enter all outsourced services not paid under a capitated arrangement, e.g., Third-Party Administrator (TPA).

Line 20: Outsourced Services (Capitated Arrangements): Enter the administrative component of the capitated subcontract in which the capitation is the funding source for paying claims for health care services performed. Example: Behavioral Health (BH), Vision.

Line 21: PBM Admin Fees – Fees based on $PMPM: Enter the expenses associated with the administration of pharmacy services provided by a Pharmacy Benefit Manager (PBM) which are calculated and billed by the PBM based on some per member per month basis (i.e., those PBM admin costs wherein the PBM's billed amounts to the MMP are based on the quantity of Members).

Line 22: PBM Admin Fees – Fees based on transaction volume: Enter the expenses associated with the administration of pharmacy services provided by a Pharmacy Benefit Manager (PBM) which are calculated and billed by the PBM based on the basis of a specified charge per transaction. Examples would include set fees per Rx, or per certain service performed.

Line 23: PBM Fees – Other: Enter the expenses associated with the administration of pharmacy services provided by a Pharmacy Benefit Manager (PBM) under an arrangement other than a

$PMPM or transaction volume based arrangement. Examples might include specified amounts per month (irrespective of membership level or transaction level), etc.

Line 24: Corporate Allocations: Enter expenses allocated, assessed, or billed by the parent or other Affiliate to the MMP. Note that corporate allocations here cannot include any cost that, if it were an unallocated cost incurred directly by the MMP, would be an unallowable cost, per the HHSC Cost Principles. Thus, among other things, these allocations cannot include any pro rata amounts or assessments including or representing interest expense, income taxes, Experience Rebates, lobbying costs, donations, contributions, liquidated damages, mark-ups, Affiliate margin or profit, entertainment, event tickets, alcohol, country club dues, golfing or similar costs, private aircraft expense or flight tickets in excess of the cost of standard coach fare, and, most fines and penalties, etc.

Line 25: Total HHSC MMP Dual Demo Administrative Expenses: Calculated as sum of lines 18 through 24 above. Note that this should not include any administrative expenses that pertain to the STAR+PLUS Program.

Line 26: Admin % to Net Revenues: Calculated as Line 25 (Total HHSC MMP Program Admin Expenses) divided by Part 1, Line 21, Net Revenues. This is the calculated Dual Program Admin rate reported by the MMP (expressed as a percentage).

Line 27: Admin $-PMPM: Calculated as Line 25 (Total HHSC MMP Program Admin Expenses) divided by Part 1, Line 1, # of Member-Months. This is the calculated Admin Dual Program Admin rate reported by the MMP, expressed in cost per member, per month.

Already Included in Total Administrative Above:

Line 28: Amount that is directly tied to TX MMP (without allocation): Enter the portion of the amount shown in Line 25, Total HHSC MMP Dual Demo Administrative Expenses, which is directly attributable to the HHSC Dual Demo Program, without need to allocate. Enter this amount in dollars. Examples would be salaries of staff that only work on the HHSC Dual Demo Program, or Marketing/Outreach that was specifically for the HHSC Dual Demo Program, etc.

Line 29: Outsourced Services (Non-Capitated Arrangements): Identify each vendor included in Line 19 of this part. Include the SFY YTD dollar amount associated with each. This may be abbreviated to the nearest thousand dollars, if clearly shown (example, “Acme Services, $4K”).

Line 30: Outsourced Services (Capitated Arrangements): Identify each vendor included in Line 20 of this part. Include the SFY YTD dollar amount associated with each. This may be abbreviated to the nearest thousand dollars, if clearly shown (example, “Acme BH Services, $4K”).

Data Certification Form

General Instructions:

1. The Data Certification Form must be submitted with the FSR Reports, and it must be signed by the MMP’s CEO, CFO, or equivalent. This sign-off may not be delegated.
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/MMP, document name, period-ending date, date of submission, state fiscal year (SFY), Program name, and service area (county) will populate from header information entered in Part 1.

Enter the following:

Data Field 9: Name & title – Type or print the name and title of the person signing the Certification.

Data Field 11: Signature – Sign the Certification.

Data Field 12: Date signed – Enter the date the form is signed (without using a formula).

Free tab

The last tab in the spreadsheet is blank, unprotected, and optional. This does not have to be used in any way. However, some firms using HHSC's FSRs have found that it is very handy to have a place to do a data dump, in their own format, and then link cells inside the other FSR tabs to this scratch sheet. So you could pre-populate your own blank FSR such that your systems could dump your relevant data into the scratch sheet tab, and then much of the rest of the spreadsheet would get filled-out. It is a form of auto-mating it, to suit your own specific data format availability. You may want to try this at some point.