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Health and Human
Services

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DOCUMENT HISTORY LOG

STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
Baseline	2.0	June 1, 2021	Initial version Uniform Managed Care Manual Chapter 5.3.1.92, STAR Kids Financial Statistical Report (FSR) Instructions. Edits “FSR Page Headers” for uniformity amongst FSR Instructions. Adds Nonemergency Medical Transportation (NEMT) reporting lines to Parts 1, 4, and 5. This chapter applies to contracts issued as a result of HHSC RFP number 529-13-0071 and replaces Chapter 5.3.1.60 for reporting transactions occurring on or after September 1, 2020 for contracts impacted by implementation of HB 1576, 86 th Legislature, Nonemergency Medical Transportation (NEMT) Services, effective June 1, 2021.
Revision	2.0.1	August 1, 2021	Accessibility approved version.

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represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.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.



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Objective

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

General

MCOs must use this template beginning with the State Fiscal Year 2021 quarter 4 reporting. MCOs must complete all STAR Kids FSRs using the locked Microsoft Excel template provided by HHSC. Data integrity is critical to the automated compilation of the data. Do not alter the file name, sheet names, existing cell locations, or formatting of the data in the file and sheets. Do not add or delete any columns or rows. **Any deviations from the locked template will render the FSR unreadable by the software application and therefore unacceptable to HHSC.**

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

There can be no outside data links to MCO accounting systems or other sources.

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

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

FSR Page Headers

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

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

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

Submission Date: Enter the month, day, and year, e.g., 6/30/2017.

Submission Type: Select the type of FSR, (e.g., Q1; Q2; Q3; Q4; Year End + 90 Days; Year End + 334 Days) from the drop-down menu.

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

Rptg Period End Date: Enter the month, day, and year, e.g., 5/31/2017.

Part 1: Summary Income Statement

Line 1: Member Months: Referenced from Part 3, Line 24, “Total Member Months.”



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

Revenues:

Line 3: Medical Premiums: Referenced from Part 3, Line 8, “Total Medical Premiums.”

Line 4: Pharmacy Premiums: Referenced from Part 3, Line 32, “Total Pharmacy Premiums.”

Line 5: Investment Income: Enter all interest and dividend income resulting from investment of funds received from the state and federal governments under the Managed Care Contract.

Line 6: Health Insurance Providers Fee Reimbursement: Enter the amount of the Health Insurance Providers Fee, which was reimbursed by HHSC as required under the Affordable Care Act (ACA), including any gross up for corporate federal income tax and state premium taxes as applicable to the FSR for each Program/Service Area.

Line 7: Other Revenue: Enter all income generated from the STAR Kids Program for the Contract Service Area other than premiums (HHSC Capitation), Health Insurance Providers Fee Reimbursement, and Investment Income. Do not include direct claim reimbursements received from HHSC.

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

Line 9: Health Insurance Providers Fee & Related Costs: Enter the sum of:

- a) the amount paid to the IRS specifically and solely for the ACA Health Insurance Providers Fee, as required under the Affordable Care Act (ACA) and as attributable to the FSR (exclude any amounts accrued for ACA Health Insurance Providers Fee which were not paid during the FSR period);
- b) the increase in the amount incurred for corporate federal income taxes resulting from the Health Insurance Providers Fee Reimbursement which is attributable to the FSR.

Do not include any increase to Premium Taxes resulting from the Health Insurance Providers Fee Reimbursement in Line 10. All Premium Taxes incurred should be included in Line 12.

Maintain for FSR audit purposes the derivations supporting items a) and b) above.

Line 10: Premium Taxes: Enter the premium taxes incurred for premiums applicable to the reporting period including any additional taxes incurred as a result of the Health Insurance Providers Fee Reimbursement from HHSC.

Line 11: Maintenance Taxes: Enter the maintenance taxes incurred for premiums applicable to the reporting period.



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Line 12: Net Revenues: Calculated as Line 8, “Total Gross Revenues,” less the sum of Line 9, “Health Insurance Providers Fee & Related Costs,” Line 10, “Premium Taxes,” and Line 11, “Maintenance Taxes.”

Medical Expenses:

Line 13: Fee-For-Service: Referenced from Part 4, Line 8, “Total Paid Claims.”

Line 14: Capitated Services: Referenced from Part 4, Line 16, “Total Paid Capitation.”

Line 15: Patient Centered Medical Home Services: Referenced from Part 5, Line 12, “Patient Centered Medical Home Services.”

Line 16: Net Reinsurance Cost: Referenced from Part 4, Line 24, “Total Net Reinsurance.”

Line 17: IBNR Accrual – Medical: Referenced from Part 4, Line 32, “Total Medical IBNR.”

Line 18: Quality Improvement: Referenced from Part 5, the sum of Line 17 and Line 27.

Line 19: Other Medical Expenses: Referenced from Part 4, Line 57, “Total Other Medical Expenses.”

Line 20: NEMT Expenses: Referenced from Part 4, Line 49, “Total NEMT Expenses.”

Line 21: Total Medical Expenses: Calculated as sum of Lines 13 through 20 above.

Line 22: Prescription Expenses (excluding PBM Admin): Referenced from Part 6, Line 11, “Prescription Expense (excluding PBM Admin).”

Line 23: Total Medical and Prescription Expenses: Calculated as sum of Line 21, “Total Medical Expenses,” and Line 22, “Prescription Expenses (excluding PBM Admin).”

Line 24: Administrative Expenses: Enter the allocated “Administrative Expenses” from the Admin FSR, Part 2, Line 69, by the applicable Program/Service Area.

Line 25: Total Expenses: Calculated as sum of Line 23, “Total Medical and Prescription Expenses,” and Line 24, “Administrative Expenses.”

Line 26: Net Income Before Taxes: Calculated as Line 12, “Net Revenues,” minus Line 25, “Total Expenses.”

Line 27: % Medical Exp to Net Revenues: Calculated as Line 21, “Total Medical Expenses,” divided by Line 12, “Net Revenues.”

Line 28: % Prescription Exp to Net Revenues: Calculated as Line 22, “Prescription Expenses (excluding PBM Admin),” divided by Line 12, “Net Revenues.”

Line 29: % Total Medical and Prescription to Net Rev. (MLR): Calculated as the sum of Line 27 “% Medical Exp to Net Revenues” and Line 28 “% Prescription Exp to Net Revenues.”



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Line 30: % Admin Exp to Net Revenues: Calculated as Line 24, “Administrative Expenses,” divided by Line 12, “Net Revenues.”

Line 31: % Net Income to Net Revenues: Calculated as Line 26, “Net Income Before Taxes,” divided by Line 12, “Net Revenues.”

Line 32: % Adj. Admin to Net Revenues (excludes taxes and Prescription pass through): Calculated as Line 24, “Administrative Expenses,” divided by the difference of Line 12, “Net Revenues,” less Line 4, “Pharmacy Premiums.”

Post-income items:

Line 33: Performance Assessment: Enter in the YTD cell the amount of the Pay for Quality (P4Q) performance assessment.

Part 2: Statistics

Line 1: Paid Medical Expenses Completion Factor: Calculated as the difference between Part 5, Line 29, “Total Medical Expenses,” and the sum of Part 5, Lines 15 and 26, “Incurred But Not Reported (IBNR),” divided by Part 5, Line 29, “Total Medical Expenses.”

Total Cost \$PMPM:

Line 2: MCO Admin Cost (including PBM Admin): Calculated as Part 1, Line 21, “Administrative Expenses,” divided by Part 1, Line 1, “Member Months.”

Line 3: Health Insurance Providers Fee & Related Costs: Calculated Part 1, Line 9, “Health Insurance Providers Fee & Related Costs,” divided by Part 1, Line 1, “Member Months.”

Line 4: Premium & Maintenance Taxes: Calculated as sum of Part 1, Line 10, “Premium Taxes,” and Part 1, Line 11, “Maintenance Taxes,” divided by Part 1, Line 1, “Member Months.”

Line 5: Medical Expenses, excl Net Reinsurance and Quality Improvement: Calculated as difference between Part 1, Line 20, “Total Medical Expenses,” and the sum of Part 1, Line 16, “Net Reinsurance Cost,” and Part 1, Line 18, “Quality Improvement,” divided by Part 1, Line 1, “Member Months.”

Line 6: Net Reinsurance: Calculated as sum of Part 5, Line 13, “Reinsurance Premiums,” and Part 5, Line 14, “Reinsurance Recoveries,” divided by Part 1, Line 1, “Member Months.”

Line 7: Quality Improvement: Calculated as Part 1, Line 18, “Quality Improvement,” divided by Part 1, Line 1 “Member Months”.

Line 8: Prescription Expenses (excluding PBM Admin): Calculated as Part 6, Line 11, “Prescription Expense (excluding PBM Admin),” divided by Part 1, Line 1, “Member Months.”



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Line 9: Subtotal: Calculated as sum of Lines 2 through 8.

Line 10: Profit/(Loss) before Experience Rebate: Calculated as Part 1, Line 25, “Net Income Before Taxes,” divided by Part 1, Line 1, “Member Months.”

Line 11: Total Cost \$PMPM to HHSC: Calculated as sum of Line 9 and Line 10.

Part 3: Medical and Pharmacy Premiums

Medical Premiums (HHSC Capitation):

Lines 1 through 7: Medical Premiums (HHSC Capitation): Each cell in this matrix is calculated and is the product of the corresponding capitation rate in the matrix of Lines 9 through 15 and the corresponding member months in the matrix of Lines 17 through 23.

Line 8: Total Medical Premiums: Calculated as sum of Lines 1 through 7

Medical Premium \$PMPM:

Lines 9 through 15: Medical Premium \$PMPM: Enter each risk group’s medical capitation rate.

Line 16: Total Medical Premium \$PMPM: Calculated as Line 8, “Total Medical Premiums,” divided by Line 24, “Total Member Months.”

Member Months:

Lines 17 through 23: Member Months: Enter the member months based on the supplemental files supporting HHSC’s monthly capitation payments to the MCO.

Line 24: Total Member Months: Calculated as sum of Lines 17 through 23

Pharmacy Premiums (HHSC Capitation):

Lines 25 through 31: Pharmacy Premiums (HHSC Capitation): Each cell in this matrix is calculated and is the product of the corresponding capitation rate in the matrix of Lines 33 through 39 and the corresponding member months in the matrix of Lines 17 through 23.

Line 32: Total Pharmacy Premiums: Calculated as sum of Lines 25 through 31

Pharmacy Premium \$PMPM:

Lines 33 through 39: Pharmacy Premium \$PMPM: Enter each risk group’s pharmacy capitation rate applicable to each month.

Line 40: Total Pharmacy Premium \$PMPM: Calculated as Line 32, “Total Pharmacy Premiums,” divided by Line 24, “Total Member Months.”

Part 4: Medical Expense by Expense Class

Paid Claims:

Lines 1 through 7: Paid Claims: Enter monthly paid claims by risk groups as incurred.



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Line 8: Total Paid Claims: Calculated as sum of Lines 1 through 7.

Paid Capitation:

Lines 9 through 15: Paid Capitation: Enter the total provider and subcontractor capitation payments by risk groups covered by the capitation payments.

Line 16: Total Paid Capitation: Calculated as sum of Lines 9 through 15

Paid Reinsurance Premiums, Net of Reinsurance Recoveries:

Lines 17 through 23: Paid Reinsurance Premiums, Net of Reinsurance Recoveries: Enter the paid reinsurance premiums net of collected reinsurance recoveries specific to each risk group the reinsurance coverage was effective. Report collected Reinsurance Recoveries by the appropriate risk group and by the incurred month of the services to which the recoveries relate.

Line 24: Total Net Reinsurance: Calculated as sum of Lines 17 through 23

Medical IBNR:

Lines 25 through 31: IBNR: Enter Incurred-But-Not-Reported (IBNR) estimate by risk group.

Line 32: Total Medical IBNR: Calculated as sum of Lines 25 through 31.

Patient Centered Medical Home Services:

Lines 33 through 39: Patient Centered Medical Home Services: Enter all medical expenses by risk group as incurred at a PCMH-approved facility.

Line 40: Total PCMH: Calculated as the sum of Lines 33 through 39.

Quality Improvement Cost:

Line 41: Quality Improvement: The sum of Part 5, Line 17, "Quality Improvement," and Part 5, Line 27, "Quality Improvement."

NEMT Expense:

Lines 42 through 48: NEMT Expenses: Enter all paid NEMT expenses for services rendered to a Member by risk group.

Line 49: Total NEMT Expenses: Calculated as the sum of Lines 42 through 48.

Other Medical Expenses:

Lines 50 through 56: Other Medical Expenses: Enter any other medical expenses or adjustments to medical expenses not captured by "Paid Claims," "Paid Capitation," "Reinsurance Premiums net of Recoveries," "IBNR," "Patient Centered Medical Home Services," or "Quality Improvement," for each risk group. Examples of these expenses include, but are not limited to: incentives paid directly to physicians, third party recoveries, other recoveries, or settlements that have not been captured through claims adjustments in the claims processing system, FQHC reimbursement received from



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HHSC, and refunds. Please note third party recoveries should be reported in the quarter in which cash is received. Do not enter recoveries in the quarter in which services were provided unless the collection occurred in that same quarter.

Also include certain pharmacy-related expenses that are not included in Part 6, “Prescription Expenses,” that cannot be processed as pharmacy encounters.

Pharmacy-related items that should be reported on the FSR under Part 4, “Other Medical Expenses,” 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 Expenses.”

Amounts reported in “Other Medical Expenses” for appropriate pharmacy DME should not have any PBM administrative expense included; all PBM Admin is to be reported in the Admin FSR.

Line 57: Total Other Medical Expenses: Calculated as sum of Lines 50 through 56.

Line 58: Other Medical Expenses: Identify each category of expense included in Lines 50 through 56, “Other Medical Expenses,” including the YTD dollar amount associated with each category of expense, if more than one.

Section Beneath Line 58: No action necessary. These lines populate with the member months’ data entered in Part 3.

Part 5: Medical Expenses by Service Type

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

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



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Component.” The amount paid covering all charges on a CMS-1500 claim is classified as PCP expense when the performing provider is the Member’s PCP.

Line 2: Physician Services: Specialist: Enter all paid expenses related to the medical care provided to a patient by a physician whose practice is limited to a particular branch of medicine or surgery, e.g., cardiology or radiology, in which a physician specializes or is certified by a board of physicians. Generally, a Member must have a referral authorized by his/her assigned PCP to receive services from a specialist.

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

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

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

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

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

The costs of emergency department ancillary services including laboratory services, radiology services, respiratory therapy services, and diagnostic studies, such as EKGs, CT scans, and supplies are also included on Line 5. Exclude non-staff attending or consulting physician billed separately as PCP or specialist services. The total amount



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paid by the MCO covering all charges on a UB04 claim that are incurred during an emergency room encounter are classified as “Emergency Room Services.” Any amounts paid for any charges on a UB04 claim that include emergency room services that were incurred on a different service date than the emergency room encounter are classified as “Outpatient Facility Services” unless they represent additional emergency room encounters.

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

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

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

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

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

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

- Bed and board in semiprivate accommodations or in an intensive care or coronary care unit including meals, special diets, and general nursing services; and an allowance for bed and board in private accommodations including meals, special diets, and general nursing services up to the hospital’s charge for its most prevalent semiprivate accommodations;
- Whole blood and packed red cells reasonable and necessary for treatment of illness or injury;



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- Newborn care including routine care and specialized nursery care for newborns with specific problems;
- Other inpatient services including organ/tissue transplant services and rehabilitation services; and
- All medically necessary services and supplies ordered by a physician.

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

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

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

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

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

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

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



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

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

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

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

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

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

Line 17: Quality Improvement: Enter a portion of the allocated "Quality Improvement Expenses" from the Quality Improvement FSR, Part 1b. Do not include any quality improvement costs reported on PCMH schedule.

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

Line 19: Total Acute Care Expenses: Calculated as sum of Lines 1 through 18.

Long-Term Care Services:

Line 20: Personal Care Services (PCS): Enter all paid expenses related to the delivery of medically and functionally necessary personal care services as specified on the Personal Care Assessment Module (PCAM).



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Line 21: Private Duty Nursing (PDN): Enter all paid expenses related to Private Duty Nursing Services provided to a Member-patient.

Line 22: MDCP Waiver Services: Enter all paid expenses related to services provided to a Member-patient under the MDCP Waiver.

Line 23: Community First Choice (CFC) Services: Enter all paid expenses related to Personal Assistance Services (PAS) or Habilitation (HAB).

Line 24: DAHS - Day Activity and Health Services: Enter all paid expenses related to Adult Day Care Services provided to a Member-patient.

Line 25: Misc. Other (PPECCs, ERS, Support Management): Enter all paid long-term care expenses for medical services and supplies rendered that are not classified in any of the medical expense classifications above. "Misc. Other" includes, but is not limited to, Prescribed Pediatric Extended Care Centers, Emergency Response Services (ERS), and Support Management provided to a Member-patient. LTSS which are included on the Individual Service Plan and are not reported elsewhere should be reported on this line.

Line 26: Incentives or Network Risk Retention: Enter any incentives paid directly to LTSS Providers, i.e., bonuses paid based on quality compliance measures.

Line 27: Incurred-But-Not-Reported (IBNR): Enter the total 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.

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 28: Quality Improvement: Enter a portion of the allocated "Quality Improvement Expenses" from the Quality Improvement FSR, Part 1b. Do not include any quality improvement costs reported on PCMH schedule.



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Line 29: Total Long-Term Care Expenses: Calculated as the sum of Lines 20 through 28.

Line 30: Total Medical Expenses: Calculated as the sum of Lines 19 and 29.

Beneath Line 30, there are balancing lines which compare “Total Medical Expenses” entered in Part 4, which is the sum of Lines 8, 16, 24, 32, and 40, 41, 49 and 57, to those on Part 5, Line 30. If the two parts do not balance the “Check” line will show “Not balanced” and a rounding adjustment may be entered in the shaded area labeled “Balance.”

Included in Total Medical Above:

Line 31: Attendant Care Enhancement Payments: Enter the total amount paid to providers for attendant care enhancement payments.

Line 32: Total Related Party Expenses: Enter the total medical expenses paid to any companies affiliated with the MCO through common ownership for providing healthcare services in support of the Texas Medicaid operations of the MCO.

Line 33: % of Medical Expenses that are Related Party: Calculated as Line 32, “Total Related Party Expenses,” divided by Line 30, “Total Medical Expenses.”

Line 34: Capitated Services: PCPs, Hospitals, and Other Providers: Enter the total capitation paid to providers that do not pay claims to other providers from the capitation payments received.

Line 35: Capitated Services: BH, Vision, etc.: Enter the total capitation paid to subcontractors in which the capitation is the funding source for paying claims for healthcare services performed in each Texas service area.

Not Included in Total Medical Above:

Line 36: Total Medical Value Added Services: Enter the expenses approved by HHSC and paid by the MCO for Medicaid Members’ services that are not covered under the HHSC Capitation nor reimbursed by HHSC. These expenses are the financial responsibility of the MCO. They are not included in “Total Medical Expenses” on the FSR. The specific Value Added Services are included in the Contract for Services between HHSC and MCO.

Line 37: Total Case-by-Case Services: Enter the expenses paid by the MCO for Medicaid Members’ additional benefits that are outside the scope of services covered under the Contract, and are not Value-Added Services. These expenses are the financial responsibility of the MCO. They are not included in “Total Medical Expenses” in the MCO FSR. Services may be based on Medical Necessity, cost-effectiveness, the wishes of the Member or the Member’s Legally Authorized Representative (LAR), or the potential for improved health status of the Member. The MCO must maintain documentation of each authorized service provided to each Member.



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Other:

Line 38: Behavioral Health Services \$PMPM: Calculated as Line 9, "Behavioral Health Services," divided by Part 1, Line 1, "Member Months."

Line 39: Vision Services \$PMPM: Calculated as Line 10, "Vision Services," divided by Part 1, Line 1, "Member Months."

Line 40: Emergency Room as a % of Medical Expenses: Calculated as Line 5, "Emergency Room Services," divided by Line 30, "Total Medical Expenses," excluding the sum of Lines 13 through 17, which are "Reinsurance Premiums," "Reinsurance Recoveries," "IBNR," "Incentives/Network Risk Retention,-" and "Quality Improvement"; and Lines 26 through 28, which are "Incentives or Network Risk Retention", "Incurred But Not Reported" and "Quality Improvement".

Part 6: Prescription Expense by Risk Group

Prescription Expense (excluding PBM Admin):

Lines 1 through 7: Prescription Expense (excluding PBM Admin): Enter the prescription expense by risk group based on Pharmacy Encounters. Exclude PBM admin fees.

Line 8: Prescription Paid Claims Expense: Calculated as sum of Lines 1 through 7.

Line 9: IBNR related to Prescriptions: Enter the estimated dollar amount of pharmacy prescriptions incurred for which claims have not been received.

Line 10: TPL pay & chase collected (related to Pharmacy only): Enter the dollars collected from third parties in the month in which cash is received. Do not enter recoveries in the month in which services were provided unless the collection occurred in that same month.

Line 11: Prescription Expense (excluding PBM Admin): Calculated as the sum of Lines 8 and 9, less Line 10.

Prescription Expense \$PMPM:

Lines 12 through 18: Prescription Expense \$PMPM: Calculated as "Prescription Expense" for each risk group as reported on Lines 1 through 7, divided by the corresponding "Member Months" for each risk group as reported on Part 3, Lines 17 through 23.

Line 19: Prescription Paid Claims Expense \$PMPM: Calculated as Line 8, "Prescription Paid Claims Expense," divided by Part 3, Line 24, "Total Member Months."

Line 20: Prescription Expense including IBNR \$PMPM: Calculated as the sum of Line 8, "Prescription Paid Claims Expense," and Line 9, "IBNR related to Prescriptions," divided by Part 3, Line 24, "Total Member Months."



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of Prescriptions:

Lines 21 through 27; # of Prescriptions: Enter the number of prescriptions filled by each risk group by month.

Line 28: # of Prescriptions in IBNR (Line 9 above): Enter the estimated number of prescriptions incurred for which claims have not been received.

Line 29; Total # of Prescriptions: Calculated as sum of Lines 21 through 28.

Cost per Prescription (excluding PBM Admin):

Line 30 through 36: Cost per Prescription (excluding PBM Admin): Calculated as “Total Prescription Expense” for each risk group as reported in Lines 1 through 7, divided by the corresponding “# of Prescriptions” for each risk group as reported on Lines 21 through 27.

Line 37: Average Cost of Paid Claims per Prescription: Calculated by dividing Line 8, “Prescription Paid Claims Expense,” by the total “# of Prescriptions” in Lines 21 through 27.

Line 38; IBNR related to Prescriptions: Calculated by dividing Line 9, “IBNR related to Prescriptions,” by Line 28, “# of Prescriptions in IBNR.”

Line 39: Average Cost per Prescription (excluding PBM Admin): Calculated as Line 11, “Prescription Expense (excluding PBM Admin),” divided by Line 29, “Total # of Prescriptions.”

Line 40: % Prescription Cost to Rx Premium: Calculated as Line 11, “Prescription Expense (excluding PBM Admin),” divided by Part 1, Line 4, “Pharmacy Premiums.”

of Prescriptions per Member-Month:

Lines 41 through 47: # of Prescriptions per Member-Month: Calculated as “# of Prescriptions” for each risk group as reported on Lines 21 through 27, divided by the corresponding “Member Months” for each risk group as reported on Part 3, Lines 17 through 23.

Line 48: Average # of Paid Prescriptions per Member-Month: Calculated as the sum of Lines 21 through 27, divided by Part 3, Line 24, “Total Member Months.”

Line 49: Average # of Prescriptions per Member-Month including IBNR: Calculated as Line 29, “Total # of Prescriptions” divided by Part 3, Line 24, “Total Member Months.”

Generic Split for Paid Prescriptions:

Line 50: % Generic, by # of Prescriptions: Enter the % of prescriptions filled with generic brands.

Line 51: % Generic, by Aggregate \$ Gross Cost: Enter the % of gross cost associated with generic prescriptions.



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Other:

Line 52: Included in Line 8 above: Non-PBM expenditures: Input the portion, if any, of Line 8 above that was not processed by the MCO's PBM (i.e., not billed to the MCO by the PBM).

Line 53: Included in Line 28 above: Non-PBM # of Rx (Prescriptions): Input the portion, if any, of Line 29 above that would correspond to the dollars in the Line 52.

Line 54: Excluded from Line 8: PBM \$ in Part 4 Other Med Exp: Input the portion, if any, of total PBM billings not processed as Encounters but reported in Part 4, "Other Medical Expenses." Include non-formulary Rx (Prescriptions) DME; do not include any admin expense.

Line 55: Excluded from Line 28: PBM # of Rx (Prescriptions) related to Line 54: Input the quantity that corresponds to the dollars in Line 54.

Line 56: Total PBM \$ billed to MCO (excl PBM Admin): Calculated as Line 52, subtracted from Line 8, "Prescription Paid Claims Expense," plus Line 54.

Line 57: Total PBM Qty of Rx (Prescriptions): Calculated as Line 53, subtracted from Line 29, "Total # of Prescriptions," plus Line 55.

Line 58: Enter the last NCPDP (National Council for Prescription Drug Programs) adjudication date of actual pharmacy payments (Pharmacy Benefit Manager/PBM invoiced date range) included in "Prescription Paid Claims Expense" Line 8 above. This date will be used in the Pharmacy Reconciliation Report.

Line 59: Pharmacy administered vaccines: Enter the dollar amount included within the Line 11 total for "Prescription Expense (excluding PBM Admin)," which is associated with vaccines administered at a pharmacy.

Data Certification Form

General Instructions:

1. The Data Certification Form must be submitted with the FSR Reports, and it must be signed by the CEO, CFO, or equivalent.
2. Certification of certain financial data is a Federal requirement.
3. It is acceptable to include the Data Certification Form pasted into the Certification tab as a PDF.

Instructions for Completing Specific Data Fields:

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

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

Data Field 9 – Sign the Certification.

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