

FINANCIAL REPORTING REQUIREMENTS

HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

Southeast and Southwest Zones

Reporting Period 01/01/15 through 12/31/15

Lehigh Capital Zone

Northeast Zone

North Central State Option Zone

North Central County Option Zone

Reporting Period 07/01/14 through 06/30/15

March 1, 2015

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Attachment AFederalizing General Assistance (GA) File Layout
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Attachment MHealth Insurer Provider Fee Financial Reporting Guidance

1.0 GLOSSARY OF TERMS

Adjudicate. To pay or reject a claim.

ASO. Administrative Services Organization.

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

BHRS. Behavioral Health Rehabilitation Services for Children and Adolescents.

C & Y. Office of Children & Youth.

CNO. Categorically Needy Only.

DHS. Pennsylvania Department of Human Services.

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

Freestanding Psychiatric Facility (previously referred to as IMD). A freestanding hospital that provides inpatient psychiatric services.

FYE. Fiscal Year End.

GA. General Assistance.

GAAP. Generally Accepted Accounting Principles.

HB. Healthy Beginnings.

HCE - NE. HealthChoices Expansion – Newly Eligible.

HIPF. Health Insurer Provider Fee.

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

HPA. *Healthy Pennsylvania* Initiative.

IMD (now referred to as Freestanding Psychiatric Facility). - Institution for Mental Disease. An institution for mental disease is a hospital with a bed capacity greater than 16 beds that dedicates 50% or greater of its beds for psychiatric inpatient services.

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

JCAHO. Joint Commission on Accreditation of Healthcare Organizations.

MA. Medicaid or Medical Assistance.

MAGI Modified Adjusted Gross Income.

MNO. Medically Needy Only.

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

PID. Pennsylvania Insurance Department.

PMPM. Per Member Per Month.

PSR. Program Standards and Requirements Document.

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

RTF. Residential Treatment Facility.

SAP. Statutory Accounting Principles.

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

TANF Temporary Assistance to Needy Families.

2.0 FINANCIAL REPORTING REQUIREMENTS TABLE

Frequency	Due Date	Title	Report #
Q	15 th of the second month after period end i.e. – period ending 03/31/XX reports are due 5/15/XX	Enrollment Table	1
Q		Primary Contractor Summary of Transactions	2
Q		Subcontractor Summary of Transactions	3
Q		Related Party Transactions and Obligations	4
Q		Risk Pool Analysis	5
M		Claims Payable (RBUCs and IBNRs)	6
M		Lag Reports	7
M		Claims Processing Report	8
Q		Analysis of Revenues and Expenses	9
M		Coordination of Benefits Report	11
M		Reinvestment Report	12
M, Q, or A		Balance Sheet	13
M, Q, or A		Statement of Revenues, Expenses, and Changes in Retained Earnings (Deficit)/Fund Balance	14
M, Q, or A		Statement of Cash Flows	15
M		Federalized GA Report	16
Q		Contract Reserves Compliance Report	17
Q		Insurance Department Quarterly Filing	18
Q		15 th of the second month after period end	Adult Outpatient Services in Alternative Settings
A	LC/NE/SO/CO – September 1 st SE/SW – March 1 st	Annual Counterpart Reports	20
A	LC/NE/SO/CO – November 15 th SE/SW – May 15 th	Annual HealthChoices Behavioral Health Contract Audit	21
A	9 months after the County's audit year end	Audited General Purpose Financial Statements	22
A	180 days after FYE	Annual Entity-Wide Audit	23
A	March 1 st	Insurance Department Annual Filing	24
A	June 30 th	Insurance Department Annual Audited Financial Statements	26
A	Last date of the contract year	Physician Incentive Arrangement	
A	LC/NE/SO/CO – May 15 th SE/SW – November 15 th	Equity Requirement	
A	LC/NE/SO/CO – May 1 st SE/SW – November 1 st	Insolvency Protection Arrangement	
A	LC/NE/SO/CO – May 1 st SE/SW – November 1 st	Risk Protection (Stop-Loss Reinsurance)	
A	LC/NE/SO/CO – October 1 st SE/SW – April 1 st	Reinsurance Experience - Estimated	
A	LC/NE/SO/CO – July 1 st SE/SW – January 2 nd	Reinsurance Experience - Actual	

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

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

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

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

3.0 INSTRUCTIONS FOR THE COMPLETION OF REPORTING FORMS

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

3.1 General Instructions

HOW TO REPORT:

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

The heading of each report should contain the following fields:

Statement as of: This should be the month, quarter, or year-end date for the report.

County: This should be the name of the County for which the report is applicable.

Reported By: This should be the entity that collected the data and compiled the report. In instances where a report contains data from more than one entity, this field should name the primary contractor.

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

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

Only contract-related income and expenses should be reported in these reports. Charitable contributions, Federal Income taxes, State Income taxes and non-HC Program interest expense allocations are examples of expenses not directly related to the HC Program and therefore, should not be reported in these reports. **Expenditures included in the financial reports that are not directly related to the operation of the program, as well as expenditures that are considered one-time administrative costs or one-time provider rate increases will be removed from the base data for rate setting purposes.**

Premium Deficiency Reserves (PDR) should **not** be included in reports that are prepared to comply with HealthChoices Financial Reporting Requirements. The primary focus of Statutory Accounting Principles is the solvency of a company and its ability to meet long-term contractual obligations. Requiring adequate statutory reserves (including PDRs) is the principle means of ensuring financial soundness. Although DHS is concerned with the

solvency of HealthChoices contractors, the HealthChoices reports are used to understand the current medical costs and administrative expenses of the HealthChoices program. Since the PDR concerns projected losses for future periods, recording it in a current period distorts the true picture for the current period.

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

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

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

Unanswered questions and blank lines or reports will not be considered properly completed. If no answers or entries are to be made, write "None", "Not Applicable" (N/A), or "-0-" in the space provided. For specific instructions on how to report blank lines or blank reports when filing electronically, please refer to the Requirements and Specifications Manual for Electronic Submission of Financial Data.

Amounts should be reported to the nearest dollar and should not include decimal places, except for per member per month (PMPM) amounts which should include two decimal places. **IMPORTANT:** When rounding or truncating numbers do not perform rounding or truncation until arriving at the final amount. (Example: If calculation is $1.5892 \times 2.059 = 3.272163$, report final amount as 3.27; not $1.59 \times 2.06 = 3.28$.)

Sanctions imposed by DHS on the Primary Contractor must be reported as follows: Report #2, Capitation Revenue (Line 2a), should disclose the gross amount of capitation revenue. Other Revenue (Line 2c) should include an offsetting negative number in the amount of the sanction.

Report #9, Other Revenue (Line 3), should also include the offsetting negative number in the amount of the sanction. If the Primary Contractor passes part or all of the sanctions on to the Subcontractor, follow the reporting instructions below for Sanctions imposed by the Primary Contractor. Sanctions must be disclosed in the footnotes to the reports.

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

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

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

WHERE TO SEND REPORTS:

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

Regular mail to:

Department of Human Services
Office of Mental Health & Substance Abuse Services
Ms. Terry Mardis
DGS Annex Complex
Shamrock Hall, Bldg. #31, 1st Floor
P.O. Box 2675
Harrisburg, PA 17105

Or overnight courier to:

Ms. Terry Mardis
Department of Human Services
Bureau of Financial Management and Administration
Division of Medicaid Finance
DGS Annex Complex
Shamrock Hall, Bldg. #31, Room #116
112 East Azalea Drive
Harrisburg, PA 17110-3594

The Harrisburg State Hospital address is to be used for overnight courier delivery only. The U.S. Postal Service does not deliver to this address. Material revisions should be mailed to the address given for paper reports or faxed to Ms. Terry Mardis at (717) 705-8128. Prior

telephonic communication of faxing of revisions must occur prior to fax transmission. The telephone number to call is (717) 772-7433.

The ASCII files containing the report data will be transferred via web submission to an address to be provided. The file transfer names will be included in the File Specifications and Record Layouts.

LATE REPORTING:

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

REPORTING OF HEALTHCHOICES REVENUES AND EXPENSES:

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

- Inpatient Psychiatric
- Inpatient D & A
- Non-Hospital D & A
- Outpatient Psychiatric
- Outpatient D & A
- Behavioral Health Rehabilitation Services for Children & Adolescents (BHRS)
- RTF - Accredited
- RTF - Non-Accredited
- Ancillary Support
- Community Support
- Other

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

- Temporary Aid to Needy Families (TANF)/Healthy Beginnings (HB) MAGI – Child
- Temporary Aid to Needy Families (TANF)/Healthy Beginnings (HB) MAGI – Adult
- SSI & Healthy Horizons w/ Medicare
- SSI & Healthy Horizons w/o Medicare – Child
- SSI & Healthy Horizons w/o Medicare – Adult
- Categorically Needy State-Only GA (CNO)
- Medically Needy State-Only GA (MNO)
- Healthy PA (HPA)
- HealthChoices Expansion – Newly Eligible (HCE-NE)

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

For purposes of these financial reports, "medical" expenses should reflect only those costs that represent claims or service costs, with the addition of individual stop loss reinsurance premiums and recoveries. All other costs, including those incurred for Utilization Review, Quality Assurance, Medical Director, Member Services, aggregate reinsurance premiums and recoveries, and all other non-medical claim costs, are to be reported under the "Administrative Expense" sections of applicable reports. This will enable DHS and its contractors to compare costs actually being incurred to the costs included in each service group in the existing capitation rates. In addition, the Department and its contractors will also be utilizing these financial reports, along with the contractors' encounter data, to develop future capitation rates.

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

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

3.2 Report #1 - Enrollment Table

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

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

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

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

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

3.3 Report #2 - Primary Contractor Summary of Transactions

The Primary Contractor must report all capitation revenue received applicable to the current period, as well as the disposition of those funds, in this report.

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

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

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

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

should be supplied to the Department as soon as it is available for adjustments to the prior year database.

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

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

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

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

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

3.4 Report #3 – Subcontractor Summary of Transactions

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

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

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

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

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

3.5 Report #4 - Related Party Transactions and Obligations

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

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

The transaction codes for this report are as follows:

- 01) Shareholder Dividends
- 02) Capital Contributions
- 03) Purchases, Sales or Exchanges of Loan Securities, Real Estate Mortgage Loans or Other Investments

- 04) Income/(Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)
- 05) Management Agreements, Service Contracts, including Contract for Services Provided by the primary contractor, or Purchased by the primary contractor (for the HealthChoices Program) from Other Affiliates, and Non-GAAP Cost Sharing Agreements
- 06) Income/(Disbursements) Incurred Under Reinsurance Agreements
- 07) Reinsurance Recoverable/(Payable) on Losses and/or Reserve Credit Taken/(Liability)
- 98) Other - include explanation in footnote or common text area.

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

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

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

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

3.6 Report #5 - Part A: Risk Pool Analysis

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Paid claims.
- RBUCs. Note that a claim is considered an RBUC immediately upon receipt and should be tracked as such. Include, in the footnote to Report #6, the amount of RBUCs that is estimated (i.e., claims in-house but not yet entered on the system).
- IBNRs. **Claims liabilities should not include the administrative portion of claim settlement expenses. Any liability for future claim settlement expense must be disclosed separately from the unpaid claim liability. This may require a qualification to the actuarial certification.**

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

Claims expense cannot be properly evaluated without adequate consideration of current trends and conditions. The following summarizes claims environment factors that should be considered.

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

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

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

1. IBNR systems must function as part of the overall financial management and claims system. These systems combine to collect, analyze and share claims data. They require effective referral, prior authorization, utilization review and discharge planning functions. In addition, a full accrual accounting system is necessary. Full accrual systems help properly identify and record the expense, together with the related liability, for all unpaid and unbilled medical services provided to members.
2. An effective IBNR system requires the development of reliable lag tables that identify length of time between provision of service, receipt of claims, and processing and payment of claims by behavioral health major service grouping. Reliable claims/cash disbursement systems generally produce most of the necessary data. Lag tables, and the projections developed from them, are most useful when there is sufficiently accurate claims history which shows stable claims lag patterns. Otherwise, the tables will need modification on a proforma basis to reflect corrections for known errors or skewed payment patterns. The data included in the lag schedules should include all information received to date in order to take advantage of all known amounts (i.e. RBUCs).
3. Accurate, complete and timely claims data should be monitored, collected, compiled and evaluated as early as possible. Whenever practical, claims data collection and analysis should begin before the service is provided (i.e. prior authorization records). This prospective claims data, together with claims data collected as the services are provided, should be used to identify claims liabilities.
4. **Claims data should also be segregated to permit analysis by behavioral health rating group, behavioral health major service grouping, major provider, and**

county, if more than one county's membership is maintained on the system.

5. Subcontractor agreements should clearly state each party's responsibility for claims/encounter submission, prior notification, authorization, and reimbursement rates. These agreements should be in writing, clearly understood and followed consistently by each party.
6. The individual IBNR amounts, once established, should be monitored for adequacy and adjusted as needed. If IBNR estimates are subsequently found to be significantly inaccurate, analysis should be performed to determine the reasons for the inaccuracy. Such an analysis should be used to refine an IBNR methodology, if applicable. **Material changes in estimates to an IBNR methodology must be reported to DHS in the period during which it occurs.**

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

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

3.8 Report #7 - Lag Reports

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

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

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

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

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

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

Lag Tables - Lag tables are used to track historical payment patterns. When a sufficient history exists and a regular claims submission pattern has been established, this methodology can be employed. Lag information should be used as a validation test for accruals calculated using other methods if it is not the primary methodology employed. Typically, the information

on the schedules is organized according to the month claims are incurred on one axis (horizontal) and the month claims are paid on the other axis (vertical). Specific information by Behavioral Health rating group, and by Behavioral Health major service grouping, must be tracked, as each population may have different characteristics.

Once a number of months become "fully developed" (i.e. claims submissions are thought to be complete for the month of service), the information can be utilized to effectively estimate IBNRs. This is done by computing the average period over which claims are submitted historically and applying this information to months that are not yet fully developed.

Lag Table Example - The following simple example demonstrates the lag table approach discussed above.

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

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

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

The following steps must be taken:

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

1. For each month not yet fully developed, the cumulative percentage (obtained from the fully developed table) should be divided into the total amount of claims paid to date for each month. The result will be the estimated total claims expense for each month.
2. Subtract all claims already paid or received (RBUCs) for that month from the estimated total claims expense for each month. The remainder represents your IBNR estimates.

<u>Month Paid</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>Total</u>
Current	\$ 1,600	\$ 1,900	\$1,600	\$ 5,100
1st Subsequent	\$ 9,700	\$10,600	\$-----	\$ 20,300

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

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

3.9 Report #8 - Claims Processing Report

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

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

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

Part B should reflect the dollar amount of claims.

- “#/\$ Amount of Claims Received” column includes all claims entered into the claims processing system with a receipt date prior to the end of the month being reported. Report the dollar amount of the claim that is allowable/authorized by the County/BH-MCO. If the dollar amount cannot be determined, include the claim on Part A and report as \$0 dollars on Part B. However, if the claim is included as part of the RBUC estimate on Report #6, Claims Payable (RBUCs and IBNRs), the estimate must be included on Part B and adjusted when the dollar amount can be determined.
- “#/\$ Amount of Clean Claims” column should include the number or dollar amount of clean claims received. If efforts are made internally to procure the necessary information to adjudicate a pended claim, the claim should be moved from the “#/\$ Amount of Claims Not Adjudicated” column to the “#/\$ Amount of Clean Claims” column and either “Paid” or

“Rejected” for the month received. However, if the claim is pended and later returned to the provider for further information, it should be removed from the “#/\$ Amount of Claims Not Adjudicated” column and shown as “Rejected” only.

- Clean Claim – A claim that can be processed without requiring additional information from the provider of the service or from a third party.
- A clean claim does not include: claims pended or rejected because they require additional information either from a provider or from internal sources (i.e. claims pended for an authorization number, etc.); a claim under review for medical necessity; or a claim submitted by a provider or contractor reported as being under investigation by a governmental agency.
- “#/\$ Amount of Claims Not Adjudicated” column should include **all** claims that have not been adjudicated. This includes approved but unpaid claims, as well as claims requiring additional information from the provider of the service and or from a third party.
- “Paid” column includes all claims for which a check has been created or an electronic payment has been transferred to the provider.
- “Clean Rejected” column includes all clean claims that have been returned to the provider or third party.
 - Clean Rejected Claim - A claim that is returned to the provider or third party due to ineligible recipient or service.
- “Unclean Rejected” column includes all unclean claims that have been returned to the provider or third party.
 - Unclean Rejected Claim - A claim that is returned to the provider or third party for additional information.

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

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

1. Inpatient Claims – Includes claims received for inpatient admissions (Psych and D&A) and RTFs;
2. Practitioner and Outpatient Claims – Includes claims for all outpatient services (Psych, D&A and Partial), Non-hospital D&A, Non-Accredited RTFs, and BHRS for children.
3. Other Claims – Includes claims for Ancillary or Community Support services, or claims received from any providers not included in category 1. or 2. above.

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

Beginning with the first month of the second contract year, this report should reflect data for the

12 most recent months of the HealthChoices program. In the event that claims from 13 months prior or before are still not adjudicated, two versions of this report should be filed; one for the most recent 12 months; and one for the prior 12 month period.

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

3.10 Report #9 - Analysis of Revenues and Expenses

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

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

Line 5 - Inpatient Psychiatric must be reported on Part A and Part B of the report by Freestanding Psychiatric Facility or Other. The Freestanding Psychiatric Facility line is only to be used for expenses related to persons between the ages of 22-64. Expenses for Freestanding Psychiatric Facilities that are related to persons not between the ages of 22-64 should be included in the Other line as well as all inpatient psychiatric expenses for facilities that are not Freestanding Psychiatric Facilities. A Freestanding Psychiatric Facility is largely defined as a hospital with a bed capacity greater than 16 beds that dedicates 50% or greater of its beds for psychiatric inpatient services. A listing of Freestanding Psychiatric Facilities is included as Attachment C.

Lines 6, 7, 9, & 12 - Refer to the OMHSAS and BDAP Medical Necessity Criteria Appendix of the HealthChoices Behavioral Health PSR effective 07/01/09 for details of items that should be included on these lines.

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

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

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

Line 15)a – Individual stop loss reinsurance premiums should be reported on this line as Medical Expense "Other". Aggregate reinsurance premiums should be reported as Administrative

“Other”. Reinsurance Recoveries should be reported in the appropriate category of service and rating group.

Line 15)b - See Section 3.1 for specific instructions for reporting additional amounts as "Other."

Line 16)f - Clinical Care/Medical Management: All Clinical Care/Medical Management expenses should be reported on this line. The amounts reported on this line should not be duplicated in any other administrative expense line on this report. Compensation, interest expense, occupancy, depreciation, and amortization, and other administrative expense lines should include Administrative Overhead costs only. Refer to Attachment F to assist in the task of determining which costs are clinical care/medical management or administrative overhead for DHS reporting purposes.

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

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

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

Amounts should be net of third party resources collected.

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

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

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

NOTE: Report Hospital stay charges (i.e. the Room and Board) in the INPATIENT fields. Report physician, lab and any procedure charges associated with an inpatient stay in the OUTPATIENT/PROFESSIONAL fields.

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

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

Complete Report 11A as follows:

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

Step 2: Identify the total number of claims with COB processed with a known TPL resource and enter the number in the appropriate row in column B.

Step 3: Identify the total number of claims denied due to a known TPL resource submitted without an EOB attached and enter the number in the appropriate row in column C.

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

Step 4: Identify the total number of claims with a TPL resource coordinated or denied by summing the totals of column B and column C and enter the number in the appropriate row in column D.

Step 5: Identify the percent of claims denied with a known TPL resource without an EOB attachment. Divide column C by column D and enter the percent in the appropriate row in column E.

Step 6: Identify the total number of unique members active with a TPL resource at the end of the quarterly reporting period (last day) and enter the total for Commercial, total for Medicare and the Total Commercial and Medicare in the appropriate row in column F. If a member has

BOTH Commercial and Medicare, report the member as having Medicare.

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

Report 11A

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

REPORT 11B- PROVIDER REPORTED: These are the **REPORTED** payments received by the provider from third party insurers after coordination of benefits has occurred. These amounts are reported by the provider in the **Other Insurance Paid** and the **Medicare Paid** fields on encounter data. The MCO should have an established process for collecting payments from third party insurers to effectively process a retroactive TPL resource or discovery of a missed coordination of benefits opportunity. These are the amounts collected from a Provider or a third party insurer **after** the MCO has already paid the Provider for the encounter/service. If the MCO initially pays a claim, discovers there is a liable third party insurer, or newly acquired coverage retroactive to the date of service, the MCO should retrospectively review the claims previously paid, determine if any fall within the effective date of eligibility, and attempt to collect the money from the provider or the third party insurer. In order for the provider to resubmit a retroactive TPL resource claim for payment, they would need to attach the appropriate EOB with the dollar amount paid by the other insurance (Provider Reported). The amount collected when a provider resubmits a claim that was previously denied due to a TPL resource without an EOB attached should be recorded as Provider Reported and captured as part of the claims payment process.

Complete Report 11B as follows:

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

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

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

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

Report 11B

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

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

Example:

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

Report 11B

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

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

Complete Report 11C as follows:

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

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

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

Step 4: If some of the recovered dollars is paid to a contractor (e.g. recovery vendor), enter

the Portion Received by the MCO in the **NET AMOUNT RECOVERED** field and DO NOT report any third party payment with the Provider Reported data if the MCO bills the third party insurer directly

Example:

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

Report 11C

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

NOTE: If an amount is recovered due to a TPL resource and not captured as “Provider Reported” in the claims system as other insurance paid, the amount should be reported on Part C as Recovered and mapped to the type of resource and type of claim. A description of the recovered amounts should be provided if the detail by type of claim is not available and recorded on the bottom section of Part C on report 11.

This report is to be submitted electronically via DHS’s secure server. The record layout for this report is included as Attachment I of this document. This report is due 45 days after the end of the program quarter and must comply with the specifications shown in **Attachment K** of this document.

3.12 Report #12 - Reinvestment Report

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

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

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

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

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

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

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

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

Allocations/contributions are funds transferred into the reinvestment account.

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

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

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

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

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

The bank statements for the reinvestment account, as well as the bank reconciliation that reconciles the general ledger to the reinvestment account bank statements, must be submitted with each month's report. The Department reserves the right to request additional documentation.

Columns are provided for reporting the number of unduplicated recipients served, current month units of service provided and dollar amount paid for those services, as well as cumulative year to date and contract to date units of service provided and dollar amount paid. **This information is no longer required to be submitted on this report, but should still be collected internally to**

monitor cost effectiveness/cost neutrality for Supplemental In-Lieu of services being funded through reinvestment.

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

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

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

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

NO FORM IS PROVIDED FOR THIS REPORT.

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

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

NO FORM IS PROVIDED FOR THIS REPORT.

3.15 Report #15 - Statement of Cash Flows

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

NO FORM IS PROVIDED FOR THIS REPORT.

3.16 Report #16 - Federalized GA Report

This report is to be provided via an electronic file transfer on a monthly basis. This report will include information on all payments for State-Only General Assistance recipients for Inpatient admissions for the following provider types:

PROMISe Provider Type: 01 Inpatient Facility

PROMISe Provider Specialty: 010 Acute Care Hospital
 019 D&A Rehab Hosp
 441 D&A Rehab Unit
 011 Private Psych Hosp
 022 Private Psych Unit
 018 Extended Acute Psych Inpatient Unit

The report is required for all GA-CNO and GA-MNO State-Only recipients who meet all of the criteria reflected on the Managed Care Payment System Table for HealthChoices in effect during the period being reported.

This report is to be submitted electronically via DHS's secure server. Record layouts for this report are included as Attachment A of this document. Data elements for this report are included as Attachment B of this document. This report is due 45 days after the end of the program month and must comply with the specifications shown in Attachments A & B of this document.

NO FORM IS PROVIDED FOR THIS REPORT (ELECTRONIC FILING ONLY). THE DATA FILE LAYOUT IS ATTACHMENT A; THE DATA ELEMENT DICTIONARY IS ATTACHMENT B.

3.17 Report #17 - Contract Reserves Compliance Report

The HealthChoices Behavioral Health PSR effective 1/01/08 specifies equity requirement: This report states whether or not the overall reserve requirement has been met. The report should include the detailed calculation used to determine compliance. If there is a lack of compliance, the report must include an analysis of the fiscal status of the contract and a corrective action plan for fiscal improvement that management plans to take to ensure compliance. All HealthChoices capitation revenues, for all contracts, must be included in the calculation of the reserve requirement for entities responsible for meeting this requirement.

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

A FORM IS PROVIDED FOR THIS REPORT.

3.18 Report #18 – Insurance Department Quarterly Filings

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

NO FORM IS PROVIDED FOR THIS REPORT.

3.19 Report #19 – Adult Outpatient Services in Alternative Settings

This report is to be completed quarterly by all Contractors with an approved supplemental service description and alternative payment arrangement for Adult Outpatient Services in an Alternative Setting. Information should be completed for each client served at the facility during the quarter on a separate tab. Instructions, Data Certification Form and Procedure Code Reference Chart for the completing the report are included as Attachments H, I and J.

A FORM IS PROVIDED FOR THIS REPORT.

3.20 Report #20 - Annual Counterpart Reports

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

THE ANNUAL CERTIFICATION STATEMENT IS PROVIDED FOR THIS REPORT.

3.21 Report #21 - Annual HealthChoices Behavioral Health Contract Audit

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

NO FORM IS PROVIDED FOR THIS REPORT.

3.22 Report #22 – Audited General Purpose Financial Statements

NO FORM IS PROVIDED FOR THIS REPORT.

3.23 Report #23 - Annual Subcontractor Entity-Wide Audit

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

NO FORM IS PROVIDED FOR THIS REPORT.

3.24 Report #24 – Insurance Department Annual Filing

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

NO FORM IS PROVIDED FOR THIS REPORT.

3.25 Report #26 - Insurance Department Annual Audited Financial Statements

These reports must be filed with PID by any licensed, risk-bearing MCO. Provide a copy of the reports as submitted to PID, including a copy of the management letter. Any revisions to these financial statements must also be submitted to DHS.

NO FORM IS PROVIDED FOR THIS REPORT.

3.26 Other Financial Requirements

1. Physician Incentive Arrangement

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

2. Equity Requirement

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

3. Insolvency Protection Arrangement

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

4. Risk Protection Arrangements (Stop-Loss Reinsurance)

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

5. Reinsurance Experience - Estimated

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

6. Reinsurance Experience - Actual

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

3.27 Financial Data Certification Form

Reports submitted to the Division of Medicaid and Financial Review (DMFR) by HealthChoices Behavioral Health Contractors require certification by authorized signatories on file with DMFR. All reports submitted electronically that are used in rate-setting require concurrent certification per

Federal BBA Regulations. The following chart identifies which reports require submission of the Financial Data Certification Form, as well as those that require concurrent electronic submission:

Submitted Concurrently	Certification Required	#	Report Description
	X	1	Enrollment Table
X	X	2	Primary Contractor Summary of Transactions
X	X	3	Subcontractor Summary of Transactions
	X	4	Related Party Transactions and Obligations
	X	5	Risk Pool Analysis
	X	6	Claims Payable (RBUCs and IBNRs)
X	X	7	Lag Reports
	X	8	Claims Processing Report
X	X	9	Analysis of Revenues and Expenses
	X	11	Coordination of Benefits Report
X	X	12	Reinvestment Report
		13	Balance Sheet
		14	Stmt of Rev, Exp, and Changes in RE (Deficit)/Fund Balance
		15	Statement of Cash Flows
		16	Federalized GA Report
		17	Contract Reserves Compliance Report
		18	Insurance Department Qtrly Filing
X	X	19	Adult Outpatient Services in an Alternative Setting
X	X	20	Annual Counterpart Reports
	X	21	Annual HealthChoices Behavioral Health Contract Audit
		22	General Purpose Financial Statements (CAFR)
		23	Annual Subcontract-or Entity-Wide Audit
		24	Insurance Department Annual Filing
		26	Insurance Department Annual Audited Fin'l Stmts (Audited SAP-based Financials)
			Physician Incentive Arrangement
			Equity Requirement
			Insolvency Protection Arrangement
			Risk Protection (Stop-Loss Reinsurance)
X	X		Estimated Reinsurance Experience
X	X		Actual Reinsurance Experience
			Actuarial Certification of Claims Liabilities

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

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

4.0 REPORTING FORMS

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

FINANCIAL DATA CERTIFICATION FORM

MONTHLY/QUARTERLY/ANNUAL CERTIFICATION STATEMENT OF

Name of Primary Contractor and Subcontractor

TO THE

PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES

FOR THE PERIOD ENDED

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

Name of Preparer _____

Title _____

Phone Number _____

I hereby attest that the information submitted in the reports herein is complete and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of a Primary Contractor's contract with the Department of Human Services.

Additionally, I attest in accordance with 42 C.F.R. § 438.604 that the reports listed in the following table have been reviewed and found to be complete, true and accurate to the best of my knowledge, information and belief and have been submitted in accordance with the agreement with the Department of Human Services. I understand that any knowing and willful false statement or representation on the attached data submission may be subject to prosecution under applicable state laws. In addition, any knowing and willful failure to fully and accurately disclose the requested information may result in termination of the agreement with the Department of Human Services.

FEDERALIZING GENERAL ASSISTANCE (GA) FILE LAYOUT

Effective August 1, 2013

NAME: Unique to each plan – xxMMYY.fga format, where:
 xx = two-digit MCO code
 MM = month of file submission
 YY = year of file submission
 .fga = constant file extension

DESCRIPTION: A monthly file provided by the MCOs to DHS containing select information about inpatient hospital claims for state GA recipients. DHS is authorized to claim the federal share for services provided to state GA recipients through capitation programs.
 Each monthly file is due approximately 45 days after the end of the program month. Files are to be placed on DHS's server in the fedga directory by the 15th of each month.

FORMAT: ASCII

RECORD LENGTH: 141

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/ Numeric</i>	<i>Special Instructions</i>
MCO Code	01-02	02	A	
Provider Type	03-04	02	A	
Provider Number	05-17	13	A	
Recipient Number	18-26	09	A	
Recipient's Current ID (on Date of Service)	27-42	16	A	
Recipient Birth Date	43-50	08	A	YYYYMMDD
Begin Service Date	51-58	08	A	YYYYMMDD

End Service Date	59-66	08	A	YYYYMMDD
Amount Reimbursed	67-75	09	N	RJ, zero fill
Amount Indicator	76	01	A	
Claim Number	77-96	20	A	LJ
Claim Adjustment Indicator	97	01	A	
Number of Days Paid	98-100	03	N	RJ, zero fill
Payment Date	101-108	08	A	YYYYMMDD
Program Status Code	109-110	02	A	
Provider Specialty	111-113	03	A	
Inpatient/Outpatient Indicator	114	01	A	I = Inpatient O = Outpatient
TPL Amount	115-123	09	N	RJ, zero fill
MCO Copayment Amount	124-132	09	N	RJ, zero fill
Medicare Paid Amount	133-141	09	N	RJ, zero fill

Effective August 2013

GENERAL ASSISTANCE FEDERAL FUNDING FILE
DATA ELEMENT DICTIONARY

<p>ELEMENT: MCO CODE</p> <p>DESCRIPTION: Two character alpha numeric, identifying the particular MCO—See attachment.</p>
<p>ELEMENT: PROVIDER TYPE</p> <p>DESCRIPTION: Two digit number identifying the type of provider: PROMISe Provider Type: April 1, 2004 01 – Inpatient Facility</p>
<p>ELEMENT: PROVIDER NUMBER</p> <p>DESCRIPTION: Thirteen digit PROMISe provider number (service provider)</p>
<p>ELEMENT: RECIPIENT NUMBER</p> <p>DESCRIPTION: Nine digit recipient CIS number.</p>
<p>ELEMENT: RECIPIENT'S CURRENT ID (on Date of Service)</p> <p>DESCRIPTION: Sixteen character alpha-numeric recipient number. The format is CCRRRRRRRAAGDLL, where: CC = County Number RRRRRRR = Record Number AAA = Rating Group (left justified with trailing blanks) G = Grant Group D = Control Digit, (not required as of 10/2003, space fill) LL = Line Number</p>
<p>ELEMENT: RECIPIENT'S BIRTH DATE</p> <p>DESCRIPTION: The recipient's date of birth. Date in YYYYMMDD format.</p>
<p>ELEMENT: BEGIN SERVICE DATE</p> <p>DESCRIPTION: The date the service began. Date in YYYYMMDD format.</p>
<p>ELEMENT: END SERVICE DATE</p> <p>DESCRIPTION: The date the service ended. Date in YYYYMMDD format.</p>

ELEMENT: AMOUNT REIMBURSED

DESCRIPTION: Amount approved for payment. If the record is an adjustment, the amount should be the adjustment amount, not the final value. Do not enter the decimal point.

ELEMENT: AMOUNT INDICATOR

DESCRIPTION: A code to indicate whether the amount is a positive or a negative value: 0 = positive amount, 1 = negative amount.

ELEMENT: CLAIM NUMBER

DESCRIPTION: A unique control number assigned to the claim by the contractor. The number must include a Julian date to indicate the date of claim receipt by the contractor. This number must appear on a record of paid claims maintained by the contractor that is available to an auditor, as provided by the contractor's contract with DHS.

(20) CHARACTER FIELD, left justified with trailing blanks.

ELEMENT: CLAIM ADJUSTMENT INDICATOR

DESCRIPTION: A code to indicate that the claim record is an adjustment: 1 = not an adjustment, 2 = an adjustment

ELEMENT: NUMBER OF DAYS PAID

DESCRIPTION: Three digit field indicating the number of days that were paid.

ELEMENT: PAYMENT DATE

DESCRIPTION: The date the provider of service was paid. YYYYMMDD format.

ELEMENT: RECIPIENT PROGRAM STATUS CODE

DESCRIPTION: A two-digit code that identifies budgets which meet certain characteristics. It is used for federal reimbursement, reporting, and general control purposes. See Supplementary MA Codes (PA 601).

ELEMENT: PROVIDER SPECIALTY

DESCRIPTION: A three-digit code that identifies provider scope of practice.

ELEMENT: INPATIENT/OUTPATIENT INDICATOR

DESCRIPTION: A one character code used to differentiate between Inpatient and Outpatient claims.

I = Inpatient

O = Outpatient

ELEMENT; TPL AMOUNT

DESCRIPTION: The amount paid by private insurance for specified service(s) thus reducing the amount paid by the MCO.
Reported in the 837 CAS segment

ELEMENT: MCO COPAYMENT AMOUNT

DESCRIPTION: Out of pocket expense paid by the recipient. Reported in the 837 CAS segment.

ELEMENT: MEDICARE PAID AMOUNT

DESCRIPTION: Amount paid by Medicare before payment is adjudicated by Medicaid.

Last Update: March 2015

**PA Medical Assistance Managed Care Organization List
(Attachment to Attachment B)**

HMO CODE	HMO NAME
03	THREE RIVERS HEALTH PLANS, INC. / MEDPLUS+
10	UPMC / BEST HEALTH CARE OF WESTERN PA
11	GATEWAY HEALTH PLAN, INC.
12	HRM HEALTH PLANS, INC. / HEALTHMATE
28	AMERIHEALTH HMO INC.
55	PARTNERSHIP HEALTH PLAN
30	UPMC / BEST HEALTH CARE OF WESTERN PA
31	GATEWAY HEALTH PLAN, INC.
33	THREE RIVERS HEALTH PLANS, INC. / MEDPLUS+
43	HEALTH RISK MANAGEMENT
45	HEALTH PARTNERS OF PHILADELPHIA
46	AMERICHoice OF PA (FORMERLY HMA)
48	KEYSTONE MERCY HEALTH PLAN
88	FAMILY CARE NETWORK (FCN)
89	LANCASTER COMMUNITY HEALTH PLAN (LHCP)
90	HIPP (HEALTH INSURANCE PREMIUM PAYMENT PLAN)
91	HIPP (HMO)
95	LONG TERM CARE CAPITATION (LTCCAP)
AL	ALLEGHENY COUNTY BEHAVIORAL HEALTH (COMMUNITY CARE BHO)
AI	ARMSTRONG/INDIANA MH/MR PROGRAM(VBH OF PA)
BE	BEAVER COUNTY BEHAVIORAL HEALTH (VBH OF PA)
BT	BUTLER COUNTY BEHAVIORAL HEALTH (VBH OF PA)
FA	FAYETTE COUNTY BEHAVIORAL HEALTH (VBH OF PA)
GR	GREENE COUNTY BEHAVIORAL HEALTH (VBH OF PA)
LW	LAWRENCE COUNTY BEHAVIORAL HEALTH (VBH OF PA)
WS	WASHINGTON COUNTY BEHAVIORAL HEALTH (VBH OF PA)
WE	WESTMORELAND COUNTY BEHAVIORAL HEALTH (VBH OF PA)
BU	BUCKS CO. BH (MAGELLAN BH)
CH	CHESTER CO. BH (COMMUNITY CARE BHO)
DE	DELAWARE COUNTY BH (MAGELLAN BH)
MO	MONTGOMERY COUNTY BH (MAGELLAN BH)
PH	PHILADELPHIA COUNTY BH (COMMUNITY BH)

HMO CODE	HMO NAME
AD	ADAMS COUNTY BEHAVIORAL HEALTH
BK	BERKS COUNTY BEHAVIORAL HEALTH
CU	CUMBERLAND COUNTY BEHAVIORAL HEALTH
DA	DAUPHIN COUNTY BEHAVIORAL HEALTH
LA	LANCASTER COUNTY BEHAVIORAL HEALTH
LB	LEBANON COUNTY BEHAVIORAL HEALTH
LE	LEHIGH COUNTY BEHAVIORAL HEALTH
NH	NORTHAMPTON COUNTY BEHAVIORAL HEALTH
PE	PERRY COUNTY BEHAVIORAL HEALTH
YO	YORK COUNTY BEHAVIORAL HEALTH
NB	NORTHEAST BEHAVIORAL HEALTH CARE CONSORTIUM
BI	BLAIR COUNTY
BS	BEHAVIORAL HEALTH SERVICES OF SOMERSET AND BEDFORD COUNTIES
CK	CARBON, MONROE, PIKE
CM	BEHAVIORAL HEALTH OF CAMBRIA COUNTY
ER	ERIE COUNTY
FF	TUSCARORA MANAGED CARE ALLIANCE (FRANKLIN & FULTON COUNTIES)
LC	LYCOMING CLINTON JOINDER BOARD
CV	NWBHP (CRAWFORD, MERCER, VENANGO)
NC	COMMUNITY CARE BEHAVIORAL HEALTH ORGANIZATION, INC. (NC SO)

PRIVATE PSYCH HOSPITAL IN-STATE (FREESTANDING)

Provider Type 01, Inpatient Facility – Provider Specialty 011, Private Psychiatric Hospital

<u>Provider Number</u>	<u>Provider Name</u>
001965180 0002	Brooke Glen Behavioral Hospital
100001913 0411	Devereux Children's Behavioral Health Center
102288577 0014	First Hospital Wyoming Valley
100728370 0001	Kidspeace Hospital
100728595 0022	Clarion Psychiatric Center
100728595 0051	The Meadows Psychiatric Center
100728595 0065	Horsham Clinic, Inc.
100741775 0009	Belmont Center for Comprehensive Treatment
100756802 0011	Montgomery MH/MR Emergency Services
100772000 0016	Philhaven Hospital
100772010 0003	Fairmount BH System
100773760 0004	Kirkbride Center
100778710 0020	Southwood Psychiatric Hospital
101277695 0001	Friends BH System LP
101666835 0001	Roxbury Psychiatric Hospital
101921938 0001	Foundations Behavioral Health
102096380 0001	PA Psychiatric Institute
102511157 0001	Haven Behavioral Hospital of Eastern Pennsylvania
102249372 0004	Berks Behavioral Health – Berkshire Pavilion

PRIVATE PSYCH HOSPITAL OUT OF STATE (FREESTANDING)

Provider Type 01, Inpatient Facility – Provider Specialty 011, Private Psychiatric Hospital

<u>Provider Number</u>	<u>Provider Name</u>	<u>State</u>
000984977 0002	Brook Lane Psychiatric Center, Inc.	MD
001394465 0001	Sheppard and Enoch Pratt Hospital	MD
001842662 0002	William S. Hall Psychiatric Institute	SC
001828823 0001	Virginia Beach Psychiatric Center	VA
001877873 0001	BHC Windsor Hospital	OH
001962750 0001	Rockford Center	DE
100001913 0413	Devereux Hospital	TX
100763182 0006	Kennedy Krieger Institute	MD
100769266 0003	Belmont Pines	OH
100769284 0003	Fox Run Hospital	OH
100776108 0003	The Browns School at Laurel Ridge	TX
102118610 0001	Meadow Wood Behavioral Health System	DE
102642613 0001	Meadow Wood Behavioral Health System	DE

Refer to Line Item 2 on the Behavioral Health Services Reporting and Classification Chart

Attachment D – Reporting Entities

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

Zone 1 Contractors

Bucks, Montgomery and Delaware Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26	
County		Q		Q**	Q**				Q*		M	A	A	A		Q		N/A	A*	A*	A				
MBH-PA	Q		Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q						A	A	A

Chester County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26	
County		Q		Q**	Q**				Q*		M	A	A	A		Q		Q	A*	A*	A				
CCBHO	Q		Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q						A	A	A

Philadelphia County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
County		Q		Q**	Q**				Q*		M	M	Q	Q		Q	N/A	Q	A*	A*	A		N/A	N/A
CBH	Q		Q	Q**	Q**	M	M	M		Q					M								A	

*These reports will be a combination of data from several reporting entities.

** Each entity must file a separate report.

Zone 2 Contractors

Allegheny County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
County	Q	Q*		Q**	Q**				Q*		M	A	A	A		Q		Q	A*	A*	A			
CCBHO			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
AHCI		Q*		Q**																		A		
UPMC												Q	Q	Q								A		

Beaver County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
County	Q	Q	N/A	Q**	Q**	M	M	M	Q*	Q	M	M	Q	Q	M	Q	N/A	Q	A	A*	A	N/A	N/A	N/A
VBH-PA				Q**	Q**							Q	Q	Q										

Fayette County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
County	Q	Q	N/A	Q**	Q**	M	M	M	Q*	Q	M	M	Q	Q	M	Q	N/A	N/A	A	A*	A	N/A	N/A	N/A
VBH of PA				Q**	Q**							Q	Q	Q										

VBH of PA/Greene County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
VBH-PA	Q	Q	N/A	Q**	Q	M	M	M	Q	Q	M	Q	Q	Q	M	Q	Q	Q	A	A	N/A	A	A	A
ValueOptions												Q	Q	Q								A		

*These reports will be a combination of data from several reporting entities.

**Each entity must file a separate report

Zone 2 Contractors – (continued)

Butler, Lawrence, Washington, and Westmoreland Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
County	Q	Q		Q**	Q**	M	M	M	Q*	Q	M	Q	Q	Q	M	Q		Q ⁽¹⁾	A*	A*	A			
VBH-PA			N/A	Q**	Q**							Q	Q	Q			N/A						N/A	N/A
SBHM				Q**							M	M	Q	Q								A		

⁽¹⁾Butler, Lawrence and Washington Only

Armstrong-Indiana

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
Armstrong/Indiana MH/MR	Q	Q		Q**	Q**	M	M	M	Q*	Q	M	Q	Q	Q	M	Q		Q	A*	A*	A			
VBH-PA			N/A	Q**	Q**							Q	Q	Q			N/A						N/A	N/A
SBHM				Q**							M	M	Q	Q								A		
County Specific Reports	A***	A***	A***				A***		A***		A***													

* These reports will be a combination of data from several reporting entities.

** Each entity must file a separate report.

*** **County specific Annual reports must be submitted upon request.**

If requested, the Individual County Annual Reports for Multi-County contracts must be submitted as follows:

- Reports #1, #2, #3, #9 & #12: Submit YTD reports in an Excel file submitted via e-mail to kbutsch@pa.gov
- Report #7: Submit extended lag report beginning January 1, 2014 through March 31, 2015 as an Excel file to be submitted via e-mail to kbutsch@pa.gov

Zone 3 Contractors

Cumberland, Dauphin, Lancaster, Lebanon and Perry Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
County	Q	Q*		Q**	Q**	M	M	M	Q*	Q	A***	M	Q	Q	M	Q	N/A	N/A	A*	A*	A		N/A	N/A
CBHNP			N/A	Q**	Q**							Q	Q	Q								A		
CABHC		Q*		Q**							M	M	Q	Q								A		
Cumberland/ Perry Joinder																						A		

*** Report #12: Submit YTD report in an Excel file submitted via e-mail to behackenbe@pa.gov . Due September 1, 2014.

Adams, Berks and York Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
County	Q	Q		Q**	Q**				Q*		M	A	A	A				N/A	A*	A*	A			
CCBHO			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
UPMC												Q	Q	Q								A		

Lehigh and Northampton Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
County	Q	Q		Q**	Q**				Q*		M	A	A	A				Q ⁽¹⁾	A*	A*	A			
MBH-PA			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A

(1) Northampton Only

* These reports will be a combination of data from several reporting entities.

** Each entity must file a separate report.

Zone 4 Contractors

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

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
NBHCC	Q	Q*	N/A	Q**	Q	M	M	M	Q*	Q	M	M	Q	Q	M	Q	N/A	N/A	A	A	N/A	A	N/A	N/A
Lackawanna	A***	A***					A***		A***		A***													
Luzerne	A***	A***					A***		A***		A***													
Susquehanna	A***	A***					A***		A***		A***													
Wyoming	A***	A***					A***		A***		A***													
CCBHO				Q**	Q							Q	Q	Q										

* These reports will be a combination of data from several reporting entities.

** Each entity must file a separate report.

*** **County specific Annual reports must be submitted upon request.**

If requested, the Individual County Annual Reports for Multi-County contracts must be submitted as follows:

- Reports #1, #2, #3, #9 & #12: Submit YTD reports in an Excel file submitted via e-mail to kbutsch@pa.gov
- Report #7: Submit extended lag report beginning July 1, 2013 through September 30, 2014 as an Excel file to be submitted via e-mail to kbutsch@pa.gov

Zone 5 Contractors

CCBH on behalf of the 23 State Option Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26	
CCBH	Q	Q	N/A	Q	Q	M	M	M	Q	Q	M	Q	Q	Q	M	Q	Q	N/A	A	A	N/A	A	A	A	
UPMC												Q	Q	Q									A		

Zone 6 Contractors

Carbon, Monroe, Pike Joinder Board

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
CMP Joinder	Q	Q		Q**	Q**				Q*		M	A	A	A				N/A	A*	A*		A		
CCBH			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
UPMC												Q	Q	Q								A		
County Specific Reports	A***	A***	A***				A***		A***		A***													

Cambria County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
Cambria County	Q	Q*		Q**	Q**				Q*		M	A	A	A				N/A	A*	A*	A			
BHoCC		Q*																				A		
VBH-PA			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
VOI												Q	Q	Q								A		

Erie County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
Erie County	Q	Q		Q**	Q**				Q*		M	A	A	A				N/A	A*	A*	A			
CCBH			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
UPMC												Q	Q	Q								A		

Zone 6 Contractors (continued)

Lycoming and Clinton Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
Lycoming/Clinton Joinder	Q	Q		Q**	Q**				Q*		M	A	A	A				N/A	A*	A*		A		
CCBH			Q*	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
County Specific Reports	A***	A***	A***				A***		A***		A***													

* These reports will be a combination of data from several reporting entities.

** Each entity must file a separate report.

*** **County specific Annual reports must be submitted upon request.**

If requested, the Individual County Annual Reports for Multi-County contracts must be submitted as follows:

- Reports #1, #2, #3, #9 & #12: Submit YTD reports in an Excel file submitted via e-mail to kbutsch@pa.gov
- Report #7: Submit extended lag report beginning July 1, 2013 through September 30, 2014 as an Excel file to be submitted via e-mail to kbutsch@pa.gov

HealthChoices Behavioral Health Program

CLAIMS PROCESSING REQUIREMENTS

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

A. Claims Processing Standards

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

Adjudication Timeliness Standards:

- A. 90% of **clean** claims must be adjudicated within **30** days.
- B. 100% of **clean** claims must be adjudicated within **45** days.
- C. 100% of **all** claims must be adjudicated within **90** days.

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

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

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

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

The amount of time required to adjudicate a paid claim is computed by comparing the date the claim was received, either in the mail or via an electronic filing, with the date the check was

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

B. Claims Processing Reports

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

ADMINISTRATIVE OVERHEAD AND CLINICAL CARE / MEDICAL MANAGEMENT COST DEFINITIONS

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

ADMINISTRATIVE OVERHEAD *	CLINICAL CARE / MEDICAL MANAGEMENT *
1. General and Administrative <ul style="list-style-type: none"> ➤ Senior operational management ➤ General administrative support staff (i.e., Administrative Assistants, Data Entry, Medical Records, Public Relations, Receptionist, etc.) ➤ Accounting and Finance ➤ Consultants/Actuaries (See #8 under Clinical Care/Medical Management for exceptions) ➤ Depreciation and Amortization ➤ Malpractice, General, and Liability Insurance ➤ Marketing ➤ Office Supplies ➤ Postage ➤ Printing and Copier expenses ➤ Recruiting ➤ Relocation ➤ Rent ➤ Training and Education (See #15 under Clinical Care/Medical Management for exceptions) ➤ Travel (See #16 under Clinical Care/Medical Management for exceptions) ➤ Utilities ➤ Other miscellaneous administrative 	1. Clinical staff salaries 2. Community Relations staff salaries 3. Medical Affairs staff salaries 4. Intake staff salaries 5. Quality Management staff salaries 6. Service Management staff salaries 7. Case Management 8. Consultants (i.e. Language and Deaf Interpreter services, Psychological testing, etc.) 9. Consulting Physician services (Peer to peer physician review of cases) 10. Intake/Member Services Coordinator 11. Medical Director services 12. Other Appropriate Clinical Staff services 13. Outreach/Consumer and Public Education 14. Quality Improvement and Management programs 15. Training for certification and licensing purposes (Clinical staff only) 16. Travel (Interagency team meetings and medical director/provider meetings) 17. 24-hour telephone accessibility for crisis response, screening, referral, and authorization 18. 24-hour accessibility to physician

ADMINISTRATIVE OVERHEAD *	CLINICAL CARE / MEDICAL MANAGEMENT *
<p>expenses</p> <ol style="list-style-type: none"> 2. Claims Processing – Direct or vendor related expenditures related to the processing of provider claims 3. Information Systems – Information systems and communications 4. Provider Services/Network <ul style="list-style-type: none"> ➤ Contracting ➤ Provider credentialing ➤ Provider education 5. Member Services <ul style="list-style-type: none"> ➤ Customer service/support ➤ Grievance and Appeals 6. Patient Transportation 7. Sanctions 8. Member Handbooks 	<p>and/or board certified addictionologist physician for consultation and review</p> <ol style="list-style-type: none"> 19. Utilization Management 20. Utilization Review

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

Prepared 2/20/01 by OMHSAS/DMFR

Adult Outpatient Services in Alternative Settings

Instructions – Quarterly Reporting

Descriptions of Tabs:

Tab	Description	Instructions for completing the tabs
Cert Form	Certification for data submitted	This form should be signed by the authorized signatories on file with OMHSAS. All reports submitted electronically that are used in rate-setting require concurrent certification per Federal BBA regulations. This form can be faxed to (717) 705-8128.
Report #19 Service Package	Type and frequency of services provided to clients	<p>1. Please fill in the Reporting Period Begin and End Dates, Client CIS #, Client SSN, Client Name, Client's County of Residence (not county where currently located, if different), Admission Date, Discharge Date, the Provider's 13 digit PROMISe ID# (which includes the Service Location) and Provider Name. The Admission date should reflect the date the client was admitted to the facility. If the client is still in the facility, the discharge date field should be left blank.</p> <p>2. Service: The chart has been pre-populated with outpatient services provided to clients in the alternative settings. For the rows labeled "Additional Service," please indicate any Medicaid reimbursable services being provided to the clients but not identified in the list, one line per service. See PC Reference Chart for potential service list.</p> <p>3. Procedure Code/Modifier (if applicable): The chart has been pre-populated with the applicable codes and unit definition. Please see the attached Procedure Code Reference Sheet for additional services and procedure codes/modifiers.</p> <p>4. Unit Definition: OMHSAS has identified MA unit definitions to aid in completing this chart. If you track these services differently, please specify the unit definition accordingly. Please note that variations on the Unit Definition are permitted; please reflect the correct total of the pre-populated units in the Units in Reporting Period column. For example, if the Individual Psychotherapy session (30 minutes) only lasted for 15 minutes, please reflect 0.5 Units in the Reporting Period column.</p> <p>5. Unit Cost: Please provide the cost per unit of service. Costs should be provided in accordance with the unit definitions.</p> <p>6. Units in Reporting Period: For each service listed, please provide the number of units of service utilized by each client during the reporting period. If this information is tracked differently, please provide comments at the bottom of the chart.</p>
Procedure Code (PC) Reference Chart	Additional types and units of service	

General Instructions:

Please complete a separate worksheet for each client in your facility. These charts should be completed quarterly and should reconcile to the monthly Alternative Payment Arrangement/837 submissions.

Excel Files are to be placed on DHS's eGov secure server according to previously defined transfer method. Any questions regarding connectivity can be directed to Barb Wadlinger at 717-346-4332 or c-bwadling@state.pa.us.

Naming Convention – xx_AOP#QTRYY format, where:

xx = two-letter county alpha code

= Calendar Quarter – 1, 2, 3 or 4

YY = two-digit year

The data certification form should be faxed to Dawn at (717) 705-8128 concurrent with report submission. The report is due no later than 45 days after the end of each reporting quarter.

If there are any questions on the quarterly report or the instructions, please contact Dawn Hamme (717) 705-8175 or dhamme@state.pa.us.

DATA CERTIFICATION FORM Adult Outpatient Services

CERTIFICATION STATEMENT OF

Name of County

TO THE

PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES

FOR THE QUARTER BEGINNING

(Month & Day) (Year)

(Month & Day) (Year)

Name of
Preparer: _____
Title: _____
Signature of Preparer: _____
Date: _____
Phone
Number: _____

I hereby attest that the information submitted in the reports herein is complete and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates a termination of a Primary Contractor's contract with the Department of Human Services.

Additionally, I attest in accordance with 42 C.F.R. § 438.604 that the information listed in the attached charts has been reviewed and found to be complete, true and accurate to the best of my knowledge, information and belief and have been submitted in accordance with the agreement with the Department of Human Services. I understand that any knowing and willful false statement or representation on the attached data submission may be subject to prosecution under applicable state laws. In addition, any knowing and willful failure to fully and accurately disclose the requested information may result in termination of the agreement with the Department of Human Services.

Procedure Code Reference Chart

Proc. Code	Price Mod.	Info Modifier	Service Description	Units
90832			Psychotherapy, 30 minutes with patient and/or family member	30 min
90853	UB		Group Psychotherapy (other than of a multiple-family group)	15 min
90792			Psychiatric diagnostic evaluation with medical services (Psychiatric Eval, Exam & Eval of Patient)	Occurrence
99201	UB		Office or other outpatient visit for the evaluation and management of a new patient (Psychiatric clinic medication visit for drug administration and evaluation)	15 min
99211	UB		Office or other outpatient visit for the evaluation and & management of an established patient (Psychiatric clinic medication visit for drug administration and evaluation)	15 min
H0034			Medication training & support (Medication Mgmt Visit)	15 min
H0036	HB		Psychiatric Rehabilitation Services	15 min
H0038			Certified Peer Specialist	15 min
S9484			Crisis Intervention Svc, MH svcs (Crisis In-Home Support)	1 hour

REPORT #11 COORDINATION OF BENEFITS FILE LAYOUT

Effective January 1, 2007

NAME: Unique to each plan – xxTPLCAMMYYYY.txt format, where:
 xx = two-letter county alpha code
 MM = two-digit month – 03, 06, 09 or 12
 YYYY = four-digit year

DESCRIPTION: A quarterly file provided by the MCOs to DHS containing select information to capture the MCO's activities involving third party resources. Each file contains three reports. Each report is separated into the types of claims that the service represents. Each report is also divided by resource type, Commercial and Medicare. Refer to the HCBH Financial Reporting Requirements document for further instructions.

Each Quarterly file is due 45 days after the end of the reporting period. Files are to be placed on DHS's server according to previously defined transfer method for each plan. Any questions regarding connectivity can be directed to Barb Wadlinger at 717-346-4332 or c-bwadling@state.pa.us.

FORMAT: ASCII
 Fixed Length
 Right justified, Zero-filled

REPORT #11, PART A RECORD - CLAIMS COST AVOIDED:**RECORD LENGTH:** 191

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/ Numeric</i>	<i>Special Instructions</i>
MCO Code	01-02	02	A	
Reporting Period	03-10	08	A	YYYYMMDD
Report Part	11	01	A	Constant "A"
Commercial I/P # claims w/COB	12-20	09	N	
Commercial I/P # claims denied	21-29	09	N	

Field Name	Record Position	Field Length	Alpha/ Numeric	Special Instructions
Commercial I/P # claims w/TPL Resource	30-38	09	N	
Commercial I/P % claims denied	39-47	09	N	
Filler – zero filled	48-56	09	N	
Commercial O/P – Professional # claims w/COB	57-65	09	N	
Commercial O/P – Professional # claims denied	66-74	09	N	
Commercial O/P – Professional # claims w/TPL resource	75-83	09	N	
Commercial O/P – Professional % claims denied	84-92	09	N	
Commercial Total active members w/TPL resource	93-101	09	N	
Medicare I/P # claims w/COB	102-110	09	N	
Medicare I/P # claims denied	111-119	09	N	
Medicare I/P # claims w/TPL resource	120-128	09	N	
Medicare I/P % claims denied	129-137	09	N	
Filler – zero filled	138-146	09	N	
Medicare O/P- Professional # claims w/COB	147-155	09	N	
Medicare O/P- Professional # claims denied	156-164	09	N	
Medicare O/P- Professional # claims w/TPL resource	165-173	09	N	

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/ Numeric</i>	<i>Special Instructions</i>
Medicare O/P- Professional % claims denied	174-182	09	N	
Medicare Total active members w/TPL resource	183-191	09	N	

REPORT #11, PART B RECORD - PROVIDER REPORTED:

RECORD LENGTH: 191

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/ Numeric</i>	<i>Special Instructions</i>
MCO Code	01-02	02	A	
Reporting Period	03-10	08	A	YYYYMMDD
Report Part	11	01	A	Constant "B"
Commercial I/P # claims	12-20	09	N	
Commercial I/P amount billed	21-29	09	N	
Commercial I/P amount reported	30-38	09	N	
Commercial O/P – Professional # claims	39-47	09	N	
Commercial O/P – Professional amount billed	48-56	09	N	
Commercial O/P – Professional amount reported	57-65	09	N	
Medicare I/P # claims	66-74	09	N	
Medicare I/P amount billed	75-83	09	N	

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/ Numeric</i>	<i>Special Instructions</i>
Medicare I/P amount reported	84-92	09	N	
Medicare O/P- Professional # claims	93-101	09	N	
Medicare O/P- Professional amount billed	102-110	09	N	
Medicare O/P- Professional amount reported	111-119	09	N	
Filler	120-191	09	N	

REPORT #11, PART C RECORD - RECOVERED:

RECORD LENGTH: 191

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/ Numeric</i>	<i>Special Instructions</i>
MCO Code	01-02	02	A	
Reporting Period	03-10	08	A	YYYYMMDD
Report Part	11	01	A	Constant "C"
Commercial I/P # claims	12-20	09	N	
Commercial I/P gross amount recovered	21-29	09	N	
Commercial I/P net \$ amount recovered by MCO	30-38	09	N	
Commercial O/P – Professional # claims	39-47	09	N	
Commercial O/P – Professional gross amount recovered	48-56	09	N	

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/ Numeric</i>	<i>Special Instructions</i>
Commercial O/P – Professional net \$ amount recovered by MCO	57-65	09	N	
Medicare I/P # claims	66-74	09	N	
Medicare I/P gross amount recovered	75-83	09	N	
Medicare I/P net \$ amount recovered by MCO	84-92	09	N	
Medicare O/P- Professional # claims	93-101	09	N	
Medicare O/P- Professional gross amount recovered	102-110	09	N	
Medicare O/P- Professional net \$ amount recovered by MCO	111-119	09	N	
Filler	120-191	09	N	

Report #11, Part C Record - Common Text Area:

Record Length: 191

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/ Numeric</i>	<i>Special Instructions</i>
MCO Code	01-02	02	A	
Reporting Period	03-10	08	A	YYYYMMDD
Report Part	11	01	A	Constant "T"
Common Text Line Number	12-13	02	A	Number each line of text beginning with 01
Description of Recovered amounts	14-191	178	A	

Revised 07/20/07

**HEALTHCHOICES BEHAVIORAL HEALTH
FINANCIAL REPORTING INSTRUCTIONS
FOR PRIMARY CONTRACTORS
COMMONWEALTH OF PENNSYLVANIA
OFFICE OF MENTAL HEALTH &
SUBSTANCE ABUSE SERVICES**

MARCH 1, 2015

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1

Introduction

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

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

This document outlines the general instructions for submitting Portable Document Format (PDF) and Excel-based monthly, quarterly and annual reports to the new Financial System. Unless specific instructions are provided, please follow the instructions set forth in the HealthChoices Behavioral Health Program Financial Reporting Requirements (FRR) for completing the required monthly, quarterly and annual reports, where applicable.

The Financial System website address is:

<https://ereporting.mercer.com/OMHSAS/Login.aspx>

2

General Overview and Requirements

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

Guidelines for Reporting

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

Note that the categories of aid or rating groups in the Excel-based quarterly report #s 1–4, 9, and annual report #2–4, 9 templates are changing due to the implementation of Medicaid enrollment according to the *Healthy PA* and HealthChoices expansion initiatives. The timing of the change to these financial reporting templates will be different for the State Fiscal Year (SFY) and Calendar Year (CY) Contractors. See Section 4 for more information.

The heading of each report should contain the following fields:

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

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

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

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

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

Monthly

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

Quarterly

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

Quarterly and Annual

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

Annual

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

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

Rounding

The report templates are formatted to round non-per member per month (PMPM) values. Therefore, amounts can be entered with decimals or rounded to the nearest dollar, except

for PMPM amounts which should include two decimal places. **IMPORTANT:** When rounding or truncating numbers, do not perform rounding or truncation until arriving at the final amount. (Example: If calculation is $1.5892 \times 2.059 = 3.272163$, report final amount as 3.27; not $1.59 \times 2.06 = 3.28$.)

Other Supporting Information

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

Features

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

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

Requirements

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

3

Overview of the Financial Reports

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

Quarterly

- Report #1

Quarterly and Annual

- Report #2
- Report #3
- Report #4 (Entity #1)
- Report #4 (Entity #2)
- Report #4 (Entity #3)
- Report #9A
- Report #9B

Monthly

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

*See Section 4 for the rating group changes impacting the Report #s: 1—3, 9 templates along with the timing for when these changes take effect. In addition, the information provided for each report below will apply to the existing and new templates, where applicable.

Additional Financial Reports

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

Please refer to the Financial Reporting Requirements (FFR) table in Section 2.0 and Attachment D in the FRR for further details. The Additional reports include, but are not limited to those listed below. A complete listing of the Additional reports to date and their

corresponding Report Group Designations for the file name can be found in Table 3 of Appendix B:

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

Instructions for Completing the Financial Reports

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

Report #1 – Enrollment Table

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

See Section 4 for template changes, guidance and timing associated with the rating group structure changes to this report resulting from the *Healthy PA* and HealthChoices Expansion initiatives.

Note that Month #1 in this tab corresponds to January and Month #12 corresponds to December for all Contractors for the same calendar. For the SFY Contractors, this means the first month of the Agreement year, July, will be Month #7 and the seventh month of the Agreement year, January, will be submitted in the next quarter's Month #1 field. The CY Contractors should continue to complete this report as they normally would.

The examples below show how a SFY Contractor would complete their Q4 2012 and Q1 2013 Report #1 tabs for the July 2012 – June 2013 contract period. Note that quarters are on a calendar year basis. In this example, ABC County’s contract is on a SFY basis and Q3 – Q4 2012 and Q1 – Q2 2013 correspond to July 2012 – June 2013.

The screenshot below shows a completed Report #1 for the Q4 2012 submission; this submission includes July 2012 – December 2012 data. Note that Month #s 1 – 6 are populated with zeros and correspond to January 2012 – June 2012.

Statement as of:	12/31/2012	(Reporting Date)													
Primary Contractor:	ABC County	(Primary Contractor Name)													
Reported By:	00000000000	(Reporting Entity)													

Rating Group	Count of Members Enrolled on Last Day of Period	Member Month Equivalents												Year to Date Total
		Month #1	Month #2	Month #3	Month #4	Month #5	Month #6	Month #7	Month #8	Month #9	Month #10	Month #11	Month #12	
TANF	3,000	-	-	-	-	-	-	3,000	3,000	3,000	3,000	3,000	3,000	18,000
Healthy Beginnings	2,000	-	-	-	-	-	-	2,000	2,000	2,000	2,000	2,000	2,000	12,000
SSI and Healthy Horizons With Medicare	900	-	-	-	-	-	-	900	900	900	900	900	900	5,400
SSI and Healthy Horizons Without Medicare	1,700	-	-	-	-	-	-	1,700	1,700	1,700	1,700	1,700	1,700	10,200
Federal GA	1	-	-	-	-	-	-	1	1	1	1	1	1	6
Categorically Needy State Only - GA	200	-	-	-	-	-	-	200	200	200	200	200	200	1,200
Medically Needy State Only - GA	100	-	-	-	-	-	-	100	100	100	100	100	100	600
TOTALS	7,901	-	-	-	-	-	-	7,901	7,901	7,901	7,901	7,901	7,901	47,406

Below is the completed Report #1 for the Q1 2013 submission (January 2013 – March 2013). This is the subsequent submission following the Q4 2012 submission above. Note that Month #s 1 – 6 will be completed in the Q2 2013 Report #1 submission.

Statement as of:	3/31/2013	(Reporting Date)													
Primary Contractor:	ABC County	(Primary Contractor Name)													
Reported By:	00000000000	(Reporting Entity)													

Rating Group	Count of Members Enrolled on Last Day of Period	Member Month Equivalents												Year to Date Total
		Month #1	Month #2	Month #3	Month #4	Month #5	Month #6	Month #7	Month #8	Month #9	Month #10	Month #11	Month #12	
TANF	4,000	4,000	4,000	4,000	-	-	-	-	-	-	-	-	-	12,000
Healthy Beginnings	3,000	3,000	3,000	3,000	-	-	-	-	-	-	-	-	-	9,000
SSI and Healthy Horizons With Medicare	1,000	1,000	1,000	1,000	-	-	-	-	-	-	-	-	-	3,000
SSI and Healthy Horizons Without Medicare	1,800	1,800	1,800	1,800	-	-	-	-	-	-	-	-	-	5,400
Federal GA	2	2	2	2	-	-	-	-	-	-	-	-	-	6
Categorically Needy State Only - GA	400	400	400	400	-	-	-	-	-	-	-	-	-	1,200
Medically Needy State Only - GA	200	200	200	200	-	-	-	-	-	-	-	-	-	600
TOTALS	10,402	10,402	10,402	10,402	-	-	-	31,206						

For additional descriptions and instruction, please consult the FRR.

Report #2 – Primary Contractor Summary of Transactions

All fields in this report are required and should be completed using numeric values. For

additional descriptions and instruction, please consult the FRR.

See Section 4 for template changes, guidance and timing associated with the rating group structure changes to this report resulting from the *Healthy PA* and HealthChoices Expansion initiatives.

Report #3 – Subcontractor Summary of Transactions

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

See Section 4 for template changes, guidance and timing associated with the rating group structure changes to this report resulting from the *Healthy PA* and HealthChoices Expansion initiatives.

Report #4 (Entity 1 – 3) – Related Party Transactions and Obligations

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

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

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

Report #6 – Claims Payable (RBUCs and IBNRs)

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

Report #7 – Lag Reports

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

Reports #8A, #8B and #8C – Claims Processing Report

Part A and B

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

Part C

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

Complete the "Date Claim Received" field using the MM/DD/YYYY date format. The "Claim Reference #", "Provider #" and "Provider Name" fields should be completed in text format. The "Service Type" and "Amount" fields should be completed using numeric values.

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

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

Part A

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

Part B

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

Report #12 – Reinvestment Report (*Effective July 2013 for the SFY Contractors and January 2014 for the CY Contractors*)

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

1. ALL HEALTHCHOICES
2. OTHER
3. TOTAL

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

Rows 40 – 74 in each Reinvestment Fund Year tab are hidden and can be expanded if more lines are needed to complete the report. In addition, the Report #12 template

includes an “Input” Tab for the Contractors to use at their discretion for completing the report. For example, Contractors can use the “Input” Tab as a data entry sheet to link to the other tabs.

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

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

Notes Tabs

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

Monthly

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

Quarterly and Annual

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

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

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

#2, 3 and 9 Notes Tabs should include values in the “1st Qtr”, “2nd Qtr”, and “3rd Qtr” columns.

4

Healthy PA and HealthChoices Expansion Impacts on the Financial Reports

As a result of the implementation of the *Healthy PA* initiative (effective January 1, 2015), 21 year olds in TANF/HB/MAGI - Child and SSI & Healthy Horizons without Medicare - Child rating groups will shift into TANF/HB/MAGI - Adult and SSI & Healthy Horizons without Medicare - Adult rating groups. There will be newly eligible 19-20 year olds joining the TANF/HB/MAGI - Child rating group as the Federal Poverty Level increases to 133%. Additionally, the State-Only GA rating groups will be eliminated, and a new rating group was created, labeled as *Healthy PA – Medically Frail*. For guidance on payments, claims and eligibility with respect to the rating groups, please see the November 2014 version of the Managed Care Payment System Table.

The HealthChoices Expansion (HCE) initiative, effective June 1, 2015, includes provisions that necessitate additional changes to the existing rating group structure of the HealthChoices program. Under these provisions, certain populations that were previously enrolled in HealthChoices prior to January 1, 2015, but left HealthChoices as part of the *Healthy PA* changes, will transition back into HealthChoices. This population will be combined with the existing *Healthy PA – Medically Frail* population (effective January 1, 2015) to form the HCE – NE rating group.

Below are the changes to the rating group structure in Report #s 1—3, 9. These changes will take effect with the following report submissions to the financial reporting website:

SFY Contractors - MAGI rating group name templates, combined eligibility rules:

- Continue to use the existing SFY 2014/2015 Quarterly Report #1—4, 9 and SFY 2014/2015 Annual Report #2—4, 9 templates with MAGI rating group names.
- Effective January 2015; include 21 year olds figures in the respective adult rating group; report *Healthy PA – Medically Frail* data in rating group 06 sections; zero out the rating group 07 sections (must be numeric, do not leave blank).
- Effective June 2015; include the HealthChoices Expansion population into rating group 06 sections.
- For SFY 2014/2015 Annual Report #2—4, 9; The template will have all 7 MAGI rating group name headings, but will be a combination of 2 quarters of data from July – December 2014 with MAGI eligibility (21 year olds reported as children; State-Only GA rating group data) and 2 quarters of data from January – June 2015 with *Healthy PA* or HealthChoices Expansion eligibility (21 year olds reported as adults; new *Healthy PA – Medically Frail* and HCE – NE rating groups).
- Rating group 06 will include the July – December Categorically Needy State-Only GA data, the January – May *Healthy PA – Medically Frail* data and the June HealthChoices Expansion data.

CY Contractors – *Healthy PA* rating group name templates, *Healthy PA* eligibility rules:

- Quarterly Report #1—4, 9: January – March 2015 quarterly report and beyond.
- Effective June 2015; include the HealthChoices Expansion population into rating group 06 sections.
- Annual Report #2—4, 9: CY 2015 annual report and beyond.

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

Financial Reporting Rating Group IDs:

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

The following rating group names stem from eligibility groupings resulting from the Modified Adjusted Gross Income (MAGI) provision of the Affordable Care Act. Note that these rating group names are consistent with the applicable Excel-based financial reporting templates that were in effect on July 1, 2013 for the SFY Contractors and January 1, 2014 for the CY Contractors.

Rating Group	Rating Group Name
01	TANF/Healthy Beginnings/MAGI – Child
02	TANF/Healthy Beginnings/MAGI – Adult
03	SSI & Healthy Horizons with Medicare
04	SSI & Healthy Horizons without Medicare – Child
05	SSI & Healthy Horizons without Medicare – Adult
06	Categorically Needy State-Only GA
07	Medically Needy State-Only GA

Note: Children are under age 22, adults are ages 22 and above.

The following rating group names stem from the *Healthy PA* initiative. Effective January 1, 2015, the two State-Only GA rating groups will no longer be reported in HealthChoices. The new *Healthy PA* – Medically Frail and HCE – NE rating groups will be entered in the Rating Group 06 section of these reports. Note that these rating group names will be used effective January 1, 2015 for the CY contractors. SFY contractors will submit any *Healthy PA* – Medically Frail or HealthChoices Expansion data in Rating Group 06: Categorically Needy State-Only GA section and enter 21 year old data in the respective adult rating

group for the SFY 2014/2015 time period in both the quarterly (effective January – June 2015) and annual reports.

Rating Group	Rating Group Name
01	TANF/Healthy Beginnings/MAGI – Child
02	TANF/Healthy Beginnings/MAGI – Adult
03	SSI & Healthy Horizons with Medicare
04	SSI & Healthy Horizons without Medicare – Child
05	SSI & Healthy Horizons without Medicare – Adult
06	<i>Healthy PA – Medically Frail</i>

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

5

Web-based Access

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

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

Accessing the Financial Report Templates and Website

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

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

Considerations for Excel 2007 or 2010 Users

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

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

Additional IT Tips for Using the Financial Report Website

Internet Connectivity

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

Internet Browser

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

Pop-up Windows

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

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

Internet Cookies

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

- Internet Explorer
 - Open Internet Explorer

- Click on Tools
- Click on Privacy
- Click Settings bar level to Low
- Click on Apply
- Firefox
 - Open Firefox
 - Click on Tools
 - Select Options
 - Select Privacy
 - Check Accept Cookies from Sites
 - Click on OK

Macintosh Computers

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

6

Submission Process

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

File Naming Conventions

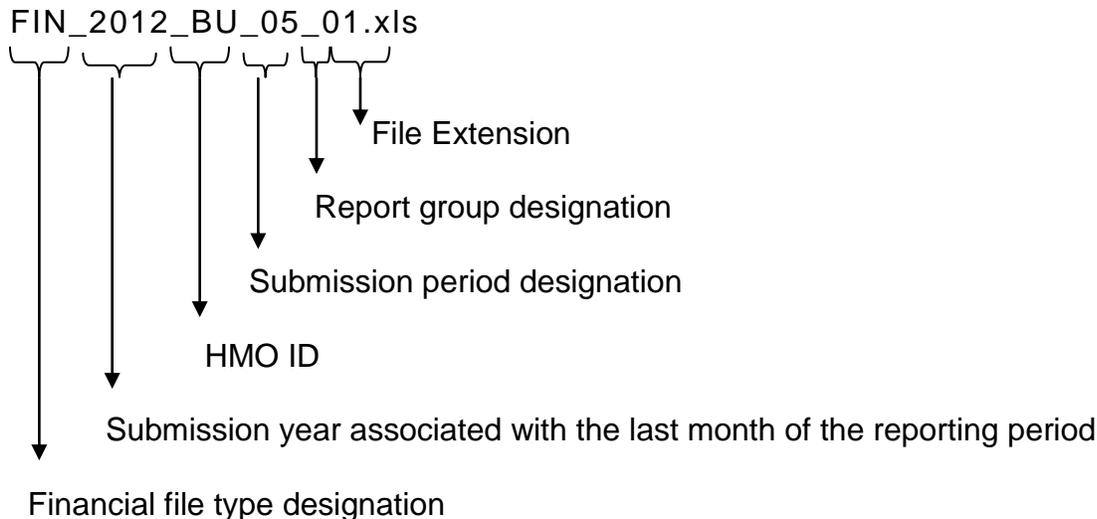
Each file that a Contractor uploads to the Financial System must conform to specific naming conventions. Any files that do not exactly follow the naming conventions will be rejected in the real-time edit process and will require resubmission. See below for information on a File Naming Convention tool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

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

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

File name example: FIN_2012_BU_05_01.xls

NOTE : This example is also located in Appendix B.



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

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

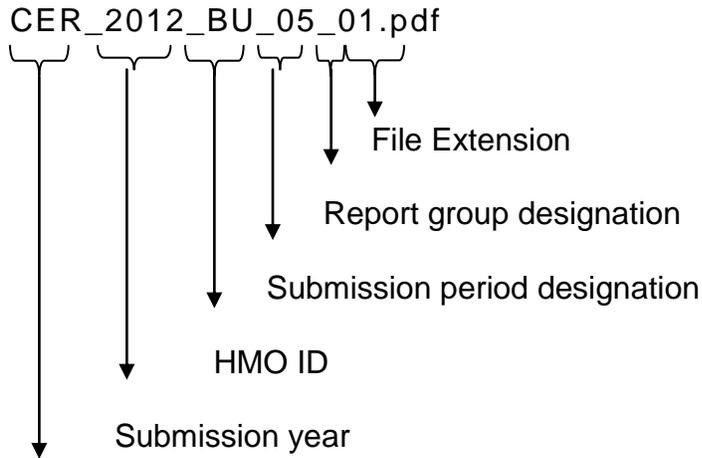
File names for submitting resubmissions due to failed edits must match the file name of the original submission. For example: a Contractor originally submits its May 2012 Monthly Reports # 6 – 8C and the file is rejected because it did not pass the real-time edits process. Upon fixing the errors, the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

Signed non-actuarial **Data Certifications of Reports 1 – 4, 6 – 9 and 12** should be uploaded through the financial submission process as PDF documents after the financial reports have been successfully submitted. As with Additional reports, these documents are not subject to critical or non-critical edits, but do need to follow the proper naming

conventions. The data certification file name should mirror the Financial Report submission for which it is being submitted with “CER” instead of “FIN” as the file type designation.

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

File name example: CER_2012_BU_05_01.pdf



Data Certification file type designation

File Naming Conventions Tool

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

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

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

Instructions for Uploading Files

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

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

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

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

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

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

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

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

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

For more details regarding the errors in 2 – 4 above, please see the “Erroneous Submissions” section below.

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

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

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

Erroneous Submissions – Non-Critical Errors

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

Non-Critical Edits:

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

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

The screenshot shows the 'Submission Edit Results' window with the following details:

Submission Edit Results	
Plan Name:	ABC County
Submitted File Name:	FIN_2011_AB_AN_04.xls
File Submission Date/Time:	1/24/2012 2:32 PM
File Disposition:	Uploaded
Submission ID:	2577

Non-Critical Errors:

- Sheet(Annual Report #2), Cell(E7) has wrong value(6007500) or Sheet(Annual Report #9A), Cell(E10) has wrong value(955816) (-1949316) <== Error - Rpt 2: SSI & Healthy Horizons w/o Medicare Cap Rev (Line 2a) must be within \$20 of Rpt 9A: SSI & Healthy Horizons w/o Medicare Cap Rev (Line 1)
- Sheet(Annual Report #2), Cell(B7) has wrong value(400000) or Sheet(Annual Report #9A), Cell(E10) has wrong value(3935226) (-3535226) <== Error - Rpt 2: TANF Cap Rev (Line 2a) must be within \$20 of Rpt 9A: TANF Cap Rev (Line 1)
- Sheet(Annual Report #9A), Cell(B1 2) has wrong value(300000) (L: 300000 = R: 0) <== Warning - Rpt 9A: TANF Other Revenue (Line 3) must equal \$0
- Sheet(Annual Report #2), Cell(G7) has wrong value(456694) or Sheet(Annual Report #2), Cell(I7) has wrong value(8414097) or Sheet(Annual Report #2), Cell(G20) has wrong value(2341.3651412301) (1525.8885284150206) <== Error - Rpt 2: ...

If the Contractor determines the data is correct, the user can proceed to upload the report by clicking “Yes” after the “Are you sure you want to submit?” or click “No” to reject the submission and go to Step 4 to resubmit a revised report.

Erroneous Submissions – Structural and Critical Errors

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

Structural Edits:

- If a file does not follow the file naming conventions, it will be rejected immediately. The error message will indicate the improper name used.
- Tab names cannot be changed, and tabs cannot be added or deleted, as these items

will cause the submission to be rejected.

- Each cell in the financial template has been programmed to only accept specific data types: text, decimal, whole number, or date.
 - Note: if the data type is decimal, a decimal point is not required but is allowed.

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

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

Critical Edits:

- Incomplete Cells — All cells must be populated.

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

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

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

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

Instructions for Downloading Submitted Reports

Contractors can download their submitted financial reports at any time. To do this, go to the “*Financial File Submission*” screen and click the underlined file in the **File Submission Dashboard** at the bottom of the page. From here user will have the option to open or save the document.

Prior Year Adjustments

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

CY 2012 and SFY 2012-2013 and Beyond

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

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

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

Steps 1 - 3: Follow Steps 1 through 3 under the “Instructions for Uploading Files” section starting on page 18.

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

Steps 5 – 7: Follow steps 5 through 7 on pages 20-21 under the section “Instructions for Uploading Files” to complete the adjusted financial report uploading process.

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

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

Generic File Submissions

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

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

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

Instructions for Generating Output Reports

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

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

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

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

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

Instructions for Generating Trend Charts

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

APPENDIX A

Financial Reporting Entity ID Numbers

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

Entity IDs by Report and Organization

Report 1

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

Report 2 and Report 9

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

Report 3

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

Report 6, Report 7 and Report 8

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

Report 4

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

Report 12

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

APPENDIX B

File Naming Conventions

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

File Naming Key

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

Table 1 – DHS Assigned HMO ID

Includes the two-character HMO ID that maps to each County/Multi-County Entity/Zone.

Table 2a – Monthly Submission Period Designation

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

Table 2b – Quarterly and Annual Submission Period Designation

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

Table 3 – Quarterly, Annual and Additional Report Group Designation

Includes the two-character code assigned to each report template.

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

File name example: FIN_2012_BU_05_01.xls

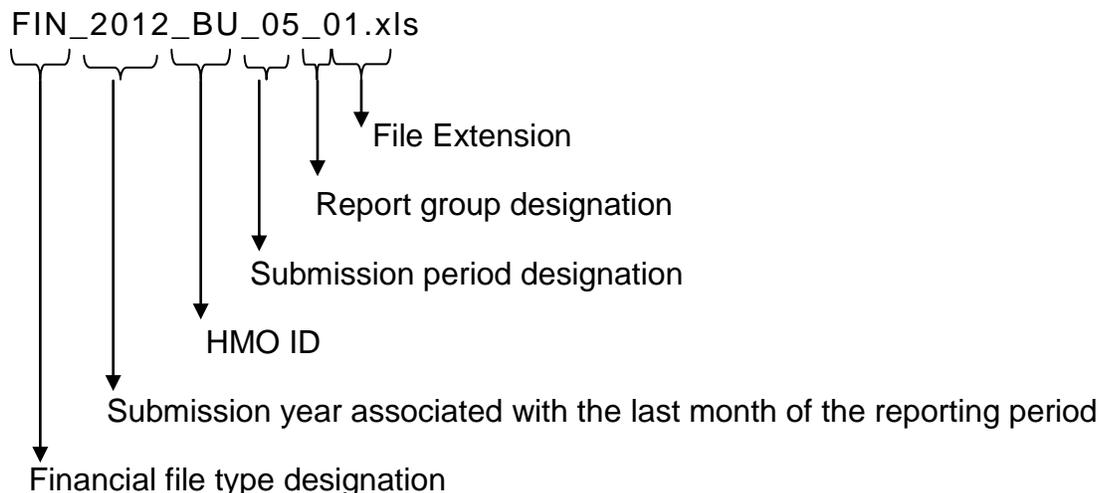


TABLE 1 - DHS Assigned HMO ID, Subcontractors and Management Corporations

Zone Year	ID	
CY	AI	Armstrong/Indiana MCE Behavioral Health
CY	AL	Allegheny County Behavioral Health
CY	BE	Beaver County Behavioral Health
CY	BT	Butler County Behavioral Health
CY	FA	Fayette County Behavioral Health
CY	GR	Greene County Behavioral Health
CY	LW	Lawrence County Behavioral Health
CY	WS	Washington County Behavioral Health
CY	WE	Westmoreland County Behavioral Health
CY	BU	Bucks County BH
CY	CH	Chester County BH
CY	DE	Delaware County BH
CY	MO	Montgomery County BH
CY	PH	Philadelphia County BH
SFY	AD	Adams County Behavioral Health
SFY	BK	Berks County Behavioral Health
SFY	CU	Cumberland County Behavioral Health
SFY	DA	Dauphin County Behavioral Health
SFY	LA	Lancaster County Behavioral Health
SFY	LB	Lebanon County Behavioral Health
SFY	LE	Lehigh County Behavioral Health
SFY	NH	Northampton County Behavioral Health
SFY	PE	Perry County Behavioral Health
SFY	YO	York County Behavioral Health
SFY	NB	Northeast Behavioral Health Care Consortium
SFY	BI	Blair HealthChoices
SFY	BS	Behavioral Health Services of Somerset And Bedford Counties
SFY	CK	Carbon, Monroe, Pike Counties
SFY	CM	Behavioral Health of Cambria County
SFY	CV	Northwest Behavioral Health (Crawford, Mercer, Venango)
SFY	ER	Erie County
SFY	FF	Tuscarora Managed Care Alliance (Franklin & Fulton Counties)
SFY	LC	Lycoming Clinton Joinder Board
SFY	NC	State Option - Community Care Behavioral Health Organization, Inc. (NC SO)
	C5	Capital Area Behavioral Health Collaborative, Inc. (CABHC)
	CC	Community Care Behavioral Health Organization (Community Care)
	CS	Community Behavioral HealthCare Network of Pennsylvania Services, Inc. (CSI)
	MB	Magellan Behavioral Health of Pennsylvania (MBH-PA)
	SB	Southwest Behavioral Health Management, Inc. (SBHM)
	VB	Value Behavioral Health of Pennsylvania, Inc. (VBH-PA)

TABLE 2a - Monthly Submission Period Designation

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

TABLE 2b - Quarterly and Annual Submission Period Designation

Zone Year¹	Submission Period (Last month in submission period)	2-Character Submission Period Designation
SFY	September	Q3
SFY	December	Q4
SFY	March	Q1
SFY	June	Q2
CY	March	Q1
CY	June	Q2
CY	September	Q3
CY	December	Q4
SFY or CY	Annual	AN

¹ Refer to Table 1 for Zone Year assignments.

TABLE 3 – Report Group Designation (as of May 2014)

Submission Period	Financial Report #	Report Group Designation
Monthly	6 – 8C	01
Monthly	12 – MAGI	28
Quarterly	1 – 4 and 9A	03
Annual	2 – 4 and 9A	04
Additional Reports		
Actual Reinsurance Experience		05
Actuarial Certification of Claims Liability (CY)		06
Balance Sheet		07
Contract Reserves Compliance Report		08
ELTSR Reinvestment Bank Statement		09
ELTSR Reinvestment Report #12		10
Equity Reserve Bank Statement		11
Estimated Reinsurance Experience		12
General Account Bank Statement		13
Parental Guaranty Quarterly Monitoring Report		14
Physician Incentive Arrangement		15
Reinsurance Waiver Report > \$75,000		16
Reinvestment Bank Statement		17
Risk & Contingency Bank Statement		18
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APPENDIX C

Financial Reporting Templates

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

Excel-based Templates

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

- Annual Reporting Template (#2-#4 & #9)_HPA eligibility.xls
- Annual Reporting Template (#2-#4 & #9)_MAGI eligibility.xls
- Monthly Reporting Template Part 1 (#6-#8).xls
- Monthly Reporting Template Part 2 (#12)_HPA eligibility.xls
- Monthly Reporting Template Part 2 (#12)_MAGI eligibility.xls
- Quarterly Reporting Template (#1-#4 & #9)_HPA eligibility.xls
- Quarterly Reporting Template (#1-#4 & #9)_MAGI eligibility.xls
- Financial Data Certification.doc

HealthChoices Behavioral Health Program

Health Insurer Provider Fee (HIPF) Financial Reporting Guidance

County Reporting

Capitation Revenue = Fee + Taxes + GRT

Capitation revenue, Report 2, Line 2a should be increased by the total amount paid by DHS to the Primary Contractor.

Other Distribution to Subcontractor, Report 2, Line 3e, should be increased by the amount paid to the subcontractor for the HIPF and HIPF-related Corporate Net Income Taxes. Note, if this line is already used for a distribution to the subcontractor, the Notes should detail the amount distributed for HIPF.

GRT, Report 2, Line 9d should be increased by the additional GRT liability due to the HIPF and related tax gross up.

BH-MCO Reporting

HIPF + Taxes

Capitation Revenue, Report 3, Line 2a, should be increased by the amount received from the County for the HIPF and HIPF-related Corporate Net Income Taxes.

Other Admin, Report 3, Line 4f, should be increased by the amount of the HIPF and HIPF-related Corporate Net Income Taxes. The Notes to Report #3 should detail the amount of the HIPF and the amount of the HIPF-related Corporate Net Income Taxes.

	Report 2	Report 3	Report 9
Revenue	X	X	X
Distribution to Subcontractor	X		
GRT	X		X
HIPF & Taxes Expense		X	X

Our preference for 2014 is that the HIPF and related expenses start being reported in the 2nd two quarters of calendar year 2014.