

**CENTENNIAL CARE
MANAGED CARE ORGANIZATION
FINANCIAL REPORTING GUIDE**

**FINANCIAL MANAGEMENT
REPORTING REQUIREMENTS**

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

EFFECTIVE JANUARY 1, 2022

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Introduction and General Instructions

1.01 Purpose and Objective

The purpose of this guide is to define the quarterly and annual financial and utilization reporting requirements submitted by the managed care organizations (MCOs) based on their contract with the State of New Mexico (State), Human Services Department (HSD), to provide services to members of the State's Medicaid managed care program, Centennial Care. This guide is intended to establish consistent and uniform reporting by all MCOs including direction and information about procedures and analyses to be performed and reported by the MCO.

The information to be provided within the reports detailed in this guide is being collected to:

- Evaluate the MCOs' financial and operational performance (at both an individual MCO level and an aggregate level).
- Monitor the financial and statistical experience of the programs.
- Reconcile to the respective period's encounter data submissions. This will allow the State to track and determine the timing and level of completeness of the encounter data.
- Inform the Centennial Care Physical Health (PH) Program, Behavioral Health (BH) Program, Long Term Services and Supports (LTSS) Program, Other Adult Group Physical Health (OAG PH) Program and Other Adult Group Behavioral Health (OAG BH) Program capitation rate development for future periods.

The Excel-based report templates are intended to supplement, not replace, additional reporting requirements included in the HSD Centennial Care Managed Care contract (MCO contract).

Key differences between these reports and other reports to be submitted to HSD are as follows:

- Grouping detail by cohort and service category.
- Incurred but not paid (IBNP) calculation detail.
- Reporting basis (incurred rather than paid).
- Timing of submission.

There is potential for some information within the various Centennial Care program area reports to be similar in nature; however, each report serves a specific purpose where reporting instructions and reporting basis may be different in order to support that purpose. Each Centennial Care report, regardless of program area, should be completed following the instructions specific to that report. To the extent there are differences in reporting basis between various program area reports containing information similar in nature, amounts will not be expected, or required, to reconcile to one another.

1.02 General Reporting Instructions

The primary objective of these instructions is to promote uniform, accurate, and complete reporting by all MCOs. The following are general instructions for completing the required Centennial Care PH, BH, LTSS, OAG PH and OAG BH Program-based financial reports:

1. Unless noted otherwise, only information pertaining to the Centennial Care Program is to be entered into the financial reports. The MCO is to input data for the period that begins with the first month the MCO was responsible to provide health care benefits to Centennial Care recipients. Data related to revenue earned or expenses incurred prior to January 1, 2014 is to be excluded from these reports.
2. Unless noted otherwise in the instructions specific to each report, Generally Accepted Accounting Principles are to be used in the preparation of these reports. All revenues and expenses are to be reported using the accrual basis of accounting. The accrual basis of accounting recognizes revenue when it is earned and expenses in the period incurred, without regard to the time of receipt or payment of cash.
3. The MCO shall submit all reports electronically, using Excel spreadsheets and attached documents, in the formats and on the forms and templates specified in this guide without alteration, to HSD's secure DMZ FTP site, unless directed otherwise by HSD. The date of receipt of the electronic version will serve as the date of receipt for the report(s). The MCO shall submit the electronic version of the report using the filename structure identified in Appendix I.
4. HSD will not provide the MCOs a prescribed and preformatted report template for every Centennial Care financial report discussed in this guide. Given the nature of certain financial reports and supporting information required to satisfy the particular financial reporting requirement per the MCO contract, a preformatted template will not sufficiently accommodate the required information. For these particular reports, MCOs can use their preferred format so long as the report includes sufficient detail to satisfy the reporting requirement. Centennial Care financial reports that fall into this category are identified as such within this guide. HSD will provide a prescribed and preformatted report template that the MCOs are required to use for all other Centennial Care financial reports discussed in this guide.
5. Two formats will be used for the prescribed and preformatted Excel-based reporting templates to be provided to the MCOs. The first format is an Excel-based program-specific financial reporting package template consisting of several reports discussed within this guide. The program-specific reporting package template is discussed in more detail within Section 2 of this guide. The other format is an Excel-based standalone reporting template specific to an individual report. These standalone reports were excluded from the program-specific reporting packages due to differences in report timing requirements and differences in report content where it would not be practical to report certain information separately across all five program-specific reporting packages. Standalone reports are discussed in Section 3.

6. To make the distinction between programs for the Centennial Care Financial Management reports, the following report naming structure is used throughout this guide and within the Excel-based reporting templates:
- PH Program-specific reports: FMB-PH Report ##
 - BH Program-specific reports: FMB-BH Report ##
 - LTSS Program-specific reports: FMB-LTSS Report ##
 - OAG PH Program-specific reports: FMB-OAGPH Report ##
 - OAG BH Program-specific reports: FMB-OAGBH Report ##
 - Centennial Care Program reports (includes all programs): FMB-ALL Report ##

Reports specific to any one particular program are identified as such within this guide.

7. All quarterly and annual reports are to be completed and submitted to HSD by the due dates outlined in this guide. Extensions to report submission dates will be considered by HSD after the MCO has contacted the HSD designated point of contact via email at least twenty-four (24) hours in advance of the report due date. Extension for submission of reports should be under rare and unusual circumstances. If HSD grants an extension, and the report is submitted before the extended deadline, the report(s) will be considered timely and not subject to penalty. Not requesting an extension within at least twenty-four (24) hours of the report due date is considered failure to report timely.
8. Line titles and column headings of the various reports are, in general, self-explanatory. Specific instructions are provided for items that may have some question as to content. Any entry for which no specific instructions are included shall be made in accordance with sound accounting principles and in a manner consistent with related items covered by specific instructions.
9. All reference to unpaid claim liability amounts or estimates in subsequent sections of this report shall include both incurred but not reported (IBNR) and reported but unpaid claims (RBUC) amounts and shall be referenced only as incurred but not paid (IBNP).
10. Unanswered questions or blank lines on any report or schedule will render the report or schedule incomplete and may result in a resubmission request. Any resubmission must be clearly identified as such. If no answers or entries are to be made, enter "None", "Not Applicable (N/A)" or "-0-" in the space provided.
11. Always utilize predefined categories or classifications before reporting an amount as "Other." Unless specified otherwise, any material amount included as "Other" requires a detailed explanation in the notes to be provided by the MCO. For this purpose, material is defined as comprising an amount greater than or equal to 5% of the total for each section. For example, if "Other" miscellaneous health care expense is less than 5% of total health care expense, no explanation is necessary. However, if "Other" miscellaneous health care expense is reported with a value that is equal to 5% or higher of total health care expenses, an explanation is necessary. Explanations related to amounts reported as "Other" are to be documented in the MCO notes. The explanation **must** itemize the components of the total amount reported as "Other".

Note there are some exceptions to the materiality requirement. For any amounts reported as “Other Income” in the revenue section of Report 1, regardless of materiality, the MCO is required to provide a detailed explanation in the MCO notes. For any amount reported as “Other-Outlier” in the BH reports, regardless of materiality, the MCO **must** provide the details in the designated Other-Outlier report. For any amounts reported as “Other LTSS Services” in the LTSS reports, regardless of materiality, the MCO is required to provide a detailed explanation in the MCO notes.

12. The MCO shall use the notes in the Excel-based report templates for explanations, disclosures, and write-ins. The notes can be narrative, in no prescribed format, which explain pertinent information, abnormalities, reasons for unusual increases/decreases, etc., as applicable to each of the reports. Providing comprehensive notes may alleviate necessary follow-up inquiries with the MCO. Additional sheets referencing the applicable reports must be attached as a means of providing further explanation, if necessary.

Throughout this guide, items requiring disclosure have been identified. However, these items should not be considered an exhaustive list. The MCO **must** use the notes any time it is necessary to provide further explanation in support of information provided within each of the reports. See Section 4.02 for additional detail regarding notes and disclosure requirements.

13. The State reserves the right to request restated financial information where program changes are deemed to have a substantial impact on the previously reported statements.
14. Input areas for the Excel-based reporting templates are shaded in yellow. Cells containing subtotals and totals are locked and calculated automatically based on data entered in the yellow shaded cells. The templates are locked and protected to ensure consistent reporting by all MCOs.

To assist MCOs with the use of the template, all cells within the template are viewable. This allows the user to move the cursor into any cell of the template and enables the user to see the formulas in the cells that calculate automatically. Although certain cells are locked and protected, the user’s ability to view the formulas should assist in the MCO’s understanding of the template and calculations performed.

It is important to note that when populating the templates with data, users are **not** to use the “cut and paste” function in Excel, as this may cause errors to the cell formulas. Additionally, certain cells have been shaded and locked to prevent data entry where data is not applicable to the particular item, cohort and/or service category.

15. Any line item or column heading with the description of “Reserved” should be left blank. These lines will be used for future reporting, if necessary.
16. Dollar amounts and per-member-per-month (PMPM) amounts shall be shown with two digits to the right of the decimal point.

17. “Quarters” correspond with calendar quarters.
18. The MCO shall submit a signed certification statement attesting to the timeliness, completeness, and accuracy of the information submitted within each report detailed in this guide. See Section 4.03 for data certification statement details.
19. In addition to all required reports, the MCO is to submit an analysis in support of the information within each report. See Section 4.04 for details regarding the analysis requirement.

1.03 Cohorts and Cohort Groupings

The financial reports detailed in this guide require most data to be reported by individual cohort and cohort groupings for each Centennial Care program. Cohort groupings are in reference to the consolidation of individual cohorts for the purpose of reporting where certain reports require a more summarized level of detail. The individual cohorts and mappings to cohort groups for each Centennial Care program are as follows:

Physical Health Program Cohort Mappings

Cohort Description	Cohort Number	Cohort Grouping
TANF/AFDC, CYFD 0–2 months Male & Female	001	TANF
TANF/AFDC, 2 months–20 years Male & Female	002	TANF
TANF/AFDC, 21 years–49 years Female	003	TANF
TANF/AFDC, 21 years–49 years Male	004	TANF
TANF/AFDC, 50+ years Male & Female	005	TANF
SSI & Waiver, 0–1 year Male & Female	006	SSI
SSI & Waiver, 1 year–20 years Male & Female	007	SSI
SSI & Waiver, 21 years–39 years Female	008	SSI
SSI & Waiver, 21 years–39 years Male	009	SSI
SSI & Waiver, 40+ years, Aged 65+ years Male & Female	010	SSI
PW, MA, 15 years–49 years Female	011	TANF
CYFD, 2 months–21 years Male & Female	012	TANF

Behavioral Health Program Cohort Mappings

Cohort Description	Cohort Number	Cohort Grouping
TANF/AFDC, All ages Male & Female	201	TANF
CYFD, All ages Male & Female	202	TANF
SSI, B&D, Waiver, 0–14 years Male & Female	203	SSI
SSI, B&D, Waiver, 15 years–20 years Male & Female	204	SSI
SSI, B&D, Waiver, 21+ years Male & Female	205	SSI
LTSS Non Dual, Male & Female	206	LTSS
LTSS Dual, Male & Female	207	LTSS

Long Term Services and Supports Program Cohort Mappings

Cohort Description	Cohort Number	Cohort Grouping
Dual Eligible — NF LOC Nursing Facility (Region 1, 3, 4)	300A	Duals
Dual Eligible — NF LOC Nursing Facility (Region 2)	310	Duals
Dual Eligible — NF LOC Nursing Facility (Region 5)	320	Duals
Dual Eligible — NF LOC Disabled and Elderly Waiver	300B	Duals
Dual Eligible — NF LOC Personal Care Option	300C	Duals
Dual Eligible — Self Direction	301	Duals
Healthy Dual	304	Duals
Non-Dual Eligible — NF LOC Nursing Facility (Region 1, 3, 4)	302A	Non-Dual
Non-Dual Eligible — NF LOC Nursing Facility (Region 2)	312	Non-Dual
Non-Dual Eligible — NF LOC Nursing Facility (Region 5)	322	Non-Dual
Non-Dual Eligible — NF LOC Disabled and Elderly Waiver	302B	Non-Dual
Non-Dual Eligible — NF LOC Personal Care Option	302C	Non-Dual
Non-Dual Eligible — Self Direction	303	Non-Dual

Other Adult Group – Physical Health Program Cohort Mappings

Cohort Description	Cohort Number	Cohort Grouping
Ages 19–29, Male	110, 112	OAG
Ages 19–29, Female	111, 114	OAG
Ages 30–39, Male	115	OAG
Ages 30–39, Female	116	OAG
Ages 40–49, Male	117	OAG
Ages 40–49, Female	118	OAG
Ages 50–64, Male & Female	119, 120, 121, 122	OAG

Other Adult Group – Behavioral Health Program Cohort Mappings

Cohort Description	Cohort Number	Cohort Grouping
Ages 19–64, Male & Female	208	OAG

1.04 Report Requirements and Due Dates

The following table lists the reports to be submitted to HSD/FMB and the required submission schedule for each report. Where multiple programs are listed for a single report, the MCO is to report program-specific information separately within either a distinct program-specific reporting package template or a standalone reporting template as directed by HSD. Where “All Programs” is indicated for any particular report, reported information is specific to the Centennial Care Program in total. Where “In Total” is indicated for any particular report, reported information will include the MCO’s total business, as necessary.

Unless specified otherwise, most reports are due to HSD quarterly or annually as identified in the table below. Reports identified with the description of “Annual Supplement” in the “Frequency of Submission” column are due to HSD on an annual basis. Most of these annual supplemental reports serve as a restatement of Reports 1 through 13 and also require accompanying MCO notes and a data certification statement. The annual supplemental reports are discussed further in Section 1.05.

Two formats will be used for the prescribed and preformatted Excel-based reporting templates to be provided to the MCOs:

- The first format is an Excel-based program-specific reporting package template consisting of several reports discussed within this guide. The program-specific reporting package template is discussed in more detail within Section 2 of this guide.
- The other format is an Excel-based standalone reporting template specific to an individual report. These standalone reports were excluded from the program-specific reporting packages due to differences in report timing requirements and differences in report content where it would not be practical to report certain information separately across all five program-specific reporting packages. Standalone reports are discussed in Section 3.

Additionally, HSD will not provide the MCOs a prescribed and preformatted report template for every Centennial Care financial report discussed in this guide. Given the nature of certain financial reports and supporting information required to satisfy the particular financial reporting requirement per the MCO contract, a preformatted template will not sufficiently accommodate the required information. For these reports, MCOs can use their preferred format so long as the report includes sufficient detail to satisfy the reporting requirement. Centennial Care financial reports and required information that fall into this category are identified by an “as needed” description within the format column. HSD will provide a prescribed and preformatted report template that the MCOs are required to use for all other Centennial Care financial reports discussed in this guide.

Report Requirements and Due Dates

Report # and Name	Program(s)	Fin Mgt Report Reference #	Format	Frequency of Submission	Due Date ¹
1 Schedule of Revenues and Expenses by Category	PH	FMB-PH 01, 01A	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
	BH	FMB-BH 01		Annual supplement	May 15
	LTSS	FMB-LTSS 01			
	OAG PH	FMB-OAGPH 01			
	OAG BH	FMB-OAGBH 01			
2 Schedule of Expenses Detail	PH	FMB-PH 02	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
	BH	FMB-BH 02		Annual supplement	May 15
	LTSS	FMB-LTSS 02			
	OAG PH	FMB-OAGPH 02			
	OAG BH	FMB-OAGBH 02			
3 Schedule of Utilization by Category	PH	FMB-PH 03	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
	BH	FMB-BH 03		Annual supplement	May 15
	LTSS	FMB-LTSS 03			
	OAG PH	FMB-OAGPH 03			
	OAG BH	FMB-OAGBH 03			
4A Subcapitation Expenses Detail	PH	FMB-PH 4A	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
	BH	FMB-BH 4A		Annual supplement	May 15
	LTSS	FMB-LTSS 4A			
	OAG PH	FMB-OAGPH 4A			
	OAG BH	FMB-OAGBH 4A			
4B Subcapitation Agreement Detail	PH	FMB-PH 4B	Predetermined Excel-based reporting package template	Annual supplement	May 15
	BH	FMB-BH 4B			
	LTSS	FMB-LTSS 4B			
	OAG PH	FMB-OAGPH 4B			
	OAG BH	FMB-OAGBH 4B			
5A Inpatient Hospital Services Lag Report	PH	FMB-PH 5A	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
	BH	FMB-BH 5A		Annual supplement	May 15
	LTSS	FMB-LTSS 5A			
	OAG PH	FMB-OAGPH 5A			
	OAG BH	FMB-OAGBH 5A			
5B Outpatient Services Lag Report	PH	FMB-PH 5B	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
	LTSS	FMB-LTSS 5B		Annual supplement	May 15
	OAG PH	FMB-OAGPH 5B			
5C Physician Services Lag Report	PH	FMB-PH 5C	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
	LTSS	FMB-LTSS 5C		Annual supplement	May 15
	OAG PH	FMB-OAGPH 5C			
5D Pharmacy Lag Report	PH	FMB-PH 5D	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
	BH	FMB-BH 5D		Annual supplement	May 15
	LTSS	FMB-LTSS 5D			
	OAG PH	FMB-OAGPH 5D			
	OAG BH	FMB-OAGBH 5D			

Report Requirements and Due Dates

Report # and Name	Program(s)	Fin Mgt Report Reference #	Format	Frequency of Submission	Due Date ¹
5E Dental Services Lag Report	PH OAG PH	FMB-PH 5E FMB-OAGPH 5E	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
				Annual supplement	May 15
5F Laboratory/ Radiology Services Lag Report	PH OAG PH	FMB-PH 5F FMB-OAGPH 5F	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
				Annual supplement	May 15
5G Other Medical Services Lag Report	PH LTSS OAG PH	FMB-PH 5G FMB-LTSS 5G FMB-OAGPH 5G	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
				Annual supplement	May 15
5H Outpatient/ Clinic Services Lag Report	BH OAG BH	FMB-BH 5H FMB-OAGBH 5H	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
				Annual supplement	May 15
5I Residential Treatment Center Lag Report	BH OAG BH	FMB-BH 5I FMB-OAGBH 5I	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
				Annual supplement	May 15
5J Behavioral Management Services Lag Report	BH OAG BH	FMB-BH 5J FMB-OAGBH 5J	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
				Annual supplement	May 15
5K BH Providers Lag Report	BH OAG BH	FMB-BH 5K FMB-OAGBH 5K	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
				Annual supplement	May 15
5L Psychosocial Rehab Services Lag Report	BH OAG BH	FMB-BH 5L FMB-OAGBH 5L	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
				Annual supplement	May 15
5M Community Services, Agencies Lag Report	BH OAG BH	FMB-BH 5M FMB-OAGBH 5M	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
				Annual supplement	May 15
5N Nursing Facility/ Hospice Lag Report	LTSS	FMB-LTSS 5N	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
				Annual supplement	May 15
5O Home- and Community-Based Waiver (HCBW) Services/ Personal Care Option Lag Report	LTSS OAG PH	FMB-LTSS 5O FMB-OAGPH 5O	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
				Annual supplement	May 15

Report Requirements and Due Dates

Report # and Name	Program(s)	Fin Mgt Report Reference #	Format	Frequency of Submission	Due Date ¹
5P Self Direction Services Lag Report	LTSS	FMB-LTSS 5P	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
				Annual supplement	May 15
5Q Medical Care Credit Lag Report	LTSS	FMB-LTSS 5Q	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
				Annual supplement	May 15
6 Encounter Comparison	PH	FMB-PH 06	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
	BH	FMB-BH 06		Annual supplement	May 15
	LTSS	FMB-LTSS 06			
	OAG PH	FMB-OAGPH 06			
	OAG BH	FMB-OAGBH 06			
7 Individual High Cost Claims	PH	FMB-PH 07	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
	BH	FMB-BH 07		Annual supplement	May 15
	LTSS	FMB-LTSS 07			
	OAG PH	FMB-OAGPH 07			
	OAG BH	FMB-OAGBH 07			
8 Value Added Services/ Non-State Plan Services Report	PH	FMB-PH 08	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
	BH	FMB-BH 08		Annual supplement	May 15
	LTSS	FMB-LTSS 08			
	OAG PH	FMB-OAGPH 08			
	OAG BH	FMB-OAGBH 08			
9 Recovery And Cost Avoidance Report	PH	FMB-PH 09	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
	BH	FMB-BH 09		Annual supplement	May 15
	LTSS	FMB-LTSS 09			
	OAG PH	FMB-OAGPH 09			
	OAG BH	FMB-OAGBH 09			
10 Outlier Services Report	BH	FMB-BH 10	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
	OAG BH	FMB-OAGBH 10		Annual supplement	May 15
11 Self Direction Expenses Report	LTSS	FMB-LTSS 11	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
				Annual supplement	May 15
12A Medical Care Credit Report	LTSS	FMB-LTSS 12A	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
				Annual supplement	May 15
12B Copay Report	PH	FMB-PH 12B	Predetermined Excel-based reporting package template	Quarterly	Quarterly ²
	BH	FMB-BH 12B		Annual supplement	May 15
	LTSS	FMB-LTSS 12B			
	OAG PH	FMB-OAGPH 12B			
	OAG BH	FMB-OAGBH 12B			

Report Requirements and Due Dates

Report # and Name	Program(s)	Fin Mgt Report Reference #	Format	Frequency of Submission	Due Date¹
13A Stop Loss Protection Report	All Programs	FMB-ALL 13A	Predetermined Excel-based standalone template	Quarterly Annual supplement	Quarterly ² May 15
13B Reinsurance Policy Report	All Programs	FMB-ALL 13B	As Needed	Annually, initially and upon renewal	April 1 And as required by the MCO contract
14 Administrative Expense Detail	PH BH LTSS OAG PH OAG BH	FMB-ALL 14	Predetermined Excel-based standalone template	Annual supplement	May 15
15 Pharmacy Supplemental Report	PH BH LTSS OAG PH OAG BH	FMB-PH 15 FMB-BH 15 FMB-LTSS 15 FMB-OAGPH 15 FMB-OAGBH 15	Predetermined Excel-based reporting package template	Annual supplement	May 15
16 Payments to IHS and Tribal 638 Providers Report	All Programs (by cohort #)	FMB-ALL 16	Predetermined Excel-based standalone template	Quarterly	Quarterly ²
17 Delivery System Improvements	All Programs	FMB-ALL 17	Predetermined Excel-based standalone template And as needed	Quarterly	Quarterly ²
18 Cash Reserve Statement	All Programs	FMB-ALL 18	As needed	Quarterly	Quarterly ²
19 Performance Bond Coverage	All Programs	FMB-ALL 19	As needed	Quarterly, initially	Initially, within 45 calendar days of the first month of capitation. 30 calendar days after notice from HSD
20 Risk Withholding Report	All Programs	FMB-ALL 20	As needed	Annually	April 1
21 Fidelity Bond or Insurance Protection	All Programs	FMB-ALL 21	As needed	Annually, initially and upon renewal	April 1 And as required by the MCO contract
22 Business Restructuring	In Total	FMB-ALL 22	As needed	As needed per contract requirements	No later than 60 calendar days following the change of ownership

Report Requirements and Due Dates

Report # and Name	Program(s)	Fin Mgt Report Reference #	Format	Frequency of Submission	Due Date ¹	
23	Medicaid-Specific Unaudited Schedule of Revenue and Expenses Report	PH BH LTSS OAG PH OAG BH	FMB-ALL 23	Predetermined Excel-based standalone template	Quarterly Annual supplement	Quarterly ² May 15
24	Medicaid-Specific Audited Schedule of Revenue and Expenses Report	PH BH LTSS OAG PH OAG BH	FMB-ALL 24	Predetermined And as needed	Annually	June 1
25	Reconciliation Schedule of Unaudited Centennial Care Financial Reports to Audited Schedule of Revenue and Expenses Report	PH BH LTSS OAG PH OAG BH	FMB-ALL 25	Predetermined Excel-based standalone template	Annually	June 1
26	Independently Audited Financial Statements	In Total	FMB-ALL 26	As needed	Annually	June 1
27A	Office of the Superintendent of Insurance Quarterly Statements	In Total	FMB-ALL 27A	As needed	Quarterly	Quarterly: 45 calendar days after quarter end
27B	Office of the Superintendent of Insurance Annual Statements	In Total	FMB-ALL 27B	As needed	Annually	March 1
29	Centennial Care MLR Report	PH BH LTSS OAG PH OAG BH	FMB-ALL 29	Predetermined Excel-based standalone template	Annually	Last Business Day in July following the contract year
N/A	MCO Notes	PH BH LTSS OAG PH OAG BH All Programs In Total	N/A	Narrative Excel-based reporting package and standalone templates And as needed	Quarterly, annually, and annual supplement	Based on due date of the report(s) the notes are meant to accompany

Report Requirements and Due Dates

Report # and Name	Program(s)	Fin Mgt Report Reference #	Format	Frequency of Submission	Due Date ¹
N/A Data Certification Statement	PH BH LTSS OAG PH OAG BH All Programs In Total	N/A	Predetermined	Quarterly, annually, and annual supplement	Based on due date of the report(s) the certification is meant to accompany

¹ If a due date falls on a weekend or State of New Mexico scheduled holiday, reports will be due the next business day.

² Quarterly financial reports are due Sixty (60) Calendar Days from the end of the first quarter, the remaining quarterly financial reports are due Forty-Five (45) Calendar Days from the end of the respective quarter.

1.05 Report Incurred and Paid Date Information

Unless specified otherwise, each report template, regardless of submission frequency, is formatted to accommodate incurred data delineated by four distinct quarters, as well as a year-to-date (YTD) total. These report templates will run on a twelve-month calendar year reporting cycle (i.e., January 1 through December 31) where “quarters” correspond to calendar quarters. For the purpose of these reports, the “current” quarter is the last quarter during the twelve-month calendar year reporting cycle being reported, and “prior” quarter(s) shall mean all quarters within the twelve-month calendar year reporting cycle prior to the current quarter. For example, in the reports for quarter-ending September 30 (July 1 through September 30 incurred dates), the third quarter is considered the current quarter; quarter 2 (April 1 through June 30 incurred dates) is considered the first prior quarter; and quarter 1 (January 1 through March 31 incurred dates) is considered the second prior quarter.

Beginning with the first quarter of the twelve-month calendar year reporting cycle (i.e., January 1 through March 31), the MCO is to submit the underlying incurred data as of quarter’s end. After each subsequent quarter-end within the reporting cycle, the MCO is to submit new data incurred in the most recent quarter, as well as restated data for claims incurred in each prior quarter within the reporting cycle. IBNP estimates for each prior quarter should also be revised to reflect the most recent look at the actual claims paid data. Do **not** include amounts for adjustments to prior quarter’s IBNP claim estimates within the current quarter.

The medical claim expenses reported for the **current quarter** are generally calculated as follows:

Claims incurred and paid during the current quarter
+ Estimated claims IBNP at the end of the current quarter

The medical claim expenses reported for the **quarter(s) prior** to the current quarter within the twelve-month reporting cycle are generally calculated as follows:

Claims incurred during the quarter(s) prior to the current quarter, regardless of date paid
+ Revised estimated claims IBNP at the end of the current quarter

Reporting financial data in this manner will take advantage of the most recent look at the actual claims paid data and the revised IBNP claims amount for each quarter within the reporting cycle, thus relying more on actual experience and less on estimates for the outstanding unpaid claims liability included within the financial reports.

Annual Supplemental Reports

The annual supplemental reports include Reports 1 through 15 and Report 23, and serve as a restatement for Reports 1 through 4A, Reports 5A through 5Q, Reports 6 through 13A, and Report 23.

Unless formatted otherwise, these reports shall contain four distinct quarters of incurred data for the most recent twelve-month calendar year-ended reporting cycle. These restated reports will differ from the fourth quarter submission of the respective reports in that they will include the benefit of an extra three months of paid run out in deriving the incurred estimates (i.e., incurred in 12 months and paid through 15 months), thus relying more on actual experience and less on estimates for the outstanding unpaid claims liability.

The fourth quarter reports due under the quarterly submission schedule will not have the benefit of three additional months of paid run out (i.e., incurred in 12 months and paid through 12 months). The run out period for each quarter's respective incurred data (based on the report submission schedule) is detailed further in the tables below.

The primary purpose of the supplemental annual submission of select reports is to support the development of Centennial Care PH Program, BH Program, LTSS Program, OAG PH Program and OAG BH Program capitation rates for future periods. The reports in this supplemental annual submission will also be used to evaluate the MCOs' financial and operational performance, monitor the financial and statistical experience of the programs over the twelve-month period, and reconcile encounter data to reported financial information.

Note the annual supplemental reports also require accompanying MCO notes, an analysis, and all applicable data certification statements.

The incurred periods of underlying data for the quarterly calendar year reporting cycle reports and the annual supplemental reports are described in the tables below.

Report Timing — Quarterly Revenue and Expense Reporting for Twelve-Month Reporting Cycle

Unless noted otherwise in this guide, all reports are to be submitted quarterly for incurred and paid periods specified in the tables below. Each table below is specific to the information to be reported within the quarter-specific designated areas of the financial reports throughout the twelve-month reporting cycle for the respective quarter. For example, information within the first table below (*Q1 Data Reporting within Twelve-Month Reporting Cycle*) pertains to the underlying data to be reported within the "Q1" columns of the various reports for the first, second, third, and fourth quarter submissions under the quarterly submission schedule, as well as underlying data to be reported within the annual supplemental reports.

Q1 Data Reporting within Twelve-Month Reporting Cycle

Submission #	Report Period Ending	Q1 Data Incurred From	Q1 Data Incurred Through	Q1 Data Paid Through	Report Due Date
1	Mar 31, 2020	Jan 1, 2020	Mar 31, 2020	Mar 31, 2020	May 30, 2020
2	Jun 30, 2020	Jan 1, 2020	Mar 31, 2020	Jun 30, 2020	Aug 15, 2020
3	Sep 30, 2020	Jan 1, 2020	Mar 31, 2020	Sep 30, 2020	Nov 15, 2020
4	Dec 31, 2020	Jan 1, 2020	Mar 31, 2020	Dec 31, 2020	Feb 15, 2021
5 - Annual Supplement	Dec 31, 2020	Jan 1, 2020	Mar 31, 2020	Mar 31, 2021	May 15, 2021

Q2 Data Reporting within Twelve-Month Reporting Cycle

Submission #	Report Period Ending	Q2 Data Incurred From	Q2 Data Incurred Through	Q2 Data Paid Through	Report Due Date
1	NA	NA	NA	NA	NA
2	Jun 30, 2020	Apr 1, 2020	Jun 30, 2020	Jun 30, 2020	Aug 15, 2020
3	Sep 30, 2020	Apr 1, 2020	Jun 30, 2020	Sep 30, 2020	Nov 15, 2020
4	Dec 31, 2020	Apr 1, 2020	Jun 30, 2020	Dec 31, 2020	Feb 15, 2021
5 - Annual Supplement	Dec 31, 2020	Apr 1, 2020	Jun 30, 2020	Mar 31, 2021	May 15, 2021

Q3 Data Reporting within Twelve-Month Reporting Cycle

Submission #	Report Period Ending	Q3 Data Incurred From	Q3 Data Incurred Through	Q3 Data Paid Through	Report Due Date
1	NA	NA	NA	NA	NA
2	NA	NA	NA	NA	NA
3	Sep 30, 2020	Jul 1, 2020	Sep 30, 2020	Sep 30, 2020	Nov 15, 2020
4	Dec 31, 2020	Jul 1, 2020	Sep 30, 2020	Dec 31, 2020	Feb 15, 2021
5 - Annual Supplement	Dec 31, 2020	Jul 1, 2020	Sep 30, 2020	Mar 31, 2021	May 15, 2021

Q4 Data Reporting within Twelve-Month Reporting Cycle

Submission #	Report Period Ending	Q4 Data Incurred From	Q4 Data Incurred Through	Q4 Data Paid Through	Report Due Date
1	NA	NA	NA	NA	NA
2	NA	NA	NA	NA	NA
3	NA	NA	NA	NA	NA
4	Dec 31, 2020	Oct 1, 2020	Dec 31, 2020	Dec 31, 2020	Feb 15, 2021
5 - Annual Supplement	Dec 31, 2020	Oct 1, 2020	Dec 31, 2020	Mar 31, 2021	May 15, 2021

The tables above describe the reporting cycle for four submissions of quarterly reports and the submission of the annual supplemental reports. Reporting periods beyond December 31, 2020, will continue with the normal reporting cycle outlined for submissions 1 through 5.

Report Timing — Lag Reports

Specific details related to the completion of the various lag reports can be found in Section 2.09 of this guide.

Only information pertaining to the Centennial Care Program is to be entered into the lag reports. Data related to expenses incurred prior to January 1, 2014 is to be excluded from the lag reports.

The lag reports are formatted to gather 36 months of data ending with the current month. The current month is the last month of the period that is being reported. For example, in the report for the period ended March 31, 2020, the current month would be March 2020.

The table below details the lag report timing requirements:

Lag Reporting

Submission #	Report Period Ending	Lag Report Incurred From	Lag Report Incurred Through	Lag Report Paid Through	Lag Report Due Date
1	Mar 31, 2020	Apr 1, 2017	Mar 31, 2020	Mar 31, 2020	May 30, 2020
2	Jun 30, 2020	Jul 1, 2017	Jun 30, 2020	Jun 30, 2020	Aug 15, 2020
3	Sep 30, 2020	Oct 1, 2017	Sep 30, 2020	Sep 30, 2020	Nov 15, 2020
4	Dec 31, 2020	Jan 1, 2018	Dec 31, 2020	Dec 31, 2020	Feb 15, 2021
5 – Annual Supplement	Dec 31, 2020	Apr 1, 2018	Mar 31, 2021	Mar 31, 2021	May 15, 2021
6	Mar 31, 2021	Apr 1, 2018	Mar 31, 2021	Mar 31, 2021	May 30, 2021
7	Jun 30, 2021	Jul 1, 2018	Jun 30, 2021	Jun 30, 2021	Aug 15, 2021
8	Sep 30, 2021	Oct 1, 2018	Sep 30, 2021	Sep 30, 2021	Nov 15, 2021
9	Dec 31, 2021	Jan 1, 2019	Dec 31, 2021	Dec 31, 2021	Feb 15, 2022
10 – Annual Supplement	Dec 31, 2021	Apr 1, 2019	Mar 31, 2022	Mar 31, 2022	May 15, 2022

The table above describes the reporting cycle for eight submissions of quarterly lag reports and two submissions of the annual supplemental lag reports. Reporting periods beyond December 31, 2021, will continue with the normal reporting cycle outlined for submissions 1 through 10.

2

Specifications for Excel-Based Reports Included Within Program-Specific Reporting Package Templates

2.01 Program-Specific Reporting Package Templates

Most of Reports 1 through 15 are included within five distinct Excel-based Medicaid financial reporting package templates specific to the Centennial Care PH, BH, LTSS, OAG PH and OAG BH programs, respectively. The reports within each program-specific reporting package template share the same due dates and contain information in support of data reported within the other reports of the respective reporting package template. Note that most of the annual supplemental reports detailed in Section 1.05 are included within the Excel-based program-specific reporting package templates.

A data certification statement will be required for the program-specific reporting packages. See Section 4.03 for additional details regarding data certification requirements.

Each Excel-based program-specific reporting package template also includes a tab for both the MCO notes and the MCO analysis. See Sections 4.02 and 4.04, respectively, for additional details regarding the MCO notes and analysis requirements.

2.02 Information Input Tab

This tab serves as a cover sheet for each of the Excel-based program-specific reporting package templates. In the information table provided, enter/select the following data elements:

- Report submission number: Indicate the report submission number by making the appropriate selection in the dropdown box located on the right side of the table. For example, “v01” for the first submission, “v02” for the second submission, etc. Note that the submission number indicated here should be consistent with the submission number used in the report’s file name. See Appendix I for electronic file naming structure guidance.
- MCO’s name: Enter the name of the MCO. Note that besides entering the name of the particular MCO on this line, the MCO must provide additional identification information by selecting the MCO’s acronym in the dropdown box located on the right side of the table. The MCO is to make certain the correct acronym is selected as the selection will impact data used elsewhere within the reporting package.
- Calendar year reporting cycle: Indicate the calendar year applicable to the report submission by making the appropriate selection in the dropdown box located on the right side of the table. Selection choices include several different calendar year periods. The MCO is to make certain the correct calendar year is selected as the selection will impact formulas and dates used elsewhere within the reporting package.
- Report submission type (quarterly or annual supplemental): Indicate whether the reporting package submission relates to the quarterly reports or the annual supplemental reports by

making the appropriate selection in the dropdown box located on the right side of the table. Selection choices include quarterly or annual supplemental. The MCO is to make certain the correct submission type is selected as this selection will impact the formulas in the check totals tab. Incorrect selection of the report type will result in false exceptions within the check totals tab. The check totals tab is discussed in more detail in Section 2.22.

- Quarters included in reports: Indicate the quarterly data included within the reporting package submission by making the appropriate selection in the dropdown box located on the right side of the table. Selection choices include Q1 only, Q1 through Q2, Q1 through Q3, or Q1 through Q4. The MCO is to make certain the correct quarters are selected as the selection will impact the formulas in the check totals tab. Incorrect selection of the quarters included within the reporting package template will result in false exceptions within the check totals tab. The check totals tab is discussed in more detail in Section 2.22.
- Report period ending: The report period ending date will automatically populate based on the selections made for both the calendar year reporting cycle and the quarters included in the reports. Outputs will include March 31, June 30, September 30, or December 31 of the applicable reporting year.
- Year-to-date period: YTD period is in reference to the months of data included in the YTD sections of the various reports. The YTD period will automatically populate based on the selections made for the calendar year reporting cycle, report submission type, and quarters included in reports. Dates will automatically populate for the following:
 - Incurred from date
 - Incurred through date
 - Paid through date

Because the dates in this section are populated automatically, the MCO must confirm the accuracy of the respective dates by entering “Yes” or “No” for each date in the spaces provided on the right side of the table (Column A of the date selection confirmation section). For any entry of “No” in Column A, the MCO must enter the actual date (Column B of the date selection confirmation section) and provide an explanation in the MCO notes.

- Lag report period: Lag report period is in reference to the months of data included in the lag reports for the report submission. The lag report periods will automatically populate based on the selections made for the calendar year reporting cycle, report submission type, and quarters included in reports. Dates will automatically populate for the following:
 - Incurred from date
 - Incurred through date
 - Paid through date (this date will populate the monthly column and row labels within each lag report)

Because the dates in this section are populated automatically, the MCO must confirm the accuracy of the respective dates by entering “Yes” or “No” for each date in the spaces provided on the right side of the table (Column A of the date selection confirmation section). For any entry of “No” in Column A, the MCO must enter the actual date (Column B of the date selection confirmation section) and provide an explanation in the MCO notes.

- Name: Enter the preparer’s name.
- Contact phone: Enter the preparer’s contact phone number.
- Contact email: Enter the preparer’s contact email address.
- Date prepared: Enter the date the report was prepared using the mm/dd/yyyy format.

Many items of information provided on this tab will flow through to the reports within each Excel-based program-specific reporting package template. As such, it is recommended that the MCO perform a thorough review of all information on this tab prior to submission of any reporting package template.

2.03 Contents Tab

This tab serves as a table of contents for each of the Excel-based program-specific reporting package templates. The upper section contains a listing of each tab by name, the name and description of the report contained within the tab, the frequency of submission for each report, and the section of this reporting guide that specifically addresses each report. Note that although a specific section of this guide is separately identified for each report, there are still many other important reporting guidelines and instructions throughout the guide that are also applicable to each report. **Prior to submission of any financial reports discussed in this guide, the MCO should review the reporting guide to ensure that all applicable guidelines and instructions have been followed.**

The lower section of the contents tab includes a listing of all the cohorts to be included within the particular reporting package template. No data or information input is required within this tab.

2.04 Report 1 — Schedule of Revenues and Expenses by Category

Financial management report reference number(s):

FMB-PH 01, FMB-PH 01A, FMB-BH 01, FMB-LTSS 01, FMB-OAGPH 01, FMB-OAGBH 01

This report is due quarterly and as an annual supplement.

This report is included in each Excel-based program-specific reporting package template.

The PH Program reporting package also includes **Report 1A**. Report 1A is formatted to display information by the risk adjusted cohort structure. While a large portion of Report 1A is auto-populated using data from Report 1, there are fields that require MCO input. Some fields within Report 1 will continue to require MCO input as well.

The purpose of Report 1 is to provide detailed information on revenues and expenses for each cohort grouping. These reports are to be completed using quarterly data for the calendar year-to-date end reporting period.

These are contract schedules of revenues and expenses; **do not** include any revenue or expense information not applicable to the Centennial Care contract.

Revenue and expense items that are not specific to any cohort groups are to be allocated proportionately to the cohort groups based on some common factor such as capitation revenue. If a portion of such a revenue or expense can be attributed to one or more cohort groups, it is acceptable to distribute only the remaining amounts using the normal method of allocation. An explanation of the allocation methodology used **must** be provided in the MCO notes.

The MCO must use paid claims data and service utilization data, completed as appropriate, to accurately and appropriately report accrued cost amounts by the various cohort groups and categories. If any costs are allocated to these groups an explanation **must** be provided in the notes.

Any line item with the description of “Reserved” should be left blank. These lines will be used for future reporting, if necessary.

Member Months

Member Months

(All programs – Line 1)

Report accumulated monthly membership for each cohort group for the period under review. A member month is equivalent to the one member for whom the MCO has recognized capitation-based revenue for the entire month. The member months shall be reported on a cumulative basis by each cohort and cohort grouping as shown on the report.

Revenues

Capitation

(All programs – Line 2)

Capitation revenue recognized on a prepaid basis from HSD for provision of a specified range of health care services for Medicaid-eligible participants for the period under review for each cohort group. Capitation revenue is to be recognized when it is earned, not when the payment is received from the State. If advance payments are made to the MCO for more than one reporting period, the portion of the payment that has not been earned must be treated as a liability (unearned premiums).

Capitation revenue should include premium taxes, New Mexico Medical Insurance Pool (NMMIP) assessments, and Health Insurance Exchange (HIX) assessments. Do **not** report capitation revenue net of premium taxes, net of NMMIP assessments, or net of HIX assessments.

Exclude any amounts for the following:

- Health Insurer Provider Fee.
- Retro Period reconciliation.
- Underwriting gain limitation.
- Hepatitis C risk corridor.
- Directed payment.
- Community Benefit reconciliation.
- Patient contribution collected by the nursing facility, community-based residential alternative facility, or other providers.

I/T/U Revenue – For Services Subject to OMB Rates

(All programs – Line 3)

Indian Health Services/Tribal Health Providers/Urban Indian Providers (I/T/U) payments received from and/or due from HSD for the provision of services to Native Americans and Medicaid members provided at I/T/Us, per Section 6.3 of the MCO contract, where the particular services are subject to specific Office of Management and Budget (OMB) service codes and rates. I/T/U means the Indian Health Service, Tribal health providers, and Urban Indian providers, including facilities that are operated by a Native American/Alaskan Indian tribe, authorized to provide services as defined in the Indian Health Care Improvement Act, 25 U.S.C. 1601 et seq.

Include only revenue related to services rendered within the period under review. For I/T/U payments received during the current quarter that are related to claims incurred within the current twelve-month calendar year reporting period, the MCO is to report the amounts with the quarter's data that corresponds to the incurred date. For example, if HSD makes a payment to the MCO in August of the current calendar year reporting period for a claim that was incurred in January of the current calendar year reporting period, the payment amount is to be reported as revenue with first quarter data of the current calendar year reporting period.

I/T/U Revenue – For Services NOT Subject to OMB Codes/Rates

(All programs – Line 4)

Indian Health Services/Tribal Health Providers/Urban Indian Providers (I/T/U) payments received from and/or due from HSD for the provision of services to Native Americans and Medicaid members provided at I/T/Us, per Section 6.3 of the MCO contract, where the particular services are **not** subject to specific OMB service codes and rates. I/T/U means the Indian Health Service, Tribal health providers, and Urban Indian providers, including facilities that are operated by a Native American/Alaskan Indian tribe, authorized to provide services as defined in the Indian Health Care Improvement Act, 25 U.S.C. 1601 et seq.

Include only revenue related to services rendered within the period under review. For I/T/U payments received during the current quarter that are related to claims incurred within the current twelve-month calendar year reporting period, the MCO is to report the amounts with the quarter's data that corresponds to the incurred date. For example, if HSD makes a payment to the MCO in August of the current calendar year reporting period for a claim that was incurred in January of the current calendar year reporting period, the payment amount is to be reported as revenue with first quarter data of the current calendar year reporting period.

Medical Care Credit Adjustments (LTSS Program only)

(LTSS – Line 5)

Received and/or expected share of cost adjustment payments due from or due to HSD for the period under review (as detailed in Section 6.9 of the MCO contract). If the amounts paid to HSD exceed the amounts received from HSD for the period under review, enter the net payment to HSD as a negative amount. Exclude patient contribution collected by the nursing facility, community-based residential alternative facility, or other providers.

Reserved for Future Use (LTSS Program only)

(LTSS – Line 6)

This line is reserved for future use, if necessary, and is not to be used to report any information at this time.

Reserved for Future Use

(PH – Line 5, BH – Line 5, LTSS – Line 7, OAG PH – Line 5, OAG BH – Line 5)

This line is reserved for future use, if necessary, and is not to be used to report any information at this time.

Other

(PH – Line 6, BH – Line 6, LTSS – Line 8, OAG PH – Line 6, OAG BH – Line 6)

Any other revenue paid by HSD to the MCO, in addition to capitation for covered services, which is not included in any other premium revenues listed above.

Include any applicable amounts for the following:

- Health Insurer Provider Fee.
- Retro Period reconciliation.
- Underwriting gain limitation.
- Hepatitis C risk corridor.
- Directed payment.
- Community Benefit reconciliation.
- Payments received from and/or due from HSD for paid claims related to State and federally approved pregnancy termination procedures rendered to eligible members per the MCO contract.

All amounts included in this line **must** be reported in detail within the Premium Revenue Detail section of Report 23. See Section 3.12 for Report 23 instructions.

Detail listings of these amounts are not required within the MCO notes of the program-specific reporting package. However, the MCO must use the MCO notes to provide confirmation that the required details have been included within Report 23.

Investment Income

(PH – Line 8, BH – Line 8, LTSS – Line 10, OAG PH – Line 8, OAG BH – Line 8)

All investment income earned during the period. Do **not** net interest income and interest expense. Interest income is to be reported as investment income. Interest expense is to be reported as an administrative expense. Investment income should be allocated to “all” lines of business in an equitable manner, should an MCO have multiple lines of business. Examples include allocating investment income on a PMPM basis, percent of total premiums, etc. If another basis for reporting investment income is utilized, provide the necessary supporting documentation in the MCO notes.

Other Income

(PH – Line 9, BH – Line 9, LTSS – Line 11, OAG PH – Line 9, OAG BH – Line 9)

Revenue from sources not identified in any of the other revenue categories. These items include, but are not limited to, other miscellaneous income items. Any reported amounts in this line **must** be accompanied by a detailed listing and description of these miscellaneous amounts in the MCO notes.

Health Care Expenses

Total incurred health care expenses from Report 2 will automatically flow through to the corresponding health care expense categories within Report 1. See Section 2.05 for information regarding these expenses.

Additional Health Care Expenses

Additional health care expense categories include the following:

- Care Coordination – Medical
- IHS, Tribal 638 & I/T/Us - Subject to OMB Rates
- IHS, Tribal 638 & I/T/Us - NOT Subject to OMB Codes/Rates
- Member Rewards – Goods and Services
- Member Rewards – Vendor Administration
- Value Added Services/Non-State Plan Approved Services
- Other – Outlier Services (BH and OAG BH Programs Only)

Total incurred expenses for additional health care services will automatically flow through from Report 2 to the corresponding additional health care expense categories within Report 1. See Section 2.05 for information regarding these expenses.

Reinsurance and Post Payment Recoveries

Reinsurance Premium Expense

(PH – Line 57, BH – Line 53, LTSS – Line 69, OAG PH – Line 57, OAG BH – Line 53)

Enter as a positive amount. Reinsurance premium payments to contracted reinsurance entities related to the cost of catastrophic claims insurance.

Reinsurance Recoveries

(PH – Line 58, BH – Line 54, LTSS – Line 70, OAG PH – Line 58, OAG BH – Line 54)

Enter as a positive amount. Reinsurance recoveries, billed and unbilled, expected to be recovered from contracted reinsurance entities. Reinsurance and other similar recoveries to be included in this line are predicated on the admitting date, where the date of admission is included in the incurred period under review. No recoveries related to prior periods are to be reported in this line item. Recoveries are to be entered as positive amounts.

Reinsurance Expense Net of Recoveries

(PH – Line 59, BH – Line 55, LTSS – Line 71, OAG PH – Line 59, OAG BH – Line 55)

Reinsurance premium expense less reinsurance recoveries. This line will calculate automatically.

Post Payment Recoveries

(PH – Line 60, BH – Line 56, LTSS – Line 72, OAG PH – Line 60, OAG BH – Line 56)

Enter as a positive amount. Cost recoveries subsequent to the payment of a claim that have not been adjusted to the original claim. These amounts are to include dollars for the following categories; 1) recoveries associated with third-party resources, 2) recoveries associated with casualty, 3) recoveries associated with program integrity efforts (fraud, waste, and abuse), and 4) other recoveries. Do not include COB payments that are deducted from payments to providers in the normal course of claims processing.

Include only recoveries related to services rendered within the period under review. For post payment recoveries received during the current quarter that are related to claims incurred within the current twelve-month calendar year reporting period, the MCO is to report the amounts with the quarter's data that corresponds to the incurred date. For example, if a third party payment is made to the MCO in August of the current calendar year reporting period for a claim that was incurred in January of the current calendar year reporting period, the payment amount is to be reported with first quarter data of the current calendar year reporting period.

Administrative Expenses

Expenses associated with the overall management and operations of the MCO are to be reported as part of each quarterly submission. Administrative expenses are required to be reported for each cohort. For each cohort, administrative expenses are to be reported as direct administrative expenses, indirect administrative expenses, care coordination administrative expenses, and fiscal management agency expenses (LTSS Program only). Note the MCO **must** provide an annual disclosure explaining the methodology used to allocate administrative expenses to each cohort and program. This requirement is discussed in more detail in Section 3.04 of this document.

Direct Administrative Expenses

(PH Report 1A – Line 62, BH – Line 58, LTSS – Line 74, OAG PH – Line 62, OAG BH – Line 58)
Administrative expenses directly incurred and expensed by the New Mexico Centennial Care MCO and recorded directly in the general ledger of the New Mexico Centennial Care MCO.

Indirect Administrative Expenses

(PH Report 1A – Line 63, BH – Line 59, LTSS – Line 75, OAG PH – Line 63, OAG BH – Line 59)
Administrative expenses allocated to the New Mexico Centennial Care MCO through a corporate allocation arrangement with a related or affiliated entity. Methodologies for allocated expenses may include PMPM, percent of revenue, percent of head counts and/or full-time equivalents, etc.

Care Coordination – Administrative

(PH Report 1A – Line 64, BH – Line 60, LTSS – Line 76, OAG PH – Line 64, OAG BH – Line 60)
Care coordination administrative expenses include the following care coordination functions: health risk assessments, data runs, referrals, case assignment, and scheduling.

For employees of the MCO who are engaged in a range of activities that support both care coordination services deemed administrative and care coordination services deemed medical per the Centennial Care contract, include only the portion of the compensation expenses that are associated with the care coordination activities deemed administrative. Similarly, for care coordination agencies contracting with the MCO that are engaged in a range of activities that support both care coordination services deemed administrative and care coordination services deemed medical per the Centennial Care contract, include only the portion of agency expenses that are associated with the care coordination activities deemed administrative.

The MCO **must** provide an explanation in the notes that describes the MCO's methodology for determination of care coordination expenses related to administrative activities and care coordination expenses related to medical activities.

The MCO **must** also provide an explanation in the notes that describes the allocation methodology used to report care coordination expenses across each Centennial Care program and each cohort within the respective program.

Fiscal Management Agency (LTSS & OAG PH Programs only)

(LTSS – Line 77, OAG PH – Line 65)

Payments to the entity contracting with the State to provide fiscal administration functions for the MCO's members receiving the self-directed community benefit.

Mi Via Consulting Agency (LTSS Program only)

(LTSS – Line 78)

Payments to State-approved consultant agencies who provide education, assistance and guidance, such as with eligibility, pre-planning and development of the Service and Support Plan and the emergency back-up plan to members who choose the self-directed community benefit.

Reserved for Future Use

(PH Report 1A – Line 65, BH – Line 61, OAG BH – Line 61)

This line is reserved for future use, if necessary, and is not to be used to report any information at this time.

Reserved for Future Use

(PH Report 1A – Line 66, BH – Line 62, LTSS – Line 79, OAG PH – Line 66, OAG BH – Line 62)

This line is reserved for future use, if necessary, and is not to be used to report any information at this time.

Non-Health Care and Non-Administrative Expenses

For the purpose of these financial reports, the following items are not considered health care expenses or administrative expenses:

Provision for State, Federal and Other Governmental Income Taxes

(PH Report 1A – Line 70, BH – Line 66, LTSS – Line 83, OAG PH – Line 70, OAG BH – Line 66)
Income tax expense paid or accrued for the period.

Premium Tax, Net of Credits

(PH Report 1A – Line 71, BH – Line 67, LTSS – Line 84, OAG PH – Line 71, OAG BH – Line 67)
Premium taxes paid or accrued for the period, net of any applicable credits.

New Mexico Medical Insurance Pool (NMMIP)

(PH Report 1A – Line 72, BH – Line 68, LTSS – Line 85, OAG PH – Line 72, OAG BH – Line 68)
NMMIP assessments paid during the period under review.

Other Assessments

(PH Report 1A – Line 73, BH – Line 69, LTSS – Line 86, OAG PH – Line 73, OAG BH – Line 69)
If applicable, state assessments other than state or federal income taxes, premium tax, and NMMIP assessments. Include applicable Health Insurer Provider Fee expenses and HIX assessment expenses in this line.

Any reported amounts in this line **must** be accompanied by a detailed listing and description in the MCO notes.

Adjustment for Prior Period IBNP Estimates

(PH Report 1A – Line 74, BH – Line 70, LTSS – Line 87, OAG PH – Line 74, OAG BH – Line 70)
This line item is required to be reported in the supplemental annual report only.

Note that for this line item, prior period refers to the twelve-month period prior to the most recently complete twelve-month period. For example, the prior period for the twelve-month calendar year 2020 reporting period is calendar year 2019.

A contra-expense is to be reported if IBNP estimates exceeded actual expenses. If there was a material error in preparation of the prior period report, a revised report must be submitted.

See Appendix H for a detailed example of a reconciliation of prior period IBNP estimates.

For all reported prior period IBNP amounts, the following items **must** be included as part of the MCO analysis:

- A reconciliation of prior period IBNR estimates (see Appendix H for an example).
- A detailed explanation of the prior period IBNP estimates.

Non-Claim Adjustments for Prior Periods

(PH Report 1A – Line 75, BH – Line 71, LTSS – Line 88, OAG PH – Line 75, OAG BH – Line 71)
Non-claim adjustments for prior periods should be reported in the period in which they become known. However, it is expected that this particular line item will rarely, if ever, be needed. Any reported amounts in this line **must** be accompanied by a detailed listing and description in the MCO notes. If there was a material error in preparation of the prior period report, a revised report shall be submitted.

2.05 Report 2 — Schedule of Expenses Detail

Financial management report reference number(s):

FMB-PH 02, FMB-BH 02, FMB-LTSS 02, FMB-OAGPH 02, FMB-OAGBH 02

This report is due quarterly and as an annual supplement.

This report is included in each Excel-based program-specific reporting package template.

The purpose of Report 2 is to collect health care expense detail related to the Centennial Care Program by individual cohort, health care service category, expense type, and time period.

Reporting Health Care Expenses

When entering expense data in Report 2, MCOs must adhere to the following guidelines:

- This report is to be completed using quarterly data for the calendar year-to-date end reporting period.
- Include only expenses for covered services per the Centennial Care contract and expenses for HSD-approved in lieu of services or settings. In lieu of services or settings are alternative services or services in settings that are not Centennial Care covered services as set forth in the Centennial Care contract, but are medically appropriate and cost effective substitutes.
- Expenses must be limited to those that represent health care service costs (i.e., hospital, medical, and LTSS). All non-health care service costs, including those incurred for utilization review, quality assurance, medical management by the MCO, and the medical director, are to be reported under the administrative expense section of Report 1.
- Physician incentive payments that are designed to incent non-administrative performance are to be categorized as a health care expense.
- Any line item with the description of “Reserved” should be left blank. These lines will be used for future reporting, if necessary.
- The MCO **must** provide a detailed explanation in the MCO notes for any amounts within Report 2 that required an allocation.

Categorization of Health Care Expenses

Health care expenses **must** be categorized by cohort and service category using criteria established by HSD and shared with the MCO.

- Reference Appendix A (PH Programs), Appendix B (BH Programs), and Appendix C (LTSS Program) for direction regarding the appropriate program-specific hierarchical categorization and reporting of health care services.
- **Appendix A, B, and C must always be utilized to classify and report health care expenses.**
- Appendix A, B, and C provide detailed descriptions of the health care service categories that define each health care expense line for each Centennial Care program.
- The tables within these appendices rank the service categories in a hierarchical order.
- Expenses for HSD-approved in lieu of services or settings are to be reported within the applicable health care service categories. Do **not** include expenses for approved in lieu of services or settings within the value added/non-state plan approved services category or the other-outlier services category. Where expenses for any approved in lieu of services or

settings are included within the health care service categories, a detailed listing of the services and corresponding expenses **must** be provided in the MCO notes. See Section 4.02 for additional information regarding requirements for MCO notes and disclosures.

- Any health care expenses that do not meet the specific criteria listed in the table are to be reported as other health care expense. An explanation for these types of expenses must be provided in the MCO notes.
- Report 2 crosswalks the health care service category detail to the various lag reports, Reports 5A through 5P. The required lag report mapping for each health care expense category is provided within Report 2.

Additional Health Care Expenses

The expenses for the following categories are **not** to be included in any other health care expense category or lag report. Where applicable, the expenses for these categories are to include estimates for any outstanding expense liability for the reporting period under review.

- Care Coordination – Medical
- IHS, Tribal 638 & I/T/Us - Subject to OMB Rates
- IHS, Tribal 638 & I/T/Us - NOT Subject to OMB Codes/Rates
- Member Rewards – Goods and Services
- Member Rewards – Vendor Administration
- Value Added Services/Non-State Plan Approved Services
- Other – Outlier Services (BH and OAG BH Programs Only)

Brief descriptions for each of these additional health care expense categories have been provided below. Please reference Appendix A (PH Programs), Appendix B (BH Programs), and Appendix C (LTSS Program) for specific direction regarding the appropriate program-specific hierarchical categorization and reporting of these additional health care services.

Care Coordination – Medical

(PH – Line 50, BH – Line 45, LTSS – Line 62, OAG PH – Line 50, OAG BH – Line 45)

The following care coordination functions are considered medical services, and the associated expenses are to be reported in this line: comprehensive needs assessment, face-to-face meetings between the care coordinator and the member, telephonic meetings between the care coordinator and the member, case management, discharge consultation, comprehensive care plan development and updates, health education provided to the member, disease management provided to the member, and costs associated with Community Health Workers.

For employees of the MCO who are engaged in a range of activities that support both care coordination services deemed administrative and care coordination services deemed medical per the Centennial Care contract, include only the portion of the compensation expenses that are associated with the care coordination activities deemed a medical service. Similarly, for care coordination agencies contracting with the MCO that are engaged in a range of activities that support both care coordination services deemed administrative and care coordination services deemed medical per the Centennial Care contract, include only the portion of agency expenses that are associated with the care coordination activities deemed a medical service.

The MCO **must** provide an explanation in the notes that describes the MCO's methodology for determination of care coordination expenses related to administrative activities and care coordination expenses related to medical activities.

The MCO **must** also provide an explanation in the notes that describes the allocation methodology used to report care coordination expenses across each Centennial Care program and each cohort within the respective program.

Please reference Appendix A (PH Programs), Appendix B (BH Programs), and Appendix C (LTSS Program) for specific direction regarding the appropriate program-specific hierarchical categorization and reporting of expenses for this particular additional health care service.

Indian Health Services, Tribal 638 and I/T/Us – Subject to OMB Rates

(PH – Line 51, BH – Line 46, LTSS – Line 63, OAG PH – Line 51, OAG BH – Line 46)

Expenses related to the payment of Indian Health Services providers, Tribal 638 facilities and I/T/Us for the provision of services to Native Americans and Medicaid members where the particular services are subject to specific OMB service codes and rates. Include only expenses related to services rendered within the period under review.

Please reference Appendix A (PH Programs), Appendix B (BH Programs), and Appendix C (LTSS Program) for specific direction regarding the appropriate program-specific hierarchical categorization and reporting of expenses for this particular additional health care service.

Indian Health Services, Tribal 638 and I/T/Us – NOT Subject to OMB Codes/Rates

(PH – Line 52, BH – Line 47, LTSS – Line 64, OAG PH – Line 52, OAG BH – Line 47)

Expenses related to the payment of Indian Health Services providers, Tribal 638 facilities and I/T/Us for the provision of services to Native Americans and Medicaid members where the particular services are **not** subject to specific OMB service codes and rates. Include only expenses related to services rendered within the period under review.

Please reference Appendix A (PH Programs), Appendix B (BH Programs), and Appendix C (LTSS Program) for specific direction regarding the appropriate program-specific hierarchical categorization and reporting of expenses for this particular additional health care service.

Member Rewards – Goods and Services

(PH – Line 53, BH – Line 48, LTSS – Line 65, OAG PH – Line 53, OAG BH – Line 48)

Expenses incurred for the actual member rewards.

Please reference Appendix A (PH Programs), Appendix B (BH Programs), and Appendix C (LTSS Program) for specific direction regarding the appropriate program-specific hierarchical categorization and reporting of expenses for this particular additional health care service.

Member Rewards – Vendor Administration

(PH – Line 54, BH – Line 49, LTSS – Line 66, OAG PH – Line 54, OAG BH – Line 49)

Expenses incurred for the administration of the member rewards program.

Please reference Appendix A (PH Programs), Appendix B (BH Programs), and Appendix C (LTSS Program) for specific direction regarding the appropriate program-specific hierarchical categorization and reporting of expenses for this particular additional health care service.

Value Added Services/Non-State Plan Approved Services

(PH – Line 55, BH – Line 50, LTSS – Line 67, OAG PH – Line 55, OAG BH – Line 50)

Expenses related to value added services (VAS) and/or non-State Plan approved services, including expenses related to State and federally approved pregnancy termination procedures rendered to eligible members per the MCO contract. VAS and non-State Plan approved services are those services or benefits offered by the MCO that are not a covered service per the MCO's contract with the State. To the extent the MCO provides VAS and/or non-State Plan approved services that have been approved by HSD to supplement the covered services in accordance with the contract, the MCO is to report the applicable expenses here. Amounts reported on this line **must** tie to amounts reported in Report 8.

Note that HSD-approved in lieu of services or settings are **not** to be included in this line. Expenses for approved in lieu of services or settings are to be reported within the applicable health care expense categories.

Please reference Appendix A (PH Programs), Appendix B (BH Programs), and Appendix C (LTSS Program) for specific direction regarding the appropriate program-specific hierarchical categorization and reporting of expenses for these particular additional health care services.

Other – Outlier Services (BH and OAG BH Programs only)

(BH – Line 51, OAG BH – Line 51)

Expenses related to outlier services. Outlier services are those services that the MCO is unable to map to any one particular service category listed in Appendix B of this guide. Amounts reported on this line **must** tie to amounts reported in Report 10.

For any amounts reported on this line, the MCO **must** provide an explanation in the MCO notes as to why the service is considered an outlier service and why it cannot be mapped to an existing category of service or program.

Note that the outlier services category was used in the behavioral health program prior to Centennial Care, but is not expected to be necessary going forward. However, the outlier services line item has been included as part of the Centennial Care BH Program and OAG BH Program financial reports in the event circumstances arise that would require its use. As such, there is no predetermined set of services or codes that is expected to be included within this particular service category.

Note that HSD-approved in lieu of services or settings and **not** to be included in this line. Expenses for approved in lieu of services or settings are to be reported within the applicable health care expense categories.

Please reference Appendix B (BH Programs) for specific direction regarding the appropriate program-specific hierarchical categorization and reporting of expenses for these particular additional health care services.

Expense Type

This report consists of data input by the MCO and data from Report 4A. Note that expenses related to global and/or subcapitated payments reported in Report 4A automatically flow through to this report.

Total incurred health care expenses from Report 2 will automatically flow through to the corresponding health care expense categories within Report 1.

Health care expenses related to paid claims, global/subcapitated payments, pharmacy rebates, settlements, shared risk arrangements, and IBNP should tie to amounts reported in Reports 5A through 5P. See Section 2.09 for additional instructions for reporting these types of expenses. Any differences **must** be accompanied by a detailed listing and description in the MCO notes. Amounts required to tie between the various reports are checked within the check totals tab.

The MCO is required to enter expenses for the following:

- Paid Claims
- Global/Subcap Payments (auto-populated from Report 4A)
- Pharmacy Rebates
- Settlements
- Shared Risk Arrangements
- IBNP

Paid Claims

Health care expenses for claims paid by the MCO for claims with dates of service within the particular quarter. Do **not** include any amounts for estimates of outstanding unpaid claims liability.

Health care expenses are to be reported net of third party liability (TPL) and coordination of benefits (COB).

Health care expenses should also be reported gross of reinsurance cost and recoveries. Amounts for reinsurance cost and recoveries are to be reported in Report 1.

Global/Subcapitation Payments

Subcapitation and global capitation expenses are to be reported according to the dates of service the capitation payments made to the providers were meant to cover.

Subcapitation expenses related solely to administrative services are to be reported in Report 1 within the applicable administrative expense line items and excluded from health care expense line items in Report 2.

Expenses related to global and/or subcapitated payments reported in Report 4A automatically flow through to this report. See Section 2.07 for additional instructions for reporting these types of expenses.

Pharmacy Rebates

Pharmacy rebate amounts anticipated/accrued for drugs dispensed in the particular quarter. Enter pharmacy rebates as a negative amount.

Settlements

Payments/recoupments that cannot be tied to a specific claim included within the paid claims column due to lack of data.

Shared Risk Arrangements

Amounts paid, or reasonably expected to be paid, to participating providers based on a contractual agreement covered within the incurred dates of service period.

Include directed payment amounts paid by the MCO. These amounts **must** match the total payment made by HSD to the MCO by rate cohort. Directed payment amounts should only be reported in the “other” services categories that correspond to Report 5G - Other Medical Services for the applicable cohorts.

IBNP

Amounts representing the current estimates for unpaid claims, including any provisions for adverse deviation.

Total

The amount, in total, for paid claims, global/subcapitated payments, pharmacy rebates, settlements, shared risk arrangements, and IBNP. Amounts in this column will calculate automatically.

2.06 Report 3 — Schedule of Utilization by Category - Units

Financial management report reference number(s):

FMB-PH 03, FMB-BH 03, FMB-LTSS 03, FMB-OAGPH 03, FMB-OAGBH 03

This report is due quarterly and as an annual supplement.

This report is included in each Excel-based program-specific reporting package template.

The purpose of Report 3 is to provide a detailed summary of select utilization information by service category and cohort during the reporting period under review. The service categories in this report have been limited to certain category groupings within Report 1, where utilization can be defined and reported with a higher level of certainty. Health care expense categories where utilization cannot be clearly defined or quantified with consistency due to the variety of services and unit types within the respective category groupings were excluded from this report.

Utilization for each applicable service category must correspond to the appropriate program-specific hierarchical service categorization used in the reporting of expenses for the respective service category and is to be reported according to the unit of measure identified in the unit description column within Report 3. All utilization for each service category in this report is to be reported using actual data without accruals or completion.

For those services where admits and/or days are listed as the unit of measure, the following calculations are to be used:

- Inpatient admits: Admits counted should be for each admission that occurred in the particular reporting period. Include data for which the MCO is both the primary payer and the secondary payer.
- Inpatient days: Days are calculated as the number of days between admit and discharge date, excluding the date of discharge and any days that are denied. If dates are equal, the inpatient day is counted as one. Days counted should be all paid days of service for each admission that occurred in the particular reporting period. If the admission and discharge do not occur in the same reporting period, all days are to be counted as occurring in the reporting period in which the admission occurs. Include data for which the MCO is both the primary payer and the secondary payer.
- Facility days: In circumstances where a continuous stay in a facility such as a nursing facility (categories 1, 2, and 3) and/or residential treatment center is required for an MCO's Centennial Care member, days counted should be all paid days of service related to the "from" and "to" date of the respective interim claim. If the "from" and "to" date do not occur in the same reporting period, all days are to be counted as occurring in the particular reporting period that corresponds to the "from" date of the interim claim.

2.07 Report 4A — Subcapitation Expenses Detail

Financial management report reference number(s):

FMB-PH 4A, FMB-BH 4A, FMB-LTSS 4A, FMB-OAGPH 4A, FMB-OAGBH 4A

This report is due quarterly and as an annual supplement.

This report is included in each Excel-based program-specific reporting package template.

The purpose of Report 4A is to collect expense detail for each of the MCO's health care service-related capitated arrangements included within the health care expenses reported in Report 1, Report 2, and applicable lag reports (Report 5A through 5P).

As subcapitated expenses related to medical services and network access are to be included within the various health care service categories in Report 1, it is necessary to use this report to detail the mapping of the expenses to each cohort and health care service line-item.

Amounts reported on each line of this report are to be mutually exclusive of amounts reported on any of the other lines within this report. Quarterly totals from this report **must** tie to the respective quarterly totals for subcapitated expenses reported on Line 39 of the applicable lag reports (Report 5).

Do not include detail for subcapitation expenses related solely to administrative services. If there are expenses for capitated arrangements in Report 1 where the MCO has included a portion within the health care expenses and the remaining portion within the administrative expenses, exclude detail related to the portion reported as an administrative expense.

For each quarter, the following data is to be reported as it pertains to any capitated arrangement the MCO has with a provider:

- Medical capitation provider name: Enter the name of the provider contracted with the MCO to provide certain services through a capitated arrangement.
 - Report only one unique provider per line. **Do not** combine multiple providers on one line. For example, if the MCO contracts with two different providers (Provider A and Provider B) to cover physician services under a capitated arrangement, information for Provider A is to be entered on one line, and information for Provider B is to be entered on a separate line.
 - A unique provider **must** be listed on multiple lines if there are multiple medical expense classifications applicable to the capitation arrangement with the respective provider. For example, if the MCO contracts with one provider (Provider C) to cover services that would fall under physician services (Line 26 of Report 1 for the PH Program) and other practitioners (Line 31 of Report 1 for the PH Program) under a capitated arrangement, information for Provider C is to be entered on one line as it relates to physician services performed under the contract. Information for Provider C is to then be entered on a separate line as it relates to the other practitioner services performed under the contract. If an allocation is needed to split the capitation amounts between different services (e.g., physician and other practitioners), a detailed description of the allocation methodology **must** be provided in the MCO notes.

- Provider at full risk, shared risk, or not at risk: Indicate whether the provider is at full risk, shared risk, or no risk for services provided under the capitated arrangement.
- Admin and margin amounts included in capitation expenses: Where applicable, enter the portion (in dollars) of the capitated expenses reported in the cohort/quarter columns attributable to the administrative and/or margin component of the capitated arrangement. Note that amounts reported in this column are meant to be informational and are not reconciled to amounts from other reports. Any amounts related to capitated expenses reported in the administrative expense section of Report 1 are to be excluded from this report.
- Health care expense mapping:
 - Report 1 line number: Enter the line number that corresponds to the Report 1 health care expense category where the capitated expenses have been reported. For example, if the expenses for a particular capitated arrangement have been included in the physician expenses in Report 1 for the PH Program, “26” should be entered. Only one line number per row is permitted. If the capitation arrangement with the provider covers multiple health care expense categories, the provider **must** be listed on multiple lines, with each line containing information specific to the particular health care expense classification. If an allocation is needed to split the capitation amounts between different services (e.g., physician and other practitioners), a detailed description of the allocation methodology **must** be provided in the MCO notes. Do **not** use text format when entering the applicable Report 1 health care expense line number as this will result in errors within the health care expense description column described below.
 - Classification of capitation expenses by Report 1 health care expense line detail: Information in this column is automatically populated based on the input made in the Report 1 line number column. Note that if a line number is entered that does not correspond with a valid Report 1 health care category of expense, an error message of “*** INVALID REPORT 1 LINE NUMBER ***” will be displayed. In this situation, the MCO must re-enter the appropriate Report 1 health care expense category line number.
- Lag report mapping:
 - Lag Report number: The lag report number that corresponds to the lag report where the capitation expenses are reported within Line 39 of the respective lag report. Information in this column is automatically populated based on the input made in the Report 1 line number column. See Section 2.09 of this guide for health care expense mapping to the various lag reports. If there are capitation expenses related to the select few health care expenses within Report 1 that are not to be included within any lag report, a value of “NA” will be displayed. See Section 2.09 of this guide for a listing of services that are not to be included within any of the lag reports.
 - Lag report where capitation expenses are reported: The lag report description that corresponds to the value in the lag report number column. Information in this column is automatically populated. Note that if an invalid Report 1 line number is entered, an error message will also be displayed in this column. In this situation, the MCO must re-enter the appropriate Report 1 health care expense category line number.

Capitation expenses are to be reported by cohort and by quarter according to the dates of service the capitation payments made to the providers were meant to cover. **Do not** report capitation expenses by quarter based on date of payment.

If an allocation is needed to split the capitation amounts between the various cohorts, a detailed description of the allocation methodology **must** be provided in the MCO notes. Additionally, if the subcapitated arrangement with the provider is PMPM-based and varies by certain populations, a detailed description must be provided in the MCO notes that identifies the provider, type of services covered under the capitated arrangement, the individual cohorts, and their respective PMPMs.

2.08 Report 4B — Subcapitation Agreement Detail

Financial management report reference number(s):

FMB-PH 4B, FMB-BH 4B, FMB-LTSS 4B, FMB-OAGPH 4B, FMB-OAGBH 4B

Report 4B is due annually with the annual supplemental reports. This report should be left blank for the quarterly submissions of the Excel-based program-specific reporting package templates.

This report is included in each Excel-based program-specific reporting package template.

The purpose of Report 4B is to collect subcapitation agreement details in support of subcapitation amounts reported in Report 1 and Report 4A. This information will be used to support the development of Centennial Care PH Program, BH Program, LTSS Program, OAG PH Program and OAG BH Program capitation rates for future periods. This information will also be used to evaluate the MCOs' financial and operational performance and monitor the financial experience of the programs. Agreement details are to be reported by each capitated service contract the MCO has with a unique provider or provider group. Information is to be provided by the historical and future twelve-month periods designated within the report.

For each capitated service contract, the following information **must** be provided:

1. Enter the name of the provider contracted with the MCO where reimbursement is made to the provider on a capitated basis.
2. Identify the twelve-month fiscal period for the dates of service the capitation payments made to the providers were meant to cover. All information entered for each contract should be representative of the arrangements in place during the designated twelve-month period.
3. Enter the portion (as a percentage) of the network that is capitated under the contract identified in item #1.
4. Describe the services provided under the contract identified in item #1. The description **must** include specific procedure codes, procedure code ranges, or a detailed written description of the services. If written descriptions are used, the detail **must** be specific enough for the reader to understand the exact services. For example, a written description

of “professional services” is too vague, as professional services can include a wide array of services that may or may not be included within the capitation agreement.

5. For capitated contracts where reimbursement is based on a PMPM basis, enter the effective begin and end date within the designated twelve-month period for each contractual PMPM amount. The PMPM in effect for this period should also be entered. If the contractual PMPM amount changed during the designated twelve-month period, it is expected that a new effective begin and end date be entered along with the new PMPM amount. For example, if the contract required a \$5.00 PMPM for the first half of calendar year 2021 and a \$5.25 PMPM the second half of the year, the following entries would be made in the spaces provided within the calendar year 2021 section of the report:

- Effective Date Begin: 01/01/21 Effective Date End: 06/30/21 PMPM: \$5.00
- Effective Date Begin: 07/01/21 Effective Date End: 12/31/21 PMPM: \$5.25

Note if the effective begin or end date of the contracted PMPM amount is outside the designated twelve-month period, the MCO should enter the date of the first day of the designated twelve-month period for the effective begin date and the date of the last day of the designated twelve-month period for the effective end date.

6. For capitated contracts where reimbursement is based on a fee basis, indicate the frequency (monthly, quarterly, annually, or other) of the fee payment in the space provided. If "other" is used as a description for the frequency of payment under the fee arrangement, an explanation **must** be provided in the MCO notes. Enter the effective begin and end dates within the designated twelve-month period for each contractual fee amount. The fee in effect for this period should also be entered. The fee amount entered in the space provided should relate to the frequency of the payment entered in this section. For example, if the fee is paid to the provider on a monthly basis, the fee amount entered should be the monthly amount and **not** the twelve-month total for the period. If the contractual fee amount changed during the designated twelve-month period, it is expected that new effective begin and end dates be entered along with the new fee amount. See item #5 above for an example of reporting information for this circumstance. Note if the effective begin or end date of the contracted fee amount is outside the designated twelve-month period, the MCO should enter the date of the first day of the designated twelve-month period for the effective begin date and the date of the last day of the designated twelve-month period for the effective end date.
7. Enter unit cost and utilization assumptions for the top 10 (based on expenditures) procedure codes of the services covered under the capitated arrangement. For each procedure code listed, enter the unit cost and utilization assumptions for the service that were used in determining the capitated amount (PMPM or fee) to be paid to the provider. The unit cost should reflect assumed cost per unit of service for the particular procedure code and **not** the assumed aggregate cost of the procedure for the entire designated twelve-month period. Utilization should reflect the assumed number of units for each service to be provided over the duration of the designated twelve-month period. Units are **not** to be entered on a utilization per 1,000 basis.

8. Enter information related to future contract periods. At the top of the section for item number 8, identify the applicable future period (e.g., “CY2022”). Enter the effective begin and end date of the particular capitated contract for the future period.

For questions 1 through 4, respond with either “Yes” or “No” in the spaces provided. If the response to either question 3 or 4 is yes, provide the procedure code detail, and cost and utilization assumptions in the space provided within the table located at the bottom of the section for item number 8. Be sure to indicate whether the code is to be added or removed from the services to be provided under the capitated arrangement. Reporting of unit cost and utilization assumptions is described in item #7 above.

For question 5, enter the projected increase as a percentage. If no increase is expected, enter zero (0). Identify the base time period and the future time period applicable to the reported percentage increase. For example, if the contracted capitation amount for CY2021 will increase 2% for CY2022, enter “2.00%” for the percentage increase. Enter “CY2021” for the base time period applicable to the 2% increase and enter “CY2022” for the future time period applicable to the 2% increase.

Note for some cells, the security settings have been set to allow the MCO to change the size in order to accommodate additional information. To the extent the MCO requires additional tables beyond those provided within the report, a copy of the Report 4B tab should be made within the Excel-based reporting package.

2.09 Reports 5A through 5Q — Electronic Lag Reports

Financial management report reference number(s):

FMB-PH 5#, FMB-BH 5#, FMB-LTSS 5#, FMB-OAGPH 5#, FMB-OAGBH 5#

These reports are due quarterly and as an annual supplement.

These reports are included in each Excel-based program-specific reporting package template.

Analyzing the accuracy of historical medical claims liability estimates is helpful in assessing the adequacy of current liabilities. In addition, valid IBNP liability estimates are crucial when utilizing financial statements in the managed care rate-setting process. The purpose of the lag reports is to provide the necessary information to make this analysis.

Each lag report requests the same type of information for each program; however, lag report category of service groupings and cohort groupings vary by each program. These cohort groupings and medical cost groupings **must** tie, in total, to the same cost groupings in the Schedule of Revenues and Expenses by Category (Report 1) and the Schedule of Expenses Detail (Report 2) for each respective program.

Cohort Groupings for Lag Reports

All program-specific lag reports contain a separate lag table for each of the applicable cohort groupings. For lag reports that require data to be reported by multiple cohort groupings, the lag tables are stacked top to bottom within the report. The lag report cohort groupings for each program are as follows:

Program	Cohort Grouping
Physical Health	TANF SSI
Behavioral Health	TANF SSI LTSS
Long Term Services and Supports	Dual Non-Dual
Other Adult Group – Physical Health	OAG
Other Adult Group – Behavioral Health	OAG

Note, if allocations are required to report any amounts by cohort groupings within the lag reports, a detailed description of the allocation methodology **must** be provided in the MCO notes.

Additional Health Care Expense Categories Not To Be Included Within the Lag Reports

The expenses for the following health care categories are **not** to be included in any lag report:

- Care Coordination – Medical
- IHS, Tribal 638 & I/T/Us – Subject to OMB Rates
- IHS, Tribal 638 & I/T/Us – NOT Subject to OMB Codes/Rates
- Member Rewards – Goods and Services
- Member Rewards – Vendor Administration
- Value Added Services/Non-State Plan Approved Services
- Other – Outlier Services (BH Program and OAG BH Program only)

Lag Report Mappings to Category of Service and Cohort Grouping

The lag report/medical services mapping identifies the health care services within Report 1 and the lag report where the expenses for those services are to be reported. The lag report mapping also identifies the cohort grouping. Where multiple cohort groupings are listed for a particular lag report, a separate lag table for each cohort grouping is required. For example, a TANF lag table and an SSI lag table are required for the inpatient hospital services lag report for the PH Program.

The lag report service mappings for each program and cohort grouping are detailed in the tables below:

Physical Health Program Lag Report Mappings

PH Lag Report #	Consolidated Lag Category of Service	Physical Health Program Report 1 Category of Service	Cohort Grouping
5A	Inpatient Hospital Services	Inpatient Hospital – Acute Inpatient – Specialty Hospital Non-Acute LTC/Skilled Nursing Facility/Respite	TANF SSI
5B	Outpatient Services	Ambulatory Surgery Centers – Outpatient Surgeries Outpatient Hospital – Emergency Room Outpatient Hospital – Urgent Care Outpatient Facility – Other Rural Health Clinics Federally Qualified Health Centers (FQHCs) Freestanding Clinics	TANF SSI
5C	Physician Services	Physicians	TANF SSI
5D	Pharmacy	Pharmacy	TANF SSI
5E	Dental Services	Dental Orthodontic Dental Children (< 21) Dental Adult Services (>=21)	TANF SSI
5F	Laboratory/Radiology Services	Laboratory Radiology	TANF SSI
5G	Other Medical Services	Ambulance Non-Emergent Transportation Home Health and Visiting Nurse Services Hospice Other Practitioners Therapies Home Visiting Pilot Home Infusion DME/Medical Supplies Orthotics Prosthetics Vision Other PH Services	TANF SSI

Behavioral Health Program Lag Report Mappings

BH Lag Report #	Consolidated Lag Category of Service	Behavioral Health Program Report 1 Category of Service	Cohort Grouping
5A	Inpatient Hospital Services	Hospital Inpatient Facility (Psychiatric Hospitalization Services) Inpatient and Residential Professional Charges	TANF SSI LTSS
5D	Pharmacy	BH Pharmaceuticals	TANF SSI LTSS
5H	Outpatient/Clinic Services	Evaluations and Therapies (Non-Hospital Outpatient) Testing (Non-Hospital Outpatient) Functional Family Therapy (FFT) (Non-Hospital Outpatient) Outpatient Hospital (Evaluations, Therapies, and BH Physical Evaluations) Partial Hospitalization Program (BH Treatment Services) Hospital Outpatient Facility (BH Treatment Services) Suboxone Treatment Methadone Treatment Rural Health Clinics FQHCs	TANF SSI LTSS
5I	Residential Treatment Center	Residential Treatment Center, ARTC and Group Homes < 21 Foster Care Therapeutic (TFC I & II) < 21 Other Residential	TANF SSI LTSS
5J	Behavioral Management Services	Skills Training & Development (Behavioral Management Services) < 21	TANF SSI LTSS
5K	Behavioral Health Providers	BH Day Treatment < 21 Intensive Outpatient Program Services (IOP) Adaptive Skills Building (ABS) Multi-Systemic Therapy (MST) Telehealth Other Professional BH Services Respite Services Applied Behavior Analysis (ABA) Pre-Tenancy/Housing Support	TANF SSI LTSS
5L	Psychosocial Rehab Services	Psychosocial Rehab Services for Adults =>18	TANF SSI LTSS

Behavioral Health Program Lag Report Mappings

BH Lag Report #	Consolidated Lag Category of Service	Behavioral Health Program Report 1 Category of Service	Cohort Grouping
5M	Community Services, Agencies	School-Based Health Center Services Assertive Community Treatment (ACT) Core Service Agencies (CSA) – Other Services Comprehensive Community Support Services (CCSS) Recovery Services Family Support Services	TANF SSI LTSS

Long Term Services and Supports Program Lag Report Mappings

LTSS Lag Report #	Consolidated Lag Category of Service	LTSS Program Report 1 Category of Service	Cohort Grouping
5A	Inpatient Hospital Services	Hospital Swing Bed – High Level of Care Hospital Swing Bed – Low Level of Care Inpatient Hospital – Acute Inpatient – Specialty Hospital	Dual Non-Dual
5B	Outpatient Services	Ambulatory Surgery Centers – Outpatient Surgeries Outpatient Hospital – Emergency Room Outpatient Hospital – Urgent Care Outpatient Facility – Other Rural Health Clinics FQHCs Freestanding Clinics	Dual Non-Dual
5C	Physician Services	Physicians Nursing Facility Professional Charges	Dual Non-Dual
5D	Pharmacy	Pharmacy	Dual Non-Dual

Long Term Services and Supports Program Lag Report Mappings

LTSS Lag Report #	Consolidated Lag Category of Service	LTSS Program Report 1 Category of Service	Cohort Grouping
5G	Other Medical Services	Ambulance	Dual
		Non-Emergent Transportation	Non-Dual
		Laboratory	
		Radiology	
		Other Practitioners	
		Therapies	
		Home Infusion	
		DME/Medical Supplies	
		Orthotics Prosthetics	
		Dental	
		Vision	
		Other Acute Care Services	
		5N	Nursing Facility/ Hospice
Nursing Facility State Owned – Low Level of Care	Non-Dual		
Nursing Facility Private – High Level of Care			
Nursing Facility Private – Low Level of Care			
Other Nursing Facility Payments			
Hospice			
Home Health and Visiting Nurse Services			
5O	HCBW Services/ Personal Care Option	Community Benefit – Respite	Dual
		Community Benefit – Adult Day Health	Non-Dual
		Community Benefit – Assisted Living	
		Community Benefit – Environmental Modifications	
		Community Benefit – Private Duty Nursing	
		Community Benefit – Emergency Response	
		Community Benefit – Other (Non-Self Direction)	
		Personal Care Option – T1019	
		Personal Care Option – 99509	
		Personal Care Option – G9006	
Personal Care Option – Other			
5P	Self Direction Services	Community Benefit – Self Direction	Dual
			Non-Dual

Medical Care Credit Lag Report

In addition to the lag reports listed in the table above, a medical care credit lag report is also required for the LTSS program. The information in this report will be used to support capitation rate setting and medical care credit adjustments between the State and the MCO. Only the medical care credit amounts are to be included in this report. The paid date is to be based on the final resolution of the claim. Where necessary, the MCO shall include an estimate of any outstanding medical care credit (Line 39 of the medical care credit lag report). The methodology for development of this estimate **must** be described in the MCO notes. The amounts in the medical care credit lag report are not expected to tie to any amounts within Report 1, as Report 1 is to exclude any medical care credit amounts where the MCO delegated the collection of medical care credit to the nursing facility or community-based residential alternative facility and paid the facility net of the applicable medical care credit amount. However, totals are expected to tie to amounts reported in the medical care credit report (Report 12A) detailed in this guide. Amounts **must** be auditable back to the encounter data, where the MCO is required to submit medical care credit information associated with claim payments to providers in their encounter data submission to the State.

The medical care credit lag report service mappings for the LTSS Program are as follows:

Long Term Services and Supports Program Lag Report Mappings

LTSS Lag Report #	Lag Category	LTSS Program Report 1 Category of Service Applicable to Patient Pay	Cohort Grouping
5Q	Medical Care Credit	Nursing Facility State Owned – High Level of Care Nursing Facility State Owned – Low Level of Care Nursing Facility Private – High Level of Care Nursing Facility Private – Low Level of Care Hospice Hospital Swing Bed – High Level of Care Hospital Swing Bed – Low Level of Care Inpatient Hospital – Acute Inpatient – Specialty Hospital	Dual Non-Dual

Other Adult Group Physical Health Program Lag Report Mappings

OAG PH Lag Report #	Consolidated Lag Category of Service	OAG PH Program Report 1 Category of Service	Cohort Grouping
5A	Inpatient Hospital Services	Inpatient Hospital – Acute Inpatient – Specialty Hospital Non-Acute LTC/Skilled Nursing Facility/Respite	OAG
5B	Outpatient Services	Ambulatory Surgery Centers – Outpatient Surgeries Outpatient Hospital – Emergency Room Outpatient Hospital – Urgent Care Outpatient Facility – Other Rural Health Clinics Federally Qualified Health Centers (FQHCs) Freestanding Clinics	OAG
5C	Physician Services	Physicians	OAG
5D	Pharmacy	Pharmacy	OAG
5E	Dental Services	Dental	OAG
5F	Laboratory/Radiology Services	Laboratory Radiology	OAG
5G	Other Medical Services	Ambulance Non-Emergent Transportation Home Health and Visiting Nurse Services Hospice Other Practitioners Therapies Home Visiting Pilot Home Infusion DME/Medical Supplies Orthotics Prosthetics Vision Other PH Services	OAG
5O	HCBW Services/Personal Care Option	Community Benefit Personal Care Option	OAG

Other Adult Group Behavioral Health Program Lag Report Mappings

OAG BH Lag Report #	Consolidated Lag Category of Service	OAG BH Program Report 1 Category of Service	Cohort Grouping
5A	Inpatient Hospital Services	Hospital Inpatient Facility (Psychiatric Hospitalization Services) Inpatient and Residential Professional Charges	OAG
5D	Pharmacy	BH Pharmaceuticals	OAG
5H	Outpatient/Clinic Services	Evaluations and Therapies (Non-Hospital Outpatient) Testing (Non-Hospital Outpatient) Functional Family Therapy (FFT) (Non-Hospital Outpatient) Outpatient Hospital (Evaluations, Therapies, and BH Physical Evaluations) Partial Hospitalization Program (BH Treatment Services) Hospital Outpatient Facility (BH Treatment Services) Suboxone Treatment Methadone Treatment Rural Health Clinics FQHCs	OAG
5I	Residential Treatment Center	Residential Treatment Center, ARTC and Group Homes < 21 Foster Care Therapeutic (TFC I & II) < 21 Other Residential	OAG
5J	Behavioral Management Services	Skills Training and Development (Behavioral Management Services) < 21	OAG
5K	Behavioral Health Providers	BH Day Treatment < 21 Intensive Outpatient Program Services (IOP) Adaptive Skills Building (ABS) Multi-Systemic Therapy (MST) Telehealth Other Professional BH Services Respite Services Applied Behavior Analysis (ABA) Pre-Tenancy/Housing Support	OAG
5L	Psychosocial Rehab Services	Psychosocial Rehab Services for Adults =>18	OAG

Other Adult Group Behavioral Health Program Lag Report Mappings

OAG BH Lag Report #	Consolidated Lag Category of Service	OAG BH Program Report 1 Category of Service	Cohort Grouping
5M	Community Services, Agencies	School-Based Health Center Services Assertive Community Treatment (ACT) Core Service Agencies (CSA) – Other Services Comprehensive Community Support Services (CCSS) Recovery Services Family Support Services	OAG

Completing the Lag Reports

For all lag reports, health care costs are to be reported net of TPL and COB, consistent with the reporting of health care expenses in Reports 1 and 2. Health care costs are to be reported gross of reinsurance cost and recoveries, as these amounts are to be reported within a separate line (Line 43) within the lag report. Health care costs must also exclude global/subcapitation payments, as these amounts are to be reported within a separate line (Line 39) within the lag report.

The schedules are arranged with month 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 on 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 39. Lines 1 through 3 contain data for payments made in the current period. Earlier data on Lines 4 through 37 shall match data on appropriate lines on the prior period's submission. If data in Lines 4 through 37 changes from the prior period's submission, an explanation **must** be provided in the MCO notes. The current month is the last month of the period that is being reported. For example, in the report for the period ended March 31, 2020, the current month would be March 2020, and the first prior month would be February 2020. **Do not** include provider risk pool distributions as payments in this schedule.

The most recent month of the current quarter is auto-populated based on the lag report dates entered in the Information Input tab; the remaining prior months' column and row headings will be completed by the template.

Although the lag reports are formatted to gather 36 months of data, the lag reports must provide data for the period that begins with the first month the MCO was responsible to provide health care benefits to Centennial Care recipients and that ends with the current month. As such, report only Centennial Care Program data related to claims incurred on or after January 1, 2014. See Section 1.05 of this guide for additional information regarding lag report timing.

Inpatient stays that span multiple months are to be recorded with the admission month as the incurred month. Interim bills that begin after the admission date are to be recorded as incurred in the month of admission.

In circumstances where a continuous stay in a facility such as a nursing facility (categories 1, 2, and 3) and/or residential treatment center is required for an MCO's Centennial Care member and interim claims billing is used for the purpose of payment to the provider, the interim bills are to be recorded with the month corresponding to the "From" date of the interim claim as the incurred month.

Global/Subcapitation Payments

(All programs – Line 39)

Global and/or subcapitation expenses are to be reported according to the dates of service the capitation payments made to the providers were meant to cover. **Do not** report capitation expenses based on date of payment. Capitated payments reported on this line are **not** to be included in any lines above Line 39.

Reporting of subcapitation expenses within the various lag reports must be consistent with the lag report/category of service mappings detailed above. For example, if the capitation agreement with the provider covers physician services, the capitation payments for the PH Program should be reported within the physician services lag report. However, if the capitation arrangement with the provider covers both physician services and other practitioner services, an allocation must be made and the capitated payments are to be reported in the physician services lag report and the other medical services lag report. A detailed description of the allocation methodology must then be provided in the MCO notes.

Pharmacy Rebates

(All programs – Line 40)

Report pharmacy rebates anticipated/accrued for drugs dispensed in the current quarter, by month. Adjust, as appropriate, any rebate amounts applicable to drugs dispensed in prior periods where actual data can be used in place of estimates made in prior reporting periods. Enter pharmacy rebates as a negative amount. Only complete this line for the pharmacy lag reports.

Settlements

(All programs – Line 41)

The MCO should report payments/recoupments on Lines 1 through 37, to the extent possible. If the MCO makes a settlement or other payment that cannot be reported on Lines 1 through 37 due to lack of data, the amount must be reported on Line 41 with the payment month used as a substitute for the service month. The MCO may also use an alternative method of reporting settlements that restates prior period amounts to reflect an actual settlement for that month. For all amounts reported on Line 41, include an explanation in the MCO notes. Do not include adjustments to IBNP amounts on this line.

Shared Risk/Incentive Arrangements

(All programs – Line 42)

Shared risk/incentive arrangements is the amount paid, or reasonably expected to be paid, to participating providers based on a contractual agreement covered within the incurred dates of service period.

Include directed payment amounts paid by the MCO. These amounts **must** match the total payment made by HSD to the MCO by rate cohort. Directed payment amounts should only be reported in Report 5G - Other Medical Services.

Reinsurance Expense Net of Recoveries

(All programs – Line 43)

Reinsurance amounts should include the reinsurance premium expenditures less the recoveries related to incurred health care services eligible for reinsurance. To the extent the reinsurance recoveries exceed the reinsurance premium expenditures in any given month, enter the amount as a negative number for that month.

Total Amount Paid to Date

(All programs – Line 44)

This line is the total amount paid to date (including subcapitation) for services rendered and equals the sum of Lines 38 through 43. This line will calculate automatically.

Current Estimate of Claims Incurred But Not Paid (IBNP), Exclusive of a Provision for Adverse Deviation

(All programs – Line 45)

Amounts on this line represent the current estimates for unpaid claims, by month of service, for the past 36 months, and the aggregate amount for all prior months. For each reporting period, the MCO **must** determine a new IBNP amount for each service month and include this amount on Line 45. The development of each IBNP should be based on the most recent paid claims data. The amounts on this line should represent the estimate of the unpaid claims liability for both IBNR and RBUCs and exclude any amounts related to a provision for adverse deviation on IBNP.

The MCO **must** provide an explanation in the MCO notes for any month prior to the twenty-fourth most recent month when the IBNP amount for that month exceeds the incurred claim estimate (Line 48) by 1%.

Provision for Adverse deviation on IBNP

(All programs – Line 46)

Amounts on this line represent the additional liability estimate that is above and beyond the MCO's best estimate of unpaid claim liability.

If no amounts are reported in this line, the MCO **must** confirm in the notes that amounts reported in Line 45 (current estimate of claims incurred but not paid, exclusive of a provision for adverse deviation) do not include any provisions for adverse deviation.

Current Estimate of IBNP, Inclusive of a Provision for Adverse Deviation

(All programs – Line 47)

Amounts on this line represent the current estimates for unpaid claims (including a provision for adverse deviation), by month of service, for the past 36 months, and the aggregate amount for all prior months. This line will calculate automatically as the sum of Line 45 and Line 46.

Total Incurred Claims

(All programs – Line 48)

Total incurred claims is the sum of Line 44 (total amount incurred and paid to date) and Line 47 (IBNP). These amounts represent current estimated amounts ultimately to be paid for health care services by month of service for the past 36 months and for all months prior to month 36. Each amount represents the health care expense for a particular month and is not to include adjustments to prior month IBNP claims estimates. This amount is comprised of claims for the incurred month that are known to be paid by the end of the reporting quarter, plus claims for the incurred month estimated to be unpaid at the end of the reporting quarter. Also included are subcapitations and adjustments.

For the supplemental annual report submission, the MCO is to provide a detailed description of the allocation methodology for their respective IBNP allocations between individual cohorts and categories of service within Report 1 for each program. The allocation methodology **must** be explained in the MCO notes. This explanation will assist in understanding the MCO's reported financial information and will significantly increase the efficiency in determining the reasonableness of the MCO's allocation and expedite the completion of the MCO financial reviews.

2.10 Report 6 — Encounter Comparison

Financial management report reference number(s):

FMB-PH 06, FMB-BH 06, FMB-LTSS 06, FMB-OAGPH 06, FMB-OAGBH 06

This report is due quarterly and as an annual supplement.

This report is included in each Excel-based program-specific reporting package template.

The purpose of Report 6 is to collect health care expense detail related to Centennial Care Program encounter data and perform a comparison between the encounter amounts and the health care expenses for paid claims reported in Report 2 – Schedule of Expenses Detail. Note that expenses reported in Report 2 automatically flow through to this report.

Encounter Input Section

The encounter input section consists of data input by the MCO for the purpose of comparison to the financial-reported health care expenses.

All amounts from encounter data must follow the same health care service categorization logic used for reporting the financial data.

Encounter data is to be limited to the same year-to-date incurred periods as the financial data. The applicable year-to-date time period is automatically displayed within the column headers of the table. The time period displayed is based on the dates entered within the Information Input tab.

The encounter input section requires the MCO to enter expenses for the following:

- Medical Claim
 - Submitted and accepted medical encounter claims.
 - Submitted and denied medical encounter claims.

Comparison Section

This section compares the encounter amounts to health care expenses for paid claims reported in Report 2.

Any differences identified in the comparison section **must** be explained in the analysis tab.

The comparison section automatically calculates the following:

- Dollar difference: Financial paid claims less encounter total submitted.
- Service category distribution: Individual service category percent of total financial paid claims for all service categories.
- Encounter percent of financial: Encounter total submitted as a percent of financial paid.

2.11 Report 7 — Individual High Cost Claims

Financial management report reference number(s):

FMB-PH 07, FMB-BH 07, FMB-LTSS 07, FMB-OAGPH 07, FMB-OAGBH 07

This report is due quarterly and as an annual supplement.

This report is included in each Excel-based program-specific reporting package template.

This report provides information about any high cost claims included within each of the program-specific lag reports and will also help inform MCO claims liability estimates. For the purpose of this report, a claim shall be considered high cost if the claim liability is either known or expected to be **\$150,000 or greater**, regardless of whether a specific reserve has been established for the particular claim.

For each high cost claim, the following information must be provided (**do not enter person name or ID**):

- Column B, cohort number: Enter the cohort number of the individual to coincide with the cohorts listed in Report 1. Cohort descriptions with the corresponding cohort numbers are detailed in Section 1.03 of this guide.
- Column C, lag mapping: For each individual high cost claim, identify the lag report number where the respective paid amount and/or reserve is reported.
- Column D, hospital/provider name: Enter the name of the hospital, facility, or provider to which the claim was paid or is being paid.
- Column E, admission date (or begin date for non-inpatient): Enter the admission date of the claim for inpatient or the begin date of the claim for non-inpatient.
- Column F, expected discharge (or end date for non-inpatient): If the claim is ongoing, enter the expected discharge date of the claim for inpatient or the end date of the claim for non-inpatient.
- Column G, actual discharge date (or end date for non-inpatient): If the claim is no longer active, enter the actual discharge date of the claim for inpatient or the end date of the claim for non-inpatient.
- Column H, initial estimated liability: Enter the initial estimated liability established for the claim.
- Column I, actual paid to date: Enter the total amount paid to date for the claim.
- Column J, estimated remaining liability: Enter the estimated remaining liability of the claim.
- Column K, total expected liability (actual paid, plus remaining estimated liability): This column automatically calculates the sum of the amount paid to date for the claim and the estimated remaining liability for the claim.
- Column L, reinsurance recovery offset (gross of reinsurance expense): Enter the actual/estimated reinsurance recovery for the claim. Note this amount is to reflect the reinsurance recovery gross of any reinsurance expense. **Do not** report the reinsurance recovery net of reinsurance expense.
- Column M, most recent paid date: Enter the most recent date where payment was made for the claim (regardless if partial or full payment was made).

- Column N, payment type: single or multiple (interim): Identify whether the payment(s) made to date for the high cost claim was a single payment (claim paid in full) or a multiple (interim) payment.

Ongoing Reporting of High Cost Claims Information

Report 7 is meant to help inform amounts reported within each of the program-specific lag reports, whether it's paid claim amounts or amounts related to current claims liability estimates. As such, information for each high cost claim that becomes fully settled within a particular twelve-month calendar year reporting period should continue to be reported within Report 7 as long as the respective claim is included within any of the program-specific lag reports. Given the lag reports contain 36 months of historical Centennial Care data, reporting high cost claims in this manner will provide valuable information related to data included within the program-specific reporting packages, even if the date of service for the particular high cost claim was prior to the first day of the current twelve-month calendar year reporting period.

To the extent the MCO feels additional information is necessary to explain any high cost claims, an explanation should be included in the MCO notes.

This report is formatted to accommodate 200 entries. If the number of applicable high cost claims exceeds the number of lines provided, the MCO should add the necessary lines to the bottom of the table so that all the high cost claims are reported within the single Report 7 Excel tab.

2.12 Report 8 — Value Added Services/Non-State Plan Approved Services

Financial management report reference number(s):

FMB-PH 08, FMB-BH 08, FMB-LTSS 08, FMB-OAGPH 08, FMB-OAGBH 08

This report is due quarterly and as an annual supplement.

This report is included in each Excel-based program-specific reporting package template.

The purpose of this report is to provide quarterly cohort and service detail in support of any VAS or non-State Plan approved service expenses reported in Report 1. VAS and non-State Plan approved services are those services or benefits offered by the MCO that are not a covered service per the MCO's contract with the State. Expenses related to State and federally approved pregnancy termination procedures rendered to eligible members, per the MCO contract, are to be included within Report 8.

To the extent the MCO provides VAS and/or non-State Plan approved services approved by HSD to supplement the covered services in accordance with the contract, including State and federally approved pregnancy termination procedures, the MCO is to report the applicable expenses by cohort and service category. The MCO is to enter service descriptions, as necessary, in the spaces provided. All rows with expenses must have a service category description that allows the reviewer to understand the type of service. The use of "Other" as a service category description is prohibited. Note that the service descriptions entered in the dollar amount table will automatically populate the PMPM table. Total amounts from this report must tie to amounts reported in the "Value Added Services/Non-State Plan Approved Services" health care expense line within Report 1.

2.13 Report 9 — Recovery and Cost Avoidance Report

Financial management report reference number(s):

FMB-PH 09, FMB-BH 09, FMB-LTSS 09, FMB-OAGPH 09, FMB-OAGBH 09

This report is due quarterly and as an annual supplement.

This report is included in each Excel-based program-specific reporting package template.

The purpose of this report is to collect information related to the MCO's activities involving third party resources and fraud and abuse.

Quarterly Tables

All dollar amounts are to be compiled using quarterly data. In the section of the table designated for amounts based on dates of service within the quarter (columns G through N), each quarterly table is to contain three months of accumulated history based on dates of service within the respective quarter. For example, columns G through N in the "Quarter One" table should only include information related to claims with dates of service within the first quarter (January 1 through March 31) of the twelve-month calendar year reporting cycle. Beginning with the first

quarter of the twelve-month calendar year reporting cycle, the MCO is to submit third party resource information based on claims with dates of service within the first quarter. After each subsequent quarter-end within the reporting cycle, the MCO is to submit new third party resource information based on claims with dates of service in the most recent quarter as well as restated data within the applicable prior quarter tables for claims with dates of service in each prior quarter within the reporting cycle.

For each cohort listed in the quarterly tables, the following information must be provided:

- Members with active resources at quarter end: Identify and report the total number of unique members with active TPL resources at the end (last day) of the quarterly reporting period. This count is to represent the total number of active members that have an identified TPL resource regardless if a claim was processed for the member.
 - Column D, commercial: Identify and report the total number of unique members with an active TPL resource of commercial insurance at the end (last day) of the quarterly reporting period.
 - Column E, Medicare: Identify and report the total number of unique members with an active TPL resource of Medicare insurance at the end (last day) of the quarterly reporting period.

If a member has both commercial and Medicare insurance, include the member count within each of the two columns. When the third party insurance is unknown, use commercial as the default.

- Claim counts:
 - Column G, count of total claims paid: Report all claims paid by the MCO during the current reporting period for claims with dates of service within the respective quarter. Claims paid are to include all claims paid at or greater than \$0.00. Additionally, the count of total claims paid should be ALL claims paid by the MCO and **not** only those claims that had commercial, Medicare or other insurance as primary payer. Denied claims should be excluded from this count.
 - Column H, count of claims paid with other insurance indicated: Report all claims paid by the MCO during the current reporting period for claims with dates of service within the respective quarter where the member had other insurance coverage. This should include claims paid at \$0.00 due to other insurance payments greater than MCO allowed amounts. In addition, claims should be reported even if the other insurance paid \$0.00 for the claim due to services not covered by other insurance. Denied claims should be excluded from this count. The count of claims reported here is a subset of the claim counts reported in column G, count of total claims paid.
- Columns I, K, and M, amount cost avoided: Cost avoided claims are those claims with dates of service within the respective quarter the MCO denies because third party health insurance-related resources exist 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 with the primary insurance carrier occurred and indicating the amount paid by the other insurance. In the amount cost avoided column, enter the MCO's Medicaid rate for the service related to the claim(s) cost avoided. The MCO shall disclose the algorithm used to identify the reported cost avoidance amounts within this report. The explanation must be provided in the MCO notes.

- Columns J and L, other insurance paid amount: Report amounts for all third party payments received by the provider for NM Centennial Care Medicaid enrollees for claims with dates of service within the respective quarter. These amounts 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. Amounts are to be reported according to the resource type of either commercial or Medicare. The reported amounts in this table should be auditable back to the MCO's claims payment system.
- Column N, actual payments received: Amounts in this column are to include recovered amounts related to a TPL resource that has not been captured in the claims processing system as other insurance. Amounts in this column are to relate to claims with dates of service within the respective quarter. Report third party payments received from either the provider or third party insurer for services and conditions which are:
 - Employment related injuries or illnesses;
 - Related to motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists; and
 - Contained in ICD-9-CM diagnosis codes 800 through 999, with the exception of code 994.6.
 - Contained in ICD-10-CM diagnosis codes S00 through T88, with the exception of codes T753XXA, T753XXD and T753XXS, or in codes Z04.1, Z04.2 and Z04.3.If the MCO uses a third-party recovery vendor, any amounts the vendor recovers (if not recorded in the claims system on individual claims as other insurance paid) is also to be reported in this column. The reported amounts in this column related to third-party vendor recoveries should reflect the portion of the recovered amount paid to the MCO and not the gross amount recovered by the third-party recovery vendor.
- Column O, actual payments received: Amounts in this column are to include recovered amounts related to a TPL resource that has not been captured in the claims processing system as other insurance. See above for examples. Amounts in this column are to relate to third party payments received in the quarter for claims with dates of service prior to the first day (January 1) of the current twelve-month calendar year reporting period. For example, if a third-party payment is made to the MCO in August of the current reporting period for a claim with a date of service eighteen months prior, the payment amount is to be reported in Column O of the Quarter Three table. Note that only information pertaining to the Centennial Care Program is to be entered into this report. Data related to expenses incurred prior to January 1, 2014 is to be excluded from the report.

Once an amount is reported as cost avoided for a particular claim, that amount should remain unchanged and continue to be reported within the same quarterly table throughout the remaining twelve-month calendar year reporting period, even if the claim is resubmitted by the provider at a later date with the necessary EOB and the MCO has processed the claim and made any applicable payments related to the claim. As new claims are received by the MCO in subsequent quarters, any amounts determined to be cost avoided for those claims should be added to amounts previously reported as cost avoided within the quarterly tables. Amounts cost avoided are to be reported within each of the quarterly tables according to the date of service of the particular claim.

Reporting Examples

To illustrate the ongoing reporting of amounts cost avoided, three examples are provided below:

- Example 1: An MCO receives a claim in February with a date of service in January of the same year and the claim is rejected due to identification of a TPL resource of commercial insurance with no attached EOB indicating the necessary coordination of benefits. The MCO then determines \$100 to be the amount cost avoided for the particular claim. In March, the provider resubmits the claim with the required EOB indicating that coordination of benefits with the primary insurance carrier occurred and that \$60 was paid by the other insurance. The MCO then pays the provider the remaining balance of \$40 as determined by the MCO's contracted rate with the provider.
- Example 2: The MCO receives a claim in June with a date of service in March. The claim has an identified TPL resource of commercial insurance, but no EOB indicating the necessary coordination of benefits. The MCO rejects the claim and determines the amount cost avoided to be \$85 for that particular claim.
- Example 3: The MCO receives a claim in September for services rendered in August. The claim has an identified TPL resource of commercial insurance, but no EOB indicating the necessary coordination of benefits. The MCO rejects the claim and determines the amount cost avoided to be \$90 for that particular claim.

To correctly report these three cost avoided amounts and the commercial insurance paid amount for the twelve-month calendar year reporting period, the MCO must do the following:

- First quarter reporting submission: Report the \$100 cost avoided amount within Column I of the Quarter One table. Report the \$60 other insurance paid amount in Column J of the Quarter One table.
- Second quarter reporting submission: Continue to report the \$100 cost avoided amount within Column I of the Quarter One table. Report the \$85 cost avoided amount within Column I of the Quarter One table. Continue to report the \$60 other insurance paid amount in Column J of the Quarter One table.
- Third quarter reporting submission: Continue to report both the \$100 and \$85 cost avoided amounts within Column I of the Quarter One table. Report the \$90 cost avoided amount within Column I of the Quarter Three table. Continue to report the \$60 other insurance paid amount in Column J of the Quarter One table.
- Fourth quarter reporting submission: Continue to report both the \$100 and \$85 cost avoided amounts within Column I of the Quarter One table. Continue to report the \$90 cost avoided amount within Column I of the Quarter Three table. Continue to report the \$60 other insurance paid amount in Column J of the Quarter One table.
- Annual supplemental report submission: Continue to report both the \$100 and \$85 cost avoided amounts within Column I of the Quarter One table. Continue to report the \$90 cost avoided amount within Column I of the Quarter Three table. Continue to report the \$60 other insurance paid amount in Column J of the Quarter One table.

Year-to-Date Table

With the exception of the counts of members with active resources at period end, all amounts within the Year-to-Date table will calculate automatically by adding up the reported amounts within each of the quarterly tables above.

For each cohort listed in the Year-to-Date table, the following information must be provided:

Members with active resources (commercial and/or Medicare) at period end: Identify and report the total number of unique members with active TPL resources that are included within the counts of each quarterly table. The year-to-date count is to represent the total number of unique members across all counts from each of the quarterly tables above.

A member with an active TPL resource across multiple quarters within the current calendar year reporting period should only be counted once within the Column D and/or Column E amounts of the Year-to-Date table. For example, if at the end of the third quarter reporting period a member was included in the quarter 1, quarter 2 and quarter 3 Medicare resource counts (Column E), that member would only be counted once in Column E of the Year-to-Date table.

A member can be included in both the Commercial and Medicare columns if they have both coverages. For example, if the same member from the previous example also had commercial coverage in the first two quarters and was included in the commercial resource counts (Column D) for quarters 1 and 2, respectively, that member be counted once in Column D of the Year-to-Date table in addition to being counted once in Column E.

Fraud and Abuse Recoveries

The purpose of this table is to collect recovery information related to the MCO's program integrity/fraud and abuse efforts. For this table, the following information must be provided:

- Column C: Enter the total number of fraud and/or abuse cases with actual recoveries. Counts are to include both cases the Medicaid Fraud & Elder Abuse Division of the New Mexico Attorney General's Office (MFEAD) approved the MCO to independently pursue and cases not requiring approval from MFEAD. Case counts should be reported in the contract year in which the service was rendered.
- Column D: Actual settlement and/or recovery amounts. These amounts are to be reported in the quarter or calendar year they appear in Report 1 and the lag reports.

Consideration for cases with dates of service that span multiple fiscal periods:

- To the extent a particular case involves claims with dates of service that span multiple fiscal periods, an allocation of the recovery amounts is acceptable. Case counts associated with allocated recovery amounts are to be reported within each applicable fiscal period identified within this table where an allocation of recovery amounts is made. For example, if a particular case results in recoveries associated with claims with dates of service in the first quarter of 2020 and multiple quarters within 2019, a case count of 1 should be included in the 2020 quarter 1 line and a case count of 1 should also be included in the 2019 line.

- For any allocations, the MCO must provide a detailed explanation in the MCO notes that also includes identification of any case counts that are duplicated across multiple contract years and the recovery amounts associated with each duplicated case count.

Consideration for case counts and recovery amounts associated with members whose member months and health care expenses are included in more than one program-specific reporting package:

- For case counts and recovery amounts associated with members whose member months and health care expenses are included in more than one program-specific reporting package template, the cohort number of the applicable members and the health care service category most applicable to the particular claim(s) associated with the case should be used as the basis for reporting the information within each applicable program-specific reporting packages.
- If the MCO is unable to tie recovery amounts back to individual cohorts/claims where a program-specific distinction can be made, an allocation of the recovery amounts is acceptable. Case counts associated with allocated recovery amounts are to be reported within each program-specific reporting package where an allocation of recovery amounts is made. For example, if a particular case results in recoveries associated with members whose member months and health care expenses are reported in the PH program and the BH program reports, a case count of 1 should be included in Report 9 of the PH program (FMB-PH 09) and a case count of 1 should also be included in Report 9 of the BH program (FMB-BH 09).
- For any allocations, the MCO must provide a detailed explanation in the MCO notes that also includes identification of any case counts that are duplicated across multiple program-specific reports and the recovery amounts associated with each duplicated case count.

Note that only information pertaining to the Centennial Care Program is to be entered into this table. The MCO is to input data for the period that begins with the first month the MCO was responsible to provide health care benefits to Centennial Care recipients. Data related to dates of service prior to January 1, 2014 is to be excluded from the table.

2.14 Report 10 — Outlier Services Report (BH Program and OAG BH Program only)

Financial management report reference number(s):
FMB-BH 10, FMB-OAGBH 10

This report is due quarterly and as an annual supplement.

This report is included in the BH and OAG BH Excel-based program-specific reporting package templates.

The purpose of this report is to provide quarterly service code detail in support of any outlier expenses reported in Report 1. Outlier services, if applicable, are those services that the MCO is unable to map to any one particular service category listed in Appendix B of this guide. Note that this report was used in the behavioral health program prior to Centennial Care, but is not expected to be necessary going forward. However, the outlier report has been included as part of the Centennial Care BH Program and OAG BH Program financial reports in the event circumstances arise that would require its use. As such, there is no predetermined set of services or codes that is expected to be included within this report.

For each quarter, the following data is to be reported as it pertains to any outlier services:

- Service code: Enter the service code (e.g., procedure code, revenue code, HCPCS code, etc.) for the service deemed to be an outlier.
- Service description: Enter the description for the service code identified in the previous column.
- Cohort number: Enter the cohort number of the individual to coincide with the cohorts listed in Report 1. Cohort descriptions with the corresponding cohort numbers are detailed in Section 1.03 of this guide.

For each outlier service entered in the report, enter the number of unique members utilizing the respective service within the quarter and the associated expenses. The year-to-date count of unique members utilizing the respective service within the total year-to-date time period should also be entered. For example, if the financial reporting period covered the first three quarters of a given year and a particular member utilized an outlier service once in the first quarter, twice in the second quarter, and did not utilize the service in the third quarter, that member would only be counted once in the year-to-date member count column for the particular service. Note that the total year-to-date expenses for each service will calculate automatically.

Total amounts from this report must tie to amounts reported in Line 51 of Report 1 for the BH Program and the OAG BH Program.

For any amounts reported in this report, the MCO **must** provide an explanation in the MCO notes as to why the service is considered an outlier service and why it cannot be mapped to an existing category of service or program.

2.15 Report 11 — Self Direction Expenses Report (LTSS Program only)

Financial management report reference number(s):
FMB-LTSS 11

This report is due quarterly and as an annual supplement.

This report is included in the LTSS Excel-based program-specific reporting package template.

The purpose of this report is to provide quarterly service category detail in support of any Community Benefit – Self Direction expenses reported in Report 1, Line 34. Totals in this report are to tie to amounts reported in Report 1, Line 34. Please reference Appendix D for direction regarding the hierarchical categorization and reporting of self direction services.

2.16 Report 12A — Medical Care Credit Report (LTSS Program only)

Financial management report reference number(s):
FMB-LTSS 12A

This report is due quarterly and as an annual supplement.

This report is included in the LTSS Excel-based program-specific reporting package template.

The purpose of this report is to provide medical care credit (as defined in Section 6.9 of the MCO contract) detail by quarter, cohort, and applicable category of service. The information in this report will be used to support capitation rate setting and medical care credit adjustments between the State and the MCO. The category description of “Reserved” is used in some sections of this report and is meant to be a placeholder for future use if necessary. **Do not** report information on any line identified as “Reserved” in the category description column of the report.

The member months in this report are automatically populated with the member months reported in Report 1.

For each of the expense categories listed, enter the applicable patient pay liability amounts for services provided within each quarter. These amounts are **not** expected to tie to any amounts within Report 1, as Report 1 is to exclude any patient pay liability amounts where the MCO delegated the collection of medical care credit to the nursing facility or community-based residential alternative facility and paid the facility net of the applicable medical care credit amount. However, totals are expected to tie to amounts reported in the medical care credit lag report (Line 40). Amounts must be auditable back to the encounter data where the MCO is required to submit medical care credit information associated with claim payments to providers in their encounter data submission to the State.

2.17 Report 12B — Copay Report

Financial management report reference number(s):

FMB-PH 12B, FMB-BH 12B, FMB-LTSS 12B, FMB-OAGPH 12B, FMB-OAGBH 12B

This report is due quarterly and as an annual supplement.

This report is included in each Excel-based program-specific reporting package template.

The purpose of this report is to provide Centennial Care member copayment detail by quarter, cohort, and applicable health care expense category. The copayment dollars and corresponding number of copayments provided in this report are for informational purposes only. The information in this report will be used to support program oversight and capitation rate setting.

The health care expense categories listed on this report reflect the broad categories where Centennial Care members are potentially subject to copayments. Note that applicability of copayments shall be based on the MCO contract.

For any service not included in the prepopulated list, the MCO must write in the applicable service description using one of the lines with a placeholder description of “Enter Applicable Service.”

Do not include information in this report related to copayment amounts applicable for non-emergency use of the emergency room and brand name drugs when a generic drug is available.

The member months in this report are automatically populated with the member months reported in Report 1.

Copayment Dollars

For each of the health care expense categories listed, enter the total copayment dollars associated with the applicable recipients and services rendered within the particular quarter, regardless of whether the provider collected the copayment from the MCO’s Centennial Care member.

The copayment amounts to be entered in this report are to reflect the copayment amounts applicable to certain Centennial Care members and services, per the MCO contract, where the MCO reduced payment to the provider by the applicable copayment amount.

Do not include estimates for copayment amounts associated with any claims incurred, but not reported. The copayment dollar amounts associated with the applicable inpatient admissions or services are to be reported within each quarter-specific column based on the admitting date or date of service, where the date of admission or date of service is included in the respective quarter.

The copayment amounts included in this report are **not** expected to tie to any amounts within Report 1, as Report 1 is to be reported net of TPL and COB (this includes copayments received by the provider and/or where the MCO paid the provider net of the applicable member copayment amount). Amounts must be auditable back to the encounter data where the MCO is required to submit member copayment information associated with claim payments to providers in their encounter data submission to the State.

Copayment Counts

For each quarter, cohort and health care expense category where dollar amounts are reported in the copayment dollars section, enter the number of copayments associated with the respective copayment amounts.

Average Amount Per Copayment

Amounts in this section will calculate automatically based on information reported within the copayment dollars and copayment counts sections and represent the average copay amount for members for the applicable services included within each health care expense category.

2.18 Reserved for Future Use

This section has been intentionally left blank.

2.19 Reserved for Future Use

This section has been intentionally left blank.

2.20 Reserved for Future Use

This section has been intentionally left blank.

2.21 Report 15 — Pharmacy Supplemental Report

Financial management report reference number(s):

FMB-PH 15, FMB-BH 15, FMB-LTSS 15, FMB-OAGPH 15, FMB-OAGBH 15

Report 15 is due annually with the annual supplemental reports. This report should be left blank for the quarterly submissions of the Excel-based program-specific reporting package templates.

This report is included in each Excel-based program-specific reporting package template.

The purpose of this report is to collect key measure of price and utilization data for pharmaceutical services.

Pharmacy Dispensing Fees Details

The following is a list of key definitions to be used in the completion of this report:

- Brand/generic: The recommended methodology to classify brand/generic status is based upon a combination of generic indicators provided by First Data Bank, the Innovator (INNOV), the New Drug Application (NDA), the Generic Therapeutic Indicator (GTI), and the Generic Manufacturer Indicator (GMI).
 - A Brand drug is defined by the following hierarchy of indicators:
 - NDC with an INNOV value of “1”
 - NDC with an NDA value of “1”
 - NDC with a GTI of “2”
 - NDC with a GTI of “4” and a GMI of “2”
 - All other values and combination of values for legend drugs are defined as a generic drug.

The following information must be provided as it relates to the MCO's pharmacy dispensing fees. Counts and corresponding fee amounts are to be based on pharmacy claims incurred during the respective reporting period.

- Calendar year/time period: Enter the most recently complete calendar year in the first row. Enter the prior calendar year in the second row. If there are spans within these time periods that have different dispensing fees, please use the additional rows provided to display all dispensing fee time spans.
- Total brand scripts: Enter the total number of legend brand prescriptions reimbursed by the MCO (excluding OTC, TPL, usual and customary (U&C) and specialty claims) during the reporting period.
- Total brand dispensing fees: Enter the actual amount paid for brand prescriptions, not the contracted dispensing fee (excluding OTC, TPL, U&C and specialty claims), during the reporting period.
- Total generic scripts: Enter the total number of legend generic prescriptions reimbursed by the MCO (excluding OTC, TPL, U&C and specialty claims) during the reporting period.
- Total generic dispensing Fees: Enter the actual amount paid for generic prescriptions, not the contracted dispensing fee (excluding OTC, TPL, U&C and specialty claims), during the reporting period.
- Total OTC scripts: Enter the total number of OTC prescriptions reimbursed by the MCO (excluding legend, TPL, U&C and specialty claims) during the reporting period.
- Total OTC dispensing fees: Enter the actual amount paid for OTC prescriptions (excluding legend, TPL, U&C and specialty claims) during the reporting period.
- Total other scripts: Enter the total number of TPL, U&C, Specialty and other prescriptions reimbursed by the MCO during the reporting period (exclude any claims counted in the other categories).
- Total other dispensing fees: Enter the actual amount paid for TPL, U&C, specialty and other claims, not the contracted dispensing fee, during the reporting period (exclude any dollars counted in the other categories).

Pharmacy Rebate Details

The following information must be provided as it relates to the MCO's pharmacy rebates. Reported information is to be based on pharmacy claims incurred during the respective reporting periods.

- Identification of time periods: The MCO must identify the applicable time period for each section of the tables by entering the necessary information.
- Historical data table: Enter the most recently complete calendar year, the first calendar year prior, and the second calendar year prior. Note that these three calendar year periods should correspond to the three calendar years included within the lag reports.
- Projection data table: Enter most recently complete calendar year and the two subsequent calendar years that correspond to projection period 1 and projection period 2, respectively.
- Rebate revenue: Enter the total rebate revenue for all drug products that received a rebate for pharmacy claims incurred during the respective reporting period.
- Total gross pharmacy spend: Enter the total pharmacy spend, gross of rebates, for pharmacy claims incurred during the respective reporting period.
- Projected rebate percentage: Enter an estimate of the projected rebate percentage expected for each time period. The reported rebate percentage should reflect the total estimated rebate revenue for the respective period divided by total gross pharmacy spend for the respective period.
- Basis for projected rebate percentages: Describe the information used to project the reported rebate percentages and provide an explanation for how the information was used in calculating the rebate projections. Examples of projection basis may include estimates based on the most current contract renewal terms, preliminary contract extension discussions, or notice from the PBM of upcoming changes, patent expiration, etc. The most recent pharmacy benefits manager (PBM) or other applicable contract effective date must also be included in this section.

2.22 Financial Report Check Figures

In addition to the reports that must be completed by the MCO, each Excel-based program-specific financial reporting package template includes a "Check Totals" tab that evaluates the consistency of the data reported within the respective template. The check figures within this tab are meant to compare data sources and identify any differences where information is expected to match. The various checks within this tab will be performed by built-in formulas that will only compare applicable information across the various tabs within each Excel-based reporting package template. These formula-based checks will accommodate some variance within a limited threshold where amounts reported within separate reports will not be required to tie exactly to the penny. The current variance threshold for reports within the reporting package template is +/- \$100. If information in these financial reports is also reported somewhere outside the Excel-based financial reporting package templates and amounts are expected to tie, any necessary reconciliation will be handled through some other means than the check totals tab.

Each cohort grouping used within the respective program-specific reporting package template will have its own section within the check totals tab. Each check evaluates amounts between two sources within the particular program-specific reporting package template where each

source is clearly identified in the first two columns of this report. Amounts from each source are also compared by each quarter. Amounts specific to each source and quarter are displayed in the report along with the calculated differences. Indication of whether any of the calculated differences are in excess of the allowable variance threshold amount is made within the check item variance threshold status section located in the far right columns of this report. The total count of instances for each quarter where the variance threshold has been exceeded is located at the top of the check item variance threshold status section.

The check totals report summary section located in the upper left portion of this report provides two items of information:

- Check item variance threshold status: This item will display either “Variance Threshold Exceeded!” when any check item difference is in excess the allowable variance threshold or it will display “All Items Within Variance Threshold” when no check item differences are in excess of the allowable variance threshold.
- Number of check items requiring action by the MCO: This item will indicate “0” when no check item differences exceed the allowable variance threshold, or it will indicate the total number of check items with differences in excess of the allowable variance threshold.

If any variance threshold has been exceeded, the MCO is to reexamine the reported data for accuracy and make any necessary corrections. If the particular program-specific reporting package is submitted with differences still in excess of the allowable variance threshold, the difference(s) must be explained in the MCO notes. Failure to include a detailed explanation in the MCO notes will render the reporting package incomplete and result in a resubmission request. Providing a detailed explanation for any variance in excess of the allowable threshold **Does Not** guarantee the reporting package will be considered complete or guarantee that a resubmission of the reporting package will not be required.

2.23 Data Export

In addition to the reports that must be completed by the MCO, each Excel-based program-specific financial reporting package template includes a “Data Export” tab that simply collects data that already exists throughout some of the reports within the respective reporting package template. No data or information input is required within this tab. MCOs are under no obligation to use the data within this tab for any particular purpose, as use of any of the data within the tables is entirely optional.

3

Specifications for Other Excel-Based and Non-Excel-Based Standalone Financial Reports

3.01 Other Excel-Based and Non-Excel-Based Standalone Financial Reports

The reports detailed in this section include financial reports required to be submitted by the MCO that are not included within the Excel-based program-specific reporting package templates discussed in Section 2 of this guide. These standalone reports vary in format and due date.

For each Excel-based standalone reporting template discussed in this section, the MCOs **must** also submit a data certification statement. For each non-Excel-based report discussed in this section where HSD will not provide the MCOs a prescribed and preformatted report template, the MCOs **must** also submit the accompanying notes, analysis and data certification statement in support of the particular report. See Section 4 of this guide for additional detail regarding these requirements.

3.02 Report 13A — Stop-Loss Protection Report

Financial management report reference number(s):
FMB-ALL 13A

This report is due quarterly and as an annual supplement.

This report is an Excel-based standalone reporting template.

The purpose of this report is to collect information that allows HSD to assess the stop-loss protections of the MCO. The information provided in this report is used to monitor the MCO's catastrophic coverage.

To the extent the MCO has multiple stop-loss agreements, changes terms of the stop-loss agreement during the applicable reporting period, or changes the contracted stop-loss entity during the applicable reporting period, a copy of the Report 13A tab should be made within the standalone Excel based reporting template to accommodate the required information for each applicable stop-loss agreement.

The Excel-based standalone reporting template specific to Report 13A contains an information input tab, the stop-loss protection report, a notes tab, and an analysis tab.

The MCO is to enter/select all information requested within the information input tab. This tab serves as a cover sheet for the information reported within the Report 13A Excel-based reporting template. Note that the report period ending date and date of service range will automatically populate based on the MCO's selection of the calendar year reporting cycle and quarters included in the report. For items requiring selection(s) to be made by the MCO, the MCO is to use the dropdown boxes located on the right side of the table.

Where applicable, the MCO name, calendar year reporting cycle and report period ending selections will flow through to the other tabs within the Report 13A Excel-based reporting template.

Reinsurance Agreement Details

The following information must be provided, where applicable, as it relates to the MCO's reinsurance agreement:

- Column C, applicable yes/no: Enter "Yes" or "No" as it applies to each line item listed in Column B.
- Column D, amount: Where "Yes" is indicated in Column C, enter the amount applicable to the respective line item in Column B. Where "No" is indicated in Column C, enter "0" as the amount.
- Column E, description and/or additional information: The MCO is to use this column to provide additional information that will help explain the nature of the reinsurance agreement as it relates to each line item listed in Column B. To the extent the MCO deems no additional information is necessary, the MCO is to enter "None" in this column for the respective line item. For some line items, Column E is the only location where information can be entered.
- Line 1, aggregate stop-loss threshold: Enter the maximum reimbursement amount the MCO can receive from the reinsurer for eligible costs per contract year.
- Line 2, maximum per enrollee per year: Enter the maximum reimbursement amount the MCO can receive from the reinsurer for eligible costs per member per contract year.
- Line 3, maximum aggregate lifetime per enrollee: Enter the maximum reimbursement amount the MCO can receive from the reinsurer for eligible costs per member over the lifetime of the member.
- Line 4, deductible per member: Enter the total amount of eligible costs the MCO must first pay per member before the MCO is eligible for reimbursement from the reinsurer.
- Line 5, coinsurance % per member: Enter the coinsurance percentage the MCO is required to pay for eligible claims once the per member deductible amount has been met.
- Line 6, coinsurance per member applicable to: Indicate whether the coinsurance percentage per member entered in Line 5 applies to the total paid claim amount, amount in excess of the deductible amount, or other (specify).
- Line 7, deductible per case: Enter the total amount of eligible costs the MCO must first pay per case before the MCO is eligible for reimbursement from the reinsurer.
- Line 8, coinsurance % per case: Enter the coinsurance percentage the MCO is required to pay for eligible claims once the per case deductible amount has been met.
- Line 9, coinsurance per case applicable to: Indicate whether the coinsurance percentage per case entered in Line 8 applies to the total paid claim amount, amount in excess of the deductible amount, or other (specify).

- Line 10, premium cost PMPM: Enter the premium cost on a PMPM basis applicable to the MCO's Centennial Care enrollees. To the extent the premium cost PMPMs differ by cohort or category of aid, the MCO is to enter the PMPM details in Column E.
- Line 11, service type(s) covered: Enter the service type(s) to which the reinsurance agreement is limited (e.g., inpatient). If the reinsurance agreement contains no service type limitations, enter "All" in Column E.
- Lines 12–17, number of enrollees exceeding stop-loss: Enter the number of the MCO's Centennial Care enrollees who generated claims in excess of the applicable stop-loss thresholds identified in the Reinsurance Agreement Details section. Enrollee counts for each quarter are to be predicated on the admitting date or date of service, where the date of admission or date of service is included in the respective quarter. If the reinsurance agreement is based on eligible costs per member over a given contract year, the enrollee should be counted only once within each quarter, where claims eligible for reimbursement (regardless of the number of eligible claims generated by the enrollee within the respective quarter) were incurred by the MCO on behalf of the respective enrollee.
- Lines 18–23, number of cases exceeding stop-loss: Enter the number of cases that generated claims in excess of the applicable stop-loss thresholds identified in the Reinsurance Agreement Details section. Case counts for each quarter are to be predicated on the admitting date or date of service, where the date of admission or date of service is included in the respective quarter.
- Lines 24–27, loss ratio:
 - Line 25, reinsurance premiums paid: Enter the reinsurance premium payments (as a positive amount) to contracted reinsurance entities related to the cost of catastrophic claims insurance. Amounts entered in this line must tie to amounts reported as reinsurance premium expense within Report 1. Any differences **must** be explained in the MCO notes.
 - Line 26, reinsurance recoveries: Enter the reinsurance recoveries (as a positive amount), billed and unbilled, expected to be recovered from contracted reinsurance entities. Reinsurance recoveries to be included in this line are to be predicated on the admitting date or date of service, where the date of admission or date of service is included in the respective quarter. No recoveries related to prior periods are to be reported in this line item. Amounts entered in this line must tie to amounts reported as reinsurance recoveries within Report 1. Any differences **must** be explained in the MCO notes.
 - Line 27, loss ratio: Reinsurance recoveries divided by reinsurance premium paid. This line will calculate automatically.
- Line 28, insolvency insurance included: Indicate whether the reinsurance agreement includes an insolvency provision.
- Line 29, name of reinsurer: Enter the name of the reinsurer.
- Line 30, intercompany reinsurance agreement: Indicate whether the reinsurance agreement is with an affiliated party.
- Line 31, policy effective dates: Using the mm/dd/yyyy format, enter the begin date and the expiration date of the stop-loss agreement.

Reinsurance Recovery Details (Per Member/Per Case)

The following information must be provided for each member and/or case eligible for reimbursement from a reinsurer through the reinsurance agreement identified in the “Reinsurance Agreement Details” section above. Note that the year-to-date total count of enrollees and cases exceeding the stop-loss thresholds reported in the “Reinsurance Agreement Details” section (Lines 17 and 23, of Column E, respectively) should tie to the total number of unique entries reported on Lines 1 through 40 within this section. **Do not enter person name or ID** anywhere in this report.

- Column B, quarter: Enter the calendar year quarter where the stop-loss threshold was met. This should be based on the admit date or date of service where the eligible claim(s) was generated that exceeded the stop-loss threshold amount.
- Column C, service type(s): Enter the service type(s) applicable to the claim(s) in excess of the stop-loss threshold.
- Column D, cohort number: Enter the cohort number applicable to the enrollee who generated the claim(s) in excess of the stop-loss threshold. Note that cohort numbers can be found in Section 1.03 of this guide.
- Column E, primary diagnosis or major procedure code: Enter the primary diagnosis code or the primary procedure code for the claim(s) where the stop-loss threshold was exceeded.
- Column F, total expenditures: Enter the total expenditures for each enrollee or case exceeding the stop-loss threshold. For agreements based on per-member thresholds, this amount should include all eligible expenses incurred on behalf of the enrollee in the quarter identified in Column B that are above and below the stop-loss threshold. For agreements based on per-case thresholds, this amount should include all eligible expenses incurred in the quarter identified in Column B that are above and below the stop-loss threshold. Do not net expenditures reported in this column against any actual or expected recovery amounts.
- Column G, total expenditures above stop-loss: Enter the total expenditures in excess of the stop-loss threshold for each enrollee or case exceeding the stop-loss threshold. For agreements based on per-member thresholds, this amount should include all eligible expenses incurred on behalf of the enrollee in the quarter identified in Column B that are above the stop-loss threshold. For agreements based on per-case thresholds, this amount should include all eligible expenses incurred in the quarter identified in Column B that are above the stop-loss threshold. Do not net expenditures reported in this column against any actual or expected recovery amounts.
- Column H, total reinsurance recoveries: Enter the reinsurance recoveries (as a positive amount), billed and unbilled, expected to be recovered from contracted reinsurance entities. Reinsurance recoveries to be included in this column are to be predicated on the admitting date or date of service, where the date of admission or date of service is included in the respective quarter identified in Column B. No recoveries related to prior periods are to be reported in this column.
- Column I, net expenditures above stop-loss: Total expenditures above the stop-loss threshold less the applicable reinsurance recoveries. This column will calculate automatically.
- Line 42, total recoveries YTD reported in Line 26 of the reinsurance agreement details table: Total reinsurance recoveries across all Centennial Care programs as reported in the reinsurance agreement details table.

- Line 43, difference: Total YTD reinsurance recoveries reported in the reinsurance agreement details table less total reinsurance recoveries reported within this table. This line will calculate automatically. Any differences **must** be explained in the MCO notes.
- Line 44, total recoveries YTD reported in Report 1, Schedule of Revenues and Expenses by Category: Enter the total year-to-date reinsurance recoveries across all Centennial Care programs reported within Report 1.
- Line 45, difference: Total reinsurance recoveries across all Centennial Care programs reported in Report 1 less total reinsurance recoveries reported within this table. This line will calculate automatically. Any differences **must** be explained in the MCO notes.

The MCO notes and analysis tabs located within the Report 13A reporting template are to be used to provide any necessary explanations or analyses that will help the reader understand the reported information.

3.03 Report 13B — Reinsurance Policy Report

Financial management report reference number(s):
FMB-ALL 13B

This report is due annually, initially and upon renewal.

The MCO is to provide a copy of its reinsurance agreement to HSD. The copy must include policies and procedures of the reinsurance agreement that allow HSD to confirm that the MCO has a minimum of one million dollars (\$1,000,000) per occurrence or per member per incurred year in reinsurance protection against financial loss due to outlier (catastrophic) cases.

If the MCO purchases reinsurance from an affiliate to satisfy the Centennial Care contract reinsurance requirement, the MCO must also submit a copy of their annual Insurance Holding Company Statement D filing showing that it submitted its reinsurance agreement to the Office of the Superintendent of Insurance for approval. The MCO must also submit the pricing details of the reinsurance agreement, including coverage period, to HSD, as well as a copy of the Office of the Superintendent of Insurance approval of the agreement.

Note that HSD will not provide the MCOs a prescribed and preformatted template for this report. Given the nature of the information required to satisfy this particular financial reporting requirement, a preformatted template will not sufficiently accommodate the required information. For this report, MCOs can use their preferred format so long as the report includes sufficient detail to satisfy the reporting requirement.

MCOs **must** also submit the accompanying notes, analysis and data certification statement in support of this report. See Section 4 of this guide for additional detail regarding these requirements.

3.04 Report 14 — Administrative Expense Detail and Supporting Documentation

Financial management report reference number(s):
FMB-ALL 14

This report is due annually with the annual supplemental reports.

This report is an Excel-based standalone reporting template.

The purpose of this report is to collect expense detail and information related to the New Mexico Centennial Care MCO's administrative services. The MCO is required to submit both Excel-based information and additional administrative documentation separate of the Excel-based templates.

Excel-Based Information

The Excel-based standalone reporting template specific to Report 14 contains an information input tab, the administrative expense detail report, administrative expense category descriptions, a tab meant to accommodate the MCO's supporting general ledger detail, a notes tab, and an analysis tab.

The MCO is to enter/select all information requested within the information input tab. This tab serves as a cover sheet for the information reported within the Report 14 Excel-based reporting template. Note that the twelve-month report period ending date will automatically populate based on the MCO's selection of the calendar year reporting cycle.

For the Administrative Expense Detail Report, Report 14, the MCO is to provide administrative expense detail by the requested categories and classifications, and also include general ledger accounts (number or code) and names with the associated expenditures in the spaces provided. Detailed descriptions of each of the requested classifications and categories are included within the Report 14 Excel-based standalone reporting template.

Report 14 contains four main sections for reporting administrative expenses:

- The first section (Columns C through F) collects detail for the MCO's total administrative expenses across all its Centennial Care programs according to whether the expenses for a particular category are classified as an MCO direct charge, a corporate allocation, or a management service agreement expense. Note that descriptions for these three classifications are provided within the Report 14 reporting template.
- The second section (Columns G through K) collects administrative expense category detail based on the MCO's allocation of total administrative expenses to each of its Centennial Care programs (PH, BH, LTSS, OAG PH and OAG BH programs). Note that amounts in Columns G through K are to represent allocations of the total administrative expenses reported in Column F. Reporting amounts for each Centennial Care program by the classifications included in the first section (Columns C through E) is not necessary.

- The third section (Columns L and M) collects general ledger account numbers/codes and descriptions associated with each of the administrative expense categories. Note that completing this section is not required if the MCO chooses to use the general ledger detail tab to provide the required crosswalk between the individual general ledger accounts and the individual expense categories of Report 14.
- The fourth section performs threshold tests and reconciliations of reported administrative expenses across several different sources, including Report 14, Report 1, and the general ledger detail to be reported within the Report 14 standalone reporting template. Some information in this section will be populated automatically using information reported in the administrative expense detail section of Report 14, while the other information will require input from the MCO (e.g., Report 1 amounts and general ledger amounts). Threshold tests and reconciliations include the following:
 - Other administrative expenses 5% threshold test (Lines 82 through 85): If the total amount reported for all other administrative expenses (Line 79) exceeds 5% of the total administrative expenses (Line 81), the MCO must provide a detailed listing of all material items and associated expenses that make up the amount reported in Line 79. The 5% threshold calculation is performed in Line 84. If Line 84 exceeds 5%, the MCO must provide the required details and use Line 85 to confirm the requirement has been satisfied. If Line 84 does not exceed 5%, the MCO is to enter “NA” on Line 85.
 - Reconciliations (Lines 86 through 88): This portion of the reconciliation section compares the total administrative expenses reported in Report 14 to the total administrative expenses reported in Report 1 (1A for PH Program) for each Centennial Care program and in total. The MCO is to use Line 87, Columns G through K, to enter the total administrative expenses from each program-specific Report 1 annual supplemental report for the applicable time period. All other cells within this section will calculate automatically. If the difference amount in any one particular cell on Line 88 is in excess of +/- \$100, the MCO must reexamination the reported information for accuracy. If Report 14 is submitted with differences still in excess of the allowable threshold, the difference(s) must be explained in the MCO notes. Failure to include a detailed explanation in the MCO notes will render Report 14 incomplete and result in a resubmission request. Providing a detailed explanation for any variance in excess of the allowable threshold **Does Not** guarantee the report will be considered complete or guarantee that a resubmission of the report will not be required.
 - Reconciliations (Line 86, Line 89 and Line 90): This portion of the reconciliation section compares the total administrative expenses reported in Report 14 to the total administrative expenses reported in the general ledger detail. The MCO is to use Line 89 to enter the total administrative expenses per the general ledger detail. Note that the general ledger amount entered by the MCO must clearly tie back to the actual general ledger detail. The amounts for each individual account included within the general ledger detail must also reconcile to the general ledger amount entered in Report 14. If the difference amount in Line 90 is in excess of +/- \$100, the MCO must reexamination the reported information for accuracy. If Report 14 is submitted with a difference still in excess of the allowable threshold, the difference must be explained in the MCO notes. Failure to include a detailed explanation in the MCO notes will render Report 14 incomplete and result in a resubmission request. Providing a detailed explanation for any variance in excess of the allowable threshold **Does Not** guarantee the report will be considered complete or guarantee that a resubmission of the report will not be required.

- Reconciliations (Column N): This portion of the reconciliation section compares the sum of administrative expenses allocated to each Centennial Care program to the total amount reported in Column F. This reconciliation is performed for each category of expense within Report 14. If the difference amount in any one particular cell in Column N is in excess of +/- \$100, the MCO must reexamine the reported information for accuracy. If Report 14 is submitted with differences still in excess of the allowable threshold, the difference(s) must be explained in the MCO notes. Failure to include a detailed explanation in the MCO notes will render Report 14 incomplete and result in a resubmission request. Providing a detailed explanation for any variance in excess of the allowable threshold **Does Not** guarantee the report will be considered complete or guarantee that a resubmission of the report will not be required.

For supporting general ledger detail, the MCO is to provide expenses by the various general ledger accounts for administrative expenses. General ledger detail must include the following for each account:

- Account name — including account number, if applicable.
- Account description.
- Calendar year-end total ending balance.
- Category where the administrative expense is bucketed in Report 14. Note that if the MCO includes the general ledger account numbers/codes and descriptions within the administrative detail report for each administrative expense category, this item is not required.

Supporting Documentation

In addition to the Excel-based information described above, the MCO is required to provide documentation in support of reported administrative expenses for the reporting period under review. Note it is acceptable for the additional documentation discussed below to be provided within the Excel-based Report 14 reporting template if that is the most efficient means of providing the required information. Each of the items below has also been included within the notes tab of the Report 14 reporting template. If an extra tab(s) is added to the reporting template in order to accommodate the required information, the MCO must identify the location of the information using the notes.

- The MCO must provide a detailed description of the methodology used to allocate administrative expenditures from the general ledger accounts to the Centennial Care PH, BH, LTSS, OAG PH and OAG BH programs. The documentation must also explain the methodology used to allocate administrative expenses between the individual cohorts within each program.
- If applicable, the MCO is to provide a detailed explanation of the cost allocation methodologies for allocated health plan expenditures and corporate administrative allocations to each line of business. In addition, the MCO must provide a detailed explanation of the methodology used to allocate administrative expenditures to general ledger accounts that are not directly chargeable to a specific account.

- The MCO must provide the following information as it relates to equipment and systems required for the administration of the New Mexico Centennial Care Program:
 - List of any system conversions, upgrades or one-time expenses/charges for the calendar year reporting period under review. Include project costs expensed or charged for the calendar year reporting period under review.
 - List of any planned system conversions, upgrades, or initiatives beyond the calendar year reporting period under review, and the budgeted cost.
 - Any other applicable information that will help HSD understand the equipment and system changes needed to operate the New Mexico Centennial Care Program.

The MCO shall provide a copy of all administrative services contracts, consulting contracts, and management service agreements/contracts (including price page and actual amounts paid under such agreements) delegating administrative functions to a third party, including related or affiliated parties. In addition, the MCO shall provide all contracts with related or affiliated parties applicable during any part of calendar-year reporting period under review, the total cost, and the amount charged to the Medicaid lines of business for the respective calendar year. If the MCO does not wish to send contracts, it is acceptable to provide a detailed list of such contracts, the total cost, and the amount charged to the Centennial Care PH, BH, LTSS, OAG PH and OAG BH programs, respectively, for the calendar year-end. This should include, but not be limited to, the following:

- Management service agreements.
- Delegated case management/disease management agreements.
- Delegated care coordination agreements.
- Delegated member/provider services agreements.
- Claims processing agreements.
- Integrated delivery system agreements.
- Agreements for the administration of pharmacy, vision, dental, or any other service claims and/or benefits.
- Any other contract with a related or affiliated party for non-medical services or charges.

3.05 Report 16 — Payments to Indian Health Services and Tribal 638 Providers

Financial management report reference number(s):
FMB-ALL 16

This report is due quarterly.

This report is an Excel-based standalone reporting template.

The purpose of this report is to collect quarterly information related to the MCO's payments to IHS and Tribal 638 providers for provision of services to Native American clients. This report will be used to help facilitate HSD's reimbursement to the MCO after comparison to the encounters and acceptance of the report. As such, this report is to contain information related to any

payments made during the reporting period under review by the MCO to the IHS and Tribal 638 providers, regardless of date of service.

Because this report will collect protected health information (PHI), the MCO is to submit this report to HSD using the prescribed secure file transmission processes as determined by HSD.

The Excel-based standalone reporting template specific to Report 16 contains an information input tab, the payments to Indian Health Services and Tribal 638 providers report, a notes tab, and an analysis tab.

The MCO is to enter/select all information requested within the information input tab. This tab serves as a cover sheet for the information reported within the Report 16 Excel-based reporting template. Note that the report period ending date will automatically populate based on the MCO's selection of the calendar year reporting cycle and report submission quarter. For items requiring selection(s) to be made by the MCO, the MCO is to use the dropdown boxes located on the right side of the table.

Where applicable, the MCO name, calendar year reporting cycle and report period ending selections will flow through to the other tabs within the Report 16 Excel-based reporting template.

For this report, the following information must be provided for each Medicaid client claim in the prescribed format for each field (**note that the required data format is located at the top of each column**):

- Column B, provider type: Enter "IHS" or "Tribal 638" as applicable.
- Column C, IHS facility NPI: Enter the NPI number of the IHS facility where the service(s) was rendered.
- Column D, IHS facility name: Enter the name of the IHS facility where the service(s) was rendered.
- Column E, service location: Enter the physical address of the location where the service(s) was provided. For the purpose of this report, physical address includes street address or physical location, city, state, and zip code of the respective location. Note that P.O. Box and general delivery addresses are not acceptable and will not be included in the reconciliation process.
- Column F, rendering provider ID: Enter the rendering provider ID for the claim.
- Column G, rendering provider name: Enter the rendering provider name for the claim.
- Column H, MCO TCN: Enter the MCO transaction control number.
- Column I, Medicaid client ID: Enter the Medicaid client ID of the client who generated the claim. This entry is to be made using text format and must contain the full fourteen (14) digits of the Medicaid ID number.
- Column J, client last name: Enter the last name of the Medicaid client who generated the claim.
- Column K, client first name: Enter the first name of the Medicaid client who generated the claim.

- Column L, client middle initial: Enter the middle initial of the Medicaid client who generated the claim.
- Column M, client date of birth: Enter the date of birth (in a mm/dd/yyyy format) of the Medicaid client who generated the claim.
- Column N, cohort number: Enter the cohort number of the Medicaid client. Cohort descriptions with the corresponding cohort numbers are detailed in Section 1.03 of this guide.
- Column O, begin date of service: Enter the begin date of service for the claim in a mm/dd/yyyy format.
- Column P, end date of service: Enter the end date of service for the claim in a mm/dd/yyyy format.
- Column Q, MCO date of payment: Enter the date (in a mm/dd/yyyy format) the MCO paid the IHS or Tribal 638 provider for services rendered to the Native American client.
- Column R, date claim received: Enter the date (in a mm/dd/yyyy format) the MCO received the claim from the IHS or Tribal 638 provider for services rendered to the Native American client.
- Column S, MCO total paid amount: Enter the amount the MCO paid the IHS or Tribal 638 provider for services rendered to the Native American client.
- Column T, total billed amount: Enter the amount the IHS or Tribal 638 provider billed the MCO for services rendered to the Native American client.
- Column U, units: Enter the number of billed units, visits, days, or scripts related to the Medicaid client claim.
- Column V, primary diagnosis code: Enter the primary diagnosis code related to the Medicaid client claim. This field may be left blank for pharmacy services.
- Column W, type of service: Indicate the type of service related to the Medicaid client claim. Indicate which of the following services apply:
 - “IP” for inpatient hospital.
 - “OP” for outpatient.
 - “RX” for pharmacy.
 - “DE” for dental.
 - “BH” for behavioral Health.
 - “ASC” for ambulatory surgical care.

If necessary, additional rows should be added to accommodate the required amount of information.

The MCO notes and analysis tabs located within the Report 16 reporting template are to be used to provide any necessary explanations or analyses that will help the reader understand the reported information.

MCOs **must** also submit the accompanying data certification statement in support of this report. See Section 4.03 of this guide for additional detail regarding this requirement.

3.06 Report 17 — Delivery System Improvements

Financial management report reference number(s):

FMB-ALL 17

This report is due quarterly.

This report is an Excel-based standalone reporting template.

The purpose of this report is to collect information on Delivery System Improvement performance penalties imposed by HSD.

The Excel-based reporting template specific to Report 17 contains an information input tab, the Delivery System Improvements report, a notes tab, and an analysis tab.

The MCO is to enter/select all information requested within the information input tab. This tab serves as a cover sheet for the information reported within the Report 17 Excel-based reporting template. For items requiring selection(s) to be made by the MCO, the MCO is to use the dropdown boxes located on the right side of the table.

Where applicable, the MCO name, calendar year reporting cycle and report period ending selections will flow through to the other tabs within the Report 17 Excel-based reporting template.

Delivery System Improvement Details

The following information must be provided as it relates to the MCO's monthly delivery system improvement fund withhold activities:

Assessed Penalties

- Contract Year – Enter contract year applicable to the assessment.
- Delivery System Improvement Target - Enter Delivery System Improvement target(s) not met.
- Assessed Penalty – Enter assessed penalty amount paid.

Penalty Dollar Expenditures

- Paid Date - Enter applicable date(s) of the reinvestment expenditure(s).
- Provider Name – Enter the provider name(s) for the penalty dollar expenditure.
- Amount Paid – Enter penalty dollar expenditures amount paid.

If the number of Assessed Penalties or Penalty Dollar Expenditures exceeds the number of lines provided, the MCO should add the necessary lines to the bottom of the table so that all the Assessed Penalties and Penalty Dollar Expenditures are included in the total amounts automatically calculated at the bottom of each table.

If the reinvestment information for any reported assessments is not known at the time this report is to be submitted, the MCO **must** note it within the report. The assessment detail should then be carried over to subsequent report submissions until the reinvestment detail is known and

complete. Any previously reported information carried over to the next report submission should be examined and updated as needed.

The MCO notes and analysis tabs located within the Excel-based Report 17 reporting template are to be used to provide any necessary explanations or analyses that will help the reader understand the reported information.

MCOs must also submit the accompanying data certification statement in support of this report. See Section 4.03 of this guide for additional detail regarding this requirement.

3.07 Report 18 — Cash Reserve Statement

Financial management report reference number(s):
FMB-ALL 18

This report is due quarterly.

The MCO is to submit a statement of account balance for the restricted insolvency protection account that will allow HSD to examine and confirm compliance with the Centennial Care contract. The required account balance each quarter will be determined by HSD. HSD will then notify the MCO of the required amount. In addition to the account balance, the statement **must** also include details of any account transactions that took place, including interest earned, subsequent to the prior quarter's statement submitted to HSD.

Note that HSD will not provide the MCOs a prescribed and preformatted template for this report. Given the nature of the information required to satisfy this particular financial reporting requirement, a preformatted template will not sufficiently accommodate the required information. For this report, MCOs can use their preferred format so long as the report includes sufficient detail to satisfy the reporting requirement.

MCOs **must** also submit the accompanying notes, analysis and data certification statement in support of this report. See Section 4 of this guide for additional detail regarding these requirements.

3.08 Report 19 — Performance Bond Coverage

Financial management report reference number(s):
FMB-ALL 19

This report is due initially and quarterly.

The MCO is to submit proof of coverage as required by the Centennial Care contract. The documentation submitted by the MCO **must** allow HSD to determine compliance with the Centennial Care contract. The required coverage amount each quarter will be determined by HSD. HSD will then notify the MCO of the required amount.

Note that HSD will not provide the MCOs a prescribed and preformatted template for this report. Given the nature of the information required to satisfy this particular financial reporting requirement, a preformatted template will not sufficiently accommodate the required information. For this report, MCOs can use their preferred format so long as the report includes sufficient detail to satisfy the reporting requirement.

MCOs **must** also submit the accompanying notes, analysis and data certification statement in support of this report. See Section 4 of this guide for additional detail regarding these requirements.

3.09 Report 20 — Risk Withholding Report

Financial management report reference number(s):
FMB-ALL 20

This report is due annually.

The MCO is to submit a risk withholding report for any contracts with providers where there are risk sharing provisions included within the contract. The report must include sufficient details to allow HSD to understand the risk sharing provisions within the contract.

If the MCO does not have risk sharing arrangements with their providers during the reporting period under review, the MCO is to submit confirmation stating such.

Note that HSD will not provide the MCOs a prescribed and preformatted template for this report. Given the nature of the information required to satisfy this particular financial reporting requirement, a preformatted template will not sufficiently accommodate the required information. For this report, MCOs can use their preferred format so long as the report includes sufficient detail to satisfy the reporting requirement.

MCOs **must** also submit the accompanying notes, analysis and data certification statement in support of this report. See Section 4 of this guide for additional detail regarding these requirements.

3.10 Report 21 — Fidelity Bond Insurance Protection

Financial management report reference number(s):

FMB-ALL 21

This report is due annually, initially and upon renewal.

The MCO is to submit proof of coverage as required by the Centennial Care contract. The documentation submitted by the MCO **must** allow to HSD to determine compliance with the Centennial Care contract.

Note that HSD will not provide the MCOs a prescribed and preformatted template for this report. Given the nature of the information required to satisfy this particular financial reporting requirement, a preformatted template will not sufficiently accommodate the required information. For this report, MCOs can use their preferred format so long as the report includes sufficient detail to satisfy the reporting requirement.

MCOs **must** also submit the accompanying notes, analysis and data certification statement in support of this report. See Section 4 of this guide for additional detail regarding these requirements.

3.11 Report 22 — Business Restructuring

Financial management report reference number(s):

FMB-ALL 22

This report is due as needed per contract requirements.

The MCO is to submit records involving any business restructuring when changes in ownership interest of five percent (5%) or more have occurred. These records shall include, but are not limited to, an updated list of names and addresses of all persons or entities having ownership interest of five percent (5%) or more. These records shall be provided no later than sixty (60) calendar days following the change of ownership.

Note that HSD will not provide the MCOs a prescribed and preformatted template for this report. Given the nature of the information required to satisfy this particular financial reporting requirement, a preformatted template will not sufficiently accommodate the required information. For this report, MCOs can use their preferred format so long as the report includes sufficient detail to satisfy the reporting requirement.

MCOs **must** also submit the accompanying notes, analysis and data certification statement in support of this report. See Section 4 of this guide for additional detail regarding these requirements.

3.12 Report 23 — Medicaid-Specific Unaudited Schedule of Revenue and Expenses

Financial management report reference number(s):
FMB-ALL 23

This report is due quarterly and as an annual supplement.

This report is an Excel-based standalone reporting template.

The purpose of this report is to provide consolidated information on revenues and expenses for each Centennial Care program.

The Excel-based reporting template specific to Report 23 contains an information input tab, the Medicaid-specific unaudited schedule of revenue and expenses, the premium revenue detail tab, a notes tab, and an analysis tab. A YTD summary tab is also included within this template that contains YTD information by each Centennial Care program. The entire Report 23 YTD summary tab is automatically populated using information from the Report 23 tab. The purpose of the Report 23 YTD summary tab is to provide a high level summary of revenues and expenses that will also be used as part of the required reconciliation (Report 25) between this report and Report 24, Medicaid-specific audited schedule of revenue and expenses.

The MCO is to enter/select all information requested within the information input tab. This tab serves as a cover sheet for the information reported within the Report 23 Excel-based reporting template. Note that the report period ending date and YTD period will automatically populate based on the MCO's selection of the calendar year reporting cycle and quarters included in the report. For items requiring selection(s) to be made by the MCO, the MCO is to use the dropdown boxes located on the right side of the table.

Where applicable, the MCO name, calendar year reporting cycle and report period ending selections will flow through to the other tabs within the Report 23 Excel-based reporting template.

The MCO notes and analysis tabs located within the Report 23 reporting template are to be used to provide any necessary explanations or analyses that will help the reader understand the reported information.

MCOs **must** also submit the accompanying data certification statement in support of this report. See Section 4.03 of this guide for additional detail regarding this requirement.

Medicaid-Specific Unaudited Schedule of Revenue and Expenses

Report 23 is to be completed using quarterly data from Report 1 (and Report 1A for the PH Program), Schedule of Revenues and Expenses by Category, for each Centennial Care program in total. Several of the line items within this report are identical to those within Report 1; however, health care expense categories are to be reported at a more consolidated level of detail within this report. The consolidated health care expense categories within this report are meant to align with the lag report groupings for each Centennial program. Section 2.09 of this guide details the service category mappings between the detail service categories within Report 1 and the consolidated category groupings used for the lag reports. The expense category mappings in the tables below identify the program-specific lag report category groupings to be used to map the program-specific Report 1 categories to the consolidated categories within Report 23.

The administrative expense categories of direct administrative expenses, indirect administrative expenses, care coordination – administrative, and fiscal management agency (LTSS Program only) are identical to the administrative categories within Report 1.

The health care expense category mappings for each program are detailed in the tables below:

Report 23 Health Care Expense Physical Health Program Category Mappings

Report 23 Service Category	Physical Health Lag Report	Physical Health Report 1 Category of Service
Inpatient Hospital Services	5A – Inpatient Hospital Services	Inpatient Hospital – Acute Inpatient – Specialty Hospital Non-Acute LTC/Skilled Nursing Facility/Respite
Nursing Facility/Hospice	NA	NA
Outpatient/Clinic Services	5B – Outpatient Services	Ambulatory Surgery Centers – Outpatient Surgeries Outpatient Hospital – Emergency Room Outpatient Hospital – Urgent Care Outpatient Facility – Other Rural Health Clinics Federally Qualified Health Centers (FQHCs) Freestanding Clinics
Physician Services	5C – Physician Services	Physicians
Behavioral Health Services	NA	NA
Pharmacy	5D – Pharmacy	Pharmacy
Home and Community Based Services	NA	NA
Dental Services	5E – Dental Services	Dental Orthodontic Dental Children (< 21) Dental Adult Services (>=21)
Lab/Rad Services	5F – Laboratory/Radiology Services	Laboratory Radiology
Other Medical Services	5G – Other Medical Services	Ambulance Non-Emergent Transportation Home Health and Visiting Nurse Services Hospice Other Practitioners Therapies Home Visiting Pilot Home Infusion DME/Medical Supplies Orthotics Prosthetics Vision Other PH Services

Report 23 Health Care Expense Behavioral Health Program Category Mappings

Report 23 Service Category	Behavioral Health Lag Report	Behavioral Health Report 1 Category of Service
Inpatient Hospital Services	5A – Inpatient Hospital Services	Hospital Inpatient Facility (Psychiatric Hospitalization Services) Inpatient and Residential Professional Charges
Nursing Facility/Hospice	NA	NA
Outpatient/Clinic Services	5H – Outpatient/Clinic Services	Evaluations and Therapies (Non-Hospital Outpatient) Testing (Non-Hospital Outpatient) Functional Family Therapy (FFT) (Non-Hospital Outpatient) Outpatient Hospital (Evaluations, Therapies, and BH Physical Evaluations) Partial Hospitalization Program (BH Treatment Services) Hospital Outpatient Facility (BH Treatment Services) Suboxone Treatment Methadone Treatment Rural Health Clinics FQHCs
Physician Services	NA	NA

Report 23 Health Care Expense Behavioral Health Program Category Mappings

Report 23 Service Category	Behavioral Health Lag Report	Behavioral Health Report 1 Category of Service
Behavioral Health Services	5I – Residential Treatment Center 5J – Behavioral Management Services 5K – Behavioral Health Providers 5L – Psychosocial Rehab Services 5M – Community Services, Agencies	Residential Treatment Center, ARTC and Group Homes < 21 Foster Care Therapeutic (TFC I & II) < 21 Other Residential Skills Training & Development (Behavioral Management Services) < 21 BH Day Treatment < 21 Intensive Outpatient Program Services (IOP) Adaptive Skills Building (ABS) Multi-Systemic Therapy (MST) Telehealth Other Professional BH Services Respite Services Applied Behavior Analysis (ABA) Pre-Tenancy/Housing Support Psychosocial Rehab Services for Adults =>18 School-Based Health Center Services Assertive Community Treatment (ACT) Core Service Agencies (CSA) – Other Services Comprehensive Community Support Services (CCSS) Recovery Services Family Support Services
Pharmacy	5D – Pharmacy	BH Pharmaceuticals
Home and Community Based Services	NA	NA
Dental Services	NA	NA
Lab/Rad Services	NA	NA
Other Medical Services	NA	NA

Report 23 Health Care Expense Long Term Services and Supports Program Category Mappings

Report 23 Service Category	LTSS Lag Report	LTSS Report 1 Category of Service
Inpatient Hospital Services	5A – Inpatient Hospital Services	Hospital Swing Bed – High Level of Care Hospital Swing Bed – Low Level of Care Inpatient Hospital – Acute Inpatient – Specialty Hospital
Nursing Facility/Hospice	5N – Nursing Facility/Hospice	Nursing Facility State Owned – High Level of Care Nursing Facility State Owned – Low Level of Care Nursing Facility Private – High Level of Care Nursing Facility Private – Low Level of Care Other Nursing Facility Payments Hospice Home Health and Visiting Nurse Services
Outpatient/Clinic Services	5B – Outpatient Services	Ambulatory Surgery Centers – Outpatient Surgeries Outpatient Hospital – Emergency Room Outpatient Hospital – Urgent Care Outpatient Facility – Other Rural Health Clinics FQHCs Freestanding Clinics
Physician Services	5C – Physician Services	Physicians Nursing Facility Professional Charges
Behavioral Health Services	NA	NA
Pharmacy	5D – Pharmacy	Pharmacy
Home and Community Based Services	5O – HCBW Services/ Personal Care Option 5P – Self Direction Services	Community Benefit – Respite Community Benefit – Adult Day Health Community Benefit – Assisted Living Community Benefit – Environmental Modifications Community Benefit – Private Duty Nursing Community Benefit – Emergency Response Community Benefit – Other (Non-Self Direction) Personal Care Option – T1019 Personal Care Option – 99509 Personal Care Option – G9006 Personal Care Option – Other Community Benefit – Self Direction
Dental Services	NA	NA
Lab/Rad Services	NA	NA

Report 23 Health Care Expense Long Term Services and Supports Program Category Mappings

Report 23 Service Category	LTSS Lag Report	LTSS Report 1 Category of Service
Other Medical Services	5G – Other Medical Services	Ambulance Non-Emergent Transportation Laboratory Radiology Other Practitioners Therapies Home Infusion DME/Medical Supplies Orthotics Prosthetics Dental Vision Other Acute Care Services

Report 23 Health Care Expense Other Adult Group Physical Health Program Category Mappings

Report 23 Service Category	OAG PH Lag Report	OAG PH Report 1 Category of Service
Inpatient Hospital Services	5A – Inpatient Hospital Services	Inpatient Hospital – Acute Inpatient – Specialty Hospital Non-Acute LTC/Skilled Nursing Facility/Respite
Nursing Facility/Hospice	NA	NA
Outpatient/Clinic Services	5B – Outpatient Services	Ambulatory Surgery Centers – Outpatient Surgeries Outpatient Hospital – Emergency Room Outpatient Hospital – Urgent Care Outpatient Facility – Other Rural Health Clinics Federally Qualified Health Centers (FQHCs) Freestanding Clinics
Physician Services	5C – Physician Services	Physicians
Behavioral Health Services	NA	NA
Pharmacy	5D – Pharmacy	Pharmacy
Home and Community Based Services	5O – HCBW Services/ Personal Care Option	Community Benefit Personal Care Option
Dental Services	5E – Dental Services	Dental
Lab/Rad Services	5F – Laboratory/ Radiology Services	Laboratory Radiology

Report 23 Health Care Expense Other Adult Group Physical Health Program Category Mappings

Report 23 Service Category	OAG PH Lag Report	OAG PH Report 1 Category of Service
Other Medical Services	5G – Other Medical Services	Ambulance Non-Emergent Transportation Home Health and Visiting Nurse Services Hospice Other Practitioners Therapies Home Visiting Pilot Home Infusion DME/Medical Supplies Orthotics Prosthetics Vision Other PH Services

Report 23 Health Care Expense Other Adult Group Behavioral Health Program Category Mappings

Report 23 Service Category	OAG BH Lag Report	OAG BH Report 1 Category of Service
Inpatient Hospital Services	5A – Inpatient Hospital Services	Hospital Inpatient Facility (Psychiatric Hospitalization Services) Inpatient and Residential Professional Charges
Nursing Facility/Hospice	NA	NA
Outpatient/Clinic Services	5H – Outpatient/Clinic Services	Evaluations and Therapies (Non-Hospital Outpatient) Testing (Non-Hospital Outpatient) Functional Family Therapy (FFT) (Non-Hospital Outpatient) Outpatient Hospital (Evaluations, Therapies, and BH Physical Evaluations) Partial Hospitalization Program (BH Treatment Services) Hospital Outpatient Facility (BH Treatment Services) Suboxone Treatment Methadone Treatment Rural Health Clinics FQHCs
Physician Services	NA	NA

Report 23 Health Care Expense Other Adult Group Behavioral Health Program Category Mappings

Report 23 Service Category	OAG BH Lag Report	OAG BH Report 1 Category of Service
Behavioral Health Services	5I – Residential Treatment Center 5J – Behavioral Management Services 5K – Behavioral Health Providers 5L – Psychosocial Rehab Services 5M – Community Services, Agencies	Residential Treatment Center, ARTC and Group Homes < 21 Foster Care Therapeutic (TFC I & II) < 21 Other Residential Skills Training & Development (Behavioral Management Services) < 21 BH Day Treatment < 21 Intensive Outpatient Program Services (IOP) Adaptive Skills Building (ABS) Multi-Systemic Therapy (MST) Telehealth Other Professional BH Services Respite Services Recovery Services Family Planning Services Applied Behavior Analysis (ABA) Pre-Tenancy/Housing Support Psychosocial Rehab Services for Adults =>18 School-Based Health Center Services Assertive Community Treatment (ACT) Core Service Agencies (CSA) – Other Services Comprehensive Community Support Services (CCSS)
Pharmacy	5D – Pharmacy	BH Pharmaceuticals
Home and Community Based Services	NA	NA
Dental Services	NA	NA
Lab/Rad Services	NA	NA
Other Medical Services	NA	NA

Premium Revenue Detail

The purpose of this section of Report 23 is to collect quarterly and YTD detail in support of the MCO's reported premium revenue. Specifically, detail in support of member months (Line 1), capitation (Line 2), and other premium revenue (Line 7).

Cohort-level detail is required for each of the following tables: PH Program, BH Program, LTSS Program, and OAG – PH and BH Programs.

All revenues are to be entered as dollars.

Total amounts in these tables are expected to tie to the reported amounts for the corresponding line-item within Report 23. For example, the quarter 1 total capitation amount in the PH Program table should tie to the amount reported on Line 2 in the PH Program quarter 1 section of Report 23.

For each cohort listed in the quarterly tables, the following information must be provided:

- Column C, member months: Report accumulated membership for the quarter. A member month is equivalent to the one member for whom the MCO has recognized capitation-based revenue for the entire month.
- Column D, capitation: Capitation revenue recognized on a prepaid basis from HSD for provision of a specified range of health care services for Medicaid-eligible participants for the quarter. Capitation revenue is to be recognized when it is earned, not when payment is received from the State. If advanced payments are made to the MCO for more than one reporting period, the portion of the payment that has not been earned must be treated as a liability (unearned premiums). Capitation revenue should include premium taxes and NMMIP assessments. Do not report capitation revenue net of premium taxes or net of NMMIP assessments. Exclude amounts for any items required to be reported in Columns E through L. For the LTSS Program, exclude patient contribution collected by the nursing facility, community-based residential alternative facility, or other providers.
- Columns E through M collect detail in support of other premium revenue (Line 7). For each applicable item listed below, enter the corresponding amount(s) included in Line 7.
 - Column E, Health Insurer Provider Fee.
 - Column F, Retro Period reconciliation.
 - Column G, underwriting gain limitation.
 - Column H (PH, LTSS, and OAG Programs only), Hepatitis C risk corridor.
 - Column I (PH, LTSS, and OAG Programs only), Directed Payment.
 - Column J (LTSS Program only), Community Benefit reconciliation.
 - Columns for “other” amounts: Each program-specific table includes multiple placeholder columns for use in reporting any amounts included in Line 7 that are unrelated to the items listed above. **For any amounts reported in the “other” columns, the MCO must provide an explanation within the notes section.**

For amounts allocated across programs and/or cohorts, a detailed explanation of the allocation methodology must be provided within the MCO notes or analysis.

Shared Risk Arrangement Expense Detail

The purpose of this section of Report 23 is to collect quarterly and YTD detail in support of the MCO's reported Shared Risk Arrangements, including Separate Payment Term Directed Payments.

All expenses are to be entered as dollars.

Total amounts in these tables are expected to tie to the reported amount within the Shared Risk Arrangements section in Report 2.

For each cohort listed in the quarterly tables, the following information must be provided:

- Columns C through F collect detail in support of separate payment term directed payment medical expenses. For each applicable item listed below, enter the corresponding amount(s).
 - Column C, University of New Mexico Medical Group (UNMMG).
 - Column D, University of New Mexico Hospital (UNMH).
 - Column E, Nursing Facility Health Care Quality Surcharge (NF HCQS) (Quality Component).
 - Column F, Hospital Access Program (HAP).
 - Columns for “other” amounts: Each program-specific table includes multiple placeholder columns for use in reporting any amounts that are unrelated to the items listed above or other shared risk arrangements. For example, future separate payment term directed payments. **For any amounts reported in the “other” columns, the MCO must provide an explanation within the notes section.**
 - Column K, Other Shared Risk Arrangements.

For amounts allocated across programs and/or cohorts, a detailed explanation of the allocation methodology must be provided within the MCO notes or analysis.

3.13 Report 24 — Medicaid-Specific Audited Schedule of Revenue and Expenses

Financial management report reference number(s):
FMB-ALL 24

This report is due annually.

The purpose of this report is to provide audited information on revenues and expenses for each Centennial Care program over the fiscal period. This report is to be completed using the accounting basis consistent with the MCO's independently audited financial statements. The audit approach is to be in conformity with accounting practices prescribed or permitted by the New Mexico Office of the Superintendent of Insurance.

There is no Excel-based standalone reporting template for this report. However, a sample report format is available for the MCOs to reference. The information contained within the sample format contains the minimum level of detail required for this report requirement. To help facilitate

the reconciliation requirement of Report 25, MCOs are encouraged to be as consistent as possible with the sample report format. Note that the sample report template does not allow for data entry, however, the report format can be copied and pasted into a separate spreadsheet for the MCO's use.

MCOs **must** also submit the accompanying notes, analysis and data certification statement in support of this report. See Section 4 of this guide for additional detail regarding these requirements.

3.14 Report 25 — Reconciliation Schedule of Unaudited Centennial Care Financial Reports to Audited Schedule of Revenue and Expenses

Financial management report reference number(s):

FMB-ALL 25

This report is due annually.

This report is an Excel-based standalone reporting template.

The purpose of this report is to provide a reconciliation of the annual information reported in Report 23, Medicaid-specific unaudited schedule of revenue and expenses report and information reported in Report 24, Medicaid-specific audited schedule of revenue and expenses report. Note that the premium revenue detail section of Report 23 is not included in this reconciliation. Because Report 23 is to be completed according to the instructions of this guide and Report 24 is to be completed using the accounting basis consistent with the MCO's independently audited financial statements, it is likely that there will be differences between the two reports. Please note, however, that any differences identified in this report, regardless if expected or considered reasonable, require a detailed explanation to be provided within the MCO notes.

The Excel-based reporting template specific to Report 25 contains an information input tab, the reconciliation schedule of unaudited Centennial Care financial reports (Report 23) to audited schedule of revenue and expenses (Report 24), a notes tab, and an analysis tab.

The MCO is to enter/select all information requested within the information input tab. This tab serves as a cover sheet for the information reported within the Report 25 Excel-based reporting template. Note that the twelve-month report period ending date will automatically populate based on the MCO's selection of the calendar year reporting cycle. For items requiring selection(s) to be made by the MCO, the MCO is to use the dropdown boxes located on the right side of the table.

Where applicable, the MCO name, calendar year reporting cycle and report period ending selections will flow through to the other tabs within the Report 25 Excel-based reporting template.

The MCO notes and analysis tabs located within the Report 25 reporting template are to be used to provide any necessary explanations or analyses that will help the reader understand the reported information and reconciling items.

MCOs **must** also submit the accompanying data certification statement in support of this report. See Section 4.03 of this guide for additional detail regarding this requirement.

3.15 Report 26 — Independently Audited Financial Statements

Financial management report reference number(s):

FMB-ALL 26

This report is due annually.

The MCO is to submit a copy of its annual independently audited financial statements, including, but not limited to, its income statement, statement of changes in financial condition or cash flow, balance sheet, notes to the financial statements, and final management letter and report of internal controls. The audited financial statements shall be specific to the operations of the Centennial Care MCO rather than a parent or umbrella organization.

Note that HSD will not provide the MCOs a prescribed and preformatted template for this report. Given the nature of the information required to satisfy this particular financial reporting requirement, a preformatted template will not sufficiently accommodate the required information. For this report, MCOs can use their preferred format so long as the report includes sufficient detail to satisfy the reporting requirement.

MCOs **must** also submit the accompanying notes, analysis and data certification statement in support of this report. See Section 4 of this guide for additional detail regarding these requirements.

3.16 Report 27A — Office of the Superintendent of Insurance Quarterly Statements

Financial management report reference number(s):

FMB-All 27A

This report is due quarterly.

The MCO is to submit a copy of its quarterly Office of the Superintendent of Insurance statements.

Note that HSD will not provide the MCOs a prescribed and preformatted template for this reporting requirement. Report 27A reporting requirements and guidance will be facilitated through the Office of the Superintendent of Insurance.

MCOs **must** also submit the accompanying notes, analysis and data certification statement in support of this report. See Section 4 of this guide for additional detail regarding these requirements.

3.17 Report 27B — Office of the Superintendent of Insurance Annual Statements

Financial management report reference number(s):
FMB-All 27B

This report is due annually.

The MCO is to submit a copy of its annual Office of the Superintendent of Insurance statements.

Note that HSD will not provide the MCOs a prescribed and preformatted template for this reporting requirement. Report 27B reporting requirements and guidance will be facilitated through the Office of the Superintendent of Insurance.

MCOs **must** also submit the accompanying notes, analysis and data certification statement in support of this report. See Section 4 of this guide for additional detail regarding these requirements.

3.18 Report 29 — Centennial Care MLR Report

Financial management report reference number(s):
FMB-All 29

The MCO is required to submit this report on an annual basis by the last Business Day in July following the contract year.

This report is an Excel-based standalone reporting template.

GENERAL INSTRUCTIONS

Non-shaded cells indicate where data entry is required. The MCO must ensure that data is entered in all fields; the report will be considered incomplete if any field is left blank. Use “0” if there is no data available to report. Formulas provided in the workbook shall not be altered by the MCO. To assist MCOs with the use of the template, all cells within the template are viewable. This allows the user to move the cursor into any cell of the template and enables the user to see the formulas in the cells that calculate automatically. It is important to note that when populating the templates with data, users are not to use the “cut and paste” function in Excel, as this may cause errors to the cell formulas.

REPORTING TIME PERIOD

Incurred in 12 months and paid through 15 months for the twelve-month Contract/MLR reporting year.

REPORT SUBMISSION

The MCO shall submit the electronic version of the report using the following file labeling format: [MCO].FIN-29.CY##.v#. The “MCO” part of the labeling should be the MCO’s acronym for their business name. With each report submission, change the contract/MLR reporting year reference (CY## - e.g., CY20), and the version number (v# - e.g., v1), as appropriate. The version number should be “1” unless the MCO is required to resubmit a report for a specified year. In those instances, the MCO will use “2” and so on for each resubmission.

OVERVIEW

Throughout these instructions for this report there are references to the 2016 Medicaid/CHIP Managed Care Final Rule and other regulations. Text of the regulations cited are also included in this document. All regulations are part of 42 CFR part 438 unless cited otherwise.

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

1. The State, through its contracts, must require each health plan to submit a report to the State that includes at least the following information for each MLR reporting year:
 - (i) Total incurred claims.
 - (ii) Expenditures on quality improving activities.
 - (iii) Expenditures related to activities compliant with § 438.8(e)(4). *Fraud prevention activities in 42 CFR 438.8(e)(4) are not part of the Medicaid MLR calculation until a standard is adopted for the private market at 45 CFR part 158.
 - (iv) Non-claims costs.
 - (v) Premium revenue.
 - (vi) Taxes, licensing and regulatory fees.
 - (vii) Methodology(ies) for allocation of expenditures.
 - (viii) Any credibility adjustment applied.
 - (ix) The calculated MLR.
 - (x) Any remittance owed to the State, if applicable.
 - (xi) A comparison of the information reported in this paragraph with the audited financial report required under § 438.3(m).
 - (xii) A description of the aggregation method used under paragraph (i) of this section.
 - (xiii) The number of member months.

This report includes items identified in regulation and some items may not apply. Some non-applicable items are noted in these instructions.

Amounts for non-risk arrangements (e.g., IHS, Tribal 638 & I/T/Us, Retroactive Period Reconciliation) are to be excluded entirely and shall not be included in any amounts in this report.

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

HSD requires the MLR to be reported by each Program, Program Total, and Total Centennial Care. HSD reserves the right to modify this requirement and obtain MLR information on different level of detail.

MLR DETAIL SECTION

MCO Name: Enter full business name of MCO.

Contract/MLR Reporting Year: Enter the applicable contract/MLR reporting year using the "CY YYYY" format (e.g., CY 2019).

A. MLR CREDIBILITY CALCULATION

Line A.1 Enter the member months by program and program total.

Line A.2 Calculated MLR credibility adjustment based on MCO member months, using the adjustment factors published by CMS at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib073117.pdf>. In the event CMS revises the credibility adjustment factors applicable to the MLR reporting year, the revised credibility adjustment factors will apply. The member month threshold for application of a credibility adjustment factor is based on total member months under the contract **for Total Legacy Programs, Total OAG Programs, and Total Centennial Care Program**. Line A.1 will record member months by program for informational purposes but Line A.2 will only include a credibility adjustment factor if the member months fall within the CMS-specified thresholds.

B. NUMERATOR

Line B.1.1 Incurred claims, including unpaid claim liabilities for the MLR reporting year:

Note that this amount should be net of all fraud recoveries, including what is reported in or out of the claims system. See §§ 438.8(e)(2)(i)(A) and 438.8(e)(2)(i)(B) and the CMS Informational Bulletin, "MLR Requirements Related to Third Party Vendors" (May 15, 2019). Includes amounts for state plan services, in lieu of services, and value-added services.

- A.** Direct claims that the health plan paid to providers (including under capitated contracts with network providers) for services or supplies covered under the contract and services meeting the requirements of § 438.3(e) provided to enrollees. Include Directed Payments approved per 438.6(c).
- B.** Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported.

Line B.1.2 IBNR for claims incurred in the period expected to be paid in months after the known runoff:

See § 438.8(e)(2)(i)(F)

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

Line B.1.3 Withholds from payments made to network providers:

See § 438.8(e)(2)(i)(C)

Line B.1.4 Amount of incentive and bonus payments made, or expected to be made, to network providers:

See § 438.8(e)(2)(iii)(A)

Line B.1.5 Changes in other claims-related reserves:

See § 438.8(e)(2)(i)(G)

Line B.1.6 Reserves for contingent benefits and the medical claim portion of lawsuits:

See § 438.8(e)(2)(i)(H)

Line B.1.7 Net payment or receipts related to state-mandated solvency funds:

See § 438.8(e)(2)(iv)

Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds.

Line B.1.8a Amount spent on fraud reduction:

See § 438.8(e)(2)(iii)(B)

The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include activities specified in § 438.8(e)(4) related to fraud prevention expenses. Note that the private market has not adopted a standard for calculating fraud prevention expenses, so amounts for fraud prevention are not part of this MLR report.

Line B.1.8b Amount of claims payments recovered through fraud reduction: Note that Line B.1.1 should be net of all fraud recoveries, including what is reported in and out of the claims system. That same recoveries amount is then reported here as a positive amount. Also, see Line B.1.8a.

Line B.1.10 Claims that are recoverable for anticipated coordination of benefits:

See § 438.8(e)(2)(i)(D)

Line B.1.11 Claims payments recoveries received as a result of subrogation:

See § 438.8(e)(2)(i)(E)

Line B.1.12 Overpayment recoveries received from network providers:

See § 438.8(e)(2)(ii)(A)

HSD expects this to include any anticipated settlements for claims incurred during the MLR reporting year, including those outside of the claims system.

Line B.1.13 Prescription drug rebates received and accrued:

See § 438.8(e)(2)(ii)(B) and the CMS Informational Bulletin, "MLR Requirements Related to Third Party Vendors" (May 15, 2019).

Line B.2.1 Activities that meet 45 CFR § 158.150(b) and are NOT EXCLUDED under 45 CFR § 158.150(c):

See § 438.8(e)(3)(i)

Include Member Rewards – Goods and Services. HSD reserves the right to request documentation that supports the classification of any expense as an activity that improves health care quality. If the expense is not supported as an activity that improves health care quality or in another expense category in the numerator, HSD will request a revised MLR calculation without those expenses.

Line B.2.2 Activities related to any EQR-related activity as described in §§ 438.358(b) and 438.358(c):

See § 438.8(e)(3)(ii)

Line B.2.3 Expenditure that is related to Health Information Technology and meaningful use:

See § 438.8(e)(3)(iii)

Any MCO expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 CFR § 158.151, and is not considered incurred claims, as defined in § 438.8(e)(2).

C. DENOMINATOR

Line C.1.1 State capitation payments, including adjustments:

See § 438.8(f)(2)(i)

Includes revenue received for Directed Payments to providers approved pursuant to § 438.6(c).

Line C.1.2 State developed one time payments for specific life events of enrollees, e.g., supplemental delivery payments:

See § 438.8(f)(2)(ii)

Line C.1.3 Earned premium withholds approved under § 438.6(b)(3):

See § 438.8(f)(2)(iii)

Include revenue received through the DSIPT program in the contract.

Line C.1.4 Unpaid cost-sharing amount that the MCO could have collected from enrollees under the contract:

See § 438.8(f)(2)(iv)

Exclude unpaid cost-sharing amounts the MCO can show it made a reasonable, but unsuccessful, effort to collect.

Line C.1.5 All changes to unearned premium reserves:

See § 438.8(f)(2)(v)

Line C.1.6 Profit sharing remittances

Includes underwriting gain limitations.

Line C.1.7 Net receipts or payments related to risk sharing mechanisms:

See § 438.8(f)(2)(vi)

The risk-sharing mechanisms referenced in § 438.5 and § 438.6 are risk adjustment, risk corridors, and state provided reinsurance and stop loss limits. Includes Hepatitis C risk corridor.

Line C.2.1 Statutory assessments to defray the operating expense of any state or federal department:

See § 438.8(f)(3)(i)

Line C.2.2 Examination fees in lieu of premium taxes as specified by state law:

See § 438.8(f)(3)(ii)

DOES NOT APPLY

Line C.2.3 Federal taxes and assessments allocated to MCO:

See § 438.8(f)(3)(iii)

Federal taxes and assessments allocated to the MCO, excluding Federal income taxes on investment income and capital gains and Federal employment taxes. This line includes assessments for the Health Insurer Providers Fee.

Line C.2.4 State and local taxes and assessments:

See § 438.8(f)(3)(iv)

Includes premium tax, NMMIP, & HIX assessments.

Line C.2.5 Amounts otherwise exempt from Federal income taxes for community benefit expenditures:

See § 438.8(f)(3)(v) and 45 CFR § 158.162(c)

HSD reserves the right to request documentation that supports the classification of any amounts as community benefit expenditures. If the expense is not supported as a community benefit expenditure or in another expense category in the denominator, HSD will request a revised MLR calculation without those expenses.

D. EXCLUDED AMOUNTS

Items excluded from the MLR calculation, but required to be reported.

Line D.1.1 Amounts paid to third party vendors for secondary network savings:

See § 438.8(e)(2)(v)(A)(1)

Line D.1.2 Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management:

See § 438.8(e)(2)(v)(A)(2) and the CMS Informational Bulletin, "MLR Requirements Related to Third Party Vendors" (May 15, 2019).

Line D.1.3 Amounts paid to a provider for professional or administrative services outside of providing services to enrollees:

See § 438.8(e)(2)(v)(A)(3)

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

Line D.1.4 Fines and penalties assessed by regulatory authorities:

See § 438.8(e)(2)(v)(A)(4)

Line D.1.5 Amounts paid to the State as remittance for prior MLR experience:

See § 438.8(e)(2)(v)(B)

Line D.1.6 Amounts for pass-through payments under § 438.6(d).

Note that there are no pass-through payments in the contract.

E. MLR CALCULATION

This section takes the prior amounts and summarizes them into subtotals and calculates the MLR according to federal regulations. HSD has elected a minimum MLR of 86.00%.

MLR SUMMARY SECTION

This worksheet summarizes the information requested by CMS and meets § 438.8(k).

NOTES AND ANALYSIS SECTION***1. EXPENSE ALLOCATION***

Certain expenses may not be attributable to one line of business. Describe methods used to allocate these expenses and how they factor into the MLR calculated for this report. See § 438.8(g).

If additional space is needed, an additional worksheet can be added to the template. If a new worksheet is added, include a comment in this section to indicate where the information is located.

A) General requirements.

(i) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.

(ii) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

B) Methods used to allocate expenses.

(i) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results.

(ii) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

(iii) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

2. FINANCIAL COMPARISON

Per § 438.8(k)(1)(xi), a comparison of the financial amounts included in this report and what is reported in the MCO's audited financials (Report #24 - Medicaid-Specific Audited Schedule of Revenue and Expenses Report) is required.

If additional space is needed, an additional worksheet can be added to the template. If a new worksheet is added, include a comment in this section to indicate where the information is located.

The financial comparison should identify where amounts in the MLR report are included in the line detail of Report #24. Any differences identified in the comparison, regardless if expected or considered reasonable, require an explanation as part of the financial comparison.

AGGREGATION METHOD

Aggregation of data. MCOs will aggregate data for all Medicaid eligibility groups covered under the contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations. See § 438.8(i). This report includes the MLR reporting required for the specific Centennial Care populations.

ATTESTATION

An attestation to the accuracy of this MLR report is required per § 438.8(n). The Centennial Care Report Attestation Form shall be used for this report. The reports will be deemed incomplete if an attestation is not included.

4

Additional Reporting Requirements

4.01 General Purpose

With each of the reports detailed in the sections above, the MCO is required to submit certain supporting information critical to the report review process. This information comes in the form of explanations and disclosures in support of reported information, attestations as to the accuracy of the reported data, and analyses performed by the MCO that address significant changes to reported information between periods.

4.02 Notes and Disclosures

The MCO shall use the “Notes” report provided within each Excel-based reporting package template and each Excel-based standalone reporting template for explanations, disclosures, and write-ins. The notes can be narrative, in no prescribed format, that explain pertinent information, abnormalities, reasons for unusual increases/decreases, etc., as applicable to each of the reports. Providing comprehensive notes may alleviate necessary follow-up inquiries with the MCO. Additional sheets referencing the applicable reports must be attached as a means of providing further explanation, if necessary.

Failure to provide adequate notes and disclosures for any of the reports discussed in this guide will render the report or schedule incomplete and may result in a resubmission request.

Security settings for the notes report allow the MCO flexibility to expand the cell size and format the rows and columns, as needed, to accommodate the necessary information.

Throughout this guide, circumstances requiring explanations to be made within the notes have been identified. However, these circumstances are not to be considered an exhaustive list. To the extent there is a circumstance not identified within this guide that requires additional information to be disclosed, the MCO should include an explanation.

Additionally, **certain disclosures are required for each submission of the financial reports regardless of circumstance.** These required disclosures are to be made within the designated sections of the notes report and include, but are not limited to, the following:

- For any amounts reported as “Other” premium revenue in the premium revenue section of Report 1, regardless of materiality, the MCO is required to provide an itemized listing within the Premium Revenue Detail section of Report 23. The MCO must provide confirmation within the program-specific reporting package notes that the required detail has been included within Report 23.

- For any amounts reported as “Other Income” in the revenue section of Report 1, regardless of materiality, the MCO is required to provide a detailed explanation in the MCO notes. The explanation **must** itemize the components of total amount reported as “Other Income”.
- Shared Risk/Incentive Arrangements within Report 2 and Report 5G: The MCO is required to provide an itemized listing within the Shared Risk Arrangement Expense Detail section of Report 23. The MCO must provide confirmation within the program-specific reporting package notes that the required detail has been included within Report 23.
- For any amounts reported as other LTSS services in the LTSS Program reports (categories of Community Benefit – Other and Personal Care Option – Other), regardless of materiality, the MCO is required to provide a detailed explanation in the MCO notes. The explanation **must** itemize the components of total amount reported as “Other”.
- LTSS Program: The MCO must provide a detailed explanation for the methodology used to assign claims to the high level of care and low level of care nursing facility and hospital swing bed service categories.
- Explanation of the allocation methodology used to report care coordination expenses across each Centennial Care program and each cohort within the respective program.
- If the particular report and/or reporting package is a resubmission of a previously submitted report, the MCO **must** identify the specific areas of the report impacted by the resubmission and provide an explanation detailing the reason for the resubmission of the report.
- Where expenses for any HSD-approved in lieu of services or settings are included within the health care service categories, the MCO must provide additional detail. At a minimum, the MCO **must** provide the following by time period and cohort:
 - Description of the in lieu of service or setting.
 - The corresponding expenses.
 - The health care service category where the expenses are reported.

The notes report within each Excel-based reporting package template and each Excel-based standalone reporting template contains specific sections that address the required disclosures for the respective report(s). The MCO shall provide the required information within these predetermined sections. To the extent a particular note applies to more than one Excel-based program-specific reporting package, the note **must** be included in each applicable reporting package.

For non-Excel-based reports requiring explanations and disclosures, the MCO shall submit the information in the MCO’s preferred format, along with the respective financial report.

4.03 Data Certification/Attestation

The purpose of the certification statement is to attest that the information submitted in the reports is current, complete, and accurate. The certification statement is required and shall be submitted to HSD along with all required reports. Note only one certification statement is required for the program-specific reporting package templates discussed in Section 2. The Centennial Care Report Attestation Form to be used for all program-specific reporting packages and reports discussed in this guide is located in Appendix M. Reports will be deemed incomplete if an attestation is not included.

Certification statement requirements:

1. The data certification statement is required for each HSD required report.
2. Signature authority must meet the terms under the MCO's contract with the State.
3. Signature authority must be submitted and approved by HSD prior to use.
4. Signature authority must be current and be renewed at least annually by providing the name, title and report-specific authorization requested to HSD.
5. "DATA" include:
 - The detailed report submitted.
 - The analysis/analytic summary of the detailed report.
 - Other documents submitted in conjunction with, or explanation of, the detailed report.
6. Responsibilities of authorized signatory:
 - Personal review of report(s) for accuracy and timeliness.
 - Personal review of reports regarding format and field completion.
 - Personal review of data in conjunction with analysis/analytic summary to determine if:
 - Differences from previous report(s) have been identified.
 - Explanations for differences have been stated.
 - Action(s) have been identified to correct a deficit or explain improvements.
 - Present additional information to, or discuss reports with, HSD staff.

Repeated errors will be reported as a compliance issue. HSD reserves the right to withdraw its approval of a signatory if errors are not corrected and/or lack of timely and accurate reporting, including a reasonable analysis of changes.

The submission of the certification statement for each report will enable the MCO to provide electronic certification signatures for reports submitted after HSD's approval of the designated signatory.

Electronic signatures are not a requirement, but may be used to replace "hard-copy" certifications to the extent the MCO chooses. It is HSD's preference that all MCOs move toward the use of electronic rather than hard-copy certifications in the future.

Unless otherwise specified, approval (including approval of delegates) will be considered applicable to both electronic and hard-copy certifications.

Appendix M contains the certification statement for all reports discussed in this guide to be signed by the MCO's Chief Financial Officer or Chief Executive Officer.

Appendix L contains the delegated authorization request form.

4.04 MCO Analysis Requirement

In addition to each of the reports detailed in this guide, the MCO shall include an analysis with the respective report that shall include, at a minimum, the following:

- Identification of any material changes (positive or negative) compared to previous reporting periods, as well as trending over time.

- An explanation for the material changes.
- An action plan or performance improvement activities addressing any changes adversely impacting the Centennial Care program.
- Any other additional information pertinent to the reporting period not otherwise included within the MCO notes.

Failure to provide an adequate analysis for any of the reports discussed in this guide will render the report or schedule incomplete and may result in a resubmission request.

HSD may assess liquidated damages for failure to address any of these requirements.

The analysis can be provided as a separate attachment to the report or, where applicable, included within supplemental working area provided in the “Analysis” tab within each Excel-based program-specific reporting package template and each Excel-based standalone reporting template. The MCO shall make copies of the “Analysis” tab, as needed, to accommodate the necessary information. The analysis must clearly identify the specific report to which it pertains.

For each non-Excel-based report discussed in this guide where HSD will not provide the MCOs a prescribed and preformatted report template, the MCO **must** also submit the accompanying analysis in the MCO’s preferred format, along with the respective financial report.

4.05 Ad Hoc — Other Reports as Needed

From time to time, additional detailed information may be required to support various program initiatives. As these ad hoc reports are identified, HSD and/or its designated agent will provide the contracted MCOs with a minimum of ten business days’ notice, as well as a template on which to respond. These ad hoc reports may be financial, statistical, and/or clinical in nature.

APPENDIX A

Physical Health Program Health Care Expense Categorization Logic and Methodology

Excel file attached separately.

APPENDIX B

Behavioral Health Program Health Care Expense Categorization Logic and Methodology

Excel file attached separately.

APPENDIX C

Long Term Services and Supports Program Health Care Expense Categorization Logic and Methodology

Excel file attached separately.

APPENDIX D

Self Direction Services Expense Categorization Logic and Methodology

Excel file attached separately.

APPENDIX E

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APPENDIX F

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APPENDIX G

List of Changes to the Financial Reporting Guide and Reports

The following table provides a summary of the changes that were made to the financial reporting guide and reports to help the reader identify and understand differences from previous versions.

Please note the table below summarizes the **significant changes** made to the financial reporting guide/reports and **does not include every change** as some changes are considered immaterial for the purpose of this list in that they do not significantly impact the financial reporting process. As this list is a summary of changes, it is highly recommended that the reader reference the relevant sections within the financial reporting guide for complete descriptions and more detailed information.

Section of Instructions / Report Name	Description of Change
Throughout	Labeling change: <i>Patient Liability</i> changed to <i>Medical Care Credit</i> .
1.04 Report Requirements and Due Dates	Report 29 – Centennial Care MLR Report added to table.
2.04 Report 1 — Schedule of Revenues and Expenses by Category	<ul style="list-style-type: none"> • Mi Via Consulting Agency line added to administrative expense section (LTSS Program). • Fiscal Management Agency line added to administrative expense section (OAG PH Program).
OAG Behavioral Health Program Reporting Package	Addition of the following health care expense categories: <ul style="list-style-type: none"> • Respite Services • Recovery Services • Family Support Services
2.09 Reports 5A through 5Q — Electronic Lag Reports	Health care expense categories added: <ul style="list-style-type: none"> • Respite Services. Report 5K – Behavioral Health Providers (OAG BH Program). • Recovery Services. Report 5M – Community Services, Agencies (OAG BH Program). • Family Support Services. Report 5M – Community Services, Agencies (OAG BH Program).
3.04 Report 14 — Administrative Expense Detail and Supporting Documentation	<ul style="list-style-type: none"> • Line added for Mi Via Consulting Agency. • Format change to allow fiscal management agency expenses for the OAG PH Program.

Section of Instructions / Report Name	Description of Change
3.12 Report 23 — Medicaid-Specific Unaudited Schedule of Revenue and Expenses	<ul style="list-style-type: none"> • Mi Via Consulting Agency line added to administrative expense section. • Format change to allow fiscal management agency expenses for the OAG PH Program. • Shared Risk Arrangement Detail: New tab/section to capture expense detail for directed payments and shared risk arrangements.
3.13 Report 24 — Medicaid-Specific Audited Schedule of Revenue and Expenses	<ul style="list-style-type: none"> • Mi Via Consulting Agency line added to administrative expense section. • Format change to allow fiscal management agency expenses for the OAG PH Program.
3.14 Report 25 — Reconciliation Schedule of Unaudited Centennial Care Financial Reports to Audited Schedule of Revenue and Expenses	<ul style="list-style-type: none"> • Mi Via Consulting Agency line added to administrative expense section. • Format change to allow fiscal management agency expenses for the OAG PH Program.
3.18 Report 29 — Centennial Care MLR Report	Instructions moved from the report template to the Centennial Care Managed Care Organization Financial Reporting Guide. No other changes made to Report 29.
Expense Categorization Logic and Methodology	<ul style="list-style-type: none"> • IHS Pharmacy NPI List – Updated lists. • IHS Misc Medical NPI List – Updated lists.
Appendix A – Physical Health Program Health Care Expense Categorization Logic and Methodology	<ul style="list-style-type: none"> • IHS, Tribal 638 & I/T/Us - NOT Subject to OMB Codes/Rates – IHS NPI changed in other criteria section. • Non-Emergent Transportation – Removed provider type 405 criteria. The definition for this provider type has changed and is no longer related to transportation.
Appendix B – Behavioral Health Program Health Care Expense Categorization Logic and Methodology	<ul style="list-style-type: none"> • Telehealth – New codes added. • Inpatient Detox – Additions to other criteria section. • Hospital Inpatient Facility – Additions to other criteria section. • Hospital Outpatient Facility – Additions to required logic and other criteria sections. • Applied Behavior Analysis – New codes added. • Other Residential – Provider type added. • OAG BH Program restrictions removed for the following health care expense categories: Respite Services, Recovery Services, and Family Support Services.
Appendix C – Long Term Services and Supports Program Health Care Expense Categorization Logic and Methodology	<ul style="list-style-type: none"> • IHS, Tribal 638 & I/T/Us - NOT Subject to OMB Codes/Rates – IHS NPI changed in other criteria section. • Non-Emergent Transportation – Removed provider type 405 criteria. The definition for this provider type has changed and is no longer related to transportation.

APPENDIX H

Example Reconciliation of Adjustment for Prior Period IBNP Estimates

Amounts for the Report 1/1A “Adjustment for Prior Period IBNP Estimates” line item are to be reported on the following lines: PH – Line 74, BH – Line 70, LTSS – Line 87, OAG PH – Line 74, OAG BH – Line 70. Note that Report 1A applies to the PH Program only.

Amounts related to the “Adjustment for Prior Period IBNP Estimates” are required to be reported in the annual supplemental report submission only. Do not include amounts within the regular quarterly report submissions.

For these financial reports, prior period refers to the twelve-month period prior to the most recently complete twelve-month period. For example, the prior period for the twelve-month calendar year 2020 reporting period is calendar year 2019.

Although the following example calculation and reconciliation of prior period IBNP estimates is limited to the PH Program, the methodology applies to the other programs.

For the example below, note the following assumptions:

- PH Program
- Calendar year reporting cycle: 2020
- Report period ending: 12/31/20
- Report submission type: Annual supplemental report submission

Calculation and Reconciliation of IBNP for Incurred Periods Prior to the Most Recent Calendar Year Ending Reporting Period

Example Based on PH Program Annual Supplemental (AS) Report Submissions Using Data from Lag Reports 5A – 5G

Where:

The Most Recent Calendar Year Ending Reporting Period is CY20 (1/1/20 – 12/31/20)

The Incurred Periods Prior to the Most Recent Calendar Year Ending Reporting Period are CY19 & Prior (12/31/19 & Prior)

	Report Submission Source	Incurred Period (Period Prior to the Most Recent CY Ending Reporting Period)	Lag Report (5A – 5G) Line # & Column #	Amount (Hypothetical – for illustration purposes only)
Calculation for health care expenses that run through the claim lag				
1	Claims paid through 3/31/21	CY20 AS	CY19 & Prior (12/31/19 & Prior)	Line 1, Column 18 through Line 15, Column 39 \$9,500,000
2	Add (+) IBNP as of 3/31/21	CY20 AS	CY19 & Prior (12/31/19 & Prior)	Line 47, Column 18 through Line 47, Column 39 \$200,000
3	Less (-) IBNP for report period ending 12/31/19 with the benefit of 3 months paid run-out (paid through 3/31/20) This amount is made up of two components: 1. The estimated amount outstanding on services incurred 12/31/19 and prior at 3/31/20. (Line 47, Column 6 through Line 47, Column 39) 2. For the same incurred services, amounts paid in the months of January 2020 through March 2020. (Line 1, Column 6 through Line 3, Column 39)	CY19 AS	CY19 & Prior (12/31/19 & Prior)	IBNP: Line 47, Column 6 through Line 47, Column 39 Including 3 months paid run-out: Line 1, Column 6 through Line 3, Column 39 \$10,000,000
4	<u>Expected</u> adjustment for prior period IBNP estimates for report period ending 12/31/20 (1+2-3)			(\$300,000)
Calculation for health care expenses that do not run through the claim lag (Includes: subcap payments, Rx rebates, settlements, shared risk arrangements, and net reinsurance expenses)				
5	Amounts paid as of 3/31/21	CY20 AS	CY19 & Prior (12/31/19 & Prior)	Line 39, Column 18 through Line 43, Column 39 \$650,000
6	Less (-) Amounts paid as of 3/31/20 for report period ending 12/31/19	CY19 AS	CY19 & Prior (12/31/19 & Prior)	Line 39, Column 6 through Line 43, Column 39 \$400,000
7	<u>Expected</u> adjustment for prior period IBNP estimates for report period ending 12/31/20 (5-6)			\$250,000
Reconciliation of IBNP for Incurred Periods Prior to the Most Recent Calendar Year Ending Reporting Period				
8	<u>Expected</u> adjustment for prior period IBNP estimates for report period ending 12/31/20 (4+7) This is the effect of the estimation error for the prior year-end IBNP. Such estimation errors are to be expected since the actual amount of unpaid claims will never exactly match the estimate made earlier.			(\$50,000)
9	<u>Reported</u> adjustment for prior period IBNP estimates for report period ending 12/31/20 Per Report 1/1A, Line 74 (PH Program)	CY20 AS		(\$45,000)
10	Difference (8-9) To the extent an amount other than the expected amount calculated in Line 8 is reported on Line 74 of Report 1/1A, the MCO is required to provide a detailed explanation in the notes and/or MCO analysis.			(\$5,000)

APPENDIX I

Electronic File Naming Structure

The MCO shall submit the electronic version of each reporting package and standalone report to HSD's secure DMZ FTP site, unless directed otherwise by HSD, using the following filename structure:

[MCO acronym].[report reference].[submission reference].[calendar year reporting cycle].
[version number]

The report reference portion of the filename relates to identification of the respective reporting package or standalone report. These can be found in the table below.

The submission reference portion of the filename relates to either a monthly submission (M1 through M12) for reports due monthly, quarterly submission (Q1, Q2, Q3 or Q4) for reports due quarterly, annual submission (AN) for reports due annually, or submission of the annual supplemental reports (AS).

The calendar year reporting cycle portion of the filename should be entered as "CY##" according to the applicable calendar year. For example: CY19, CY20, etc.

The version number portion of the filename should reflect the submission number for the particular file. For example: v01 (for the first submission), v02 (for the second submission), etc.

Additional consideration shall be made in the filename structure for the data certification statements (DataCert) and any files containing information in support of the financial reports (SupInfo). Supporting information might include, but is not limited to, notes, disclosures and MCO analyses that are not otherwise included within the Excel-based reporting templates. The MCO shall submit the electronic version of the data certification statement and any supporting information using the following filename structure:

[MCO acronym].[report reference].[submission reference].[calendar year reporting cycle].
[version number].DataCert.

Or

[MCO acronym].[report reference].[submission reference].[calendar year reporting cycle].
[version number].SupInfo.

An example filename for the first version of the 2020 fourth quarter submission of the Excel-based PH Program-specific reporting package template and accompanying electronic data certification statement using the required structure would be as follows:

[MCO acronym].FIN-PHPkg.Q4.CY20.v01.xlsx

[MCO acronym].FIN-PHPkg.Q4.CY20.v01.DataCert.pdf

Report Filename Reference

Reporting Package/Standalone Report Description	Report Reference
Excel-based PH Program-specific reporting package template (Includes Reports 1, 1A, 2, 3, 4A, 4B, 5A, 5B, 5C, 5D, 5E, 5F, 5G, 6, 7, 8, 9, 12B, 15, notes and analysis)	FIN-PHPkg
Excel-based BH Program-specific reporting package template (Includes Reports 1, 2, 3, 4A, 4B, 5A, 5D, 5H, 5I, 5J, 5K, 5L, 5M, 6, 7, 8, 9, 10, 12B, 15, notes and analysis)	FIN-BHPkg
Excel-based LTSS Program-specific reporting package template (Includes Reports 1, 2, 3, 4A, 4B, 5A, 5B, 5C, 5D, 5G, 5N, 5O, 5P, 5Q, 6, 7, 8, 9, 11, 12A, 12B, 15, notes and analysis)	FIN-LTSSPkg
Excel-based OAG PH Program-specific reporting package template (Includes Reports 1, 2, 3, 4A, 4B, 5A, 5B, 5C, 5D, 5E, 5F, 5G, 5O, 6, 7, 8, 9, 12B, 15, notes and analysis)	FIN-OAGPHPkg
Excel-based OAG BH Program-specific reporting package template (Includes Reports 1, 2, 3, 4A, 4B, 5A, 5D, 5H, 5I, 5J, 5K, 5L, 5M, 6, 7, 8, 9, 10, 12B, 15, notes and analysis)	FIN-OAGBHPkg
Report 13A Excel-based standalone reporting template	FIN-13A
Report 13B standalone report	FIN-13B
Report 14 Excel-based standalone reporting template	FIN-14
Report 16 Excel-based standalone reporting template	FIN-16
Report 17 Excel-based standalone reporting template	FIN-17
Report 18 standalone report	FIN-18
Report 19 standalone report	FIN-19
Report 20 standalone report	FIN-20
Report 21 standalone report	FIN-21
Report 22 standalone report	FIN-22
Report 23 Excel-based standalone reporting template	FIN-23
Report 24 standalone report	FIN-24
Report 25 Excel-based standalone reporting template	FIN-25
Report 26 standalone report	FIN-26
Report 27A standalone report	FIN-27A
Report 27B standalone report	FIN-27B
Report 29 standalone report	FIN-29

APPENDIX J

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APPENDIX K

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APPENDIX L

Delegated Authorization Request

DELEGATED AUTHORIZATION REQUEST (DATA CERTIFICATION/ATTESTATION)

MCO Name _____ **Date** _____

Delegate(s)

I hereby request approval for:

Name: _____

Title: _____

Phone: _____ E-mail _____

To act as my authorized representative for the purpose of approval of the following reports submitted to the Human Services Department.

Report Name	Report #
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Signed: _____

Title: _____ (CEO or CFO)

Date: _____

I have been advised of and accept the responsibilities required under this delegation of signature authority.

Signed: _____ (delegate)

Title: _____ (delegate)

Date: _____

Signature authority must be current and be renewed at least annually by providing the name, title and report-specific authorization requested to HSD. HSD requires prior approval of each individual responsible for the certification of specific documents, analyses and reports. Such individuals must meet the following requirements under Section 4.21.1.17:

- A. The CONTRACTOR'S Chief Executive Officer;
- B. The CONTRACTOR'S Chief Financial Officer; or

The CONTRACTOR'S Chief Financial Officer; or an individual who has delegated authority to sign for, and who reports directly to, the CONTRACTOR'S Chief Executive Officer or Chief Financial Officer.

APPENDIX M

Centennial Care Report Attestation Form



Centennial Care Report Attestation Form

Report Information Attestation

Report Name:

Report Number:

Reporting Period:

Submission Date:

Attestation

I, _____, in my capacity as _____, from MCO name, after being authorized to represent MCO name, declare upon oath and attest to the accuracy, completeness, and truthfulness of the data in the document referenced above based on my best knowledge, information and belief.

I attest that there is no additional information to report, or intentionally hidden, or not disclosed as requested. I understand that New Mexico Human Services Department (HSD) reserves the right to impose corrective action and/or monetary sanctions if any information is not disclosed or falsely submitted.

Attestation and Penalties

The MCO shall ensure that all data is accurate and appropriately formatted in the workbook prior to submitting the report. Per Section 4.21 of the Centennial Care contract, failure to submit accurate reports and/or failure to submit properly formatted reports in accordance with the contract may result in monetary penalties of \$5,000 per report, per occurrence (Section 7.3).

The MCO shall include a signed attestation with each report. Failure to submit a signed attestation form by the report due date will result in the entire report being late. Per Sections 4.21 and 7.3 of the contract, failure to submit timely reports in accordance with the contract may result in monetary penalties of \$1,000 per report, per calendar day. The \$1,000 per day damage amounts will double every ten calendar days.

Related Contract Requirements

1. Section 4.21 – Reporting Requirements
2. Section 7.3 – Failure to Meet Agreement Requirements

Signature

Printed Name

Signature

Date