New York State Department of Health
Bureau of Managed Care Fiscal Oversight

Managed Long Term Care – Partial (MLTCCR)
QUARTERLY AND ANNUAL OPERATING REPORTS

Any questions regarding this document should be directed to:

Bureau of Managed Care Fiscal Oversight
Office of Health Insurance Programs
New York State Department of Health
Corning Tower, OCP-Room 1609
Albany, New York 12237-0063
P: (518) 474-5050
bmcfhelp@health.ny.gov

Contents

Introduction

The Managed Long Term Care Cost Report (MLTCCR) must be completed and submitted on or before its filing deadline by each partially-capitated Managed Long Term Care Plan. All plans are required to file the MLTCCR with the NYS Department of Health and to also send copies to the State Insurance Department.

The MLTCCR includes a balance sheet and schedules related to revenue and expenses, enrollment and utilization by the premium groups enrolled by the plan.

The MLTCCR must be completed for each of the Medicaid Managed Long Term Care rating regions in which the plan serves Medicaid Managed Long Term Care enrollees. In addition, a combined (statewide) report for all regions is also required. However, for plans that operate in only one region a duplicate statewide report is not required.

With the exception of the Schedule A (Balance Sheet), Schedule B (Consolidated Statement of Revenue and Expenses), Schedule D3 (Administrative Expenses), Schedule H (Claims Aging Schedule), Schedule I (Summary of Plan's Transactions with Any Affiliates), Schedule J (Claims and Interest Penalties Paid During the Year and Schedule B2 (Projected NYS Consolidated Revenues and Expenses), the MLTCCR) is program specific If an MLTC plan is filing in more than one region, Schedules A, Consolidated B, H, I, J and B2 do not need to be completed in the regional reports. Schedule D3 Administrative Expenses will need to be completed for Statewide and all regional reports.

It is helpful to have this document printed and ready to reference as you work though the Operating Report. If you have any questions, please contact the Bureau of Managed Care Fiscal Oversight – bmcfhelp@health.ny.gov

Using the Report Manager Software

- Each time you run the software you have the choice of starting a New Report or working with an Existing File. When Starting a New Report, you must select the Plan name from a drop down list. The New Report screen also identifies the ending date for the report.
- If you choose to work with an Existing Report, you will be presented with a file open dialog so you may choose and open the file you want to work on.
- As with any program it is a good idea to save your work frequently. This will prevent the loss of information as you enter your data.

Tables

The MLTCCR is comprised of a series of tables. Entering data on the various tables completes the schedule. Wherever possible, the program calculates numbers and brings forward to Schedule B – Revenue and Expense Statement numbers that were entered on other tables.

All of the tables have pre-labeled rows that cannot be changed. Some tables also have one or more open rows that you can label specifically for your report. To do this, double click on the open row in order to enter your own row label. Then type the label and hit enter. The label entry may be changed by double clicking again. You may remove a label entry by double clicking and spacing over it.

Edits

Edits are included in the MLTCCR .XML file to help ensure data accuracy, integrity, and completeness. To run edits in the Report Manager, click the Action tab, then hover on Validation Method to choose 'Current Worksheet' or 'Entire Report'. All edits for the worksheet will be displayed in the Validation Results tab at the bottom of the screen. You can then filter to see All Rules, All Errors, or Critical Errors only. All critical errors must be resolved prior to the report file being finalized.

Notepad

Choose Notepad from the menu bar to open the Notepad. The Notepad is used for any explanations or clarifications that you need to provide regarding your report. The Notepad is automatically included in the file that is uploaded to the Department of Health.

Finalizing Data

Before a file can be sent to the Department of Health it must be "Finalized". To Finalize a report, choose Actions then Finalize Report. A Data Control Number (DCN) is assigned and the file is saved.

DCN

The DCN is a unique identification number that is assigned when a report is finalized. The DCN appears in the title at the top of the program screen. It is included on all printouts produced by the software and in the file that is uploaded to the Department of Health.

If any revisions are made to the electronic file after it has been assigned a DCN, a new DCN will automatically be generated when the revised file is finalized.

If revisions are made to your report after you have submitted a .PNP file, a new file must be submitted and both the CEO and CFO must recertify the report via the Healthcare Financial Data Gateway (HFDG) on the Health Commerce System (HCS) website.

Printing

To print a copy of your report, choose File, Print, then Export as Excel or Export As .PDF. You will then be able to choose specific tables or click on Select All. A file will be created you can then save to your computer and print.

Filing Requirements

- 1st Quarter – January 1 - March 31 — Due Date is May 15th
- 2nd Quarter – January 1 - June 30 — Due Date is August 15th
- 3rd Quarter – January 1 - September 30 — Due Date is November 15th
- Annual Report – January 1 - December 31 — Due Date is April 1st

Note: When the deadline falls on a Saturday or Sunday, the due date is rolled forward to the next business day.

No extensions to due dates for quarterly and annual cost reports will be granted.

Hard copies are not required as a part of your submission. All MLTC plans must submit an electronic copy of the MLTCCR in .PDF format by the filing deadline to the New York State Department of Financial Services at the following email address:

MMCORfilings@dfs.ny.gov

The MCO must electronically certify each Regional and Statewide report submitted. The Electronic Certification should be completed by the Chief Executive Officer and Chief Financial Officer (or the person having charge of the financial records of the plan)

Configure Your .PNP File

Prior to entering data into the .PNP file, you need to configure the report for your plan. After the new MLTCCR .XML file has been downloaded and installed, you need to make a series of selections from the menu.

Welcome Screen

At the Welcome Screen, you can select one of two buttons:

- Work with an existing report, or
- Start a new report

When starting a new report, the next menu will require you to make a number of choices to configure your MLTCCR:

- **Plan Name –** Select the name of your plan from the drop-down menu as shown
- **Region –** Select the New York City Metro Region from the drop-down menu.
- **Report Types** - this will be automatically completed, click Next, then Finish at the bottom of the screen.
- **File Name –** The software provides you with a default naming convention for you to use to save your report data.
- **Location** - will save the data to a default location, or you can change this by clicking the Change Location button.

General Information Form

The General Information Form is used to supply the Department with information about the plan and the plan staff responsible for the reliability of the financial information submitted in the report. A box will be displayed prompting you to complete this form when your .PNP file is created. All mandatory items will be flagged with a  icon. This screen must be completed prior to your .PNP file being finalized.

Schedule A - Balance Sheet

The report shows the overall financial position of the plan, including assets, liabilities and net worth. Managed Long Term Care plans should report the balance sheet of the entire Article 44 business. This table only needs to be completed within the statewide report for plans that operate in more than one managed long term care region.

The Balance Sheet has been modified in the 2007 2nd Quarter MLTCCR to be consistent with the Mainstream MMCOR and now allows plans operating other lines of business such as Medicaid Managed Care, to report consistent with State Insurance Regulation 172. It follows the format of the National Association of Insurance Commissioners (NAIC) reporting requirements and New York State Insurance Department (SID) annual and quarterly reports. **This schedule should be completed in accordance with the NAIC Accounting Practices and Procedure Manual, and State Insurance Regulation 172 for all plans.**

ASSETS:

Current Assets:

These are assets that are relatively liquid, usually short-term holdings, held for less than one year. Restricted assets for grants, contracts, reserves, etc., are not included.

0001. Cash - Cash in the bank or on hand, available for current use. Does not include restricted cash.

0002. Short Term Investments - Readily salable investments acquired with temporarily unneeded cash. Does not include restricted securities.

0003. Premiums Receivable - Net - Gross amounts collectible from groups or individuals who receive services from the plan, less the amount accrued for premiums determined to be uncollectible for the period.

0004. Interest Receivable - Interest earned on investments but not received.

0140. NYS Medicaid Reinsurance Recovery Receivable – Gross amounts collectible from the State of New York for enrollees who exceed the plan's stop-loss thresholds. This data is not applicable to the Managed Long Term Care Program.

0006. Other Receivables - Net - Gross amounts collectible from sources other than plan members or groups, less the amount accrued for receivables determined to be uncollectible during the period.

0007. Prepaid Expenses - Future expenses paid in advance such as unexpired insurance.

0200. Risk Share Receivable - Do not report any data at this time. This line will be used at a later date to report capitation payments due from NYS as a result of risk sharing under the risk corridor rate methodology.

0008. Aggregate Write-Ins for Current Assets - Non-restricted current assets including inventories not included in the above categories. Detail should be entered in the space provided on lines 9 through 13.

0015. Total Current Assets - Total of the above categories (Sum of lines 0001 through 0008 + 0140).

Other Assets:

Assets including insolvency requirements, contracts, grants, reserves, etc.

0016. NYS Escrow Account Balance – The escrow account deposit required by §98-1.11(f) of the NYS MCO Regulations should be reported here. The amount deposited in the escrow account shall be adjusted annually by the last day of March of each calendar year and must be equal to the greater of 5% of the estimated expenditures for health care services for the calendar year conforming to the year of filing, or $100,000.

0018. Amounts Due From Affiliates - Assets held for contract, grants, reserves including cash, securities receivables, other, etc. Please explain the nature of these amounts in the Notepad.

0019. Loan Escrow - Funds for which loan notes have been signed by the plan but not drawn down. Funds may be held by the plan or an escrow agent.

0020. Long Term Investments - Investments held for a period longer than twelve months.

0111. Intangible Assets and Goodwill - Net - Assets of no physical substance: may include patents, copyrights, licenses, franchises. Provide the gross amount less amortization. Enter details in the space provided.

0017. Other Restricted Assets – Other restricted assets not included in any of the other asset lines, including Board designated restricted assets.

0124. Aggregate Write-Ins for Other Assets - Show non-current assets not included in the above categories. Enter detail in the space provided on lines 24 through 28. Not to be used for any portion of the NYS Escrow Account Balance.

0030. Total Other Assets - Total of the above categories (Sum of lines 0016 through 0020, 0111 through 0116 and 0124.)

Property and Equipment:

Fixed assets including land, building, building improvements, furniture and equipment and leasehold improvements.

0031. Land - Real estate owned by the plan.

0032. Buildings and Improvements - Net - Buildings owned by the plan and improvements made to plan-owned buildings and land less accumulated depreciation.

0035. Construction in Progress - Buildings or improvements in progress or under construction. These items will be capitalized upon completion or utilization.

0033. Furniture and Equipment - Net - Includes medical equipment, office equipment and furniture owned by the plan, less accumulated depreciation.

0034. Leasehold Improvements - Net - Improvements to facilities not owned by the plan. Provide the gross amount less amortization.

0137. Aggregate Write-ins for Other Equipment - Include fixtures, automobiles and other fixed assets not reported above. Enter detail in the space provided on lines 0037 through 0041.

0045. Total Property and Equipment - Net - Sum of lines 0031 through 0044. The total Property and Equipment categories should be less Accumulated Depreciation. Depreciation is an accounting practice recognizing the consumption of the value of a fixed asset during the asset's useful life. Depreciation expenses are charged to the expense categories representing the cost center to which the fixed asset is assigned.

0050. Total Assets - Total of Current Assets, Other Assets and Property and Equipment (Sum of lines 0015, 0030 and 0045).

LIABILITIES AND NET ASSETS

Current Liabilities:

Current liabilities may be defined as obligations whose liquidation is reasonably expected to occur within one year.

0051. Accounts Payable - Amounts due to creditors for the acquisition of goods and services (trade and vendors rather than health care providers) on a credit basis.

0052. Claims Payable - Medical and hospital claims received but not yet paid. This is not an estimate of anticipated liability but an actual dollar amount for claims approved for payment, but not yet paid.

0054. Accrued Inpatient Claims (Not Reported) - Hospital and institutional care claims incurred that are not reported and/or booked as claims payable, including IBNR claims.

0055. Accrued Physician Claims (Not Reported) - IBNR claims incurred for physicians and ancillary (such as lab and X-ray) services by providers under an arrangement with the plan.

0056. Accrued Referral Claims (Not Reported) - Claims incurred for consultants and referrals to providers outside a plan arrangement. These claims are usually paid on a fee-for-service basis.

0057. Accrued Other Medical - Other incurred medical expenses including emergency room, out-of-area services, payroll, etc.

0058. Accrued Medical Incentive Pool - Accruals for withholds from IPAs, capitated medical groups or other such arrangement in which the plan may return incentive funds to providers.

0059. Unearned Premiums - Income received or booked in advance of the period to which it applies. A liability exists to render service in the future.

0060. Loans and Notes Payable - Current - Principal amount on loans due within one year.

0201. Risk Share Payable – Do not report any data at this time. This line will be used at a later date to report capitation payments due to NYS as a result of risk sharing under the risk corridor rate methodology.

0162. Aggregate Write-Ins for Current Liabilities – Current liabilities not included in the above categories including accrued payroll and taxes. Enter detail in the space provided on lines 0062 through 0066.

0069. MLR Rebate Payable – Due to NYS - Total amounts owed by the plan to New York State for Managed Care MLR remittances. This should include the following lines of business: Medicaid, HARP, HIV SNP, MAP, MLTC, FIDA, EP, CHP. The MLR Rebate Payable should include all pending MC MLR liabilities for applicable lines of business.

0070. Total Current Liabilities - Total of Current Liability categories (Sum of lines 0051-0060 + 0162).

Other Liabilities:

Other liabilities are obligations of a long term nature; liquidation of liabilities is not expected in the current year.

0071. Loans and Notes - Loans and notes signed by the plan, excluding current portion payable. Include federal loans.

0072. Amounts Due to Affiliates - Amounts owed by the plan to affiliates. Please explain the nature of these amounts in the Notepad.

0173. Aggregate Write-Ins for Other Liabilities - Show other liabilities of a long term nature. Enter detail in the space provided on lines 0073 through 0077.

0079. Non-Current Total Liabilities - Total of Other Liability Categories (Sum of lines 0071 through 0078).

0080. Total Liabilities - Sum of Total Current Liabilities and Total Other Liabilities (Sum of lines 0070 and 0079).

Net Worth:

Net Worth includes ownership or donated capital, restricted funds, reserves and earnings or losses including the following:

0121. Donated Capital – Capital donated to non-profit organizations. Do not include loans. Describe the nature of the donation as well as any restrictions on this capital in the notepad.

0122. Capital – Par value of stock; stated amount of owner's direct equity in the plan.

0123. Paid in Surplus – Amount overstated value of line 0122; reflects actual amount in excess of par or stated reserves.

0081. NYS Contingency Reserve – Report the contingent reserve amount specified by 98-1.11(e).

0183. Aggregate Write-Ins For Other Net Worth Items - Other net worth items not contained in the above categories. Enter the detail in the spaces provided on lines 0083 through 0087.

0089. Unassigned Surplus – Unassigned retained earnings; cumulative earnings or deficit from operations net of reserves and restricted funds.

0105. Total Net Worth Excluding Non-Admitted Assets – Total of Lines 0121 through 0123 and 0081, 0183 and 0189. This is the entity's net worth reported on a SAP basis.

0110. Total Liabilities and Net Worth Excluding Non–Admitted Assets – total of lines 0080 and 0105. This is the entity's net assets on a SAP basis.

0090. Total Net Worth Including Non-Admitted Assets – Difference between total assets in column 00011 line 50 and liabilities in column 00011 line 0080. This is the entity's net worth on a GAAP basis.

0100. Total Liabilities and Net Worth Including Non-Admitted Assets- Total of Lines 0080 and 0090. This is the entity's assets on a GAAP basis.

Schedule A-1 - Net Worth Reconciliation

For plans which operate in more than one region, this table is only to be completed in the Statewide Report.

In Schedule A-1, Net Worth at last year's end and Net Income, from Schedule A and Consolidated Schedule B respectively, are summed along with entered amounts Changes in Non-admitted Assets, Dividends to Stockholders, Withdrawals of Equity (transfers of assets to member entities of not-for-profit corporations) and Change in net unrealized capital gains/losses less capital gains tax. This amount is compared to the Net Worth reported for the current period on Schedule A. Any amount list in the Difference line 0007 must be itemized and described in lines 0008 - 0017.

Schedule B: Revenue and Expense Statement – Total Plan

Report fully accrued revenues and expenses, as defined below in the format indicated for the period.

PLEASE NOTE: For all Schedule B columns except Other Enrollees Amount (00113) and Total Plan Previous Year PMPM (00117), data entries in the supporting Schedule B-1 for each Premium Group will be brought forward and totals for the plan in Schedule B will be calculated by the MLTCCR.

Schedule Column Headings –

00111 – Total Plan Amount – All revenue received and expenses incurred related to the provision of services offered by the plan. This column will be automatically calculated by adding together the Medicaid enrollee amount and the Other enrollee amount.

00112 – Medicaid Enrollees Amount – All revenue received and expenses incurred related to the provision of services to Medicaid enrollees, should be reported in the Medicaid Enrollees Amount column. **PLEASE NOTE**: On the annual report, entries must be made on Schedule B-1 and the MLTCCR report will bring forward the data to Schedule B.

00113 – Other Enrollees Amount – Enter the amounts of all revenue received and expenses incurred related to the provision of services to **anyone other than a Medicaid enrollee**.

00114 – Total Plan PMPM – This is automatically calculated using 00111 – Total Plan Amount divided by the member months reported on Line 0001.

00115 – Medicaid PMPM – This is automatically calculated using 00112 – Medicaid Enrollee Amount divided by the member months reported on Line 0001.

00116 - Other PMPM – This is automatically calculated using 00113 – Other Enrollee Amount divided by the member months reported on Line 0001.

00117 – Total Plan Previous Year PMPM – Enter the previous year PMPM values for each category as they were reported on your prior year's annual report.

Schedule Line Items –

0001. Total Member Months - A member month is equivalent to one person for whom the plan has recognized capitation-based premium revenue for one month.

REVENUE:

0401 - 0004. Medicare Part C, Medicare Part D, Medicaid and Other Payor Premium Revenue - Report period revenue recognized on a prepaid basis for enrollees for provision of a specified range of health services over a defined period of time, normally one month. If advance payments are made to the plan for months subsequent to the reporting period, the portion of the payment that has not yet been earned must be treated as a liability (Unearned Premiums). Do not include Medicaid client cost share in Medicaid premium revenue**. Additionally, amounts received from New York State for Quality Incentive VAPP and Minimum Wage should not be reported on this line but on lines 417 and 419, respectively.**

Plans should report the premium they receive/earn. Withholds should be reported as premium when it is earned. This applies to all withholds, including Encounter Withholds and Enrollment Cap Withholds.

The amount of the premium that is withheld should not be initially reported. It should be reported when the plan is certain they meet metrics and will receive the withhold. If the withhold is received in a subsequent reporting period, it should be reported as a prior period revenue adjustment on Schedule G-3 – Schedule of Extraordinary Items.

0013. Spenddown & NAMI: The total amount of medical expense the Local Department of Social Services (LDSS) determines a "medically needy" individual must incur in any period in order to be eligible for medical assistance (as currently described in 18 NYCRR 360-4.8).

NAMI is defined as the total amount of net available monthly income (NAMI) determined by the LDSS that a nursing home resident must pay monthly to the nursing home in accordance with the requirements of the medical assistance program.

Spenddown and NAMI should not be reduced by bad debts. Report bad debt associated with Spenddown and NAMI on Schedule D-3 line 0060.

0018. HR&R Revenue – Health Recruitment & Retention (HR&R) Designated for PHL Section 3614.9 funding for the purposes of improving recruitment, training and retention of home health aides or other personnel with direct patient care responsibility (HR&R revenue.)

Enter HR&R Revenue for the current period in the space provided. HR&R expenses should match the revenue, and the expenses should be allocated to Home Health Care and/or Personal Care under Medical Expenses. Adjustments needed for HR&R revenue related to prior periods should be reported on line 2 of Schedule G-3 as an adjustment for prior period HR&R revenue.

0416. Quality Incentive Pool Award - Funds awarded to plans for meeting the tenets of The Quality Strategy for the New York State Medicaid Managed Care Program (the Quality Strategy). Plans are eligible to receive amounts based upon meeting established quality measurements. Awards are determined based upon the calculation of a plan specific quality score and distributed as a lump sum payment. Enter the amount of the QI Pool Award amount received in the current period in the space provided.

0417. Quality Incentive /Vital Access Provider Pool (QI/VAPP) – Designated for compliance with PHL Section 3614-c Home Care Worker Wage Parity and a Quality Incentive/ VAP pool program which focuses on quality home and personal care services in MLTC. Enter the QI/VAPP revenue for the current period in the space provided. QI/VAPP expenses should match the revenue and the expenses should be reported on line 0418.

0419. Minimum Wage - Please report the amount of Minimum Wage funding and Surplus/Taxes funding received from the State in your rates, for the reporting period as calculated on your Schedule F.

0010. Total Premium Revenue - Total of lines 0401 through 0004, 0013, 0018, 0416, 0417, and 0419. This amount will be computed automatically. No data entry is required.

0014. Coordination of Benefits (COB) - Income from Coordination of Benefits (third party recoveries) and subrogation.

0077. Reinsurance Recoveries - Income from the settlement of reinsurance claims incurred during the reporting period. This item is treated as an addition to premium revenue.

0420. Total Premium Revenue (inc. COB and Recoveries) – Total of lines 0010, 0014, and 0077. This amount will be computed automatically. No data entry is required.

0016. Net Investment Income – The total income and expense attributable to the plan's investment activities, from all sources, during the report period. Details should be reported on Schedule G.

0019-0020. Other Revenue - Revenue from sources not covered in the previous revenue accounts, such as recovery of bad debts or gain on sales of capital assets, etc. Enter detail in space provided.

0030. Total Revenue - Total of premium revenue and other revenue lines 0014, 0016, 0019-0020, and 0077. This amount will be computed automatically. No data entry is required.

EXPENSES:

Inpatient Expenses:

0031. Inpatient Acute Medical and Surgical: - Not a covered service in the MLTC benefit package.

0032. Inpatient Mental Health/Substance Abuse: Not a covered service in the MLTC benefit package.

0403. Inpatient Maternity Delivery: Not a covered service in the MLTC benefit package.

0404. Total Hospital Inpatient Care: Not calculated.

Other Medical and Hospital Expenses:

0034. Primary Care Physician – Not a covered service in the MLTC benefit package.

0405. Prenatal/Postpartum Maternity Services - Not a covered service in the MLTC benefit package.

0406. Outpatient/Physical Rehab/Therapy – These are services provided for the maximum reduction of physical or mental disability and restoration of the enrollee to his or her best functional level. Rehabilitation services include care and services rendered by independent physical therapists, speech-language pathologists and occupational therapists on an outpatient basis outside of the home. Home-based services should be reported under Home Health Care.

0036. Ambulatory Surgery - Not a covered service in the MLTC benefit package.

0037. Other Professional Services - Costs for services provided by non-physician providers engaged in the delivery of medical services not otherwise specified in this report. This includes outpatient services provided outside the home by dieticians, social workers and audiologists.

0038. Emergency Room - Not a covered service in the MLTC benefit package.

0039. Outpatient Mental Health - Not a covered service in the MLTC benefit package.

0040. Outpatient Drug and Alcohol Abuse - Not a covered service in the MLTC benefit package.

0041. Dental - Expense includes but shall not be limited to preventive, prophylactic and other dental care, services and supplies, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition.

0407. Pharmacy – Part D – Not a covered service in the MLTC benefit package.

0408. Pharmacy – Non-Part D - Not a covered service in the MLTC benefit package.

0409. Home Health Care - Expenses for home health services provided including therapeutic and preventive nursing services, private duty nursing, home health aide services and rehabilitation therapies. Includes pharmaceutical costs for IV therapies. For Medicaid covered services the costs of a home health aide should be reported as Personal Care if the aide is performing only personal care services with no health-related tasks (vital signs, transferring with hoyer lift, stable dressings, ostomy care, prepare meals for complex diets, maintenance exercise programs). PACE and MAP plans should follow Medicare's definition of home health aide services when reporting Medicare covered home health care services. Home Health Care is reported with both an hourly and a per visit unit cost for the service. The cost amounts for these HHC services will flow from the applicable CCLN's in Exhibit B-1 by premium group.

0033. Nursing Facility - The cost of a nursing facility, a licensed institution which provides room and board, nursing and related care services, commonly used items and equipment, supplies and services used for the medical and nursing benefit of patients. The Medicaid cost allocation for this benefit should be equal to the number of skilled nursing days in excess of 100 days per benefit period.

0410. Transportation – Emergent - Not a covered service in the MLTC benefit package.

0411. Transportation – Non-Emergent - Transportation service for assistance in getting to the day health centers, outpatient facilities or other providers. This may include the expenses of licensed driver(s) providing all the transportation for plan's enrollees and the cost of operating, maintaining and servicing the vehicles.

0048. Diagnostic Testing, Lab and X-Rays – Not a covered service in the MLTC benefit package.

0412. Family Planning – Not a covered service in the MLTC benefit package.

0049. Vision Care Including Eyeglasses – The cost of testing the vision and prescribing glasses to correct eye defects. This category includes the cost of eyeglasses but excludes ophthalmologist costs related to the treatment of disease or injury to the eye; the latter can be billed Fee-For-Service.

0050. Podiatry – Medically necessary foot care, including care for medical conditions affecting lower limbs. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of a pathological condition.

0060. Durable Medical Equipment and Other - Expense of durable medical equipment (DME), medical/surgical supplies, prosthetics and orthotics, and orthopedic footwear. Durable medical equipment are devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a practitioner in the treatment of a specific medical condition and which have all the following characteristics:

- can withstand repeated use for a protracted period of time;
- are primarily and customarily used for medical purposes;
- are generally not useful in the absence of an illness or injury; and,

- are not usually fitted, designed or fashioned for a particular individual's use. Where equipment is intended for use by only one patient, it may be either custom-made or customized.

Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances, durable medical equipment or orthopedic footwear which treat a specific medical condition and which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value.

Prosthetic appliances and devices are appliances and devices which replace any missing part of the body.

Orthotic appliances and devices are appliances and devices used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.

Orthopedic footwear are shoes, shoe modifications or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.

0057. Personal Care - Expense of providing some or total assistance with such activities as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks in the enrollee's home. The unit cost to be reported must be the **hourly cost** for the service.

0125. Consumer Directed Personal Assistance Program (CDPAP) – Expense of personal assistance with such activities as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks in the enrollee's home and is directed by the enrollee. The unit cost to be reported must be the **hourly cost** for the service.

0062. Personal Emergency Response Services - Expense for electronic devices which enable enrollees to secure immediate help in the event of physical, emotional or environmental emergency.

0064. Home Delivered Meals - Expense of providing nutritionally adequate meals in the enrollee's home.

0044. Adult Day Health Care - Payments to ADHC providers for the cost of the care and services provided at the adult day care site, under the medical supervision of a physician, to enrollees who are functionally impaired, not homebound.

0045. Social Day Care - Expense of attending a structured, comprehensive program which provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24-hour period.

0413. Other Medical Services – All other medical services not covered by other categories of service. The MLTCCR report will carry over the total amount of other medical services entered into the supporting Schedule B-1 for each premium group.

Effective January 1, 2018, Value Base Payment arrangement for Level 2 or higher are required to implement at least one Social Determinant of Health (SDH) intervention. MCOs and providers in Level 1 VBP arrangements may also implement Social Determinant of Health interventions (VBP Roadmap, p. 48-49). Expenditures made to support DOH approved VBP SDH interventions should be included in Other Medical. These expenditures should also include the "funding advance" (seed money) that is made to support SDH interventions in Level 2 and 3 arrangements. MCOs may only include SDH related expenditures in Other Medical, if the expenditure supports a DOH approved SDH intervention within a DOH approved VBP (Level, 1, 2 or 3) arrangement.

The plans should report the detail of Other Medical Services expenses in the supporting Schedule B-1 and Exhibit B. HCRA assessment costs should **NOT** be reported as Other Medical Services expenses. HCRA assessment costs should be allocated to the applicable category of service line.

0075. Gross Medical & Hospital Expenses - Total of all lines from Inpatient Acute Medical/Surgical through Other Medical Services.

0015. Reinsurance Premium Cost – Enter the cost of purchasing third party reinsurance coverage for the reporting period. **This item is treated as an addition to medical expense.**

0415. Prepaid Capitation and Target Based Reconciliation - This line should be completed by MCOs who have entered into contractual agreements with providers such as IPAs, ACOs or hospital networks for shared savings, shared risk, and/or capitation arrangements. The amount to be reported in this line is the difference between what the MCO paid or allocated to the contracted provider and what the MCO reported as claims expenditures of the contracted provider.

Amounts reported in this line will reflect of the sum of all prepaid capitation & target-based reconciliation adjustments from Tables 9D, 9D-1, 9E, and 9E-1.

Negative balances are reported when claims expenditure of the contracted providers exceeds what the MCO paid or allocated to the providers.

Positive balances are reported when claims expenditure of the contracted providers are less than what the MCO paid or allocated to the providers.

Fee-for-service and capitated (sub-capitated providers) expenses are reported in the applicable medical categories described above. For example, physician expenses are reported in the applicable Primary Care, Specialty Care or Prenatal/Postpartum Maternity Service lines and inpatient expenses should be reported in the applicable inpatient category lines.

0418. Quality Incentive VAPP Expense - Report the expenses associated with payments made to Qualified Incentive Pool Providers (QIPP). The expenses should reflect the cost of investments for home and personal care aide services.

0076. Provider and Quality Incentive Payments - Use this line to report any reduction to medical expenses. Physician withholds retained by the plan should be included here **(adjustments should be made on annual reports only).** Report withholds retained by the plans as a negative value. Profit sharing is not an expense and should not be reported in this line item.

Also report any Quality or Clinical Incentive Payments, which are expenditures associated with bonus or incentive payments to providers who meet specified clinical or quality of care goals and standards.

0080. Total Medical and Hospital Expenses - Total of gross medical and hospital expenses (Line 0075), PLUS Reinsurance Premium Cost, Incentive Pool Adjustment, Prepaid Capitation & Target Based-Reconciliation, and Quality Incentive VAPP.

0047. Care Management (Schedule D-2) – The salaries and fringe benefit costs of professional staff performing care management activities related to the post-enrollment assessment of enrollees and the development, implementation and monitoring of care. Includes assisting enrollees to access necessary covered services as identified in the care plan and referral and coordination of other services in support of the care plan including medical, social, educational, psychosocial and other services irrespective of whether the needed services are covered under the capitation payment.

Do not include activities related to quality improvement, enrollment and assisting enrollees with the Medicaid renewal process, which should be reported as administration costs. Non-professional services such as member services should not be included as part of care management. Translation services should be included in member services.

Do not include expenses related to activities that occur **prior to** a person's enrollment in the plan; these costs should be reported as part of Intake and Enrollment costs on Schedule D-3 and D-3B Administrative Expenses.

Total expenses from Schedule D-2 are carried over by the MLTCCR report.

0081. Allowable Administration (Schedule D-3) - Costs associated with the overall Statewide management and operations of the plan. **Total costs from Schedule D-3 are carried over by the MLTCCR report.** The cost of personnel and non-personnel services that are shared with other lines of business should be allocated to the plan based on the amount of resources actually used by the plan. Such costs should be documented via administrative or management contracts including allocation or cost methodology.

0085. Total Medical and Administrative Expenses - Total of Medical and Hospital and Administration Expenses (total of lines 0080, 0047, and 0081).

0086. Premium Income (Loss) - Excess or deficiency of total premium revenues (including COB and Recoveries) over total medical, care management and administration expenses. This line will be calculated automatically; no data entry is required.

0098. Non-Allowable Expenses – Cost of non-allowable administration including contributions, donations, lobbying expenses, entertainment cost, fines and penalties. This data comes from Schedule D-3.

0090. Operating Income (Loss) - Excess or deficiency of total revenues over total operating expenses. This line will be calculated automatically; no data entry is required.

0095. Aggregate Write-ins for Other Expenses – Non-premium related expenses which are not ordinarily included in the Extraordinary Items line should be reported on this line. This line will be completed based on entries made in supporting Schedule G-2 for each Premium Group.

0096. Prior Period Revenue Adjustments and Extraordinary Items – This line will be automatically completed based on entries made in Schedule G-3. An extraordinary item is a non-recurring gain or loss that meets the following criteria:

a. The events must be unusual; that is, highly abnormal and unrelated to or only incidentally related to the ordinary activities of the entity.

b. The events must occur infrequently; that is, they should be of a type that would not reasonably be expected to recur in the foreseeable future.

0093. Provision for Taxes - All income taxes for the report period.

0094. Adjustments for Prior Period IBNR Estimates – This line should include a reconciliation of prior period IBNR estimates. A contra-expense would be reported if IBNR estimates exceeded actual expenses. Total Adjustment amount is brought forward from Schedule G-3.

0100. Net Income (Loss) - Excess or deficiency of total revenues over total expenses less taxes. This line will be calculated automatically; no data entry is required.

SCHEDULE B - Consolidated Statement of Revenue and Expenses

Since some MLTC plans have multiple lines of business, this schedule summarizes revenue and expenses of MLTC PACE, MLTC Partial, Medicare Advantage, Medicaid Advantage Plus, FIDA, DISCO, and HARP. Plans should report revenue and expenses for all other lines of business, including Medicaid Managed Care, Medicaid Advantage, and commercial lines of business, in Column 00124, "Other." Revenue and expenses will be automatically filled in the partially-capitated column from Schedule B. Data entry will be required for all other lines of business. This table only needs to be completed within the statewide report for plans that operate in more than one managed long term care region.

The 2019 MLTCCR has been modified to reflect a change in the reporting of revenues and expenses. The changes are a result of changes in how MLTC Plan capitation premiums are billed and the Nursing Home Transition programmatic change.

- Effective March 1, 2017, all members in a Partial Capitation plan are required to be billed through eMedNY using rate code 3478 only;
- Effective February 1, 2015 all eligible beneficiaries age 21 and over for both dual and non-dual eligible populations in need of long term placement in a nursing facility as defined by §1919(a)(1)(C) or 42 U.S.C. 1396r requirements for nursing facilities, were required join a Medicaid Managed Care Plan (MMCP) or Managed Long Term Care plan (MLTCP);

Schedule B-1 - Medicaid Revenue and Expense Analysis – by Premium Group

Members are to be classified in one of two premium groups and Plans are now required to separately report the revenues and expenses as follows:

- **Community**: Enrollees (Duals and Non-Duals) receiving community based long term care services.
- **Nursing Home Permanent Placement**: Enrollees (Duals and Non-Duals) receiving long term care services, are permanently placed in a nursing facility and transitioned into a Managed Long Term Plan.

Column Headings:

Medicaid Current YTD – In this column, the plan will enter the individual premium group's total member months, revenue and expenses for the report year for Medicaid-eligible enrollees. The aggregate of this column for all of the plan's premium groups will be carried to Schedule B, "Medicaid Enrollee Amount" column by the software.

Medicaid Current YTD, PMPM – This column will be calculated by the software.

Medicaid Previous Calendar Year PMPM as of 12/31 – The plan should input the revenue and expense PMPM amounts for the premium group from the plan's prior calendar year cost report.

Line Items:

The categories of expenses on Schedule B-1 are a duplicate of Schedule B; therefore, the definitions for Schedule B apply to Schedule B-1. The plan should enter the expense amounts in Schedule B-1. The MLTCCR report will carry all expense amounts from Schedule B-1 for each Premium Group to Schedule B for totaling.

Administration Expense:

The software calculates Statewide administration expenses PMPM from Schedule D-3 and uses the same administration PMPM for all premium groups.

Care Management:

The care management costs are entered on Schedule D-2 and are allocated to Schedule B-1.

SCHEDULE B-2 - Projected NYS Consolidated Revenue and Expense Statement

Schedule B-2 is an annual-only, calendar year projection of the MCO is revenue and expenses across all applicable product lines: Partial Capitation; PACE; Medicare Advantage; or Other for the upcoming year. All individual revenue and expense items will be summed in the consolidated column.

Line 0019, Subtotal Medical and Hospital Expenses, will be used to calculate the required escrow deposit of five percent (5%) of projected medical expenses for the year, shown at the bottom of Schedule B-2.

For plans that operate in more than one region, this table only needs to be completed within the Statewide report.

SCHEDULE D-2 - Care Management

All plans must complete this schedule. Please report the salaries and fringe benefit costs of professional staff performing care management activities related to the post-enrollment assessment of enrollees and the development, implementation and monitoring of care**.** Includes assisting enrollees to access necessary covered services as identified in the care plan and referral and coordination of other services in support of the care plan including medical, social, educational, psychosocial and other services irrespective of whether the needed services are covered under the capitation payment. **Do not include activities related to quality improvement, enrollment and assisting enrollees with the Medicaid renewal process, which should be reported as administration costs. Non-professional services such as member services should not be included as part of care management. Translation services should be included in member services.**

Do not include expenses related to activities that occur **prior to** a person's enrollment in the plan; these costs should be reported as part of Intake and Enrollment costs on Schedule D-3 and D-3B Administrative Expenses.

Line #0001 – Care Management Supervisor Costs: Using the direct or contracted column sets, please enter the number of FTEs performing supervisory functions and the Salary and Fringe Benefits cost of your supervisory staff. Supervisors may be in the "role" of supervisor for an amount of time that is actually less than a full FTE. For care managers with supervisory duties, enter their time spent on supervisory duties (i.e., 0.4) on Line #0001, Column 00611 and the time spent working with enrollees (i.e., 0.6) on Line #0002, Column 00611. For care management supervisors with other administrative duties, enter the portion of their time spent on care management on Line #0001, Column 00611 on the care management schedule and their remaining time on the appropriate line on Schedule D-3 in Administration. For example, for a supervisor who also oversees the Intake & Enrollment staff, enter 0.5 for Care Management and 0.5 for Intake & Enrollment on Schedule D-3.

Staffing Ratio Column: For line 0001, enter the ratio of supervisory staff to employee, not enrollee. For example, if one supervisor oversees the work of five people, the ratio would be 1:5.

Line #0002 –Care Managers: Using the direct or contracted column sets, please enter the number of FTEs and Salary and Fringe Benefits cost for care managers.

Line #0003 – Other: Plans should use this section only if there are other professional staff whose primary function involves care management activities; include in the Notepad a description of the functions of staff reported in this area. As indicated above, do not include activities related to quality improvement, intake and enrollment and assisting enrollees with the Medicaid renewal process. These should be reported as administration expenses. Nonprofessional services such as member services activities should be reported as administration expenses. Translation services should be included in member services.

Staffing Ratio Column: For lines 0002 through 0013, enter the ratio of each line's staff (total FTE's) to enrollees pursuant to the plan's staffing model. For example, if your staffing model is one care manager to 30 enrollees, enter the ratio as 1:30.

Line #0025 – Total Care Management: These totals will be computed by the MLTCCR report.

Line #0026 – Of the total care management on line 0025, please enter the total FTEs and Salary and Fringe Benefits cost for the Care Management staff employed by the social day care program.

Line #0027 – Of the total care management on line 0025, please enter the total FTEs and Salary and Fringe Benefits cost for the Care Management staff not employed by the social day care program.

Allocating Care Management Costs:
The software allocates care management costs across the premium group Schedule B-1(s) based on the relationship of total medical costs per premium group to total medical costs for all enrollees within the region.

SCHEDULE D-2A – Care Management Expense – Contracted Services

List on the schedule all of the plan's care management administrative service agreements. The listing should include all contracts for services that are reported by the plan as care management expense.

00621. Panel Size: Please report the number of members enrolled in the plan that received care management services from the Contractor.

00622. Member Months: Report the total member months for members receiving services from the listed Contractor.

00623. Contracted Fee PMPM: Report the payment amount of the contracted fee paid to the care management provider.

00624. Care Management Expense: Report the total expenditure under the contract applicable to the report period.

SCHEDULE D-3 - Administration Expense – Total

<< This schedule is included only in the annual, semi-annual reports and third quarter reports. This schedule must be completed in all Statewide and Regional reports.>>

Please note the same statewide administrative cost should be entered in every regional and statewide report in Schedules D1, D2 and D3. The PMPM administrative cost will be the same in each region and statewide. The program will allocate gross administrative costs to each region according to the proportion of member months in the region compared to statewide member months.

Administration expenses refer to costs associated with the overall management and operation of the plan. Schedule D-3 is the first of three administration cost schedules. Schedule D-3 is a schedule of total Statewide administration costs. Schedule D-3A is a detailed list of the plan's management and administration contracts documenting services provided, gross contract costs and type of corporate affiliation. Schedule D-3A is a stand-alone schedule. Schedule D-3B is a schedule of administration personnel costs and FTEs. The totals on D-3B are brought forward to Schedule D-3, line 002, Salary and Fringe Benefits for both the Direct and Contracted Costs. For plans filing in more than one region, Schedules D-3, D-3A and D-3B will need to be completed in all regional and Statewide reports.

the total administration expenses incurred by the plan for the cost report period. There is a separate column to report costs incurred directly by the plan and a separate column to report contracted costs. These columns should reflect non-salary costs except for line 002, Salary and Fringe Benefits. When completing Schedule D-3 lines 003-099, only report *non-personnel costs* for each of these categories. All personnel costs are reported on Schedule D3-B. Additionally, QI-VAPP Administration Expense should be reported as an aggregate write-in for Other Admin. Expenses under the subsequent D-3 Contracted or Personnel Expense Schedules.

Definitions of the administration cost categories are provided below:

0001. Rent ($0 for Occupancy of Own Building): Rent for all premises occupied by the Plan, excluding rent for the occupancy of its own buildings. Expenses incurred as a tenant for light, heat, water, fuel, interest, taxes, building maintenance, alterations and service, etc.

0002. Salaries and Fringe Benefits: Salaries and wages, bonuses and incentive compensation to employees, overtime payments, continuation of salary during temporary short-time absences, dismissal allowances, payments to employees while in training and other compensation to employees not specifically designated herein. Includes fees and other compensation to directors for attendance at board or committee meetings and other fees and compensation paid to them in their capacities as directors or committee members. Agency compensation other than commissions.

Fringe benefits are contributions by the company for pension and total permanent disability benefits, life insurance benefits, accident, health, hospitalization, medical, surgical, or other temporary disability benefits under a self-administered or trusted plan or for the purchase of annuity or insurance contracts. Benefits also include appropriation or any other assignment of fund by company in connections with any benefit plan of the types enumerated herein, e.g., the net periodic postretirement benefit cost, whether it's defined in terms of specified benefits or in terms of monetary amounts.

0003. Legal Fees and Expenses: Court cost, penalties and all fees or retainers for legal services or expenses in connection with matters before administrative or legislative bodies. Does not include salaries and expenses of plan personnel. Does not include legal expenses in connection with investigations, litigation and settlement of policy claims. Does not include legal fees associated with real estate transactions.

0004. Utilization Management/Quality Improvement: Costs associated with appeals and external review, including fees paid to independent parties. Cost of reference material to support UM functions, training costs and seminars. Include in the costs the plan's Quality Improvement program.

0005. Traveling Expense: Traveling expenses of officers, other employees, directors and agents, including hotel, meals, conference fees, telephone, telegraph and postage charges incurred while traveling. Amounts allowed employees for use of their cars on company business. The cost of, or depreciation on, and maintenance and running expenses of company-owned automobiles. Does not include such expenses properly chargeable to Real Estate Expense.

0006. Advertising: Newspaper, magazine and trade journal advertising for the purpose of solicitation and conservation of business. Billboard, sign and directory advertising. Television, radio broadcasting and motion picture advertising, excluding subjects dealing wholly with health and welfare. All canvassing or other care literature, such as pamphlets, circulars, leaflets, policy illustration forms and other sales aids, printed material, etc., prepared for distribution to the public by agents or through the mail for the purpose of solicitation and conservation of business. All calendars, blotters, wallets, advertising novelties etc., for distribution to the public. Printing, paper stock, etc., in connection with advertising. Prospect and mailing lists when used for advertising purposes. Fees and expenses of advertising agencies related to advertising.

Does not include pamphlets on health, welfare and educational subjects. Advertising required by law, regulation or ruling except to the extent that it substantially exceeds the space required for compliance. Does not include expenses for help wanted ads or advertising in connection with investments.

0026. Marketing: Refers to those personnel-related functions designed to persuade individuals to become enrolled in the plan. This may entail selling the plan to prospective individuals using direct sales or brokers. The marketing function is responsible for designing advertising campaigns to increase a plan's visibility. It may also include communications with enrollees through newsletters or special mailings.

0007. Finance, Auditing, Actuarial: This category would include the functions normally associated with the accounting functions of the plan, including financial reporting and rate setting.

0008. Claims Processing: Includes those functions which are involved with the receipt and adjudication of medical claims from health providers for services provided to plan enrollees.

0009. Provider Relations, Recruitment, and Contracting: Provider Relations serves as the link between the plan and the plan's providers who serve the program. Provider Relations representatives educate and assist network providers while actively recruiting medical professionals who may not currently participate in the program. Provider relations also renders provider education, assists with provider problems and resolutions. This area also disseminates the plan's policies and facilitates the exchange of information with providers. Credentialing includes the review and documentation of professional providers including licensure, malpractice history, analysis of practice patterns and certification. Contracting refers to the process of establishing contracts with participating providers.

0010. Member Services: The cost of providing services to individual enrollees of the plan, typically associated with answering enrollee questions, resolution of member problems and grievances as well as assisting enrollees in making appointments, translation and communication assistance, and orientation activities.

0011. Management Information Systems (MIS): Equipment and software used for establishing and maintaining an information system. Salaries and fringe benefits of MIS staff are included on Schedule D-3B.

0012. Telephone, Postage, Express and Telegraph: Freight and cartage. Cables, radiograms and teletype. Charges used for use, installation and maintenance of related equipment if not included elsewhere.

0013. Printing and Stationery: Policy forms, riders, supplementary contracts, applications, etc., rate books, instruction manuals, and all other printed material which is not required to be included in any other expense classification. Office supplies, pamphlets on health, welfare and educational subjects. Annual reports to policyholders and stockholders if not included in Marketing.

0014. Occupancy, Depreciation and Amortization: The costs of occupancy to the plan which are directly associated with the plan's administration. Included in occupancy are costs of using a facility, fire and theft insurance, utilities, repairs and maintenance, office cleaning, building security, etc.

The amount of depreciation and amortization expense which is directly associated with administration services. Depreciation is the incremental consumption of the value of a fixed asset during the asset's useful life. Amortization expense is the allocation of the costs of certain assets over their estimated service lives; e.g. leasehold improvements.

0015. Rental of Equipment: Rental of office machines except for such charges as may be reported in Telephone, Postage, Express and Telegraph.

0016. Boards, Bureaus and Association Fees: All dues and assessments of organizations of which the plan is a member. Also include all dues for employees and agents memberships on the plan's behalf. Does not include contributions in connection with scientific, disease prevention, or other activity directly pertaining to the welfare of enrollees and the public.

0017. Insurance, Except on Real Estate: Premiums for Workers Compensation burglary, hold-up, forgery and public liability insurance, fidelity or surety bonds, insurance on contents of company-occupied buildings and all other insurance or bonds not included elsewhere.

0018. Collection and Bank Service Charges: Collection charges on checks and drafts and charges for checking accounts and money orders.

0019. Payroll Taxes: Do not include income taxes.

0020. Other Taxes: Do not include income taxes.

0022. Intake and Enrollment: The cost associated with the recruitment of enrollees. This should include the cost to process the new enrollee and the initial care plan.

0024. Employee Recruitment and Retention: The expenses associated with the cost of recruitment and retention of employees. Expenses for Human Resources should be included.

0045. Franchise Tax: This is a premium tax paid by for-profit HMOs pursuant to §1500 of Article 33 of NYS Tax Law. The MTA surcharge should also be included in the franchise tax line.

0099. Aggregate Write-ins for Other Expenses: Non-salary costs that are not appropriately assigned to the plan's administration categories defined above. Do not include marketing expenses or any other expenses that can be included in the above categories. For example, do not report consulting services as other. Report consulting services in the cost category applicable to services provided.

0030. Total Allowable Administration Expenses: Sum of the lines listed above.

Non-Allowable Administrative Costs

0032. Contributions and Donations – Report donations or gifts to charitable, civic, educational, medical or political entities.

0033. Lobbying Expenses – Report expenses for lobbying and political activities. Lobbying is any activity whereby a directed effort is made to influence legislation. Political activities include plan involvement with political parties, candidates/incumbents of political parties, and political action committees or similar committees or associations.

0034. Entertainment Costs – Report costs for entertainment, including tickets to sporting or other events, alcoholic beverages, golf outings, ski trips, cruises, professional musicians or other entertainers. Costs incurred for purposes of employee morale, specifically, for an annual employee picnic, an annual Christmas or holiday party, an annual employee award ceremony or for sponsorship of employee athletic programs (bowling, softball, basketball teams, etc.), to the extent that they are reasonable, would not be included as a non-allowable expense, and should be reported under Employee Recruitment and Retention.

0035. Interest, Fines and Penalties – Report fines or monetary penalties imposed for violations of Federal, State or local laws. Include interest on claims paid after 45 days. Encounter Penalties and OMIG Penalties for the current period should be reported here. If penalties are for a prior-period they should be reported on Schedule G-2.

0060. Uncollectible Spenddown and NAMI – The amount of bad debt expense related to Spenddown and NAMI.

0061. State Income Taxes - report expenses for State income taxes.

0036. Other Non-allowable Expenses – Other costs not related to the provision of services to enrollees. Planning and development costs that are expensed by the plan and incurred for the purpose of developing other product lines should be reported on this line. For example, a partially capitated plan that plans to open a PACE program or an MLTC plan that develops a Medicare Advantage plan. Planning and development costs would include feasibility studies, consultants and plan staff.

0037. Total Non-allowable administration expenses – Sum of non-allowable lines above.

0100. Total Administration Expenses – The total of allowable and non-allowable administration expenses above.

0097. Statewide Member Months – Report the total member months for all regions in which the MLTC plan operates.

SCHEDULE D-3A - Administration Expenses – Contracted Services

<< This schedule is included only in the annual, semi-annual reports and third quarter reports and must be completed in all Statewide and regional reports. >>

List on the schedule all of the plan's administration and management service agreements.

The listing should include all contracts for services that are reported by the plan as administration expense. These would include contracts for management services, actuarial services, financial services, accounting services, other consulting services, marketing services, legal services, etc. Enter the name of the contractor, a brief description of the services rendered, the type of affiliation to the plan, if any, and the total expenditure under the contract applicable to the report period.

It is important to note that you must include all types of affiliation your contractor has with the plan. For example, your plan may have common ownership, be part of the same holding company and share key personnel; in this case you would enter 2, 4 and 5 in the Type of Affiliation column.

Type of Affiliation Code Numbers:

1. None
2. Common Ownership
3. Common Board of Directors
4. Part of the Same Holding Company
5. Share the same Key Personnel

SCHEDULE D-3B - Administration Expense – Personnel Expense

<< This schedule is included only in the annual, semi-annual reports and third quarter reports and must be completed in all Statewide and regional reports. >>

0001. Executive Management: The salary and fringe benefits associated with the personnel that have overall responsibility for the administration and management of the plan. Should include Chief Executive Officer, Chief Operating Officer, President, Vice President, Executive Director and/or Plan Administrator. The plan's Chief Financial Officer (CFO) should be included on Line 0007 – Finance, Auditing and Actuarial. Do not include any assistants or support staff on this line, the costs for this staff should be reported on line 0075, "Administrative Support". There must be a value entered for this category.

0003. Medical Director: The salary and fringe benefits associated with the physician who has the responsibility for the overall medical administration for the plan. For PACE plans, if the Medical Director also provides physician services, include in this category **only** the time spent in the capacity of the Medical Director.

It is important to note that the salaries and fringe benefit costs on Schedule D-3B will be automatically posted to Line 002, Salaries and Fringes on Schedule D-3.

In addition to the above categories, a value must be entered for the following: Marketing and/or Advertising; Finance, Auditing, and Actuarial; Claims Processing; Member Services; MIS; Intake and Enrollment. Failure to report salary costs on these lines will result in a critical edit.

SCHEDULE D-6 - Claims Analysis

Section A: Claims Incurred During Current Period -

Claims incurred shall include medical expenses for services provided in the report period which are either paid or unpaid and are reported as medical expenses in Schedule B.

The sum of the amounts reported in Columns B (Claims Paid), C (Claims Reported But Not Paid) and D (IBNR Claims) should reconcile to the total medical and hospital expenses reported in Line 0075 of Schedule B.

Enter in Column B all payments actually made during the year for inpatient care, nursing home days, primary and specialty physician services, emergency room, home health care, personal care, consumer directed personal assistance services and all other medical services provided during the report period.

Enter in Column C the amount of claims which have been reported and processed but not paid during the report period.

Enter in Column D the amount of claims that the plan estimates have been incurred but not reported (IBNR) by providers during the report period.

Column E will calculate IBNR as a percent of total expense for each category of service.

In Column A, Line 0051 "Total Expenses – Capitated," enter the total cost of capitation arrangements for which no IBNR has been estimated in Column D. Capitated arrangements for primary care, dental, vision, etc., would typically fall into this category. In Column A, Line 0052 "Total Expenses – Paid FFS," enter the cost of all other arrangements, including prepaid capitation & target-based reconciliation arrangements, for which accrued costs have been estimated in Column D. The sum of Capitated expenses and FFS expenses in Column A, Lines 0051 and 0052 should equal the sum of the Total Expenses shown in Column A, Line 0025.

Column A Line 0053: Enter the number of claims processed and paid during the report period. If a single payment is made for multiple services then count this as one claim.

Section B: Claims Unpaid –

Enter in Column A the amount of reported unpaid claims incurred during prior years for each of the categories of service indicated. This amount is for informational purposes only and should not be included in Section A, Column B (Claims Paid) for reconciling the current year expenses.

Column B will bring in the values entered in Section A, Column C, Lines 0001 through 0007 (claims reported but not paid during the **current** period for each of the categories of service indicated).

Column C will bring in the calculated totals from Section C, Column E, Lines 0026 through 0032 (total **prior period** IBNR for each of the categories of service indicated).

Column D will bring in the values entered in Section A, Column D, Lines 0001 through 0007 (the amount of IBNR claims during the current period for the categories of service indicated).

Column E will calculate the total unpaid claim amounts shown in Columns A through D, Lines 0026 through 0032.

Section C: Reconciliation of Prior Period IBNR

Enter in Columns A through D the respective year's IBNR reserve for each category of service indicated. The total reported for each prior period should be mutually exclusive. Column E will calculate the total prior period IBNR amounts entered in Columns A through D. These total amounts will be carried to Section B, Column C.

Please provide an explanation in the Notepad section if the plan continues to carry IBNR claims that are more than 2 years old.

SCHEDULE D-7 - Premiums Receivable

This schedule identifies aging of premiums receivable. The schedule provides separate rows to detail the amounts and age of receivables related to Medicaid, Medicare, private payer, Spenddown/NAMI, Allowance for Doubtful Accounts and HR&R Revenue. Additional rows are provided for 'Other' categories of receivables. Total receivables are automatically computed for each of the six Aging Categories as well as for each of the Premium Receivable Categories represented in the table. The total dollars of all aging and receivables

categories must equal the amount reported in Schedule A. Column 00011, Line 0003 – 'Premiums Receivable – Net'.

For plans that operate in more than one region, this table only needs to be completed in the Statewide report.

TABLE 9D – Non-VBP Shared Savings (Losses)

Table 9D should be completed by plans with target-based arrangements that **do not meet** the definition of Value Based Payment (VBP) as described in the VBP Roadmap. This includes all target-based arrangements such as shared savings and/or shared risk. Such agreements are typically made between the MCO and IPAs, ACOs and/or providers such as Hospital Networks.

- On lines 0007 and 0008 enter the member months and the premium revenue the MCO received from New York State for the membership included in the target expenditure based arrangement.
- On Line 0001, Target Expenditure, enter the total expenditure target for the members in the arrangement. The Target Expenditure is the amount the MCO and the IPA/ACO and/or provider contractually agreed to.
- On Line 0006, Additional Plan Payments, enter any additional payments paid to providers by the MCO.
- Line 0009 is the total of line 0001 and line 0006
- On Lines 0002 – 0004, enter the actual medical claims expenses for services covered under the target expenditure based arrangements incurred by in-network and out-of-network providers under the three categories shown: Actual Claims Paid, Claims Reported But Not Paid, and Claims Incurred But Not Reported.
- Line 0010, Total Claim Expenses, is the total of lines 0002 – 0004.
- Line 0011, Total Surplus or (Loss), is the difference between Line 9, Total Target Expenditure, and Line 10, Total Claim Expenses.
- Line 0012, Plan Surplus or (Loss) is the proportion of Line 11, Total Surplus or (Loss), that the MCO retains.
- Line 0005, IPA/ACO/Provider's Surplus or (Loss), is the proportion of Line 11, Total Surplus or (Loss), that the IPA/ACO/Provider receives from the MCO.

TABLE 9D-1 – Non-VBP Prepaid Capitation

Table 9D-1 should be completed by plans with prepaid capitation arrangements that **do not meet** the definition of Value Based Payment (VBP) as described in the VBP Roadmap. Such agreements are typically made between the MCO and IPAs, ACOs and/or providers such as Hospital Networks.

- On lines 0007 and 0008 enter the member months and the premium revenue the MCO received from New York State for the membership included in the prepaid capitation arrangement.
- On Line 0001, Capitation Payments, enter the total prepaid capitation payments made to the IPA/ACO and/or Provider for members in the arrangement.
- On Line 0006, Additional Plan Payments, enter any additional payments paid to providers by the MCO.
- Line 0009, Total Capitation and Additional Payments, is the total of line 0001 and line 0006
- On Lines 0002 – 0004, enter the actual medical claims expenses for services covered under the prepaid capitation arrangement incurred by in-network and out-of-network providers under the three categories shown: Actual Claims Paid, Claims Reported But Not Paid, and Claims Incurred But Not Reported.
- Line 0010, Total Claim Expenses, is the total of lines 0002 – 0004.
- Line 0011, Total Surplus or (Loss), is Line 9, Total Capitation and Additional Payments, less Line 10, Total Claim Expenses. This amount reconciles MCO reported IPA/ACO/Provider costs to the amount of prepaid capitation payments received by the IPA/ACO Provider from the MCO.
- Line 0012, Plan Surplus or (Loss) is the proportion of Line 11, Total Surplus or (Loss), that the MCO retains. Under prepaid capitation arrangements, the MCO would not typically retain a surplus or loss. We would expect this line to be $0 in most cases.
- Line 0005, IPA/ACO/Provider's Surplus or (Loss), under prepaid capitation arrangements, this line should be equal to line 0011, Total Surplus or (Loss) in most cases.

TABLE 9E - VBP Shared Savings (Loss)

Table 9E should be completed by plans with target-based arrangements **meet** the definition of Value Based Payment (VBP) Level 2 as described in the VBP Roadmap. This includes all target-based arrangements such as

shared savings and/or shared risk for LHCSA, CHHA and SNF. Such agreements are typically made between the MCO and IPAs, ACOs and/or providers such as Hospital Networks.

- On lines 0007 and 0008 enter the member months and the premium revenue the MCO received from New York State for the membership included in the target expenditure based arrangement.
- On Line 0001, Target Expenditure, enter the total expenditure target for the members in the arrangement. The Target Expenditure is the amount the MCO and the IPA/ACO and/or provider contractually agreed to.
- On Line 0006, Additional Plan Payments, enter any additional payments paid to providers by the MCO.
- Line 0009 is the total of line 0001 and line 0006
- On Lines 0002 – 0004, enter the actual medical claims expenses for services covered under the target expenditure based arrangements incurred by in-network and out-of-network providers under the three categories shown: Actual Claims Paid, Claims Reported But Not Paid, and Claims Incurred But Not Reported.
- Line 0010, Total Claim Expenses, is the total of lines 0002 – 0004.
- Line 0011, Total Surplus or (Loss), is the difference between Line 9, Total Target Expenditure, and Line 10, Total Claim Expenses.
- Line 0012, Plan Surplus or (Loss) is the proportion of Line 11, Total Surplus or (Loss), that the MCO retains.
- Line 0005, IPA/ACO/Provider's Surplus or (Loss), is the proportion of Line 11, Total Surplus or (Loss), that the IPA/ACO/Provider receives from the MCO.

TABLE 9E-1 - VBP Prepaid Capitation

Table 9E-1 should be completed by plans with prepaid capitation arrangements that **meet** the definition of Value Based Payment (VBP) Level 3 as described in the VBP Roadmap for LHCSA, CHHA and SNF. Such agreements are typically made between the MCO and IPAs, ACOs and/or providers such as Hospital Networks.

- On lines 0007 and 0008 enter the member months and the premium revenue the MCO received from New York State for the membership included in the prepaid capitation arrangement.
- On Line 0001, VBP Capitation Payments, enter the total prepaid capitation payments made to the IPA/ACO and/or Provider for members in the arrangement.
- On Line 0006, Additional Plan Payments, enter any additional payments paid to providers by the MCO.
- On Line 0009, Total Capitation and Additional Payments, is the total of line 0001 and line 0006.
- On Lines 0002 – 0004, enter the actual medical claims expenses for services covered under the prepaid capitation arrangement incurred by in-network and out-of-network providers under the three categories shown: Actual Claims Paid, Claims Reported But Not Paid, and Claims Incurred But Not Reported.
- Line 0010, Total Claim Expenses, is the total of lines 0002 – 0004.
- Line 0011, Total Surplus or (Loss), is Line 9, Total Capitation and Additional Payments, less Line 10, Total Claim Expenses. This amount reconciles MCO reported IPA/ACO/Provider costs to the amount of prepaid capitation payments received by the IPA/ACO Provider from the MCO.
- Line 0012, Plan Surplus or (Loss) is the proportion of Line 11, Total Surplus or (Loss), that the MCO retains. Under prepaid capitation arrangements, the MCO would not typically retain a surplus or loss. We would expect this line to be $0 in most cases.
- Line 0005, IPA/ACO/Provider's Surplus or (Loss), under prepaid capitation arrangements, this line should be equal to line 0011, Total Surplus or (Loss) in most cases.

SCHEDULE F - IBNR Reserve Calculation

01101. Claims Reported (Paid & Unpaid):

In Column 01101 identify the dollar amount of paid and unpaid claims received for each month of service for the report year.

01102. Percent Complete:

In Column 01102 identify on a monthly basis the plan's completion factor representing the estimated percent of all reporting claims for each service month utilizing statistics developed from historical claims experience, authorized claims or other (please describe in Notepad). For example, if when filing the semi-annual cost report through historical experience, you estimate that 75% of all claims are received

by June 30 of the report year for services rendered in April of the report year, then 75% should be entered into Column 01102 for the month of April.

When completing Column 01102 for the annual MLTCCR, it is expected that the completion factors will run from smallest to the largest as you fill in Column 01102. In other words, it is expected that the plan will have the fewest claims received and adjudicated for dates of service in December. As the form is completed, there should be more claims processed with November dates of service than for December and November will have slightly fewer claims processed than October. At the bottom of the Schedule is Line 0012 for January dates of service which will be the most complete. January should have the largest completion factor of all your months.

01103. Estimated Expense:

In Column 01103, divide Column 01101 by Column 01102. This represents the estimated total expense of all claims for services rendered in a given month. For example, the estimated total expense for services rendered during April of the report year would be 100,000 based on 75,000 of known claims (paid & unpaid) and an estimated completion factor of 75%.

01104. Adjustment:

This column should be used to record any adjustments that may be necessary to properly reflect the monthly projected expense. Examples of such adjustments may include: a "cushion" to establish a more/less conservative estimate than is established using completion factors; an adjustment for known factors that will have an impact on claims for a particular month. ***An explanation of the adjustment(s) should be included in the Notepad.***

01105. Projected Expense:

This column calculates automatically and is the sum of columns C and D and reflects the projected expenditures of all claims for a given month of service for the report year.

01106. I.B.N.R. Reserve:

Column 01106 is the difference between Column 01105 and Column 01101 and represents the amount incurred but not reported expenses or IBNR. Column F, Line No. 20 should agree with the IBNR reported on Schedule D-6, Column D, Line No. 25.

If these figures do not agree, you must provide an explanation as to where you are posting this liability on your Balance Sheet. Please provide this explanation in the Notepad section of the report. It is important to note that if you are purchasing services from a plan affiliate, the Department considers the transaction a medical claim and should be reported as a claim payable.

0021, 0022 and 0023 - Percent Completed: Please indicate how your plan developed the completion factors used in Column B. Did your plan used historic claims data and develop lag tables with that data? Are you using a service authorization system and estimating how many authorized services have yet to be delivered (or have been delivered but not yet billed?) Or is the system a combination of the two methods? If you are using a combination method or a method other than authorizations or lag tables, please explain the methodology in the Notepad section of the report.

SCHEDULE G - Schedule of Net Investment Income

Total income and expense attributable to the plan's investment activity, from all sources, during the cost period. The Net Investment Income on line 0025 must match the Net Investment Income reported on Schedule B, column 00111, line 0016.

SCHEDULE G-1 - Adjustments for Prior Period IBNR Estimates

This table will provide the supporting detail to the line *Adjustments for Prior Period IBNR Estimates* on Schedule B. Separate lines are provided on Schedule G-4 to breakdown the Amount of Write-Off by service year.

For plans with Prepaid Capitation & Target-Based Reconciliation arrangements, adjustments to prior period IBNR claims that are the liability of a prepaid capitation and/or target-based providers should not be reported in Schedule G-1 but instead should be reflected in Tables 9D, 9D-1, 9E or 9E-1; such adjustments would not affect the plan's net income but would affect the prior period profit or loss of the prepaid capitation and/or target based reconciliation providers reported in Tables 9D, 9D-1, 9E or 9E-1 .

- **Prior reporting period ending balance - IBNR and Claims Reported But Not Paid** – Report the prior reporting period ending balance of IBNR and claims reported but not paid, excluding prepaid capitation and target based reconciliation arrangements.

- **Claim payments made to providers during the current reporting period for prior reporting periods dates of service**– Report current period payments for claims with prior reporting periods dates of service, excluding those related to prepaid capitation and target based reconciliation arrangements.

- **Remaining prior period IBNR and Claims Reported But Not Paid** – Report the amount of remaining prior period IBNR and claims reported but not paid, excluding prepaid capitation and target based reconciliation arrangements.

- **Adjustments to prior period IBNR**- This column is a calculated field. If the result is a negative, this represents an overstatement of prior reporting period IBNR expenses (reduce IBNR and increase to Net Income). The prior reporting period IBNR expenses must be adjusted by using the calculated amount to reduce current reporting period expenses. If the result is a positive, this represents an understatement of prior reporting period IBNR expenses (increase IBNR and decrease to Net Income). The prior reporting period IBNR expenses must be adjusted by using the calculated amount to increase current reporting period expenses.

- **Total recoveries-**Report total current reporting period recoveries for services provided in prior reporting periods, excluding those for prepaid capitation and target based reconciliation arrangements. **Recovery amounts should be entered as negatives**.

- **Amount of Write-off**- Calculated field will report the sum of the previous two columns (Adjustments to Prior Period IBNR and Total Recoveries). The total amount calculated in this column, Line 0010 will automatically flow to Schedule B, Line 0094.

SCHEDULE G-2 - Aggregate Write-Ins for Other Expenses

This table will provide the supporting detail to the line *Aggregate Write-ins for Other Expenses* on Schedule B. Separate lines are provided on Schedule G-2 to break down by expense the total Other Expenses to be included on Schedule B during current reporting period. *Aggregate Write-ins for Other Expenses* will automatically flow to the corresponding line on Schedule B – Statement of Revenue and Expenses.

- **Line 0006 Non-State Plan Services** – Report expenses for services provided to members that are not reimbursable by the NYS Medicaid Program, either in managed care or fee-for-service. (The State Plan is a document, approved by CMS, that describes the services covered by the state's Medicaid program. Services not included in the State Plan are considered non-State Plan services).
- **Line 0007 Increase in Reserves for A & H Contracts (Accident & Health)** - When the expected claims payments or incurred costs, claim adjustment expenses and administrative costs exceed the premiums to be collected for the remainder of a contract period, a premium deficiency reserve shall be recognized by recording an additional liability for the deficiency, with a corresponding charge to operations.
- **Line 0008 Encounter Penalty (applies to Medicaid, HARP, HIV SNP, PACE, MLTCP, MAP, MA) –** Report expenses related to Encounter penalty if related to a prior period. If the Encounter Penalty is for the current period it should be reported on Schedule D-3 in Line 0035 Interest, Fines and Penalties.
- **Line 0009 OMIG Penalty -** Report monetary penalties based on misstatement of fact on Cost Reports if related to a prior period. (Notice of Proposed Agency Action- Pursuant to 18 NYCRR 516.2). If the OMIG penalty is for the current period it should be reported on Schedule D-3 in Line 0035 Interest, Fines and Penalties.

SCHEDULE G-3 - Prior Period Revenue Adjustments and Extraordinary Items

This table will provide the supporting detail to the line *Prior Period Revenue Adjustments and Extraordinary Items* on Schedule B. Please refer to the instructions for Schedule B regarding the types of gains or losses to be included in Extraordinary Items.

Please note that Line 0001 of Schedule G-3 (Adjustment for Prior Period Revenue) should be used only to identify any adjustments made to revenue for a prior reporting period, such as an under/over-accrual of revenue that was not reported in the prior reporting period. Any entry on this line will require a breakdown in the NOTEPAD, by date of service year, of the individual adjustments for prior period revenue aggregated on Line 0001.

Please note that adjustments needed for HR&R revenue related to prior periods should be identified on Line 0002 of Schedule G-3.

Any amount the plan owes NY State for the Medical Loss Ratio (MLR) Calculation can be reported in Line 0011-MLR Remittance.

Total *Prior Period Revenue Adjustments and Extraordinary Items* (Line 0099) will automatically flow to the corresponding line on Schedule B – Statement of Revenue and Expenses.

SCHEDULE G-4 – Detail of Current Reporting Period Recoveries for Services Provided in Prior Reporting Period

All payments recovered in the current reporting period from providers for services provided in prior reporting periods should be reported on this table. This table is only completed in your Annual report.

This table has two sections:

- NON Prepaid Capitation & Target-Based Reconciliation arrangements
- Prepaid Capitation & Target-Based Reconciliation arrangements (9D, 9D-1, 9E, 9E-1)

NON Prepaid Capitation & Target-Based Reconciliation arrangements

Plans should report information for NON-prepaid capitation & target-based reconciliation arrangements on Lines 0010-0013.

Recovery amounts should be entered as negatives.

- **Line 0010** – Report amounts recovered in the current reporting period due to fraud, waste and abuse for services provided in prior reporting periods
- **Line 0011** – Report amounts recovered in the current reporting period from coordination of benefit activities for services provided in prior reporting periods.
- **Line 0012** – Report amounts recovered in the current reporting period from retroactive adjustments to claims for services provided in prior reporting periods.
- **Line 0013** –Report amounts recovered in the current reporting period from all other activities with services provided in prior reporting periods.
- **Line 0099** – Calculated field will report the sum of Lines 0010-0013. The amounts should agree with amounts reported on Schedule G-1, column 1207.

Prepaid Capitation & Target-Based Reconciliation arrangements (9D, 9D-1, 9E, 9E-1)

Plans should report information for prepaid capitation & target-based reconciliation arrangements on Lines 0014-0017

Recovery amounts should be entered as negatives.

- **Line 0014** – Report amounts recovered in the current reporting period due to fraud, waste and abuse for services provided in prior reporting periods
- **Line 0015** – Report amounts recovered in the current reporting period from coordination of benefit activities for services provided in prior reporting periods.
- **Line 0016** – Report amounts recovered in the current reporting period from retroactive adjustments to claims for services provided in prior reporting periods.
- **Line 0017** –Report amounts recovered in the current reporting period from all other activities with services provided in prior reporting periods.
- **Line 0098** – Calculated field will report the sum of Lines 0014-0017.

SCHEDULE H - Aging Analysis of Unpaid Claims

Schedule H only needs to be completed within the statewide report for plans that operate in more than one managed long term care region. This Schedule is used to list unpaid claims by provider. Individually list in the applicable columns all health care creditors with $5,000 or more of outstanding claims payable or with 10% of the Plan's total claims payable (reported, excluding amounts withheld), whichever is greater. Group the total of all other payables and enter on the line entitled "Aggregate Accounts Not Individually Listed". Report claims payable from date of receipt of claim by the plan or in the case of capitation and other non-fee service expenses, from the date bill is received by the plan. This table should reflect all lines of business. The total should match the total of claims payable from Schedule B.

To determine which creditors should be listed individually, multiply total claims payable by ten percent. If this amount is greater than $5,000, list all creditors owed more than the ten percent threshold. If ten percent of claims payable is less than $5,000, list only creditors owed more than $5,000. If no creditor is owed more than 10% of claims payable, the plan is not required to list individual creditors. However, the plan must still provide the aging detail of the total claims payable.

There are twenty five lines, allowing the plan to report the largest providers and vendors. Double click on the title line and enter the vendor or provider name and then enter the dollar amounts of the unpaid claims. Schedule H requires plans to report outstanding claims in four time periods: 1-30 days, 31-45 days, 46-90 days and 91 days old or greater.

EXHIBIT A1 - Analysis of Enrolled Population

Exhibit A1 is an analysis of the plan's enrollee population, from the end of the prior year to the last day of the report period, broken down by premium group. Dual Eligible and Non-Dual Eligible have been combined for the partially-capitated plans. There is also an additional line (0021) for Non-Medicaid members.

Column 03101, Total Enrollees (End of Prior Year) -- This should be the plan's reported enrollment level from the end of the prior year.

Column 03105, 'Net Shifts Among Groups', Column 03102, 'New Enrollees' and Column 03103 'Disenrollment's' are all intended to contain YTD amounts.

0003. Community– Enrollees (Duals and Non-Duals) receiving community based long term care services.

0004. Nursing Home Permanent Placement: Enrollees (Duals and Non-Duals) in need of long term placement in a nursing facility that transitioned into a Managed Long Term Plan

0010 – 0014 – Other Medicaid Enrollees - More lines have been added to allow plans to enter Medicaid enrollees that do belong in the above definitions

0020. Total Medicaid Members – The sum of the above lines 0001 through 0014

0021. Non-Medicaid Enrollees – Enrollees who are not eligible for Medicaid and whose premiums are paid for by programs or sources other than Medicaid (for example, Private Pay members).

0030. TOTAL – The sum of lines 0001-0021

For each premium group listed enter the total enrollees at the end of the prior year in Column 03101. Enter net shifts among groups YTD in Column 03105, all new enrollees YTD in Column 03102; and, enter all voluntary and involuntary disenrollments YTD in Column 03103. The totals automatically calculate for each premium group in Column 03104. Column 03105 is the net shift among groups which totals to zero.

EXHIBIT A2 – Analysis of Enrolled Population by County

Exhibit-A2 is to provide the Department with a regional and county breakdown of your plan's membership. Using the premium groups specified under Exhibit-A1, please list your plan's member months by the county listed in the first Column. Column 03207 is provided for Non-Medicaid enrollees.

EXHIBIT A3 – Hospital and Nursing Facility Utilization

This schedule reports the number of inpatient hospital days, the number of enrollees receiving care in nursing facilities and the number of nursing facility days of care.

Line No. 0001. -- Report total number of inpatient hospital days for the quarter. This should include out of area hospitalizations. Report all hospital days regardless of who pays for the stay.

Line No. 0002. -- Report the number of enrollees who received nursing facility care for one or more days during the quarter. This number should exclude those enrollees who were admitted to a nursing facility solely for respite care.

Line No. 0013. – Report the total number of admissions to nursing facility during the quarter excluding respite.

Line No 0003. -- Report the total number of nursing facility days during the quarter that were covered 100% by Medicare fee-for-service billings by the nursing facility provider.

Line No. 0004. -- Report the total number of nursing facility days during the quarter that were jointly covered by Medicare fee-for-service and the MLTC plan. These would be days of care which Medicare would be the primary payer and the program would have either co-pay or co-insurance responsibilities.

Line No. 0005. -- Report the total number of nursing facility days during the quarter that the MLTC plan was 100% responsible for payment.

Line No. 0006 -- Report the total number of nursing facility days during the quarter that responsibility for payment was with payers other then Medicare or the MLTC plan.

Line No. 0011 -- Report the total number of enrollees who received nursing facility care for respite purposes only for one or more days during the quarter.

Line No. 0012 -- Report the total number of nursing facility days of care for respite only during the quarter.

EXHIBIT A4 – Nursing Facility Discharges

Use this schedule to report number of enrollees discharged from nursing facilities during the quarter. The discharge information is categorized by death or other. The discharges should be further categorized by the total length of stay in the nursing facility of the enrollee discharged.

For partially capitated plans do not report discharges from a nursing facility if the stay was covered 100% by Medicare. Only report discharges from a nursing facility when a plan is partially or fully responsible for payment of the stay. In determining the total number of days in the nursing facility do not include days covered 100% by Medicare or other payer.

For Example: For the first quarter, if an enrollee who has been in a nursing facility for 185 days, dies, and the entire stay in the nursing facility was partially or fully covered by the plan, the discharge would be reported on line 001-Death under the column 181-365 days. However, if in the first quarter an enrollee who has been in a nursing facility for 110 days, dies, and the first 20 days of the nursing facility stay were covered 100% by Medicare, then the discharge would be reported on line 001-Death under the column 61-90 days. (110 days less 20 days not paid by plan).

EXHIBIT A5 – Personal Care Hours Year To Date

This Schedule is for reporting member months and total (paid and accrued) hours of service for the MEDICAID ENROLLEES receiving personal care services. Member months and total hours for the month should be reported based on the categories in this section. For example, on Line 0001 “700+ hours per month” please report the year-to-date number of member months in which Medicaid enrollees received 700 or more hours of personal care during the month and the total number of hours of personal care, including accrued hours, provided during those months. The total number of personal hours reported on line 10 should reconcile to the total number of units of accrued personal care services reported on Exhibit B lines 25 (Personal Care).

EXHIBIT A6 – Home Health Care Hours Year To Date

This Schedule is for reporting member months and total (paid and accrued) hours of service for the MEDICAID ENROLLEES receiving home health care services. Member months and total hours for the month should be reported based on the categories in this section. For example, on Line 0001 “700+ hours per month” please report the year-to-date number of member months in which Medicaid enrollees received 700 or more hours of home health care during the month and the total number of hours of home health care, including accrued hours, provided during those months. The total number of Home Health Care Aide hours must equal the total number of Home Health Care Aide hours reported on Exhibit B, Line 0056.

EXHIBIT A7 – CDPAP Hours Year to Date

This Schedule is for reporting member months and total (paid and accrued) hours of service for the MEDICAID ENROLLEES utilizing CDPAP services. Member months and total hours for the month should be reported based on the categories in this section. For example, on Line 0001 “700+ hours per month” please report the year-to-date number of member months in which Medicaid enrollees received 700 or more hours of CDPAP during the month and the total number of hours of CDPAP, including accrued hours, provided during those months. The total number of CDPAP hours must equal the hours of CDPAP reported on Exhibit B, Line 0045.

EXHIBIT B – Utilization of Services: Total Medicaid

<< This schedule is included only in the annual, semi-annual reports and third quarter reports. >>

Exhibit B captures the total number of times a service is used by the plan’s Medicaid enrollees during the report period. If the service is used multiple times by a plan’s Medicaid enrollee, each instance is counted.

Exhibit B for partially-capitated MLTC plans rolls up the actual and accrued numbers of services reported in the supporting Exhibit B-1 for the corresponding enrollee group (Community and Nursing Home Permanent

Placement). Exhibit B also computes the unit cost of the service and the average number of service units used per enrollee per year.

EXHIBIT B-1 – Utilization of Services: Enrollee Group

<< This schedule is included only in the annual, semi-annual reports and third quarter reports. >>

An Exhibit B-1 must be completed for each enrollee group depending upon whether the enrollee resides in the community or has been permanently placed in a nursing home.

CBLTC services are defined as: Nursing Services in the home, Home Health Care (which is further defined as traditional CHHA services such as therapies or home health aide service in the home), Personal Care Services in the home (including Level 1), Adult Day Health Care, Private Duty Nursing; and effective November 1, 2012 Consumer Directed Personal Assistance Services. Social Day Care, used as a substitute for in home Personal Care Services, is no longer considered as a CBLTC service for purposes of determining plan eligibility. Social Day Care remains a benefit in the service package.

For each service listed, please provide the following:

Total Number of Service Units (Actual): Total units of service provided to the plan's Medicaid enrollees during the report period based on claims actually paid. These amounts are carried forward to Exhibit B.

Total Number of Service Units (Actual + Accrued): This should include actual claims paid (which are reported in the actual service column) plus claims reported but not paid and incurred but not reported claims (IBNR). The accrued number of service units will always be larger than the actual.

Unit Cost: The total cost incurred providing the service, divided by the units of service provided during the report period. These amounts are computed automatically.

Average # of Service Units Used Per Enrollee Per Year - Total number of service units accrued / (total number of Medicaid member months divided by twelve). These amounts are computed automatically.

The following represent the definitions for the medical categories:

- Inpatient Medical/Surgical – NA – not a covered service under the MLTC benefit package.
- Mental Health/Substance Abuse – NA – not a covered service under the MLTC benefit package.
- Maternity Delivery – NA – not a covered service under the MLTC benefit package.
- Primary Care Physician – NA – not a covered service under the MLTC benefit package.
- Specialty Care Services – NA – not a covered service under the MLTC benefit package.
- Prenatal/Postpartum Maternity Services – NA – not a covered service under the MLTC benefit package.
- Ambulatory Surgery – NA – not a covered service under the MLTC benefit package
- Outpatient/Physical Rehab/Therapy – Each time a patient receives therapy services regardless of the number of procedures or clinicians seen. This includes physical, occupational and speech therapies but does not include mental health, drug and alcohol abuse therapy.
- Emergency Room – NA – not a covered service under the MLTC benefit package.

- Outpatient Mental Health NA – not a covered service under the MLTC benefit package.

- Outpatient Drug and Alcohol Treatment – NA – not a covered service under the MLTC benefit package.

- Dental – Each time a patient receives dental care services regardless of the number of procedures or clinicians seen.

- Home Health Care Aide and Home Health Care – Other – The number of units for provision of home health care, should be recorded in hours or visits depending on the type of service provided. In Exhibit B-1, report the total number of hours for Home Health Care Aide. Also report the total number of visits for Home Health Care – Other. The amounts for service units and costs for Home Health Care will flow from the applicable CCLN's in Exhibit B-2 by premium group.

- Nursing Facility – The number of actual and accrued days associated with institutional nursing home stays incurred by the plan during the report period.

- Transportation – Emergent – NA – not a covered service under the MLTC benefit package.

- Transportation – Non Emergent – The number of one-way trips for treatment of non-emergency medical conditions only.

- Family Planning – NA – not a covered service under the MLTC benefit package.

- Vision Care Including Eyeglasses – Each time a patient receives vision care services regardless of the number of procedures or clinicians seen. This includes optometrist services but should not include ophthalmologist visits that should be billed Fee-For-Service. In addition, a visit to pick up eyeglasses does not constitute a visit.

- Podiatry – The number of podiatry visits.

- Personal Care – The number of hours spent providing some or total assistance with such activities as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks in the enrollee's home. Services by Home Health Aides when not accompanied by skilled nursing care or rehabilitation therapy services should be reported as Personal Care.

- Consumer Directed Personal Assistance Program - The number of hours spent providing some or total assistance with such activities as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks in the enrollee's home, as directed by the enrollee. Services by Home Health Aides when not accompanied by skilled nursing care or rehabilitation therapy services should be reported as Personal Care.

- Personal Emergency Response Services – The number of electronic devices which enable enrollees to secure immediate help in the event of physical, emotional or environmental emergency.

- Home Delivered and Congregate Meals – The number of nutritionally adequate meals provided in the enrollee's home.

- Adult Day Health Care – The number of days an enrollee receives care and services provided at the adult day health care site, under the medical supervision of a physician. The enrollee must be functionally impaired, not homebound.

- Social Day Care – The number of days an enrollee attends a structured, comprehensive program that provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24-hour period.

- Other Medical Services – All other medical services not covered by other categories of service.

EXHIBIT B-2 – Total Utilization of HHC Services MLTC

<< This table is included only in the annual, semi-annual reports and third quarter reports. >>

Exhibit B-2 captures the total utilization of Home Health Care services used by the plan's enrollees during the reporting period. Home Health Care should be reported by category of who is performing the service; Home Health Care Aide or Other. If the service is used multiple times by a plan's enrollee, each instance is counted.

No data entry is required on Exhibit B-2 - Total HHC Utilization. Exhibit B-2 - Total HHC Utilization rolls up the actual and accrued numbers of HHC services by premium group reported in Exhibit B-2 –Utilization of HHC Services by Premium Group. Exhibit B-2 also computes the unit cost of the service and the average number of service units used per enrollee per year.

EXHIBIT B-2 –Utilization of HHC Services by Premium Group

<< These tables are included only in the annual, semi-annual reports and third quarter reports. >>

Exhibit B-2's must be completed for each premium group with a Medicaid PMPM capitation rate.

Home Health Care – The number of units for provision of home health care should be recorded in hours or visits depending on the type of service provided**. In Exhibit B-2, utilization is to be reported in hours for services performed by the Home Health Care Aide and in visits when performed by anyone else in Home Health Care - Other.**

If a value is entered for Home Health Care Hours or Visits on Exhibit B-2, there must be a cost associated with the Hours or Visits and the cost must be reported on Exhibit B-2.

The amounts for service units and costs will flow into the applicable Exhibit B-1 by premium group.

EXHIBIT C – Number of enrollees utilizing Services

<< This schedule is included in all reports. >>

Identify the number of enrollees **during the quarter** that used the following services. For the annual report the data on this schedule should be for the period October through December. For the Semi-Annual report, the data on this schedule should be for the period April through June. For the 3rd quarter report the data should be for the period July through September.

Nursing Facility

Line 0001. Enter enrollees that were in a Nursing Facility for the entire reporting period.

Social Day Care

Line 0002.: Enter enrollees who **ONLY** used Social Day Care Program and **did not** use Nursing Facility, Personal Care, or Consumer Directed Personal Assistance Services or Home Health Care.

Line 003: Enter enrollees who used Social Day Care Programs **as well as** Personal Care and/or Home Health Care.

Line 0012: Total of lines 0002 and 0003.

Personal Care (PC) Only

Line 0004: Enter enrollees who used **ONLY** Personal Care and **did not** use Nursing Facility, Social Day Care, Home Health Care or Consumer Directed Personal Assistance Services.

Consumer Directed Personal Assistance Program (CDPAP) Only

Line 0015: Enter enrollees who used **ONLY** Consumer Directed Personal Assistance and **did not** use Personal Care, Nursing Facility, Social Day Care, or Home Health Care

Home Health Care (HHC) Only:

Enter enrollees who **ONLY** used the following home health care services and **did not** use Nursing Facility, Social Day Care, Personal Care or Consumer Directed Personal Assistance Services.

Line 0007 - Nursing and Therapies only

Line 0008 - HHA and Nursing and/or Therapies

Line 0009 - Total Home Health Care (sum of 2 previous lines)

Personal Care and Home Health Care Only –

Line 0010 – Enter enrollees who used both Personal Care **and** Home Health Care but **did not** use Nursing Facility or Social Day Care.

Nursing Facility and Personal Care or Home Health Care -

Line 0013 – Enter the number of enrollees who were in a Nursing Facility for part of the quarter and also used Personal Care or Home Health Care.

Enrollees who did not use Social Day Care, Personal Care, Home Health Care, or Nursing Facilities -

Line 0011 - Number of enrollees who **did not** use Social Day Care, Personal Care, Home Health Care or any Nursing Facility.

Line 0014 - Total Number of Enrollees – The software will calculate the total number of enrollees using services by summing lines 1, 4, 9, 10, 13 and 11.

APPENDIX A

Medicaid Managed Care Benefit Regions for the MLTC Program

New York Metro	Mid-Hudson/ Northern Metro	Northeast/ Western		Rest of State			
Bronx	Dutchess	Albany	Onondaga	Allegany	Columbia	Jefferson	Schuyler
Kings	Orange	Erie	Orleans	Broome	Cortland	Lewis	Seneca
Nassau	Putnam	Fulton	Rensselaer	Cattaraugus	Delaware	Livingston	Steuben
New York	Rockland	Genesee	Saratoga	Cayuga	Essex	Oneida	St. Lawrence
Queens	Sullivan	Madison	Schenectady	Chautauqua	Franklin	Ontario	Tioga
Richmond	Ulster	Monroe	Warren	Chemung	Greene	Oswego	Tompkins
Suffolk		Montgomery	Washington	Chenango	Hamilton	Otsego	Wayne
Westchester		Niagara	Wyoming	Clinton	Herkimer	Schoharie	Yates