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07/2010

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SECTION A
REPORTS

The State has defined operational and financial reports the contractor must submit. The reports in this section are those for which the State has a defined format or template or multiple data elements. The reports are referenced according to the contract Article to which they correspond, beginning with Article 3. In cases where a specific report format or template does not exist, the State instead has defined required report elements, all of which must be addressed in full. The actual structure of such reports is being left to the discretion of the contractor with prior DMAHS approval. Note that additional reports are required and described in the contract.

A.4.0 Provision of Health Care Services

A.4.1 Provider Network File

Electronic Media Provider Files

There are two provider file layouts; **Non-Institutional** and **Institutional**. Each file type should include all counties in which the contractor will be operational for Medicaid and NJ FamilyCare. Contractors will be required to submit complete and up-to-date network files to DMAHS.

Non-Institutional Provider Network Files must include all health care professionals – Primary Care Practitioners (PCPs), physician specialists, general dentists, dental specialists, other health care professionals such as optometrists, chiropractors, therapists, etc. with appropriate primary care or specialty care indicators.

The Institutional Network File must include all other ancillary, hospitals, and specialty care providers.

All provider files must be submitted in an electronic format, in ASCII text fixed-width format according to the specifications in Attachments A & B. Please note that field names are not carried with the data in this format. Therefore, it is not necessary to use the field names as they appear. However, it is imperative to use the specified field order and sizes (i.e. the full structure) even if only submitting a subset of your network. You must allow for the specified number of spaces for every requested data field.

File names are to conform to the following convention. (e.g. @***####.txt)

where @ = 'i' for institutional or 'n' for non-institutional.
where *** = plan code
where #### = month and day

ATTACHMENT A

HMO Non-Institutional Provider Network File Specifications

Non-Institutional					
Field	**Field Name**	**Size**	**When Required**	**Definition**	**Example**
1	Last Name	22	A	Individual Provider's Surname; may include Jr. or III. Name of group or medical school is unacceptable.	Jones, Jr.
2	First Name	15	A	Provider's First Name; should include middle initial. Name of group or medical school is unacceptable.	Tom T.
3	SSN	9	B	Provider's Social Security Number (SSN). Do not use hyphens or spaces.	150999999
4	Tax ID	9	B	Provider's Tax ID Number. Do not use hyphens or spaces.	229999999
5	Degree	5	A	MD, DO, etc. Do not use periods.	DO
6	Primary	1	A	Is this a primary care provider? (Y or N) Do not indicate Y for dental providers.	Y
7	Practice Name	45	B	Name of Practice if different than provider's last name	Jones Family Practice
8	Address 1	60	A	Place/physical street address where services are rendered. Always start with street number if one is contained in the actual address of the practice. "Serving This Area" is not acceptable.	225 Main St.
9	Address 2	30	B	Building Name, PO Box etc.	Suite 3
10	City	22	A	Proper Name for Municipality in which practice office is located. No abbreviations.	South Orange
11	State	2	A	Two Character State Abbreviation, NJ or other with rare exceptions	NJ
12	Zip	5	A	Five (5) Digit Zip Code	08888
13	Phone	10	A	For service address, include Area Code, Prefix & Number. No spaces or dashes.	6095882705
14	County	2	A	Two (2) digit code for county in which office is actually located	07
15	Office Hours	63	A	List days and hours when patients can be seen at this site.	M9-5, T1-5, Th1-7,
16	Specialty Code	3	A	See NJ DMAHS OMHC Specialty Codes list. Submit only one (1) Specialty Code per record.	123
17	Age Restrictions	4	B	Specialty code in string field 16, 1st 2 = min age, 2nd 2 = max age, 0000 if none for a specialty. Omit if no specialty is limited.	1234
18	Hosp Affl1	5	B	Hospital Code where provider has admitting privileges. *Required for Physicians, Podiatrists & Oral Surgeons.	A1234
19	Hosp Affl2	5	B	If more than One	A1234
20	Hosp Affl3	5	B	If more than Two	A1234
21	Hosp Affl4	5	B	If more than Three	A1234
22	Hosp Affl5	5	B	If more than Four	A1234
23	Languages	10	A	Must be at least one even if English; See Language Code List. No Spaces/Commas/Slashes/Hyphens, etc.	EFG9
24	Plan Code	3	A	Three (3) Digit Plan Code	099
25	Panel Status	1	A	O = Open (accepting new patients) C= Closed (not accepting new patients)	O
26	Specialty Name	30	B	Show one narrative specialty name per record.	Family Practice
27	Panel Capacity	4	B	Potential Number of Members: PCPs & General Dentists, should not exceed 2000 unless authorized by DMAHS. PCPs and PCDs.	2000
28	Members Assigned	4	B	Actual Number of Members Assigned: PCPs & PCDs.	900
29	Record Type	3	B	a = addition of record to file (excludes d) c = information in unique provider record has been updated d = deletion of record from file (excludes a & c) s = multiple listing of provider, unique specialty l = multiple listing of provider, unique location Use all that apply. No commas. No punctuation.	sa
30	Date	10	A	Fill with date Network Update File or Application Network File was submitted to DMAHS mm/dd/yyyy	06/01/2000
31	Servicing County	2	A	If other than actual county; include a record for each county served. Out-of-county physicians may not be considered in applications except where specified in the contract.	01
32	Total Hours	2	B	Total number of hours for record. Round down. PCPs and PCDs.	20
33	Medicaid ID	7	B	Provider's Medicaid-assigned ID	1234567

34	Special Needs Code	5	A	Indicates provider has expertise serving specific populations. Use all OMHC special needs codes that apply to provider, including D=developmental disabilities, A=Aged and H=HIV and/or AIDS. N = None. If "N", cannot contain other codes.	AD
35	Handicapped Accessible	1	C	Use Y if facility is Handicapped Accessible	***Y***
36	Taxonomy Code	10	A	Health Care Provider Taxonomy Code Alpha-Numeric according to specifications.	1234567890
37	NJ State License Number	12	A	New Jersey State License NumberAlpha-Numeric.	12AB12345678
38	Out of State License	12	B	Used when the HMO Provider is located or services are provided outside of New Jersey	Alpha-Numeric
39	Alternative Provider Indicator	1	A	"Y" if Provider is being reported as an Alternative Provider. The Taxonomy and Specialty Code submitted with the record should reflect the appropriate services provided. "N" if Provider is not being reported as an Alternative Provider.	Y
40	Individual (NPI)	10	A	10-position all numeric identification number assigned by the National Plan and Provider Enumeration System (NPPES) to uniquely identify a health care provider Numeric. If not individual NPI, must submit reason to the State.	1234567890
41	Latitude	8	A	Decimal degrees without the decimal (.) and without (-) the minus sign. Numeric	74144259
42	Longitude	8	A	Decimal degrees without the decimal (.) and without (-) the minus sign. Numeric	74144259
43	Record ID	5	A	A unique numeric field, sequential by integer. The sequence should start with one (1) and increase by one (1) for each record submitted.	1, 2, … 99999
44	Group NPI	10	B	10 Position all numeric identification number assigned by the National Plan and Provider Enumeration System (NPPES) to uniquely identify a health care provider. Numeric. Must submit Group NPI if any affiliation with a group.	1234567890

A = Always Required B = Required When Applicable C = Optional

ATTACHMENT B

HMO Institutional Provider Network File Specifications

Institutional

Field	Field Name	Size	When Required	Definition	Example
1	Provider Name	45	A		Doc's Drugs
2	Provider Type	30	A		Pharmacy
3	Provider Tax ID	9	A	Provider's Tax ID Number	229999999
4	Address1	60	A	Always start with street number if one is contained in the actual physical street address of the practice. "Serving This Area" is not acceptable.	22 Main St.
5	Address2	30	B	Building Name, PO Box, etc.	Suite 3
6	City	22	A	Proper Name for Municipality in which practice office is located. No abbreviations.	South Orange
7	State	2	A	Two Character State Abbreviation, NJ with rare exceptions	NJ
8	Zip	5	A	Five (5) Digit Zip Codes	08888
9	Phone	10	A	Include Area Code, Prefix & Number. No spaces or dashes.	6095882705
10	County	2	A	Two (2) digit code for county in which office is actually located	07
11	Plan Code	3	A	Three (3) Digit Plan Code	099
12	Specialty Code	3	A	See NJ DMAHS OMHC Specialty Codes list. Submit only one (1) Specialty Code per record.	500
13	Servicing County	2	A	If other than actual county; include a record for each county served. Out-of-county institutions may not be considered in applications except where specified in the contract.	01
14	Date	10	A	Fill with date Network Update File or Application Network File was submitted to DMAHS mm/dd/yyyy	06/01/2000
15	Record Type	3	B	a = addition of record to file (excludes d) c = information in unique provider record has been updated d = deletion of record from file (excludes a) s = multiple listing of provider, unique specialty 1 = multiple listing of provider, unique location Use all that apply. No commas. No punctuation.	sa
16	Medicaid ID	7	B	Provider's Medicaid-assigned ID	1234567
17	Institutional Code	5	B	Use appropriate Hospital or FQHC Parent Site Code, reference Attachment E or Attachment F	A1234
18	Taxonomy Code	10	A	Health Care Provider Taxonomy Code Alpha-Numeric according to specifications.	1234567890
19	NJ State License Number	12	A	New Jersey State License Number Alpha-Numeric.	12AB12345678
20	Out of State License	12	B	Used when the HMO Provider is located or services provided outside of New Jersey	Alpha-Numeric
21	Alternative Provider Indicator	1	A	"Y" if Provider is being reported as an Alternative Provider. The Taxonomy and Specialty Code submitted with the record should reflect the appropriate services provided. "N" if Provider is not being reported as an Alternative Provider.	Y
22	Individual NPI	10	B	10-position all numeric identification number assigned by the National Plan and Provider Enumeration System (NPPES) to uniquely identify a health care provider Numeric If no individual NPI, must submit reason to the State.	1234567890
23	Latitude	8	A	Decimal degrees without the decimal (.) and without (-) the minus sign Numeric.	74144259
24	Longitude	8	A	Decimal degrees without the decimal (.) and without (-) the minus sign Numeric.	74144259
25	Record ID	5	A	A unique numeric field, sequential by integer. The sequence should start with one (1) and increase by one (1) for each record submitted.	1, 2, … 99999
26	Group NPI	10	B	10-position all numeric identification number assigned by the Naterail Plan and Provider Enumeration System (NPPES) to uniquely, identify a health care provider. Numeric. Must submit Group NPI if any affiliation with a group.	1234567890

A – Always Required

B – Required When Applicable
C – Optional

Attachment C
Specialty Codes
N=Non-Institutional I=Institutional

Code	Network	Specialty		Code	Network	Specialty
000	N	Unknown		142	I	SpinaBifida Centers/Provider
010	N	General Practice		143	I	Adult Scoliosis
020	N	General Surgery		145	I	Spinal Cord Injury
021	N	Surgery, Pediatric		150	N	Certified Nurse Midwife
030	N	Allergy		160	N	OB/GYN
031	N	Ped Allergy		162	N	NP OB/GYN
032	I	Medical Toxicology		164	N	NP Women's Health
034	N	Infectious Disease		165	I	Maternal Fetal Medicine
035	N	Pediatric Infectious Disease		166	N	NP Maternity/Child Health
036	N	Endocrinology		167	N	Genetics
037	N	Reproductive Endocrinology		168	I	Genetic Testing & Counseling Center
038	N	Pediatric Endocrinology		170	N	Ophthalmology, Otology, Laryngology, Rhinology (Osteopaths Only)
040	N	Otology, Laryngology, Rhinology, Otolaryngology/ENT		180	N	Ophthalmology
041	N	ENT Pediatric		181	N	Ped Ophthalmology
042	N	Speech		190	N	NP Gerentology
043	N	Audiology		191	N	Geriatrics
050	N	Anesthesiology		200	N	Orthopedics
051	N	Ped Anesthesiology		201	N	Pediatric Orthopedics
060	N	Cardiology, Cardiovascular Disease		204	N	Rheumatology
061	N	Pediatric Cardiology		205	N	Ped Rheumatology
070	N	Dermatology		210	N	Clinical Pathology
080	N	Family Practice		220	N	Pathology
082	N	NP Family		223	I	Hemophilia Treatment Center
090	N	Gynecology (Osteopaths Only) – Fetal Medicine		224	I	HIV/AIDS Center
100	N	Gastroenterology		225	I	Pediatric HIV Treatment Center
101	N	Pediatric Gastroenterology		226	I	Sickle Cell Disease & Other Hemoglobinopathies Centers
110	N	Internal Medicine		230	N	Peripheral Vascular Disease or Surgery (Osteopaths Only)
120	N	Manipulative Therapy (Osteopaths Only)		232	N	Cardiovascular Surgery
130	N	Neurology		240	N	Plastic Surgery
131	N	Neurology Pediatric		250	N	Physical Medicine
140	N	Neurosurgery		251	I	Pediatric Physical Medicine

Code	Network	Specialty		Code	Network	Specialty
141	N	Pediatric Neurosurgery		260	N	Psychiatry
262	N	NP Psychiatric Mental Health		402	N	Sports Medicine
270	N	Psychiatry; Neurology (Osteopaths Only)		404	N	Pain Management
280	N	Proctology		410	N	Emergency Medicine
282	N	Colon/Rectal Surgery		412	N	Critical Care Medicine
290	N	Pulmonology		420	N	Heterogeneous Group
291	N	Ped Pulmonology		440	N	Public Health
300	N	Radiology		450	N	NP Community Health
302	N	NP Oncology		460	N	NP School Health
303	N	Radiation Oncology		470	N	NP Adult Health
305	N	Gynecologic Oncology		480	N	Podiatry
306	N	Hematology		490	N	Miscellaneous (Admin. Medicine)
307	N	Ped Hematology		500	I	Pharmacy
308	N	Oncology		510	I	Medical Supply Company with Certified Orthotist
309	N	Pediatric Oncology		470	N	NP Adult Health
310	N	Roentgenology, Radiology (Osteopaths Only)		520	I	Medical Supply Company with Certified Prosthetist
320	N	Radiation Therapy (Osteopaths Only)		530	I	Medical Supply Company with Certified Prosthetist Orthotist
330	N	Thoracic Surgery		531	N	Pedorthist
331	N	Ped Thoracic Surgery		540	I	Medical Supply Company-Not Incl. Included in 510, 520, 530
340	N	Urology		545	I	Durable Medical Equipment
341	N	Pediatric Urology		550	N	Individual Certified Orthotist
350	N	Chiropractor		560	N	Individual Certified Prosthetist
360	N	Nuclear Medicine		570	N	Individual Certified Prosthetist Orthotist
370	N	Pediatrics		580	N	Individual Not Included in 550, 560, 570
371	N	Adolescent Medicine		590	I	Ambulance Service Supplier, Private
372	N	NP Pediatric		600	I	Welfare Agencies & Clinics
373	N	Neonatology		610	N	Psychologist
374	N	NP Neonatal		580	I	Individual Not Included in 550, 560, 570
375	N	Perinatology		611	N	Child Development
376	N	NP Perinatal		612	I	Psychological Services
380	I	Home Health Agency		620	N	Individual Physical Therapist
390	N	Nephrology		622	N	Individual Occupational Therapist
391	N	Pediatric Nephrology		623	N	Speech Pathologist

Code	Network	Specialty		Code	Network	Specialty
400	N	Hand Surgery		624	N	Audiologist
625	I	Hearing Aid Provider		820	I	Private Duty Nursing
630	N	Dentist, DDS, DMD		822	I	Adult Liaison Services
640	N	Oral Surgeon, Dental		824	I	Child Liaison Services
642	N	Maxilofacial Surgery		830	I	Intensive Supervision
645	I	Cleft Lip/Palate – Craniofacial Center		831	I	ABC Waiver
650	N	Endodontist		840	I	Special Group Foster Home
660	N	Orthodontist		850	I	Hospice
670	N	Prosthodontist		860	I	Hospitals
680	N	Pedodontist		861	I	Nursing Home
690	N	Periodontist		862	I	Respite
700	I	Independent Laboratory (billing independently)		864	I	TBI Respite Inpatient
705	I	Radiology Center		868	I	Subacute Care Facility
710	N	Clinic or Other Group Practice, Except GPP		870	N	All Other
720	I	Personal Care Assistance - Aged & Disabled		871	I	Pediatric Tertiary Center
722	I	Personal Care Assistance - Mental Health		872	I	Child Abuse Regional Diagnosis Center
725	I	Day Training		873	I	Lead Poisoning Treatment Center
728	I	Transportation Services		875	I	Organ Transplant Provider/Center
730	I	Early Intervention		87A	I	Organ Transplant - Liver
740	I	Special Education		87B	I	Organ Transplant - Lung
741	I	Child Development/Child Eval. Ctr.		87C	I	Organ Transplant - Heart
743	I	Autism and Attention Deficits		87D	I	Organ Transplant - Heart-Lung
744	I	Center for Care of Children with PKU		87E	I	Organ Transplant - Pancreas
750	I	Other Medical Care		87F	I	Organ Transplant - Kidney
760	I	Adult Day Care		87G	I	Organ Transplant - Cornea
762	I	TBI Day Program		87H	I	Organ Transplant - Intestine
770	I	Medical Day Care – Free Standing		87I	I	Organ Transplant - Bone Marrow including Autologous Bone Marrow Transplants
780	I	Medical Day Care – Hospital Based		880	I	Optician
790	I	Medical Day Care – LTC Based		881	I	Optical Appliance Provider
800	I	Renal Dialysis		890	N	Optometrist
810	I	Case Management – GSHP		910	I	Independent Clinic – Ambulatory Surgery Ctr
812	I	Case Management – CCPED		920	I	Independent Clinic – Drug/Alcohol
813	I	Child Clinic Case Management		930	I	Independent Clinic – Family Planning
814	I	Case Management – Model Waivers		940	I	Independent Clinic – Mental Health
816	I	Case Management – ACCAP		950	I	Federally Qualified Health Center (FQHC)

Code	Network	Specialty		Code	Network	Specialty
817	I	TBI Case Management		955	I	School-Based Health Service Programs
819	I	Adult Clinic Case Management		960	I	Independent Clinic – Cerebral Palsy
965	I	Independent Clinic – Birthing Center		985	I	TBI Behavior Program
970	I	DOH Clinic		986	I	TBI Community Residential Services
980	I	Home Health – CCPED/Home Care Expansion		987	I	TBI Transportation
982	I	Homemaker – CCPED		988	I	TBI Therapies
983	I	TBI Environmental Modification		989	I	TBI Counseling
984	I	TBI in Home Care		990	N	All Specialties

Providers should be listed in the appropriate files as indicated in the Network column.
Note: this categorization of providers is only relevant for network processing for DMAHS Office of Quality Assurance (OQA). This does not affect the Institutional or Non-Institutional classifications with regard to billing, payment, etc.

ATTACHMENT D

NJDHS, DMAHS, OMHC
Provider Network File Codes

Language Codes

A	Arabic
B	Hebrew
C	Chinese
D	Greek
E	English
F	French
G	German
H	Hindi
I	Italian
J	Hungarian
K	Korean
L	Polish
M	Tagalog
N	Japanese
O	Pakistani
P	Portuguese
Q	Indian
R	Filipino
S	Persian
T	Russian
U	Danish
V	Spanish/No English
W	Turkish
X	Vietnamese
Y	Yugoslavian
Z	Other
0	American Sign Language
1	Swedish
2	Spanish/Understands English
3	Ukranian
4	Dutch
5	Urdu
6	Romanian
7	Mandann
8	Iranian
9	Thai

County Codes

01	Atlantic
02	Bergen
03	Burlington
04	Camden
05	Cape May
06	Cumberland
07	Essex
08	Gloucester
09	Hudson
10	Hunterdon
11	Mercer
12	Middlesex
13	Monmouth
14	Morris
15	Ocean
16	Passaic
17	Salem
18	Somerset
19	Sussex
20	Union
21	Warren
99	Out of State

ATTACHMENT E
Hospital Code List

Hospital Name	County Location	Codes
Ancora Psychiatric Hospital	Atlantic	P0101
AtlantiCare Regional Medical Center-City Division	Atlantic	H0102
AtlantiCare RegionalMedical Center-Mainland Division	Atlantic	H0103
Bacharach Institute for Rehabilitation	Atlantic	R0104
Shore Memorial Hospital	Atlantic	H0105
William B. Kessler Memorial Hospital	Atlantic	R0106
Bergen Regional Medical Center	Bergen	H0201
Englewood Hospital and Medical Center	Bergen	H0202
Hackensack University Medical Center	Bergen	H0203
Holy Name Hospital	Bergen	H0204
Kessler Institution for Rehabilitation-Kessler Saddle Brook	Bergen	R0205
Ramapo Ridge Psychiatric Hospital – Christian Health Care Center	Bergen	P0207
Select Specialty Hospital – Northeast New Jersey	Bergen	S0208
The Valley Hospital	Bergen	H0209
Lourdes Medical Center of Burlington County	Burlington	H0301
Deborah Heart and Lung Center	Burlington	S0302
Hampton Behavioral Health Center/Universal Health Services	Burlington	P0303
Marlton Rehabilitation Hospital	Burlington	R0304
Virtua-Memorial Hospital Burlington County	Burlington	H0305
Virtua-West Jersey Hospital-Marlton	Burlington	H0306
Weisman Children’s Rehabilitation Hospital	Burlington	R0307
The Cooper Health System	Camden	H0401
Kennedy Memorial Hospital-UMC Cherry Hill	Camden	H0402
Kennedy Memorial Hospital-UMC Stratford	Camden	H0403
Our Lady of Lourdes Medical Center	Camden	H0404
Virtua West Jersey Hospital-Berlin	Camden	H0405
Virtua West Jersey Hospital-Voorhees	Camden	H0406
Cape Regional Medical Center	Cape May	H0501
South Jersey Healthcare-Regional Medical Center	Cumberland	H0602
Clara Maass Medical Center	Essex	H0701
East Orange General Hospital	Essex	H0703

Hospital Name	County Location	Codes
Kessler Institution for Rehabilitation-Kessler West	Essex	R0706
Newark Beth Israel Medical Center	Essex	H0707
St. Barnabas Medical Center	Essex	H0708
St. Michael's Medical Center	Essex	H0710
The Mountainside Hospital	Essex	H0711
UMDNJ-University Hospital	Essex	H0712
VA New Jersey Health Care System-East Orange	Essex	V0713
Kennedy Memorial Hospitals-UMC Washington Township	Gloucester	H0801
Underwood Memorial Hospital	Gloucester	H0802
Bayonne Medical Center	Hudson	H0901
Christ Hospital	Hudson	H0902
Hudson County Meadowview Hospital	Hudson	P0903
Liberty Health-Jersey City Medical Center	Hudson	H0905
Liberty Health-Meadowlands Hospital	Hudson	H0906
Palisades Medical Center	Hudson	H0907
Hoboken University Medical Center	Hudson	H0908
Hunterdon Medical Center	Hunterdon	H1001
Senator Garrett W. Hagedorn Psychiatric Hospital	Hunterdon	P1002
Capital Health System-Fuld Campus	Mercer	H1101
Capital Health System-Mercer Campus	Mercer	H1102
University Medical Center at Princeton	Mercer	H1103
Robert Wood Johnson University Hospital at Hamilton	Mercer	H1104
St. Francis Medical Center	Mercer	H1105
St. Lawrence Rehabilitation Center	Mercer	R1106
Trenton Psychiatric Hospital	Mercer	P1107
JFK Medical Center	Middlesex	H1201
Raritan Bay Medical Center-Old Bridge	Middlesex	H1202
Raritan Bay Medical Center-Perth Amboy	Middlesex	H1203
Robert Wood Johnson University Hospital-New Brunswick	Middlesex	H1204
St. Peter's University Hospital	Middlesex	H1205
JFK Johnson Rehabilitation Institute	Middlesex	R1206
University Behavioral HealthCare-UMDNJ	Middlesex	P1207
Bayshore Community Hospital	Monmouth	H1301

Hospital Name	County Location	Codes
CentraState Healthcare System	Monmouth	H1302
Jersey Shore University Medical Center	Monmouth	H1303
Monmouth Medical Center	Monmouth	H1304
Riverview Medical Center	Monmouth	H1305
Specialty Hospital at Monmouth	Monmouth	R1306
Atlantic Rehabilitation Institute	Morris	R1401
Morristown Memorial Hospital	Morris	H1402
St. Clare's Health Services-Denville	Morris	H1403
Greystone Park Psychiatric Hospital	Morris	P1404
Kessler Institute for Rehabilitation -Kessler Chester	Morris	R1405
St. Clare's Hospital-Dover	Morris	H1406
Chilton Memorial Hospital	Morris	H1407
Community Medical Center	Ocean	H1501
Kimball Medical Center	Ocean	H1502
Meridian Health-Ocean Medical Center	Ocean	H1503
Southern Ocean County Hospital	Ocean	H1504
HEALTHSOUTH Rehabilitation Hospital of Toms River	Ocean	R1505
St. Barnabas Behavioral Health Network	Ocean	P1506
St Joseph's Regional and Medical Center-Paterson	Passaic	H1603
St. Joseph's Wayne Hospital	Passaic	H1604
St. Mary's Hospital-Passaic	Passaic	H1605
South Jersey Healthcare-Elmer Hospital	Salem	H1701
The Memorial Hospital of Salem County	Salem	H1702
Carrier Clinic	Somerset	P1801
The Matheny Medical and Education Center	Somerset	S1802
Somerset Medical Center	Somerset	H1803
VA New Jersey Health Care System-Lyons	Somerset	V1804
Newton Memorial Hospital	Sussex	H1901
St. Clare's Hospital/Sussex	Sussex	H1902
Overlook Hospital	Union	H2002
Robert Wood Johnson University Hospital at Rahway	Union	H2003
Trinitas Hospital-Williamson Street Campus	Union	H2004
Runnells Specialized Hospital	Union	S2007

Hospital Name	County Location	Codes
Summit Oaks Hospital	Union	P2008
Hackettstown Regional Medical Center	Warren	H2101
Warren Hospital	Warren	H2102

ATTACHMENT F

FQHC Parent Site Code List

FQHC Name	County	Code
AtlantiCare Health Services	Atlantic	F0101
Southern Jersey Family Medical Centers	Atlantic	F0102
CAMcare Health Corporation	Camden	F0401
Project Hope, Inc	Camden	F0402
Community Health Care, Inc	Cumberland	F0601
Newark Community Health Centers, Inc	Essex	F0701
Newark Homeless Health Care	Essex	F0708
Horizon Health Center	Hudson	F0901
North Hudson Community Action Corporation Health Care	Hudson	F0902
Metropolitan Family Health Network	Hudson	F0903
Henry J. Austin Health Center, Inc	Mercer	F1101
Eric B. Chandler Health Center	Middlesex	F1201
Jewish Renaissance Health Center	Middlesex	F1202
Monmouth Family Health Center	Monmouth	F1301
Visiting Nurse Assn. of Central Jersey Community Health Center	Monmouth	F1302
Zufall Health Center	Morris	F1401
Lakewood Resource and Referral Center – CHEMED	Ocean	F1501
Ocean Health Initiatives, Inc.	Ocean	F1502
Patterson Community Health Center	Passaic	F1601
Neighborhood Health Center Plainfield	Union	F2001

A.4.2 Organ Transplant Procedure

ORGAN TRANSPLANTATION BILLING POLICY AND PROCEDURE

Policy

1. Responsibility for Medicaid/NJ FamilyCare HMO beneficiaries' inpatient hospital costs (donor and recipient) resides with the HMO, with one exception, below.

2. Exception: Fee-for-Service (FFS) Medicaid will pay for transplant-related donor and recipient inpatient hospital costs for an individual placed on a transplant list (solid organs), or having a physician's written affirmative decision for transplant (non-solid organs, and other specific circumstances where no transplant list exists), while in the Medicaid FFS program prior to initial enrollment in the contractor's plan.

3. For individuals already enrolled in an HMO who transfer to another HMO, Medicaid FFS will **not** pay for the transplant-related costs referenced in number 1, above, regardless of timing of placement on list, or timing of a written affirmative decision for transplant. The HMOs involved themselves must settle such cases.

4. For individuals enrolled in an HMO who briefly (i.e., less than 60 days) return to FFS Medicaid, for any reason, and subsequently return to the HMO, FFS Medicaid will not pay for any transplant-related costs referenced in number 1, above. The costs remain the responsibility of the HMO.

Definitions

Non-solid Organs – includes blood, bone marrow, peripheral stem cells, and umbilical cord cells.
Organ Procurement and Transplanting Network (OPTN) – a national organ transplantation network administered by the United Network for Organ Sharing (UNOS) consisting of the national patient organ transplantation waiting list and an organ placement center.
Solid Organs – vascularized organs, including: liver, kidney, pancreas, heart, lung, and intestine.
United Network for Organ Sharing (UNOS) – a private nonprofit organization under contract with the US Department of Health and Human Services to administer the Organ Procurement and Transplanting Network (OPTN). UNOS is responsible for the national patient organ transplantation waiting list and the computerized organ allocation system.

Procedures for Billing

1. The HMO will submit a completed DMAHS Transplantation Billing Request (FD-403 -- attached) to the DMAHS Office of Utilization Management (OUM). For transplant of solid organs, the HMO's submittal must include proof of the date of UNOS entry. This may include a copy of the list with a dated entry, or a copy of a confirmation from the transplant facility indicating that an enrollee has been added to the list. (Patients should receive confirmation of their placement on the national waiting list from their transplant hospital. UNOS does not send written confirmation of status to patients.)

   For circumstances where there does not exist a centralized list or equivalent (i.e., non-solid organs, related donor, etc.), the verification process will vary depending on the specific circumstances of the transplant. However, for each transplant, there should exist a physician's written affirmative decision for transplant. The HMO shall be responsible for providing documentation to support the date of transplant decision with the fully completed FD-403 request form.

2. The DMAHS OUM will be responsible for review and approval of the FD-403, and notification to the HMO of the disposition of the request.

DEPARTMENT OF HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

TRANSPLANTATION BILLING REQUEST

HMO REQUESTING APROVAL: _____

HMO CARE MANAGER: _____

TELEPHONE: _____

E-MAIL ADDRESS: _____

BENEFICIARY NAME: _____

BENEFICIARY MEDICAID I.D. NUMBER: _____

BENEFICIARY ADDRESS: _____

_____

_____

BENEFICIARY DOB: _____

TYPE OF TRANSPLANT: _____

TRANSPLANT PROGRAM/FACILITY NAME: _____

PCP NAME: _____

PCP ADDRESS: _____

PCP TELEPHONE: _____

DATE OF UNOS ENTRY (SOLID ORGAN): _____
(ATTACH PROOF OF ENTRY)

DATE OF AFFIRMATIVE DECISION: _____
(NON-SOLID)

OTHER INSURANCE: _____

POLICY I.D. NUMBER: _____

POLICY GROUP NUMBER: _____

FD-403 **REV: 07/03**

A.4.3 Network Accessibility Analysis

Network Accessibility Analysis for New Jersey Medicaid/NJ FamilyCare

To enable DMAHS to accurately compare the accessibility of each contractor's managed care networks for New Jersey Medicaid/NJ FamilyCare, the contractor's analysis must meet the following data standards and report specifications.

A – Data Standards

1) The contractor should use the most recent eligibility data files provided by DMAHS. The contractor must geocode each member by street address to assure accuracy and consistency between respondents' analyses. The file contains eligibility information for each county within the State.

2) All contractor's network provider addresses should be exactly geocoded. For any address that cannot be exactly geocoded, the address should be geocoded using a technique that takes into account population density. Placing providers at zip code centroids or randomly within zip codes is not acceptable.

3) If more than one provider is located at the same address, all providers at that address should have the same geographic coordinates.

4) Physicians should be classified based on their primary specialty only. For example, a pediatric cardiologist should be classified as cardiologist, not a pediatrician.

5) The provider file must include the capacity for each primary care provider/general dentist.

6) For providers who have more than one office location, indicate each location by a separate record in the provider file. Divide the capacity of the provider by the number of locations. For example, if the provider capacity is 150, and the provider has two offices, each office would have a capacity of 75. The "individual capacity" option should be used when reporting PCPs/PCDs.

B – Report Specifications

1) Prepare a separate geographic accessibility analysis for each county. Separate analyses are required as follows:

a. Adult PCPs (FP, GP, IM) for ages 21 and up

Page Code	Access Standard	Description
1	--	This cover page of each report includes plan name, county, beneficiary group and date.
2	--	This page uses a graph to illustrate the percentage of beneficiaries who have access to a group of providers at various distances. It includes a table showing the average distances to the nearest choices of one, two, three, four and five providers.
3	--	This page shows, by zip code, the average distance for beneficiaries to two providers and the percentage of beneficiaries having two providers within 2, 6, 10 and 15 miles.
4	Urban	This page shows the number of providers, the number of beneficiaries with access to two providers and the average distance to up to five providers for beneficiaries with access. It also analyzes beneficiary accessibility in ten key cites.
5	Urban	This page shows, by zip code, the number and percentage of beneficiaries who do not have access to a choice of two providers and the average distance to one and two providers.
6	Non-Urban	This page shows the number of providers, the number of beneficiaries with access to one provider and the average distance to up to five providers for beneficiaries with access. It also analyzes beneficiary accessibility in ten key cites.
7	Non-Urban	This page shows, by zip code, the number and percentage of beneficiaries who do not have access to one provider and their average distance to one provider.
8	--	This includes documentation about the report and its data sources.
9	Urban	This county map shows beneficiary locations for those who do not have access to two providers. Use 2 point black circles for beneficiaries.

b. Pediatric PCPs (FP, Ped, and GP) Children under age 21

Page Code	Access Standard	Description
1	--	This cover page of each report includes plan name, county, beneficiary group and date.
2	--	This page uses a graph to illustrate the percentage of beneficiaries who have access to a group of providers at various distances. It includes a table showing the average distances to the nearest choices of one, two, three, four and five providers.

Page Code	Access Standard	Description
3	--	This page shows, by zip code, the average distance for beneficiaries to two providers and the percentage of beneficiaries having two providers within 2, 6, 10 and 15 miles.
4	Urban	This page shows the number of providers, the number of beneficiaries with access to two providers and the average distance to up to five providers for beneficiaries with access. It also analyzes beneficiary accessibility in ten key cities.
5	Urban	This page shows, by zip code, the number and percentage of beneficiaries who do not have access to a choice of two providers and the average distance to one and two providers.
6	Non-Urban	This page shows the number of providers, the number of beneficiaries with access to one provider and the average distance to up to five providers for beneficiaries with access. It also analyzes beneficiary accessibility in ten key cities
7	Non-Urban	This page shows, by zip code, the number and percentage of beneficiaries who do not have access to one provider and their average distance to one provider
8	--	This includes documentation about the report and its data sources
9	Urban	This county map shows beneficiary locations for those who do not have access to two providers. Use 2 point black circles for beneficiaries.

c. General Dentists

Page Code	Access Standard	Description
1	--	This cover page of each report includes plan name, county, beneficiary group and date.
2	--	This page uses a graph to illustrate the percentage of beneficiaries who have access to a group of providers at various distances. It includes a table showing the average distances to the nearest choices of one, two, three, four and five providers.
3	--	This page shows, by zip code, the average distance for beneficiaries to two providers and the percentage of beneficiaries having two providers within 2, 6, 10 and 15 miles.
4	Urban	This page shows the number of providers, the number of beneficiaries with access to two providers and the average distance to up to five providers for beneficiaries with access. It also analyzes beneficiary accessibility in ten key cities.
5	Urban	This page shows, by zip code, the number and percentage of beneficiaries who do not have access to a choice of two providers and the average distance to one and two providers.
6	Non-	This page shows the number of providers, the number of

Page Code	Access Standard	Description
	Urban	beneficiaries with access to one provider and the average distance to up to five providers for beneficiaries with access. It also analyzes beneficiary accessibility in ten key cities
7	Non-Urban	This page shows, by zip code, the number and percentage of beneficiaries who do not have access to one provider and their average distance to one provider
8	--	This includes documentation about the report and its data sources
9	Urban	This county map shows beneficiary locations for those who do not have access to two providers. Use 2 point black circles for beneficiaries.

d. Hospitals

Page Code	Access Standard	Description
1	--	This cover page of each report includes plan name, county, beneficiary group and date.
2	--	This page shows, by zip code, the average distance for beneficiaries to one hospital within 15 miles or 30 minutes (whichever is less) and the percentage of beneficiaries having one hospital within 15 miles or 30 minutes (whichever is less).
3	--	This page shows the number of providers, the number of beneficiaries with access to one hospital within 15 miles or 30 minutes (whichever is less) for beneficiaries with access. It also analyzes beneficiary accessibility in ten key cities.
4	--	This page shows, by zip code, the number and percentage of beneficiaries who do not have access to one hospital within 15 miles or 30 minutes (whichever is less).
5	--	This page shows the number of providers, the number of beneficiaries with access to one hospital within 15 miles or 30 minutes (whichever is less) for beneficiaries with access. It also analyzes beneficiary accessibility in ten key cities
6	--	This page shows, by zip code, the number and percentage of beneficiaries who do not have access to one hospital within 15 miles or 30 minutes (whichever is less) and their average distance to one provider.
7	--	This includes documentation about the report and its data sources
8	--	This county map shows beneficiary locations for those

Page Code	Access Standard	Description
		who do not have access to one hospital within 15 miles or 30 minutes (whichever is less). Use 2 point black circles for beneficiaries.
9	--	This county map shows provider locations. Use 12 point light gray circles for individual and 12 point black triangles for multiple provider locations.
10	--	This should be a hard copy of the geocoded provider file, which must include name, specialty/type, address, zip code, individual capacity (where applicable), geographic coordinates and geocoding method return code.

e. Cardiologist, Dermatologist, Endocrinologist, Otolaryngologist (ENT), General Surgeon, Neurologist, Obstetrician/Gynecologist, Oncologist, Ophthalmologist, Orthopedist, Oral Surgeon, Psychologist, Urologist

Page Code	Access Standard	Description
1	--	This cover page of each report includes plan name, county, beneficiary group and date.
2	--	This page shows, by zip code, the average distance for beneficiaries to one provider within 45 miles or 1 hour (whichever is less) and the percentage of beneficiaries having one provider within 45 miles or 1 hour (whichever is less).
3	--	This page shows the number of providers, the number of beneficiaries with access to one provider within 45 miles or 1 hour (whichever is less)–for beneficiaries with access. It also analyzes beneficiary accessibility in ten key cities.
4	--	This page shows, by zip code, the number and percentage of beneficiaries who do not have access to one provider within 45 miles or 1 hour (whichever is less).
5	--	This page shows the number of providers, the number of beneficiaries with access to one provider within 45 miles or 1 hour (whichever is less) for beneficiaries with access. It also analyzes beneficiary accessibility in ten key cities
6	--	This page shows, by zip code, the number and percentage of beneficiaries who do not have access to one provider within 45 miles or 1 hour (whichever is less)and their average distance to one provider.

Page Code	Access Standard	Description
7	--	This includes documentation about the report and its data sources
8	--	This county map shows beneficiary locations for those who do not have access to one provider within 45 miles or 1 hour (whichever is less). Use 2 point black circles for beneficiaries.
9	--	This county map shows provider locations. Use 12 point light gray circles for individual and 12 point black triangles for multiple provider locations.
10	--	This should be a hard copy of the geocoded provider file, which must include name, specialty/type, address, zip code, individual capacity (where applicable), geographic coordinates and geocoding method return code.

2). To support the Geoaccess report, a Microsoft excel workbook must be prepared for each county. The excel workbook shall list all of the providers utilized in the Geoaccess report.

a. Each County Workbook shall contain a separate sheet for each of the following specialties:

Adult PCP
Pediatric PCP
General Dentist
Hospital
Cardiology
Dermatology
Endocrinology
ENT
General Surgery
Neurology
OB/GYN
Oncology
Ophthalmology
Oral Surgery
Orthopedist
Psychiatry

b. Each sheet shall include the following column headers:
- Last Name
- First Name
- MI
- Individual National Provider Indicator (NPI)

- Degree
- Address
- Address2
- City
- State
- ZIP
- Phone
- Speciality Code
- Taxonomy Code

c. Each County workbook shall also contain one sheet for use by the Centers for Medicare and Medicaid Services that lists participating providers who are available to provide the following specialty services:
   - Allergy/Immunology
   - Anesthesiology
   - Audiologist
   - Cardiology-Pediatric
   - Chiropractor
   - Colon & Rectal Surgery
   - Emergency Medicine
   - Endocrinology-Pediatric
   - Endodontia
   - Gastroenterology-Adult & Pediatric
   - General Surgery-Pediatric
   - Geriatric Medicine,
   - Hematology/Oncology-Pediatric
   - Infectious Disease-Adult
   - Medical Genetics
   - Nephrology-Pediatric
   - Plastic Surgery
   - Prosthodontia
   - Pulmonary Disease-Adult& Pediatric
   - Radiation Oncology
   - Rheumatology-Adult & Pediatric

d. The CMS sheet shall include the following column headers:

   - CMS Specialty
   - Specialty Code
   - Last Name
   - First Name
   - Individual NPI
   - Degree
   - PRACTICE NAME
   - Address1

- Address2
- City
- STATE
- Zip
- PHONE
- COUNTY Name
- Providers Specialty
- Taxonomy Code

Figure 1

A.4.4 Certification of Contractor Provider Network

CERTIFICATION OF PROVIDER NETWORK REPORT

I, _____, hereby certify both personally and on behalf
(*Name & Title of HMO Officer)*

of _____ __that all of the health care providers whose names appear
(*Name of HMO)*

on the attached and/or transmitted Provider Network Report, dated _____,
(*Date*)

have signed valid, written contracts with _____, which are currently in effect
(*Name of HMO)*

and are similar in all material respects to the sample provider agreements submitted on

_____ to, and approved by, the Division of Medical Assistance and Health Services,
(*Date*)

by _____. I further certify that all of the providers listed have expressly
(*Name of HMO)*

agreed to serve, and are currently serving, New Jersey Medicaid and NJ FamilyCare

beneficiaries who enroll in _____.
(*Name of HMO*)

I certify that the foregoing statements made by me are true, and attest that based on

best knowledge, information, and belief as of the date indicated below, all information

submitted to DMAHS is accurate, complete, and truthful, and certify that no material fact

has been omitted from this form. I am aware that if any of the foregoing statements made by

me are willfully false, _____, may be subject to the imposition of
(*Name of HMO)*

sanctions and/or liquidated damages. I understand that I must abide by all applicable

Federal and State laws for any false claims, statements, or documents, or concealment

of a material fact. I have read and am familiar with the contents of this submission.

Signature: _____

Print Name: _____

Title of HMO Officer: _____

Name of HMO: _____

Date: _____

A.7.0 Terms And Conditions

A.7.1 Certifications

A.7.1.A

(Certification Form)

This certification includes the State of New Jersey's language for data submission certification for the New Jersey Medicaid/NJ FamilyCare program.

CERTIFICATION OF ENROLLMENT INFORMATION RELATING TO PAYMENT UNDER THE MEDICAID/NJ FAMILYCARE PROGRAM

CERTIFICATION

Pursuant to the contract(s) between the Department of Human Services and the (name of managed care organization (MCO), provider certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the New Jersey Medical Assistance Program as an MCO designated as Plan number (insert Plan identification number(s) here.) (Name of MCO) acknowledges that if payment is based on enrollment data, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

(Name of MCO) hereby requests payment from the New Jersey Medical Assistance Program under contracts based on enrollment data submitted and in doing so makes the following certification to the Department of Human Services (DHS) as required by the Federal regulations at 42 CFR 438.600 (et. al.).

(Name of MCO) has reported to the DHS for the month of (indicate month and year) all new enrollments, disenrollments, and any changes in the enrollees' status. (Name of MCO) has reviewed the monthly membership report for the month of (indicate month and year) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to DHS in this report is accurate, complete, and truthful, and I hereby certify that NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM AND/OR THE DATA SUBMISSION.

I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO (Name of MCO). I UNDERSTAND THAT I MUST COMPLY WITH ALL APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR

CONCEALMENT OF A MATERIAL FACT. I HAVE READ AND AM FAMILIAR WITH THE CONTENTS OF THIS SUBMISSION.

_____

(INDICATE NAME AND TITLE
(CFO, CEO, OR DELEGATE))
on behalf of

_____

(INDICATE NAME OF BUSINESS ENTITY)

_____

DATE

A.7.1.B

(Certification Form)

This certification includes the State of New Jersey's language for data submission certification for the New Jersey Medicaid/NJ FamilyCare program.

CERTIFICATION OF ENCOUNTER INFORMATION RELATING TO PAYMENT UNDER THE MEDICAID/NJ FAMILYCARE PROGRAM

CERTIFICATION

Pursuant to the contract(s) between the Department of Human Services and the (name of managed care organization (MCO), provider certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the New Jersey Medical Assistance Program as an MCO designated as Plan number (insert Plan identification number(s) here.) (Name of MCO) acknowledges that if payment is based on encounter data, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

(Name of MCO) hereby requests payment from the New Jersey Medical Assistance Program under contracts based on encounter data submitted and in doing so makes the following certification to the Department of Human Services (DHS) as required by the Federal regulations at 42 CFR 438.600 (et. al.).

(Name of MCO) has reported to the DHS for the month of (indicate month and year) all new encounters, (indicate type of data – inpatient hospital, outpatient hospital, physician, etc.). (Name of MCO) has reviewed the encounter data for the month of (indicate month and year) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to DHS in this report is accurate, complete, truthful, and I hereby certify that NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM AND DATA SUBMISSION.

I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO (Name of MCO). I UNDERSTAND THAT I MUST COMPLY WITH ALL APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR

CONCEALMENT OF A MATERIAL FACT. I HAVE READ AND AM FAMILIAR WITH THE CONTENTS OF THIS SUBMISSION.

_____

(INDICATE NAME AND TITLE
(CFO, CEO, OR DELEGATE))
on behalf of

_____

(INDICATE NAME OF BUSINESS ENTITY)

_____

DATE

A.7.1.C

(Certification Form)

This certification includes the State of New Jersey's language for data submission certification for the New Jersey Medicaid/NJ FamilyCare program.

CERTIFICATION OF ANY INFORMATION REQUIRED BY THE STATE AND CONTAINED IN CONTRACTS, PROPOSALS, AND RELATED DOCUMENTS RELATING TO PAYMENT UNDER THE MEDICAID/NJ FAMILYCARE PROGRAM

CERTIFICATION

Pursuant to the contract(s) between the Department of Human Services and the (name of managed care organization (MCO), provider certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the New Jersey Medical Assistance Program as an MCO designated as Plan number (insert Plan identification number(s) here.) (Name of MCO) acknowledges that if payment is based on any information required by the State and contained in contracts, proposals, and related documents, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

(Name of MCO) hereby requests payment from the New Jersey Medical Assistance Program under contracts based on any information required by the State and contained in contracts, proposals, and related documents submitted and in doing so makes the following certification to the Department of Human Services (DHS) as required by the Federal regulations at 42 CFR 438.600 (et. al.).

(Name of MCO) has reported to the DHS for the period of (indicate dates) all information required by the State and contained in contracts, proposals, and related documents submitted. (Name of MCO) has reviewed the monthly membership report for the period of (indicate dates) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to DHS in this report is accurate, complete, and truthful, and I hereby certify that NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM AND/OR THE DATA OR INFORMATION SUBMISSION.

I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO (Name of MCO). I UNDERSTAND THAT I MUST COMPLY WITH ALL APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR
CONCEALMENT OF A MATERIAL FACT. I HAVE READ AND AM FAMILIAR WITH THE CONTENTS OF THIS SUBMISSION.

_____

(INDICATE NAME AND TITLE
(CFO, CEO, OR DELEGATE))
on behalf of

_____

(INDICATE NAME OF BUSINESS ENTITY)

_____

DATE

A.7.1.D

CERTIFICATION REGARDING LOBBYING

The undersigned certifies to the best of his or her knowledge that:

No federal appropriated funds have been paid or will be paid to any person by or on behalf of the contractor for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative contract, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

If any funds other than federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative contract, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative contract, and the contract exceeds $100,000, the contractor shall complete and submit Standard Form-LLL "Disclosure of Lobbying Activities" in accordance with its instructions.

The contractor shall include the provisions of this section in all provider contracts under this contract and require all participating providers whose provider contracts exceed $100,000 to certify and disclose accordingly to the contractor.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction pursuant to 31 U.S.C. 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

SIGNATURE: _____ DATE: _____

NAME (PRINT): _____

TITLE: _____

ORGANIZATION: _____

A.7.1.E

HIV/AIDS/HEMOPHILIA/ANGIOEDEMA
CERTIFICATION BY HMO MEDICAL DIRECTOR

Month of Certification _____

Run Date _____

I, _____, hereby certify on behalf of _____
Name of Medical Director *Name of HMO*

that _____, Medicaid ID number_____,
Name of Member

a member of said HMO, has been diagnosed by his/her treating physician with and/or is being treated for HIV or AIDS, Hemophilia requiring Factors VIII or IX or Angioedema (circle any that apply). If including more than one member, you may attach a written list of members specifying the diagnosis of each individual.

The number of members with HIV is ____; AIDS ___; Factor VIII ___; Factor IX____; Angioedema ____

I certify that the foregoing statements are true, and attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to DMAHS is accurate, complete and truthful, and certify that no material fact has been omitted from this form. I am aware that if any foregoing statements made by me are willfully false, _____, may be subject to the imposition of sanctions and/or
Name of HMO
liquidated damages. I understand that I must abide by all applicable Federal and State laws for any false claims, statements, or documents, or concealment of a material fact. I have read and am familiar with the contents of this submission.

Signature of Medical Director: _____

Print Name: _____

Title: _____

Date: _____

A.7.2 Fraud and Abuse

A. The contractor shall report to the OMIG with copies to DMAHS, Office of Managed Health Care, all identified instances (proven or suspected) of provider, subcontractor, and enrollee fraud and abuse with supporting case documentation attached to the report.

The contractor must submit quarterly the following report with monthly data identified by reporting month:

Month
Year

	Beginning of the month		Added during the month		Completed/closed		End of Month	
	Provider	Enrollee	Provider	Enrollee	Provider	Enrollee	Provider	Enrollee
# Of Cases								
Totals								

B. The contractor must report in detail to OMIG with copies to DMAHS, Office of Managed Health Care, the following information for cases involving providers, subcontractors, and enrollees:

Case name
Date opened
Reason for initiating case
Date of notification to OMIG
Date of approval from OMIG
Personnel assigned to case
Date of completion
Findings
Date of screening with OMIG
Actions

C. The contractor must submit quarterly to OMIG with a copy to DMAHS, Office of Managed Health Care the following report of FTE hours devoted solely to DMAHS related fraud and abuse cases, reviews and initiatives. The contractor shall report the data by employee.

EMPLOYEE		DMAHS RELATED FRAUD AND ABUSE CASE(S), REVIEW(S), AND INTIATIVE(S)		TOTAL HOURS DEVOTED SOLEY TO DMAHS FRAUD/ABUSE
Last Name	First Name	Name/Description (List each case, review, or initiative separately, along with hours devoted solely to DMAHS for each.)	Sub-total Hours	Total Hours

A.7.3

Table 1 **Medicaid Enrollment by Primary Care Providers**

The contractor shall submit Table 1 in spreadsheet (Excel) format. Listed alphabetically by last name, provider type and for each primary care physician, primary care dentist, primary care CNP/CNS, and primary care physician assistant, the contractor shall enter the total number of enrollees for the reporting period.

STATE OF NEW JERSEY
Plan Name _____ **Quarter Ending_____**

TABLE 1

MEDICAID ENROLLMENT BY PRIMARY CARE PROVIDERS

Primary Care Providers list, by type of provider, alphabetically by last name with one line for each county in which provider practices

Primary Care Physicians					
National Provider Identification (NPI)	**Last Name**	**First Name**	**Specialty**	**County**	**Total # Enrollees for Reporting Period**
Dentists					
(NPI)	**Last Name**	**First Name**	**Specialty**	**County**	**Total # Enrollees for Reporting Period**
CNP/CNSs					
(NPI)	**Last Name**	**First Name**	**Specialty**	**County**	**Total # Enrollees for Reporting Period**
Physician Assistants					
(NPI)	**Last Name**	**First Name**	**Specialty**	**County**	**Total # Enrollees for Reporting Period**

Total		
Total # PCPs		
Total # PCPs With Enrollees		
Total # PCPs Without Enrollees		
Total # Dentists		
Total # Dentists With Enrollees		
Total # Dentists Without Enrollees		
Total # CNP/CNSs		
Total # CNP/CNSs With Enrollees		
Total # CNP/CNSs Without Enrollees		
Total # PAs		
Total # PAs With Enrollees		
Total # PAs Without Enrollees		

A.7.5

Table 3 **Grievance Summary**

Table 3A
The contractor shall submit electronically to DMAHS a quarterly report of all utilization management (UM) enrollee grievance/appeal requests and dispositions. The database format provided by DMAHS shall be used for reporting information for the reporting period and all open cases to date.

Table 3B
The contractor shall submit electronically to DMAHS a quarterly report of all non-utilization management (UM) enrollee grievance/appeal requests and dispositions. The database format provided by DMAHS shall be used for reporting information for the reporting period and all open cases to date.

Table 3C
The contractor shall submit electronically to DMAHS, a quarterly report of all provider grievance/appeal requests and dispositions. The database format provided by DMAHS shall be used for reporting information for the reporting period and all open cases to date.

Table 3A: Utilization Management Grievances/Appeals

HMO:_____

Reporting Period: (Year/Month)_____

ORN (Original Recipient Number)	Last Name	First Name	DOB	Age	PSC	Appeal Initiator	Appeal Stage	Appeal Type	Date Received	Date Acknowledgement Letter Sent	Appeal Category	Description	Reviewer	Outcome	Resolution	Date Resolved	Expedited	Date Letters Sent

Total Received_____ **Total Resolved_____**

VALID VALUES

PROGRAM STATUS CODE (PSC)

110	OAA CN-SSI MP	310	TANF & AFDC-C-CN Regular MP	492	NJC Pregnant, 133% to <=185%
120	OAA CN-Medicaid only, NMP	320	AFDC-C-CN Regular NMP	493	Family income from 201% thru 250% of FPL, Child 0 to 19
130	OAA CN-Categorically Related-NMP-NFM	330	AFDC-C-CN Regular-Categorically Related-NM	494	Family income from 251% thru 300% of FPL, Child 0 to 19
140	OAA CN-Institutional Resident-NFM	340	MN-Pregnant Women-No Spenddown	550	PRUCOL-Blind
150	PRUCOL-Aged	350	MN-Pregnant Women-Spenddown	560	AB-CN HCEP
160	OAA CN-HCEP	440	AFDC-F-CN NMP-NFM-REACH	570	Blind-MN-No Spenddown
170	Aged MN-No Spenddown	450	AFDC-N-CN Adults-MP/NMP-NFM	590	NJC-Blind-Optional Categorically Needy
180	Aged MN-Spenddown	451	AFDC-N Adults and TANF	591	Ticket to Work, 100-150% FPL
190	NJC-Aged, OCN-Optional Categorically Needy	452	AFDC-N Adults but no TANF	600	DYFS-Optional Foster Care-Adoption Assistance (County <22)
210	DA-CN SSI MP	460	AFDC-N-CN Children-MP/NMP-Categorically Related-FM	601	ISS-SSI MP (Div of Public Welfare BLO ISS, County >21)
220	DA-CN Medicaid only-NMP	461	AFDC-N Children and TANF	620	DYFS-SSI/Foster Children and Adoption Assistance (DYFS County <22)
230	DA-CN Categorically Related, NMP, NFM	462	AFDC-N Children but no TANF	621	ISS-Medicaid Only-SSI Related (Div of Public Welfare BLO ISS, County >21)
240	DA-CN Institutional resident, NFM	470	AFDC-N-CN Child/Adult-NM-NF-REACH-TDI/UIB, no 3/6	630	DYFS-Title IV-E Foster Children (DYFS County <22)
250	PRUCOL-Disabled	480	NJ Care/KidCare-Child, Optional Categorically Needy Plan A to 100%	631	ISS-AFDC Related AFDC Recipient (Div of Public Welfare BLO ISS, County >21)
260	DA-CN HCEP	481	NJ Care/KidCareC-CHILD, OCN, 2-6 years to 133%	640	ISS-Institutional Resident-NFM
270	DA-MN-No Spenddown	482	NJC Child <=1, 133% to 185%	641	CSOCI-Only
280	DA-MN-Spenddown	483	NJC Child born after 9/83, <=100%	650	DYFS-State Program-NFM
290	NJC-Disabled, Optional Categorically Needy	484	NJC/KidCare Child <= 19, <=100% FPL Plan A	700	FC HealthAccess, 0-150%, Plan D Services 100% State Funds
291	Ticket to Work, 100-150% FPL	485	NJC/KidCare Child age 6-19, 100% to 133% FPL Plan A	701	FC HealthAccess, 151-250% Plan D Services 100% State Funds
292	Ticket to Work, 151-185% FPL	486	NJC/KidCare Child Age 1-19, 133% to 150% FPL Plan B	710	MAA-NFM-Age 65 and over
293	Ticket to Work, 186-200% FPL	487	NJC/KidCare Child Age 1-19, 150% to 185% FPL, premium/co-pay required Plan C	730	PAAD Under 65-Disabled Casino Fund
294	Ticket to Work, 201-250% FPL	488	NJC/KidCare Child age 1-19, 185% to 200% FPL, premium/co-pay required Plan C	740	PAAD Over 65-Upper Income Casino Fund
295	Breast and Cervical Cancer	489	NJC/KidCare FFS newborns Plan C	750	PAAD Over 65-Lower Income General Fund
300	FC Health Access, 0-150%, Plan D Services 100% State Funds	490	NJC Pregnant, OCN <=100%	760	GA-General Assistance Program
301	FC Health Access, 151-250%, Plan D Services 100% State Funds	491	NJC Pregnant, OCN, 100-133%	761	NJFC, Other Adults, 0-23%FPL

con't PROGRAM STATUS CODE (PSC)

762 NJFC, Other Adults, 24-50% FPL
763 NJFC, Other Adults, 51-100% FPL
770 Cystic Fibrosis
780 ADDP
800 Juvenile Services-Not Refugee
810 County Juvenile Services
830 Senior Gold--Disabled
840 Senior Gold-Aged

Appeal Stage

1 Stage 1
2 Stage 2

Appeal Type

1 Medical
2 Dental
3 Special Needs

Appeal Category

1 Denial of Inpatient Hospital Days
1 Reduction of acuity level (inpatient)
3 Denial of surgical procedure
4 Denial of emergency services
5 Denial of outpatient medical treatment/diagnostic testing
6 Denial of outpatient rehabilitation therapy (PT, OT, Cardiac, Speech, etc.)
7 Denial of home health care
8 Denial of hospice care
9 Denial of skilled nursing facility
10 Denial of medical equipment (DME) an/or supplies
11 Denial of referral to out-of-network specialist
12 Service not a covered benefit
13 Service considered experimental/investigational
14 Service considered cosmetic, not medically necessary
15 Service considered dental, not medically necessary
16 Pharmacy
17 Other (Define)

Appeal Outcome

1 Denial Overturned
2 Denial Upheld

Expedited

-1 Yes
0 No

Table 3B: Non-Utilization Management Grievances/Appeals

HMO:_____

Reporting Period(Year/Month):_____

ORN (Original Recipient Number)	Last Name	First Name	DOB	Age	PSC	Grievance Category	Date Received	Date Resolved	Description	Resolution	Satisfaction	DMAHS Referred?

Total Received_____ **Total Resolved_____**

VALID VALUES

PROGRAM STATUS CODE (PSC)

110	OAA CN-SSI MP	310	TANF & AFDC-C-CN Regular MP	492	NJC Pregnant, 133% to <=185%
120	OAA CN-Medicaid only, NMP	320	AFDC-C-CN Regular NMP	493	Family income from 201% thru 250% of FPL, Child 0 to 19
130	OAA CN-Categorically Related-NMP-NFM	330	AFDC-C-CN Regular-Categorically Related-NM	494	Family income from 251% thru 300% of FPL, Child 0 to 19
140	OAA CN-Institutional Resident-NFM	340	MN-Pregnant Women-No Spenddown	550	PRUCOL-Blind
150	PRUCOL-Aged	350	MN-Pregnant Women-Spenddown	560	AB-CN HCEP
160	OAA CN-HCEP	440	AFDC-F-CN NMP-NFM-REACH	570	Blind-MN-No Spenddown
170	Aged MN-No Spenddown	450	AFDC-N-CN Adults-MP/NMP-NFM	590	NJC-Blind-Optional Categorically Needy
180	Aged MN-Spenddown	451	AFDC-N Adults and TANF	591	Ticket to Work, 100-150% FPL
190	NJC-Aged, OCN-Optional Categorically Needy	452	AFDC-N Adults but no TANF	600	DYFS-Optional Foster Care-Adoption Assistance (County <22)
210	DA-CN SSI MP	460	AFDC-N-CN Children-MP/NMP-Categorically Related-FM	601	ISS-SSI MP (Div of Public Welfare BLO ISS, County >21)
220	DA-CN Medicaid only-NMP	461	AFDC-N Children and TANF	620	DYFS-SSI/Foster Children and Adoption Assistance (DYFS County <22)
230	DA-CN Categorically Related, NMP, NFM	462	AFDC-N Children but no TANF	621	ISS-Medicaid Only-SSI Related (Div of Public Welfare BLO ISS, County >21)
240	DA-CN Institutional resident, NFM	470	AFDC-N-CN Child/Adult-NM-NF-REACH-TDI/UIB, no 3/6	630	DYFS-Title IV-E Foster Children (DYFS County <22)
250	PRUCOL-Disabled	480	NJ Care/KidCare-Child, Optional Categorically Needy Plan A to 100%	631	ISS-AFDC Related AFDC Recipient (Div of Public Welfare BLO ISS, County >21)
260	DA-CN HCEP	481	NJ Care/KidCareC-CHILD, OCN, 2-6 years to 133%	640	ISS-Institutional Resident-NFM
270	DA-MN-No Spenddown	482	NJC Child <=1, 133% to 185%	641	CSOCI-Only
280	DA-MN-Spenddown	483	NJC Child born after 9/83, <=100%	650	DYFS-State Program-NFM
290	NJC-Disabled, Optional Categorically Needy	484	NJC/KidCare Child <= 19, <=100% FPL Plan A	700	FC HealthAccess, 0-150%, Plan D Services 100% State Funds
291	Ticket to Work, 100-150% FPL	485	NJC/KidCare Child age 6-19, 100% to 133% FPL Plan A	701	FC HealthAccess, 151-250% Plan D Services 100% State Funds
292	Ticket to Work, 151-185% FPL	486	NJC/KidCare Child Age 1-19, 133% to 150% FPL Plan B	710	MAA-NFM-Age 65 and over
293	Ticket to Work, 186-200% FPL	487	NJC/KidCare Child Age 1-19, 150% to 185% FPL, premium/co-pay required Plan C	730	PAAD Under 65-Disabled Casino Fund
294	Ticket to Work, 201-250% FPL	488	NJC/KidCare Child age 1-19, 185% to 200% FPL, premium/co-pay required Plan C	740	PAAD Over 65-Upper Income Casino Fund
295	Breast and Cervical Cancer	489	NJC/KidCare FFS newborns Plan C	750	PAAD Over 65-Lower Income General Fund
300	FC Health Access, 0-150%, Plan D Services 100% State Funds	490	NJC Pregnant, OCN <=100%	760	GA-General Assistance Program
301	FC Health Access, 151-250%, Plan D Services 100% State Funds	491	NJC Pregnant, OCN, 100-133%	761	NJFC, Other Adults, 0-23%FPL

Table 3B: Non-Utilization Management Grievances/Appeals

con't PROGRAM STATUS CODE (PSC)

762	NJFC, Other Adults, 24-50% FPL
763	NJFC, Other Adults, 51-100% FPL
770	Cystic Fibrosis
780	ADDP
800	Juvenile Services-Not Refugee
810	County Juvenile Services
830	Senior Gold--Disabled
840	Senior Gold-Aged

GRIEVANCE CATEGORY

1	Appointment Availability, PCP
2	Appointment Availability, Specialist
3	Appointment Availability, Other Type of Provider
4	Waiting Time Too Long at Office, PCP
5	Waiting Time Too Long at Office, Specialist
6	Dissatisfaction with Quality of Medical Care, PCP
7	Dissatisfaction with Quality of Medical Care, Specialist
8	Dissatisfaction with Quality of Medical Care, Hospital
9	Dissatisfaction with Quality of Medical Care, Other Type of Provider
10	Diffficulty in Obtaining Access to a Health Care Professional after Hours
11	Difficulty Related to Obtaining Emergency Services
12	Dissatisfaction with Dental Services
13	Dissatisfaction with Vision Services
14	Dissatisfaction with Ancillary Services (Home health, DME, Therapy, etc.)
15	Dissatisfaction with Plan Benefit Design
16	Dissatisfaction with Provider Office Administration
17	Dissatisfaction with marketing, Member services, Member Handbook, etc.
18	Dissatisfaction with Utilization Management Appeal Process
19	Denial of Clinical Treatment for Covered Service
20	Dissatisfaction with Provider Network
21	Difficulty in Obtaining Referral to Network Specialist of Member's Choice
22	Difficulty in Obtaining Referrals for Ancillary Services (Home Health, DME, etc.)
23	Difficulty in Obtaining Referrals for Covered Services--Eye Care
24	Difficulty in Obtaining Referrals for Covered Services--Dental Services
25	Difficulty with Plan Policies Regarding Specialty Referrals
26	Laboratory Issues
27	Pharmacy/Formulary Issues
28	Reimbursement Problems/Unpaid Claims
29	Enrollment
30	Difficulty in Obtaining Access to a Health Care Professional

MEMBER SATISFACTION

1	Satisfied
2	Not Satisfied
3	TBD
4	Unable to obtain feedback

DMAHS Referred

-1	Yes
0	No

Table 3C: Provider Grievances/Appeals

HMO:
Reporting Period (Year/Month):

Provider ID (Federal Tax ID Number)	Provider Name	Provider Type	Grievance Category	Date Received	Date Resolved	Description	Staff	Action Taken	Resolution	Written Notification	Referred by DMAHS?

Total Received_____ **Total Resolved**_____

VALID VALUES

PROVIDER TYPE

1 PCP
2 Specialist
3 Dental Provider
4 Hospital
5 Other Provider

GRIEVANCE CATEGORY

1 Claim issues (reimbursement, timeliness, resubmission), PCP
2 Claim Issues (reimbursement, timeliness, resubmission), Specialist
3 Claim Issues (reimbursement, timeliness, resubmission), Hospital
4 Claim Issues (reimbursement, timeliness, resubmission), Other Provider
5 Complexity of Administrative Process
6 Difficulty Obtaining Prompt Authorization for Needed Medical Services
7 Credentialing/Recredentialing
8 Termination
9 Dissatisfaction with Provider Manual
10 Dissatisfaction with Responsiveness of Provider Services
11 Dissatisfaction with UM Appeal Process/Medical Management Guidelines
12 Dissatisfaction with Provider Network
13 Coordination of Benefits
14 Denials of service prior authorization requests
15 Denials of specialty referrals
16 Enrollee allocation inequities
17 Pharmacy Issues
18 Other (Define)

WRITTEN NOTIFICATION

-1 Yes
0 No

DMAHS Referred

-1 Yes
0 No

A.7.7

Table 5 **Hospital Specific Data**

The contractor shall report on an annual basis, hospital-specific data for Medicaid and NJ FamilyCare enrollees for whom hospital services were rendered during the reporting calendar year. The report shall include data with a payment date starting January 1 of the previous year through January 31 of the current year and shall be due by March 1 of the current year following the twelve-month claims lag period after the close of the reporting calendar year. The report shall include data of all inpatient hospital services for all Medicaid/NJ FamilyCare enrollees, by hospital and by program type, with discharge dates during the reporting calendar year. The report shall only reflect the latest claim status of any record. A record is defined as the same enrollee on the same date of service span. Do not include former adjustments or former denials. The contractor shall electronically submit data in a comma delimited ASCII data file according to the specifications in Table 5 – Reimbursement File Specifications. Field names are carried with the data in this format. Therefore, it is necessary to use the field names as they appear. The contractor must combine data for hospitals to which the contractor has assigned multiple provider numbers. The data elements required for each hospital include:

- Hospital Name
- Federal Tax ID Number
- Patient Last Name
- Patient First Name
- Latest Claim Number
- NJ Medicaid ID Number
- HMO Assigned Member ID Number
- Patient Account Number
- Admission Date
- Discharge Date
- DRG Number Paid
- Amount Billed/Charged
- Length of Stay Paid Days
- Length of Stay Denied Days
- Payment Amount (final)
- Final Payment Date (from January 1 of the reporting calendar year through January 31st of the year the report is electronically submitted)
- Program Status Code
- Medicaid or NJ Family Care Indicator

Use discharge date as service date for inpatient services.

For an updated list of hospitals, the contractor shall utilize the DHSS website:

www.state.nj.us/health/hcsa/hospitalsearch/index.html.

Click on “General Acute Care Hospital” and “Start Search”.

TABLE 5

Reimbursement File Specifications

Field	Field Name	Size	When Required	Definition	Example
1	Hospital Name	45	A	See A.4.1 Attachment E, Hospital Code List for proper names	New Jersey Hospital
2	Federal Tax ID Number	9	A	Provider's Tax ID Number	201999999
3	Patient Last Name	25	A	Patient Last Name	Smith
4	Patient First Name	25	A	Patient First Name	Sally
5	Latest Claim Number	15	A	HMO individually assigned claim number (from most current claim)	2006A0520B10 245
6	NJ Medicaid Client ID Number	12	A	NJ Medicaid assigned current client ID Number	123456789112
7	HMO Assigned Member ID Number	20	A	HMO uniquely identified Assigned Member ID Number	12345678912
8	Patient Account Number	20	A	Hospitals unique identification number assigned to each record	12345AD45654
9	Admission Date	10	A	Admission Date	12/15/2001
10	Discharge Date	10	A	Discharge Date	12/15/2001
11	DRG	5	A	Paid DRG on claim	015
11	Amount Billed/Charged	10	A	Amount Billed/Charged. No comma.	1000000.00
12	Length of Stay Paid Days	3	A	Total number of PAID days paid on claims (per record)	122
13	Length of Stay Denied Days	3	A	Total number of DENIED days on claim (per record)	112
14	Payment Amount	10	A	Payment Amount. No comma.	1000000.00
15	Final Payment Date	10	A	Most Current Payment Date	12/15/2001
16	Program Status Code	3	A	3 digit code assigned to recipient to identify what Plan they are associated with	123
17	Medicaid or NJ FamilyCare Indicator	6	A	Indicate Plan (Medicaid, NJ FamilyCare A, B, C, D)	MCaid, Plan A, B, C, or D

A = Always Required B = Required When Applicable

A.7.11

Tables 9, 9A & 9B

Table 9 is designed as an HMO self-reporting tool for utilization and expenditures by category of service, for all dates of service within a calendar year. The report is to be submitted twice for each calendar year. It shall be submitted once after six months of claims data have accrued or been adjudicated for the previous calendar year, and once after 12 months of claims data have accrued or been adjudicated for the previous calendar year.

Table 9B summarizes amounts paid by the HMO in sub-capitation, as well as other medical expenditures that are not reported on Table 9A or submitted as non-summary encounter records.

The reporting schedule for Tables 9A and 9B specifies: file naming conventions; the date of service period for each report (i.e., calendar year); the closing dates for accrual/adjudication (June 30 and December 31); and the report due dates.

The samples and documentation for Tables 9A and 9B specify the data sources, output field names and definitions, and required file format for the respective reports. The first line of the text file must contain exact field names. The report number must be exact, and consistent with the file specifications. Formatting errors will result in file rejection.

A.7.11

Table 9
Reporting Schedule

Report Number	Report Period (Service Date)	Through Date (Adjudicated as of)	Due Date
T9A12-04	CY 2004	31-Dec-05	01-Mar-06
T9B12-04	CY 2004	31-Dec-05	01-Mar-06
T9B06-05	CY 2005	30-Jun-06	29-Aug-06
T9A06-05	CY 2005	30-Jun-06	29-Aug-06
T9B12-05	CY 2005	31-Dec-06	01-Mar-07
T9A12-05	CY 2005	31-Dec-06	01-Mar-07
T9A06-06	CY 2006	30-Jun-07	29-Aug-07
T9B06-06	CY 2006	30-Jun-07	29-Aug-07
T9A12-06	CY 2006	31-Dec-07	29-Feb-08
T9B12-06	CY 2006	31-Dec-07	29-Feb-08
T9B06-07	CY 2007	30-Jun-08	29-Aug-08
T9A06-07	CY 2007	30-Jun-08	29-Aug-08
T9B12-07	CY 2007	31-Dec-08	01-Mar-09
T9A12-07	CY 2007	31-Dec-08	01-Mar-09
T9B06-08	CY 2008	30-Jun-09	29-Aug-09
T9A06-08	CY 2008	30-Jun-09	29-Aug-09
T9B12-08	CY 2008	31-Dec-09	01-Mar-10
T9A12-08	CY 2008	31-Dec-09	01-Mar-10
T9B06-09	CY 2009	30-Jun-10	29-Aug-10
T9A06-09	CY 2009	30-Jun-10	29-Aug-10
T9A12-09	CY 2009	31-Dec-10	01-Mar-11
T9B12-09	CY 2009	31-Dec-10	01-Mar-11
T9A06-10	CY 2010	30-Jun-11	29-Aug-11
T9B06-10	CY 2010	30-Jun-11	29-Aug-11
T9B12-10	CY 2010	31-Dec-11	29-Feb-12
T9A12-10	CY 2010	31-Dec-11	29-Feb-12

A.7.11

Table 9A Documentation

Submit a comma-delimited ASCII text file (.txt extension) according to the data element order 01-09. Files created in Excel and converted to a .csv do not meet the file format requirements. Qualify all text field with quotes. Do not use commas or dollar signs in numeric values. Use two decimal places in all financial fields.

Data Element		Field Name for Text File	Source	Definition	Format
01	Table 9A Report Number	Report Number	Table 9 Reporting Schedule	8 byte field where: T9A = Table 9A 06 or 12 = months after close of calendar year XX= calendar year of date of service	Text
02	HMO	HMO		3 byte HMO Plan Code	Text
03	Enc Group	Enc Group	Managed Care Category of Service Matrix	2 byte code that indicates the Encounter Group	Text
04	MC CoS	MC CoS	Managed Care Category of Service Matrix	1 byte character that identifies the Category of Service	Text
05	Unduplicated Recipients	Unduplicated Enrollees Served	Claims from FFS providers and encounters from sub-capitated providers	Unduplicated number of enrollees receiving one or more services in the report period.	Numeric (no decimal space, no comma)
06	Lines	Lines-Days-Prescriptions	Claims from FFS providers and encounters from sub-capitated providers	Count of claim lines (837P, 837D, 837I OP, 837I HH, 837I LTC)	Numeric (no decimal space, no comma)
06	Days	Lines-Days-Prescriptions	Claims from FFS providers and encounters from sub-capitated providers	Sum of Inpatient days between admission and discharge	Numeric (no decimal space, no comma)
06	Prescriptions	Lines-Days-Prescriptions	Claims from FFS providers and encounters from sub-capitated providers	Count of prescriptions (NCPDP format)	Numeric (no decimal space, no comma)

07	Units	Units	Claims from FFS providers and encounters from sub-capitated providers	Sum of units of service	Numeric (no decimal space, no comma)
08	Amount Paid FFS	Amount Paid FFS	Paid claims from FFS providers	The actual amount paid to fee-for-service providers. This does not include sub-capitation amounts paid or EPSDT incentives.	Numeric (no dollar sign, no decimal space, no comma)
09	Amount Charged	Amount Charged	Paid claims from FFS providers	The amount charged by providers on fee-for-service claims. Does not include EPSDT incentive payments.	Numeric (no dollar sign, no decimal space, no comma)

Table 9A
Semi-Annual Utilization and Medical Expenditure Summary

Report Number	HMO	Enc Group	MC CoS	Unduplicated Enrollees Served	Lines-Days-Prescriptions	Units	Amount Paid FFS	Amount Charged
T9A12-04	999	AU	K	1	1	1	1.00	1.00
T9A12-04	999	AU	O	1	1	1	1.00	1.00
T9A12-04	999	DD	D	1	1	1	1.00	1.00
T9A12-04	999	EP	D	1	1	1	1.00	1.00
T9A12-04	999	EP	O	1	1	1	1.00	1.00
T9A12-04	999	EP	S	1	1	1	1.00	1.00
T9A12-04	999	EP	Y	1	1	1	1.00	1.00
T9A12-04	999	ER	E	1	1	1	1.00	1.00
T9A12-04	999	FP	U	1	1	1	1.00	1.00
T9A12-04	999	HA	B	1	1	1	1.00	1.00
T9A12-04	999	HA	J	1	1	1	1.00	1.00
T9A12-04	999	HH	H	1	1	1	1.00	1.00
T9A12-04	999	HH	O	1	1	1	1.00	1.00
T9A12-04	999	HO	G	1	1	1	1.00	1.00
T9A12-04	999	HO	H	1	1	1	1.00	1.00
T9A12-04	999	IA	I	1	1	1	1.00	1.00
T9A12-04	999	LS	L	1	1	1	1.00	1.00
T9A12-04	999	LS	O	1	1	1	1.00	1.00
T9A12-04	999	ME	B	1	1	1	1.00	1.00
T9A12-04	999	ME	H	1	1	1	1.00	1.00
T9A12-04	999	ME	O	1	1	1	1.00	1.00
T9A12-04	999	ME	Q	1	1	1	1.00	1.00
T9A12-04	999	MH	E	1	1	1	1.00	1.00
T9A12-04	999	MH	I	1	1	1	1.00	1.00
T9A12-04	999	MH	M	1	1	1	1.00	1.00
T9A12-04	999	MH	O	1	1	1	1.00	1.00
T9A12-04	999	MS	B	1	1	1	1.00	1.00
T9A12-04	999	MS	H	1	1	1	1.00	1.00
T9A12-04	999	MS	O	1	1	1	1.00	1.00
T9A12-04	999	MS	R	1	1	1	1.00	1.00
T9A12-04	999	OO	O	1	1	1	1.00	1.00
T9A12-04	999	OT	3	1	1	1	1.00	1.00
T9A12-04	999	OT	C	1	1	1	1.00	1.00
T9A12-04	999	OT	F	1	1	1	1.00	1.00
T9A12-04	999	PC	2	1	1	1	1.00	1.00
T9A12-04	999	PO	P	1	1	1	1.00	1.00
T9A12-04	999	RA	O	1	1	1	1.00	1.00
T9A12-04	999	RA	X	1	1	1	1.00	1.00
T9A12-04	999	RX	A	1	1	1	1.00	1.00
T9A12-04	999	RX	B	1	1	1	1.00	1.00
T9A12-04	999	RX	O	1	1	1	1.00	1.00
T9A12-04	999	SA	E	1	1	1	1.00	1.00
T9A12-04	999	SA	I	1	1	1	1.00	1.00
T9A12-04	999	SA	N	1	1	1	1.00	1.00
T9A12-04	999	SA	O	1	1	1	1.00	1.00

Report Number	HMO	Enc Group	MC CoS	Unduplicated Enrollees Served	Lines-Days-Prescriptions	Units	Amount Paid FFS	Amount Charged
T9A12-04	999	SM	3	1	1	1	1.00	1.00
T9A12-04	999	SM	4	1	1	1	1.00	1.00
T9A12-04	999	SM	5	1	1	1	1.00	1.00
T9A12-04	999	TR	O	1	1	1	1.00	1.00
T9A12-04	999	TR	T	1	1	1	1.00	1.00
T9A12-04	999	UN	Z	1	1	1	1.00	1.00
T9A12-04	999	VC	3	1	1	1	1.00	1.00
T9A12-04	999	VC	V	1	1	1	1.00	1.00
T9A12-04	999	VC	W	1	1	1	1.00	1.00

Table 9A Sample

"Report Number","HMO","Enc Group","MC CoS","Unduplicated Enrollees Served","Lines-Days-Prescriptions","Units","Amount Paid FFS","Amount Charged"

"T9A12-04","999","AU","K",1,1,1,1.00,1.00
"T9A12-04","999","AU","O",1,1,1,1.00,1.00
"T9A12-04","999","DD","D",1,1,1,1.00,1.00
"T9A12-04","999","EP","D",1,1,1,1.00,1.00
"T9A12-04","999","EP","O",1,1,1,1.00,1.00
"T9A12-04","999","EP","S",1,1,1,1.00,1.00
"T9A12-04","999","EP","Y",1,1,1,1.00,1.00
"T9A12-04","999","ER","E",1,1,1,1.00,1.00
"T9A12-04","999","FP","U",1,1,1,1.00,1.00
"T9A12-04","999","HA","B",1,1,1,1.00,1.00
"T9A12-04","999","HA","J",1,1,1,1.00,1.00
"T9A12-04","999","HH","H",1,1,1,1.00,1.00
"T9A12-04","999","HH","O",1,1,1,1.00,1.00
"T9A12-04","999","HO","G",1,1,1,1.00,1.00
"T9A12-04","999","HO","H",1,1,1,1.00,1.00
"T9A12-04","999","IA","I",1,1,1,1.00,1.00
"T9A12-04","999","LS","L",1,1,1,1.00,1.00
"T9A12-04","999","LS","O",1,1,1,1.00,1.00
"T9A12-04","999","ME","B",1,1,1,1.00,1.00
"T9A12-04","999","ME","H",1,1,1,1.00,1.00
"T9A12-04","999","ME","O",1,1,1,1.00,1.00
"T9A12-04","999","ME","Q",1,1,1,1.00,1.00
"T9A12-04","999","MH","E",1,1,1,1.00,1.00
"T9A12-04","999","MH","I",1,1,1,1.00,1.00
"T9A12-04","999","MH","M",1,1,1,1.00,1.00
"T9A12-04","999","MH","O",1,1,1,1.00,1.00
"T9A12-04","999","MS","B",1,1,1,1.00,1.00
"T9A12-04","999","MS","H",1,1,1,1.00,1.00
"T9A12-04","999","MS","O",1,1,1,1.00,1.00
"T9A12-04","999","MS","R",1,1,1,1.00,1.00
"T9A12-04","999","OO","O",1,1,1,1.00,1.00
"T9A12-04","999","OT","3",1,1,1,1.00,1.00
"T9A12-04","999","OT","C",1,1,1,1.00,1.00
"T9A12-04","999","OT","F",1,1,1,1.00,1.00
"T9A12-04","999","PC","2",1,1,1,1.00,1.00
"T9A12-04","999","PO","P",1,1,1,1.00,1.00
"T9A12-04","999","RA","O",1,1,1,1.00,1.00
"T9A12-04","999","RA","X",1,1,1,1.00,1.00
"T9A12-04","999","RX","A",1,1,1,1.00,1.00
"T9A12-04","999","RX","B",1,1,1,1.00,1.00
"T9A12-04","999","RX","O",1,1,1,1.00,1.00
"T9A12-04","999","SA","E",1,1,1,1.00,1.00
"T9A12-04","999","SA","I",1,1,1,1.00,1.00
"T9A12-04","999","SA","N",1,1,1,1.00,1.00
"T9A12-04","999","SA","O",1,1,1,1.00,1.00
"T9A12-04","999","SM","3",1,1,1,1.00,1.00
"T9A12-04","999","SM","4",1,1,1,1.00,1.00
"T9A12-04","999","SM","5",1,1,1,1.00,1.00
"T9A12-04","999","TR","O",1,1,1,1.00,1.00
"T9A12-04","999","TR","T",1,1,1,1.00,1.00
"T9A12-04","999","UN","Z",1,1,1,1.00,1.00
"T9A12-04","999","VC","3",1,1,1,1.00,1.00
"T9A12-04","999","VC","V",1,1,1,1.00,1.00
"T9A12-04","999","VC","W",1,1,1,1.00,1.00

A.7.11

Table 9B Documentation

Submit a comma-delimited ASCII text file (.txt extension) according to the data element order 01-09. Files created in Excel and converted to a .csv do not meet the file format requirements. Qualify text fields with quotes. Do not use commas or dollar signs in numeric values. Use two decimal places in all financial fields.

Data Element	Field Name for Text File	Source	Definition	Format
01 Table 9B Report Number	Report Number/Text File Name	Table 9 Reporting Schedule	8 byte field where: T9B = Table 9B 06 or 12 = months after close of calendar year XX= calendar year of date of service	Text
02 HMO	HMO		3 byte HMO Plan Code	Text
03 Capitation Provider Type	Capitation Provider Type	HIPAA Companion Guide	3 byte code that identifies the type of provider	Text
04 Capitation Code	Capitation Code	HIPAA 834 Register/Roster	5 byte code that indicates the premium group	Text
05 Unduplicated Recipients	Unduplicated Subcapitated Enrollees	HMO's Proprietary Management Information System	The unduplicated number of enrollees for whom one or more sub-capitation payments were made by the HMO in the reporting period.	Numeric (no decimal space, no comma)

06	Amount Paid in Capitation	Amount Paid in Capitation	HMO's Proprietary Management Information System	The actual amount paid to sub-capitated service proiders.	Numeric (no dollar signs, no decimal space, no comma)
07	Other Payments	Other Payments	HMO's Proprietary Management Information System	Additional medical expenditure not reported as Amount Paid FFS or Amount Paid in Capitation	Numeric (no dollar signs, no decimal space, no comma)

Table 9B Sample

"Report Number/Text File Name","HMO","Capitation Provider Type","Capitation Code","Unduplicated Subcapitated Enrollees","Amount Paid in Capitation","Other Payments"
"T9B12-04","999","100","49399",10,1000.00,
"T9B12-04","999","200","49399",10,1000.00,
"T9B12-04","999","300","49399",10,1000.00,
"T9B12-04","999","400","49399",10,1000.00,
"T9B12-04","999","500","49399",10,1000.00,
"T9B12-04","999","600","49399",10,1000.00,
"T9B12-04","999","700","49399",10,1000.00,
"T9B12-04","999","800","49399",10,1000.00,
"T9B12-04","999","900","49399",10,1000.00,

A.7.12

Table 12 Pharmacy Prior Authorization/Denial Report

The contractor shall report the number of pharmacy prior authorizations and denials on a quarterly basis.

STATE OF NEW JERSEY

Plan Name _____ Quarter Ending _____

TABLE 12

Total Number of Pharmacy Claims Processed:	**xx,xxx**
Total Number of Claims Requesting Prior Authorization:	**xx,xxx**
Total Number of Approved Claims	**x,xxx (x.x%)**
Total Number of Denials	**x,xxx (x.x%)****
Breakdown of Denials	**Totals**
a. Clinical Criteria Not Met	xx
b. Directed Intervention	xx
c. Drug-Drug Interaction	xx
d. Duration Exceeded	xx
e. Excessive Dose	xx
f. Incomplete Information	xx
g. Mandatory Generic	xx
h. Prescriber Decreased Dose	xx
i. Prescriber Denies Writing Prescription	xx
j. Medication Discontinued by Prescriber	xx
k. Multiple Pharmacies	xx
l. Multiple Prescribers	xx
m. No Diagnosis Provided	xx
n. Prescriber Changed to OTC Product	xx
o. Therapeutic Duplication	xx
p. Unacceptable Diagnosis	xx
q. Other	xx
Total # Denials	
** See attachment for explanation of categories	

Explanation of Denial Categories

	Category	Explanation	Example/Comment
a.	**Clinical Criteria Not Met**	Claim does not meet approved criteria	Drug written for indication not approved.
b.	**Directed Intervention**	Claim does not meet any of the other clinical categories	- Prescriber requests denial until patient is seen in office. In this case "Med discontinued by prescriber" should not be used. - Pharmacy provider did not return call after verifying claim with prescriber. - Fraud issue - Name mismatch - Therapeutic duplication - Prescriber was contacted regarding duplication (antihistamines, ppi, nsaids) and has stated that patient can finish first med before starting second med.
c.	**Drug-Drug Interaction**	Self explanatory	
d.	**Duration Exceeded**	Duration limit established by DUR exceeded	Could be extended with provider's justifiable clinical request
e.	**Excessive Dose**	Dose exceeds reasonable therapeutic recommendation	
f.	**Incomplete Information**	Prescriber did not provide requested information	Diagnosis/ICD-9, Lab values, Ht, Wt, e.t.c.
g.	**Mandatory Generic**	Brand name requested without reasonable /clinical justification	Side effects with generic is a reason for exemption
h.	**Prescriber Decreased Dose**	Self explanatory	For example, decrease from BID to QD dosing
i.	**Prescriber Denies writing RX**	Prescriber denies writing prescription	Could be wrong info from pharmacy or fraud
j.	**Medication Discontinued by Prescriber**	Self explanatory	Change in therapy
k.	**Multiple Pharmacies**	Patient presents script for similar drug to different pharmacies	
l.	**Multiple Prescribers**	Patient goes to multiple providers for the same drug or similar drugs	
m.	**No Diagnosis Provided**	Prescriber did not provide diagnosis required as part of approval criteria	Verification of diagnosis from prescriber's office will suffice.
n.	**Prescriber Changed to OTC Product**	Prescriber changed from prescription brand to OTC brand	Non-sedating antihistamines
o.	**Therapeutic Duplication**	Requested drug belongs to the same therapeutic class as one on profile	Aciphex® and Nexium®
p.	**Unacceptable Diagnosis**	Diagnosis provided does not meet approved criteria	Some flexibility allowed with prescriber's input

A.7.17

Table 15 **Pharmacy Lock-In Participants**

The contractor, if a Pharmacy Lock-in program is implemented, shall report the status of participants each quarter, including total number of enrollees at start of quarter, number of new lock-in enrollees, number of enrollees released from lock-in during the quarter, and total number of lock-in enrollees at end of quarter. This report should be sorted by county.

STATE OF NEW JERSEY

Plan Name _____ Quarter Ending _____

TABLE 15

PHARMACY LOCK-IN PARTICIPANTS

	Gender							
	M	F	AFDC	SSI - ABD	DYFS	NJ FamilyCare	Reason For Lock-In	County
# Lock-In Enrollees at Start of Quarter								
<10								
10-15								
16-20								
21-44								
45-54								
65+								
Total								
# New Lock-In Enrollees This Quarter								
<10								
10-15								
16-20								
21-44								
45-54								
65+								
Total								
# Released From Lock-In This Quarter								
<10								
10-15								
16-20								
21-44								
45-54								
65+								
Total								
Total Lock-Ins at End of Quarter								
<10								
10-15								
16-20								
21-44								
45-54								
65+								
Total								

A.7.18

Table 16 **Ratio of Prior Authorizations Denied to Requested**

The contractor shall report the number of prior authorizations requested and denied each quarter by category of service. If prior authorization is not required, indicate "NA" for not applicable.

STATE OF NEW JERSEY

Plan Name _____ Quarter Ending _____

TABLE 16

RATIO OF PRIOR AUTHORIZATIONS DENIED TO REQUESTED

Table 16 Line #	PA Type	Group	MC CoS	Number of PAs Requested	Number of PAs Denied	Final Number PAs Resolved*
01	Inpatient Hospital	IA	1			
03	Physician Specialty Services	SM	3			
04	Outpatient Hospital	OO	O			
05	Other Professional Services	HA	B,J			
05	Other Professional Services	OT	3,C,F			
05	Other Professional Services	AU	K,O			
05	Other Professional Services	VC	3,V,W			
06	DME/Medical Supplies	ME	B,H,O,Q			
06	DME/Medical Supplies	MS	R,O,H,B			
07	Prosthetics & Orthotics	PS	P			
08	Dental	EP	D			
08	Dental	DD	D			
09	Pharmacy Formulary	RX	B,O			
10	Formulary Off-formulary	RX	B,O			
11	HIV/AIDS Reimbursable Drugs	RX	A			
12	Home Health Care	HH	H,O			
13	Transportation	TR	T,O			
14	EPSDT Private Duty Nursing	EP	Y			
15	Other Medical					
16	Total					

*Total number of Prior Authorizations (PAs) with denials upheld or reversed. Excludes any pending PA considerations.

A.7.20 Federally Qualified Health Center Payments

Table 18A FQHC Payments
The contractor shall submit quarterly reports of total payments for each contracted FQHC.

Quarterly reports by month of service are required for each FQHC under contract with the HMO contractor. The reports must include data from all sites of each FQHC. These reports should be submitted on diskette in an Excel format.

The contractor must retain all supporting documentation as long as there is a contractual arrangement with the FQHC. If the contract with the FQHC is terminated, for any reason, the supporting documentation must be relinquished to the State within thirty days after the date of termination.

Instructions for Completing Table 18
A separate Table 18 must be completed for each FQHC.

Line 1: - Name of HMO
Enter the name of the Health Maintenance Organization.

Line 2: - Federally Qualified Health Center
Enter the name and provider number of the Federally Qualified Health Center (FQHC) to which payments were made. The contractor must identify each FQHC with a contractual relationship and the effective date and termination date of the contract, if applicable (Lines 2, 3, and 4 on Table 18).

Line 3: - Effective Date of Contract
Enter the beginning and ending date of the current contract with the FQHC. The contractor must identify this information for each contracted FQHC.

Line 4: - Termination Date of Contract
If the contract with FQHC has been terminated, enter the termination date.

Line 5: -Payment Quarter
The contractor must identify the reporting quarter on Line 5. Payments by service date are to be reported based on calendar year quarters, i.e. March, June, September and December. Enter the first and last date of the quarter for which payments are being reported.

Line 6 – Type of Payments
All Medicaid and NJ FamilyCare managed care payments made for the quarter, including capitation, fee-for-service, referral fund, and any other managed care payments made to the FQHC, from the first day of the quarter to the end of the calendar year quarter, must be reported.

If there is a payment mixture such as fee-for-service and capitation, identify the amount of payment for each category.

On Table 18, the total payments made during each quarter should be reported in column 14. The payments must be segregated by month of service. The contractor must report these payments on Lines 6A through 6E. In columns 1-12, report a breakdown of the total payments by month the service being paid for was provided. Specify the month and year at the top of each column. There are 12 month-of-service columns. If payments were made for more than 12 months of service, add additional columns.

Payments by service date should be segregated by type. For example, all capitation payments are to be reported on line 6A, case management fees are to be reported on line 6B and fee-for-service payments are to be reported on line 6C.

Financial incentives to reduce unnecessary utilization of services or otherwise reduce patient costs that were paid to the FQHC should be reported on line 6D. Financial penalties, such as withholding a portion of the capitation payments, should be reported on line 6D as a negative amount. Financial incentives/penalties should be reported by service date. Please specify on line 6D the type of payment that is being reported.

Additional rows should be added to Table 18 for any other type of payments made to the FQHC. All payments must be segregated by service date. Please specify the type of payment that is being reported on each row.

STATE OF NEW JERSEY

Plan Name _____ Quarter Ending _____

TABLE 18A
FQHC PAYMENTS

1. Name of HMO		
2. Federally Qualified Health Center (name and HMO assigned provider number)	Name:	No.:
3. Effective Date of Contract	From:	To:
4. Termination Date of Contract, if applicable*		
5. Payment Quarter	From:	To:

	MONTH OF SERVICE (SPECIFY)**											
6. Type of Payments												
A. Capitation												
B. Case Management Fees												
C. Fee for Service												
D. Other (Specify)***												
E. Other Specify												
F. Total payments (Lines A through D)												

*If contract is terminated within the effective dates of the contract indicated in #3, enter termination date.
** Add additional columns as necessary.
***Financial incentives to reduce unnecessary utilization of services or otherwise reduce patient costs that were paid to the FQHC should be reported on Line 6D. Financial penalties, such as withholding a portion of the capitation payments should be reported on line 6D as a negative amount. Financial incentives/penalties should be reported by service date. Specify on Line 6D the type of payment that is being reported. Add rows as necessary to report other type(s) of payments.

Table 18 B Federally Qualified Health Center Encounters

The contractor shall submit quarterly reports of total adjudicated encounters for each contracted FQHC.

Quarterly reports by month of service are required for each FQHC under contract with the HMO contractor. The reports must include data from all sites of each FQHC. These reports should be submitted on diskettes in Excel format.

The contractor must retain all supporting documentation as long as there is a contractual arrangement with the FQHC. If the contract with the FQHC is terminated for any reason, the supporting documentation must be relinquished to the State within thirty days after the date of termination.

The table for encounters is divided between two primary sections: core services and other ambulatory services. Space has been provided in the other specialized service area for a service that may be unique to an FQHC and not specifically identified.

It should be noted that some services are specifically identified under the specialized services category, yet they would be provided by a physician, such as Norplant, and would be considered physician services. However, for the purposes of reporting, and to uniquely track these services, they are to be identified separately and the encounter associated with these services shown under their specific category. For Norplant services, line 15, the number of Norplant insertions/removals is to be recorded. The actual visit should not be included in the Physician Cost Center, line 1, column 2.

While care has been taken to account for the variety of services provided in an FQHC and establish a corresponding service line, blank lines have been provided for reporting of additional special services. Refer to N.J.A.C. 10:66-4.1(b) for the appropriate definition of a medical encounter.

Instructions for Completing Table 18 – FQHC Encounters

A separate Table 18 must be completed for each FQHC. Encounters must be segregated by calendar month of service.

Line A: - Name of HMO
Enter the name of the HMO.

Line B: - Federally Qualified Health Center
Enter the name and provider number of the Federally Qualified Health Center (FQHC) under contract with the HMO. The contractor must identify each FQHC with a contractual relationship and the effective date and termination date of the contract, if applicable (Lines B, C, and D on Table 18).

Line C: - Effective Date of Contract
Enter the beginning and ending date of the current contract with the FQHC. The contractor must identify this information for each contracted FQHC.

Line D: - Termination of Contract
If the contract with FQHC has been terminated, enter the termination date.

Line E: - Encounter Quarter
Encounters by service date are to be reported based on calendar year quarters, i.e., March, June, September, and December. Enter the first and last date of the calendar year quarter for which encounters are being reported.

Line F: - Month of Service
Enter the month of service for the encounters reported in each column.

Lines 1 – 6: Enter in the appropriate service category all adjudicated encounters provided during the quarter, from the first day of the quarter to the end of the calendar year quarter. The encounters must be segregated by month of service. Any corrections o prior period encounter reports should be entered in a separate column. Enter the month and year on Line F of the column for any corrections to prior period encounter reports.

Line 7: - Enter the sum of Lines 1 through 6 in each column.

Lines 10 – 24: Enter in the appropriate service category all adjudicated encounters provided during the quarter, from the first day of the quarter to the end of the calendar year quarter. The encounters must be segregated by month of service. Any corrections to prior period encounter reports should be entered into a separate column. Enter the month and year on Line F of the column for any corrections to prior period encounter reports.

Line 25: - Enter the sum of Lines 10 through 24 in each column.

Line 26: - Enter the sum of Lines 7 and 25 in each column.

Line 27: - Enter the number of Medicaid managed care pneumococcal and influenza vaccine injections. Any corrections to prior period encounter reports should be entered in a separate column. Enter the month and year at the top of the column for any corrections to prior period encounter reports.

STATE OF NEW JERSEY

TABLE 18B

FQHC ENCOUNTERS

A.	Name of HMO	
B.	Federally Qualified Health Center (Name and HMO assigned provider number)	FQHC Name: FQHC Number:
C.	Effective Date of Contract	From: To:
D.	Termination Date of Contract, if applicable*	
E.	Encounter Quarter	From: To:

		Current Quarter - Specify Month				Prior Period Adjustment - Specify Month and Year								
F.	Month of Service													
Core Services														
1	Physician													
2	Nurse Practitioner													
3	Nurse - Mid-Wife													
4	Clinical Psychologist													
5	Clinical Social Worker													
6	Physician Services Under Arr.													
7	Total Core Encounter (Lines 1-6)													
Other Specialized Services														
10	Dentist													
11	Dental Hygienist													
12	Ob/Gynecology													
13	Ob/Gynecology-Delivery ONLY													
14	Home Care Services													
15	Norplant													
16	Podiatry													
17	Eye Care Program													
18	Chiropractic Services													
19	Family Planning													
20	EPSDT Services													
21	Other (Specify)													
22	Other (Specify)													
23	Other (Specify)													
24	Other (Specify)													
25	Total Other Spec. Svs. (Lines 10-24)													
26	Total Medicaid Managed Care Encounters (Sum Line 7 + Line 25)													
27	*Pneumococcal/Influenza Vaccine Injections													

* If contract is terminated within the effective dates of the contract indicated in #3 termination date.

** Add additional columns as necessary.

Table 18 C - FQHC Managed Care Wraparound Electronic Claim Detail Specifications				
Field #	**Field Name**	**Description**	**Field Layout**	**Example**
1	FQHC Federal Tax Identification Number (TIN)	**Required.** Enter the federally assigned Employer Identification Number (EIN) of the file submitter. EIN is also referred to as the Tax Identification Number (TIN).	PIC 9(9)	**123456789**
2	Facility Name (identify by FQHC servicing site)	**Required.** Enter the name of the FQHC site performing the service. This may not be the billing or the main site.	PIC X(50)	**Satellite Office 3**
3	Medicaid Provider Number (Servicing Site)	**Required.** FQHC's have different Medicaid provider numbers assigned to different sites. Enter the seven-digit Medicaid number assigned to the FQHC site providing the service.	PIC X(7) Left justify.	**1234567**
4	Clinical Practitioner National Provider Number (NPI)	Enter the federally assigned National Provider Identifier (NPI) of the servicing clinical practitioner. For Clinical Social Workers leave blank.	PIC 9(10)	**1234567890**
5	HMO Name	**Required**. Enter the name of the HMO the FQHC is submitting this claim to.	PIC X(25)	**Americhoice**
6	Patient Last Name	**Required**. Enter the Last Name of the patient or the baby's last name.	PIC X(50)	**Smith**
7	Patient First Name	**Required**. Enter the First Name of the patient or the baby's first name.	PIC X(50)	**Jane OR Newborn**
8	Patient Medicaid Assigned ID	Enter the Medicaid Recipient ID Number. (The Recipient ID consists of 12 digits. The first 10 digits are the Medicaid case number and digits 11 and 12 are the person number.) **EXCEPTION:** When billing for services provided to newborns, providers may enter the Medicaid Recipient ID Number of the Medicaid-eligible mother for up to 60 days from the date of birth (through the end of the month in which the 60th day occurs).	PIC X(12)	**123456789112**
9	Patient HMO Assigned ID	**Required.** Enter the HMO Recipient ID Number.	PIC X(20)	**HMO045878J42**
10	Patient Social Security Number	**Required**. Enter the patient's social security number (SSN#) or the baby's mother's SSN#. **Must be a valid numeric format (999999999).**	PIC 9(9)	**123456789**
11	Patient Birth Date	**Required**. Enter the date of birth of the patient. **Include four position Year** AND **numeric date format of MMDDYYYY.**	PIC 9(8)	**01271923**
12	Patient Gender Code	**Required.** Enter (**M**)ale or (**F**)emale	PIC X(1)	**M or F**
13	Patient Account Number	**Required.** The FQHC internal assigned number associating a unique number to a recipient	PIC X(20)	**AG258632XC**
14	HMO-assigned ICN	**Required.** Enter the HMO Assigned ICN.	PIC X(20)	**2010052080502**
15	Service Date	**Required**. Enter a date of service for each procedure code billed. **Include four position Year** AND **numeric date format of MMDDYYYY.**	PIC 9(8)	**10271923**
16	Procedure Code	**Required**. Enter applicable HCPCS Procedure Code	PIC X(5)	**90050 or D0120**
17	Procedure Code Modifier 1	Modifier 1 (HCPCS & CPT-4) - 1 - If this field is not used leave blank.	PIC X(2)	**22 or EP or HE**
18	Procedure Code Modifier 2	Modifier 2 (HCPCS & CPT-4) - 1 - If this field is not used leave blank.	PIC X(2)	**22 or EP or HE**
19-21	Diagnosis Codes (up to 3 codes, use five-digit codes)	**Diagnosis 1 is required** Diagnosis 2-3 use as appropriate. Enter the ICD-9-CM codes describing the principal diagnosis. "E" codes are not valid as principal	PIC X(6)V99	**230.05 or 230.00 or 230.50**

		diagnosis codes. The principal diagnosis code can include the use of "V" codes. USE TWO DECIMAL POINTS FOR ALL DIAGNOSIS		
22	Units of Service	**Required**. Enter a quantitative measure of visits or units of services rendered for the appropriate procedure code. (The maximum number of units is 999.)	PIC 9(3)	**3**
FQHC Managed Care Wraparound Electronic Claim Detail Specifications (Page 2)				
23	Charge Amount	**Required.** Enter the amount billed / charged to the HMO for related services.	PIC 9(6)V99	**230.05**
24	Paid Amount	**Required**. Enter the total HMO payments received pertaining to the related procedure code during the wraparound period. **DO NOT USE COMMAS. If CAP Payment Category, paid amount = $0.00.**	PIC 9(6)V99	**230.05 OR 0.00**
25	HMO Payment Category (Capitation / Fee-For-Service)	**Required**. Enter three digit Payment Category depending on HMO payment methods. • **CAP** - Capitation (HMO Paid Amount = $0.00) OR • **FFS** - Fee-For-Service	PIC X(3)	**CAP or FFS**
26	Check Date	**Required**. Enter the date of the check from the HMO detailing payments associated with the Recipient and procedure code. **Include four position Year** AND **numeric date format of MMDDYYYY.**	PIC 9(8)	**12312001**
27	Check Number	**Required.** Sequence Number corresponding to the check	PIC X(15)	**12345678**
28	Claim Disposition	**Required**. Indicate if this encounter submission is (**P**)aid, (**D**)enied, (**A**)djusted or (**V**)oided	PIC X(1)	**P, D, A or V**
29	Fatal Error Code	Indicate all error code(s) that resulted directly in the denial of the claim. Error codes that are for informational purposes only do not need to be listed.	PIC X(15)	**230 or 003800732**

*** Wraparound Period is defined as the period beginning the first date of the calendar quarter to the 25th day after the end of the calendar quarter. For example, January 1 through April 25; April 1 through July 25; July 1 through October 25; and October 1 through January 25.

Table 18 D - FQHC Managed Care Wraparound Revenue Detail				
Field #	**Field Name**	**Description**	**Field Layout**	**Example**
1	FQHC Federal Tax Identification Number (TIN)	**Required.** Enter the federally assigned Employer Identification Number (EIN) of the file submitter. EIN is also referred to as the Tax Identification Number (TIN).	PIC 9(9)	**123456789**
2	Facility Name (identify by FQHC servicing site)	**Required.** Enter the name of the FQHC site performing the service.	PIC X(50)	**FQHC Office**
3	HMO Name	**Required**. Enter the name of the HMO.	PIC X(25)	**Americhoice**
4	Patient Last Name	**Required**. Enter the Last Name of the patient or the baby's last name.	PIC X(50)	**Smith**
5	Patient First Name	**Required**. Enter the First Name of the patient or the baby's first name.	PIC X(50)	**Jane OR Newborn**
6	Patient Medicaid Assigned ID	Enter the Medicaid Recipient ID Number. (The Recipient ID consists of 12 digits. The first 10 digits being the Medicaid case number and digits 11 and 12 are the person number.) EXCEPTION: When billing for services provided to newborns, providers may enter the Medicaid Recipient ID Number of the Medicaid-eligible mother for up to 60 days from the date of birth (through the end of the month in which the 60th day occurs).	PIC X(12) Left justify.	**123456789112**
7	Patient HMO Assigned ID	**Required.** Enter the HMO Recipient ID Number	PIC X(20) Left justify.	**HMO045878J42**
8	Patient Social Security Number	**Required**. Enter the patient's social security number (SSN#) or the baby's mother SSN#. **Must be a valid numeric format (999999999).**	PIC 9(9)	**123456789**
9	Patient Birth Date	**Required**. Enter the date of birth of the patient. **Include four position Year** AND **numeric date format of MMDDYYYY.**	PIC 9(8)	**1271923**
10	Patient Gender Code	**Required.** Enter (**M**)ale or (**F**)emale	PIC X(1)	**M or F**
11	Patient Account Number	**Required.** The FQHC internal assigned number associating a unique number to a recipient	PIC X(20)	**AG258632XC**
12	Begin Date of Service / Coverage Period	**Required**. Enter the beginning date of service for each revenue reported / covered period. **Include four position Year** AND **numeric date format of MMDDYYYY.**	PIC 9(8)	**10271923**
13	End Date of Service / Coverage Period	**Required**. Enter the last date of service for each revenue reported / covered period. **Include four position Year** AND **numeric date format of MMDDYYYY.**	PIC 9(8)	**10271923**
14	Check Date	**Required**. Enter the date of the check from the HMO detailing revenue associated with the Recipient. **Include four position Year** AND **numeric date format of MMDDYYYY.**	PIC 9(8)	**12312001**
15	Check Number	**Required.** Sequence Number corresponding to the check	PIC X(15)	**12345678**

16	HMO Paid Amount	**Required**. Enter the total HMO payments made to the FQHC per patient, separated by Payment Category, pertaining to each check received during the wraparound period. **** If more than one payment is made for the same patient during the wraparound period a separate line should be used to report each payment. **DO NOT USE COMMAS.**	PIC 9(6)V99	**230.05**
17	Payment Category	**Required.** Enter if the revenue is for (I) Incentive, (C) Capitation, (M) Case Management, (P) Patient Payment, (S) Settlement or (O) Other	Pic X(1)	**I or C or M or P or S or O**

*** Wraparound Period is defined as the period beginning the first date of the calendar quarter to the 25th day after the end of the calendar quarter. For example, January 1 through April 25; April 1 through July 25; July 1 through October 25; and October 1 through January 25.

A.7.21 Contractor Financial Reporting Manual for Medicaid/NJ FamilyCare Rate Cell Grouping Costs

Contractor Financial Reporting Manual for Medicaid/NJ FamilyCare Rate Cell Grouping Costs

State of New Jersey

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Introduction

Purpose

The objective of this Financial Reporting Specifications is to ensure uniformity, accuracy and completeness in reporting Medicaid/NJ FamilyCare rate cell groupings. In addition, the provision of this Financial Reporting Specifications to the Contractors will help to eliminate inconsistencies, as reports can vary in the presentation of items such as allocation of expenses, accrual of incurred-but-not-reported (IBNR) claims, handling of maternity claims, and other items. All reports shall be submitted as outlined in the general instructions. The financial reports submitted from this Financial Reporting Specifications will be used in future rate setting and to better assess the financial performance of Contractors.

The reports in this Financial Reporting Specifications are to supplement, not replace, the reporting requirements currently required in the Division of Medical Assistance and Health Services (DMAHS) Managed Care Contract (please refer to Section A of the contract). Key differences between this Financial Reporting Specifications and the reports currently submitted to DMAHS are as follows:

- Rate cell grouping detail;
- Regional detail;
- IBNR calculation detail; and
- Timing of submissions.

Rate Cell Groupings

This Financial Reporting Specifications requires key cost reporting by rate cell grouping. Rate cells have been combined into 8 rate cell groupings for Medicaid/NJ FamilyCare Managed Care reporting purposes. Please note that maternity and newborn costs are reported as separate rate cell groupings and shall be excluded from other rate cell groupings. The rate cell groupings are as follows:

Rate Cell Reference	Rate Cell Grouping	Capitation Stem Code	Description
Table #19 – Part A	Non ABD Adults – Plan A	373, 394	Non- ABD adults eligible for Aid to Families with Dependent Children (AFDC), New Jersey Care Pregnant Women (NJCPW), or for services through the DDD.

Rate Cell Reference	Rate Cell Grouping	Capitation Stem Code	Description
Table #19 – Part B	Non ABD Children – Plan A, B, & C	173, 193	Non-ABD eligible children with family income up to and including 200% FPL, AFDC, or NJ KidCare A.
Table #19 – Part C	FamilyCare Parents - Plan D	594	Parents/caretakers with children below the age of 23, and children from the age of 19 through 22 years, who are full-time students who do not qualify for AFDC Medicaid. Single adults and couples without dependent children. Includes Health Access individuals without dependent children. Parents over 21 years of age with classification based on restricted alien status prior to 4/1/10.
Table #19 – Part D	NJ KidCare- Plan D	993,	Eligible children with family income between 201% and up to and including 350% FPL, with/without AIDS, or NJ Kidcare.
Table #19 – Part E	ABD with Medicare	773, 795, 796	ABD (Aged, Blind, and/or Disabled) individuals who receive Medicare including those eligible for services through the Division of Developmental Disabilities (DDD).
Table #19 – Part F	ABD without Medicare –	494, 812, 873, 895	ABD individuals not receiving Medicare including individuals eligible for services through the DDD.

Rate Cell Reference	Rate Cell Grouping	Capitation Stem Code	Description
Table #19 – Part R1	Maternity	N/A	Please refer to criteria outlined in the instructions for Table 19 Part R1 in the Report Specifications section.
Table #19 – Part R2	Newborn	Includes newborn claims costs associated within: 80399, 90399	Please refer to criteria outlined in the instructions for Table 19 Part R2, in the Report Specifications section.

Geographic Regions

Some of the reports in this Contractor Reporting Specifications request information from the three major geographic districts corresponding to those used in rate setting (Northern, Central, and Southern). These districts are further split into five districts to be used for other reports as noted. Listed below are the counties included in each geographic district:

Northern		Central	Southern	
Northeastern – Urban District 1a	Northwestern – Non-Urban District 1b	Urban District 2	Southern – Urban District 3a	Southern – Non-Urban District 3b
Bergen	Hunterdon	Essex	Burlington	Atlantic
Hudson	Morris	Mercer	Camden	Cape May
Passaic	Somerset	Middlesex	Monmouth	Cumberland
	Sussex	Union	Ocean	Gloucester
	Warren			Salem

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General Instructions

The following are general instructions for completing the various tables required to be submitted by the Contractors to DMAHS. These instructions are designed to promote uniformity in reporting.

Due Dates

All Medicaid/NJ FamilyCare revenues and expenses must be reported using the accrual basis of accounting. Reports shall be submitted quarterly and are due 45 days following each quarter end.

12-Month Period End Reports Due Each Quarter

Quarter Ending:	Due Date:
March 31	May 15
June 30	August 15
September 30	November 15
December 31	February 15

Annual Supplemental Reports Due

Quarter Ending:	Due Date:
September 30	November 10

If a due date falls on a weekend or State holiday, reports will be due the next business day. Any additional information beyond this reporting manual critical to the actuarially sound development of capitation rates will be requested in writing and be due within 15 days of the request.

In the event that Medicaid financial statements are submitted with errors that require restatement, DMAHS, in its sole discretion, shall require the Contractor to engage independent auditors to do a more thorough review or audit of the financial statements. DMAHS shall not reimburse the Contractor for any additional costs related to an additional review or audit.

Format

The Contractor will submit these reports electronically, using Excel spreadsheets in the formats and on the forms specified in this manual without alteration. Copies of the reports are included in Appendix D of this manual.

HMO Financial Application

The contractor shall submit the completed reports using the HMO Financial Reporting Application (FRA). The FRA is a secure web-based portal used to submit the Excel Spreadsheets that comprise the Medicaid Financial Reports (MFR). The contractor will log into the FRA using a unique username and password and submit the reports. Upon submission, the MFR data will pass through a series of edits to measure completeness and the basic accuracy of the mandatory reports. The contractor will then be notified via the system if the reports were rejected along with a description of the error.

The URL for the FRA is https://secure.mercerhg.com/njfin/

Annual Audit Requirement

Please refer to Section 7.27 for the audit requirements in the managed care contract.

Other Instructions

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

Incorporate adjustments to prior data in the current reporting period. Adjustments for prior period IBNR estimates shall be included on Table 19, Part S2, in Line 45, and a detailed reconciliation shall be included on Table 19, Part S3. Information about any adjustments that pertain to prior periods shall be explained in a note to the reports. However, if there was material error in preparation of the prior period report, a revised report shall be submitted.

Unanswered questions or blank lines on any report or schedule will render the report or schedule incomplete and may result in a resubmission request. Any resubmission must be clearly identified as such. If no answers or entries are to be made, write “None”, “Not Applicable (N/A)”, or “-0-” in the space provided. Always use predefined categories or classifications before reporting an amount as “Other”.

Dollar amounts shall be reported to the nearest dollar. Per member per month (PMPM) amounts, however, shall be shown with two digits to the right of the decimal point.

Additional sheets referencing the applicable reports must be attached for further explanation. The Contractor shall use “Notes to Financial Reports” in Appendix B for write-ins and explanations.

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Report Specifications

Table 20: Lag Reports (Parts A-D)
Submission Due after Each Quarter End

Analyzing the accuracy of historical medical claims liability estimates is necessary in assessing the adequacy of current liabilities. In addition, valid IBNR liability estimates are crucial when utilizing financial statements in the managed care rate setting process. This schedule provides the necessary information to make this analysis.

Information is provided on Inpatient Hospital, Physician, Pharmacy, and Other Medical Payments on Parts A through D, respectively, with all rate cell groupings combined. Lag report information shall be provided for each Medical Cost Grouping as defined below and map to the corresponding consolidated category of service for the corresponding incurral period within Table 19, Part S2. A detailed reconciliation of the lag report information and Income Statements by Rate Cell Group shall be included on Table 19, Part S3. Information about any adjustments that pertain shall be explained in a note to the reports.

Consolidated Category of Service	Income Statement Reference	Medical Cost Grouping	Lag Report Reference
Inpatient Hospital	Table #19 – Part S2, Line 9	Inpatient Hospital	Table #20 – Part A
Reinsurance Expenses	Table #19 – Part S2, Line 25	Inpatient Hospital	Table #20 – Part A
Primary Care	Table #19 – Part S2, Line 10	Physician	Table #20 – Part B
Physician Specialty Services	Table #19 – Part S2, Line 11	Physician	Table #20 – Part B
Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products)	Table #19 – Part S2, Line 18	Pharmacy	Table #20 – Part C
Reimbursable HIV/AIDS Drugs and Blood Products	Table #19 – Part S2, Line 19	Pharmacy	Table #20 – Part C
Outpatient Hospital (excludes ER)	Table #19 – Part S2, Line 12	Other	Table #20 – Part D
Other Professional Services	Table #19 – Part S2, Line 13	Other	Table #20 – Part D

Consolidated Category of Service	Income Statement Reference	Medical Cost Grouping	Lag Report Reference
Emergency Room	Table #19 – Part S2, Line 14	Other	Table #20 – Part D
DME/Medical Supplies	Table #19 – Part S2, Line 15	Other	Table #20 – Part D
Prosthetics and Orthotics	Table #19 – Part S2, Line 16	Other	Table #20 – Part D
Dental	Table #19 – Part S2, Line 17	Other	Table #20 – Part D
Home Health, Hospice, & PDN	Table #19 – Part S2, Line 20	Other	Table #20 – Part D
Transportation	Table #19 – Part S2, Line 21	Other	Table #20 – Part D
Lab & X-ray	Table #19 – Part S2, Line 22	Other	Table #20 – Part D
Vision Care including Eyeglasses	Table #19 – Part S2, Line 23	Other	Table #20 – Part D
Mental Health/ Substance Abuse	Table #19 – Part S2, Line 24	Other	Table #20 – Part D
EPSDT Medical & PDN	Table #19 – Part S2, Line 26	Other	Table #20 – Part D
EPSDT Dental	Table #19 – Part S2, Line 27	Other	Table #20 – Part D
Family Planning	Table #19 – Part S2, Line 28	Other	Table #20 – Part D
Other Medical	Table #19 – Part S2, Line 29	Other	Table #20 – Part D

* Please reference Appendix C for the new Managed Care Category of Service codes.

The schedules are arranged with the month of service horizontally and the month of payment vertically. Therefore, payments made during the current month for services rendered during the current month would be reported in Line 1, Column 3, while payments made during the current month for services rendered in prior months would be reported on Line 1, Columns 4 through 39. Please note that columns 13 through 38 and rows 11 through 36 are hidden in the sample worksheet. Lines 1 through 3 contain data for payments made in the current period. Earlier data on Lines 4 through 37 shall match data on appropriate lines on the prior period's submission. If Lines 4 through 37 change from the prior period's submission, include an explanation. The current month is the last month of the period that is being reported. For example, in the report for the period ended June 30, 2003, the current month would be June 2003, and the first prior month would be May 2003. **Do not** include risk pool distributions as payments in this schedule.

Table 20 must provide data for the period beginning with the first month the Contractor is responsible for providing medical benefits to Medicaid/NJ FamilyCare recipients, and ending with the current month.

Line 39 – Subcapitation payments shall be reported here, by month of payment. They are not to be included above Line 39. For the current period, Line 39 shall contain new data in Columns 3 through 5. Data in columns 6 through 38 shall match data in appropriate columns on the prior period's submission. If columns 6 through 38 change from the prior period's submission, include an explanation.

Line 40 – Report pharmacy rebates anticipated for drugs dispensed this period. Adjust as appropriate any adjustment applicable to a prior period. Only complete for the Pharmacy Payment report, Part C.

Line 41 – The Contractor shall report payments on Lines 1 through 36. If the Contractor makes a settlement or other payment that cannot be reported on Lines 1 through 36 due to lack of data, the amount shall be reported on Line 41. If the service month(s) can be determined, the settlement dollars can be allocated to the service month. Otherwise, the payment month can be used as a substitute for the service month. If an amount is shown on Line 41 in columns 3 through 5, include an explanation. If columns 6 and greater change from the prior submission, also include an explanation.

Line 42 – This line is the total amount paid to date for services rendered. Line 42 shall equal the sum of Lines 38, 39, and 41. For the Pharmacy Payment report, Part C, also include Line 40.

Line 43 – This line provides the current estimate of remaining liability for unpaid claims for each month of service. The amount in each column on this line must be updated each period. The amount in Column 40 is the sum of amounts in Columns 3 through 39. The sum of the amounts in Column 40, in parts A through D, is the unpaid claim liability (IBNR and reported-but-unpaid-claims (RBUC)). Please refer to Attachment A for a methodology for calculating IBNR.

Line 44 – The total incurred claims is the sum of Line 42 (the amounts paid to date) and Line 43 (estimate of unpaid claims liability). Amounts on Line 44 are shown for each month.

DMAHS recognizes that claims liabilities may include the administrative portion of claim settlement expenses. Any liability for future claim settlement expense must be disclosed in the notes in the reports.

Table 20E Individual High Cost Claim Reserves

The contractor shall provide information regarding any high cost claimant for which they specifically set a reserve which is included in Table 20. For each such claimant, the following information should be provided (individual name or ID is not required):

The rate cell of the individual to coincide with the rate cells listed in Table 19

The name of the hospital, facility or provider that the claim is being paid to

The admission date or begin date of the claim

The expected discharge date or end date of the claim if the claim is ongoing

The actual discharge date or end date if the claim is no longer active

The total estimated liability for the claim

The total reserve being held for the claim

The total paid amount for the claim

The date the claim was paid

Table 20F Additional Lag Information

To further support the information provided in Table 20, the contactor shall indicate whether or not the following items are included in the IBNR estimate, the percent included in the IBNR for that item and the total dollar amount included for that item.

Margin – The additional liability included in IBNR that is above and beyond the contractor's best estimate of unpaid claim liability.

Claims Adjudication Expense – The expense associated with processing and paying future claims that is included in IBNR.

Loss Adjustment Expense – The expense associated with settling claims including salaries of adjusters, legal fees, court costs, expert witnesses and investigation costs.

Premium Deficiency Reserve – The additional liability included in IBNR 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.

Table 19: Income Statement by Rate Cell Grouping (Parts A – R2)
Submission Due after Each Quarter End

This report is meant to provide detailed summary information on revenues and expenses. A consolidated report is to be completed for each of the six (6) rate cell groupings and for Maternity and Newborn, with Table 19 Part S2 being the summation of Parts A-R2 respectively for the12-months ending. For reporting purposes, AIDS revenues and expenses are included or excluded from the rate cell groupings as indicated on the report forms and in the chart defining the rate cell groupings provided on page 3.

Additionally, State fiscal year-end information will be provided on separate annual reports to be completed with the first fiscal quarter ending reports (September 30). This information shall include all data with incurred dates through the most recent completed state fiscal year, with paid data through September 30 (incurred in 12 months, paid in 15 months). Reports are to be completed for each of the 6 rate cell groupings and for Maternity and Newborn categories. Besides quarter ending September 30, this information is **not required** for any other quarter ending time periods.

Do not include maternity or newborn revenues or expenses in Parts A – F. Only include Maternity and newborn revenues and maternity expenses on the Income Statement for Maternity, Part R1, and for All Rate Cell Groupings, Part S2. Include newborn expenses on the Income Statement for Newborn, Part R2, and for All Rate Cell Groupings, Part S2. Include Maternity costs associated with the following codes for still births or live births after the twelfth week of gestation, excluding elective/induced abortions:

DRG Codes: 370-375 or 650-652

Note that these codes are based on CMS-DRG version 24. Any other DRG version used to identify maternity costs must be mapped back to the codes listed above. This will ensure that only the intended maternity costs are identified and any non-maternity related codes are not inappropriately captured due to coding differences between DRG versions.

Additionally, Table 19, Part R2 (Income Statement for Newborn) includes newborn claims for the partial month of birth and the first two (2) months thereafter, previously reported in the AFDC/NJCPW/KidCare A, NJ KidCare B, C, and D, and Blind/Disabled rate cell groupings. Age shall be determined by counting the child's age as of their last birthday, on the first of the month in which the claim is incurred.

Except for non-State Plan services (Part T), all revenues and expenses must be reported on Table 19 (A-R2) using the accrual basis of accounting for the requested period. Each report is based on statewide reporting. Each report must provide total dollar amounts and PMPM amounts. Cells shaded are not to be filled out.

The non-State Plan services (see: Supplemental Benefits, Article 4.1.8 of the contract) report (Part T) has been created to provide information on benefits/services reported within Table 19, Parts A-S2 in excess of the State Plan and is only required with the annual fiscal year report. All medical and administrative expenses must be reported

using actual incurred and paid data for the requested period. Unit cost expenses for the non-State Plan services must also be provided. An example of non-State Plan approved medical expenses would be enhanced eyeglass allowance and over-the-counter drugs for adults.

Member Months

A member month is equivalent to the one member for whom the Contractor has recognized capitation-based revenue for the entire month. Where the revenue is recognized for only part of a month for a given individual, a partial, pro-rated member month shall be counted. A partial member month is pro-rated based on the actual number of days in a particular month. The member months shall be reported on a cumulative basis by the rate cell grouping as shown on the report. Enter the number of member months for the current period in Member Months line for each rate cell grouping.

The Maternity Income Statement, Part R1, shall list number of deliveries, rather than member months.

Newborn member months will be reported within Part R2 and are not to be included in any other rate cell grouping or with Part S2. It is expected that there shall be approximately 2.5 member months reported for each delivery as the newborn time period is on average 75 days. Any variation from 2.5 member months may suggest a reporting inconsistency. For counting newborn member months, it is appropriate to group by age (in months) and then sum the first 2 months. As defined in the previous section, age should be determined by counting the child's age as of their last birthday, on the first of the month in which the claim was incurred. The following example illustrates the formula for determining a child's age in months:

Example: Date of birth = January 15
- Age on January 1st - 0 months (count of 17/31 is 0 month age)
- Age on February 1st - 0 months (an additional count of 1 goes into 0 month age)
- Age on March 1st - 1 month (count of 1 for 1 month age)
- Age on April 1st - 2 months (count of 1 placed in 2 month age)
- Sum = Newborn Member Months (through example expect to have average 2.5 newborn member months per delivery)

This is consistent with the logic that DMAHS uses when making a capitation payment. If it is easier for the Contractor, count in whole numbers in the 0 month age cell (replace the pro-rated 17/31 with a count of 1). If this logic is utilized, the Contractor must note the counting methodology.

Revenue

Line 1 – Capitated Premiums—Revenue recognized on a prepaid basis for enrollees for provision of a specified range of health services over a defined period of time, generally one month. If advance payments are made to the Contractor, for more than one

reporting period, the portion of the payment that has not been earned must be treated as a liability (Unearned Premiums). Refer to Part S3 for reconciliations.

Line 2 – Maternity[1]—Supplemental payment per pregnancy outcome. This line item shall only be included in Part R1 (Maternity) and Part S2 (All Rate Cell Groupings).

Line 3 – Total Premiums—All Medicaid/NJ FamilyCare premiums paid to the Contractor reported on lines 1and 2. A detailed reconciliation of total premiums received and reported on the Income Statement in Part S2 shall be included on Table 19, Part S3. Information about any differences shall be explained in a note to the reports.

Line 4 – Reimbursable HIV/AIDS Drugs and Blood Products – Supplemental payment for HIV/AIDS drugs (protease inhibitors and, effective 7/1/01, other anti-retrovirals) and clotting factor VIII and IX blood products.

Line 5 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Service Incentive Payment – Supplemental payment for EPSDT services.

Line 6 – Other – Any other revenue paid by DMAHS to the Contractor in addition to capitation for covered services that is not included in lines above.

Line 7 – Total Other Reimbursements – Total reimbursements excluding capitation (the sum of lines 4 through 6).

Line 8 – Total Premiums & Reimbursements – Total reimbursements (the sum of lines 3 and 7).

Expenses

Medical and Hospital

Line 9 – Inpatient Hospital—Code 01—See the Managed Care Category of Service Codes.

Line 10 – Primary Care—Code 10P— See the Managed Care Category of Service Codes

Line 11 – Physician Specialty Services—Code 10S— See the Managed Care Category of Service Codes

[1] Because costs for pregnancy outcomes were not included in the capitation rates, a separate maternity payment is paid for pregnancy outcomes (each live birth, still birth, or miscarriage occurring at or after the thirteenth (13th) week of gestation). This supplemental payment reimburses Contractors for its inpatient hospital, antepartum, and postpartum costs incurred in connection with delivery. Costs for care of the baby are included only for the first two months of newborn claims in the AFDC/NJCPW/NJ KidCare A, NJ KidCare B, C, and D, and Blind/Disabled rate cell groupings.

Line 12 – Outpatient Hospital (excludes ER)—Code 04N— See the Managed Care Category of Service Codes.

Line 13 – Other Professional Services—Codes 14, 15S, 17, PAS— See the Managed Care Category of Service Codes.

Line 14 – Emergency Room—Code 04E— See the Managed Care Category of Service Codes.

Line 15 – DME/Medical Supplies—Codes 30, 31, 32— See the Managed Care Category of Service Codes.

Line 16 – Prosthetics and Orthotics—Code 18— See the Managed Care Category of Service Codes.

Line 17 – Covered Dental—Code 11— See the Managed Care Category of Service Codes.

Line 18 – Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products)—Code 20N– See the Managed Care Category of Service Codes.

Line 19 – Reimbursable HIV/AIDS Drugs and Blood Products—Code 20H— See the Managed Care Category of Service Codes.

Line 20 – Home Health, Hospice, PDN—Codes 40, 50, PDN— See the Managed Care Category of Service Codes.

Line 21 – Transportation—Code 70— See the Managed Care Category of Service Codes.

Line 22 – Lab & X-ray—Codes 60, 65— See the Managed Care Category of Service Codes.

Line 23 – Vision Care including Eyeglasses—Codes 09, 13— See the Managed Care Category of Service Codes.

Line 24 – Mental Health/Substance Abuse—Codes MH, SA— See the Managed Care Category of Service Codes.

Line 25 – Reinsurance Expenses—Expenses for reinsurance or “stop-loss” insurance made to a contracted reinsurer.

Line 25a – Reinsurance Reimbursements & COB – Income from the settlement of claims resulting from a policy with a private reinsurance carrier and from Coordination of Benefits (COB) and Subrogation. Alternatively, COB for a particular claim may be recognized as a negative claim expense. This should entered as a negative number.

Line 26 – EPSDT Medical & PDN —Codes 08D, EPM— See the Managed Care Category of Service Codes.

Line 27 – EPSDT Dental —Code EPD— See the Managed Care Category of Service Codes.

Line 28 – Family Planning—Code FP— See the Managed Care Category of Service Codes.

Line 29 – Other Medical—Code XM— See the Managed Care Category of Service Codes.

Line 30 – Total Medical and Hospital—The total of all medical and hospital expenses. (sum of lines 9 through 29).

Administration

Administrative expenses are only required to be reported on the forms for all rate cell groupings Table 19 (Part S2). This eliminates the need to allocate these costs across the remaining rate cell groupings, although the Contractor has the option of reporting this allocation. Administration must also be reported on Part T if the Contractor provides any non-State Plan services. Costs associated with the overall management and operation of the Contractor including the following components:

Line 31 – Compensation—All expenses for administrative services including compensation and fringe benefits for personnel time devoted to or in direct support of administration. Include expenses for management contracts. Do not include marketing expenses here.

Line 32 – Occupancy, Depreciation, and Amortization.

Line 33 – Interest expense—Interest paid during the period on loans and untimely claims payment.

Line 34 – Education/Outreach and Marketing—Expenses incurred for education and outreach activities for enrollees. Expenses directly related to marketing activities including advertising, printing, marketing salaries and fringe benefits, commissions, broker fees, travel, occupancy, and other expenses allocated to the marketing activity.

Line 35 – Sanctions—Expenses related to events where DMAHS finds the contractor to be out of compliance with the program standards, performance standards, or the terms and conditions of the Medicaid managed care contract.

Line 36 – Corporate Overhead Allocations—All expenses for management fees, and other allocations of corporate expenses. Methodologies for allocated expenses may include PMPM, percent of revenue, percent of head counts and/or full-time equivalents (FTE), etc. Include an explanation of the expenses included and the basis of methodology in the notes to the financial reports.

Line 37 – Subcontracted/Delegated Administrative Services—Administrative portion of delegated administrative expenses such as Pharmacy Benefits Manager (PBM) or Third Party Administrators (TPA) payments that cover costs such as claims processing and medical management of the PBM/TPA. An example of TPA expenses includes dental subcontractors and delegated case management administrative expenses.

Line 38 – Other Costs which are not appropriately assigned to the health plan administration categories defined in lines 31 to 37 above.

Line 39 – Total Administration—The total of costs of administration (the sum of lines 31 through 38).

Line 40 – Total Expenses—The sum of Total Medical and Hospital Expenses (line 30) and Total Administration (line 39).

Line 41 – Operation Income (Loss)—Excess or deficiency of Total Revenue (line 8) minus Total Expenses (line 40).

Line 42 – Investment Income.

Line 43 – Provision for State, Federal, and Other Governmental Income Taxes—All income taxes for the period.

Line 44 – Other than Income Taxes—Expenses other than State or federal income taxes (i.e., State assessments irrespective of profit position).

Line 45 – Adjustment for prior period IBNR estimates—Shall include reconciliation within Part S3, an explanation of prior period IBNR estimates, and a detailed calculation within Table 20, Parts A through D. A contra-expense would be reported if IBNR estimates exceeded actual expenses.

In the explanation below, the term “IBNR” (Incurred But Not Reported) is used to represent all claims incurred but unpaid. In statutory accounting for HMOs the incurred claims for a period are calculated as follows:

	Example for 12 Month Ending 06/30/20xx Reporting Period	Example using Dollars
Claims paid in the period	Claims paid in 12 Month ending 06/30/20xx	$48,000,000
+ IBNR at the end of the period	+ IBNR as of 06/30/20xx	+ $11,000,000
– IBNR at the end of the prior period	– IBNR as of 03/31/20xx	– $9,000,000
+ Subcapitation Payments, Pharmacy Rebates, Settlements at the end of the period	+ Subcapitation Payments, Pharmacy Rebates, Settlements as of 06/30/20xx	+ $500,000
– Subcapitation Payments, Pharmacy Rebates, Settlements at the end of the prior period	- Subcapitation Payments, Pharmacy Rebates, Settlements as of 03/31/20xx	– $450,000

– Claims incurred in the period	Claims incurred in 12 Months ending 06/30/20xx	$50,050,000

The above calculation can be split into two components — the first for services rendered in the period and the second for services rendered prior to the period, as follows:

	Incurred in 12 Month Ending 06/30/20xx	Incurred in 03/31/20xx & Prior	Total
Claims Paid in Qtr Ending 06/30/20xx	$39,500,000	$8,500,000	$48,000,000
+ IBNR as of 06/30/20xx	$10,900,000	$100,000	$11,000,000
– IBNR as of 03/31/20xx	None	$9,000,000	$9,000,000
+ Subcapitation Payments, Pharmacy Rebates, Settlements as of 06/30/20xx	$50,000	$450,000	$500,000
– Subcapitation Payments, Pharmacy Rebates, Settlements as of 03/31/20xx	None	$450,000	$450,000
– Recognized in – Qtr Ending 06/30/20xx	$50,450,000	– $400,000	$50,050,000

In the example above, claims incurred in the 12 months ending 06/30/20xx are $50.45 million. This is the amount that would be shown on Report #19S2 line 30; the Statewide Total Hospital and Medical Expense for the 12 months ended 06/30/20xx. The negative $0.4 million would be reported on line 45 Adjustment for prior period IBNR estimates. This is the effect of the estimation error for the prior year-end IBNR. Such estimation errors are to be expected, since the actual amount of unpaid claims will never exactly match the estimate made earlier.

The sum of the amounts on lines 30 and 45 shall be consistent with the statutory accounting amount of claims recognized as incurred in the period, $50 million in the example above. Any non-claim adjustments for prior periods are not to be grouped into Line 45, but in line 46, and shall be explained in a note to the reports. A detailed reconciliation of prior period IBNR shall be included on Table 19, Part S3.

Line 46 – Non-claim adjustments for prior periods.

Line 47 – Net Income (Loss)—Operation Income (Loss) (line 41) plus Investment Income (Line 42) minus Lines 43, 44, 45, and 46.

Table 21: Maternity Outcome Counts
Submission Due after Each Quarter End

This report provides counts of second and third trimester maternity outcomes[2] for the current period and year-to-date. Please refer to the report specifications of Table 19: Income Statement by Rate Cell Grouping in the member month section regarding newborn member months relative to this report.

The Contractor will provide counts for the following:

- Live births
  - Cesarean Section deliveries
  - Vaginal deliveries
- Non-live births

These counts will be reported for the following rate cell groupings and geographic areas:

Rate Cell Grouping	Geographic Area
AFDC/NJCPW/NJ KidCare A	Northwestern - Urban
AFDC/NJCPW/NJ KidCare A	Northeastern – Non-Urban
AFDC/NJCPW/NJ KidCare A	Central
AFDC/NJCPW/NJ KidCare A	Southern - Urban
AFDC/NJCPW/NJ KidCare A r	Southern – Non-Urban

Multiple births should be counted as one maternity outcome.

Table 4: Claims Processing Lag Report (Parts A & B)
Submission Due after Each Quarter End

This report is meant to provide a detailed summary of manually and electronically submitted claims that were processed during the quarter.

Table 4A

Use Table 4A, to report **manually submitted** claims that were processed during the quarterly period. Claims submitted and processed electronically must be reported separately on Table 4B. Manual claims submission shall be processed within 40 days of receipt. Report amounts for each consolidated category of service and total listed in Column 1 in the following columns:

Column 2 – Non-Processed Claims from Prior Quarters — Enter the number of manually submitted claims on-hand that were unprocessed as of the closing date of the last quarterly period. The number shall be the same as was reported in Column 16 of the prior quarterly report.

[2] Still or live births at or after the thirteenth week of gestation, excluding elective abortions.

Column 3 – Claims Received During Quarter — Enter the amount of all manually submitted claims that were received during the quarterly period being reported.

Column 4 – Total Claims — Enter the sum of Columns 2 and 3.

Column 5 – Claims Processed This Quarter — Enter the amount of all manually submitted claims processed (both paid and denied) during the quarterly period being reported. Do not count pended claims.

Column 6 – 01-40 Days — Enter the number of manually submitted claims that were processed (either paid or denied) within 40 days of their receipt. Note: The number of days required to process a claim is calculated by comparing the date the claim was received by the contractor to the date the claim was paid or denied by the contractor (See Article 7.16.5 of the contract for further detail).

Column 7 – Percent of Total — Enter the percentage of manually submitted claims processed within 40 days (Compared to total claims processed. Divide Column 6 by Column 5 to arrive at percent.).

Column 8 – 41–60 Days — Enter the number of manually submitted claims that were processed (either paid or denied) between 41–60 days of their receipt.

Column 9 – Percent of Total — Enter the percentage of manually submitted claims processed between 41–60 days (Compared to total claims processed. Divide Column 8 by Column 5 to arrive at percent.).

Column 10 – 61–90 Days — Enter the number of manually submitted claims that were processed (either paid or denied) between 61–90 days of their receipt.

Column 11 – Percent of Total — Enter the percentage of manually submitted claims processed between 61–90 days (Compared to total claims processed. Divide Column 10 by Column 5 to arrive at percent.).

Column 12 – Days >91— Enter the number of manually submitted claims that were processed (either paid or denied) at least 91 days of their receipt.

Column 13 – Percent of Total — Enter the percentage of manually submitted claims processed at least 91 days of their receipt. (Compared to total claims processed. Divide Column 12 by Column 5 to arrive at percent.).

Column 14 – Non-processed Claims On-Hand at End of Quarter — Enter the number of manually submitted claims on hand that were not processed as of closing date of the last report period. (Should be the difference of Column 4 minus Column 5). Same number should match number of claims entered in Column 2 of next quarter report.

Column 15 – Percent of Claims Not Processed at End of Quarter — Divide Column 14 by Column 4 to arrive at percent.

Table 4B

Use Table 4B to report **electronically submitted** claims that were processed during the quarterly period. Claims submitted and processed manually must be reported separately on Table 4A. Electronic claims submission shall be processed within 30 days of receipt. Report amounts for each consolidated category of service and total listed in Column 1 in the following columns:

Column 2 – Non-Processed Claims from Prior Quarters — Enter the number of electronically submitted claims on-hand that were unprocessed as of the closing date of the last quarterly period. The number should be the same as was reported in Column 16 of the prior quarterly report.

Column 3 – Claims Received During Quarter — Enter the amount of all electronically submitted claims that were received during the quarterly period being reported.

Column 4 – Total Claims — Enter the sum of Columns 2 and 3.

Column 5 – Claims Processed This Quarter — Enter the amount of all electronically submitted claims processed (both paid and denied) during the quarterly period being reported. Do not count pended claims.

Column 6 – 01-30 Days — Enter the number of electronically submitted claims that were processed (either paid or denied) within 30 days of their receipt. Note: The number of days required to process a claim is calculated by comparing the date the claim was received by the contractor to the date the claim was paid or denied by the contractor (See Article 7.16.5 of the contract for further detail).

Column 7 – Percent of Total — Enter the percentage of electronically submitted claims processed within 30 days (Compared to total claims processed. Divide Column 6 by Column 5 to arrive at percent.).

Column 8 – 31–60 Days — Enter the number of electronically submitted claims that were processed (either paid or denied) between 31–60 days of their receipt.

Column 9 – Percent of Total — Enter the percentage of electronically submitted claims processed between 41–60 days (Compared to total claims processed. Divide Column 8 by Column 5 to arrive at percent.).

Column 10 – 61–90 Days — Enter the number of electronically submitted claims that were processed (either paid or denied) between 61-90 days of their receipt.

Column 11 – Percent of Total — Enter the percentage of electronically submitted claims processed between 61–90 days (Compared to total claims processed. Divide Column 10 by Column 5 to arrive at percent.).

Column 12 – 91-120 Days — Enter the number of electronically submitted claims that were processed (either paid or denied) at least 91days of their receipt.

Column 13 – Percent of Total — Enter the percentage of electronically submitted claims processed at least 91days of their receipt (Compared to total claims processed. Divide Column 12 by Column 5 to arrive at percent.).

Column 14 – Non-processed Claims On-Hand at End of Quarter — Enter the number of electronically submitted claims on hand that were not processed as of closing date of the last report period. (Should be the difference of Column 4 minus Column 5). Same number should match number of claims entered in Column 2 of next quarter report.

Column 15 – Percent of Claims Not Processed at End of Quarter — Divide Column 14 by Column 4 to arrive at percent.

Grand Totals for 4A and 4B

Columns 2-6, 8, 10, 12, 16 - Add total from line 18 Part A and total from line 18 Part B.

Grand Total Percentage calculations:

For Column 7, divide Column 6 grand totals for 4A and 4B by Column 5
For Column 9, Combine grand totals from Column 6 and Column 8 and divide that sum by Column 5
For Column 11, Combine the grand totals of Column 6, Column 8 and Column 10 and divide that sum by Column 5

Table 6: Allowable Direct Medical Expenditures

Submission Due After Each Quarter End

The contractor shall report quarterly its expenditures for allowable direct medical activities for purposes of calculating the medical cost ratio.

Expenses are to be reported for the current quarter and for the past 12 months.

Table 7: Stop Loss Summary (Parts A – C)

Submission Due after Each Quarter End

The contractor shall identify reinsurance coverage in effect during the calendar year for the reporting period ending December 31 of each year.

Part A – Coverage – The contractor shall list specific information about the stop loss policy.

- Aggregate Stop-Loss Threshold
- Maximum Per Enrollee Per Year
- Maximum Aggregate Lifetime per Enrollee
- Includes Insolvency Insurance (Y/N)
- Deductible
- Cost of Premiums PMPM

Part B - For each of the designated eligibility categories, the contractor shall report the total number of enrollees that exceeded the stop-loss threshold and the total net expenditures exceeding the stop-loss threshold during the period.

Part C – List Details for Each Individual (Name or ID Not Required) – For each individual, the Contractor shall report the net expenditures above stop-loss, primary diagnosis/major procedure and reinsurance recoveries. Reinsurance recoveries should be totaled for all individuals.

Table 10: Third Party Liability and Fraud/Abuse Collections

Submission Due after Each Quarter End

The Contractor shall report for the current quarter and the last 12 months the categories of all third party liability collections and shall include the amounts and nature of all third party payments recovered for Medicaid/ NJ FamilyCare enrollees, including but not limited to, payments for services and conditions which are:

- covered through coordination of benefits;
- employment related injuries or illnesses;
- related to motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists; and
- contained in diagnosis Codes 800 through 999 (ICD9CM) with the exception of Code 994.6.

The Contractor shall report for the current quarter and the last 12 months the following through the Contractor's Fraud and Abuse (FA) unit for Medicaid/NJ FamilyCare enrollees.

- the total number of claims for which fraud, waste, and abuse investigations were initiated;
- the number of potential fraud, waste, and abuse claims turned over to DMAHS;
- the estimated value of the claims turned over to DMAHS; and
- total fraud, waste, and abuse collections recovered.

The Contractor shall note if third party liability collections and fraud and abuse collections are reflected as income or claim reductions withinTables 19 and 20.

Table 11: Utilization and Unit Cost Information (Parts A – B)

Annual Submission Due after September 30 Quarter End

The Contractor shall submit on an annual basis a detailed summary of utilization and unit cost information during the year.

Cost & Utilization by Non-FamilyCare Rate Cell Grouping

The Contractor shall complete the Excel template labeled “11A” providing a year-over-year comparison of the current and preceding State fiscal year incurred claims experience. The information shall include all data with incurred dates through the previous and most recent state fiscal year, with paid data through September 30 (incurred in 12 months, paid in 27 months for previous State fiscal year, and 15 months for recent State fiscal year). The information shall be reported by category of service for the non-FamilyCare rate cells of A, B and D-F using the financial category of service mapping provided at the bottom of the table. Data must reconcile to Report 19, Parts A, B and D-F by category of service, by rate cell, and in total.

Cost & Utilization by FamilyCare Rate Cell Grouping

The Contractor shall complete the Excel template labeled “11B” providing a year-over-year comparison of the current and preceding State fiscal year incurred claims experience. The information shall include all data with incurred dates through the previous and most recent State fiscal year, with paid data through September 30 (incurred in 12 months, paid in 27 months for previous State fiscal year, and 15 months for recent State fiscal year). This information shall by reported by category of service for NJ FamilyCare rate cell C using the financial category of service mapping provided at the bottom of the table. Data must reconcile to the Report 19, Part C by category of service, and in total.

Definitions of key utilization measures are provided in Appendix B.

Table 14: HMO Administrative Expenses

Annual Submission Due after September 30 Quarter End

The Contractor shall submit on the fiscal quarter year ending reports (September 30) a detailed summary of administrative and claims expense information during the year. Besides quarter ending September 30, this information is not required for any other quarter ending time periods.

Only parts B and C are required and included in the template. Part A has been removed. Part B has been modified from prior versions.

Documentation

With Table 14 the Contractor shall provide a chart of general ledger expense accounts and a crosswalk mapping of these accounts to the reporting manual’s rate cell grouping costs. Detail shall include the following:

- account name,
- account description,
- SFY-end, total year-ending balance,
- SFY-end, total year-ending balance allocated to Medicaid/NJ FamilyCare program, and
- designation between medical and administrative expense account.

The Contractor shall provide all corporate cost allocation schedules and methodologies for allocated Contractor expenditures and corporate administrative allocations to each line of business. In addition, the Contractor shall provide all allocation schedules and the methodology used to allocate administrative expenditures to general ledger accounts that are not directly chargeable to a specific account. **Note: If there are no changes since last year's submission, the Contractor shall indicate as such and provide no additional information.**

Administrative Contracts and Related Party Charges

The Contractor shall provide a copy of all administrative services contracts and management agreements (including price page) delegating administrative functions to a third party, including related or affiliated parties. In addition, the Contractor shall provide all contracts with related or affiliated parties applicable during any part of SFY-end. **Note: If there are no changes since last year's submission, the Contractor shall indicate as such and shall not provide the contracts.** If the Contractor does not wish to send contracts, the Contractor shall provide a detailed list of such contracts, the total cost, and the amount charged to Medicaid/NJ FamilyCare program for SFY-end. For each contract the Contractor shall also provide the total cost of the contract and the amount charged to Medicaid/NJ FamilyCare program for SFY-end. This shall include, but not be limited to, the following:

- management service agreements,
- PBM services agreement,
- delegated CM/DM agreements,
- delegated member/provider services agreements,
- claims processing agreements,
- integrated delivery system agreements,
- agreements for the administration of dental, vision, and pharmacy claims and/or benefits, and
- any other contract with a related or affiliated party for non-medical services or charges.

Administrative Expense Detail

Table 14B is broken out by the various administrative expense categories from Table 19. For each category, the contractor shall provide that total dollar amount reported as administration expense which should tie to the amount reported in Table 19.

Some categories are broken out in to subcategories. For each category and subcategory, the contractor shall provide the following:

- The GL accounts and account descriptions for each account that pertains to that subcategory
- HMO direct changes for that subcategory
- Corporate allocation dollars for that subcategory

- Management service agreement dollars for that subcategory

The Contractor shall reconcile the amounts reported per the SFY-end, Table 19, with the information being submitted in Table 14.

Capitation Arrangements

Depending on the arrangement with providers, a Contractor shall include either the entire portion of the capitation payment in a medical expense line, or it will break out a portion of the capitation amount and report that in an administrative expense line. Examples of services that may be capitated have been provided. However, if there are other capitated services, the Contractor shall include these services on the worksheet. Based upon the above information, the Contractor shall complete Table 14C for each service that the Contractor contracts with providers on a capitated basis.

Appendix A

IBNR Methodology

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

Selection of the most appropriate system for estimating IBNR claims expense requires judgment based on a Contractor's own circumstances, characteristics, and the availability and reliability of various data sources. A primary estimation methodology along with supplementary analysis usually produces the most accurate IBNR estimates. Other common elements needed for successful IBNR systems are as follows:

- An IBNR system must function as part of the overall financial management and claims system. These systems combine to collect, analyze, and share claims data. They require effective referral, prior authorization, utilization review, and discharge planning functions. Also, the Contractor must have a full accrual accounting system. Full accrual accounting systems help properly identify and record the expense, together with the related liability, for all unpaid and unbilled medical services provided to Contractor members.

- An effective IBNR system requires the development of reliable lag tables that identify the length of time between provision of service, receipt of claims, and processing and payment of claims by major provider type (inpatient hospital, physician, pharmacy, and other medical). Reliable claims/cash disbursement systems generally produce most of the necessary data. Lag tables, and the projections developed from them, are most useful when there is sufficient, accurate claims history, which show stable claims lag patterns. Otherwise, the tables will need modification, on a pro forma basis, to reflect corrections for known errors or skewed payment patterns. The data included in the lag schedules shall include all information received to date in order to take advantage of all known amounts (i.e., RBUCs and paid claims).

Accurate, complete, and timely claims data shall be monitored, collected, compiled, and evaluated as early as possible. Whenever practical, claims data collection and analysis shall begin **before** the service is provided (i.e., prior authorization records). This prospective claims data, together with claims data collected as the services are provided, shall be used to identify claims liabilities. Claims data shall also be segregated to permit analysis by major rate code, region/county, and consolidated category of service.

Subcontractor agreements shall clearly state each party's responsibility for claims/encounter submission, prior notification, authorization, and reimbursement rates. These agreements shall be in writing, clearly understood and followed consistently by each party.

The individual IBNR amounts, once established, shall be monitored for adequacy and adjusted as needed. If IBNR estimates are subsequently found to be significantly inaccurate, analysis

shall be performed to determine the reasons for the inaccuracy. Such an analysis shall be used to refine a Contractor's IBNR methodology if applicable.

There are several different methods that can be used to determine the amount of IBNRs. The Contractor shall employ the one that best meets its needs and accurately estimates its IBNRs. If a Contractor is utilizing a method different from the methods included herein, a detailed description of the process must be submitted to DMAHS for approval. This process may be described in the "Notes to Financial Reports" section. The IBNR methodology used by the Contractor must be evaluated by the Contractor's independent accountant or actuary for reasonableness.

Case Basis Method

Accruals are based on estimates of individual claims and/or episodes. This method is generally used for those types of claims where the amount of the cost will be large, requiring prior authorization. The final estimated cost could be made after the services have been authorized by the Contractor. For example, if a Contractor knows how many hospital days were authorized for a certain time period, and can incorporate the contracted reimbursement arrangement(s) with the hospital(s), a reasonable estimate should be attainable. This is also the most common and can be the most accurate method for small and medium sized organizations.

Average Cost Method

As the name suggests, average costs of services are used to estimate total expense. Two primary average cost methods are discussed below. It is important to note that each method may be used by a Contractor to estimate different categories of IBNRs (i.e., hospitalization vs. other medical). Also, either method may be utilized in conjunction with other IBNR methodologies discussed in this document.

PMPM Averages

Under this method the average costs are based on the population of each rate code (or group of homogenous rate codes) over a given time period, in this case one month. The average cost may cover one or more service categories and is multiplied by the number of members in the specific population to estimate the total expense of the service category. Any claims paid are subtracted from the expense estimate that results in the IBNR liability estimate for that service category.

Per Diem or Per Service Averages

Averages for this method are of specific occurrences known by the Contractor at the time of the estimation. Therefore, it is first necessary to know how many hospital days, procedures or visits were authorized as of the date for which the IBNR is being estimated. Again, once the total expense has been estimated, the amount of related paid claims shall be subtracted to get the IBNR liability. This method is primarily used for hospitalization IBNRs as Contractors know the amount of hospital days authorized at any given time.

Lag Tables

Lag tables are used to track historical payment patterns. When a sufficient history exists and a regular claims submission pattern has been established, this methodology can be employed. All Contractors shall use lag information as a validation test for accruals calculated using other methods, if it is not the primary methodology employed. Typically, the information on the schedules is organized according to the month claims are incurred on the horizontal axis and the month claims are paid by the Contractor on the vertical axis.

Once a number of months becomes “fully developed” (i.e. claims submissions are thought to be complete for the month of service), the information can be utilized to effectively estimate IBNRs. Computing the average period over which claims are submitted historically and applying this information to months that are not yet fully developed does this.

Appendix B

Key Utilization Definitions

The definitions of key utilization measures are provided below.

CATEGORY OF SERVICE MEASURE	MEASURE	TYPE OF UTILIZATION/ PROXY FOR	DEFINITIONS
Inpatient Hospital	Inpatient Hospital Days	Quantity/Days	Days are calculated as follows: Number of days between Admit and Discharge dates (Exclude admit and denied days. Include discharge day). If dates are equal, inpatient day is counted as one (1). Days counted should be all paid days of service, regardless of year, for each admission that occurred in the year. If the admission and discharge do not occur in the same year, all days are counted as occurring in the year in which the admission occurs. Include data for which you are both the primary payor and the secondary payor.
Primary Care Services	Primary Care Visits	Quantity/Services	A visit is defined as one or more professional contacts between a patient and unique service provider on a unique date of service.
Physician Specialty Services	Physician Specialty Visits	Quantity/Services	A visit is defined as one or more professional contacts between a patient and a unique service provider on a unique date of service.

CATEGORY OF SERVICE MEASURE	MEASURE	TYPE OF UTILIZATION/ PROXY FOR	DEFINITIONS
Emergency Room	Emergency Room Visits	Quantity/Services	This measure summarizes utilization of Emergency Department Visits and Observation Room Stays that result in discharge. Observation and/or Emergency Room Stays resulting in an inpatient admission should not be counted on this report. Each visit to an Emergency Department that does not result in an admission should be counted once, regardless of the intensity of care required during the stay or the length of stay. Patients admitted to the hospital from the Emergency Department should not be included in counts of visits. Visits to urgent care centers should be counted.
Dental	Dental Visits	Claim Count/Visits	A visit is defined as one or more professional contacts between a patient and a unique service provider on a unique date of service.
Pharmacy	Prescriptions	Claim Count/Prescriptions	A prescription is defined as one fill of a prescription that is filled by a pharmacist based on the written order to supply a particular medication for a specific patient with instructions for its use.
Outpatient Facility	Outpatient Facility Visits	Quantity/Services	A visit is defined as one or more professional contacts between a patient and a unique service provider on a unique date of service. The visit can be to a free standing or a hospital outpatient department.
DME/Medical Supplies & Orthotics/Prosthetics	DME/Medical Supplies & Orthotics/Prosthetics Units	Claim Count/Claims	A unit is counted as one for each unique claim.

CATEGORY OF SERVICE MEASURE	MEASURE	TYPE OF UTILIZATION/ PROXY FOR	DEFINITIONS
Home Health Care	Home Health Care Services	Quantity/Services	A service is defined as one or more professional contacts between a patient and a unique service provider on a unique date of service.
Laboratory & Radiology	Laboratory & Radiology Units	Claim Count/Claims	A unit is counted as one for each unique claim.
Transportation	Transportation Units	Claim Count/Transports	A unit is counted as one for each unique claim. Round trip transportation is considered one unit.
All Other Practitioners and Services	All Other Practitioner and Services	Quantity/Services	A service is defined as one or more professional contacts between a patient and a unique service provider on a unique date of service.

Appendix C

Managed Care Category of Service Codes

The definiation of managed care category of service codes are defined in the matrix below.

Hierarchy Line #	Enc Group	Group Name	MC CoS	MC CoS Name	Line # for Financials	TAXONOMY	Bill Type	Specific Therapeutic Class	Procedure or Revenue Code	Primary Diagnosis Code	Patient Age	HIPAA Format	Other
010	MS	Medical Supplies	B	Pharmacy - Not Reimbursable	15			X0A-X8V, Y0E, Y1A-Y1B, Y2G, Y4B, Y5A-Y5C, Y7A-Y7B, Y8B, Y9A				NCPDP	
020	ME	Medical Equipment	B	Pharmacy - Not Reimbursable	15			Y0A-Y0B, Y0D, Y3A-Y3C				NCPDP	
030	HA	Hearing Aids	B	Pharmacy - Not Reimbursable	15			Y8A				NCPDP	
040	RX	Pharmacy	A	Pharmacy - Reimbursable	19			W5B, W5C, W5I-W5P , W5Q, W5T, W5U, M0E, M0F				NCPDP	
050	RX	Pharmacy	B	Pharmacy - Not Reimbursable	18							NCPDP	
060	MH	Mental Health	I	Inpatient Hospital	24		11x, 12x			Primary diagnosis: V11-V11.99, V40-V40.99, V61-V62.9, V71.0-V71.09, V79.8-V79.9, 293.89-293.9, 294.10-294.11, 295-302.9, 306-310, 311-314.9, 648.4-648.44, V17.0, V66.3, V67.3		837I	Payment Code: B, C, D, E, I, J, K, S, U, W, X, Z
070	SA	Substance Abuse	I	Inpatient Hospital	24		11x, 12x			Primary diagnosis: 291.3, 291.4, 291.5-291.8, 291.81, 291.82, 291.89-292.0, 292.1-292.12, 292.2, 292.8, 292.84-292.89, 303-305.0, 305.2-305.9, 648.3-648.34, V65.42, V79.1		837I	Payment Code: B, C, D, E, I, J, K, S, U, W, X, Z
080	IA	Inpatient Acute	I	Inpatient Hospital	09		11x, 12x					837I	
090	MH	Mental Health	E	Outpatient Hospital, Emergency Room	24		13x		450-459	Primary diagnosis: V11-V11.99, V40-V40.99, V61-V62.9, V71.0-V71.09, V79.8-V79.9, 293.89-293.9, 294.10-294.11, 295-302.9, 306-310, 311-314.9, 648.4-648.44, V17.0, V66.3, V67.3		837I	Payment Code: B, C, D, E, I, J, K, S, U, W, X, Z
100	SA	Substance Abuse	E	Outpatient Hospital, Emergency Room	24		13x		450-459	Primary diagnosis: 291.3, 291.4, 291.5-291.8, 291.81, 291.82, 291.89-292.0, 292.1-292.12, 292.2, 292.8, 292.84-292.89, 303-305.0, 305.2-305.9, 648.3-648.34, V65.42, V79.1		837I	Payment Code: B, C, D, E, I, J, K, S, U, W, X, Z
110	ER	Emergency Room	E	Outpatient Hospital, Emergency Room	14		13x		450-459			837I	
120	EP	EPSDT	O	Outpatient Hospital not ER	26		13x		510, 515	Primary diagnosis: V20-V20.2, V70.0,V70.3-V70.9, V30.0-V34.2, V36	Age<21	837I	
130	MH	Mental Health	O	Outpatient Hospital not ER	24		13x, 2xx			Primary diagnosis: V11-V11.99, V40-V40.99, V61-V62.9, V71.0-V71.09, V79.8-V79.9, 293.89-293.9, 294.10-294.11, 295-302.9, 306-310, 311-314.9, 648.4-648.44, V17.0, V66.3, V67.3		837I	Payment Code: B, C, D, E, I, J, K, S, U, W, X, Z
140	MH	Mental Health	O	Outpatient Hospital not ER	24		13x, 2xx		513, 900-919			837I	Payment Code: B, C, D, E, I, J, K, S, U, W, X, Z
150	SA	Substance Abuse	O	Outpatient Hospital not ER	24		13x, 2xx			Primary diagnosis: 291.3, 291.4, 291.5-291.8, 291.81, 291.82, 291.89-292.0, 292.1-292.12, 292.2, 292.8, 292.84-292.89, 303-305.0, 305.2-305.9, 648.3-648.34, V65.42, V79.1		837I	Payment Code: B, C, D, E, I, J, K, S, U, W, X, Z
160	RX	Pharmacy*	O	Outpatient Hospital not ER	18		13x, 2xx		250-259			837I	
170	MS	Medical Supplies	O	Outpatient Hospital not ER	15		13x, 2xx		270-279			837I	
180	ME	Medical Equipment	O	Outpatient Hospital not ER	15		13x, 2xx		290-299			837I	
190	LS	Laboratory Services	O	Outpatient Hospital not ER	22		13x, 2xx		80000-89999, G0103, G0107, G0328, P2028-P9615, Q0091, Q0111-Q0116, Rev 300-319			837I	
200	RA	Radiology	O	Outpatient Hospital not ER	22		13x, 2xx		70000-79999, G0030-G0047, G0125, G0130, G0202-G0234, G0252-G0254, G0275, G0278, G0296, G0336, Q0092, R0070-R0076, S8030-S8092, Rev 320-359, Rev 400-409			837I	
210	AU	Audiology	O	Outpatient Hospital not ER	13		13x, 2xx		470-479			837I	
220	TR	Transportation	O	Outpatient Hospital not ER	21		13x, 2xx		540-549			837I	
230	HH	Home Health	O	Outpatient Hospital not ER	20		14x					837I	
240	OO	Outpatient Other	O	Outpatient Hospital not ER	12		13x, 2xx, 7xx, 8xx					837I	
250	MS	Medical Supplies	H	Home Health	15		3xx		270-279			837I	
260	ME	Medical Equipment	H	Home Health	15		3xx		290-299			837I	
265	HO	Hospice Services	H	Home Health	20		3xx		650-659			837I	
270	HH	Home Health	H	Home Health	20		3xx					837I	
280	EP	EPSDT	D	Dental	27				D0000-D9999, 00000-09999		Age<21	837D	not Cap Code (40199, 40299, 40399, 65499, 67499, 68499, 27699, 276A9, 276C9, 56199, 56299, 57399, 57199, 57899, 58499, 90399, 92599, 93399, 95499, 97499, 98499)

Managed Care Category of Service Codes

The definiation of managed care category of service codes are defined in the matrix below.

285	EP	EPSDT	D	Dental	27				D1000-D1999, 01000-01999, D0100-D0999, 00100-00999		Age<12	837D	Cap Code (27699, 276C9, 57199, 57899, 58499, 90399, 92599, 93399, 95499, 97499, 98499)
290	DD	Dental	D	Dental	17				D0000-D9999, 00000-09999			837D	not Cap Code (27699, 276A9, 276C9, 40199, 40299, 40399, 57199, 56199, 56299, 57399, 57899, 58499, 65499, 67499, 68499, 90399, 92599, 93399, 95499, 97499, 98499)
310	DD	Dental	D	Dental	17				41800-41899			837P	not Cap Code (27699, 276A9, 276C9, 40199, 40299, 40399, 57199, 56199, 56299, 57399, 57899, 58499, 65499, 67499, 68499, 90399, 92599, 93399, 95499, 97499, 98499)
320	MS	Medical Supplies	R	Medical Supplies	15				A4206-A7526, A9150-A9700, B4034-B9999, K0137-K0194, K0277-K0283, K0400-K0401, K0407-K0411, K0415-K0416, K0419-K0439, K0450-K0451, K0529-K0530, K0536-K0537, K0539-K0540, K0561-K0597, K0611-K0614, K0620-K0626, S8100-S8190, S8401-S9001, T4521-T4542, T5001, T5999			837P	
321	MS	Medical Supplies	R	Medical Supplies	15	332B			Q3000-Q3012, Q4001-Q4051, Q9945-Q9950, S9208-S9379, S9490-S9590			837P	
330	ME	Medical Equipment	Q	Durable Medical Equipment	15				A9900-A9999, E0100-E2599, E2601-E8002, J1817, J7500-J7502, J7515, J7517, J7608, J7611-J7622, J7624, J7626-J7631, J7633, J7635-J7644, J7648-J7649, J7658-J7659, J7668-J7669, J7680-J7684, K0001-K0109, K0119-K0121, K0195, K0268-K0270, K0284, K0412, K0417-K0418, K0452, K0455-K0462, K0501, K0503-K0509, K0511-K0516, K0518-K0528, K0531-K0534, K0538, K0541-K0552, K0600-K0610, K0615-K0619, K0627, K0650-K0669			837P	
340	HA	Hearing Aids	J	Hearing Aids	15				V5008-V5999, Y4630, Y4640			837P	
350	HA	Hearing Aids	J	Hearing Aids	15	332S						837P	
360	MH	Mental Health	M	Mental Health	24					Primary diagnosis: V11-V11.99, V40-V40.99, V61-V62.9, V71.0-V71.09, V79.8-V79.9, 293.89-293.9, 294.10-294.11, 295-302.9, 306-310, 311-314.9, 648.4-648.44, V17.0, V66.3, V67.3		837P	Payment Code: B, C, D, E, I, J, K, S, U, W, X, Z
370	SA	Substance Abuse	N	Substance Abuse	24					Primary diagnosis: 291.3, 291.4, 291.5-291.8, 291.81, 291.82, 291.89-292.0, 292.1-292.12, 292.2, 292.8, 292.84-292.89, 303-305.0, 305.2-305.9, 648.3-648.34, V65.42, V79.1		837P	Payment Code: B, C, D, E, I, J, K, S, U, W, X, Z
380	FP	Family Planning	U	Family Planning	28				54056, 56501, 57100, 57452, 57454, 57460, 57500, 57511, 81002, 82948, 86696, 87270, 87274, 87320, 87490, 87491, 87590, 87591, 87620, 87621, 88175, 88305, 90649, 90746, 90772, J3490, Y7633, Y7634			837P	Modifier 1 = FP
382	FP	Family Planning	U	Family Planning	28				85018			837P	Modifier 1 = FP, 2 = QW
384	FP	Family Planning	U	Family Planning	28				11975, 11977, 58300, 58752, 76948, 89329, 89330, J1055, J1056, J7300, J7302-J7304, J7307, Z4333, Z4334			837P	
385	FP	Family Planning	U	Family Planning	28				11976, 11981-11983, 36415, 37788, 52010, 54300, 54304, 54308, 54312, 54316, 54318, 54322, 54324, 54326, 54328, 54332, 54336, 54340, 54344, 54348, 54352, 54360, 54400, 54401, 54405, 54450, 54500, 54505, 54830, 55200, 55300, 55520, 55530, 55535, 55540, 55600, 55605, 55680, 55870, 57160, 57335, 57410, 57415, 57505, 57720, 57800, 58100, 58120, 58140, 58145, 58301, 58340, 58400, 58540, 58740, 58750, 58760, 58770, 58900, 74740, 76856, 76857, 76870, 81000, 81025, 82160, 82465, 82947, 83516, 83518, 84066, 84702, 84703, 85013, 86255, 86256, 86359, 86360, 86592, 86593, 86631, 86632, 86674, 86687-86689, 86694, 86695, 86701-86703, 86729, 86762, 86781, 87075, 87076, 87086, 87110, 87164, 87184, 87205, 87207, 87210, 87220, 87250, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 89300, 89310, 89320, 89325, 90706, 90707, 99201-99205, 99211-99215, 99221-99223, 99231-99233, 99238, 99241-99245, 99251-99255, 99383-99387, 99393-99397, J0696, Q0111			837P	FP Indicator on Claim

Managed Care Category of Service Codes

The definiation of managed care category of service codes are defined in the matrix below.

386	FP	Family Planning	U	Family Planning	28					Primary diagnosis: 697, 9617, 9724, V2509, V251, V252, V2549, V254-V2543, V255, V258, V259, V25-V2503, V263, V2631-V2635, V2639, V2651, V2652, V280, V615		837P	
388	FP	Family Planning	U	Family Planning	28					Primary diagnosis: 0029, 6019, 6071-6073, 6079, 612, 620, 621, 6212, 631, 632, 633, 6359, 636, 638, 6383, 6389, 6392-6394, 640, 6442, 650, 6511-6514, 6519, 6522, 6524, 658, 6581, 6589, 6591, 6592, 660, 6619, 664, 6652, 6671, 668, 6691, 6692, 6699, 670, 675, 6751, 6759, 6762, 6769, 6811, 6812, 6819, 6821-6823, 6829, 6921, 6922, 6929, 6942, 6949, 7011-7014, 7072, 7073, 7074, 7092, 8782-8785, 8789, 8794, 8795, 890-8909, 897, 913, 9131-9136, 9139, 914, 9141-9146, 9149, 9618, 9725, 9771, 9773, 9774, 9924		837P	FP Indicator on Claim
390	LS	Laboratory Services	L	Laboratory Services	22	29						837P	
400	LS	Laboratory Services	L	Laboratory Services	22				80000-89999, G0103, G0107, G0328, P2028-P9615, Q0091, Q0111-Q0116			837P	
410	RA	Radiology	X	Radiology	22				70000-79999, G0030-G0047, G0125, G0130, G0202-G0234, G0252-G0254, G0275, G0278, G0296, G0336, Q0092, R0070-R0076, S8030-S8092			837P	
430	EP	EPSDT	Y	EPSDT Private Duty Nursing	26				S9123-S9124		Age<21	837P	
440	EP	EPSDT	S	EPSDT Medical	26				99381-99385, 99391-99395, 99431, 99432, 99460, 99461, 99462		Age<21	837P	
450	EP	EPSDT	S	EPSDT Medical	26				99201-99205, 99211-99215, 99420	Primary diagnosis: V20-V20.2, V70.0,V70.3-V70.9, V30.0-V34.2, V36	Age<21	837P	
465	HH	Home Health	H	Home Health	20				G0129, G0154, S9122-S9124, S9127-S9131, T1000-T1004, T1019-T1022, T1030, T1031, 99500-99600			837P	
470	PO	Prosthetics & Orthotics	P	Prosthetics & Orthotics	16				K0112-K0116, K0440-K0449, K0556-K0560, K0628-K0649, L0000-L9999			837P	
480	AU	Audiology	K	Audiology	13	231, 237, 2355						837P	
490	VC	Vision Care	W	Optical Appliances	23				S0500-S0592, V2020-V2799			837P	
500	VC	Vision Care	V	Optometrist Services	23	15						837P	
510	VC	Vision Care	3	Physician	23	207W						837P	
515	TR	Transportation	T	Transportation	21				A0020-A0999, Q3019-Q3020, S0207-S0215, T2001-T2007			837P	
530	SM	Standard Medical	4	Nurse Specialty	13, 10 if PCI	363L, 367						837P	
540	OT	Other Therapies	F	Podiatrist Services	13	21						837P	
550	OT	Other Therapies	C	Chiropractic & Other Therapies	13	Not 20			97001-97799, 98925-98943			837P	
560	HO	Hospice Services	G	Hospice Services	20				S9125, S9126, T2042			837P	
580	SM	Standard Medical	5	Physician Assistant	13, 10 if PCI	363A						837P	
590	OT	Other Therapies	3	Physician	13	20			97001-97799, 98925-98943			837P	
600	SM	Standard Medical	3	Physician	11, 10 if PCI	20						837P	
610	UN	Unclassified	Z	Other	29							Any	All Remaining Encounters
Deleted 520	PC	Primary Care	2	Primary Care (Physician MD or DO, Nurse Practitioner, Nurse Midwife,Physician Assistant)	10				Not 97001-97799, Not 98925-98943			837P	2310A/NM101 = P3, 2420F/NM101 = P3
Deleted 460	EP	EPSDT	S	EPSDT Medical	26				99431 and 99432 Redistributed to Line 440	V30.0-V34.2, V36 Redistributed to Lines 120 and 450		837P	
Deleted From 385	FP	Family Planning	U	Family Planning					9924				
Deleted From 386	FP	Family Planning	U	Family Planning						6576			
Deleted From 388	FP	Family Planning	U	Family Planning						0028, 5421, 5844, 5845, 5846, 6309, 6491, 6495, 6501, 6509, 6579, 6673, 6679, 6813, 6909, 7022, 7029, 7031, 7075, 8879, 8926, 9449			

Appendix D

Report Forms

12-Month Period End Reports Due after Each Quarter End

This section includes copies of the forms to be completed electronically by the Contractor for each quarter end.

- Certification Statement at Each Quarter End
- Table 4: Claims Processing Lag Report
  - Part A: Claims Processing Lag Report for Manually Submitted Claims
  - Part B: Claims Processing Lag Report for Electronically Submitted Claims
- Table 6: Allowable Direct Medical Expenditures
- Table 7: Stop Loss Summary
- Table 10: Third Party Liability and Fraud/Abuse Collections
- Table 19:
  - Part A-R2: Income Statement by Rate Cell Grouping On Claims Incurred for current 12 month end
  - Part S2: All Income Statement by all At Risk Rate Cell Grouping On Claims Incurred for current 12 month
  - Part S3: Reconciliations
- Table 20: Lag Report
  - Part A: Lag Report for Inpatient Hospital Payments
  - Part B: Lag Report for Physician Payments
  - Part C: Lag Report for Pharmacy Payments
  - Part D: Lag Report for Other Medical Payments
- Table 21: Maternity Outcome Counts
- Notes to Financial Reports

Annual Supplemental Reports Due

This section includes copies of the forms to be completed electronically by the Contractor for each September 30 quarter end.

- Certification Statement at Each September 30 Quarter End
- Table 11: Utilization and Unit Cost Information
- Table 14: HMO Administrative Expenses
- Table 19:
  - Part A-R2: Income Statement by Rate Cell Grouping On Claims Incurred for state fiscal year (SFY) end at 09/30
  - Part S2: All Income Statement by all At-Risk Rate Cell Grouping On Claims Incurred for current 12 month end
  - Part S3: Reconciliations
  - Part T: Non-State Plan Services
- Table 20: Lag Report
  - Part A: Lag Report for Inpatient Hospital Payments

  - Part B: Lag Report for Physician Payments
  - Part C: Lag Report for Pharmacy Payments
  - Part D: Lag Report for Other Medical Payments
- General Ledger for period ending June 30. This should only include items pertaining to the Medicaid line of business and should reconcile to the Administration total on Table 19 S2.

- Notes to Financial Reports

Appendix E

Certification Statement for Each Quarter End

The Certification Statement is located on the following pages.

The Certification Statement shall be submitted quarterly to David Moran, the Director, HMO Financial Reporting, on the same due dates as required in the General Instructions.

Certification Statement – Annual Reports

The Certification Statement is located on the following pages.

A Certification Statement shall be submitted annually to David Moran, the Director, HMO Financial Reporting, on the same due dates as required in the General Instructions.

CERTIFICATION STATEMENT FOR EACH QUARTER END

OF

_____
(Contractor Name)

TO THE

NEW JERSEY DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

FOR THE PERIOD ENDED

_____
(Month/Day/Year)

Name of Preparer _____

Title _____

Phone Number _____

Please check which tables are included with this packet:

☐ Table 4 A and B
☐ Table 6
☐ Table 7
☐ Table 10
☐ Table 19 A-R2, S2, S3
☐ Table 20 A-D
☐ Table 21
☐ Notes

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

_____	_____	_____
Date	Chief Financial Officer	Signature

CERTIFICATION STATEMENT FOR EACH SEPTEMBER 30 QUARTER END

OF

_____
(Contractor Name)

TO THE

NEW JERSEY DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

FOR THE PERIOD ENDED

_____
(Month/Day/Year)

Name of Preparer _____

Title _____

Phone Number _____

Please check which tables are included with this packet:

☐ Table 11 A-B ☐ Table 19 A-R2, S2, S3, T ☐ GL at 06/30
☐ Table 14 ☐ Table 20 A-D ☐ Notes

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

_____	_____	_____
Date	Chief Financial Officer	Signature

NOTES TO FINANCIAL REPORTS

Any notes or further explanations of any items contained in any of the reports or in the reporting of financial disclosures are to be noted here. Appropriate references and attachments are to be used as necessary. Space is provided below or you may use a separate page as necessary.

Table 19 – Parts A through R2, - Income Statement by Rate Cell Grouping On Claims Incurred for CURRENT 12 MONTH END

HMO Name: _____

For the Current 12 months Ending: _____

Income Statement $ by Rate Cell Grouping A through R2

	Rate Cell Description	Non ABD Adults	Non ABD Children	FamilyCare Parents	NJ KidCare	ABD W Medicare	ABD W/O Medicare		Maternity	Newborns	At Risk Total
	Plan	A	A, B & C	D	D	A	A			less than 75 days	
	Cap Stems	373, 394	173, 193	594	993	773, 795, 796	494, 812, 873, 895			803, 903	
	Table 19 Part :	A	B	C	D	E	F		R1	R2	
	Member Months [1]										
REVENUES:											
1	Capitated Premiums										
2	Maternity										
3	**Total Premiums (lines 1-2)**										
4	Reimbursable HIV/AIDS Drugs and Blood Products										
5	EPSDT Incentive Payment										
6	Other										
7	**Total Other Reimbursements (lines 4-6)**										
8	**TOTAL Premiums & Reimbursements (Lines 3 & 7)**										
EXPENSES:											
MEDICAL AND HOSPITAL											
9	Inpatient Hospital										
10	Primary Care										
11	Physician Specialty Services										
12	Outpatient Hospital (excludes ER)										
13	Other Professional Services										
14	Emergency Room										
15	DME/Medical Supplies										
16	Prosthetics & Orthotics										
17	Covered Dental										
18	Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products)										
19	Reimbursable HIV/AIDS Drugs and Blood Products										
20	Home Health, Hospice, & PDN										
21	Transportation										
22	Lab & X-ray										
23	Vision Care including Eyeglasses										
24	Mental Health/Substance Abuse										
25	Reinsurance Expenses										
25a	**less: Reinsurance Reimbursements & COB (Table 7 Part -C)**										
26	EPSDT Medical & PDN										
27	EPSDT Dental - EPD										
28	Family Planning										
29	Other Medical										
30	**TOTAL MEDICAL & HOSPITAL (9 through 29)**										
ADMINISTRATION:											
31	Compensation										
32	Occupancy/Depreciation/Amortization										
33	Interest Expense										
34	Education/Outreach/Marketing										
35	Sanctions										
36	Corporate Overhead Allocations										
37	Subcontracted/Delegated Administrative Services										
38	Other										
39	**TOTAL ADMINISTRATION (31 through 38)**										
40	**TOTAL EXPENSES (30+39)**										
41	**OPERATING INCOME (LOSS) (8-40)**										
42	**Investment Income**										
43	Provision for State, Federal, and Other Governmental Income Taxes										
44	Other than Income Taxes [2]										
45	Adjustment for prior period IBNR estimates										
46	Non-claim adjustments for prior periods										
47	**NET INCOME (LOSS) (41+42-43-44-45-46)**										

HMO Name: _____

For the Current 12 months Ending: _____

Income Statement $ by Rate Cell Grouping A through R2

	Rate Cell Description	Non ABD Adults	Non ABD Children	FamilyCare Parents	NJ KidCare	ABD W Medicare	ABD W/O Medicare		Maternity	Newborns	At Risk Total
	Plan	A	A, B & C	D	D	A	A			less than 75 days	
	Cap Codes	373, 394	173, 193	594	993	773, 795, 796	494, 812, 873, 895			803, 903	
	Table 19 Part :	A	B	C	D	E	F		R1	R2	
	Member Months [1]										
REVENUES:											
1	Capitated Premiums										
2	Maternity										
3	**Total Premiums (lines 1-2)**										
4	Reimbursable HIV/AIDS Drugs and Blood Products										
5	EPSDT Incentive Payment										
6	Other										
7	**Total Other Reimbursements (lines 4-6)**										
8	**TOTAL Premiums & Reimbursements (Lines 3 & 7)**										
EXPENSES:											
MEDICAL AND HOSPITAL											
9	Inpatient Hospital										
10	Primary Care										
11	Physician Specialty Services										
12	Outpatient Hospital (excludes ER)										
13	Other Professional Services										
14	Emergency Room										
15	DME/Medical Supplies										
16	Prosthetics & Orthotics										
17	Covered Dental										
18	Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products)										
19	Reimbursable HIV/AIDS Drugs and Blood Products										
20	Home Health, Hospice, & PDN										
21	Transportation										
22	Lab & X-ray										
23	Vision Care including Eyeglasses										
24	Mental Health/Substance Abuse										
25	Reinsurance Expenses										
25a	**less: Reinsurance Reimbursements & COB (Table 7 Part -C)**										
26	EPSDT Medical & PDN										
27	EPSDT Dental - EPD										
28	Family Planning										
29	Other Medical										
30	**TOTAL MEDICAL & HOSPITAL (9 through 29)**										
ADMINISTRATION:											
31	Compensation										
32	Occupancy/Depreciation/Amortization										
33	Interest Expense										
34	Education/Outreach/Marketing										
35	Sanctions										
36	Corporate Overhead Allocations										
37	Subcontracted/Delegated Administrative Services										
38	Other										
39	**TOTAL ADMINISTRATION (31 through 38)**										
40	**TOTAL EXPENSES (30+39)**										
41	**OPERATING INCOME (LOSS) (8-40)**										
42	**Investment Income**										
43	Provision for State, Federal, and Other Governmental Income Taxes										
44	Other than Income Taxes [2]										
45	Adjustment for prior period IBNR estimates										
46	Non-claim adjustments for prior periods										
47	**NET INCOME (LOSS) (41+42-43-44-45-46)**										

1 - Maternity /Newborn member months not to be included in At Risk MM Total.

2 - Reported items other than State or Federal income taxes (i.e. State assessments irrespective of profit position).

Table #20 – Part A – Lag Report for Inpatient Hospital Payments

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____
(HMO Name)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)
		. . . Month in Which Service Provided . . .																				
Line	Month of Payment	Current Month	1st Prior Month	2nd Prior Month	3rd Prior Month	4th Prior Month	5th Prior Month	6th Prior Month	7th Prior Month	8th Prior Month	9th Prior Month	10th Prior Month	11th Prior Month	12th Prior Month	13th Prior Month	14th Prior Month	15th Prior Month	16th Prior Month	17th Prior Month	18th Prior Month	19th Prior Month	20th Prior Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month												$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month													$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month														$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month															$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month																$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month																	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month																		$ -	$ -	$ -	$ -
19	18th Prior Month																			$ -	$ -	$ -
20	19th Prior Month																				$ -	$ -
21	20th Prior Month																					$ -
22	21st Prior Month																					
23	22nd Prior Month																					
24	23rd Prior Month																					
25	24th Prior Month																					
26	25th Prior Month																					
27	26th Prior Month																					
28	27th Prior Month																					
29	28th Prior Month																					
30	29th Prior Month																					
31	30th Prior Month																					
32	31st Prior Month																					
33	32nd Prior Month																					
34	33rd Prior Month																					
35	34th Prior Month																					
36	35th Prior Month																					
37	Months Before 35th Prior Month																					
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																					
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

$ -	Cells with this lighter shading are amounts first reported this twelve-month period, amounts restated this twelve–month period, or totals which depend (in whole or in part) on such amounts.
$ -	Cells with this darker shading are amounts initially reported in a prior twelve-month period that appear again, but in a different location on the spreadsheet. If cells change from the prior period's submission, include an explanation in the "Notes" tab.
	Cells with this shading are not to be filled out.

Notes: 1 - Settlements that could not be reflected in the paid claims above.

Table #20 – Part A – Lag Repor

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

(1)	(2)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)	(35)	(36)	(37)	(38)	(39)	(40)
Line	**Month of Payment**	21st Prior Month	22nd Prior Month	23rd Prior Month	24th Prior Month	25th Prior Month	26th Prior Month	27th Prior Month	28th Prior Month	29th Prior Month	30th Prior Month	31st Prior Month	32nd Prior Month	33rd Prior Month	34th Prior Month	35th Prior Month	Months Before 35th Prior Month	Total Paid by Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
19	18th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	19th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
21	20th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
22	21st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23	22nd Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24	23rd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	24th Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
26	25th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27	26th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
28	27th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
29	28th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	29th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
31	30th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
32	31st Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -
33	32nd Prior Month												$ -	$ -	$ -	$ -	$ -	$ -
34	33rd Prior Month													$ -	$ -	$ -	$ -	$ -
35	34th Prior Month														$ -	$ -	$ -	$ -
36	35th Prior Month															$ -	$ -	$ -
37	Months Before 35th Prior Month																$ -	$ -
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																	
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Table #20 – Part B – Lag Report for Physician Payments

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____
(HMO Name)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)
		. . . Month in Which Service Provided . . .																				
Line	Month of Payment	Current Month	1st Prior Month	2nd Prior Month	3rd Prior Month	4th Prior Month	5th Prior Month	6th Prior Month	7th Prior Month	8th Prior Month	9th Prior Month	10th Prior Month	11th Prior Month	12th Prior Month	13th Prior Month	14th Prior Month	15th Prior Month	16th Prior Month	17th Prior Month	18th Prior Month	19th Prior Month	20th Prior Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month												$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month													$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month														$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month															$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month																$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month																	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month																		$ -	$ -	$ -	$ -
19	18th Prior Month																			$ -	$ -	$ -
20	19th Prior Month																				$ -	$ -
21	20th Prior Month																					$ -
22	21st Prior Month																					
23	22nd Prior Month																					
24	23rd Prior Month																					
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30	29th Prior Month																					
31	30th Prior Month																					
32	31st Prior Month																					
33	32nd Prior Month																					
34	33rd Prior Month																					
35	34th Prior Month																					
36	35th Prior Month																					
37	Months Before 35th Prior Month																					
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																					
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

$ -	Cells with this lighter shading are amounts first reported this twelve-month period, amounts restated this twelve–month period, or totals which depend (in whole or in part) on such amounts.
$ -	Cells with this darker shading are amounts initially reported in a prior twelve-month period that appear again, but in a different location on the spreadsheet. If cells change from the prior period's submission, include an explanation in the "Notes" tab.
	Cells with this shading are not to be filled out.

Notes: 1 - Settlements that could not be reflected in the paid claims above.

Table #20 – Part B – Lag Repor

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

(1)	(2)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)	(35)	(36)	(37)	(38)	(39)	(40)
Line	**Month of Payment**	21st Prior Month	22nd Prior Month	23rd Prior Month	24th Prior Month	25th Prior Month	26th Prior Month	27th Prior Month	28th Prior Month	29th Prior Month	30th Prior Month	31st Prior Month	32nd Prior Month	33rd Prior Month	34th Prior Month	35th Prior Month	Months Before 35th Prior Month	Total Paid by Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
19	18th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	19th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
21	20th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
22	21st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23	22nd Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24	23rd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	24th Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
26	25th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27	26th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
28	27th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
29	28th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	29th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
31	30th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
32	31st Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -
33	32nd Prior Month												$ -	$ -	$ -	$ -	$ -	$ -
34	33rd Prior Month													$ -	$ -	$ -	$ -	$ -
35	34th Prior Month														$ -	$ -	$ -	$ -
36	35th Prior Month															$ -	$ -	$ -
37	Months Before 35th Prior Month																$ -	$ -
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																	
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Table #20 – Part C – Lag Report for Pharmacy Payments

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____
(HMO Name)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)
		. . . Month in Which Service Provided . . .																				
Line	**Month of Payment**	Current Month	1st Prior Month	2nd Prior Month	3rd Prior Month	4th Prior Month	5th Prior Month	6th Prior Month	7th Prior Month	8th Prior Month	9th Prior Month	10th Prior Month	11th Prior Month	12th Prior Month	13th Prior Month	14th Prior Month	15th Prior Month	16th Prior Month	17th Prior Month	18th Prior Month	19th Prior Month	20th Prior Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month												$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month													$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month														$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month															$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month																$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month																	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month																		$ -	$ -	$ -	$ -
19	18th Prior Month																			$ -	$ -	$ -
20	19th Prior Month																				$ -	$ -
21	20th Prior Month																					$ -
22	21st Prior Month																					
23	22nd Prior Month																					
24	23rd Prior Month																					
25	24th Prior Month																					
26	25th Prior Month																					
27	26th Prior Month																					
28	27th Prior Month																					
29	28th Prior Month																					
30	29th Prior Month																					
31	30th Prior Month																					
32	31st Prior Month																					
33	32nd Prior Month																					
34	33rd Prior Month																					
35	34th Prior Month																					
36	35th Prior Month																					
37	Months Before 35th Prior Month																					
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Payments, Rebates and Settlements (38+39+40+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

$ -	Cells with this lighter shading are amounts first reported this twelve-month period, amounts restated this twelve–month period, or totals which depend (in whole or in part) on such amounts.
$ -	Cells with this darker shading are amounts initially reported in a prior twelve-month period that appear again, but in a different location on the spreadsheet. If cells change from the prior period's submission, include an explanation in the "Notes" tab.

Notes: 1 - Settlements that could not be reflected in the paid claims above.

Table #20 – Part C – Lag Repor

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

(1)	(2)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)	(35)	(36)	(37)	(38)	(39)	(40)
Line	**Month of Payment**	21st Prior Month	22nd Prior Month	23rd Prior Month	24th Prior Month	25th Prior Month	26th Prior Month	27th Prior Month	28th Prior Month	29th Prior Month	30th Prior Month	31st Prior Month	32nd Prior Month	33rd Prior Month	34th Prior Month	35th Prior Month	Months Before 35th Prior Month	Total Paid by Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
19	18th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	19th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
21	20th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
22	21st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23	22nd Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24	23rd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	24th Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
26	25th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27	26th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
28	27th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
29	28th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	29th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
31	30th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
32	31st Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -
33	32nd Prior Month												$ -	$ -	$ -	$ -	$ -	$ -
34	33rd Prior Month													$ -	$ -	$ -	$ -	$ -
35	34th Prior Month														$ -	$ -	$ -	$ -
36	35th Prior Month															$ -	$ -	$ -
37	Months Before 35th Prior Month																$ -	$ -
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Payments, Rebates and Settlements (38+39+40+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Table #20 – Part D – Lag Report for Other Medical Payments

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____
(HMO Name)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)
		. . . Month in Which Service Provided . . .																				
Line	Month of Payment	Current Month	1st Prior Month	2nd Prior Month	3rd Prior Month	4th Prior Month	5th Prior Month	6th Prior Month	7th Prior Month	8th Prior Month	9th Prior Month	10th Prior Month	11th Prior Month	12th Prior Month	13th Prior Month	14th Prior Month	15th Prior Month	16th Prior Month	17th Prior Month	18th Prior Month	19th Prior Month	20th Prior Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month												$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month													$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month														$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month															$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month																$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month																	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month																		$ -	$ -	$ -	$ -
19	18th Prior Month																			$ -	$ -	$ -
20	19th Prior Month																				$ -	$ -
21	20th Prior Month																					$ -
22	21st Prior Month																					
23	22nd Prior Month																					
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31	30th Prior Month																					
32	31st Prior Month																					
33	32nd Prior Month																					
34	33rd Prior Month																					
35	34th Prior Month																					
36	35th Prior Month																					
37	Months Before 35th Prior Month																					
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																					
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

$ -	Cells with this lighter shading are amounts first reported this twelve-month period, amounts restated this twelve–month period, or totals which depend (in whole or in part) on such amounts.
$ -	Cells with this darker shading are amounts initially reported in a prior twelve-month period that appear again, but in a different location on the spreadsheet. If cells change from the prior period's submission, include an explanation in the "Notes" tab.
	Cells with this shading are not to be filled out.

Notes: 1 - Settlements that could not be reflected in the paid claims above.

Table #20 – Part D – Lag Repor

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

(1)	(2)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)	(35)	(36)	(37)	(38)	(39)	(40)
Line	**Month of Payment**	21st Prior Month	22nd Prior Month	23rd Prior Month	24th Prior Month	25th Prior Month	26th Prior Month	27th Prior Month	28th Prior Month	29th Prior Month	30th Prior Month	31st Prior Month	32nd Prior Month	33rd Prior Month	34th Prior Month	35th Prior Month	Months Before 35th Prior Month	Total Paid by Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
19	18th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	19th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
21	20th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
22	21st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23	22nd Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24	23rd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	24th Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
26	25th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27	26th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
28	27th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
29	28th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	29th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
31	30th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
32	31st Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -
33	32nd Prior Month												$ -	$ -	$ -	$ -	$ -	$ -
34	33rd Prior Month													$ -	$ -	$ -	$ -	$ -
35	34th Prior Month														$ -	$ -	$ -	$ -
36	35th Prior Month															$ -	$ -	$ -
37	Months Before 35th Prior Month																$ -	$ -
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																	
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Table #20 – Parts E & F – Lag Support

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____
(HMO Name)

E. Individual High Cost Claim Reserves

List Details for Each Individual (Name or ID Not Required)

	Rate Cell (A - R2)	Hospital Name	Admission Date (or Begin Date for non-Inpatient)	Expected Discharge (or End Date for non-Inpatient)	Actual Discharge Date (or End Date for non-Inpatient)	Total Estimated Liability	Total Reserve when Paid	Paid Amount	Paid Date
1						$ -	$ -	$ -	
2						$ -	$ -	$ -	
3						$ -	$ -	$ -	
4						$ -	$ -	$ -	
5						$ -	$ -	$ -	
6						$ -	$ -	$ -	
7						$ -	$ -	$ -	
8						$ -	$ -	$ -	
9						$ -	$ -	$ -	
10						$ -	$ -	$ -	
11						$ -	$ -	$ -	
12						$ -	$ -	$ -	
13						$ -	$ -	$ -	
14						$ -	$ -	$ -	
15						$ -	$ -	$ -	
16						$ -	$ -	$ -	
17						$ -	$ -	$ -	
18						$ -	$ -	$ -	
19						$ -	$ -	$ -	
20						$ -	$ -	$ -	
21						$ -	$ -	$ -	
22						$ -	$ -	$ -	
23						$ -	$ -	$ -	
24						$ -	$ -	$ -	
25						$ -	$ -	$ -	

F. Additional Lag Information

Are the following being applied?

	Yes/No	Percent Applied in IBNR	Total Amount
Margin		0.00%	$ -
Claims Adjudication Expense		0.00%	$ -
Loss Adjustment Expense		0.00%	$ -
Premium Deficiency Reserve		0.00%	$ -

Table 19 – Part S2 - Income Statement by ALL AT-RISK Rate Cell Grouping On Claims Incurred for CURRENT 12 MONTH END

HMO Name: _____

For the Current 12 Months Ending: _____

Report #2, Table 19, Part S2

	Rate Cell Description	12 Months Paid Claims	12 Months RBUC & IBNR	12 Month Totals [1]	PMPM
	Member Months [2]				
REVENUES:					
1	Capitated Premiums				
2	Maternity				
3	**Total Premiums (lines 1-2)**				
4	Reimbursable HIV/AIDS Drugs and Blood Products				
5	EPSDT Incentive Payment				
6	Other				
7	**Total Other Reimbursements (lines 4-6)**				
8	**TOTAL Premiums & Reimbursements (Lines 3 & 7)**				
EXPENSES:					
MEDICAL AND HOSPITAL					
9	Inpatient Hospital				
10	Primary Care				
11	Physician Specialty Services				
12	Outpatient Hospital (excludes ER)				
13	Other Professional Services				
14	Emergency Room				
15	DME/Medical Supplies				
16	Prosthetics & Orthotics				
17	Covered Dental				
18	Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products)				
19	Reimbursable HIV/AIDS Drugs and Blood Products				
20	Home Health, Hospice, & PDN				
21	Transportation				
22	Lab & X-ray				
23	Vision Care including Eyeglasses				
24	Mental Health/Substance Abuse				
25	Reinsurance Expenses				
25a	less: Reinsurance Reimbursements & COB (Table 7 Part -C)				
26	EPSDT Medical & PDN				
27	EPSDT Dental - EPD				
28	Family Planning				
29	Other Medical				
30	**TOTAL MEDICAL & HOSPITAL (9 through 29)**				
ADMINISTRATION:					
31	Compensation				
32	Occupancy/Depreciation/Amortization				
33	Interest Expense				
34	Education/Outreach/Marketing				
35	Sanctions				
36	Corporate Overhead Allocations				
37	Subcontracted/Delegated Administrative Services				
38	Other				
39	**TOTAL ADMINISTRATION (31 through 38)**				
40	**TOTAL EXPENSES (30+39)**				
41	**OPERATING INCOME (LOSS) (8-40)**				
42	Investment Income				
43	Provision for State, Federal, and Other Governmental Income Taxes				
44	Other than Income Taxes [3]				
45	Adjustment for prior period IBNR estimates				
46	Non-claim adjustments for prior periods				
47	**NET INCOME (LOSS) (41+42-43-44-45-46)**				

Notes:

1 - Summation of Parts A-R2.

2 - Newborn member months not to be included in Total.

3 - Reported items other than State or Federal income taxes (i.e. State assessments irrespective of profit position).

Table #19 – Part S3 – Income Statement by Rate Cell Grouping

Reconciliations

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____

(HMO Name)

Revenue Reconciliation

Only 5 rows provided (insert additional rows if needed)	Date	Check #	Capitation Premiums	Maternity Reimbursement	HIV / AIDS - Blood Products Reimbursement	EPSDT Premiums	Other	Total Premiums/ Reimbursements
1	01/00/00	00000	$ -	$ -	$ -	$ -	$ -	$ -
2	01/00/00	00000	$ -	$ -	$ -	$ -	$ -	$ -
3	01/00/00	00000	$ -	$ -	$ -	$ -	$ -	$ -
4	01/00/00	00000	$ -	$ -	$ -	$ -	$ -	$ -
5	01/00/00	00000	$ -	$ -	$ -	$ -	$ -	$ -
6 Totals Received from the State			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
7 Unearned Premiums			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8 Change in Receivables / Unearned Premiums			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
9 Other			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
10 Total Premiums Reconciled to 19 S-2			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Notes:

$ - Cells with this shading are calculated fields and are not to be filled out.

1 - Detail any differences in the "Notes" section.

Table #19 – Part S3 – Income Statement by Rate Cell Grouping

Reconciliations

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____
(HMO Name)

Lag Triangle and Income Statement Reconciliation for Twelve Month End												
Lag Report		Table #19 – Parts S1 & S2		Twelve-Month Paid Claims			Twelve-Month IBNR & RBUC			Twelve-Month Total $		
Lag Report #	Medical Cost Grouping	Line #	Consolidated Category of Service	Lag Report	Table #19 – Part S2	Difference [1]	Lag Report	Table #19 – Part S2	Difference [1]	Lag Report	Table #19 – Part S2	Difference [1]
Table #20 – Part A	Inpatient Hospital	9	Inpatient Hospital	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Table #20 – Part B	Physician	10 11	Primary Care Physician Specialty Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Table #20 – Part C	Pharmacy	18 19	Pharmacy (not to include Reimbursable HIV/AIDS D Reimbursable HIV/AIDS Drugs and Blood Products	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Table #20 – Part D	Other	12 13 14 15 16 17 20 21 22 23 24 26 27 28 29	Outpatient Hospital (excludes ER) Other Professional Services Emergency Room DME/Medical Supplies Prosthetics & Orthotics Covered Dental Home Health, Hospice, & PDN Transportation Lab & X-ray Vision Care including Eyeglasses Mental Health/Substance Abuse EPSDT Medical & PDN EPSDT Dental - EPD Family Planning Other Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total		30	Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Notes:

$ - Cells with this shading are calculated fields and are not to be filled out.

1 - Detail any differences in the "Notes" section.

Table #19 – Part S3 – Income Statement by Rate Cell Grouping

Reconciliations

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____ _____ _____
(HMO Name)

Prior Period IBNR Reconciliation for Twelve Month End		
		Incurred in Twelve Months Prior to _____
1	Claims Paid in Most Recent Twelve Month End	$ -
2	+ IBNR as of Most Recent Twelve Months (line 43 of #2A-D lag triangles)	$ -
3	- IBNR as of Prior Twelve Month End	$ -
4	+ Subcapitation Payments, Pharmacy Rebates, Settlements as of Most Recent Twelve Months (lines 39+40+41 of #20A-D lag triangles)	$ -
5	- Subcapitation Payments, Pharmacy Rebates, Settlements as of Prior Twelve Month End	$ -
6	**Prior Period IBNR Adjustment for Twelve Month End (lines 1+2-3+4-5)**	**$ -**
7	**Table #19 – Parts S2 Adjustment for prior period IBNR estimates (line 45 of Table #19S2)**	**$ -**
8	**Difference (lines 6-7)**	**$ -**

Notes:
$ - Cells with this shading are calculated fields and are not to be filled out.
1 - Detail any differences in the "Notes" section.

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

Table #4 - Claims Processing Lag Report

For the Three Months Ending

HMO

4A Claims Processing for Manually Submitted Claims

						Claims Processed During Quarter									
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	CONSOLIDATED CATEGORY OF SERVICE	Non Processed Claims from Prior Quarters	Claims Received During Quarter	Total Claims (Cols 2+3)	Claims Processed This Quarter	01-40 Days	Percent of Total	41-60 Days	Percent of Total	61-90 Days	Percent of Total	Days > 91	Percent of Total	Non-Processed Claims on Hand at End of Quarter	Percent of Non-Processed Claims on Hand at End of Quarter (col 16/col 4)
1	Inpatient Hospital	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
2	Primary Care	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
3	Physician Specialty Services	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
4	Outpatient Hospital (excludes ER)	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
5	Other Professional Services	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
6	Emergency Room	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
7	DME/Medical Supplies	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
8	Prosthetics & Orthotics	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
9	Dental	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
10	Pharmacy	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
12	Home Health, Hospice, & PDN	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
13	Transportation	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
14	Lab and X-Ray	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
15	Vision Care & Eyeglasses	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
16	Mental Health/Substance Abuse	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
17	Other Medical	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
18	**TOTAL**	**-**	**-**	**-**	**-**	**-**	**0.0%**	**-**	**0.0%**	**-**	**0.0%**	**-**	**0.0%**	**-**	**0.0%**

Table #4 – Part B – Claims Processing Lag Report for Electronically Submitted Claims

						Claims Processed During Quarter									
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	CONSOLIDATED CATEGORY OF SERVICE	Non Processed Claims from Prior Quarters	Claims Received During Quarter	Total Claims (Cols 2+3)	Claims Processed This Quarter	01-30 Days	Percent of Total	31-60 Days	Percent of Total	61-90 Days	Percent of Total	Days > 91	Percent of Total	Non-Processed Claims on Hand at End of Quarter	Percent of Non-Processed Claims on Hand at End of Quarter (col 16/col 4)
1	Inpatient Hospital	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
2	Primary Care	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
3	Physician Specialty Services	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
4	Outpatient Hospital (excludes ER)	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
5	Other Professional Services	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
6	Emergency Room	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
7	DME/Medical Supplies	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
8	Prosthetics & Orthotics	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
9	Dental	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
10	Pharmacy	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
12	Home Health, Hospice, & PDN	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
13	Transportation	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
14	Lab and X-Ray	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
15	Vision Care & Eyeglasses	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
16	Mental Health/Substance Abuse	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
17	Other Medical	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
18	**TOTAL**	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%

Grand Totals for 4A and 4B	0	0	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	

Table 6 - Allowable Direct Medical Expenditures
For Purposes of Calculating Medical Cost Ratio

_____
HMO

For the Period Ending _____

List the employee title or function, or contracted association for salaried individuals who have performed Allowable Direct Medical Expenditure functions during the quarter and the last 12 months. Allowable Direct Medical Expenditures are the total salary costs of performing functions related to the following categories: 1) assessments(s) of an enrollee's risk factors; 2) development of Individual Health Care Plans; 3) provision of face to face medical education or anticipatory guidance; 4) activities required to maintain compliance with EPSDT lead screening and pre-natal care. Reporting of direct medical expenditures shall reflect only those activities approved by the State in the Medical Cost Ratio- Direct Medical Expendiures Plan. Other care management functions are considered administrative and unallowable.

Number of Employee's Directly Involved	Employee Title / Name of Outreach Association	Category (Care Management, Face-to-Face, Compliance with EPSDT, et.al.)	Allowable Compensation this Quarter	Allowable Compensation Last 12 Months
	Case Manager RN - Plan	Risk Assessment		
	Case Manager RN - Plan	Individual HC Planning		
	Case Manager RN - Plan	Medical Education / Guidance		
	Case Manager RN - Plan	EPSDT Compliance		
	Outreach Association	Risk Assessment		
	Outreach Association	Individual HC Planning		
	Outreach Association	Medical Education / Guidance		
	Outreach Association	EPSDT Compliance		
Totals*			$ -	$ -

I certify the expenses reported as allowable are the true and accurate salary costs of the individuals listed above and meet the definition of an Allowable Direct Medical Expenditure defined in Section 8.4.1.A of the managed care contract. Further, I certify these costs are included and have been reported as Adminitrative costs in Table 19S2 - Compensation

(Signature) _____

Name and Title _____

Table #7 – Parts A-C – Stop Loss Summary

FOR THE CALENDAR YEAR ENDING _____ **FOR** _____
(HMO Name)

A. Coverage

Aggregate Stop-Loss Threshold	Maximum Per Enrollee Per Year	Maximum Aggregate Lifetime per Enrollee	Includes Insolvency Insurance (Y/N)	Deductible	Cost of Premiums PMPM
$ -	$ -	$ -		$ -	$ -
Policy Expiration Date			00/00/00		

B.

Category of Eligibility:	AFDC	ABD	NJ KidCare	FamilyCare	TOTAL
Number of Enrollees Exceeding Stop Loss	-	-	-	-	-
Net Expenditures Above Stop Loss	$ -	$ -	$ -	$ -	$ -

C. List Details for Each Individual (Name or ID Not Required)

	Net Expenditures Above Stop-Loss	Primary Diagnosis/Major Procedure	Reinsurance Recoveries [1]
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
Total (lines 1 through 15)			
Table #19, Parts S2, Line 6			
Difference [2]			

Notes: 1 - Total Reinsurance Recoveries must tie to Table 19, Part S2, Line 6.
2 - Detail any differences in the "Notes" section.

Table #10 – Third Party Liability and Fraud/Abuse Collections *

HMO

For the Period Ending

Third Party Liability

Consolidated Category of Aid	Current Quarter: Employment Related	Current Quarter: Motor Vehicle Related	Current Quarter: Other	Current Quarter: Health Insurance	Last 12 Months: Employment Related	Last 12 Months: Motor Vehicle Related	Last 12 Months: Other	Last 12 Months: Health Insurance	I- Income C- Claim Reduction
AFDC**		$ -	$ -	$ -		$ -	$ -	$ -	
DYFS	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Aged with Medicare & Other Dual Eligibles	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Aged w/o Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Blind and Disabled with Medicare+	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Blind and Disabled without Medicare+	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
NJ KidCare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
NJ FamilyCare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	

Fraud/Abuse

Consolidated Category of Aid	Current Quarter: Claims Initiated	Current Quarter: Claims Turned over to DHAHS	Current Quarter: Estimated Value of Claims turned over to DMAHS	Current Quarter: Collections	Last 12 Months: Claims Initiated	Last 12 Months: Claims Turned over to DHAHS	Last 12 Months: Estimated Value of Claims turned over to DMAHS	Last 12 Months: Collections	I- Income C- Claim Reduction
AFDC**			$ -	$ -			$ -	$ -	
DYFS			$ -	$ -			$ -	$ -	
Aged with Medicare & Other Dual Eligibles			$ -	$ -			$ -	$ -	
Aged w/o Medicare			$ -	$ -			$ -	$ -	
Blind and Disabled with Medicare+			$ -	$ -			$ -	$ -	
Blind and Disabled without Medicare+			$ -	$ -			$ -	$ -	
NJ KidCare			$ -	$ -			$ -	$ -	
NJ FamilyCare			$ -	$ -			$ -	$ -	
Total			$ -	$ -			$ -	$ -	

Notes:
Enter the total amount collected for each eligible category
For AFDC, include New Jersey Care children and pregnant women
For Blind and Disabled w/ wo Medicare include essential spouses
For TPL and Fraud/Abuse collections Indicate I for Income and C for claims reduction on Income Statement

Table #21 - Maternity Outcome Counts [1]

FOR THE TWELVE MONTHS ENDING _____ FOR _____

(HMO Name)

	Current 12 Month Period				
	Live Births		Non-live Births	Newborn Member Mo's	Ratio MMs / Births [2]
	C-Section	Vaginal			
Northwestern – Non-Urban AFDC/NJCPW/NJ KidCare A					
Northeastern – Non-Urban AFDC/NJCPW/NJKidCare A					
Central – Urban AFDC/NJCPW/NJ KidCare A					
Southern Central – Urban AFDC/NJCPW/NJ KidCare A					
Southern – Non-Urban AFDC/NJCPW/NJ KidCare A					
STATEWIDE All Other					
TOTAL					

Notes:

1 - Only outcomes on or after the thirteenth week of gestation should be included in this report, excluding elective abortions.

2 - It is expected that there shall be approximately 2.5 newborn member months reported for each delivery as the newborn time period is on average 75 days. Any variation from 2.5 member months may suggest a reporting inconsistency.

NOTES TO FINANCIAL REPORTS

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

FOR THE TWELVE MONTHS ENDING _____

FOR _____
(HMO Name)

Any notes or further explanations of any items contained in any of the reports or in the reporting of financial disclosures are to be noted here. Appropriate references and attachments are to be used as necessary. Space is provided below or you may use a separate page as necessary.

Table #4 **– Part A – Claims Lag Report for Manually Submitted Claims** **– Part B – Claims Lag Report for Electronically Submitted Claims**	
Table #6 **– Allowable Direct Medical Expenditures**	
Table #7 **– Parts A-C – Stop Loss Summary**	
Table #10 **– Third Party Liability and Fraud/Abuse Collections**	
Table #19 **– Parts A-R – Income Statement By Rate Cell Grouping**	
Table #20 **– Part A – Lag Report for Inpatient Hospital Payments** **– Part B – Lag Report for Physician Payments** **– Part C – Lag Report for Pharmacy Payments** **– Part D – Lag Report for Other Medical Payments**	
Table #21 **– Maternity Outcome Counts**	

Attach Copy of the General Ledger for the period ending 6-30-XX

NOTES TO FINANCIAL REPORTS

FOR THE SFY ENDING 6-30-08

FOR _____
(HMO Name)

Any notes or further explanations of any items contained in any of the reports or in the reporting of financial disclosures are to be noted here. Appropriate references and attachments are to be used as necessary. Space is provided below or you may use a separate page as necessary.

Table #11 **– Part A – Cost and Utilization by AFDC Rate Cell Grouping** **– Part B – Cost and Utilization by FamilyCare Parents/Adults Rate Cell Grouping**	
Table #14 **– Part A – Member Months and Income Statement** **– Part B – Administrative Cost Detail** **– Part C – Capitation Arrangements**	
Table #19 **– Parts A-S2 – Income Statement By Rate Cell Grouping** **– Part T – Non-State Plan Service Expenses**	
Table #20 **– Part A – Lag Report for Inpatient Hospital Payments** **– Part B – Lag Report for Physician Payments** **– Part C – Lag Report for Pharmacy Payments** **– Part D – Lag Report for Other Medical Payments**	

Table #14C – Capitation Arrangements
Current State Fiscal Year End

FOR THE STATE FISCAL-ENDING AT 09/30: _____ _____
(HMO Name)

CAPITATED SERVICES			Current State Fiscal Year End			
	Covered Service	**Provider at Full-Risk (Yes or No)**	**Total Amount Reported as Medical Expense**	**Reported Medical Expense Line # on Report 2, Table 19**	**Total Amount Reported as Administrative Expense**	**Reported Administrative Expense Line # on Report 2, Table 19**
1	Vision		$ -		$ -	
2	Dental		$ -		$ -	
3	Lab/Radiology		$ -		$ -	
5	Mental Health		$ -		$ -	
6	Triage Services/Nurse Hotline		$ -		$ -	
7	Primary Care Physicians		$ -		$ -	
8	Other #1		$ -		$ -	
9	Other #2		$ -		$ -	
10	Other #3		$ -		$ -	
11	Other #4		$ -		$ -	
12	Other #5		$ -		$ -	
13	Other #6		$ -		$ -	
14	Other #7		$ -		$ -	
15	**Total**		**$ -**		**$ -**	

Notes:
1. Gray highlighted cells denotes calculation.

Attach Copy of the General Ledger for the period ending 6-30-XX

Table 19 – Parts A through R2, - Income Statement by Rate Cell Grouping On Claims Incurred for CURRENT 12 MONTH END

HMO Name: _____

For the Current 12 months Ending: _____

Income Statement $ by Rate Cell Grouping A through R2

	Rate Cell Description	Non ABD Adults	Non ABD Children	FamilyCare Parents	NJ KidCare	ABD W Medicare	ABD W/O Medicare		Maternity	Newborns	At Risk Total
	Plan	A	A, B & C	D	D	A	A			less than 75 days	
	Cap Stems	373, 394	173, 193	594	993	773, 795, 796	494, 812, 873, 895			803, 903	
	Table 19 Part :	A	B	C	D	E	F		R1	R2	
	Member Months [1]										
REVENUES:											
1	Capitated Premiums										
2	Maternity										
3	**Total Premiums (lines 1-2)**										
4	Reimbursable HIV/AIDS Drugs and Blood Products										
5	EPSDT Incentive Payment										
6	Other										
7	**Total Other Reimbursements (lines 4-6)**										
8	**TOTAL Premiums & Reimbursements (Lines 3 & 7)**										
EXPENSES:											
MEDICAL AND HOSPITAL											
9	Inpatient Hospital										
10	Primary Care										
11	Physician Specialty Services										
12	Outpatient Hospital (excludes ER)										
13	Other Professional Services										
14	Emergency Room										
15	DME/Medical Supplies										
16	Prosthetics & Orthotics										
17	Covered Dental										
18	Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products)										
19	Reimbursable HIV/AIDS Drugs and Blood Products										
20	Home Health, Hospice, & PDN										
21	Transportation										
22	Lab & X-ray										
23	Vision Care including Eyeglasses										
24	Mental Health/Substance Abuse										
25	Reinsurance Expenses										
25a	**less: Reinsurance Reimbursements & COB (Table 7 Part -C)**										
26	EPSDT Medical & PDN										
27	EPSDT Dental - EPD										
28	Family Planning										
29	Other Medical										
30	**TOTAL MEDICAL & HOSPITAL (9 through 29)**										
ADMINISTRATION:											
31	Compensation										
32	Occupancy/Depreciation/Amortization										
33	Interest Expense										
34	Education/Outreach/Marketing										
35	Sanctions										
36	Corporate Overhead Allocations										
37	Subcontracted/Delegated Administrative Services										
38	Other										
39	**TOTAL ADMINISTRATION (31 through 38)**										
40	**TOTAL EXPENSES (30+39)**										
41	**OPERATING INCOME (LOSS) (8-40)**										
42	**Investment Income**										
43	Provision for State, Federal, and Other Governmental Income Taxes										
44	Other than Income Taxes [2]										
45	Adjustment for prior period IBNR estimates										
46	Non-claim adjustments for prior periods										
47	**NET INCOME (LOSS) (41+42-43-44-45-46)**										

HMO Name: _____

For the Current 12 months Ending: _____

Income Statement $ by Rate Cell Grouping A through R2

	Rate Cell Description	Non ABD Adults	Non ABD Children	FamilyCare Parents	NJ KidCare	ABD W Medicare	ABD W/O Medicare		Maternity	Newborns	At Risk Total
	Plan	A	A, B & C	D	D	A	A			less than 75 days	
	Cap Codes	373, 394	173, 193	594	993	773, 795, 796	494, 812, 873, 895			803, 903	
	Table 19 Part :	A	B	C	D	E	F		R1	R2	
	Member Months [1]										
REVENUES:											
1	Capitated Premiums										
2	Maternity										
3	**Total Premiums (lines 1-2)**										
4	Reimbursable HIV/AIDS Drugs and Blood Products										
5	EPSDT Incentive Payment										
6	Other										
7	**Total Other Reimbursements (lines 4-6)**										
8	**TOTAL Premiums & Reimbursements (Lines 3 & 7)**										
EXPENSES:											
MEDICAL AND HOSPITAL											
9	Inpatient Hospital										
10	Primary Care										
11	Physician Specialty Services										
12	Outpatient Hospital (excludes ER)										
13	Other Professional Services										
14	Emergency Room										
15	DME/Medical Supplies										
16	Prosthetics & Orthotics										
17	Covered Dental										
18	Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products)										
19	Reimbursable HIV/AIDS Drugs and Blood Products										
20	Home Health, Hospice, & PDN										
21	Transportation										
22	Lab & X-ray										
23	Vision Care including Eyeglasses										
24	Mental Health/Substance Abuse										
25	Reinsurance Expenses										
25a	**less: Reinsurance Reimbursements & COB (Table 7 Part -C)**										
26	EPSDT Medical & PDN										
27	EPSDT Dental - EPD										
28	Family Planning										
29	Other Medical										
30	**TOTAL MEDICAL & HOSPITAL (9 through 29)**										
ADMINISTRATION:											
31	Compensation										
32	Occupancy/Depreciation/Amortization										
33	Interest Expense										
34	Education/Outreach/Marketing										
35	Sanctions										
36	Corporate Overhead Allocations										
37	Subcontracted/Delegated Administrative Services										
38	Other										
39	**TOTAL ADMINISTRATION (31 through 38)**										
40	**TOTAL EXPENSES (30+39)**										
41	**OPERATING INCOME (LOSS) (8-40)**										
42	**Investment Income**										
43	Provision for State, Federal, and Other Governmental Income Taxes										
44	Other than Income Taxes [2]										
45	Adjustment for prior period IBNR estimates										
46	Non-claim adjustments for prior periods										
47	**NET INCOME (LOSS) (41+42-43-44-45-46)**										

1 - Maternity /Newborn member months not to be included in At Risk MM Total.

2 - Reported items other than State or Federal income taxes (i.e. State assessments irrespective of profit position).

Table #20 – Part A – Lag Report for Inpatient Hospital Payments

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____
(HMO Name)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)
		. . . Month in Which Service Provided . . .																				
Line	Month of Payment	Current Month	1st Prior Month	2nd Prior Month	3rd Prior Month	4th Prior Month	5th Prior Month	6th Prior Month	7th Prior Month	8th Prior Month	9th Prior Month	10th Prior Month	11th Prior Month	12th Prior Month	13th Prior Month	14th Prior Month	15th Prior Month	16th Prior Month	17th Prior Month	18th Prior Month	19th Prior Month	20th Prior Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month												$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month													$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month														$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month															$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month																$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month																	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month																		$ -	$ -	$ -	$ -
19	18th Prior Month																			$ -	$ -	$ -
20	19th Prior Month																				$ -	$ -
21	20th Prior Month																					$ -
22	21st Prior Month																					
23	22nd Prior Month																					
24	23rd Prior Month																					
25	24th Prior Month																					
26	25th Prior Month																					
27	26th Prior Month																					
28	27th Prior Month																					
29	28th Prior Month																					
30	29th Prior Month																					
31	30th Prior Month																					
32	31st Prior Month																					
33	32nd Prior Month																					
34	33rd Prior Month																					
35	34th Prior Month																					
36	35th Prior Month																					
37	Months Before 35th Prior Month																					
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																					
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

$ -	Cells with this lighter shading are amounts first reported this twelve-month period, amounts restated this twelve–month period, or totals which depend (in whole or in part) on such amounts.
$ -	Cells with this darker shading are amounts initially reported in a prior twelve-month period that appear again, but in a different location on the spreadsheet. If cells change from the prior period's submission, include an explanation in the "Notes" tab.
	Cells with this shading are not to be filled out.

Notes: 1 - Settlements that could not be reflected in the paid claims above.

Table #20 – Part A – Lag Repor

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

(1)	(2)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)	(35)	(36)	(37)	(38)	(39)	(40)
Line	**Month of Payment**	21st Prior Month	22nd Prior Month	23rd Prior Month	24th Prior Month	25th Prior Month	26th Prior Month	27th Prior Month	28th Prior Month	29th Prior Month	30th Prior Month	31st Prior Month	32nd Prior Month	33rd Prior Month	34th Prior Month	35th Prior Month	Months Before 35th Prior Month	Total Paid by Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
19	18th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	19th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
21	20th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
22	21st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23	22nd Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24	23rd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	24th Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
26	25th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27	26th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
28	27th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
29	28th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	29th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
31	30th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
32	31st Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -
33	32nd Prior Month												$ -	$ -	$ -	$ -	$ -	$ -
34	33rd Prior Month													$ -	$ -	$ -	$ -	$ -
35	34th Prior Month														$ -	$ -	$ -	$ -
36	35th Prior Month															$ -	$ -	$ -
37	Months Before 35th Prior Month																$ -	$ -
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																	
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Table #20 – Part B – Lag Report for Physician Payments

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____
(HMO Name)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)
		. . . Month in Which Service Provided . . .																				
Line	Month of Payment	Current Month	1st Prior Month	2nd Prior Month	3rd Prior Month	4th Prior Month	5th Prior Month	6th Prior Month	7th Prior Month	8th Prior Month	9th Prior Month	10th Prior Month	11th Prior Month	12th Prior Month	13th Prior Month	14th Prior Month	15th Prior Month	16th Prior Month	17th Prior Month	18th Prior Month	19th Prior Month	20th Prior Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month												$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month													$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month														$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month															$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month																$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month																	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month																		$ -	$ -	$ -	$ -
19	18th Prior Month																			$ -	$ -	$ -
20	19th Prior Month																				$ -	$ -
21	20th Prior Month																					$ -
22	21st Prior Month																					
23	22nd Prior Month																					
24	23rd Prior Month																					
25	24th Prior Month																					
26	25th Prior Month																					
27	26th Prior Month																					
28	27th Prior Month																					
29	28th Prior Month																					
30	29th Prior Month																					
31	30th Prior Month																					
32	31st Prior Month																					
33	32nd Prior Month																					
34	33rd Prior Month																					
35	34th Prior Month																					
36	35th Prior Month																					
37	Months Before 35th Prior Month																					
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																					
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

$ -	Cells with this lighter shading are amounts first reported this twelve-month period, amounts restated this twelve–month period, or totals which depend (in whole or in part) on such amounts.
$ -	Cells with this darker shading are amounts initially reported in a prior twelve-month period that appear again, but in a different location on the spreadsheet. If cells change from the prior period's submission, include an explanation in the "Notes" tab.
	Cells with this shading are not to be filled out.

Notes: 1 - Settlements that could not be reflected in the paid claims above.

Table #20 – Part B – Lag Repor

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

(1)	(2)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)	(35)	(36)	(37)	(38)	(39)	(40)
Line	**Month of Payment**	21st Prior Month	22nd Prior Month	23rd Prior Month	24th Prior Month	25th Prior Month	26th Prior Month	27th Prior Month	28th Prior Month	29th Prior Month	30th Prior Month	31st Prior Month	32nd Prior Month	33rd Prior Month	34th Prior Month	35th Prior Month	Months Before 35th Prior Month	Total Paid by Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
19	18th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	19th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
21	20th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
22	21st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23	22nd Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24	23rd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	24th Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
26	25th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27	26th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
28	27th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
29	28th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	29th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
31	30th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
32	31st Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -
33	32nd Prior Month												$ -	$ -	$ -	$ -	$ -	$ -
34	33rd Prior Month													$ -	$ -	$ -	$ -	$ -
35	34th Prior Month														$ -	$ -	$ -	$ -
36	35th Prior Month															$ -	$ -	$ -
37	Months Before 35th Prior Month																$ -	$ -
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																	
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Table #20 – Part C – Lag Report for Pharmacy Payments

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____
(HMO Name)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)
		. . . Month in Which Service Provided . . .																				
Line	**Month of Payment**	Current Month	1st Prior Month	2nd Prior Month	3rd Prior Month	4th Prior Month	5th Prior Month	6th Prior Month	7th Prior Month	8th Prior Month	9th Prior Month	10th Prior Month	11th Prior Month	12th Prior Month	13th Prior Month	14th Prior Month	15th Prior Month	16th Prior Month	17th Prior Month	18th Prior Month	19th Prior Month	20th Prior Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month												$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month													$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month														$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month															$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month																$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month																	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month																		$ -	$ -	$ -	$ -
19	18th Prior Month																			$ -	$ -	$ -
20	19th Prior Month																				$ -	$ -
21	20th Prior Month																					$ -
22	21st Prior Month																					
23	22nd Prior Month																					
24	23rd Prior Month																					
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28	27th Prior Month																					
29	28th Prior Month																					
30	29th Prior Month																					
31	30th Prior Month																					
32	31st Prior Month																					
33	32nd Prior Month																					
34	33rd Prior Month																					
35	34th Prior Month																					
36	35th Prior Month																					
37	Months Before 35th Prior Month																					
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Payments, Rebates and Settlements (38+39+40+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

$ -	Cells with this lighter shading are amounts first reported this twelve-month period, amounts restated this twelve–month period, or totals which depend (in whole or in part) on such amounts.
$ -	Cells with this darker shading are amounts initially reported in a prior twelve-month period that appear again, but in a different location on the spreadsheet. If cells change from the prior period's submission, include an explanation in the "Notes" tab.

Notes: 1 - Settlements that could not be reflected in the paid claims above.

Table #20 – Part C – Lag Repor

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

(1)	(2)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)	(35)	(36)	(37)	(38)	(39)	(40)
Line	**Month of Payment**	21st Prior Month	22nd Prior Month	23rd Prior Month	24th Prior Month	25th Prior Month	26th Prior Month	27th Prior Month	28th Prior Month	29th Prior Month	30th Prior Month	31st Prior Month	32nd Prior Month	33rd Prior Month	34th Prior Month	35th Prior Month	Months Before 35th Prior Month	Total Paid by Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
19	18th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	19th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
21	20th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
22	21st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23	22nd Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24	23rd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	24th Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
26	25th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27	26th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
28	27th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
29	28th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	29th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
31	30th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
32	31st Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -
33	32nd Prior Month												$ -	$ -	$ -	$ -	$ -	$ -
34	33rd Prior Month													$ -	$ -	$ -	$ -	$ -
35	34th Prior Month														$ -	$ -	$ -	$ -
36	35th Prior Month															$ -	$ -	$ -
37	Months Before 35th Prior Month																$ -	$ -
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Payments, Rebates and Settlements (38+39+40+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Table #20 – Part D – Lag Report for Other Medical Payments

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____
(HMO Name)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)
		. . . Month in Which Service Provided . . .																				
Line	Month of Payment	Current Month	1st Prior Month	2nd Prior Month	3rd Prior Month	4th Prior Month	5th Prior Month	6th Prior Month	7th Prior Month	8th Prior Month	9th Prior Month	10th Prior Month	11th Prior Month	12th Prior Month	13th Prior Month	14th Prior Month	15th Prior Month	16th Prior Month	17th Prior Month	18th Prior Month	19th Prior Month	20th Prior Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month												$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month													$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month														$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month															$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month																$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month																	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month																		$ -	$ -	$ -	$ -
19	18th Prior Month																			$ -	$ -	$ -
20	19th Prior Month																				$ -	$ -
21	20th Prior Month																					$ -
22	21st Prior Month																					
23	22nd Prior Month																					
24	23rd Prior Month																					
25	24th Prior Month																					
26	25th Prior Month																					
27	26th Prior Month																					
28	27th Prior Month																					
29	28th Prior Month																					
30	29th Prior Month																					
31	30th Prior Month																					
32	31st Prior Month																					
33	32nd Prior Month																					
34	33rd Prior Month																					
35	34th Prior Month																					
36	35th Prior Month																					
37	Months Before 35th Prior Month																					
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																					
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

$ -	Cells with this lighter shading are amounts first reported this twelve-month period, amounts restated this twelve–month period, or totals which depend (in whole or in part) on such amounts.
$ -	Cells with this darker shading are amounts initially reported in a prior twelve-month period that appear again, but in a different location on the spreadsheet. If cells change from the prior period's submission, include an explanation in the "Notes" tab.
	Cells with this shading are not to be filled out.

Notes: 1 - Settlements that could not be reflected in the paid claims above.

Table #20 – Part D – Lag Repor

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

(1)	(2)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)	(35)	(36)	(37)	(38)	(39)	(40)
Line	**Month of Payment**	21st Prior Month	22nd Prior Month	23rd Prior Month	24th Prior Month	25th Prior Month	26th Prior Month	27th Prior Month	28th Prior Month	29th Prior Month	30th Prior Month	31st Prior Month	32nd Prior Month	33rd Prior Month	34th Prior Month	35th Prior Month	Months Before 35th Prior Month	Total Paid by Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
19	18th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	19th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
21	20th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
22	21st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23	22nd Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24	23rd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	24th Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
26	25th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27	26th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
28	27th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
29	28th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	29th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
31	30th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
32	31st Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -
33	32nd Prior Month												$ -	$ -	$ -	$ -	$ -	$ -
34	33rd Prior Month													$ -	$ -	$ -	$ -	$ -
35	34th Prior Month														$ -	$ -	$ -	$ -
36	35th Prior Month															$ -	$ -	$ -
37	Months Before 35th Prior Month																$ -	$ -
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																	
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Table #20 – Parts E & F – Lag Support

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____
(HMO Name)

E. Individual High Cost Claim Reserves

List Details for Each Individual (Name or ID Not Required)

	Rate Cell (A - R2)	Hospital Name	Admission Date (or Begin Date for non-Inpatient)	Expected Discharge (or End Date for non-Inpatient)	Actual Discharge Date (or End Date for non-Inpatient)	Total Estimated Liability	Total Reserve when Paid	Paid Amount	Paid Date
1						$ -	$ -	$ -	
2						$ -	$ -	$ -	
3						$ -	$ -	$ -	
4						$ -	$ -	$ -	
5						$ -	$ -	$ -	
6						$ -	$ -	$ -	
7						$ -	$ -	$ -	
8						$ -	$ -	$ -	
9						$ -	$ -	$ -	
10						$ -	$ -	$ -	
11						$ -	$ -	$ -	
12						$ -	$ -	$ -	
13						$ -	$ -	$ -	
14						$ -	$ -	$ -	
15						$ -	$ -	$ -	
16						$ -	$ -	$ -	
17						$ -	$ -	$ -	
18						$ -	$ -	$ -	
19						$ -	$ -	$ -	
20						$ -	$ -	$ -	
21						$ -	$ -	$ -	
22						$ -	$ -	$ -	
23						$ -	$ -	$ -	
24						$ -	$ -	$ -	
25						$ -	$ -	$ -	

F. Additional Lag Information

Are the following being applied?

	Yes/No	Percent Applied in IBNR	Total Amount
Margin		0.00%	$ -
Claims Adjudication Expense		0.00%	$ -
Loss Adjustment Expense		0.00%	$ -
Premium Deficiency Reserve		0.00%	$ -

Table 19 – Part S2 - Income Statement by ALL AT-RISK Rate Cell Grouping On Claims Incurred for CURRENT 12 MONTH END

HMO Name: _____

For the Current 12 Months Ending: _____

Report #2, Table 19, Part S2

	Rate Cell Description	12 Months Paid Claims	12 Months RBUC & IBNR	12 Month Totals [1]	PMPM
	Member Months [2]				
REVENUES:					
1	Capitated Premiums				
2	Maternity				
3	**Total Premiums (lines 1-2)**				
4	Reimbursable HIV/AIDS Drugs and Blood Products				
5	EPSDT Incentive Payment				
6	Other				
7	**Total Other Reimbursements (lines 4-6)**				
8	**TOTAL Premiums & Reimbursements (Lines 3 & 7)**				
EXPENSES:					
MEDICAL AND HOSPITAL					
9	Inpatient Hospital				
10	Primary Care				
11	Physician Specialty Services				
12	Outpatient Hospital (excludes ER)				
13	Other Professional Services				
14	Emergency Room				
15	DME/Medical Supplies				
16	Prosthetics & Orthotics				
17	Covered Dental				
18	Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products)				
19	Reimbursable HIV/AIDS Drugs and Blood Products				
20	Home Health, Hospice, & PDN				
21	Transportation				
22	Lab & X-ray				
23	Vision Care including Eyeglasses				
24	Mental Health/Substance Abuse				
25	Reinsurance Expenses				
25a	less: Reinsurance Reimbursements & COB (Table 7 Part -C)				
26	EPSDT Medical & PDN				
27	EPSDT Dental - EPD				
28	Family Planning				
29	Other Medical				
30	**TOTAL MEDICAL & HOSPITAL (9 through 29)**				
ADMINISTRATION:					
31	Compensation				
32	Occupancy/Depreciation/Amortization				
33	Interest Expense				
34	Education/Outreach/Marketing				
35	Sanctions				
36	Corporate Overhead Allocations				
37	Subcontracted/Delegated Administrative Services				
38	Other				
39	**TOTAL ADMINISTRATION (31 through 38)**				
40	**TOTAL EXPENSES (30+39)**				
41	**OPERATING INCOME (LOSS) (8-40)**				
42	Investment Income				
43	Provision for State, Federal, and Other Governmental Income Taxes				
44	Other than Income Taxes [3]				
45	Adjustment for prior period IBNR estimates				
46	Non-claim adjustments for prior periods				
47	**NET INCOME (LOSS) (41+42-43-44-45-46)**				

Notes:

1 - Summation of Parts A-R2.

2 - Newborn member months not to be included in Total.

3 - Reported items other than State or Federal income taxes (i.e. State assessments irrespective of profit position).

Table #19 – Part S3 – Income Statement by Rate Cell Grouping

Reconciliations

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____

(HMO Name)

Revenue Reconciliation

Only 5 rows provided (insert additional rows if needed)	Date	Check #	Capitation Premiums	Maternity Reimbursement	HIV / AIDS - Blood Products Reimbursement	EPSDT Premiums	Other	Total Premiums/ Reimbursements
1	01/00/00	00000	$ -	$ -	$ -	$ -	$ -	$ -
2	01/00/00	00000	$ -	$ -	$ -	$ -	$ -	$ -
3	01/00/00	00000	$ -	$ -	$ -	$ -	$ -	$ -
4	01/00/00	00000	$ -	$ -	$ -	$ -	$ -	$ -
5	01/00/00	00000	$ -	$ -	$ -	$ -	$ -	$ -
6 Totals Received from the State			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
7 Unearned Premiums			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8 Change in Receivables / Unearned Premiums			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
9 Other			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
10 Total Premiums Reconciled to 19 S-2			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Notes:

$ - Cells with this shading are calculated fields and are not to be filled out.

1 - Detail any differences in the "Notes" section.

Table #19 – Part S3 – Income Statement by Rate Cell Grouping

Reconciliations

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____
(HMO Name)

Lag Triangle and Income Statement Reconciliation for Twelve Month End												
Lag Report		Table #19 – Parts S1 & S2		Twelve-Month Paid Claims			Twelve-Month IBNR & RBUC			Twelve-Month Total $		
Lag Report #	Medical Cost Grouping	Line #	Consolidated Category of Service	Lag Report	Table #19 – Part S2	Difference [1]	Lag Report	Table #19 – Part S2	Difference [1]	Lag Report	Table #19 – Part S2	Difference [1]
Table #20 – Part A	Inpatient Hospital	9	Inpatient Hospital	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Table #20 – Part B	Physician	10 11	Primary Care Physician Specialty Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Table #20 – Part C	Pharmacy	18 19	Pharmacy (not to include Reimbursable HIV/AIDS D Reimbursable HIV/AIDS Drugs and Blood Products	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Table #20 – Part D	Other	12 13 14 15 16 17 20 21 22 23 24 26 27 28 29	Outpatient Hospital (excludes ER) Other Professional Services Emergency Room DME/Medical Supplies Prosthetics & Orthotics Covered Dental Home Health, Hospice, & PDN Transportation Lab & X-ray Vision Care including Eyeglasses Mental Health/Substance Abuse EPSDT Medical & PDN EPSDT Dental - EPD Family Planning Other Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total		30	Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Notes:

$ - Cells with this shading are calculated fields and are not to be filled out.

1 - Detail any differences in the "Notes" section.

Table #19 – Part S3 – Income Statement by Rate Cell Grouping

Reconciliations

FOR THE TWELVE MONTHS ENDING _____ **FOR** _____ _____ _____
(HMO Name)

Prior Period IBNR Reconciliation for Twelve Month End		
		Incurred in Twelve Months Prior to _____
1	Claims Paid in Most Recent Twelve Month End	$ -
2	+ IBNR as of Most Recent Twelve Months (line 43 of #2A-D lag triangles)	$ -
3	- IBNR as of Prior Twelve Month End	$ -
4	+ Subcapitation Payments, Pharmacy Rebates, Settlements as of Most Recent Twelve Months (lines 39+40+41 of #20A-D lag triangles)	$ -
5	- Subcapitation Payments, Pharmacy Rebates, Settlements as of Prior Twelve Month End	$ -
6	**Prior Period IBNR Adjustment for Twelve Month End (lines 1+2-3+4-5)**	**$ -**
7	**Table #19 – Parts S2 Adjustment for prior period IBNR estimates (line 45 of Table #19S2)**	**$ -**
8	**Difference (lines 6-7)**	**$ -**

Notes:
$ - Cells with this shading are calculated fields and are not to be filled out.
1 - Detail any differences in the "Notes" section.

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

Table #4 - Claims Processing Lag Report

For the Three Months Ending

HMO

4A Claims Processing for Manually Submitted Claims

						Claims Processed During Quarter									
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	CONSOLIDATED CATEGORY OF SERVICE	Non Processed Claims from Prior Quarters	Claims Received During Quarter	Total Claims (Cols 2+3)	Claims Processed This Quarter	01-40 Days	Percent of Total	41-60 Days	Percent of Total	61-90 Days	Percent of Total	Days > 91	Percent of Total	Non-Processed Claims on Hand at End of Quarter	Percent of Non-Processed Claims on Hand at End of Quarter (col 16/col 4)
1	Inpatient Hospital	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
2	Primary Care	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
3	Physician Specialty Services	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
4	Outpatient Hospital (excludes ER)	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
5	Other Professional Services	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
6	Emergency Room	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
7	DME/Medical Supplies	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
8	Prosthetics & Orthotics	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
9	Dental	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
10	Pharmacy	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
12	Home Health, Hospice, & PDN	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
13	Transportation	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
14	Lab and X-Ray	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
15	Vision Care & Eyeglasses	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
16	Mental Health/Substance Abuse	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
17	Other Medical	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
18	**TOTAL**	**-**	**-**	**-**	**-**	**-**	**0.0%**	**-**	**0.0%**	**-**	**0.0%**	**-**	**0.0%**	**-**	**0.0%**

Table #4 – Part B – Claims Processing Lag Report for Electronically Submitted Claims

						Claims Processed During Quarter									
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	CONSOLIDATED CATEGORY OF SERVICE	Non Processed Claims from Prior Quarters	Claims Received During Quarter	Total Claims (Cols 2+3)	Claims Processed This Quarter	01-30 Days	Percent of Total	31-60 Days	Percent of Total	61-90 Days	Percent of Total	Days > 91	Percent of Total	Non-Processed Claims on Hand at End of Quarter	Percent of Non-Processed Claims on Hand at End of Quarter (col 16/col 4)
1	Inpatient Hospital	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
2	Primary Care	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
3	Physician Specialty Services	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
4	Outpatient Hospital (excludes ER)	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
5	Other Professional Services	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
6	Emergency Room	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
7	DME/Medical Supplies	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
8	Prosthetics & Orthotics	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
9	Dental	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
10	Pharmacy	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
12	Home Health, Hospice, & PDN	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
13	Transportation	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
14	Lab and X-Ray	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
15	Vision Care & Eyeglasses	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
16	Mental Health/Substance Abuse	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
17	Other Medical	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
18	**TOTAL**	-	-	-	-	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%

Grand Totals for 4A and 4B	0	0	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	

Table 6 - Allowable Direct Medical Expenditures
For Purposes of Calculating Medical Cost Ratio

_____
HMO

For the Period Ending _____

List the employee title or function, or contracted association for salaried individuals who have performed Allowable Direct Medical Expenditure functions during the quarter and the last 12 months. Allowable Direct Medical Expenditures are the total salary costs of performing functions related to the following categories: 1) assessments(s) of an enrollee's risk factors; 2) development of Individual Health Care Plans; 3) provision of face to face medical education or anticipatory guidance; 4) activities required to maintain compliance with EPSDT lead screening and pre-natal care. Reporting of direct medical expenditures shall reflect only those activities approved by the State in the Medical Cost Ratio- Direct Medical Expendiures Plan. Other care management functions are considered administrative and unallowable.

Number of Employee's Directly Involved	Employee Title / Name of Outreach Association	Category (Care Management, Face-to-Face, Compliance with EPSDT, et.al.)	Allowable Compensation this Quarter	Allowable Compensation Last 12 Months
	Case Manager RN - Plan	Risk Assessment		
	Case Manager RN - Plan	Individual HC Planning		
	Case Manager RN - Plan	Medical Education / Guidance		
	Case Manager RN - Plan	EPSDT Compliance		
	Outreach Association	Risk Assessment		
	Outreach Association	Individual HC Planning		
	Outreach Association	Medical Education / Guidance		
	Outreach Association	EPSDT Compliance		
Totals*			$ -	$ -

I certify the expenses reported as allowable are the true and accurate salary costs of the individuals listed above and meet the definition of an Allowable Direct Medical Expenditure defined in Section 8.4.1.A of the managed care contract. Further, I certify these costs are included and have been reported as Adminitrative costs in Table 19S2 - Compensation

(Signature) _____

Name and Title _____

Table #7 – Parts A-C – Stop Loss Summary

FOR THE CALENDAR YEAR ENDING _____ **FOR** _____
(HMO Name)

A. Coverage

Aggregate Stop-Loss Threshold	Maximum Per Enrollee Per Year	Maximum Aggregate Lifetime per Enrollee	Includes Insolvency Insurance (Y/N)	Deductible	Cost of Premiums PMPM
$ -	$ -	$ -		$ -	$ -
Policy Expiration Date			00/00/00		

B.

Category of Eligibility:	AFDC	ABD	NJ KidCare	FamilyCare	TOTAL
Number of Enrollees Exceeding Stop Loss	-	-	-	-	-
Net Expenditures Above Stop Loss	$ -	$ -	$ -	$ -	$ -

C. List Details for Each Individual (Name or ID Not Required)

	Net Expenditures Above Stop-Loss	Primary Diagnosis/Major Procedure	Reinsurance Recoveries [1]
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
Total (lines 1 through 15)			
Table #19, Parts S2, Line 6			
Difference [2]			

Notes: 1 - Total Reinsurance Recoveries must tie to Table 19, Part S2, Line 6.
2 - Detail any differences in the "Notes" section.

Table #10 – Third Party Liability and Fraud/Abuse Collections *

HMO

For the Period Ending

Third Party Liability

Consolidated Category of Aid	Current Quarter: Employment Related	Current Quarter: Motor Vehicle Related	Current Quarter: Other	Current Quarter: Health Insurance	Last 12 Months: Employment Related	Last 12 Months: Motor Vehicle Related	Last 12 Months: Other	Last 12 Months: Health Insurance	I- Income C- Claim Reduction
AFDC**		$ -	$ -	$ -		$ -	$ -	$ -	
DYFS	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Aged with Medicare & Other Dual Eligibles	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Aged w/o Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Blind and Disabled with Medicare+	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Blind and Disabled without Medicare+	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
NJ KidCare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
NJ FamilyCare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	

Fraud/Abuse

Consolidated Category of Aid	Current Quarter: Claims Initiated	Current Quarter: Claims Turned over to DHAHS	Current Quarter: Estimated Value of Claims turned over to DMAHS	Current Quarter: Collections	Last 12 Months: Claims Initiated	Last 12 Months: Claims Turned over to DHAHS	Last 12 Months: Estimated Value of Claims turned over to DMAHS	Last 12 Months: Collections	I- Income C- Claim Reduction
AFDC**			$ -	$ -			$ -	$ -	
DYFS			$ -	$ -			$ -	$ -	
Aged with Medicare & Other Dual Eligibles			$ -	$ -			$ -	$ -	
Aged w/o Medicare			$ -	$ -			$ -	$ -	
Blind and Disabled with Medicare+			$ -	$ -			$ -	$ -	
Blind and Disabled without Medicare+			$ -	$ -			$ -	$ -	
NJ KidCare			$ -	$ -			$ -	$ -	
NJ FamilyCare			$ -	$ -			$ -	$ -	
Total			$ -	$ -			$ -	$ -	

Notes:
Enter the total amount collected for each eligible category
For AFDC, include New Jersey Care children and pregnant women
For Blind and Disabled w/ wo Medicare include essential spouses
For TPL and Fraud/Abuse collections Indicate I for Income and C for claims reduction on Income Statement

Table #21 - Maternity Outcome Counts [1]

FOR THE TWELVE MONTHS ENDING _____ FOR _____

(HMO Name)

	Current 12 Month Period				
	Live Births		Non-live Births	Newborn Member Mo's	Ratio MMs / Births [2]
	C-Section	Vaginal			
Northwestern – Non-Urban AFDC/NJCPW/NJ KidCare A					
Northeastern – Non-Urban AFDC/NJCPW/NJKidCare A					
Central – Urban AFDC/NJCPW/NJ KidCare A					
Southern Central – Urban AFDC/NJCPW/NJ KidCare A					
Southern – Non-Urban AFDC/NJCPW/NJ KidCare A					
STATEWIDE All Other					
TOTAL					

Notes:

1 - Only outcomes on or after the thirteenth week of gestation should be included in this report, excluding elective abortions.

2 - It is expected that there shall be approximately 2.5 newborn member months reported for each delivery as the newborn time period is on average 75 days. Any variation from 2.5 member months may suggest a reporting inconsistency.

Table #14B - HMO Administrative Expenses
For the State Fiscal Year Ending 6-30-20XX
HMO Name

Categories	Administrative Category Descriptions	GL Accounts	General Ledger Account Name	Total Amount Reported as Administration Expense	HMO Direct Charge	Corporate Allocation	Management Service Agreement
31.0							
31.1	Compensation - Based in NJ						
31.2	Compensation - Corporate allocation for direct support						
31.3	Compensation - Executive officers - Board of Directors						
31.4	Share / Stock Based Compensation						
32.0							
32.1	Amortization - Direct Charges						
32.2	Amortization - Other Allocations						
	Add lines & Account #'s for Goodwill, Intangibles, etc.)						
32.3	Depreciation/ Occupancy - NJ Locations						
32.4	Depreciation/ Occupancy - Corporate Allocations						
33.0	Interest Expense						
34.0	Education / Outreach / Marketing						
34.xx	(add lines for account numbers &expenses involving Direct Mailings, Telemarketing, Surveys, Market research, Printing and postage costs,						
	Charitable contributions - Community Relations						
35.0	Sanctions - Imposed and deducted from capitation/ collected by DMAHS						
36.0	Corporate Overhead Allocations						
36.1	Cost Plus Administrative Charges						
36.xx	Add Lines to detail charges						
37.0	Subcontracted Administrative Services						
37.1	Dental, Pharmacy, etc.						
37.2	Claims Processing						
37.3	Other- Add lines & provide details						
38.0	Other						
38.1	Lobbying Expenses						
38.2	Professional Fees						
38.3	Legal: - litigation & Settlements						
38.4	Audit, Tax and Actuarial fees						
38.5	Contributions & Donations (if not detailed at Line 34)						
38.6	Travel, Conferences, Conventions, Etc						
38.7	Goodwill						
38.8	Royalties						
38.9	Long Term Borrowing						
38.10	Cost Plus Administrative Charges (If not included above)						
38.11	Medical Liability Insurance						
38.12	Utilities, Security, Facilities Management Costs						
38.13	State and Federal income taxes not included in Table 19S2, Line 43						
	Totals						

Table #20 – Part A – Lag Report for Inpatient Hospital Payments

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

For the SFY-end 6/30 as of 09/30 _____

As of _____ FOR _____
(HMO Name)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)
		. . . Month in Which Service Provided . . .																				
Line	Month of Payment	Current Month	1st Prior Month	2nd Prior Month	3rd Prior Month	4th Prior Month	5th Prior Month	6th Prior Month	7th Prior Month	8th Prior Month	9th Prior Month	10th Prior Month	11th Prior Month	12th Prior Month	13th Prior Month	14th Prior Month	15th Prior Month	16th Prior Month	17th Prior Month	18th Prior Month	19th Prior Month	20th Prior Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month												$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month													$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month														$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month															$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month																$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month																	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month																		$ -	$ -	$ -	$ -
19	18th Prior Month																			$ -	$ -	$ -
20	19th Prior Month																				$ -	$ -
21	20th Prior Month																					$ -
22	21st Prior Month																					
23	22nd Prior Month																					
24	23rd Prior Month																					
25	24th Prior Month																					
26	25th Prior Month																					
27	26th Prior Month																					
28	27th Prior Month																					
29	28th Prior Month																					
30	29th Prior Month																					
31	30th Prior Month																					
32	31st Prior Month																					
33	32nd Prior Month																					
34	33rd Prior Month																					
35	34th Prior Month																					
36	35th Prior Month																					
37	Months Before 35th Prior Month																					
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																					
41	Settlements[1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

$ -	Cells with this lighter shading are amounts first reported this twelve-month period, amounts restated this twelve–month period, or totals which depend (in whole or in part) on such amounts.
$ -	Cells with this darker shading are amounts initially reported in a prior twelve-month period that appear again, but in a different location on the spreadsheet. If cells change from the prior period's submission, include an explanation in the "Notes" tab.
	Cells with this shading are not to be filled out.

Notes: 1 - Settlements that could not be reflected in the paid claims above.

Table #20 – Part A – Lag Repor

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

(1)	(2)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)	(35)	(36)	(37)	(38)	(39)	(40)
Line	**Month of Payment**	21st Prior Month	22nd Prior Month	23rd Prior Month	24th Prior Month	25th Prior Month	26th Prior Month	27th Prior Month	28th Prior Month	29th Prior Month	30th Prior Month	31st Prior Month	32nd Prior Month	33rd Prior Month	34th Prior Month	35th Prior Month	Months Before 35th Prior Month	Total Paid by Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
19	18th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	19th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
21	20th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
22	21st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23	22nd Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24	23rd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	24th Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
26	25th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27	26th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
28	27th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
29	28th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	29th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
31	30th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
32	31st Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -
33	32nd Prior Month												$ -	$ -	$ -	$ -	$ -	$ -
34	33rd Prior Month													$ -	$ -	$ -	$ -	$ -
35	34th Prior Month														$ -	$ -	$ -	$ -
36	35th Prior Month															$ -	$ -	$ -
37	Months Before 35th Prior Month																$ -	$ -
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																	
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Table #20 – Part B – Lag Report for Physician Payments

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

For the SFY-end 6/30 as of 09/30 _____

As of _____ FOR _____
(HMO Name)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)
		. . . Month in Which Service Provided . . .																				
Line	Month of Payment	Current Month	1st Prior Month	2nd Prior Month	3rd Prior Month	4th Prior Month	5th Prior Month	6th Prior Month	7th Prior Month	8th Prior Month	9th Prior Month	10th Prior Month	11th Prior Month	12th Prior Month	13th Prior Month	14th Prior Month	15th Prior Month	16th Prior Month	17th Prior Month	18th Prior Month	19th Prior Month	20th Prior Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month												$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month													$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month														$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month															$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month																$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month																	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month																		$ -	$ -	$ -	$ -
19	18th Prior Month																			$ -	$ -	$ -
20	19th Prior Month																				$ -	$ -
21	20th Prior Month																					$ -
22	21st Prior Month																					
23	22nd Prior Month																					
24	23rd Prior Month																					
25	24th Prior Month																					
26	25th Prior Month																					
27	26th Prior Month																					
28	27th Prior Month																					
29	28th Prior Month																					
30	29th Prior Month																					
31	30th Prior Month																					
32	31st Prior Month																					
33	32nd Prior Month																					
34	33rd Prior Month																					
35	34th Prior Month																					
36	35th Prior Month																					
37	Months Before 35th Prior Month																					
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																					
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

$ -	Cells with this lighter shading are amounts first reported this twelve-month period, amounts restated this twelve–month period, or totals which depend (in whole or in part) on such amounts.
$ -	Cells with this darker shading are amounts initially reported in a prior twelve-month period that appear again, but in a different location on the spreadsheet. If cells change from the prior period's submission, include an explanation in the "Notes" tab.
	Cells with this shading are not to be filled out.

Notes: 1 - Settlements that could not be reflected in the paid claims above.

Table #20 – Part B – Lag Repor

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

(1)	(2)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)	(35)	(36)	(37)	(38)	(39)	(40)
Line	**Month of Payment**	21st Prior Month	22nd Prior Month	23rd Prior Month	24th Prior Month	25th Prior Month	26th Prior Month	27th Prior Month	28th Prior Month	29th Prior Month	30th Prior Month	31st Prior Month	32nd Prior Month	33rd Prior Month	34th Prior Month	35th Prior Month	Months Before 35th Prior Month	Total Paid by Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
19	18th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	19th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
21	20th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
22	21st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23	22nd Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24	23rd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	24th Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
26	25th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27	26th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
28	27th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
29	28th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	29th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
31	30th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
32	31st Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -
33	32nd Prior Month												$ -	$ -	$ -	$ -	$ -	$ -
34	33rd Prior Month													$ -	$ -	$ -	$ -	$ -
35	34th Prior Month														$ -	$ -	$ -	$ -
36	35th Prior Month															$ -	$ -	$ -
37	Months Before 35th Prior Month																$ -	$ -
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																	
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Table #20 – Part C – Lag Report for Pharmacy Payments

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

For the SFY-end 6/30 as of 09/30 _____

As of _____ FOR _____
(HMO Name)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)
		. . . Month in Which Service Provided . . .																				
Line	Month of Payment	Current Month	1st Prior Month	2nd Prior Month	3rd Prior Month	4th Prior Month	5th Prior Month	6th Prior Month	7th Prior Month	8th Prior Month	9th Prior Month	10th Prior Month	11th Prior Month	12th Prior Month	13th Prior Month	14th Prior Month	15th Prior Month	16th Prior Month	17th Prior Month	18th Prior Month	19th Prior Month	20th Prior Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month												$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month													$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month														$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month															$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month																$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month																	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month																		$ -	$ -	$ -	$ -
19	18th Prior Month																			$ -	$ -	$ -
20	19th Prior Month																				$ -	$ -
21	20th Prior Month																					$ -
22	21st Prior Month																					
23	22nd Prior Month																					
24	23rd Prior Month																					
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31	30th Prior Month																					
32	31st Prior Month																					
33	32nd Prior Month																					
34	33rd Prior Month																					
35	34th Prior Month																					
36	35th Prior Month																					
37	Months Before 35th Prior Month																					
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
41	Settlements[1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Payments, Rebates and Settlements (38+39+40+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

$ -	Cells with this lighter shading are amounts first reported this twelve-month period, amounts restated this twelve–month period, or totals which depend (in whole or in part) on such amounts.
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Notes: 1 - Settlements that could not be reflected in the paid claims above.

Table #20 – Part C – Lag Repor

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

(1)	(2)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)	(35)	(36)	(37)	(38)	(39)	(40)
Line	**Month of Payment**	21st Prior Month	22nd Prior Month	23rd Prior Month	24th Prior Month	25th Prior Month	26th Prior Month	27th Prior Month	28th Prior Month	29th Prior Month	30th Prior Month	31st Prior Month	32nd Prior Month	33rd Prior Month	34th Prior Month	35th Prior Month	Months Before 35th Prior Month	Total Paid by Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
19	18th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	19th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
21	20th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
22	21st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23	22nd Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24	23rd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	24th Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
26	25th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27	26th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
28	27th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
29	28th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	29th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
31	30th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
32	31st Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -
33	32nd Prior Month												$ -	$ -	$ -	$ -	$ -	$ -
34	33rd Prior Month													$ -	$ -	$ -	$ -	$ -
35	34th Prior Month														$ -	$ -	$ -	$ -
36	35th Prior Month															$ -	$ -	$ -
37	Months Before 35th Prior Month																$ -	$ -
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Payments, Rebates and Settlements (38+39+40+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Table #20 – Part D – Lag Report for Other Medical Payments

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

For the SFY-end 6/30 as of 09/30 _____

As of _____ FOR _____
(HMO Name)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)
		. . . Month in Which Service Provided . . .																				
Line	Month of Payment	Current Month	1st Prior Month	2nd Prior Month	3rd Prior Month	4th Prior Month	5th Prior Month	6th Prior Month	7th Prior Month	8th Prior Month	9th Prior Month	10th Prior Month	11th Prior Month	12th Prior Month	13th Prior Month	14th Prior Month	15th Prior Month	16th Prior Month	17th Prior Month	18th Prior Month	19th Prior Month	20th Prior Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month												$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month													$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month														$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month															$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month																$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month																	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month																		$ -	$ -	$ -	$ -
19	18th Prior Month																			$ -	$ -	$ -
20	19th Prior Month																				$ -	$ -
21	20th Prior Month																					$ -
22	21st Prior Month																					
23	22nd Prior Month																					
24	23rd Prior Month																					
25	24th Prior Month																					
26	25th Prior Month																					
27	26th Prior Month																					
28	27th Prior Month																					
29	28th Prior Month																					
30	29th Prior Month																					
31	30th Prior Month																					
32	31st Prior Month																					
33	32nd Prior Month																					
34	33rd Prior Month																					
35	34th Prior Month																					
36	35th Prior Month																					
37	Months Before 35th Prior Month																					
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																					
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

$ -	Cells with this lighter shading are amounts first reported this twelve-month period, amounts restated this twelve–month period, or totals which depend (in whole or in part) on such amounts.
$ -	Cells with this darker shading are amounts initially reported in a prior twelve-month period that appear again, but in a different location on the spreadsheet. If cells change from the prior period's submission, include an explanation in the "Notes" tab.
	Cells with this shading are not to be filled out.

Notes: 1 - Settlements that could not be reflected in the paid claims above.

Table #20 – Part D – Lag Repor

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

(1)	(2)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)	(35)	(36)	(37)	(38)	(39)	(40)
Line	**Month of Payment**	21st Prior Month	22nd Prior Month	23rd Prior Month	24th Prior Month	25th Prior Month	26th Prior Month	27th Prior Month	28th Prior Month	29th Prior Month	30th Prior Month	31st Prior Month	32nd Prior Month	33rd Prior Month	34th Prior Month	35th Prior Month	Months Before 35th Prior Month	Total Paid by Month
1	Current Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	1st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	2nd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	3rd Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	4th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	5th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	6th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	7th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	8th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	9th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	10th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	11th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	12th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	13th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	14th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
16	15th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
17	16th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
18	17th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
19	18th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	19th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
21	20th Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
22	21st Prior Month	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23	22nd Prior Month		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24	23rd Prior Month			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	24th Prior Month				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
26	25th Prior Month					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27	26th Prior Month						$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
28	27th Prior Month							$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
29	28th Prior Month								$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	29th Prior Month									$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
31	30th Prior Month										$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
32	31st Prior Month											$ -	$ -	$ -	$ -	$ -	$ -	$ -
33	32nd Prior Month												$ -	$ -	$ -	$ -	$ -	$ -
34	33rd Prior Month													$ -	$ -	$ -	$ -	$ -
35	34th Prior Month														$ -	$ -	$ -	$ -
36	35th Prior Month															$ -	$ -	$ -
37	Months Before 35th Prior Month																$ -	$ -
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
39	Subcapitation Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Pharmacy Rebates																	
41	Settlements [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
42	Sum of Claims, Subcapitation Payments and Settlements (38+39+41)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43	Current Estimate of Remaining Liability (Incurred but not Reported Claims)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
44	Total Incurred Claims (42+43)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Table 19 – Parts A through R2 - Income Statement by Rate Cell Grouping On Claims Incurred for STATE FISCAL YEAR (SFY) END AT 09/30

HMO Name: _____

For the SFY-end 6/30 as of 09/30 _____

Income Statement $ by Rate Cell Grouping A through R2

	Rate Cell Description	Non ABD Adults	Non ABD Children	FamilyCare Parents	NJ KidCare	ABD W Medicare	ABD W/O Medicare		Maternity	Newborns	At Risk Total
	Plan	A	A, B & C	D	D	A	A				
	Cap Stems	373, 394	173, 193	594	993	773, 795, 796	494, 812, 873, 895		803, 903		
	Table 19 Part :	A	B	C	D	E	F		R1	R2	
	Member Months [1]										
REVENUES:											
1	Capitated Premiums										
2	Maternity										
3	**Total Premiums (lines 1-2)**										
4	Reimbursable HIV/AIDS Drugs and Blood Products										
5	EPSDT Incentive Payment										
6	Other										
7	**Total Other Reimbursements (lines 4-6)**										
8	**TOTAL Premiums & Reimbursements (Lines 3 & 7)**										
EXPENSES:											
MEDICAL AND HOSPITAL											
9	Inpatient Hospital										
10	Primary Care										
11	Physician Specialty Services										
12	Outpatient Hospital (excludes ER)										
13	Other Professional Services										
14	Emergency Room										
15	DME/Medical Supplies										
16	Prosthetics & Orthotics										
17	Covered Dental										
18	Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products)										
19	Reimbursable HIV/AIDS Drugs and Blood Products										
20	Home Health, Hospice, & PDN										
21	Transportation										
22	Lab & X-ray										
23	Vision Care including Eyeglasses										
24	Mental Health/Substance Abuse										
25	Reinsurance Expenses										
25a	**less: Reinsurance Reimbursements & COB (Table 7 Part -C)**										
26	EPSDT Medical & PDN										
27	EPSDT Dental - EPD										
28	Family Planning										
29	Other Medical										
30	**TOTAL MEDICAL & HOSPITAL (9 through 29)**										
ADMINISTRATION:											
31	Compensation										
32	Occupancy/Depreciation/Amortization										
33	Interest Expense										
34	Education/Outreach/Marketing										
35	Sanctions										
36	Corporate Overhead Allocations										
37	Subcontracted/Delegated Administrative Services										
38	Other										
39	**TOTAL ADMINISTRATION (31 through 38)**										
40	**TOTAL EXPENSES (30+39)**										
41	**OPERATING INCOME (LOSS) (8-40)**										
42	**Investment Income**										
43	Provision for State, Federal, and Other Governmental Income Taxes										
44	Other than Income Taxes [2]										
45	Adjustment for prior period IBNR estimates										
46	Non-claim adjustments for prior periods										
47	**NET INCOME (LOSS) (41+42-43-44-45-46)**										

HMO Name: _____

For the SFY-end 6/30 as of 09/30 _____

Income Statement $ by Rate Cell Grouping A through R2

	Rate Cell Description	Non ABD Adults	Non ABD Children	FamilyCare Parents	NJ KidCare	ABD W Medicare	ABD W/O Medicare		Maternity	Newborns	At Risk Total
	Plan	A	A, B & C	D	D	A	A				
	Cap Codes	373, 394	173, 193	594	993	773, 795, 796	494, 812, 873, 895		803, 903		
	Table 19 Part :	A	B	C	D	E	F		R1	R2	
	Member Months [1]										
REVENUES:											
1	Capitated Premiums										
2	Maternity										
3	**Total Premiums (lines 1-2)**										
4	Reimbursable HIV/AIDS Drugs and Blood Products										
5	EPSDT Incentive Payment										
6	Other										
7	**Total Other Reimbursements (lines 4-6)**										
8	**TOTAL Premiums & Reimbursements (Lines 3 & 7)**										
EXPENSES:											
MEDICAL AND HOSPITAL											
9	Inpatient Hospital										
10	Primary Care										
11	Physician Specialty Services										
12	Outpatient Hospital (excludes ER)										
13	Other Professional Services										
14	Emergency Room										
15	DME/Medical Supplies										
16	Prosthetics & Orthotics										
17	Covered Dental										
18	Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products)										
19	Reimbursable HIV/AIDS Drugs and Blood Products										
20	Home Health, Hospice, & PDN										
21	Transportation										
22	Lab & X-ray										
23	Vision Care including Eyeglasses										
24	Mental Health/Substance Abuse										
25	Reinsurance Expenses										
25a	**less: Reinsurance Reimbursements & COB (Table 7 Part -C)**										
26	EPSDT Medical & PDN										
27	EPSDT Dental - EPD										
28	Family Planning										
29	Other Medical										
30	**TOTAL MEDICAL & HOSPITAL (9 through 29)**										
ADMINISTRATION:											
31	Compensation										
32	Occupancy/Depreciation/Amortization										
33	Interest Expense										
34	Education/Outreach/Marketing										
35	Sanctions										
36	Corporate Overhead Allocations										
37	Subcontracted/Delegated Administrative Services										
38	Other										
39	**TOTAL ADMINISTRATION (31 through 38)**										
40	**TOTAL EXPENSES (30+39)**										
41	**OPERATING INCOME (LOSS) (8-40)**										
42	**Investment Income**										
43	Provision for State, Federal, and Other Governmental Income Taxes										
44	Other than Income Taxes [2]										
45	Adjustment for prior period IBNR estimates										
46	Non-claim adjustments for prior periods										
47	**NET INCOME (LOSS) (41+42-43-44-45-46)**										

1 - Newborn member months not to be included in Total.

2 - Reported items other than State or Federal income taxes (i.e. State assessments irrespective of profit position).

Table 19 – Part S2 - Income Statement by ALL AT-RISK Rate Cell Grouping On Claims Incurred for SFY END AT 09/30

HMO Name: _____
For the SFY-end 6/30 as of 09/30 _____
Report #2, Table 19, Part S2

	Rate Cell Description	12 Months Paid Claims	12 Months RBUC & IBNR	12 Month Totals[1]	PMPM
	Member Months [2]				
REVENUES:					
1	Capitated Premiums				
2	Maternity				
3	**Total Premiums (lines 1-2)**				
4	Reimbursable HIV/AIDS Drugs and Blood Products				
5	EPSDT Incentive Payment				
6	Other				
7	**Total Other Reimbursements (lines 4-6)**				
8	**TOTAL Premiums & Reimbursements (Lines 3 & 7)**				
EXPENSES:					
MEDICAL AND HOSPITAL					
9	Inpatient Hospital				
10	Primary Care				
11	Physician Specialty Services				
12	Outpatient Hospital (excludes ER)				
13	Other Professional Services				
14	Emergency Room				
15	DME/Medical Supplies				
16	Prosthetics & Orthotics				
17	Covered Dental				
18	Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products)				
19	Reimbursable HIV/AIDS Drugs and Blood Products				
20	Home Health, Hospice, & PDN				
21	Transportation				
22	Lab & X-ray				
23	Vision Care including Eyeglasses				
24	Mental Health/Substance Abuse				
25	Reinsurance Expenses				
25a	less: Reinsurance Reimbursements & COB (Table 7 Part -C)				
26	EPSDT Medical & PDN				
27	EPSDT Dental - EPD				
28	Family Planning				
29	Other Medical				
30	**TOTAL MEDICAL & HOSPITAL (9 through 29)**				
ADMINISTRATION:					
31	Compensation				
32	Occupancy/Depreciation/Amortization				
33	Interest Expense				
34	Education/Outreach/Marketing				
35	Sanctions				
36	Corporate Overhead Allocations				
37	Subcontracted/Delegated Administrative Services				
38	Other				
39	**TOTAL ADMINISTRATION (31 through 38)**				
40	**TOTAL EXPENSES (30+39)**				
41	**OPERATING INCOME (LOSS) (8-40)**				
42	Investment Income				
43	Provision for State, Federal, and Other Governmental Income Taxes				
44	Other than Income Taxes [3]				
45	Adjustment for prior period IBNR estimates				
46	Non-claim adjustments for prior periods				
47	**NET INCOME (LOSS) (41+42-43-44-45-46)**				

Notes:
This report is for the twelve months incurred claims expenses ending State Fiscal Year June 30, totals should be reported with an additional three months of paid claims at quarter ending September 30.
1 - Summation of Parts A-R2.
2 - Newborn member months not to be included in Total.
3 - Reported items other than State or Federal income taxes (i.e. State assessments irrespective of profit position).

Table #19 – Part S3 – Income Statement by Rate Cell Grouping

Reconciliations

FOR THE SFY ENDING 6-30-08 _____ **FOR** _____
(HMO Name)

Revenue Reconciliation

Only 5 rows provided (insert additional rows if needed)	Date	Check #	Capitation Premiums	Maternity Reimbursement	HIV / AIDS - Blood Products Reimbursement	EPSDT Premiums	Other	Total Premiums/ Reimbursements
1	01/00/00	00000	$ -	$ -	$ -	$ -	$ -	$ -
2	01/00/00	00000	$ -	$ -	$ -	$ -	$ -	$ -
3	01/00/00	00000	$ -	$ -	$ -	$ -	$ -	$ -
4	01/00/00	00000	$ -	$ -	$ -	$ -	$ -	$ -
5	01/00/00	00000	$ -	$ -	$ -	$ -	$ -	$ -
6 Totals Received from the State			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
7 Unearned Premiums			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8 Change in Receivables / Unearned Premiums			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
9 Other			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
10 Total Premiums Reconciled to 19 S-2			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Notes:

$ - Cells with this shading are calculated fields and are not to be filled out.

1 - Detail any differences in the "Notes" section.

Table #19 – Part S3 – Income Statement by Rate Cell Grouping

Reconciliations

FOR THE SFY ENDING 6-30-08 _____ **FOR** _____
(HMO Name)

Lag Triangle and Income Statement Reconciliation for Twelve Month End

Lag Report		Table #19 – Parts S1 & S2		Twelve-Month Paid Claims			Twelve-Month IBNR & RBUC			Twelve-Month Total $		
Lag Report #	Medical Cost Grouping	Line #	Consolidated Category of Service	Lag Report	Table #19 – Part S2	Difference [1]	Lag Report	Table #19 – Part S2	Difference [1]	Lag Report	Table #19 – Part S2	Difference [1]
Table #20 – Part A	Inpatient Hospital	9	Inpatient Hospital	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Table #20 – Part B	Physician	10 11	Primary Care Physician Specialty Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Table #20 – Part C	Pharmacy	18 19	Pharmacy (not to include Reimbursable HIV/AIDS D Reimbursable HIV/AIDS Drugs and Blood Products	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Table #20 – Part D	Other	12 13 14 15 16 17 20 21 22 23 24 26 27 28 29	Outpatient Hospital (excludes ER) Other Professional Services Emergency Room DME/Medical Supplies Prosthetics & Orthotics Covered Dental Home Health, Hospice, & PDN Transportation Lab & X-ray Vision Care including Eyeglasses Mental Health/Substance Abuse EPSDT Medical & PDN EPSDT Dental - EPD Family Planning Other Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total		30	Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Notes:

$ - Cells with this shading are calculated fields and are not to be filled out.

1 - Detail any differences in the "Notes" section.

Table #19 – Part S3 – Income Statement by Rate Cell Grouping

Reconciliations

FOR THE SFY ENDING 6-30-08 _____ **FOR** _____
(HMO Name)

Prior Period IBNR Reconciliation for Twelve Month End		
		Incurred in Twelve Months Prior to _____
1	Claims Paid in Most Recent Twelve Month End	$ -
2	+ IBNR as of Most Recent Twelve Months (line 43 of #2A-D lag triangles)	$ -
3	- IBNR as of Prior Twelve Month End	$ -
4	+ Subcapitation Payments, Pharmacy Rebates, Settlements as of Most Recent Twelve Months (lines 39+40+41 of #20A-D lag triangles)	$ -
5	- Subcapitation Payments, Pharmacy Rebates, Settlements as of Prior Twelve Month End	$ -
6	**Prior Period IBNR Adjustment for Twelve Month End (lines 1+2-3+4-5)**	**$ -**
7	**Table #19 – Parts S2 Adjustment for prior period IBNR estimates (line 45 of Table #19S2)**	**$ -**
8	**Difference (lines 6-7)**	**$ -**

Notes:
$ - Cells with this shading are calculated fields and are not to be filled out.
1 - Detail any differences in the "Notes" section.

Table #19 – Part T – Non-State Plan Service Expenses by Rate Cell Grouping

Non-State Plan Services [1]

FOR THE STATE FISCAL-ENDING AT 09/30: **2009** **FOR** _____
(HMO Name)

		Non ABD Adults		Non ABD Children		FamilyCare Parents		NJ KidCare	
	Expenses	**Twelve-Month $**	**Twelve-Month Units**	**Twelve-Month $**	**Twelve-Month Units**	**Twelve-Month $**	**Twelve-Month Units**	**Twelve-Month $**	**Twelve-Month Units**
EXPENSES:									
MEDICAL & HOSPITAL NON-STATE PLAN SERVICES									
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11	**TOTAL MEDICAL & HOSPITAL NON-STATE PLAN SERVICES** (1 through 10)								
ADMINISTRATION FOR NON-STATE PLAN SERVICES*									
12	**TOTAL ADMINISTRATION**								
TOTAL EXPENSES FOR NON-STATE PLAN SERVICES									
13	**TOTAL EXPENSES** (11 + 12)								

Notes: 1 - All medical and administrative expenses must be reported using actual incurred and paid data for the current period of the calendar year (no reserves).

Non-State Plan Services Description
1
2
3
4
5
6
7
8
9
10

*If medical and hospital claim costs exist for non-State Plan services, then must have some amount of administration for non-State Plan services

Table #19 – Part T – Non-State Plan Service Expenses by Rate Cell Grou

Non-State Plan Services [1]

FOR THE STATE FISCAL-ENDING AT 09/30: **2009**

		ABD W Medicare		ABD W/O Medicare		Maternity		Newborns	
	Expenses	Twelve-Month $	Twelve-Month Units	Twelve-Month $	Twelve-Month Units	Twelve-Month $	Twelve-Month Units	Twelve-Month $	Twelve-Month Units
EXPENSES:									
MEDICAL & HOSPITAL NON-STATE PLAN SERVICES									
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11	**TOTAL MEDICAL & HOSPITAL NON-STATE PLAN SERVICES** (1 through 10)								
ADMINISTRATION FOR NON-STATE PLAN SERVICES*									
12	**TOTAL ADMINISTRATION**								
TOTAL EXPENSES FOR NON-STATE PLAN SERVICES									
13	**TOTAL EXPENSES** (11 + 12)								

Notes: 1 - All medical and administrative expenses must be reported using actual incurred and paid data for the current period of the calendar year (no reserves).

Non-State Plan Services Description

1
2
3
4
5
6
7
8
9
10

*If medical and hospital claim costs exist for non-State Plan services, then must have some amount of administration for non-State Plan services

Table #11A – Utilization and Unit Cost Information

For Inpatient Hospital, Primary Care Services, Physician Specialty Services, Emergency Room, Dental, Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products), Outpatient Facility, DME/Medical Supplies, Home Health Care, Laboratory and Radiology, Transportation, and All Other Practitioners & Services

FOR THE STATE FISCAL-ENDING AT 09/30: _____ _____
(HMO Name)

Utilization Data by Rate Cell

COA		Inpatient Hospital							
		Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Admits	Previous SFY-end @ 09/30 Days	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Admits	Current SFY-end @ 09/30 Days
A	Non ABD Adults (Cap Stems: 171, 172, 183, 274A9, 473A9, 474A9)								
B	Non ABD Children (Cap Stems: 125, 143, 274C9, 625, 633, 473C9, 474C9)								
D	NJ KidCare (Cap Stems: 925, 933, 276C9)								
E	ABD W Medicare (Cap Stems: 711, 813, 823, 863, 483, 484, 284)								
F	ABD W/O Medicare (Cap Stems: 710, 810, 812, 493, 494)								
Subtotal	**Parts A, B, and D-F**								

COA		Primary Care Services					
		Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Visits	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Visits
A	Non ABD Adults (Cap Stems: 171, 172, 183, 274A9, 473A9, 474A9)						
B	Non ABD Children (Cap Stems: 125, 143, 274C9, 625, 633, 473C9, 474C9)						
D	NJ KidCare (Cap Stems: 925, 933, 276C9)						
E	ABD W Medicare (Cap Stems: 711, 813, 823, 863, 483, 484, 284)						
F	ABD W/O Medicare (Cap Stems: 710, 810, 812, 493, 494)						
Subtotal	**Parts A, B, and D-F**						

COA		Physician Specialty Services					
		Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Visits	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Visits
A	Non ABD Adults (Cap Stems: 171, 172, 183, 274A9, 473A9, 474A9)						
B	Non ABD Children (Cap Stems: 125, 143, 274C9, 625, 633, 473C9, 474C9)						
D	NJ KidCare (Cap Stems: 925, 933, 276C9)						
E	ABD W Medicare (Cap Stems: 711, 813, 823, 863, 483, 484, 284)						
F	ABD W/O Medicare (Cap Stems: 710, 810, 812, 493, 494)						
Subtotal	**Parts A, B, and D-F**						

COA		Emergency Room					
		Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Visits	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Visits
A	Non ABD Adults (Cap Stems: 171, 172, 183, 274A9, 473A9, 474A9)						
B	Non ABD Children (Cap Stems: 125, 143, 274C9, 625, 633, 473C9, 474C9)						
D	NJ KidCare (Cap Stems: 925, 933, 276C9)						
E	ABD W Medicare (Cap Stems: 711, 813, 823, 863, 483, 484, 284)						
F	ABD W/O Medicare (Cap Stems: 710, 810, 812, 493, 494)						
Subtotal	**Parts A, B, and D-F**						

Table #11A – Utilization and Unit Cost Information

For Inpatient Hospital, Primary Care Services, Physician Specialty Services, Emergency Room, Dental, Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products), Outpatient Facility, DME/Medical Supplies, Home Health Care, Laboratory and Radiology, Transportation, and All Other Practitioners & Services

FOR THE STATE FISCAL-ENDING AT 09/30: _____ _____
(HMO Name)

Utilization Data by Rate Cell

COA		Dental					
		Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Visits	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Visits
A	Non ABD Adults (Cap Stems: 171, 172, 183, 274A9, 473A9, 474A9)						
B	Non ABD Children (Cap Stems: 125, 143, 274C9, 625, 633, 473C9, 474C9)						
D	NJ KidCare (Cap Stems: 925, 933, 276C9)						
E	ABD W Medicare (Cap Stems: 711, 813, 823, 863, 483, 484, 284)						
F	ABD W/O Medicare (Cap Stems: 710, 810, 812, 493, 494)						
Subtotal	**Parts A, B, and D-F**						

COA		Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products)					
		Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Scripts	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Scripts
A	Non ABD Adults (Cap Stems: 171, 172, 183, 274A9, 473A9, 474A9)						
B	Non ABD Children (Cap Stems: 125, 143, 274C9, 625, 633, 473C9, 474C9)						
D	NJ KidCare (Cap Stems: 925, 933, 276C9)						
E	ABD W Medicare (Cap Stems: 711, 813, 823, 863, 483, 484, 284)						
F	ABD W/O Medicare (Cap Stems: 710, 810, 812, 493, 494)						
Subtotal	**Parts A, B, and D-F**						

COA		Outpatient Facility					
		Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Visits	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Visits
A	Non ABD Adults (Cap Stems: 171, 172, 183, 274A9, 473A9, 474A9)						
B	Non ABD Children (Cap Stems: 125, 143, 274C9, 625, 633, 473C9, 474C9)						
D	NJ KidCare (Cap Stems: 925, 933, 276C9)						
E	ABD W Medicare (Cap Stems: 711, 813, 823, 863, 483, 484, 284)						
F	ABD W/O Medicare (Cap Stems: 710, 810, 812, 493, 494)						
Subtotal	**Parts A, B, and D-F**						

COA		DME/Medical Supplies & Orthotics/Prosthetics					
		Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Units	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Units
A	Non ABD Adults (Cap Stems: 171, 172, 183, 274A9, 473A9, 474A9)						
B	Non ABD Children (Cap Stems: 125, 143, 274C9, 625, 633, 473C9, 474C9)						
D	NJ KidCare (Cap Stems: 925, 933, 276C9)						
E	ABD W Medicare (Cap Stems: 711, 813, 823, 863, 483, 484, 284)						
F	ABD W/O Medicare (Cap Stems: 710, 810, 812, 493, 494)						
Subtotal	**Parts A, B, and D-F**						

Table #11A – Utilization and Unit Cost Information

For Inpatient Hospital, Primary Care Services, Physician Specialty Services, Emergency Room, Dental, Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products), Outpatient Facility, DME/Medical Supplies, Home Health Care, Laboratory and Radiology, Transportation, and All Other Practitioners & Services

FOR THE STATE FISCAL-ENDING AT 09/30:_____ _____
(HMO Name)

Utilization Data by Rate Cell

COA		Home Health Care					
		Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Services	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Services
A	Non ABD Adults (Cap Stems: 171, 172, 183, 274A9, 473A9, 474A9)						
B	Non ABD Children (Cap Stems: 125, 143, 274C9, 625, 633, 473C9, 474C9)						
D	NJ KidCare (Cap Stems: 925, 933, 276C9)						
E	ABD W Medicare (Cap Stems: 711, 813, 823, 863, 483, 484, 284)						
F	ABD W/O Medicare (Cap Stems: 710, 810, 812, 493, 494)						
Subtotal	**Parts A, B, and D-F**						

COA		Laboratory & Radiology					
		Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Units	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Units
A	Non ABD Adults (Cap Stems: 171, 172, 183, 274A9, 473A9, 474A9)						
B	Non ABD Children (Cap Stems: 125, 143, 274C9, 625, 633, 473C9, 474C9)						
D	NJ KidCare (Cap Stems: 925, 933, 276C9)						
E	ABD W Medicare (Cap Stems: 711, 813, 823, 863, 483, 484, 284)						
F	ABD W/O Medicare (Cap Stems: 710, 810, 812, 493, 494)						
Subtotal	**Parts A, B, and D-F**						

COA		Transportation					
		Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Units	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Units
A	Non ABD Adults (Cap Stems: 171, 172, 183, 274A9, 473A9, 474A9)						
B	Non ABD Children (Cap Stems: 125, 143, 274C9, 625, 633, 473C9, 474C9)						
D	NJ KidCare (Cap Stems: 925, 933, 276C9)						
E	ABD W Medicare (Cap Stems: 711, 813, 823, 863, 483, 484, 284)						
F	ABD W/O Medicare (Cap Stems: 710, 810, 812, 493, 494)						
Subtotal	**Parts A, B, and D-F**						

COA		All Other Practitioners and Services					
		Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Services	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Services
A	Non ABD Adults (Cap Stems: 171, 172, 183, 274A9, 473A9, 474A9)						
B	Non ABD Children (Cap Stems: 125, 143, 274C9, 625, 633, 473C9, 474C9)						
D	NJ KidCare (Cap Stems: 925, 933, 276C9)						
E	ABD W Medicare (Cap Stems: 711, 813, 823, 863, 483, 484, 284)						
F	ABD W/O Medicare (Cap Stems: 710, 810, 812, 493, 494)						
Subtotal	**Parts A, B, and D-F**						

Table #11A – Utilization and Unit Cost Information

For Inpatient Hospital, Primary Care Services, Physician Specialty Services, Emergency Room, Dental, Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products), Outpatient Facility, DME/Medical Supplies, Home Health Care, Laboratory and Radiology, Transportation, and All Other Practitioners & Services

FOR THE STATE FISCAL-ENDING AT 09/30:_____ _____
(HMO Name)

Utilization Data by Rate Cell

Reconciliations to Table 19 A - F	Rate Cell Total	Report Totals	Difference
Non ABD Adults - Table 19 Rate Cell A - Total Medical Expense			
Non ABD Children - Table 19 Rate Cell B - Total Medical Expense			
NJ KidCare - Table 19 Rate Cell D - Total Medical Expense			
ABD W Medicare - Table 19 Rate Cell E - Total Medical Expense			
ABD W/O Medicare - Table 19 Rate Cell F - Total Medical Expense			
Totals			

Notes:

1.

COS from Financials	COS from this Submission
Inpatient Hospital	Inpatient Hospital
Primary Care	Primary Care Services
Physician Specialty Services	Physician Specialty Services
Outpatient Hospital	Outpatient Facility
Other Professional Services	All Other Practitioners and Services
Emergency Room	Emergency Room
DME/Medical Supplies	DME/Medical Supplies & Orthotics/Prosthetics
Prosthetics & Orthotics	DME/Medical Supplies & Orthotics/Prosthetics
Dental	Dental
Pharmacy	Pharmacy
Reimbursable HIV/AIDS Drugs and Blood Products	Excluded
Home Health Care	Home Health Care
Transportation	Transportation
Lab & X-ray	Laboratory & Radiology
Vision Care	All Other Practitioners and Services
Mental Health/Substance Abuse	All Other Practitioners and Services
Reinsurance Expenses	Inpatient Hospital
EPSDT Medical & PDN	All Other Practitioners and Services
EPSDT Dental - EPD	All Other Practitioners and Services
Family Planning	All Other Practitioners and Services
Other Medical	All Other Practitioners and Services

Table #11B– Utilization and Unit Cost Information

For Inpatient Hospital, Primary Care Services, Physician Specialty Services, Emergency Room, Dental, Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products), Outpatient Facility, DME/Medical Supplies, Home Health Care, Laboratory and Radiology, Transportation, and All Other Practitioners & Services

FOR THE STATE FISCAL-ENDING AT 09/30:_____ _____
(HMO Name)

Utilization Data by Rate Cell

COA	Inpatient Hospital							
	Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Admits	Previous SFY-end @ 09/30 Days	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Admits	Current SFY-end @ 09/30 Days
C FamilyCare Parents (Cap Stems: 561, 562, 573, 276A9)								

COA	Primary Care Services					
	Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Visits	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Visits
C FamilyCare Parents (Cap Stems: 561, 562, 573, 276A9)						

COA	Physician Specialty Services					
	Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Visits	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Visits
C FamilyCare Parents (Cap Stems: 561, 562, 573, 276A9)						

COA	Emergency Room					
	Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Visits	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Visits
C FamilyCare Parents (Cap Stems: 561, 562, 573, 276A9)						

COA	Dental					
	Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Visits	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Visits
C FamilyCare Parents (Cap Stems: 561, 562, 573, 276A9)						

Table #11B– Utilization and Unit Cost Information

For Inpatient Hospital, Primary Care Services, Physician Specialty Services, Emergency Room, Dental, Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products), Outpatient Facility, DME/Medical Supplies, Home Health Care, Laboratory and Radiology, Transportation, and All Other Practitioners & Services

FOR THE STATE FISCAL-ENDING AT 09/30:_____ _____
(HMO Name)

COA	Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products)					
	Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Scripts	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Scripts
C FamilyCare Parents (Cap Stems: 561, 562, 573, 276A9)						

COA	Outpatient Facility					
	Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Visits	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Visits
C FamilyCare Parents (Cap Stems: 561, 562, 573, 276A9)						

COA	DME/Medical Supplies & Orthotics/Prosthetics					
	Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Units	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Units
C FamilyCare Parents (Cap Stems: 561, 562, 573, 276A9)						

COA	Home Health Care					
	Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Services	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Services
C FamilyCare Parents (Cap Stems: 561, 562, 573, 276A9)						

COA	Laboratory & Radiology					
	Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Units	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Units
C FamilyCare Parents (Cap Stems: 561, 562, 573, 276A9)						

Table #11B– Utilization and Unit Cost Information

For Inpatient Hospital, Primary Care Services, Physician Specialty Services, Emergency Room, Dental, Pharmacy (not to include Reimbursable HIV/AIDS Drugs and Blood Products), Outpatient Facility, DME/Medical Supplies, Home Health Care, Laboratory and Radiology, Transportation, and All Other Practitioners & Services

FOR THE STATE FISCAL-ENDING AT 09/30: _____ _____
(HMO Name)

COA	Transportation					
	Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Units	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Units
C FamilyCare Parents (Cap Stems: 561, 562, 573, 276A9)						

COA	All Other Practitioners and Services					
	Previous SFY-end @ 09/30 Member Months	Previous SFY-end @ 09/30 Incurred $	Previous SFY-end @ 09/30 Services	Current SFY-end @ 09/30 Member Months	Current SFY-end @ 09/30 Incurred $	Current SFY-end @ 09/30 Services
C FamilyCare Parents (Cap Stems: 561, 562, 573, 276A9)						

Reconciliations to Table 19 A - F	Rate Cell Total	Report Totals	Difference
FamilyCare Parents - Table 19 Rate Cell C - Total Medical Expense			

Notes:

1.

COS from Financials	COS from this Submission
Inpatient Hospital	Inpatient Hospital
Primary Care	Primary Care Services
Physician Specialty Services	Physician Specialty Services
Outpatient Hospital	Outpatient Facility
Other Professional Services	All Other Practitioners and Services
Emergency Room	Emergency Room
DME/Medical Supplies	DME/Medical Supplies & Orthotics/Prosthetics
Prosthetics & Orthotics	DME/Medical Supplies & Orthotics/Prosthetics
Dental	Dental
Pharmacy	Pharmacy
Reimbursable HIV/AIDS Drugs and Blood Products	Excluded
Home Health Care	Home Health Care
Transportation	Transportation
Lab & X-ray	Laboratory & Radiology
Vision Care	All Other Practitioners and Services
Mental Health/Substance Abuse	All Other Practitioners and Services
Reinsurance Expenses	Inpatient Hospital
EPSDT Medical & PDN	All Other Practitioners and Services
EPSDT Dental - EPD	All Other Practitioners and Services
Family Planning	All Other Practitioners and Services
Other Medical	All Other Practitioners and Services

Table #14C – Capitation Arrangements
Current State Fiscal Year End

FOR THE STATE FISCAL-ENDING AT 09/30: _____ _____
(HMO Name)

CAPITATED SERVICES			Current State Fiscal Year End			
	Covered Service	**Provider at Full-Risk (Yes or No)**	**Total Amount Reported as Medical Expense**	**Reported Medical Expense Line # on Report 2, Table 19**	**Total Amount Reported as Administrative Expense**	**Reported Administrative Expense Line # on Report 2, Table 19**
1	Vision		$ -		$ -	
2	Dental		$ -		$ -	
3	Lab/Radiology		$ -		$ -	
5	Mental Health		$ -		$ -	
6	Triage Services/Nurse Hotline		$ -		$ -	
7	Primary Care Physicians		$ -		$ -	
8	Other #1		$ -		$ -	
9	Other #2		$ -		$ -	
10	Other #3		$ -		$ -	
11	Other #4		$ -		$ -	
12	Other #5		$ -		$ -	
13	Other #6		$ -		$ -	
14	Other #7		$ -		$ -	
15	**Total**		**$ -**		**$ -**	

Notes:
1. Gray highlighted cells denotes calculation.

Attach Copy of the General Ledger for the period ending 6-30-XX

NOTES TO FINANCIAL REPORTS

FOR THE SFY ENDING 6-30-08

FOR _____
(HMO Name)

Any notes or further explanations of any items contained in any of the reports or in the reporting of financial disclosures are to be noted here. Appropriate references and attachments are to be used as necessary. Space is provided below or you may use a separate page as necessary.

Table #11 **– Part A – Cost and Utilization by AFDC Rate Cell Grouping** **– Part B – Cost and Utilization by FamilyCare Parents/Adults Rate Cell Grouping**	
Table #14 **– Part A – Member Months and Income Statement** **– Part B – Administrative Cost Detail** **– Part C – Capitation Arrangements**	
Table #19 **– Parts A-S2 – Income Statement By Rate Cell Grouping** **– Part T – Non-State Plan Service Expenses**	
Table #20 **– Part A – Lag Report for Inpatient Hospital Payments** **– Part B – Lag Report for Physician Payments** **– Part C – Lag Report for Pharmacy Payments** **– Part D – Lag Report for Other Medical Payments**	

NOTES TO FINANCIAL REPORTS

FOR MEDICAID/NJ FAMILYCARE
MANAGED CARE REPORTING ONLY

FOR THE TWELVE MONTHS ENDING _____

FOR _____
(HMO Name)

Any notes or further explanations of any items contained in any of the reports or in the reporting of financial disclosures are to be noted here. Appropriate references and attachments are to be used as necessary. Space is provided below or you may use a separate page as necessary.

Table #4 **– Part A – Claims Lag Report for Manually Submitted Claims** **– Part B – Claims Lag Report for Electronically Submitted Claims**	
Table #6 **– Allowable Direct Medical Expenditures**	
Table #7 **– Parts A-C – Stop Loss Summary**	
Table #10 **– Third Party Liability and Fraud/Abuse Collections**	
Table #19 **– Parts A-R – Income Statement By Rate Cell Grouping**	
Table #20 **– Part A – Lag Report for Inpatient Hospital Payments** **– Part B – Lag Report for Physician Payments** **– Part C – Lag Report for Pharmacy Payments** **– Part D – Lag Report for Other Medical Payments**	
Table #21 **– Maternity Outcome Counts**	

NOTES TO FINANCIAL REPORTS

FOR THE SFY ENDING 6-30-08

FOR _____
(HMO Name)

Any notes or further explanations of any items contained in any of the reports or in the reporting of financial disclosures are to be noted here. Appropriate references and attachments are to be used as necessary. Space is provided below or you may use a separate page as necessary.

Table #11 **– Part A – Cost and Utilization by AFDC Rate Cell Grouping** **– Part B – Cost and Utilization by FamilyCare Parents/Adults Rate Cell Grouping**	
Table #14 **– Part A – Member Months and Income Statement** **– Part B – Administrative Cost Detail** **– Part C – Capitation Arrangements**	
Table #19 **– Parts A-S2 – Income Statement By Rate Cell Grouping** **– Part T – Non-State Plan Service Expenses**	
Table #20 **– Part A – Lag Report for Inpatient Hospital Payments** **– Part B – Lag Report for Physician Payments** **– Part C – Lag Report for Pharmacy Payments** **– Part D – Lag Report for Other Medical Payments**	

A.8.0 Financial Provisions

A.8.1 Other Coverage Information

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

MEDICAID THIRD PARTY LIABILITY

Please Complete Entire Form:

MEDICAID NUMBER

PERSON NUMBERS COVERED BY INSURANCE

CASE NAME | FIRST NAME | BIRTH DATE | SOCIAL SECURITY NUMBER

INS. NUMBER	POLICY NUMBER / HIC NUMBER	GROUP NUMBER	COV TYPE	POL HLDR	EFFECTIVE DATE	TERMINATION DATE

Attach copy of front and back of insurance card(s)

Name of Policy Holder: _____

SSN of Policy Holder: _____ – _____ – _____

Name, Address and Phone Number of Insurance Carrier: _____
Name

_____ *Street Address*

_____ *City*

_____ *State*

_____ *Zip Code*

_____ — _____ — _____ *Telephone Number*

Enter relationship of policy holder in policy holder block.

Relationship are as follows:

1. Self
2. Dependent of Medicaid Head of Household
3. Absent Parent
4. Non-case Adult

Enter the two digit code in the coverage block which corresponds to the type of insurance coverage reflected in the policy.

The allowance codes are:

01 Inpatient Hospital
02 Medical/Surgical
03 Major Medical
04 Medicare Supplemental
05 Prescription
06 Dental
07 Optical
08 Hospital and Medical/Surgical
09 Long Term Care
10 HMO or P.O.S. Plans with Rx
11 HMO or P.O.S. no Rx
12 Outpatient Hospital
13 Hospital Medical/Surgical and Major Medical
14 Hospital Medical/Surgical, Major Medical and Rx
15 Hospital Medical/Surgical, Major Medical, Rx and Dental
16 Hospital Medical/Surgical, Major Medical, Rx, Dental and Optical
17 HMO or P.O.S. Plans Rx and Dental
18 HMO or P.O.S. Plans Rx, Dental and Optical
21 Capitated/Non-HMO (PPO/EPO) Plan w/Rx
22 Capitated/Non-HMO (PPO/EPO) Plan w/o Rx
23 Capitated/Non-HMO (PPO/EPO) Plan, Rx and Dental
24 Capitated/Non-HMO (PPO/EPO) Plan, Rx, Dental and Optical
25 Medicare Supplement w/Rx
26 Mental Health

Has any person listed under this case number sustained a traumatic injury in the last 5 years? ☐ Yes ☐ No If yes, name of injured party: _____

Date if injury: _____ Where did injury take place? _____ Description: _____

_____

_____ *Worker's Name (please print) and Telephone #*

_____ *Date*

NUM	DATA ELEMENTS	DESCRIPTION	FIELD LENGTH	A/N	MANDAT. OR OPTIONAL	COMMENTS
HEADER INFORMATION						
1	FILE CREATION DTE	FILE CREATION DATE	8	N	M	DATE FILE WAS CREATED BY HMO
BASE INFORMATION						
1	RECIP ID NUMB	RECIPIENT ID NUMBER	12	A	O	RECIPIENT ID (FOR TPL UNIT)
2	CURR RECIP ID NUMB	CURRENT RECIPIENT ID NUMBER	12	A	M	MEDICAID NUMBER
3	SOURCE OF LAST CHG	SOURCE OF LAST CHANGE	6	A	M	HMO PLAN CODE: "078 ", "082 ", "086 ", "091 ", "096 "
4	ACTION CDE	BASE ACTION CODE	1	A	M	ADD (A) OR CHANGE (C)OR T(TERM)
5	RECIP LAST NAME	RECIPIENT LAST NAME	12	A	M	LAST NAME
6	RECIP FIRST NAME	RECIPIENT FIRST NAME	7	A	M	FIRST NAME
9	DTE BIRTH	DATE OF BIRTH	8	N	M	FORMAT CCYYMMDD
10	POLICY HOLDER NAME LAST	POLICY HOLDER LAST NAME	12	A	M	FIRST NAME OF POLICY HOLDER
11	POLICY HOLDER NAME FIRST	POLICY HOLDER FIRST NAME	7	A	M	LAST NAME OF POLICY HOLDER
12	POLICY HOLDER SSN	POLICY HOLDER SSN	9	A	M	SSN OF POLICY HOLDER
14	TPL INS CDE	TPL INSURER CODE	3	A	M	CHANGE: NEW INSURER CODE (104 - 132 ARE VALID), ADD: ANY VALID INSURER CODE.
15	OLD INS CDE	OLD INSURER CODE	3	A	O	EXISTED INSURER CODE TO BE UPDATED. USED FOR CHANGE ONLY. All old fields will be verified with Marla.
16	TPL POLICY NUMB	TPL POLICY NUMBER	13	A	M	NEW POLICY NUMBER
17	OLD POLICY NUMB	OLD POLICY NUMBER	13	A	O	EXISTING POLICY NUMBER TO BE UPDATED. USED FOR CHANGE ONLY.
18	TPL GROUP NO	TPL GROUP NUMBER	15	A	O	THE GROUP NUMBER OF THE POLICY, USUALLY THE EMPLOYER OR UNION.
19	OLD GROUP NO	OLD GROUP NUMBER	15	A	O	THE EXISTING GROUP NUMBER OF THE POLICY, USUALLY THE EMPLOYER OR UNION. USED FOR CHANGE ONLY.
20	TPL POL HOLDER	POLICY HOLDER RELATION	1	A	M	RELATIONSHIP CODE. (Valid Values are 1 - Case Person Insured, 2 - Dependent of Case Person, 3 - Dependent of Absent Parent, 4 - Dependent of other adult
21	OLD POL HOLDER	OLD POLICY HOLDER RELATION	1	A	O	RELATIONSHIP CODE. (Valid Values are 1 - Case Person Insured, 2 - Dependent of Case Person, 3 - Dependent of Absent Parent, 4 - Dependent of other adult
22	TPL COVAGE TYPE	TPL COVERAGE TYPE	2	A	M	NEW COVERAGE TYPE (1 - 26).
23	OLD COVAGE TYPE	OLD COVERAGE TYPE	2	A	O	EXISTING COVERAGE TYPE TO BE UPDATED. USED FOR CHANGE ONLY.
26	TPL COVAGE BEG DTE	TPL COVERAGE BEGIN DATE	8	N	M	EFFECTIVE DATE (CCYYMMDD)
27	OLD COVAGE BEG DTE	OLD COVERAGE BEGIN DATE	8	N	O	EXISTING COVERAGE EFFECTIVE DATE TO BE UPDATED (CCYYMMDD). USED FOR CHANGE ONLY.
28	TPL COVAGE END DTE	TPL COVERAGE END DATE	8	N	M	NEW TERMINATION DATE (CCYYMMDD)
29	OLD COVAGE END DTE	OLD COVERAGE END DATE	8	N	O	EXISTING TERMINATION DATE TO BE UPDATED (CCYYMMDD). USED FOR CHANGE ONLY. OPEN ENDED DATE SHOULD BE 99999999.
TRAILER INFORMATION						
1	REC CTR	RECORD COUNT	8	N	M	NUMBER OF RECORDS IN THE FILE

A.8.2 Tort/Accident Referral Form

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

TORT – ACCIDENT REFERRAL FORM

Please use other side if necessary

HMO_____ HMO#_____ PHONE_____

PART A: IDENTIFICATION

CLIENT'S NAME_____ HSP#_____

SOCIAL SECURITY # _____

DATE OF ACCIDENT/INCIDENT _____

NATURE OF INJURY _____

TYPE OF ACCIDENT _____
(auto – fall – med. malpractice, etc.)

ATTORNEY FOR CLIENT _____
(NAME-ADDRESS-PHONE) _____

_____

Please attach: (1) Any copies of pleadings or any other documents in your possession including subpoenas or requests for medical information from an attorney, insurance company or client; (2) HMO claim/payment information from date of accident to present.

PART B: SERVICES

SERVICE DATE(S)	PROVIDER NAME	DIAGNOSIS CODE & DESCRIP	PROCEDURE CODE & DESCRIP	PROVIDER CHARGES	HMO PAYMENT

_____
NAME OF PERSON COMPLETING FORM - DATE

A.8.3 Estate Referral Form

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

ESTATE REFERRAL FORM

HMO Notification of Deceased Members Age 55 and Older **Quarter Ending** _____

HMO _____ **HMO ID#** _____

This will serve as notification that the following members of our health care plan age 55 or older have died.

Member Name	DOB	SSN	Date of Death	Medicaid ID#

SECTION B
REFERENCE MATERIALS

This section contains all reference materials affiliated with the contract. They are presented according to the Article to which they correspond, beginning with Article 2.

B.2.0 Conditions Precedent

B.2.1 Readiness Review

READINESS REVIEW

The following information will be reviewed and discussed during the Division of Medical Assistance and Health Services readiness review:

1. Administration and Organizational Structure

    - Tour office/facility
    - Identify any changes in organizational structure
        - interim plans to delegate responsibilities
    - Identify chain of command
        - identify and introduce of management team

2. Quality Management

    - Identify and meet staff and flow of responsibilities
    - Review final plans for implementation of Quality Management Committees
    - Review procedures for interdepartmental coordination on quality issues
    - Review final policy and procedure manuals
    - Review credentialing files

3. Provider Relations

    - Identify and meet staff and flow of responsibilities
    - Process for staff education
    - Review staff procedure manuals/documents
    - Policy on provider education and outreach
    - Processing and monitoring of provider inquiries and complaints
    - Evaluation/effectiveness of Provider Relation Services
    - Recruitment policy
    - Review record keeping of provider files

4. Member Services/Customer Services

    - Identify and meet staff and flow of responsibilities
    - Process for staff education
    - Review staff procedure manuals/documents
    - Policy on member education and outreach
    - Processing and monitoring member inquiries and complaints
    - Is 24 hour coverage in place
    - Bilingual staff/translation ability
    - Evaluation/effectiveness of Member Services
    - Plans for the initiation of member surveys
    - Telephone hotline staff and system
    - Enrollment

5. Enrollment

    - Identify and meet staff and flow of responsibilities
    - Process for staff education
    - Review staff procedure manuals/documents
    - Processing and monitoring enrollment process

- Evaluation/effectiveness of Member Services

6. Complaints and Grievances

- Identify responsible staff
- Identify process and resolution of complaint
- Tracking
- Incorporation into quality assurance activities
- Process for maintaining confidentiality

7. Marketing

- Identify and meet marketing staff
- Education/training of marketing staff
- Review of marketing plan/sites for enrollment
- Inspect materials inventory

8. Record Keeping

- Check security of record keeping system
- Provider and member files
- Plans for record retention
- Confidentiality

9. Utilization Management

- Identify and meet responsible staff
- Education/training of staff
- Process for authorization/denials of services
- Coordination of alternative services/approvals
- Referrals/Precertification

10. Fiscal Responsibility

- Meet responsible Financial staff
- Review Provider Payment claims screens
- Review Financial Management screens

11. Management Information Systems

- Review Provider Payment claims screens
- Review Member and Provider screens
- Review Quality and Utilization Management screens
- Review capability for reporting
- Identify staff

B.3.0 Managed Care Management Information Systems

B.3.2 Data Files Resource Guide

	FROM	TO	FREQUENCY	DEFINITION
HIPAA 835 - Encounters	UNISYS	HMO	Weekly	This file represents the remittance advice for encounters received and processed by Unisys. The HIPAA 835 is a nationally defined format and is the required format for New Jersey as of 01/01/2005. Detailed information regarding this file is available in the HIPAA Implementation and New Jersey Medicaid Companion Guides. This file is available via the NJMMIS website.
HIPAA 835 - Capitation and FFS Claims	UNISYS	HMO	Weekly	This file represents the remittance advice for capitation and fee-for-service (FFS) claims created by Unisys. The 835 is a nationally defined format and is the required format for New Jersey. Detailed information regarding this file is available in the HIPAA Implementation and New Jersey Medicaid Companion Guides. This file is available via the NJMMIS website.
RHMF Extracts	UNISYS	HMO	Monthly	These files represent demographic, eligibility, and enrollment data for all HMO enrollees from the Unisys Recipient History Master File (RHMF), and is produced as part of the monthly capitation run by Unisys. Each of these file extracts is detailed below. These files are available on the NJMMIS website.
► **RHMF Extract Base Records**	UNISYS	HMO	Monthly	This file extract will contain demographic data for each enrollee. The data elements include: Original ID, Last Name, First Name, Middle Initial, Date of Birth, Address Line 1, Address Line 2, Address Line 3, Address Line 4, Address Line 5, Address Line 6, Zip Code, Social Security Number, Gender Code, and Race Code. This file is in comma-delimited format.
► **RHMF Extract -- Eligibility Records**	UNISYS	HMO	Monthly	This file extract will contain a complete eligibility history for each enrollee. The data elements include: Original ID, Current ID, Program Status Code, Eligibility Extension Code, Effective Date, Termination, County of Residence, and County of Supervision. This file is in comma-delimited format.
► **RHMF Extract -- Enrollment Records**	UNISYS	HMO	Monthly	This file extract will contain a complete managed care enrollment history for each enrollee. The data elements include: Original ID, Current ID, HMO Code, Payment Code, Effective Date, Termination Date, Capitation Code, and Health Benefit Indicator. This file is in comma-delimited format.

	FROM	TO	FREQUENCY	DEFINITION
Denied Encounters Edit File	UNISYS	HMO	Monthly	This data file contains the NJ Medicaid edit codes posted to denied encounters. This file will contain the Internal Control Number (ICN) assigned to each encounter, along with a maximum of ten (10) edit codes. It serves to alert the HMO regarding local edit codes, which are no longer permitted on the national remittance format (835) under HIPAA. It is a comma-delimited file.
TPL Extracts	UNISYS	HMO	Monthly	This file represents third party liability (TPL) data for all HMO beneficiaries as contained on the Unisys TPL Resource File. This file is available via the NJMMIS website.
Pharmacy Claims - Aged, Blind, and Disabled (ABD) Enrollees	UNISYS	HMO	Monthly	This file represents pharmacy claims data for aged, blind or disabled (ABD) individuals. This file is available on the NJMMIS website.
Diagnosis Data - ABDs and DDD	UNISYS	HMO	Monthly	The State provides diagnosis data to HMOs to aid in establishing a medical history of enrollees. This data file represents six months of FFS claim diagnosis data for each HMO enrollee that is classified as either ABD or as a client of DDD in the upcoming service month. The file includes the following data elements: Original ID, Current ID, DDD Indicator (Y/N), From Date of Service, Through Date of Service, Service Code, and Diagnosis Codes (five occurrences). The file is in comma-delimited format.
HIPAA 837 Encounters	HMO	UNISYS	As Needed	This file represents the nationally defined format for submission of non-pharmacy encounters (institutional, professional, and dental). It is the required format for New Jersey Medicaid. Detailed information regarding this file is available in the HIPAA Implementation and New Jersey Medicaid Companion Guides.
HIPAA NCPDP Encounters	HMO	UNISYS	As Needed	This file represents the nationally defined format for submission of pharmacy encounters. It is the required format for New Jersey Medicaid. Detailed information regarding this file is available in the HIPAA Implementation and New Jersey Medicaid Companion Guides.

	FROM	TO	FREQUENCY	DEFINITION
834 Daily	OIT	HMO	Daily	This file represents the nationally defined format for the communication of enrollment data to the HMOs. It has no proprietary equivalent, but is made available to provide more timely information. Detailed information regarding this file is available in the HIPAA Implementation and New Jersey Medicaid Companion Guides. This file is made available via the OIT "Portal" website.
834 Weekly	OIT	HMO	Weekly	This file represents the nationally defined format for the communication of enrollment data to the HMOs. Detailed information regarding this file is available in the HIPAA Implementation and New Jersey Medicaid Companion Guides. This file is made available via the OIT "Portal" website.
Certification Data	HMO	OIT	As Needed	The file represents certification data and identifies HMO enrollees as HIV, AIDS, or blood factor 8/9 dependent.
HMO Provider Network	HMO	STATE	Monthly	This file represents data for the HMOs provider network.

B.4.0 Provision Of Health Care Services

B.4.1 Benefit Packages

The services delineated on the following pages must be provided by the contractor.

SERVICE DESCRIPTIONS

1. **Primary care**

a. all physician services, primary and specialty. "Physicians' services," whether furnished in the office, the enrollee's home, a hospital, a nursing facility, or elsewhere, means services furnished by a physician (M.D. or D.O.):

i. within the scope of practice of medicine or osteopathy as defined by New Jersey State law or laws of the state in which the service is being provided; and

ii. by and under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

b. in accordance with State certification/licensure requirements, standards, and practices, primary care may also include:

i. certified nurse midwife -- a registered professional nurse who meets the following requirements:

- is currently licensed to practice in New Jersey as a registered professional nurse;
- is legally authorized under New Jersey State law or regulations to practice as a nurse-midwife;
- except as provided in Subsection a.iv., has completed a program of study and clinical experience for nurse-midwives, as specified by the State.

ii. certified nurse practitioner -- a licensed professional nurse who meets New Jersey's advanced educational and clinical practice requirements beyond the two to four years of basic nursing education required of all registered nurses and is certified by the State Board of Nursing.

iii. clinical nurse specialist -- a licensed professional nurse who meets New Jersey's advanced educational and clinical practice requirements beyond the two to four years of basic nursing education required of all registered nurses and meets the specific qualifications for the designated nursing specialty and is certified by the State Board of Nursing; and

iv. physician assistant. A person who holds a current valid license issued by the New Jersey Board of Medical Examiners to practice as a physician assistant in New Jersey pursuant to N.J.A.C. 12:35-2B.

c. services rendered at independent clinics. "Clinic Services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

i. services furnished at the clinic by or under the direction of a physician or dentist;

ii. services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address; or
iii. services furnished at the clinic that are nurse-midwife services.

2. **Preventive health care and counseling** and health promotion including referrals to WIC programs

3. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program services** means:

a. preventive pediatric health care;
b. screening and diagnostic services to determine physical or mental defects in beneficiaries under age 21; and
c. health care, treatment, and other measures to correct or ameliorate any defects and conditions discovered.

See Article 4.2 for program requirements. EPSDT program services also include non-legend drugs, ventilator services in the home, and private duty nursing when indicated as a result of EPSDT screening. "Private Duty Nursing" means nursing services for enrollees who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital. These services are provided:

a. by a registered nurse or a licensed practical nurse;
b. under the direction of the enrollee's physician; and
c. to an enrollee in his or her own home or other community setting

4. **Emergency medical care** - 24 hours/day, 7 days/week

5. **Inpatient Hospital Services**, including Rehabilitation Hospitals and Post-acute Care Facilities. The contractor shall be responsible for inpatient hospital costs of enrollees with a dual diagnosis (physical plus mental health/substance abuse condition) whose primary diagnosis is not mental health or substance abuse related. "Inpatient hospital services" means services that:

a. are ordinarily furnished in a hospital for the care and treatment of inpatients;
b. except in the case of nurse midwife and podiatric services, are furnished under the direction of a physician;
c. are furnished in an institution that:

i. is maintained primarily for the care and treatment of patients with disorders other than mental diseases;
ii. is licensed or formally approved as a hospital by an officially designated authority in the State in which the hospital is located;
iii. except in the case of medical supervision of nurse-midwife services, meets the requirements for participation in Medicare as a hospital; and
iv. has in effect a utilization review plan, applicable to all Medicaid patients.

A rehabilitation hospital facility licensed by New Jersey to provide medical rehabilitation services means a facility that:

a. provides therapy services for the primary purpose of assisting in the habilitation/rehabilitation of disabled individuals through an integrated program of:

   i. medical evaluation and services; and
   ii. psychological, social or vocational evaluation and services; and

b. is operated under competent medical supervision.

6. **Outpatient Hospital Services** is defined as preventive, diagnostic, therapeutic, or palliative services that:

   a. are furnished to outpatients;
   b. except in the case of nurse-midwife services, are furnished by or under the direction of a physician or dentist;
   c. are furnished by an institution that:

      i. is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and
      ii. except in the case of medical supervision of nurse-midwife services, meets the requirements for participation in Medicare as a hospital.

7. **Laboratory Services** means professional and technical laboratory services:

   a. ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law or ordered by a physician but provided by an independent laboratory;
   b. provided in an office or similar facility other than a hospital outpatient department or clinic; and
   c. furnished by a laboratory that meets the requirements of CLIA and the requirements for participation in Medicare.

   All laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Act (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those providers with certificates of waiver will provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory services.

8. **Radiology Services** - diagnostic and therapeutic means professional and technical radiological services

9. **Prescription drugs**
   - legend drugs
   - non-legend drugs covered by the Medicaid program

   "Prescription drugs" means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance, that are:

a. prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her professional practice as defined and limited by federal and State law;
b. dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and
c. dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

10. **Family planning services** means those services necessary for the delay or prevention of pregnancy, pregnancy testing and counseling and follow-up care for complications associated with contraceptive methods issued by the family planning provider. Also includes, but is not limited to sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing.

    Elective induced abortions (and related services) and infertility treatment services are excluded;

11. **Audiology Services**, including diagnostic, screening, preventive, corrective services, and any necessary supplies and equipment, provided by an audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within his or her practice under State law.

12. **Podiatrist Services:** excludes routine hygienic care of the feet, including the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, in the absence of a pathological condition.

13. **Chiropractor Services** includes only services that:

    a. are provided by a chiropractor who is licensed in New Jersey or in the state in which he/she practices; and
    b. consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State Medicaid program to perform and meets standards issued under 42 CFR 405.232(b).

14. **Optometrist Services** -- an optometrist is an individual who is licensed by the New Jersey State Board of Optometry to engage in the practice of optometry, or licensed to engage in the practice of optometry in the state in which he/she performs such functions.

15. **Optical Appliances** - Artificial eyes, lenses, frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist.

16. **Hearing Aid Services** – The provision of hearing aids, hearing aid accessories, ear mold impressions, routine follow-ups and adjustments, and repairs after warranty expiration.

17. **Home Health Agency Services** means services that are provided to an enrollee:

    a. at his or her place of residence, excluding a hospital, nursing facility, or intermediate care facility; and
    b. on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days.

Services include: nursing services by a registered nurse and/or licensed practical nurse; home health aide service; medical supplies and equipment, and appliances suitable for use in the home; and audiology services.

Home Health Agency Services must be provided by a home health agency that is licensed through the Department of Health and Senior Services as a home health agency and meets Medicare participation requirements.

18. **Hospice Agency Services:** Provided by an agency that meets Medicare certification requirements.

19. **Durable Medical Equipment (DME)**/Assistive Technology Devices in accordance with existing Medicaid regulations.

Plan D Covered Durable Medical Equipment

Alternating Pressure Pads
Bed Pans
Bladder Irrigation Supplies
Blood Glucose Monitors and Supplies
Canes
Commodes **Note: Bathroom devices permanently attached are not covered.**
Crutches and Related Attachments
Fracture Frames
Gastrostomy Supplies
Hospital Beds (Manual, Semi-Electric, Full Electric) and Related Equipment
Ileostomy Supplies
Infusion Pumps
Intermittent Positive Pressure Breathing (IPPB) Treatments and Related Supplies
IV Poles
Jejunostomy Supplies
Lancets and Related Devices
Loop Heals/Loop Toes Devices
Lymphedema Pumps
Manual Wheelchairs and Related Equipment **Note: Motorized wheelchairs are not covered.** **Note: Types of covered wheelchairs include: full-reclining; high-strength lightweight; heavy duty; and semi-reclining.**
Mattress Overlays **Note: Low air loss and air fluidized bed systems not covered.**
Nasogastric Tubing
Nebulizers and Related Supplies
Needles
Ostomy Supplies
Over-Bed Tables
Oxygen and Related Equipment and Supplies **Note: Liquid and gas systems and oxygen concentrators are covered.** **Note: Ventilation systems are not covered.**
Pacemaker monitors
Parenteral Nutrition

Patient Lifts
Pneumatic Appliances Sitz Bath
Suction Machines and Related Supplies
Syringes
Tracheostomy Supplies
Traction/Trapeze Apparatus
Urinals
Urinary Pouches and Related Supplies
Urine Glucose Tests
Walkers and Related Attachments
Wheelchair Seating/Support Systems

20. **Medical Supplies**

21. **Prosthetics and Orthotics** (delivered by licensed and/or ABC accredited providers) including certified shoe provider services. "Prosthetic devices" means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law to:

    a. artificially replace a missing portion of the body;
    b. prevent or correct physical deformity or malfunction; or
    c. support a weak or deformed portion of the body.

    “Orthotic appliances” means a device or brace prescribed by a physician or other licensed practitioner within the scope of his/her practice as defined by State law for the purpose of providing support, increased function, and overcoming physical impairment or defects.

    a. a brace includes rigid and semi-rigid devices used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

22. **Dental Services:**

    Dental services should be provided in accordance with N.J.A.C. 10:56 and should include preventive, diagnostic, major and minor restorative, endodontic, surgical, and adjunctive services, periodontic, and prosthodontic services, provided by or under the supervision of a dentist in the practice of his or her profession, including treatment of:

    a. the teeth and associated structures of the oral cavity; and
    b. disease, injury, or impairment that may affect the oral or general health of the enrollee.

    Orthodontic services are only to be provided to children in cases where medical necessity can be proven, such as cases involving developmental and facial deformities causing functional difficulties in speech and mastication, and trauma. Orthodontic treatment will refer to limited, interceptive, and comprehensive orthodontic treatment as well as all other ancillary orthodontic services, with these services being considered only when the medical criteria for exemptions as noted above have been met.

    Continuity of care to case completion will apply as follows:

- When an orthodontic case is in progress or retention as of July 1, 2010
- When an orthodontic case required pre-treatment extractions and they were provided prior to July 1, 2010
- When a client with an orthodontic case in progress changes HMOs

Orthodontic services will not be continued upon termination from a NJ FamilyCare/Medicaid program.

Medical and surgical services of a dentist provided by a doctor of dental medicine or dental surgery are services that:

a. if furnished by a physician, would be considered physician's services;
b. may be furnished either by a physician or by a doctor of dental medicine or dental surgery; and
c. are furnished by a doctor of dental medicine or dental surgery who is authorized to furnish those services in New Jersey or in the state where he/she practices.

23. **Organ Transplants**--medically necessary organ transplants including, liver, lung, heart, heart-lung, pancreas, kidney, cornea, intestine, and bone marrow including autologous bone marrow transplants.

24. **Transportation Services** including ambulance, medical intensive care units (MICUs), and invalid coach (including lift equipped vehicles) for any in-plan service or out-of-plan service. Transportation includes expenses for transportation and other related travel expenses determined to be necessary by DMAHS to secure medical examinations and treatment for an enrollee. Lower mode/livery transportation will be the financial responsibility of the contractor if the contractor refers a patient to an out of county or out of State provider when the services could have been rendered in-county/in-State within the contractor's network.

    Note: for SSI individuals requiring transportation by invalid coach who choose to see a provider outside of their county of residence, the contractor will not be responsible for furnishing transportation in such situations.

25. **Post-acute care -** rendered at acute care hospital or nursing facility for 30 days or less. Must be a Medicaid participating provider.

26. **MH/SA Services** – Mental health services include but are not limited to comprehensive intake evaluation; off-site crisis intervention; family therapy; family conference; psychological testing; and medication management. See Medicaid provider manuals for detailed service list.

B.4.5 Head Start Programs

HEAD START PROGRAMS

Atlantic/Cape May
Atlantic Human Resources, Inc.
Carolyn H. Atherly, Director
One South New York Ave.
Atlantic City, NJ 08401
Phone 609-348-4166
Fax 609-449-1327

Atlantic/Cumberland Counties
Rural Opportunities, Inc.
Ramona Merlina, Director
510 East Landis Ave.
Vineland, NJ 08360-3101
Phone 609-696-1800 x 31
Fax 609-696-4892

Bergen County Head Start
Vivian Fergy, Acting Director
C/O St. Cecilia High School
65 West Demarest Ave.
Englewood, NJ 07631
Phone 201-969-0200
Fax 201-968-0240

Burlington
Burlington County Head Start
Carolyn E. Henderson, Director
718 South Route 130
Burlington, NJ 08016
Phone 609-261-2323
Fax 609-261-8520

Camden
Giants House Parent Child Center
Gladys Adximah, Director
3201 Federal Street
Camden, NJ 08103
Phone 609-541-2846
Fax 609-541-5332

Camden
Camden County CEO Head Start
Barbara Dempsey, Director
500 Pine Street
Camden, NJ 08103
Phone 609-964-2100 x 11
Fax 609-964-0428

Cumberland/Gloucester/Salem
Tri-County Head Start
Cynthia Wythe-Mosley, Director
30 Giles Street
Bridgeton, NJ 08302-1816
Phone 609-453-0804
Fax 609-453-8016

East Orange Child Development
Sarah Masaford, Executive Director
50 Washington Street
PO Box 890
East Orange, NJ 07019
Phone 973-676-1110
Fax 973-676-8026

Essex
Babyland Nursery, Inc.
Mary Smith, Director
755 South Orange Ave.
Newark, NJ 07108
Phone 973-399-3400
Fax 973-399-2076

Essex
Newark Preschool Council;
Audrey West, Executive Director
10 Park Place
Newark, NJ 07102
Phone 973-621-5980
Fax 973-621-6051

Essex
Montclair Child Development
Audrey Fletcher, Executive Director
272 Baldwin Street
Glen Ridge, NJ 07028
Phone 973-783-0220
Fax 973-680-0059

Essex
Leagury Head Start
Veronica Ray, Executive Director
1020 Broad Street
Newark, NJ 07102
Phone 973-643-8357
Fax 973-624-1268

Essex
Friendly Fuld Head Start
Kim Baldwin, Director
71 Boyd Street
Newark, NJ 07103
Phone 973-642-3143
Fax 973-623-2080

Hudson
North Hudson Head Start
Lorraine C. Johnson, Director
533-535 41st Street
Union City, NJ 07087
Phone 201-617-0901
Fax 201-501-0272

Hudson County
Jersey City Child Development
Esther Lee, Executive Director
93-103 Nelson Ave.
Jersey City, NJ 07037
Phone 201-656-1500
Fax 201-656-4468

Hudson
HOPES Head Start
Ora Welch, Executive Director
301 Garden Street
Hoboken, NJ 07030
Phone 201-656-3711
Fax 201-656-8213

Hudson County
Bayonne Head Start
Lauretta Allston, Director
20 West 8th Street
Bayonne, NJ 07002
Phone 201-437-7702
Fax 201-437-2810

Mercer County
Trenton Head Start
Jeri Smith, Executive Director
222 East State Street
Trenton, NJ 08618
Phone 609-392-2113
Fax 609-695-0359

Mercer County
Mercer County Head Start
Consuelo Mc Damlet, Executive Director
2238 Hamilton Ave.
Trenton, NJ 08619
Phone 609-563-5894
Fax 609-588-5885

Middlesex County
Middlesex County Head Start
Carol Kempner, Director
1215 Livingston Avenue
North Brunswick, NJ 08902
Phone 732-646-4600x222
Fax 732-646-3728

Monmouth County
ICCC Head Start
Angeline Harris, Executive Director
36 Ridge Road
Neptune, NJ 07753
Phone 732-988-7736
Fax 732-988-4511

Morris County
Morris County Head Start
Ellenn Jambonis, Executive Director
18 Thompson Ave.
Dover, NJ 07801
Phone 973-328-3882
Fax 973-328-3386

Ocean County
Ocean County Head Start
Barbara Brown, Director
40 Washington Street
Toms River, NJ 08754
Phone 732-244-6333
Fax 732-349-4227

Ocean County
LEAP, Inc.
Orest Nadrags, Executive Director
30 Eighth Street
Lakewood, NJ 08701
Phone 973-364-4333
Fax 973-364-4236

Passaic County
Center For Family Resources
Sharon Weln, Executive Director
12 Morris Road
Ringwood, NJ 07456
Phone 973-962-8055
Fax 973-962-1129

Passaic County
Passaic City Head Start
Passaic Mala, Director
68-72 Third Street, 2nd Floor
Passaic City, NJ 07055
Phone 973-365-5780
Fax 973-458-9380

Passaic County
Concerned Parents for Head Start
Cecile Dickey, Executive Director
90 Martin Street
Paterson, NJ 07302
Phone 973-345-9555
Fax 973-345-6719

Somerset County
Somerset County Child Development
Gloria Strickland, Executive Director
429 Lewis Street PO Box 119
Somerset, NJ 08893
Phone 732-945-5886
Fax 732-846-7569

Union County
Twp. Of Union Public Schools Head Start
Jean Denrew, Director
C/O Hamilton School
1231 Burnet Ave.
Union, NJ 07083
Phone 973-851-8563
Fax 973-851-6784

Union County
Union Twp. CAO Head Start
Jennifer Alford, Director
333 North Broad
Elizabeth, NJ 07201
Phone 973-629-9199
Fax 973-629-5190

Union County
Second Street Youth Center
Yvonne Thomas, Executive Director
933 South Second
Plainfield, NJ 07063
Phone 973-361-0161
Fax 973-756-6570

Warren/Sussex/Hunterdon
NORWESCAP Head Start
Linda Kane, Director
481 Memorial Pkwy, Parkview Building
Phillipsburg, NJ 08865
Phone 973-654-3830
Fax 973-454-0362

B.4.7 Local Health Departments

The contractor shall utilize the following DHSS website to access an updated list of Local Health Departments in New Jersey:

http://www.state.nj.us/health/lh/lhdirectory.pdf

B.4.8 WIC Referral Forms

New Jersey State Department of Health
WIC/HEALTHSTART

REFERRAL/NUTRITION ASSESSMENT FOR WOMEN

Please see instructions on last page

NAME OF CLIENT	TELEPONE NUMBER	DATE OF BIRTH
ADDRESS OF CLIENT	CHECK ONE: ☐ Pregnant ☐ Breastfeeding ☐ Non-Breastfeeding	

REFERRAL *(To be completed by Health Professional, including second page)*

ANTHROPOMETRIC AND LABORATORY DATE (One Blood Test is Required)

First Prenatal Check-up: Date: ____/____/____ # Weeks Gestation _____ Weight (pounds) _____ Pre-Preg (pounds) _____ Usual Wt (pounds) _____

Current Check-up: Date: ____/____/____ # Weeks Gestation _____ Weight (pounds) _____ Height (inches) _____

Blood Test: Date: ____/____/____ Hb(mg/dl) _____ Hct _____% EP(ug/dl) _____ Lead _____ Other _____

MEDICAL HISTORY

Gravida _____ Para _____ Ab/Misc _____ Stillbirth _____ EDC _____ ADC _____ ☐ Vag ☐ "C" Section

Past Med/Surg History _____

Current Medical Problem(s) _____

Previous Preg Complications _____ Date Last Preg Ended _____/_____/_____

Physician/Clinic _____ Phone _____

Signature of Health Professional _____ Date: _____/_____/_____

WIC APPOINTMENT: Date: _____/_____/_____ Time: _____

ASSESSMENT *(To be completed by Client or Health Professional)*

1) Are you taking any of the following?

Vitamins/Minerals	☐ Yes	☐ No	Amount: _____	Type: _____
Iron	☐ Yes	☐ No	Amount: _____	Type: _____
Over-the-Counter Medicines	☐ Yes	☐ No	Amount: _____	Type: _____
Special Medicines	☐ Yes	☐ No	Amount: _____	Type: _____
"Street" Drugs	☐ Yes	☐ No	Amount: _____	Type: _____

2) How much did you smoke before you were pregnant? Amount: _____
How much do you smoke now? Amount: _____

3) How much beer, wine cooler, or liquor do you drink per week? Amount: _____

4) Are you on a special diet now? ☐ Yes ☐ No Prior to pregnancy? ☐ Yes ☐ No

5) Are you experiencing?

Nausea	☐ Yes	☐ No	Heartburn	☐ Yes	☐ No
Frequent Vomiting	☐ Yes	☐ No	Flatus ("Gas")	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No	Dental Problems	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Bleeding Gums	☐ Yes	☐ No

6) Do you eat?

Paint Chips	☐ Yes	☐ No	Dirt	☐ Yes	☐ No
Laundry Starch	☐ Yes	☐ No	Clay	☐ Yes	☐ No
Corn Starch	☐ Yes	☐ No	Plaster	☐ Yes	☐ No
Ice	☐ Yes	☐ No	Other Cravings	☐ Yes	☐ No

7) Do you have a working?

Stove	☐ Yes	☐ No	Sink with water supply	☐ Yes	☐ No
Refrigerator	☐ Yes	☐ No			

8) Are you on any program?

WIC	☐ Yes	☐ No	HealthStart/	☐ Yes	☐ No
Child Support Enf	☐ Yes	☐ No	Presumptively Eligible	☐ Yes	☐ No
Food Stamps	☐ Yes	☐ No	AFDC/Medicaid	☐ Yes	☐ No

9) How do you plan to or presently feed your baby?
Breastmilk ☐ Yes ☐ No Formula ☐ Yes ☐ No Undecided? ☐ Yes ☐ No

10) Do you do the following daily?

Work	☐ Yes	☐ No	Type: _____
Care for Children	☐ Yes	☐ No	How Many: _____
Exercise	☐ Yes	☐ No	Type: _____

11) If pregnant, how much weight (pounds) do you plan to gain? _____

12) Where do you plan to or presently take your child for medical care? _____

New Jersey State Department of Health **REFERRAL/NUTRITION ASSESSMENT FOR WOMEN**
WIC/HEALTHSTART

INSTRUCTIONS

--- AGENCY USE ONLY ---

Referral Section *(Complete by Health Professional)*

1) Fill in client's name, address, phone number, date of birth, or use addressograph stamp.

2) Check status of woman being referred.

3) Fill in data on first prenatal check-up and current check-up, if applicable.

4) One blood test is required prior to submitting this form to WIC. Pregnant women need blood test that was done during pregnancy. Postpartum women (breastfeeding and non-breastfeeding) need blood test that was done after delivery.

5) Complete Gravida, Para, Abortions, Miscarriages.

6) Fill in EDC (Estimated Date of Confinement) for prenatal clients.

7) Fill in ADC (Actual Date of Confinement), vaginal or "C" Section delivery for postpartum clients.

8) Complete past medical/surgical history based on client's record.

9) Fill in any pertinent current medical problems diagnosed.

Information in this section should NOT include most recent pregnancy for postpartum women.

10) Complete previous pregnancy complications, referring to list below:
Write approximate letter or letters on space provided.
   a) Hx of low birth weight infant(s) [<5.5 pounds]
   b) Hx of premature infant(s) [<37 weeks gestation)
   c) Hx of infant(s) > 10 pounds at birth
   d) Hx of or planned C-section
   e) Multiple pregnancy or recent multiple birth
   f) Medical problems (e.g., diabetes, hypertension, preeclampsia, eclampsia)
   g) Disability that may compromise adequacy of diet
   h) Social or environmental condition that may compromise adequacy of diet
   i) Substance use (e.g., alcohol, drugs, cigarettes, pica)
   j) Vitamin/mineral supplement or medicine prescription
   k) Special formula prescription and medical reason for its necessity
   l) Other pertinent health/medical data

1) Fill in physician's name or clinic and phone number.

2) Signature of referring health professional IS REQUIRED, with current date.

Assessment Section/Food Frequency *(Page 1 and 2)*

1) This section may be completed by the client or a health professional.

2) If completed by client, it must be reviewed by the health professional for accuracy and completeness. Check the appropriate answer for questions 1-18. Any responses that do NOT meet WIC and/or HealthStart standards demand further clarification.

3) The health professional should compare the food frequency with the recommended servings needed daily for pregnant/postpartum women and formulate a nutrition plan of care accordingly.

4) The Nutrition Assessment and Plan of Care must be written according to the hospital/HealthStart Agency/WIC State policy and procedure.

5) Upon completion of nutrition education, the health professional must circle the appropriate Nutrition Education Topics and record the date. (More topics below) If materials are provided, write the appropriate Topic Code in the space labeled "Other".

05 – Child Nutrition	11 – Mealtime Psychology	18 – Sugar in Diet
06 – Dental Health	12 – Nutrients in WIC Foods	19 – Vitamin A in Diet
07 – Fat in Diet	15 – Salt in Diet	20 – Vitamin C in Diet
08 – Food Budget/Consumer Awareness/Meal Planning	16 – Smoking & Pregnancy	44 – Now Show
	17 – Snacking	45 – Client Refused
09 – Fruit and Vegetables		

NAME AND ADDRESS OF WIC PROGRAM, HEALTHSTART AGENCY, PHYSICIAN OR CLIIC:	TELEPHONE NUMBER

INSTRUCTIONS

Assessment Section/Food Frequency *(Page 1 and 2)*

1) This section may be completed by the client or a health professional.

2) If completed by the client, it must be reviewed by the health professional for accuracy and completeness. Check the appropriate answer for questions 1-18. Any responses that do NOT meet WIC and/or HealthStart standards demand further clarification.

3) The health professional should compare the food frequency with the recommended servings needed daily for pregnant/postpartum women and formulate a nutrition plan accordingly.

4) The Nutrition Assessment and Plan of Care must be written according to the hospital/HealthStart Agency/WIC State policy and procedure.

5) Upon completion of nutrition education, the health professional must circle the appropriate Nutrition Education Topic Code and write the date education was provided.

6) Listed below are a continuation of nutrition Education Topics. If materials are provided, write the appropriate Topic Code in the space labeled "Other".

05 – Child Nutrition
06 – Dental Health
07 – Fat in the Diet
08 – Food Budgeting/Consumer Awareness/Meal Planning
09 – Fruit and Vegetables
11 – Mealtime Psychology
12 – Nutrients in WIC Foods
15 – Salt in the Diet
16 – Smoking and Pregnancy
17 – Snacking
18 – Sugar in Diet
19 – Vitamin A in Diet
20 – Vitamin C in Diet
44 – No Show
45 – Client Refused

B.4.9 Mental Health/Substance Abuse Screening Tools

☐ **AmeriChoice** ☐ **Amerigroup** ☐ **Horizon NJ Health** ☐ **Health Net** ☐ **University Health Plans**

Well-Being Screening Tool
For Adolescents & Adults
Patient Problem Questionnaire

Patient Name:_____**Date Completed:**_____
Member ID#:_____**PCP Name:**_____

The purpose of this questionnaire is to identify problems your doctor may be able to help you with.
Please answer all questions by checking one box per question.

	During the past month generally (questions 1 – 11):	YES	NO
1.	Have you been feeling tired or have low energy?		
2.	Have you been having trouble sleeping? (Too much or too little)		
3.	Have you been feeling sad, hopeless, or unusually happy?		
4.	Have you been feeling bad about yourself that you are a failure or have let yourself or your family down?		
5.	Have you been having trouble concentrating on things, such as watching TV, reading the newspaper, or reading a book?		
6.	Have you been feeling on edge, nervous?		
7.	Have your eating patterns or appetite changed?		
8.	Have you been trying not to gain weight (making yourself vomit, taking excessive laxatives, or exercising more than an hour per day)?		
9.	Have you felt sudden fear or panic for no obvious reason?		
10.	Have you been having thoughts that you would be better off dead, or of hurting yourself?		
11.	Are you troubled by being unable to control your anger or by having thoughts about hurting others?		
12.	Have you		
	a. Ever felt you ought to cut down on your drinking or drug use?		
	b. Ever felt annoyed by people who comment on your drinking or drug use?		
	c. Ever felt bad or guilty about your drinking or drug use?		
	d. Ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover (eye opener)?		
13.	Do you have any other concerns about your well-being? Please explain. _____		
14.	Have you ever sought treatment for any of the above problems for which you checked yes?		
15.	If you checked off yes to **any** of the above questions, how difficult have these problems made it for you to do your work, go to school, take care of things at home or get along with other people? Not Difficult At All Somewhat Difficult Very Difficult Extremely Difficult		

B.4.10 Centers of Excellence

The table on the following pages lists centers of excellence.

Centers of Excellence

Pediatric Ambulatory Tertiary Centers

William Sharrar, M.D., Medical Director
Cooper Hospital/University Medical Center
Three Cooper Plaza
Camden, New Jersey 08103-1489
Phone: (609) 342-2298

Averil Jones, Nurse Manager
Children's Hospital of New Jersey at Newark Beth Israel
Tertiary Services
201 Lyons Avenue
Newark, New Jersey 07112
Phone: (973) 926-7328

Mary Lotze, RN, Administrator
UMDNJ/Robert Wood Johnson Medical School
Tertiary Services
97 Paterson Street
New Brunswick, New Jersey 08903
Phone: (908) 235-7080

Regional Cleft Lip/Palate Craniofacial Anomalles Centers

Marilyn Cohen, Coordinator
Cooper Hospital/University Medical Center
Cleft Palate Services
900 Centennial Blvd
Voorhees, New Jersey 08043
Phone: (609) 325-6720

Beryl Chassen, Coordinator
Monmouth Medical Center
Cleft Palate Services
300 Second Avenue
Long Branch, New Jersey 07740-6565
Phone: (732) 870-5695

Tena Turner, RN, MA., Coordinator
Bipin Patel, M.D., Medical Director
St. Peter's Medical Center
Cleft Palate Services
254 Easton Avenue
New Brunswick, New Jersey 08901-1780
Phone: (732) 745-7943

William Roche, Coordinator, Craniofacial Center
St. Joseph's Medical Center
703 Main Street
Paterson, New Jersey 07503
Phone: (973) 754-2924

New Jersey Statewide Network Of Pediatric HIV treatment Centers

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FXB Center
University of Medicine & Dentistry of New Jersey
ADMC #4
30 Bergen St.
Newark, NJ 07107
(973) 972-0400 FAX (973) 972-0396

Newark Beth Israel Medical Center
Family Treatment Center, G3
201 Lyons Ave.
Newark, NJ 07112
(973) 926-8004 FAX (973) 926-4584 or 6452

Department of Pediatrics
Cooper Hospital/University Medical Center
3 Cooper Plaza, Suite 200, Rm. 202
Camden, NJ 08103
(856) 342-2089 FAX (856) 968-8414

Jersey City Medical Center
AIDS Health Services
50 Baldwin Ave.
Jersey City, NJ 07304
(201) 915-2295 FAX (201) 915-2213

Robert Wood Johnson Medical School
Department of Pediatrics
Division of Immunology, Allergy & Infectious Diseases
1 Robert Wood Johnson Place, PO BOX 19
New Brunswick, NJ 08903
(732) 235-7894 FAX (732) 235-7419

St. Joseph's Hospital & Medical Center
Department of Community Medicine
703 Main St.
Paterson, NJ 07503
(973) 754-4713 FAX (973) 279-3618

Affiliate Center

Jersey Shore Medical Center
Department of Pediatrics A-240
1945 Corlies Ave.
Neptune, NJ 07754
(732) 776-4271 FAX (732) 776-4648

Comprehensive Regional Sickle Cell/Hemoglobinopathies Treatment Centers

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Jersey City Medical Center
Department of Pediatrics
50 Baldwin Avenue
Clinic Building, 5th Floor
Jersey City, New Jersey 07304-3199
Renuka B. Nigam, M.D., Chief
Pediatric Hematology/Oncology
(201) 915-2455

Newark Beth Israel Medical Center
201 Lyons Avenue
Newark, New Jersey 07112-2094
Peri Kamalaker, M.D., Director
Pediatric Hematology/Oncology
(973) 926-7161

The Institute for Children with Cancer and Blood Disorders
The Cancer Institute of New Jersey
195 Little Albany St.
New Brunswick, NJ 08901
Richard Drachtman, M.D.
Division of Pediatric Hematology/Oncology
Phone: (732) 235-7898

University Hospital/UMDNJ
Division of Pediatric Hematology/Oncology
UH Room F342
150 Bergen Street
Newark, NJ 07013-2406
Phone: (973) 972-1011 or 972-0658

Medical Center
Tomorrow's Children Institute
Hackensack University Medical Center
30 Prospect Avenue
Hackensack, New Jersey 07601-1991
Frances Flug, M.D.
Pediatric Hematology/Oncology
(201) 996-5437

Children's Hospital of Philadelphia
New Jersey Section of Hematology/Oncology
Specialty Care Center
1012 Laurel Oak Road
Voorhees, NJ 08043
Susan F. Travis, M.D., Director
Phone: (856) 435-7502

UMDNJ/NJ Medical School
Comprehensive Sickle Cell Program
185 South Orange Ave.
Newark, NJ 07103
Anne Hurlet, M.D.
Phone: (973) 972-1061

St. Joseph's Hospital and Medical Center
703 Main Street
Paterson, NJ 07503
Jill Manell, M.D.
Chief, Pediatric Hematology/Oncology
Phone: (973) 754-3229 or 754-2500

St. Barnabas Medical Center
101 Old Short Hills Road
Livingston, NJ 07039
Anne G. Nepo, M.D.
Pediatric Hematology/Oncology
Phone: (973) 325-6700

PKU Treatment Centers

Barbara Marcelo Evans, M.D., Medical Director
Cooper Hospital/University Medical Center
Southern New Jersey Regional PKU Program
Three Cooper Plaza – Suite 200
Camden, New Jersey 08103-1489
Phone: (609) 963-3689

Carol Gernat, Coordinator
Anna Haratounian, M.D., Medical Director
Children's Hospital of New Jersey at Newark Beth Israel
Regional PKU Program
201 Lyons Avenue
Newark, New Jersey 07112
Phone: (973) 926-6898

Genetic Centers

Patricia Griggs, RNC
Atlantic City Medical Center
Genetic Services
1925 Pacific Avenue
Atlantic City, NJ 08401
Phone: (609) 441-8156
FAX: (609) 441-8157

Lynn Howard, Coordinator
Genetics Program
The Children's Regional Hospital
Three Cooper Plaza, Suite 309

Camden, NJ 08103
Phone: (856) 968-7248
FAX: (856) 968-7257

Carolyn Lieber, Manager
Genetics Services
Don Imus WFAN Ped. Ctr., 2nd Fl.
Hackensack University Medical Center
Suite 258
30 Prospect Avenue
Hackensack, NJ 07601
Phone: (201) 996-5264
FAX: (201) 996-0827

Jane Murphy, MS Coordinator
Genetic Services
Jersey City Medical Center
50 Baldwin Avenue, 8th Floor Clinic Bldg.
Jersey City, NJ 07304-3199
Phone: (201) 915-2095
FAX: (201) 915-2481

Carolee Watkins, M.S., MA, CGC
Coordinator, Genetics Services
Capitol Health System at Mercer
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Trenton, NJ 08607-1658
Phone: (609) 394-4072
FAX: (609) 394-4148

Judith Rokeach, RN, BSN
Coordinator, Genetic Services
Monmouth Medical Center
300 Second Avenue
Long Branch, NJ 07740
Phone: (732) 923-6526
FAX: (732) 923-6528

Joan Atkin, M.D. (SC)
Morristown Memorial Hospital
Genetic Center (Box 120)
100 Madison Avenue
Morristown, New Jersey 07962-1956
Phone: (973) 971-5636
FAX: (973) 290-7365

Loraine Suslack, MS
Genetic Counselor
Center for Human & Molecular Genetics
UMDNJ-New Jersey Medical School
Doctors Office Center
90 Bergen StreetNewark, NJ 07103
Phone: (973) 972-3311
FAX: (973) 972-3310

Debra Day-Salvatore, M.D., Ph.D.
Director, Division of Clinical Services
St. Peter's Medical Center
Department of Genetics
254 Easton Avenue, MOB 2190
New Brunswick, New Jersey 08903-0591
Phone: (732) 745-6678
FAX: (732) 249-2687

Hemophilia Program

Cooper Hospital/University Medical Center

3 Cooper Plaza - Room 220
Camden, New Jersey 08103
Jack Goldberg, M.D.
Division Head Hematology/Oncology
Phone: (856) 963-3572
FAX: (856) 338-9211

St. Michael's Medical Center
Regional Hemophilia Center
268 Dr. Martin Luther King Jr. Blvd
Newark, New Jersey 07102-2094
Franklin Desposito, M.D.
Phone: (973) 877-5347
Nancy Gonzalez, Coordinator
Phone: (973) 877-4512
FAX: (973) 877-2823

University of Medicine and Dentistry of New Jersey/
Robert Wood Johnson Medical School
One Robert Wood Johnson Place, PO Box 19
New Brunswick, New Jersey 08903-0019
Parvin Saidi, M.D., Director
NJ Regional Hemophilia Program
Phone: (732) 235-7679
Ann Lerner, Administrator
Phone: (732) 235-7681
FAX: 732-235-7115

Barbara Marcello Evans, MD
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Three Cooper Plaza
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Norma Altreche, LCSW
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50 Baldwin Ave.
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1945 Corlies Ave.
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Patricia Munday, Director of Child Evaluations
John F. Kennedy Medical Center
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Teri Criscone, Administrative Director
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Morristown, NJ 07960-6095
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Roberta DiHoff, Ph.D., Director

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Child Evaluation Center
65 South State Street
Vineland, NJ 08360-4893
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Barbara Caspi, Program Administrator
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201 Lyons Ave.
Newark, NJ 07112
Phone: (973) 926-6688

07/2010 Accepted

B.4.11 Special Child Health Services Network

The contractor shall utilize the following DHSS website to access an updated list of Special Child Health Services County Case Management Units:

http://www.state.nj.us/health/fhs/sch/sccase.shtml

B.4.12 Reserved

B.4.13 Statewide Family Centered HIV Care Network (Ryan White Title IV)

The contractor shall utilize the following DHSS website to access an updated list of the Statewide Family Centered HIV Network – (Ryan White Title V) centers.

http://www.state.nj.us/health/fhs/sregional.htm

B.4.14 New Jersey QAPI Standards

STANDARD I: WRITTEN QAPI DESCRIPTION - The organization has a written description of its Quality Assessment and Performance Improvement Program (QAPI). This written description meets the following criteria:

A. goals and objectives - The written description contains a detailed set of QA objectives which are developed annually and include a timetable for implementation and accomplishment. The QAPI includes performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction.

B. scope -

1. The scope of the QAPI is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service, such as and including: availability, accessibility, coordination, and continuity of care.

2. The QAPI methodology provides for review of the entire range of care provided by the organization, by assuring that all demographic groups, care settings, (e.g., inpatient, ambulatory, [including care provided in private practice offices] and home care), and types of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review. (This review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis).

3. The QAPI describes how it will meet the outcomes and performance standards specified in the contract.

C. specific activities - The written description specifies quality of care studies and performance improvement projects and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities are clearly identified and are appropriate.

D. continuous activity - The written description provides for continuous performance of the activities, including tracking of issues over time.

E. provider review - The QAPI provides for:

1. review by physician and other health professionals of the process followed in the provision of health services; and

2. feedback to health professionals and HMO staff regarding performance and patient results.

F. **focus on health outcomes** - The QAPI methodology addresses health outcomes to the extent consistent with existing technology.

STANDARD II: SYSTEMATIC PROCESS OF QUALITY ASSESSMENT AND IMPROVEMENT - The QAPI objectively and systematically monitors and evaluates the quality and appropriateness of care and service to enrollees, through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis.

The QAPI has written guidelines for its quality of care studies and related activities which include:

A. **specification of clinical or health services delivery areas to be monitored**

1. The monitoring and evaluation of care reflects the population serviced by the managed care organization in terms of age groups, disease categories, and special risk status.

2. For the Medicaid population, the QAPI monitors and evaluates, at a minimum, care and services in certain priority areas of concern selected by the State. Clinical focus areas applicable to all enrollees are as follows:

   a) Primary, secondary, and/or tertiary prevention of acute conditions;
   b) Primary, secondary, and/or tertiary prevention of chronic conditions;
   c) Care of acute conditions;
   d) Care of chronic conditions;
   e) High-volume services
   f) High-risk services; and
   g) Continuity and coordination of care

3. The State may require an organization to conduct particular projects that are specific to the organization and that relate to topics and involve quality indicators of the State choosing.

4. Organizations may collaborate with one another, subject to the approval of the State.

5. If a project is conducted over a period of more than one review year the project will be considered as achieving improvement in each year for which it achieves an improvement meeting the requirements specified or a project may be considered as achieving improvement in each year for which it achieves an improvement that does <u>not</u> meet the requirements specified but that constitutes an intermediate target specified in a project work plan developed in consultation with the State.

6. At its discretion and/or as required by the State Medicaid agency, the organization's QAPI also monitors and evaluates other important aspects of care and service.

   a) Non-clinical focus areas applicable to all enrollees are as follows:

      i) Availability, accessibility, and cultural competency of services;
      ii) Interpersonal aspects of care, e.g., quality of provider/patient encounters; and
      iii) Appeals, grievances, and other complaints.

   b) Within each required focus area, the organization selects a specific topic or topics to be addressed by a project. Topics should be selected and prioritized to achieve the greatest practical benefit for enrollees.

B. use of quality indicators - Quality indicators are measurable variables relating to a specified clinical or health services delivery area, which are reviewed over a period of time to monitor the process or outcomes of care delivered in that area.

1. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience, or health services research.

2. All indicators measure changes in health status, functional status, or enrollee satisfaction, or valid proxies of these outcomes. Measures of processes are used as a proxy for outcomes only when those processes have been established through published studies or a consensus of relevant practitioners to be significantly related to outcomes.

3. Indicators selected for a topic in a clinical focus area include at least some measure of change in health status or functional status or process of care proxies for these outcomes. Indicators may also include measures of satisfaction.

4. Methods and frequency of data collection are appropriate and sufficient to detect need for program change. Assessment of the organization's performance on the selected indicators is based on systematic, ongoing collection and analysis of valid and reliable data.

   a) The organization establishes a baseline measure of its performance on each indicator, measures changes in performance, and continues measurement for at least one year after a desired level of performance is achieved.

b) When sampling is used, sampling methodology for assessment of the organization's performance shall be such as to ensure that the data collected validly reflect:
   i) The performance of all practitioners and providers who serve Medicaid/NJ FamilyCare enrollees and whose activities are the subject of the indicator; and
   ii) The care given to the entire population (including special populations with complex care needs) to which the indicator is relevant.

C. use of clinical care standards/practice guidelines -

1. The QAPI studies and other activities monitor quality of care against clinical care or health service delivery standards or practice guidelines specified for each area identified in "A," above.

2. Guidelines are based on reasonable medical evidence or a consensus of health care professionals in the particular field, consider the needs of the enrolled population, are developed in consultation with contracting health care professionals, and are reviewed and updated periodically. Guidelines, including any admission, continued stay, and discharge criteria used by the organization, are communicated to all providers and enrollees when appropriate, and to individual enrollees when requested.

3. The standards/guidelines focus on the process and outcomes of health care delivery, as well as access to care.

4. A mechanism is in place for continuously updating the standards/guidelines.

5. The standards/guidelines shall be included in provider manual developed for use by HMO providers or otherwise disseminated to providers as they are adopted.

6. The standards/guidelines address preventive health services.

7. Standards/guidelines are developed for the full spectrum of populations enrolled in the plan.

8. The QAPI shall use these standards/guidelines to evaluate the quality of care provided by the managed care organization's providers, whether the providers are organized in groups, as individuals, as IPAs, or in combination thereof.

9. The organization implements written policies and procedures for evaluating new medical technologies and new uses of existing

technologies. The evaluations take into account coverage decisions by Medicare intermediaries and carriers, national Medicare coverage decisions, and federal and state Medicaid coverage decisions, as appropriate.

D. analysis of clinical care and related services -

1. Appropriate clinicians monitor and evaluate quality through review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care and related service. For quality issues identified in the QAPI's targeted clinical areas, the analysis includes the identified quality indicators and uses clinical care standards or practice guidelines.

2. Multidisciplinary teams are used, where indicated, to analyze and address systems issues.

3. From 1. and 2., clinical and related service areas requiring improvement are identified.

E. implementation of remedial/corrective actions -

The QAPI includes written procedures for taking appropriate remedial action whenever, as determined under the QAPI, inappropriate or substandard services are furnished, or services that should have been furnished were not.

These written remedial/corrective action procedures include:

1. specification of the types of problems requiring remedial/corrective action;

2. specification of the person(s) or body responsible for making the final determinations regarding quality problems;

3. specific actions to be taken;

4. provision of feedback to appropriate health professionals, providers and staff;

5. the schedule and accountability for implementing corrective actions;
6. the approach to modifying the corrective action if improvements do not occur;

7. procedures for terminating the affiliation with the physician, or other health professional or provider.

F. assessment of effectiveness of corrective actions -

1. As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.

2. The managed care organization assures follow-up on identified issues to ensure that actions for improvement have been effective.

G. evaluation of continuity and effectiveness of the QAPI -

1. The managed care organization conducts a regular and periodic examination of the scope and content of the QAPI to ensure that it covers all types of services in all settings, as specified in STANDARD I-B-2.

2. At the end of each year, a written report on the QAPI is prepared, which addresses: QA studies and other activities completed; trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the QAPI.

3. There is evidence that QA activities have contributed to significant improvements in the care delivered to members.

4. The organization's interventions result in significant demonstrable improvement in its performance as evidenced in repeat measurements of the quality indicators specified for each performance improvement project undertaken by the organization.

   a) When a project measures performance on quality indicators by collecting data on all units of analysis in the population to be studied (i.e., a census), significant improvement is demonstrated by achieving:

      i) In the case of a statewide Medicaid project, a benchmark level of performance defined in advance by the State Medicaid agency; or
      ii) In the case of a project developed by the organization itself, a benchmark level of performance that is defined in advance by the organization. The organization's benchmark must reduce the performance gap (the percent of cases in which the measure is failed) by at least 10 percent.
      iii) In the case of a project developed by the organization to reduce disparities between minorities and other members, a reduction of at least 10 percent in the number of minority enrollees (or the specified unit of analysis) that do not achieve the desired outcome as defined by the quality indicators.

b) When a project measures performance on quality indicators by collecting data on a subset (sample) of the units of analysis in the population to be studied, significant improvement is demonstrated by achieving the benchmarks specified in a) above and the quantitative improvement demonstrated in the repeated measurements is statistically significant with a "p value" of less than or equal to .10.

i) The sample or subset of the study population shall be obtained through random sampling.
ii) The samples used for the baseline and repeat measurements of the performance indicators shall be chosen using the same sampling frame and methodology.

c) The improvement is reasonably attributable to interventions undertaken by the organization (i.e., a project and its results have face validity).

5. The organization sustains the improvements in performance for at least one year after the improvement in performance is first achieved. Sustained improvement is documented through the continued measurement of quality indicators for at least one year after the performance improvement project is completed.

STANDARD III: ACCOUNTABILITY TO THE GOVERNING BODY - The Governing Body of the organization is the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the managed care organization. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

A. oversight of QAPI - There is documentation that the Governing Body has approved the overall QAPI and an annual QA plan.

B. oversight entity - The Governing Body has formally designated an accountable entity or entities within the organization to provide oversight of QA, or has formally decided to provide such oversight as a committee of the whole.

C. QAPI progress reports - The governing Body routinely receives written reports from the QAPI describing actions taken, progress in meeting QA objectives, and improvements made.

D. annual QAPI review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the QAPI which includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered, to assess the QAPI's continuity, effectiveness and current acceptability.

E. **program modification** - Upon receipt of regular written reports from the QAPI delineating actions taken and improvements made, the Governing Body takes action when appropriate and directs that the operational QAPI be modified on an ongoing basis to accommodate review findings and issues of concern within the managed care organization (MCO). This activity is documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to Quality Assurance.

STANDARD IV: ACTIVE QA COMMITTEE - The QAPI delineates an identifiable structure responsible for performing QA functions within the MCO. This committee or other structure has:

A. **regular meetings** - The structure/committee meets on a regular basis with specified frequency to oversee QAPI activities. This frequency is sufficient to demonstrate that the structure/committee is following-up on all findings and required actions, but in no case are such meetings less frequent that quarterly.

B. **established parameters for operating** - The role, structure and function of the structure/committee are specified.

C. **documentation** - There are records documenting the structure's/committee's activities, findings, recommendations and actions.

D. **accountability** - The QAPI committee is accountable to the Governing Body and reports to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions.

E. **membership** - There is active participation in the QA committee from health plan providers, who are representative of the composition of the health plan's providers.

STANDARD V: QAPI SUPERVISION - There is a designated senior executive who is responsible for program implementation. The organization's Medical Director has substantial involvement in QA activities.

STANDARD VI: ADEQUATE RESOURCES - The QAPI has sufficient material resources; and staff with the necessary education, experience, or training; to effectively carry out its specified activities.

STANDARD VII: PROVIDER PARTICIPATION IN THE QAPI -

A. Participating physicians and other providers are kept informed about the written QA plan.

B. The MCO includes in all its provider contracts and employment agreements, for both physicians and non-physician providers, a requirement securing cooperation with the QAPI.

C. Contracts specify that hospitals and other contractors will allow the managed care organization access to the medical records of its members.

D. Includes a provider appeals process.

E. Description of how providers are to be involved in the design, implementation, review and follow-up of quality activities.

F. Description of how needed changes will be instituted.

STANDARD VIII: DELEGATION OF QAPI ACTIVITIES - The MCO remains accountable for health services management and all QAPI functions, even if certain functions are delegated to other entities. If the managed care organization delegates any activities to other entities:

A. There is a written agreement describing: the delegated activities; the delegate's accountability for these activities; the frequency of reporting to the managed care organization; and provides for revocation of the delegation or other remedies for inadequate performance.

B. The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

C. There is evidence of continuous and ongoing evaluation of delegated activities at least annually, including approval of quality improvement plans and regular specified reports.

D. The organization evaluates the entity's ability to perform the delegated activities prior to delegation.

E. If the organization delegates selection of providers to another entity, the organization retains the right to approve, suspend, or terminate any provider selected by that entity.

STANDARD IX: CREDENTIALING AND RECREDENTIALING - The QAPI contains the following provisions to determine whether physicians and other health care professionals, who are licensed by the State and who are under contract to the MCO, are qualified to perform their services.

A. **written policies and procedures** - The managed care organization has written policies and procedures for the credentialing process, which includes the

organization's initial credentialing of practitioners, as well as its subsequent recredentialing, recertifying and/or reappointment of practitioners.

B. **oversight by Governing body** - The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.

C. **credentialing entity** - The plan designates a credentialing committee or other peer review body which makes recommendations regarding credentialing decisions.

D. **scope** - The plan identifies those practitioners who fall under its scope of authority and action. This shall include, at a minimum, all physicians, dentists, and other licensed independent practitioners included in the review organization's literature for members, as an indication of those practitioners whose service to members is contracted or anticipated.

E. **process** - The initial credentialing process obtains and reviews verification of the following information, at a minimum:

1. the practitioner holds a current valid license to practice;

2. valid DEA or CDS certificate, as applicable;

3. graduation from medical school and completion of a residency, or other post-graduate training, as applicable;

4. work history;

5. professional liability claims history;

6. good standing of clinical privileges at the hospital designated by the practitioner as the primary admitting facility; (This requirement may be waived for practices which do not have or do not need access to hospitals.)

7. the practitioners hold current, adequate malpractice insurance according to the plan's policy;

8. any revocation or suspension of a State license or DEA number;

9. any sanctions imposed by Medicare and/or Medicaid for example, suspensions, debarment, or recovery action; and

10. any censure by the State or County Medical Association.

11. The organization requests information on the practitioner from the National Practitioner Data Bank and the State Board of Medical Examiners or other appropriate professional licensing board, depending on the provider type

12. The application process includes a statement by the applicant regarding:

    a) any physical or mental health problems that may affect current ability to provide health care;
    b) any history of chemical dependency/substance abuse;
    c) history of loss of license and/or felony convictions;
    d) history of loss or limitation of hospital privileges or disciplinary activity; and
    e) an attestation to correctness / completeness of the applications.

    This information should be used to evaluate the practitioner's current ability to practice.

13. There is an attestation from each potential primary care practitioner's office, that the physical office meets ADA requirements or describes how accommodation for ADA requirements are made and that medical recordkeeping practices conform with the managed care organization's standards.

F. **recredentialing** - A process for the periodic reverification of clinical credentials (recredentialing, reappointment, or recertification) is described in the organization's policies and procedures.

1. There is evidence that the procedure is implemented at least every three years.

2. The MCO conducts periodic review of information from the National Practitioner Data Bank, along with performance data, on all physicians, to decide whether to renew the participating physician agreement. At a minimum, the recredentialing, recertification or reappointment process is organized to verify current standing on items listed in "E-1" through "E-7", above and item "E-12" as well.

3. The recredentialing, recertification or reappointment process also includes review of data from:

    a) member complaints;
    b) results of quality reviews;
    c) performance indicators;
    d) utilization management and;

e) reverifications of hospital privileges and current licensure.

G. delegation of credentialing activities - If the managed care organization delegates credentialing (and recredentialing, recertification, or reappointment) activities, there is a written description of the delegated activities, and the delegate's accountability for these activities. There is also evidence that the delegate accomplished the credentialing activities. The managed care organization monitors the effectiveness of the delegate's credentialing and reappointment or recertification process.

H. retention of credentialing authority - The managed care organization retains the right to approve new providers and sites, and to terminate or suspend individual providers. The organization has policies and procedures for the suspension, reduction or termination of practitioner privileges.

I. reporting requirement - There is a mechanism for, and evidence of implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.

J. appeals process - There is a provider appellate process for instances where the managed care organization chooses to reduce, suspend or terminate a practitioner's privileges with the organization.

1. The contractor shall not terminate a contract with a health care professional for participation in the contractor's network unless the contractor provides to the health care professional a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing. This section shall not apply in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a State licensing board or other governmental agency that impairs the health care professional's ability to practice.

2. No contractor shall terminate or refuse to renew a contract for participation in the contractor's network solely because the health care professional has (1) advocated on behalf of the enrollee; (2) filed a complaint against the contractor; (3) appealed a decision of the contractor; or (4) requested a hearing or review pursuant to this section.

3. For each institutional provider or supplier, the organization determines, and redetermines at specified intervals, that the provider or supplier:

   a) Is licensed to operate in the state, and is in compliance with any other applicable state or federal requirements;
   b) Is reviewed and approved by an appropriate accrediting body or is determined by the organization to meet standards established by the organization itself; and

c) In the case of a provider or supplier providing services to Medicare enrollees, is approved for participation in Medicare. (Note: This requirement does not apply to providers of additional or supplemental services for which Medicare has no approval standards.)

4. The organization notifies licensing and/or disciplinary bodies or other appropriate authorities, including but not limited to, the Health Care Integrity and Protection Data Bank, when a health care professional's or institutional provider or supplier's affiliation is suspended or terminated because of quality deficiencies, or as required pursuant to 45 CFR Part 61.

5. The organization ensures compliance with federal requirements prohibiting employment or contracts with individuals excluded from participation under either Medicare or Medicaid.

STANDARD X: ENROLLEE RIGHTS AND RESPONSIBILITIES - The organization demonstrates a commitment to treating members in a manner that acknowledges their rights and responsibilities.

A. **written policy on enrollee rights** - The organization has a written policy that complies with federal and state laws affecting the rights of enrollees and that recognizes the following rights of members:

1. to be treated with respect, dignity, and need for privacy;

2. to be provided with information about the organization, its services, the practitioners providing care, and members rights and responsibilities and to be able to communicate and be understood with the assistance of a translator if needed.

3. to be able to choose primary care practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners;

4. to participate in decision-making regarding their health care, to be fully informed by the Primary Care Practitioner, other health care provider or Care Manager of health and functional status, and to participate in the development and implementation of a plan of care designed to promote functional ability to the optimal level and to encourage independence;

5. to voice grievances about the organization or care provided and recommend changes in policies and services to plan staff, providers and outside representatives of the enrollee's choice, free of restraint, interference, coercion, discrimination or reprisal by the plan or its providers;

6. to formulate advance directives;

7. to have access to his/her medical records in accordance with applicable Federal and State laws.

8. to be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse or neglect;

9. to be free of hazardous procedures;

10. to receive information on available treatment options or alternative courses of care;

11. to refuse treatment and be informed of the consequences of such refusal; and

12. to have services provided that promote a meaningful quality of life and autonomy for members, independent living in members' homes and other community settings as long as medically and socially feasible, and preservation and support of members' natural support systems

B. **written policy on enrollee responsibilities** - The organization has a written policy that addressees members' responsibility for cooperating with those providing health care services. This written policy addresses members' responsibility for:

1. providing, to the extent possible, information needed by professional staff in caring for the member; and

2. following instructions and guidelines given by those providing health care services.

C. **communication of policies to providers and organization staff** - A copy of the organization's policies on members' rights and responsibilities is provided to all participating providers annually. The organization must monitor and promote compliance with the policies by the contractor's staff and affiliated providers.

D. **communication of policies to enrollees/members** - Upon enrollment and annually thereafter, members are provided a written statement that includes information on the following:

1. rights and responsibilities of members including the specific informational requirements of this section;

2. benefits and services included and excluded as a condition of membership, and how to obtain them, including a description of:

a) procedures for obtaining services, including authorization requirements;
b) any special benefit provisions (for example, co-payment, higher deductibles, rejection of claim) that may apply to service obtained outside the system;
c) procedures for obtaining services covered by the Medicaid fee-for-service program;
d) the procedures for obtaining out-of-area coverage; and
e) policies on referrals for specialty and ancillary care.

3. provisions for after-hours and emergency coverage;

4. the organization's policy and procedures on referrals for specialty care and ancillary services;

5. charges to members, if applicable, including:

   a) policy on payment of charges;
   b) co-payment and fees for which the member is responsible; and
   c) what to do if a member receives a bill for services.

6. procedures for notifying those members affected by the termination or change in any benefits, services, service delivery office/site, or affiliated providers.

7. procedures for appealing decisions adversely affecting the member's coverage, benefits, or relationship to the organization.

8. procedures for changing practitioners;

9. procedures for disenrollment; and

10. procedures for voicing complaints and/or grievances and for recommending changes in policies and services.

E. enrollee/member grievance procedures - The organization has, and communicates to enrollees, staff, and providers, a system(s), linked to the QAPI, for resolving members' complaints and formal grievances. This system includes:

1. procedures for registering and responding to complaints and grievances in a timely fashion (organizations should establish and monitor standards for timeliness);

2. documentation of the substance of complaints or grievances, and actions taken;

3. procedures to ensure a resolution of the complaint or grievance;

4. aggregation and analysis of complaint and grievance data and use of the data for quality improvement; and

5. an appeal process for grievances.

F. enrollee/member suggestions - Opportunity is provided for members to offer suggestions for changes in policies and procedures.

G. steps to assure accessibility of services - The managed care organization takes steps to promote accessibility of all services, both clinical and non-clinical, offered to members, including those with limited English proficiency and reading skills, with diverse cultural and ethnic backgrounds, the homeless and individuals with physical and mental disabilities. These steps include:

1. The points of access to primary care, specialty care, and hospital services are identified for members.

2. At a minimum, members are given information about:

   a) how to obtain services during regular hours of operations;
   b) how to obtain emergency and after-hours care;
   c) how to obtain second opinions;
   d) how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care;
   e) how to select a PCP from among those accepting new enrollees; and.
   f) physical accessibility.

H. written information for members -

1. Member information (for example, subscriber brochures, announcements, handbooks) is written in prose that is readable and easily understood.

2. Written information is available, as needed, in the languages of the major population groups served. A "major" population is one which represents at least 5% of a plan's membership.

I. confidentiality of patient information - The organization acts to ensure that the confidentiality of specified patient information and records is protected.

1. The organization has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records.

2. Information from, or copies of, records may be released only to authorized individuals, and the organization must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas.

3. The organization ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the medical care organization.

4. The organization shall hold confidential all information obtained by its personnel about enrollees related to their examination, care and treatment and shall not divulge it without the enrollee's authorization, unless:

   a) it is required by law;
   b) it is necessary to coordinate the patient's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment;
   c) it is necessary in compelling circumstances to protect the health or safety of an individual.

5. Any release of information in response to a court order is reported to the patient in a timely manner.

6. Enrollee records may be disclosed, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual enrollee in any report of the research or otherwise disclose participant identity in any manner.

J. treatment of minors and individuals with disabilities - The organization has written policies regarding the appropriate treatment of minors and individuals with disabilities.

K. assessment of member satisfaction – If the organization conducts periodic surveys of member satisfaction with its services, the following must be included in the surveys.

1. The surveys include content on perceived problems in the quality, availability, and accessibility of care including difficulties experienced by people with disabilities in finding primary care doctors or specialists who are trained and experienced in treating people with disabilities.

2. The surveys assess at least a sample of:

a) all Medicaid members;
b) Medicaid member requests to change practitioners and/or facilities; and
c) disenrollment by Medicaid members.

3. As a result of the surveys, the organization:

a) identifies and investigates sources of dissatisfaction;
b) outlines action steps to follow-up on the findings; and
c) informs practitioners and providers of assessment results.

4. The organization reevaluates the effects of the above activities.

L. preservation and support of members' natural support systems.

STANDARD XI: STANDARDS FOR AVAILABILITY AND ACCESSIBILITY - The MCO has established standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice; and member service lines). Performance on these dimensions of access are assessed against the standards.

STANDARD XII: MEDICAL RECORDS STANDARDS

A. accessibility and availability of medical records -

1. The MCO shall include provisions in provider contracts for appropriate access to the medical records of its enrollees for purposes of quality reviews conducted by the Secretary, State Medicaid agencies, or agents thereof.

2. Records are available to health care practitioners at each encounter.

3. The MCO conducts ongoing programs to monitor compliance with its policies and procedures for medical records.

B. recordkeeping - Medical records may be on paper or electronic. The Plan takes steps to promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review as follows:

1. medical record standards - The organization sets standards for medical records. The records reflect all aspects of patient care, including ancillary services. These standards shall, at a minimum, include requirements for:

a) patient identification information - Each page or electronic file in the record contains the patient's name or patient ID number.

b) personal/biographical data - Personal/biographical data includes: age; sex; address; employer; home and work telephone numbers; and marital status.

c) entry date - All entries are dated.

d) provider identification - All entries are identified as to author.

e) legibility - The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer.

f) allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies -- NKA) is noted in an easily recognizable location.

g) past medical history - (for patients seen 3 or more times) Past medical history is easily identified including serious accidents, operations, illnesses. For children, past medical history related to prenatal care and birth.

h) immunizations - for pediatric records (ages 12 and under) there is a completed immunization record or a notation that immunizations are up-to-date.

i) diagnostic information

j) medication information

k) identification of current problems - Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record.

l) smoking/ETOH/substance abuse - Notation concerning cigarettes and alcohol use and substance abuse is present. (For patients 12 years and over and seen 3 or more times.) Abbreviations and symbols may be appropriate.

m) consultations, referrals, and specialist reports - Notes from any consultations are in the record. Consultation, lab, and x-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.

n) emergency care

o) hospital discharge summaries - discharge summaries are included as part of the medical record for: (1) all hospital admissions which occur while the patient is enrolled in the MCO and (2) prior admissions as necessary.

p) advance directive - For medical records of adults, the medical record documents whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.

2. patient visit data - documentation of individual encounters must provide adequate evidence of, at a minimum:

   a) history and physical examination - Appropriate subjective and objective information is obtained for the presenting complaints;
   b) plan of treatment;
   c) diagnostic tests;
   d) therapies and other prescribed regimens;
   e) follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN. Unresolved problems from previous visits are addressed in subsequent visits.
   f) referrals and results thereof; and
   g) all other aspects of patient care, including ancillary services.

C. record review process –

1. The MCO has a system (record review process) to assess the content of medical records for legibility, organization, completion and conformance to its standards.

2. The record assessment system addresses documentation of the items list in B, above.

3. The organization ensures appropriate and confidential exchange of information among providers, such that:

   a) A provider making a referral transmits necessary information to the provider receiving the referral;
   b) A provider furnishing a referral service reports appropriate information to the referring provider;
   c) Providers request information from other treating providers as necessary to provide care;
   d) If the organization offers a point-of-service benefit or other benefit providing coverage of services by non-network providers, the organization transmits information about services used by an enrollee under the benefit to the enrollee's primary care provider; and
   e) When an enrollee chooses a new primary care provider within the network, the enrollee's records are transferred to the new provider in a timely manner that ensures continuity of care.

4. The organization has policies and procedures for sharing enrollee information with any organization with which the enrollee may subsequently enroll.

STANDARD XIII: UTILIZATION REVIEW -

A. **written program description** - The organization has a written utilization management program description which includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

B. **scope** - The program has mechanisms to detect underutilization as well as overutilization.

C. **preauthorization and concurrent review requirements -** For organizations with preauthorization or concurrent review programs:

1. The organization implements written policies and procedures, reflecting current standards of medical practice, for processing requests for initial authorization of services or requests for continuation of services.

    a) The policies specify time frames for responding to requests for initial and continued determinations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited response to requests for authorization of urgently needed services.
    b) Criteria for decisions on coverage and medical necessity are clearly documented, are based on reasonable medical evidence or a consensus of relevant health care professionals, and are regularly updated.
    c) Mechanisms are in place to ensure consistent application of review criteria and compatible decisions.
    d) A clinical peer reviews all decisions to deny authorization on grounds of medical appropriateness.
    e) The requesting provider and the enrollee are promptly notified of any decision to deny, limit, or discontinue authorization of services. The notice specifies the criteria used in denying or limiting authorization and includes information on how to request reconsideration of the decision pursuant to the procedures established. The notice to the enrollee must be in writing.
    f) Compensation to persons or organizations conducting utilization management activities shall not be structured so as to provide inappropriate incentives for denial, limitation or discontinuation of authorization of services.
    g) The organization does not prohibit providers from advocating on behalf of enrollees within the utilization management process.
    h) Mechanisms are in effect to detect both underutilization and overutilization of services.

2. Preauthorization and concurrent review decisions are supervised by qualified medical professionals.

3. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate.

4. The reasons for decisions are clearly documented and available to the member.

5. There are well-publicized and readily available appeals mechanisms for both providers and patients. Notification of a denial includes a description of how to file an appeal.

6. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.

7. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.

8. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

STANDARD XIV: CONTINUITY OF CARE SYSTEM - The MCO has put a basic system in place which promotes continuity of care and case management including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for people with disabilities.

STANDARD XV: QAPI DOCUMENTATION -

A. **scope -** The MCO shall document that it is monitoring the quality of care across all services and all treatment modalities, according to its written QAPI. (The review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.)

B. **maintenance and availability of documentation -** The MCO must maintain and make available to the State, and upon request to the Secretary, studies, reports, protocols, standards, worksheets, minutes, or such other documentation as may be appropriate, concerning its QA activities and corrective actions.

STANDARD XVI: COORDINATION OF QA ACTIVITY WITH OTHER MANAGEMENT ACTIVITY - The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QA activity, are documented and reported to appropriate individuals within the organization and through the established QA channels.

A. QA information is used in recredentialing, recontracting and/or annual performance evaluations.

B. QA activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances.

C. There is a linkage between QA and the other management functions of the health plan such as:

1. network changes;

2. benefits redesign;

3. medical management systems (e.g., pre-certification);

4. practice feedback to physicians;

5. patient education; and

6. member services.

B.4.15 Hysterectomy and Sterilization Procedures and Consent Forms

HYSTERECTOMY RECEIPT OF INFORMATION FORM
FD-189

Federally prescribed documentation regulations for hysterectomies are extremely rigid. Specific Medicaid requirements must be met and documented on the Hysterectomy Receipt of Information Form (FD-189). Any claim (hospital, operating physician, anesthesiologist, clinic, etc) involving hysterectomy procedures must have a properly completed FD-189 attached when submitted for payment. Hysterectomy claims are hard copy restricted; electronic billing is not permitted.

Additional information concerning Medicaid policy governing hysterectomy procedures may be found in Title 10, Subchapter 54, Section V Physicians' Services, included with your manual.

Providers may obtain additional copies of the FD-189 form from the Fiscal Agent; however, photocopies of the FD-189 are acceptable.

A sample of the Hysterectomy Receipt of Information Form and instructions for the form's proper completion are included for reference.

State of New Jersey
Department of Human Services
Division of Medical Assistance
and Health Services

HYSTERECTOMY RECEIPT OF INFORMATION FORM

A woman who has a hysterectomy can never again get pregnant. When you have a hysterectomy, the doctor removes your uterus (womb). You can not have a baby after your uterus is removed and you will not have menstrual periods anymore.

I received the above information orally and in writing from _____
name of clinic or
_____ before my operation was performed.
physician

I talked to _____ about a hysterectomy. _____
name of responsible person(s) *she/he/they*
discussed it with me and gave me a chance to ask questions and answered them for me before the operation.

I have read all of this notice. I agree that it is a true description of what was explained to me by _____ of _____ and that
name of staff member *clinic/hospital/physician*
all my questions were answered to my satisfaction.

I, _____, hereby consent (or did consent) of my own free
name of recipient
will to have a hysterectomy done by _____ and/or
physician
associate(s) or assistant(s) of his or her choice.

I consent (or did consent) to any other medical treatment that the doctor thinks is (was) necessary to preserve my health.

I also consent to the release of this form and other medical records about the operation to representatives of the United States Department of Health and Human Services or employees of programs or projects funded by that Department <u>but only for</u> purposes of determining if Federal laws were observed.

_____ _____
Recipient's Signature **Date: Month/Day/Year**

FD-189 (Rev 7/83) 7472 M ED 7/83

Item-By-Item Instructions for Completing the
Hysterectomy Receipt of Information Form FD-189 (Rev 3/91)

1) ***Name of Clinic or Physician:*** Enter the name of the clinic or physician who provided the information.

2) ***Name of Responsible Person(s):*** Enter the name of the individual who discussed the procedure with the recipient.

3) ***She/He/They:*** Enter appropriate selection.

4) ***Name of Staff Member:*** Enter the name of the individual who explained the procedure to the recipient.

5) ***Clinic/Hospital/Physician:*** Enter the name of the clinic/hospital or physician's office in which the individual who explained the procedure is affiliated.

6) ***Recipient's Name:*** Copy the recipient's name as printed on the Medicaid Identification Card. First name must be entered first.

7) ***Name of Physician:*** Enter the physician's name.

8) ***Recipient's Signature and Date:*** Recipient must personally sign and hand date the completed form.

Consent Form – 7473 M ED

Federally prescribed documentation regulations for sterilization procedures are extremely rigid. Specific Medicaid requirements must be met and documented on the Consent Form prior to the sterilization of an individual.

The Consent Form is a replica of the form contained in the Federal Regulations and must be utilized by providers when submitting claims for sterilization procedures. Any claim (hospital, operating physician, anesthesiologist, clinic, etc) involved in a sterilization procedure must have a properly completed Consent Form attached when it is submitted for payment. Sterilization claims are hard copy restricted; electronic billing is not permitted.

Additional information concerning Medicaid policy governing sterilization procedures may be found in Title 10, Subchapter 54, Section V Physicians' Services, included with you manual.

Providers may obtain additional copies of the Consent Form from the Fiscal Agent; however, photocopies of the Consent Form are acceptable.

A sample of the Consent Form and instructions for the form's proper completion are provided for reference.

CONSENT FORM

NOTICE: YOUR DECISION, AT ANY TIME, NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVEING FEDERAL FUNDS.

CONSENT TO STERILIZATION
STATEMENT OF PERSON OBTAINING CONSENT

I have asked for and received information about sterilization from _____.
doctor or clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with
specify type of operation
the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____.
month/day/year

I, _____, hereby consent of my own free will to be
recipient
sterilized by _____ by a method called
doctor
_____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare or Employees of programs or projects funded by that Department, but only for determining if Federal laws were observed.

_____ Date: _____
signature *month/day/year*

You are requested to supply the following information, but it is not required:
Race and ethnicity designation. Please check one:

[ ] American Indian or Alaska Native
[ ] Asian or Pacific Islander
[ ] Black (not of Hispanic origin)
[ ] Hispanic
[ ] White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ Date: _____
interpreter *month/day/year*

7473-M ED 3/81

Before _____ signed the
name of individual
consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ Date: _____
signature of person obtaining consent *month/day/year*

_____
facility

_____
address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on _____.
name of individual to be sterilized *date of sterilization operation*

I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible
specify type of operation
procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(*Instructions for use of alternative final paragraphs:* Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than thirty (30) days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph that is not used.)

1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.
2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):
   [ ] Premature deliver
   [ ] Individual's expected date of delivery:
   [ ] Emergency abdominal surgery:
   (describe circumstances);

_____ Date: _____
physician *month/day/year*

Item-By-Item Instructions for Completing the
Sterilization Consent Form Section 1 Consent to Sterilization

1) ***Doctor or Clinic:*** Enter the name of the physician or clinic.

2) ***Sterilization Procedure:*** Enter the name of the sterilization procedure.

3) ***Recipient's Date of Birth:*** Enter recipient's date of birth in month, day, and year sequence (mm/dd/yy).

4) ***Recipient's Name:*** Copy the recipient's name as printed on the Medicaid Identification Card. First name must be entered first.

5) ***Doctor:*** Enter physician's name who is performing the procedure

6) ***Type of Sterilization:*** Enter the method of sterilization chosen.

7) ***Recipient's Signature and Date:*** Recipient must personally sign and hand date form at least thirty (30) days, but not more than 180 days prior to surgery.

Section II Race and Ethnicity Designation:

8) ***Race and Ethnicity Designation:*** OPTIONAL INFORMATION requested by the Federal Government, but is NOT required.

Section III Interpreter's Statement: *To be used only when the Recipient does not speak English*

9) ***Language Used:*** Enter language used.

10) ***Interpreter's Signature:*** Interpreter must sign and date form at least thirty (30) days, but not more than 180 days prior to the sterilization procedure.

Section IV Statement of Person Obtaining Consent

11) ***Name of Individual:*** Enter the name of the recipient as it appears in Section I, item 4.

12) ***Sterilization/Operation:*** Enter the name of the sterilization procedure.

13) ***Signature of Person Obtaining Consent:*** Signature and date of the person who explains the procedure to the recipient and obtains the recipient's consent. Must be completed at least thirty (30) days, but not more than 180 days prior to the sterilization procedure.

14) ***Facility's* Name and Address:** Enter the name and address of the facility or physician's office with which the person obtaining the consent is affiliated.

15) ***Name of Individual to be Sterilized:*** Enter the recipient's name as it appears in Section I, item 4.

16) ***Date of Sterilization*:** Enter the date of the sterilization in month, day, and year sequence (mm/dd/yy).

17) ***Specify Type of Operation:*** Enter the name of the sterilization procedure.

18) ***Paragraphs 1) and 2):*** The physician must indicate the paragraph that applies to recipient's situation. Paragraph 1) states that at least thirty (30) days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. Paragraph 2) states that the sterilization was performed less than thirty (30) days, but more than 72 hours after the date of the individual's signature on the consent form. The circumstances are premature delivery (state the expected date of delivery) or emergency abdominal surgery (describe the emergency).

19) ***Physician's Signature and Date:*** Physician must sign and date form after the surgery has been performed.

B.4.16 Regional Child Abuse and Neglect Diagnostic and Treatment Centers

NEW JERSEY CHILD ABUSE REGIONAL DIAGNOSTIC CENTERS

Children's House (serving Bergen, Passaic, Morris, Sussex, Warren and Hudson counties)
Northern Regional Diagnostic Center for Child Abuse and Neglect
Hackensack University Medical Center
300 Atlantic Street
Hackensack, NJ 07601
(201) 966-2271
Fax (201) 996-4926
Clinical Coordinator and Director of Operations – Colleen Kearney, RN, BSN, SANE
Medical Director – Dr. Julia DeBellis
DYFS Contact Person – Deanna Ladas, MSW, LSW

Children's Hospital Abuse Management Program (CHAMP) (serving Essex County)
Children's Hospital of New Jersey at Newark Beth Israel Medical Center
201 Lyons Avenue at Osborne Terrace, 13
Newark, NJ 07112
(973) 926-5590
Fax (973) 923-6487
Program Co-Directors – Dr. Anna Haroutunian and Peggy Foster
Medical Director – Dr. Anna Haroutunian
Supervising Psychologist – Anthony D'Urso
DYFS Contact Person – Doris Chodoreoff, Coordinator; make referrals to her at (973) 926-2266

Central Jersey Regional Child Abuse Center (serving Middlesex, Union, Somerset, Hunterdon, Monmouth, Ocean, and Mercer counties)

(A) Child Protection Center (physical abuse)
mailing address:
Saint Peter's Medical Center
254 Easton Avenue
New Brunswick, NJ 08901
Fax (732) 745-2344
site address:
123 How Lane
New Brunswick, NJ 08901
(732) 745-9449
Program Director – Dr. Bipin Patel, Chairman of the Department of Pediatrics
Medical Co-Directors – Dr. Elizabeth Susan Hodgson and Dr. Cynthia Barabas
DYFS Contact Person – Patti Cizin, RN, CPNP, Program Coordinator

(B) Child Sexual Abuse Program
Robert Wood Johnson Medical School
1 Robert Wood Johnson Place, CN 19
New Brunswick, NJ 08903
(732) 235-6146
Fax (732) 235-6006
Program Director – Dr. Bipin Patel, Chairman, St. Peter's Medical Center Dept. of Peds.
Medical Director – Dr. Linda Shaw
DYFS Contact Persons – Mary Fierro, LCSW, Program Coordinator, Rachel Cohen, MSW, LCSW, or Liana Acosta, BA
clinical sites:

(1) Clinical Academic Building
125 Paterson Street
New Brunswick, NJ 08903

(2) Elizabeth General Medical Center
Elizabeth General East
655 East Jersey Avenue
Elizabeth, NJ 07206

(3) Trenton Health Department
222 East State Street
Trenton, NJ 08608

Center for Children's Support (serving Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, and Salem counties)
University of Medicine and Dentistry of New Jersey – School of Osteopathic Medicine
42 East Laurel Road
Suite 1100
Stratford, NJ 08084
(609) 566-7036
Fax (609) 566-6108
Program and Medical Director – Dr. Martin Finkel
Director of Mental Health Services – Dr. Esther Deblinger
Program Coordinator – Bob Raynor
DYFS Contact Person for medical examination – Gwen Barton, MSW, LCSW
DYFS Contact Person for mental health services – Gladys Rosario, MSEd

B.5.0 ENROLLEE SERVICES

B.5.1 Notification of Newborns

State of New Jersey
Division of Medical Assistance and Health Services

Notification of Newborns

HMO:

Date of Submission: **Acct. Coordinator:**

Mother's HSP	Mother's Name	HMO Effective Date	Newborn's Name	DOB	Sex_

Signature:
Print Name:
Phone:

Date:

B.5.2 Cost-Sharing Requirements for NJ FamilyCare C and D Enrollees

REQUIREMENTS FOR
NJ FAMILYCARE C ENROLLEES

PERSONAL CONTRIBUTION TO CARE (PCC) FOR NJ FAMILYCARE- C Enrollees

For beneficiaries solely eligible through NJ FamilyCare- C, PCCs will be required for certain services provided to individuals whose family income is above 150% and up to and including 200% of the federal poverty level. Exception – Both Eskimos and Native American Indian children under the age of 19, identified by Race Code 3, shall not be required to pay a personal contribution to care.

The total family (regardless of family size) limit on all cost-sharing may not exceed 5% of the annual family income.

Below is listed the services requiring PCCs and the amount of each PCC.

SERVICE	AMOUNT OF PCC
1. Outpatient Hospital Clinic Visits	$5 PCC for each outpatient visit that is not for preventive services
2. Emergency Room Services Covered for Emergency Services only. [Note: Triage and medical screenings must be covered in all situations.]	$10 PCC
3. Physician Services	$5 PCC for each visit (except for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment' age appropriate immunizations; prenatal care; and pap smears, when appropriate.
4. Independent Clinic Services	$5 PCC for each practitioner visit (except for preventive care services)
5. Podiatrist Services	$5 PCC for each visit
6. Optometrist Services	$5 PCC for each visit
7. Chiropractor Services	$5 PCC for each visit
8. Drugs	$1 for generic drugs; $5 for brand name drugs
9. Nurse Midwives	$5 PCC for each visit (except for prenatal care visits)
10. Dentist	$5 PCC for each visit (except for preventive dentistry services)

11. Nurse Practitioners	$5 PCC for each visit (except for preventive care services

COST-SHARING REQUIREMENTS FOR
NJ FAMILYCARE D ENROLLEES

COPAYMENTS FOR NJ FAMILYCARE –D ENROLLEES
Copayments will be required of parents/caretakers solely eligible through NJ FamilyCare D whose family income is between 151% and up to including 200% of the federal poverty level. The same copayments will be required of children solely eligible through NJ FamilyCare D whose family income is between 201% and up to and including 350% of the federal poverty level. Exception – Both Eskimos and Native American Indians under the age of 19 are not required to pay copayments.

The total family limit (regardless of family size) on all cost-sharing may not exceed 5% of the annual family income.

Below is listed the services requiring copayments and the amount of each copayment.

SERVICE	AMOUNT OF COPAYMENT
1. Outpatient Hospital Clinic Visits, including Diagnostic Testing	$5 copayment for each outpatient clinic visit that is not for preventive services
2. Hospital Outpatient Mental Health Visits	$25 copayment for each visit, except CHIP beneficiaries under the age of 19 have a $5 copayment for each visit pursuant to the MHPAEA of 2008.
3 Outpatient Substance Abuse Services for Detoxification	$5 copayment for each visit
4. Hospital Outpatient Emergency Services Covered for Emergency Services only, including services provided in an outpatient hospital department or an urgent care facility. [Note: Triage and medical screenings must be covered in all situations.]	$35 copayment; no copayment is required if the member was referred to the Emergency Room by his/her primary care provider for services that should have been rendered in the primary care provider's office or if the member is admitted into the hospital.
5. Primary Care Provider Services provided during normal office hours	$5 copayment for each visit (except for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; prenatal care; or preventive dental services). The $5 copayment shall only apply to the first prenatal visit.
6. Primary Care Provider Services during non-office hours and for home visits	$10 copayment for each visit
7. Podiatrist Services	$5 copayment for each visit

SERVICE	AMOUNT OF COPAYMENT
8. Optometrist Services	$5 copayment for each visit, except for newborns covered under fee-for-service.
9. Outpatient Rehabilitation Services, including Physical Therapy, Occupational Therapy, and Speech Therapy	$5 copayment for each visit
10. Prescription Drugs	$5 copayment. If greater than a 34-day supply of a prescription drug is dispensed, a $10 copayment applies.
11. Nurse Midwives	$5 copayment for the first prenatal visit; $10 for services rendered during non-office hours and for home visits. No copayment for preventive services or newborns covered under fee-for-service.
12. Physician specialist office visits during normal office hours	$5 copayment per visit
13. Physician specialist office visits during non-office hours or home visits	$10 copayment per visit
14. Nurse Practitioners	$5 copayment for each visit (except for preventive care services) $10 copayment per non-office hour visits
15. Psychologist Services	$5 copayment for each visit
16. Laboratory and X-ray Services	$5 copayment for each visit that is not part of an office visit

B.7.0 Terms And Conditions

B.7.1 Physician Incentive Plan Provisions

The following provides information on the physician incentive payment provisions.

PHYSICIAN INCENTIVE PLAN PROVISIONS

I. GENERAL PROVISIONS

A. In accordance with 42 CFR 417, the contractor may operate a physician incentive plan only if:

1. No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; and

2. The stop-loss protection, enrollee survey, and disclosure requirements of 42 CFR 417.479 are met.

B. The requirements apply to physician incentive plans between the contractor and individual physicians or physician groups with whom they contract to provide medical services to Medicaid enrollees. The requirements also apply to subcontracting arrangements. These requirements apply only to physician incentive plans that base compensation (in whole or in part) on the use or cost of services furnished to Medicaid recipients.

II. PROHIBITED PHYSICIAN PAYMENTS

No specific payment of any kind may be made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit covered medically necessary services covered under the contractor's contract furnished to an individual enrollee. Indirect payments include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

III. DETERMINATION OF SUBSTANTIAL FINANCIAL RISK

Substantial financial risk occurs when the incentive arrangements place the physician or physician group at risk for amounts beyond the risk threshold, if the risk is based on the use or costs of referral services. Amounts at risk based solely on factors other than a physician's or physician group's referral levels do not contribute to the determination of substantial financial risk. The risk threshold is 25 percent.

IV. ARRANGEMENTS THAT CAUSE SUBSTANTIAL FINANCIAL RISK

For purposes of this contract, potential payments means the maximum anticipated total payments (based on the most recent year's utilization and experience and any current or anticipated factors that may affect payment amounts) that could be received if use or costs of referral services were low enough. The following physician incentive plans cause substantial financial risk if risk is based (in whole or in part) on use or costs of referral services and the patient panel size is not greater than 25,000 patients:

A. Withholds greater than 25 percent of potential payments.

B. Withholds less than 25 percent of potential payments if the physician or physician group is potentially liable for amounts exceeding 25 percent of potential payments.

C. Bonuses that are greater than 33 percent of potential payments minus the bonus.

D. Withholds plus bonuses if the withholds plus bonuses equal more than 25 percent of potential payments. The threshold bonus percentage for a particular withhold percentage may be calculated using the formula:

$$\text{Withhold \%} = -0.75\ (\text{Bonus \%}) + 25\%$$

E. Capitation arrangements, if:

1. The difference between the maximum potential payments and minimum potential payments is more than 25 percent of the maximum potential payments; or

2. The maximum and minimum potential payments are not clearly explained in the physician's or physician group's contract.

F. Any other incentive arrangements that have the potential to hold a physician or physician group liable for more than 25 percent of potential payments.

V. REQUIREMENTS FOR PHYSICIAN INCENTIVE PLANS THAT PLACE PHYSICIANS AT SUBSTANTIAL FINANCIAL RISK

A contractor that operates incentive plans that place physicians or physician groups at substantial financial risk must do the following:

A. Conduct enrollee surveys. These surveys must:

1. Include either all current Medicaid enrollees in the contractor's plan and those who have disenrolled (other than because of loss of eligibility in Medicaid or relocation outside the contractor's service area) in the past 12 months, or a sample of these same enrollees and disenrollees;

2. Be designed, implemented, and analyzed in accordance with commonly accepted principles of survey design and statistical analysis;

3. Address enrollees/disenrollees satisfaction with the quality of the services provided and their degree of access to the services; and

4. Be conducted no later than one year after the effective date of this contract, and at least annually thereafter.

B. Ensure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with the following requirements:

1. If aggregate stop-loss protection is provided, it must cover 90 percent of the costs of referral services (beyond allocated amounts) that exceed 25 percent of potential payments.

2. If the stop-loss protection provided is based on a per-patient limit, the stop-loss limit per patient must be determined based on the size of the

patient panel and may be a single combined limit or consist of separate limits for professional services and institutional services. In determining patient panel size, the patients may be pooled, in accordance with Section VI. Stop-loss protection must cover 90 percent of the costs of referral services that exceed the per-patient limit. The per-patient stop-loss limit is as follows:

Panel Size	Single Combined Limit	Separate Institutionalized Limit	Separate Professional Limit
Less than 1,000	$6,000	$10,000	$3,000
1,001 – 5,000	$30,000	$40,000	$10,000
5,001 – 8,000	$40,000	$60,000	$15,000
8,001 – 10,000	$75,000	$100,000	$20,000
10,001 – 25,000	$150,000	$200,000	$25,000
25,001+	None	None	None

VI. DISCLOSURE REQUIREMENTS

A. What must be disclosed to the Department.

1. Information concerning physician incentive plans as required or requested in detail sufficient to enable the Department to determine whether the incentive plan complies with the requirements specified in this Article.

a. Whether services not furnished by the physician or physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of other aspects of the plan need not be made.

b. The type of incentive arrangement (e.g., withhold, bonus, capitation).

c. If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus.

d. Proof that the physician or physician group has adequate stop-loss protection, including the amount, coinsurance and type of stop-loss protection.

e. The panel size and, if patients are pooled, the method used. Pooling is permitted only if: it is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or physician group; the physician or physician group is at risk for referral services with respect to each of the categories of patients being pooled; the terms of the compensation arrangements permit the physician or physician group to spread the risk across the categories of patients being pooled; the distribution of payments to physicians from the risk pool is not calculated separately by patient category; and the terms of the risk borne by the physician or physician group are comparable for all categories of patients being pooled. If these conditions are met, the physician

or physician group may u se either or both of the following to pool patients:

(1) Pooling any combination of commercial, Medicare, or Medicaid patients enrolled in a specific HMO or CMP in the calculation of the panel size.

(2) Pooling together, by a physician group that contracts with more than one HMO, CMP, or health insuring organization (as defined in 42 CFR 438.2), or prepaid health plan (as defined in 42 CFR 438.2) the patients of each of those entities.

f. In the case of capitated physicians or physician groups, capitation payments paid to primary care physicians for the most recent year broken down by percent for primary care services, referral services to specialists, and hospital and other types of provider (for example, home health agency) services.

g. In the case of those prepaid plans that are required to conduct beneficiary surveys, the survey results.

B. When disclosure must be made to the Department.

1. An organization must provide the information required by Section IV.A to the Department.

a. Prior to approval of its contract: [CMS will not approve an HMO's or CMP's contract unless the HMO or CMP has provided the information required in this Section]

b. Upon the contract anniversary or renewal effective date or on request by CMS.

c. Survey results are due three (3) months after the end of the contract year or upon request by CMS.

C. Disclosure to Medicaid enrollees. The contractor must provide the following information to any Medicaid enrollee who requests it:

1. Whether the prepaid plan uses a physician incentive plan that affects the use of referral services.

2. The type of incentive arrangement.

3. Whether stop-loss protection is provided.

4. If the prepaid plan was required to conduct a survey, a summary of the survey results.

VII. REQUIREMENTS RELATED TO SUBCONTRACTING ARRANGEMENTS

A. Physician groups. A contractor that contracts with a physician group that places the individual physician members at substantial risk for services they do not furnish must do the following:

1. Disclose to the Department any incentive plan between the physician group and its individual physicians that bases compensation to the physician on the use or cost of services furnished to Medicaid enrollees. The disclosure must include the information specified in this Section and be made at the times specified herein.

2. Provide adequate stop-loss protection to the individual physicians.

3. Conduct enrollee surveys as specified in Section V.A.

B. Intermediate entities. A contractor that contracts with an entity (other than a physician group and may include an individual practice association and a physician hospital organization) for the provision of services to Medicaid enrollees must do the following:

1. Disclose to the Division any incentive plan between the contractor and a physician or physician group that bases compensation to the physician or physician group on the use or cost of services furnished to Medicaid enrollees. The disclosure must include the information required to be disclosed under this Section and be made at times specified herein.

2. If the physician incentive plan puts a physician or physician group at substantial financial risk for the cost of services the physician or physician group does not furnish:

a. meet the stop-loss protection requirements of this section; and

b. conduct enrollee surveys as specified Section V.A.

C. For purposes of this Section, an entity includes, but is not limited to, an individual practice association that contracts with one or more physician groups and a physician hospital organization.

VIII. SANCTIONS AGAINST THE CONTRACTOR

CMS may apply intermediate sanctions, or the Office of Inspector General may apply civil money penalties described in Article 7.16 if CMS determines that the contractor fails to comply with the requirements of this section.

B.7.2 <u>Provider Contract/Subcontract Provisions</u>

MACBRIDE PRINCIPLES CERTIFICATION FORM

COMPLETE THIS CERTIFICATION IN COMPLIANCE WITH MACBRIDE PRINCIPLES AND NORTHERN IRELAND ACT OF 1989

Pursuant to Public Law 1995, c.134, a contractor must complete the certification below by checking one of the two representations listed and signing where indicated.

I certify, pursuant to N.J.S.A. 52:34-12.2 that the entity for which I am authorized to contract:

____ has no ongoing business activities in Northern Ireland and does not maintain a physical presence therein through the operation of offices, plants, factories, or similar facilities, either directly or indirectly, through intermediaries, subsidiaries or affiliated companies over which it maintains effective control; or

____ will take lawful steps in good faith to conduct any business operations it has in Northern Ireland in accordance with the MacBride principles of nondiscrimination in employment as set forth in N.J.S.A. 52:18A-89.5 and in conformance with the United Kingdom's Fair Employment (Northern Ireland) Act of 1989, and permit independent monitoring of their compliance with those principles.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Signature: **Date:**

Print Name:

Title:

Firm Name:

PROVIDER CONTRACT /SUBCONTRACT PROVISIONS

1. ITEMS TO BE ADDRESSED - ALL PROVIDER CONTRACTS/ SUBCONTRACTS

The State is not specifying verbatim language for the following items, but they must be addressed in all provider contracts/subcontracts, as applicable:

A. Term. The provider contract/subcontract must specify the term of the agreement, including the beginning and ending dates, as well as methods of extension, re-negotiation and termination.

B. Scope of Service. The provider contract/subcontract must define the provider/subcontractor's scope of service (more specific requirements in this area are outlined for FQHC and hospital providers – see Sections 3 and 4 below).

C. Subcontractor Qualifications. A subcontractor performing a specific part of the contractor's obligations shall meet all of the requirements related to the services that the subcontractor is contracting to perform.

D. Reimbursement. The provider contract/subcontract must include a reimbursement schedule and payment policy in compliance with federal and State statutes. The payment description must make clear whether there is financial risk or incentive payments and, if so, what they are specifically. Physician incentive payment plans must comply with the provisions of 42 CFR 417. Reimbursement for FQHCs must be in accordance with Article 8.10.

E. Insurance. The provider contract/subcontract must require appropriate insurance coverage, including professional malpractice insurance, comprehensive general liability insurance, and automobile liability insurance. The minimum coverage for malpractice shall be $1,000,000 per incident/$3,000,000 aggregate. In addition, the provider/subcontractor must agree that any insurance obtained by the provider/subcontractor shall not limit the provider/subcontractor's indemnification of the State and enrollees.

F. Cooperation. The provider contract/subcontract must require the provider/subcontractor's cooperation and participation in the contractor's quality management and utilization management system, including credentialing/recredentialing; appointment standards; and enrollee and provider complaint and grievance system.

G. Encounter Data. In addition to the requirement in 2.N. below to provide encounter data, the provider contract/subcontract must include an incentive system for providers/subcontractors to assure submission of encounter data. At a minimum, the system shall include:

1. Mandatory provider/subcontractor profiling that includes complete and timely submissions of encounter data. Contractor must set specific requirements for profile elements based on data from encounter submissions.

2. Contractor must set up data submission specifications and requirements based on encounter data elements for which compliance performance will be both rewarded and/or sanctioned.

H. Monitoring by Contractor. The provider contract/subcontract shall acknowledge that the responsibilities performed by the provider/subcontractor are monitored on an ongoing basis and that the contractor is ultimately responsible to the Department for the performance of all services. It must include provisions for monitoring the performance of its providers/subcontractors and ensuring that performance is consistent with the contract between the contractor and the Department. This shall include the contractor's right to revoke the provider contract/subcontract if the provider/subcontractor does not perform satisfactorily. If the provider contract/subcontract provides for the selection of providers, the provider contract/subcontract must state that the contractor retains the right to approve, suspend, or terminate any such arrangement.

I. Monitoring/Enforcement by State. The provider contract/subcontract shall provide that the Department may require the contractor to terminate the provider contract/subcontract if performance is not consistent with the contract between the contractor and the Department.

J. Notice. The provider contract/subcontract must require the provider/subcontractor to notify the contractor of any change in licensing or hospital admitting status.

K. Equality of Access. Unless a higher standard is required by the contractor's contract with the State, the provider/subcontractor shall provide the same level of medical care and health service to DMAHS enrollees as it does to enrollees under private or group contracts.

L. Severability. The provider contract/subcontract must include a severability clause.

M. Amendments. The provider contract/subcontract must include provisions regarding contract amendments and modifications.

N. Termination. The provider contract/subcontract must specify procedures and criteria for terminating the contract, including suspension, termination, or exclusion from a state or federal health care program and the requirements in 2.G. and H. below

O. Such other information as may be required for provider contracts/subcontracts by other sections in this contract.

2. REQUIRED LANGUAGE – ALL PROVIDER CONTRACTS AND SUBCONTRACTS

The following text must be included verbatim in all provider contracts and subcontracts (to the extent applicable to the provider contract/subcontract). The language either may be included in the body of the provider contract/subcontract or as an amendment.

The provider/subcontractor agrees to serve enrollees in New Jersey's managed care program and, in doing so, to comply with all of the following provisions:

A. SUBJECTION OF PROVIDER CONTRACT/SUBCONTRACT

This provider contract/subcontract shall be subject to the applicable material terms and conditions of the contract between the contractor and the State and shall also be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the contractor.

B. COMPLIANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS

The provider/subcontractor agrees that it shall carry out its obligations as herein provided in a manner prescribed under applicable federal and State laws, regulations, codes, and guidelines including New Jersey licensing board regulations, the Medicaid, NJ KidCare, and NJ FamilyCare State Plans, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services.

C. APPROVAL OF PROVIDER CONTRACTS/SUBCONTRACTS AND AMENDMENTS

The provider/subcontractor understands that the State reserves the right in its sole discretion to review and approve or disapprove this provider contract/subcontract and any amendments thereto.

D. EFFECTIVE DATE

This provider contract/subcontract shall become effective only when the contractor's agreement with the State takes effect.

E. NON-RENEWAL/TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT

The provider/subcontractor understands that the contractor shall notify DMAHS at least 30 days prior to the effective date of the suspension, termination, or voluntary withdrawal of the provider/subcontractor from participation in the contractor's network. If the termination was "for cause," the contractor's notice to DMAHS shall include the reasons for the termination. Provider resource consumption patterns shall not constitute "cause" unless the contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers.

F. ENROLLEE-PROVIDER COMMUNICATIONS

1. The contractor shall not prohibit or restrict the provider/subcontractor from engaging in medical communications with the provider's/subcontractor's patient, either explicit or implied, nor shall any provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication prohibit medical communication between the provider/subcontractor and the provider's/subcontractor's patient.

Providers/subcontractors shall be free to communicate freely with their patients about the health status of their patients, medical care or treatment options regardless of whether benefits for that care or treatment are provided under the provider contract/subcontract, if the professional is acting within the lawful scope of practice. Providers/subcontractors shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.

2. Nothing in section F.1 shall be construed:

   a. To prohibit the enforcement, including termination, as part of a provider contract/subcontract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by the contractor to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider), but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers/subcontractors and their patients; or

   b. To permit a health care provider to misrepresent the scope of benefits covered under this provider contract/subcontractor or to otherwise require the contractor to reimburse providers/subcontractors for benefits not covered.

G. RESTRICTION ON TERMINATION OF PROVIDER CONTRACT/ SUBCONTRACT BY CONTRACTOR

The contractor shall not terminate this provider contract/subcontract for either of the following reasons:

1. Because the provider/subcontractor expresses disagreement with the contractor's decision to deny or limit benefits to a covered person or because the provider/subcontractor assists the covered person to seek reconsideration of the contractor's decision; or because the provider/subcontractor discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the contractor or not, policy provisions of the contractor, or the provider/subcontractor’s personal recommendation regarding selection of a health plan based on the provider/subcontractor’s personal knowledge of the health needs of such patients.

2. Because the provider/subcontractor engaged in medical communications, either explicit or implied, with a patient about medically necessary treatment options, or because the provider/subcontractor practiced its

profession in providing the most appropriate treatment required by its patients and provided informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

H. TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT – STATE

The provider/subcontractor understands and agrees that the State may order the termination of this provider contract/subcontract if it is determined that the provider/subcontractor:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any enrollee, including significant marketing abuses;

2. Takes any action that threatens the fiscal integrity of the Medicaid program;

3. Has its certification suspended or revoked by DOBI, DHSS, and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;

4. Becomes insolvent or falls below minimum net worth requirements;

5. Brings a proceeding voluntarily or has a proceeding brought against it involuntarily, under the Bankruptcy Act;

6. Materially breaches the provider contract/subcontract; or

7. Violates state or federal law.

I. NON-DISCRIMINATION

The provider/subcontractor shall comply with the following requirements regarding nondiscrimination:

1. The provider/subcontractor shall accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

2. ADA Compliance. The provider/subcontractor shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the provider/subcontractor shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are

"qualified individuals with a disability" covered by the provisions of the ADA. The contractor shall supply a copy of its ADA compliance plan to the provider/subcontractor.

A "qualified individual with a disability" as defined pursuant to 42 U.S.C.§12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

The provider/subcontractor shall submit to [insert name of HMO] a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and certifies that the provider/subcontractor meets ADA requirements to the best of the provider/subcontractor's knowledge. The provider/subcontractor warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the provider/subcontractor to be in compliance with the ADA. Where applicable, the provider/subcontractor must abide by the provisions of section 504 of the federal Rehabilitation Act of 1973, as amended, regarding access to programs and facilities by people with disabilities.

3. The provider/subcontractor shall not discriminate against eligible persons or enrollees on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the provider/subcontractor on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4. The provider/subcontractor shall comply with the Civil Rights Act of 1964 (42 USC 2000d), the regulations (45 CFR Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10: 2-1 through N.J.S.A. 10: 2-4, N.J.S.A. 10: 5-1 et seq. and N.J.S.A. 10: 5-38, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. The provider/subcontractor shall not discriminate against any employee engaged in the work required to produce the services covered by this provider/subcontractor contract, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, marital status, religion, disability or sexual or affectional orientation or preference.

5. Scope. This non-discrimination provision shall apply to but not be limited to the following: recruitment, hiring, employment upgrading, demotion, transfer, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship included in PL 1975, Chapter 127.

6. Grievances. The provider/subcontractor agrees to forward to [insert HMO name] copies of all grievances alleging discrimination against enrollees because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental handicap for review and appropriate action within three (3) business days of receipt by the provider/subcontractor.

J. OBLIGATION TO PROVIDE SERVICES AFTER THE PERIOD OF THE CONTRACTOR'S INSOLVENCY AND TO HOLD ENROLLEES AND FORMER ENROLLEES HARMLESS

1. The provider/subcontractor shall remain obligated to provide all services for the duration of the period after the contractor's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized enrollee, until the enrollee has been discharged from the inpatient facility.

2. The provider/subcontractor agrees that under no circumstances, (including, but not limited to, nonpayment by the contractor or the state, insolvency of the contractor, or breach of agreement) will the provider/subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for covered services other than provided in section 2.P.

3. The provider/subcontractor agrees that this provision shall survive the termination of this provider contract/subcontract regardless of the reason for termination, including insolvency of the contractor, and shall be construed to be for the benefit of the contractor or enrollees.

4. The provider/subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the provider/subcontractor and enrollees, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services provided under the terms and conditions of this continuation of benefits provisions.

5. The provider/subcontractor agrees that any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the approval by the State.

6. The provider/subcontractor shall comply with the prohibition against balance billing as described within the payment in-full provision of N.J.S.A. 30:4D-6(c).

K. INSPECTION

The provider/subcontractor shall allow the New Jersey Department of Human Services, the U.S. Department of Health and Human Services (DHHS), and other authorized State agencies, or their duly authorized representatives, to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the provider contract/subcontract, and to inspect, evaluate, and

audit any and all books, records, and facilities maintained by the provider/subcontractor pertaining to such services, at any time during normal business hours (and after business hours when deemed necessary by DHS or DHHS) at a New Jersey site designated by the State. Inspections may be unannounced for cause.

The subcontractor shall also permit the State, at its sole discretion, to conduct onsite inspections of facilities maintained by the provider/subcontractor, prior to approval of their use for providing services to enrollees.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this provider contract/subcontract, including working papers, reports, financial records and books of account, medical records, dental records, prescription files, provider contracts and subcontracts, credentialing files, and any other documentation pertaining to medical, dental, and nonmedical services to enrollees. Upon request, at any time during the period of this provider contract/subcontract, the provider/subcontractor shall furnish any such record, or copy thereof, to the Department or the Department's External Review Organization within 30 days of the request. If the Department determines, however, that there is an urgent need to obtain a record, the Department shall have the right to demand the record in less than 30 days, but no less than 24 hours.

L. RECORD MAINTENANCE

The provider/subcontractor shall agree to maintain all of its books and records in accordance with the general standards applicable to such book or record keeping.

M. RECORD RETENTION

The provider/subcontractor hereby agrees to maintain an appropriate recordkeeping system for services to enrollees. Such system shall collect all pertinent information relating to the medical management of each enrolled beneficiary and make that information readily available to appropriate health professionals and the Department. Records must be retained for the later of:

1. Five (5) years from the date of service, or

2. Three (3) years after final payment is made under the provider contract/subcontract and all pending matters are closed.

If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site and on request to agencies of the State of New Jersey and the federal government. For enrollees who are eligible through the Division of Youth and Family Services, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with need to protect the enrollee's confidentiality.

If an enrollee disenrolls from the contractor, the provider/subcontractor shall release medical records of the enrollee as may be directed by the enrollee,

authorized representatives of the Department and appropriate agencies of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Section 2.R., Confidentiality, and at no cost to the enrollee.

N. DATA REPORTING

The provider/subcontractor agrees to provide all necessary information to enable the contractor to meet its reporting requirements, including specifically with respect to encounter reporting. The encounter data shall be in a form acceptable to the State.

O. DISCLOSURE

1. The provider/subcontractor further agrees to comply with the Prohibition On Use Of Federal Funds For Lobbying provisions of the contractor's agreement with the State.

2. The provider/subcontractor shall comply with financial disclosure provision of 42 CFR 434, 1903 (m) of the S.S.A., and N.J.A.C. 10:49-19.

3. The provider/subcontractor shall comply with the disclosure requirements concerning ownership and control, related business transactions and persons convicted of a crime pursuant to 42 CFR 455.100-106.

P. LIMITATIONS ON COLLECTION OF COST-SHARING

The provider/subcontractor shall not impose cost-sharing charges of any kind upon Medicaid or NJ FamilyCare A and B enrollees. Personal contributions to care for NJ FamilyCare C enrollees and copayments for NJ FamilyCare D enrollees shall be collected in accordance with the attached schedule.

Q. INDEMNIFICATION BY PROVIDER/SUBCONTRACTOR

1. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents from any and all claims or losses accruing or resulting from its negligence in furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

2. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from liability deriving or resulting from its insolvency or inability or failure to pay or reimburse any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

3. The provider/subcontractor agrees further that it will indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any and all claims for services for which the provider/subcontractor receives payment.

4. The provider/subcontractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished to it under this provider contract/subcontract, or for any libelous or otherwise unlawful matter contained in such data that the provider/subcontractor inserts.

5. The provider/subcontractor shall indemnify the State, its officers, agents and employees, and the enrollees and their eligible dependents from any injury, death, losses, damages, suits, liabilities judgments, costs and expenses and claim of negligence or willful acts or omissions of the provider/subcontractor, its officers, agents, and employees arising out of alleged violation of any State or federal law or regulation. The provider/subcontractor shall also indemnify and hold the State harmless from any claims of alleged violations of the Americans with Disabilities Act by the subcontractor/provider.

R. CONFIDENTIALITY

1. General. The provider/subcontractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of the provider/subcontractor and the contractor and Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 (g) and N.J.A.C. 10:49-9.4. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of this provider contract/subcontract including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by the contractor's plan that are eligible through the Division of Youth and Family Services, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with the need to protect the enrollee's confidentiality.

2. Enrollee-Specific Information. With respect to any identifiable information concerning an enrollee that is obtained by the provider/subcontractor, it: (a) shall not use any such information for any purpose other than carrying out the express terms of this provider contract/subcontract; (b) shall promptly transmit to the Department all requests for disclosure of such information; (c) shall not disclose except as otherwise specifically permitted by the provider contract/subcontract, any such information to any party other than the Department without the Department’s prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., and (d) shall, at the expiration or termination of the provider contract/subcontract, return all

such information to the Department or maintain such information according to written procedures sent by the Department for this purpose.

3. Employees. The provider/subcontractor shall instruct its employees to keep confidential information concerning the business of the State, its financial affairs, its relations with its enrollees and its employees, as well as any other information which may be specifically classified as confidential by law.

4. Medical Records and management information data concerning enrollees shall be confidential and shall be disclosed to other persons within the provider's/subcontractor's organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of this provider contract/subcontract.

5. The provisions of this article shall survive the termination of this provider contract/subcontract and shall bind the provider/subcontractor so long as the provider/subcontractor maintains any individually identifiable information relating to Medicaid/NJ FamilyCare beneficiaries.

6. Notification in Case of Breach. Should there be a breach of confidentiality with respect to the data, information or records described in this section, the provider/subcontractor is responsible for complying, at a minimum, with the following statues and regulations: (1) Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), 42 U>S>C> 17932 et. seq. and the implementing regulations at 45 CFR Part 164, subpart D; and (2) the Identity Theft Prevention Act, N.J.S.A. 56:11-44 et. seq.

S. CLINICAL LABORATORY IMPROVEMENT

The provider/subcontractor shall ensure that all laboratory testing sites providing services under this provider contract/subcontract have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratory service providers with a certificate of waiver shall provide only those tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

T. FRAUD AND ABUSE

1. The provider/subcontractor agrees to assist the contractor as necessary in meeting its obligations under its contract with the State to identify, investigate, and take appropriate corrective action against fraud and/or abuse (as defined in 42 CFR 455.2) in the provision of health care services.

2. If the State has withheld payment and/or initiated a recovery action against the provider/subcontractor, or withheld payments pursuant to 42 CFR 456.23 and NJAC 10:49-9.10(a), the contractor shall have the right to

withhold payments from the provider/subcontractor and/or forward those payments to the State.

U. THIRD PARTY LIABILITY

1. The provider/subcontractor shall utilize, whenever available, and report any other public or private third party sources of payment for services rendered to enrollees.

2. Except as provided in subsection 3. below, if the provider/subcontractor is aware of third party coverage, it shall submit its claim first to the appropriate third party before submitting a claim to the contractor.

3. In the following situations, the provider/subcontractor may bill the contractor first and then coordinate with the liable third party, unless the contractor has received prior approval from the State to take other action.

    a. The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.
    b. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.
    c. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay.

    d. The claim is for a child who is in a DYFS supported out of home placement.
    e. The claim involves coverage or services mentioned in 3.a, 3.b, 3.c, or 3.d, above in combination with another service.

4. If the provider/subcontractor knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, the provider/subcontractor may bill the contractor without having received a written denial from the third party.

5. Sharing of TPL Information by the Provider/Subcontractor.

    a. The provider/subcontractor shall notify the contractor within thirty (30) days after it learns that an enrollee has health insurance coverage not reflected in the health insurance provided by the contractor, or casualty insurance coverage, or of any change in an enrollee's health insurance coverage.
    b. When the provider/subcontractor becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, the provider/subcontractor shall notify the contractor in writing, including the enrollee's name and Medicaid identification number, date of accident/incident, nature of injury, name and address of enrollee's legal representative, copies of pleadings, and any other documents related to the action in the provider's/subcontractor's possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the

c. The provider/subcontractor shall notify the contractor within thirty (30) days of the date it becomes aware of the death of one of its Medicaid enrollees age 55 or older, giving the enrollee's full name, Social Security Number, Medicaid identification number, and date of death.

d. The provider/subcontractor agrees to cooperate with the contractor's and the State's efforts to maximize the collection of third party payments by providing to the contractor updates to the information required by this section.

V. ENROLLEE PROTECTIONS AGAINST LIABILITY FOR PAYMENT

1. As a general rule, if a participating or non-participating provider renders a covered service to a managed care enrollee, the provider's sole recourse for payment, other than collection of any authorized cost-sharing and /or third party liability, is the contractor, not the enrollee. A provider may not seek payment from, and may not institute or cause the initiation of collection proceedings or litigation against, an enrollee, an enrollee's family member, any legal representative of the enrollee, or anyone else acting on the enrollee's behalf unless subsections (a) through and including (f) or subsection (g) below apply:

   a. (1) The service is not a covered service; or (2) the service is determined to be medically unnecessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and

   b. The enrollee is informed in writing before the service is rendered that one or more of the conditions listed in subsection (a) above exist, and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges; and

   c. The service is not an emergency or related service covered by the provisions of 42 USC 1396u-2(b)(2)(A)(i) , 42 CFR 438.114 and/or NJAC 10:74-9.1; and

   d. The service is not a trauma service covered by the provisions of NJAC 11:24-6.3(a)3.i; and

   e. The protections afforded to enrollees under 42 USC 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9, and/or NJAC 11:24-15.2(b)7.ii do not apply; and

   f. The provider has received no program payments from either DMAHS or the contractor for the service; or

   g. The enrollee has been paid for the service by a health insurance company or other third party (as defined in NJSA 30:4D-3.m), and the enrollee has failed or refused to remit to the provider that portion of the third party's payment to which the provider is entitled by law.

2. Notwithstanding any provision in this contract to the contrary, an enrollee shall not be responsible for the cost of care, except for any authorized cost-sharing, under the following circumstances:

a. The services are provided in association with an emergency department visit or inpatient stay at a participating network hospital, whether or not the servicing provider(s) or the admitting physician is a participating provider in the contractor's network; or

b. The enrollee obtains a referral/authorization for services by, and schedules an appointment with, a participating specialist, but a non-participating specialist affiliated with the same practice as the participating specialist renders the services because the participating specialist is not available.

3. FQHC PROVIDER CONTRACTS/SUBCONTRACTS

In addition to the provisions described in Sections 1 and 2, FQHC provider contract/subcontracts must:

A. List each specific service to be covered.

B. Include the credentialing requirements for individual practitioners.

C. Include an assurance that continuation of the FQHC contract is contingent on maintaining quality services and maintaining the Primary Care Evaluation Review (PCER) by the federal government at a good quality level. FQHCs must make available to the contractor the PCER results annually which shall be considered in the contractor's QM reviews for assessing quality of care.

4. HOSPITAL PROVIDER CONTRACT/SUBCONTRACTS

In addition to the provisions described in Sections 1 and 2, hospital provider contract/subcontracts must comply with all of the following:

A. Hospital contracts shall list each specific service to be covered including:

1. Inpatient services;
2. Anesthesia and whether professional services of anesthesiologists and nurse anesthetists are included;
3. Emergency room services
   a. Triage fee - whether facility and professional fees are included;
   b. Medical screening fee - whether facility and professional fees are included;
   c. Specific treatment rates for:
      (1) Emergent services
      (2) Urgent services
      (3) Non-urgent services
      (4) Other
   d. Other - must specify
4. Neonatology - facility and professional fees
5. Radiology
   a. Diagnostic
   b. Therapeutic
   c. Facility fee
   d. Professional services

6. Laboratory - facility and professional services
7. Outpatient/clinic services must be specific and address
   a. School based service programs
   b. Audiology therapy and therapists
8. AIDS Centers
9. Any other specialized service or center of excellence
10. Hospice services if the hospital has an approved hospice agency which is Medicare certified.
11. Home Health agency services if hospital has an approved home health agency license from the Department of Health and Senior Services which meets licensing and Medicare certification participation requirements.
12. Any other service.

B. The contractor shall pay for all medical screening services rendered to its enrollees by hospitals and emergency room physicians. The amount and method of reimbursement for medical screenings shall be subject to negotiation between the contractor and the hospital and directly with non-hospital-salaried emergency room physicians and shall include reimbursement for urgent care and non-urgent care rates. Additional fees for additional services may be included at the discretion of the contractor and the hospital.

C. Prior authorization for medical screenings, emergency care, or urgent care situations at the hospital emergency room shall not be required. The hospital emergency room physician may determine the necessity for contacting the PCP or the contractor for information about a patient who presents with an urgent condition.

5. PCP PROVIDER CONTRACTS/SUBCONTRACTS

In addition to the provisions in 1 and 2, PCP provider contracts/subcontracts shall include the responsibilities of the PCP, including that the PCP shall:

A. Supervise, coordinate, and manage enrollee's care

B. Maintain the enrollee's medical record

C. Provide 24 hour/7 day a week access

D. Make referrals for specialty care

B.7.37 DISCLOSURE STATEMENT OF OWNERSHIP AND CONTROL INTEREST, RELATED BUSINESS TRANSACTIONS AND PERSONS CONVICTED OF A CRIME.

This form shall be submitted to the DMAHS annually and upon request. For definitions, procedures and requirements refer to 42 CFR 455.100-106 (copy attached). **ATTACH SEPARATE SHEETS**

I. Identifying Information of Disclosing Entity (HMO)

Name of Disclosing Entity (HMO) and D/B/A

_____

_____

Street Address City County State Zip Code

_____

Telephone No. Medicaid Provider No.

II. Ownership and Control Interest

List the name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more and the relationship to another as spouse, parent, child, or sibling.

NAME	ADDRESS	RELATIONSHIP

Also, list the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must keep copies of all these requests and the responses to them; make them available to the Secretary or the Medicaid agency upon request; and advise the Medicaid agency when there is no response to a request.

NAME	ADDRESS	RELATIONSHIP

III. Disclosure by Contractor: Information related to business transactions.

Provide ownership information of
(1) Any subcontractor with whom the contractor has had business transactions totaling more than $ 25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between the contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5-year period ending on the date of the request.

NAME	ADDRESS	OWNERSHIP

Disclose information on types of transactions with a "party in interest" as defined in Section 1318(b) of the Public Health Service Act (Section 1903(m)(4)(A) of the Social Security Act).

IV. Disclosure of Information on persons convicted of crimes.

Identity of any person who has ownership or control interest in the HMO, or is an agent or managing employee of the HMO; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

Are there any directors, officers, agents, or managing employees of the HMO who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

Yes ___ No ___ If yes, list names and addresses of individuals or corporations.

_____
_____
_____
_____
_____
_____
_____
_____

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed), Title and HMO

_____

Signature, Date

_____

ATTACH SEPARATE SHEETS

REMARKS:

B.7.5 EPSDT Codes

EPSDT RELATED PROCEDURE CODES
CMS DESIGNATIONS AND EPSDT AND LEAD SCREENING PERFORMANCE CRITERIA

MEDICAL	DENTAL	LEAD SCREENING	AGE GROUPINGS	NJ PERIODICITY SCHEDULE
Age Groupings: Birth to 20 years Procedure codes: 99381 to 99385; 99391 to 99395; **99201 to 99205 **99211 to 99215 **99420 99460,99461,99462Claim Type (03) and Dx Code: V20-V202; V700; or V703-V709 and Rev Code of OP510, OP515; **Must have Dx Code: V20-V202; V700; V703-V709; V30-V34, V36	Any Dental Service: D0100 to D9999; 00100 to 09999; Y2105 to Y3005; Preventive Dental: D1000 to D1999; 01000 to 01999; Y2105 to Y2125; Treatment Services: D2000 to D9999; 02000 to 09999; Y2505 to Y3005 7/1/03 implement ADA codes, alpha-numeric changing initial "0" to "D". Effective 7/1/03 following codes are replaced: Y2115 to D1510 52 Y2125 to D9999 22 Y2505 to D5899 22 Y2105 76 to D4355 76	Age Groupings: 1 yr through 5 yrs. Procedure Code: 83655 <u>and Dx code is NOT</u> 984.0 to 984.9; E861.5; or E866.0; *36405 59; *36415 59 **83655 52; ***36406 59; ***36415 59; ***36416 59 Effective Dates: *10/1/00; **7/1/02; ***9/03	< 1 year 1-2 years 3-5 years 6-9 years 10-14 years 15-18 years 19-20 years	Birth Under 6 weeks 2 months 4 months 6 months 9 months 12 months 15 months 18 months 24 months Then annually through 20 years of age.

EPSDT AND LEAD SCREENING PERFORMANCE CRITERIA

Health plan EPSDT and lead screening performance is measured using a two part process that:

1. Identifies the total eligible population during a calendar year, and
2. Applies HEDIS measurement criteria and CMS diagnosis and procedure codes to the total populations encounter data for the same period.

CMS – recognized CPT – 4 and HCPC/ADA (dental) codes and HEDIS measurement criteria are frequently updated. The State of New Jersey, DMAHS uses the latest information available in the performance calculations each calendar year.

DMAHS data specifications for EPSDT and lead screenings performance measurement are as follows:

<u>Data Specifications</u>

1. EQRO Validated HEDIS 2010, Technical Specifications for the Following Categories:
   a. Well Child Visits by age range: 1) 0-15 months, 2) 3 – 6 years, 3) 12 – 21 years
   b. Childhood Immunization Status, Combination 3
   c. Annual Dental Visits in Children: 1) Plans A, B, C under age 21, 2) Plan D between 2 – 12 years of age
   d. Lead Screening in Children Up to and including 24 months of age.

2. Other Measurement Considerations
   - One of the data months must be December
   - The child's age for the HEDIS age range must be determined as of December 31
   - Exclude NJ FamilyCare D children 12 years and over from the Dental calculation.

B.7.13 FORM OF AGREEMENT CONCERNING CONTRACTUAL GUARANTY FOR HMO

This Agreement dated the _____day of _____, is made by HMO, a New Jersey health maintenance organization created pursuant to N.J.S.A. 26:2J-1, et seq. (hereinafter referred to as the "Contractor") and Parent Corporation, a (blank) corporation (hereinafter referred to as the "Guarantor"), and The State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services (hereinafter referred to as "DMAHS"); and

WHEREAS, the Contractor is a duly licensed New Jersey HMO and has entered into a contract with DMAHS to provide health services to beneficiaries of New Jersey Medicaid and New Jersey FamilyCare (hereinafter referred to as the "Contract"); and

WHEREAS, the Contract provides for certain requirements such as the submission of encounter data (as defined in the Contract) to DMAHS and sets forth certain provisions for financial withholds, sanctions and liquidated damages for failure to comply with the contractual requirements with respect thereto; and

WHEREAS, the Contract provides for certain supplemental payments to the Contractor which are subject to financial reconciliations through a process outlined in the Contract; and

WHEREAS, the Contract allows for the offset of monthly premium paid by DMAHS to the Contractor to satisfy any withholds, sanctions, liquidated damages and the recovery of overpayments; and

WHEREAS, the Contractor has entered into a transaction to sell certain of its assets to a third party, including the right to serve its New Jersey Medicaid/NJ FamilyCare membership; and

WHEREAS, the above referenced transaction will result in all Medicaid/NJ FamilyCare membership being transitioned from the Contractor to the third party as of (blank date); and

WHEREAS, the termination of the Contract will occur on a future date following the sale of the Contractor's assets and the Contractor has certain post-sale requirements to satisfy including to continue to file encounter data until such data is complete and accurate ("Post-Sale Obligations"); and

WHEREAS, there is an on-going reconciliation of overpayments and potential underpayments between the Contractor and DMAHS ("Reconciliation"); and

WHEREAS, there is no contractual mechanism for the application of an encounter withhold or collection of sanctions, liquidated damages or reimbursement of overpayments for the period of time when the Contractor is no longer receiving monthly premium payments from DMAHS; and

WHEREAS, DMAHS has expressed its intent to offset future estimated withholds and an acknowledged overpayment from Contractor's (blank date) monthly premium payment; and

WHEREAS, all parties recognize that this proposed offset would negatively impact Contractor's cash flow; and

WHEREAS, Guarantor holds (blank)% of the outstanding stock of the Contractor and has entered into a parental guaranty covering the financial requirements established by the New Jersey Department of Banking and Insurance; and

WHEREAS, the Guarantor is willing to guarantee for the period of Post-Sale Obligations the payment of any sanctions, liquidated damages imposed or assessed by DMAHS and refunds of any overpayments to DMAHS, and is also willing to fund withhold amounts as may be contractually determined after all dispute mechanisms have been exhausted.

NOW, THEREFORE, the parties agree as follows:

1. DMAHS agrees to invoice Guarantor and Contractor for any amounts due under the Contract related to the encounter data submission requirements; including any withhold amounts that have been finally determined through the procedures set forth in the Contract to be due from Contractor pursuant to the terms of the Contract.

2. DMAHS agrees to invoice Guarantor and Contractor for any amounts that may be due to it resulting from the Reconciliation. If any amounts have been offset from the Contractor's (blank date) premium payment pending the implementation of this Agreement, DMAHS agrees that it will subsequently refund such to the Contractor once this Agreement is fully executed.

3. Both Contractor and Guarantor agree, jointly and severally, that payment will be made to DMAHS for such invoiced amounts within 20 business days of receipt of the invoice, notwithstanding the status of the Contract.

4. Any subsequent reimbursements contractually determined to be due to Contractor from DMAHS shall be paid to Contractor within 20 business days.

5. Any disputes between the parties will be resolved in accordance with the terms of the Contract and New Jersey law.

6. Invoices are to be mailed as follows:
    a. From date of signature of this Agreement to (blank) – HMO; ATTN: (blank)
    b. From (blank) forward – (blank), ATTN: (blank)

7. Payments are to be mailed to State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services, ATTN: (blank), 5 Quakerbridge Plaza, Post Office Box 712, Trenton, New Jersey 08625.

8. Any refunds relating to the invoiced amounts shall be paid as set forth in paragraph 4. above.

9. All parties agree to notify each other promptly of any changes to addresses for invoicing and payment.

10. All parties understand that the payment of any invoice pursuant to the terms of this Agreement does not automatically mean that either the Contractor or the Guarantor agree with DMAHS's determination and, as set forth above, Contractor and Guarantor hereby reserve the right to dispute any such amount in accordance with the terms set forth in the Contract in effect on (blank) or otherwise applicable to the amount in dispute notwithstanding the then status of the Contract.

11. Nothing in this Agreement shall preclude DMAHS from utilizing any federal or state statutory or regulatory remedy in the event of a Contractor or Guarantor breach of any

provision of this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement to be effective as of the date first written above.

PARENT CORPORATION	DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
By:_____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____

HMO

By: _____

Name: _____

Title: _____

SECTION C
CAPITATION RATES

MANAGED CARE CAPITATION BASE RATES SFY2011, CRCS 3.1

Category	Benefit Plan	Age/Sex	Rating District	SFY11 Rates
Children (< 21 yrs of age) in AFDC, NJ Care, DYFS or KidCare A-C	Plan A, B, C	< 21 M&F	Statewide	$ 143.43
Parents in AFDC (greater than 21 years of age), or all ages in NJCPW	Plan A	21+ M&F	Statewide	$ 353.24
KidCare D	Plan D	< 21 M&F	Statewide	$ 126.17
FamilyCare Parents 0-200% / FC Adults 0-100% and Hlth Access	Plan D	21+ M&F	Statewide	$ 237.95
ABD with Medicare and Other Dual Eligibles	Plan A	All	Statewide	$ 168.53
ABD without Medicare	Plan A	All	Statewide	$ 595.46
Maternity		All	Northeastern	$ 13,028.48
Maternity		All	Northwestern	$ 13,131.95
Maternity		All	Central	$ 14,164.61
Maternity		All	South Central	$ 14,320.24
Maternity		All	Southern	$ 14,257.99
ABD with Medicare DDD, All, Add-on		All	Statewide	$ 9.51
ABD without Medicare DDD / Non-ABD DDD, All, Add-on		All	Statewide	$ 29.10
All Categories Rate Cell Based on Projected SFY11 Enrollment	All	All	Statewide	$ 239.63

SECTION D
CONTRACTOR'S DOCUMENTATION

D.1 <u>Contractor's QAPI/Utilization Management Plans</u>

(To be inserted)

D.2 Contractor's Grievance Process

(To be inserted)

D.3 <u>Contractor's Provider Network</u>

(To be inserted)

D.4 <u>Contractor's List of Subcontractors</u>

(To be inserted)

D.5 <u>Contractor's Supplemental Benefits</u>

(To be inserted)

D.6 <u>Contractor's Representative</u>

(To be inserted)