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	Version 2.4	

TEXAS HEALTH AND HUMAN SERVICES

DOCUMENT HISTORY LOG

STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
Baseline	2.0	March 1, 2012	<p>Initial version: Uniform Managed Care Manual, Chapter 5.11, "Affiliate Report."</p> <p>Chapter 5.11 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, and 529-12-0003.</p>
Revision	2.1	March 1, 2012	<p>"Applicability of Chapter 5.11" is amended to remove references to CHIP Perinatal as a program and to add Children's Medicaid Dental Services.</p> <p>Section I, "Report Schedule" is amended to clarify the reporting requirements and due dates.</p> <p>Section II, "Report Contents" is amended to clarify the requirements regarding hospital affiliates.</p> <p>Section III, "Signed Attestation" is added.</p>
Revision	2.2	September 1, 2012	<p>"Applicability of Chapter 5.11" is amended.</p> <p>Section I, "Report Schedule" is modified to change the annual report due date from August 31 to September 1.</p>
Revision	2.3	October 15, 2014	<p>Revision 2.3 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, 529-12-0003, and 529-13-0042; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.</p> <p>"Applicability of Chapter 5.11" is modified to add the Medicare-Medicaid Dual Demonstration.</p>
Revision	2.4	November 15, 2015	<p>Revision 2.4 applies to contracts issued as a result of HHSC RFP numbers 529-08-0001, 529-10-0020, 529-12-0002, 529-12-0003, 529-13-0042, 529-13-0071, and 529-15-0001; and to</p>



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STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
			Medicare-Medicaid Plans (MMPs) in the Dual Demonstration. "Applicability of Chapter 5.11" is modified to add the STAR Kids Program.

¹ Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.

² Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.

³ Brief description of the changes to the document made in the revision.



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Applicability of Chapter 5.11

Applicability Modified by Versions 2.1, 2.2, 2.3, and 2.4

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR, STAR+PLUS (including the Medicare-Medicaid Dual Demonstration), CHIP, STAR Kids, and STAR Health, and the Dental Contractors providing Children’s Medicaid and CHIP Dental Services to Members through dental health plans, and any other Texas Medicaid or CHIP capitated managed care contract that references this Report. In this chapter, references to “CHIP” or the “CHIP Managed Care Program(s)” apply to the CHIP Program and CHIP Dental Contractors. References to “Medicaid” or the “Medicaid Managed Care Program(s)” apply to the STAR, STAR+PLUS, STAR Kids, and STAR Health Programs, and Medicaid Dental Contractors. The term “MCO” includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, Dental Contractors, Medicare-Medicaid Plans (MMPs), and any other entities licensed or approved by the Texas Department of Insurance. The requirements in this chapter apply to all Programs, except where noted.

I. Report schedule

The MCO must submit an Affiliate Report:

Section I. Report Schedule Modified by Versions 2.1 and 2.2

1. during Readiness Review (by the date identified in the Contract);
2. annually by September 1 each year; and
3. on an as-occurs basis.

The “as-occurs” update is due within 30 days of the event triggering the change. A triggering event is any change in the information provided under Section II(2)(a), “Transactions types for each Affiliate.” An as-occurs update is not required if all three of the following are true:

1. the only change is a revision in the aggregate annual dollars estimated for a transaction;
2. the revision is less than a 10% change (cumulative since the last Affiliate Report filed); and,
3. there was no change in pricing terms.

Any change in pricing terms (other than for providers), regardless of the percentage impact, requires both an update of the report and HHSC’s prior written approval.



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The annual submission is due in full every year, even if there have been no changes.

II. Report contents

The Affiliate Report must contain the following:

1. Affiliates.

- a. Affiliate list. A list of all Affiliates with whom the MCO has, or may have, any transactions or business, where such transactions or business might be included as expenses in the FSR.

For a hospital system that is an Affiliate of the MCO, and that includes numerous Affiliate medical providers utilized by the MCO, these hospital/medical services providers (that are all owned by the same ultimate owner) may be consolidated, and treated as a single Affiliate for purposes of this report. The consolidation must exclude any separate contracts for Behavioral Health networks, vision, disease management, reinsurance, or administrative services. Any excluded parts of the otherwise consolidated Affiliate hospital/ medical services provider system should each be treated as a separate Affiliate.

For each Affiliate, include the estimated annual aggregate dollars in FSR-recorded transactions between the MCO and the Affiliate. List Affiliates in descending order of aggregate annual FSR dollars.

- b. Affiliate descriptions. For each listed Affiliate, the MCO must:
 - i. Indicate the basic nature of the Affiliate relationship (e.g., parent, wholly-owned subsidiary, sister company under common ownership)
 - ii. Indicate the Affiliate's total annual revenues from all sources, and also indicate the portion from external non-affiliated sources.
 - iii. Indicate the number of employees (staff and management) that are dedicated full-time to the Affiliate's business. Provide the approximate square feet of office space dedicated solely to the Affiliate's business. Indicate the locations of these employees and office space.

Section II. Report Contents
Modified by
Version 2.1



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- iv. Provide an organizational chart for the Affiliate, showing key personnel of the Affiliate (name and title), their location, and whether they are dedicated full or part-time to the Affiliate's business. Indicate the person (name and title) to whom the top executive of the Affiliate reports.
- v. Indicate if any of the Affiliate's staff are located in the same office building or complex as any of the MCO's staff. If so, the MCO must indicate what proportion of the Affiliate's total staff is co-located with the MCO.
- vi. Indicate if any of the Affiliate's staff are employed by the same legal entity as the MCO's employees. If so, identify the proportion of the Affiliate's staff that is employed by the entity.

2. Transactions

- a. Transaction types for each Affiliate. For HHSC's prior review and approval, provide a schedule of each type of transaction the MCO anticipates may incur with each Affiliate listed above. The schedule must show each type of service and transaction that, under the provisions of the Contract, would be recorded as an expense in the FSR. The schedule must include financial and pricing terms for each proposed transaction type, including:
 - i. A description of each service to be provided (e.g., "parental administrative services, including accounting, legal, claims processing," "behavioral health services network," or "hospital and medical services providers");
 - ii. An estimated aggregate annual dollar amount for each service or transaction that may be incurred by the MCO during the State Fiscal Year;
 - iii. Any per-unit, per-member-per-month (PMPM) percentage, fixed monthly, or other basis of Affiliate pricing to the MCO;
 - iv. A list of the types of costs incurred by the Affiliate and included in the price to the MCO (e.g., payroll costs; facilities occupancy costs; insurance; depreciation and amortization; travel);
 - v. Any Affiliate overhead allocation methods included in the price to the MCO; and
 - vi. Any assumed mark-ups or margins between related entities, etc. Indicate whether there are any mark-ups, margins, profits,



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or add-ons, or any assessments or allocations that HHSC or its external auditor determine are similar.

Note that HHSC's prior written approval is required for any changes in proposed pricing or other terms with Affiliates during the Term of the Contract. HHSC's approval does not exempt the Subcontract from audit, nor from the requirement to conform with the Contract's requirements, including the Cost Principles.

- b. Transaction background and comparative information. For each Affiliate transaction listed on the schedule, identify:
- i. The proportion of the Affiliate's total annual revenues that the MCO's estimated annual payments under the proposed Affiliate transaction would represent.
 - ii. Whether the Affiliate provides the same or similar services to any unaffiliated external entity. If so, provide the Affiliate's pricing terms with unaffiliated entities. (This item does not apply to any Affiliate hospital system, as described in Section II (1)(a).)
 - iii. Whether the Affiliate provides the same or similar services to another Affiliate. If so, indicate whether the price is ever lower than the price for the Affiliate transaction listed on the schedule.
 - iv. Whether the MCO has procured the same or similar services from a non-Affiliate. If the MCO has done so in the last 5 years, indicate the names of any unaffiliated suppliers, and the prices of these services from the unaffiliated suppliers. (This item does not apply to any Affiliate hospital system, as described in Section II (1)(a).)

III. Signed Attestation

The Affiliate Report must conclude with the following:



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Section III.
Signed
Attestation Added
by Version 2.1

I attest that the information contained in this Affiliate Report, including any attached exhibits, is complete, comprehensive, accurate, and not misleading, to the best of my knowledge.

Legal Signature: _____

Printed name: _____

Date signed: _____

Title: _____

(must be Chief Executive Officer, or the MCO's equivalent; no delegation)

On behalf of: _____

(MCO's legal name)

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.