Report forms revised as deemed necessary by the Department of Health.

Rev. 1/95 3/96

PENNSYLVANIA DEPARTMENT OF HEALTH
BUREAU OF HEALTH CARE FINANCING
MANAGED CARE PLANS
QUARTERLY REPORT

GENERAL INFORMATION

1. Date of Filing: The quarterly report is to be filed no later than 45 days after the close of each quarter ending March 31, June 30, September 30 and December 31. Therefore, the Managed Care Plans Quarterly Report should be received by the Bureau of Health Care Financing on the following respective dates: May 15, August 15, November 15 and February 15. The quarterly report for the fourth quarter ending December 31 is to be submitted in addition to the Annual Status Report.

2. Blank lines and unanswered questions will be perceived as incomplete. If no entries are to be made, write "not applicable (N/A)", "none" or "-0-" in the space provided.

3. The report should be submitted to:

PENNSYLVANIA DEPARTMENT OF HEALTH
BUREAU OF HEALTH CARE FINANCING
ROOM 1030 HEALTH AND WELFARE BUILDING
CORNER OF SEVENTH AND FORSTER
HARRISBURG PA 17120

ATTENTION MCP QUARTERLY REPORT TEAM

Enclose in the submission **two** sets of the Managed Care Quarterly Report, **two** sets of Financial Report #2, Statement Of Revenue, Expenses And Net Worth (which is also submitted to the Insurance Department) and **two** sets of Grievance data reports.

DEFINITIONS AND REPORTING INSTRUCTIONS

I. MEMBERSHIP

Source of Enrollment

Private Sector: All members not covered by a Medicare or Medicaid contract. Provide breakout of Health Maintenance Organization (HMO) and Gatekeeper Preferred Provider Organization (GPPO) Private Sector Insured and Private Sector Self-Funded Enrollment under the Traditional Product and Point of Service (POS).

Title XVIII (Medicare): Those members covered by a Medicare contract. List data separately for the following:
(1) members covered by a competitive medical plan (CMP) or at-risk contract
(2) Members covered under a cost contract.

Title XIX (Medicaid): Members enrolled under a prepaid contract between an HMO and the Pennsylvania Department of Public Welfare under Title XIX of the Social Security Act.

A. Member: An individual who has been enrolled as a subscriber or an eligible dependent of a subscriber and for whom the HMO has accepted the responsibility for the provision of basic health services and contracted supplemental health services.

   This column shows members at the close of the preceding quarter and should be identical to the figures reported in Column I, E, in last quarter's report.

B. Additions During Quarter: List number of members added during current reporting period.

C. Terminations During Quarter: List number of members disenrolled during current reporting period.

D. Net Change for Quarter: Column B - Column C.

E. Total Members at Close of Period: Column A + Column B - Column C.

F. Cumulative Member Months Per Quarter: For the purpose of these quarterly reports, a member month is equivalent to one member for whom the HMO has recognized premium revenue for one month. When the revenue is recognized for only part of a month (or other relevant time period) for a given individual, a prorated partial member month may be counted. Include previously unreported retroactive enrollment. Accumulate member months for each quarter.

Please note that the Bureau is also requesting **special** enrollment/utilization data report supplements for major subcontracting entities (e.g. Medical Assistance) to HMOs which have assumed some delivery system responsibility and financial risk for services, and **which**, in effect, operate independently of the HMO. Enclose the enrollment/utilization information in separate supplements.

II. UTILIZATION DATA

A-D. Ambulatory Encounters: The accrued ambulatory encounters experienced by the total membership during the time period; "Ambulatory Encounters" are further defined as follows:

1) Ambulatory Services: Health services provided to HMO/GPPO members who are not confined to a health care institution. Ambulatory services are often referred to as "outpatient" services as distinct from "inpatient" services.

2) Encounter: A face-to-face contact between an HMO member and a provider of health care services who exercises independent judgment in the care and provision of health service(s) to the member. The term "independent' is used synonymously with self-reliance, to distinguish between providers who assume major responsibility for the care of individual members and all other personnel who assist in that care. (Encounter excludes immunization.)

$$\text{Annualized Member Ambulatory Encounters} = \frac{\text{Total Number of Encounters for Quarter}}{\text{Total Member Months for Quarter}} \times 4$$

Note: Use formula above to arrive at the annualized encounters.

A. Primary Care Physician: Encounters provided by primary care physicians only. Complete as appropriate.

B. Specialty Care Physician: Encounters provided by specialist physician. Complete as appropriate.

C. Nonphysician: Encounters provided by other health professionals. Complete as appropriate.

D. Total: Totals of Columns A, B and C.

E. Total Patient Days Incurred: The accrued number of hospital patient days experienced by the total membership during the quarter.

Patient day (from American Hospital Association Uniform Definition):
A "patient day" is defined as a unit of measure to denote lodging facilities provided and services rendered to one inpatient between the census-taking hour on two successive days with the day of discharge being counted only when the patient was admitted on the same day. A patient day pertains only to inpatients and is a measurement of the routine service rendered to inpatients and expressed in days of care. When a patient is admitted and discharged on the same day, this period must be counted as one patient day and taken into consideration when computing total patient

days, average daily census and other statistical rates. Newborns whose inpatient stay is concurrent with the mother's stay should not be counted separately from the mother's patient days. Newborns whose inpatient stay is longer than the mother's should be counted as separate patient days for the period beginning with the discharge of the mother.

F. Annualized Hospital Days/1,000 = $\frac{\text{(Column II, E (Total Days) X 4)}}{\text{(Column I, F (Cumulative Member Months) ÷ 3)}} \times 1000$

G. Average Length of Stay: Column E divided by the number of admissions during the period.

H-I. The number of claims for emergency health delivery services, including emergency physician and hospital costs incurred by HMO/GPPO members.

The "in area" is specified as the HMO's/GPPO's defined service delivery area. All other areas are "out of area." Complete as appropriate.

III. PERSONNEL/PROVIDER DATA

1-3. Primary Care Physician Information: A physician under contract with an HMO/GPPO who supervises, coordinates and provides initial and basic care to members, initiates their referral for specialist care and maintains continuity of patient care.

1. Primary Care Physician Information:

   a. List number of primary care physicians at the close of the preceding quarter.

   b. List number of primary care physicians added during the current reporting period.

   c. List number of primary care physicians terminated during the current reporting period.

   d. a + b less c.

2. Full-Time: Amount of time considered the normal or standard amount for working during a given period. Full-time equivalent is the total number of hours worked by primary care physicians divided by full-time. Complete as appropriate.

3. List the total number of delivery sites where primary care services are delivered. This includes the number of solo and multiple-physician practice sites (IPA and Network), as well as the number of health centers (Group and Staff).

4. Includes physicians, hospitals, skilled nursing facilities and other providers of health care services that enable the HMO to provide basic health services. Complete as appropriate.

5. Attach the names and specific job titles of all significant personnel changes occurring this quarter. Significant personnel changes include: Chief Executive Officer, Medical Director(s), Members of the Board of Directors and any other key plan personnel. A biographical statement should be included for any new board members.

IV. GRIEVANCE DATA

Grievance: A formal expression of a complaint which cannot be resolved to the member's satisfaction. All grievances shall be committed to written form either by the member or the HMO/GPPO prior to processing.

Grievance Consideration/Hearing: A process when a member requests a formal administrative review resulting from a claim denial, denial of service, etc., during the thirty-day period following notification.

Pending From Previous Quarter: List the number of first and second-level grievances in which action is pending from the previous reporting quarter. This would include grievance filings in which a hearing was held, but a decision has yet to be officially determined; and grievance filings in which Department of Health (DOH) intervention following a second-level decision and appeal resulted in the DOH requiring the HMO/GPPO to "rehear" the case.

Filed This Quarter: List the number of first and second-level grievances filed by members during the reporting quarter.

Totals: Calculate the total number of first and second-level grievances which were pending from the previous reporting quarter and those which have been filed during the current quarter.

Withdrawn This Quarter: List the number of first and second-level grievances which were withdrawn by the member during the reporting quarter.

Decisions This Quarter: List the number of first and second-level decisions for the quarter, differentiated between "in favor of the member" or "in favor of the HMO/GPPO."

Pending This Quarter: List the number of first and second-level grievances in which action is pending during the reporting quarter. This would include grievance filings in which a hearing is yet to be held; grievance filings in which a hearing was held, but a decision has yet to be officially determined; and grievance filings in which Department of Health (DOH)

intervention following a second-level decision and appeal to DOH resulted in the DOH requiring the HMO/GPPO to "rehear" the case.

V. STATEMENT OF REVENUE AND EXPENSES

Follow instructions provided by the Pennsylvania Insurance Department for Report #2, Statement of Revenue, Expenses and Net Worth with the exception that the Health Department requires Report #2 to be submitted with the HMO Quarterly Report for the fourth quarter (October - December). Please be sure that the calculations represent only the data for the current quarterly period and not a cumulative year-to-date figure. It is essential to provide the member month statistic.

VI. CERTIFICATION

3/96

PENNSYLVANIA DEPARTMENT OF HEALTH
BUREAU OF HEALTH CARE FINANCING
MANAGED CARE PLANS
QUARTERLY REPORT

Quarter/Year:	
Name of plan:	

I. MEMBERSHIP

Source of Enrollment	(A) Total Members at Close of Last Quarter	(B) Additions During Quarter	(C) Terminations During Quarter	(D) Net Change for Quarter	(E) Total Members at Close of Quarter	(F) Cumulative Member Months for Quarter
HMO						
1. Private Sector Insured						
a. Traditional Product						
b. Point of Service (P.O.S.)						
2. Private Sector Self-funded						
Traditional Product						
b. Point of Service						
3. Title XVIII Medicare Risk Contract						
4. Title XVIII Medicare Cost Contract						
5. Title XIX Medicaid						
6. SUBTOTALS						
GPPO						
7. Private Sector Insured						
a. Traditional Product						
b. Point of Service						
8. Private Sector Self-funded						
a. Traditional Product						
b. Point of Service						
9. SUBTOTALS						
TOTALS						

MANAGED CARE PLANS QUARTERLY REPORT
PLAN NAME: _____

II. UTILIZATION DATA

Source of Enrollment	Annualized Member Ambulatory Encounters				(E) Total Patient Days Incurred	(F) Annualized Hospital Days/1,000	(G) Average Length of Stay
	(A) Primary Care Physician	(B) Specialty Care Physician	(C) Non-physician	(D) Total			
1. Private Sector a. Traditional Product							
b. Point of Service							
2. Title XVIII Medicare Risk Contract							
3. Title XVIII Medicare Cost Contract							
4. Title XIX Medicaid							
5. TOTAL							

(H) In-Area Emergency Claims		(I) Out-of-Area Claims		(J) Out-of-Plan Authorized Referrals	
6. Received		Received		Ambulatory	
7. Paid		Paid		Inpatient	
8. Pending		Pending			
9. Rejected		Rejected			

MANAGED CARE PLANS QUARTERLY REPORT
PLAN NAME: _____

III. PERSONNEL/PROVIDER DATA

1. Provide the following information regarding number of primary care physicians: (a)+ (b) - (c) = (d)

(a) = enrollees at the close of the last quarter	(b) = enrollees added this quarter	(c) = enrollees terminated this quarter	(d) = enrollees at the close of the quarter

2. Number of full-time equivalent primary care physicians (Group and Staff models only)		
3. Number of primary care delivery sites		
4. Have the standard contractual arrangements for providers been changed or amended this quarter? Indicate by placing an (X) in the appropriate box. If the answer is yes, then attach a listing of all such changes.	YES	NO
5. Have any significant personnel changes occurred in the plan this quarter? Indicate by placing an "X" in the box. If the answer is yes, then attach a listing of all such changes.	YES	NO

IV. GRIEVANCE DATA

GRIEVANCES	FIRST LEVEL	SECOND LEVEL
1. Pending From Previous Quarter		
2. Filed This Quarter		
3. TOTALS		
4. Withdrawn This Quarter		
5. Decisions This Quarter		
a) In Favor Of Member		
b) In Favor Of HMO/GPPO		
6. Pending This Quarter		

Attach a brief summary of each first and second-level grievance filed or decided this quarter. In order to protect patient confidentiality, please ensure names and addresses are not included in the summaries. A unique confidential identifier should be assigned to each case for tracking purposes. Include in the individual summaries, the nature of the dispute, the HMO's position, the member's position and the dollar amount which is in dispute.

MANAGED CARE PLANS QUARTERLY REPORT
PLAN NAME: _____

V. STATEMENT OF REVENUE AND EXPENSES

Attach a completed copy of the Pennsylvania Insurance Department Report #2, Statement of Revenue, Expenses and Net Worth for the current reporting period.

VI. CERTIFICATION

To the best of my knowledge and belief, all information contained herein is accurate and true.

_____ _____
(Signature of Person Completing Report) Date

_____ _____
(Medical Director's Signature) Date

NOTE: When submitting a report for the fourth quarter (October 1 through December 31), the Department of Health requires that a Statement of Revenue and Expenses indicating the financial information specific to the fourth quarter be prepared and included with the HMO Quarterly Report.

REMINDER: **Two sets** of the HMO Quarterly Report, **two sets** of the Report #2 of the Insurance Department Financial Report Statement of Revenue, Expenses and Net Worth and **two sets** of the Grievance Data Report must be submitted on a quarterly basis to the Department of Health.

Rev. 1/95 3/96

PENNSYLVANIA DEPARTMENT OF HEALTH
Managed Care Plans
1995 Annual Status Report

Reporting Instructions

I. GENERAL INFORMATION

A. Managed Care Plans

Section 9.91 of the Department of Health regulations requires each organization which has received a Certificate of Authority to operate a Health Maintenance Organization (HMO) to submit an annual report detailing its activities of the previous calendar year (defined as January 1 through December 31).

During the past year, a number of HMO-affiliated third party claims administrators (TPAs) or insurance companies have filed and had approved primary care gatekeeper Preferred Provider Organizations (GPPO). Although GPPOs are often referred as "point of service" (POS) products by the managed care industry, the approved GPPOs have been utilized to provide both traditional HMO-like products and POS products to the self-funded market place.

A primary care physician GPPO is an organization (either an insurance company, third party claims administrator, Blue Cross/Blue Shield plan, etc.) which has applied for and received approval, under the PPO Act and regulations, to offer a primary care GPPO. Most approved GPPOs have met the Joint Policy Statement on GPPO Review and Approval (31 PA Code Sections 152.101 to 105) standards by subcontracting with their licensed HMO affiliates (under Pennsylvania Department of Health-approved subcontracting arrangements) to provide GPPO services. GPPOs not subcontracting with affiliated HMOs should report using the supplement entitled "Gatekeeper Preferred Provider Organization (GPPO) Not Subcontracting With Affiliated HMOs."

Historically, HMOs have utilized affiliated organizations approved as gatekeeper PPOs as a mechanism to offer services to self-funded employers. Thus, most of the GPPOs have been approved as nonrisk assuming or ERISA-exempt gatekeeper PPOs. A few entities have obtained approval of insured product GPPOs.

For all practical purposes, the GPPO enrollees will be treated like HMO members for the

purposes of reporting utilization data, personnel/provider data, grievance resolution and statement of revenue and expenses; but for the purposes of reporting enrollment, the Department requests a breakout for self-funded business and other unique products. Please note that we are requesting special enrollment/utilization data report supplements for major subcontracting entities to HMOs which have assumed some delivery system responsibility and financial risk for services, and which, in effect, operate somewhat independently of the HMO. Currently, this happens principally at the Medical Assistance level. The utilization, personnel/provider data and grievance resolution data need not to be broken out between insured and self-funded business HMO and GPPO products but should collectively include information from all product lines. Similarly, county breakout enrollment would include all enrollment with no break out of insured/self-funded/POS products on a county basis (use Supplement for Special Programs).

The HMO assumes reporting responsibilities for a GPPO when the GPPO subcontracts with a licensed HMO for the delivery of health services to GPPO enrollees. Since the HMO's affiliate's delivery system is being utilized, the HMO affiliate is responsible for reporting GPPO experience.

The Department's reporting requirements by HMO are included as **Chart 1**, which is located on page 3. This chart lists each approved HMO, the affiliated GPPO whose experience should be included in this report by the HMO as well as any special (independent medical assistance subcontractor) experience required to be reported.

This chart also lists the two currently approved GPPOs which do not lease an affiliated HMO's delivery system, and which, therefore, must complete this report under their own names, following the "special instructions for direct reporting 'GPPOs'" included in the reporting package.

Before submitting the Managed Care Plans Annual Status Report, make sure attachments are properly tabbed and labeled. Provide a cover page listing each section and corresponding attachment(s). **Two sets** of the Managed Care Plans Annual Status Report with attachments and two sets of the annual NAIC financial report submitted to the Commissioner of Insurance must be submitted to the Department of Health by **April 30th** of the current year. Reports shall be submitted to:

PENNSYLVANIA DEPARTMENT OF HEALTH
BUREAU OF HEALTH CARE FINANCING
ROOM 1030 HEALTH AND WELFARE BUILDING
CORNER OF SEVENTH AND FORSTER
HARRISBURG PA 17120

ATTENTION MCP ANNUAL REPORT TEAM

DEPARTMENT OF HEALTH
BUREAU OF HEALTH CARE FINANCING

REPORTING STATUS FOR HMO POINT OF SERVICE (POS) GATEKEEPER PREFERRED PROVIDER ORGANIZATIONS (GPPO) AND SPECIAL PROGRAMS 3

CHART 1

	AFFILIATED GPPO WHOSE EXPERIENCE SHOULD BE INCLUDED IN THIS REPORT	SPECIAL PROGRAMS FOR WHICH EXPERIENCE MUST BE REPORTED IN THIS REPORT
ADVANTAGE HEALTH PLAN		
AETNA HEALTH PLANS OF CENTRAL AND EASTERN PA	AETNA LIFE INSURANCE COMPANY	MERCY HEALTH PLAN
AETNA HEALTH PLANS OF WESTERN PA	AETNA LIFE INSURANCE COMPANY	
ALLIANCE HEALTH NETWORK		
CIGNA HEALTH CARE OF PA	CONNECTICUT GENERAL LIFE INS. CO. (CIGNA FLEX-CARE) (CIGNA HEALTH ACCESS)	
FIRST PRIORITY HEALTH	-GATEKEEPER PPO HMO OF NORTHEASTERN PA -BLUE CROSS OF NORTHEAST PA	
GEISINGER HEALTH PLAN	GEISINGER MEDICAL MANAGEMENT CORP.	
GREATER ATLANTIC HEALTH SERVICE		
HEALTHAMERICA CENTRAL	HEALTHASSURANCE (CONVENTRY)	
HEALTHAMERICA OF PITTSBURGH	HEALTHASSURANCE (COVENTRY)	
HEALTHCARE MANAGEMENT ALTERNATIVES		
HEALTHGUARD OF LANCASTER	HEALTHGUARD MANAGEMENT SERVICES CO.	
[illegible] HEALTH PLAN OF PA		
[illegible]LTH PARTNERS OF PHILA.		
KEYSTONE HEALTH PLAN CENTRAL	-KEYSTONE HEALTH PLAN MANAGEMENT CO. -CAPITAL BLUE CROSS/PA BLUE SHIELD	
KEYSTONE HEALTH PLAN EAST	KEYSTONE HEALTH SYSTEM INC.	MERCY HEALTH PLAN
KEYSTONE HEALTH PLAN WEST	BLUE CROSS OF WESTERN PA/BLUE SHIELD	GATEWAY HEALTH PLAN
MEDIGROUP HMO		
OXFORD HEALTH PLAN OF PA		
PRUDENTIAL HEALTH CARE PLAN		
QUALMED PLANS FOR HEALTH OF PA		
THREE RIVERS HEALTH PLANS		
US HEALTHCARE HMO PA	CORPORATE HEALTH ADMINISTRATORS	
US HEALTHCARE PITTSBURGH	CORPORATE HEALTH ADMINISTRATORS	

Please note that if an HMO has an affiliated GPPO not listed above, please contact the Department (717- 787-5193) immediately for clarification and instructions.

INDEPENDENT GATEKEEPER PREFERRED PROVIDER ORGANIZATION (GPPO)

(SEE SEPARATE REPORT INSTRUCTIONS)

GPPOS NOT SUBCONTRACTING WITH AN AFFILIATED HMO TO LEASE THE HMO's DELIVERY SYSTEM
CAPITAL BLUE CROSS/ PA BLUE SHIELD (CBC/PBS)
INDEPENDENCE BLUE CROSS/PA BLUE SHIELD (IBC/PBS)
METROPOLITAN LIFE INSURANCE CO. ("METLIFE")

Section 1565 of the HMO Act gives the Department of Health authority to impose penalties for noncompliance with reporting mandates.

I. GOVERNING/ADMINISTRATIVE STAFFING

Each plan must provide a current listing of its Board members by name and affiliation. Indicate those Board members who are subscriber representatives. Section 9.96 of the regulations require plans to maintain a Board, one third of which consists of subscribers who have no direct relationship other than through enrollment to the HMO. If the plan is not in compliance with this regulation, please provide justification.

Key plan staff should be listed by name and title. If a position is vacant, please so indicate and provide the current status of efforts to fill this vacancy.

A copy of the current organizational chart that demonstrates reporting relationships and provides the name of the staff member filling each position should be included.

A copy of the Corporate bylaws should be enclosed only if changes have been made since last year's submittal. Plans reporting for the first time must attach their bylaws.

II. PLAN DESCRIPTION

A. Plan Ownership

Describe the direct or indirect ownership of the plan by any other company, corporation, group of companies, etc. Explain if there has been a change in ownership of the HMO in the past twelve months.

B. Status

Place an "X" in the appropriate space indicating the status of the corporation.

C. Federal Qualification

Indicate by placing an "X" in the appropriate space indicating whether the plan has received its federal qualification from the Department of Health and Human Services and the effective date. Indicate if federal qualification has been requested and if the application is currently pending.

D. Effective Date of First Subscriber Contract

Enter the date the plan initiated its first subscriber contract.

E. Service Area

Describe the plan's service area by each county for which the Department of Health has given approval to operate. Indicate if only a portion of a county is applicable. Also include portions of your service area that are outside, yet adjacent, to the Commonwealth. If the GPPO service area is the same as that of the HMO, mark the box labeled as "Same as HMO." If different from the HMO service area, then mark the box and include the specific counties. Service area expansions which the Department has not yet approved should not be included.

F. Managed Care Product(s) Identification

1. If the HMO/GPPO utilizes product name descriptions for various products, report the type(s) of managed care product(s) by identifying the product(s) by placing the name(s) and providing a brief description of the fundamental nature of the product(s) in the appropriate space(s) on the table.

   Using the example below, please complete the chart with the proper HMO/GPPO product names and provide a brief description.

Managed Care Product(s) Identification

Product Names	Description
Good Choice	Traditional HMO product with mid-range co-pays
Best Choice	Traditional HMO product with low copays
Inexpensive Choice	Traditional HMO with high copays
Open Choice	Point of service (POS) product
Elder Choice	Medicare risk contract program
Freedom Choice	Self-funded POS plan offered by the GPPO

III. ENROLLMENT DATA

Enrollment data required in this section is supplemental to information being reported on the Department's Quarterly Report for the quarter ending December 31. Be sure that the data being reported on both forms is consistent.

A. Membership by Model Type and Source of Enrollment

The total number of members enrolled as of December 31 of the reporting year by model type and the source of enrollment.

A "traditional HMO" product is one in which services for nonemergency care are covered only if approved or referred by a member's primary care physician. A traditional HMO product may be delivered either under a private sector insured (fixed price) mechanism, under the name of the HMO, or on a private sector self-funded basis, either in the name of the HMO itself (if the HMO has received approval of a self-funded rider to its basic HMO group master contract) or in the name of an affiliate primary care gatekeeper PPO entity.

A "point of service" (P.O.S.) product is one in which the HMO or an affiliate of the HMO provides coverage with reduced benefits if the HMO member fails to obtain an in-network referral from his or her primary care physician. Once again, a P.O.S. product can be provided by the HMO itself directly, usually through an approved rider to its group master contract. More often, however, the P.O.S. product is offered through an affiliated primary care GPPO entity.

Please enter enrollment data according to the Model Type which most accurately reflects the model of your plan. If the plan's delivery system is a combination of two or more models (mixed model), complete multiple rows.

Group Model - The HMO <u>contracts</u> with a medical group or groups to deliver services to its enrollees.

Staff Model - The physicians are <u>hired</u> by the HMO and paid a fixed salary.

Network - The HMO contracts <u>directly</u> with several group practices and/or individual physicians to provide health care services to the HMO enrollees. Gatekeeper Preferred Provider Organization - Data reported here should pertain only to GPPO enrollees. All experience should be reported under "Private Sector."

B. Enrollment by Age and Sex of Members

Describe the ending December 31 enrollment by Sex and Age cohorts listed on the chart. If actual age data is not available in these categories, actuarial adjustments are acceptable. If adjustments have been made, so indicate.

C. Membership by County or Residence

List all Pennsylvania **counties** (not cities) in which plan members reside. Break down the enrollment into the following categories: private sector, Medicare and Medicaid. Plans with membership outside Pennsylvania should indicate that these persons are out-of-state enrollees and list only the state from which they originate. GPPO enrollment should be included in this breakout.

Special note: In future reports, the Department may request county breakout and utilization data designated by HMO and GPPO. Reporting HMOs should ensure that they have capacity to report this data in the future.

D. Enrollment by Type of Prepayment Contract

HMO: Describe subscriber enrollment by the type of prepayment contract. Group contracts include all commercial contracts with private sector employers and governmental employees. Total members include the subscriber, the subscriber's spouse and eligible dependents.

Government contracts include only members and contractual arrangements between the plan and the Health Care Financing Administration or Department of Public Welfare for Medicare and Medicaid, respectively.

An individual, nongroup contract is a contract obtained directly from the HMO by a member who is not affiliated with a group.

Source of Enrollment (Private Sector, Medicare, Medicaid) is consistent with the categories described on the Quarterly Reporting format. Medicare and Medicaid correspond to Titles XVIII and XIX, respectively, of the Social Security Act. Private sector enrollment includes all members not covered by a Medicare or Medicaid contract.

An individual, conversion contract is a contract obtained from the HMO by a member who was initially enrolled as a group subscriber and upon leaving the group, has exercised his/her right to convert to an individual, direct payment contract with the HMO. COBRA conversions should be reported under this category.

E. HMO or GPPO Contracts and Members by Size of Employer

Please describe the number of contracts and the number of members according to the size of the employer. Employer size is based on the number of persons employed within the firm on a full-time basis plus any part-time personnel who are eligible for health insurance coverage. Count only those contracts in which members have been enrolled during the calendar year being reported.

F. Dental/Vision Services/Point of Service Product

Please indicate if the plan is offering an approved dental or vision care program in conjunction with its basic health services. Provide enrollment levels as of December 31.

IV. DELIVERY SYSTEM DATA

If the same delivery system and standards applicable to GPPO enrollees are being applied to HMO members for IV. A to D, please indicate by marking the box. If there are important differences, describe these differences on a separate exhibit.

A. Annual Quality Assurance Report

In accordance with Section 9.91 of the regulations, attach a copy of the most recent quality assurance report that has been approved by the board of directors. Section 9.74 of the regulations requires that an Annual Report be presented to the board of the quality assurance activities of the plan.

B. Plan Standards

The Department of Health requires plans to promulgate standards and methodologies to verify that its panel of primary care physicians can accept and serve HMO and GPPO patients in accordance with a minimum level of quality.

The plan should describe the standard that is employed system-wide for each indicator listed for IV.B. If the number of patients per hour varies according to Pediatric or Adult patient load, please give both standards.

C. Medical Complement

The plan must provide a listing of primary care physicians, speciality care providers and facilities under contract with the HMO. Preprinted materials may be submitted.

1. Primary Care Physicians

Give total number and list all primary care physicians with whom the plan has a contractual arrangement to supervise, coordinate and provide basic medical care. This list should provide, at minimum, the following information:

a. Physician name or names if group practice
b. Physician specialty
c. Physician degree
d. Practice location(s) by street and city
e. Hospital privileges with a hospital for which the plan has a contractual arrangement

2. Specialty Care Physicians
Give total number and list all specialty physicians with whom the plan has a contractual arrangement or utilizes for specialty care authorized by the primary care physician. The following information is necessary:

a. Physician name or names if associated with a group practice
b. Physician specialty
c. Physician degree
d. Practice location(s) by street and city
e. Hospital affiliation

3. Health Centers
List the name and location of all health centers where medical care is provided. This applies to Group/Staff model HMOs only.

4. Medical Residents
Indicate whether the plan uses medical residents to supplement the physician services component in an ambulatory setting. The Department permits such affiliation provided it is consistent with high quality, cost-effective medical care, and there is adequate disclosure to members.

5. Directly Owned Sites Or Employed Clinicians
Indicate if the HMO/GPPO directly owns sites or employs clinicians involved in direct patient care. Provide the name of the sites, addresses, clinicians and specialties when applicable.

D. Reimbursement/Payment Mechanisms

1. - 2. Physician
Please indicate the typical mode by which the HMO reimburses physician providers for providing health services to commercial subscribers.

Capitation: Physician receives a predetermined rate for delivering contractual services, based on the number of members for a designated period of time. Provider receives no additional payment for delivering a service pursuant to his/ her responsibility.

Salary: Fixed compensation paid on a regular basis for services (usually to employees of the organization).

Modified or discounted fee-for-service: Provider receives payment at the time the service is rendered. The amount of fee-for-service is predetermined and modified or discounted by a certain percentage of the provider's current charge.

Fee Schedule: Payment is based on a schedule which designates payment for each covered service.

Combination: Provider is paid by different modes for different groups of services. For example, a gynecologist may be reimbursed on a capitation basis for routine gynecological care and on a fee-for-service basis for specialized gynecological care. Specify the type of financial modes being combined.

3. Hospital and Other Facilities

Using Table 1, describe the type of financial arrangements the plan has negotiated with hospitals and other contracted health facilities. Specify the type of financial arrangement according to the type of service for which the HMO has contracted. Please use the following service categories:

a. Acute Care
b. Skilled Nursing
c. Hospice
d. Rehabilitation
e. Home Health
f. Drug and Alcohol

E. Grievance Resolution System

HMO: Section 9.73 of the HMO regulations and the Pennsylvania Department of Health HMO Grievance System Operational Standards require each plan to have a written grievance procedure for the resolution of subscriber grievances. A copy of the notice sent to subscribers on a yearly basis explaining the plan's grievance

process should be enclosed. Also, indicate the date the annual notice was sent out.

F. Calendar Year Grievance

Pending from previous year: List the number of first and second-level grievances on which action is pending from the previous reporting year. This would include grievance filings in which a hearing was held, but a decision has yet to be officially determined; and grievance filings in which the Department of Health (DOH) intervention following a second-level decision and appeal resulted in the DOH requiring the HMO to reconsider the case. This figure should agree with last year's "Pending This Year" figure.

Filed this year: List the number of first and second-level grievances which were withdrawn by the member during the reporting year.

Withdrawn this year: List the number of first and second-level grievances filed by members during the reporting year.

Decisions this year: List the number of first and second-level decisions for the year, distinguishing between "in favor of the member" or "in favor of the HMO."

Pending this year: List the number of first and second-level grievances in which action is pending during this reporting year. This includes the same "pending criteria" as indicated under "Pending From Previous Year" above.

G. Disenrollment

Enter the number of plan members who disenrolled or terminated during the calendar year being reported by the reason of termination. Terminations have been divided into voluntary and involuntary categories.

H. Consumer Satisfaction

Describe any consumer satisfaction surveys that were undertaken during the past calendar year. The methodology employed and data results must be included. If the survey was conducted in accordance with waiver requirements for a low-option plan, separate results must be indicated.

I. Marketing

The plan should attach a copy of its most recent marketing materials available to plan members and prospective members.

J. Referral

The plan should attach a copy of the current standard referral form used by PCPs in making in-plan or out-of-plan referrals.

V. Professional Staffing

A. Capacity Determination

Each plan has the responsibility to verify that primary care physicians employed by the plan or under contractual arrangements are providing adequate access to subscribers of prepaid health care services. Accordingly, the Department requires submission of standards and methodologies to verify the physician's ability to accept and serve HMO patients.

The plan should describe any changes in its methodology for assessing physician capacity. Please include standards and methodologies for monitoring physician capacity on an initial and ongoing basis.

Group/Staff model plans should complete Sections A and B. Network and IPA models should complete Sections A and C. Mixed model plans may be required to complete all three sections.

B. Medical Complement

Note: This section is to be completed by those plans who are structured, either partially or entirely, as a group or staff model HMO. If a plan also operates an IPA or network model, VI.B. must be completed.

Full-time equivalent is the number of hours worked divided by full-time.

A 40-hour work week should be used as the standard for determining full-time equivalency for practitioners who provide patient care to HMO members on only a part-time basis. For practitioners who serve both HMO and non-HMO patients, full-time equivalency should be based on the amount of time the practitioner is available to see HMO patients.

1. Primary Care Physicians
The ratio of primary care physicians to total members is calculated by dividing total members at close of quarter as listed on the 12/31 Quarterly Report by the total FTE of primary care physicians reported in 1a.

2. Physician Extenders

Enter the number of each type of extender employed by the plan and give totals. A physician extender should be counted as one-half of a physician or .5 FTE.

3. Total Primary Care Personnel
Total primary care personnel is calculated by summing the FTE of primary care physicians and the FTE of physician extenders.

4. Specialty Care Physicians
Enter the number of specialty physicians whom the plan utilizes for specialty care. The same rules for full-time equivalency are applicable here.

5. Total Medical Personnel
This ratio is calculated as follows:

$$\frac{\text{Enrollment on December 31 of current calendar year}}{\text{Total Medical Personnel Participating in Plan}}$$

VI. UTILIZATION DATA

A. Inpatient Utilization by Type of Service

HMO: Complete the chart for each type of inpatient admission. Hospital Admissions are divided into four basic types of service, based on the treatment modality. The four inpatient admission types are:

1. Medical - admissions which treat physical illnesses where no major surgical procedure is performed.

2. Surgical - admissions which treat surgical procedures as the primary method for treatment.

3. Obstetric - admissions pertaining to pregnancy and childbirth, as well as to maternal and perinatal complications.

4. Mental Health - admissions requiring treatment for psychiatric illnesses, such as depression, psychosis and anxiety. Do not include substance abuse treatments. Substance abuse data is reported in Section VIII.

B. Outpatient Utilization

A-D. Ambulatory Encounters: The accrued ambulatory encounters experienced by the total membership during the time period; "Ambulatory Encounters" are further defined as follows:

1) Ambulatory Services: Health services provided to HMO/GPPO members who are not confined to a health care institution. Ambulatory services are often referred to as "outpatient" services, as distinct from "inpatient" services.

2) Encounter: A face-to-face contact between an HMO member and a provider of health care services who exercise independent judgment in the care and provision of health service(s) to the member. The term "independent' is used synonymously with self-reliance, to distinguish between providers who assume major responsibility for the care of individual members and all other personnel who assist in that care (Encounter excludes immunization).

A. Primary Care Physician: Encounters provided by primary care physicians only. Complete as appropriate.

B. Specialty Care Physician: Encounters provided by specialist physician. Complete as appropriate.

C. Nonphysician: Encounters provided by other health professionals. Complete as appropriate.

D. Total: Totals of Columns A, B and C.

C. List the number of claims for emergency health delivery services including emergency physician and hospital costs incurred by HMO/GPPO members.

The "in area" is specified as the HMO's/GPPO's defined service delivery area. All other areas are "out of area." Complete as appropriate.

Identify out-of-plan authorized referrals as ambulatory or inpatient.

VII. FINANCIAL DATA

A. Copayments

Please list the average copayment required by a plan member during the reported calendar year for routine primary care including routine doctor's office visits and

preventive health care services such as routine well-baby care and periodic health physicals/assessments performed during a practice's regular business hours.

A weighted mean should be used to calculate the "average" copayment where there is a disproportionate number of members in various copay categories.

Recognizing that a plan may employ various coverage options in which the co-payment for routine care may vary, we ask you to provide the maximum co-payment amount. Provide the maximum co-payment for hospital emergency room care.

B. Financial Analysis

The financial data request in this section corresponds to the information being submitted to the Pennsylvania Department of Insurance under the Health Maintenance Organization Financial Report of Affairs and Conditions. The information requested by the Department of Health can be found on the following pages of the Financial Report:

Total Current Assets	p. 2; line 8
Total Current Liabilities	p. 3; line 8
Total Medical & Hospital Expense	p. 4; line 21
Total Health Care Revenue	p. 4; line 21 minus line 6, minus line 9
Total Administrative Expense	p. 4; line 27
Net Income	p. 4; line 32
Total Revenue	p. 4; line 7

C. Premiums

Please list your Department of Insurance-approved two-tier community rate for basic health services during the first quarter of 1995 and 1996. Basic Health Service rates should include emergency care, ambulatory physician care, inpatient hospital care, inpatient physician care and outpatient and preventive medical

services. If basic health rates also include prescription drug coverage or home health services, please indicate.

VIII. BEHAVIORAL HEALTH BENEFITS

1-14. Please answer the questions 1 through 14 **ONLY** if the plan **SUBCONTRACTS** with a behavioral health organization or other entity to provide management of substance abuse and mental health benefits.

15-20. Answer questions accordingly. If the answers require attachments or tables, label with tabs.

21. Substance Abuse: Provide the information requested under the appropriate categories.

Number of Members: Provide number of members treated during the calendar year for substance abuse in Inpatient Detox, Nonhospital Residential, Partial Hospitalization or Outpatient facilities.

Visits per 1,000: Provide the number of visits by members under substance abuse treatment for outpatient facilities during the calendar year for each one thousand covered individuals.

Admissions per 1,000 Subscribers: Provide the total number of Nonhospital, inpatient detox admissions and partial hospitalization by plan member during the calendar year for each one thousand covered individuals.

Inpatient Days per 1,000 Members/Year: Provide the total number of days by plan members during a calendar year for each one thousand covered individuals.

Average Length of Stay (L.O.S.): Calculate the L.O.S. by dividing the total days by the number of members.

Per Member Per Month: Provide the average PMPM costs for each category of service.

IX. EMERGENCY AND OUT-OF-AREA SERVICES

Attach a copy of your definition of what constitutes "emergency" as well as a definition of "out-of-area" services.

X. CERTIFICATION

This report must be signed by both the Plan Medical Director and Chief Executive Officer, certifying the accuracy and completeness of the report. Signature is required for local plan executives, not corporate administrators, where applicable.

If you have any questions regarding the completion of the Managed Care Plans Annual Status Report, please contact Steven Horner at (717) 787-5193.

1/95, 3/96

PENNSYLVANIA DEPARTMENT OF HEALTH
MANAGED CARE PLANS
ANNUAL STATUS REPORT
BUREAU OF HEALTH CARE FINANCING
For Year Ending December 31, **1995**

HMO

Name of plan:	
Address:	
Telephone number:	
Fax number:	
Report completed by:	(Name & Title)
Contact person:	(Name & Title)
Name of affiliated GPPO being reported in this report.	

I. GOVERNING/ADMINISTRATIVE SERVICES

A. BOARD OF DIRECTORS

Name (Chairperson)	Affiliation	SUBSCRIBER REPRESENTATIVE	
		YES	NO

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

B. BOARD OFFICERS

President:	
Vice President:	
Secretary:	
Treasurer:	

C. PLAN STAFF

	Name	Title
Chief Executive Officer:		
Chief Operations Officer:		
Medical Director:		
QA Coordinator:		
Utilization Review Director:		
Financial Officer:		
Member Relations Director:		
Provider Relations Director:		

D. HMO: Attach a plan organizational chart including the Board of Directors and Executive Staff. Provide the name of the staff member filling each position.

GPPO: Attach a corporate organizational chart(s) explaining the relationship between the HMO and the GPPO affiliate. Include the name of the staff member filling each position on the organization chart(s). Enclose chart(s) as Attachment ____.

E. Have there been revisions to the Corporate by-laws? ☐ Yes ☐ No
If yes, enclose revisions as Attachment ____.

II. PLAN DESCRIPTION

A. PLAN OWNERSHIP: _____
Has there been a change in plan ownership during the past 12 months?
☐ Yes ☐ No
If yes, enclose change(s) as Attachment ____.

B. STATUS: (Indicate by placing an "X" in the appropriate answer box.)
☐ Profit ☐ Nonprofit

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

C. FEDERAL QUALIFICATION: (Indicate by placing an "X" in the appropriate box.)

❑ Yes ❑ No ❑ Pending Date / /

D. EFFECTIVE DATE OF FIRST SUBSCRIBER CONTRACT: / /

E. SERVICE AREA:

List the counties in your approved service area. Indicate any changes (*) during the past year.

GPPO Service Area: Check the appropriate box.

❑ Same as HMO

❑ Different (If different, then list GPPO counties seperately in Attachement ____).

F. MANAGED CARE PRODUCT(S) IDENTIFICATION:

1. Proper Product Name and Brief Description

Product Names	Description

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

III. ENROLLMENT DATA

A: List Pennsylvania Membership by Model Type and Source of Enrollment:

	Private-Sector		Private Sector Self-funded		Medicare		Medicaid	Total
	Traditional	P.O.S.	Traditional	P.O.S.	Risk	Cost		
HMO								
Group								
Staff								
Network								
GPPO								
Totals								

B. Enrollment by Age and Sex of Members:

Age	Male	Female	Total December 31 Enrollment
0-4			
5-19			
20-44			
45-64			
65 and Over			
Unknown			
Totals			

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

C. List total membership by county of residence as of December 31 of the reporting calendar year.

	ENROLLMENT		
County	Private Sector	Medicare	Medicaid
Totals			

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

D. Total members by type of prepayment contract as of December 31:

Type of prepayment contract	Total Members Enrolled by Category
1. Group contracts	
a. State Employees	
Traditional	
Point of Service	
b. Federal Employees	
Traditional	
Point of Service	
c. Private Sector	
Traditional	
Point of Service	
2. Government Contracts	
a. Title XVIII Medicare Risk Contract	
b. Title XVIII Medicare Cost Contract	
c. Title XIX Medicaid	
3. Non-Group Contracts	
a. Individual, Non-Group Contract	
b. Individual, Conversion Contract	
3. Total	

E. HMO or GPPO contracts and members by size of employer:

Employer Size (number of employees)	Total Members
Less than 25	
25 - 49	
50 - 99	
100 - 499	
500 - 999	
1,000 or More	

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

F. Does the plan offer the following:

Optional Additional Cost Services/Benefits	Yes (X)	No (X)	Pending (X)	Enrollment for 12/31
1. Dental Service				
2. Vision Care Service				
3. Prescription Drug Service				

IV. DELIVERY SYSTEM DATA

GPPO: If same as HMO for GPPO enrollees then check box ☐.

A. ANNUAL QUALITY ASSURANCE REPORT:
Attach a copy of the Quality Assurance Report submitted to the Board of Directors, summarizing quality assurance studies that were undertaken during the past 12 months. A description of the quality assurance study results obtained and subsequent action should be included for each quality assurance study undertaken.

B. PLAN STANDARDS:

Please indicate the quality standard that the plan has established for its primary care physicians for the following:

1. Number of patients seen per hour		
2. Acceptable patient waiting time (in minutes)		
3. Number of office hours each primary care physician must be available per week		
4. Physician call-back time (in minutes)	Emergency	Non Emergency
5. Waiting time for scheduling routine primary care		
6. Waiting time for scheduling an urgent care visit		

C. MEDICAL COMPLEMENT:
Please provide a listing of the following types of health providers by category. Please submit the recent list of providers for the plan made available to the members. Enclose response in Attachment ____.

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

1. Number of primary care physicians	FP/GP	PED.	General Internal Medicine	Other (list)

2. Number of speciality physicians	
3. Number of health centers (Group/Staff Model HMOs only):	

4. Does the plan use medical residents in an ambulatory setting? ❑Yes ❑ No

5. Does the HMO/GPPO directly own sites or employ clinicians involved in direct patient care? ❑Yes ❑ No

If Yes, then provide the name(s) of the site(s), address(es) of the site(s), name(s) of clinician(s) and speciality(ties) on Attachment ____.

D. TYPE OF REIMBURSEMENT/PAYMENT MECHANISMS (Check):

1. Primary Care Physicians

	X
Capitation	
Salary	
Modified Fee-For-Service	
Fee Schedule	
Combination of above (describe)	
Other (describe)	

Attach copies of the current primary care physician contracts and reimbursement system methodology.. Response enclosed in Attachment ____.

B. Report the number of primary care physicians exclusively contracting with the reporting HMO. Response enclosed in Attachment ____.

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

2. Specialty Care Physicians

	X
Capitation	
Salary	
Modified Fee-For-Service	
Fee Schedule	
Combination of above (describe)	
Other (describe)	

Attach copies of the current specialty care physician contract and reimbursement system methodology including all variations differing from fee-for-service.

3. List the name, address and type of financial arrangement (e.g., discount from charges, per diem, capitated, etc.) the plan has with all hospital and other contracted health facilities. (using format similar to Table 1). Additionally, include a copy of your generic hospital contract and reimbursement methodology for any capitated agreement.

E. Grievance Resolution:
Enclose a copy of the annual notice sent to subscribers informing them of the plan's grievance process. Also indicate the date the annual notice was sent. Date: _____

F.

	Pending From previous year	Filled This Year	Withdrawn This year	Decisions this Year		Pending This Year
				In Favor of Member	In Favor of HMO	
1. 1st Level						
2. 2nd Level						
3. Totals						

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

G. Disenrollment:

Category	Total Disenrollments
Voluntary	
1. Dissatisfaction with Plan	
2. Change of Residence (Out of Service Area)	
Involuntary	
3. Loss of Coverage	
4. Death	
5. Number of members involuntary disenrolled/terminated by HMO during the calendar year.	
Unknown	
Total	

H. CONSUMER SATISFACTION:

1. Has the Plan conducted a consumer satisfaction survey during the past calendar year? ❑ Yes ❑ No
   If yes, then summarize the methodology employed and the results.
   Response enclosed in Attachment ____.

   Enclose a copy of the consumer satisfaction survey marked as Attachment ____.

I. MARKETING:
Attach a copy of the plan's current marketing literature designated as Attachment ____.

J. REFERRAL:
Attach a copy of the plan's current standard referral form designated as Attachment ____.

V. PROFESSIONAL STAFFING

A. CAPACITY DETERMINATION: Describe in Attachment ____ any changes in the plan's methodology for accessing physician capacity. Include standards and methodologies for monitoring physician capacity on an initial and continuing basis.

B. MEDICAL COMPLEMENT - GROUP/STAFF MODELS ONLY:
1. Primary Care Physicians

a. Number of full-time equivalent primary care physicians participating in plan as of December 31.	
b. Ratio of full-time equivalent primary care physicians per total members.	

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

2. Physician Extenders

a. Number of full-time equivalent nurse practitioners	
b. Number of full-time equivalent physician assistants	
c. Number of full-time equivalent extenders (2a + 2b)	

3. Total Primary Care Personnel

a. Total of all primary care personnel (1a + 2c)	
b. Ratio of primary care personnel per total members	

4. Specialty Care Physicians

a. Number of specialty care physicians participating in plan	

5. Total Medical Personnel

a. Total medical personnel participating in plan as of December 31 (3a + 4a)	

C. Medical Complement - Network Models Only:

Number of primary care physicians leaving during the calendar year	
Number of primary care physicians added during the calendar year	
Number of primary care physicians participating in plan as of December 31	

VI. UTILIZATION DATA

A. INPATIENT UTILIZATION BY TYPE OF SERVICE

Type of Service	(a) Admissions per 1,000 Members	(b) Total Patient Days Incurred	(c) Average Length Of Stay (LOS)	(d) Inpatient Days Per 1,000 Members/Year
1. Medical				
2. Surgical				
3. Obstetric				
4. Mental Health				

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

B. OUTPATIENT UTILIZATION

Source of Enrollment	Annualized Member Ambulatory Encounters			
	(A) Primary Care Physician	(B) Specialty Care Physician	(C) Non-Physician	(D) Total
1. Private Sector -Traditional Product				
-Point of Service				
2. Title XVIII Medicare Risk Contract				
3. Title XVIII Medicare Cost Contract				
4. Title XIX Medicaid				
5. TOTAL				

C. The number of claims for emergency health delivery services including emergency physician and hospital costs incurred by HMO/GPPO members.

In-Area Emergency Claims		Out-Of-Area Emergency Claims		Out-Of-Plan Authorized Referrals	
6. Received		Received		Ambulatory	
7. Paid		Paid		Inpatient	
8. Pending		Pending			
9. Rejected		Rejected			

VI I. **FINANCIAL DATA**

A. Co-Payments: $

1. List range of co-payment for routine primary care	
2. Maximum co-payment for hospital emergency room care	

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

B. Financial Analysis:
Please complete the following information for the current and previous reporting years.

	Current Year, 1995	Previous Year, 1994
1. Total Current Assets	$	$
2. Total Current Liabilities	$	$
3. Current Ratio (B1/B2)		
4. Total Medical & Hospital Expenses	$	$
5. Total Health Care Revenue	$	$
6. Health Care Expense Ratio (B4/B5)		
7. Total Administrative Expense	$	$
8. Administrative Expense Ratio (B7/B5)		
9. Net Income (Loss)	$	$
10. Total Revenue	$	$
11. Profit Margin (B9/B10)		

C. Premium:

1. 1995 First Quarter Premiums - Single Coverage	$
1996 First Quarter Premiums - Single Coverage	$
2. 1995 First Quarter Premiums - Family Coverage	$
1996 First Quarter Premiums - Family Coverage	$
3. Percent Increase in HMO Premium Rate from Preceding Calendar Year (%)	

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

VIII. BEHAVIORAL HEALTH

Provide the name, title and telephone number of personnel completing this portion of the report.

Name	Title	Telephone Number

If subcontracting, then complete 1-14.

1. Name of Subcontractor	Telephone Number

2. Check services provided by the subcontractor:

SERVICES	X	COMMENTS
Credentialing/ Recredentialing		
Provider Contracting		
Patient Assessment		
Overall Management of Patient Care		
Quality Assurance		
Utilization Review		
Complaint/Grievance Resolution		
Provisions of Care		
Other:		
Other:		

3. Does your quality improvement plan reflect oversight of these activities?

❑ Yes ❑ No

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

4. Do you have a DOH-approved oversight plan for these services? ☐ Yes ☐ No

5. How is the subcontractor reimbursed for services?
   Enclose current contract between HMO and each Behavioral Health Organization subcontractor. Response enclosed in Attachment ___.
   Enclose current sample contract between each Behavioral Health Organization and its participating direct providers of care. Response enclosed in Attachment ___.

6. How does the subcontractor reimburse facilities/providers?
   Response enclosed in Attachment ____.

   List any facilities/providers on Attachment ___ who are reimbursed on an other than per diem or fee-for-service basis (Use the format in Table 2).

7. How does the subcontractor monitor facilities/providers to ensure that financial incentives (e.g. capitation) do not adversely affect patient care. Response enclosed in Attachment ____.

8. Does the HMO have available a mechanism whereby a provider/therapist of a mental health or substance abuse service who believes that a utilization management decision is incorrect and not in the best interest of a patient, may appeal such decision to the HMO and/or, act as an advocate for the patient, without penalty (such as diminished future referrals or termination from participation)?
   ☐ Yes ☐ No If **Yes**, include description of mechanism, describe how this is made known to the provider and supply evidence of notification.
   Response enclosed in Attachment ___.

9. Attach a copy of the plan's contract with the subcontractor, unless the subcontract was reviewed by DOH during the HMO licensing process in the past year.
   Response enclosed in Attachment ____.

10. Attach a copy of the plan's most recent monitoring report of the subcontractor's performance.
    Response enclosed in Attachment ___.

11. Is the direct number for behavioral health service organization listed on the members identification card and in the provider directory? ☐ Yes ☐ No If **Yes**, then provide evidence. Response enclosed in Attachment ___.

12. Describe (in Attachment ____) how a member accesses behavioral health services. Is a member required to obtain a referral from the primary care physician for behavioral health services? ☐ Yes ☐ No

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

13. Please list numbers of FTE **clinical** staff employed by the HMO and GPPO or the Behavioral Health Organization if subcontracted, performing the following function:

FUNCTION	NUMBER
Assessment only	
Case management only	
Assessment and case management combined	

What is the minimum level of training and experience required for a person performing the assessment function? Response enclosed in Attachment _____.

14. Enclose a copy of each behavioral health subcontractor's credentialing criteria. Credentialing criteria enclosed in Attachment ____.

15. Does the plan contract **directly** with any behavioral health facilities/providers using a reimbursement mechanism other than per diem rate or fee for service?
❑ Yes ❑ No If **Yes**, then please list these facilities/providers and arrangements on Attachment ___ (Using the format in Table 2).

Indicate how the plan monitors these providers to ensure that financial incentives do not adversely affect patient care? Refer to Attachment ___.

16. Report all substance abuse providers/facilities in a format similar to **Table 3**.

17. Indicate the criteria set used for substance abuse level of care placement?

Criteria	X
Unmodified ASAM	
Unmodified Cleveland	
Other:	

18. Are medical records reviewed for behavioral health providers in conjunction with the credentialing/recredentialing process? ❑ Yes ❑ No
Comments: Response enclosed in Attachment ___.

19. Has the plan or subcontractor conducted any **clinical** quality assurance audits in the area of behavioral health during the last year? ❑ Yes ❑ No
If **Yes**, attach a summary of the audit and results/findings in Attachment ___.

MANAGED CARE PLANS ANNUAL STATUS REPORT
PLAN NAME: _____

20. Behavioral Health Grievances

A. Number of Grievances Received	Number Resolved		Number of Grievances Pending
	In favor of member	In favor of plan	
First Level			
Second Level			

21. Substance Abuse

	# of Members	Visits Per 1,000	Admissions Per 1,000	Days Per 1,000	Average Length of Stay	Average Cost Per Member Per Month
Inpatient Detox						
Non-Hospital Residential						
Partial Hospitalization						
Outpatient						
Totals						

IX. **Attach copy of your approved definition of emergency and out-of-area services.**

X. **Certification**:

I certify to the best of my knowledge and belief that all information contained here in is accurate and true.

_____ _____
(Signature of Plan Chief Executive Office) (Date)

_____ _____
(Signature of Plan Medical Director) (Date)

717-787-5193

March 18, 1996

FIELD(HMO)
FIELD(STREET 1)
FIELD(STREET 2)
FIELD(CITY)

ATTENTION: CHIEF EXECUTIVE OFFICER

I am writing to update the situation regarding calendar year 1995 HMO Annual Report forms and 1996 HMO Quarterly Report forms. Included with a letter dated February 15, 1996, was a 1995 HMO Annual Report document which required additional data and information beyond that reported in prior years. The proposed 1996 HMO Quarterly Report also required form and content revisions from the 1995 report format.

After meeting with the Managed Care MIS Advisory Committee, which we convened with help from the Managed Care Association of Pennsylvania for the express purpose of providing industry input into our data collection and analysis activities, we learned of concerns with the lack of advance notice for reporting in the new format as well as questions regarding the necessity of certain additional data elements.

The MIS Advisory Committee and others of you who have contacted us directly have legitimate concerns. Certainly, our intent is to work cooperatively with the industry to reach our mutual goal of ensuring that high quality, cost-effective care is provided to HMO members in an environment in which competition, consumer choice and the marketplace focus on not only price but quality of health care services. Our goals in working with the MIS Advisory Committee shall be to: (a) comprehensively review all current data reporting requirements, (b) identify the need for data and what valid regulatory purpose its collection addresses, (c) justify any request for collection and reporting of additional information, and (d) avoid duplication of data collection by coordinating data-sharing between Health, Insurance and the Department of Welfare.

We have decided to maintain the status quo as reflected in existing reporting formats. Enclosed you will find a 1995 HMO Annual Report form for completion. This form is identical to the 1994 Annual Report form. This 1995 HMO Annual Report form should be filed with the Department not later than 5:00 p.m. on April 30, 1996.

HMO quarterly reports should continue to be submitted in the existing format, a copy of which is attached for your information. We will be working with the MIS Task Force to revise the quarterly report form, with a target date of June 1996. Please be assured that we will provide advance notice of at least an entire quarter (3-month) before implementing changes in the quarterly report format.

I apologize for any inconvenience you or your staff may experience because of this change back to the status quo in terms of HMO data reporting formats. If you or your staff do have questions, please contact Mr. Steven Horner, our Managed Care Science Research Associate at 717-787-5193.

If you have any questions regarding the general content of this letter, please feel free to call me directly. I look forward to our addressing together the developmental, regulatory and competitive challenges of the managed care industry for 1996 and beyond.

Sincerely,

Frank W. Clark
Acting Director
Bureau of Health Care Financing

Attachments

1/95,3/96

PENNSYLVANIA DEPARTMENT OF HEALTH
MANAGED CARE PLANS
GATEKEEPER PREFERRED PROVIDER ORGANIZATION (GPPO) NOT SUBCONTRACTING WITH AFFILIATED HMOS

Reporting Instructions:

I. GENERAL BACKGROUND: A GPPO not subcontracting with a licensed HMO cannot offer an exclusive provider organization (HMO-like) product. The GPPO must include an out-of-network benefit covering care not rendered by or referred by the member's Primary Care Physician (PCP). The Department of Health approved GPPOs, whether insured, self-funded or both, **not** subcontracting with an approved affiliated HMO but contracting directly with providers and under obligation to directly meet HMO standards in terms of health service delivery system, quality assurance system and grievance system, should follow these instructions.

The Department of Health requires each GPPO to submit an annual report detailing the GPPO activities of the previous calendar year (defined as January 1 through December 31). As stated in 31 PA Code Section 152.105, GPPOs are responsible for establishing and maintaining compliance with the same Department of Health standards regarding quality of care oversight as required of HMOs for quality assurance, assurance of access to care, external quality assurance assessment, and enrollee grievance system. Two sets of the Managed Care Plans Annual Status Report for a GPPO not subcontracting with an affiliated HMO, attachments which should be tabbed with a cover page listing all attachments and which section of the report they pertain to, and additional advertising, marketing and enrollee literature must be submitted to the Department of Health by April 30 of the current year.

If the GPPO is serving self-funded clients only, any data requiring financial information may be modified and annotated to so indicate.

The completed Annual Status Report for GPPOs not subcontracting with affiliated HMOs shall be submitted to:

PENNSYLVANIA DEPARTMENT OF HEALTH
BUREAU OF HEALTH CARE FINANCING
ROOM 1030 HEALTH AND WELFARE BUILDING
CORNER OF SEVENTH AND FORSTER
HARRISBURG PENNSYLVANIA 17120

ATTENTION MCP ANNUAL REPORT TEAM

Using the Pennsylvania Department of Health's Managed Care Plans Annual Status Report, fill out the sections applicable for the GPPO not subcontracting with affiliated HMOs or lease of its delivery system. The sections are as follows: **I. C, D; II. A, B, D, E, F; III. A, B, D, E; IV. A, B, C, D, E, F, G; V. A, B; VI.; VII. A; VIII; IX; X.** For section I. D, include a corporate organizational chart of the GPPO, including the names of staff members filling each position.

1/95, 3/96

PENNSYLVANIA DEPARTMENT OF HEALTH
SUPPLEMENT FOR SPECIAL PROGRAMS
MANAGED CARE PLANS ANNUAL STATUS REPORT
For Year Ending December 31, 1995

Plan Name: _____

Name Of Subcontracting Entity: _____

Indicate The Type Of Service: _____

1. **ENROLLMENT DATA**

List total membership by county of residence as of December 31 of the reporting calendar year.

	ENROLLMENT		
County	Private Sector	Medicare	Medicaid
TOTALS			

1995 MANAGED CARE PLANS (SPECIAL PROGRAMS) ANNUAL STATUS REPORT
PLAN: _____

2. **UTILIZATION DATA**

A. INPATIENT UTILIZATION BY TYPE OF SERVICE

Type of Service	(a) Admissions per 1,000 Members	(b) Total Patient Days Incurred	(c) Average Length of Stay (LOS)	(d) Inpatient Days Per 1,000 Members/Year
1. Medical				
2. Surgical				
3. Obstetric				
4. Mental Health				

B. OUTPATIENT UTILIZATION

Source of Enrollment	Annualized Member Ambulatory Encounters			
	(A) Primary Care Physician	(B) Specialty Care Physicians	(C) Non-Physician	(D) Total
1. Private Sector -Traditional Product				
-Point of Service				
2. Title XVIII Medicare Risk Contract				
3. Title XVIII Medicare Cost Contract				
4. Title XIX Medicaid				
5. TOTAL				

C. Enclose any additional information such as annual reports submitted to the Pennsylvania Department of Public Welfare that illustrate the prepaid Medical Assistance program.

1995 MANAGED CARE PLANS (SPECIAL PROGRAMS) ANNUAL STATUS REPORT
PLAN: _____

Note: This supplement provides a breakdown of information for Medical Assistance; however, the enrollment and utilization information reported in this supplement should be incorporated in the data reported in the Managed Care Plans Annual Status Report

1995 MCP ANNUAL STATUS REPORT
PLAN: _____

Table 1

FACILITY FINANCIAL ARRANGEMENTS

KEY

D = Discount from Usual Charges
P = Per Diem Arrangement
C = Capitated
Other = (Please Specify)

SERVICES
1 = Acute Care
2 = Skilled Nursing
3 = Hospice
4 = Rehabilitation
5 = Home Health
6 = Drug and Alcohol

FACILITY/ PROVIDER FINANCIAL ARRANGEMENTS

Name of Facility/Provider	Contract with Plan or Subcontractor	Type of Service(s) Under Contract	Financial Arrangement (Check)			
			D	P	C	Other

Table 2

1995 MCP ANNUAL STATUS REPORT
PLAN: _____

Behavioral Health Facility/ Providers Reimbursed On An Other-Than-Per-Diem or Fee-For-Service Arrangement:

KEY

C = Capitated
Other = (Please Specify)

FACILITY/ PROVIDER FINANCIAL ARRANGEMENTS

Name of Facility/Provider	Contract with Plan or Subcontractor	Type of Service(s) Under Contract	Financial Arrangement (Check)	
			C	Other (Describe)

T. E 3

SUBSTANCE ABUSE PROVIDERS/FACILITIES

LAN NAME: _____

ST SUBCONTRACTOR IF APPLICABLE: _____

KEY

Inpatient Hospital Detoxification	= 1
Inpatient Hospital Drug-Free	= 2
Psychiatric Hospital Detoxification	= 3
Psychiatric Hospital Drug-Free	= 4
Inpatient Nonhospital Detoxification	= 5
Inpatient Nonhospital Drug-Free	= 6
Partial Hospitalization Drug- Free	= 7
Outpatient Drug-Free	= 8

DRUG AND ALCOHOL FACILITY NO.	NAME OF PROVIDER	ADDRESS (LIST ALL SERVICE LOCATIONS)	CONTRACTED SERVICES (INDICATED BY NUMBER ON KEY) CHECK ALL THAT APPLY (X)							
			1	2	3	4	5	6	7	8