pennsylvania
INSURANCE DEPARTMENT
1311 Strawberry Square
Harrisburg, PA 17120

BUREAU OF MANAGED CARE

ANNUAL REPORT FORM

For Year Ending December 31, 2023

GENERAL INFORMATION

When preparing the Annual Report, make sure documents are properly labeled. In addition to the Annual Report form, provide a cover page listing each section and corresponding attachment(s). Please do not alter the contents or tables in the Annual Report Form template. The Annual Report with attachments must be received by the Bureau of Managed Care on or before **April 30**.

Name of Plan:		NAIC CoCode:	
Address:			
Plan telephone:			
Plan fax:			
Website:			
Report completed by: Name:			
Title:			
Telephone:			
Email:			
Behavioral Health reporting by: Name:			
Title:			
Telephone:			
Email:			
Additional Plan Contact: Name:			
Title:			
Telephone:			
Email:			
Affiliated Gatekeeper Preferred Provider Organization (GPPO)			

I. GOVERNANCE

A. BOARD OF DIRECTORS

Name (Chairperson)	Affiliations	Subscriber Representative	
		Yes	No
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

B. BOARD OFFICERS

President:	
Vice President:	
Secretary:	
Treasurer:	

C. PLAN STAFF

	Name	Email
Chief Executive Officer		
Chief Operations Officer		
Medical Director		
QA/QI Coordinator		
Utilization Review Director		
Financial Officer		
Member Relations Director		
Provider Relations Director		
Government Relations Director		
Credentialing		
Contract Review		
Network Review		

D. HMO: ORGANIZATIONAL CHARTS

HMO: Provide a plan organizational chart including the Board of Directors and Executive Staff. Provide the name of the staff member filling each position. Provide the charts as an Attachment.

GPPO: Provide 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). Provide the chart(s) as an **Attachment**.

E. CORPORATE BY-LAW REVISIONS

	Yes	No
Have there been revisions to the corporate by-laws? If yes, provide revisions as an **Attachment**.	☐	☐

II. MANAGED CARE PRODUCTS

Managed Care Product Identification:

Product Names	Description

III. ENROLLMENT DATA

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

	Individual	**Small Group fully-insured**	**Large Group fully-insured**	**Small Group self-funded**	**Large Group self-funded**	**Medicare Advantage**	**Medicare Supplemental**	**CHIP**	**HealthChoices**	**Community HealthChoices**
Adams										
Allegheny										
Armstrong										
Beaver										
Bedford										

	Individual	Small Group fully-insured	Large Group fully-insured	Small Group self-funded	Large Group self-funded	Medicare Advantage	Medicare Supplemental	CHIP	HealthChoices	Community HealthChoices
Berks										
Blair										
Bradford										
Bucks										
Butler										
Cambria										
Cameron										
Carbon										
Centre										
Chester										
Clarion										
Clearfield										
Clinton										
Columbia										
Crawford										
Cumberland										
Dauphin										
Delaware										
Elk										
Erie										
Fayette										
Forest										
Franklin										
Fulton										
Greene										
Huntingdon										
Indiana										
Jefferson										
Juniata										
Lackawanna										
Lancaster										
Lawrence										
Lebanon										

	Individual	Small Group fully-insured	Large Group fully-insured	Small Group self-funded	Large Group self-funded	Medicare Advantage	Medicare Supplemental	CHIP	HealthChoices	Community HealthChoices
Lehigh										
Luzerne										
Lycoming										
McKean										
Mercer										
Mifflin										
Monroe										
Montgomery										
Montour										
Northampton										
Northumberland										
Perry										
Philadelphia										
Pike										
Potter										
Schuylkill										
Snyder										
Somerset										
Sullivan										
Susquehanna										
Tioga										
Union										
Venango										
Warren										
Washington										
Wayne										
Westmoreland										
Wyoming										
York										
Other										
Out of State										
TOTALS										

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

Adams	☐	Allegheny	☐	Armstrong	☐	Beaver	☐	Bedford	☐
Berks	☐	Blair	☐	Bradford	☐	Bucks	☐	Butler	☐
Cambria	☐	Cameron	☐	Carbon	☐	Centre	☐	Chester	☐
Clarion	☐	Clearfield	☐	Clinton	☐	Columbia	☐	Crawford	☐
Cumberland	☐	Dauphin	☐	Delaware	☐	Elk	☐	Erie	☐
Fayette	☐	Forest	☐	Franklin	☐	Fulton	☐	Greene	☐
Huntingdon	☐	Indiana	☐	Jefferson	☐	Juniata	☐	Lackawanna	☐
Lancaster	☐	Lawrence	☐	Lebanon	☐	Lehigh	☐	Luzerne	☐
Lycoming	☐	McKean	☐	Mercer	☐	Mifflin	☐	Monroe	☐
Montgomery	☐	Montour	☐	Northampton	☐	Northumberland	☐	Perry	☐
Philadelphia	☐	Pike	☐	Potter	☐	Schuylkill	☐	Snyder	☐
Somerset	☐	Sullivan	☐	Susquehanna	☐	Tioga	☐	Union	☐
Venango	☐	Warren	☐	Washington	☐	Wayne	☐	Westmoreland	☐
Wyoming	☐	York	☐						

C. Disenrollment

	CATEGORIES					
	VOLUNTARY		**INVOLUNTARY**		**UNKNOWN**	
Line of Business	1. Dissatisfaction with Plan	2. Change of residence (moved out of service area)	3. Disenrollment/ Termination	4. Death	5. Unknown/ Other	TOTALS
Individual						
Small Group fully-insured						
Large Group fully-insured						
Small Group self-funded						
Large Group self-funded						
Medicare Advantage						
Medicare Supplemental						
CHIP						
HealthChoices						
Community HealthChoices						
TOTALS						

IV. DELIVERY SYSTEM INFORMATION

A. ANNUAL QUALITY ASSURANCE REPORT

Provide as an **Attachment** a copy of the most recent 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 and subsequent actions should be included for each and listed in an **Attachment**.

B. PLAN STANDARDS

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

	Number of patients seen per hour	Acceptable patient wait time (in minutes)	Number of office hours each Primary Care Provider must be available per week	Physician call-back time (in minutes)
Line of Business				
Individual				Emergency: Nonemergency:
Small Group fully-insured				Emergency: Nonemergency:
Large Group fully-insured				Emergency: Nonemergency:
Small Group self-funded				Emergency: Nonemergency:
Large Group self-funded				Emergency: Nonemergency:
Medicare Advantage				Emergency: Nonemergency:
Medicare Supplemental				Emergency: Nonemergency:
CHIP				Emergency: Nonemergency:
HealthChoices				Emergency: Nonemergency:
Community HealthChoices				Emergency: Nonemergency:

	Maximum wait time for scheduling an urgent care visit (days)	Maximum wait time for scheduling routine primary care (days)	Maximum wait time for scheduling mental health care (days)	Maximum wait time for scheduling SUD care (days)
Line of Business				
Individual		Initial visit: Follow-up:	Initial visit: Follow-up:	Initial visit: Follow-up:
Small Group fully-insured		Initial visit: Follow-up:	Initial visit: Follow-up:	Initial visit: Follow-up:
Large Group fully-insured		Initial visit: Follow-up:	Initial visit: Follow-up:	Initial visit: Follow-up:
Small Group self-funded		Initial visit: Follow-up:	Initial visit: Follow-up:	Initial visit: Follow-up:
Large Group self-funded		Initial visit: Follow-up:	Initial visit: Follow-up:	Initial visit: Follow-up:
Medicare Advantage		Initial visit: Follow-up:	Initial visit: Follow-up:	Initial visit: Follow-up:
Medicare Supplemental		Initial visit: Follow-up:	Initial visit: Follow-up:	Initial visit: Follow-up:
CHIP		Initial visit: Follow-up:	Initial visit: Follow-up:	Initial visit: Follow-up:
HealthChoices		Initial visit: Follow-up:	Initial visit: Follow-up:	Initial visit: Follow-up:
Community HealthChoices		Initial visit: Follow-up:	Initial visit: Follow-up:	Initial visit: Follow-up:

C. PROVIDER DIRECTORY

Please provide URLs for the public facing provider directories as an **Attachment**.

D. CONTRACTS

Provide a list of approved contract names and approval dates for:

- primary care physicians,
- specialists, and
- hospitals.

Also include a list of all IDS contracts and their approval dates currently in effect. The contracts should include reimbursement methodology.

E. CONSUMER SATISFACTION

If a consumer satisfaction survey was conducted in the past calendar year,

- provide the summarized methodology employed and the results in an **Attachment**.
- provide a copy of the consumer satisfaction survey as an **Attachment**

F. MARKETING

Provide a copy of the most recent marketing materials available to plan members and prospective members (e.g., Quarterly Newsletter) as an **Attachment**.

G. REFERRALS

Provide a copy of the current standard referral form used by PCPs in making in-plan or out-of-plan referrals as an **Attachment**.

V. COMPLAINT & GRIEVANCE RESOLUTION SYSTEM

Provide copies of the current enrollee literature, including subscription agreements, enrollee handbooks and any mass communications to enrollees concerning complaint and grievance rights and procedures in an **Attachment**. Please note that these numbers should not include behavioral health complaints. These will be accounted for in section IX.C. below.

A. COMPLAINTS SUMMARY – SINGLE-LEVEL INTERNAL APPEAL

TABLE A	Pending from previous year	Filed this year	Withdrawn this year	Decisions this year			Pending this year
				Overturned	Upheld	Partially upheld	
First level							
External							

B. COMPLAINTS – TWO-LEVEL INTERNAL APPEAL

TABLE B	Pending from previous year	Filed this year	Withdrawn this year	Decisions this year			Pending this year
				Overturned	Upheld	Partially upheld	
First level							
Second level							
External							

C. GRIEVANCE

TABLE C	Pending from previous year	Filed this year	Withdrawn this year	Decisions this year			
				Overturned	Upheld	Partially upheld	Pending this year
Internal Grievances							
Personal Assistance Services							
Home Modifications							
Other HCBS							
Skilled/Private							

Duty Nursing Services							
Dental Services							
Level of Care							
Out-of-Network							
Experimental/ Investigational							
Medical Procedures							
Durable Medical Equipment/ Medical Supplies							
Pharmacy							
Other							
TOTAL							

TABLE C	Pending from previous year	Filed this year	Withdrawn this year	Decisions this year			
				Overturned	Upheld	Partially upheld	Pending this year
External Grievances							
Personal Assistance Services							
Home Modifications							
Other HCBS							
Skilled/Private Duty Nursing Services							
Dental Services							
Level of Care							
Out-of-Network							
Experimental/ Investigational							
Medical Procedures							
Durable Medical Equipment/ Medical Supplies							
Pharmacy							
Other							
TOTAL							

VI. UTILIZATION DATA

A. INPATIENT UTILIZATION BY TYPE OF SERVICE

Type of Service	Admissions per 1,000 Members	Total Patient Days Incurred	Average Length of Stay	Inpatient Days per 1,000 Members/Year
Medical				
Surgical				
Obstetric				
Mental Health				
Substance Use Disorder (SUD)				

B. OUTPATIENT UTILIZATION (per 1,000 members)

Source of Enrollment	Primary Care	Specialty Care	Mental Health Services	SUD Services
Individual				
Small Group fully-insured				
Large Group fully insured				
Small group self-funded				
Large group self-funded				
Medicare Advantage				
Medicare Supplemental				
CHIP				
HealthChoices				
Community HealthChoices				

C. EMERGENCY SERVICES

In-Area Emergency Claims		Out-of-Area Emergency Claims	
Received/Total		Received/Total	
Paid		Paid	
Pending		Pending	
Rejected		Rejected	

D. AUTHORIZED OUT-OF-NETWORK REFERRAL

	Outpatient	Inpatient
Received/Total		
Approved		
Denied		
Pending		

VII. INTEGRATED DELIVERY SYSTEMS (IDS)

Name of IDS	Address	Type (e.g., Behavioral Health)	Enrollment

VIII. CERTIFIED REVIEW ENTITY (CRE)

Name of CRE	Address	Phone	Type (e.g., Durable Medical Equipment)

IX. BEHAVIORAL HEALTH

A. SUBCONTRACTOR SERVICES

Subcontractor	Contact Name	Telephone #	Email	Services Provided	Reimbursement model (provide documentation, e.g., current contract, reimbursement policies, as **Attachments**)

B. QUESTIONS

	Yes	No
1. Does your quality improvement plan reflect oversight of these activities? Provide documentation, including improvement plan, monitoring reports, as **Attachments**	☐	☐
2. Do you have an approved oversight plan for these services? Provide oversight plans in an **Attachment**	☐	☐
3. Does the subcontractor monitor facilities/providers to ensure that financial incentives (e.g., capitation) do not adversely affect patient care? Provide relevant documentation in an **Attachment**	☐	☐
4. 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)? Provide relevant documentation in an **Attachment**		
5. Is the direct number for behavioral health service organization listed on the member's identification card and in the provider directory?	☐	☐
6. Is a member required to obtain a referral from the primary care physician for behavioral health services? Provide a description of how members access behavioral health services in an **Attachment**	☐	☐
7. Do the subcontractor's credentialing criteria differ from the plan's credentialing criteria? Provide a copy of credentialing criteria in an **Attachment**	☐	☐
8. Does the plan contract directly with any behavioral health facilities/providers using a reimbursement mechanism other than per diem rate or fee for service? Provide relevant documentation in an **Attachment**	☐	☐
9. Are medical records reviewed for behavioral health providers in conjunction with credentialing/recredentialing process? Provide relevant documentation in an **Attachment**	☐	☐
10. Has the plan or subcontractor conducted any **clinical** quality assurance audits in the area of behavioral health during the last year? Provide relevant documentation in an **Attachment**	☐	☐

C. BEHAVIORAL HEALTH COMPLAINTS AND GRIEVANCES

Single-level complaints

	Pending from previous year		Filed this year		Withdrawn this year		Decisions this year						Pending this year	
							Overturned		Upheld		Partially Upheld			
	MH	SUD	MH	SUD	MH	SUD	MH	SUD	MH	SUD	MH	SUD	MH	SUD
First level														
External														

Two-level complaints

	Pending from previous year		Filed this year		Withdrawn this year		Decisions this year						Pending this year	
							Overturned		Upheld		Partially Upheld			
	MH	SUD	MH	SUD	MH	SUD	MH	SUD	MH	SUD	MH	SUD	MH	SUD
First level														
Second level														
External														

C. BEHAVIORAL HEALTH COMPLAINTS AND GRIEVANCES CONTINUED

Grievances

	Pending from previous year		Filed this year		Withdrawn this year		Decisions this year						Pending this year	
							Overturned		Upheld		Partially Upheld			
	MH	SUD	MH	SUD	MH	SUD	MH	SUD	MH	SUD	MH	SUD	MH	SUD
First level														
External														

D. SUBSTANCE USE DISORDER TREATMENT DATA

	# 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 non-hospital detox		N/A				
Non-Hospital Residential/ Inpatient		N/A				
Partial Hospitalization /Intensive Outpatient			N/A	N/A	N/A	
Outpatient			N/A	N/A	N/A	

X. CERTIFICATION

Signature of Plan Chief Executive Officer Date

Signature of Plan Medical Director Date