pennsylvania
DEPARTMENT OF HEALTH
912 Health & Welfare Building, 7th and Forster St
Harrisburg, PA 17120

pennsylvania
INSURANCE DEPARTMENT
1311 Strawberry Square
Harrisburg, PA 17120

BUREAU OF MANAGED CARE

ANNUAL STATUS REPORT
For year Ending December 31, 2020

When preparing the Annual Report, make sure documents are properly labeled. Provide a cover page listing each section and corresponding attachment(s). The Annual Report with attachments and **a copy** of the annual NAIC financial report must be received by the Bureau of Managed Care on or before **April 30**.

Section 9.604(a)(8) refers to reimbursement information that is to be submitted to the Department (via the Bureau of Managed Care) and to be kept confidential by the agency. To meet this requirement, include this information as a separate document clearly labeled **Confidential Reimbursement Information. Please include "CONFIDENTIAL" in the file name. Information not labeled this way will be part of the annual report material that is available for public review and download.**

Name of plan:	
Address:	
Company telephone number:	
Company Fax Number:	
Web Site:	
Report completed by:	Name
	Title
	Phone number
Contact person:	Name
	Title
	Phone number
Affiliated GPPO:	Name

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I. GOVERNING/ADMINISTRATIVE SERVICES

A. BOARD OF DIRECTORS

("X" the appropriate answer box.)

NAME (Chairperson)	**AFFILIATIONS**	**Subscriber Representative**	
		Yes	No
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

B. BOARD OFFICERS

President:	
Vice President:	
Secretary:	
Treasurer:	

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C. PLAN STAFF

	Name	Title
Chief Executive Officer		
Chief Operation Officer		
Medical Director		
QA/QI Coordinator		
Utilization Review Director		
Financial Officer		
Member Relations Director		
Provider Relations Director		

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D. 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 chart(s) 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. Have there been revisions to the corporate by-law? ☐Yes ☐No
F. If yes, provide revisions as an **Attachment**.

II. PLAN DESCRIPTION

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

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

C. FEDERAL QUALIFICATION: (Indicate by placing an "X' in the appropriate box.)
☐Yes ☐No ☐Pending Date: / /

D. EFFECTIVE DATE OF FIRST SUBSCRIBER CONTRACT Date: / /

E. SERVICE AREA: 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	☐						

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GPPO Service Area: Check the appropriate box. ☐ Same as HMO ☐ Different
If different, list GPPO counties separately in an **Attachment**.

F. MANAGED CARE PRODUCT (S) IDENTIFICATION:

Proper Product Name and Brief Descriptions

Product Names	Description

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III. ENROLLMENT DATA

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

	Private Sector	Private Sector Self-funded	Medicare+Choice	HealthChoices (Medicaid)	Total
HMO					
Group					
Staff					
Network					
GPPO					
Total					

B. Enrollment by Age and Sex of Members:

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

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

County	Private	Medicare	Medicaid	County	Private	Medicare	Medicaid
Adams				Lancaster			
Allegheny				Lawrence			
Armstrong				Lebanon			
Beaver				Lehigh			
Bedford				Luzerne			
Berks				Lycoming			
Blair				Mckean			
Bradford				Mercer			
Bucks				Mifflin			
Butler				Monroe			
Cambria				Montgomery			
Cameron				Montour			
Carbon				Northampton			
Centre				Northumberland			
Chester				P e r r y			
Clarion				Philadelphia			
Clearfield				Pike			
Clinton				Potter			
Columbia				Schuylkill			
Crawford				Snyder			
Cumberland				Somerset			
Dauphin				Sullivan			
Delaware				Susquehanna			
Elk				Tioga			
Erie				Union			
Fayette				Venango			
Forest				Warren			
Franklin				Washington			
Fulton				Wayne			
Greene				Westmoreland			
Huntingdon				Wyoming			
Indiana				York			
Jefferson				Other			
Juniata				Out of State			
Lackawanna							
Totals	Private:	Medicare:	Medicaid:	Grand: Total			

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D. Total members by type of prepayment contract as 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. Medicare+Choice	
b. HealthChoice (Medicaid)	
3. Non-Group Contacts	
a. Individual, Non-Group Contract	
b. Individual, Conversion Contract	
Total	

E. Plan 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	

F. Place and (X) in the appropriate response:

Optional Additional Cost Services/Benefits	Yes	No	Enrollment for 12/31
1. Dental Service	☐	☐	
2. Vision Care Services	☐	☐	
3. Prescription Drugs	☐	☐	

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IV. DELIVERY SYSTEM DATA

GPPO: If the system is that same for GPPO and HMO enrollees, please place an (X) in the box. If the systems differ, explain in an **Attachment**.

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 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:

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:

Health Providers	Attachments were information can be found
Primary care physician list	
Specialty care physician	
Health care center	
Recent list of provider and facilities made available to the members	

Please include the number of physicians and centers listed:

1. Primary Care Physicians				2. Specialty Physicians	3. Heath Centers (Group/staff/&model HMOs only)
FP/GP	PED	Gen Med	Other (List)		

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

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

   If yes, provide the names(s) of the site(s), address(es) of the site(s), name(s) of clinician(s) and specialty/(ies) in an **Attachment**.

D. TYPE OF REIMBURSEMENT/PAYMENT MECHANISMS:

1. Primary Care Physicians (Check the type)

Capitation	**S**alary	**M**odified Fee-for-Service	**F**ee Schedule	Combination of **CSMF** (describe)	Other (describe)

Provide copies of the current primary care physician contracts and reimbursement system methodology in an Attachment.

Report the number of primary care physicians exclusively contracting with reporting HMO in an Attachment.

2. Specialty Care Physicians (Check the type)

Capitation	**S**alary	**M**odified Fee-for-Service	**F**ee Schedule	Combination of **CSMF** (describe)	Other (describe)

Provide copies of the current specialty care physician contract and reimbursement system methodology including all variations differing from fee-for-service in an **Attachment**.

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 the format in **Table 1**) in an **Attachment**. Additionally, include a copy of your generic hospital contract and reimbursement methodology for any capitated agreement.

E. Complaint and Grievance Resolution System:

Enclose a copy 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**.

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F. Calendar Year Summary of Complaints and Grievances

COMPLAINTS

	Pending from previous year	Filed this year	Withdrawn this year	Decisions this year In Favor of		Pending this year
				Member	HMO	
1. 1st Level						
2. 2nd Level						
3. Total						

GRIEVANCES

	Pending from previous year	Filed this year	Withdrawn this year	Decisions this year In Favor of		Pending this year
				Member	HMO	
4. 1st Level						
5. 2nd Level						
6. Total						

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 disenrollment/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 summarized the methodology employed and the results in an **Attachment.**

Provide a copy of the consumer satisfaction survey as an **Attachment**.

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I. MARKETING:
Provide a copy of the plan's current marketing literature as an **Attachment**.

J. REFERRAL:
Provide a copy of the plan's current standard referral form as an **Attachment**.

V. PROFESSIONAL STAFFING

A. CAPACITY DETERMINATION: Describe in an **Attachment** any changes in the plan's methodology for assessing 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 member	
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	

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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				

B. OUTPATIENT UTILIZATION

Annualized Member Ambulatory Encounters				
Source of Enrollment	(A) Primary Care Physician	(B) Specialty Care Physician	(C) Non-Physician	(D) Total
1. Private Sector				
a. Traditional Product				
b. Point of Service				
2. Medicare + Choices				
3. HealthChoices (Medicaid)				
Total				

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

In-Area Emergency Claims		Out-Of-Area Emergency Claims		Out-Of-Plan Authorized Referral	
Received		Received		Ambulatory	
Paid		Paid		Inpatient	
Pending		Pending			
Rejected		Rejected			

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VII. FINANCIAL DATA

A. Co-payment:	
1. List range of co-payment for routine primary case	$
2. Maximum co-payment for hospital emergency room care	$

B. Financial Analysis:		
	Current Year	Previous Year
1. Total Current Assets	$	$
2. Total Current Liabilities	$	$
3. Current Ration (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:		
	200	200
1. First Quarter Premiums-Single Coverage	$ (ending years figures)	$ (previous years figures)
2. First Quarter Premiums-Family	$ (ending years figures)	$ (previous years figures)
3. Percent change in HMO Premium Rate from preceding calendar year		(%)

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VIII. INTEGRATED DELIVERY SYSTEMS (IDS)

Provide the name, address, type and enrollment for all the contracted Integrated Delivery Systems (IDS)

Name of IDS	Address	Type (e.g. behavioral health)	Enrollment

IX. CERTIFIED REVIEW ENTITY (CRE)

Provide the name, address and type for all contracted utilization review entities (CRE)

Name of CRE	Address	Type (e.g. durable medical equipment)

X. BEHAVIORAL HEALTH

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

Name	Title	Telephone number

SUBCONTRACTING: Questions 1-14

1. Names	
Name of Subcontractor	Telephone Number

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2. Services		
Services	X	Comments
Credentialing/Recredentialing	☐	
Provider Contracting	☐	
Patient Assessment	☐	
Overall management of Patient Care	☐	
Quality Assurance/Quality Improvement	☐	
Utilization Review	☐	
Compliant/Grievance Resolution	☐	
Provision of Care	☐	
Other	☐	

3. Does your quality improvement plan reflect oversight of these activities? ☐Yes ☐No

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

5. How is the subcontractor reimbursed for services? Provide current contract between HMO and each Behavioral Health Organization subcontractor in an **Attachment**.

   Provide current sample contract between each Behavioral Health Organization and its participating direct providers of care. Response provided in an **Attachment**.

6. How does the subcontractor reimburse facilities/providers? Response provided in an **Attachment.**

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

7. How does the subcontractor monitor facilities/provides to ensure that financial incentives (e.g., capitation) do not adversely affect patient care? The response is listed in an **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 in an **Attachment**.

9. Provide 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 in an **Attachment**.

10. Provide a copy of the plan's most recent monitoring report of the subcontractor's performance in an **Attachment.**

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11. Is the direct number for behavioral health service organization listed on the member's identification card and in the provider directory?

12. Describe in an **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

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? Provide an **Attachment**.

14. Provide a copy of each behavioral health subcontractor's credentialing criteria in an **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 in an **Attachment (Using Table 2's format)**

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 credentialing/recredentialing process? ☐Yes ☐No
Please include the response in an **Attachment**.

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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 an **Attachment**.

20. Number of Behavioral Health Grievances Received			
Number of Grievance Received	Number Resolved		Number of Grievances Pending
	Member's Favor	Plan's Favor	
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						
Other						

XI. Provide copy of your approved definition of emergency and out-of-area services as an Attachment.

XII. Certification:

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

_____ _____
Signature of Plan Chief Executive Officer **Date**

_____ _____
Signature of Plan Medical Director **Date**

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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
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	
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			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	

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Table 2

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)
			☐	
			☐	
			☐	
			☐	
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			☐	

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TABLE 3

XIII. SUBSTANCE ABUSE PROVIDERS/FACILITIES

LIST 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
			☐	☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐	☐
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			☐	☐	☐	☐	☐	☐	☐	☐
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