



1311 Strawberry Square  
Harrisburg, PA 17120

# BUREAU OF MANAGED CARE

## QUARTERLY REPORT FORM

### GENERAL INFORMATION

When preparing the Quarterly Report, make sure documents are properly labeled. In addition to the Quarterly Report form, provide a cover page listing each section and corresponding attachment(s). Please do not alter the contents or tables in the Quarterly Report Form template. Quarterly Reports with attachments must be received by the Bureau of Managed Care on or before **45 days after the close of each calendar quarter**.

Quarter:		Year:	
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. ENROLLMENT DATA**

A. List total membership by enrollment type as of the last day of the reporting calendar quarter.

	<b>Individual</b>	<b>Small Group fully-insured</b>	<b>Large Group fully-insured</b>	<b>Small Group self-funded</b>	<b>Large Group self-funded</b>	<b>Medicare Advantage</b>	<b>Medicare Supplemental</b>	<b>CHIP</b>	<b>HealthChoices</b>	<b>Community HealthChoices</b>
Total Members at close of last Quarter										
Additions during this Quarter										
Terminations during this Quarter										
Net change for the Quarter										
Total Members at close of this Quarter										

**II. COMPLAINT & GRIEVANCE RESOLUTION SYSTEM**

If there has been a substantive change since the last Annual Report filed, 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**.

A. COMPLAINTS SUMMARY – SINGLE-LEVEL INTERNAL APPEAL

<b>TABLE A</b>	Pending from previous quarter	Filed this quarter	Withdrawn this quarter	Decisions this quarter			Pending this quarter
				Overturned	Upheld	Partially upheld	
<b>FIRST LEVEL</b>							
Not a covered service							
Out-of-Network (OON) services not covered							
Other							
<b>TOTAL:</b>							
<b>EXTERNAL</b>							
Not a covered service							
Out-of-Network							

(OON) services not covered							
Other							
<b>TOTAL:</b>							

**B. COMPLAINTS – TWO-LEVEL INTERNAL APPEAL**

TABLE B	Pending from previous quarter	Filed this quarter	Withdrawn this quarter	Decisions this quarter			Pending this quarter
				Overturned	Upheld	Partially upheld	
<b>FIRST LEVEL</b>							
Quality complaint							
Network Adequacy							
Other							
<b>TOTAL:</b>							
<b>SECOND LEVEL</b>							
Quality Complaint							
Network Adequacy							
Other							
<b>TOTAL:</b>							
<b>EXTERNAL</b>							
Quality Complaint							
Network Adequacy							
Other							
<b>TOTAL:</b>							

**C. GRIEVANCE**

TABLE C	Pending from previous quarter	Filed this quarter	Withdrawn this quarter	Decisions this quarter			Pending this quarter
				Overturned	Upheld	Partially upheld	
<b>Internal Grievances</b>							
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							

<b>INTERNAL TOTAL:</b>							
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							
<b>EXTERNAL TOTAL:</b>							

**III. 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/Quarter
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				



**B. 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	

**V. PROVIDER NETWORK**

Provide the Plan’s network reporting most recently submitted as an **Attachment**.

**VI. CERTIFICATION**

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Signature of Plan Chief Executive Officer

Date

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Signature of Plan Medical Director

Date