# PENNSYLVANIA DEPARTMENT OF HEALTH
# BUREAU OF MANAGED CARE

## *Annual Report Instructions*

GENERAL INFORMATION

Department of Health regulations (28 Pa Code §9.604) require that a managed care plan - HMO, GPPO, IDS, Hospital Plan Corporation, and Professional Health Services Plan Corporation - submit to the Department a detailed report of its activities during the preceding calendar year on or before April 30.

Section 9.604(a)(8) indicates that "copies of the currently utilized generic or standard form health care provider contracts including copies of any deviations from the standard contracts and reimbursement methodologies." ***To meet this requirement, please include a copy of the most recent DOH approved (copy with the DOH approved stamp on it) contract for: primary care physician, specialist, and hospital. Also include a list of all IDS contracts currently in effect.***

Section 9.604(a)(8) also refers to reimbursement information that is to be submitted to the Department and to be kept confidential by the agency. To meet this requirement, include this information in a separate envelope clearly labeled: **Confidential Reimbursement Information.** Information not labeled this way will be part of the annual report material that is available for public review and copy.

Below are some general definitions to assist in preparing the Report:

Gatekeeper PPO (GPPO)

The Department's regulations define a gatekeeper as: a primary care provider selected by an enrollee or appointed by a managed care plan, or the plan or an agent of the plan serving as the primary care provider, from whom an enrollee shall obtain covered health care services, a referral, or approval for covered, nonemergency health services as a precondition to receiving the highest level of coverage available under the managed care plan.

For reporting purposes, information regarding GPPO enrollees will be submitted as it is for HMO members, including, but not limited to such information as: utilization data, provider data, grievance resolution and statement of revenue and expenses. For the reporting of enrollment, the Department requests a breakout for self-funded business and other unique products.

Integrated Delivery system (IDS)

An IDS as a partnership, association, corporation or other legal entity which does the following:

1) enters into a contractual arrangement with a managed care plan

2) employs or has contracts with providers (participating providers)
3) agrees under its arrangements with a managed care plan to do the following: provide or arrange for the provision of a defined set of health care services to managed care members covered under a managed care plan benefits contract principally through its participating providers
4) assume under the arrangements some responsibility for conduct, in conjunction with the managed care plan and under compliance monitoring of the managed care plan's quality assurance, utilization review, credentialing, provider relations or related functions.
5) perform claim processing and other functions.

Certified Utilization Review Entity (CRE)

A CRE is any entity certified pursuant to subchapter K of the managed care regulations and performs utilization review on behalf of a managed care plan.

Report Submission

When preparing the Annual Report, make sure attachments are properly tabbed and labeled. Provide a cover page listing each section and corresponding attachment(s). **Two sets** of the Annual Report with attachments and **one copy** of the annual NAIC financial report must be received by the Department of Health on or before **April 30**.

Submit Reports to:

PENNSYLVANIA DEPARTMENT OF HEALTH
BUREAU OF MANAGED CARE
ROOM 912, HEALTH AND WELFARE BUILDING
625 FORSTER STREET
HARRISBURG, PENNSYLVANIA 17120

## I. GOVERNING/ADMINISTRATIVE SERVICES

Provide a current listing of the Board members by name and affiliation. Indicate those Board members who are subscriber representatives.

Key plan staff should be listed by name and title. If a position is vacant, so indicate and describe current efforts to fill the vacancy.
Attach a copy of the current organizational chart that delineates reporting relationships and provides the name of the staff member filling each position.

A copy of the Corporate bylaws should be enclosed only if changes have been made since last year's submission. 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 managed care plan 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. Supply the effective date of qualification. 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 plan utilizes product name descriptions for various products or lines of business then identify trade name product type and key features.

Using the example below, please complete the chart with the proper managed care plan 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 |
| Gold 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 is consistent on both forms.

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 "managed care plan" is a health care plan that uses a gatekeeper to manage the utilization of health care services; integrates the financing and delivery of health care services to enrollees by arrangements with health care providers selected to participate on the basis of specific standards; and provides financial incentives for enrollees to use the participating health care providers in accordance with procedures established by the plan. A managed care plan includes health care arranged through an entity operating under any of the following: Section 630 of the Insurance Company Law of 1921, the Health Maintenance Organization Act (40 P.S. §§ 1551-1568), the Fraternal Benefits Societies Code, 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations) and 40 Pa.C.S. Chapter 63 (relating to professional health services plan corporations).

A managed care plan includes an entity, including a municipality, whether licensed or unlicensed, that contracts with or functions as a managed care plan to provide health care services to enrollees. Managed care plans require the enrollee to obtain a referral from any primary care provider in its network as a condition to receiving the highest level of benefits for specialty care.

This term does not include ancillary service plans as defined by the act or an indemnity arrangement which is primarily fee for service.

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 contracts with a medical group or groups to deliver services to its enrollees.

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

Network - The HMO contracts directly 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 of 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.

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 Centers for Medicare and Medicaid Services (formerly HCFA) 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+Choice corresponds to the Medicare population and HealthChoices corresponds to the Medicaid population. 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

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

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 attachment.

A. Annual Quality Assurance Report

In accordance with Section 9.604(a)(9) of the regulations, attach a copy of the most recent quality assurance report that has been approved by the board of directors.

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 plan 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 electronic listings (CD or Flash Drive) of primary care physicians, specialty care providers, facilities, and groups under contract with the plan. Addendum 1 provides the guidelines need to format the tables to be

submitted electronically through CD or Flash Drive in the formats listed in Tables 4, 5 and 6. Please reference

The Addendum 1 for instructions.

1. **Provider: Table 4**

Primary Care Physicians and Specialty Care Physicians

Give total number and list all primary care physicians and specialty physicians with whom the plan has a contractual arrangement to supervise, coordinate, and provide basic medical care. Specialty Care Physicians also include those authorized by the primary care physician. (Reference Table 4 for Format)

2 **Group: Table 5**

Provider Group

List the name and location of all groups in the network. (Reference Table 5 for Format)

3. **Facility: Table 6**

Include all institutional providers, ancillary providers and contractors such as hospitals, ambulatory care centers etc.

D. Reimbursement/Payment Mechanisms

1. Primary Care Physician and
2. Specialty Care Physician

Indicate the typical way the plan reimburses physicians 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.

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 plan 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. 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.

F. Calendar Year Complaints and Grievances

Pending from previous year: List the number of first and second-level grievances on which action is pending from the previous reporting year. This includes 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 intervention following a second-level decision and appeal resulted in the DOH requiring the plan 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 complaints and grievances filed by members during the reporting year.

Please note that many quality of care issues arise and are resolved prior to their reaching the formal complaint / grievance process. Quality of care complaints include such things as: physician rudeness, inappropriate touching, unclean office, etc. The member usually wants the matter investigated and may also want any number of plan responses, including physician termination and/or an apology. When these matters are satisfactorily resolved between the plan and the member, they are **not** counted as Act 68 complaints / grievances, and are not included in the tabulations for the annual report.

However, if the matter is not satisfactorily resolved, and the member files

a formal complaint / grievance regarding the issue, it becomes an event that **needs to be included** in the annual report. If the plan is able to resolve part of the issue (e.g., the plan will pay for the services) but not all (the plan will not terminate the physician as per member's request) it is counted as an *uphold* for the plan.

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

Decisions this year: List the number of first and second-level decisions for complaints and grievances for the year, distinguishing between "in favor of the member" or "in favor of the HMO." (See comment in "Filed this Year" above).

Pending this year: List the number of first and second-level complaints and 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. Include the methodology used and the survey results.

I. Marketing

Attach a copy of the most recent marketing materials available to plan members and prospective members (e.g. Quarterly Newsletter).

J. Referral

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 plan 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.

B. Medical Complement - (Group/Staff models only)

Note: This section is to be completed by those plans that are structured, either partially or entirely, as a group or staff model plan. 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 practitioners.

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

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

C. Medical Complement - Used for Network models only.

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.

## VI. UTILIZATION DATA

A. Inpatient Utilization by Type of Service

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

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 IX.

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 plan members.

The "in area" is specified as the plan'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. Co-payments

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 are 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 that you provide the maximum co-payment amount. Also, 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 in the following sections of the Annual Statement (HMO-Association Edition):

| | |
|---|---|
| Total Current Assets | Report # 1 - Part A |
| | |

| | |
|---|---|
| Total Current Liabilities | Report # 1 - Part B |
| Total Medical & Hospital Expenses | Report # 2 - Expenses: Less |
| Total Health Care Revenue | Report # 2 |
| Total Administrative Expense | Report # 2 - Administration |
| Net Income | Report # 2 - Administration |
| Total Revenue | Report # 2 - Revenues |

C. Premiums

List your Department of Insurance-approved two-tier community rate for basic health services during the first quarter of the reporting year and the previous year. 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. INTEGRATED DELIVERY SYSTEMS (IDS)

If the managed care organization contracts with an IDS then complete the table by listing the name, address, type and enrollment of the IDS. For more information on IDSs refer to the Statements of Policy, Title 28 PA Code Chapter 9, Approval of Provider Contracting Arrangements between HMOs and PHOs, POS and IDSs.

## IX. UTILIZATION REVIEW ENTITY (URE)

If the managed care organization contracts with an URE then complete the table by listing the name, address and type of the URE. For more information on UREs refer to Act 68 (40 P.S. §§ 991.2151-2152).

## X. BEHAVIORAL HEALTH

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.

## XI. EMERGENCY AND OUT-OF-AREA SERVICES

Attach a copy of the plan's definition of what constitutes "emergency" as well as a definition of "out-of-area" services.

## XII. 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 the Bureau of Managed Care at (717) 787-5193.

# Addendum:  Provider Network

## Provider: Table 4

| | Identifier | Definition | Instruction |
|---|---|---|---|
| 1 | LastName | health provider's last name | **required** |
| 2 | FirstName | health provider's first name, or initials | **required** |
| 3 | MiddleName | Health provider's middle name or initial | optional |
| 4 | Suffix | Examples: DO, MD, RN, Jr. III, etc | optional |
| 5 | FEINNo (13 digit) | Federal Employer ID Number | **required** |
| 6 | ProviderNPINo (10 digit) | Federal National Provider ID Number | **required** |
| 7 | MAProvNo | State Medical Assistance (MA) provider Number | optional |
| 8 | GroupName | If provider is member of medical group practice, name of that group practice | **required** |
| 9 | GroupNPINo (10 digit) | Federal National Provider ID Number of the group named on line 7 | **required** |
| 10 **X** | FacilityName | Facility type or institution that provider is on staff of, has admitting privileges to.. | **required** |
| 11 **X** | FacilityNPINo (10 digit) | Federal National Provider ID Number of facility of the facility named on line 9 | **required** |
| 12 | MedicalSpecialty | Medical Specialty | **required** |
| 13 | BoardCertSpec | ABMS or DO Certified specialty | Include if available |
| 14 | Subspecialty | | Include if available |
| 15 | Adr1 | Example: 123 Plainview Ave, | **Primary Address of the health provider, required** |
| 16 | Adr2 | Example: Suite #87 | optional |
| 17 | City | Example: Pittsburgh | **required** |
| 18**XX** | State | Example: PA | **required** |
| 19 | Zip ( 5 digit) | 99999 | **required** |
| 20 | PhoneNo (10 digit) | 999-999-9999 | **required** |
| 21 | County | Example: Allegheny | **required** |
| 22 | Longitude | (west) -162.7389 | **REQUIRED in decimal degree** |
| 23 | Latitude | (north) 54.4281 | **REQUIRED in decimal degree** |
| 24 | MedicareProv (Yes/No) | Does provider serve Medicare recipients | Choose yes or no |
| 25 | MedicaidProv (Yes/No) | Does provider serve Medicaid recipients | Choose yes or no |
| 26 | CHIPProv (Yes/No) | Does provider serve CHIP recipients | Choose yes or no |
| 27 | AdultBasic (Yes/No) | Does provider serve AdultBasic recipients | Choose yes or no |

**X Facility Name / Facility NPI #-** must list multiple facility names and NPI # individually. If health

provider is on staff at multiple facilities, must list health provider's name multiple times with facility addresses/sites.

**XX State-** Pennsylvania or adjoining states where plan members access network services. Please do NOT provide entire national provider directory.

## Group: Table 5

| | Identifier | Definition | Instruction |
|---|---|---|---|
| 1 | GroupName | Name of group practice | **REQUIRED** must list group name with EACH site address |
| 2 | GroupNPINo (10 digit) | Federal National Provider ID Number of the group named on line #1 | Include if available |
| 3 | FEINNo (13 digit) | Federal Employer ID Number | **required**, unless NPI is provided |
| 4<br>**X** | Adr1 | Example: 123 Planview Ave, | **required** |
| 5<br>**X** | Adr2 | Example: Suite #87 | optional |
| 6 | City | Example: Pittsburgh | **required** |
| 7<br>**XX** | State | Example: PA | **required** |
| 8 | Zip ( 5 digit) | 99999 | **required** |
| 9 | PhoneNo (10 digit) | 999-999-9999 | **required** |
| 10 | County | Example: Allegheny | **required** |
| 11 | Longitude | (west) -162.7389 | **REQUIRED in decimal degree** |
| 12 | Latitude | (north) 54.4281 | **REQUIRED in decimal degree** |

**X Adr1 / Adr2-** must list group name with each site address. If a group has multiple addresses/sites, each site must be listed, with full address and group name.

**XX State**- Pennsylvania or adjoining states where plan members access network services. Please do NOT provide entire national provider directory.

## Facility: Table 6

| | Identifier | Definition | Instruction |
|---|---|---|---|
| 1 | FacilityName | Name of Facility | **required** |
| 2 | FacilityNPINo (10 digit) | Federal National Provider ID Number of facility of the facility named on line 1 | **required** |
| 3 | FEINNo (13 digit) | Federal Employer ID Number | required, unless NPI is provided |
| 4 **X** | Type of Facility | Type of facility example: hospital, ambulatory surgery, outpatient unit, pharmacy, free-standing lab etc | **required** |
| 5 | Adr1 | Example: 123 Planview Ave, | **required** |
| 6 | Adr2 | Example: Suite #87 | optional |
| 7 | City | Example: Pittsburgh | **required** |
| 8 **XX** | State | Example: PA | **required** |
| 9 | Zip ( 5 digit) | 99999 | **required** |
| 10 | Phone No (10 digit) | 999-999-9999 | **required** |
| 11 | County | Example: Allegheny | **required** |
| 12 | Longitude | (west) -162.7389 | **REQUIRED in decimal degree** |
| 13 | Latitude | (north) 54.4281 | **REQUIRED in decimal degree** |

**X Type of facility**- includes all institutional providers, ancillary providers and contractors. Examples include: hospitals, ambulatory care centers, ambulatory surgery canters, dialysis centers, urgent care centers, hospice providers/facilities, home health, durable medical equipment providers, freestanding MRI, labs, radiology, rehabilitation ( outpt and inpt) facilities, skilled nursing care facilities, and pharmacies.

Ambulance providers- ground and air- do **NOT** need to be included.

**XX State**- Pennsylvania or adjoining states where plan members access network services.
Please do NOT provide entire national provider directory.