Rev. 12/03

PENNSYLVANIA DEPARTMENT OF HEALTH
BUREAU OF MANAGED CARE

QUARTERLY REPORT INSTRUCTIONS

GENERAL INFORMATION

1. Date of Filing: The quarterly report is to due no later than **45 days** after the close of each quarter ending March 31, June 30, September 30 and December 31. The Managed Care Plans' Quarterly Report must be received by the Bureau of Managed Care 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 separate from the annual report that is due later.

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

3. Enclose in your 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 Complaints/Grievance data reports.

The report should be submitted to:

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

Questions regarding reporting requirements can be directed to the Bureau at (717) 787-5193.

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) and provide breakdown by Insured and Self-Funded Enrollment and Point of Service (POS).

Medicare Advantage: Those members covered by a Medicare Advantage contract. List data separately for the following:

HealthChoices (Medicaid): Those members covered by a Medicaid contract.

A. Member: An individual who has been enrolled as a subscriber or an eligible dependent of a subscriber and for whom the plan 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: Provide number of members added during current reporting period.

C. Terminations During Quarter: Provide 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 integrated delivery systems and provider networks to HMOs which have assumed some plan administrative 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 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 a 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).

$$\text{Annualized Member Ambulatory Encounters} = \frac{\text{Total Number of Encounters for Quarter}}{\text{(Total Member Months for Quarter) / 3}} \times 4$$

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

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

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

C. Nonphysician: Encounters provided by other health professionals (e.g. Physician Assistants, CRNPs and Nurse Midwives). Complete as appropriate.

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

E. Total Patient Days Incurred: The total 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 their mother's should be counted as separate patient days for the period beginning with the discharge of the mother.

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

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 the plan who supervises, coordinates and provides initial and basic face to face encounter 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, as well as the number of health centers.

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. COMPLAINT AND GRIEVANCE DATA

Section A: Complete these charts for complaint and grievance systems in effect after passage of Act 68.

Grievance: A request by an enrollee or a health care provider, with the written consent of the enrollee, to have a managed care plan or utilization review entity review the denial of

a health care service based on **medical necessity and appropriateness**. This includes cases in which the managed care plan: disapproves full or partial payment for a requested health service; approves the provision of a requested health care service for a lesser scope or duration than requested; or disapproves payment of the provision of a requested service but approves payment for the provision of an alternative health care service.

Complaint: A dispute or objection regarding a participating health care provider, coverage, including contract exclusions and non-covered benefits as well as the operations or management policies of a managed care plan.

General Reference (Used for Sections A and C):

Pending From Previous Quarter: List the number of first and second level complaints and grievances in which action is pending from the previous reporting quarter. This would include complaint and 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 plan to "rehear" the case.

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

Totals: Calculate the total number of first and second level complaints and 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 complaints and grievances that were withdrawn by the member during the reporting quarter.

Initiated This Quarter: Indicate the number of first and second level complaints and grievances initiated by the member and provider during the reporting quarter.

Total Number of Decisions Made 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 plan."

Pending This Quarter: List the number of first and second level complaints and grievances in which action is pending during the reporting quarter. This would include complaint and grievance filings in which a hearing is yet to be held; complaint and grievance filings in which a hearing was held, but a decision has yet to be officially determined; and complaint and grievance filings in which the Department of Health (DOH) or the Department of Insurance (DOI) intervention following a second level decision and appeal to DOH/DOI resulted in the DOH/DOI requiring the plan to "rehear" the case.

Section B: Submit information regarding first and second-level complaints and grievances by type and disposition using the elements identified on the sample template. *This section is revised from previous years. Please call the Bureau with any questions.*

Section C: Complete the chart for grievances that were delegated to independent external utilization review entities

V. STATEMENT OF REVENUE AND EXPENSES

Follow the instructions provided by the Pennsylvania Insurance Department for **Report #2, Statement of Revenue, Expenses and Net Worth**. Submit Report #2 with the Managed Care Plans Quarterly Report for every quarter. Please be sure that the financial information and calculations represent only the data for the current quarterly period and not just a cumulative year-to-date figure. It is also essential to provide the member month statistic. When submitting a quarterly report for the fourth quarter (October 1 through December 31), the Department of Health requires that the Statement of Revenue and Expenses be specific for the fourth quarter.

VI. CERTIFICATION

To verify that the information contained in the Managed Care Plans Quarterly Report is accurate and true, the signatures of the person completing the report and Medical Director are necessary.