**BUREAU OF MANAGED CARE**

**ANNUAL REPORT FORM**

**For Year Ending December 31, 2024**

# 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) |  | | |

## GOVERNANCE

### BOARD OF DIRECTORS

|  |  |  |  |
| --- | --- | --- | --- |
| **Name**  **(Chairperson)** | **Affiliations** | **Subscriber Representative** | |
| **Yes** | **No** |
|  |  |  |  |
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### BOARD OFFICERS

|  |  |
| --- | --- |
| **President:** |  |
| **Vice President:** |  |
| **Secretary:** |  |
| **Treasurer:** |  |

### 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** |  |  |

### ORGANIZATIONAL CHARTS

All products (including PPO, EPO, and 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**.

### CORPORATE BY-LAW REVISIONS

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

## PRODUCT IDENTIFICATION (All Lines of Business)

**Product Identification:**

|  |  |
| --- | --- |
| Product Names | Description |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

## ENROLLMENT DATA

1. Membership by County of Residence - List total membership by county of residence as of December 31 of the reporting calendar year for all lines of business under this NAIC Code.

|  | **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 |  |  |  |  |  |  |  |  |  |  |
| 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 |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |
| Out of State |  |  |  |  |  |  |  |  |  |  |
| TOTALS |  |  |  |  |  |  |  |  |  |  |

1. 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 |  |  | | | | | |

1. Disenrollment - Enter the number of plan members who disenrolled during the calendar year.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **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

### 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**.

### 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: |
| 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: |
| 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: |

### PROVIDER DIRECTORY

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

### 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.

### 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.**

### MARKETING

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

### 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, AND ADVERSE BENEFIT DETERMINATION RESOLUTION SYSTEM (Please refer to the Annual Report Instructions)

Provide copies of the current enrollee literature, including subscription agreements, enrollee handbooks and any mass communications to enrollees concerning complaint, grievance, and adverse benefit determination appeal 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.

### MEDICAID & CHIP COMPLAINTS SUMMARY – SINGLE-LEVEL INTERNAL APPEAL

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TABLE A** | Filed this quarter | Withdrawn this quarter | Decisions this quarter | | |
| Overturned | Upheld | Partially upheld |
| **FIRST LEVEL** | | | | | |
| Not a covered service |  |  |  |  |  |
| Out-of-Network (OON) services not covered |  |  |  |  |  |
| Other |  |  |  |  |  |
| **TOTAL:** |  |  |  |  |  |
| **EXTERNAL** | | | | | |
| Not a covered service |  |  |  |  |  |
| Out-of-Network (OON) services not covered |  |  |  |  |  |
| Other |  |  |  |  |  |
| **TOTAL:** |  |  |  |  |  |

### MEDICAID & CHIP COMPLAINTS – TWO-LEVEL INTERNAL APPEAL

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TABLE B** | Filed this quarter | Withdrawn this quarter | Decisions this quarter | | |
| Overturned | Upheld | Partially upheld |
| **FIRST LEVEL** | | | | | |
| Quality Complaint |  |  |  |  |  |
| Network Adequacy |  |  |  |  |  |
| Other |  |  |  |  |  |
| **TOTAL:** |  |  |  |  |  |
| **SECOND LEVEL** | | | | | |
| Quality Complaint |  |  |  |  |  |
| Network Adequacy |  |  |  |  |  |
| Other |  |  |  |  |  |
| **TOTAL:** |  |  |  |  |  |
| **EXTERNAL** | | | | | |
| Quality Complaint |  |  |  |  |  |
| Network Adequacy |  |  |  |  |  |
| Other |  |  |  |  |  |
| **TOTAL:** |  |  |  |  |  |

### MEDICAID & CHIP INTERNAL GRIEVANCE

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TABLE C** | Filed this year | Withdrawn this year | Decisions this year | | |
| Overturned | Upheld | Partially upheld |
| 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** |  |  |  |  |  |

### MEDICAID & CHIP EXTERNAL GRIEVANCE

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TABLE D** | Filed this year | Withdrawn this year | Decisions this year | | |
| Overturned | Upheld | Partially upheld |
| 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** |  |  |  |  |  |

1. COMMERCIAL INSURER INTERNAL COMPLAINT

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TABLE E** | Filed this quarter | Withdrawn this quarter | Decisions this quarter | | |
| Overturned | Upheld | Partially upheld |
| **FIRST LEVEL** | | | | | |
| Quality Complaint |  |  |  |  |  |
| Network Adequacy |  |  |  |  |  |
| Other |  |  |  |  |  |
| **TOTAL:** |  |  |  |  |  |
| **SECOND LEVEL** | | | | | |
| Quality Complaint |  |  |  |  |  |
| Network Adequacy |  |  |  |  |  |
| Other |  |  |  |  |  |
| **TOTAL:** |  |  |  |  |  |

### COMMERCIAL INSURER INTERNAL APPEALS OF AN ADVERSE BENEFIT DETERMINATION

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TABLE F** | Filed this year | Withdrawn this year | Decisions this year | | |
| Overturned | Upheld | Partially upheld |
| Medical Necessity |  |  |  |  |  |
| Appropriateness of Service |  |  |  |  |  |
| Health Care Setting |  |  |  |  |  |
| Level of Care |  |  |  |  |  |
| Effectiveness of a Covered Benefit |  |  |  |  |  |
| Experimental and Investigational |  |  |  |  |  |
| Disputes regarding an insurer’s compliance with the surprise billing and cost sharing |  |  |  |  |  |
| Recissions of coverage |  |  |  |  |  |
| Other |  |  |  |  |  |
| **TOTAL** |  |  |  |  |  |

### COMMERCIAL INSURER EXTERNAL APPEALS OF AN ADVERSE BENEFIT DETERMINATION

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TABLE G** | Filed this year | Withdrawn this year | Decisions this year | | |
| Overturned | Upheld | Partially upheld |
| Medical Necessity |  |  |  |  |  |
| Appropriateness of Service |  |  |  |  |  |
| Health Care Setting |  |  |  |  |  |
| Level of Care |  |  |  |  |  |
| Effectiveness of a Covered Benefit |  |  |  |  |  |
| Experimental and Investigational |  |  |  |  |  |
| Disputes regarding an insurer’s compliance with the surprise billing and cost sharing |  |  |  |  |  |
| Recissions of coverage |  |  |  |  |  |
| Other |  |  |  |  |  |
| **TOTAL** |  |  |  |  |  |

## VI. UTILIZATION DATA (Please refer to the Annual Report Instructions)

### 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 |  |  |  |  |
| 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

### SUBCONTRACTOR SERVICES

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

1. QUESTIONS

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| 1. Does your quality improvement plan reflect oversight of these activities?   Provide documentation, including improvement plan, monitoring reports, as **Attachments.** |  |  |
| 1. Do you have an approved oversight plan for these services?   Provide oversight plans in an **Attachment.** |  |  |
| 1. 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.** |  |  |
| 1. 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** |  |  |
| 1. Is the direct number for behavioral health service organization listed on the member’s identification card and in the provider directory? |  |  |
| 1. 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** |  |  |
| 1. Do the subcontractor’s credentialing criteria differ from the plan’s credentialing criteria?   Provide a copy of credentialing criteria in an **Attachment** |  |  |
| 1. 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** |  |  |
| 1. Are medical records reviewed for behavioral health providers in conjunction with credentialing/recredentialing process?   Provide relevant documentation in an **Attachment** |  |  |
| 1. 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** |  |  |

1. BEHAVIORAL HEALTH COMPLAINTS AND GRIEVANCES

**Single-level complaints**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Filed this year | | Withdrawn this year | | Decisions this year | | | | | |
| Overturned | | Upheld | | Partially Upheld | |
|  | MH | SUD | MH | SUD | MH | SUD | MH | SUD | MH | SUD |
| First level |  |  |  |  |  |  |  |  |  |  |
| External |  |  |  |  |  |  |  |  |  |  |

**Two-level complaints**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Filed this year | | Withdrawn this year | | Decisions this year | | | | | |
| Overturned | | Upheld | | Partially Upheld | |
|  | MH | SUD | MH | SUD | MH | SUD | MH | SUD | MH | SUD |
| First level |  |  |  |  |  |  |  |  |  |  |
| Second level |  |  |  |  |  |  |  |  |  |  |
| External |  |  |  |  |  |  |  |  |  |  |

**Grievances**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Filed this year | | Withdrawn this year | | Decisions this year | | | | | |
| Overturned | | Upheld | | Partially Upheld | |
|  | MH | SUD | MH | SUD | MH | SUD | MH | SUD | MH | SUD |
| First level |  |  |  |  |  |  |  |  |  |  |
| External |  |  |  |  |  |  |  |  |  |  |

1. SUBSTANCE USE DISORDER TREATMENT DATA (Please refer to the Annual Report Instructions)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Number 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 |