**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) |  |

## ENROLLMENT DATA

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

|   | **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** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Total Members at close of the previous Quarter |  |  |  |  |  |  |  |  |  |  |
| Additions during this Quarter |  |  |  |  |  |  |  |  |  |  |
| Terminations during this Quarter |  |  |  |  |  |  |  |  |  |  |
| Net change for the Quarter |  |  |  |  |  |  |  |  |  |  |
| Total Members at close of this Quarter |  |  |  |  |  |  |  |  |  |  |

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

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**.

### 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| **TABLE A** | Filed this quarter | Withdrawn this quarter | Decisions this quarter |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:** |  |  |  |  |  |
| **TABLE A CONTINUED** | Filed this quarter | Withdrawn this quarter | Decisions this quarter |
| Overturned | Upheld | Partially upheld |
| **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 quarter | Withdrawn this quarter | Decisions this quarter  |
| 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 quarter | Withdrawn this quarter | Decisions this quarter  |
| 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** |  |  |  |  |  |

E. 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:** |  |  |  |  |  |

1. COMMERCIAL INSURER INTERNAL APPEALS OF AN ADVERSE BENEFIT DETERMINATION

|  |  |  |  |
| --- | --- | --- | --- |
| **TABLE F** | Filed this quarter | Withdrawn this quarter | Decisions this quarter  |
| 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** |  |  |  |  |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **TABLE G** | Filed this quarter | Withdrawn this quarter | Decisions this quarter |
| 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** |  |  |  |  |  |

## UTILIZATION DATA (Please refer to the Quarterly 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/Quarter |
| Medical |  |  |  |  |
| Surgical |  |  |  |  |
| Obstetric |  |  |  |  |
| Mental Health |  |  |  |  |
| Substance Use Disorder (SUD) |  |  |  |  |

### 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 |  |  |  |  |

### EMERGENCY SERVICES

|  |  |
| --- | --- |
| In-Area Emergency Claims | Out-of-Area Emergency Claims |
| Received/Total |  | Received/Total |  |
| Paid |  | Paid |  |
| Pending |  | Pending |  |
| Rejected |  | Rejected |  |

### AUTHORIZED OUT-OF-NETWORK REFERRAL

|  |  |  |
| --- | --- | --- |
|  | Outpatient | Inpatient |
| Received/Total |  |  |
| Approved |  |  |
| Denied |  |  |
| Pending |  |  |

## BEHAVIORAL HEALTH

1. BEHAVIORAL HEALTH COMPLAINTS AND GRIEVANCES

**Single-level complaints**

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

**Two-level complaints**

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

**Grievances**

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

B. SUBSTANCE USE DISORDER TREATMENT DATA (Please refer to the Quarterly Report Instructions)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  Number of Members | Visits per 1,000 | Admissions per 1,000 | Days per 1,000 | Average Length of Stay | Average Cost PerMember 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 |  |

## PROVIDER NETWORK

Provide the Plan’s network in the format most recently submitted to the applicable regulatory body as an **Attachment**. For Medicaid and CHIP products, use formats submitted to the Department of Human Services. For commercial products, use formats submitted to the Insurance Department or its delegated contractor.

## CERTIFICATION

|  |  |
| --- | --- |
|  |  |
| Signature of Plan Chief Executive Officer | Date |
| Signature of Plan Medical Director | Date |