HMO Annual Supplement Report Instructions

DIFP
Department of Insurance
Financial Institutions &
Professional Registration

Missouri Department of Insurance, Financial Institutions and Professional Registration
Division of Market Regulation, Statistics Section

Summary of Changes
HMO Supplement Report Instructions

The Supplement Report has been substantially revised for the 2012 and subsequent data years. Please note the following changes.

1. The quarterly reports have been suspended, and the annual report has been reduced simplified.

2. The T1, T6, and T7 exhibits have been eliminated.

3. Formats for the remaining exhibits have been changed. Specifically, the separate exhibits for HMO, POS, Medicare and Medicaid business have been consolidated into a single exhibit.

4. Additionally, exhibits T3 – T5 have been consolidated into a single exhibit.

5. All data elements, definitions and reporting standards for the retained exhibits remain unchanged from the prior year.

6. Please note that the retained exhibits have not been renumbered. For example, the old T2 exhibit is still named T2, even though there is no longer a T1 exhibit. This convention was adopted to maintain consistency with prior reports.

Due Date: Filings are due on April 15 of each year. If April 15 falls on a non-business day, then the filing is due on the first business day subsequent to April 15.

Filing fee: $50.00 (§354.495 RSMo)

SERFF: REQUIRED – see page 13 for instructions for submitting in SERFF.

The responsibility for collecting the supplement report has been transferred to the statistics section. Direct inquiries regarding the annual supplement filings to the Statistics Section to

Theresa Case, (573) 526-3911, or Theresa.Case@insurance.mo.gov

Or

Rachel Crowe, (573) 751-3163, or Rachel.Crowe@insurance.mo.gov

DIFP on the World Wide Web:

Information regarding this and other required filings may also be obtained on the DIFP website at: http://insurance.mo.gov/industry/filings/mc/index.php

General Instructions for Tables 2-5, Cost of Services Table, Supplements 1, 2 and 3

How to define Missouri Membership:

Reporting should be consistent with the Financial Annual Statement. If your company prepares the Financial Statements on some basis other than "Live or Work", then a Special State Page will be required. The Special State Page will be prepared utilizing the "Live or Work" rule.

LIVE: If reporting on a residential (enrollee/subscriber's home Zip Code) basis, then the only activity reported in this Supplemental Filing should be for Missouri Zip Codes (63001 - 65899).

WORK: If reporting on a group (contracts entered into with Missouri employers) basis, then the activity reported in this Supplemental Filing should be that of all enrollees or subscribers associated with those Missouri Groups.

Supplement 1 - Enrollment by Zip Code: This report should also be prepared using one of the methodologies stated above. For residential-based reporting, this report will contain only the Missouri Zip Codes (63001 - 65899) of current enrollees/subscribers. For group-based reporting, this report will contain the residential zip codes for all enrollees/subscribers associated with the Missouri groups, which may fall outside of the State of Missouri.

Tables (2-5), Cost of Services and Supplements: Instructions and Formatting Guidelines

1) Please submit Table 2-5, the Cost of Services Table, and Supplements via SERFF. A template in Microsoft Excel format for each of the required filings may be downloaded from our website at: http://insurance.mo.gov/industry/filings/mc/index.php

2) The Utilization Tables 2-5, Cost of Services Table, and the supplements must be filed containing information based on **Missouri's "Live or Work" Rule**. Also, "dates of service" should reflect the date costs were incurred, not the date the claim was received from the provider.

3) **DO NOT** include any Administrative Services Only (ASO) or Statements of Statutory Accounting Principles (SSAP) #47 enrollment, membership or utilization data in any of the Tables submitted.

   Note: ASO enrollees are defined as enrollees of the Health Maintenance Organization (HMO) for which the HMO performs administrative services only, such as claims processing for self-insured entities (third party at risk). The HMO has not issued an insurance policy (regardless of whether an identification card is issued) and therefore is not subject to any type of loss or liability caused by claims incurred by the ASO enrollees. SSAP #47 enrollees are defined as similar to ASO in that the business is considered self-insured. However, it's found to actually represent insurance risk for the company. One example is reinsurance, but some network rental contracts also fall under this category.

4) POS Out-of-Network activity: **All** POS activity should be included, both in-network and out-of-network, regardless of how POS Out-of-Network is reflected in the financial statements. For networks with multiple tiers, only the **best** level of benefits from the member's point of view is considered "in network" for purposes of the Supplement Report. All activity should be reported, but activity that occurs at less than the **best** level of benefits should be reported as "out-of-network" on Table 3-5.

5) Applied Behavior Analysis (ABA): ABA costs are to be reported separately from other mental health costs. ABA encounters, which are on Table 3-5 (formerly reported on Table 4) under "Other Professional Provider Encounters", are separate from mental health. ABA costs and encounters should not be double counted. They are mental health services, but they should not appear in both the existing mental health lines and in the ABA lines.

   If you contract out one or several services, you must obtain the utilization and cost information from the company/network with whom you contract and incorporate that data into Table 3-5 and the Cost of Services Table. **The Missouri Department of Insurance, Financial Institutions and Professional Registration will not accept a separate filing from the company/network with whom you have contracted to provide specified services.**

6) Data submitted as part of this report should be internally consistent, and reasonably reconcile with other filings, such as the Financial Annual Statement. The DIFP will review all filings to ensure the maximum degree of accuracy possible.

   When the review process results in a request for corrected data, please submit only those portions cited.

   Please remember that Dates of Service should reflect the date incurred, not the date the claim was received from the provider.

Instructions

TABLE 2: Hospital Utilization

Facility Type	Line Number	Medical Service
General Hospital/Acute Care Facility	A1	Medical/Surgical (non-maternity, non-mental health)
General Hospital/Acute Care Facility	A2.1	Maternity - Normal
General Hospital/Acute Care Facility	A2.2	Maternity - C-Section
General Hospital/Acute Care Facility	A2.3	Maternity - Other
General Hospital/Acute Care Facility	A2.4	Subtotal Maternity (A2.1 + A2.2 + A2.3)
General Hospital/Acute Care Facility	A3	Newborn
General Hospital/Acute Care Facility	A4.1	Mental Health - Chemical Dependency
General Hospital/Acute Care Facility	A4.2	Mental Health - Other
General Hospital/Acute Care Facility	A4.3	Subtotal Mental Health (A4.1 + A4.2)
General Hospital/Acute Care Facility	A5	Subtotal - Part A (A1 +A2.4 + A3 +A4.3)
Specialty Facility	B1	Rehabilitation Care
Specialty Facility	B2	Nursing Home (SNF/ICF)
Specialty Facility	B4.1	Mental Health Chemical Dependency
Specialty Facility	B4.2	Mental Health - Other
Specialty Facility	B4.3	Subtotal Mental Health (B4.1 + B4.2)
Specialty Facility	B5	Subtotal - Part B (B1 + B2 + B4.3)
Total Hospital	C1	Grand Total (A5 + B5)

Data elements: Days, Admissions

Reported separately for HMO, POS, Medicare and Medicaid

A. General Hospital/Acute Care Facility

Line A1 Medical/Surgical: Refers to general hospital/acute inpatient care; includes any hospital days for services except maternity and mental health, e.g. pediatric, gynecology, neurology, etc.

Lines A2.1 – A2.4 Maternity: Refers to care connected with a live birth in a general hospital or acute care facility; only mothers' days should be counted, not newborns'. Please be sure and break down this data into the following categories:

Line A2.1 Normal
Line A2.2 C-Section
Line A2.3 Other
Line A2.4: Subtotal (A2.1 + A2.2 + A2.3)

Line A.3 Newborn: A newborn is considered admitted to the hospital only after the mother has been discharged. Please count 'Days' as days accrued by the newborn after the mother is discharged.

Lines A4.1 – A4.3 Mental Health: Inpatient days when provided in acute care facilities, as opposed to psychiatric long-term institutions or wards. Acute Mental Health care in an Acute Care Facility. Please note that mental health care includes care for any condition listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including psychiatric, mental retardation and developmental disability conditions. This data should be broken down into two subcategories:

Line A4.1 Chemical Dependency
Line A4.2 Other
Line A4.3 Subtotal

B. **Specialty Facility** - Refers to inpatient stays in freestanding specialized facilities as opposed to acute inpatient hospital stays, except for Mental Health (see below).

Line B1 Rehabilitation: inpatient stays at a freestanding rehabilitation facility.

Line B2 Nursing Home (SNF/ICF): An SNF provides services to patients who require primarily restorative or skilled nursing care. An ICF provides services to patients not requiring the degree of care provided by a hospital or SNF but who require care and services provided at institutional facilities.

Lines B4.1 – B4.3 Mental Health: Inpatient days when provided in specialized institutions or wards (specific area within an Acute Care Facility). Long-term Mental Health Care provided in a specialized institution, or a specific area within an Acute Care facility. Mental Health provided in a Residential Care setting. Please note that mental health care includes care for any condition listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including psychiatric, mental retardation and developmental disability conditions. This data should be broken down into two subcategories

Line B4.1 Chemical Dependency/Detoxification
Line B4.2 Other
Line B4.3 Subtotal (B4.1 + B4.2)

Line B5 Subtotal Part B (Line B1 +B2 +B4.3)

Line C1 Grand Total Inpatient Utilization- Line A5 + B5

TABLE 3 – 5: Outpatient Utilization

Beginning in data year 2012, tables 3, 4, and 5 were combined into a single table, renamed table 3-5.

Line Number	Service Category	Service
1	Hospital Emergency Care	In-Network ER Utilization
2	Hospital Emergency Care	Out-of-Network ER Utilization
3	Physician Encounters	Primary Care
4	Physician Encounters	Pediatric Specialists
5	Physician Encounters	OB/GYN
6	Physician Encounters	Mental Health/Psychiatry/Chemical Dependency
7	Physician Encounters	Other Specialties
8	Other Professional Providers	Mental Health (Excluding ABA)
9	Other Professional Providers	Applied Behavior Analysis (ABA)
10	Other Professional Providers	Chiropractic
11	Other Professional Providers	All Others
12	Other Services (Non-Admissions)	Home Health Care Visits
13	Other Services (Non-Admissions)	Surgical Center (non-hospital)
14	Other Services (Non-Admissions)	In/Out Surgery (Hospital/ Ambulatory-Same Day Surgery)
15	Other Services (Non-Admissions)	Birthing Center/Room
16	Other Services (Non-Admissions)	Non-Residential Mental Health Care
17	Other Services (Non-Admissions)	Other (not specified above)

Data elements: Encounters

Lines 1 – 2 Hospital Emergency Care: ER utilization should be based upon members who were **not** admitted to the hospital from the ER. Admits to hospital from ER should be captured in Table 2.

Line 1. **In-Network ER Utilization:** Emergency Room utilization within the contracted network**.**

Line 2. Out-of-Network ER Utilization: Emergency Room utilization outside of the contracted network. (NOTE: includes out of town utilization as well as local non-contracted ER utilization).

Lines 3-11 Ambulatory Utilization by Provider Type: Ambulatory Care includes services provided on an ambulatory basis (patient received care by going to physicians' offices, outpatient departments or health centers) by both physicians and non-physicians. Exclude emergency room care reported on lines. Please note: See page 12 for American Medical Association Medical Provider Code breakdown. There is also a list of codes that should not appear on this table. The excluded codes represent medical professionals that an enrollee would not schedule an appointment with to receive care.

Lines 3 – 7 Physician Encounters by Specialty:

Line 3 - Primary Care: Member encounters with Primary Care Physicians
Line 4 - Pediatric Specialists: Encounters with Pediatric Specialists
Line 5 - OB/GYN: Obstetricians and Gynecologist
Line 6 - Mental Health/Psychiatry/Chemical Dependency
Line 7 – Other Specialists: Specialist encounters that do not fall in the above mentioned categories

Lines 8 – 11 Other Professional Provider Encounters: Consists of all other non-physician providers meeting the ambulatory care criteria, such as Mental Health, Optometry, Podiatry, Dentistry, Chiropractic, Physician Assistants, Nurse Practitioners, among others.
Line 8 - Mental Health (i.e. Psychologist)
Line 9 - Chiropractic
Line 10 - Applied Behavior Analysis (ABA)
Line 11 - All Others

Lines 12 – 17 Other Services (Non-Admissions): Intended to capture other non-admission types of services such as Home Health Care visits, Surgery in a free-standing facility, same day hospital surgery, birthing rooms, psychiatric daycare, and non-residential mental health care.

Home Health Care Visits: Care provided by health care personnel in the patients' home.

A. **Surgical Center (non-hospital):** Same-day surgery performed in a freestanding surgical center.
B. **In/Out Surgery (hospital) or Ambulatory Same-Day Surgery:** Surgery performed in a hospital but does not entail admission into the hospital.
C. **Birthing Center/Room:** Normal delivery in a birthing center or room not entailing admission to the hospital.
D. **Non-Residential Mental Health Care:** Mental health care provided in an institution during the daytime **or** nighttime only (beyond a simple ambulatory care encounter). Please note that mental health care includes care for any condition listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including psychiatric, mental retardation and developmental disability conditions.
E. **Other:** All other non-admissions that do not fall into one of the above-mentioned categories. Please footnote the category (s) of data being captured.

COST OF SERVICES TABLE

Line Number	Line
1	Inpatient Hospital
2	Outpatient Hospital
3	Prescription Drugs (not inpatient)
4	Inpatient Physician, Surgeon, Anesthesia, etc.
5	Outpatient Physician, Surgeon, Anesthesia, etc.
6	Emergency Room
7	Chiropractic visits
8	Prostheses & Expenses
9	Inpatient Mental Health
10	Outpatient Mental Health
11	Diagnostic, X-Ray, Laboratory

Line Number	Line
12	Other
13	Total Medical Costs (Sum of Lines 1 - 12)
14	Total Capitation Costs
15	Total Medical Costs Less Capitation Costs (Line 13 - Line 14)
16	Average Number of Plan Members, CY
17	Total Plan Members, CY
18	Cumulative Member Months
19	Average Age of Plan Members
20	No. Members Receiving Services, Incurred CY

Data Elements: Total medical costs (lines 1-15) / Members (lines 16-20), Deductibles / Copayments, COB Savings, Other Offsets, Total Paid, Cost Per Member Per Month, Reinsurance

Definitions of Column Headings:

- **A. Total Medical Cost:** Total cost incurred for services provided to enrollees during the reporting period, net of any negotiated discounts with providers. Costs should be calculated on a claims basis, **excluding IBNR.**
- **B. Deductibles/Co-payments:** Total amount of payments made by enrollees in the form of any required co-payment or coinsurance.
- **C. COB Savings:** Coordination of Benefit Savings – Total amount of any savings related to coordination of benefits for enrollees with coverage under more than one plan.
- **D. Other Offsets:** Total amount of any reduction in payment due to prior over-payments, capitation with-holds, and other amounts by which payments to medical providers are reduced, such as risk sharing arrangements, which aren't captured in co-pay and COB columns already. It should EXCLUDE: co-insurance, non-covered items or services, or re-insurance expenses.
- **E. Total Paid:** Total Paid = Total Medical Cost-Deductibles/Co-payments-COB-Other Offsets
- **F. Per Member Per Month:** PMPM = Total Paid / Cumulative Member Months
- **G. Reinsurance:** If the HMO has reinsurance and chooses to report reinsurance on this table, reinsurance should be reported in this column. If the reinsurance recovery amount is specific to one of the cost categories on this table, put the amount in that cost category.

Definitions of Cost Categories:

- **A. Inpatient Hospital:** Costs incurred due to the utilization reported on Table 2, Part A, excluding mental health costs.
- **B. Outpatient Hospital:** Costs incurred due to the utilization reported on Table 5 - In/Out Surgery Hospital/Ambulatory-Same Day Surgery (line 10), excluding Non-Hospital services.
- **C. Prescription Drugs (not inpatient):** All covered outpatient prescription costs.
- **D. Inpatient Physician, Surgeon, Anesthesia, etc.:** Physician costs incurred as a result of the utilization reported on Table 2, Part A, as well as hospitalist costs, if any.
- **E. Outpatient Physician, Surgeon, Anesthesia, etc.:** Physician costs incurred as a result of the utilization reported on Table 4, excluding Mental Health/Psychiatry/Chemical Dependency (line 12), Mental Health (line 21) and Chiropractic (line 22).
- **F. Emergency Room:** Costs incurred due to the utilization reported on Table 3.
- **G. Chiropractic:** Costs incurred due to the utilization reported on Table 4 – Chiropractic (line 22).
- **H. Hair Prostheses & Expenses:** Costs incurred due to the RSMo 376.1222, as applicable to only Medicaid and MCHCP.
- **I. Inpatient Mental Health:** Costs incurred due to the utilization reported on Table 2 – Mental Health (lines 18 and 36). Please note that mental health care includes care for any condition listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including psychiatric, mental retardation and developmental disability conditions.
- **J. Outpatient Mental Health:** Costs incurred due to the utilization reported on Table 4 – Mental Health (lines 12 and 21) and Table 5 – Mental Health (line 12). Please note that mental health care includes care for any condition listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including psychiatric, mental retardation and developmental disability conditions.

K. Applied Behavior Analysis (ABA): Costs incurred due to utilization reported on Table 4 – Applied Behavior Analysis (line 22). The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use direct observation, measurement, and functional analysis of the relationships between environment and behavior.

L. Diagnostic, X-ray, Laboratory: Imaging, pathology, X-ray and lab charges due to utilization reported on Tables 2 through 5

M. Other: On this line, report financial figures for all other Cost Categories not listed in this table. Please footnote what 'Other' includes.

N. Total Capitation Costs: Include here all costs for which payment is made on a capitated basis (see definition of Capitation on page 8). NOTE**: If Capitation Costs are reported, you must footnote what those costs refer to, (e.g. mental health services, etc…). If you have more than one category listed in this footnote, please break out your Capitation Costs by each category.**

Cost Categories: Please be sure to include all categories listed on the attached example table. Your filing will be considered incomplete if you report that you are unable to provide all the Cost Category data requested. (For example: you must be able to separate Inpatient and Outpatient Hospital costs, Inpatient and Outpatient Physician costs, etc…) Costs from subcontractors should be incorporated in the appropriate categories.

Supplement 1: Instructions and Formatting Guidelines

1) Supplement 1 should include information pertaining to Missouri and the adjacent metropolitan areas (as defined on page 4, item 3) that extend into Illinois and Kansas, in a manner that conforms to Missouri's "Live or Work" Rule. This information should conform to the methodology used by the Company to prepare the Quarterly/Annual Financial Statement. If your company prepares the Financial Statements on some basis other than "Live or Work", then a Special State Page will be required. The Special State Page will be prepared utilizing the "Live or Work" rule.

4) Exclude Administrative Services Only (ASO) membership. ASO enrollees are defined as enrollees of the Health Maintenance Organization (HMO) for which the HMO performs administrative services only, such as claims processing for self-insured entities (third party at risk). The HMO has not issued an insurance policy (regardless of whether an identification card is issued) and therefore is not subject to any type of loss or liability caused by claims incurred by the ASO enrollees. SSAP #47 enrollees are defined as similar to ASO in that the business is considered self-insured. However, it's found to actually represent insurance risk for the company. One example is reinsurance, but some network rental contracts also fall under this category.

SUPPLEMENT 1

Enrollment by Zip Code- ***Reporting Period (e.g. Q2_2010)***

Company Name

Zip Code	HMO	POS	Medicare	Medicaid
63125	250	50	0	20
65201	117	33	0	16
etc…				

A. Zip Code: Enrollment for all of Missouri and the adjacent metropolitan areas of Illinois and Kansas should be included in Supp1. Each record must contain a unique Zip Code. Please check your file carefully for duplicate Zip Codes before you submit your file to DIFP. **NOTE: If duplicate Zip Codes are found your filing will be considered unsatisfactory.**

1. If this supplement is being prepared on a "Live" basis, there will only be Missouri zip codes.
2. If this supplement is being prepared on a "Work" basis, then we will see zip codes for Missouri as well as that of the surrounding states.
3. Total Enrollment is reported as of the last day of the Reporting Period.

B. HMO: Must contain all HMO product enrollment for the reporting period.

C. POS: Must contain all POS product enrollment for the reporting period.

D. Medicare: Must contain all Medicare product enrollment for the reporting period.

E. Medicaid: Must contain all Medicaid product enrollment for the reporting period.

Annual Supplement 2

Small and Large Employer Premium and Enrollment

Line Number	Line
1	Small Employer (2-50 employees)
2	Small employers in associations with rate differentials exceeding 20 percent
3	Small employers in associations with rate differentials not exceeding 20 percent
4	Large Employer/Union (over 50 employees)
5	Large employers in associations with rate differentials exceeding 20 percent
6	Large employers in associations with rate differentials not exceeding 20 percent

Data Elements: Number of contracts as of 12/31, Number of enrollees as of 12/31, Number of insured employers, Direct Premium Written, Direct Premium Earned, Direct Losses Paid, Direct Losses Incurred

Please EXCLUDE any information regarding:

- Individual enrollment
- ASO & SSAP #47 enrollment
- Medicare enrollment
- Medicaid enrollment

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Enrollment should reflect enrollment at year-end.

A. Total group enrollment should equal line 1 + 4.

a) Item 1 represents activity pertaining to Small Employers

i) Item 2 represents small employers in associations with rate differentials exceeding 20 percent.

ii) Item 3 represents small employers in associations with rate differentials not exceeding 20 percent.

b) Item 4 represents large employers (over 50 Employees)

i) Item 5 represents large employers in associations with rate differentials exceeding 20 percent.

ii) Item 6 represents large employers in associations with rate differentials not exceeding 20 percent.

c) By definition, if data is reported on line 2, data must also be reported on line 5. Similarly, if data is reported on line 3, data must also be reported on line 6.

d) Lines 2 and 5 – Report business for associations in which the index rate for any class of business exceeds the rate for any other class by more than 20 percent. This business should be exempt from the rating provisions of 379.936.1(1) RSMo, as per 376.421.1(5)(e) RSMo.

e) Lines 3 and 6 – Includes business for associations in which the index rate for any rating period for any class of business does not exceed any other class of business by more than 20 percent.

E. Please note that total group enrollment will be compared to the State Page of the Annual Financial Statement.

Annual Supplement 3 – Annual Questionnaire

Please complete the questionnaire included in supplement 3. Information reported on supplement 3 will be included in the DIFP's annual report of HMOs.

Below is a listing of Medical Providers as defined by the American Medical Association.

APPROVED MEDICAL PROVIDERS:

- Aerospace Medicine
- Allergy
- Allergy and Immunology
- Anesthesiology
- Cardiology
- Cardiovascular Diseases
- Child Psychiatry
- Critical Care Medicine
- Dermatology
- Diabetes
- Diagnostic Radiology
- Diagnostic Roentgenology
- Emergency Medicine
- Endocrinology
- Family Practice
- Gastroenterology
- General Practice
- General Preventive Medicine
- Geriatrics
- Hematology
- Hematology and Oncology
- Immunology
- Infectious Diseases
- Internal Medicine
- Laryngology
- Med. Diseases of the Chest
- Medical Oncology
- Neoplastic Diseases
- Nephrology
- Neurology
- Neurology and Psychiatry
- Nuclear Medicine
- Nuclear Radiology
- Nutrition
- Occupational Medicine
- Ophthalmology
- Other (specify)
- Otolaryngology
- Otology
- Otorhinolaryngology
- Physical Medicine & Rehab
- Prevent Med/Aerospace Med
- Prevent Med/Occup Med.
- Prevent Med/Occup-Environmental Med
- Prevent Med/Public Health
- Proctology
- Psychiatry
- Psychoanalysis
- Public Health
- Pulmonary Diseases
- Radiation Oncology
- Radiation Therapy
- Radiology
- Rehabilitation Medicine
- Reproductive Endocrinology
- Rheumatology
- Roentgenology
- Sclerotherapy
- Special Proficiency Osteopathic Manipulative Med
- Surgery-Abdominal
- Surgery-Cardiovascular
- Surgery-Colon & Rectal
- Surgery-Facial Plastic
- Surgery-General
- Surgery-General Vascular
- Surgery-Hand
- Surgery-Head and Neck
- Surgery-Neurological
- Surgery-Oro-Facial Plastic
- Surgery-Orthopedic
- Surgery-Otorhinolaryngology & Oro-Facial Plastic
- Surgery-Plastic
- Surgery-Plastic & Reconst.
- Surgery-Thoracic
- Surgery-Thoracic Cardiovascular
- Surgery-Traumatic
- Surgery-Urological
- Surgery-Vascular
- Therapeutic Radiology
- Urology

OB/GYN:

- Gynecological Oncology
- Gynecology
- Maternal & Fetal Medicine
- Neonatal/Perinatal Medicine
- OB/GYN
- Obstetrics
- Surgery-Obstetrics/GYN

PEDIATRICS:

- Adolescent Medicine
- Child Neurology
- Neonatology
- Pediatric Allergy
- Pediatric Cardiology
- Pediatric Endocrinology
- Pediatric Hematology/Oncology
- Pediatric Nephrology
- Pediatric Pulmonology
- Pediatric Radiology
- Pediatrics
- Surgery-Pediatric

EXCLUDED PROVIDERS:

- Anatomic Path. & Lab. Med.
- Anatomic Pathology
- Anatomic/Clinical Pathology
- Bloodbanking Pathology
- Chemical Pathology
- Clinical Pathology
- Clinical Pharmacology
- Cytopathology
- Dermatopathology
- Diagnostic Laboratory
- Forensic Pathology
- Immunopathology
- Laboratory Medicine
- Legal Medicine
- Medical Microbiology
- Neuropathology
- Pathology
- Radioactive Isotopes

Instructions for submitting the filing in SERFF

In Step 3 of the Filing Wizard:

choose the TOI "HOrg03 Health Organizations – Other,"

then select the Sub TOI "HOrg03.QA HMO Annual Data Report"

In Step 4 of the Filing Wizard, choose the Filing Type "Reports."

Once you've completed the Filing Wizard and are preparing your filing, enter 'N/A' on the State Specific Field.

Please attach the completed Excel spreadsheet to the Supporting Documentation tab.