Health Card Survey and Prior Authorization Report Instructions

Due Date: April 1 annually

Who Must File the Report?

Health carriers with more than 1,000 Maine covered lives as reported in Rule 940 and Rule 945 reports filed with the Maine Bureau of Insurance must report information required by 24-A M.R.S. § 4302.

Location of the Report Form

What to Report
All information reported must be based on Maine resident enrollees ONLY.

Section I: Background Information

1) Number of covered persons in all fully-insured health insurance or HMO plans issued as of the last day of the calendar year.
2) Number of covered persons covered in self-insured health plans administered by the carrier as of the last day of the calendar year.
3) Customer service phone number.
4) Days/hours the customer service phone number is staffed.
5) Website.
6) Accreditations (e.g. NCQA, URAC, etc.)
7) Products offered in Maine (list by product name and indicate product type [e.g. HMO, POS, PPO] and in which market the product is available [e.g. individual, small group, large group]).
8) Geographic area(s) in Maine in which products are offered.
9) Provider-to-enrollee ratio by geographic region.
10) Provider-to-enrollee ratio by medical specialty.

Section II: Utilization Review
If UR subcontractors are used (i.e., mental health network, claims administrator), please provide the following for EACH subcontractor.

1) Name
2) Address
3) Phone number for covered persons and providers to access review staff,
4) Type of UR review performed, and
5) Accreditation (e.g. URAC).

Section III: Prior Authorizations and Concurrent Review

1) All items and services that require a prior authorization, including the respective CPT code.

2) Number of requests for all authorizations, including prospective and concurrent authorization requests (also known as reauthorization requests).
3) Number of reauthorization requests for ongoing care that were approved, aggregated for all items and services.
4) Number of reauthorization requests for ongoing care that were denied, aggregated for all items and services.
5) Number of standard prior authorization requests that were approved, aggregated for all items and services.
6) Number of standard prior authorization requests that were denied, aggregated for all items and services.
7) Number of prior authorization requests that were approved after the timeframe for review was extended based on the need for outside consultation, aggregated for all items and services.
8) Number of prior authorization requests that were denied after the timeframe for review was extended based on the need for outside consultation, aggregated for all items and services.
9) Number of prior authorization requests that were approved after the timeframe for review was extended based on a carrier request for additional information, aggregated for all items and services.
10) Number of prior authorization requests that were denied after the timeframe for review was extended based on a carrier request for additional information, aggregated for all items and services.
11) Number of denied standard prior authorization requests that were approved after appeal, aggregated for all items and services.
12) Number of denied standard prior authorization requests that were denied after appeal, aggregated for all items and services.
13) Number of expedited prior authorization requests that were approved, aggregated for all items and services.
14) Number of expedited prior authorization requests that were denied, aggregated for all items and services.
15) Number of denied expedited prior authorization requests that were approved after appeal, aggregated for all items and services.
16) Number of denied expedited prior authorization requests that were denied after appeal, aggregated for all items and services.
17) Average and median time that elapsed between receiving all necessary information following the submission of a standard prior authorization request and a determination by the carrier, aggregated for all items and services.
18) Average and median time that elapsed between the submission of an expedited prior authorization request and a decision by the carrier, aggregated for all items and services, and
19) Average and median time that elapsed between receiving all necessary information following the submission of a concurrent care reauthorization request to extend a course of treatment and a determination by the carrier, aggregated for all items and services.
20) The number of prior authorizations in which the services requested or performed include chiropractic services.

The percentages in this section will be calculated automatically based on the numbers submitted.

Section IV: Complaints, Appeals, and Grievances

1) The ratio of the total number of complaints (all grievances and appeals combined) received to the total number of enrollees, reported by the following categories:
    a. Claim denials/delays
    b. Medical necessity of care
    c. Accessibility of care
    d. Behavioral Health
    e. Chiropractic services
    f. Non-renewals/termination
    g. All other issues
2) The ratio of the number of adverse benefit determinations issued to the number of complaints (all grievances and appeals combined) received, reported by the type of adverse benefit determination involved.
3) The number and ratio of the total number of successful enrollee appeals to the total number of appeals filed broken out by the type of appeal. Please include first level, second level, and external reviews combined in this calculation.
4) The number of first level appeals, and the number overturned in favor of the enrollee at first level.
5) The number of first level appeals that were appealed to the second level, and the number that were overturned at second level in favor of the enrollee.
6) The number of complaints (all grievances and appeals combined) related to chiropractic services.
7) Total number, amount and disposition of any malpractice claims settled by the carrier.
8) The number of lawsuits filed by enrollees over adverse benefit determinations.

Section V: Disenrollments

1) The number of enrollees (including dependents) who disenrolled from a plan voluntarily.
2) The five most common reasons stated by these enrollees for their disenrollment.
3) The number of enrollees who disenrolled from a plan involuntarily.
4) The number of providers who disenrolled from the carrier.
5) The five most common reasons stated by these providers for their disenrollment.

Section VI. Enrollee Satisfaction

1) Does the carrier conduct surveys among enrollees (yes/no) using the Consumer Assessment of Health Plans Survey? If yes, please provide a copy of the results. If no, how does the carrier gauge enrollee satisfaction? Please provide the results obtained through these methods.

2) Please provide a provider-to-enrollee ratio broken out by geographic region and medical specialty.

3) What actions, if any, has the carrier taken as a result of collecting and analyzing enrollee satisfaction data?

Definitions

- "Standard" means a non-expedited review.
- "Expedited" means an expedited review for a service or a prescription drug when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.
- "Concurrent" or "Reauthorization" means a review conducted during a patient's hospital stay or course of treatment.
- "Adverse benefit determination" has the same meaning as Rule 850 § 5(A) and includes both medical and non-medical determinations.
- "Prospective review" means utilization review conducted prior to an admission or a course of treatment. Rule 850 § 5(HH).
- "Grievance" has the same meaning as in Rule 850 § 5(S) and means a written complaint (including complaints submitted via e-mail), submitted by or on behalf of a covered person regarding:
    1) The availability, delivery or quality of health care services, including a complaint regarding an adverse health care treatment decision made pursuant to utilization review;
    2) Claims payment, handling or reimbursement for health care services;
    3) Matters pertaining to the contractual relationship between a covered person and a health carrier; or
    4)Adverse benefit determinations.

All information should be reported for the prior calendar year (January 1-December 31)

If you have questions about the content of the report, please contact Pamela Stutch at (207) 624-8458 or at pamela.stutch@maine.gov.

Please submit the report in Excel format to keith.a.fougere@maine.gov