Qlarant

MARYLAND Department of Health

HealthChoice
Maryland's Medicaid Managed Care Program

# Medicaid Managed Care Organization

# 2019 Focused Review Report Grievances, Appeals, & Denials

Submitted November 2019

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# 2019 Focused Review Report
# Grievances, Appeals, & Denials

## Introduction

Maryland's HealthChoice Program (HealthChoice) is a managed care program based upon a comprehensive system of continuous quality improvement that includes problem identification, analysis, corrective action, and reevaluation. The objective is to identify areas for improvement by developing processes and systems capable of profiling and tracking information regarding the care and services received by HealthChoice enrollees.

The Maryland Department of Health (MDH) is required annually to evaluate the quality of care (QOC) provided to Maryland Medical Assistance enrollees in HealthChoice Managed Care Organizations (MCOs). MDH, pursuant to 42 CFR Part 438, Subpart D and Code of Maryland Regulations (COMAR) 10.09.65, is responsible for monitoring the QOC provided to MCO enrollees when delivered. Under Federal law [Section 1932(c)(2)(A)(i) of the Social Security Act], MDH is required to contract with an External Quality Review Organization (EQRO) to perform an independent annual review of services provided under each MCO contract to ensure that the services provided to the enrollees meet the standards set forth in the regulations governing the HealthChoice Program. MDH contracts with Qlarant to serve as the EQRO.

Qlarant conducts quality studies focused on determining MCO compliance with federal and state laws and regulations pertaining to the appropriateness of denials of service and the handling of grievances and appeals. These studies consist of quarterly evaluations of grievance, appeal, and pre-service denial reports submitted by each MCO, along with an annual record review. This is the third annual focused review conducted for MDH.

Assessment of MCO compliance was completed by applying the performance standards defined for Calendar Year (CY) 2018. Quarterly studies of grievances, appeals, and pre-service denials were conducted for the third and fourth quarters of 2018, and the first and second quarters of 2019. The annual record review encompassed member grievances, appeals, and pre-service denials that occurred during CY 2018. The nine MCOs evaluated during these time frames were:

- Aetna Better Health of Maryland (ABH)
- AMERIGROUP Community Care (ACC)
- Jai Medical Systems, Inc. (JMS)
- Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare Community Plan (UHC)
- University of Maryland Health Partners (UMHP)

## Purpose and Objectives

The purpose of this review was to:

1. Assess MCO compliance with federal and state regulations governing member and provider grievances, member appeals, pre-service authorization requests, and adverse determinations; and
2. Facilitate increased compliance within these areas by illustrating trends and opportunities for improvement.

Review objectives addressed the following:

- Validate the data provided by MCOs in the quarterly grievance, appeal, and pre-service denial reports.
- Provide an avenue for MCOs to compare their performance with their peers through distribution of quarterly reports.
- Identify MCO opportunities for improvement and provide recommendations.
- Request corrective action when an MCO demonstrates consistent non-compliance with one or more review components.

## Methodology

MDH requires all HealthChoice MCOs to submit quarterly Grievance, Appeal, and Pre-Service Denial Reports within 30 days of the close of the quarter in an approved form to Qlarant. Qlarant developed a review tool for each reporting category that MDH approved for use in validating and evaluating quarterly MCO reports. Appendices A, B, and C include the review tools (templates) for Grievances, Appeal, and Pre-Service Denials. Following validation of the data MCOs submitted, these review tools allowed Qlarant to enter data from the MCO reports and identify areas of non-compliance. Qlarant aggregated MCO results to allow MCO peer group comparisons. MCO-specific trends were identified after three quarters of data was available. Quarterly reports to MDH included an analysis of MCO data and recommendations, as appropriate. MCOs were provided a separate report of quarterly reviews which included areas for follow-up when data issues, ongoing non-compliance, or negative trends were identified.

In addition to quarterly reviews of MCO submitted reports, Qlarant conducted an annual record review of a sample of CY 2018 grievance, appeal, and pre-service denial records. Records were requested from February 1, 2018, based upon the revised implementation date of several regulatory changes. Each MCO provided Qlarant with a listing of grievances, appeals, and pre-service denials for CY 2018. Qlarant selected 35 cases from each listing of grievances using a random sampling approach and requested that each MCO upload the selected case records to the Qlarant portal. Using the 10/30 rule, an initial sample of 10 grievance records was reviewed. If an area of non-compliance was discovered, an additional 20 records were reviewed for the non-compliant component.

Since there were multiple changes to the appeal and preauthorization related standards for CY 2018, Qlarant selected only 13 cases from each MCO appeal and preservice denial listings for a baseline review. Review was limited to a random sample of 10 appeal and 10 pre-service denial cases. No additional reviews were conducted for any areas of non-compliance. Results of the overall grievance, appeal, and pre-service denial record reviews, including strengths, best practices, and opportunities for improvement, were provided to MDH as a component of each MCO's SPR report. Results of the record reviews were also shared with appropriate staff while onsite at each MCO, including technical assistance as needed, to facilitate improved compliance.

# Limitations

The validity of MCO submitted quarterly grievance, appeal, and denial reports has improved over the prior annual report period; however, ongoing issues with the accuracy and completeness of the data continued for several MCOs through the first quarter of 2019. For example, ABH only reported "expedited" outpatient pharmacy denials for the first three quarters. KPMAS reported only medical necessity denials within one expedited category and all expedited (medical necessity and administrative) denials in another category for the first three quarters. During this time, technical assistance was provided to MCOs, as needed. Additionally, revisions were made to the MCO reporting forms to improve clarity.

In addition to formula errors and confusion related to reporting fields, incomplete data was reported. UHC did not provide denial reports from its dental vendor until the second quarter of 2019. JMS reported a significant increase in member grievances for the second quarter of 2019, which was attributed to a recent customer service training leading to improved identification of grievances. It is likely that other MCOs may be unaware that grievances are being under reported as well. Because of these continuing opportunities for improvement, some caution must be exercised in reviewing these results.

# Results

This section provides MCO-specific review results of select grievance, appeal, and pre-service denial measures in table format. Graphical representation is also displayed, where applicable. These data facilitate comparisons of MCO performance over time and in relation to peers based on quarterly reports and annual record review results.

The percentage of compliance demonstrated for various components is represented by a review determination of met, partially met, or unmet, as follows:

| | |
|---|---|
| Met | Compliance consistently demonstrated |
| Partially Met (PM) | Compliance inconsistently demonstrated |
| Unmet | No evidence of compliance |

## Grievance Results

A grievance is an expression of dissatisfaction about any matter other than an action and is defined in COMAR 10.09.62.01B(64). COMAR 10.09.71.02C(1) describes three categories of grievances:

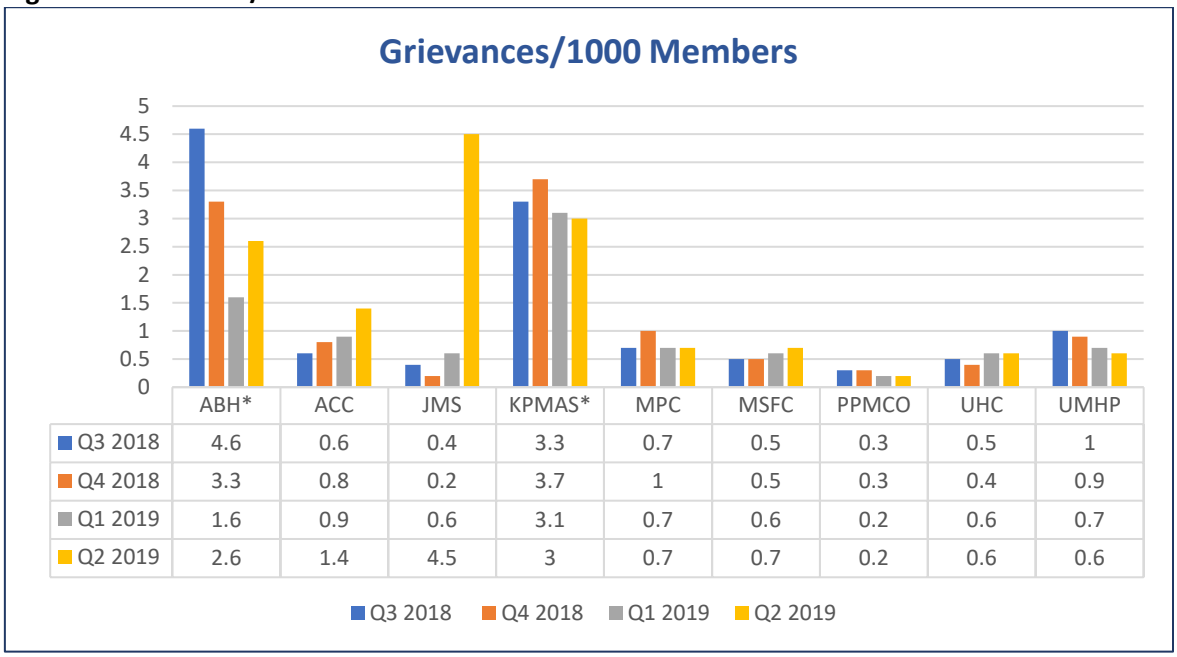
**Category 1:** Emergency medically related grievances
Example: Emergency prescription or incorrect prescription provided
**Category 2:** Non-emergency medically related grievances
Example: DME/DMS-related complaints about repairs, upgrades, vendor issues, etc.
**Category 3:** Administrative grievances
Example: Difficulty finding a network PCP or specialist

The MCO grievance review encompassed a review of comparative statistics and an assessment of compliance with federal and state laws and regulations as follows:

- Comparative Statistics
  - Grievances filed per 1000 members
  - Grievances filed per 1000 providers
- Resolution Time Frames (based upon 100% compliance)
  - Emergency medically related grievances resolved within 24 hours
  - Non-emergency medically related grievances resolved within 5 days
  - Administrative grievances resolved within 30 days
- Grievance Definitions
  - Must meet the definition of an expression of dissatisfaction about any matter other than an action.
  - May include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.
- Grievance Documentation: Grievance issue must be fully described in the enrollee record.
- Grievance Determination:
  - Grievance determination must be documented in the enrollee record, appropriately address the grievance issue, and identify the steps taken to resolve the issue.
  - Written determination must be forwarded to:
    1. Enrollee who filed the grievance;
    2. Individuals and entities required to be notified of the grievance; and
    3. The Department's complaint unit (for complaints referred to the MCO by the Department's complaint unit).

Figure 1 displays a comparison of MCO grievances per 1000 members for four quarters.

**Figure 1. Grievances/1000 Members**




| | ABH* | ACC | JMS | KPMAS* | MPC | MSFC | PPMCO | UHC | UMHP |
|---|---|---|---|---|---|---|---|---|---|
| Q3 2018 | 4.6 | 0.6 | 0.4 | 3.3 | 0.7 | 0.5 | 0.3 | 0.5 | 1 |
| Q4 2018 | 3.3 | 0.8 | 0.2 | 3.7 | 1 | 0.5 | 0.3 | 0.4 | 0.9 |
| Q1 2019 | 1.6 | 0.9 | 0.6 | 3.1 | 0.7 | 0.6 | 0.2 | 0.6 | 0.7 |
| Q2 2019 | 2.6 | 1.4 | 4.5 | 3 | 0.7 | 0.7 | 0.2 | 0.6 | 0.6 |

*Major outlier in comparison to other MCOs

Both ABH and KPMAS were major outliers in grievances per 1000 members for all four quarters. Access related issues represented the majority of ABH grievances, while customer service related categories represented the majority of KPMAS grievances, consistent with the prior 12-month period. JMS had a major uptick in grievances for the second quarter of 2019. JMS attributed this increase to recent customer service training focused on member grievances. In view of apparent under reporting in past quarters, it is anticipated that JMS grievances per 1000 will be reported at a much higher level in the future. For the other MCOs, reported grievances per 1000 members fall within a fairly narrow range.

Table 1 displays comparisons of MCO reported compliance with resolution time frames for member grievances based on MCO quarterly submissions.

**Table 1. MCO Reported Compliance with Member Grievance Resolution Time Frames**

| Quarter | ABH | ACC | JMS | KPMAS | MPC | MSFC | PPMCO | UHC | UMHP |
|---|---|---|---|---|---|---|---|---|---|
| **Q3 2018** | Met | Met | Met | PM | Met | PM | PM | Met | Met |
| **Q4 2018** | Met | Met | Met | PM | Met | PM | PM | Met | Met |
| **Q1 2019** | PM | Met | PM | PM | Met | PM | PM | PM | Met |
| **Q2 2019** | PM | Met | PM | Met | Met | Met | PM | Met | Met |

PM-Partially Met

Three MCOs (ACC, MPC, and UMHP) met the resolution time frames for member grievances in all four quarters. UHC demonstrated full compliance for three of the four quarters. ABH and JMS met the required time frames in two of the four quarters. KPMAS and MSFC only met the required time frames in Q2 2019. PPMCO did not fully meet the resolution time frames in any of the four quarters.

Table 2 offers a comparison of MCO reported grievances per 1000 providers for four quarters.

**Table 2. MCO Reported Grievances/1000 Providers**

| Quarter | ABH | ACC | JMS | KPMAS | MPC | MSFC | PPMCO | UHC | UMHP |
|---|---|---|---|---|---|---|---|---|---|
| **Q3 2018** | 1.79* | NA | 0.36 | NA | 1.48* | 0.17 | NA | NA | 0.73 |
| **Q4 2018** | 0.12 | NA | NA | NA | 0.48 | 0.17 | NA | 0.13 | 0.48 |
| **Q1 2019** | 0.10 | NA | 0.17 | NA | 0.46 | 0.17 | 1.00* | NA | 0.20 |
| **Q2 2019** | 0.30 | NA | NA | NA | 1.14* | NA | NA | NA | 0.30 |

NA-Not Applicable

*Major outlier in comparison to other MCOs

MCO reported grievances per 1000 providers consistently remained low for the majority of MCOs. For third quarter of 2018, both ABH and MPC were major outliers for this measure in comparison to all other MCOs; however, each MCO has demonstrated a downward, although uneven, trend since then. For the first quarter of 2019, PPMCO was a major outlier. For the second quarter of 2019, MPC grievances per 1000 providers exceeded all other MCOs; however, overall provider grievances have demonstrated a downward, although uneven, trend as previously noted.

Table 3 displays comparisons of MCO reported compliance with resolution time frames for provider grievances based on MCO quarterly submissions.

**Table 3. MCO Reported Compliance with Provider Grievance Resolution Time Frames**

| Quarter | ABH | ACC | JMS | KPMAS | MPC | MSFC | PPMCO | UHC | UMHP |
|---|---|---|---|---|---|---|---|---|---|
| **Q3 2018** | Met | NA | Met | NA | Met | Met | NA | Met | Met |
| **Q4 2018** | NA | NA | NA | NA | PM | Met | NA | Met | Met |
| **Q1 2019** | Met | NA | Met | NA | Met | Met | NA | Met | Met |
| **Q2 2019** | Met | NA | NA | NA | Met | NA | NA | NA | Met |

NA-Not applicable as the MCO did not receive any provider grievances during the reporting period.
PM-Partially Met

All MCOs, as applicable, met the resolution time frames for provider grievances throughout the four quarters with one exception. MPC compliance with required resolution time frames was partially met in the fourth quarter of 2018. MCOs that did not receive any provider grievances for the quarter were reported as NA for compliance for that quarter.

Table 4 presents a comparison of the annual grievance record review results across MCOs. Results are based upon a random selection of grievance records during CY 2018. Reviews were conducted utilizing the 10/30 rule.

**Table 4. CY 2018 MCO Annual Grievance Record Review Results**

| Requirement | ABH | ACC | JMS | KPMAS | MPC | MSFC | PPMCO | UHC | UMHP |
|---|---|---|---|---|---|---|---|---|---|
| Appropriately Classified | Met | Met | Met | Met | PM | Met | Met | Met | Met |
| Issue Is Fully Described | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| Resolution Timeliness | Met | Met | Met | PM | PM | Met | PM | Met | Met |
| Resolution Appropriateness | Met | Met | Met | PM | Met | Met | Met | Met | Met |
| Resolution Letter | Met | Met | Met | PM | PM | PM | Met | Met | Met |

PM - Partially Met

MPC received a finding of partially met for “Appropriately Classified,” as it did not correctly identify the category of the grievance. All MCO records reviewed demonstrated a full description of the grievance issue. Resolution timeliness was met by six MCOs. KPMAS, MPC, and PPMCO did not consistently meet time frames for resolution. KPMAS demonstrated an opportunity for improving the appropriateness of the resolution. Six MCOs (ABH, ACC, JMS, PPMCO, UHC, and UMHP) received a finding of met for the resolution letter. KPMAS and MSFC received a finding of partially met as resolution letters were not consistently provided in response to a member grievance. MPC received a finding of partially met as resolution letters did not identify or describe the grievance, and the resolution was not adequately documented in most cases.

## Appeal Results

An appeal is a request for a review of an action as stated in COMAR 10.09.62.01B(13). The regulation provides the following definitions of an action:

- Action 1: Denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
- Action 2: Reduction, suspension, or termination of a previously authorized service
- Action 3: Denial, in whole or part, of payment for a service
- Action 4: Failure to provide services in a timely manner (i.e., if the MCO fails to provide services within the time frames defined by the State in COMAR 10.09.66.07)
- Action 5: Failure of an MCO to act within the required appeal time frames set in COMAR (i.e., COMAR 10.09.71.05)
- Action 6: The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, or other enrollee financial liabilities

In April 2016, CMS issued final regulations that revised existing Medicaid managed care rules for contract periods beginning on or after July 1, 2017. As a result, MDH communicated to the MCOs new regulatory requirements for appeal processing with an effective date of January 1, 2018. This date was subsequently revised to dates of services requested on or after February 1, 2018, to allow the MCOs additional time for implementation of the new requirements. Updates to COMAR 10.09.71.05 as they relate to MCO reported appeal results addressed in this report include the following:

- MCOs may only have one level of enrollee appeal, and enrollees must first appeal to the MCO before requesting a State fair hearing.
- Except for expedited appeals, MCOs shall resolve each appeal and provide notice of resolution, as expeditiously as the enrollee's health condition requires within 30 days from the date the MCO receives the appeal unless an extension is requested.
- Expedited appeals shall be resolved as expeditiously as the enrollee's health condition requires but no later than 72 hours after the MCO receives the appeal.

Providers can file an appeal on behalf of a member with their written consent. Maryland's regulations previously did not require the provider to seek written authorization before filing an appeal on the member's behalf.

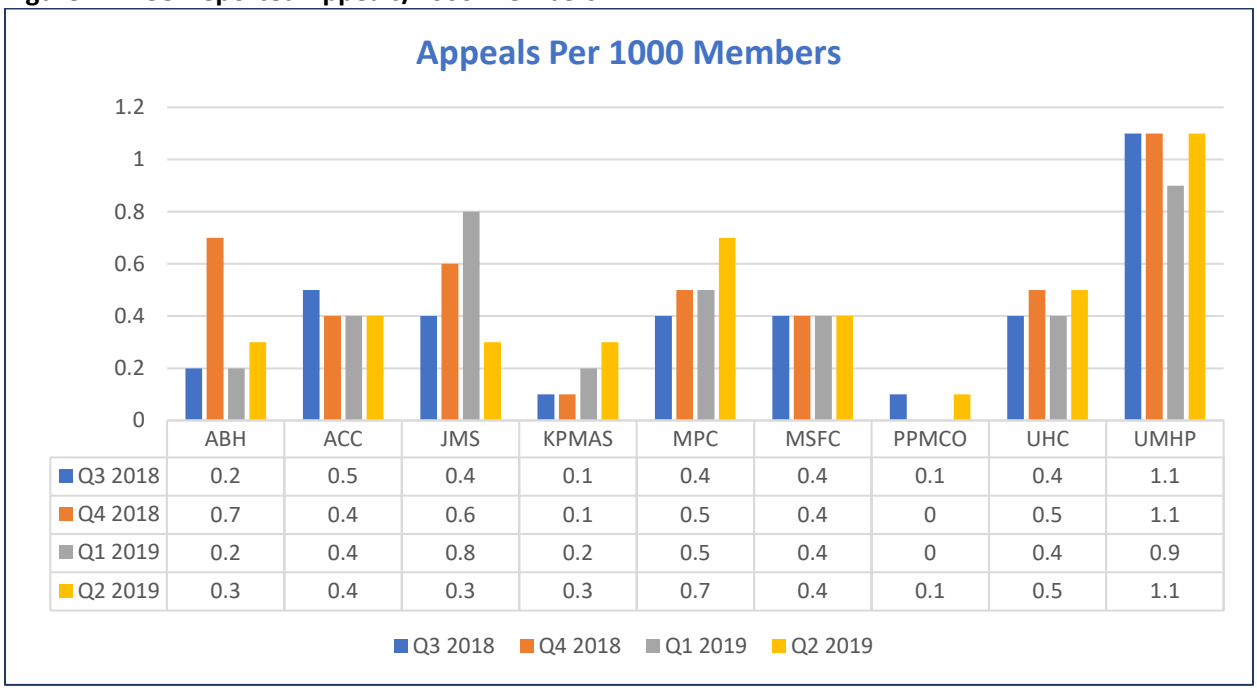
The MCO appeal review encompassed the following comparative statistics and an assessment of compliance with federal and state laws and regulations:

- Comparative Statistics: Appeals Filed Per 1000 Members
- Resolution Time Frames (based upon 100% compliance)
  - Expedited appeals are required to be completed within 72 hours of receipt. Notification of the appeal decision is required within 24 hours of the decision and within the overall 72-hour time frame.
  - Non-emergency appeals are required to be completed within 30 days, unless an extension is requested of no more than 14 days.

- Appeal Processing: Appeals are to be processed as expeditiously as the enrollee's health requires.
- Notifications of Denial of an Expedited Request
- Appeal Documentation: Appeal decisions are to be documented fully in the enrollee record.
- Decision Made by Health Care Professional with Appropriate Expertise
- Written Notification: The appeal resolution is to be provided to the enrollee in a written letter and must include results in easy to understand language.

Figure 2 provides a comparison of MCO reported appeals per 1000 members based on MCO quarterly submissions.

**Figure 2. MCO Reported Appeals/1000 Members**




| | ABH | ACC | JMS | KPMAS | MPC | MSFC | PPMCO | UHC | UMHP |
|---|---|---|---|---|---|---|---|---|---|
| Q3 2018 | 0.2 | 0.5 | 0.4 | 0.1 | 0.4 | 0.4 | 0.1 | 0.4 | 1.1 |
| Q4 2018 | 0.7 | 0.4 | 0.6 | 0.1 | 0.5 | 0.4 | 0 | 0.5 | 1.1 |
| Q1 2019 | 0.2 | 0.4 | 0.8 | 0.2 | 0.5 | 0.4 | 0 | 0.4 | 0.9 |
| Q2 2019 | 0.3 | 0.4 | 0.3 | 0.3 | 0.7 | 0.4 | 0.1 | 0.5 | 1.1 |

NA – Not Applicable
*Outlier in comparison to other MCOs

UMHP has consistently been at the top of the range in reported appeals per 1000 members in comparison to all other MCOs during all four quarters. This mirrors the prior year's findings as well. For the remaining eight MCOs, appeals per 1000 members fall within a relatively narrow range from quarter to quarter for each MCO and across MCOs.

Comparisons of MCO reported compliance with resolution time frames for member appeals are displayed in Table 5 based on MCO quarterly submissions.

**Table 5. MCO Reported Compliance with Member Appeal Resolution Time Frames**

| Quarter | ABH | ACC | JMS | KPMAS | MPC | MSFC | PPMCO | UHC | UMHP |
|---|---|---|---|---|---|---|---|---|---|
| **Q3 2018** | Met | Met | Met | Met | Met | Met | PM | PM | Met |
| **Q4 2018** | PM | Met | Met | Met | Met | PM | Met | PM | Met |
| **Q1 2019** | Met | Met | Met | Met | Met | Met | PM | Met | Met |
| **Q2 2019** | Met | Unmet | Met | PM | Met | Met | Unmet | PM | Met |

NA-Not Applicable; PM-Partially Met

Three MCOs (JMS, MPC, and UMHP) consistently met appeal resolution time frames for the four quarters reviewed. Four MCOs (ABH, ACC, KPMAS, and MSFC) demonstrated compliance for three quarters. PPMCO and UHC demonstrated compliance for one quarter. It does not appear that the change in the resolution time frame for expedited appeals from three business days to 72 hours had an impact on MCO compliance results.

Table 6 provides a comparison of appeal record review results across MCOs. Results are based upon a random selection of appeal records reviewed for CY 2018. Ten records were reviewed for each MCO. Additional records were not reviewed for any areas of non-compliance, since this was considered a baseline review due to several changes to the standards.

**Table 6. CY 2018 MCO Appeal Record Review Results**

| Requirement | ABH | ACC | JMS | KPMAS | MPC | MSFC | PPMCO | UHC | UMHP |
|---|---|---|---|---|---|---|---|---|---|
| Processed Based Upon Level of Urgency | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| Compliance with Verbal Notification of Denial of an Expedited Request | Unmet | Met | NA | Met | NA | NA | NA | Met | NA |
| Compliance with Written Notification of Denial of an Expedited Request | Met | Met | NA | Unmet | NA | NA | NA | Met | NA |
| Compliance with 72-hour Time Frame for Expedited Appeal Resolution | PM | Met | NA | Met | NA | Met | NA | Met | Met |
| Compliance with Verbal Notification of Expedited Appeal Decision | Unmet | Unmet | NA | Met | NA | Met | NA | Met | Met |
| Compliance with 24-hour Time Frame for Written Notification of Expedited Appeal Decision | PM | Met | NA | Met | NA | Met | NA | Met | Met |
| Compliance with Written Notification Time Frame for Non-Emergency Appeal | Met | Met | Met | Met | Met | Met | PM | Met | Met |
| Appeal Decision Documented | Met | Met | Met | Met | Met | Met | Met | Met | Met |

| Requirement | ABH | ACC | JMS | KPMAS | MPC | MSFC | PPMCO | UHC | UMHP |
|---|---|---|---|---|---|---|---|---|---|
| Decision Made by Health Care Professional with Appropriate Expertise | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| Decision Available to Enrollee in Easy to Understand Language | Met | Met | Met | Met | PM | Met | Met | Met | PM |

NA-Not Applicable; PM – Partially Met

Review of a sample of MCO records demonstrated that all nine MCOs processed appeals based upon the level of urgency; documented the appeal decision in the case record; and utilized health care professionals with appropriate clinical expertise in making appeal determinations. Of the four MCOs where a denial of a request for an expedited appeal resolution was documented, ABH did not provide evidence of a reasonable attempt to provide verbal notification of the denial and received an unmet. KPMAS did not demonstrate compliance with the time frame for written notification of the denial of an expedited request. Six MCOs had one or more requests for expedited appeal resolution, with four (KPMAS, MSFC, UHC, and UMHP) demonstrating compliance with all resolution and notification requirements. ABH received a finding of partially met for compliance with the 72-hour time frame for appeal resolution and an unmet for compliance with verbal notification of an expedited appeal decision. ACC also received a finding of unmet for compliance with verbal notification of an expedited appeal decision. Only PPMCO received a partially met for compliance with the notification time frame for non-emergency appeals. Seven of the MCOs provided the decision to the enrollee in easily understandable language. MPC and UMHP received a finding of partially met for this requirement.

## Pre-Service Denial Results

Actions and decisions regarding services to enrollees that require preauthorization by the MCO are defined in COMAR 10.09.71.04. In April 2016, CMS issued final regulations that revised existing Medicaid managed care rules for contract periods beginning on or after July 1, 2017. In response, MDH communicated to the MCOs these new regulatory requirements for services that require preauthorization. The effective date of January 1, 2018, was subsequently revised to dates of services requested on or after February 1, 2018, to allow the MCOs additional time for implementation of the new requirements. For January dates of service, compliance with determination time frames continued to be assessed based upon the prior regulation of two business days of receipt of necessary clinical information but no later than seven calendar days. Updates to COMAR 10.09.71.04 resulting from CMS regulatory changes to preauthorization determination time frames include the following:

- For standard authorization decisions, the MCO shall make a determination within 2 business days of receipt of necessary clinical information, but not later than 14 calendar days.
- For expedited authorization decisions, the MCO shall make a determination and provide notice no later than 72 hours after receipt of the request for services.
- For all covered outpatient drug authorization decisions, the MCO shall provide notice by telephone or other telecommunication device within 24 hours of a preauthorization request.

Additional regulatory requirements specified in COMAR 10.09.71.04 include:

- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested:
  - Shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease; and
  - May not be arbitrarily based solely on diagnosis, type of illness, or condition.
- Standard and expedited authorization decisions may be extended up to 14 calendar days under certain specified conditions.
- An MCO shall give an enrollee written notice of any action within the following time frames:
  - 24 hours from the date of determination for emergency, medically related requests;
  - 72 hours from the date of determination for nonemergency, medically related requests;
  - At least 10 days before the action for termination, suspension, or reduction of a previously authorized covered service; and
  - For denial of payment, at the time of any action affecting the claim.
- A notice of adverse action shall be in writing and:
  - Be translated for enrollees who speak prevalent non-English languages;
  - Include language clarifying that oral interpretation is available for all languages and how to access it;
  - Be written in an easily understood language and format that takes into consideration enrollees with special needs;
  - Be available in alternative formats;
  - Inform enrollees that information is available in alternative formats and how to access those formats; and
  - Contain the following information:
    - The action the MCO has made or intends to make;
    - The reasons for the action, including the right for the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the MCO's action;
    - The enrollee's right to request an appeal of the MCO's action;
    - The procedures for exercising the rights described;
    - The circumstances under which an appeal process can be expedited and how to request it;
    - The enrollee's right to have benefits continue pending resolution of the appeal;
    - How to request that benefits be continued; and
    - The circumstances under which the enrollee may be required to pay the costs of the services.

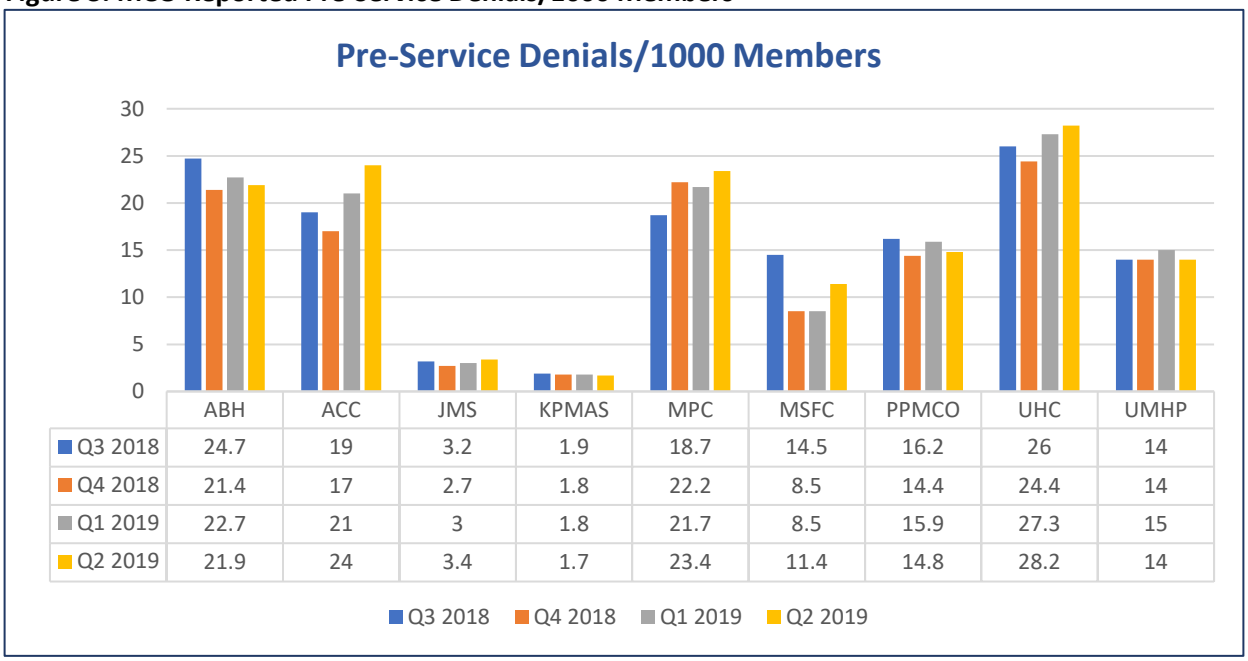
The MCO pre-service denial review encompassed the following comparative statistics and compliance with federal and state laws and regulations:

- Comparative Statistics: Pre-service Denials Rendered Per 1000 Members
- Determination time frame compliance (for dates of service as of February 1, 2019) based upon a compliance threshold of 95%:
  - For standard requests within 2 business days of receipt of necessary clinical information but no later than 14 calendar days from date of initial request.
  - For outpatient pharmacy requests within 24 hours of a preauthorization request.
  - For expedited requests determination and notice no later than 72 hours after receipt of request for service.

- Adverse determination notification time frame compliance (for dates of service as of February 1, 2019) based upon a compliance threshold of 95%:
  - For standard and outpatient pharmacy authorization decisions, within 72 hours from the date of the determination.
  - For expedited authorization decisions within 24 hours from the date of the determination.
  - For any previously authorized service at least 10 days prior to reducing, suspending, or terminating a covered service.
- Adverse Determinations
  - Must be based upon medical necessity criteria and clinical policies.
  - Must be rendered by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
- Adverse Determination Letters: Must include all 17 required regulatory components.

Figure 3 provides a comparison of MCO reported pre-service denials per 1000 members based on MCO quarterly submissions.

**Figure 3. MCO Reported Pre-Service Denials/1000 Members**




| | ABH | ACC | JMS | KPMAS | MPC | MSFC | PPMCO | UHC | UMHP |
|---|---|---|---|---|---|---|---|---|---|
| Q3 2018 | 24.7 | 19 | 3.2 | 1.9 | 18.7 | 14.5 | 16.2 | 26 | 14 |
| Q4 2018 | 21.4 | 17 | 2.7 | 1.8 | 22.2 | 8.5 | 14.4 | 24.4 | 14 |
| Q1 2019 | 22.7 | 21 | 3 | 1.8 | 21.7 | 8.5 | 15.9 | 27.3 | 15 |
| Q2 2019 | 21.9 | 24 | 3.4 | 1.7 | 23.4 | 11.4 | 14.8 | 28.2 | 14 |

Pre-service denials per 1000 members have varied by MCO but have generally remained within a fairly narrow range within each MCO over the four quarters reviewed. Pharmacy denials represent either the first or second most frequent service category for pre-service denials. While much improved over the prior four quarters, there remain some reporting inconsistencies that impact the data reported, including:

- ABH only reported "expedited" pharmacy denials for the first three quarters.
- KPMAS reported only medical necessity denials within one expedited category and all expedited (medical necessity and administrative ) in another for the first three quarters.
- UHC did not report pre-service denials from its dental vendor for the first three quarters of the review period.

As noted in the prior annual report, the consistently low number of denials for JMS and KPMAS is believed to be related to their clinic-based plan models.

Compliance with COMAR requirements for the timeliness of pre-service determinations was assessed based upon self-report through MCO submissions of quarterly reports and an annual record review. Quarterly data represented the entire population or a statistically significant sample. Table 7 displays results of the MCO's reported compliance with pre-service determination time frames.

**Table 7. MCO Reported Compliance with Pre-Service Determination Time Frames (Quarterly Reports)**

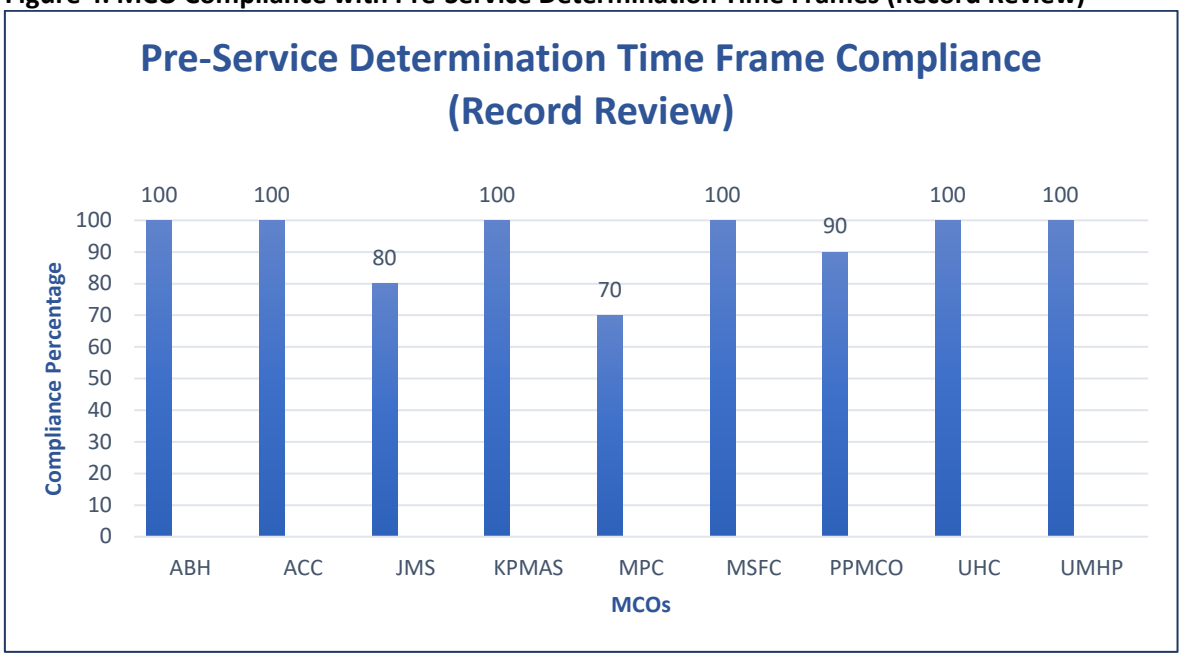
| Report Quarter | ABH | ACC | JMS | KPMAS | MPC | MSFC | PPMCO | UHC | UMHP |
|---|---|---|---|---|---|---|---|---|---|
| Compliance with Expedited Pre-Service Determination Time Frames | | | | | | | | | |
| Q3 2018 | 100% | 92% | NA | 100% | 100% | 100% | 67% | 99% | NA |
| Q4 2018 | 100% | 100% | NA | 100% | NA | NA | 54% | 90% | 100% |
| Q1 2019 | NA | 100% | 100% | 100% | 67% | 100% | 78% | 93% | 100% |
| Q2 2019 | NA | 100% | NA | 100% | 67% | 100% | 25% | 100% | 100% |
| Compliance with Standard Pre-Service Determination Time Frames | | | | | | | | | |
| Q3 2018 | 100% | 98% | 100% | 97% | 88% | 100% | 92% | 98% | 100% |
| Q4 2018 | 69% | 96% | 95% | 99% | 93% | 100% | 83% | 98% | 100% |
| Q1 2019 | 99% | 91% | 100% | 98% | 97% | 100% | 94% | 99% | 100% |
| Q2 2019 | 96% | 97% | 100% | 95% | 97% | 100% | 97% | 99% | 100% |
| Compliance with Outpatient Pharmacy Pre-Service Determination Time Frames | | | | | | | | | |
| Q3 2018 | 100% | 100% | 100% | NA | 95% | 100% | 98% | 100% | 100% |
| Q4 2018 | NA | 100% | 100% | NA | 97% | 100% | 98% | 100% | 100% |
| Q1 2019 | 100% | 100% | 100% | NA | 97% | 97% | 96% | 100% | 100% |
| Q2 2019 | 100% | 100% | 100% | NA | 98% | 96% | 97% | 100% | 100% |

NA-Not Applicable

Four of the MCOs ( JMS, KPMAS, MSFC, and UMHP) met or exceeded the 95% threshold for all applicable categories based upon a review of MCO quarterly reports. Compliance results by category ranged from 25% to 94% for the remaining five MCOs (ABH, ACC, MPC, PPMCO, and UHC).

Record reviews also were conducted to assess compliance with the COMAR requirement for timeliness of pre-service determinations. Ten records were reviewed for each MCO. Additional records were not reviewed for any areas of non-compliance since this was considered a baseline review due to several changes to the standards. Results are highlighted in Figure 4.

**Figure 4. MCO Compliance with Pre-Service Determination Time Frames (Record Review)**




All but three of the MCOs (JMS, MPC, and PPMCO) met or exceeded the 95% threshold based upon the annual review of the MCO's records. JMS had a compliance rate of 80% , MPC had a rate of 70%, and PPMCO had a rate of 90%.

Compliance with COMAR requirements for the timeliness of adverse determination notifications was assessed based upon MCO submissions of quarterly reports and an annual record review. Quarterly data represented the entire population or a statistically significant sample. Results are based upon a random selection of adverse determination records reviewed for CY 2018. Ten records were reviewed for each MCO. Additional records were not reviewed for any areas of non-compliance since this was considered a baseline review due to several changes to the standards. Table 8 displays the issues identified during a review of each MCO's adverse determination records.

**Table 8. MCO Adverse Determination Records Review Issues**

| MCO | Issues Identified |
|---|---|
| ABH | Letter Components |
| ACC | Letter Components |
| JMS | Turn Around Times |
| KPMAS | Letter Components |
| MPC | Turn Around Times & Letter Components |
| MSFC | Letter Components |
| PPMCO | Turn Around Times & Letter Components |
| UHC | Letter Components |
| UMHP | Letter Components |

Results of MCO reported compliance with adverse determination notification time frames based on the quarterly reports are highlighted in Table 9.

**Table 9. MCO Reported Compliance with Adverse Determination Notification Time Frames (Quarterly Reports)**

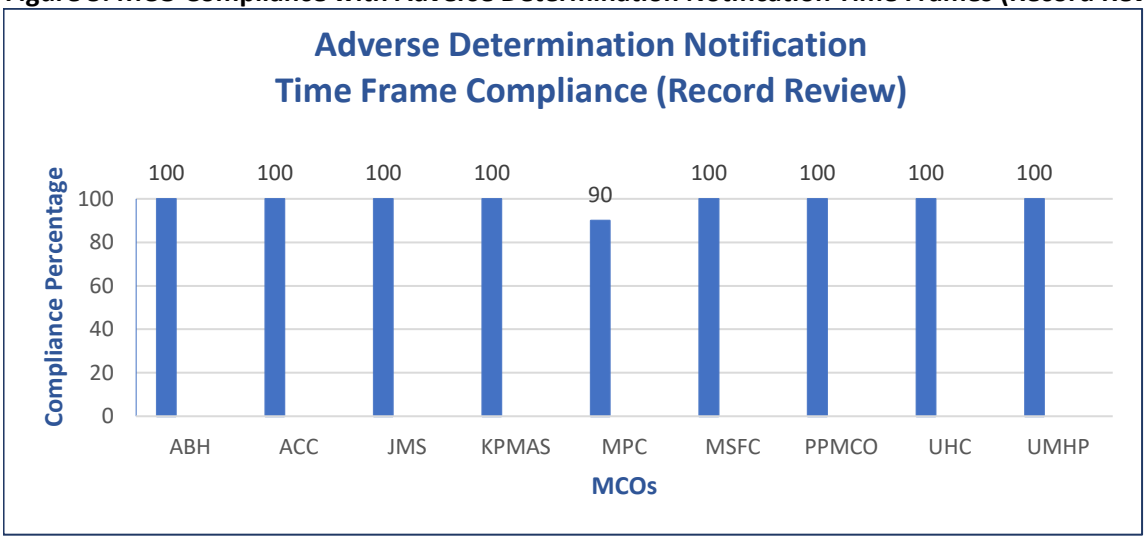
| Report Quarter | ABH | ACC | JMS | KPMAS | MPC | MSFC | PPMCO | UHC | UMHP |
|---|---|---|---|---|---|---|---|---|---|
| Compliance with Expedited Adverse Determination Notification Time Frames | | | | | | | | | |
| Q3 2018 | 100% | 100% | NA | 100% | 50% | 100% | 68% | 100% | N/A |
| Q4 2018 | 100% | 100% | NA | 100% | NA | NA | 47% | 100% | 100% |
| Q1 2019 | 100% | 100% | 100% | 100% | 33% | 100% | 75% | 100% | 100% |
| Q2 2019 | NA | 75% | NA | 100% | 100% | NA | 25% | 100% | 100% |
| Compliance with Standard Adverse Determination Notification Time Frames | | | | | | | | | |
| Q3 2018 | 94% | 99% | 100% | 99% | 97% | 86% | 93% | 99% | 100% |
| Q4 2018 | 60% | 99% | 100% | 100% | 98% | 97% | 82% | 99% | 100% |
| Q1 2019 | 98% | 98% | 100% | 100% | 98% | 97% | 91% | 99% | 100% |
| Q2 2019 | 99% | 80% | 100% | 100% | 98% | 84% | 95% | 100% | 100% |
| Compliance with Outpatient Pharmacy Adverse Determination Notification Time Frames | | | | | | | | | |
| Q3 2018 | 100% | 100% | 100% | NA | 99% | 100% | 97% | 100% | 100% |
| Q4 2018 | NA | 100% | 100% | NA | 98% | 100% | 98% | 100% | 100% |
| Q1 2019 | NA | 100% | 100% | NA | 100% | 97% | 96% | 100% | 100% |
| Q2 2019 | 100% | 100% | 100% | NA | 100% | 96% | 97% | 100% | 100% |

NA-Not Applicable

Four of the MCOs ( JMS, KPMAS, UHC, and UMHP) met or exceeded the 95% threshold for all applicable categories upon a review of MCO quarterly reports. Compliance results by category ranged from 25% to 94% for the remaining five MCOs (ABH, ACC, MPC, MSFC, and PPMCO).

Record reviews also were conducted to assess compliance with the COMAR requirement for timeliness of adverse determination notifications. Ten records were reviewed for each MCO. Additional records were not reviewed for any areas of non-compliance since this was considered a baseline review due to several changes to the standards. Results are highlighted in Figure 5.

**Figure 5. MCO Compliance with Adverse Determination Notification Time Frames (Record Review)**




All but MPC demonstrated 100% compliance with adverse determination notification time frames based upon the record review. MPC compliance was below the 95% threshold at 90%.

Table 10 provides a comparison of denial record review results across MCOs for CY 2018. Results are based upon a random selection of denial records. Ten records were reviewed for each MCO. Additional records were not reviewed for any areas of non-compliance since this was considered a baseline review due to several changes to the standards.

**Table 10. Results of CY 2018 Denial Record Reviews**

| Requirement | ABH | ACC | JMS | KPMAS | MPC | MSFC | PPMCO | UHC | UMHP |
|---|---|---|---|---|---|---|---|---|---|
| Appropriateness of Adverse Determinations | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| Compliance with Pre-Service Determination Time Frames | Met | Met | PM | Met | PM | Met | PM | Met | Met |
| Compliance with Adverse Determination Notification Time Frames | Met | Met | Met | Met | PM | Met | Met | Met | Met |
| Required Letter Components | PM | PM | Met | PM | PM | PM | PM | PM | PM |

PM-Partially Met

All MCOs demonstrated compliance with the appropriateness of adverse determinations supported by medical necessity criteria and MCO-specific clinical policies. Six MCOs met or exceeded the 95% threshold for compliance with determination time frames. Three MCO (JMS, MPC, and PPMCO) did not consistently meet the compliance threshold for determination time frames. All MCOs but MPC met or exceeded the threshold for timely notification of an adverse determination. Only JMS demonstrated compliance with all required letter components. The majority of MCOs did not provide the revised time frame for filing an appeal in the adverse determination notification letter.

# Recommendations

Overall, the MCOs demonstrated fairly strong and consistent results in meeting regulations relating to grievances, appeals, and pre-service denials. This may be attributed to comprehensive MCO oversight by MDH and its effective use of Qlarant as the contracted EQRO. Compliance with regulatory time frames continues to be the greatest challenge as evidenced by MCO results in the majority of categories. Corrective action plans (CAPs) through the Systems Performance Review process are in place to address MCOs that have had ongoing issues in demonstrating compliance. As necessary, MDH has also instituted a quarterly review to assess progress in CAP implementation and related performance measures.

As a result of opportunities identified following the 2018 focused review, MDH:

- Required MCOs to report quarterly compliance with outpatient drug preauthorization decision and notification time frames which assisted in bringing to light some implementation issues with this new requirement. For example, two MCOs did not have a process for documenting telephonic or other telecommunication notifications to providers within 24 hours of the request.
- Further clarified new System Performance Review standards for grievances, appeals, and pre-service denials for the CY 2019 Interim Review based upon opportunities identified during the CY 2018 SPR.

The following recommendations are offered in response to new and/or continuing opportunities for improvement:

- **MCOs:** Implement managed care model notices recently revised by MDH to reflect current regulatory requirements and increased clarity for both the MCOs and the members. The use of such templates are considered a best practice.
- **MDH:** Provide guidance to the MCOs regarding requirements for member grievances that are received from the State. This includes processing and reporting all receipts as grievances and providing a member resolution letter for each.
- **MDH:** Revise the MCO quarterly pre-service denial reporting form to improve clarity of reporting fields.
- **MDH:** Consider developing a separate denial category for “dental services” which is currently reported in the “Other” category. This would assist in highlighting any trends in this “value added” service and allow for improved peer comparisons since some MCOs do not provide adult dental services.
- **MDH:** Consider including in the next onsite SPR conducting ongoing training with front line member call center staff to assess their understanding of what constitutes a grievance in view of possible under reporting in this area.

# Conclusions

This report includes studies of MCO grievance, appeal, and denial quarterly reports from the third quarter of 2018 through the second quarter of 2019. Additionally, a sample of grievance, appeal, and denial records were reviewed for CY 2018. Based upon the outcomes of these studies, supplemented by the annual record reviews, most MCOs demonstrated strong and consistent results in meeting the majority of grievance, appeal, and denial requirements. This level of compliance helps to ensure the delivery of quality care and services to HealthChoice members is timely and accessible. Below are strengths identified in specific review components where all, or a majority, of the MCOs were in compliance:

- Appropriate classification and resolution of grievances
- Full documentation of grievance issues
- Grievance resolution letters
- Provider grievance resolution time frames
- Appeals processed based upon level of urgency
- Appeal decisions made by health care professional with appropriate expertise
- Appeal decisions documented and available to the member in easy to understand language
- Adverse determinations appropriate based upon MCO medical necessity criteria and policies

Major opportunities for improvement where five or more of the MCOs did not meet requirements on a consistent basis are identified in the following areas:

- Timely resolution of member grievances
- Timely resolution of member appeals
- Timely pre-service determinations
- Timely adverse determination notifications
- Required components in adverse determination letters

As noted in the Limitations section, the validity of the data submitted by the MCOs continues to be a challenge, although there has been marked improvement since the first quarter of 2019. Consequently, assessment results documented in this report need to be considered with some caution. Subsequent reporting will yield a greater level of confidence in the review outcomes for annual reporting.

# Appendix A
# MCO-Specific Summaries

MCO summary findings are based upon select performance measures trended over time and taken from the MCO quarterly reviews. Separate report templates listing review components for Grievances, Appeal, and Pre-Service Denials are found in Appendices A, B, and C.

The MCO-specific results from quarterly assessments and CY 2018 record reviews are highlighted in the following grievance, appeal, and pre-service denial summaries. Each MCO summary includes the following, as applicable:

- MCO-specific trends
- Comparison with Other MCOs
- Compliance
- Strengths
- Best Practices
- Opportunities
- Recommendations

| Aetna Better Health of Maryland | |
|---|---|
| **Trends** | ✓ For the first three quarters of the review period member grievances per 1000 demonstrated a downward trend but a slight uptick was reported for the most recent quarter. Grievances represent primarily access-related issues.<br>✓ Appeal results were fairly consistent over four quarters. No negative trends identified.<br>✓ Denials per 1000 members demonstrate an uneven but overall upward trend. Pharmacy services was the top one or two service categories during the review period. |
| **Comparison to Other MCOs** | ✓ Member grievances per 1000 are at the upper end of the MCO range.<br>✓ Appeal results are generally consistent with all other MCOs with appeals per 1000 at the lower end of the MCO range.<br>✓ Denial results are generally consistent with all other MCOs with denials per 1000 at the upper end of the MCO range. |
| **Compliance** | ✓ Member grievance resolution time frames were fully met for two of the four quarters; provider grievances met the time frame for all three applicable quarters.<br>✓ The time frame for notification of standard appeal resolution was consistently met for all four quarters. The time frame for notification of an expedited appeal was not consistently met.<br>✓ Compliance with verbal notification of denial of an expedited request and verbal notification of an expedited appeal decision was not met based upon a sample of records reviewed.<br>✓ Pre-Service determination time frames met or exceeded the 95% threshold for three of the four quarters. Notification time frames were fully met in two of the four quarters. |
| **Strengths** | ✓ Grievances and their resolutions were well documented. Grievance resolutions were appropriate.<br>✓ Full compliance with time frame for notification of standard appeal resolution for all four quarters. |
| **Opportunities** | ✓ Consistency in demonstrating compliance with member grievance resolution time frames.<br>✓ Consistency in documenting reasonable attempts to provide enrollee prompt verbal notice of denial of expedited appeal resolution.<br>✓ Consistency in documenting reasonable attempts to provide enrollee prompt verbal notice of expedited appeal resolution.<br>✓ Timely resolution of denials of expedited appeal requests.<br>✓ Timely written notification of expedited appeal resolutions.<br>✓ Accurate dates in member appeal acknowledgment and resolution letters.<br>✓ Consistent use of current MDH template for all adverse determination notifications.<br>✓ Adverse determination notifications consistently provide an explanation of the requested care.<br>✓ Consistency in demonstrating compliance with pre-service and adverse determination notification time frames. |

| Aetna Better Health of Maryland | |
|---|---|
| **Recommendations** | ✓ Ensure effective process is in place for monitoring compliance with all regulatory time frames for grievances, appeals, and pre-service determinations and adverse determination notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated.<br>✓ Audit a sample of grievance, appeal, and denial letters on a routine basis to ensure use of MDH required templates and accuracy and completeness of content. |

| AMERIGROUP Community Care | |
|---|---|
| **Trends** | ✓ Grievance results are fairly consistent over four quarters, however the member grievances per 1000 rate has steadily increased over the last four quarters.<br>✓ Appeal results are fairly consistent over the four quarters. Pharmacy Services was the top service category for all four quarters. No negative trends were identified.<br>✓ Pre-service denial results are fairly consistent over four quarters, however pre-service denials per 1000 has been increasing the last two quarters. Pharmacy services was the top service category for pre-service denials for all four quarters. |
| **Comparison with Other MCOs** | ✓ Grievance results are generally consistent with all other MCOs.<br>✓ Appeal results are generally consistent with all other MCOs with the appeal rate per 1000 members at mid-range.<br>✓ Pre-service denial results are generally consistent with all other MCOs; however, the denials per 1000 rate is approaching the upper end of the MCO range. |
| **Compliance** | ✓ Member grievance resolution time frames were fully met for all four quarters. No provider grievances were received during the review time frame.<br>✓ Appeal resolution time frames were fully met for three of the four quarters.<br>✓ Pre-service determination time frames met or exceeded the 95% threshold in two of the four quarters. Notification time frames demonstrated full compliance in three of the four quarters. |
| **Strengths** | ✓ Grievances and their resolutions were well documented. Grievance resolutions were appropriate.<br>✓ Compliance with grievance resolution time frames was consistently met in all four quarters. |
| **Best Practices** | ✓ Resolution letters are in plain language and describe well the grievance and the resolution.<br>✓ Appeal resolution letters include a detailed description of the reason for upheld decisions in plain language.<br>✓ Excellent use of plain language in all adverse determination letters. Letters advise of the availability of an ACC case manager to help member explore other options, like services within their community that may be free or of little cost if services requested exceed benefit limits, is included in all letters with contact number provided. |
| **Opportunities** | ✓ Consistent compliance with appeal resolution time frames.<br>✓ Documentation of attempt to provide verbal notification of expedited appeal resolution.<br>✓ Adverse determination notices consistently identify the correct time frame for filing an appeal.<br>✓ Adverse determination notices include required information on the reviewer including name, title, and credentials.<br>✓ Consistent compliance with pre-service determination and adverse determination notification time frames. |
| **Recommendations** | ✓ Ensure effective process is in place for monitoring compliance with all regulatory time frames for appeals and pre-service determinations and adverse determination notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated.<br>✓ Audit a sample of adverse determination letters on a routine basis to ensure use of MDH required template and accuracy and completeness of content. |

| Jai Medical Systems, Inc. | |
|---|---|
| **Trends** | ✓ Reported grievances per 1000 members demonstrated a significant increase the last quarter which the MCO attributed to recent customer service training focused on member grievances. Billing/financial issues represent a high percentage (44% - 62%) of member grievances in the last two quarters.<br>✓ Appeal results are fairly consistent over four quarters with all appeals related to Pharmacy Services. No negative trends identified.<br>✓ Pre-service denial results are fairly consistent over four quarters. No negative trends identified. Pharmacy services was the top service category for pre-service denials for all four quarters. |
| **Comparison with Other MCOs** | ✓ Grievance results are generally consistent with all other MCOs although JMS was a major outlier in member grievances per 1000 for the last quarter.<br>✓ Appeal results are generally consistent with all other MCOs.<br>✓ Pre-service denial results are generally consistent with all other MCOs; however, the MCO is at the low end of the MCO range in denials per 1000 members. |
| **Compliance** | ✓ Resolution time frames for member grievances were met for two of the four quarters; provider grievances met the time frames for the two applicable quarters.<br>✓ Appeal resolution time frames were consistently met for all four quarters.<br>✓ Pre-service determination time frames met or exceeded the 95% threshold for all four quarters for medical authorization requests. Time frames were not consistently met for pharmacy requests.<br>✓ Adverse determination notification frames were consistently met for all four quarters.<br>✓ No evidence that requesting provider was contacted within 24 hours of review outcome for outpatient pharmacy PA requests. |
| **Strengths** | ✓ Grievances are appropriately classified and fully described in case notes.<br>✓ Full compliance with appeal resolution time frames was demonstrated for all four quarters. |
| **Best Practices** | ✓ Adverse determination letters include a very detailed description of the reason for the denial and any additional information needed in easy to understand language.<br>✓ All appeal resolution letters are in plain language and include the board certification and specialty of the physician who reviewed the appeal. |
| **Opportunities** | ✓ Full description of the grievance in all resolution letters.<br>✓ Stated time frame for resolution is consistent with grievance category in all acknowledgment letters.<br>✓ Billing/financial grievances.<br>✓ Consistent compliance with grievance resolution time frames.<br>✓ Consistent compliance with preauthorization time frame for all outpatient pharmacy requests.<br>✓ Documentation that requesting provider was contacted within 24 hours of review outcome for outpatient pharmacy PA requests. |

| Jai Medical Systems, Inc. | |
|---|---|
| **Recommendations** | ✓ Ensure effective process is in place for monitoring compliance with all regulatory time frames for grievances and outpatient pharmacy pre-service determinations including documentation of provider contact to inform of pharmacy review outcome. Increase frequency and scope of monitoring until consistent compliance is demonstrated.<br>✓ Consider conducting a root cause analysis of billing/financial related member grievances to identify opportunities for improvement.<br>✓ Audit a sample of grievance acknowledgement and resolution letters on a routine basis to ensure completeness and accuracy of content. |

| Kaiser Permanente of the Mid-Atlantic States, Inc. | |
|---|---|
| **Trends** | ✓ Grievance results are fairly consistent over four quarters; however, member grievances relating to attitude/service have represented the majority of KPMAS grievances.<br>✓ Appeals per 1000 has been steadily increasing quarter over quarter for the last three quarters.<br>✓ Pre-service denial results are fairly consistent with a slight overall decrease in denials per 1000 from the third quarter of 2018. No negative trends identified. Medical/Surgical pre-service denials remained the top service category for all four quarters. |
| **Comparison with Other MCOs** | ✓ KPMAS has remained at the top of the range for three of the four quarters for member grievances among the mature MCOs. Additionally, KPMAS was the only MCO demonstrating an opportunity for improving resolution appropriateness based upon the record review. Compliance with the requirement for resolution letters also was at the low end of the range.<br>✓ Appeal results are generally consistent with all other MCOs.<br>✓ Pre-service denial results are generally consistent with all other MCOs. Pre-service denials per 1000 members is below the range of the other MCOs, possibly due to the MCO's model. |
| **Compliance** | ✓ Compliance with resolution time frames for member grievances was met in one of the four quarters; there were no provider grievances. Only 20% of grievances demonstrated evidence of a resolution letter based on a review of 30 records.<br>✓ Notification of appeal resolution demonstrated full compliance in three of the four quarters.<br>✓ Compliance with pre-service determination and adverse determination notification time frames was demonstrated at or above the 95% threshold for all four quarters. |
| **Strengths** | ✓ Full compliance with pre-service notification and adverse determination notification time frames.<br>✓ Reasons for adverse determinations are very detailed in adverse determination notification letters. |
| **Opportunities** | ✓ Consistency in sending resolution or case closure letters to any member who filed a grievance and others, as appropriate.<br>✓ Complete and appropriate resolution of all grievances documented in case records and member resolution letters.<br>✓ Consistent compliance with member grievance resolution time frames.<br>✓ Attitude/service related grievances.<br>✓ Written notice of denial of expedited appeal resolution provided within regulatory time frame.<br>✓ Consistent compliance with time frames for notice of appeal resolution.<br>✓ Adverse determination notices consistently identify the correct time frame for filing an appeal. |
| **Recommendations** | ✓ Ensure policies and procedures document the COMAR requirement for sending resolution letters to any member who filed a grievance and others, as appropriate. This includes members whom the MCO was unable to |

| Kaiser Permanente of the Mid-Atlantic States, Inc. | |
|---|---|
| | contact by phone and as a result closed the case. Consider implementing a process for auditing a sample of grievance records to ensure resolutions are appropriate and a resolution letter has been sent to any member who has filed a grievance.<br>✓ Ensure effective process is in place for monitoring compliance with all regulatory time frame requirements for written notification of grievance and appeal resolutions. Increase frequency and scope of monitoring until consistent compliance is demonstrated.<br>✓ Consider conducting a root cause analysis of service/attitude-related member grievances to identify opportunities for improvement.<br>✓ Utilize MDH required template for all notices and audit MCO content on a routine basis to ensure accuracy. |

| Maryland Physicians Care | |
|---|---|
| **Trends** | ✓ Grievance results are fairly consistent over four quarters with no negative trends identified. Access-related issues represent over a third of all member grievances over the four quarters under review.<br>✓ Appeal results are fairly consistent; however, there has been a slight upward trend in appeals per 1000 members from the third quarter of 2018. Pharmacy Services was the top service category for all four quarters.<br>✓ Pre-service denial results are fairly consistent over four quarters; however, denials per 1000 demonstrate an uneven but overall increase from the third quarter of 2018. Diagnostic lab remained the top pre-service denial category followed by pharmacy services for all four quarters. |
| **Comparison with Other MCOs** | ✓ Grievance results are generally consistent with all other MCOs, however, MPC was the only MCO demonstrating an opportunity for improving the assignment of grievances to the appropriate category based upon the record review.<br>✓ Appeal results are generally consistent with all other MCOs.<br>✓ Pre-service denial results are generally consistent with all other MCOs, however, pre-service denials per 1000 is at the upper end of the MCO range. |
| **Compliance** | ✓ Reported resolution time frames were consistently met for member grievances, however, compliance was not fully met for one of the four quarters for provider grievances.<br>✓ Appeal resolution time frames were consistently met for all four quarters.<br>✓ Overall pre-service denial determination time frames were below the compliance threshold for all four quarters. Overall compliance with notification time frames was demonstrated in two of the four quarters. |
| **Strengths** | ✓ Appeals well documented in case notes.<br>✓ Full compliance with appeal resolution time frames was reported for all four quarters. |
| **Opportunities** | ✓ Appropriate categorization of grievances.<br>✓ Consistent compliance with provider grievance resolution time frames.<br>✓ Grievance and resolution appropriately described in all resolution letters in easy to understand language.<br>✓ Access related member grievances.<br>✓ Appeal resolution letters consistently written in easily understandable language.<br>✓ Compliance with all required letter components for pre-service denials including explanation of the reason for the denial in easily understandable language and correct appeal filing time frame.<br>✓ Consistent compliance with preauthorization determination and adverse determination notification time frames. |
| **Recommendations** | ✓ Consider re-educating staff on appropriate categorization of grievances and audit call records on a routine basis to ensure effectiveness of training.<br>✓ Ensure effective process is in place for monitoring compliance with all regulatory time frames for grievances and pre-service determinations and adverse determination notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated.<br>✓ Audit a sample of grievance, appeal, and denial letters on a routine basis to ensure use of MDH required templates and accuracy and completeness of content in easy to understand language. |

| Maryland Physicians Care | |
|---|---|
| | ✓ Consider conducting a root cause analysis of access-related member grievances to identify opportunities for improvement. |

| MedStar Family Choice, Inc. | |
|---|---|
| **Trends** | ✓ Grievance results are fairly consistent over four quarters, however, member grievances per 1000 has been trending slightly upward over the last two quarters. Access-related issues have represented approximately a third of all grievances in three of the four quarters reviewed.<br>✓ Appeal results are fairly consistent over four quarters. No negative trends were identified.<br>✓ Pre-service denial results are fairly consistent over four quarters; however, the pre-service denials per 1000 members demonstrates considerable fluctuations due to issues with the MCO's new dental vendor and more recent issues with potentially fraudulent prescriptions for expensive non-formulary creams and ointments. Dental denials have consistently remained the top category for pre-service denials throughout the review period. |
| **Comparison with Other MCOs** | ✓ Grievance results are generally consistent with all other MCOs.<br>✓ Appeal results are generally consistent with all other MCOs.<br>✓ Pre-service denial results are generally consistent with all other MCOs. |
| **Compliance** | ✓ Overall compliance with resolution time frames for member grievances was met in only one of the four quarters; provider grievances were resolved within regulatory time frames for the three applicable quarters.<br>✓ Appeal resolution time frames were met in three of the four quarters.<br>✓ Pre-service denial determination and notification time frames met or exceeded the 95% threshold in all quarters under review. |
| **Strengths** | ✓ Case notes and resolution letters provide a detailed description of the grievance and resolution.<br>✓ Appeal letters in plain language and provide detailed information on the reason for the uphold decision.<br>✓ Adverse determination letters in easy to understand language with detailed explanation of reason for the denial and additional information needed for reconsideration. |
| **Best Practices** | ✓ All resolution letters are in plain language and include the board certification and specialty of the physician who reviewed the appeal. |
| **Opportunities** | ✓ Consistent mailing of resolution letters to any member who filed a grievance and others, as appropriate.<br>✓ Consistent compliance with resolution time frames for member grievances.<br>✓ Consistent compliance with appeal resolution time frames. |
| **Recommendations** | ✓ Audit grievance records on a routine basis to ensure a grievance resolution letter is sent to any member who filed a grievance through either the State, the MCO's TPA, or directly with the MCO.<br>✓ Ensure effective process is in place for monitoring compliance with all regulatory time frames for grievances and appeal resolution notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated. |

| Priority Partners | |
|---|---|
| **Trends** | ✓ Grievance results are fairly consistent over four quarters with the exception of a downward trend in member grievances over the last three quarters. Attitude and billing/financial issues consistently represent the majority of grievances.<br>✓ Appeal results are fairly consistent over four quarters, although appeals per 1000 members has trended slightly upward over the last two quarters.<br>✓ Pre-service denial results are fairly consistent over four quarters. Pre-service denials per 1000 members has demonstrated an uneven but overall downward trend over the review period. Pharmacy services was the top service category for pre-service denials for all four quarters and represent over half of all denials. |
| **Comparison with Other MCOs** | ✓ Grievance results are generally consistent with all other MCOs with the exception of compliance with resolution time frames.<br>✓ Appeal results are generally consistent with all other MCOs, although the MCO's appeals per 1000 members rate is at the bottom of the range.<br>✓ Pre-service denial results are generally consistent with all other MCOs. |
| **Compliance** | ✓ Compliance with resolution time frames for member grievances was not fully met in any of the four quarters. No provider grievances were reported.<br>✓ Full compliance with appeal resolution time frames has been demonstrated only in one of the four quarters.<br>✓ Pre-service determination and adverse determination notification time frames were not fully met during the entire review period. |
| **Strengths** | ✓ Grievances and their resolution are well documented in case notes and resolutions are appropriate. |
| **Best Practices** | ✓ Grievance resolution letters are in plain language and provided in both English and Spanish.<br>✓ Appeal resolution letters are in plain language with a detailed explanation as to the reason for the decision for both upheld and overturned determinations, the criteria used, the documentation considered in reviewing the case, and the qualifications of the physician who made the determination. |
| **Opportunities** | ✓ Reporting of grievances by type, emergent-medically related, non-emergent medically related, and administrative. According to MCO the reporting system used to document grievances does not allow for categorization of grievances by type.<br>✓ Consistent compliance with grievance resolution time frames.<br>✓ Grievance resolution letters consistently provide a description of the grievance.<br>✓ Attitude and billing/financial related member grievances.<br>✓ Consistent compliance with appeal resolution time frames. Accurate date of appeal receipt in acknowledgment letters.<br>✓ Consistent compliance with pre-service determination and adverse determination notification time frames. Compliance with all required letter components including reviewer name, title, and credentials, reason for |

| Priority Partners | |
|---|---|
| | denial in easily understandable language, and correct appeal filing time frame. |
| **Recommendations** | ✓ Ensure reporting of grievances by type through either a system upgrade or manual process.<br>✓ Ensure effective process is in place for monitoring compliance with all regulatory time frames for grievances, appeals, and pre-service determinations and adverse determination notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated.<br>✓ Consider conducting a root cause analysis of attitude and billing/financial related member grievances to identify opportunities for improvement.<br>✓ Utilize MDH required template for all notices and audit MCO content on a routine basis to ensure accuracy. |

| UnitedHealthcare Community Plan | |
|---|---|
| **Trends** | ✓ Grievance results are fairly consistent over four quarters. No negative trends identified. Billing/financial issues remain in the top two of member grievances.<br>✓ Appeal results are fairly consistent over the last four quarters, however, full compliance with resolution time frames remains uneven. Pharmacy Services was the top service category for all four quarters representing no less than 74% of appeals.<br>✓ Pre-service denial results are fairly consistent over four quarters. Pharmacy services was the top service category for pre-service denials for all four quarters representing approximately three quarters of all denials. |
| **Comparison with Other MCOs** | ✓ Grievance results are generally consistent with all other MCOs.<br>✓ Appeal results are generally consistent with all other MCOs; however, expedited requests remain at the top of the MCO range.<br>✓ Pre-service denial results are generally consistent with all other MCOs; however, the MCO remains at the top of the range for pre-service denials per 1000. |
| **Compliance** | ✓ Full compliance with resolution time frames for member grievances was met in three of four quarters; time frames for provider grievances were consistently met in all applicable quarters.<br>✓ Full compliance with appeal resolution time frames was met in only one of four quarters.<br>✓ Compliance with pre-service determination time frames exceeded the 95% threshold in two of the four quarters. Notification time frames were met in all four quarters. UHC did not include pre-service denials from its dental vendor in its count for the first three quarters of the review period. |
| **Strengths** | ✓ Grievances and their resolution are well documented and resolutions are appropriate. |
| **Best Practices** | ✓ Both acknowledgment and resolution letters are in plain language and are very detailed in describing the grievance and the resolution, as appropriate. |
| **Opportunities** | ✓ Consistent compliance with the resolution time frame for member grievances.<br>✓ Billing/financial related member grievances.<br>✓ Consistent compliance with appeal resolution time frames.<br>✓ Consistent compliance with pre-service determination time frames. |
| **Recommendations** | ✓ Ensure effective process is in place for monitoring compliance with all regulatory time frames for grievances, appeals, and pre-service determinations. Increase frequency and scope of monitoring until consistent compliance is demonstrated.<br>✓ Consider conducting a root cause analysis of billing/financial related member grievances to identify opportunities for improvement. |

| University of Maryland Health Partners | |
|---|---|
| **Trends** | ✓ Member grievances have been trending downward the last three quarters. Grievances relating to attitude/service issues, continue to represent the majority of grievances.<br>✓ Appeal results are fairly consistent over four quarters. No negative trends identified. Pharmacy Services was the top service category for all four quarters representing the majority of appeals.<br>✓ Pre-service denial results are fairly consistent over four quarters. No negative trends were identified. Pharmacy services was the top service category for pre-service denials for all four quarters representing approximately three quarters of all denials. |
| **Comparison with Other MCOs** | ✓ Grievance results are generally consistent with all other MCOs.<br>✓ Appeal results are generally consistent with all other MCOs with one major outlier. Appeals per 1000 members remain at the top of the MCO range.<br>✓ Pre-service denial results are generally consistent with all other MCOs. |
| **Compliance** | ✓ Full compliance with member and provider grievance resolution time frames was demonstrated in all four quarters.<br>✓ Appeal resolution time frames were consistently met for all four quarters.<br>✓ Compliance with pre-service denial determination and notification time frames were met consistently during the review period. |
| **Strengths** | ✓ 100% compliance with grievance resolution time frames.<br>✓ 100% compliance with appeal resolution time frames for all four quarters.<br>✓ Appeals are well documented in case notes.<br>✓ 100% compliance with pre-service determination and notification time frames for all four quarters. |
| **Best Practices** | ✓ Excellent documentation of provider follow-up in response to QOC/QOS grievances.<br>✓ Detailed descriptions of grievance and resolution (as appropriate) in member acknowledgment and resolution letters as well as in case notes. |
| **Opportunities** | ✓ Consistent use of plain language in grievance and appeal resolution letters with acronyms spelled out and explained.<br>✓ Body of adverse determination letter includes reviewer's name, title, and credentials.<br>✓ Adverse determination letter includes correct appeal filing time frame. |
| **Recommendations** | ✓ Consider routinely auditing a sample of grievance, appeal, and adverse determination letters to ensure use of plain language, complete, and accurate content.<br>✓ Consider conducting a root cause analysis of service/attitude related member grievances to identify opportunities for improvement. |

# Appendix B
# Grievance Review Templates

| <MCO><br>Grievances for <X> Quarter, 20xx<br>Results & Analysis | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | **Current Quarter** | **Prior Quarter** | **Q4 20xx** (2 quarters prior to current) | **Status** | **Other MCO Results** |
| **Total Participant Grievances Received in the Qtr.** | | | | o | |
| **Total Participant Grievances Resolved in the Qtr.** | | | | o | |
| **Grievances/1000 Participants** | | | | o | |
| **Participant Grievances by Category** | | | | | |
| Cat. 1: Emergency medically related (rate/1000) | | | | o | |
| Cat. 2: Non-emergency medically related (rate/1000) | | | | o | |
| Cat. 3: Administrative (rate/1000) | | | | o | |
| **Top 5 Participant Grievances by Service Category** | | | | | **Top 5 Categories** |
| Code/Description (#/%) | | | | o | |
| Code/Description (#/%) | | | | o | |
| Code/Description (#/%) | | | | o | |
| Code/Description (#/%) | | | | o | |
| Code/Description (#/%) | | | | o | |
| **Participant Grievances TAT Met (standard 100% compliance)** | | | | | |
| Category 1: Emergency medically related (#/%) | | | | o | |
| Category 2: Non-emergency medically related (#/%) | | | | o | |
| Category 3: Administrative (#/%) | | | | o | |
| | | | | | |
| **Total Provider Grievances Received in the Qtr.** | | | | o | |
| **Total Provider Grievances Resolved in the Qtr.** | | | | o | |
| **Grievances/1000 Providers** | | | | o | |
| **Provider Grievances by Category** | | | | | |
| Cat. 1: Emergency medically related (rate/1000) | | | | o | |
| Cat. 2: Non-emergency medically related (rate/1000) | | | | o | |

| <MCO><br>Grievances for <X> Quarter, 20xx<br>Results & Analysis | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| Cat. 3: Administrative (rate/1000) | | | | ○ | |
| **Top 5 Provider Grievances by Service Category** | | | | | **Top 5 Categories** |
| Code/Description (#/%) | | | | ○ | |
| Code/Description (#/%) | | | | ○ | |
| Code/Description (#/%) | | | | ○ | |
| Code/Description (#/%) | | | | ○ | |
| Code/Description (#/%) | | | | ○ | |
| **Provider Grievances TAT Met (standard 100% compliance)** | | | | | |
| Category 1: Emergency medically related (#/%) | | | | ○ | |
| Category 2: Non-emergency medically related (#/%) | | | | ○ | |
| Category 3: Administrative (#/%) | | | | ○ | |
| **Analysis** | | | | | |
| **Recommendations** | | | | | |
| **Legend**<br>○ Neutral<br>○ Met, if applicable<br>○ Negative trend-Requires MCO explanation from MCO<br>○ Not met, if applicable. (May require a CAP)<br>N/A - Not Applicable | | | | | |

# Appendix C
# Appeal Review Templates

| <MCO><br>Appeals for <X> Quarter, 20xx<br>Results & Analysis | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | **Current Quarter** | **Prior Quarter** | **QX 20xx** (2 quarters prior to current) | **Status** | **Other MCO Results** |
| **Total Appeals Received in the Quarter** | | | | o | |
| **Total Appeals Resolved in the Quarter** | | | | o | |
| **Appeals/1000 Participants** | | | | o | |
| **Appeal Outcomes (#/%)** | | | | o | |
| Upheld (#/%) | | | | o | |
| Overturned (#/%) | | | | o | |
| Partially Overturned (#/%) | | | | o | |
| **Overturn Rate by Action** | | | | | |
| Action 1 (#/%) | | | | o | |
| Action 2 (#/%) | | | | o | |
| Action 3 (#/%) | | | | o | |
| Action 4 (#/%) | | | | o | |
| Action 5 (#/%) | | | | o | |
| **Partial Overturn Rate by Action** | | | | | |
| Action 1 (#/%) | | | | o | |
| Action 2 (#/%) | | | | o | |
| Action 3 (#/%) | | | | o | |
| Action 4 (#/%) | | | | o | |
| Action 5 (#/%) | | | | o | |
| **Top 5 Service Categories** | | | | | |
| ***Category 1*** | | | | | |
| Resolved (#/%) | | | | o | |
| Overturn (#/%) | | | | o | |
| Partial Overturn (#/%) | | | | o | |
| ***Category 2*** | | | | | |
| Resolved (#/%) | | | | o | |
| Overturn (#/%) | | | | o | |
| Partial Overturn (#/%) | | | | o | |

| <MCO><br>Appeals for <X> Quarter, 20xx<br>Results & Analysis | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| ***Category 3*** | | | | | |
| Resolved (#/%) | | | | ○ | |
| Overturn (#/%) | | | | ○ | |
| Partial Overturn (#/%) | | | | ○ | |
| ***Category 4*** | | | | | |
| Resolved (#/%) | | | | ○ | |
| Overturn (#/%) | | | | ○ | |
| Partial Overturn (#/%) | | | | ○ | |
| ***Category 5*** | | | | | |
| Resolved (#/%) | | | | ○ | |
| Overturn (#/%) | | | | ○ | |
| Partial Overturn (#/%) | | | | ○ | |
| **Expedited Appeals (#/%)** | | | | ○ | |
| **Extended Appeals (#/%)** | | | | ○ | |
| **Resolution TAT Met (standard 100% compliance)** | | | | | |
| Expedited (#/%) | | | | ○ | |
| Non-emergency (#/%) | | | | ○ | |
| **Analysis** | | | | | |
| **Recommendations** | | | | | |

**Legend**
○ Neutral
○ Met, if applicable
○ Negative trend. (Requires explanation from MCO)
○ Not met, if applicable. (May require a CAP)

N/A - Not Applicable
N/R- Not Reported

# Appendix D
# Pre-Service Denial Review Templates

| <MCO><br>Pre-Service Denials for <X> Quarter 20xx<br>Results & Analysis | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | **Current Quarter** | **Prior Quarter** | **QX 20xx** (2 QTRs prior to current) | **Status** | **Other MCO Results** |
| **Under 21 (#/%)** | | | | o | |
| **Expedited Med. Nec. Pre-Service Denials Non-Outpatient Pharm. (#/%)** | | | | o | |
| **Expedited Med. Nec. Pre-Service Denials Outpt. Pharm. (#/%)** | | | | o | |
| **Pre-Service Denials/1000 Members** | | | | o | |
| **Total Pre-Service Denials** | | | | o | |
| Denied (#/%) | | | | o | |
| Reduced (#/%) | | | | o | |
| Terminated (#/%) | | | | o | |
| **Top 5 Service Categories** (#/%) | | | | | |
| Service Category 1: | | | | o | |
| Service Category 2: | | | | o | |
| Service Category 3: | | | | o | |
| Service Category 4: | | | | o | |
| Service Category 5: | | | | o | |
| **Top 5 Denial Reasons** (#/%) | | | | | |
| Denial Reason 1: | | | | o | |
| Denial Reason 2: | | | | o | |
| Denial Reason 3: | | | | o | |
| Denial Reason 4: | | | | o | |
| Denial Reason 5: | | | | o | |
| **Determination TAT Met (standard 95% compliance)** | | | | | |
| Expedited Non-Outpt. Pharm. (#/%) | | | | o | |
| Expedited Outpt. Pharm. (#/%) | | | | o | |
| Non-Emergent (#/%) | | | | o | |
| **Notification TAT Met (standard 95% compliance)** | | | | | |
| Expedited Non-Outpt. Pharm. (#/%) | | | | o | |
| Expedited Outpt. Pharm. (#/%) | | | | o | |
| Non-Emergent (#/%) | | | | o | |
| **Analysis** | | | | | |
| **Recommendations** | | | | | |
| **Legend**<br>o Neutral<br>o Met, if applicable | | | | | |
| o Negative trend. (Requires explanation from MCO)<br>o Not met, if applicable. (May require CAP) | | | | | |

| <MCO><br>Pre-Service Denials for <X> Quarter 20xx<br>Results & Analysis | | | | |
|---|---|---|---|---|
| | | | | |
| N/A - Not Applicable<br>N/R - Not Reported | | | | |
| | | | | |
| **Time Frame** | **CY 20xx** | | | |
| **Required Letter Components** | | | | |
| | | | | |
| Determinations (95% threshold)<br>Adverse Determination Notifications (95% threshold) | | | | |
| | | | | |
| Decision based on criteria, policy, coverage, adm. | | | | |