Qlarant

Maryland
DEPARTMENT OF HEALTH

HealthChoice
Maryland's Medicaid Managed Care Program

Medicaid Managed Care Organization

2020 Focused Review Report
Grievances, Appeals, & Denials

Submitted October 2020

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2020 Grievances, Appeals, & Denials

Focused Review Report

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 provided to Maryland Medical Assistance enrollees in HealthChoice managed care organizations (MCOs) [as defined in Code of Federal Regulations (42 CFR Part 438, Subpart D) and Code of Maryland Regulations (COMAR) 10.67.04]. Under the Social Security Act [Section 1932(c)(2)(A)(i)], 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 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 fourth annual focused review conducted for MDH.

Assessment of MCO compliance was completed by applying the performance standards defined for calendar year (CY) 2019. Quarterly studies of grievances, appeals, and pre-service denials were conducted for the third and fourth quarters of 2019, and the first and second quarters of 2020. The annual record review encompassed member grievances, appeals, and pre-service denials that occurred during CY 2019. 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 is 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 address 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 to Qlarant. Qlarant developed a review tool (templates) for each reporting category that MDH approved for use in validating and evaluating quarterly MCO reports. Appendices B, C, and D include the 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 2019 grievance, appeal, and pre-service denial records. Records were requested from July 1 through October 31, 2019, to allow MCOs an opportunity to address several recent regulatory changes that were not fully implemented as observed during the systems performance review (SPR) conducted in early 2019. Each MCO provided Qlarant with a listing of grievances, appeals, and pre-service denials for this time period. 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.

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 for each MCO, including technical assistance as needed, to facilitate improved compliance.

Limitations

The validity of MCO submitted quarterly grievance, appeal, and denial reports has deteriorated over the prior annual report period. The majority of MCOs have been required to resubmit at least one quarterly report which is often followed by a second resubmission as a result of continuing errors. Analysis of issues identified ongoing formula errors, incomplete reporting such as absence of provider grievances and categorization of grievances by type, and failure to use current reporting templates. Based upon these issues and feedback from MCOs, it does not appear that all MCOs have a process in place for quality oversight of these reports. MCOs also do not utilize the instructions on the MCO Resource Site to assist with understanding and calculating the various report fields. Technical assistance continued to be provided to individual MCOs as needed and additional revisions to reporting forms have been made to improve clarity; however, the impact on report quality has been minimal. 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. This data facilitates 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, as follows:

Table 1. Review Determinations

Review Determinations	
Met	Compliance consistently demonstrated
Partially Met (PM)	Compliance inconsistently demonstrated
Unmet (UM)	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 10.67.01.01. COMAR 10.67.09.02 describes three categories of grievances:

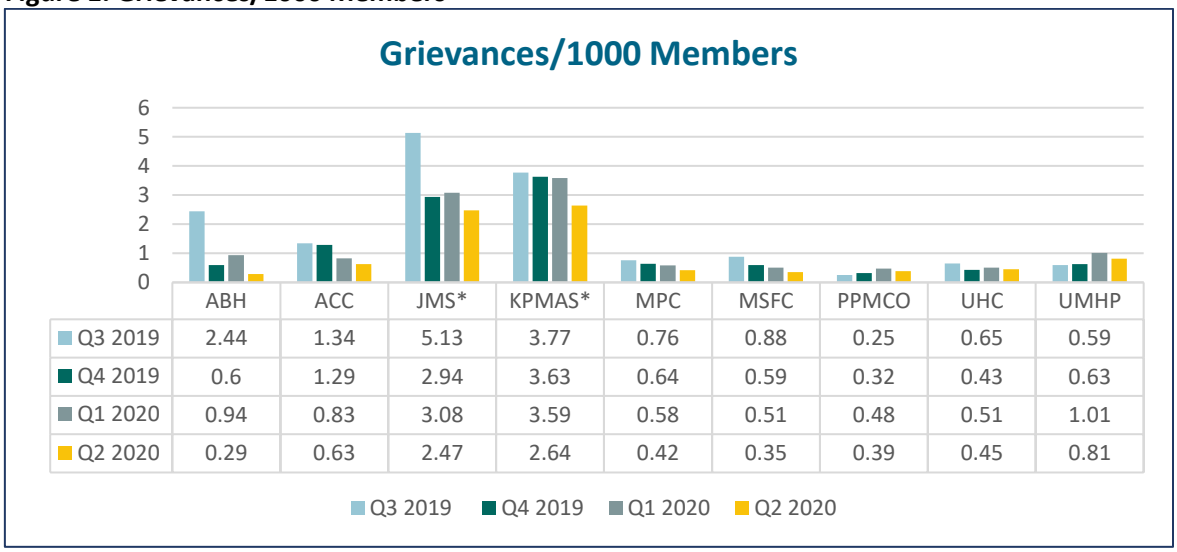
Category 1: Emergency medically related grievances
Example: Emergency prescription or incorrect prescription provided
Category 2: Non-emergency medically related grievances
Example: Durable Medical Equipment/Disposable Medical Supplies (DME/DMS)-related complaints about repairs, upgrades, or vendor issues.
Category 3: Administrative grievances
Example: Difficulty finding a network primary care provider 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 overall and by categories
  - Top 5 member grievance service categories
  - Grievances filed per 1000 providers overall and by categories
  - Top 5 provider grievance service categories
- 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 2019	2.44	1.34	5.13	3.77	0.76	0.88	0.25	0.65	0.59
Q4 2019	0.6	1.29	2.94	3.63	0.64	0.59	0.32	0.43	0.63
Q1 2020	0.94	0.83	3.08	3.59	0.58	0.51	0.48	0.51	1.01
Q2 2020	0.29	0.63	2.47	2.64	0.42	0.35	0.39	0.45	0.81

*Major outlier in comparison to other MCOs

Both JMS and KPMAS were major outliers in grievances per 1000 members for all four quarters. Billing and financial related issues represented the majority of JMS grievances, while attitude/service related categories represented the majority of KPMAS grievances, consistent with the prior 12-month period. ABH's third quarter results continued the prior year trend and were attributed to access related grievances driven by specialty gaps throughout the MCO's service area. Success in closing these gaps is demonstrated by the major decline in the grievances per 1000 rate in subsequent quarters. All MCOs demonstrated a decrease in grievances from the first to the second quarter which appears to be related to the decrease in utilization of services related to the COVID-19 pandemic.

The overall top service category for member grievances for all four quarters within the review period was billing/financial issues. Among the drivers of these issues are enrollees failing to present their Medicaid identification card at the time of service, provider billing errors, or MCO enrollment record errors. Billing/financial issues were closely followed by attitude/service related grievances, including practitioner, administrative staff, and MCO customer service. Similarly, provider grievances throughout the review period were primarily related to billing/financial issues with 'other' cited as the next most common source of grievances.

While improved over the prior four quarters, there remains some reporting inconsistencies that impact the reported data, including:

- ACC did not begin reporting provider grievances until the fourth quarter.
- UHC did not begin reporting provider grievances until the second quarter.
- PPMCO did not begin reporting grievances by the appropriate category until the first quarter. According to PPMCO, its reporting system for documenting grievances does not allow for categorization of grievances to the two medically related grievance categories.
- UMHP was not reporting grievances for the two medically related categories. It was subsequently discovered that its grievance policy was too restrictive in defining grievances in these two categories.
- MPC reported that it overstated provider grievances for the first through the third quarter of 2019 due to a formula error.
- PPMCO did not begin reporting provider grievances until the fourth quarter when it resubmitted its third quarter revised report which included provider grievances.

Table 2 displays comparisons of MCO reported compliance with resolution time frames for member grievances based on MCO quarterly submissions. As a result of the State of Emergency declared by Governor Hogan in response to the COVID-19 pandemic, the Maryland Managed Care Organization Association made a request of MDH to relax the compliance threshold for grievance resolution timeliness. MDH agreed to relax the threshold from 100% to 90% during the State of Emergency. Compliance for the second quarter was determined based upon the lower threshold. Since the State of Emergency was declared on March 5, 2020, it was not possible to assess the impact of the change on the first quarter MCO reported results.

Table 2. MCO Reported Compliance with Member Grievance Resolution Time Frames

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2019	PM	Met	PM	PM	PM	PM	PM	Met	Met
Q4 2019	PM	PM	PM	PM	Met	Met	PM	Met	Met
Q1 2020	PM*	Met	Met	PM*	Met	Met	PM*	Met	Met
Q2 2020	Met	Met	Met	PM	Met	Met	PM	Met	Met

PM - Partially Met
*Since the compliance threshold was lowered for the third month of the quarter, it is not possible to determine compliance for the entire quarter for these MCOs.

Two MCOs (UHC and UMHP) met the resolution time frames for member grievances in all four quarters. (Results from review of a sample of member grievance records described in Table 4 found UMHP compliance with grievance resolution time frames PM.) ACC, MPC, and MSFC demonstrated full compliance for three of the four quarters. JMS met the required time frames in two of the four quarters. ABH only met the required time frames in the second quarter; however, as noted above, it is not possible to determine the impact of the lower compliance threshold for one month on the entire first quarter. KPMAS and PPMCO did not fully meet the resolution time frames in any of the four quarters. Based upon the low compliance percentages reported for the first quarter, it is unlikely that the lowered threshold for March would have contributed to compliance for the entire quarter.

Table 3 offers a comparison of MCO reported grievances per 1000 providers for four quarters.

Table 3. MCO Reported Grievances/1000 Providers

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2019	0.42	NA	0.33	NA	0.73*	NA	0.39	NA	0.80*
Q4 2019	0.06	1.23*	0.21	NA	0.05	NA	0.66	NA	0.69
Q1 2020	0.74	1.13*	NA	NA	0.10	NA	0.69	NA	0.47
Q2 2020	0.99*	0.43	0.11	NA	NA	NA	0.08	0.49	0.36

NA - Not Applicable/No data reported
*Major outlier in comparison to other MCOs

MCO reported grievances per 1000 providers consistently remained low for the majority of MCOs. Both MPC and UMHP were major outliers for the third quarter in comparison to other MCOs. ACC was a major outlier for the fourth and first quarters. ABH was a major outlier for the second quarter. ACC began reporting provider grievances in the fourth quarter and UHC in the second quarter. Both KPMAS and MSFC have consistently reported the absence of provider grievances. Several MCOs experienced a decrease in provider grievances from the first to the second quarter which appears related to the decrease in utilization of services related to the COVID-19 pandemic.

Table 4 displays comparisons of MCO reported compliance with resolution time frames for provider grievances based on MCO quarterly submissions.

Table 4. MCO Reported Compliance with Provider Grievance Resolution Time Frames

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2019	PM	NA	Met	NA	PM	NA	PM	NA	Met
Q4 2019	Met	PM	Met	NA	Met	NA	Met	NA	Met
Q1 2020	Met	PM	NA	NA	Met	NA	Met	NA	Met
Q2 2020	PM	PM	Met	NA	NA	NA	Met	PM	Met

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

Based upon the seven MCOs reporting provider grievances, two MCOs (JMS and UMHP) demonstrated full compliance with regulatory time frames in all applicable quarters. MPC and PPMCO demonstrated full compliance in all applicable quarters but one. ABH compliance with resolution time frames was demonstrated in two of four quarters. ACC and UHC compliance was PM in all applicable quarters. MCOs that did not receive any provider grievances for the quarter were reported as NA for compliance for that quarter.

Table 5 presents a comparison of the annual grievance record review results across MCOs. Results are based upon a random selection of grievance records during CY 2019. Reviews were conducted utilizing the 10/30 rule.

Table 5. CY 2019 MCO Annual Grievance Record Review Results

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

PM - Partially Met; **UM** - Unmet

Six MCOs (ABH, JMS, KPMAS, MPC. MSFC, and UHC) received a finding of met for "Appropriately Classified." Three MCOs (ACC, PPMCO, and UMHP) received a finding of PM as they did not consistently identify the appropriate grievance category. All MCO records reviewed demonstrated a full description of the grievance issue. "Resolution Timeliness" was met by five MCOs (ABH, JMS, MPC, MSFC, and UHC). ACC, KPMAS, and UMHP did not consistently meet time frames for resolution. PPMCO received a finding of UM as it did not meet the resolution time frame for any grievance within the sample reviewed. ACC demonstrated an opportunity for improving the appropriateness of the resolution. Seven MCOs (ABH, JMS, MPC, MSFC, PPMCO, UHC, and UMHP) received a finding of met for the "Resolution Letter." ACC received a finding of PM as three resolution letters did not document an appropriate resolution of the grievance. KPMAS received a finding of PM as only 43% of the grievances within the sample reviewed received a resolution letter.

Appeal Results

An appeal is a request for a review of an action as stated in COMAR 10.67.01.01. 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 10.67.05.07)
- **Action 5:** Failure of an MCO to act within the required appeal time frames set in COMAR (i.e. COMAR 10.67.09.05)
- **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, the Centers for Medicare and Medicaid Services (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 10.67.09.05 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 the member's written consent. Maryland's regulations previously did not require the provider to seek written authorization before filing an appeal on the member's behalf.

In 2019, MDH communicated an additional requirement to the MCOs pertaining to expedited appeals. The 72-hour time frame for expedited appeals was updated to include both the resolution and notification.

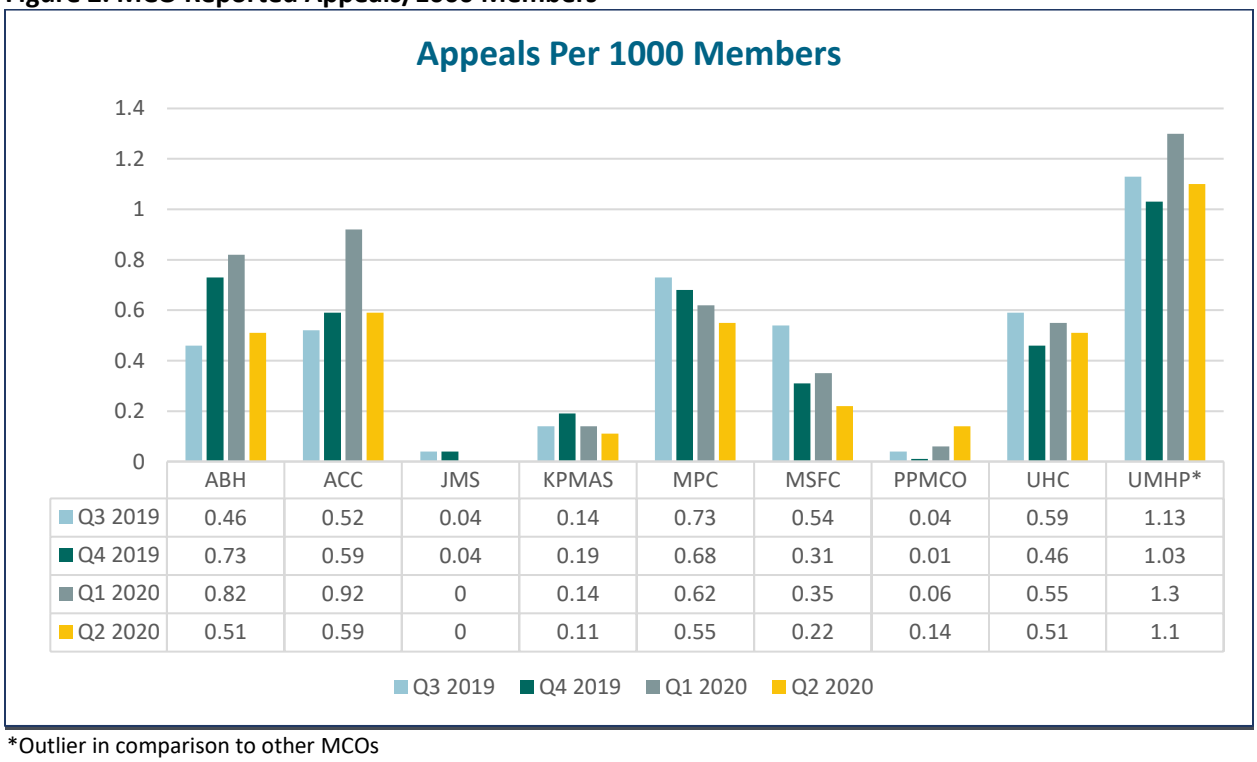
The MCO appeal review encompassed the following comparative statistics and an assessment of compliance with federal and state laws and regulations:

- Comparative Statistics:
  - Appeals Filed Per 1000 Members
  - Percentages of Appeals Received from Denials

  - Percentages of Appeals Submitted by Members and by Providers
  - Percentages of Upheld and Overturned Denials
  - Percentages of Overturns by Action Types (1-6)
  - Percentages of Upholds by Action Types (1-6)
  - Top 5 Service Categories
  - Percentages of Expedited Appeals
  - Percentages of Extended Appeals
- 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 2019	0.46	0.52	0.04	0.14	0.73	0.54	0.04	0.59	1.13
Q4 2019	0.73	0.59	0.04	0.19	0.68	0.31	0.01	0.46	1.03
Q1 2020	0.82	0.92	0	0.14	0.62	0.35	0.06	0.55	1.3
Q2 2020	0.51	0.59	0	0.11	0.55	0.22	0.14	0.51	1.1

*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. Three MCOs (JMS, KPMAS, and PPMCO) occupy the lower end of the range which may be partially attributed to their lower denials per 1000 rate.

While improved over the prior four quarters, some reporting inconsistencies remain that impact the data reported, including:

- MSFC continued to report adult dental denials through the fourth quarter.
- UMHP continued to report adult dental denials which were discovered and corrected in the second quarter.
- PPMCO has been reporting all expedited appeals as provider, rather than member, appeals. Recent MCO correspondence reported that expedited appeals are being reported as member appeals as of May 16, 2020.
- PPMCO has been reporting standard pre-service appeals as provider, rather than member, appeals. According to the MCO, this will be remedied as of September 15, 2020.

Each MCO reports its top five appeal service categories for each quarter. Table 6 displays the place of the pharmacy services category by MCO for each of the four quarters of the review period.

Table 6. Place of Pharmacy Services Appeal Category on Top Five MCO List

Quarter	ABH	ACC	JMS	KPMAS	MPC*	MSFC*	PPMCO*	UHC	UMHP*
Q3 2019	1st	2nd	1st	NA	1st	3rd	1st	1st	1st
Q4 2019	1st	1st	1st	NA	1st	1st	1st	1st	1st
Q1 2020	1st	1st	NA	NA	1st	1st	1st	1st	1st
Q2 2020	1st	1st	NA	NA	1st	2nd	1st	1st	1st

NA - Not Applicable/No data reported
*MCOs reporting Pharmacy services: chronic pain management on top five list for at least one quarter

As noted in the prior year's report, pharmacy services was the most frequent service category occupying the top spot for the majority of MCOs throughout the review period. Six MCOs (ABH, JMS, MPC, PPMCO, UHC, and UMHP) reported it as the top service category for all applicable quarters in the review period. ACC reported it as the top service category in three of the four quarters and in second place in the remaining quarter. MSFC reported it in the top spot for two quarters, the second spot for one, and the third for the remaining quarter. Four MCOs (MPC, MSFC, PPMCO, and UMHP) also reported appeals related to pharmacy services: chronic pain management within their top five list for at least one quarter. KPMAS has consistently reported no denials for pharmacy services so this category was absent from their list for the entire review period. JMS had no reported appeals for the first or second quarter.

Comparisons of MCO reported compliance with resolution time frames for member appeals are displayed in Table 7 based on MCO quarterly submissions.

Table 7. MCO Reported Compliance with Member Appeal Resolution Time Frames

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2019	Met	PM	Met	Met	Met	Met	Met	PM	Met
Q4 2019	Met	PM	Met	PM	Met	Met	PM	Met	Met
Q1 2020	PM	PM	NA	Met	Met	Met	PM	Met	Met
Q2 2020	PM	PM	NA	Met	Met	Met	PM	Met	Met

NA - Not Applicable/No data reported; **PM** - Partially Met

Four MCOs (JMS, MPC, MSFC, and UMHP) consistently met appeal resolution time frames for all associated quarters. Two MCOs (KPMAS and UHC) demonstrated compliance for three quarters. ABH demonstrated compliance for two quarters while PPMCO met the compliance threshold of 100% for only one quarter. ACC received a PM for all four quarters.
Table 8 provides a comparison of appeal record review results across MCOs. Results are based upon a random selection of appeal records reviewed for CY 2019.

Table 8. CY 2019 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	PM	Met	PM	Met	Met
Compliance with Verbal Notification of Denial of an Expedited Request	UM	NA	NA	NA	UM	NA	NA	NA	Met
Compliance with Written Notification of Denial of an Expedited Request	Met	NA	NA	NA	Met	NA	NA	NA	Met
Compliance with 72-hour Time Frame for Expedited Appeal Resolution and Notification	Met	NA	NA	Met	UM	Met	PM	Met	NA
Compliance with Verbal Notification of Expedited Appeal Decision	UM	NA	NA	UM	UM	Met	UM	Met	NA
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	PM	Met	Met
Decision Made by Health Care Professional with Appropriate Expertise	Met	Met	Met	Met	PM	Met	PM	Met	Met
Decision Available to Enrollee in Easy to Understand Language	Met	Met	Met	Met	PM	Met	PM	Met	Met

NA - Not Applicable/No data reported; **PM** - Partially Met; **UM** – Unmet

Review of MCO records demonstrated that seven of the nine MCOs processed appeals based upon the level of urgency. MPC received a finding of PM as processing of an expedited appeal was delayed while awaiting member written consent authorizing the provider to file on their behalf. PPMCO received a finding of PM as an expedited appeal was processed as standard with no evidence that the request for an expedited resolution was denied and communicated to the member orally and in writing.

Denials of requests for an expedited resolution were found within the sample of records reviewed from ABH, MPC, and UMHP. All three MCOs demonstrated compliance with providing member written notification of denial of an expedited resolution within the required time frame. Two of the MCOs (ABH and MPC) received a finding of UM as there was no evidence of a reasonable attempt to provide prompt oral notification of denial of a request for an expedited resolution.

Requests for an expedited resolution were documented in case records for six of the MCOs. There were no expedited requests in the sample of records reviewed from ACC, JMS, and UMHP. Two of the MCOs (MSFC and UHC) received a finding of met for documenting a reasonable attempt to provide oral notification of the resolution to the member. Review of case records from the four remaining MCOs (ABH, KPMAS, MPC, and PPMCO) provided no evidence of a reasonable attempt to provide the member with oral notification of the resolution. Four of the MCOs (ABH, KPMAS, MSFC, and UHC) demonstrated compliance with the 72-hour time frame for resolving and providing the member with written notice of an expedited resolution. MPC received a finding of UM and PPMCO received a finding of PM for demonstrating compliance with this time frame.

All MCOs but PPMCO demonstrated full compliance with providing the member with a written appeal resolution which included documentation of the appeal decision within the required time frame. PPMCO received a finding of PM as it did not consistently provide members with an appeal resolution letter.

Seven of the MCOs received a finding of met for Decision Made by Health Care Professional with Appropriate Clinical Expertise. MPC received a finding of PM as the appeal reviewer did not consistently appear to have the appropriate expertise based upon the MCO's policies. PPMCO received a finding of PM as appeal case notes provided no evidence of physician review.

All but two MCOs received a finding of met for Decision Available to Enrollee in Easy to Understand Language. MPC received a finding of PM as its resolution letters were not consistently written in plain language. PPMCO received a finding of PM as it did not consistently provide resolution letters for all appeals.

Pre-Service Denial Results

Actions and decisions regarding services to enrollees that require preauthorization by the MCO are defined in COMAR 10.67.09.04. 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. Updates to COMAR 10.67.09.04 resulting from CMS regulatory changes to preauthorization (PA) 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 10.67.09.04 include:

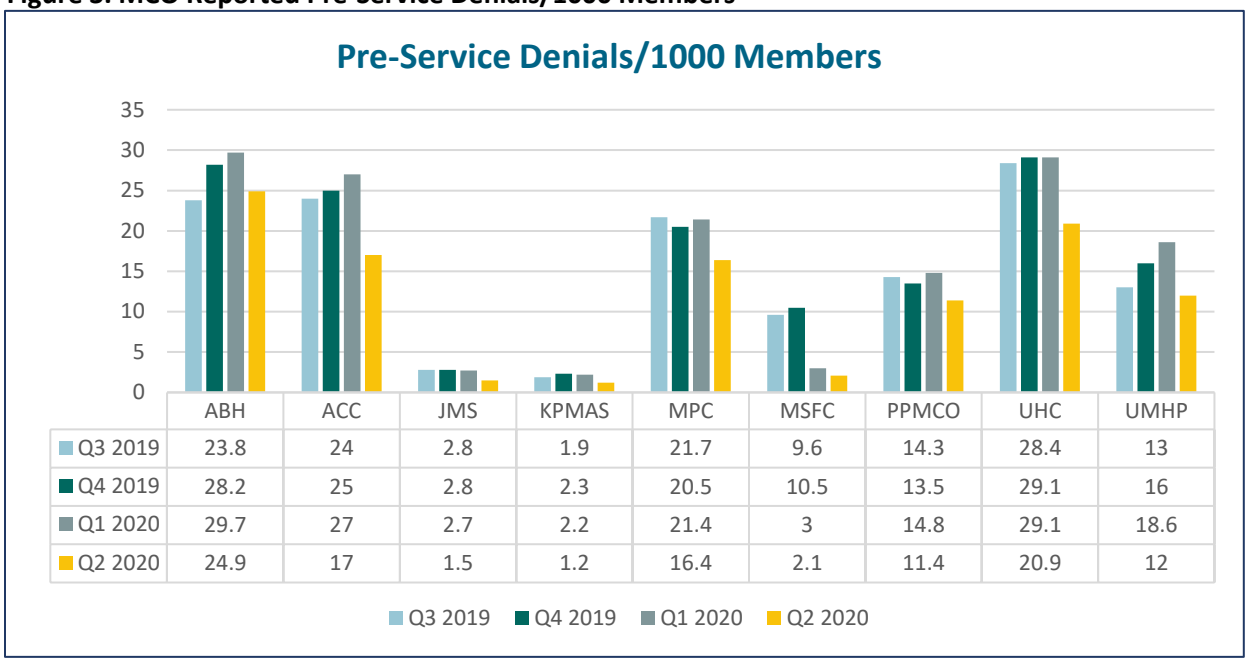
- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested:
  - Shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease; and
  - May not be arbitrarily 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
  - Percentages of PA Requests with Complete Information
  - Percentages of PA Requests Requiring Additional Information
  - Percentages of PA Requests Approved
  - Percentages of PA Requests Denied
  - Percentages of Pre-Service Denials for Members Under 21
  - Percentages of Pre-Service Denials for Standard Medical, Expedited Medical, and Outpatient Pharmacy
  - Top 5 Service Categories
  - Top 5 Denial Reasons
  - Determination and Notification Turnaround Time Compliance Percentages
  - Prescriber Notification Turnaround Time Compliance Percentages
- Determination time frame compliance 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 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 and within 72 hours from the date of receipt.
  - For any previously authorized service at least 10 days prior to reducing, suspending, or terminating a covered service.
- Prescriber notification of review outcome within 24 hours of receipt of a preauthorization request
- 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 2019	23.8	24	2.8	1.9	21.7	9.6	14.3	28.4	13
Q4 2019	28.2	25	2.8	2.3	20.5	10.5	13.5	29.1	16
Q1 2020	29.7	27	2.7	2.2	21.4	3	14.8	29.1	18.6
Q2 2020	24.9	17	1.5	1.2	16.4	2.1	11.4	20.9	12

The rate of pre-service denials per 1000 members has varied by MCO but have generally remained within a fairly narrow range within each MCO over the first three quarters of the review period. All MCOs demonstrated a decrease in preservice denials per 1000 members in the second quarter of 2020. This appears related to the decreased number of PA requests received during the quarter as a result of the temporary closure of provider offices and restrictions on elective surgery due to COVID-19. The significant decline in MSFC's rate beginning in the first quarter is attributed to MDH's decision to exclude denials for MCO value-added services, such as adult dental. According to MSFC, the majority of its denials had been for adult dental services. While improved over the prior four quarters, some reporting inconsistencies remain that impact the data reported, including:

- MSFC did not include requests for additional information in its calculation of compliance with prescriber notification of the outcome of an outpatient pharmacy preauthorization request within 24 hours in its first quarter report.
- There appears to be an inconsistency in reporting HepC denials among the MCOs.

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.

Each MCO reports its top five denial service categories for each quarter. Table 9 displays the place of the pharmacy services category by MCO for each of the four quarters of the review period.

Table 9. Place of Pharmacy Services Denial Category on Top Five MCO List

Quarter	ABH	ACC	JMS*	KPMAS	MPC	MSFC	PPMCO*	UHC*	UMHP*
Q3 2019	1st	1st	1st	NA	2nd	3rd	1st	1st	1st
Q4 2019	1st	1st	1st	NA	2nd	2nd	1st	1st	1st
Q1 2020	1st	1st	1st	NA	2nd	1st	1st	1st	1st
Q2 2020	2nd	1st	1st	NA	2nd	1st	1st	1st	1st

NA - Not Applicable/No data reported

*MCOs reporting Pharmacy services: chronic pain management on top five list for at least one quarter

Pharmacy services continue to appear on the top five service category list for denials for all MCOs with the exception of KPMAS that did not report any pharmacy denials during the review period. Five MCOs (ACC, JMS, PPMCO, UHC, and UMHP) reported it as the top service category for all four quarters in the review period. ABH reported it as the top service category in three of the four quarters and in second place in the remaining quarter. MSFC reported it in the top spot for two quarters, the second spot for one, and the third for the remaining quarter. MPC reported it in second place in all four quarters. Four MCOs (JMS, PPMCO, UHC, and UMHP) also reported denials related to pharmacy services: chronic pain management within their top five list for two to four of the quarters.

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 10 displays results of the MCO's reported compliance with pre-service determination time frames. As a result of the State of Emergency declared by Governor Hogan in response to the COVID-19 pandemic, Maryland Managed Care Organization Association made a request of MDH to relax the compliance threshold for preauthorization determination timeliness. MDH agreed to relax the threshold from 95% to 90% during the State of Emergency. Compliance for the second quarter was determined based upon the lower threshold. Since the State of Emergency was declared on March 5, 2020, it was not possible to assess the impact of the change on the first quarter MCO reported results.

Table 10. 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 for Medical Denials									
Q3 2019	NA	96%	100%	NA	NA	NA	33%	99%	100%
Q4 2019	100%	93%	NA	100%	NA	100%	17%	97%	100%
Q1 2020	100%	97%	NA	100%	100%	100%	25%*	96%	100%
Q2 2020	100%	88%	NA	100%	100%	0%	63%	100%	NA
Compliance with Standard Pre-Service Determination Time Frames for Medical Denials									
Q3 2019	94%	94%	99%	97%	98%	100%	82%	98%	100%
Q4 2019	95%	72%	96%	99%	97%	100%	73%	99%	100%
Q1 2020	96%	90%*	NA	96%	100%	100%	76%*	97%	100%
Q2 2020	93%	99%	75%	98%	99%	100%	97%	99%	97%
Compliance with Outpatient Pharmacy Pre-Service Determination Time Frames for Denials									
Q3 2019	100%	100%	100%	NA	100%	100%	97%	100%	100%
Q4 2019	99%	100%	100%	NA	100%	97%	98%	100%	100%
Q1 2020	98%	100%	99%	NA	99%	93%*	98%	100%	100%
Q2 2020	97%	100%	100%	NA	99%	100%	98%	100%	100%

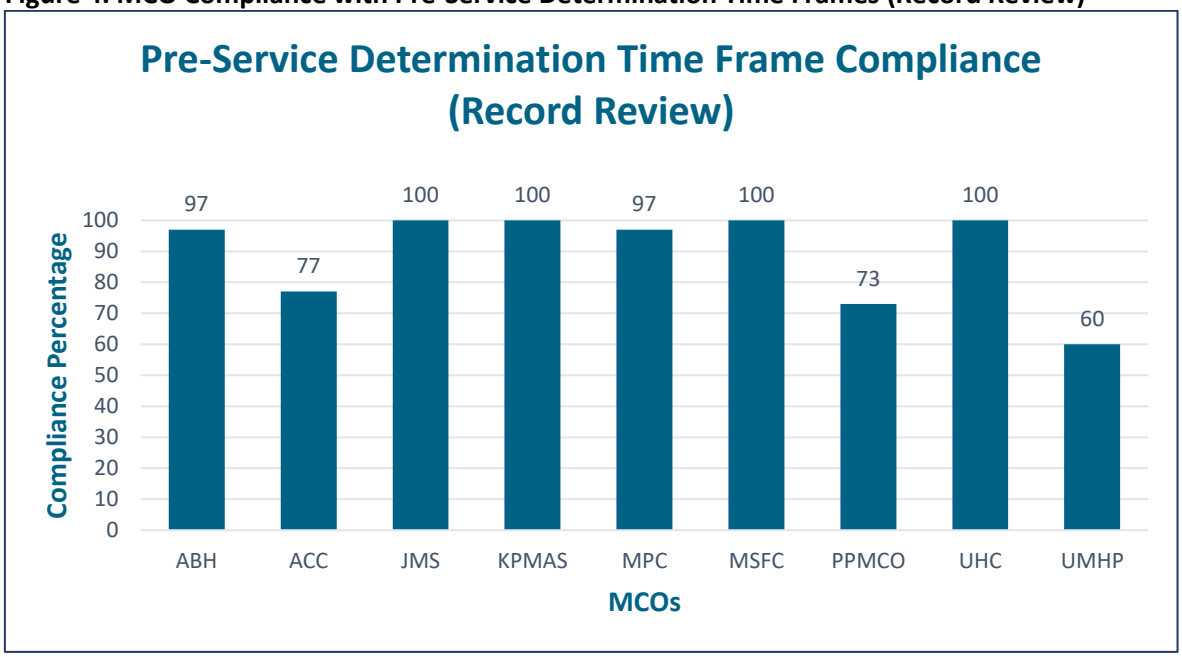
NA - Not Applicable/No data reported

***Red** - Result below the 95% compliance threshold for third, fourth, and first quarters and below the 90% threshold for the second quarter.

Four of the MCOs (KPMAS, MPC, UHC, and UMHP) met or exceeded the compliance threshold for all applicable categories based upon a review of MCO quarterly reports. Compliance results by category ranged from 0% (this only represented three expedited determinations for one MCO) to 94% for the remaining five MCOs (ABH, ACC, JMS, MSFC, and PPMCO).

Record reviews also were conducted to assess compliance with the COMAR requirement for timeliness of pre-service determinations. Results are based upon a random selection of pre-service adverse determination records from CY 2019. Results are highlighted in Figure 4.

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



All but three of the MCOs (ACC, PPMCO, and UMHP) met or exceeded the 95% threshold based upon the annual review of the MCO's records. ACC had a compliance rate of 77%, PPMCO had a rate of 73%, and UMHP had a rate of 60%.

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. Annual record results are based upon a random selection of adverse determinations from CY 2019. Reviews were limited to 10 records as described above. Table 11 displays the issues identified during a review of each MCO's adverse determination records.

Table 11. MCO Adverse Determination Records Review Issues

MCO	Issues Identified
ABH	Notification Turn Around Times & Letter Components
ACC	Determination Turn Around Times
JMS	Documentation of Prescriber Notification
KPMAS	None
MPC	None
MSFC	None
PPMCO	Determination Turn Around Times
UHC	None
UMHP	Determination Turn Around Times & Letter Components

Results of MCO reported compliance with adverse determination notification time frames based on the quarterly reports are highlighted in Table 12. In addition to relaxing the compliance threshold for preauthorization determination timeliness during the declared State of Emergency, MDH also relaxed the threshold for adverse determination notification timeliness from 95% to 90% as of March 5, 2020.

Table 12. 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 Medical Adverse Determination Notification Time Frames									
Q3 2019	NA	100%	100%	NA	NA	NA	67%	100%	100%
Q4 2019	100%	100%	NA	100%	NA	100%	17%	100%	100%
Q1 2020	100%	96%	NA	100%	100%	100%	25%*	100%	100%
Q2 2020	100%	100%	NA	100%	100%	0%	38%	100%	NA
Compliance with Standard Medical Adverse Determination Notification Time Frames									
Q3 2019	93%	98%	100%	100%	99%	100%	79%	100%	100%
Q4 2019	99%	98%	100%	100%	100%	100%	71%	100%	100%
Q1 2020	99%	94%*	NA	99%	99%	100%	74%*	100%	100%
Q2 2020	97%	99%	100%	100%	99%	100%	97%	100%	100%
Compliance with Outpatient Pharmacy Adverse Determination Notification Time Frames									
Q3 2019	100%	100%	100%	NA	100%	100%	97%	100%	100%
Q4 2019	99%	100%	100%	NA	100%	97%	98%	100%	100%
Q1 2020	98%	100%	99%	NA	99%	91%*	98%	100%	100%
Q2 2020	97%	100%	100%	NA	99%	99%	100%	100%	100%
Compliance with Prescriber Notification of Outcome within 24 Hours									
Q3 2019	NA	NA	NA	NA	NA	NA	NA	NA	NA
Q4 2019	99%	NA	NA	95%	NA	NA	98%	NA	NA
Q1 2020	99%	100%	99%	100%	100%	87%*	98%	100%	97%
Q2 2020	100%	100%	100%	98%	100%	100%	98%	100%	100%

NA - Not Applicable/No data reported

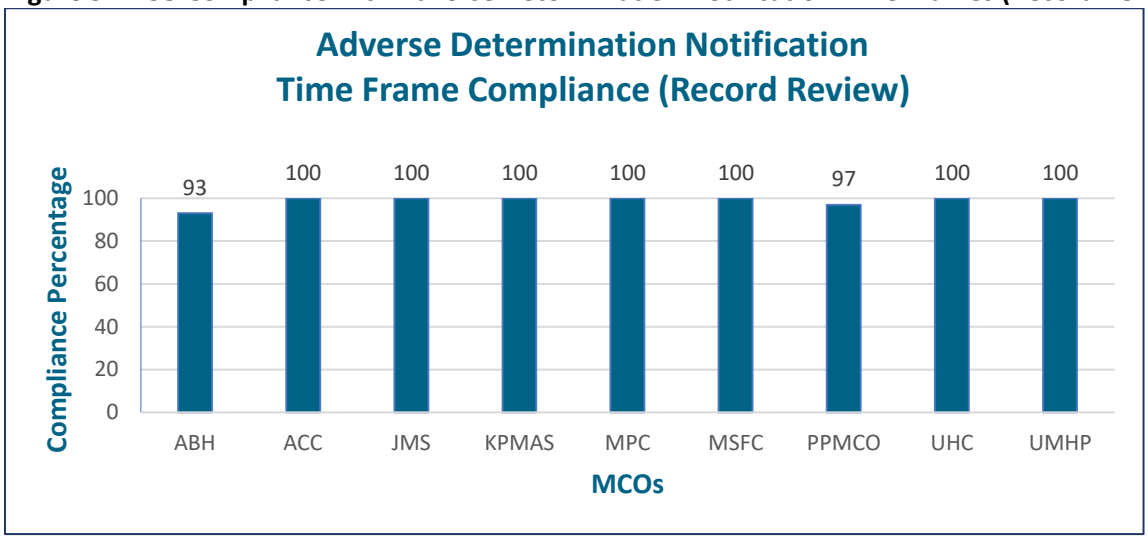
***Red** - Results below the 95% compliance threshold for third, fourth, and first quarters and below the 90% threshold for the second quarter.

Five of the MCOs (JMS, KPMAS, MPC, UHC, and UMHP) met or exceeded the 95% threshold for all applicable categories upon review of MCO quarterly reports. It is likely that ACC also may have demonstrated compliance for all four quarters; however, the impact of the lowered threshold for March could not be determined on overall results for the entire quarter. Compliance results by category ranged from 0% (this only represented three expedited determinations for one MCO) to 94% for the remaining four MCOs (ABH, ACC, MSFC, and PPMCO).

Record reviews also were conducted to assess compliance with the COMAR requirement for timeliness of adverse determination notifications. Results are based upon a random selection of adverse

determination records from CY 2019. Reviews were limited to 10 records from each MCO as described above. Results are highlighted in Figure 5.

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



All but ABH met or exceeded the 95% compliance threshold for adverse determination notification time frames based upon the record review. ABH compliance was slightly below the 95% threshold at 93%.

Table 13 provides a comparison of adverse determination record review results across MCOs from CY 2019. Results are based upon a random selection of adverse determination records from CY 2019. Reviews were limited to 10 records from each MCO as described above.

Table 13. Results of CY 2019 Adverse Determination 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	PM	Met	Met	Met	Met	PM	Met	PM
Compliance with Adverse Determination Notification Time Frames	PM	Met	Met	Met	Met	Met	Met	Met	Met
Required Letter Components	PM	Met	Met	Met	Met	Met	Met	Met	PM
Compliance with Prescriber Notification	Met	Met	PM	NA	Met	Met	Met	Met	NA

PM - Partially Met
NA – Not Applicable/No data reported

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 (ACC, PPMCO, and UMHP) did not consistently meet the compliance threshold for determination time frames. All MCOs but ABH, met

or exceeded the compliance threshold for timely notification of an adverse determination. Seven MCOs demonstrated compliance with all required letter components. ABH received a finding of PM as the enrollee's right to be provided their medical record upon request and free of charge was frequently missing from the adverse determination notification. Additionally, five of the letters incorrectly stated the appeal filing time frame. UMHP received a finding of PM as it did not include the right to continuation of benefits in any of the letters reviewed. While KPMAS included all 17 required letter components the letters reviewed within the sample did not include an additional five days in the appeal filing date to account for mailing.

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 SPR 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 2019 focused review, MDH:

- Revised managed care model notices to assist MCOs with completing all required fields; required embedding calendar dates for any time frame requirements to better inform members of any deadlines; and simplified the language to improve readability. MCOs provided input during the revision process and were advised in October 2019 of the January 2020 effective date for production.
- Waived the acknowledgement letter for both emergency medically related and non-emergency medically related grievances if the MCO resolves the grievance within five days or within the regulatory requirement, whichever is less.
- Revised all MCO grievance, appeal, and denial reporting templates and accompanying instructions to improve clarity and value of reporting fields.
- Eliminated reporting of optional services provided by some MCOs (i.e. adult dental) to facilitate improved comparisons of reported data across MCOs.

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

- **MDH:** Require MCOs to implement routine quality oversight of all grievance, appeal, and denial quarterly report submissions.
- **MDH:** Explore options to support data quality of MCO quarterly grievance, appeal, and denial reports.
- **MDH:** Consider including in the next onsite SPR a session with member and provider call center staff to assess their understanding of what constitutes a grievance and provide technical assistance as needed in view of possible under reporting in this area.
- **MDH:** Cross check MCO reported provider grievances with grievances that are submitted to MDH to ensure all grievances are counted in MCO reports.

- **MDH:** Clarify the requirements for HepC preauthorization and appeal reporting requirements as it does not appear there is a consistent understanding among the MCOs.
- **MDH:** Consider conducting a focused record review of pharmacy related denials and appeals to determine key drivers of the consistently high volume among MCOs.
- **MDH:** Explore options for implementing the federal requirement for enrollee written consent for a provider or authorized representative to file an appeal on their behalf to ensure this regulation does not present an access issue.
- **MDH:** Consider submitting revised language for COMAR 10.67.09.02 to replace grievance "decision time frames" with "resolution and notification time frames" and a recommendation to include the requirement for sending written acknowledgment of grievance receipt within 5 calendar days. As currently written, there are no regulatory time frames for sending the member a written resolution of their grievance. Similarly, this regulation does not include the requirement for sending a written acknowledgement of receipt of a member grievance.
- **MCOs:** Cross train at least one additional staff member on quarterly grievance, appeal, and denial reports to ensure continuity in the event of staff turnover or absence.
- **MCOs:** Educate appeal staff to process appeals based upon the initial filing date, (oral or written) rather than the date written consent is received from the member authorizing the provider to file on their behalf.
- **MCOs:** Educate preauthorization staff on requirements to request additional clinical information as needed within 2 business days of receipt of the preauthorization request and make a determination within two business days of receipt of additional clinical information. (The 14 calendar day time frame for making a determination has led to confusion relating to these requirements.)
- **MCOs:** Ensure new model notices are consistently used and that embedded calendar dates are accurately calculated.
- **MCOs:** The number of provider grievances appears to be under reported by at least some of the MCOs. It does not appear that all MCOs have an effective process in place for capturing provider grievances which may be submitted to various departments, such as Provider Relations, Customer Service, Utilization Management, Care Management. MCOs need to establish a cross functional work group to address the various points of entry and develop a process for aggregation of all grievances to support accurate reporting.

Conclusions

This report includes studies of MCO grievance, appeal, and denial quarterly reports from the third quarter of 2019 through the second quarter of 2020. Additionally, a sample of grievance, appeal, and adverse determination records were reviewed for CY 2019. 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
- 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
- Written notification time frame for expedited and non-emergency appeal resolution and notification
- Timely pre-service adverse determination written notifications
- Required components in adverse determination letters
- 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 resolution of provider grievances
- Verbal notification of expedited appeal decisions
- Timely pre-service determinations

As noted in the Limitations section, validity of the data submitted by the MCOs continues to be a challenge evidencing an ongoing absence of quality oversight. 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 B, C, and D.

The MCO-specific results from quarterly assessments and CY 2019 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	✓ Grievances per 1000 members over the four quarters of the review period reflect an uneven but overall downward trend primarily attributed to ABH's success in closing specialty gaps in its provider network. These gaps were a major contributor to the large number of access related grievances. ✓ Grievances per 1000 providers over the four quarters of the review period demonstrate an uneven but overall upward trend. ✓ The rates of pre-service denials and appeals per 1000 demonstrated an upward trend for the fourth and first quarters. The decline in the second quarter was most likely related to decreased preauthorization requests due to COVID-19. ✓ Pharmacy services was the top appeal service category for all four quarters and ranked in the top five for pre-service denials.
Comparison to Other MCOs	✓ Member grievances per 1000 are at the lower end of the MCO range. ✓ The appeals per 1000 rate is mid-range. ✓ The denials per 1000 rate is at the higher end of the MCO range.
Compliance	✓ Member grievance resolution time frames were fully met in only one of three quarters. Compliance for the first quarter could not be determined due to the lowering of the threshold in the third month of the quarter. Provider grievances were fully met in two of the four quarters. ✓ The time frames for notification of appeal resolution were fully met in two of the four quarters. ✓ Compliance with verbal notification of denial of an expedited request and verbal notification of an expedited appeal decision was not met based upon the sample of records reviewed. ✓ Pre-service determination time frames met or exceeded the compliance threshold in all categories for three of the four quarters. Notification time frames met or exceeded the compliance threshold for all categories in three of the four quarters.
Strengths	✓ Grievance records were well organized with excellent layout and included a full description of the grievance and appropriate resolution. ✓ All member grievance letters were in plain language and fully described the grievance and the steps taken to resolve. ✓ All appeal resolution letters were written in plain language. ✓ All adverse determination letters were written in plain language and included a detailed explanation of the reason(s) for the determination.
Opportunities	✓ Consistency in demonstrating compliance with member and provider grievance resolution time frames. ✓ Consistency in documenting reasonable attempts to provide enrollee prompt verbal notice of denial of expedited appeal resolution. ✓ Consistency in documenting reasonable attempts to provide enrollee prompt verbal notice of expedited appeal resolution. ✓ Use of the approved appeal resolution template letter for all appeals, including pharmacy.

Aetna Better Health of Maryland	
Opportunities ***continued…***	✓ Consistency in demonstrating compliance with appeal resolution notification time frames. ✓ Consistent inclusion of all required components in adverse determination letters. ✓ Consistency in demonstrating compliance with pre-service and adverse determination notification time frames.
Recommendations	✓ Conduct routine audits of appeal processing which include compliance with regulatory requirements and use of MDH approved templates. ✓ Ensure an effective process is in place for monitoring compliance with all regulatory time frames for grievances, appeals, pre-service determinations, and adverse determination notifications, including both oral and written notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated. ✓ Audit a sample of 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	✓ Grievances per 1000 members over the four quarters of the review period reflect a consistent downward trend. ✓ Participant education issues remain the top member grievance for all four quarters ranging from 28% to 43%. ✓ ACC did not begin reporting provider grievances until the fourth quarter. Since that time the grievances per 1000 rate has demonstrated a downward trend. ✓ The rates of pre-service denials and appeals per 1000 demonstrated a slight upward trend for the fourth and first quarters. The decline in the second quarter was most likely related to decreased preauthorization requests due to COVID-19. ✓ Pharmacy services was the top pre-service denial category for all four quarters. It was the top appeal service category for three of the four quarters placing second in the remaining quarter.
Comparison with Other MCOs	✓ The member grievances per 1000 rate varies between the low and mid-range of the other MCOs. ✓ The provider grievances per 1000 rate was a major outlier during the first two quarters ACC began reporting and subsequently moved to mid-range for the last quarter reported. ✓ The appeal rate per 1000 is at mid-range. ✓ The rate of pre-service denials per 1000 is at the higher end of the MCO range.
Compliance	✓ Member grievance resolution time frames were fully met in three of the four quarters. Provider grievance resolution time frames were not fully met in any of the reporting quarters. ✓ Appeal resolution time frames were not fully met in any of the four quarters. ✓ Pre-service determination time frames did not consistently meet the compliance threshold in all service categories for three of the four quarters.

AMERIGROUP Community Care	
Compliance ***continued…***	Compliance for the first quarter could not be determined due to the lowering of the threshold in the third month of the quarter. ✓ Notification time frames met or exceeded the compliance threshold in three of the four quarters. Compliance for the first quarter could not be determined due to the lowering of the threshold in the third month of the quarter.
Strengths	✓ Member grievance and appeal resolution letters were written in plain language. ✓ All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial.
Best Practices	✓ Reasons for both upheld and overturned decisions of a denial upon appeal were clearly and fully described in appeal resolution letters.
Opportunities	✓ Consistent compliance with time frame for sending the member an acknowledgment letter of the grievance. ✓ Consistent compliance with resolving member and provider grievances within regulatory time frames. ✓ Correct categorization of grievances. ✓ Documentation of steps to resolve grievances in the case record. ✓ Grievance resolution letters include an appropriate resolution. ✓ Consistency in date of grievance resolution documented in member resolution letter and member record. ✓ Participant education member grievances ✓ Consistency in demonstrating compliance with appeal resolution notification time frames. ✓ Consistency in demonstrating compliance with pre-service and adverse determination notification time frames.
Recommendations	✓ Based upon the number of opportunities identified for improvement in addressing member grievances, retraining of grievance staff is indicated as well as implementation of an effective process for monitoring the overall grievance process from intake through notification of resolution. Increase frequency and scope of monitoring until consistent compliance is demonstrated. ✓ Consider conducting a root cause analysis of participation education related grievances to identify opportunities for improvement. ✓ Ensure an effective process is in place for monitoring compliance with all regulatory time frames for grievances, appeals, pre-service determinations, and adverse determination notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated.
Jai Medical Systems, Inc.	
Trends	✓ The rate of reported grievances per 1000 members demonstrates an uneven but downward trend over the four quarters of the review period. ✓ Billing/financial issues represent a high percentage (58%-79%) of member grievances during the review time frame.

Jai Medical Systems, Inc.	
Trends *continued…*	✓ The rate of reported grievances per 1000 providers demonstrates a slight downward trend. ✓ The appeal rate per 1000 was fairly consistent over the first two quarters with no appeals reported for the last two quarters. According to JMS, this is related to the relaxing of requirements for HepC treatment. ✓ Pharmacy services was the top appeal service category for the two quarters. ✓ Pre-service denials per 1000 are fairly consistent over the first three quarters of the review period. The decline in the second quarter was most likely related to decreased preauthorization requests due to COVID-19. ✓ Pharmacy services was the top service category for pre-service denials for all four quarters.
Comparison with Other MCOs	✓ JMS was a major outlier in its member grievances per 1000 rate for all four quarters; it is at the low end of the range for provider grievances per 1000. ✓ The appeal rate per 1000 is at the bottom of the MCO range. ✓ Pre-service denials per 1000 are very near the bottom of the range.
Compliance	✓ Resolution time frames for member grievances were met for two of the four quarters; provider grievances met the time frames for the three applicable quarters. ✓ Appeal resolution time frames were consistently met for the two applicable quarters. ✓ Pre-service determination time frames met or exceeded the 95% threshold in all categories for three of the four quarters. ✓ Adverse determination notification frames met or exceeded the compliance threshold for all four quarters. ✓ There was no documentation in case records of prescriber notification of review outcome within 24 hours of an outpatient pharmacy request.
Strengths	✓ Member grievances are appropriately classified and fully described in case notes. ✓ All member grievance letters were written in plain language with a full description of the grievance and an appropriate resolution. ✓ Full compliance with appeal resolution time frames was demonstrated for all applicable quarters ✓ All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial. ✓ All adverse determination notification time frames met or exceeded the compliance threshold for all four quarters.
Best Practices	✓ All appeal resolution letters not only provided the credentials of the physician reviewer but also any specialized training relevant to the appeal request.
Opportunities	✓ Billing/financial member grievances. ✓ Consistent compliance with member grievance resolution time frames. ✓ Consistent compliance with pre-service determination time frames. ✓ Documentation that prescriber was notified of review outcome within 24 hours of receipt of PA request on a consistent basis.

Jai Medical Systems, Inc.	
Recommendations	✓ Provide staff training including procedures for documenting telephonic contact of prescriber of review outcome within required time frame. Audit case notes on a routine basis to ensure that documentation supports compliance. ✓ Ensure an effective process is in place for monitoring compliance with all regulatory time frames for grievances and pre-determinations. Increase frequency and scope of monitoring until consistent compliance is demonstrated. ✓ Consider conducting a root cause analysis of billing/financial related member grievances to identify opportunities for improvement.
Kaiser Permanente of the Mid-Atlantic States, Inc.	
Trends	✓ The rate of member grievances per 1000 has been fairly consistent over four quarters; member grievances relating to attitude/service have represented the majority of KPMAS grievances ranging from 34% to 62%. ✓ KPMAS has consistently reported the absence of provider grievances. ✓ The appeal rate per 1000 has varied slightly over the four quarters with a slight downward trend observed in the last three quarters. The second quarter rate was the lowest within this time period possibly related to decreased preauthorization requests due to COVID-19. ✓ The majority of appeals are in the medical/surgical service category. ✓ The rate of pre-service denials per 1000 was fairly consistent for the first three quarters of the review period. The decline in the second quarter was most likely related to decreased preauthorization requests due to COVID-19. ✓ Medical/Surgical pre-service denials remained the top service category for all four quarters.
Comparison with Other MCOs	✓ KPMAS was a major outlier in its member grievances per 1000 rate for all four quarters. ✓ KPMAS did not demonstrate compliance with member grievance resolution time frames in three of the four quarters. Compliance for the first quarter could not be determined due to the lowering of the threshold in the third month of the quarter. ✓ The appeal rate per 1000 is near the bottom of the MCO range, ✓ KPMAS is the only MCO that reported no pharmacy appeals as it had no reported denials for pharmacy services. ✓ The rate of pre-service denials per 1000 is consistently below the range of the other MCOs, possibly due to the MCO's model.
Compliance	✓ Compliance with resolution time frames for member grievances was not fully met in any quarter. ✓ Grievance resolution letters were found in only 43% of the sample of grievance records reviewed. ✓ Notification of appeal resolution demonstrated full compliance in three of the four quarters.

Kaiser Permanente of the Mid-Atlantic States, Inc.	
Compliance ***continued…***	✓ There was no evidence in case notes of a reasonable attempt to provide the member with oral notification of an expedited appeal resolution. ✓ Compliance with pre-service determination and adverse determination notification time frames was demonstrated at or above the threshold for all four quarters.
Strengths	✓ Thorough documentation of grievance and steps to resolve in all case notes. ✓ All grievances appropriately categorized and resolved. ✓ Appeal resolution letters were written in plain language. ✓ All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial. ✓ Consistent compliance with pre-service determination and adverse determination notification time frames.
Best Practices	Appeal case records were very detailed.
Opportunities	✓ Consistent compliance with regulatory time frames for sending grievance acknowledgment and resolution letters. ✓ Grievance resolution letters consistently include a description of the grievance and its resolution. ✓ Named fields in letter templates are replaced with required information such as member name or description of the grievance. ✓ MDH-approved grievance letter templates are consistently used. (Letters for the commercial product line were sent for two grievances.) ✓ Attitude/service related member grievances. ✓ Documentation of a reasonable attempt to provide oral notification of an expedited appeal resolution. ✓ Consistent compliance with time frames for notice of appeal resolution. ✓ Adverse determination letters reflect accurate calculation of appeal filing deadline.
Recommendations	✓ Based upon the number of opportunities identified for improvement in demonstrating compliance with time frames for written acknowledgement and resolution of grievances; use of the appropriate grievance resolution letter template; and resolution letter contents, retraining of grievance staff is indicated as well as implementation of an effective process for quality monitoring. ✓ Consider conducting a root cause analysis of service/attitude-related member grievances to identify opportunities for improvement. ✓ Train appeal staff and audit appeal case records to ensure there is documentation of a reasonable attempt to provide oral notification of expedited appeal resolution. ✓ Ensure an effective process is in place for monitoring compliance with all regulatory time frames for appeal resolutions. Increase frequency and scope of monitoring until consistent compliance is demonstrated. ✓ Review calculation of appeal filing deadlines in adverse determination letters to ensure the date reflects five additional days for mailing.

Maryland Physicians Care	
Trends	✓ The member grievances per 1000 rate was fairly consistent over four quarters with a slight downward trend observed. ✓ Access related grievances represent the majority of grievances ranging from 51% to 64%. ✓ The reported rate for provider grievances per 1000 has remained fairly steady over the last two reported quarters after a near MCO high in the third quarter. ✓ The rate of appeals per 1000 has demonstrated a steady decline over the last three reported quarters. The decline in the second quarter was most likely related to decreased preauthorization requests due to COVID-19. ✓ Pharmacy Services was the top appeal service category for all four quarters. ✓ The rate of pre-service denials per 1000 was fairly consistent for the first three quarters of the review period. The decline in the second quarter was most likely related to decreased preauthorization requests due to COVID-19. ✓ Pharmacy related pre-service denials occupied the second spot in the top five service category list for all four quarters.
Comparison with Other MCOs	✓ The member grievances per 1000 rate remains at the lower end of the MCO range. For the last two reported quarters, MPC is at the low end of the range in provider grievances per 1000 after appearing near the top of the range in the third quarter. ✓ The appeal rate per 1000 is mid-range. ✓ The rate of pre-service denials per 1000 is at the higher end of the MCO range.
Compliance	✓ MPC met the resolution time frame for member and provider grievances in all applicable quarters but one. ✓ Appeal resolution time frames were consistently met for all four quarters. ✓ There was no evidence in case notes of a reasonable attempt to provide the member with prompt oral notification of denial of an expedited appeal request. ✓ There was no evidence in case notes of a reasonable attempt to provide the member with oral notification of an expedited appeal resolution. ✓ The compliance threshold for pre-service determinations and adverse determination notifications was met or exceeded for all service categories in all four quarters.
Strengths	✓ All grievances were appropriately categorized and resolved. ✓ Case notes were very detailed in describing the grievance and steps to resolve. ✓ All grievance letters were written in plain language and describe the grievance and its resolution. ✓ All appeal resolution letters were written in plain language. ✓ All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial. ✓ Consistent compliance with appeal resolution time frames was reported for all four quarters.

Maryland Physicians Care	
Strengths *continued…*	✓ Consistent compliance with pre-service determination and adverse determination notification time frames was reported for all four quarters.
Opportunities	✓ Consistent compliance with member and provider grievance resolution time frames. ✓ Access related member grievances. ✓ Appeals are consistently processed based upon level of urgency. ✓ Receipt date of the appeal is not revised to reflect the date of written consent. ✓ Appeal case notes document denials of requests for an expedited resolution and a reasonable attempt to provide the member with oral notice of the denial of a request for an expedited appeal resolution ✓ Appeal decisions are made by health care professionals with appropriate clinical expertise consistent with the MCO's policies. ✓ Consistency in documenting reasonable attempts to provide member prompt verbal notice of expedited appeal resolution. ✓ All appeal resolution letters are written in plain language.
Recommendations	✓ Ensure an effective process is in place for monitoring compliance with all regulatory time frames for grievances. Increase frequency and scope of monitoring until consistent compliance is demonstrated. ✓ Consider conducting a root cause analysis of access related member grievances to identify opportunities for improvement. ✓ Retrain appeals staff to ensure the appeal receipt date is not revised to date of written consent and revise appeal policies and procedures accordingly. ✓ Routinely audit appeal case records to ensure complete documentation of denials of request for an expedited resolution and oral notification of the denial of an expedited request and resolution of expedited requests. ✓ Assign appeal cases to health care professionals consistent with their training and experience. ✓ Routinely audit a sample of appeal resolution letters to ensure they are written in plain language. Retrain letter staff as indicated.
MedStar Family Choice, Inc.	
Trends	✓ The member grievances per 1000 rate has consistently declined over the four quarters under review. ✓ Access related grievances range from 35% to 49%. ✓ MSFC is only one of two MCOs that consistently reported the absence of provider grievances. ✓ The appeal rate per 1000 demonstrates an uneven but downward trend. The decline in the second quarter was most likely related to decreased preauthorization requests due to COVID-19. ✓ Appeals related to pharmacy services have occupied one of the top three spots during this review period. ✓ The rate of pre-service denials per 1000 demonstrated a significant decline in the first quarter which was sustained in the second quarter. According to the

MedStar Family Choice, Inc.	
Trends *continued…*	MCO, this was a result of eliminating adult dental denials, an optional benefit, based upon a decision from MDH. ✓ The pharmacy services category occupied the top spot for denials for the first and second quarters and ranked in second and third place respectively in the third and fourth quarters.
Comparison with Other MCOs	✓ The rate of member grievances per 1000 is at the lower end of the MCO range. ✓ The appeals per 1000 rate is mid-range. ✓ The rate of pre-service denials per 1000 has been at the low end of the MCO range the last two quarters of the review period after eliminating adult dental denials as noted above.
Compliance	✓ Overall compliance with resolution time frames for member grievances was fully met in three of the four quarters. ✓ Appeal resolution time frames were met in all four quarters. ✓ Pre-service determinations and adverse determination notifications met or exceeded the compliance threshold in all categories for two of the four quarters. Compliance for the first quarter could not be determined due to the lowering of the threshold in the third month of the quarter.
Strengths	✓ Case notes and resolution letters provide a detailed description of the grievance and resolution. ✓ All grievances were appropriately categorized and resolved. ✓ All grievance letters were written in plain language. ✓ Consistent compliance with appeal resolution time frames was reported for all four quarters. ✓ All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial.
Best Practices	✓ All appeal resolution letters are in plain language and provide detailed explanation of the reason for the uphold decision.
Opportunities	✓ Consistent compliance with member grievance resolution time frames. ✓ Access related member grievances. ✓ Receipt date of the appeal is not revised to reflect the date of written consent. ✓ Appeal resolution letters state reason for the overturn decision rather than only stating “request meets medical necessity.” ✓ Consistent compliance with meeting regulatory time frames for pre-service determinations and adverse determination notifications.
Recommendations	✓ Ensure an effective process is in place for monitoring compliance with all regulatory time frames for grievances, pre-service determinations, and adverse determination notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated. ✓ Consider conducting a root cause analysis of access related member grievances to identify opportunities for improvement. ✓ Retrain appeals staff to ensure the appeal receipt date is not revised to date of written consent and revise appeal policies and procedures accordingly.

Priority Partners	
Recommendations *continued…*	✓ Consider explaining the reason for overturned decisions upon appeal beyond "request meets medical necessity."
Trends	✓ The rate of member grievances per 1000 remained fairly consistent over the four quarters reviewed. ✓ Attitude and billing/financial issues consistently represent the majority of grievances. ✓ The rate of provider grievances per 1000 steadily increased after PPMCO began reporting provider grievances in the third quarter but declined significantly in the second quarter. The closure of provider offices and elective surgery restrictions due to COVID-19 are believed to be contributing factors as billing/financial issues are the major source of provider grievances. ✓ The rate of appeals per 1000 has demonstrated an uneven but overall upward trend. ✓ Pharmacy Services was the top appeal service category for all four quarters. ✓ The rate of pre-service denials per 1000 was fairly consistent for the first three quarters of the review period. The decline in the second quarter was most likely related to decreased preauthorization requests due to COVID-19. ✓ Pharmacy services was the top service category for both appeals and pre-service denials for all four quarters of the review period.
Comparison with Other MCOs	✓ Member grievances are at the low end of the MCO range; however, PPMCO is the only MCO that did not fully meet the resolution time frame for member grievances in all four quarters despite a CAP that has been in place for at least two years. ✓ The appeals per 1000 rate is at the bottom of the MCO range. ✓ The rate of pre-service denials per 1000 is at mid-range.
Compliance	✓ PPMCO did not demonstrate compliance with member grievance resolution time frames in three of the four quarters. Compliance for the first quarter could not be determined due to the lowering of the threshold in the third month of the quarter. Compliance with resolution time frames for provider grievances was fully met in three of the four quarters. ✓ Compliance with appeal resolution time frames has been demonstrated in only one of the four quarters. ✓ There was no evidence in case notes of a reasonable attempt to provide the member with oral notification of an expedited appeal resolution. ✓ Pre-service determination and adverse determination notification time frames did not meet the 95% threshold consistently in three of the quarters. Compliance for the first quarter could not be determined due to the lowering of the threshold in the third month of the quarter.
Strengths	✓ Grievances and their resolution are well documented in case notes and resolutions are appropriate. ✓ All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial.

Priority Partners	
Best Practices	✓ Grievance resolution letters are in plain language and provided in both English and Spanish.
Opportunities	✓ Appropriate categorization of grievances (emergency-medically related, non-emergency medically related, and administrative). ✓ Consistent compliance with grievance resolution time frames. ✓ Attitude and billing/financial related member grievances. ✓ Appeals are processed based upon level of urgency and, if expedited resolution request denied, decision is documented in case notes and communicated orally and in writing to the member. ✓ Consistency in documenting reasonable attempts to provide enrollee prompt verbal notice of expedited appeal resolution. ✓ Appeal case notes document physician review of appeals. ✓ Consistency in sending a resolution letter for all appeals. ✓ Consistent compliance with appeal resolution time frames. ✓ Consistent compliance with pre-service determination and adverse determination notification time frames. ✓ Adverse determination letters consistently identify the correct deadline for requesting continuation of benefits.
Recommendations	✓ Retrain grievance staff and conduct routine audits to ensure appropriate categorization of grievances. ✓ Consider conducting a root cause analysis of attitude and billing/financial related member grievances to identify opportunities for improvement. ✓ Based upon multiple opportunities identified for improving appeal processing, documentation, and compliance with time frames, retrain appeal staff and conduct routine monitoring of case notes and resolution letters. ✓ Ensure an effective process is in place for monitoring compliance with all regulatory time frames for grievances, appeals, pre-service determinations, and adverse determination notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated. ✓ Review calculation of continuation of benefits deadline in adverse determination letters to ensure the date reflects five additional days for mailing.
UnitedHealthcare Community Plan	
Trends	✓ The rate of member grievances per 1000 has been fairly consistent over four quarters. ✓ Billing/financial issues occupied one of the top two member grievance service categories over the review period. ✓ UHC began reporting provider grievances in the second quarter so trending is not available. ✓ The rate of appeals per 1000 demonstrates an uneven but overall downward trend over the four quarters.

UnitedHealthcare Community Plan	
Trends *continued…*	✓ The rate of pre-service denials per 1000 was fairly consistent for the first three quarters of the review period. The decline in the second quarter was most likely related to decreased preauthorization requests due to COVID-19. ✓ Pharmacy services was the top service category for both appeals and pre-service denials for all four quarters of the review period.
Comparison with Other MCOs	✓ UHC is at the lower end of the MCO range in member grievances per 1000. ✓ For its first quarter of reporting provider grievances its rate was mid-range, ✓ UHC was only one of two MCOs demonstrating full compliance with member grievance resolutions time frames. ✓ The rate of appeals per 1000 is at mid-range. ✓ The rate of pre-service denials per 1000 is at the top of the range.
Compliance	✓ Consistent compliance with resolution time frames for member grievances was met in all four quarters; compliance with provider resolution time frames was not fully met in the second quarter, its first quarter of reporting. ✓ Consistent compliance with appeal resolution time frames was met in three of the four quarters. ✓ Compliance with pre-service determination and adverse determination notification time frames met or exceeded the threshold in all four quarters.
Strengths	✓ Grievances and their resolution are well documented in case notes and in resolution letters. ✓ Grievances are appropriately categorized and resolved. ✓ Consistent compliance with member grievance resolution time frames in all four quarters. ✓ All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial. ✓ Consistent compliance with pre-service determination and adverse determination notification time frames in all four quarters.
Best Practices	✓ Grievance case records provide comprehensive documentation of peer review in response to quality of care) complaints and include all correspondence between service providers (i.e. primary care providers, transportation vendor), as applicable. ✓ Grievance resolution letters are in plain language and provide a full description of the grievance and the steps to resolve including feedback from service providers in response to any quality of care/quality of service) issues. ✓ All member adverse determination and appeal letters were written in plain language and include the Non-Discrimination Statement in both English and Spanish.
Opportunities	✓ Consistent compliance with the resolution time frames for provider grievances. ✓ Billing/financial related member grievances. ✓ Consistent compliance with appeal resolution time frames. ✓ Adverse determination letters consistently identify the correct deadlines for requesting an appeal and continuation of benefits.
Recommendations	✓ Consider conducting a root cause analysis of billing/financial related member grievances to identify opportunities for improvement.

UnitedHealthcare Community Plan	
Recommendations ***continued…***	✓ Review calculation of appeal filing and request for continuation of benefits deadlines in adverse determination letters to ensure that the dates reflects five additional days for mailing. ✓ Ensure an effective process is in place for monitoring compliance with all regulatory time frames for provider grievances and member appeals. Increase frequency and scope of monitoring until consistent compliance is demonstrated.
University of Maryland Health Partners	
Trends	✓ The member grievances per 1000 rate had been trending upward but declined in the last reporting quarter. ✓ Billing/financial issues have been trending up the last two quarters and now represent over half of member grievances. ✓ Provider grievances have been trending downward during the period of the review. The appeal rate per 1000 remained fairly consistent over the four quarters. ✓ Pharmacy Services was the top service category for all four quarters representing the majority of appeals. ✓ The rate of pre-service denials per 1000 demonstrated an upward trend over the first three quarters of the review period. The decline in the second quarter was most likely related to decreased preauthorization requests due to COVID-19. ✓ Pharmacy services was the top service category for both appeals and pre-service denials for all four quarters of the review period.
Comparison with Other MCOs	✓ The member grievances per 1000 rate is at the lower end of the MCO range; the provider grievances rate per 1000 has been mid-range for the last three quarters after reaching the top of the range in the third quarter. ✓ UMHP is only one of two MCOs to demonstrate full compliance with member and provider grievance resolution time frames. ✓ The appeal rate per 1000 was at the top of the MCO range for all four quarters. ✓ The rate of pre-service denials per 1000 is at mid-range.
Compliance	✓ Consistent compliance with member and provider grievance resolution time frames was demonstrated in all four quarters. ✓ Appeal resolution time frames were consistently met for all four quarters. ✓ Consistent compliance with pre-service determinations and adverse determination notification time frames during the review period.
Strengths	✓ All grievance resolutions were appropriate. ✓ Consistent compliance with grievance resolution time frames for all four quarters. ✓ Consistent compliance with appeal resolution time frames for all four quarters. ✓ All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial.

University of Maryland Health Partners	
Strengths *continued…*	✓ Consistent compliance with pre-service determination and adverse determination notification time frames for all four quarters.
Best Practices	✓ Case records provided comprehensive documentation of the grievance and the steps to resolve including responses from providers and vendors as appropriate. This detailed feedback was also included in resolution letters. ✓ All appeal resolution letters provided extremely detailed information in plain language as to the reason for the uphold or overturn of the initial denial.
Opportunities	✓ Appropriate categorization of grievances. ✓ Billing/financial related member grievances. ✓ Compliance with sending written acknowledgment of member grievances within 5 calendar days. (Only 27% of the grievances within the sample reviewed met this time frame.) ✓ Timely mailing of grievance resolution letters. (Many resolutions letters were sent out several days after the grievance was resolved, one as late as 17 days after the resolution. ✓ Use of adverse determination model notice template which includes language re continuation of benefits rights, process and time frame for requesting.
Recommendations	✓ Retrain staff and conduct routine audits to ensure appropriate categorization of grievances. ✓ Consider conducting a root cause analysis of billing/financial related member grievances to identify opportunities for improvement. ✓ Monitor timeliness of mailing of grievance acknowledgment and resolution letters. ✓ Routinely audit a sample of adverse determination letters to ensure that the current MDH model notice template is being used.

Appendix B

Grievance Review Templates

<MCO> Grievances for <X> Quarter <Year> Results & Analysis						
	Current Quarter	**Prior Quarter**	**Qx 20xx**	**Qx 20xx**	**Status**	**Other MCO Results**
Total Member Grievances Received in the Qtr.					○	
Total Member Grievances Resolved in the Qtr.					○	
Grievances/1000 Members					○	
Member Grievances by Category (rate/1000)						
Cat.1: Emergency medically related					○	
Cat. 2: Non-emergency medically related					○	
Cat. 3: Administrative					○	
Top 5 Member Grievances Received by Service Category						**Top 5 Categories**
Service Category (#/%)					○	
Service Category (#/%)					○	
Service Category (#/%)					○	
Service Category (#/%)					○	
Service Category (#/%)					○	
Member Grievances TAT Met (standard 100% compliance)						
Cat. 1: Emergency medically related (#/%)					○	
Cat. 2: Non-emergency medically related (#/%)					○	
Cat. 3: Administrative (#/%)					○	
Total Provider Grievances Received in the Qtr.					○	
Total Provider Grievances Resolved in the Qtr.					○	
Grievances/1000 Providers					○	

Provider Grievances by Category (rate/1000)						
Cat.1: Emergency medically related					○	
Cat. 2: Non-emergency medically related					○	
Cat. 3: Administrative					○	
Top 5 Provider Grievances Received by Service Category						**Top 5 Categories**
Service category (#/%)					○	
Service category (#/%)					○	
Service category (#/%)					○	
Service category (#/%)					○	
Provider Grievances TAT Met (standard 100% compliance)						
Cat. 1: Emergency medically related (#/%)					○	
Cat. 2: Non-emergency medically related (#/%)					○	
Cat. 3: Administrative (#/%)					○	

Analysis

Recommendations

Legend

○ Neutral
○ Met, if applicable
○ Negative trend. (Requires MCO explanation)
○ Not met, if applicable. (May require a CAP)
NA - Not Applicable

Appendix C

Appeal Review Templates

<MCO> Appeals for <X> Quarter<Year> Results & Analysis						
	Current Quarter	**Prior Quarter**	**Qx 20xx**	**Qx 2xx**	**Status**	**Other MCO Results**
Total Appeals Received in the Quarter					O	
Total Appeals Resolved in the Quarter					O	
Appeals/1000 Members					O	
Member Appeal Sources						
Appeals from Denials Received (#/%)					O	
Appeals Submitted by Members (#/%)					O	
Appeals Submitted by Providers (#/%)					O	
Appeal Outcomes					O	
Upheld (#/%)					O	
Overturned (#/%)					O	
Overturn by Action Type						
Action 1 (#/%)					O	
Action 2 (#/%)					O	
Action 3 (#/%)					O	
Action 4 (#/%)					O	
Action 5 (#/%)					O	
Action 6 (#/%)					O	
Upheld by Action Type						
Action 1 (#/%)					O	
Action 2 (#/%)					O	
Action 3 (#/%)					O	
Action 4 (#/%)					O	
Action 5 (#/%)					O	
Action 6 (#/%)					O	
Top 5 Service Categories						
Category 1						

Resolved (#/%)					○	
Upheld (#/%)					○	
Overturn (#/%)					○	
Category 2						
Resolved (#/%)					○	
Upheld (#/%)					○	
Overturn (#/%)					○	
Category 3						
Resolved (#/%)					○	
Upheld (#/%)					○	
Overturn (#/%)					○	
Category 4						
Resolved (#/%)					○	
Upheld (#/%)					○	
Overturn (#/%)					○	
Category 5						
Resolved (#/%)					○	
Upheld (#/%)					○	
Overturn (#/%)					○	
Expedited Appeals (#/%)					○	
Extended Appeals (#/%)					○	
Resolution TAT Met (standard 100% compliance)						
Expedited (#/%)					○	
Non-emergency (#/%)					○	

Analysis

Recommendations

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

Appendix D

Pre-Service Denial Review Templates

<MCO> Pre-Service Denials for <X> Quarter <Year> Results & Analysis						
	Current Quarter	**Prior Quarter**	**Qx 20xx**	**Qx 20xx**	**Status**	**Other MCO Results**
Total PA Requests Received in the Quarter					o	
Total A Requests Received with Complete Information (#/%)					o	
Total PA Requests Requiring Additional Information (#/%)					o	
Total PA Requests Approved (#/%)					o	
Total PA Requests Denied (#/%)					o	
Total Pre-Service Denials in the Quarter					o	
Pre-Service Denials for Members Under 21 (#/%)					o	
Standard Pre-Service Medical Denials (#/%)					o	
Expedited Pre-Service Medical Denials (#/%)					o	
Pre-Service Outpt. Pharmacy Denials (#/%)					o	
Pre-Service Denials/1000 members					o	
Top 5 Service Categories						
Top Service Category (#/%)					o	
Top Service Category (#/%)					o	
Top Service Category (#/%)					o	
Top Service Category (#/%)					o	
Top Service Category (#/%)					o	
Top 5 Denial Reasons						
Denial Reason:					o	
Denial Reason:					o	
Denial Reason:					o	
Denial Reason:					o	
Denial Reason:					o	
Determination TAT Met (standard 95% compliance)						

Standard Pre-Service Medical Denials (#/%)					o	
Expedited Pre-service Medical Denials (#/%)					o	
Pre-Service Outpt. Pharmacy Denials (#/%)					o	
Notification TAT Met (standard 95% compliance)						
Standard Pre-Service Medical Denials (#/%)					o	
Expedited Pre-Service Medical Denials (#/%)					o	
Pre-Service Outpt. Pharmacy Denials (#/%)					o	
Prescriber Notification TAT Requirement						
Prescriber Notification of Outcome within 24 Hours (#/%)					o	

Analysis

Recommendations

Legend
o Neutral
o Met, if applicable
o Negative trend. (Requires MCO explanation)
o Not met, if applicable. (May require a CAP)
NA - Not Applicable