Medicaid Managed Care Organization

2021 Focused Review Report Grievances, Appeals, & Denials

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2021 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. This independent review ensures services provided to enrollees meet the standards set forth in CFR and COMAR 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. Qlarant's 2021 study is the fifth annual focused review conducted for MDH.

Assessment of MCO compliance was completed by applying performance standards defined for calendar year (CY) 2020. Quarterly studies of grievances, appeals, and pre-service denials were conducted for the third and fourth quarters of 2020 and the first and second quarters of 2021. The annual record review encompassed enrollee grievances, appeals, and pre-service denials that occurred during CY 2020. The nine MCOs evaluated during these timeframes were:

- Aetna Better Health of Maryland (ABH)
- AMERIGROUP Community Care (ACC)
- CareFirst Community Health Plan (CFCHP)[1]
- 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)

[1] Formerly University of Maryland Health Partners

Purpose and Objectives

The purpose of this review is to:

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

This focused study activity addresses the following:

- Validation of the data provided by MCOs in the quarterly grievance, appeal, and pre-service denial reports.
- Provides an avenue for MCOs to compare their performance with their peers.
- Identifies MCO opportunities for improvement and provides recommendations.
- Requests 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 each quarter to Qlarant. Qlarant develops MDH-approved templates as a review tool for each reporting category 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 comparisons. MCO-specific trends were identified after three quarters of data were available. Quarterly reports submitted 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 the reports submitted by the MCOs, Qlarant conducted an annual record review of a sample of CY 2020 grievance, appeal, and pre-service denial records. Records were requested from July 1 through October 31, 2020, to allow MCOs an opportunity to address and fully implement several recent regulatory changes noted as incomplete during the systems performance review (SPR) conducted in early 2020. 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 using a random sampling approach and requested each MCO to upload the selected case records to the Qlarant portal. Using the 10/30 rule, an initial sample of 10 grievance, 10 appeal, and 10 denial records were 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

Validity of the MCO-submitted quarterly grievance, appeal, and denial reports has demonstrated continued improvement over this annual report period. Decreases have occurred in both the number of MCOs required to resubmit at least one of their quarterly reports and in the number of errors within each report. Analysis of issues identified ongoing formula errors, blank fields, inconsistencies between the numbers reported, and incomplete data. Incomplete data issues could involve failure to include data reported by delegates, or all preauthorization (PA) requests, in determining compliance with prescriber notifications of the outcome of the MCO's review.

While the total number of grievances was not impacted, Qlarant recently discovered that two MCOs incorrectly assigned some grievances to the "Other" service category. Qlarant discovered one MCO incorrectly utilized less stringent National Committee for Quality Assurance standards for reporting timeframe compliance for adverse determinations and notifications. Although this issue was corrected at the start of the review period, it presented challenges in comparing MCO performance to prior quarters.

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 Qlarant-provided instructions on the MCO Resource Site to assist with understanding and calculating various report fields. Technical assistance continued to be provided to individual MCOs, as needed. In view 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. Annual record review results and quarterly reports inform these results and provide comparisons of MCO performance over time and in relation to peers.

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
<u>Example:</u> Emergency prescription or incorrect prescription provided

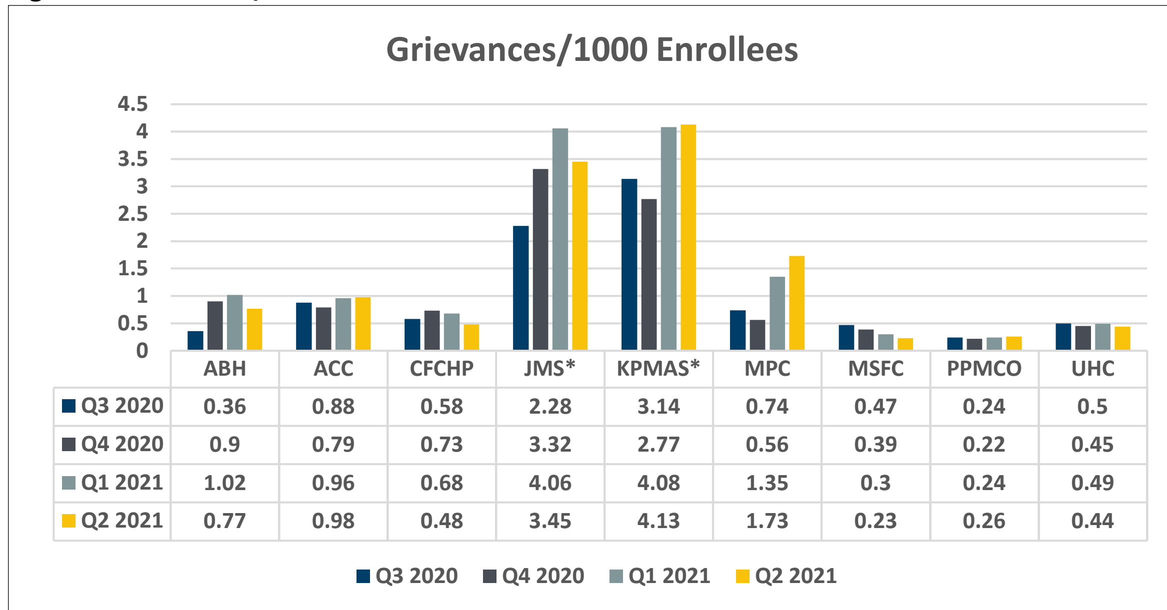
Category 2: Non-emergency medically related grievances
Example: Durable Medical Equipment/Disposable Medical Supplies-related complaints about repairs, upgrades, or vendor issues.
Category 3: Administrative grievances
Example: Difficulty finding a network primary care provider or specialist

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 enrollees overall and by categories
  - Top 5 enrollee grievance service categories
  - Grievances filed per 1000 providers overall and by categories
  - Top 5 provider grievance service categories
- Resolution Timeframes (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 steps taken to resolve the issue.
  - Written determination must be forwarded to:
    1. An enrollee who filed the grievance;
    2. Individuals and entities that are 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 enrollees for four quarters.

Figure 1. Grievances/1000 Enrollees



	ABH	ACC	CFCHP	JMS*	KPMAS*	MPC	MSFC	PPMCO	UHC
Q3 2020	0.36	0.88	0.58	2.28	3.14	0.74	0.47	0.24	0.5
Q4 2020	0.9	0.79	0.73	3.32	2.77	0.56	0.39	0.22	0.45
Q1 2021	1.02	0.96	0.68	4.06	4.08	1.35	0.3	0.24	0.49
Q2 2021	0.77	0.98	0.48	3.45	4.13	1.73	0.23	0.26	0.44

*Major outlier in comparison to other MCOs

Both JMS and KPMAS were major outliers in grievances per 1000 enrollees for all four quarters, for their increased amount of grievances compared to their peers. 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. MPC's grievances per 1000 rate spiked in the first and second quarters. According to the MCO, this was due to the delegation of multiple services to a vendor with more specialized criteria.

Billing/financial issues were the overall service category with the most amount of enrollee grievances for all four quarters within the review period. Factors causing 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 attitude/service and "other" cited as the next most common sources of grievances. These findings are consistent with the prior review period.

Table 2 displays quarterly comparisons of MCO-reported compliance with resolution timeframes for enrollee grievances. As a result of the COVID-19 public health emergency, the Maryland Managed Care Organization Association (MMCOA) requested that MDH relax the compliance threshold for grievance resolution timeliness. MDH agreed to relax the compliance threshold from 100% to 90% during the COVID-19 public health emergency. This lowered threshold remained in place throughout the period under review.

Table 2. MCO Reported Compliance with Enrollee Grievance Resolution Timeframes

Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2020	M	M	M	M	M	M	M	M	M
Q4 2020	PM	M	M	M	M	M	M	M	M
Q1 2021	M	M	M	M	M	M	M	M	PM
Q2 2021	PM	M	M	M	M	M	M	PM	M

Green – M (Met); Yellow – PM (Partially Met)

Six MCOs (ACC, CFCHP, JMS, KPMAS, MPC, and MSFC) Met resolution timeframes for enrollee grievances in all four quarters. PPMCO and UHC demonstrated full compliance for three of the four quarters. ABH Met the required timeframes in two of the four quarters. This improvement in compliance from the prior review period may be partially related to the relaxed compliance threshold in place for all four quarters.

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	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2020	1.35	1.46	1.66	NA	NA	NA	NA	0.08	1.40
Q4 2020	1.14	1.45	4.60*	0.10	NA	NA	0.31	0.15	1.90
Q1 2021	0.60	1.28	2.15*	0.10	NA	0.24	0.36	1.09	1.10
Q2 2021	0.46	2.28	2.05	0.29	NA	0.33	NA	3.09*	0.98

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

In general, MCO-reported grievances per 1000 providers have increased during this review period due to improved reporting and subsequent enhanced clarification of results. CFCHP was a major outlier for the fourth and first quarters, which it attributed to unfounded payment disputes from one provider group. PPMCO was a major outlier for the second quarter. The MCO attributed its performance to authorization denials from its specialty vendors and lack of provider ePREP completion. KPMAS has consistently reported the absence of provider grievances. MPC and MSFC reported no provider grievances for two of the four quarters.

Table 4 displays quarterly comparisons of MCO-reported compliance with resolution timeframes for provider grievances.

Table 4. MCO Reported Compliance with Provider Grievance Resolution Timeframes

Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2020	M	UM	M	NA	NA	NA	NA	M	M
Q4 2020	UM	M	M	M	NA	NA	M	M	UM
Q1 2021	M	M	M	M	NA	M	M	M	M
Q2 2021	M	M	M	M	NA	M	NA	M	M

Green – M (Met); Red – UM (Unmet); White – NA (Not Applicable as the MCO did not receive any provider grievances during the reporting period.)

Of the eight MCOs who reported provider grievances, five MCOs (CFCHP, JMS, MPC, MSFC, and PPMCO) demonstrated full compliance with regulatory timeframes in all applicable quarters. ABH, ACC, and UHC demonstrated full compliance in all applicable quarters but one. MCOs that did not receive any provider grievances were reported as NA for compliance for that quarter. The relaxed threshold had minimal impact on compliance.

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 2020. Reviews were conducted utilizing the 10/30 rule.

Table 5. CY 2020 MCO Annual Grievance Record Review Results

Requirement	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Appropriately Classified	M	M	M	M	M	M	M	M	M
Acknowledgement Letter Timeliness	PM	M	PM	M	M	M	M	M	M
Issue Is Fully Described	M	M	M	M	M	M	M	M	M
Resolution Timeliness	PM	M	M	M	M	M	M	M	M
Resolution Appropriateness	M	M	M	M	M	M	M	M	M
Resolution Letter Sent	M	M	M	M	PM	M	M	M	M

Green – M (Met); Yellow – PM (Partially Met)

Six MCOs (ABH, JMS, MPC, MSFC, PPMCO, and UHC) received a finding of Met in all six categories. Three categories, “Appropriately Classified,” “Issue Is Fully Described,” and “Resolution Appropriateness,” were consistently Met by all MCOs.

Two MCOs (ABH and CFCHP) received a finding of Partially Met for “Acknowledgment Letter Timeliness.” ABH Met the five-calendar-day timeframe for sending a grievance acknowledgment letter in 33% of the records reviewed. CFCHP did not provide evidence to support that an acknowledgment letter was sent for grievance timeframe extensions, even when the extension was requested well after the five-day timeframe. Additionally, CFCHP’s acknowledgment letters did not meet the regulatory timeframe, often missing it by one day. Overall, CFCHP demonstrated compliance with sending an acknowledgment letter in 42% of the records reviewed. One MCO (ABH) received a finding of Partially Met for “Resolution Timeliness,” as resolutions Met the regulatory timeframes in 67% of the records

reviewed. KPMAS received a finding of Partially Met for “Resolution Letter Sent” as no evidence could support that a resolution letter was sent to one enrollee.

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 timeframes defined by the State in COMAR 10.67.05.07)
- **Action 5:** Failure of an MCO to act within the required appeal timeframes 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 implementing the new requirements. Updates to COMAR 10.67.09.05, as they relate to MCO-reported appeal results addressed in this report, included 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 an enrollee with the enrollee’s written consent. COMAR previously did not require the provider to seek written authorization before filing an appeal on the enrollee’s behalf.

In 2020, MDH communicated an additional requirement to the MCOs pertaining to expedited appeals. The 72-hour timeframe for expedited appeals was updated to include both the resolution and notification.

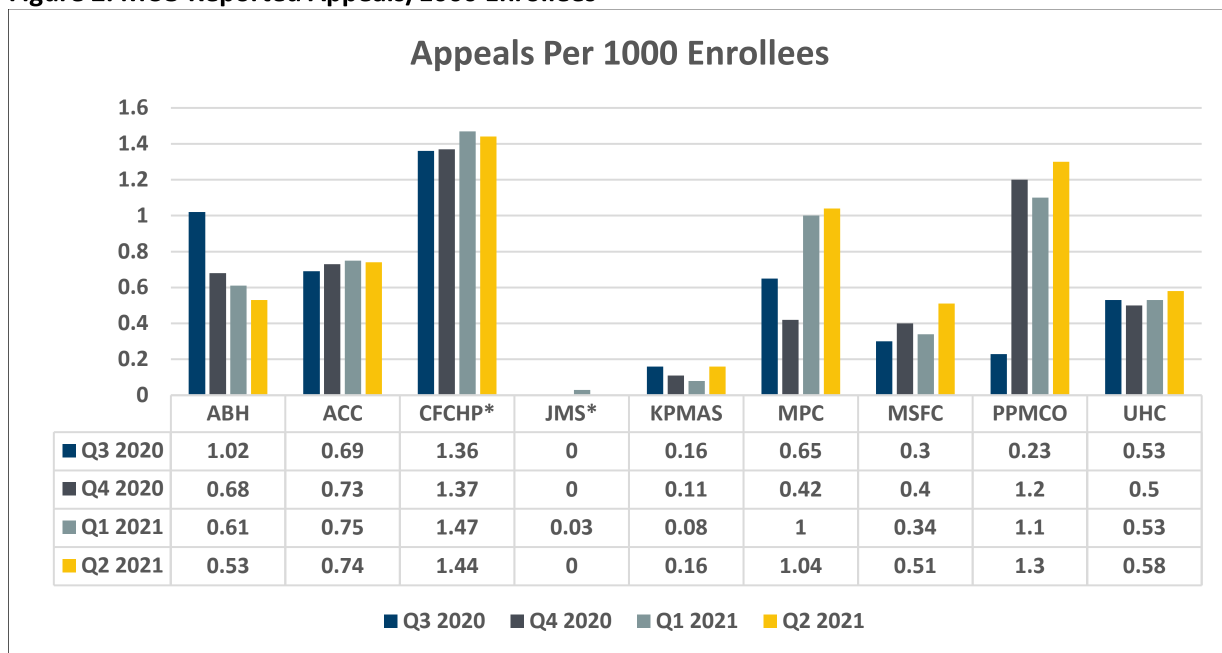
Effective November 13, 2020, CMS amended CFR 42.438.406 (b) (3) to allow oral inquiries seeking to appeal an adverse benefit determination to be treated as appeals. This eliminated the previous requirement for requiring an oral appeal to be followed by a written, signed appeal.

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 Enrollees
  - Percentages of Appeals Received from Denials
  - Percentages of Appeals Submitted by Enrollees 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 Timeframes (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 timeframe.
  - 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 an easily understood language.

Figure 2 provides a quarterly comparison of MCO reported appeals per 1000 enrollees.

Figure 2. MCO Reported Appeals/1000 Enrollees



	ABH	ACC	CFCHP*	JMS*	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2020	1.02	0.69	1.36	0	0.16	0.65	0.3	0.23	0.53
Q4 2020	0.68	0.73	1.37	0	0.11	0.42	0.4	1.2	0.5
Q1 2021	0.61	0.75	1.47	0.03	0.08	1	0.34	1.1	0.53
Q2 2021	0.53	0.74	1.44	0	0.16	1.04	0.51	1.3	0.58

*Outlier in comparison to other MCOs

CFCHP has consistently been at the top of the range in reported appeals per 1000 enrollees in comparison to all other MCOs during the four quarters under review. This mirrors findings from the prior two annual review periods. Three MCOs (JMS, KPMAS, and MSFC) occupy the lower end of the range, which may be partially attributed to their lower denials per 1000 rate.

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

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

Quarter	ABH*	ACC*	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO*	UHC*
Q3 2020	1st	2nd	2nd	NA	NA	1st	1st	1st	1st
Q4 2020	1st	2nd	1st	NA	NA	2nd	1st	1st	1st
Q1 2021	1st	2nd	1st	1st	NA	2nd	1st	1st	1st
Q2 2021	1st	2nd	1st	NA	4th	1st	1st	1st	1st

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

As noted in the 2019 and 2020 annual reports, Pharmacy Services was the most frequent service category occupying the top spot for the majority of MCOs throughout the review period. Four MCOs (ABH, MSFC, PPMCO, and UHC) reported it as the top service category for all applicable quarters in the review period. CFCHP reported it as the top service category in three of the four quarters and in second place in the remaining quarter. MPC reported it in the top spot for two quarters and in the second spot for the remaining two quarters. ACC reported it in the second spot for all four quarters. Four MCOs (ABH, ACC PPMCO, and UHC) also reported appeals related to Pharmacy Services: Chronic pain management was reported within their top five list for at least one quarter.

Quarterly comparisons of MCO-reported compliance with resolution timeframes for enrollee appeals are displayed in Table 7.

Table 7. MCO Reported Compliance with Enrollee Appeal Resolution Timeframes

Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2020	PM	PM	M	NA	UM	M	M	PM	M
Q4 2020	UM	PM	M	NA	M	M	M	UM	M
Q1 2021	PM	PM	M	M	M	M	M	M	PM
Q2 2021	PM	UM	M	NA	M	PM	M	M	PM

Green – M (Met); Yellow – PM (Partially Met); Red – UM (Unmet); White – NA (Not Applicable)

Three MCOs (CFCHP, JMS, and MSFC) consistently Met appeal resolution timeframes for all associated quarters (when applicable). Two MCOs (KPMAS and MPC) demonstrated compliance for three quarters. Two MCOs (PPMCO and UHC) demonstrated compliance for two quarters. Two MCOs (ABH and ACC) received a Partially Met for three quarters and an Unmet for one quarter.

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 2020.

Table 8. CY 2020 MCO Appeal Record Review Results

Requirement	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Processed Based Upon Level of Urgency	PM	M	M	NA	M	M	M	M	M
Compliance with Verbal Notification of Denial of an Expedited Request	PM	M	PM	NA	PM	NA	NA	NA	NA
Compliance with Written Notification of Denial of an Expedited Request	UM	M	M	NA	PM	NA	NA	NA	NA
Compliance with 72-hour Timeframe for Expedited Appeal Resolution and Notification	UM	NA	M	NA	NA	NA	NA	M	M
Compliance with Verbal Notification of Expedited Appeal Decision	UM	NA	M	NA	NA	NA	NA	UM	M
Compliance with Written Notification Timeframe for Non-Emergency Appeal	PM	M	M	NA	PM	M	M	M	M
Appeal Decision Documented	M	M	M	NA	M	M	M	M	M
Decision Made by Health Care Professional with Appropriate Expertise	M	M	M	NA	M	M	M	M	M
Decision Available to Enrollee in Easy to Understand Language	M	M	M	NA	M	PM	M	PM	M

Green – M (Met); Yellow – PM (Partially Met); Red – UM (Unmet); White – NA (Not Applicable)

In CY 2020, eight of the nine MCOs had appeals. JMS had no appeals during the timeframe for record review. Review of MCO appeal records demonstrated that three MCOs (ACC, MSFC, and UHC) of the eight MCOs received a finding of Met in all applicable categories.

All MCOs received a Met finding for “Processed Based Upon Level of Urgency” except ABH, as processing and notification of resolution of an expedited appeal was significantly delayed resulting in a Partially Met finding.

Denials of requests for an expedited resolution were found within the sample of records reviewed from ABH, CFCHP, and KPMAS. All three MCOs received a finding of Partially Met for compliance with verbal notification of denial of an expedited request, as there was no evidence of a reasonable attempt to provide the enrollee with prompt oral notification of the denial. ABH received an Unmet and KPMAS a Partially Met for compliance with written notification of the denial of an expedited request.

Requests for an expedited resolution were documented in case records for four MCOs (ABH, CFCHP, PPMCO, and UHC). There were no expedited requests in the sample of records reviewed from ACC, JMS, KPMAS, MPC, and MSFC. Two of the MCOs (CFCHP and UHC) received a finding of Met for documenting a reasonable attempt to provide oral notification of the resolution to the enrollee. Review of case records from the two remaining MCOs (ABH and PPMCO) provided no evidence of a reasonable attempt to provide the enrollee with oral notification of the resolution resulting in a finding of Unmet. Three of the MCOs (CFCHP, PPMCO, and UHC) demonstrated compliance with the 72-hour timeframe for resolving and providing the enrollee with written notice of an expedited resolution. ABH received a finding of Unmet for compliance with this timeframe.

Six of the eight applicable MCOs (ACC, CHCHP, MPC, MSFC, PPMCO, and UHC) demonstrated full compliance with providing the enrollee with a written resolution for a non-emergency appeal within the required timeframe. Two MCOs (ABH and KPMAS) received a Partially Met finding as they did not consistently meet the non-emergency timeframe for sending enrollees an appeal resolution letter.

All MCOs received a finding of Met, as applicable, in two categories, “Appeal Decision Documented” and “Decision Made by Health Care Professional with Appropriate Expertise.”

All but two of the eight applicable MCOs (MPC and PPMCO) received a finding of Met for “Decision Available to Enrollee in Easy to Understand Language.” Both MCOS received a Partially Met finding as their resolution letters were not consistently written in plain language.

Pre-Service Denial Results

Actions and decisions regarding services to enrollees that require PA 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 PA. 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 implementing the new requirements. Updates to COMAR 10.67.09.04 resulting from CMS regulatory changes to PA determination timeframes included 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 PA 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 timeframes:
  - 24 hours from the date of determination for emergency, medically related requests;
  - 72 hours from the date of determination for non-emergency, 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.

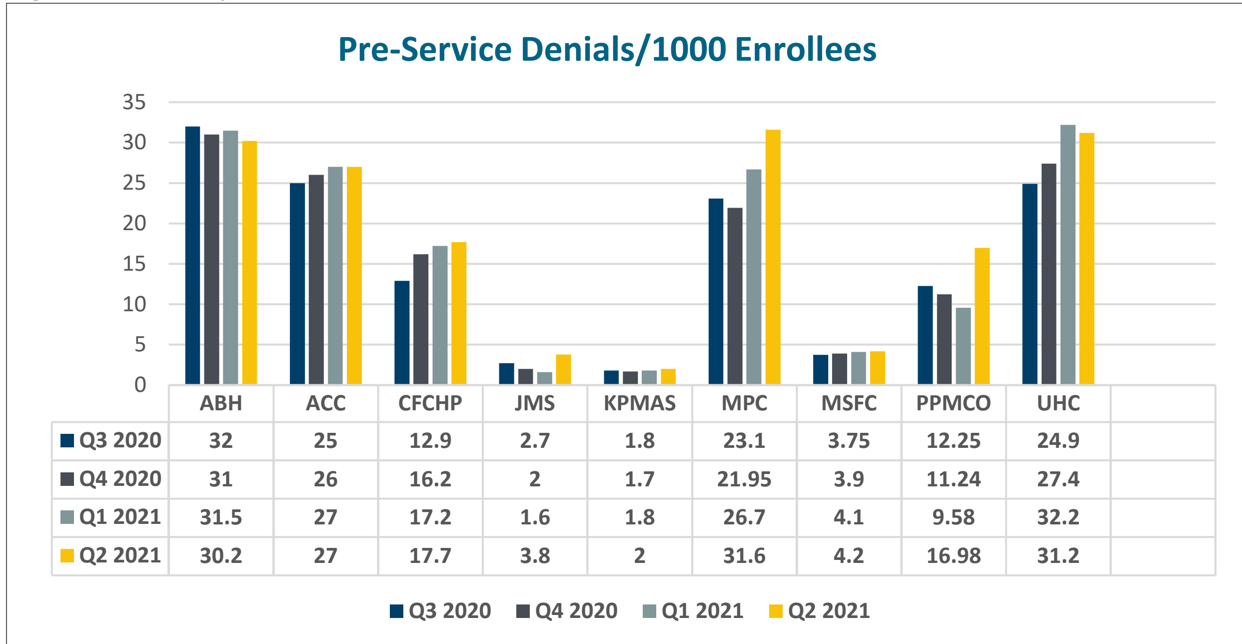
The MCO pre-service denial review encompassed the following comparative statistics and compliance with federal and state laws and regulations:

- Comparative Statistics:
  - Pre-service Denials Rendered Per 1000 Enrollees
  - 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 Enrollees 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 timeframe 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 the date of initial request.
  - For outpatient pharmacy requests within 24 hours of a PA request.
  - For expedited requests, determination and notice no later than 72 hours after receipt of request for service.
- Adverse determination notification timeframe 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 PA 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 quarterly comparison of MCO reported pre-service denials per 1000 enrollees.

Figure 3. MCO Reported Pre-Service Denials/1000 Enrollees



	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2020	32	25	12.9	2.7	1.8	23.1	3.75	12.25	24.9
Q4 2020	31	26	16.2	2	1.7	21.95	3.9	11.24	27.4
Q1 2021	31.5	27	17.2	1.6	1.8	26.7	4.1	9.58	32.2
Q2 2021	30.2	27	17.7	3.8	2	31.6	4.2	16.98	31.2

The rates of pre-service denials per 1000 enrollees have varied among MCOs but have generally remained within a fairly narrow range within each MCO over the first three quarters. Both MPC and PPMCO experienced recent spikes as a result of delegating utilization review of several specialty

services. As noted in the 2020 annual report for grievances, appeals, and denials, 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 ranking of the pharmacy services category by MCO for each of the four quarters of the review period.

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

Quarter	ABH	ACC	CFCHP	JMS*	KPMAS	MPC	MSFC	PPMCO*	UHC*
Q3 2020	1st	1st	1st	1st	NA	2nd	1st	1st	1st
Q4 2020	1st	1st	1st	1st	NA	2nd	1st	1st	1st
Q1 2021	1st	1st	1st	1st	NA	2nd	1st	1st	1st
Q2 2021	1st	1st	1st	1st	NA	2nd	1st	2nd	1st

NA - Not Applicable/No data reported
*MCOs reporting Pharmacy services: Chronic pain management on their 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 except KPMAS, as KPMAS did not report any pharmacy denials during the review period. Six MCOs (ABH, ACC, CFCHP, JMS, MSFC, and UHC) reported Pharmacy Services as the top service category for all four quarters in the review period. PPMCO reported it as the top service category in three of the four quarters and in second place in the remaining quarter. MPC reported it in the second spot for all four quarters. Three MCOs (JMS, PPMCO, and UHC) also reported denials related to Pharmacy Services: Chronic pain management within their top five list for all four 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 timeframes. As a result of the COVID-19 public health emergency, MMCOA requested that MDH relax the compliance threshold for PA determination timeliness. MDH agreed to relax the threshold from 95% to 90% during the COVID-19 public health emergency. This lowered threshold remained in place throughout the period under review.

Table 10. MCO Reported Compliance with Pre-Service Determination Timeframes (Quarterly Reports)

Report Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Compliance with Expedited Pre-Service Determination Timeframes for Medical Denials									
Q3 2020	**100%**	**95%**	**100%**	**NA**	**100%**	**100%**	**100%**	**50%**	**100%**
Q4 2020	**100%**	**91%**	**100%**	**NA**	**NA**	**100%**	**100%**	**73%**	**96%**
Q1 2021	**100%**	**96%**	**100%**	**NA**	**100%**	**97%**	**NA**	**85%**	**100%**
Q2 2021	**100%**	**95%**	**NA**	**NA**	**100%**	**100%**	**100%**	**96%**	**100%**

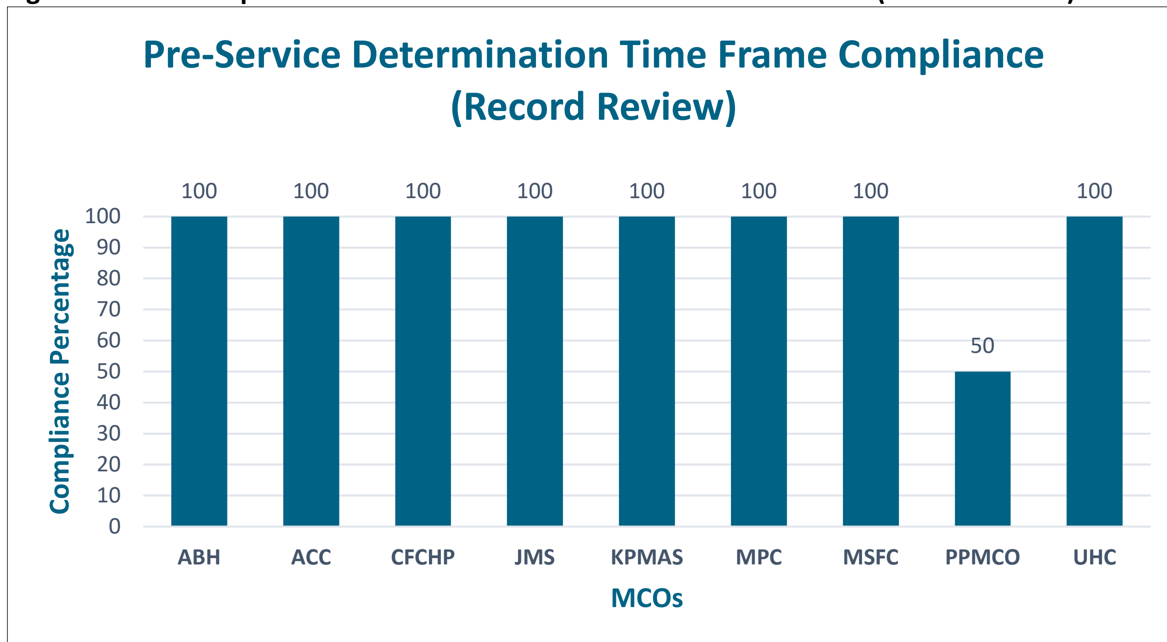
Report Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Compliance with Standard Pre-Service Determination Timeframes for Medical Denials									
Q3 2020	**91%**	**95%**	**99%**	**NA**	**99%**	**100%**	**100%**	**83%**	**99%**
Q4 2020	**74%**	**96%**	**96%**	**100%**	**99%**	**98%**	**100%**	**89%**	**98%**
Q1 2021	**89%**	**96%**	**98%**	**75%**	**98%**	**99%**	**100%**	**99%**	**99%**
Q2 2021	**98%**	**97%**	**71%**	**100%**	**99%**	**100%**	**100%**	**100%**	**99%**
Compliance with Outpatient Pharmacy Pre-Service Determination Timeframes for Denials									
Q3 2020	**100%**	**100%**	**100%**	**100%**	**NA**	**99%**	**99%**	**94%**	**100%**
Q4 2020	**100%**	**100%**	**99%**	**100%**	**NA**	**99%**	**100%**	**99%**	**100%**
Q1 2021	**100%**	**100%**	**100%**	**98%**	**NA**	**99%**	**98%**	**99%**	**100%**
Q2 2021	**100%**	**100%**	**100%**	**100%**	**NA**	**99%**	**98%**	**99%**	**100%**

Green – M (Met); Red – UM (Unmet- did not meet the relaxed 90% threshold); White – NA (Not Applicable)

Five of the MCOs (ACC, KPMAS, MPC, MSFC, and UHC) Met or exceeded the compliance threshold for all applicable categories in each of the four quarters. All MCOs Met or exceeded the compliance threshold for outpatient pharmacy determinations for all four quarters. PPMCO was the only MCO that did not meet the compliance threshold for expedited requests, as PPMCO fell below in three of the four quarters. Two MCOs (CFCHP and JMS) missed the compliance threshold for standard requests in one quarter while ABH and PPMCO fell below in two of the four quarters.

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 2020. Results are highlighted in Figure 4.

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



Review of the record sample demonstrated that all MCOs, with the exception of PPMCO, exceeded the 90% threshold for pre-service determination timeframe compliance. PPMCO, at 50% compliance, was well below the 90% threshold.

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 2020. 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	Letter Components – Incorrect Timeframes
ACC	Letter Components – Incorrect Timeframes
CFCHP	Use of Plain Language in Enrollee Letters
JMS	None
KPMAS	None
MPC	None
MSFC	None
PPMCO	Determination Turn Around Times & Use of Plain Language in Enrollee Letters
UHC	None

Results of MCO-reported compliance with adverse determination notification timeframes based on the quarterly reports are highlighted in Table 12. In addition to relaxing the compliance threshold for PA determination timeliness during the Covid-19 public health 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 Timeframes (Quarterly Reports)

Report Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Compliance with Expedited Medical Adverse Determination Notification Timeframes									
Q3 2020	100%	96%	100%	NA	100%	100%	100%	75%	100%
Q4 2020	100%	100%	100%	NA	NA	100%	100%	73%	96%
Q1 2021	100%	100%	100%	NA	100%	92%	NA	85%	100%
Q2 2021	100%	94%	NA	NA	100%	100%	100%	96%	100%
Compliance with Standard Medical Adverse Determination Notification Timeframes									
Q3 2020	99%	95%	100%	NA	100%	99%	100%	80%	100%
Q4 2020	97%	97%	100%	100%	99%	99%	100%	85%	100%
Q1 2021	99%	98%	100%	100%	100%	98%	100%	97%	99%
Q2 2021	99%	94%	100%	88%	100%	100%	100%	100%	98%
Compliance with Outpatient Pharmacy Adverse Determination Notification Timeframes									
Q3 2020	100%	100%	100%	100%	NA	100%	97%	100%	100%
Q4 2020	100%	100%	100%	100%	NA	100%	100%	100%	100%
Q1 2021	100%	100%	99%	100%	NA	100%	97%	100%	100%
Q2 2021	100%	100%	100%	100%	NA	100%	97%	100%	100%
Compliance with Prescriber Notification of Outcome within 24 Hours									
Q3 2020	100%	100%	100%	100%	99%	100%	100%	97%	100%
Q4 2020	100%	100%	100%	100%	98%	100%	100%	99%	100%
Q1 2021	100%	100%	99%	100%	100%	99%	100%	98%	100%
Q2 2021	100%	100%	99%	100%	100%	100%	100%	99%	100%

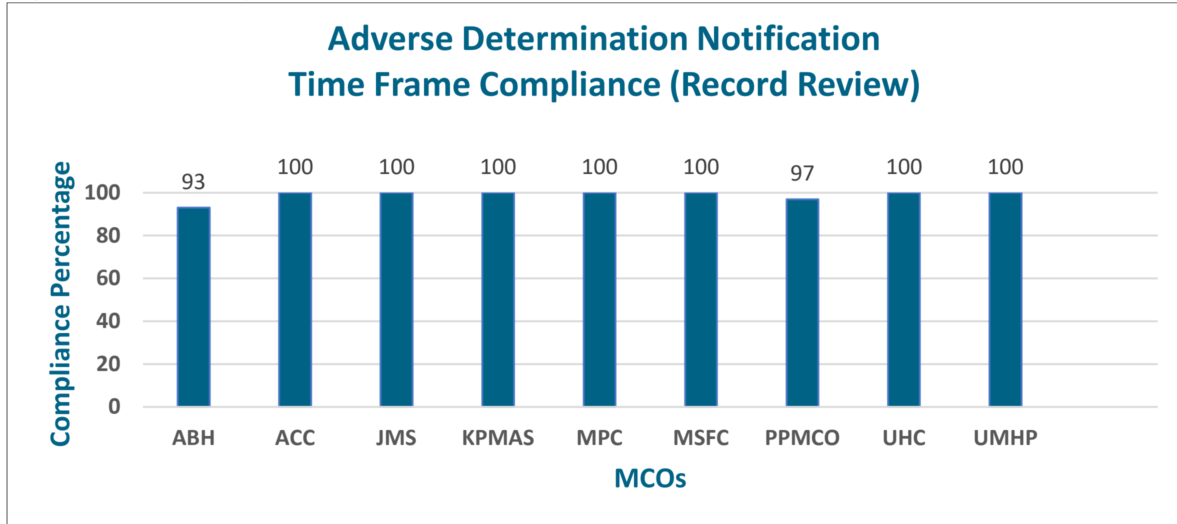
Green – M (Met); Red – UM (Unmet- did not meet the relaxed 90% threshold); White – NA (Not Applicable)

Seven of the MCOs (ABH, ACC, CFCHP, KPMAS, MPC, MSFC, and UHC) Met or exceeded the relaxed 90% threshold for all applicable categories upon review of MCO quarterly reports. All MCOs Met the compliance threshold for outpatient pharmacy adverse determination notifications and prescriber notifications in all four quarters. PPMCO was the only MCO that did not meet the compliance threshold for expedited adverse determination notifications, as PPMCO fell below in three of the four quarters. All MCOs, with the exception of two (JMS and PPMCO), Met the compliance threshold for standard requests. JMS fell below the threshold in one quarter at 88% and PPMCO did not meet the threshold in two quarters at 80% and 85%.

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 2020. 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 Timeframes (Record Review)



All MCOs demonstrated 100% compliance with adverse determination notification timeframes based upon the record review.

Table 13 provides a comparison of adverse determination record review results across MCOs from CY 2020. Results are based upon a random selection of adverse determination records from CY 2020. Reviews were limited to 10 records from each MCO as described above.

Table 13. Results of CY 2020 Adverse Determination Record Reviews

Requirement	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Appropriateness of Adverse Determinations	M	M	M	M	M	M	M	M	M
Compliance with Pre-Service Determination Timeframes	M	M	M	M	M	M	M	PM	M
Compliance with Adverse Determination Notification Timeframes	M	M	M	M	M	M	M	M	M
Required Letter Components	M	M	M	M	M	M	M	M	M
Compliance with Prescriber Notification	M	M	NA	M	NA	NA	M	M	M

Green – M (Met); Yellow – PM (Partially Met); White – NA (Not Applicable/No data reported)

Eight MCOs demonstrated compliance with all requirements. PPMCO received a finding of Partially Met, as its compliance with pre-service determination timeframes fell below the established threshold.

While not specifically reflected in the above scoring for required letter components, opportunities for improvement were noted for several MCOs. ABH and ACC adverse determination letters often included

an additional five days for filing an appeal or requesting continuation of benefits. PPMCO and UHC did not consistently demonstrate that adverse determination letters were written in an easily understood language.

Corrective Action Plans

Quarterly submissions of corrective action plans (CAPs) are in place for several MCOs as a result of continuing opportunities for improvement. MCOs did not receive CAPs relating to grievances. Ongoing CAPs related to adverse determinations and enrollee appeals are as follows:

- Compliance with pre-service determination timeframes – ACC, PPMCO
- Compliance with timeframes for enrollee notification of appeal resolution – ABH, ACC, KPMAS, PPMCO
- Compliance with verbal and written enrollee notification requirements for denial of a request for an expedited appeal – ABH
- Compliance with required adverse determination letters components – ABH

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 timeframes for appeal resolution/notification presents the greatest opportunity for improvement. CAPs through the SPR process are in place to address MCOs with ongoing issues in demonstrating compliance. As necessary, MDH has also instituted a quarterly review to assess progress in CAP implementation and related performance measures. Improvement in compliance is expected during the next review annual cycle as MDH has lowered the appeal-timeliness threshold from 100% to 95%.

As a result of opportunities identified following the 2020 focused review, MDH:

- Transferred responsibility for review and approval of Hepatitis C medication PA requests to the MCOs as of January 1, 2021. A new category to track Hepatitis C pre-service denials has been established with reporting to begin as of the fourth Quarter 2021. This change has eliminated confusion among some MCOs as to Hepatitis C reporting requirements.
- Issued guidance to the MCOs regarding the processing of standard and written appeal requests filed by a provider on behalf of an enrollee to ensure the requirement for enrollee-written consent does not present an access to care barrier.
- As an interim step to address the absence of COMAR language requiring written acknowledgment and written resolution of an enrollee grievance, MDH has included MCO requirements in the CY 2021 SPR standards for providing enrollees written acknowledgment of grievance receipt and sending the enrollee a written resolution of their grievance within a timeframe established by the MCO.

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

- **MDH, Continued Opportunity:** Require MCOs to implement routine quality oversight of all grievance, appeal, and denial quarterly report submissions. This is a carryover recommendation from the 2020 Annual Report. Annual, individual meetings between MCOs and MDH to discuss this issue were delayed due to the COVID-19 public health emergency.
- **MDH, Continued Opportunity:** Explore options to support data quality of MCO quarterly grievance, appeal, and denial reports. This is a carryover recommendation from the 2020 Annual Report. Annual, individual meetings between MCOs and MDH to discuss this issue were delayed due to the COVID-19 public health emergency.
- **MDH, Continued Opportunity:** Cross-check MCO-reported provider grievances with grievances that are submitted to MDH to ensure all grievances are accounted for in MCO report submissions. This is a carryover recommendation from the 2020 Annual Report and is currently on hold until resources are available.
- **MDH, Continued Opportunity:** Consider conducting a focused record review of pharmacy-related denials and appeals to determine key factors of the consistently high volume among MCOs. This is a carryover recommendation from the 2020 Annual Report and is currently on hold until resources are available.
- **MDH, New Opportunity:** Consider including compliance with timeframes for sending written acknowledgment of grievance receipt, written resolution of grievance, and written acknowledgment of appeal receipt in the quarterly grievance and appeal reports submitted by the MCOs. This supports inclusion of these requirements in the CY 2021 SPR standards.
- **MDH, New Opportunity:** When aligning MCO quarterly grievance reporting fields with a new CMS state-reporting template, assess the need for additional grievance service categories. Based upon a review of grievances assigned to the “Other” category, consider developing two new service categories. The inclusion of “Quality of Facility” would address care delivered outside of the practitioner’s office, such as multi-specialty sites, hospitals, rehabilitation centers, and labs and radiology provider sites.
- **MCOs, Continued Opportunity:** 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, Continued Opportunity:** Educate appeal staff to process appeals filed by a provider on behalf of the enrollee consistent with the transmittal issued by MDH on March 16, 2020.
- **MCOs, Continued Opportunity:** Educate PA staff on requirements to request additional clinical information, as needed, within two business days of receipt of the PA request, and make a determination within two business days of receipt of additional clinical information. This is a carryover recommendation from the 2020 Annual Report and has been highlighted in the CY 2021 SPR standards.
- **MCOs, Continued Opportunity:** The number of provider grievances continues 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 workgroup to address the various points of entry and develop a process for aggregating all grievances to support accurate reporting. This is a carryover recommendation from the 2020 Annual Report. While several

MCOs have shown some improvement in identifying and reporting provider grievances, opportunities for improvements remain among other MCOs.

Conclusions

This report includes studies of MCO grievance, appeal, and denial quarterly reports from the third quarter of 2020 through the second quarter of 2021. Additionally, a sample of grievance, appeal, and adverse determination records was reviewed for CY 2020. Based upon the outcomes of these studies and 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 enrollees 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
- Timely written acknowledgment of receipt of enrollee grievances
- Full documentation of grievance issues
- Timely resolution of enrollee and provider grievances
- Grievance resolution letters sent to enrollees
- Appeals processed based upon the level of urgency
- Appeal decisions made by a health care professional with appropriate expertise
- Appeal decisions are documented and available to the enrollee in easy to understand language
- Timely pre-service determinations
- Timely pre-service adverse determination written notifications
- Timely prescriber notifications of PA review outcome
- 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/written notification of enrollee appeal resolutions

As noted in the Limitations section, the validity of the data submitted by the MCOs, while much improved, 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. It is anticipated that subsequent reporting will continue to yield a greater level of confidence in the review outcomes for annual reporting.

Appendix A

MCO-Specific Summaries

Summarized MCO 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 2020 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
- Improvements
- Opportunities
- Recommendations

Additionally, an evaluation of the impact on quality, access, and timeliness has been included for each of the above categories as applicable. For the purpose of this evaluation, Qlarant has adopted the following definitions for quality, access, and timeliness:

- **Quality**, as it pertains to external quality review, is defined as "the degree to which an MCO or Prepaid Inpatient Health Plan increases the likelihood of desired health outcomes of its participants (as defined in 42 CFR 438.320[2]) through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge." ([CMS], Final Rule: Medicaid Managed Care; 42 CFR Part 400, et. al. Subpart D– Quality Assessment and Performance Improvement, [June 2002]).
- **Access** (or accessibility), as defined by the National Committee for Quality Assurance, is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and enrollee services." (2006 Standards and Guidelines for the Accreditation of Managed Care Organizations).
- **Timeliness**, as it relates to utilization management decisions and as defined by the National Committee for Quality Assurance, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care." (2006 Standards and Guidelines for the Accreditation of Managed Care Organizations). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care." (Envisioning the National Health Care Quality Report, 2001).

Due to the limited impact on access across all MCOs, we have not included Access as a category in the below table.

Quality	Timeliness	NA	Aetna Better Health of Maryland	
		√	**Trends**	• Reported enrollee grievances per 1000 rates demonstrated a steady increase for the first three quarters of the review period, with a decrease reported for the second quarter. • Reported grievances per 1000 providers over the four quarters of the review period demonstrate a consistent downward trend. • Billing/financial issues have represented the vast majority of provider grievances. • The rate of pre-service denials per 1000 remained relatively stable, while appeals per 1000 demonstrated a downward trend. • Pharmacy services was the top denial and appeal service category for all four quarters.
		√	**Comparison to Other MCOs**	• Enrollee grievances per 1000 are near the middle of the MCO range. Provider grievances per 1000 ranged from low to mid-range. • The appeals per 1000 rate is mid-range. • The denials per 1000 rate is at the high end of the MCO range.
	√		**Compliance**	• Written acknowledgment of grievance receipt was evident in only 33% of the records reviewed. • Enrollee grievance resolution timeframes were fully Met in two of the four quarters. Provider grievances were fully Met in three of the four quarters. • Timeframes for appeal resolution/written notification were either Partially Met or Unmet. • Compliance with verbal notification of denial of an expedited appeal request was Partially Met, and verbal notification of an expedited appeal decision was Unmet based upon the sample of records reviewed. • Pre-service determination timeframes Met or exceeded the compliance threshold in all categories in two of the four quarters. • Adverse determination notification timeframes Met or exceeded the compliance threshold for all categories in each of the four quarters.

Quality	Timeliness	NA	Aetna Better Health of Maryland	
√			**Strengths**	• Consistent compliance was demonstrated in meeting the timeframes for adverse determination notifications. • Grievance records were well organized with an excellent layout and included a full description of the grievance and appropriate resolution. • All enrollee 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.
√	√		**Improvements**	• Adverse determination notifications Met or exceeded the compliance threshold in all quarters. • Consistent use of the approved appeal resolution template was demonstrated.
√	√		**Opportunities**	• Improve consistency in demonstrating compliance with time frame requirements for written acknowledgement of grievances. • Improve consistency in demonstrating compliance with enrollee and provider grievance resolution, appeal resolution/notification, and pre-service determination timeframes. • Improve consistency in documenting reasonable attempts to provide enrollees with prompt verbal notice of a denial of an expedited appeal resolution. • Improve consistency in documenting reasonable attempts to provide enrollees with prompt verbal notice of an expedited appeal resolution. • Adverse determination letters include correct timeframes for appeals and the continuation of benefits.
√	√		**Recommendations**	• Conduct a barrier analysis and implement associated action plans to ensure compliance with all regulatory timeframes for grievances, appeals, pre-service determinations, and adverse determination notifications, including oral and written notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Routinely audit a sample of adverse determination letters, including those issued by delegated entities, to ensure the accuracy of content.

Quality	Timeliness	NA	AMERIGROUP Community Care	
		√	**Trends**	• Rates of reported grievances per 1000 enrollees have remained relatively stable over the review period of this report. • After a slight downward trend during the first three quarters of the review period, the rate of reported provider grievances demonstrated a fairly large increase in the second quarter. • Billing/financial issues have represented the vast majority of provider grievances. • The rates of pre-service denials and appeals per 1000 have remained relatively stable over the review period. • Pharmacy services was the top pre-service denial category and occupied the second spot for appeals in all four quarters
		√	**Comparison with Other MCOs**	• Enrollee grievances per 1000 are near the middle of the MCO range. The provider grievances per 1000 rate is mid-MCO range. • 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**	• Enrollee grievance resolution timeframes were fully Met in all four quarters. Provider grievance resolution timeframes were fully Met in three of the four quarters. • Timeframes for written notification of appeal resolution were either Partially Met or Unmet. • Pre-service determination timeframes consistently Met the relaxed compliance threshold in all service categories for all four quarters. • Notification timeframes Met or exceeded the relaxed compliance threshold for all four quarters.
√			**Strengths**	• Consistent compliance demonstrated in meeting timeframes for enrollee grievance resolutions, pre-service determinations, and adverse determination notifications. • Enrollee grievances and steps to resolve were well described in case notes and resolution letters. • Enrollee grievance and appeal resolution and adverse determination letters were written in plain language.
√			**Best Practices**	• Reasons for both upheld and overturned decisions of a denial upon appeal were clearly and fully described in appeal resolution letters.

Quality	Timeliness	NA	AMERIGROUP Community Care	
√	√		**Improvements**	• Effective management of the grievance process has resulted in improvements in case record documentation, categorization of grievances, and compliance with regulatory timeframes. • Compliance with enrollee grievance resolution timeframes has been consistently demonstrated. • Compliance with pre-service determination and adverse determination notification timeframes has been consistently demonstrated.
√	√		**Opportunities**	• Consistent compliance with resolving provider grievances within regulatory timeframes. • Consistency in demonstrating compliance with appeal resolution/ notification timeframes. • Adverse determination letters include correct timeframes for appeals and the continuation of benefits.
√	√		**Recommendations**	• Conduct a barrier analysis and implement associated action plans to ensure compliance with all regulatory timeframes for provider grievances and enrollee appeals. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Routinely audit a sample of adverse determination letters to ensure accuracy of content.
Quality	**Timeliness**	**NA**	**CareFirst Community Health Plan**	
		√	**Trends**	• Both the enrollee and provider grievances per 1000 rates have been trending downward the last two quarters. • Billing/financial issues are the top service category for both enrollee and provider grievances. • The appeal rate per 1000 remained fairly consistent over the four quarters. • Pharmacy Services was the top service category for three quarters and occupied the second spot in the remaining quarter. • The rate of pre-service denials per 1000 demonstrated an upward trend over the review period. • Pharmacy services was the top service category for appeals in all four quarters of the review period.

Quality	Timeliness	NA	CareFirst Community Health Plan	
		√	**Comparison with Other MCOs**	• The enrollee grievances per 1000 rate is at the lower end of the MCO range; the provider grievances per 1000 rate is at the high end of the range. • 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**	• Written acknowledgment of grievance receipt was evident in only 42% of the records reviewed. • Consistent compliance in meeting enrollee and provider grievance resolution timeframes was demonstrated in all four quarters. • Appeal resolution/notification timeframes were consistently Met in all four quarters. • Compliance with verbal notification of denial of an expedited appeal request was evident in only 71% of the records reviewed. • With the exception of one category in one quarter, all pre-service determination timeframes were Met. • Consistent compliance with adverse determination notification timeframes was demonstrated during the review period.
		√	**Strengths**	• Consistent compliance in meeting grievance resolution, appeal resolution/notification, and adverse determination notification timeframes was demonstrated throughout the review period. • Grievance resolution letters provide a full description of the grievance and the required steps to resolve.
√			**Best Practices**	• All appeal resolution letters provided extremely detailed information in plain language to explain the reasoning for an uphold or overturn of the initial denial.
√	√		**Improvements**	• Appropriate categorization of grievances. • Timely mailing of enrollee grievance resolution letters. • Consistent use of adverse determination letter template.
√	√		**Opportunities**	• Grievance resolution letters are supported by comprehensive case notes with full documentation of the grievance and required steps to resolve. • Billing/financial-related enrollee grievances. • Compliance with sending written acknowledgment of enrollee grievances within five calendar days. • Consistent compliance with verbal notification of denial of an expedited appeal request. • Consistent compliance with pre-service determination timeframes. • Adverse determination letters provide an explanation of requested service in plain language.

Quality	Timeliness	NA	CareFirst Community Health Plan	
√	√		**Recommendations**	• Retrain grievance staff on required case documentation and routinely audit a sample of cases to ensure compliance. • Consider conducting a root cause analysis of billing/financial-related enrollee grievances to identify opportunities for improvement. • Monitor timeliness of mailing of grievance acknowledgment letters on a routine basis. • Retrain appeal staff on the requirement for making a reasonable attempt to provide verbal notification of a denial of an expedited appeal request and routinely audit a sample of cases to ensure compliance. • Ensure an effective process is in place for monitoring compliance with regulatory timeframes for pre-service determinations. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Routinely audit a sample of adverse determination letters to ensure consistent use of plain language.

Quality	Timeliness	NA	Jai Medical Systems, Inc.	
		√	**Trends**	• The rate of reported grievances per 1000 enrollees demonstrates an uneven but overall upward trend since the third quarter. • Billing/financial issues represented the majority of enrollee grievances in the first three quarters of the review period, with a decline to 42% in the last quarter. • The rate of reported grievances per 1000 providers increased in the second quarter from a stable rate the prior two quarters. • JMS had no appeals in three of the four quarters and only one for pharmacy services in the remaining quarter. According to JMS, this is related to the relaxing of requirements for Hepatitis C treatment. • Pre-service denials per 1000 have remained relatively stable over the review period with a slight upward tick in the last quarter. • 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 enrollee 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 were at or very near the bottom of the range.

Quality	Timeliness	NA	Jai Medical Systems, Inc.	
	√		**Compliance**	• Resolution timeframes for enrollee and provider grievances were consistently Met during the review period. • The appeal resolution timeframe was consistently Met for the one applicable quarter. • With the exception of one category in one quarter, all pre-service determination and adverse determination notification timeframes were Met.
√			**Strengths**	• All grievance resolution timeframes were consistently Met during the review period. • All enrollee grievance letters were written in plain language with a full description of the grievance and an appropriate resolution. • All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial.
	√		**Improvements**	• Consistent compliance was demonstrated with resolution timeframes for enrollee grievances.
√	√		**Opportunities**	• Billing/financial enrollee grievances. • Consistent compliance with pre-service determination and adverse determination notification timeframes.
√	√		**Recommendations**	• Ensure an effective process is in place for monitoring compliance with all regulatory timeframes for pre-service determinations and adverse determination notification timeframes. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Consider conducting a root cause analysis of billing/financial-related enrollee grievances to identify opportunities for improvement.
Quality	**Timeliness**	**NA**	**Kaiser Permanente of the Mid-Atlantic States, Inc.**	
		√	**Trends**	• The reported rate of enrollee grievances per 1000 has trended much higher in the last two quarters of the review period. • Enrollee grievances relating to attitude/service have represented the majority of KPMAS grievances ranging from 54% to 67%. • KPMAS has consistently reported the absence of provider grievances. • The appeal rate per 1000 has varied within a narrow range over the four quarters. • The rate of pre-service denials per 1000 was fairly consistent during the review period. • Medical/Surgical pre-service denials remained the top service category for all four quarters.

Quality	Timelines	NA	Kaiser Permanente of the Mid-Atlantic States, Inc.	
		√	**Comparison with Other MCOs**	• KPMAS was a major outlier in its enrollee grievances per 1000 rate for all four quarters. • KPMAS is the only MCO that has consistently reported no provider grievances. • The appeal rate per 1000 is near the bottom of the MCO range. • The rate of pre-service denials per 1000 was at or slightly above the bottom of the range of the other MCOs, possibly due to KPMAS' model. • KPMAS is the only MCO that reported no pre-service denials for pharmacy services.
√	√		**Compliance**	• Compliance with the resolution timeframes for enrollee grievances was Met in each of the four quarters. • Grievance resolution letters were found in 97% of the sample of records reviewed. • Notification of appeal resolution demonstrated full compliance in three of the four quarters. • The approved appeal letter template was used in only 40% of • the sample of records reviewed. • No documentation was available to support verbal notification of the denial of an expedited appeal request in two of three records reviewed, and no evidence of written notification was included in one of the records. • KPMAS consistently Met regulatory timeframes for pre-service determinations and adverse determination notifications.
√			**Strengths**	• Consistent compliance was demonstrated in meeting the timeframes for the resolution of enrollee grievances, pre-service determinations, and adverse determination notifications. • Thorough documentation of grievance and required steps to resolve was evident in all case notes of records reviewed. • 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.
√	√		**Improvements**	• Consistent compliance was demonstrated in sending acknowledgment of grievance receipt to enrollees and resolving grievances within regulatory timeframes. • Grievance resolution letters consistently include a description of the grievance and its resolution. • Adverse determination letters reflect accurate calculation of appeal filing deadlines.

Quality	Timeliness	NA	Kaiser Permanente of the Mid-Atlantic States, Inc.	
√	√		**Opportunities**	• Consistent compliance with sending enrollees a grievance resolution letter. • High percentage of attitude/service-related enrollee grievances. • Consistent compliance with appeal resolution/notification timeframes. • MDH-approved appeal letter templates are consistently used. • Consistent compliance with verbal and written notification of denial of an expedited appeal request.
√	√		**Recommendations**	• Conduct routine audits of enrollee records to ensure that all grievances receive a written resolution letter. • Consider conducting a root cause analysis of service/attitude-related enrollee grievances to identify opportunities for improvement. • Ensure an effective process is in place for monitoring compliance with all regulatory timeframes for appeal resolutions/notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Conduct routine audits of enrollee records to ensure consistent use of appeal letter templates. • Retrain appeal staff and audit appeal case records to ensure there is documentation of a reasonable attempt to provide verbal and written notification of denial of an expedited appeal request.
Quality	**Timeliness**	**NA**	**Maryland Physicians Care**	
		√	**Trends**	• The enrollee grievances per 1000 rate has steadily increased over the last two quarters. • The rate per 1000 of provider grievances increased slightly from the first to the second quarter with no grievances reported in the third and fourth quarters. • The rate of appeals per 1000 has increased considerably over the last two quarters, which MPC attributed to implementing a cardiology program. • Pharmacy Services occupied one of the top two appeal service category spots for all four quarters. • The rate of pre-service denials per 1000 has been steadily increasing the last two quarters. • Pharmacy related pre-service denials occupied the second spot in the top five service category list for all four quarters.

Quality	Timeliness	NA	Maryland Physicians Care	
		√	**Comparison with Other MCOs**	• The enrollee grievances per 1000 rate is at the mid-range. • For the last two reported quarters, MPC is at the low end of the range in provider grievances per 1000. No grievances were reported for the first two quarters of the review period. • The appeal rate per 1000 is approaching the higher end of the range. • The rate of pre-service denials per 1000 is at the higher end of the MCO range.
	√		**Compliance**	• MPC met the resolution timeframe for enrollee and provider grievances in all applicable quarters. • Appeal resolution timeframes were Met in three of the four quarters. • The compliance threshold for pre-service determinations and adverse determination notifications was Met or exceeded for all service categories in all four quarters.
√	√		**Strengths**	• Consistent compliance in meeting timeframes for grievances, pre-service determinations, and adverse determination notifications was demonstrated throughout the review period. • 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 adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial.
√	√		**Improvements**	• Consistent compliance was demonstrated in meeting all grievance resolution timeframes. • Appeals are consistently processed based upon the level of urgency. • Receipt date of the appeal is not revised to reflect the date of written consent. • Appeal decisions are made by health care professionals with appropriate clinical expertise consistent with the MCO's policies.
√	√		**Opportunities**	• Consistent compliance with timeframes for appeal resolution/notification. • All appeal resolution letters are written in plain language.
√	√		**Recommendations**	• Ensure an effective process is in place for monitoring compliance with all regulatory timeframes for appeals. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Routinely audit a sample of appeal resolution letters to ensure they are written in plain language. Retrain letter staff, as indicated.

Quality	Timeliness	NA	MedStar Family Choice, Inc.	
		√	**Trends**	• The enrollee grievances per 1000 rate has consistently declined over the four quarters under review. • Access-related grievances range from over 50% in the third and fourth quarters to 33% in the second quarter. • MSFC reported no provider grievances for the third and second quarters of the review period. The rate per 1000 increased slightly from the fourth to the first quarter. • The appeal rate per 1000 demonstrates an uneven but upward trend. • Pharmacy services was the top appeal service category for all four quarters. • The rate of pre-service denials per 1000 demonstrated a slight but steady increase over the review period. • Pharmacy services was the top denial service category for all four quarters.
		√	**Comparison with Other MCOs**	• The rate of enrollee grievances per 1000 is at the lower end of the MCO range, as is the provider rate for the two reported quarters. • The appeals per 1000 rate is at the lower end of the range. • The rate of pre-service denials per 1000 has remained at the low end of the MCO range.
	√		**Compliance**	• Compliance with resolution timeframes for enrollee and provider grievances was fully Met in all applicable quarters. • Appeal/notification timeframes were Met in all four quarters. • Pre-service determinations and adverse determination notification timeframes Met or exceeded the compliance threshold in all categories.
√	√		**Strengths**	• Consistent compliance was demonstrated with all timeframes for grievances, appeals, pre-service determinations, and adverse determination notifications. • Case notes and resolution letters fully describe the grievance and steps to resolve. • All grievance letters were written in plain language. • All appeal resolution letters are in plain language and provide a detailed explanation of the reason for the uphold decision. • All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial.
√			**Best Practices**	• Enrollee resolution letters related to provider quality of service grievances include the provider's response.
	√		**Improvements**	• Consistent compliance was demonstrated with meeting regulatory timeframes for enrollee grievance resolutions.

Quality	Timeliness	NA	MedStar Family Choice, Inc.	
			Improvements (continued)	• Consistent compliance was demonstrated with meeting regulatory timeframes for pre-service determinations and adverse determination notifications.
	√		**Opportunities**	• Appeal receipt date is not changed to reflect the date of enrollee consent.
	√		**Recommendations**	• Retrain appeals staff to ensure the appeal receipt date is not revised to the date of written consent, and revise appeal policies and procedures accordingly.
Quality	**Timeliness**	**NA**	**Priority Partners**	
		√	**Trends**	• The rate of enrollee grievances per 1000 remained fairly consistent over the four quarters reviewed. • Attitude/service issues were the top service category for all four quarters ranging from 41% to 50%. • The rate of provider grievances per 1000 steadily increased over the review period, spiking in the second quarter. According to the MCO, this increase was primarily driven by authorization denials (Evicore and pharmacy related) and claims disputes, over half of which were for lack of ePREP completion. • The rate of appeals per 1000 spiked in the fourth quarter and has remained relatively stable since then. According to PPMCO, this increase is most likely the result of now classifying all provider expedited appeals as enrollee appeals. • Pharmacy Services was the top appeal service category for all four quarters. • The rate of pre-service denials per 1000 increased considerably in the second quarter, after a downward trend demonstrated in the prior quarters. According to PPMCO, this spike is the result of Evicore now reporting all required fields. • Pharmacy services was the top service category for pre-service denials for three of the four quarters, and occupied the second spot in the remaining quarter.
		√	**Comparison with Other MCOs**	• Enrollee grievances are at the bottom of the MCO range. • Provider grievances moved from the bottom of the range of grievances in the first two quarters to near the top or at the top of the range in the subsequent two quarters. • The appeals per 1000 rate began the review period at the bottom of the range, but moved to the higher end of the range in the subsequent three quarters. • The rate of pre-service denials per 1000 is at mid-range.

Quality	Timeliness	NA	Priority Partners	
√	√		**Compliance**	• PPMCO Met enrollee grievance resolution timeframes in three of the four quarters. • Compliance with resolution timeframes for provider grievances was fully Met in all four quarters. • Compliance with appeal resolution timeframes has been demonstrated in two of the four quarters. • There was no evidence of verbal or written enrollee consent for appeals filed by a provider on behalf of the enrollee. • There was no evidence in case notes of a reasonable attempt to provide the enrollee with oral notification of an expedited appeal resolution. • Pre-service determination and adverse determination notification timeframes did not meet the relaxed compliance threshold consistently in three quarters.
√	√		**Strengths**	• Grievances and their resolution are well documented in case notes and resolution letters. • Consistent compliance was demonstrated in meeting the resolution timeframe for provider grievances.
√	√		**Improvements**	• Appropriate categorization of grievances (emergency-medically related, non-emergency medically related, and administrative) was demonstrated. • Appeals are processed based upon the level of urgency. • Adverse determination letters consistently identify the correct deadline for requesting continuation of benefits.
√	√		**Opportunities**	• Consistent compliance with enrollee grievance resolution timeframes. • Attitude/service-related enrollee grievances. • Compliance with reasonable attempt to provide verbal notification of expedited appeal resolution. • Enrollee consent is documented in a case record when a provider is filing an appeal on behalf of the enrollee. • Consistent compliance with appeal resolution timeframes. • Appeal resolution letters reflect correct calculated dates, appeal receipt dates, and appeal resolution dates. • Consistent compliance with pre-service determination and adverse determination notification timeframes. • If additional clinical information is required it is requested within • 2 business days of receipt of the request. • Appeal and adverse determination letters consistently written in plain language.

Quality	Timeliness	NA	Priority Partners	
√	√		**Recommendations**	• Conduct a root cause analysis and implement associated action plans to ensure consistent compliance with grievance, appeal, 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 attitude/service-related enrollee grievances to identify opportunities for improvement. • Retrain appeal staff and conduct routine audits on appeal case documentation requirements, including verbal notification of an expedited resolution and enrollee consent when a provider is filing an appeal on their behalf. • Audit appeal and adverse determination letters on a routine basis to ensure use of plain language and correct content.
Quality	**Timeliness**	**NA**	**UnitedHealthcare Community Plan**	
		√	**Trends**	• The rate of enrollee grievances per 1000 has been fairly consistent over four quarters. • Billing/financial issues were the top grievance service category for all quarters. • After an increase in the fourth quarter, provider grievances have been steadily decreasing. • The rate of appeals per 1000 has remained relatively stable during the review period. • The rate of pre-service denials per 1000 demonstrated a steady decrease from the third (2020) quarter through the first (2021) quarter, with a slight decline in the second quarter. • 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 enrollee grievances per 1000. • The rate of provider grievances per 1000 was at the higher end of the MCO range in the first two quarters of the review period, moving to mid-range in the remaining two quarters. • The rate of appeals per 1000 is at mid-range. • The rate of pre-service denials per 1000 is near or at the top of the range.

Quality	Timeliness	NA	UnitedHealthcare Community Plan	
√	√		**Compliance**	• Compliance with enrollee and provider grievance resolution timeframes was Met in three of the four quarters. • Compliance with appeal resolution timeframes was Met in two of the four quarters. • Compliance with pre-service determination and adverse determination notification timeframes Met or exceeded the threshold in all four quarters.
√	√		**Strengths**	• Grievances and their resolution are well documented in case notes and in resolution letters. • 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 timeframes was demonstrated 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., PCPs, transportation vendor), as applicable. • Grievance resolution letters are written in plain language and provide a full description of the grievance and the steps required to resolve, including feedback from service providers in response to any quality of service issues. • All enrollee grievance, appeal, and adverse determination letters included the Non-Discrimination Statement in both English and Spanish.
√	√		**Improvements**	• Adverse determination letters consistently identify the correct deadlines for requesting an appeal and continuation of benefits.
√	√		**Opportunities**	• Consistent compliance with the resolution timeframes for enrollee and provider grievances. • Billing/financial related enrollee grievances. • Consistent compliance with appeal resolution/notification timeframes.
√	√		**Recommendations**	• Conduct a root cause analysis and implement associated action plans to ensure consistent compliance with grievance and appeal timeframes. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Consider conducting a root cause analysis of billing/financial-related enrollee grievances to identify opportunities for improvement.

Appendix B

Grievance Review Template

<MCO> Grievances for <X> Quarter <Year> Results & Analysis						
	Current Quarter	**Prior Quarter**	**Qx 20xx**	**Qx 20xx**	**Status**	**Other MCO Results**
Total Enrollee Grievances Received in the Qtr.					○	
Total Enrollee Grievances Resolved in the Qtr.					○	
Grievances/1000 Enrollees					○	
Enrollee Grievances by Category (rate/1000)						
Cat.1: Emergency medically related					○	
Cat. 2: Non-emergency medically related					○	
Cat. 3: Administrative					○	
Top 5 Enrollee Grievances Received by Service Category						**Top 5 Categories**
Service Category (#/%)					○	
Service Category (#/%)					○	
Service Category (#/%)					○	
Service Category (#/%)					○	
Service Category (#/%)					○	
Enrollee 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)
○ Unmet, if applicable (May require a CAP)
NA - Not Applicable

Appendix C

Appeal Review Template

<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					○	
Total Appeals Resolved in the Quarter					○	
Appeals/1000 Enrollees					○	
Enrollee Appeal Sources						
Appeals from Denials Received (#/%)					○	
Appeals Submitted by Enrollees (#/%)					○	
Appeals Submitted by Providers (#/%)					○	
Appeal Outcomes					○	
Upheld (#/%)					○	
Overturned (#/%)					○	
Overturn by Action Type						
Action 1 (#/%)					○	
Action 2 (#/%)					○	
Action 3 (#/%)					○	
Action 4 (#/%)					○	
Action 5 (#/%)					○	
Action 6 (#/%)					○	
Upheld by Action Type						
Action 1 (#/%)					○	
Action 2 (#/%)					○	
Action 3 (#/%)					○	
Action 4 (#/%)					○	
Action 5 (#/%)					○	
Action 6 (#/%)					○	
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)
○ Unmet, if applicable (May require a CAP)
NA - Not Applicable

Appendix D

Pre-Service Denial Review Template

<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					○	
Total A Requests Received with Complete Information (#/%)					○	
Total PA Requests Requiring Additional Information (#/%)					○	
Total PA Requests Approved (#/%)					○	
Total PA Requests Denied (#/%)					○	
Total Pre-Service Denials in the Quarter					○	
Pre-Service Denials for Enrollees Under 21 (#/%)					○	
Standard Pre-Service Medical Denials (#/%)					○	
Expedited Pre-Service Medical Denials (#/%)					○	
Pre-Service Outpt. Pharmacy Denials (#/%)					○	
Pre-Service Denials/1000 enrollees					○	
Top 5 Service Categories						
Top Service Category (#/%)					○	
Top Service Category (#/%)					○	
Top Service Category (#/%)					○	
Top Service Category (#/%)					○	
Top Service Category (#/%)					○	
Top 5 Denial Reasons						
Denial Reason:					○	
Denial Reason:					○	
Denial Reason:					○	
Denial Reason:					○	
Denial Reason:					○	
Determination TAT Met (standard 95% compliance)						

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

Analysis

Recommendations

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