MARYLAND Department of Health

HealthChoice
Maryland's Medicaid Managed Care Program

Medicaid Managed Care Organization

2018 Focused Review Report Grievances, Appeals, and Denials

Calendar Year 2018

Qlarant

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2018 Focused Review Report
Grievances, Appeals, & Denials

Introduction

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

The Maryland Department of Health (MDH) is required annually to evaluate the quality of care (QOC) provided to Maryland Medical Assistance enrollees in HealthChoice Managed Care Organizations (MCOs). MDH, pursuant to 42 CFR 438.204 and Code of Maryland Regulations (COMAR) 10.09.65, is responsible for monitoring the QOC provided to MCO enrollees when delivered. Under Federal law [Section 1932(c)(2)(A)(i) of the Social Security Act], MDH is required to contract with an External Quality Review Organization (EQRO) to perform an independent annual review of services provided under each MCO contract to ensure that the services provided to the enrollees meet the standards set forth in the regulations governing the HealthChoice Program. MDH contracts with Qlarant to serve as the EQRO.

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

Assessment of MCO compliance was completed by applying the performance standards defined for Calendar Year (CY) 2017. Quarterly studies of grievances, appeals, and pre-service denials were conducted for the third and fourth quarters of 2017, and the first and second quarters of 2018. The annual record review encompassed member grievances, appeals, and pre-service denials that occurred during CY 2017. The nine MCOs evaluated during these time frames were:

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

ABH joined the HealthChoice Program in October 2017; therefore quarterly reports were submitted for the fourth quarter of 2017 and thereafter. Additionally, an annual record review for CY 2017 was not completed for ABH, as the MCO was in operation for just over two months of the calendar year.

Purpose and Objectives

The purpose of this review was to:

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

Review objectives addressed the following:

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

Methodology

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

In addition to quarterly reviews of MCO submitted reports, Qlarant conducted an annual record review of a sample of CY 2017 grievance, appeal, and pre-service denial records. Each MCO provided Qlarant with a listing of grievances, appeals, and pre-service denials for CY 2017. Qlarant selected 35 cases from each listing using a random sampling approach and requested that each MCO upload the selected case records to the Qlarant portal. Using the 10/30 rule, an initial sample of 10 grievance, appeal, and 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 this record review, including strengths, best practices, and opportunities for improvement, were provided to MDH. MCOs were also provided with the results from each of the record reviews. Both reports included peer comparisons for each of the review components.

Limitations

Review of quarterly MCO grievance, appeal, and denial reports has identified only minor improvements in the validity of report data over the prior annual report period. Appeal reporting, in particular, includes ongoing formula errors that calculate totals in the quarterly reporting forms and a failure by several of the MCOs (ABH, KPMAS, and MPC) to comply with required reporting elements. Provider administrative appeals were still being included in reports by three MCOs (ACC, KPMAS, and PPMCO) in this review period. Additionally, one MCO (MSFC) has been excluding provider-submitted appeals on behalf of members. Reporting of pre-service denials has had similar issues. Two MCOs (ACC and UHC) were not including denials from at least one of their delegated entities. One MCO (UHC) included inpatient concurrent review denials in its reports. As a result of these continuing opportunities for improvement, caution must be exercised in reviewing the results contained in this report.

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. Such presentation of data facilitates comparisons of MCO performance over time and in relation to peers based on quarterly reports and annual record review results.

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

Met	Compliance consistently demonstrated
Partially Met	Compliance inconsistently demonstrated
Unmet	No evidence of compliance

Grievance Results

A grievance is an expression of dissatisfaction about any matter other than an action and is defined in COMAR 10.09.62.01B(58-1). COMAR 10.09.71.02C(1) describes three categories of grievances:

Category 1: Emergency medically related grievances
Example: Emergency prescription or incorrect prescription provided

Category 2: Non-emergency medically related grievances
Example: DME/DMS-related complaints about repairs, upgrades, vendor issues, etc.

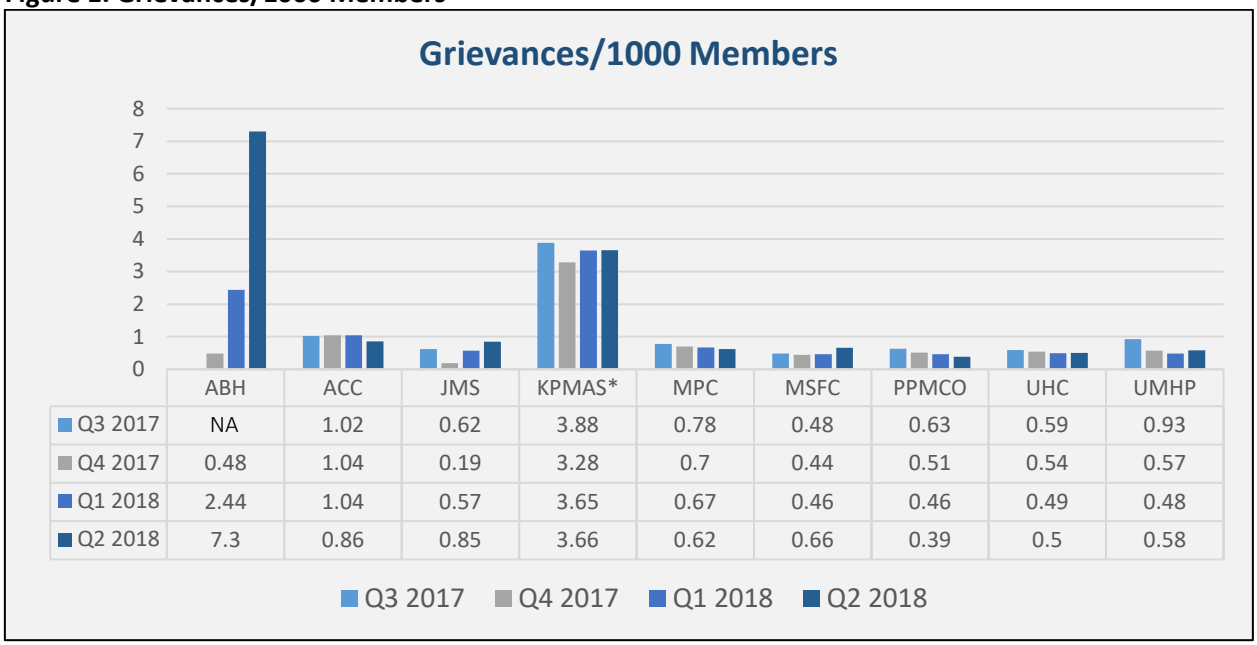
Category 3: Administrative grievances
Example: Difficulty finding a network PCP or specialist

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

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

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

Figure 1. Grievances/1000 Members



	ABH	ACC	JMS	KPMAS*	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017	NA	1.02	0.62	3.88	0.78	0.48	0.63	0.59	0.93
Q4 2017	0.48	1.04	0.19	3.28	0.7	0.44	0.51	0.54	0.57
Q1 2018	2.44	1.04	0.57	3.65	0.67	0.46	0.46	0.49	0.48
Q2 2018	7.3	0.86	0.85	3.66	0.62	0.66	0.39	0.5	0.58

NA – Not Applicable
*Major outlier in comparison to other MCOs

KPMAS was a major outlier in grievances per 1000 members for all four quarters with attitude/service-related categories representing the majority of issues. ABH began reporting in Q4 of 2017. Grievances per 1000 members have been trending upward, however, performance fluctuations are expected from newer MCOs. Grievances per 1000 members for the remaining MCOs fall within a fairly narrow range.

Table 1 offers a comparison of MCO reported grievances per 1000 providers for four quarters.

Table 1. MCO Reported Grievances/1000 Providers

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017	NA	0.00	0.00	0.56	0.22	0.00	0.03	0.00	4.94*
Q4 2017	0.00	0.00	0.00	0.00	0.47	0.00	0.14	0.00	0.87
Q1 2018	0.00	0.00	0.19	0.00	0.29	0.00	1.10*	0.07	0.09
Q2 2018	1.08	0.00	0.00	0.00	0.31	0.38	0.00	0.07	0.00

NA-Not Applicable
*Major outlier in comparison to other MCOs

MCO Reported Grievances per 1000 providers consistently remain low for the majority of MCOs. For third quarter of 2017, UMHP was a major outlier for this measure in comparison to all other MCOs; however, the MCO has demonstrated a downward trend since then. For the first quarter of 2018, PPMCO was a major outlier. For the second quarter of 2018, ABH grievances per 1000 providers exceeded all other MCOs; however, performance fluctuations are expected from newer MCOs.

Comparisons of MCO reported compliance with resolution time frames for member grievances based on MCO quarterly submissions are displayed in Table 2 for four quarters.

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

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017	NA	Met	Met	PM	Met	PM	Met	PM	Met
Q4 2017	Met	Met	Met	PM	Met	PM	Met	Met	PM
Q1 2018	Met	Met	Met	PM	Met	PM	PM	PM	Met
Q2 2018	Met	Met	Met	Unmet	Met	Met	PM	Met	Met

NA-Not Applicable; PM-Partially Met

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

Comparisons of MCO reported compliance with resolution time frames for provider grievances based on MCO quarterly submissions are displayed in Table 3.

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

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017	NA	NA	NA	Met	Met	NA	Met	NA	Met
Q4 2017	NA	NA	NA	NA	Met	NA	Met	NA	Met
Q1 2018	NA	NA	Met	NA	Met	NA	Met	NA	Met
Q2 2018	Met	NA	NA	NA	Met	Met	NA	Met	NA

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

All MCOs, as applicable, met the resolution time frames for provider grievances throughout the four quarters. MCOs that did not receive any provider grievances for the quarter were reported as NA for compliance for that quarter.

Table 4 presents a comparison of the annual grievance record review results across MCOs. Results are based upon a random selection of grievance records during CY 2017. Reviews were conducted utilizing the 10/30 rule.

Table 4. CY 2017 MCO Annual Grievance Record Review Results

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

PM - Partially Met

One MCO (ACC) received a finding of partially met for “Appropriate Classification” as they did not correctly identify the category of the grievance upon receipt. All MCO records reviewed demonstrated full explanation of the grievance issue. Resolution timeliness was met by all MCOs with the exception of MSFC and PPMCO. Two MCOs (JMS and KPMAS) demonstrated an opportunity for improving the appropriateness of the resolution.

Four of the MCOs (ACC, PPMCO, UHC, and UMHP) received a finding of met for the resolution letter component. The remaining five MCOs received a partially met or unmet score due to inconsistent or missing resolution letters within the records reviewed.

Appeal Results

An appeal is a request for a review of an action as stated in COMAR 10.09.62.01B(12-1). The regulation provides the following definitions of an action:

- Action 1: Denial or limited authorization of a requested service, including the type or level of service
- 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 10.09.66.07)
- Action 5: Failure of an MCO to act within the required appeal time frames set in COMAR (i.e., COMAR 10.09.71.05)

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

- MCOs may only have one level of enrollee appeal, and enrollees must first appeal to the MCO before requesting a State fair hearing.
- Except for expedited appeals, MCOs shall resolve each appeal and provide notice of resolution, as expeditiously as the enrolee'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.

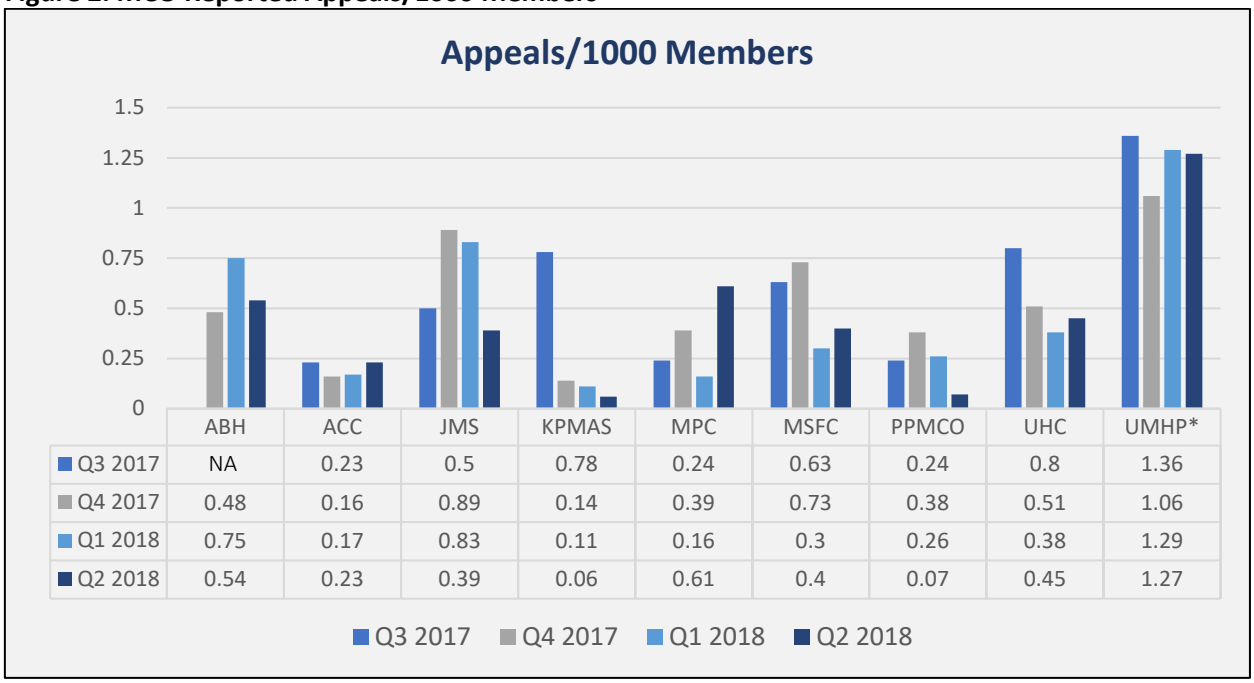
Providers can file appeals on a member's behalf. Maryland's regulations previously did not not require the provider to seek written authorization before filing an appeal on the member's behalf.

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

- Comparative Statistics: Appeals Filed Per 1000 Members
- Resolution Time Frames (based upon 100% compliance)
  - Expedited appeals are required to be completed within three business days.
  - Non-emergency appeals are required to be completed within 30 days, unless an extension is requested.
- Appeal Processing: Appeals are to be processed as expeditiously as the enrollee's health requires.
- Notifications of Denial of an Expedited Request
- Appeal Documentation: Appeal decisions are to be documented fully in the enrollee record.
- Decision Made by Health Care Professional with Appropriate Expertise
- Written Notification: The appeal resolution is to be provided to the enrollee in a written letter and must include results in easy to understand language by the member.

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

Figure 2. MCO Reported Appeals/1000 Members



	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP*
Q3 2017	NA	0.23	0.5	0.78	0.24	0.63	0.24	0.8	1.36
Q4 2017	0.48	0.16	0.89	0.14	0.39	0.73	0.38	0.51	1.06
Q1 2018	0.75	0.17	0.83	0.11	0.16	0.3	0.26	0.38	1.29
Q2 2018	0.54	0.23	0.39	0.06	0.61	0.4	0.07	0.45	1.27

NA – Not Applicable
*Outlier in comparison to other MCOs

UMHP has consistently been at the top of the range in reported appeals per 1000 members in comparison to all other MCOs during all four quarters. MCO-specific trending and comparisons between MCOs, however, is not feasible at this time since several MCOs (ACC, KPMAS, MSFC, and PPMCO) were either including provider administrative appeals or omitting provider appeals on behalf of members in this measure during this time frame. Also, because of these issues it is difficult to assess the impact of moving to one level of appeal beginning February 1, 2018, for those MCOs that previously provided a two-level appeal process.

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

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

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017	NA	Met	Met	PM	Met	PM	PM	PM	Met
Q4 2017	Met	Met	Met	PM	Met	PM	Met	Met	Met
Q1 2018	Met	Met	Met	PM	Met	Met	PM	PM	Met
Q2 2018	Met	Met	Met	Met	Met	Met	Unmet	PM	Met

NA-Not Applicable; PM-Partially Met

Five MCOs (ABH, ACC, JMS, MPC, and UMHP) consistently met appeal resolution time frames for the four quarters reviewed. MSFC demonstrated compliance for two quarters. KPMAS, PPMCO, and UHC demonstrated compliance for one quarter. It does not appear that the change in the resolution time

frame for expedited appeals from three business days to 72 hours effective February 1, 2018, had an impact on MCO compliance results.

Table 6 provides a comparison of appeal record review results across MCOs. Results are based upon a random selection of appeal records reviewed for CY 2017. Reviews were conducted utilizing the 10/30 rule.

Table 6. CY 2017 MCO Appeal Record Review Results

Requirement	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Processed Based Upon Level of Urgency	Met	Met	Met	Met	Met	Met	Met	Met
Compliance with Verbal Notification of Denial of an Expedited Request	NA	NA	NA	NA	NA	NA	NA	Met
Compliance w/ Written Notification of Denial of an Expedited Request	NA	NA	NA	NA	NA	NA	NA	Met
Compliance with Resolution Time Frame for Expedited Appeal	Met	NA	Met	NA	Met	NA	Met	Met
Compliance with Notification Time Frame for Non-Emergency Appeal	Met	Met	Met	Met	Met	Met	Met	Met
Appeal Decision Documented	Met	Met	Met	Met	Met	Met	Met	Met
Decision Made by Health Care Professional w/ Appropriate Expertise	Met	Met	Met	Met	Met	Met	Met	Met
Decision Available to Enrollee in Easy to Understand Language	Met	Met	PM	Met	Met	Met	Met	Met

NA-Not Applicable; PM – Partially Met

All but one MCO demonstrated compliance with each review component. KPMAS received a score of partially met for the requirement to provide the appeal decision to the enrollee in easy to understand language.

Pre-Service Denial Results

Actions and decisions regarding services to enrollees that require preauthorization by the MCO are defined in COMAR 10.09.71.04. The regulation states that the MCO shall make a determination in a timely manner so as not to adversely affect the health of the enrollee and within 2 business days of receipt of necessary clinical information, but no later than 7 calendar days from the date of the initial request. It further details that:

- 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.
- Notices of a decision to deny an authorization shall be provided to the enrollee and the regulation provider within the following time frames:
  - 24 hours from the date of determination for emergency, medically related requests; and
  - 72 hours from the date of determination for nonemergency, medically related requests.
- An MCO shall give an enrollee written notice of any action, except for denials of payment which do not require notice to the enrollee, within the following time frames:
  - At least 10 days before the action for termination, suspension, or reduction of a previously authorized covered service.
- 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; and
  - Inform enrollees that information is available in alternative formats and how to access those formats.

In April 2016, CMS issued final regulations that revised existing Medicaid managed care rules for contract periods beginning on or after July 1, 2017. As a result, MDH communicated to the MCOs new regulatory requirements for certain services that require preauthorization with an effective date of January 1, 2018. This date was subsequently revised to dates of services requested on or after February 1, 2018, to allow the MCOs additional time for implementation of the new requrements. Updates to COMAR 10.09.71.04 as they relate to MCO reported preauthorization determination time frame results addressed in this report include the following:

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

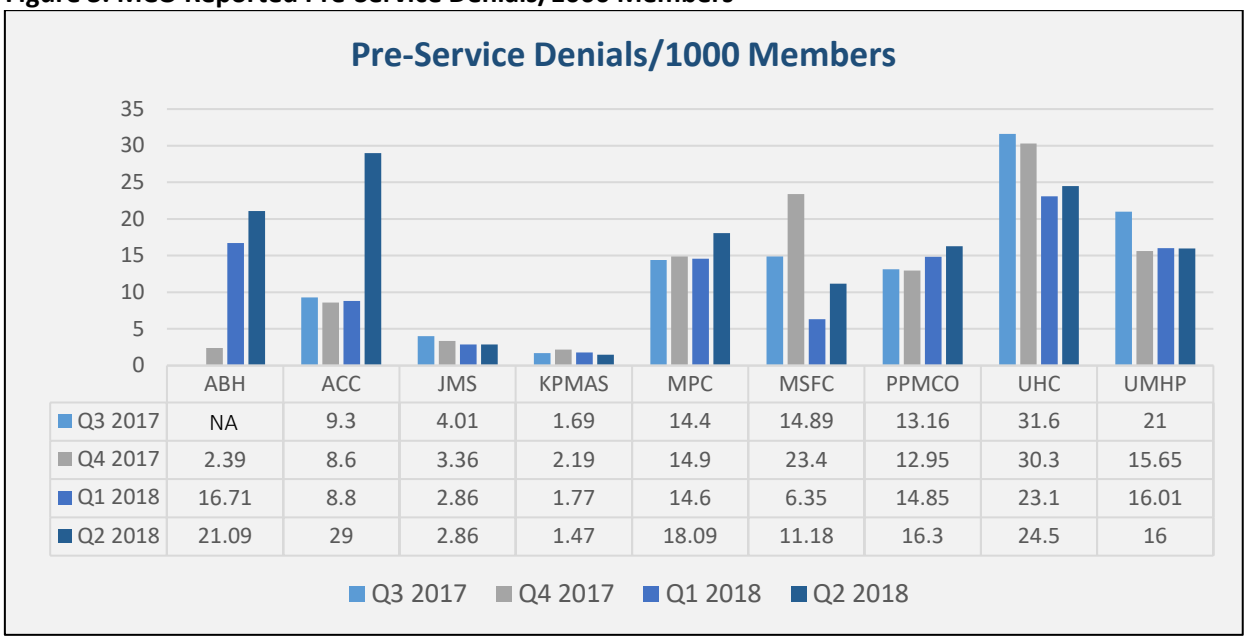
The MCO pre-service denial review encompassed the following comparative statistics and compliance with federal and state laws and regulations:

- Comparative Statistics: Pre-service Denials Rendered Per 1000 Members
- Preauthorization Time Frames: Determinations provided within 2 business days of receipt of necessary clinical information but no later than 7 calendar days from date of initial request based on a compliance threshold of 95%
- Notice of Decision to Deny Time Frames: Initial services provided to enrollee within 24 hours for emergency, medically related requests and not more than 72 hours for non-emergency, medically related requests based upon a compliance threshold of 95%

- Notification Time Frames: For any previously authorized service written notice to enrollee is provided at least 10 days prior to reducing, suspending, or terminating a covered service based upon a compliance threshold of 95%.
- 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 16 required regulatory components.

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

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



	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017	NA	9.3	4.01	1.69	14.4	14.89	13.16	31.6	21
Q4 2017	2.39	8.6	3.36	2.19	14.9	23.4	12.95	30.3	15.65
Q1 2018	16.71	8.8	2.86	1.77	14.6	6.35	14.85	23.1	16.01
Q2 2018	21.09	29	2.86	1.47	18.09	11.18	16.3	24.5	16

NA – Not Applicable

Overall, pre-service denials have been trending upward for most MCOs. Primarily, pharmacy service requests appear to be driving the increase. MCO-specific trending and comparisons between MCOs, however, are not feasible at this time since delegate denials have not been submitted consistently by all MCOs throughout the review period. Limitations preventing MCO comparisons include:

- ACC omitted pharmacy denials until the second quarter of 2018.
- UHC included inpatient concurrent review denials in its count. It is currently working on the ability to submit denials from their dental vendor.
- MSFC changed its dental vendor, who initially reported denials by request rather than by tooth/procedure.

Despite these issues, the consistently low number of denials for JMS and KPMAS is believed to be related to their clinic-based plan models.

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

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

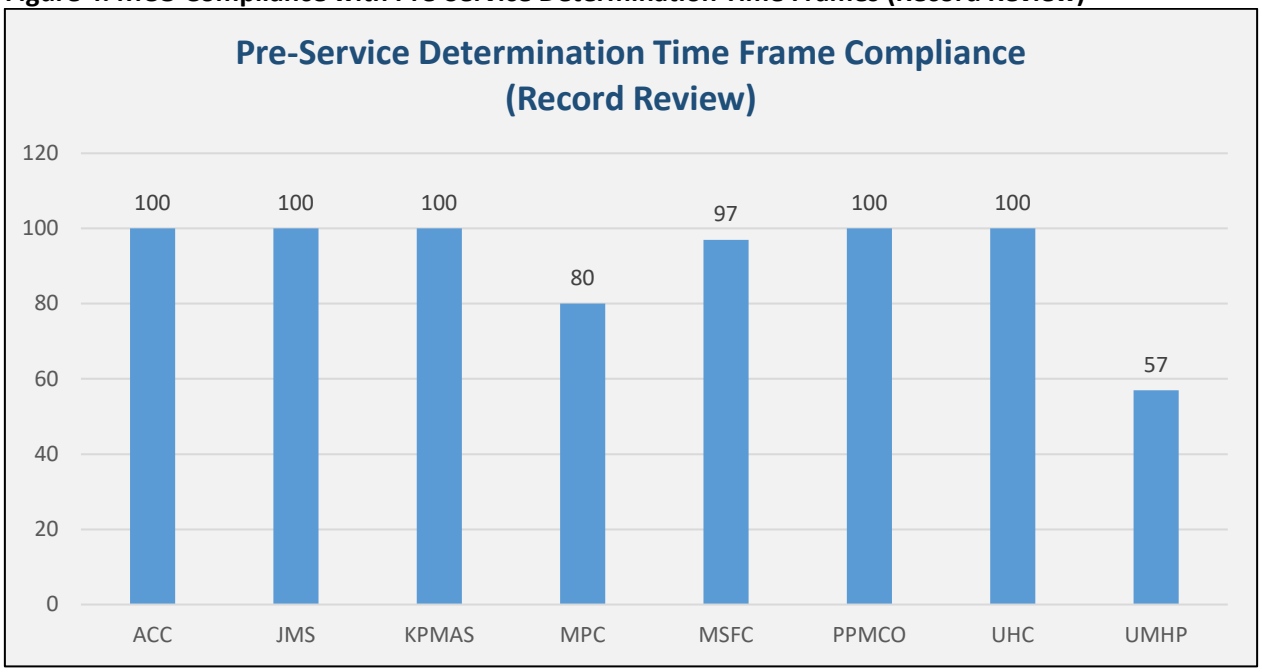
Report Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017 Emergency	N/A	N/A	100%	100%	73%	100%	92%	70%	95%
Q4 2017 Emergency	N/A	N/A	100%	88%	97%	100%	95%	64%	95%
Q1 2018 Emergency	100%	N/A	100%	83%	95%	84%	97%	100%	99%
Q2 2018 Emergency	100%	N/A	100%	100%	98%	96%	98%	98%	100%
Q3 2017 Non-Emergency	N/A	97%	99%	94%	85%	100%	99%	97%	99%
Q4 2017 Non-Emergency	100%	99%	100%	84%	91%	100%	90%	87%	99%
Q1 2018 Non-Emergency	100%	99%	100%	93%	96%	100%	42%	99%	99%
Q2 2018 Non-Emergency	100%	99%	96%	95%	95%	100%	98%	100%	100%

Four of the MCOs (ABH, ACC, JMS, and UMHP) met or exceeded the 95% threshold based upon a review of MCO quarterly reports. Overall compliance results ranged from 42% to 94% for the remaining five MCOs (KPMAS, MPC, MSFC, PPMCO, and UHC). ABH did not begin reporting until Q4 for which they did not have emergency requests. ACC did not have emergent requests for any of the quarters reviewed.

Effective February 1, 2018, MDH extended the time frame for non-emergency pre-service determinations from 7 to 14 calendar days and required the MCO to make a determination and provide notice no later than 72 hours after receipt of an expeditred request for services to be consistent with federal regulations. While extension of the time frame for standard authorization requests did not have a noticeable impact on overall compliance in the first quarter of 2018, all MCOs exceeded the 95% compliance threshold for the second quarter. This is the best result for the four quarters. Not only does this change allow more time for the MCOs to obtain additional clinical information from the requesting provider but it also may have a positive impact on the volume of appeals. Frequently adverse determinations are overturned on appeal as a result of the provider submitting additional clinical information not provided with the intial pre-service request.

Record reviews were also conducted to assess compliance with COMAR requirement for timeliness of pre-service determinations. The record review was based upon the 10/30 rule. Results are highlighted in Figure 4.

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



All but two of the MCOs (MPC and UMHP) met or exceeded the 95% threshold based upon the annual review of the MCO's records. MPC had a compliance rate of 80% while UMHP had a rate of 57%.

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. Record reviews were conducted based upon the 10/30 rule. Table 8 displays the number of records reviewed and the issues identified.

Table 8. MCO Adverse Determination Records Reviewed

MCO	Records Reviewed	Issues Identified
ACC	10	None
JMS	10	None
KPMAS	10	None
MPC	30	Turn Around Times & Letter Components
MSFC	30	Turn Around Times & Letter Components
PPMCO	30	Letter Compliance
UHC	30	Letter Compliance
UMHP	30	Turn Around Times & Letter Components

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

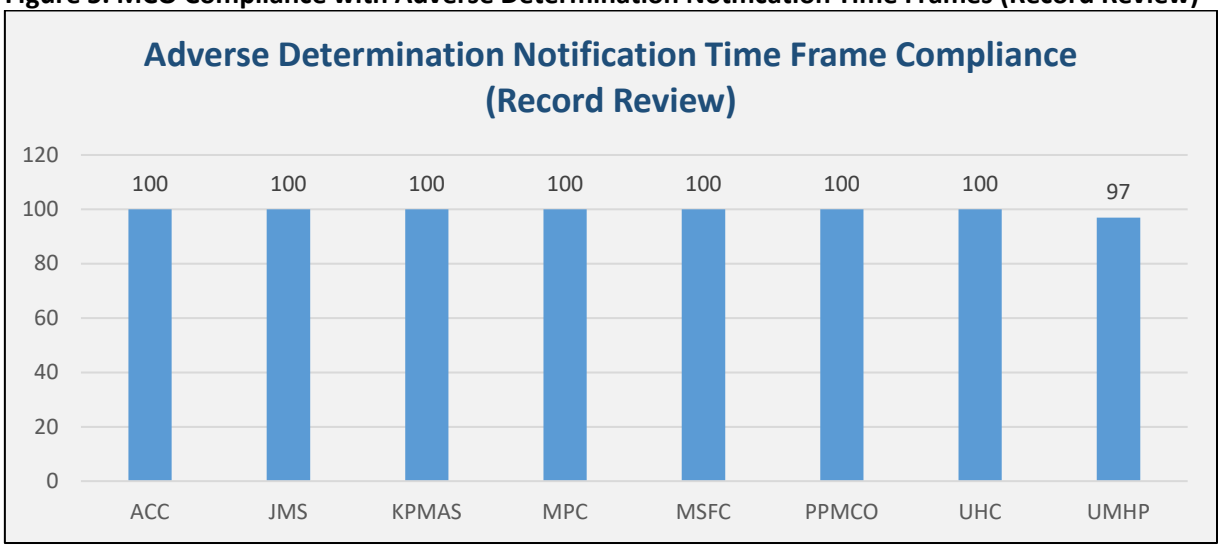
Table 9. MCO Reported Compliance with Adverse Determination Notification Time Frames (Quarterly Reports)

Report Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017 Emergency	N/A	N/A	100%	100%	100%	100%	98%	98%	100%
Q4 2017 Emergency	N/A	N/A	100%	100%	99%	100%	95%	98%	99%
Q1 2018 Emergency	100%	N/A	100%	83%	100%	95%	96%	100%	100%
Q2 2018 Emergency	100%	N/A	100%	100%	100%	96%	98%	99%	100%
Q3 2017 Non-Emergency	N/A	99%	100%	100%	96%	100%	96%	98%	100%
Q4 2017 Non-Emergency	100%	96%	100%	100%	93%	100%	98%	88%	96%
Q1 2018 Non-Emergency	100%	99%	97%	99%	98%	100%	35%	100%	99%
Q2 2018 Non-Emergency	94%	99%	100%	99%	98%	98%	96%	100%	100%

Four of the MCOs (ACC, JMS, MSFC and UMHP) met or exceeded the 95% threshold based upon a review of MCO quarterly reports. Overall MCO reported compliance results ranged from 35% to 94% for the remaining five MCOs (ABH, KPMAS, MPC, PPMCO, and UHC). ABH did not begin reporting until Q4, for which they did not have emergency requests. ACC did not report any emergent requests for any of the quarters reviewed.

Results of compliance with adverse determination notification time frames based on the annual record review of CY 2017 records are highlighted in Figure 5.

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



All eight MCOs met or exceeded the 95% threshold based upon an annual review of the MCO's records. Seven of the eight demonstrated 100% compliance.

Table 10 provides a comparison of denial record review results across MCOs for CY 2017. Results are based upon a random selection of denial records. Reviews were conducted utilizing the 10/30 rule.

Table 10. Results of CY 2017 Denial Record Reviews

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

PM-Partially Met

All MCOs demonstrated compliance with the appropriateness of adverse determinations supported by medical necessity criteria and MCO-specific clinical policies. All but two MCOs (MPC and UMHP) met or exceeded the pre-service determination time frame threshold of 95% and all MCOs were compliant with the adverse determination notification time frames. Only half of the MCOs included all 16 required components in member adverse determination letters. The most frequent missing component was the Notice of Nondiscrimination which became a requirement in the fourth quarter of 2016.

Recommendations

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

As a result of opportunities identified following the 2017 focused review, MDH:

- Developed and implemented managed care model notices for denials, appeals, and grievances in February 2018.
- Released a written clarification of what constitutes a grievance as defined in COMAR which has resulted in MCOs improving classification of grievances and inquiries.
- Approved new System Performance Review standards for CY 2018 relating to the following:
  - Written notification of grievance determinations, even when a case is closed, because of inability to contact the member.
  - Documentation of reasonable efforts to provide the member with prompt verbal notice of the denial of an expedited appeal resolution and evidence of a written notice within two calendar days.
  - Evidence that appeal decisions are made by health care professionals who have appropriate clinical expertise in treating the member's condition or disease consistent with the MCO's policies and procedures.

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

- In view of ongoing issues with the validity of the data reported by the MCOs, it is recommended that MDH consider pursuing appropriate action through its Performance Monitoring Policies, including the use of sanctions, if an MCO fails to demonstrate improvement. In the absence of valid data assessment of full compliance, identification of MCO-specific trends and comparisons of individual MCO results with MCO ranges is limited.
- For outpatient drug adverse determinations, require MCOs to report compliance with the 72-hour written notice requirement separately from the 72-hour time frame for standard authorization requests. This will ensure consistency in reporting delegated pharmacy denials among the MCOs and provide additional detail to better identify opportunities for improvement relating to medical and/or pharmacy compliance with written notification requirements.

MCO-Specific Summaries

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

The MCO-specific results from quarterly assessments and CY 2017 record reviews are highlighted in the following grievance, appeal, and pre-service denial summaries. Each MCO summary includes the following, as applicable:

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

Aetna Better Health of Maryland	
Trends	✓ Member and provider grievances per 1000 demonstrate an upward trend quarter over quarter reflecting the maturation process of this new MCO. No negative trends identified for grievances. ✓ Appeal results are fairly consistent over three quarters. No negative trends identified for appeals. ✓ Denials per 1000 members demonstrate an upward trend quarter over quarter, reflecting the maturation process of this new MCO. No negative trends identified for pre-service denials.
Comparison to Other MCOs	✓ Results are generally consistent with all other MCOs taking into consideration the recent entry into the HealthChoice system.
Compliance	✓ Grievance resolution time frames were met for all three quarters. ✓ Appeal resolution time frames were consistently met for all three quarters. ✓ Pre-Service determination and notification time frames met or exceeded the 95% threshold for all three quarters with one exception. ✓ Compliance with the pre-service determination notification time frame for non-emergent denials fell to 94% in the second quarter.
Strengths	✓ 100% compliance with appeal resolution time frames for all three quarters.
Opportunities	✓ Continuing formula errors that calculate totals in the quarterly reporting forms in appeal reports.
Notes	✓ ABH commenced operations on October 23, 2017. ✓ Record review results for grievances, appeals, and pre-service denials are not included in view of the limited number available during CY 2017. ✓ Quarterly results need to be viewed with caution due to the small numbers.
Recommendations	✓ ABH must correct ongoing formula errors and improve its oversight of report accuracy.

AMERIGROUP Community Care	
Trends	✓ Grievance results are fairly consistent over four quarters. No negative trends identified. ✓ Appeal results are fairly consistent, although there has been a slight upward trend in the last three quarters. No negative trends identified. ✓ Pre-service Denial results are fairly consistent over four quarters. No negative trends identified.
Comparison with Other MCOs	✓ Grievance results are generally consistent with all other MCOs. ✓ Appeal results are generally consistent with all other MCOs; however, the appeal rate per 1000 members remains slightly below all other MCOs. ✓ Pre-service denial results are generally consistent with all other MCOs; however, it is the only MCO that has never reported any emergent denials.
Compliance	✓ Member Grievance resolution time frames were met for all four quarters. No provider grievances were received during the review time frame. ✓ Appeal resolution time frames were consistently met for all four quarters. MCO included provider administrative appeals in reports throughout the review period. ✓ Pre-service determination and notification time frames met or exceeded the 95% threshold for all four quarters. ACC only began including pharmacy denials in second quarter.
Strengths	✓ Grievances and their resolutions were well documented. Grievance resolutions were appropriate. Compliance with time frames was consistently met in all four quarters. ✓ 100% compliance with appeal resolution time frames for all four quarters.
Best Practices	✓ Resolution letters are in plain language and describe well the grievance and the resolution. ✓ Appeal resolution letters are written in plain language and for medical necessity appeals the title and specialization of the Medical Director/designee is included. ACC includes a Maryland Medicaid Appeal Form in all resolution letters when the first level appeal results in an uphold decision. ✓ Excellent use of plain language in all adverse determination letters. Availability of ACC case manager to help member explore other options, like services within their community that may be free or of little cost if services requested exceed benefit limits, included in all letters with contact number provided. Detailed attachment to all letters on ACC appeal process.
Opportunities	✓ Appropriate classification of a grievances. ✓ Inappropriate inclusion of provider administrative appeals in quarterly reports. ✓ Adverse determination letters need to be updated to replace Enrollee Help Line with HealthChoice Help Line.
Recommendations	✓ Ensure auditing process incorporates guidance from MDH relating to the definition of a grievance. ✓ Eliminate reporting of provider administrative appeals in quarterly appeal reports before a reliable analysis can be performed to compare to other MCOs. ✓ Update adverse determination letters to replace Enrollee Help Line with HealthChoice Help Line. MCO requested to investigate lack of reported emergent denials. Will continue to monitor performance individually and against MCO ranges to assess potential opportunities for improvement.

Jai Medical Systems, Inc.	
Trends	✓ Grievance results are fairly consistent over four quarters, however, there has been a slight uptick in member grievances per 1000 the last three quarters. All member grievances relate to access or attitude/service issues. ✓ Appeal results are fairly consistent over four quarters with a downward trend in appeals per 1000 members the last three quarters. No negative trends identified. ✓ Pre-service denial results are fairly consistent over four quarters. No negative trends identified.
Comparison with Other MCOs	✓ Grievance results are generally consistent with all other MCOs. However, its compliance with the requirement for resolution letters was at the low end of the range. ✓ Appeal results are generally consistent with all other MCOs. ✓ Pre-service denial results are generally consistent with all other MCOs; however, the MCO is at the low end of the MCO range in denials per 1000 members.
Compliance	✓ Resolution time frames for member and provider grievances were met for all four quarters. ✓ Appeal resolution time frames were consistently met for all four quarters. ✓ Pre-service determination and notification time frames met or exceeded the 95% threshold for all four quarters.
Strengths	✓ Grievances are appropriately classified, fully described in case notes, and 100% compliant with resolution time frames. ✓ 100% compliance with appeal resolution time frames for all four quarters. ✓ Compliance is demonstrated in all areas for pre-service denials.
Best Practices	✓ All appeal resolution letters are in plain language and include the board certification and specialty of the physician who reviewed the appeal.
Opportunities	✓ Consistency in sending resolution or case closure letters to any member who filed a grievance and others, as appropriate. ✓ Complete and appropriate resolution of all grievances. ✓ Access and attitude/service grievances. ✓ Adverse determination letters need to be updated to replace Enrollee Help Line with HealthChoice Help Line.
Recommendations	✓ Ensure policies and procedures document the COMAR requirement for sending resolution letters to any member who filed a grievance and others, as appropriate. This includes members whom the MCO was unable to contact by phone and as a result closed the case. ✓ Consider implementing a process for auditing a sample of grievance records to ensure resolutions are appropriate and a resolution letter has been sent to any member who has filed a grievance. ✓ Consider conducting a root cause analysis of access and attitude/service related member grievances to identify opportunities for improvement. ✓ Update adverse determination letters to replace Enrollee Help Line with HealthChoice Help Line.

Kaiser Permanente of the Mid-Atlantic States, Inc.	
Trends	✓ Greivance results are fairly consistent over four quarters; however, member grievances relating to attitude/service have represented the highest number of grievances over the four quarters reviewed. ✓ Appeal results are fairly consistent over four quarters, however, there has been a downward trend in appeals per 1000 members the last three quarters after KPMAS discontinued including provider administrative appeals in error. No negative trends identified. ✓ Pre-service denial results are fairly consistent over three quarters. Reporting errors identified in the third and fourth quarters have been resolved. No negative trends identified.
Comparison with Other MCOs	✓ KPMAS has remained at the top of the range all four quarters for participant member grievances among the established MCOs. Additionally, resolution appropriateness was a major outlier based upon results of the annual record review as 6 of the 20 grievance records reviewed demonstrated incomplete or inappropriate resolutions. Case notes reflected an apology from the member but no evidence was provided that the MCO communicated what action it would take to resolve the grievance. Compliance with the requirement for resolution letters also was at the low end of the range. ✓ Appeal results are generally consistent with all other MCOs, except for resolution letter compliance. The majority of resolution letters reviewed were either incomplete, inaccurate, and/or did not provide a denial reason but rather only a code. ✓ Pre-service denial results are generally consistent with all other MCOs. Pre-service denials per 1000 members are below the range of the other MCOs, possibly due to the MCO's model.
Compliance	✓ Resolution time frames have not been met for member grievances for the four quarters reviewed. Compliance with the resolution time frame for provider grievances was met in the only quarter they were received. ✓ Compliance with the resolution time frame for non-emergency appeals was not met in three of the four quarters resulting in a Systems Performance Review CAP. ✓ KPMAS demonstrated compliance with pre-service denial determination time frames only in the second quarter. Compliance with notification time frames was met in all quarters except the first.
Strengths	✓ Grievances are well-documented.
Best Practices	✓ Well documented appeal records include detailed arguments on behalf of the members for the coverage.

Kaiser Permanente of the Mid-Atlantic States, Inc.	
Opportunities	✓ Consistency in sending resolution or case closure letters to any member who filed a grievance and others, as appropriate. Complete and appropriate resolution of all grievances. Consistent compliance with member resolution time frames. Attitude/service related grievances. ✓ Member appeal resolution letters need to be complete, accurate, and provide a clear explanation of the reason for the decision in easy to understand language. Continuing formula errors that calculate totals in the quarterly reporting forms occur. ✓ Pre-service denial adverse determination letters need to be updated to replace Enrollee Help Line with HealthChoice Help Line.
Recommendations	✓ Ensure policies and procedures document the COMAR requirement for sending resolution letters to any member who filed a grievance and others, as appropriate. This includes members whom the MCO was unable to contact by phone and as a result closed the case. Consider implementing a process for auditing a sample of grievance records to ensure resolutions are appropriate and a resolution letter has been sent to any member who has filed a grievance. ✓ Increase oversight to ensure that it consistently meets member grievance resolution time frames. Consider conducting a root cause analysis of service/attitude-related member grievances to identify opportunities for improvement. ✓ Develop a process for auditing appeal resolution letters before they are mailed and provide necessary staff training, as indicated, to ensure that letters are complete, accurate, and written in plain language. KPMAS must correct ongoing formula errors and improve its oversight of report accuracy. ✓ Increase oversight of medical necessity review process to ensure compliance with pre-service denial determination time frames. Update adverse determination letters to replace Enrollee Help Line with HealthChoice Help Line. Will continue to monitor performance individually and against MCO ranges to assess potential opportunities for improvement.

Maryland Physicians Care	
Trends	✓ Grievance results are fairly consistent over four quarters, although there has been a slight downward trend in grievances received quarter over quarter. Access-related issues represent the majority of grievances over the four quarters under review. ✓ Appeal results are fairly consistent; however, there has been a slight upward trend in appeals per 1000 members quarter over quarter. ✓ Pre-service denial results are fairly consistent over four quarters; however, there was a slight uptick in denials per 1000 members reported for the second quarter. No negative trends were identified.
Comparison with Other MCOs	✓ Greivance results are generally consistent with all other MCOs with one major exception. MPC demonstrated no evidence of compliance with the requirement for resolution letters. ✓ Appeal results are generally consistent with all other MCOs. ✓ Pre-service denial results are generally consistent with all other MCOs. Based upon the annual record review, MPC is at the low end of the range for required letter components.
Compliance	✓ Resolution time frames consistently met for member and provider grievances. ✓ Appeal resolution time frames were consistently met for all four quarters. ✓ Pre-service denial determination and notification time frames met or exceeded the 95% threshold for the first and second quarters of 2018. Notifications demonstrated compliance in the third quarter.
Strengths	✓ Grievances and their resolutions are well documented and resolutions are appropriate. 100% compliance with resolution time frames. ✓ 100% compliance with appeal resolution time frames for all four quarters.
Opportunities	✓ Compliance with requirement for sending a resolution letter to any member who has filed a grievance. ✓ Access related member grievances. ✓ Continuing formula errors that calculate totals in the quarterly reporting forms occur. ✓ Compliance with all 16 required letter components for pre-service denials. ✓ Consistent use of HealthChoice Help Line, which has replaced the Enrollee Help Line, in all letters. ✓ Consistent compliance with pre-service denial determination time frames.
Recommendations	✓ Ensure its policies and procedures document the COMAR requirement for sending resolution letters to any member who filed a grievance and others, as appropriate. This includes members whom the MCO was unable to contact by phone and as a result closed the case. ✓ Consider implementing a process for auditing a sample of grievance records to ensure a resolution letter has been sent to any member who has filed a grievance. ✓ Consider conducting a root cause analysis of access-related member grievances to identify opportunities for improvement. ✓ Correct ongoing formula errors and improve its oversight of report accuracy. ✓ Implement or review audit process to ensure all adverse determination letters include all required components and updated language. ✓ Increase oversight of medical necessity review process to ensure continued compliance with determination time frames.

MedStar Family Choice, Inc.	
Trends	✓ Grievance results are fairly consistent over four quarters, however, member grievances per 1000 have been trending upward over the last three quarters. ✓ Appeal results are fairly consistent over four quarters. No negative trends were identified. ✓ Pre-service denial results are fairly consistent over four quarters; however, the total pre-service denials per 1000 members demonstrates considerable fluctuations due to an MCO reported transcription error in the fourth quarter and the new dental vendor reporting denials per request rather than by tooth/procedure in the first quarter.
Comparison with Other MCOs	✓ Grievance results are generally consistent with all other MCOs with two exceptions. It is a major outlier for resolution timeliness and is at the low end of the range for demonstrating compliance with the requirement for a resolution letter. ✓ Appeal results are generally consistent with all other MCOs. ✓ Pre-service denial results are generally consistent with all other MCOs.
Compliance	✓ Compliance with resolution time frames for member non-emergency medically-related grievances has not been met for the third and fourth quarters and for the first three quarters for administrative grievances. The resolution time frame has been met for the only two provider grievances received during the four quarters under review. ✓ Appeal resolution time frames were met in two of the four quarters. MCO acknowledged that it had not been including provider submitted appeals on behalf of members until the second quarter. ✓ Pre-service denial determination and notification time frames met or exceeded the 95% threshold in all but the first quarter when the emergent determination time frame was not met.
Strengths	✓ Grievances and their resolutions are well-documented. Resolutions are appropriate. Three attempts are made to contact a member who filed a grievance before the case is closed.
Best Practices	✓ All resolution letters are in plain language and include the board certification and specialty of the physician who reviewed the appeal.
Opportunities	✓ Consistent mailing of resolution letters to any member who filed a grievance and others, as appropriate. Consistent compliance with resolution time frames for member grievances. Documentation of correct date of grievance receipt. ✓ Compliance with appeal resolution time frames. Improved oversight of appeal reporting.
Recommendations	✓ Ensure its policies and procedures document the COMAR requirement for sending resolution letters to any member who filed a grievance and others, as appropriate. This includes members whom the MCO was unable to contact by phone and as a result closed the case. Additionally, the MCO needs to increase its oversight to ensure that it consistently meets member grievance resolution time frames. Date of grievance receipt needs to reflect date that the Third Party Administrator (TPA) receives grievances, if not sent directly to MCO. ✓ Improve its oversight to ensure appeal resolution time frames are consistently met. It is also recommended that oversight of reporting be increased.

Priority Partners	
Trends	✓ Grievance results are fairly consistent over four quarters with the exception of a downward trend in member grievances quarter over quarter. No negative trends identified. ✓ Appeal results are fairly consistent over four quarters, although appeals per 1000 members has trended downward over the last three quarters. Compliance with resolution time frames has been trending downward the last two quarters. ✓ Pre-service denial results are fairly consistent over four quarters. Pre-service denials per 1000 members have been trending up the last three quarters although still within the range of the other MCOs. Additionally, the percentage of emergent denials has increased considerably in the first two quarters of 2018.
Comparison with Other MCOs	✓ Grievance results are generally consistent with all other MCOs with member grievances at the low end of the range. ✓ Appeal results are generally consistent with all other MCOs, although its appeals per 1000 members are at the low end of the range. ✓ Pre-service denial results are generally consistent with all other MCOs, although it is well above all the other MCOs in its percentage of emergent denials. Based upon the annual record review, PPMCO is at the low end of the range for required letter components.
Compliance	✓ Compliance with resolution time frames for member grievances was not fully met in the first two quarters of 2018. All provider grievances met the resolution time frames. ✓ Full compliance with resolution time frames has been demonstrated only in the fourth quarter 2017. MCO acknowledged it has been including provider administrative appeals in reports throughout the review period. ✓ Consistent compliance with the 95% threshold was only demonstrated in the second quarter of 2018 for both emergent and non-emergent denials. Compliance with notification time frames has been met in three of the four quarters for both emergent and non-emergent denials.
Strengths	✓ Grievances and their resolution are well documented and resolutions are appropriate.
Best Practices	✓ Resolution letters are in plain language and provided in both English and Spanish. ✓ Appeal resolution letters are in plain language with a detailed explanation as to the reason for the decision for both upheld and overturned determinations, the criteria used, the documentation considered in reviewing the case, and the qualifications of the physician who made the determination.

Priority Partners	
Opportunities	✓ Consistent compliance with resolution time frames for member grievances. ✓ Consistent compliance with appeal resolution time frames. Resolution time frame identified in appeal acknowledgment letters. Inappropriate inclusion of provider administrative appeals in quarterly reports. ✓ Consistent compliance with pre-service denial determination and notification time frames. Compliance with all 16 required letter components and consistent replacement of Enrollee Help Line with HealthChoice Help Line.
Recommendations	✓ Increase MCO oversight to ensure that member grievance resolution time frames are consistently met. ✓ A quarterly Systems Performance Review CAP is currently in place to address non-compliance with appeal resolution time frames. Revise appeal acknowledgment letters to identify resolution time frames applicable to the specific appeal. MCO must eliminate reporting of provider administrative appeals in quarterly appeal reports. ✓ A Systems Performance Review CAP is currently in place to address non-compliance with pre-service denial determination and notification time frames. Implement or review audit process to ensure all adverse determination letters include all required components and updated language.

UnitedHealthcare Community Plan	
Trends	✓ Grievance results are fairly consistent over four quarters. ✓ Appeal results are fairly consistent over the last three quarters, having stabilized after a fairly large decrease in the appeals per 1000 members rate in third quarter. No negative trends were identified. ✓ Pre-service denial results are fairly consistent over four quarters with one exception. Emergent denials decreased considerably in the second quarter of 2018 after the MCO discovered that it was including inpatient concurrent review denials in its count. No negative trends identified.
Comparison with Other MCOs	✓ Grievance results are generally consistent with all other MCOs with member and provider grievances per 1000 at the low end of the MCO range. ✓ Appeal results are generally consistent with all other MCOs; however, expedited requests remain above the high end of the MCO range. ✓ Pre-service denial results are generally consistent with all other MCOs; however, emergent requests have been at the top of the range of other MCOs based upon the error identified above. Based upon the annual record review, UHC is at the low end of the range for required letter components.
Compliance	✓ Compliance with resolution time frames for member grievances was met in two of four quarters. Two quarters fell slightly below the 100% threshold for administrative grievances at 98% and 99%. Compliance with the resolution time frame for provider grievances was met in the one applicable quarter. ✓ Appeal resolution time frames were not met consistently for three of the four quarters. ✓ Consistent compliance with pre-service denial determination and notification time frames has been demonstrated for the first and second quarters of 2018. UHC has not been including denials from its dental vendor in its count.
Strengths	✓ Grievances and their resolution are well documented and resolutions are appropriate.
Best Practices	✓ Resolution letters are in plain language and are very detailed in describing the grievance and the resolution. UHC also provides a written acknowledgement of each grievance, only one of two MCOs to do so. ✓ All appeal resolution letters are in plain language and include the board certification and specialty of the reviewer.
Opportunities	✓ Consistent compliance with the resolution time frame for member administrative grievances. ✓ Consistent compliance with appeal resolution time frames. ✓ Consistent compliance with pre-service denial determination and notification time frames. Compliance with all 16 required letter components and consistent replacement of Enrollee Help Line with HealthChoice Help Line. Inclusion of dental vendor denials in its count.
Recommendations	✓ Increase oversight of compliance with the resolution time frame for member administrative grievances. ✓ Improve oversight of appeal resolution time frames to ensure compliance with time frames is consistently met. ✓ Implement or review audit process to ensure all adverse determination letters include all required components and updated language. Include denials from dental vendor in its count. Increase oversight of medical necessity review process to ensure continued compliance with time frames.

University of Maryland Health Partners	
Trends	✓ Member grievances have been trending upward the past three quarters. Grievances relating to attitude/service issues, in particular, have been trending up the last four quarters and now represent 60% of all grievances. Provider grievances have demonstrated a downward trend quarter over quarter. ✓ Appeal results are fairly consistent over four quarters, although there has been a slight downward trend in appeals per 1000 members the last three quarters. This decrease possibly is the result of UMHP changing its appeal per 1000 members rate calculation to be consistent with the other MCOs. No negative trends identified. ✓ Pre-service denial results are fairly consistent over four quarters. Denials per 1000 members has remained relatively stable after UMHP implemented a correction to its formula for calculating the measure prior to the fourth quarter report.
Comparison with Other MCOs	✓ Grievance results are generally consistent with all other MCOs. ✓ Appeal results are generally consistent with all other MCOs with one major outlier. Appeals per 1000 members remain above the top of the MCO range. ✓ Pre-service denial results are generally consistent with all other MCOs; however, it is outside of the range of other MCOs for required letter components based upon the annual record review.
Compliance	✓ Compliance with grievance resolution time frames was met for three of the four quarters. The time frame was not met for member grievances in the fourth quarter. ✓ Appeal resolution time frames were consistently met for all four quarters. ✓ Compliance with pre-service denial determination and notification time frames are met consistently for both non-emergent and emergent denials.
Strengths	✓ Grievances and their resolution are well documented and resolutions are appropriate. ✓ 100% compliance with appeal resolution time frames for all four quarters.
Best Practices	✓ All members submitting a grievance receive both an acknowledgement letter describing the grievance and the time frame for resolution and a resolution letter. All letters are written in plain language. ✓ All denials upheld on appeal include a comprehensive three-page document, Appeal Rights Description, with the appeal resolution letter. All letters are in plain language.
Opportunities	✓ Quality of grievance resolution letters. Attitude/service related grievances. ✓ Specialty of appeal reviewer not included in all resolution letters. ✓ Compliance with all 16 required letter components and consistent replacement of Enrollee Help Line with HealthChoice Help Line.
Recommendations	✓ Consider routinely auditing a sample of grievance resolution letters to ensure use of proper grammar and complete sentences. Consider conducting a root cause analysis of service/attitude related member grievances to identify opportunities for improvement. ✓ Consider including the specialty of the physician reviewer in all clinical appeal resolution letters. ✓ Implement or review audit process to ensure all adverse determination letters include all required components and updated language.

Conclusions

This second year report includes studies of MCO grievance, appeal, and denial quarterly reports from the third quarter of 2017 through the second quarter of 2018. Additionally, a sample of grievance, appeal, and denial records were reviewed for CY 2017. Based upon the outcomes of these studies, supplemented by the annual record reviews, most MCOs demonstrated strong and consistent results in meeting the majority of grievance, appeal, and denial requirements. This level of compliance helps to ensure the delivery of quality care and services to HealthChoice members is timely and accessible. Below are strengths identified in specific review components where all, or a majority, of the MCOs were in compliance:

- Apropriately classified and resolved grievances
- Fully documented grievance issues
- Processed appeals based upon level of urgency
- Documented appeal decisions well and resolved appeals timely
- Made appeal decisions by health care professional with appropriate expertise
- Made appeal decisions available to the enrollee in easy to understand language
- Appropriately provided adverse determinations

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:

- Member grievance resolution time frames
- Grievance resolution letters
- Pre-service determination time frames
- Adverse determination notification time frames
- Required components in adverse determination letters

As noted in the Limitations section, the validity of the data submitted by the MCOs continues to be a challenge after two years, despite detailed instructions and ongoing technical assistance. Consequently, assessment results documented in this report need to be considered with some caution. Subsequent reporting will yield a greater level of confidence in the review outcomes for annual reporting.

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

Top 5 Provider Grievances by Service Category					**Top 5 Categories**
Code/Description (#/%)				○	
Code/Description (#/%)				○	
Code/Description (#/%)				○	
Code/Description (#/%)				○	
Code/Description (#/%)				○	
Provider Grievances TAT Met (standard 100% compliance)					
Category 1: Emergency medically related (#/%)				○	
Category 2: Non-emergency medically related (#/%)				○	
Category 3: Administrative (#/%)				○	
Analysis					
Recommendations					

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

<MCO> Grievances Record Review for CY 20xx Results & Analysis			
	CY 20xx	**Status**	**Other MCO Results**
Appropriately classified as a grievance		○	
Type of Grievance			
Emergency		○	
Non-Emergency		○	
Administrative		○	
Issue is Fully Described		○	
Grievance Category			
Access		○	
Quality		○	
Timeliness		○	
Professionalism		○	
Other		○	
Resolution Timeliness		○	
Resolution Appropriateness		○	
Resolution Letter		○	
Analysis			
Recommendations			

○ Neutral
○ Met, if applicable
○ Negative trend. (Requires explanation from MCO)
○ Not met, if applicable. (May require a CAP)
N/A - Not Applicable
N/R- Not Reported

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

Second Level Overturn Rate by Action					
Action 1 (#/%)				○	
Action 2 (#/%)				○	
Action 3 (#/%)				○	
Action 4 (#/%)				○	
Action 5 (#/%)				○	
Second Level Partial Overturn Rate by Action					
Action 1 (#/%)				○	
Action 2 (#/%)				○	
Action 3 (#/%)				○	
Action 4 (#/%)				○	
Action 5 (#/%)				○	
Top 5 Service Categories					
Category 1					
Resolved (#/%)				○	
Overturn (#/%)				○	
Partial Overturn (#/%)				○	
Category 2					
Resolved (#/%)				○	
Overturn (#/%)				○	
Partial Overturn (#/%)				○	
Category 3					
Resolved (#/%)				○	
Overturn (#/%)				○	
Partial Overturn (#/%)				○	
Category 4					
Resolved (#/%)				○	
Overturn (#/%)				○	
Partial Overturn (#/%)				○	
Category 5					
Resolved (#/%)				○	
Overturn (#/%)				○	
Partial Overturn (#/%)				○	
Expedited Appeals (#/%)				○	
Extended Appeals (#/%)				○	
Resolution TAT Met (standard 100% compliance)					
Expedited (#/%)				○	
Non-emergency (#/%)				○	

Analysis
Recommendations

Legend

○ Neutral

○ Met, if applicable

○ Negative trend. (Requires explanation from MCO)

○ Not met, if applicable. (May require a CAP)

N/A - Not Applicable

N/R- Not Reported

<MCO> Appeals Record Review for CY 20xx Results & Analysis			
	CY 20xx	**Status**	**Other MCO Results**
Processed Based Upon Level of Urgency		O	
Type of Appeal			
Expedited		O	
Non-Emergency		O	
Extended		O	
Denial of Expedited Request			
Verbal notification attempted		O	
Written notification within 2 calendar days		O	
Compliance with Appeal Time Frames			
Expedited (within 3 business days of request)		O	
Non-Emergency (within 30 calendar days of receipt)		O	
Decision Documented		O	
Decision Made by Health Care Professional with Appropriate Clinical Expertise		O	
Decision Available to Enrollee in Easy to Understand Language		O	
Analysis			
Recommendations			
Legend O Neutral O Met, if applicable O Partially met O Not met, if applicable. (May require a CAP) N/A - Not Applicable N/R - Not Reported			

<MCO> Pre-Service Denials for <X> Quarter 20xx Results & Analysis					
	Current Quarter	**Prior Quarter**	**QX 20xx** (2 QTRs prior to current)	**Status**	**Other MCO Results**
Under 21 (#/%)				○	
Emergent Med. Necessary Service (#/%)				○	
Pre-Service Denials/1000 Members				○	
Total Pre-Service Denials				○	
Denied (#/%)				○	
Reduced (#/%)				○	
Terminated (#/%)				○	
Top 5 Service Categories (#/%)					
Service Category 1:				○	
Service Category 2:				○	
Service Category 3:				○	
Service Category 4:				○	
Service Category 5:				○	
Top 5 Denial Reasons (#/%)					
Denial Reason 1:				○	
Denial Reason 2:				○	
Denial Reason 3:				○	
Denial Reason 4:				○	
Denial Reason 5:				○	
Determination TAT Met (standard 95% compliance)					
Emergent (#/%)				○	
Non-Emergent (#/%)				○	
Notification TAT Met (standard 95% compliance)					
Emergent (#/%)				○	
Non-Emergent (#/%)				○	
Analysis					
Recommendations					

Legend

○ Neutral

○ Met, if applicable

○ Negative trend. (Requires explanation from MCO)

○ Not met, if applicable. (May require CAP)

N/A - Not Applicable

N/R - Not Reported

Annual Adverse Determination Record Review - CY 20xx				
Time Frame	**CY 20xx**	**CY 20xx Status**	**Comments**	**Other MCOs**
Required Letter Components		o		
Compliance with Pre-service TATs				
Determinations (95% threshold)		o		
Adverse Determination Notifications (95% threshold)		o		
Appropriateness of Adverse Determinations				
Decision based on criteria, policy, coverage, adm.		o		