Qlarant

Maryland
DEPARTMENT OF HEALTH

Medicaid Managed Care Organization

Grievances, Appeals, & Denials Focused Review Report

Measurement Year 2022

Revised March 2024

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Grievances, Appeals, & Denials

Focused Review Report

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Introduction

The Maryland Department of Health (MDH) administers the state's Medicaid managed care program, Maryland HealthChoice Program (HealthChoice). HealthChoice operates under a Centers for Medicare and Medicaid Services (CMS) 1115 waiver and the Code of Maryland Regulations (COMAR) to provide quality health care that is patient-focused, prevention-oriented, coordinated, accessible, and cost-effective. MDH is responsible for evaluating the quality of care provided to enrollees by HealthChoice's managed care organizations.

Federal regulations require MDH to contract with an external quality review organization (EQRO) to provide annual, independent reviews assessing quality, access, and timeliness of care. This independent review ensures services provided to enrollees meet the standards governing the HealthChoice program in the Code of Federal Regulations (CFR) and COMAR. MDH contracts with Qlarant to meet federal regulations and evaluate quality, access, and timeliness of care through analysis of grievances, appeals, and denials.

HealthChoice emphasizes continuous quality improvement by structuring a comprehensive system 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. 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.

Assessment of MCO compliance was completed by applying performance standards defined for measurement year (MY) 2022. Quarterly studies of grievances, appeals, and pre-service denials were conducted for the first through third quarters of MY 2022, while the fourth quarter included annual data for MY 2022. The annual record review included enrollee grievances, appeals, and pre-service denials that occurred during MY 2022. The following MCOs were assessed in this report:

- Aetna Better Health of Maryland (ABH)
- CareFirst Community Health Plan (CFCHP)
- 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)
- Wellpoint Maryland (WPM)[1]

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;
2. Facilitate increased compliance within the above areas by illustrating trends and opportunities for improvement; and
3. Ensure that HealthChoice enrollees are not denied access to medically necessary services and supports.

This focused study activity addresses the following:

- Validation of the data provided by MCOs in the quarterly and annual grievance, appeal, and pre-service denial report submissions.
- Comparison of each MCO's performance with their peers.
- Identification of MCO opportunities for improvement and providing recommendations.

Methodology

Qlarant assesses MCO compliance based on MCO-reported data. MDH requires all MCOs to submit quarterly Grievance, Appeal, and Pre-Service Denial (GAD) Reports to Qlarant within 30 days of the close of each quarter, with the annual report submitted 30 days after the close of the fourth quarter. Qlarant develops MDH-approved templates for each reporting category as a review tool to validate and evaluate quarterly MCO reports. Appendices B, C, and D include the review templates for Grievances, Appeals, and Pre-Service Denials, respectively. Following validation of the data MCOs submitted, these review tools allowed Qlarant to enter data from the MCO reports and identify areas of noncompliance. Qlarant aggregated MCO results to allow MCO comparisons. MCO-specific trends were identified after three-quarters of the data were available. Quarterly reports submitted to MDH included an analysis of MCO data and recommendations, as appropriate. MCOs were provided separate

[1] Formerly Amerigroup Community Care (ACC) as of January 1, 2023.

reports for summarizing quarterly review findings, which included areas for follow-up when data issues, ongoing noncompliance, 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 MY 2022 sample of grievance, appeal, and pre-service denial records. Records were requested from July 1 through October 31, 2022, 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 2022. Each MCO provided Qlarant with a listing of grievances, appeals, and pre-service denials for MY 2022. 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 ten grievance, ten appeal, and ten denial records were reviewed. If an area of noncompliance was discovered, an additional 20 records were reviewed for the noncompliant component(s).

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

Data Validity Analysis

Threats to the validity of the MCO-submitted quarterly grievance, appeal, and denial reports continue to be assessed. For each quarter of MY 2022, MCOs showed improvements in GAD report documentation. In particular, MCOs had fewer report resubmissions and fewer errors within each report. Limitations in the accuracy of the self-reported MCO data are noted below.

- Feedback from the MCOs identified ongoing formula errors, uncertainty with what template to use, and general frustration with the data entry process. When needed, only two MCOs routinely documented why their data was skewed. Despite MCOs having to submit a signed attestation to the accuracy of their reports, there still seem to be some instances of limited quality oversight of the GAD process.

- Several factors threatened the validity of the data reported early in Q1. At the beginning of the year, incorrect formulas in the MCOs' appeals reporting template required manual recalculation. Some MCOs were able to override the formulas in the locked cells which did not appear to impact the accuracy of the data reported, such as reporting the per 1,000 rate at two or more decimal points when the formula appeared to be limited to only whole numbers. Some of the data fields in the denial report template had formulas based upon incorrect instruction; the denominator for the percentages of prior authorization requests approved and denied is based upon the overall total of prior authorization requests rather than the overall total of prior authorization requests resolved. These fields and the related instructions have been identified for updates. Additionally, the formula for rates per 1,000 needed to be revised to allow for trending.

- Some of the GAD service and reason codes may limit actionable interventions. For example, codes reported by the MCOs in the category of "Other," are too vague and do not support identification and trending of relevant information.

- Another potential limitation to the accuracy of the data is underreported grievances. Because of a corporate audit, one MCO discovered that many grievances resolved and closed by the Customer Service Department were not being logged into their complaint and grievance-tracking database. A new workflow was created to address this issue.

- A final limitation to consider is that Maryland MCOs' GAD data for MY 2022 consists of three quarters and one annual submission for what would be the fourth quarter. As a result, positive or negative data trends were not as easily determined.

Going forward, these continuing opportunities for improvement must be addressed to ensure data accuracy and validity.

Results

This section provides MCO-specific findings from a review of performance against select grievance, appeal, and pre-service denial measures. The data used to inform results came from two sources: MCO-reported quarterly and annual grievance, appeal, and denial data for MY 2022; and from an annual record review specific to documentation practices for GAD metrics for a shorter time period: July-October 2022. When evident, data trends are identified for the first three quarters of the year and for the full year separately. Findings are displayed in table and graphical format, as appropriate, and are depicted for three consecutive quarters and the year (MY 2022). In most cases, the results between the quarterly and annual findings are similar. The data also allow for 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 (M)	≥95% for all quarters = Met (M) Compliance consistently demonstrated
Partially Met (PM)	≥95% for at least one quarter but not all quarters = Partially Met (PM) Compliance inconsistently demonstrated
Unmet (UM)	< 95% for all quarters = Unmet (UM) No evidence of compliance
Not Applicable (NA)	Not Applicable – used when information is not available for a category under review

Grievance Results

A grievance is an expression of dissatisfaction about any matter other than an adverse action and is defined in COMAR 10.67.01.01. COMAR 10.67.09.02 describes three categories of grievances:

- **Category 1**: Emergency medically related grievances
  - Example: Emergency prescription or incorrect prescription provided
- **Category 2**: Non-emergency medically related grievances
  - Example: Durable Medical Equipment/Disposable Medical Supplies-related complaints about repairs, upgrades, or vendor issues.
- **Category 3**: Administrative grievances
  - Example: Difficulty finding a network primary care provider or specialist

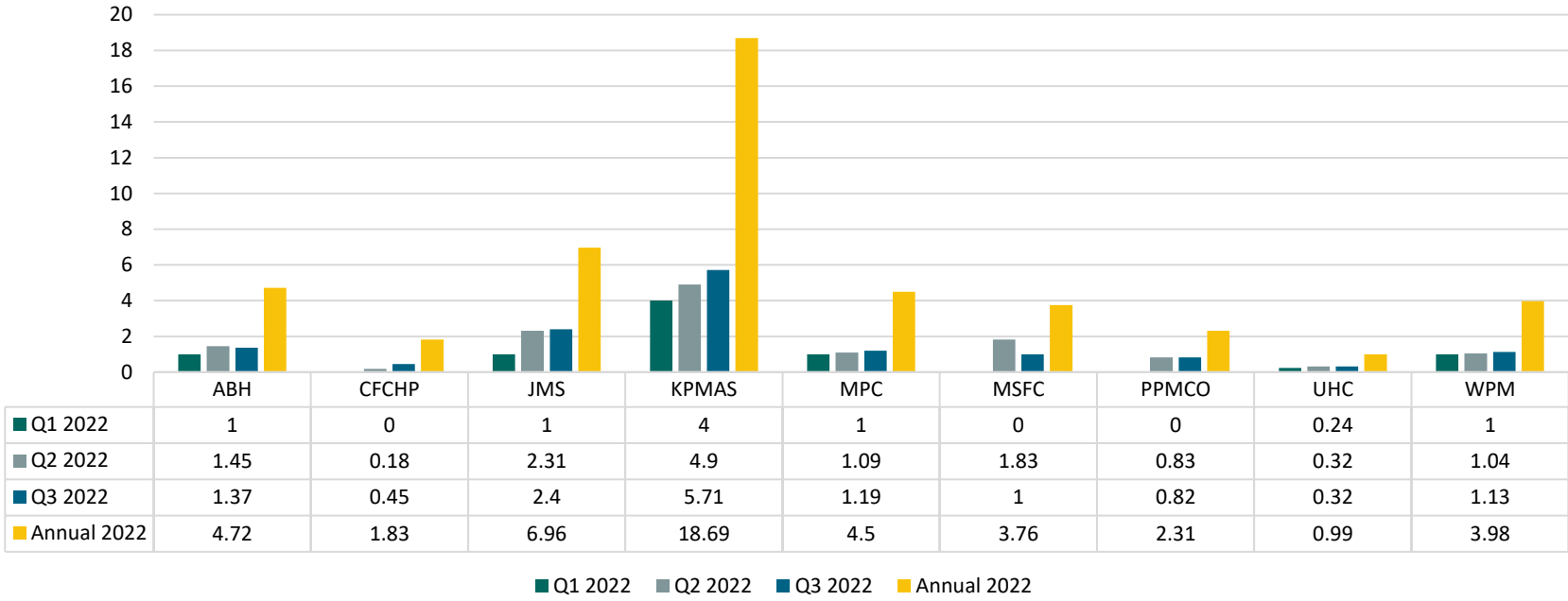
The MCO grievances review encompassed a review of comparative statistics and an assessment of compliance with federal and state laws and regulations as follows:

- Comparative Statistics
  - Grievances filed per 1,000 enrollees overall and by categories
  - Top 5 enrollee grievance service categories
  - Grievances filed per 1,000 providers overall and by categories
  - Top 5 provider grievance reason categories
- Resolution Timeframes (based upon 95% 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 1,000 enrollees for quarterly and annual reviews.

Figure 1. Grievances/1,000 Enrollees



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Q1 2022	1	0	1	4	1	0	0	0.24	1
Q2 2022	1.45	0.18	2.31	4.9	1.09	1.83	0.83	0.32	1.04
Q3 2022	1.37	0.45	2.4	5.71	1.19	1	0.82	0.32	1.13
Annual 2022	4.72	1.83	6.96	18.69	4.5	3.76	2.31	0.99	3.98

Analysis of 2022 grievance data is consistent with the prior 12-month period. KPMAS was a major outlier again in grievances per 1,000 enrollees for all three quarters and the year due to their high rate of grievances compared to their peers. This was true, especially for administrative grievances per 1,000. Attitude/service-related categories represented the majority of KPMAS grievances and JMS had the next highest rate for the year, with the majority of their grievances related to billing/financial issues. CFCHP and UHC had the lowest number of grievances for each of the timeframes reviewed.

Consistent with the prior annual report, billing/financial issues remain the top reason category for enrollee grievances for all three quarters and the year. Billing/financial issues were followed closely by access-related grievances, including pharmacy-prescription issues, attitude/service-related, "Other", and quality of care grievances. Similarly, provider grievances were billing/financial in nature with "other," and attitude/service cited as the next most common sources of grievances. These provider-specific findings are also consistent with the prior annual review period. The top grievance service categories for MY 2022 were medical surgical, pharmacy services, "other," diagnostic/lab: radiology, and vision.

Table 2 displays quarterly and annual comparisons of MCO-reported compliance with resolution timeframes for enrollee grievances. The MDH-established compliance threshold for MY 2022 was 95%.

Table 2. MCO Reported Compliance with Enrollee Grievance Resolution Timeframes

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Q1 2022	M	M	M	M	M	M	PM	M	M
Q2 2022	M	M	M	PM	M	M	PM	M	M
Q3 2022	M	PM	M	PM	M	PM	PM	M	M
Annual 2022	**M**	**PM**	**M**	**PM**	**M**	**M**	**M**	**M**	**M**

Five MCOs (ABH, JMS, MPC, UHC, and WPM) met resolution timeframes for enrollee grievances in all three quarters and for the year. MSFC demonstrated full compliance for three of the four timeframes and CFCHP in two quarters. PPMCO and KPMAS met the required timeframes in only one quarter.

Table 3 displays a comparison of MCO-reported grievances per 1,000 providers for the quarterly and annual reviews.

Table 3. MCO-Reported Grievances/1,000 Providers

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Q1 2022	0.54	2.58	0.19	0.00	0.08	0.10	0.83	0.12	1.73
Q2 2022	0.11	3.58	0.19	0.00	0.16	0.00	0.34	0.19	1.19
Q3 2022	0.07	0.74	.09	0.00	0.00	0.00	0.68	0.00	1.43
Annual 2022	**0.54**	**6.61**	**0.5**	**0.00**	**0.22**	**1.03**	**0.45**	**0.65**	**5.11**

MCO-reported grievances per 1,000 providers show variation across the nine MCOs. KPMAS has consistently reported the absence of provider grievances, while MSFC reported no provider grievances for quarters two and three. UHC and MPC reported no provider grievances for the third quarter. Of the eight MCOs reporting, CFCHP and WPM documented the highest number of grievances per 1,000 for the year and MPC, PPMCO, and JMS reported the lowest.

Table 4 displays quarterly comparisons of MCO-reported compliance with resolution timeframes for provider grievances. The MDH threshold is set at 95%.

Table 4. MCO-Reported Compliance with Provider Grievance Resolution Timeframes

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Q1 2022	M	M	M	NA	M	M	M	M	M
Q2 2022	M	M	M	NA	M	M	M	M	M
Q3 2022	NA	M	M	NA	NA	NA	M	M	M
Annual 2022	**M**	**PM**	**M**	**NA**	**M**	**M**	**M**	**M**	**M**

NA = Not Applicable

Of the eight MCOs who reported provider grievances, all but CFCHP demonstrated compliance with regulatory timeframes in all applicable quarters and for the year. CFCHP's compliance rating for administrative grievances for the year was 85%. For the first three quarters of the year, CFCHP was at 100% compliance. MCOs reporting no provider grievances were assigned NA for compliance for the relevant timeframe.

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 MY 2022. Reviews were conducted utilizing the 10/30 rule.

Table 5. MY 2022 MCO Annual Grievance Record Review Results

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Appropriately Classified	M	M	M	M	M	M	M	M	PM
Acknowledgment Letter Timeliness	M	PM	M	M	M	M	M	M	M
Issue Is Fully Described	M	UM	M	M	M	M	M	M	M
Resolution Timeliness	M	PM	M	M	M	M	M	M	PM
Resolution Appropriateness	M	M	M	M	M	M	M	M	M
Resolution Letter Timeliness	M	PM	M	M	M	M	M	M	NA
Resolution Letter in Easy-to-Understand Language	M	PM	M	M	M	M	M	M	M

NA = Not Applicable

Seven MCOs (ABH, JMS, KPMAS, MPC, MSFC, PPMCO, and UHC) received a finding of *Met* in all seven categories. One category, "Resolution Appropriateness," was consistently *Met* by all MCOs.

Two MCOs (CFCHP and WPM) received a finding of *Partially Met* for "Resolution Timeliness." CFCHP met the regulatory timeframe for grievance resolution in 77% of the 30 records reviewed. One record exceeded the five-calendar day timeframe for medically non-urgent grievances by 24 days. The remaining grievances that exceeded the regulatory timeframe were administrative with resolutions ranging from 31 to 45 days. WPM met the resolution timeframe in 90% of the 30 records reviewed. Non-compliance was attributed to the incorrect categorization of pharmacy-related grievances as administrative rather than medically non-urgent. This also resulted in WPM receiving a finding of *Partially Met* for "Appropriately Classified," as only 77% of grievances were categorized appropriately.

In addition to "Resolution Timeliness," CFCHP received a finding of *Partially Met* for both acknowledgment and resolution letter timeliness at 77% and 80%, respectively. CFCHP also received a finding of *Partially Met* as resolution letters only included a description of the grievance in 40% of the records reviewed. A finding of *Unmet* resulted from CFCHP providing incomplete documentation of grievances in case notes as steps to resolve and the resolution were missing. It should also be noted that CFCHP used a Medicare Advantage template for 10% of the resolution letters.

Appeal Results

An appeal is a request for a review of an action, as stated in COMAR 10.67.01.01. The regulation provides the following definitions of an action:

- Action 1: Denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- Action 2: Reduction, suspension, or termination of a previously authorized service.
- Action 3: Denial, in whole or part, of payment for a service, except for administrative denials of unclean claims.
- 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.

Appeal results assessed compliance with the following COMAR 10.67.09.05 regulations:

- 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 a 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.

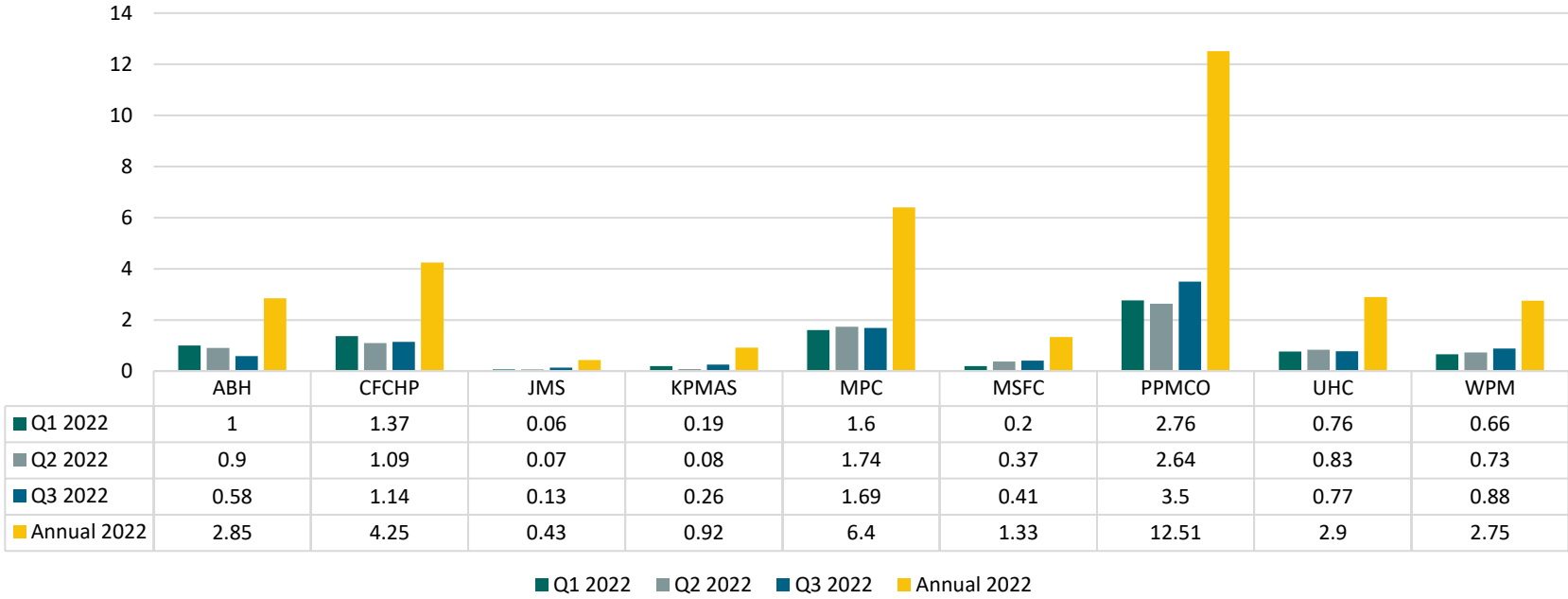
Providers can file an appeal on behalf of an enrollee, with the enrollee's written consent. COMAR previously did not require the provider to seek written authorization before filing an appeal on the enrollee's behalf. In 2020, MDH updated the expedited appeal's 72-hour timeframe to include both the resolution and notification.

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

- Comparative Statistics:
  - Appeals Filed Per 1,000 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 (95% threshold)
  - 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 3 provides a quarterly and annual comparison of MCO-reported appeals per 1,000 enrollees.

Figure 3. MCO-Reported Appeals/1,000 Enrollees



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Q1 2022	1	1.37	0.06	0.19	1.6	0.2	2.76	0.76	0.66
Q2 2022	0.9	1.09	0.07	0.08	1.74	0.37	2.64	0.83	0.73
Q3 2022	0.58	1.14	0.13	0.26	1.69	0.41	3.5	0.77	0.88
Annual 2022	2.85	4.25	0.43	0.92	6.4	1.33	12.51	2.9	2.75

In comparison to all other MCOs during the year under review, PPMCO continues to be at the top of the range in reported appeals per 1,000 enrollees. MPC and CFCHP are second and third in this ranking. Three MCOs (JMS, KPMAS, and MSFC) occupy the lower end of the range, which may be partially attributed to their lower denials per 1,000 rate. Each MCO reports its top five appeal service categories for each of the three quarters and the year. The top five appeal categories for MY 2022 align with preservice denials as follows:

- Pharmacy
- DME/DMS
- Medical/Surgical
- Medical/Surgical: Related to Therapies (PT, OT, SLP)
- Diagnostic/Lab:

Pharmacy Services was the most prevalent service category occupying the top spot for the majority of MCOs for the past three calendar years. To illustrate this, Table 6 displays the ranking of the pharmacy services category by MCO for three quarters and the year.

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

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC*	WPM*
Q1 2022	1st	1st	1st	5th	3rd	1st	1st	1st	2nd
Q2 2022	1st	1st	1st	NA	3rd	1st	1st	1st	1st
Q3 2022	1st	1st	2nd	NA	3rd	1st	1st	1st	2nd
Annual 2022	**1st**	**1st**	**1st**	**NA**	**2nd**	**1st**	**1st**	**1st**	**2nd**

*MCOs reporting Pharmacy Services: Chronic pain management on their top five list for at least one quarter
NA = Not Applicable

Five MCOs (ABH, CFCHP, MSFC, PPMCO, and UHC) reported it as the top service category in the review period. WPM reported it in the top spot for quarter two and the second spot for the remaining three quarters. Pharmacy services occupied either the second or the third rank for MPC. Two MCOs (UHC and WPM) also reported appeals related to "Pharmacy Services: Chronic pain management" within their top five list for at least one quarter. A designation of NA means the pharmacy services category was not reported in the top five. KPMAS marked it as fifth in the first quarter of 2022 and had no other reportable quarters.

Quarterly and annual 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/Notification Timeframes

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Q1 2022	M	M	M	PM	PM	PM	M	PM	PM
Q2 2022	M	M	M	M	M	M	M	M	M
Q3 2022	M	M	M	M	M	M	M	M	M
Annual 2022	**M**	**M**	**M**	**PM**	**PM**	**M**	**M**	**M**	**PM**

Four MCOs (ABH, CFCHP, JMS, and PPMCO) consistently met appeal resolution/notification timeframes for all associated quarters (when applicable). Two MCOs (MSFC and UHC) demonstrated compliance for three quarters. Three MCOs (KPMAS, MPC, and WPM) demonstrated compliance for two quarters.

Table 8 provides a comparison of appeal record review results across MCOs. Results are based upon a random selection of appeal records reviewed for MY 2022.

Table 8. MY 2022 MCO Appeal Record Review Results

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

NA = Not Applicable

A review of MCO appeal records demonstrated five of the nine MCOs (ABH, JMS, MPC, MSFC, and UHC) received a finding of *Met* in all applicable categories.

All MCOs received a finding of *Met*, as applicable, for "Processed Based Upon Level of Urgency," "Compliance with Written Notification of Denial of an Expedited Request," "Compliance with Written Notification timeframe for Non-Emergency Appeal," "Appeal Decision Documented," and "Decision Made by Health Care Professional with Appropriate Clinical Expertise."

Six of the nine MCOs (ABH, JMS, KPMAS, MPC, MSFC, and UHC) received a finding of *Met* for compliance with the timeframe for sending the enrollee written acknowledgment of appeal receipt. The three remaining MCOs (CFCHP, PPMCO, and WPM) received a finding of *Partially Met*. Timeframes for outlier CFCHP records ranged from six to 17 days. One acknowledgment letter was missing from a PPMCO record, and the other

outlier was sent in 15 days. Similarly, one WPM record did not include an acknowledgment letter, and one acknowledgment letter was sent in 28 days.

Denials of requests for an expedited resolution were found within the sample of records reviewed from three MCOs (KPMAS, PPMCO, and UHC). All three MCOs received a finding of *Met* for "Compliance with Written Notification of Denial of an Expedited Request." PPMCO received a finding of *Unmet* for "Compliance with Verbal Notification of Denial of an Expedited Request" for the one applicable record.

"Compliance with the 72-hour timeframe for Expedited Appeal Resolution and Notification" was met by five of the six applicable MCOs (ABH, MSFC, PPMCO, UHC, and WPM). KPMAS received a finding of *Unmet* for the one applicable record, as the notification was not sent for 30 days following the appeal receipt. According to case notes, the enrollee requested an expedited appeal; however, it was processed as standard with no evidence the expedited request was denied. Three of the MCOs (ABH, MSFC, and UHC) received a finding of *Met* for "Compliance with Verbal Notification of Expedited Appeal Decision." KPMAS received a finding of *Unmet* for the one record described above that was processed as standard with no evidence of denial of the expedited request. PPMCO also received a finding of *Unmet* as no documentation was provided in case records of verbal notification of resolution for its six expedited appeals. WPM received a finding of *Partially Met* as only five of 13 expedited appeal records demonstrated verbal notice of resolution.

Seven of the MCOs (ABH, JMS, KPMAS, MPC, MSFC, UHC, and WPM) received a finding of *Met* for "Decision Available to Enrollee in Easy-to-Understand Language." Both CFCHP and PPMCO received a finding of *Partially Met* as their resolution letters were not consistently written in easy-to-understand language.

Pre-Service Denial Results

Actions and decisions regarding services to enrollees and requiring prior authorization by the MCO are defined in COMAR 10.67.09.04. In compliance with COMAR 10.67.09.04, prior authorization determination timeframes included the following:

- For standard authorization decisions, the MCO shall make a determination within two business days of receipt of necessary clinical information, but no 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 prescriber notice by telephone or other telecommunication device within 24 hours of a prior authorization 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 ten 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 easy-to-understand 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.

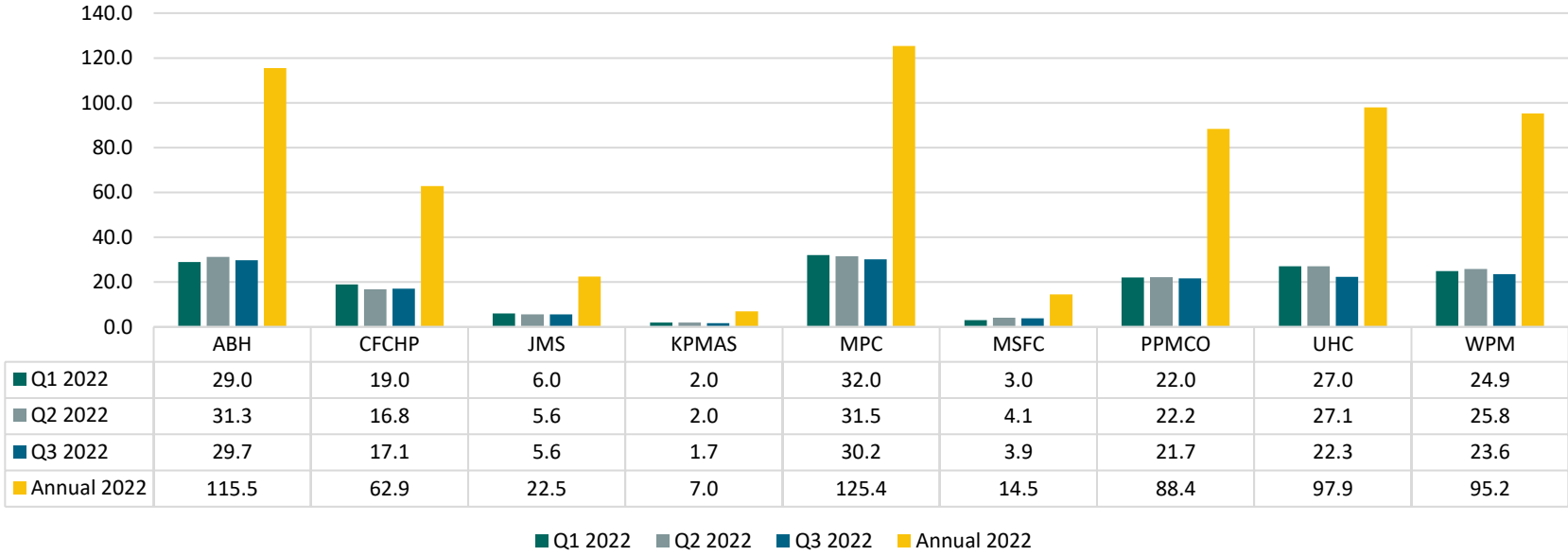
The MCO pre-service denial review encompassed the following comparative statistics and compliance with federal and state laws and regulations:

- Comparative Statistics:
    - Pre-service Denials Rendered Per 1,000 Enrollees
    - Percentages of prior authorization Requests with Complete Information

  - Percentages of prior authorization Requests Requiring Additional Information
  - Percentages of prior authorization Requests Approved
  - Percentages of prior authorization 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 threshold of 95%:
  - For standard requests within two business days of receipt of necessary clinical information, but no later than 14 calendar days from the date of the initial request.
  - For outpatient pharmacy requests within 24 hours of a prior authorization request.
  - For expedited requests, determination and notice no later than 72 hours after receipt of a request for service.
- Adverse determination notification timeframe compliance based upon a 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 ten days prior to reducing, suspending, or terminating a covered service.
- Prescriber notification of review outcome within 24 hours of receipt of a prior authorization request 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 17 required regulatory components.

Figure 4 provides a quarterly and annual comparison of MCO-reported pre-service denials per 1,000 enrollees.

Figure 4. MCO-Reported Pre-Service Denials/1,000 Enrollees



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Q1 2022	29.0	19.0	6.0	2.0	32.0	3.0	22.0	27.0	24.9
Q2 2022	31.3	16.8	5.6	2.0	31.5	4.1	22.2	27.1	25.8
Q3 2022	29.7	17.1	5.6	1.7	30.2	3.9	21.7	22.3	23.6
Annual 2022	115.5	62.9	22.5	7.0	125.4	14.5	88.4	97.9	95.2

The rates of pre-service denials per 1,000 enrollees show that JMS, KPMAS, and MSFC have few denials in comparison to the other six MCOs. ABH, MPC, and UHC had the highest pre-service denial rates among the MCOs for the first three quarters of the year. When looking at the annual data, ABH, MPC, UHC, and WPM, are outliers demonstrating the highest pre-service denial rates. Each MCO reports its top five denial service categories for each quarter. The top five preservice denial service categories for MY 2022 were:

- Pharmacy Services
- Diagnostic/Lab: Radiology
- Medical/Surgical
- Medical/Surgical- Related to Therapies (PT/OT/SLP)
- DME/DMS

Table 9 provides a quarterly and annual comparison of the top five MCO-reported pharmacy services denial categories per 1,000 enrollees.

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

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Q1 2022	1st	1st	1st	NA	2nd	1st	1st	1st	1st
Q2 2022	1st	1st	1st	NA	2nd	1st	2nd	1st	1st
Q3 2022	1st	1st	1st	NA	2nd	1st	2nd	1st	1st
Annual 2022	**1st**	**1st**	**1st**	**NA**	**2nd**	**1st**	**1st**	**1st**	**1st**

NA = Not Applicable

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, CFCHP, JMS, MSFC, UHC, and WPM) reported Pharmacy Services as the top service category for three quarters and the year. PPMCO reported it as the top service category in the first quarter and for the year, and in second place in the remaining two quarters. As with last year, MPC reported it in the second spot for all three quarters and the year. As with MY 2021 results, three MCOs (JMS, PPMCO, and UHC) reported denials related to Pharmacy Services: Chronic pain management within their top five list for each timeframe. MSFC added this service category to their top five list in the last quarter of CY 2022.

Compliance with COMAR requirements for the timeliness of pre-service determinations was assessed based on self-reporting 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 the results of the MCO's reported compliance with pre-service determination timeframes. The MDH-established compliance threshold for MY 2022 was 95%.

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

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Compliance with Expedited Pre-Service Determination Timeframes for Medical Denials									
Q1 2022	100%	100%	NA	100%	100%	100%	99%	100%	100%
Q2 2022	92%	100%	100%	100%	100%	100%	97%	100%	96%
Q3 2022	100%	100%	NA	100%	98%	NA	96%	100%	94%
Annual 2022	**99%**	**100%**	**100%**	**100%**	**99%**	**100%**	**98%**	**100%**	**98%**
Compliance with Standard Pre-Service Determination Timeframes for Medical Denials									
Q1 2022	98%	99%	100%	96%	100%	99%	99%	100%	98%
Q2 2022	99%	100%	100%	96%	100%	99%	100%	100%	94%
Q3 2022	99%	100%	100%	88%	100%	98%	100%	100%	78%
Annual 2022	**98%**	**100%**	**100%**	**92%**	**100%**	**99%**	**99%**	**100%**	**84%**
Compliance with Outpatient Pharmacy Pre-Service Determination Timeframes for Denials									
Q1 2022	100%	100%	100%	NA	100%	96%	99%	100%	100%
Q2 2022	100%	99%	100%	100%	99%	97%	99%	100%	100%
Q3 2022	99%	99%	99%	100%	98%	100%	99%	100%	100%
Annual 2022	**100%**	**99%**	**99%**	**100%**	**99%**	**98%**	**99%**	**100%**	**100%**

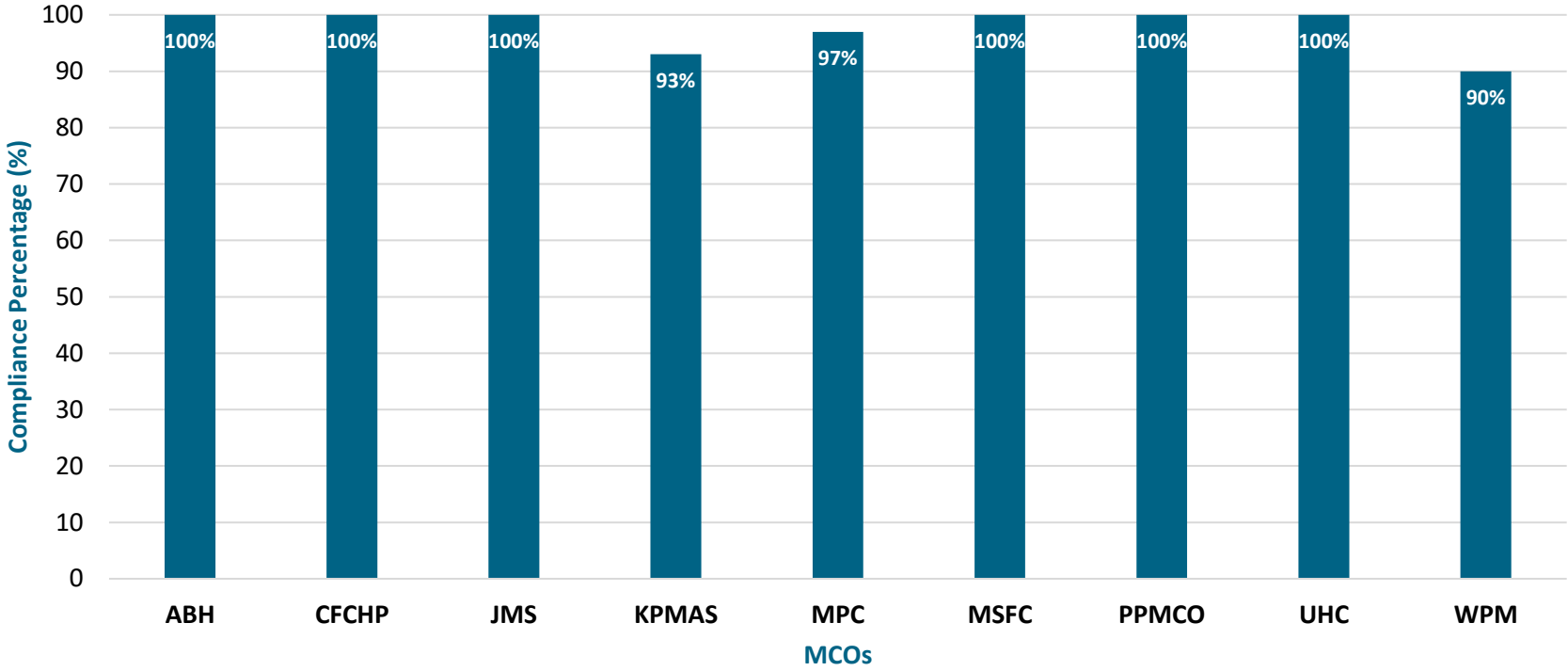
NA = Not Applicable

UHC was the only MCO to score 100% on TAT for expedited, standard, and outpatient pharmacy pre-service determinations for each quarter and the year.

Six of the MCOs (CFCHP, JMS, MPC, MSFC, PPMCO, and UHC) met or exceeded the compliance threshold for all applicable categories in each of the three quarters and the year. All MCOs met or exceeded the compliance threshold for outpatient pharmacy determinations for all three quarters and the year. ABH and WPM did not meet the compliance threshold for expedited requests in one quarter. KPMAS and WPM did not meet compliance with the standard pre-service determination timeframes for quarter three and the year. All MCOs exceeded the performance threshold for outpatient pharmacy pre-service determination timeframes.

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 MY 2022. Results are highlighted in Figure 5.

Figure 5. MCO Compliance with Pre-Service Determination Timeframes (Record Review)



A review of the record sample demonstrated that seven of the MCOs (ABH, CFCHP, JMS, MPC, MSFC, PPMCO, and UHC) met or exceeded the 95% threshold for pre-service determination timeframe compliance. Both KPMAS and WPM fell slightly below at 93% and 90% respectively. Though the percentages are not identical, these findings align with the findings from the review of KPMAS's and WPM's self-reported quarterly denial reports.

Table 11 provides a comparison of adverse determination record review results across MCOs. Results are based upon a random selection of adverse determination records reviewed for MY 2022.

Table 11. MCO Adverse Determination Records Review Issues

MCO	Issues Identified
ABH	Letter Components - Use of Easy-to-Understand Language in Enrollee Letters
CFCHP	Letter Components - Use of Easy-to-Understand Language in Enrollee Letters
UHC	Several pharmacy requests were identified as "expedited". Based upon COMAR there is no "expedited" category for pharmacy requests.

Results of MCO-reported compliance with adverse determination notification timeframes, based on the quarterly and annual reports, are highlighted in Table 12.

Table 12. MCO Reported Compliance with Adverse Determination Notification Timeframes

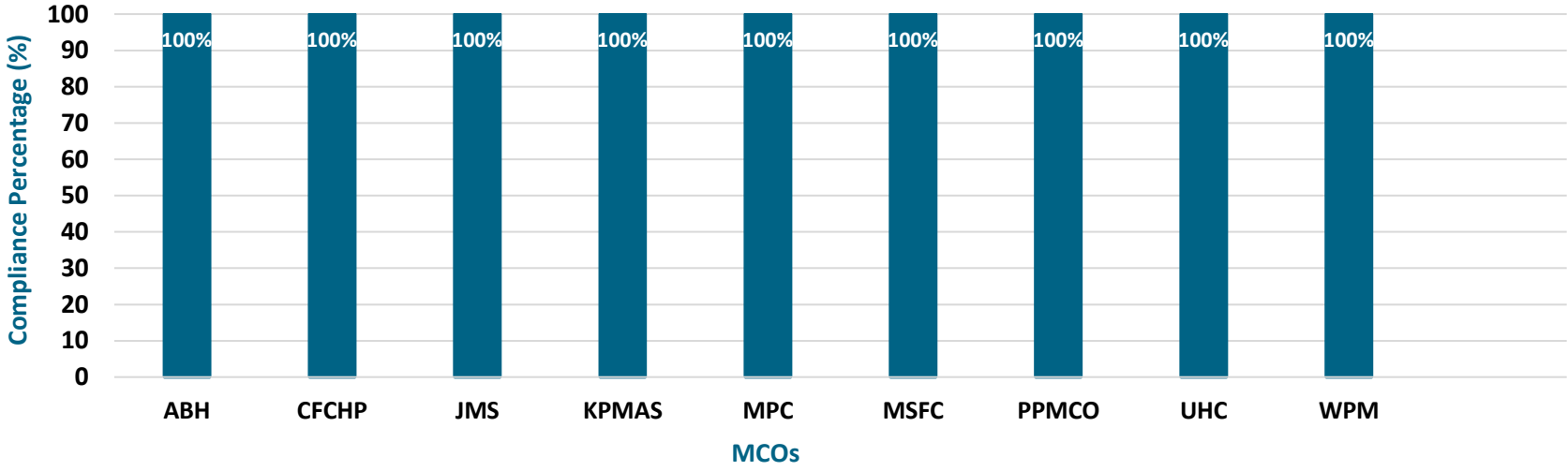
Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Compliance with Expedited Medical Adverse Determination Notification Timeframes									
Q1 2022	100%	100%	NA	100%	100%	100%	98%	100%	96%
Q2 2022	100%	100%	100%	100%	100%	100%	96%	100%	98%
Q3 2022	100%	100%	NA	100%	95%	NA	95%	100%	100%
Annual 2022	**100%**	**100%**	**100%**	**100%**	**98%**	**100%**	**95%**	**100%**	**97%**
Compliance with Standard Medical Adverse Determination Notification Timeframes									
Q1 2022	98%	100%	100%	91%	100%	99%	99%	100%	98%
Q2 2022	99%	100%	100%	97%	100&	100%	99%	100%	98%
Q3 2022	99%	100%	100%	95%	98%	99%	99%	100%	98%
Annual 2022	**98%**	**100%**	**100%**	**96%**	**99%**	**99%**	**96%**	**100%**	**98%**
Compliance with Outpatient Pharmacy Adverse Determination Notification Timeframes									
Q1 2022	100%	100%	100%	NA	100%	91%	100%	100%	100%
Q2 2022	100%	99%	99%	100%	100%	98%	100%	100%	100%
Q3 2022	99%	99%	100%	100%	100%	100%	100%	100%	100%
Annual 2022	**100%**	**99%**	**100%**	**100%**	**100%**	**97%**	**100%**	**100%**	**100%**
Compliance with Prescriber Notification of Outcome within 24 Hours									
Q1 2022	100%	100%	100%	100%	100%	96%	99%	100%	100%
Q2 2022	100%	99%	100%	100%	100%	98%	99%	100%	100%
Q3 2022	100%	100%	99%	100%	99%	100%	99%	100%	100%
Annual 2022	**100%**	**99%**	**99%**	**100%**	**100%**	**98%**	**99%**	**100%**	**100%**

NA = Not Applicable

Only two outliers fell short of full compliance within adverse determination notification TAT categories in Q1 MY 2022. For standard medical adverse notification timeframes, KPMAS fell below the compliance threshold of 95% and MSFC did not meet the same threshold for outpatient pharmacy adverse determination notifications. The remaining MCOs (ABH, CFCHP, JMS, MPC, PPMCO, UHC, and WPM) met or exceeded the compliance threshold for all applicable categories. All MCOs also met the compliance threshold for outpatient pharmacy prescriber notifications in all three quarters and the year.

Record reviews also were conducted to assess compliance with the COMAR requirement for timeliness of adverse determination notifications. Results are highlighted in Figure 6 and are based upon a random selection of adverse determination records from MY 2022.

Figure 6. MCO Compliance with Adverse Determination Notification Timeframes (Record Review)



All MCOs demonstrated 100% compliance with adverse determination notification timeframes. Table 13 provides a comparison of adverse determination record review results across MCOs. Results are based upon a random selection of adverse determination records from MY 2022.

Table 13. Results of MY 2022 Adverse Determination Record Reviews

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

NA = Not Applicable

Four MCOs demonstrated compliance with all requirements, as applicable. Both KPMAS and WPM received a finding of *Partially Met* for "Compliance with Pre-Service Determination Timeframes" as compliance at 93% and 90%, respectively, was below the MDH threshold of 95%. Both ABH and CFCHP received a finding of *Partially Met* for "Required Letter Components," as adverse determination letters were not consistently written in easy-to-understand language. MPC received a finding of *Partially Met* for "Compliance with Prescriber Notification," as telephonic notification of the requesting prescriber of the outcome of the preauthorization review exceeded the 24-hour timeframe in one of the two applicable records.

Corrective Action Plans

As part of the quarterly GAD review process, MCOs that demonstrated noncompliance with one or more timeliness requirements were not placed on a corrective action plan (CAP) in MY 2022. The data validity section, earlier in this report, identifies continued inconsistencies within some of the MCOs report submissions. Instead of requesting a CAP, Qlarant teams accountable for SPR and GAD reviews worked directly with individual MCOs to provide technical assistance when incorrect templates were used, when report errors were identified, and when Qlarant required an explanation of unusual data variances. Any corrective action needed to address non-compliant GAD findings was requested at the time of the annual SPR. For example, for MY 2022, CAPs were required for any *Partially Met* or *Unmet* GAD-related standard identified during the annual SPR performed by Qlarant. The GAD-related standards fall predominantly within 42 CFR Part 438 Subpart D on coverage and authorization of services and quality, Subpart E on enrollee rights, and Subpart F on the MCOs' grievances and appeals systems.

The SPR CAP process requires each MCO to submit a CAP, which details the actions to be taken to correct any deficiencies identified during the SPR. CAPs must be submitted within 45 calendar days of receipt of the SPR final results. CAPs are reviewed by Qlarant and determined adequate only if they address the following required elements and components:

- Action item(s) to address each required element or component
- Methodology for evaluating the effectiveness of actions taken
- Timeframe for evaluating each action item, including plans for evaluation
- Responsible party for each action item

In the event that a CAP is deemed unacceptable, Qlarant will provide technical assistance to the MCO until an acceptable CAP is submitted.

Corrective action plans are in place for eight MCOs (ABH, CFCHP, KPMAS, MPC, MSFC, PPMCO, UHC, and WPM) because of identified opportunities for improvement in the MY 2022 SPR. These CAPs included content specific to grievances, denials, and appeals.

Recommendations

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

Efforts continue to support MCOs in meeting regulatory requirements pertaining to grievances, appeals, and pre-service denials. MDH continues its comprehensive MCO oversight of GAD through its EQRO in order to ensure enrollees are not denied medically necessary services and supports and that there is a timely and effective avenue for enrollees to have recourse through the appeal process.

MCOs have shown improvements in reporting and regulatory compliance over the course of MY 2022. Moving forward, MCOs continue to have opportunities to improve, as noted in Table 13, with the timeliness of determination and notification decisions and in documenting GAD appropriately in the enrollee record. CAPs through the SPR process are in place to address MCOs with ongoing issues in demonstrating compliance.

Because of opportunities identified following the MY 2021 focused review, Table 14 displays MDH's implementation and planned implementation of the following changes:

Table 14. Implementation of MY 2021 Recommendations

MY 2021 Recommendations	MDH Implementation
Require MCOs to implement routine quality oversight of all grievance, appeal, and denial quarterly report submissions and explore options to support ongoing data quality of reports.	MDH and the EQRO have begun sharing resubmission data with the MCOs. In addition, MDH continues to adjust the submission templates to include formulas and macros that promote accurate reporting.
Crosscheck MCO-reported provider grievances with grievances that are submitted to MDH to ensure all grievances are accounted for in MCO report submissions.	MDH is working on an internal process to compare self-reported MCO data to complaint data through its customer service lines.
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 is working on an internal process to review preauthorization denials more closely on at least a semiannual basis.
Consider including compliance with timeframes for sending a written acknowledgment of grievance receipt, a written resolution of the grievance, and a written acknowledgment of appeal receipt in the quarterly grievance and appeal reports submitted by the MCOs. This supports the inclusion of these requirements in the CY 2021 SPR standards.	MDH will work with the EQRO to determine what would be an appropriate metric to measure compliance with this requirement, as the element is already captured in the Systems Performance Review process.
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.	MDH will evaluate including additional grievance categories to MCO reporting.

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

- **MDH Opportunity**: Continue to explore options with Qlarant and the MCOs to reduce the complexity/redundancy of the GAD data collection process. Examples to consider:
    - Conduct a crosswalk of SPR standards with quarterly GAD reporting data to determine where redundancies can be eliminated.

  - Consider eliminating the annual GAD record review currently performed as part of the SPR. Align the record review with the quarterly GAD review to provide more real time results.
  - Identify the most relevant GAD metrics to monitor on a quarterly and annual basis. These should be meaningful data that the MCOs and MDH can act upon to make improvements (i.e., those required by regulatory bodies and those that may adversely affect enrollee access to medically necessary services). These could include for example, all clinically related grievances, denials, and appeals timeliness metrics, denial and appeal rates, decisions to uphold or overturn as well as monitoring appeals and denials. Performance thresholds should be developed for each metric and should be evidence-based or based on historical MCO data.

- **MDH Opportunity**: Convene a meeting with Qlarant and the MCOs to obtain feedback on the GAD process. Identify systemic barriers hindering the accuracy of data entry and aspects of the process that are working well. Clarify all performance requirements and expectations.
- **MDH Opportunity:** Initiate a more real time corrective action plan process for GAD. Corrective action plans must be based upon clearly defined performance metrics, such as the 95% threshold MDH currently has in place, to monitor GAD timeliness metrics.
- **MDH Opportunity:** Consider making GAD a Performance Improvement Project (PIP) that can be structured and consistent in its implementation. The process is familiar to the MCOs and requires ongoing monitoring by the EQRO and MDH.
- **MCO Opportunity.** Provide greater explanation of data variances when submitting GAD quarterly reports. The reports have a place for this and not all MCOs use this section to aid in the analysis of data. All "Other" reason and service categories in the top five should clearly describe what "Other" issues are.
- **MCO Opportunity:** The number of provider grievances continues to be underreported 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, and 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.

Conclusions

This report includes studies of MCO grievance, appeal, and denial quarterly reports for MY 2022. Additionally, a sample of grievance, appeal, and adverse determination records were reviewed for MY 2022.

Conclusions for the GAD review for MY 2022 are drawn primarily from Annual GAD Report data found in Tables 2, 4, 7, 10, and 12 and the annual record review data is found in Tables 5, 8, 11, and 13 and Figures 5 and 6. Table 15 provides a summary of the opportunities identified from a review of these data.

Table 15. Summary of Opportunities for Improvement Identified in the MY 2022 GAD Review

Improvement Opportunities by End of MY 2022	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Grievances-GAD Reports									
Compliance with Enrollee Grievance Resolution Timeframes	-	X	-	X	-	-	-	-	-
Compliance with Provider Grievance Resolution Timeframes	-	X	-	-	-	-	-	-	-
Grievance Record Review Results									
Appropriately Classified	-	-	-	-	-	-	-	-	X
Acknowledgment Letter Timeliness	-	X	-	-	-	-	-	-	-
Issue Is Fully Described	-	X	-	-	-	-	-	-	-
Resolution Timeliness	-	X	-	-	-	-	-	-	X
Resolution Letter Timeliness	-	X	-	-	-	-	-	-	-
Resolution Letter in Easy-to-Understand Language	-	X	-	-	-	-	-	-	-
Appeals-GAD Reports									
Compliance with Enrollee Appeal Resolution/Notification Timeframes	-	-	-	X	X	-	-	-	X
Appeal Record Review Results									
Compliance with Timeframe for Written Appeal Acknowledgment Letter	-	X	-	-	-	-	X	-	X
Compliance with Verbal Notification of Denial of an Expedited Request	-	-	-	-	-	-	X	-	-
Compliance with 72-hour Timeframe for Expedited Appeal Resolution/ Notification	-	-	-	X	-	-	-	-	-
Compliance with Verbal Notification of Expedited Appeal Decision	-	-	-	X	-	-	X	-	X
Decision Available to Enrollee in Easy-to-Understand Language	-	X	-	-	-	-	X	-	-
Pre-Service Denials-GAD Reports									
Compliance with Standard Pre-Service Determination Timeframes for Medical Denials	-	-	-	X	-	-	-	-	X

Improvement Opportunities by End of MY 2022	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Pre-Service Determination Timeframes (Record Review)	-	-	-	X	-	-	-	-	X
Adverse Determination Records Review Results									
Letter Components – Use of Easy-to-Understand Language in Enrollee Letters	X	X	-	-	-	-	-	-	-
Inappropriate classification pharmacy requests were identified as "expedited	-	-	-	-	-	-	-	X	-
Adverse Determination Record Reviews									
Compliance with Pre-Service Determination Timeframes	-	-	-	X	-	-	-	-	X
Required Letter Components	X	X	-	-	-	-	-	-	-
Compliance with Prescriber Notification	-	-	-	-	X	-	-	-	-

X= Opportunity for improvement
(-) = No opportunity for improvement

- Four MCOs (CFCHP, KPMAS, PPMCO, and WPM) account for 85% of the opportunities for improvement, with PPMCO contributing 13% of the opportunities.

- When looking at individual MCOs, the following opportunities are noted:
  - The two ABH findings are related to documentation of adverse determinations.
  - CFCHP's issues are predominately with grievance systems timeliness and documentation.
  - KPMAS and WPM findings cross all three GAD categories.
  - MPC had two issues, one with appeals resolution/notification timeliness and documentation of prescriber notification.
  - PPMCO's findings are focused on improving documentation in appeal records.
  - UHC had one finding related to adverse determination record review: inappropriate classification of a pharmacy request as expedited.

- Of significance is that JMS and MSFC had no negative findings at the end of the year. ABH and MPC had two, and UHC only one.

This level of compliance helps to ensure the delivery of quality care and services to HealthChoice enrollees. With the exception of outliers noted above, MCO strengths are 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 grievances
- Timeliness of grievance resolution letters
- Grievance resolution letters written in easy-to-understand language
- Appeals processed based on the level of urgency of enrollee appeal resolutions
- Appeal decisions made by a healthcare professional with appropriate expertise
- Appeal decisions are documented and available to the enrollee in an easy-to-understand language
- Timely pre-service determinations
- Timely pre-service adverse determination written notifications
- Timely prescriber notifications of prior authorization review outcome
- Required components in adverse determination letters
- Adverse determinations appropriate based upon MCO medical necessity criteria and policies

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, Appeals, and Pre-Service Denials are found in Appendices B, C, and D.

The MCO-specific results from quarterly assessments and annual 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 to other MCOs
- Compliance
- Strengths
- Improvements
- Opportunities
- Recommendations

Additionally, an evaluation of the impact on quality and timeliness has been included for each of the above categories, as applicable. Due to the limited impact on access across all MCOs, it has not been included as a category in the tables that follow.

For this evaluation, Qlarant has adopted the following definitions for quality 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]).
- **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).

Table 14. ABH Specific Summary: Strengths, Improvements, Recommendations

Quality	Timeliness	Aetna Better Health of Maryland	
X		**Trends**	• Overall results have remained consistent over the year.
X		**Comparison to Other MCOs**	• Uniquely lists Substance Abuse as the second most prevalent member service grievance. • Member and provider grievances per 1,000 remain at the low end of the MCO range. • Appeals per 1,000 are at the bottom end of the MCO range. • Percentage of prior authorization requests received with complete information is in the top of the MCO range

	X	**Compliance**	• For both the record review and the quarterly/annual self-reported GAD data:
			  ○ All grievance and appeal timeframes met for acknowledgment, resolution, and notification.
			  ○ All timeframes met for pre-service determinations, prescriber notifications, and adverse determination notifications.

X	X	**Strengths**	• Consistently exceeds compliance thresholds for all record reviews and quarterly/annual GAD self-report data. • Consistently meets all appeals resolution timeframes for expedited and non-emergency appeals. • Consistently meets member and provider grievance metrics at 100% for the year. • Both grievance acknowledgment and resolution letters provided a detailed description of the enrollee grievance.
X	X	**Improvements**	• Consistent compliance in meeting timeframes for appeal resolution/notification. • Consistent compliance with enrollee verbal notification of an expedited appeal decision. • Appeal acknowledgment and resolution letters are written in plain language, include required and correct content in all fields, and use proper grammar. • Consistent compliance in meeting timeframes for pre-service determinations.
X		**Opportunities**	• Adverse determination notifications written in easy-to-understand language.
X		**Recommendations**	• Routinely audit a sample of adverse determination notifications to ensure the use of easy-to-understand language. • All appeal acknowledgment letters included a statement that the enrollee has requested to continue receiving services while their appeal is being reviewed. In most cases, this statement is inappropriate, as the service, being appealed is a discrete one-time service, such as an MRI. This statement should only be

Quality	Timeliness	Aetna Better Health of Maryland	
			used when an enrollee specifically requests continuation of benefits; otherwise, the statement should be revised to reflect the right of the enrollee to continuation of benefits and potential member liability if the denial is upheld.

Table 15. CFCHP Specific Summary: Strengths, Improvements, Recommendations

Quality	Timeliness	CareFirst Community Health Plan	
	X	**Trends**	• Compliance with timeframe for enrollee grievance resolution shows a decline from Q2 to the end of year.
X		**Comparison to Other MCOs**	• Reports the highest number of provider grievances/1,000 at 6.61/1,000. • Percentage of prior authorization requests received with complete information in the top of the MCO range Percentage of prior authorization requests approved are toward the top of the other MCO results range. • Expedited pre-service medical denials are at the low end of the range.
X	X	**Compliance**	GAD Reports: • Compliance with timeframes for member grievance resolution for Category 3: Administrative Grievance did not meet the required threshold in Q3 and for the year. • Compliance with timeframes for provider grievance resolution for Category 3: Administrative Grievance did not meet the required threshold for the year. • Compliance with member resolution timeframes exceeded the threshold for both standard and expedited appeals in all three quarters and the year. • Compliance with all determination/notification timeframes in all three quarters and the year for pre-service denials. Record Review: • Compliance with the timeframe for written acknowledgment of grievance receipt was evident in 63% of the records reviewed.

Quality	Timeliness	CareFirst Community Health Plan	
			• Compliance with the timeframe for grievance resolution was evident in 77% of the records reviewed. • Compliance with the timeframe for written grievance resolution notification was evident in 80% of the records reviewed. • Compliance with the required content for grievance resolution letters was evident in 40% of the records reviewed. • Compliance with the timeframe for written acknowledgment of appeal receipt was evident in 77% of the records reviewed. • Compliance with the timeframe for appeal resolution notification was evident in 100% of the records reviewed. • Compliance with timeframes for determination and notification of pre-service denials for standard, expedited, and outpatient pharmacy was reported via the quarterly GAD reports and by record review to exceed the threshold in all categories. • All timeframes met for pre-service determinations, prescriber notifications, and adverse determination notifications.
X	X	**Strengths**	• All grievances appropriately categorized and resolved. • Member resolution timeframes exceeded the threshold for both standard and expedited appeals in all three quarters and the year. • Met compliance for determination/notification timeframes in all three quarters and the year for pre-service denials. • MCO routinely reaches out for technical assistance to improve processes.
	X	**Improvements**	• Consistent compliance with pre-service determination timeframes.
X	X	**Opportunities**	• Improve timeframes for resolution for both member and provider Category 3: administrative grievances. • Consistent timeframe compliance for grievance acknowledgment letters, resolution, and grievance resolution letters. • Consistent compliance with required content for grievance resolution notifications (description of grievance). • Use of correct template for grievance resolution letters.

Quality	Timeliness	CareFirst Community Health Plan	
			• Adverse determination and appeal resolution letters written in easy-to-understand language. • Grievance case notes include documentation of investigation and resolution.
X	X	**Recommendations**	• Increase monitoring of timeframe compliance for written acknowledgment of grievance and appeal receipt, grievance resolution, and grievance and appeal resolution notifications until consistent compliance is demonstrated over multiple measurement periods. • Conduct routine audits of grievance resolution and adverse determination letters to ensure the use of correct letter templates and content in easy-to-understand language. • In view of the number of opportunities related to grievances, retrain grievance staff on procedures and timeframes for processing grievances.

Table 16. JMS Specific Summary: Strengths, Improvements, Recommendations

Quality	Timeliness	Jai Medical Systems, Inc.	
X		**Trends**	• Overall results have been consistent over the last year.
X		**Comparison to Other MCOs**	• Member and provider grievances/1,000 are at the low end of the MCO range. • Emergency medically related member grievances/1,000 are the highest of all MCOs. • There is an absence of or extremely low number of appeals.
	X	**Compliance**	**No deficiencies were noted for the year.** GAD Reports: • Timeframes met for member and provider grievances at 100% for the year in all applicable categories. • Reports 100% compliance with the appeal resolution timeframe for expedited and non-emergency appeals. Record review: • All grievance and appeal timeframes met for acknowledgment, resolution, and notification.

Quality	Timeliness	Jai Medical Systems, Inc.	
			• All timeframes met for pre-service determinations, prescriber notifications, and adverse determination notifications.
X	X	**Strengths**	• Consistently met member and provider grievance resolution metrics and appeal resolution timeframes. • Met all pre-service denial determination and notification timeframes for the year. • All grievances appropriately categorized and resolved. Case notes fully document grievance, interventions, and resolution. • All adverse determination letters were written in easy-to-understand language and provided detailed information describing the reason for the adverse determination and any additional information needed for reconsideration.
	X	**Improvements**	• Consistent compliance with adverse determination notification timeframes.
		Opportunities	There are no formal opportunities.
X		**Recommendations**	• It was observed in the sample record review that all appeals were overturned because the prescriber submitted additional information upon appeal. JMS may want to consider strategies for improving the completeness of outpatient pharmacy prior authorization requests submitted by providers.

Table 17. KPMAS Specific Summary: Strengths, Improvements, Recommendations

Quality	Timeliness	Kaiser Permanente of the Mid-Atlantic States, Inc.	
X	X	**Trends**	• KPMAS results showed greater variation from other MCOs • Unmet timeframes for emergency medically related grievances showed a downward trend in Q2, Q3, and for the year.
X		**Comparison to Other MCOs**	• Member administrative grievances per 1,000 remain the highest. • Top grievance reason codes differ from the other MCOs in two categories, Attitude/Service - Administrative Staff (3B), and Attitude/Service - MCO Customer Service (3C). • Only 25% of appeals are from denials received. • Most appeals (97%) come from members, not providers. • Percentage of prior authorization requests received with complete information is the highest of MCOs. • Percentage of prior authorization requests approved went from the highest in Q3 2022 to the lowest for the year. • Denials per 1,000 members remain the lowest. • Percentage of preservice denials for members < 21 years of age is at the top of the range. • Percentage of standard pre-service medical denials is the highest. • Expedited pre-service medical denials and pre-service outpatient pharmacy denials are the lowest.
	X	**Compliance**	GAD Reports: • Unmet timeframes for emergency medically related grievances showed a downward trend in Q2, Q3, and for the year. • Timeframes not met with expedited appeals resolution timeframes in Q1 and for the year. • Met compliance with pre-service denials determination and notification timeframes in all categories, except standard pre-service medical denials. Record Review: • All grievance timeframes met for acknowledgment, resolution, and notification. • Consistent timeframe compliance for appeal acknowledgment letters.

Quality	Timeliness	Kaiser Permanente of the Mid-Atlantic States, Inc.	
			• No evidence of compliance with expedited appeal resolution verbal and written notification timeframe (member requested expedited resolution; however, the appeal was processed as standard, with no evidence of denial of an expedited request.) • Consistent timeframe compliance for standard appeal resolution/notification letters. • Compliance with pre-service determination timeframes was 93%. • Consistent compliance with the timeframe for adverse determination notifications.
X	X	**Strengths**	• Grievances appropriately categorized and resolved. • Met compliance with appeal acknowledgment letters, appeal resolutions, and pre-service denials determination/notification timeframes in all categories but one.
X	X	**Improvements**	• Appropriate categorization of grievances. • Consistent compliance in meeting resolution timeframes for enrollee grievances. • Consistent compliance in meeting the timeframe for written acknowledgment of enrollee appeal receipt. • Consistent compliance in meeting the timeframes for adverse determination notifications.
X	X	**Opportunities**	• Consistent compliance with timeframes for emergency medically related grievances. • Consistent compliance with expedited appeals resolution timeframes • Consistent compliance with notifying enrollees orally and in writing of the denial of a request for expedited appeal resolution. • Consistent compliance in meeting the 95% threshold for timeliness of pre-service determinations.
X	X	**Recommendations**	• Routinely audit a sample of grievance acknowledgment and resolution letters. Mandatory fields were left blank in one of the acknowledgment letters and the date of grievance receipt identified in a resolution letter was different from the date in the case notes. • It was observed that many grievances were the result of adult members receiving routine vision services in less than 24 months. Benefit is for one routine eye exam every two years. While stated in the member handbook, a process should be established to advise enrollees of their eligibility at the time an appointment is made. • Routinely audit a sample of case notes to ensure that enrollees are notified, both verbally and in writing, of any denial of a request for an expedited appeal resolution.

Quality	Timeliness	Kaiser Permanente of the Mid-Atlantic States, Inc.	
			• Increase monitoring of compliance with determination timeframes, until consistent compliance is demonstrated over multiple measurement periods.

Table 18. MPC Specific Summary: Strengths, Improvements, Recommendations

Quality	Timeliness	Maryland Physicians Care	
X		**Trends**	• Overall results have been consistent over the last year.
X		**Comparison to Other MCOs**	• Member grievances per 1,000 are at the lower end of the MCO range. • Provider grievances per 1,000 are at the lowest of the range. • Primary source for appeals is providers, the most of all the MCOs. • Percentage of overturned denials has remained consistently in the lower range. • Pre-service denials per 1,000 members rate is at the top of the MCO range.
X	X	**Compliance**	GAD Reports: • Compliance met for all member and provider grievance resolution timeframes. • Compliance with the timeframe for expedited appeals fell below the threshold for all applicable timeframes in the year. • Compliance with the non-emergency appeals resolution timeframe was reported at 100% • Compliance with pre-service denial determination and notification TATs met the compliance threshold for the year. Record Review: • All grievance and appeal timeframes met for acknowledgment, resolution, and notification. • Compliance with determination and adverse determination timeframes met. • Compliance with 24-hour prescriber notification of review outcome was 50% (one of two applicable records).
X		**Strengths**	• Minimal compliance issues for the year.

Quality	Timeliness	Maryland Physicians Care	
			• Met all applicable grievance and pre-service denial metrics for the year. • Comprehensive case notes document grievance, investigation, and resolution. All are appropriately categorized and resolved. Resolution letters in plain language and fully describe the grievance and resolution. • All appeal resolution letters were written in easy-to-understand language and provided detailed explanations of the enrollee's needs and reason for the decision. • All adverse determination letters were written in easy-to-understand language and provided a detailed explanation of the requested services and the reason(s) for the determination.
	X	**Improvements**	• Compliance with the self-reported timeframe for expedited appeals fell below the threshold for the year, though there is a noticeable improvement from Q3 2022 to the end of the year. • Consistent compliance with the timeframe for sending enrollee acknowledgment of appeal receipt. • Consistent compliance with the timeframes for appeal resolution/notification in record review.
	X	**Opportunities**	• Consistent compliance with required 24-hour, prescriber-notification timeframes. • Consistent compliance with the timeframes for expedited appeals.
X		**Recommendations**	• Increase routine monitoring of case notes until consistent compliance is demonstrated with the timeframe for prescriber notification of review outcomes over multiple measurement periods.

Table 19. MSFC Specific Summary: Strengths, Improvements, Recommendations

Quality	Timeliness	MedStar Family Choice, Inc.	
X		**Trends**	• Overall results have been consistent over the last year.
X		**Comparison to Other MCOs**	• Member grievances per 1,000 rate are at the low end of the MCO range. • Percentage of expedited appeals at the high end. • Percentage of prior authorization requests approved was the highest for the year.
X	X	**Compliance**	**No deficiencies were noted for year-end.** GAD Reports:

Quality	Timeliness	MedStar Family Choice, Inc.	
			• Reported compliance with provider grievance resolution timeframes. • Reported non-compliance with timeliness on non-emergency medically related grievances. • Reported compliance with non-emergency and expedited appeal resolution timeframes. • Reported compliance with all pre-service denial determination and notification timeframes for the year. Record Review: • All grievance and appeal timeframes met for acknowledgment, resolution, and notification. • All timeframes met for pre-service determinations, prescriber notifications, and adverse determination notifications. • All member grievances were resolved within regulatory timeframes, with the exception of Non-emergency Medically Related grievances (50% for Q3 and 93% for the year). • All grievance and appeal timeframes met for acknowledgment, resolution, and notification. • All timeframes met for pre-service determinations, prescriber notifications, and adverse determination notifications.
X		**Strengths**	• Consistently met all appeals and pre-service denial metrics. • All grievances appropriately categorized and resolved. Case notes fully document the grievance, investigation, and resolution. • Adverse determination and appeal resolution letters provide one of the best examples of the use of easy-to-understand language.
	X	**Improvements**	• Consistent compliance with adverse determination notification timeframes.
	X	**Opportunities**	• Consistent compliance with timeliness on non-emergency medically related grievances.
		Recommendations	There are no formal recommendations.

Table 20. PPMCO Specific Summary: Strengths, Improvements, Recommendations

Quality	Timeliness	Priority Partners	
X		**Trends**	• Overall results have been consistent over the last year.
X		**Comparison to Other MCOs**	• Member grievances per 1,000 are at the lower end of the MCO range. • Appeals per 1,000 members is the highest of the MCOs. • Prior authorization requests received with complete information continue to be the lowest of the MCO range.
X	X	**Compliance**	Quarterly GAD Reports: • Compliance with administrative grievance resolution met in all 3 quarters and the year. • Emergency medically related grievances did not meet compliance with TAT in Q3. • Non-emergency medically related grievance timeframes did not meet compliance in all three quarters and then improved to 100% at the end of the year. • Compliance with expedited and non-emergency appeals resolution timeliness met in all three quarters and the year. • Standard, expedited, and pharmacy pre-service denial determination and notification timeframes met in all quarters and for the year. Record Review: • All grievance timeframes met for acknowledgment, resolution, and notification. • Compliance with the timeframe for appeal acknowledgment letters was 93%. • Timeframes for expedited appeal resolution/notification were 100% and 96% for standard appeal resolution/notification. • There was no evidence of enrollee oral notification of an expedited appeal resolution in case notes.
X	X	**Strengths**	• Met administrative grievance resolution in all 3 quarters and the year. • Standard, expedited, and pharmacy pre-service denial determination and notification timeframes consistently met compliance in MY 2022. • All grievances appropriately categorized and resolved. • Grievances, investigation, and resolution are well documented in case notes.

Quality	Timeliness	Priority Partners	
X	X	**Improvements**	• PPMCO made improvements to the TAT for member administrative grievances and non-emergency medically related grievances moving from non-compliance in the first three quarters to a compliance rate of 100% for the year. • Appropriate categorization of grievances (emergency-medically related, non-emergency medically related, and administrative). • Consistent compliance with enrollee grievance resolution timeframes.
X	X	**Opportunities**	• Consistent compliance with emergency medically related and non-emergency medically related grievance timeframes. • Consistent compliance with the timeframe for appeal acknowledgments. • Consistent compliance in documenting oral notifications to enrollees of expedited appeal resolution. • All appeal resolution letters are written in easy-to-understand language.
X	X	**Recommendations**	• Continue efforts to identify causes for non-compliance in emergency and non-emergency grievance resolution timeframes. • Retrain the appeals team on documentation standards for expedited appeals and use of easy-to-understand language in enrollee appeal letters. • Routinely audit appeal case notes to ensure compliance with documentation standards. • Routinely audit appeal resolution letters to ensure the use of easy-to-understand language. • Increase monitoring of timeframe compliance for appeal acknowledgment letters until consistent compliance is demonstrated over multiple measurement periods.

Table 21. UHC Specific Summary: Strengths, Improvements, Recommendations

Quality	Timeliness	UnitedHealthcare Community Plans	
X		**Trends**	• Overall, UHC's results have been consistent over the last year.
X	X	**Comparison to Other MCOs**	• Only MCO to meet 100% of grievance TAT metrics in all applicable categories and in all four timeframes. • Member grievances per 1,000 are the lowest of the MCOs.

Quality	Timeliness	UnitedHealthcare Community Plans	
			• Appeals per 1,000 members it is at the low end of the range. • Percentage of expedited appeals is at the top of the range. • Percentage of prior authorization requests received with complete information is the lowest across MCOs.
X	X	**Compliance**	**No major deficiencies in the year except for misclassifying a pharmacy request.** GAD Quarterly Reports: • Met grievance and denial TAT metrics in all applicable categories and in all four timeframes reviewed. • Expedited appeals resolution did not meet compliance in Q1 2022. All subsequent quarters met compliance. Record Review: • All grievance and appeal timeframes met for acknowledgment, resolution, and notification. • All timeframes met for pre-service determinations, prescriber notifications, and adverse determination notifications. • Compliance with resolution timeframes met the established threshold this year for both non-emergency and expedited appeals. • Compliance with pre-service denial determination and notification timeframes met 100% in all categories during each review period.
X	X	**Strengths**	• In quarterly GAD reports, UHC consistently provides explanations for data variances and documents its own improvement strategy to include, for example, staff training, process modification, and increased oversight. • Met 100% of grievance and denial TAT metrics in all applicable categories during each review period. • All grievances appropriately categorized and resolved. Comprehensive case notes document grievance, investigation, and resolution. Letters were written in easy-to-understand language and described grievance and resolution. In particular, paraphrasing the member's grievances in his or her own words reflects member's concern is heard and understood. • Thorough documentation of enrollee appeals in case notes.
X	X	**Improvements**	• Appropriate categorization of grievances.

Quality	Timeliness	UnitedHealthcare Community Plans	
			• Consistent compliance in meeting timeframe for written acknowledgment of receipt of enrollee grievance. • Consistent compliance in meeting the timeframe for written acknowledgment of receipt of enrollee appeal. • Consistent compliance with appeal resolution/notification timeframes. • Date of appeal is the date the provider filed on behalf of the enrollee, not the date of enrollee consent.
		Opportunities	There are no formal opportunities.
X		**Recommendations**	• Several pharmacy requests were incorrectly identified as expedited. Based upon COMAR, there is no expedited category for pharmacy prior authorization requests.

Table 22. WPM Specific Summary: Strengths, Improvements, Recommendations

Quality	Timeliness	Wellpoint Maryland	
X		**Trends**	• Standard pre-service medical denial determinations were on a downward trend in the first three quarters of the year with performance at 98%, 94%, and 78%. At year-end, performance is at 83%,
X		**Comparison to Other MCOs**	• Member grievances per 1,000 are at the low end of the MCO range. • Provider grievances per,1000 are at the high end of the MCO range. • Member appeals per 1,000 falls at the low end of the range. • Percentage of prior authorization requests received with complete information is high. • Percentage of prior authorization requests approved is low. • Percentage of Pre-Service Outpatient Pharmacy Denials is low.
X	X	**Compliance**	GAD Quarterly Reports: • Met TAT compliance at 100% for all applicable member and provider grievance categories in all three quarters and the year. • Met the non-emergency appeals resolution timeliness threshold in all three quarters and the year.

Quality	Timeliness	Wellpoint Maryland	
			• Did not meet expedited appeals resolution timeframes in all three quarters and the year. Percentages during each review period varied as follows: Q1 (83%), Q2 (93%), Q3 (94%), and year (87%). • Did not meet expedited pre-service denial determination timeframes in Q3. • Did not meet standard pre-service medical denial determination timeframes in Q2 and Q3 and for the year. Percentages varied as follows: Q1-98%, Q2-94%, Q3-78%, and year-84% • Met pre-service denial notification timeframes in all three quarters and the year. Record Review: • Compliance with the timeframe for the grievance acknowledgment letter was 100%. • Compliance with the timeframe for grievance resolution was 90%. • Compliance with the timeframe for the appeal acknowledgment letter was 93%. • Compliance with the appeal resolution notification timeframe was 100%. • Compliance with providing oral notice of an expedited appeal resolution was 38%. • Compliance with the pre-service determination timeframe was 90%. • Compliance with timeframes for prescriber notification of review outcome and enrollee adverse determination notice was 100%.
X	X	**Strengths**	• WPM requests team meetings with Qlarant to remedy non-compliant metrics. • Consistently met compliance at 100% for all applicable member and provider grievance categories in all three quarters and the year. • Consistently met the non-emergency appeals resolution timeliness threshold in all three quarters and the year. • All grievances appropriately resolved.
X	X	**Improvements**	• Initial, then consistent compliance with expedited appeals resolution timeframes. • Consistent compliance with timeframes for resolution/notification of enrollee appeals. • Consistent compliance with timeframes for adverse determination notifications. • Use of the current letter template and easy-to-understand language in pharmacy adverse determination letters.
	X	**Opportunities**	• Compliance with timeframes for expedited appeals resolution.

Quality	Timeliness	Wellpoint Maryland	
			• Consistent compliance with expedited and standard pre-service denial determination timeframes. • Appropriate categorization of grievances. • Consistent compliance with grievance resolution timeframe. • Consistent compliance with the timeframe for appeal acknowledgment letters and reasonable attempts to provide enrollees with oral notice of expedited resolution.
X	X	**Recommendations**	• Provide training to the grievance team focused on the appropriate categorization of grievances and associated resolution timeframes. Routinely conduct audits of case notes to ensure appropriate categorization and compliance with resolution timeframes. • Increase monitoring of timeframe compliance for grievance resolution, appeal acknowledgment letters, and pre-service determinations, until consistent compliance is demonstrated over multiple measurement periods. • Conduct routine audits of appeal case notes for documentation of reasonable attempts to provide enrollee verbal notice of expedited appeal resolution. • Audit a random sample of enrollee appeal letters to ensure the correct template is used. One acknowledgment letter was for a provider rather than an enrollee appeal.

Appendix B: Grievance Review Template

<MCO> Grievances for <X> Quarter<Year> Results & Analysis						
	Current Quarter	**Prior Quarter**	**Qx 202x**	**Qx 202x**	**Status**	**Other MCO Results**
Total Member Grievances Received in the Quarter						
Total Member Grievances Resolved in the Quarter						
Grievances/1000 Members						
Member Grievances by Category						
Category 1: Emergency medically related (rate/1000)						
Category 2: Non-emergency medically related (rate/1000)						
Category 3: Administrative (rate/1000)						
Top 5 Member Grievances Received by Service Code						
Service Code (#/%)						
Service Code (#/%)						
Service Code (#/%)						
Service Code (#/%)						
Service Code (#/%)						
Member Grievances TAT Met (standard 95% compliance)						
Category 1: Emergency medically related (#/%)						
Category 2: Non-emergency medically related (#/%)						
Category 3: Administrative (#/%)						
Total Provider Grievances Received in the Quarter						
Total Provider Grievances Resolved in the Quarter						
Grievances/1000 Providers						

<MCO> Grievances for <X> Quarter<Year> Results & Analysis						
	Current Quarter	**Prior Quarter**	**Qx 202x**	**Qx 202x**	**Status**	**Other MCO Results**
Provider Grievances by Category						
Category 1: Emergency medically related (rate/1000)						
Category 2: Non-emergency medically related (rate/1000)						
Category 3: Administrative (rate/1000)						
Top 5 Provider Grievances Received by Service Category						
Service Code (#/%)						
Service Code (#/%)						
Service Code (#/%)						
Service Code (#/%)						
Service Code (#/%)						
Provider Grievances TAT Met (standard 95% compliance)						
Category 1: Emergency medically related (#/%)						
Category 2: Non-emergency medically related (#/%)						
Category 3: Administrative (#/%)						
Analysis						
Recommendations						

Appendix C: Appeal Review Template

<MCO> Appeals for <X> Quarter<Year> Results & Analysis						
	Current Quarter	**Prior Quarter**	**Qx 202x**	**Qx 202x**	**Status**	**Other MCO Results**
Total Appeals Received in the Quarter						
Total Appeals Resolved in the Quarter						
Appeals/1000 Members						
Member Appeal Sources						
Appeals from Denials Received (#/%)						
Appeals Submitted by Members (#/%)						
Appeals Submitted by Providers (#/%)						
Appeal Outcomes						
Upheld (#/%)						
Overturned (#/%)						
Overturned 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						

<MCO> Appeals for <X> Quarter<Year> Results & Analysis						
	Current Quarter	**Prior Quarter**	**Qx 202x**	**Qx 202x**	**Status**	**Other MCO Results**
Resolved (#/%)						
Upheld (#/%)						
Overturned (#/%)						
Category 2						
Resolved (#/%)						
Upheld (#/%)						
Overturned (#/%)						
Category 3						
Resolved (#/%)						
Upheld (#/%)						
Overturned (#/%)						
Category 4						
Resolved (#/%)						
Upheld (#/%)						
Overturned (#/%)						
Category 5						
Resolved (#/%)						
Upheld (#/%)						
Overturned (#/%)						
Expedited Appeals (#/%)						
Extended Appeals (#/%)						
Resolution TAT Met (standard 95% compliance)						
Expedited (#/%)						
Non-Emergency (#/%)						
Analysis						
Recommendations						

Appendix D: Pre-Service Denial Review Template

<MCO> Pre-Service Denials for <X> Quarter<Year> Results & Analysis						
	Current Quarter	**Prior Quarter**	**Qx 202x**	**Qx 202x**	**Status**	**Other MCO Results**
Total PA Requests Received in the Quarter						
Total PA 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 Members Under 21 (#/%)						
Standard Pre-Service Medical Denials (#/%)						
Expedited Pre-Service Medical Denials (#/%)						
Pre-Service Outpatient Pharmacy Denials (#/%)						
Pre-Service Denials/1000 Members						
Top 5 Service Categories						
Service Category (#/%)						
Service Category (#/%)						
Service Category (#/%)						
Service Category (#/%)						
Service Category (#/%)						
Top 5 Denial Reasons						
Denial Reason						
Denial Reason						
Denial Reason						

<MCO> Pre-Service Denials for <X> Quarter<Year> Results & Analysis						
	Current Quarter	**Prior Quarter**	**Qx 202x**	**Qx 202x**	**Status**	**Other MCO Results**
Denial Reason						
Denial Reason						
Determination TAT Met (standard 95% compliance)						
Standard Pre-Service Medical Denials (#/%)						
Expedited Pre-Service Medical Denials (#/%)						
Pre-Service Outpatient Pharmacy Denials (#/%)						
Notification TAT Met (standard 95% compliance)						
Standard Pre-Service Medical Denials (#/%)						
Expedited Pre-Service Medical Denials (#/%)						
Pre-Service Outpatient Pharmacy Denials (#/%)						
Prescriber Notification TAT Requirements						
Prescriber Notification of Outcome within 24 Hours (#/%)						
Analysis						
Recommendations						