Maryland
DEPARTMENT OF HEALTH

Maryland HealthChoice Program

Grievances, Appeals, & Denials Focused Review Report

Measurement Year 2025

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Qlarant

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Maryland HealthChoice Program

Grievances, Appeals, and Denials Focused Review Report

Executive Summary

HealthChoice Program Overview

Maryland's Medicaid Managed Care Program, known as HealthChoice, is a comprehensive system of continuous quality improvement, which includes problem identification, analysis, corrective action, and re-evaluation to identify and address areas for improvement. HealthChoice serves Marylanders on Medicaid by developing processes and systems capable of profiling and tracking information regarding the care received by HealthChoice enrollees. Guiding principles for HealthChoice's operations are to provide quality healthcare that is equitable, patient-focused, prevention-oriented, coordinated, accessible, and cost-effective. HealthChoice emphasizes health promotion and disease prevention and requires managed care organizations (MCOs) to provide health education and outreach services.

External Quality Review

The Maryland Department of Health (MDH) is responsible for evaluating the quality of care provided to eligible HealthChoice enrollees by contracted MCOs. MDH contracts with Qlarant to conduct external quality reviews (EQRs) and to assess compliance with standards governing the HealthChoice program in the Code of Federal Regulations (CFR) and Code of Maryland Regulations (COMAR) through the Centers for Medicare & Medicaid Services (CMS) protocols. Qlarant's annual, independent reviews evaluate quality, access, and timeliness of care; assess appropriateness of denials through quarterly review of service denial reports submitted by each MCO; and assess handling of grievances and appeals annually through record reviews.

This report assesses MCO compliance with federal and state regulations in a validation of grievance, appeal, and pre-service denial data (GAD) against performance standards defined for measurement year (MY) 2025. No MCOs were exempt from this task and include the following:

- Aetna Better Health of Maryland (ABH)
- CareFirst BlueCross BlueShield 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)

Objective

Qlarant conducts quality studies to ensure MCOs comply with federal and state regulations governing requirements and timelines of notices for enrollee and provider grievances, enrollee appeals, pre-service authorization requests, and adverse determinations; facilitates increased compliance by illustrating trends and opportunities for improvement (OFI) and providing recommendations; and ensures HealthChoice enrollees are not denied access to medically necessary services and supports. These studies consist of quarterly and annual validations of data provided by the MCOs, annual record reviews, and a comparison of each MCO's performance with their peers, including year-over-year performance assessments when data is available.

Key Findings

MY 2025 GAD review conclusions were drawn from MCO-reported compliance data and from GAD record review findings. MCOs submitted GAD reports quarterly for the first three quarters of MY 2025 and annual data in lieu of the fourth quarter. Annual record reviews involved assessing MCO compliance with GAD processing requirements, timeliness of notifications to enrollees, letter content requirements, and ease of understanding communications/letters to enrollees. The tables below compare the number and type of MCO OFIs.

MY 2025's GAD studies observed the following about MCO compliance:

- **Continued Opportunities.** Four MCOs account for 26 of the 36 OFIs in both the record review and MCO-reported findings (CFCHP: 7, KPMAS: 6, MSFC: 7, and UHC: 6). UHC has had a continued OFI for demonstrating evidence in case notes of prescriber notification by telephone or telecommunication device of the outcome of a preauthorization request within 24 hours of receipt for the last three MYs. PPMCO is the only MCO having resolved all of their previous OFIs noted over the past two years to have zero in MY 2025.

Table 1. Annual Trending Comparison of GAD Opportunities for Improvement

Improvement Opportunities Comparison	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total # of Opportunities MY 2023	1	2	2	1	3	1	5	6	3
Total # of Opportunities MY 2024	0	1	1	3	1	2	5	8	2
Total # of Opportunities MY 2025	3	7	2	6	2	7	0	6	3
MY 2023 to MY 2025 Comparison	**+2**	**+5**	**0**	**+5**	**-1**	**+6**	**-5**	**0**	**0**
MY 2024 to MY 2025 Comparison	**+3**	**+6**	**+1**	**+3**	**+1**	**+5**	**-5**	**-2**	**+1**

- OFI amounts decreased from MY to MY; + OFI amounts increased from MY to MY

Table 2. MY 2025 Summary of Opportunities for Improvement

Improvement Opportunities	MY 2025
GAD Reports	**MCO**
Grievances: Emergency grievance resolution timeliness	KPMAS
Grievances: Non-emergency grievance resolution timeliness	UHC
Grievances: Administrative Provider grievance resolution timeliness	UHC and WPM
Appeals: Expedited enrollee appeal resolution timeliness	CFCHP and KPMAS
Appeals: Non-emergency enrollee appeal resolution timeliness	JMS
Pre-Service Denials: Expedited pre-service denial resolution/determination timeliness	MSFC and UHC
Pre-Service Denials: Expedited pre-service denial notification timeliness	MSFC and UHC
Pre-Service Denials: Standard pre-service denial resolution/determination timeliness	CFCHP
Pre-Service Denials: Standard pre-service denial notification timeliness	CFCHP
Record Review Results	**MCO**
Grievances: Appropriately classified.	ABH and UHC
Grievances: Acknowledgement letters include correct resolution timeframe.	CFCHP
Appeals: Written confirmation of an oral appeal removed from acknowledgment letter.	ABH
Appeals: Compliance with timeframe for enrollee written appeal acknowledgment.	JMS
Appeals: Compliance with appropriate MD HealthChoice appeal acknowledgment letter template.	WPM
Appeals: Acknowledgment letters include accurate resolution/notification timeframes and dates.	KPMAS and MSFC
Appeals: Compliance with providing oral notice to enrollee of an expedited appeal resolution.	ABH, MSFC, and WPM
Appeals: Compliance with providing written notice to enrollee of an expedited appeal resolution	MSFC
Appeals: Compliance with providing oral notice to enrollee of denial of an expedited appeal resolution.	CFCHP and MPC
Appeals: Compliance with providing written notification of denial of an expedited appeal request.	MPC
Appeals: Compliance with timeframe for written notice of standard appeal resolution.	KPMAS and MSFC
Appeals: Compliance with timeframe for written resolution/notification of expedited appeal resolution.	KPMAS
Appeals: Compliance with appropriate MD HealthChoice appeal resolution letter template.	CFCHP
Appeals: Appeal resolution letters consistently reference correct enrollee name.	KPMAS
Appeals: Appeal records uploaded are consistent with requirements.	MSFC
Adverse Determinations: Compliance with 24-hour prescriber notification	UHC
Adverse Determinations: Compliance with including copy to requesting provider on adverse determination letters.	CFCHP

Measurement Year 2025

Methodology

Description of Data Obtained. Qlarant assessed MCO compliance based on MCO-reported data and conducted an annual record review of MY 2025's sample of grievance, appeal, and pre-service denial records. Each MCO provided Qlarant with a listing of grievances, appeals, and pre-service denials for MY 2025. Qlarant selected 40 cases from each listing, using a random sampling approach, and requested each MCO upload the selected case records. Reviews utilized the 10/30 rule, where initial samples of ten grievance, ten appeal, and ten denial records were reviewed; and an additional 20 records were reviewed when noncompliant components were identified within the first ten records.

Technical Methods of Data Collection and Analysis. Qlarant develops MDH-approved templates for each reporting category as a review tool to validate and evaluate quarterly and annual MCO report submissions. Following validation of the data MCOs submitted, these review tools allowed Qlarant to enter data from the MCO reports and identify areas of noncompliance. Aggregated MCO results allow peer comparisons and identification of MCO-specific trends after three years of data are available. Quarterly and annual reports submitted to MDH included analysis of MCO data and recommendations, as appropriate. MCOs received separate reports with summarized quarterly review findings to identify areas for follow-up when data issues, ongoing noncompliance, or negative trends were identified. MDH received results of the overall grievance, appeal, and pre-service denial record reviews, including strengths, best practices, and opportunities for improvement, as a component of each systems performance review (SPR) report. Appropriate staff for each MCO received results of the record reviews and received technical assistance, as needed, to facilitate improved compliance.

Annual record reviews and reports are used to assist in determining MCO performance scores for various components and provide peer comparisons and trended performance results. Unless otherwise indicated, all three-year comparisons in the report refer to 2023, 2024, and 2025.

Performance Thresholds. Recent studies conducted by the Office of the Inspector General (OIG) and the Government Accountability Office (GAO)[1],[2] emphasize the importance of monitoring grievances, appeals, and denials to ensure enrollees in managed care have access to needed services. The OIG identified and selected seven MCO parent companies with the largest number of people enrolled in comprehensive, risk-based MCOs across all states. These seven parent companies operated 115 MCOs in 37 states, which enrolled a total of 29.8 million people in 2019. OIG collected data on denials and related appeals for each MCO they operated. OIG also surveyed state Medicaid agency officials from the 37 states to examine selected aspects of state oversight of MCO prior authorization (PA) denials and appeals, along with state processes for external medical reviews and state fair hearing.

[1] July 2023. Office of Inspector General (OIG). High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care.
[2] March 2024, Government Accountability Office (GAO) report, Medicaid Managed Care Additional Federal Action Needed to Fully Leverage New Appeals and Grievance Data.

42 CFR §438.210 defines federal standards and allows MCOs to set limits on the amount of care given to HealthChoice enrollees (e.g., a specific number of visits for therapies). MCOs may also request prior authorization from providers to determine the medical necessity of, for example, certain diagnostic or surgical procedures. MDH recognizes the importance of the OIG's monitoring, as Maryland MCOs receive a fixed payment for each enrollee served, with the expectation that each MCO ensures enrollees receive appropriate and timely access to the array of benefits HealthChoice offers. MDH must monitor MCO practices against the freedoms allowed by CFR regulations and provide the necessary safeguards to prevent MCOs from limiting or denying needed care to benefit financially.

In MY 2025, MDH worked with Qlarant to identify performance thresholds for several GAD metrics. Without a performance threshold and benchmark, MCO oversight is far more subjective and does not allow for valid peer-to-peer comparisons. These metrics would enhance the ability to determine performance variances that may exist within the Managed Care Program Annual Report (MCPAR) requirements. Using guidance from the GAO studies and as a place to obtain baseline data, MDH established performance thresholds for the following metrics:

- Establishing the standard for all timeliness metrics to meet or exceed a 95% compliance score.
- Identifying grievances, appeals, and denials per 1,000 enrollees and utilizing the median score of the nine MCOs as a gauge for peer-to-peer comparisons.
- Identifying percent of appeals with more than 50% overturned, indicating favor to the enrollee.

No performance thresholds are placed on grievances. This practice encourages both enrollees and providers to report their concerns. All grievances are categorized and assessed for performance improvement opportunities.

Qlarant used four determinations to identify the MY 2025 compliance designations used to document MCO performance outcomes specific to timeliness of GAD determinations and notifications for both MCO-reported and record review findings: *Met (M*), *Partially Met (PM)*, *Unmet (UM)*, and *Not Applicable (NA)*. These determinations are based upon the percentage of MCO compliance to specific GAD measures, such as timeliness of resolutions and notifications. MDH established a minimum compliance threshold for MY 2025 timeliness metrics at 95%.

Table 3. MY 2025 GAD Timeliness Review Determinations

Review Determination	Explanation of Determination
Met	MCO achieves ≥95% for all reporting periods and demonstrates consistent compliance.
Partially Met	MCO achieves ≥95% for at least one reporting period, but not all reporting periods; and demonstrates inconsistent compliance.
Unmet	MCO achieves <95% for all reporting periods and demonstrates no evidence of compliance.
Not Applicable	Qlarant uses when information is not available for a category under review.
Compliance Threshold	**MDH established minimum compliance for MY 2025 timeliness metrics at 95%.**

Corrective Action Plans (CAPs). 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. As part of the quarterly GAD review process, MCOs that demonstrated noncompliance with one or more timeliness requirements were not placed on a CAP in MY 2025. Instead of requesting a CAP, Qlarant's teams accountable for SPR and GAD reviews work directly with individual MCOs to provide technical assistance when data gaps and 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.

Recognizing the need to provide more real-time and meaningful feedback to the MCOs, Qlarant and MDH continue to collaborate to identify key GAD performance metrics that align with recommendations from CMS and MDH and have the most immediate impact on enrollee care and outcomes. Until such time that all MCOs perform favorably against an established threshold, or when CMS and/or MDH establish a different performance threshold, Qlarant will continue to use the key performance indicators outlined in the *Performance Thresholds* subsection above as a means for providing MCOs with guidance and education to reduce the need for more formal corrective action.

Timelines. MY 2025's GAD reviews are quarterly and annual, with record requests from July 1 through October 31, 2025. This timeline allows MCOs an opportunity to address and fully implement any recent regulatory changes noted as incomplete during the SPR conducted earlier in 2025. All MCOs submit quarterly GAD reports to Qlarant within 30 days after the close of the first three quarters, while the fourth quarter includes review of the annual data submitted 30 days after the close of the fourth quarter. Any required CAPs identified through the SPR must be submitted within 45 calendar days of receipt of the final SPR results.

Grievance Results

Description

A grievance is an expression of dissatisfaction about any matter other than an adverse action and is defined in COMAR 10.67.01.01. Grievances 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, employee, or failure to respect the enrollee's rights, regardless of whether remedial action is required. COMAR 10.67.09.02.C1 describes three grievance categories:

- **Category 1:** Emergency medically related grievances
  - Example: Emergency prescription or incorrect prescription provided
- **Category 2:** Non-emergency medically related grievances
  - Example: Durable medical equipment (DME)/disposable medical supplies (DMS)-related complaints about repairs, upgrades, or vendor issues.
- **Category 3:** Administrative grievances
  - Example: Difficulty finding a network primary care provider or specialist.

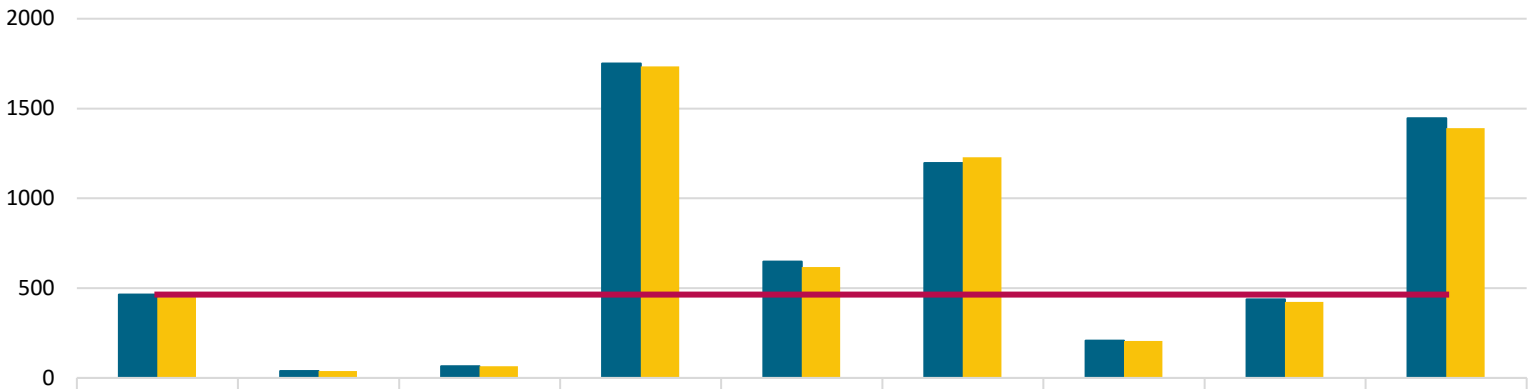
Comparative Statistics

This section includes comparative statistics and trends results for MCO-reported grievances received and resolved in MY 2025, enrollee grievances per 1,000 enrollees and per 1,000 providers for annual reviews; and identifies the most prevalent enrollee grievance reason codes and the most prevalent enrollee and provider grievance service categories.

Enrollee Grievances Received and Resolved

In MY 2025, Maryland MCOs collectively received 6,251 enrollee grievances and resolved 6,154 (98%). The figure on the next page shows each MCO's performance on these two metrics. The range of enrollee grievances received across MCOs is 38 to 1,750, with the median as 464. The graph illustrates that KPMAS, MPC, MSFC, and WPM reported grievance counts above the median.

Figure 1. MY 2025 Enrollee Grievances Received and Resolved (MCO-Reported Results)

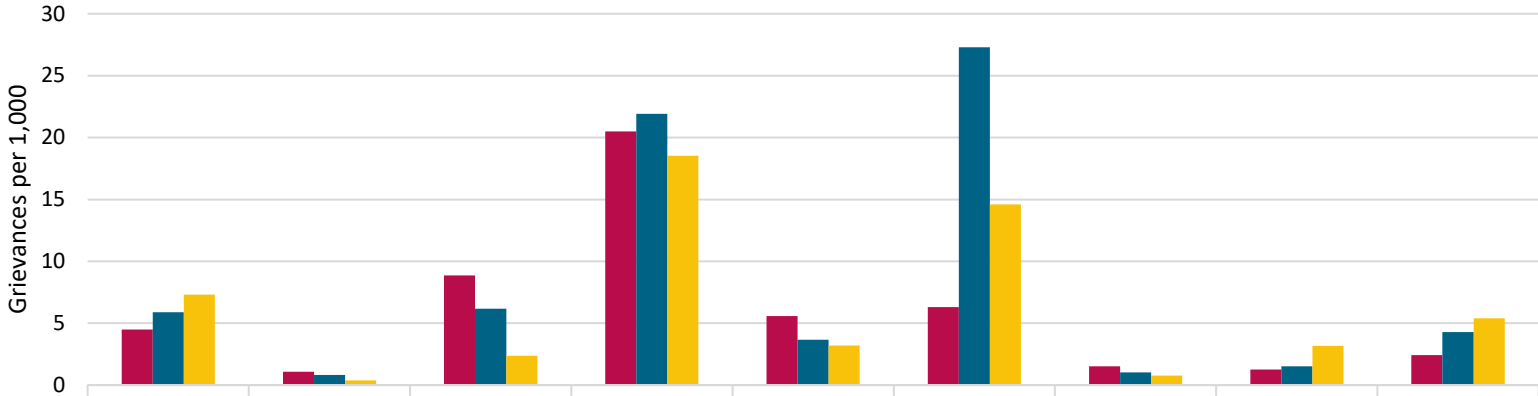


	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Received	464	38	66	1750	647	1197	207	437	1445
Resolved	450	38	66	1735	617	1229	205	424	1390
Median	464	464	464	464	464	464	464	464	464

Enrollee Grievances per 1,000

Enrollee grievances per 1,000 are determined using each MCO's total enrollee population at the time of the annual GAD assessment. This calculation provides a standardized method for making comparisons across MCOs for identifying variances and recommending OFIs. The figure on the next page shows the rates of MCO-reported grievances per 1,000 enrollees across MCOs over the trending years (MYs 2023 through 2025).

Figure 2. Annual Trending MCO Reported Grievances per 1,000 Enrollees (MCO-Reported Results)



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2023	4.48	1.08	8.85	20.50	5.57	6.31	1.53	1.26	2.41
Annual 2024	5.88	0.81	6.16	21.91	3.67	27.30	1.03	1.52	4.28
Annual 2025	7.30	0.37	2.36	18.54	3.21	14.60	0.78	3.18	5.39

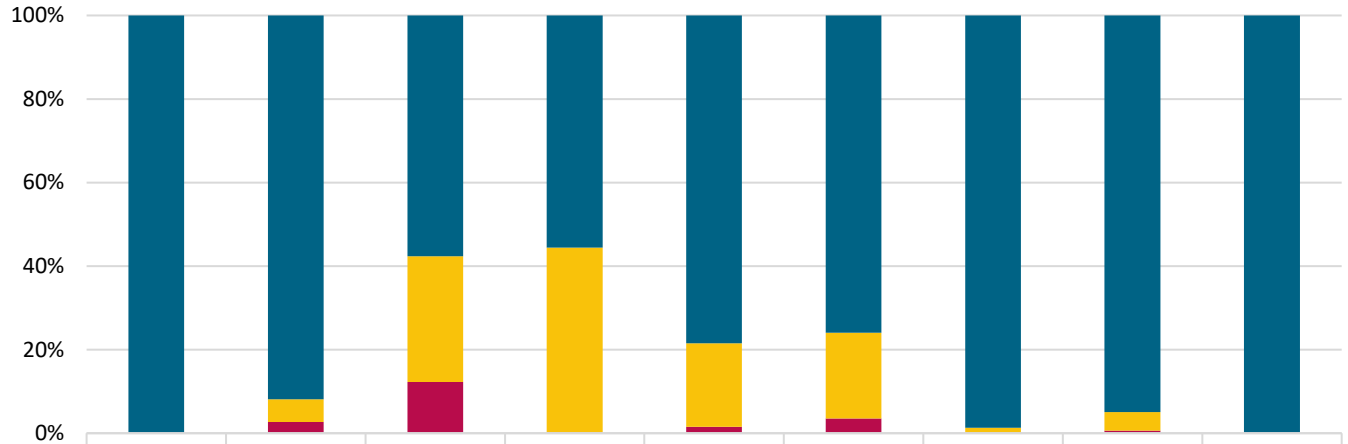
MY 2025's GAD studies observed the following about rates per 1,000 enrollee grievances:

- **Median.** All nine MCOs reported enrollee grievances for MY 2025. The range across MCOs is 0.37 to 18.54. The median for grievances per 1,000 enrollees is 3.21. When assessed by per 1,000 enrollees, the MCOs with enrollee grievances above the median include ABH (7.30), KPMAS (18.54), MSFC (14.60), and WPM (5.39). MCOs falling below the median include CFCHP (0.37), JMS (2.36), PPMCO (0.78), and UHC (3.18). MPC falls at the median (3.21).
- **Peer Comparisons.** CFCHP (0.37) continues to have the lowest enrollee grievances per 1,000 and KPMAS (18.54) the highest. KPMAS reported the highest number in 2023 and 2025, while MSFC held the highest rate in 2024.
- **Trending.** Overall, the median for enrollee grievances per 1,000 is trending downward, from MY 2023 (4.48) to MY 2024 (4.28), and continuing into MY 2025 (3.21). Six MCOs showed a decline in enrollee grievances per 1,000 from MY 2024 to MY 2025. The three outliers (ABH, UHC, and WPM) have grievances per 1,000 on an upward trend throughout MY 2023 to MY 2025. CFCHP documented the lowest enrollee grievances per year for all three years of measurement.

For MY 2025, the figure on the next page illustrates the number of grievances per 1,000 received by category of grievance and by MCO:

- **Median.** For the administrative category, the range is 0.34 (CFCHP) to 11.09 (MSFC), and the median is 3.02. Qlarant utilizes the median for means of peer comparison.
- **Peer Comparison.** ABH (7.30), KPMAS (10.30), MSFC (11.09), and WPM (5.39) have the highest enrollee grievances per 1,000 for Category 3: Administrative. The range for Category 2: Non-emergency is 0.00 to 8.21. KPMAS and MSFC are the outliers with the highest per 1,000 rate of 8.21 and 3.00, respectively. The remainder of the MCOs have grievances at or below 0.71, with ABH and WPM reporting zero. The number of grievances in Category 1: Emergency Medically Related, is even smaller with ABH, PPMCO, and WPM having zero, to MSFC having the highest (0.51) and JMS the next highest (0.29).
- **Trending.** The figure below shows that most enrollee grievances fall into Category 3: Administrative. Very few Category 2: Standard, Non-emergency Medically Related enrollee grievances were reported in MY 2025.

Figure 3. MY 2025 Enrollee Grievances per 1,000 by Category (MCO-Reported Results)



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Category 3: Administrative	7.30	0.34	1.36	10.30	2.51	11.09	0.76	3.02	5.39
Category 2: Non-emergency	0.00	0.02	0.71	8.21	0.64	3.00	0.01	0.14	0.00
Category 1: Emergency	0.00	0.01	0.29	0.03	0.05	0.51	0.00	0.02	0.00

Enrollee Grievance Reason and Service Codes

MCOs identify the top reasons for enrollee grievances and the most prevalent service categories for enrollee grievances within each quarterly report. MCOs can submit rationale for data variances, including comparisons to prior quarters or years. MY 2025's GAD studies observed the following about categorizing enrollee grievances:

- **Peer Comparisons.** In MY 2025, the top five most prevalent reasons for enrollee grievances fell into the following categories by rank: 2/Access; 2B/Access-Pharmacy/Prescription Issues; 3/Attitude/Service; a three-way tie of reasons codes 1/Quality, 3A/Attitude/Service-Practitioner, and 4/Billing/Financial; and finally, 7/Other. The table below provides a crosswalk of individual MCO top reasons against the MY 2025 MCO aggregate top five. Access, access-pharmacy/prescription, and MCO and provider attitude and services were prevalent with most MCOs.

Table 4. MY 2025 Enrollee Grievance Reason Codes - Aggregate Top 5 by MCO (MCO-Reported Results)

Reason Code	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
2/Access	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	**7**
2B/Access-Pharmacy/Prescription	No	Yes	Yes	No	Yes	Yes	Yes	No	Yes	**6**
3/Attitude/Service	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	**6**
1/Quality	No	Yes	Yes	Yes	No	No	No	Yes	Yes	**5**
3A/Attitude/Service-Practitioner	Yes	No	Yes	No	Yes	Yes	Yes	No	No	**5**
4/Billing/Financial	Yes	No	No	No	Yes	Yes	Yes	Yes	No	**5**
7/Other	No	Yes	No	Yes	No	No	Yes	No	No	**3**

MCOs also identify the top five enrollee grievance service categories with their quarterly and annual submissions. For MY 2025 the table below lists the top five service categories in the order of prevalence, including: 5A/Pharmacy Services, 4A/Medical Surgical, 9/Other, 8/Vision, and 1A/Diagnostic/Lab.

Table 5. MY 2025 Enrollee Grievance Service Categories - Aggregate Top 5 by MCO (MCO-Reported Results)

Service Category	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
5A/Pharmacy Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**9**
4A/Medical Surgical	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	**8**
9/Other	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	**7**
8/Vision Services	Yes	Yes	No	Yes	No	No	No	No	Yes	**4**
1A/Diagnostic/Lab	No	No	No	No	No	Yes	No	Yes	Yes	**3**

Each of the nine MCOs identified 5A/Pharmacy Services in the top five service categories. Eight MCOs (except PPMCO) had 4A/Medical Surgical in the top five. Seven MCOs identified 9/Other in the top five, and four had 8/Vision. While still appearing in the top five, 1A/Diagnostic/Lab shows a decline in prevalence for MY 2025.

The table below offers comparisons of reason codes and service categories over the three-year period, MYs 2023 to 2025. MY 2025's GAD studies observed the following about top grievance reason codes and service categories:

- **Year-to-Year Comparison.** In comparison to MY 2024, 4/Billing/Financial moved out of the top position and 2B/Access-Pharmacy/Prescription Issues moved into the top five during MY 2025.
- **Contributing Factors.** A downward trend in total grievances is reportedly driven by a substantial reduction in billing and financial errors through provider and enrollee education. Other MCO-reported factors contributing to enrollee dissatisfaction in MY 2025 continue to include balanced billing as a result of enrollees failing to present their Medicaid identification card at the time of service; access-related grievances about office locations or difficulty in accessing a needed service, such as mental health; pre-service denials for services, such as Botox; and pharmacy-prescription issues, such as computer errors delaying receipt of medication. Enrollees continue to express concerns with attitude/service issues resulting from disliking the provider or MCO and negative perceptions, such as rudeness or lack of quality with the practitioner, MCO, and staff; and poor MCO customer service experience.

Table 6. Annual Trending Enrollee Grievance Reason Codes – Aggregate Top 5 by Prevalence (MCO-Reported Results)

MY 2023	MY 2024	MY 2025
1: 3A/Attitude/Service **2:** 3B/Attitude/Service-Administrative Staff **3:** 2/Access **4:** 2B/Access: Pharmacy Prescription **5:** 4/Billing/Financial	**1:** 4/Billing/Financial **2:** 2/Access **3:** 3/Attitude/Service **4:** 7/Other **5: (Tie)** 3A/Attitude/Service-Practitioner **5: (Tie)** 3C/Attitude/Service-MCO Customer Service **5: (Tie)** 1/Quality	**1**: 2/Access **2:** 2B/Access-Pharmacy/Prescription **3:** 3/Attitude/Service **4: (Tie)** 1/Quality **4: (Tie)** 3A/Attitude/Service: Practitioner **4: (Tie)** 4/Billing/Financial **5:** 7/Other

Table 7. Annual Trending Enrollee Grievance Service Categories – Aggregate Top 5 by Prevalence (MCO-Reported Results)

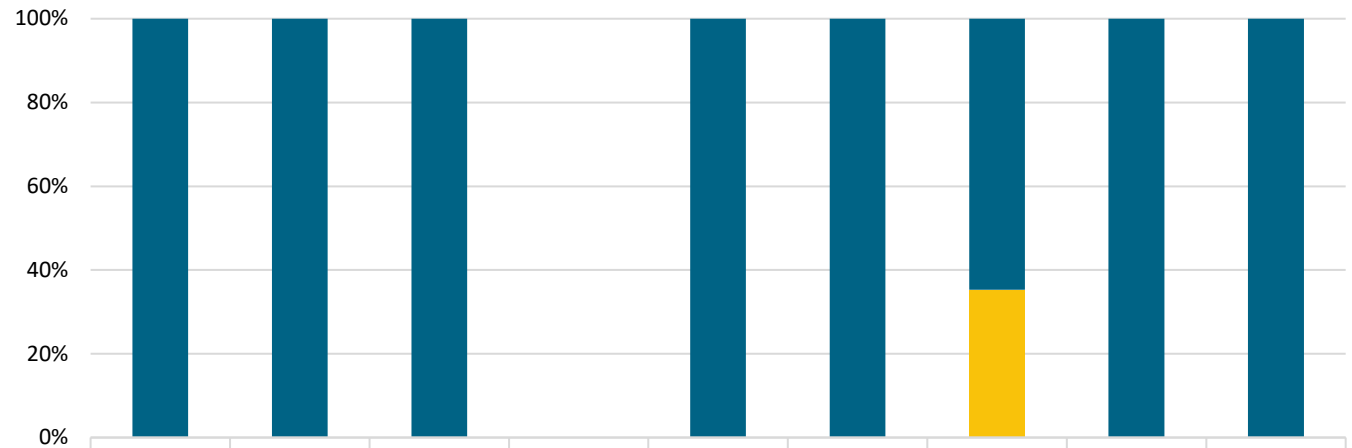
MY 2023	MY 2024	MY 2025
1: 4A/Medical Surgical **2:** 5A/Pharmacy Services **3**: 5B/Pharmacy Services: Chronic Pain Management **4:** 1B/Diagnostic/Lab: Radiology **5:** 1A/Diagnostic/Lab	**1:** 4A/Medical Surgical **2:** 9/Other **3:** 5A/Pharmacy Services **4**: 8/Vision Services **5:** 1B/Diagnostic/Lab: Radiology	**1:** 5A/Pharmacy Services **2:** 4A/Medical Surgical **3:** 9/Other **4:** 8/Vision Services **5:** 1A/Diagnostic/Lab

Provider Grievances per 1,000

The figure on the next page illustrates the number of grievances per 1,000 received by category of grievance and by MCO. MY 2025's GAD studies observed the following about rates per 1,000 provider grievances:

- MCOs received 217 provider grievances in MY 2025, demonstrating that relatively few provider grievances were reported in the year. Eight MCOs (except KPMAS) had Category 3: Administrative provider grievances, while KPMAS reports no provider grievances. PPMCO is the only MCO reporting Category 2: Standard Non-Emergency provider grievances.

Figure 4. MY 2025 Provider Grievances per 1,000 by Category (MCO-Reported Results)



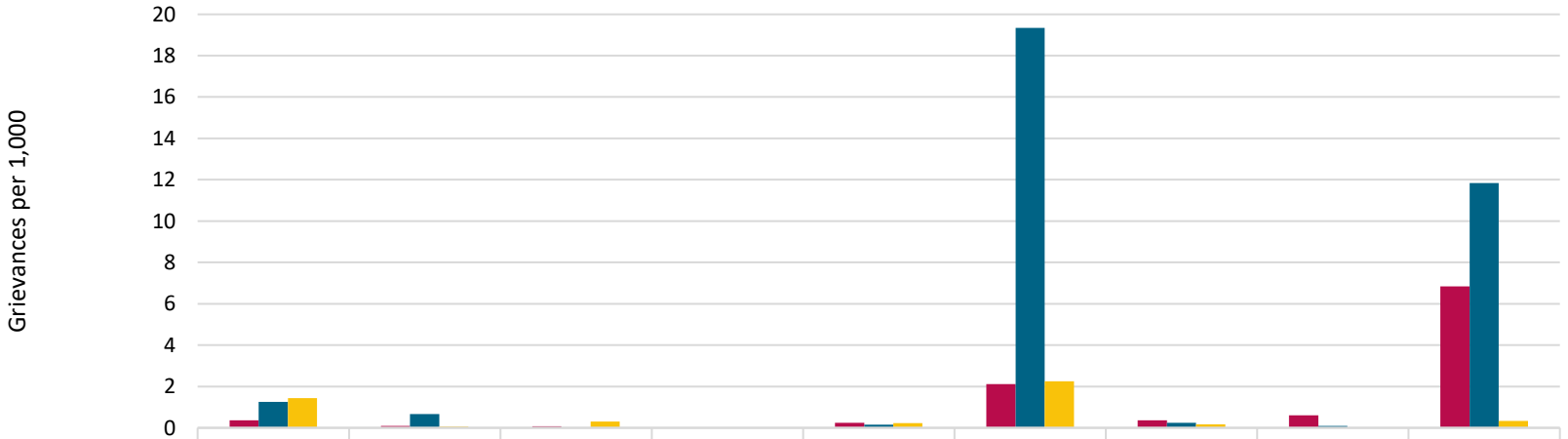
	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Category 3: Administrative	1.44	0.06	0.30	0.00	0.23	2.25	0.11	0.02	0.33
Category 2: Non-emergency	0.00	0.00	0.00	0.00	0.00	0.00	0.06	0.00	0.00
Category 1: Emergency	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

The figure on the next page illustrates the rates of MCO-reported provider grievances per 1,000 over the trending MYs (MYs 2023 through 2025). MY 2025's GAD studies observed the following about observed trends for rates per 1,000 provider grievances:

- **Median.** The median for provider grievances per 1,000 in MY 2025 is 0.23. Provider grievances per 1,000 were the highest for MSFC (2.25) and lowest for UHC (0.02), excluding KPMAS (0). MSFC's number of provider grievances declined from MY 2024 to MY 2025 because of a reduction in data system and billing errors.
- **Peer Comparison.** In MY 2025, provider grievances are virtually flat across the MCOs, with significant drops from MSFC and WPM. PPMCO is the only MCO with a Category 2: Non-Emergency provider grievance. In comparing MY 2024 and MY 2025, JMS and KPMAS reported no provider grievances in MY 2024, and provider grievances per 1,000 were the highest for MSFC (19.35), WPM (11.84), and lowest for UHC (0.10).
- **Trending.** The median for provider grievances per 1,000 data indicates a downward trend from MY 2023 (0.36), to MY 2024 (0.25), and through into MY 2025 (0.23). KPMAS continues to report no provider grievances in all three years.

- **Contributing Factors**. Provider grievances ranged from providers' dissatisfaction with claim submissions, PA review delays, and providers upset claim checks were not received timely.

Figure 5. Annual Trending Providers Grievances per 1,000 (MCO-Reported Results)



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2023	0.36	0.10	0.08	0.00	0.24	2.12	0.37	0.61	6.85
Annual 2024	1.25	0.66	0.00	0.00	0.16	19.35	0.25	0.10	11.84
Annual 2025	1.44	0.06	0.30	0.00	0.23	2.25	0.17	0.02	0.33

Provider Grievances Service Categories

MCOs identify the top service categories for provider grievances and the most prevalent sources of provider grievances within each quarterly report. MCOs can submit rationale for data variances, including comparisons to prior quarters or years. MY 2025's GAD studies observed the following about categorizing provider grievances:

- **Category Frequency.** For MY 2024 and MY 2025, there were only three categories that surfaced in the top five for service categories for provider grievances. In MY 2023, five categories were noted. The top reasons are included in the table below. MY 2025's three top categories pertain to 4/Finance/Billing, 3/Attitude/Service, and the 7/Other category. In comparing MY 2024 to MY 2025, 3/Attitude/

Service replaced 6/Substance Abuse. These two have been interchangeable in the last two years. Comparing MY 2023 to MY 2024, 6/Substance Abuse replaced 3/Attitude/Service in the top service categories. These two categories have been interchangeable over the last three years.

Table 8. Annual Trending Provider Grievance Service Categories – Aggregate Top 5 by Prevalence (MCO-Reported Results)

MY 2023 Service Categories	MY 2024 Service Categories	MY 2025 Service Categories
1: 4/Finance/Billing **2:** 3/Attitude/Service **3:** 3B/Administrative Staff **4:** 3C/MCO Customer Service **5:** 7/Other	**1:** 4/Finance/Billing **2**: 7/Other **3:** 6/Substance Abuse	**1:** 4/Finance/Billing **2**: 7/Other **3**: 3/Attitude/Service

Enrollee and Provider Other Codes

For the past three years, the "Other" category has posted in the top five reason and service categories for enrollee and provider grievances. MCOs are offering more data to inform what is classified under the "Other" codes for grievances. Some examples are highlighted in the table below for 9/Other codes and 7/Other categories. Many of the elements of these "Other" codes may be integrated into existing reason and service categories. This warrants further discussion with Qlarant, the MCOs, and MDH for strategies to address this.

Table 9. Examples of MCO-Reported Other Category and Code Classifications

9/Other Reason Code	7/Other Service Category
Accessibility: Other	Denial of DME
Administrative: Billed for Services	Health Plan issue
Accessibility: Facility/Office Too Far	Issues with Vision Services
Accessibility: Referrals for Specialty Care	Americans with Disability Act requirements
Administrative: Other	Benefits
Service Delivery: Pharmacy Computer Error	Confidentiality
Service Delivery: Do Not Like Provider/Facility	Discrimination
Balanced Billing	Eligibility
Access to Behavioral Health	Equipment
Health Plan Concern	Facility
MCO Staff attitude	Grievance and Appeal Process
Provider care	Member Enrollment

Resolution Timeframes

This section shows annual comparisons of MCO-reported compliance with resolution timeframes for enrollee and provider grievances. Compliance with the following resolution timeframes is based on the MDH-established compliance score (95%):

- Emergency medically related: 24 hours
- Non-emergency medically related: 5 calendar days
- Administrative timeframe: 30 calendar days

Enrollee Grievance Resolution Timeliness

MY 2025's GAD studies observed the following about timeliness of enrollee grievance resolutions:

Compliance. The table below illustrates MY 2025 turnaround time (TAT) compliance for enrollee grievance resolution by grievance category. Seven MCOs met all performance requirements for resolution timeliness of enrollee grievances. Two MCOs (KPMAS and UHC) did not meet compliance. Most enrollee grievances reported are for Category 3: Administrative. All MCOs scored 100% in this category.

Table 10. MY 2025 Enrollee Grievances Resolution TAT by Category (MCO-Reported Results)

Categories	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Category 1: Total Resolved (#)	0	1	8	3	10	42	0	2	0
Category 1: Total Meeting TAT (#)	0	1	8	2	10	42	0	0	0
Category 1: Percent Meeting TAT (%)	**NA**	**100%**	**100%**	**67% UM**	**100%**	**100%**	**NA**	**0% UM**	**NA**
Category 2: Total Resolved (#)	0	2	20	770	127	247	3	19	0
Category 2: Total Meeting TAT (#)	0	2	20	751	127	246	3	17	0
Category 2: Percent Meeting TAT (%)	**NA**	**100%**	**100%**	**98%**	**100%**	**100%**	**100%**	**90% UM**	**NA**
Category 3: Total Resolved (#)	450	35	38	962	480	940	202	403	1390
Category 3: Total Meeting TAT (#)	450	35	38	957	478	940	201	402	1390
Category 3: Percent Meeting TAT (%)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Percentages are rounded to the nearest whole number for reporting purposes.
Unmet (UM) <95% for reporting period

Peer Comparisons. In Category 2: Non-emergency Medically Related enrollee grievances, six MCOs reported compliance with resolution TAT, five at 100%, and one at 98%. ABH and WPM reported no Category 2 grievances in MY 2025. The one outlier is UHC, which fell below the 95%

threshold for the second year in a row for this category. In MY 2025, UHC had 17 of 19 Category 2: Non-emergency Medically Related enrollee grievances that met timeliness metrics, resulting in a compliance rate of 90%. This is an improvement from MY 2024 (62%).

Three MCOs (ABH, PPMCO, and WPM) had no Category 1: Emergency Medically Related grievances. Of the six MCOs that did, CFCHP, JMS, MPC, and MSFC all reported 100% compliance in Category 1. KPMAS and UHC did not meet the resolution TAT for two Category 1: Emergency Medically Related grievances (67% and 0% respectively).

Trending. The table below compares three years (MYs 2023 to 2025) of MCOs' performance in enrollee grievance TAT by grievance category. Six MCOs (ABH, CFCHP, JMS, MPC, MSFC, and WPM) exceeded the performance threshold for resolution timeliness in all categories. The two outliers were KPMAS and UHC.

For Category 1: Emergency Medically Related, KPMAS did not meet compliance in MYs 2023 and 2025, with performance at 92% and 67%, respectively. No grievances were reported by KPMAS for MY 2024 in this category. UHC has repeatedly not met compliance over the trended period (MY 2023 (80%), MY 2024 (17%), MY 2025 (0%)).

For Category 2: Non-emergency Medically Related enrollee grievances, six MCOs (ABH, JMS, KPMAS, MPC, MSFC, and WPM) met TAT compliance in all three years. While UHC's performance fell below threshold in all three years, the MCO improved from MY 2024 to MY 2025, with an increase of 28 percentage points. PPMCO did not meet compliance in MY 2024 (85%).

Contributing Factors. MCOs not staffing on the weekend causes delays in processing.

Table 11. Annual Trending of Compliance with Enrollee Grievance Resolution Timeframes (MCO-Reported Results)

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Emergency Medically Related: Annual 2023	NA	NA	100%	**92%** UM	100%	100%	NA	**80%** UM	NA
Emergency Medically Related: Annual 2024	100%	100%	100%	NA	100%	100%	NA	**17%** UM	NA
Emergency Medically Related: Annual 2025	NA	100%	100%	**67%** UM	100%	100%	NA	**0** UM	NA
Non-emergency Medically Related: Annual 2023	NA	NA	100%	99%	100%	100%	100%	**74%** UM	100%
Non-emergency Medically Related: Annual 2024	100%	NA	96%	97%	97%	100%	**85%** PM	**62%** UM	NA
Non-emergency Medically Related: Annual 2025	NA	100%	100%	98%	100%	100%	100%	**90%** UM	NA
Administrative: Annual 2023	100%	99%	100%	100%	100%	100%	99%	99%	98%
Administrative: Annual 2024	100%	99%	99%	100%	100%	100%	100%	95%	100%
Administrative: Annual 2025	100%	100%	100%	100%	100%	100%	100%	100%	100%

Unmet (UM) <95% for all reporting periods
Partially Met (PM) and Black font ≥95% for at least one reporting period, but not all reporting periods
NA = Not Applicable

Provider Grievance Resolution Timeliness

The table below shows annual comparisons for three years (MYs 2023 through 2025) of MCO-reported compliance with resolution timeframes for provider grievances. MY 2025's GAD studies observed the following about timeliness of provider grievance resolutions:

- **Compliance**. A total of six MCOs (ABH, CFCHP, JMS, MPC, MSFC, and PPMCO) were compliant with provider grievance resolution timeliness. UHC (80%) and WPM (90%) are the outliers for Category 3: Administrative Grievances. KPMAS had no reported provider grievances across the three categories.
- **Trending**. UHC and WPM were not compliant with Category 3: Administrative grievance resolution TAT in all three years. UHC has a year-over-year downward trend (94%, 91%, and 80%) and WPM improved from MY 2024 to MY 2025 (71% to 90%).

Table 12. MY 2025 Provider Grievances Resolution TAT by Category (MCO Reported Results)

Categories	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Category 1: Total Resolved (#)	0	0	0	0	0	0	0	0	0
Category 1: Total Meeting TAT (#)	0	0	0	0	0	0	0	0	0
Category 1: Percent Meeting TAT (%)	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
Category 2: Total Resolved (#)	0	0	0	0	0	0	11	0	0
Category 2: Total Meeting TAT (#)	0	0	0	0	0	0	11	0	0
Category 2: Percent Meeting TAT (%)	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**100%**	**NA**	**NA**
Category 3: Total Resolved (#)	23	2	5	0	13	18	51	5	90
Category 3: Total Meeting TAT (#)	23	2	5	0	13	18	51	4	81
Category 3: Percent Meeting TAT (%)	**100%**	**100%**	**100%**	**NA**	**100%**	**100%**	**100%**	**80% UM**	**90% UM**

Percentages are rounded to the nearest whole number for reporting purposes.
Unmet (UM) <95% for reporting period
NA = Not Applicable

Table 13. Annual Trending of Compliance with Provider Grievance Resolution Timeframes (MCO-Reported Results)

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Emergency Medically Related: Annual 2023	NA	NA	NA	NA	NA	NA	NA	NA	NA
Emergency Medically Related: Annual 2024	NA	NA	NA	NA	NA	NA	NA	NA	NA
Emergency Medically Related: Annual 2025	NA	NA	NA	NA	NA	NA	NA	NA	NA
Non-emergency Medically Related: Annual 2023	NA	NA	NA	NA	100%	NA	NA	NA	NA
Non-emergency Medically Related: Annual 2024	NA	NA	NA	NA	NA	NA	NA	NA	NA
Non-emergency Medically Related: Annual 2025	NA	NA	NA	NA	NA	NA	100%	NA	NA
Administrative: Annual 2023	100%	100%	100%	NA	100%	100%	100%	**94%** UM	**92%** UM
Administrative: Annual 2024	100%	100%	NA	NA	100%	100%	100%	**91%** UM	**71%** UM
Administrative: Annual 2025	100%	100%	100%	NA	100%	100%	100%	**80%** UM	**90%** UM

Percentages are rounded to the nearest whole number for reporting purposes.
Unmet (UM) <95% for all reporting periods
NA = Not Applicable

Documentation and Determination Requirements

Record Review Requirements

Annual reviews compare records against the following grievance requirements:

- Fully describe the grievance when **documenting the issue** in the enrollee record.
- Appropriately address and identify steps taken to resolve the grievance issue when **documenting the grievance determination** in the enrollee record.
- **Forward written determinations** to the enrollee filing the grievance, individuals and entities required to receive notification of the grievance, and MDH's complaint unit (for complaints referred to the MCO by MDH's complaint unit).

Record Review Results

The following table compares annual record review results across MCOs across grievance resolution requirements. MY 2025's GAD studies observed the following about compliance with grievance requirements in enrollee records:

- **Compliance.** Eight MCOs (CFCHP, JMS, KPMAS, MPC, MSFC, PPMCO, UHC, and WPM) demonstrated compliance above the MDH compliance score (95%) in all seven categories. ABH fell below the MDH compliance score (93%) for resolution appropriateness as the

MCO closed two grievances after inability to contact enrollees to inappropriately request release of protected health information in response to a provider billing issue. The majority of MCO grievances in MY 2025 were categorized as administrative and followed by non-emergency, medically related. The top grievances were related to 4/Billing/Financial issues and 3/Attitude/Service.

- **Prior Year Comparison.** In comparing MY 2024 to MY 2025, five MCOs (ABH, JMS, KPMAS, MSFC, and UHC) in MY 2024 exceeded the compliance score (95%) in all seven categories and four MCOs (CFCHP, MPC, PPMCO, and WPM) performed below the compliance score. WPM fell below the compliance score for grievances appropriately classified (87%). Two MCOs (CFCHP and MPC) fell below the compliance score for acknowledgment letter timeliness at 90% and 87%, respectively. PPMCO fell below the compliance score for resolution timeliness, resolution appropriateness, and resolution letter timeliness, all at 73%. In MY 2025, WPM demonstrated improvement in achieving 100% compliance with appropriate classification of grievances. Both CFCHP and MPC demonstrated improvement in achieving 100% compliance with acknowledgment letter timeliness. PPMCO demonstrated improvement in achieving 100% compliance with resolution timeliness, resolution appropriateness, and resolution letter timeliness.
- **Trending.** While improvement trends from MY 2023 to MY 2025 are a bit uneven, notable improvement in the number of MCOs demonstrating full compliance in all seven categories increased from six in MY 2023 to eight in MY 2025, with five in MY 2024. Additionally, the number of requirements that fell below the compliance score decreased from three in MY 2023 to one in MY 2025, with six in MY 2024.

Table 14. MY 2025 MCO Annual Grievance Results (Record Review)

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Appropriately Classified	100%	100%	100%	100%	100%	100%	100%	97%	100%
Acknowledgement Letter Timeliness (5 days)*	100%	100%	100%	100%	100%	100%	100%	100%	100%
Issue is Fully Described	100%	100%	100%	100%	100%	100%	100%	100%	100%
Resolution Timeliness	100%	100%	100%	100%	100%	100%	100%	97%	100%
Resolution Appropriateness	**93%** UM	100%	100%	100%	100%	100%	100%	100%	100%
Resolution Letter Timeliness (based upon MCO's policy)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Resolution Letter in Easy-to-Understand Language	100%	100%	100%	100%	100%	100%	100%	100%	100%

Unmet (UM) <95% for reporting period
* = measured in calendar days

Appeal Results

Requirements

Appeals must comply with the following COMAR 10.67.09.05 regulations:

- MCOs may have only 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.
- With the enrollee's written consent, providers can file an appeal on behalf of an enrollee.

Comparative Statistics

This section includes comparative statistics and trends results for MCO-reported appeals per 1,000 enrollees for annual reviews, and identifies the ranking of the pharmacy service categories to the following statistics:

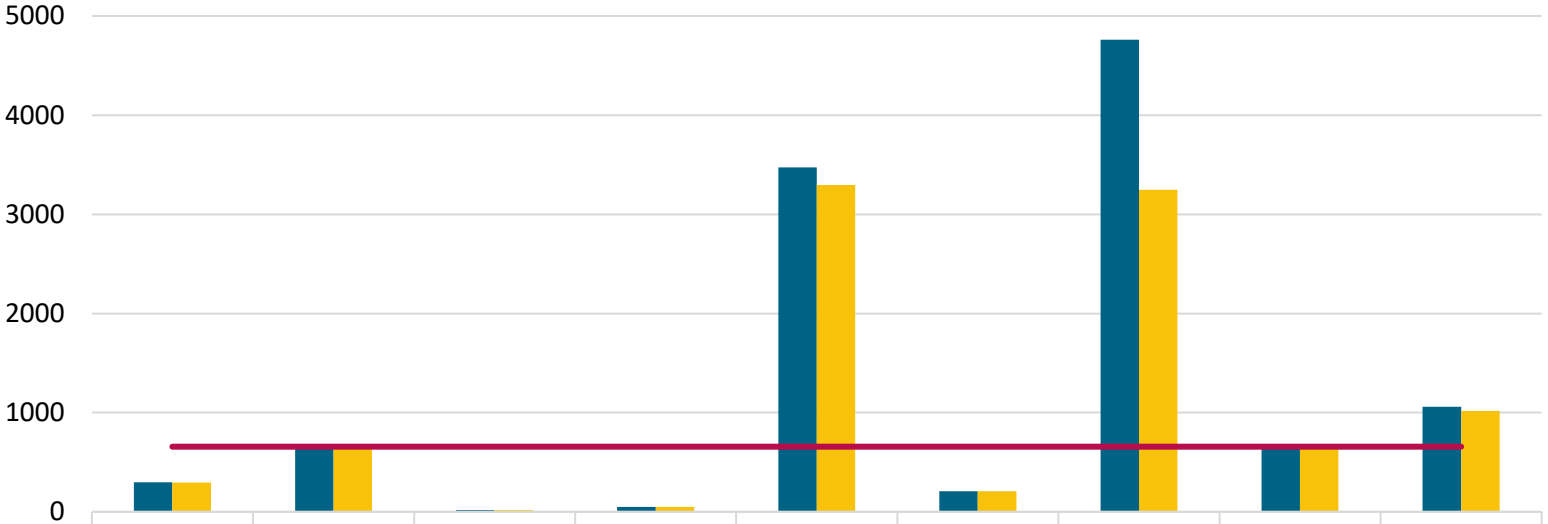
- Appeals Received and Resolved
- Appeals Filed Per 1,000 Enrollees
- Percentages of Appeals Received from Denials
- Percentages of Appeals Submitted by Enrollees and Providers
- Percentages of Upheld and Overturned Denials
- Percentages of Overturns and Upholds by Action Types (1-7)
- Top 5 Service Categories
- Percentages of Expedited and Extended Appeals
- Percentages of Pharmacy-related service codes

Enrollee Appeals Received and Resolved

In MY 2025, Maryland MCOs collectively received 11,188 enrollee appeals and resolved 9,477 (85%). The figure on the next page shows each MCO's appeal counts and the ratio of received to resolved.

Seven MCOs (CFCHP, JMS, MPC, MSFC, PPMCO, UHC, and WPM) receive their enrollee appeals primarily from providers submitting on behalf of the enrollee. ABH and KPMAS report their majority coming from enrollees. The range of enrollee appeals received across MCOs is 16 to 4,762. The median is 657. PPMCO has the highest number of enrollee appeals received (4,762), followed by MPC (3,474) and WPM (1,060). The remaining MCOs have received less than 1,000. MSFC (207), KPMAS (50), and JMS (16) received the least number of appeals in MY 2025. One contributing factor distinguishing the MCOs with the lowest number of appeals received is the model of care delivery. KPMAS using a fully employer model while MSFC, and JMS utilize a similar hybrid employer model with affiliated practices to deliver care instead of a network of individual and group practitioners.

Figure 6. MY 2025 Enrollee Appeals Received and Resolved (MCO-Reported Results)



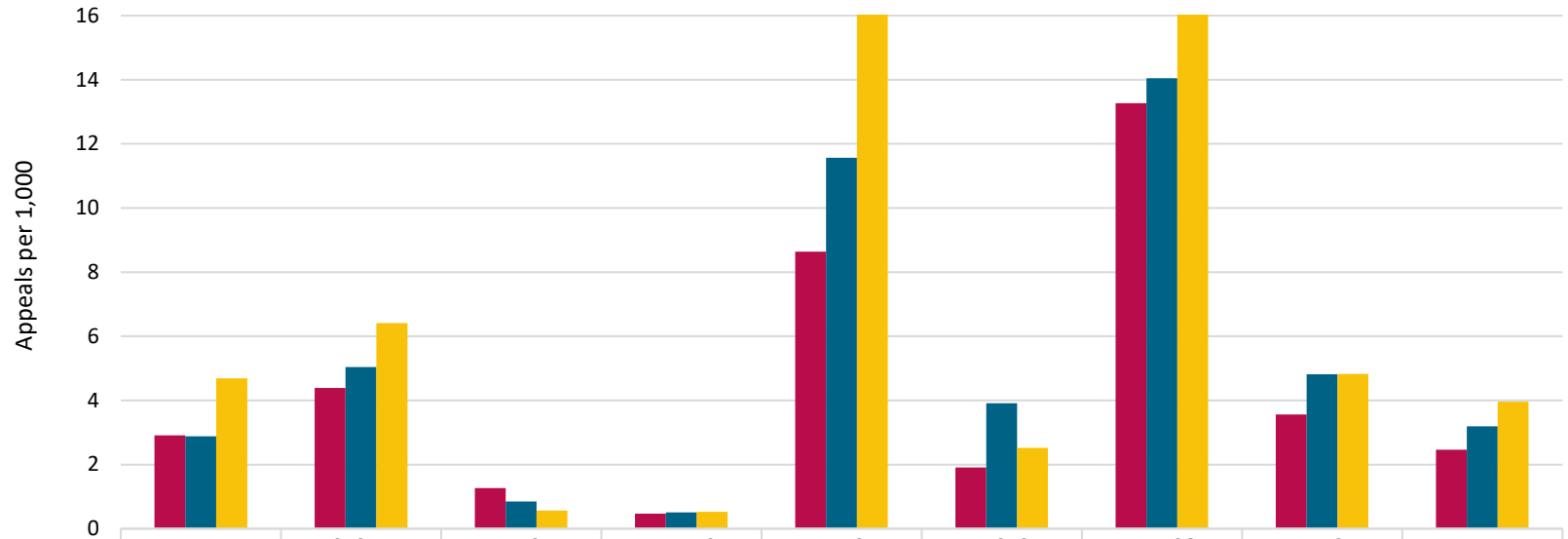
	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Received	298	657	16	50	3474	207	4762	664	1060
Resolved	294	671	16	50	3295	209	3247	678	1017
Median	657	657	657	657	657	657	657	657	657

Enrollee Appeals per 1,000

The figure on the next page shows the rates of MCO-reported appeals per 1,000 enrollees across MCOs over three measurement years (MYs 2023 through 2025). MY 2025's GAD studies observed the following about rates per 1,000 enrollee appeals:

- **Median.** All nine MCOs received appeals in MY 2025. The median for appeals per 1,000 enrollees is 4.69. Four MCOs exceed the median: UHC (4.83), CFCHP (6.41), MPC (17.21), and PPMCO (17.85). The four MCOs who received appeals below the median: KPMAS (0.53), JMS (0.57), MSFC (2.52), and WPM (3.96). ABH's MY 2025 rate is at the median (4.69).
- **Peer Comparisons.** PPMCO (17.85) has the highest appeals per 1,000 enrollees in MY 2025, with MPC (17.21) reporting the next highest. KPMAS (0.53) and JMS (0.57) hold the lowest rate of appeals per 1,000.
- **Trending.** Several patterns emerged when comparing MY 2024 to MY 2025, and MY 2023 to MY 2025. First, there are more appeals per 1,000 enrollees in MY 2025 than MY 2024 for seven of the nine MCOs (ABH, CFCHP, KPMAS, MPC, PPMCO, UHC, and WPM). The outliers are JMS and MSFC. JMS declined by 0.28, and MSFC declined by 1.4 between MY 2024 and MY 2025. PPMCO reports the highest number of appeals per 1,000 for all three measurement years: MY 2023 (13.27), MY 2024 (14.05), and MY 2025 (17.85). KPMAS consistently reported the least number of appeals over the three-year period: MY 2023 (0.47), MY 2024 (0.51), and MY 2025 (0.53). JMS is the only MCO where appeals per 1,000 enrollees declined year-over-year: MY 2023 (1.27), MY 2024 (0.85), and MY 2025 (0.57). On the contrary, six MCOs showed incremental increases in enrollee appeals per 1,000 between MY 2023 and MY 2025: CFCHP, KPMAS, MPC, PPMCO, UHC, and WPM. MPC had the most significant increase from MY 2023 (8.64) to MY 2025 (17.21), with a difference of 8.57 per 1,000.

Figure 7. Annual Trending Appeals per 1,000 Enrollees (MCO-Reported Results)



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2023	2.91	4.39	1.27	0.47	8.64	1.91	13.27	3.56	2.46
Annual 2024	2.88	5.04	0.85	0.51	11.57	3.91	14.05	4.82	3.19
Annual 2025	4.69	6.41	0.57	0.53	17.21	2.52	17.85	4.83	3.96

Appeal Service Codes

MCOs identify the top service categories for enrollee appeals within each quarterly and annual report. MCOs can submit rationale for data variances, including comparisons to prior quarters or years. MY 2025's GAD studies observed the following about categorizing enrollee appeals:

- **Category Frequency.** The table below lists MY 2025's top five prevalent service categories obtained from the MCO aggregate. In order of prevalence, the top five include: 5A/Pharmacy Services, 2/DME/DMS, 4A/Medical Surgical, 4C/Medical Surgical: related to Therapies, and 1B/Diagnostic/Lab: Radiology. All nine MCOs had 5A/Pharmacy Services in their top five. Eight MCOs had 2/DME/DMS and 4A/Medical Surgical, six MCOs had 4C/Medical Surgical: related to Therapies, and five had 1B/Diagnostic/Lab: Radiology. An additional five service codes surfaced including: 1A/Diagnostic/Lab (MSFC), 3/Inpatient Hospitalization (UHC), 5B/Pharmacy Services: Chronic Pain Management (CFCHP, JMS, and MSFC), 8/Vision Services, and 11/Long Term Care (KPMAS). For MY 2025, JMS reported receiving two applicable appeal service codes, both pharmacy-related.

Table 15. MY 2025 Appeal Service Categories - Aggregate Top 5 by MCO (MCO-Reported Results)

Service Category	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
5A/Pharmacy Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**9**
2/DME/DMS	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	**8**
4A/Medical Surgical	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	**7**
4C/Medical Surgical: related to Therapies	Yes	Yes	No	No	Yes	No	Yes	Yes	Yes	**6**
1B/Diagnostic/Lab: Radiology	Yes	No	No	No	Yes	No	Yes	Yes	Yes	**5**
Other Service Category Codes	NA	5B	5B	8 and 11	NA	1A and 5B	NA	3A	NA	**5**

Information in Table 16 confirms the consistency of appeal service categories over the three-year period (MYs 2023 to 2025). Other than the order of prevalence, the top five appeal service categories have remained the same. The top five appeal service codes also align with MY 2025 pre-service denials, except for 4C/Medical Surgical: related to Therapies and 5B/Pharmacy services: Chronic Pain Management in denials. With the appeals service categories, there are two categories related to Medical Surgical: general Medical Surgical and Medical Surgical related to rehabilitation therapies, such as physical, occupational, and speech language.

Table 16. Annual Trending Appeals Service Categories – Aggregate Top 5 (MCO-Reported Results)

MY 2023 Service Categories	MY 2024 Service Categories	MY 2025 Service Categories
1: 4A/Medical Surgical	**1:** 4A/Medical Surgical	**1:** 5A/Pharmacy Services
2: 5A/Pharmacy Services	**2:** 5A/Pharmacy Services	**2:** 2/DME/DMS
3: 2/DME/DMS	**3:** 2/DME/DMS	**3:** 4A/Medical Surgical
4: 4C/Medical Surgical: related to Therapies	**4:** 1B/Diagnostic Lab: Radiology	**4:** 4C/Medical Surgical: related to Therapies
5: 1B/Diagnostic Lab: Radiology	**5:** 4C/Medical Surgical: related to Therapies	**5:** 1B/Diagnostic Lab: Radiology

Appeal Outcomes and Action Type Analysis

Description. The predominant source for MCO appeals is from denials received. Seven MCOs receive 100% of their appeals from denials, whereas ABH receives 99% from denials and KPMAS receives 70%. MDH monitors denials and appeals outcomes to ensure that enrollees are not denied access to needed care. An appeal outcome is the result of an appeal being upheld or overturned by the MCO (or other state entity). An overturned appeal is viewed as a favorable outcome for the enrollees. In MY 2024, MDH proposed a baseline threshold of above 50% overturned, to assess MCO performance.

COMAR 10.67.01.01 defines an appeal as a request for review of an action. Appeals upheld or overturned are distinguished by the type of adverse decision made. For MY 2025's GAD studies, seven types of actions are assessed on a quarterly and annual basis. COMAR categorizes appeals through the following actions:

- **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 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:** Denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, or other enrollee financial liabilities.
- **Action 7:** Resolved appeals related to plan denial of an enrollee's right to request out-of-network care.

Action Type Results. There are seven action types for enrollee appeals. Action Type 1 typically is the most common enrollee appeal type. Action Type 1 is an MCO's denial or limited authorization of a requested service, including the type or level of service; the requirements for medical necessity, appropriateness, setting; or the effectiveness of a covered benefit.

MCOs submit quarterly and annual appeals reports segmenting appeals according to action type. The table below displays each MCO's MY 2025 appeal volume and percentage of overturned and upheld appeals by the seven action types. The data shows that approximately 99% of enrollee appeals in MY 2025 were for Action Type 1. Enrollee appeals were also received for Action Types 2 and 3. Two MCOs had Action Types 5 and 6. UHC had one appeal in Action Type 5 and MSFC had two in Action Type 6. In MY 2025, there were no MCOs with appeals for Action Type 4 and Action Type 7.

Table 17. MY 2025 Appeals Overturned and Upheld by Action Type (MCO-Reported Results)

Action Type	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Action Type 1: Appeals Overturned (#)	89	459	0	11	881	101	1672	358	553
Action Type 1: Appeals Overturned (%)	31%	68%	0%	34%	27%	53%	57%	53%	54%
Action Type 1: Appeals Upheld (#)	198	212	0	21	2412	68	1252	318	464
Action Type 1: Appeals Upheld (%)	69%	32%	0%	66%	73%	36%	43%	47%	46%
Action Type 1: Total Appeals (#)	**287**	**671**	**0**	**32**	**3293**	**169**	**2924**	**676**	**1017**
Action Type 2: Appeals Overturned (#)	1	0	0	0	0	15	0	0	0
Action Type 2: Appeals Overturned (%)	100%	0%	0%	0%	0%	83%	0%	0%	0%
Action Type 2: Appeals Upheld (#)	0	0	0	6	0	2	0	0	0
Action Type 2: Appeals Upheld (%)	0%	0%	0%	100%	0%	11%	0%	0%	0%
Action Type 2: Total Appeals (#)	**1**	**0**	**0**	**6**	**0**	**17**	**0**	**0**	**0**
Action Type 3: Appeals Overturned (#)	2	0	7	7	1	0	0	1	0
Action Type 3: Appeals Overturned (%)	33%	0%	50%	58%	50%	0%	0%	100%	0%
Action Type 3: Appeals Upheld (#)	4	0	7	5	1	0	0	0	0
Action Type 3: Appeals Upheld (%)	67%	0%	50%	42%	50%	0%	0%	0%	0%
Action Type 3: Total Appeals (#)	**6**	**0**	**14**	**12**	**2**	**0**	**0**	**1**	**0**
Action Type 5: Appeals Overturned (#)	0	0	0	0	0	0	0	0	0
Action Type 5: Appeals Overturned (%)	0%	0%	0%	0%	0%	0%	0%	0%	0%
Action Type 5: Appeals Upheld (#)	0	0	0	0	0	0	0	1	0
Action Type 5: Appeals Upheld (%)	0%	0%	0%	0%	0%	0%	0%	100%	0%
Action Type 5: Total Appeals (#)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**
Action Type 6: Appeals Overturned (#)	0	0	0	0	0	0	0	0	0
Action Type 6: Appeals Overturned (%)	0%	0%	0%	0%	0%	0%	0%	0%	0%
Action Type 6: Appeals Upheld (#)	0	0	0	0	0	2	0	0	0
Action Type 6: Appeals Upheld (%)	0%	0%	0%	0%	0%	100%	0%	0%	0%
Action Type 6: Total Appeals (#)	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**0**	**0**

Percentages are rounded to the nearest whole number for reporting purposes.

Action Types 4 and 7 are not included in this table as no MCO reported appeals applicably categorized in either type.

MCOs with overturned rates above the 50% threshold (in favor of the enrollee) include: CFCHP (68%), MSFC (53%), PPMCO (57%), UHC (53%), and WPM (54%). MPC has the lowest overturn rate (27%), followed by ABH (31%) and KPMAS (34%). JMS reported no Action Type 1 appeals for MY 2025.

The table below provides information on each MCO's Action Type 1 enrollee appeals, both overturned and upheld percentages, over the trended period (MYs 2023 through 2025). Only the overturned data is analyzed in this section, given its focus as favorable to the enrollee if overturned appeals are higher than upheld.

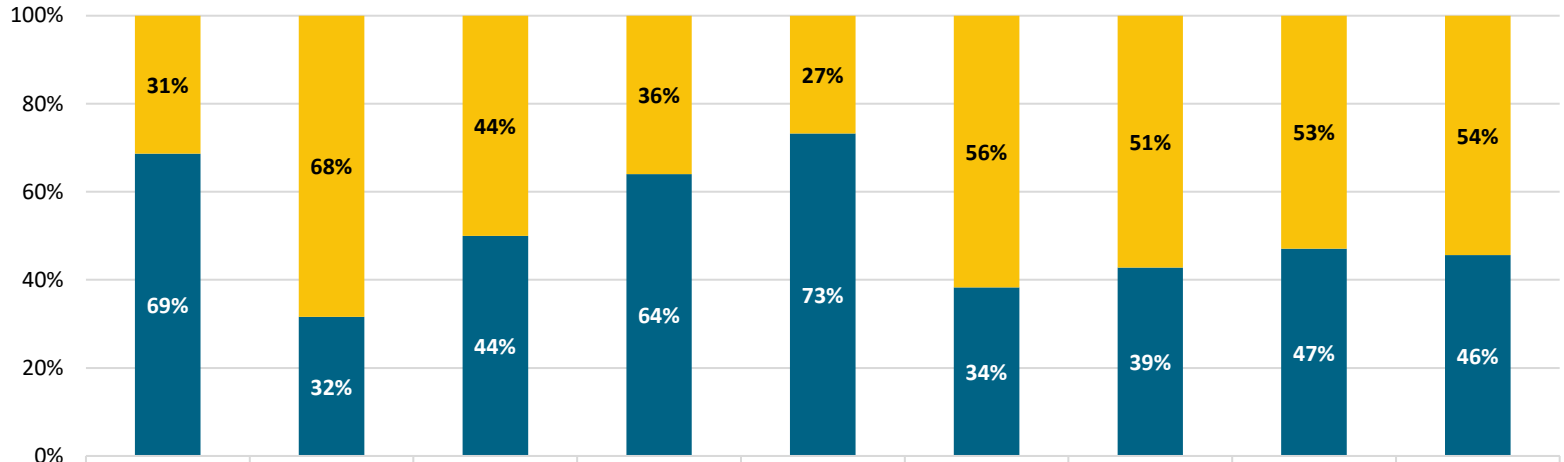
The range of MCO percentages for overturned appeals in MY 2025 is 0% to 68% and the median is 53%. In MY 2024, the range was higher at 40% to 78% and the median lower at 52%. MY 2023's range is closer to MY 2025, at 19% to 68%, and the median lower still at 50%. This indicates that there is a slight increase in the median of Action Type 1 enrollee appeals annually from MY 2023 to MY 2025. Four MCOs (CFCHP, KPMAS, PPMCO, and WPM), have an increase in percentages from MYs 2023 to 2025. The other five (ABH, JMS, MPC, MSFC, and UHC) have declined in the percentages of Action Type 1 enrollee appeals from MYs 2023 to 2025.

Table 18. Annual Trending MCO Percentages of Overturned and Upheld Appeals for Action Type 1 (MCO-Reported Results)

Action Type 1 Outcome	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Overturned: Annual 2023	40%	52%	68%	19%	32%	66%	48%	57%	50%
Overturned: Annual 2024	41%	66%	78%	52%	40%	71%	50%	53%	47%
Overturned: Annual 2025	31%	68%	0%	34%	27%	53%	57%	53%	54%
Upheld: Annual 2023	60%	49%	32%	81%	68%	34%	52%	43%	50%
Upheld: Annual 2024	59%	34%	22%	48%	60%	29%	44%	47%	53%
Upheld: Annual 2025	69%	32%	0%	66%	73%	36%	43%	47%	46%

Percentages are rounded to the nearest whole number for reporting purposes.

Figure 8. All Type Appeals Upheld to Overturned by MCO MY 2025 (MCO-Reported Results)



	ABH	CFCHP	JMS*	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Overturned	92	459	7	18	882	116	1672	359	553
Upheld	202	212	7	32	2413	72	1252	319	464

Percentages are rounded to the nearest whole number for reporting purposes.
*JMS percentage does not equate to 100%, due to two appeals being dismissed without resolution.

Pharmacy Appeals Results

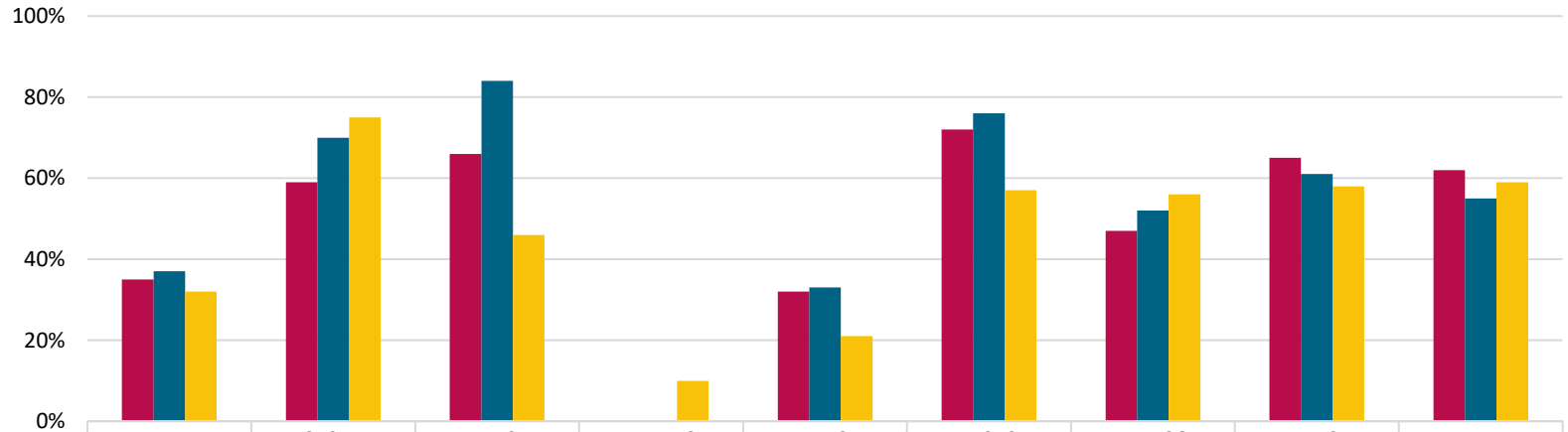
The table below shows the ranking of pharmacy as a service category over three measurement years (MYs 2023 through 2025). MY 2025's GAD studies observed the following about MCO ranking for pharmacy service categories:

- Pharmacy Services has remained a top appeals category over the last three years. Seven MCOs have had 5A/Pharmacy Services in the number one position for three years in a row (CFCHP, JMS, MPC, MSFC, PPMCO, UHC, and WPM). ABH had pharmacy in the second position for MY 2023 and MY 2024, and first in MY 2025. KPMAS had no pharmacy appeals in MY 2023 and MY 2024. In MY 2025, KPMAS had 20% of its appeals as pharmacy-related, resulting in pharmacy services in second place of their top five. The data is consistent over time given the three-year median percentages: MY 2023 (59%), MY 2024 (55%), and MY 2025 (56%).

Table 19. Annual Trending Ranking of Pharmacy Services as a Top Five Appeal Category on MCO Lists

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2023	2nd	1st	1st	NA	1st	1st	1st	1st	1st
Annual 2024	2nd	1st	1st	NA	1st	1st	1st	1st	1st
Annual 2025	1st	1st	1st	2nd	1st	1st	1st	1st	1st

Figure 9. Annual Trending Pharmacy Appeals Percentage Overturned by MCO (MCO-Reported Results)



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
MY 2023	35%	59%	66%	0%	32%	72%	47%	65%	62%
MY 2024	37%	70%	84%	0%	33%	76%	52%	61%	55%
MY 2025	32%	75%	46%	10%	21%	57%	56%	58%	59%

Percentages are rounded to the nearest whole number for reporting purposes.

Pharmacy overturns have increased annually for CFCHP and PPMCO. UHC had a decline in Pharmacy Overturns year-over-year. JMS had a significant drop in Pharmacy appeals from MY 2024 (84%) to MY 2025 (46%).

Resolution Timeframes

Requirements

Appeals must comply with the following resolution timeframes:

- Complete **expedited appeals within 72 hours**. Notifying the enrollee of the appeal decision is required within 24 hours of the decision and within the overall 72-hour timeframe.
- Complete **non-emergency appeals within 30 days** unless an extension is requested of no more than 14 days.
- Process appeals as expeditiously as the enrollee's health requires.
- Notify the enrollee of denial of an expedited request.

Resolution Timeframe Results

The table on the next page shows annual comparisons for three years (MYs 2023 through 2025) of MCO-reported compliance with resolution timeframes for expedited and non-emergency enrollee appeals. MY 2025's GAD studies observed the following about timeliness of enrollee appeal resolution:

- **Compliance.** All nine MCOs report having enrollee appeals in each measurement year. As with MY 2024, seven MCOs exceeded the compliance threshold (95%) for appeal resolution timeframes for expedited appeals, and eight met the timeliness requirement for non-emergency appeals in MY 2025. The two outliers were CFCHP (71%) and KPMAS (75%), both for missing the compliance threshold on TAT for expedited appeals. For expedited appeals, KPMAS fell below the compliance threshold (95%), at 75%, indicating performance concerns two years in a row. KPMAS did make improvements in MY 2025 for standard non-emergency appeals. The rate moved from non-compliance in MY 2024 (93%) to compliance in MY 2025 (98%). For the non-emergency appeals category, JMS is the only MCO not meeting timeliness requirements with a score of 92% compliance for 11 enrollee appeals. JMS was compliant at 100% in all three years for expedited appeals. The MCO scored 100% on all metrics until MY 2025.
- **Trending.** ABH is the only MCO with appeal resolution TAT scores of 100% for three years running. Comparing MY 2023 to MY 2025, KPMAS and CFCHP have declines in expedited enrollee appeals year-over-year.
- **Contributing Factors**. According to individual MCOs, an increase in outpatient (OP) pharmacy appeals and denials resulted from the de-delegation of OP pharmacy that began in Q4 2024. Other contributing factors identified for missed appeals TAT compliance are a scanner failing to identify urgent key words that help identify an expedited request, enrollees not completing the appropriate approval forms, and lack of appropriate clinical documentation to make a determination.

Compliance with the following resolution timeframes is based on the MDH-established compliance score (95%):

- Expedited: 72 hours
- Non-emergency: 30 calendar days

Table 20. Annual Trending of Compliance with Enrollee Appeal Resolution Timeframes (MCO-Reported Results)

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Expedited: Annual 2023	100%	100%	100%	100%	**92%** PM	**100%** PM	99%	**95%** PM	**97%** PM
Expedited: Annual 2024	100%	97%	100%	**80%** PM	100%	97%	99%	**92%** PM	**97%** PM
Expedited: Annual 2025	100%	**71%** PM	100%	**75%** PM	97%	100%	98%	97%	98%
Non-emergency: Annual 2023	100%	100%	100%	100%	99%	**100%** PM	100%	100%	**95%** PM
Non-emergency: Annual 2024	100%	100%	100%	**93%** PM	100%	100%	100%	97%	99%
Non-emergency: Annual 2025	100%	97%	**92%** PM	98%	100%	96%	100%	100%	99%

Percentages are rounded to the nearest whole number for reporting purposes.
Partially Met (PM) and Black font ≥95% for at least one reporting period, but not all reporting periods

Documentation and Determination Requirements

Record Review Requirements

Annual reviews compare records against the following appeal requirements:

- Fully **document appeal decisions** in the enrollee record.
- Ensure that a **health care professional with appropriate expertise makes decisions.**
- Provide the **enrollee with the appeal resolution in a written letter** and include results in an easy-to-understand language.

Record Review Results

The following table identifies compliance with appeal requirements and compares annual record review results across MCOs. MY 2025's GAD studies observed the following about MCO compliance with enrollee appeal requirements:

- **Compliance.** Two MCOs (PPMCO and UHC) demonstrated compliance, at or above the 95% threshold established by MDH, in all applicable categories. JMS fell below the compliance score for written appeal acknowledgment within five business days of receipt for two standard appeals as no acknowledgment letters were found in the record. Two MCOs (CFCHP and MPC) fell below the compliance score for enrollee verbal notification of the denial of an expedited appeal request at 83% and 10%, respectively. MPC non-compliance

was based upon notifying the provider verbally rather than the enrollee of the denial. MPC fell below the compliance score for enrollee written notification of the denial of an expedited appeal request (90%), as no letter was found in the record submitted for review. Two MCOs (KPMAS and MSFC) fell below the compliance score with the timeframe for expedited appeal resolution notification at 0% and 80%, respectively. Three MCOs (ABH, MSFC, and WPM) fell below the compliance threshold for verbal notification of expedited appeal resolution at 0%, 80%, and 50%, respectively. Two MCOs (KPMAS and MSFC) fell below the compliance score with the timeframe for written notification of non-emergency appeal resolution at 86% and 68%, respectively. Resolution letters were missing from eight of MSFC's appeal records submitted for review.

- **Prior Year Comparison.** When comparing MY 2024 to MY 2025, six MCOs (ABH, CFCHP, JMS, MPC, PPMCO, and WPM) demonstrated compliance in all applicable categories, at or above the score of 95%. The three remaining MCOs (KPMAS, MSFC, and UHC) fell below the compliance score in at least one category. UHC fell below the compliance score for timeliness of written notification of denial of an expedited request (67%), and verbal notification of an expedited appeal decision (79%). MSFC fell below the compliance score with the 72-hour timeframe for expedited appeal resolution (50%). KPMAS fell below the compliance score with decision available to the enrollee in easy-to-understand language (80%). In MY 2025, KPMAS demonstrated improvement in achieving compliance with providing enrollees appeal decisions in easy-to-understand language. UHC demonstrated improvement in achieving compliance with timeliness of appeal acknowledgment letters. Additionally, UHC demonstrated improvement in achieving compliance with written notice of denial of an expedited appeal request and with verbal notice of expedited appeal resolution.
- **Trending.** Assessing trends from MYs 2023 to 2025, improvement has been uneven with a decline in the number of MCOs demonstrating compliance, at or above the compliance score of 95%, in all applicable categories. MY 2025 shows a considerable decline from MY 2024 and below MY 2023. Three MCOs (ABH, KPMAS, and MSFC) in MY 2023 demonstrated compliance in all applicable categories. MY 2024 showed considerable improvement with six MCOs (ABH, CFCHP, JMS, MPC, PPMCO, and WPM) demonstrating compliance in all applicable categories. Compliance with processing of appeals based upon level of urgency and decision made by healthcare professionals with appropriate expertise were consistently met in all three MYs. No specific trends were identified among areas of identified non-compliance.

Table 21. MY 2025 MCO Annual Appeal Results (Record Review)

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Processed Based Upon Level of Urgency	100%	100%	100%	100%	100%	100%	100%	100%	100%
Compliance with Timeframe for Written Appeal Acknowledgement Letter (5 days)*	100%	100%	**0% UM**	100%	97%	97%	100%	95%	100%
Compliance with Verbal Notification of Denial of an Expedited Request	NA	**83% UM**	NA	NA	**10% UM**	NA	NA	100%	100%
Compliance with Written Notification of Denial of an Expedited Request (2 days)*	NA	100%	NA	NA	**90% UM**	NA	NA	100%	100%
Compliance with Timeframe for Expedited Appeal Resolution Notification (72 hours)	100%	NA	100%	**0% UM**	NA	**80% UM**	100%	100%	100%
Compliance with Verbal Notification of Expedited Appeal Decision	**0% UM**	NA	100%	100%	NA	**80% UM**	100%	100%	**50% UM**
Compliance with Written Notification Timeframe for Non-emergency Appeal (30 days)*	100%	100%	100%	**86% UM**	100%	**68% UM**	100%	100%	100%
Appeal Decision Documented	100%	100%	100%	100%	100%	100%	100%	100%	100%
Decision Made by Health Care Professional with Appropriate Experience	100%	100%	100%	100%	100%	100%	100%	100%	100%
Decision Available to Enrollee in Easy-to-Understand Language	100%	100%	100%	100%	100%	100%	100%	100%	100%

Unmet (UM) <95% for reporting period
Not Applicable (NA)
* = measured in calendar days

Pre-Service Denial Results

Requirements

COMAR 10.67.09.04 defines actions and decisions regarding services to enrollees and requiring prior authorization by the MCO. Timeframes compliant with prior authorization determination requirements include:

- Determinations for standard authorization decisions made by the MCO within two business days of receipt of necessary clinical information, but no later than 14 calendar days.

- Determinations for expedited authorization decisions made by the MCO, and notice provided, within 72 hours after receiving the request for services.
- Prescriber notice for all covered outpatient drug authorization decisions provided by the MCO through 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 healthcare professional who has appropriate clinical expertise in treating the enrollee's condition or disease; and
    - May not be 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.

- 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 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 healthcare professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
- Adverse Determination Letters: Must include all 16 required regulatory components.

Comparative Statistics

The "Pre-Service Denials" section of the report considers the most up-to-date federal MCPAR requirements for monitoring MCO performance on processing PA requests for enrollee services. This state oversight is critical for ensuring the health and safety of enrollees. Comparative statistics assess MCO performance in MY 2025, provide comparisons from MY 2024 to MY 2025, and consider trends or patterns over a three-year period from MYs 2023 to 2025. Data includes raw numbers on the volume of PA requests and corresponding percentages of the MCO aggregate; whether requests come with complete information or required additional information; if requests were approved or denied; if approval occurred before appeal or with an extended timeframe; if requests were resolved or unresolved, and the average time to decision. For MCO peer comparisons, data is converted to per thousand enrollees based upon the MCOs enrollee population in the review period. Pre-service denials are studied for timeliness of determination and notification, denial reasons, service categories, and by the type of PA request and denial (i.e., standard medically related, expedited medically related, administrative, and outpatient pharmacy).

Comparative statistics include data in table and graph format for the following:

- Prior Authorization Requests Received by Number and Type
- Percentages of PA Requests by MCO

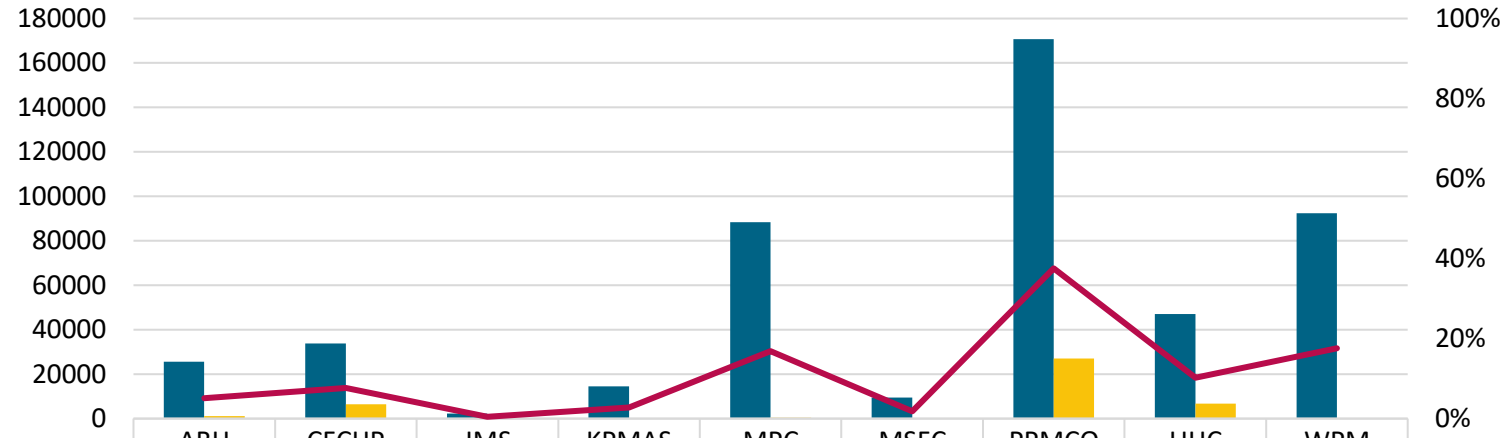
- Percentages of Prior Authorization Requests with Complete Information or Requiring Additional Information
- Percentages of Prior Authorization Requests Approved and Denied
- Percent of Prior Authorizations Received and Denied
- Pre-service Denials Rendered Per 1,000 Enrollees
- Percentage of Pre-Service Denials for Enrollees Under 21
- Percentages of Pre-service Denials by Type: Standard Medical and Expedited Medical
- Percentages of OP Pharmacy Denials
- Top 5 Service Categories
- Top 5 Denial Reasons
- Determination and Notification TAT Compliance Percentages by Category of Denial
- Prescriber Notification TAT Compliance Percentages

Prior Authorizations

In MY 2025, a total of 526,545 PA requests were received across all nine MCOs. The figure below shows the total number of requests received by each MCO and differentiates the type as standard or expedited. MY 2025's GAD studies observed the following about prior authorization requests:

- Most PA requests in MY 2025 were standard, non-emergency requests. Eighty-three percent of the total PA requests received across all MCOs are contributed by the following four: MPC (17%), PPMCO (38%), UHC (10%), and WPM (18%). There is a potential opportunity for these MCOs to reduce the number and type of services requiring prior authorization before services being rendered.

Figure 10. MY 2025 Standard and Expedited PA Requests by MCO (MCO-Reported Results)



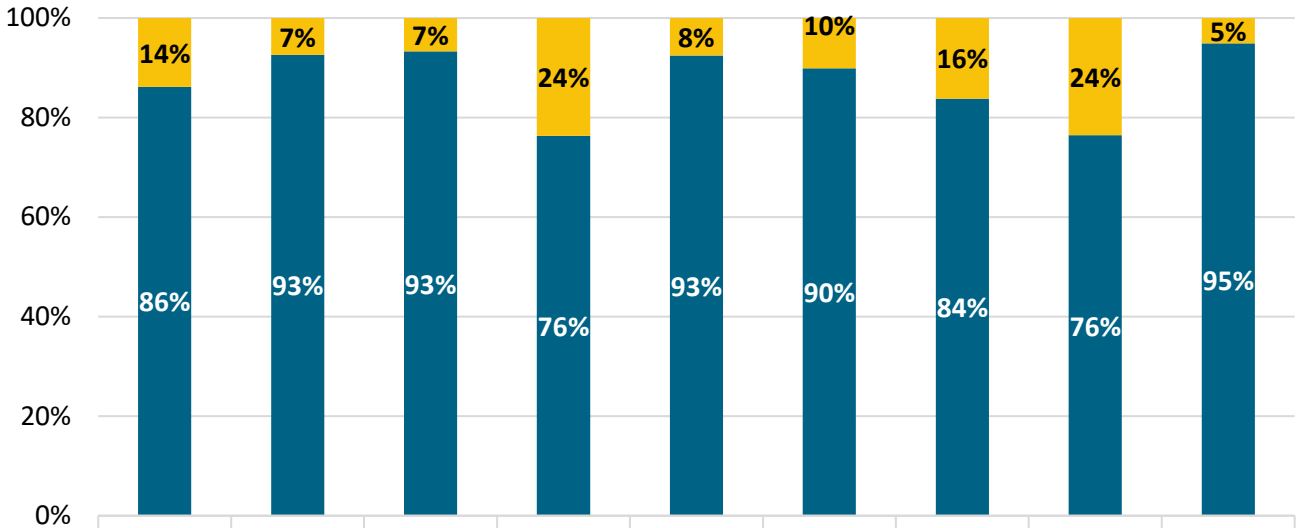
	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Standard	25650	33789	2283	14541	88369	9416	170753	47119	92450
Expedited	1142	6472	148	54	361	97	26991	6733	177
Percent of Total PA Requests	5%	8%	0%	3%	17%	2%	38%	10%	18%

Percentages are rounded to the nearest whole number for reporting purposes.

In some instances, MCOs are delayed in determining whether to approve or deny a PA request. The figures below offer a comparison of the percentage frequency that an MCO receives or does not receive complete information from the referring provider before determining to approve or deny the PA request.

- **Trends.** The percentage of PA requests that come to the MCOs with complete information is consistent over three years and averages 87% to 88%. The percent of total PA requests shown in Figure 10 represents each MCO's contribution to the state's total of PA requests.

Figure 11. MY 2025 PA Requests Information Requirements (MCO-Reported Results)



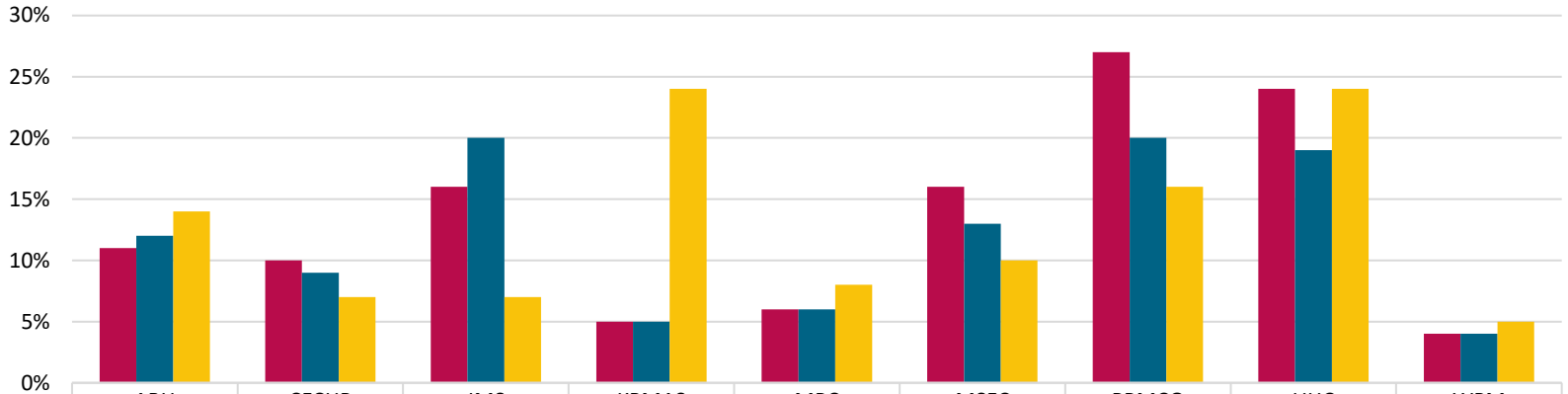
	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Requiring Additional Information	3713	2985	163	3458	6684	964	32033	12688	4702
Complete Information	23079	37276	2268	11137	82046	8549	165629	41164	87925

Percentages are rounded to the nearest whole number for reporting purposes.

MY 2025's GAD studies observed the following about prior authorization requests:

- **Trending.** From MY 2024 to MY 2025, five MCOs (ABH, KPMAS, MPC, UHC, and WPM) required additional information from providers before making an authorization decision. The remaining four MCOs (CFCHP, JMS, MSFC, and PPMCO) did not. Comparing MY 2023 to MY 2025, ABH has a year-over-year increase in needing more information for authorization decisions. Three MCOs (CFCHP, MSFC, and PPMCO) show a year-over-year decline in needing more information for a decision.

Figure 12. Annual Trending PA Requests Requiring Additional Information (MCO-Reported Results)



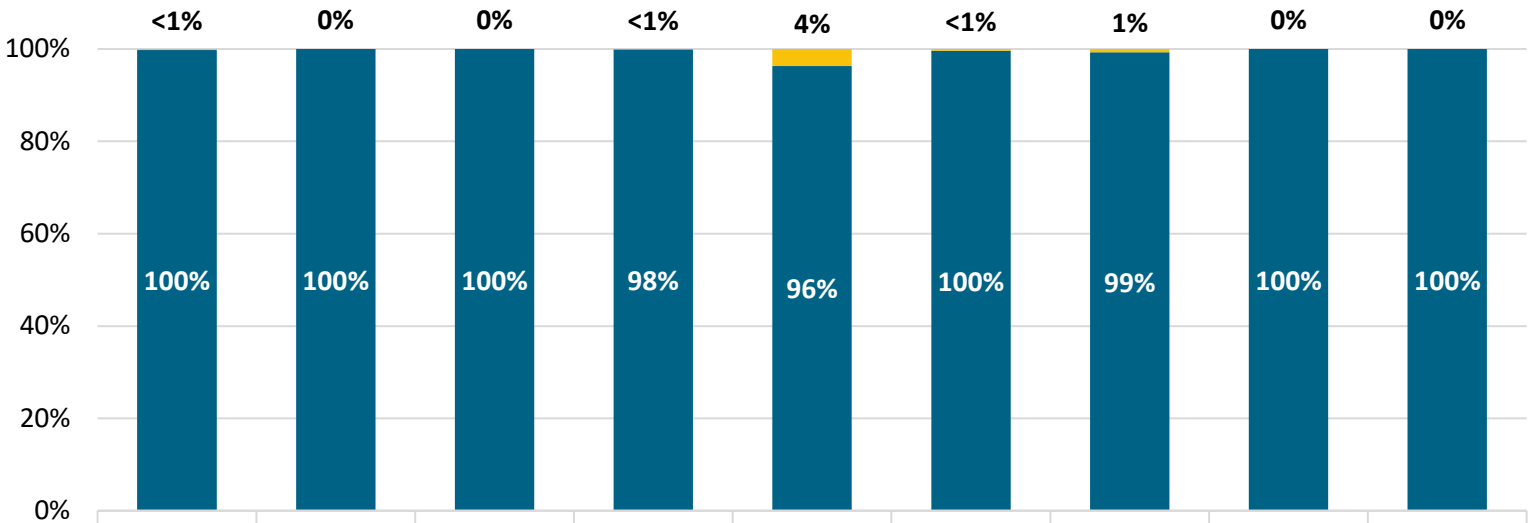
	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
MY 2023	11%	10%	16%	5%	6%	16%	27%	24%	4%
MY 2024	12%	9%	20%	5%	6%	13%	20%	19%	4%
MY 2025	14%	7%	7%	24%	8%	10%	16%	24%	5%

Percentages are rounded to the nearest whole number for reporting purposes.

MY 2025's GAD studies observed the following about prior authorization requests:

- **Resolution Frequency.** The figure below affirms the nine MCOs' ability to come to a resolution on disposition of PA requests. Six MCOs (ABH, CFCHP, JMS, MSFC, UHC, and WPM) show a 100% resolution (rounded) percentage. The remaining three are above 95%: KPMAS (98%), MPC (96%), and PPMCO (99%).

Figure 13. MY 2025 Resolved and Unresolved PA Requests (MCO-Reported Results)



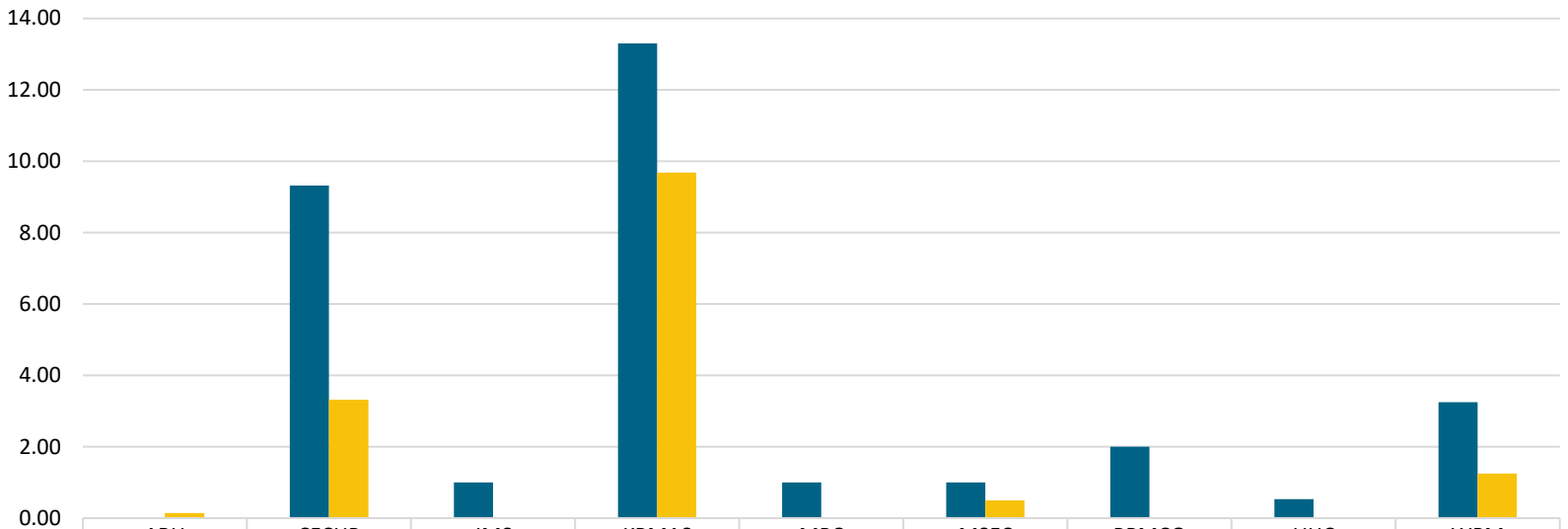
	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Unresolved	53	0	0	16	3274	36	1361	0	0
Resolved	26739	40261	2431	14280	85456	9477	196383	53852	92627

Percentages are rounded to the nearest whole number for reporting purposes.

Determinations for standard authorization decisions must be made by the MCO within two business days of receipt of necessary clinical information, but no later than 14 calendar days. Expedited authorization decisions must be made by the MCO, and notice provided, within 72 hours after receiving the request for services. MY 2025's GAD studies observed the following about prior authorization requests:

- Starting in MY 2025, as part of quarterly and annual reports, MCOs submitted data on the median times it takes to make a PA decision. The figure below shows the median time in number of days. All MCOs met the requirements for processing a standard authorization within 14 calendar days. KPMAS had the highest number of days (13.30) and ABH the lowest (0.03). For expedited PAs, KPMAS did not meet the TAT requirement of 72 hours (9.68). CFCHP was close to the threshold (3.32). The remaining seven MCOs fell within the 72-hour threshold at a range of 0.00 to 1.25. JMS, MPC, and PPMCO reported no expedited PA requests.

Figure 14. MY 2025 Median Time to Make a PA Decision Standard and Expedited (MCO-Reported Results)

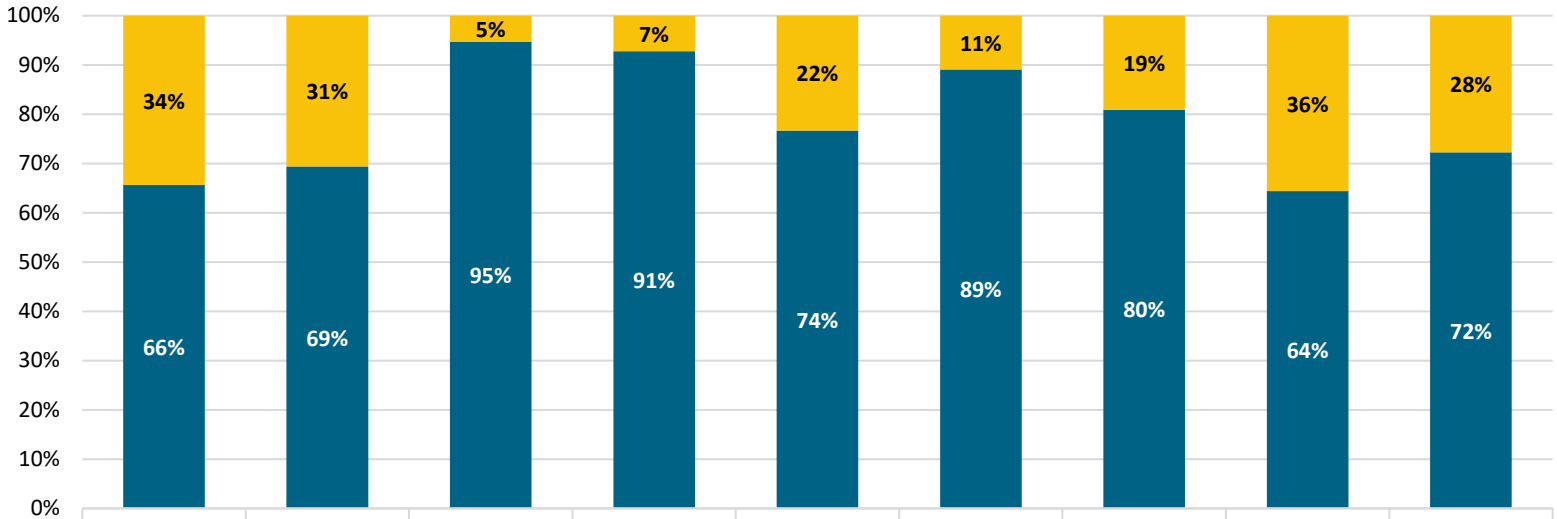


	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Standard	0.03	9.32	1.00	13.30	1.00	1.00	2.00	0.53	3.25
Expedited	0.14	3.32	0.00	9.68	0.00	0.50	0.00	0.01	1.25

MY 2025's GAD studies observed the following about prior authorization requests:

- Of the 526,545 PA requests received by Maryland MCOs in MY 2025, 395,580 (75%) were approved and 125,916 (24%) were denied. The figure below contrasts volume amounts and percentages of approved and denied PA requests for each MCO. The following table offers a three-year snapshot of PA requests received by MCOs by percentage of their approvals and denials. JMS continues to have the lowest percentage of denials (5%) with UHC reporting the highest (36%).

Figure 15. MY 2025 PA Request Approvals and Denials by MCO Percentage (MCO-Reported Results)



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Denied	9191	12311	130	1031	19907	1032	37445	19166	25703
Approved	17548	27940	2301	13249	65549	8445	158938	34686	66924

Percentages are rounded to the nearest whole number for reporting purposes.

In MY 2025, the MCO median for approvals is 74%, and the median for denials is 22%. MY 2025's GAD studies observed the following about prior authorization requests:

- JMS has the highest PA approval rate (95%), followed by KPMAS (91%),MSFC (89%), and PPMCO (80%). These MCOs are above the median of approved PAs (74%). The lowest PA approval score is UHC (64%), followed by ABH (66%), CFCHP (69%), and WPM (72%). These four MCOs fall below the median of approved PAs. MPC falls at the median.

Table 22. Annual Trending MCO Approvals and Denials (MCO-Reported Results)

PA Request Outcome	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
2023 Approved	69%	70%	84%	93%	74%	85%	82%	66%	74%
2023 Denied	31%	31%	16%	7%	26%	15%	18%	34%	26%
2024 Approved	71%	67%	85%	94%	72%	77%	80%	66%	71%
2024 Denied	29%	33%	15%	6%	28%	23%	21%	34%	30%
2025 Approved	66%	69%	95%	91%	74%	89%	80%	64%	72%
2025 Denied	34%	31%	5%	7%	22%	11%	19%	36%	28%

Percentages are rounded to the nearest whole number for reporting purposes.

Beginning with MY 2025, MCOs now submit data pertaining to PA requests approved after appeal. The table below shows the variation in MCO findings. Eight MCOs had PA requests approved after appeal. JMS reports none. The range in raw numbers is 0 to 513 approvals. In percentage, the range is 0.0% (JMS) to 1.27% (CFCHP) of PA requests approved. CFCHP has the highest percentage of approvals, followed by UHC (0.38%) and ABH (0.28%).

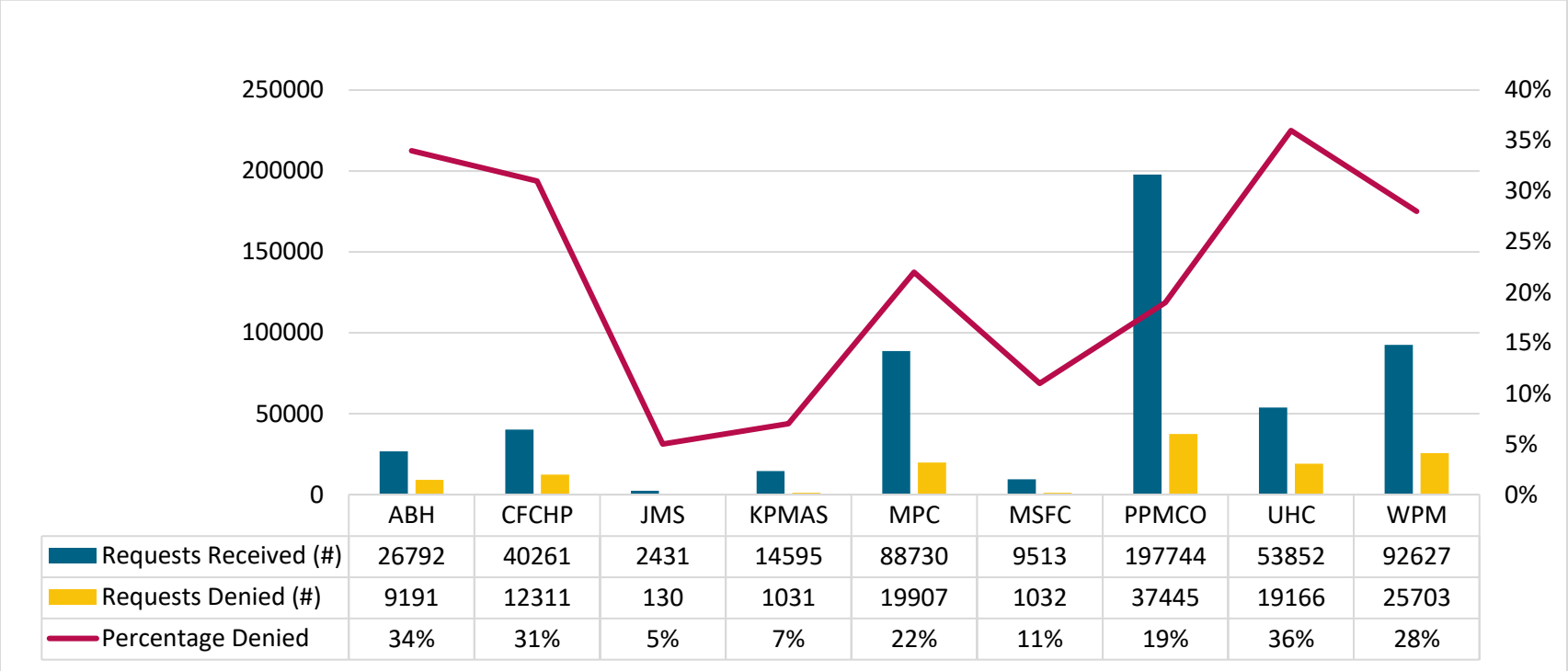
Table 23. MY 2025 Total PA Requests Approved After Appeal (MCO-Reported Results)

PA Requests	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total PA Requests Approved After Appeal (#)	74	513	0	11	107	17	451	207	100
PA Requests Approved After Appeal (%)	0.28%	1.27%	0%	0.08%	0.12%	0.18%	0.23%	0.38%	0.11%
Total PA Requests Approved with an Extended Timeframe (#)	1,201	1,892	0	0	14	6	3,448	2,491	0
PA Requests Approved with an Extended Timeframe (%)	5%	5%	0%	0%	0%	0%	2%	5%	0%

Pre-Service Denials

Of those PA requests that were received, MCOs report the number and percentage of those that are denied. The figure below provides this information.

Figure 16. MY 2025 PA Requests Received and Percent Denied by MCO (MCO-Reported Results)



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Requests Received (#)	26792	40261	2431	14595	88730	9513	197744	53852	92627
Requests Denied (#)	9191	12311	130	1031	19907	1032	37445	19166	25703
Percentage Denied	34%	31%	5%	7%	22%	11%	19%	36%	28%

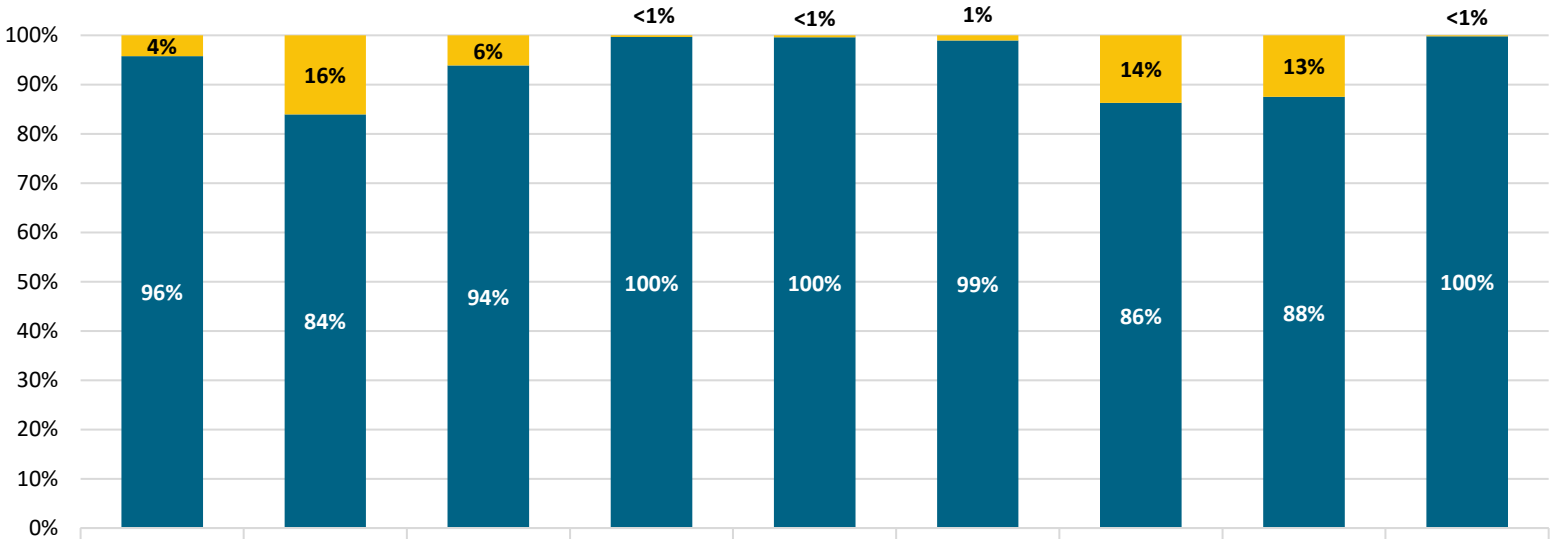
Percentages are rounded to the nearest whole number for reporting purposes.

Pre-Service Denials by Type: Standard and Expedited

Pre-service denials data can be segmented further to determine the number and percentages of denials that are standard and expedited. The figure below shows the MCO percentages of standard and expedited pre-service medical denials. Pharmacy denials will be addressed later in this report. MY 2025's GAD studies observed the following about prior authorization requests:

- **Peer Comparison:** There are a relatively small number of pre-service expedited medical denials for MY 2025. CFCHP, PPMCO, and UHC have the highest number of expedited denials at 16%, 14%, and 13%, respectively. KPMAS, MPC, and WPM have none, and the remainder of the MCOs report percentages of 6% and lower.

Figure 17. MY 2025 Percentage of Resolved Pre-Service Authorizations by Type (MCO-Reported Results)



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Expedited	1138	6472	148	50	353	97	26946	6733	177
Standard	25601	33789	2283	14230	85103	9380	169437	47119	92450

Percentages are rounded to the nearest whole number for reporting purposes.

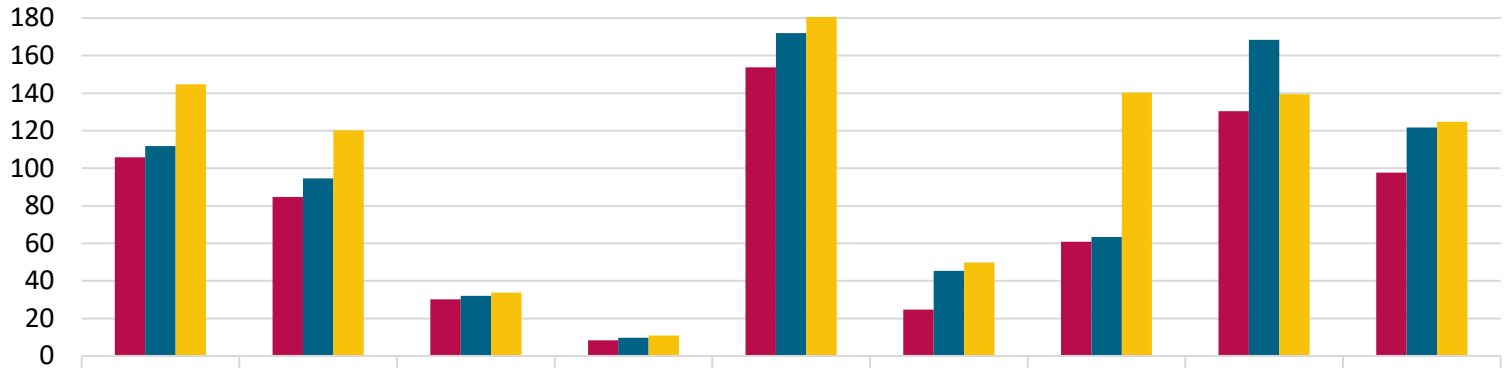
Pre-Service Denials per 1,000

Defining Factors. Qlarant considers several factors when establishing a pre-service denial rate per 1,000 enrollees. The first is the percentage of prior authorization requests the MCO approves or denies. Of those prior authorization requests denied, a denial rate is calculated based upon the number of denials per 1,000 enrollees and a median is determined. The median allows comparisons to be made across the nine MCOs, year over year. MDH provides the population data for the review period.

The figure below illustrates MCO pre-service denial rates per 1,000 enrollees from MYs 2023 to 2025. MY 2025's GAD studies observed the following about prior authorization requests:

- **Median.** For MY 2025, the MCO range for PA requests approved is 64% to 95% and for those denied is 5% to 36%. The pre-service denial median is 22%. This is a decline from the prior two years when the median for MY 2024 and MY 2023 were 28% and 26%, respectively. Calculating pre-service denials per 1,000 enrollees, the median is 124.72. In MY 2024, it was lower (94.63) and lower still in MY 2023 (84.64). MPC continues to have the highest denial rate per 1,000 (220.15), up from MY 2024 (171.95) and from MY 2023 (153.77). KPMAS has the lowest denial rate at MY 2025 (10.93), MY 2024 (9.73), and MY 2023 (8.40).
- **Trending.** Three-year comparisons show an upward trend in pre-service denials per 1,000 enrollees for all MCOs except UHC. UHC had comparable denial rates in MY 2023 and MY 2025, with an increase in percentage in MY 2024.
- **Contributing Factors.** MCOs indicated that pre-service pharmacy denials are due to non-medically necessary medication requests for weight-loss drugs, including Wegovy, Zepbound, Ozempic, Jardiance, and Mounjaro. One MCO reported an increase in total pre-service medical denials in MY 2025 due to the large volume of requests for genetic testing from non-participating genetic lab companies, codes that are not on the fee schedule, and where the testing is not going to alter the course of the treatment.

Figure 18. Annual Trending MCO-Reported Denials per 1,000 Enrollees (MCO-Reported Results)



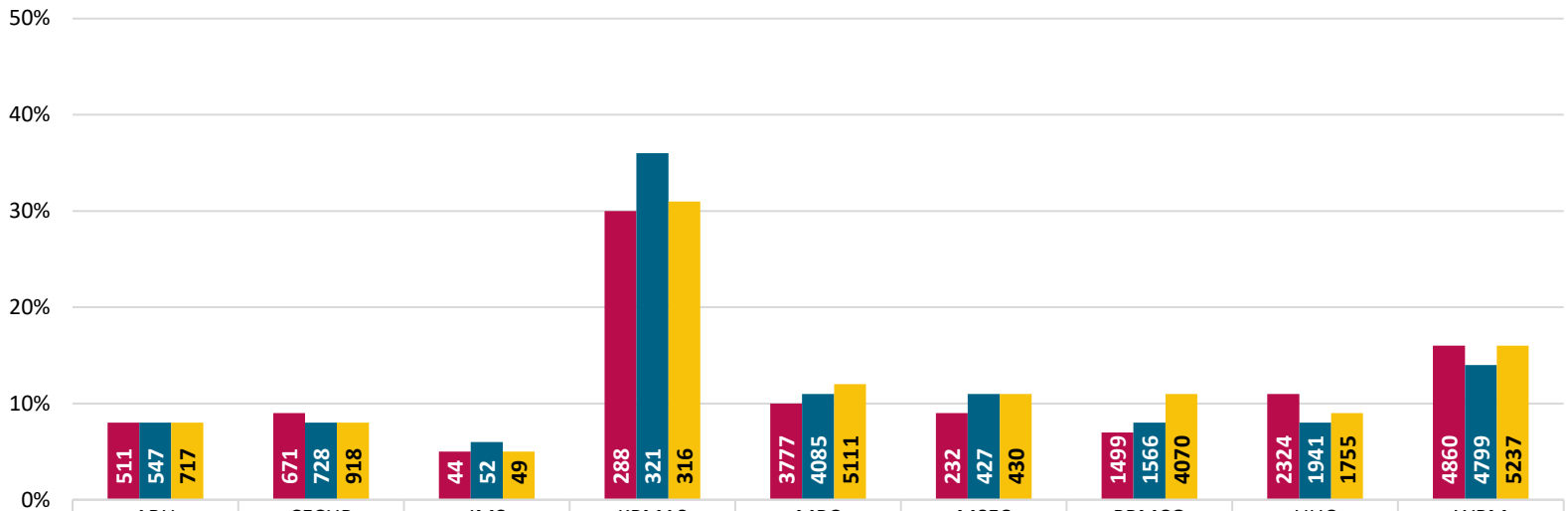
	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2023	105.83	84.64	30.07	8.40	153.77	24.71	60.76	130.33	97.73
Annual 2024	111.84	94.63	32.02	9.73	171.95	45.36	63.40	168.46	121.72
Annual 2025	144.64	120.07	33.81	10.93	220.15	49.74	140.33	139.36	124.72

Pre-service Denials Enrollees <21 by MCO

Pre-service denials in enrollees under age 21 is an important metric to monitor, given the federal regulations pertaining to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefits. EPSDT services are a federally mandated component of Medicaid that requires MCOs to cover all medically necessary and medically appropriate services for children and youth under age 21. At this time, there is no performance goal or threshold established for pre-service denials in children and youth under age 21. The figure below demonstrates the percentage of denials, by MCO, for the EPSDT population across MYs 2023 to 2025. MY 2025's GAD studies observed the following about prior authorization requests:

- **Median**. The median for MY 2025 is 11%. Comparatively, the median in MY 2024 was 8% and 9% in MY 2023.
- **Peer Comparison.** When comparing MY 2024 to MY 2025, there are four MCOs (ABH, CFCHP, JMS, and UHC) with pre-service denials below the 11% median for the EPSDT population.
- **Trending.** In MY 2025, the range of pre-service denials in this population is 5% to 31% for MY 2025. Comparatively, in MY 2024, it was 6%-36%; and 5% to 30% in MY 2023. From MYs 2023 to 2025, MPC and PPMCO show a year-over-year increase in denials, though the percentage point difference is small. KPMAS is an outlier for enrollee denials of the EPSDT population in comparison to the remaining MCOs, with denial rates hovering in the 30% to 36% range in all three years, starting with MY 2025 (31%, 36%, and 30%). The next largest percentage is WPM with denial rates of 16%, 14%, and 16%. ABH has maintained a rate of 8% for all three years. UHC's rate in MY 2023 was 11% and has come down to 8% in MY 2024 and 9% in MY 2025.

Figure 19. Annual Trending Percent of Pre-Service Denials for Enrollees < 21 (MCO-Reported Results)



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
MY 2023	8%	9%	5%	30%	10%	9%	7%	11%	16%
MY 2024	8%	8%	6%	36%	11%	11%	8%	8%	14%
MY 2025	8%	8%	5%	31%	12%	11%	11%	9%	16%

Percentages are rounded to the nearest whole number for reporting purposes.

Pre-service Denial Service and Reason Codes

MCOs identify the top reasons for pre-service denials and the most prevalent service categories within each quarterly report. MCOs can submit rationale for data variances, including comparisons to prior quarters or years.

Top 5 Preservice Denial Service Categories. In MY 2025, the top five pre-service denial service codes in order of prevalence are listed below:

- 4A/Medical/Surgical
- 5A/Pharmacy services
- 1B/Diagnostic/Lab: Radiology
- 2/DME/DMS

- 5B/Pharmacy services: Chronic Pain Management

These results are identical to MY 2024 and MY 2023 both in content and rank, with one exception. MY 2023 tied 5B/Pharmacy services: Chronic Pain Management with 4C/Medical Surgical: related to Therapies) for fifth place.

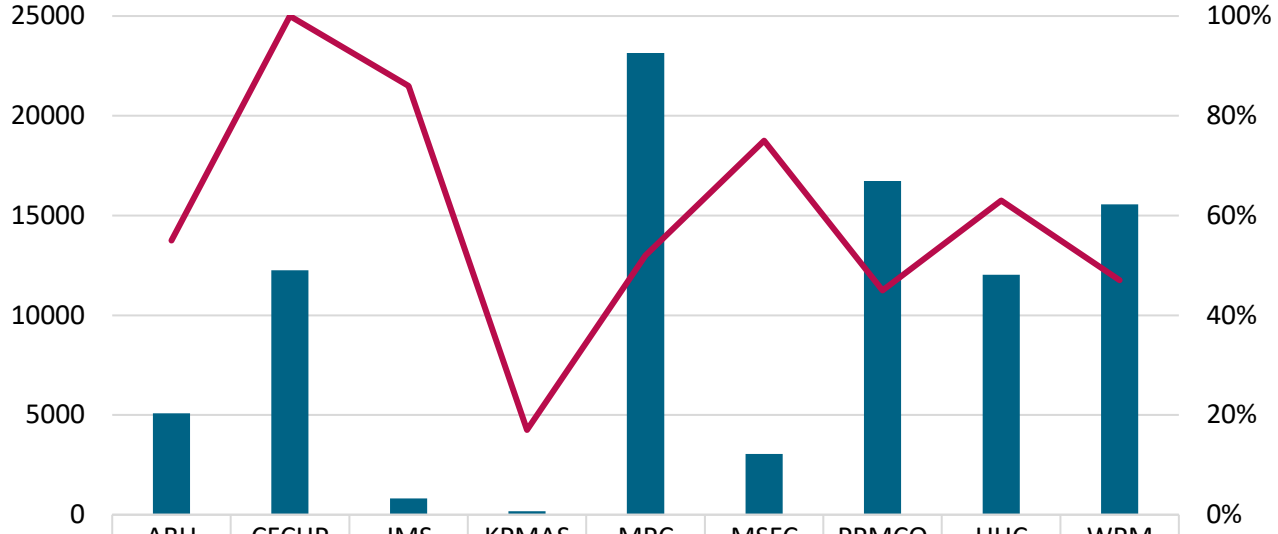
Top 5 Pre-Service Denial Reason Codes. In MY 2025, the most prevalent reasons for pre-service denials in order of prevalence include:

- NMN-1 Not Medically Necessary/Full Denial
- ADM-5 Administrative/Not a Covered Benefit or Service
- NMN-2 Not Medically Necessary – Partial Authorization
- NMN-3 Not Medically Necessary/Full Denial/Lack of Complete Clinical Information
- ADM-4 Administrative/Out of Network Provider

Other than a change in order of prevalence, this list is the same as MY 2024. In MY 2023, there were only four top reason codes, and these four did not include NMN-2 Not Medically Necessary – Partial Authorization. Also of note, no "Other" codes 7 and 9 surfaced in the top five for pre-service denial service categories or reason codes.

Outpatient Pharmacy Denials. Pre-Service Outpatient Pharmacy Denials continues to be one of the top five service categories year-over-year. In MY 2025, MCOs processed 88,852 Pre-service OP Pharmacy denials. In the figure below, the range across MCOs for Pre-Service Outpatient Pharmacy Denials is the widest at 17% to 100%. The median is 55%. The median was 52% in MY 2024 and 64% in MY 2023. Based upon MY 2025 data, CFCHP reports the highest denial rate for pre-service outpatient pharmacy (100%), followed by JMS (86%) and MSFC (75%). ABH is in the mid-range. KPMAS documented the lowest number and percentage at 17%.

Figure 20. MY 2025 Pre-Service OP Pharmacy Denials (MCO-Reported Results)

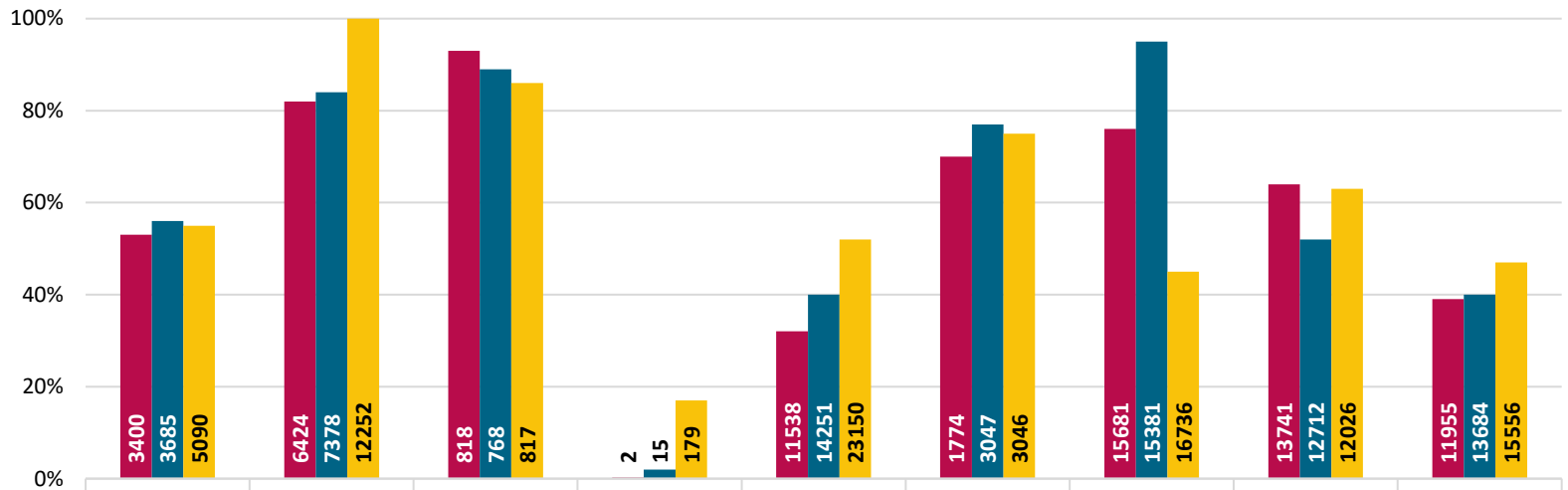


	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Outpatient Pharmacy Denials (#)	5090	12252	817	179	23150	3046	16736	12026	15556
Percent of Total Denials	55%	100%	86%	17%	52%	75%	45%	63%	47%

Percentages are rounded to the nearest whole number for reporting purposes.

The following figure highlights the prevalence of Pre-service OP Pharmacy denials over the three-year period, MYs 2023 to 2025. Comparing MY 2024 OP Pharmacy denials to MY 2025, six MCOs reported increases in percentage of these denials (CFCHP, KPMAS, MPC, PPMCO, UHC, and WPM). The three MCOs with declines in OP Pharmacy denials include ABH, JMS, and MSFC. The following figure illustrates a rise in OP Pharmacy denials year-over-year for CFCHP and WPM. KPMAS reports a minimal number of pharmacy denials throughout the trending period; MY 2023 (0.2%) to MYs 2024 (2%) and 2025(17%). MCOs report the contributing factors to this increase as denial of weight loss drugs that are not medically necessary, or denial of drugs prescribed that would not alter the outcome of the current treatment or therapy.

Figure 21. Annual Trending MCO Percentage of Pre-Service OP Pharmacy Denials (MCO-Reported Results)



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
MY 2023	53%	82%	93%	0.20%	32%	70%	76%	64%	39%
MY 2024	56%	84%	89%	2%	40%	77%	95%	52%	40%
MY 2025	55%	100%	86%	17%	52%	75%	45%	63%	47%

Percentages are rounded to the nearest whole number for reporting purposes.

Resolution Timeframes

Requirements

Qlarant assesses compliance with COMAR requirements for the timeliness of pre-service denials and adverse determinations through MCO-reported compliance, MCO annual GAD reports, and a record review of GAD documentation. Pre-service denials are first assessed through the timeliness of determinations and resolution, and then through the timeliness of notification to the enrollee and provider on the outcome.

Results

Pre-Service Denial Resolution and Notification Timeliness. MY 2025's GAD studies observed the following about timeliness of pre-service denial resolutions and notifications:

- **MCO-Reported Results**. MCOs are assessed for compliance of timeliness with a denial resolution (determination) and for the timeliness of an enrollee notification of the outcome in the following three categories: Expedited Pre-Service Medical Denials, Standard Pre-Service Medical Denials, and Pre-Service Outpatient Pharmacy Denials. In addition, MCOs are assessed for compliance with timeliness of a notification to prescribers of the outcome of a pharmacy-related PA decision.
- **Compliance.** The following tables below show annual comparisons for three years (MYs 2023 through 2025) of MCO-reported compliance with timeframes for adverse determination resolution and notification. Prescriber notifications of outcomes (within 24 hours) relate only to adverse determination and notifications. All data is MCO-reported. Seven MCOs met timeliness requirements for resolution and notification of expedited pre-service medical denials. The two outliers are MSFC and UHC. MSFC only reported two expedited denials, one that did not meet either resolution or notification timeliness (50%). UHC's expedited pre-service medical denial TAT was 94%. While not in compliance, this is an improvement from Q3 MY 2025's result of 91%. Eight MCOs performed at or above the 95% threshold for resolution and notification timeliness for standard pre-service medical denials. The outlier was CFCHP with a 93% compliance rate for both resolution and notification timeliness. All nine MCOs met resolution and notification compliance requirements for pre-service outpatient pharmacy. All nine MCOs met the TAT for prescriber notification within 24 hours of the decision. Comparing MY 2024 to MY 2025, in MY 2024, all nine MCOs met compliance with resolution and notification requirements in all three categories.
- **Trending.** Several trends are identified when comparing findings over the trending period (MYs 2023 through 2025). For expedited pre-service medical denials, JMS and KPMAS scored 100% compliance in all three years. MPC was the only MCO scoring 100% for all three years for standard pre-service medical denials. Pre-service outpatient pharmacy resolution TAT was the most successful, with five MCOs (CFCHP, KPMAS, MSFC, UHC, and WPM) scoring 100% in all three years.

Compliance with the following resolution timeframes is based on the MDH-established compliance score (95%):

- Expedited (medical): 72 hours
- Standard (medical): two business days to 14 calendar days.
- Outpatient Pharmacy: 24 hours
- Prescriber notification of outcome: within 24 hours

Table 24. Annual Trending of Compliance with Pre-Service Determination Timeframes (MCO-Reported Results)

Denial Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Expedited (Medical): Annual 2023	99%	100%	100%	100%	99%	100%	98%	100%	99%
Expedited (Medical): Annual 2024	99%	100%	100%	100%	100%	100%	98%	100%	99%
Expedited (Medical): Annual 2025	96%	96%	100%	100%	98%	**50%** PM	97%	**94%** PM	100%
Standard (Medical): Annual 2023	99%	99%	100%	99%	100%	99%	99%	100%	99%
Standard (Medical): Annual 2024	100%	99%	100%	99%	100%	99%	99%	100%	100%
Standard (Medical): Annual 2025	96%	**93%** PM	99%	99%	100%	99%	99%	99%	99%
Outpatient Pharmacy: Annual 2023	100%	100%	98%	100%	99%	100%	99%	100%	100%
Outpatient Pharmacy: Annual 2024	100%	100%	98%	100%	98%	100%	99%	100%	100%
Outpatient Pharmacy: Annual 2025	99%	100%	98%	100%	100%	100%	99%	100%	100%

Percentages are rounded to the nearest whole number for reporting purposes.
Partially Met (PM) and Black font ≥95% for at least one reporting period, but not all reporting periods

Table 25. Annual Trending of Compliance with Adverse Determination Notification Timeframes (MCO-Reported Results)

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Expedited (Medical): Annual 2023	99%	100%	100%	100%	99%	100%	95%	100%	96%
Expedited (Medical): Annual 2024	98%	100%	**91%** PM	100%	99%	100%	97%	100%	99%
Expedited (Medical): Annual 2025	96%	96%	100%	100%	95%	**50%** PM	98%	**94%** PM	100%
Standard (Medical): Annual 2023	99%	100%	98%	100%	100%	99%	100%	100%	99%
Standard (Medical): Annual 2024	99%	100%	100%	99%	100%	100%	95%	100%	99%
Standard (Medical): Annual 2025	95%	**93%** PM	100%	100%	100%	98%	100%	99%	99%
Outpatient Pharmacy: Annual 2023	100%	99%	100%	100%	100%	100%	100%	100%	100%
Outpatient Pharmacy: Annual 2024	100%	100%	100%	100%	100%	99%	100%	100%	100%
Outpatient Pharmacy: Annual 2025	99%	100%	100%	99%	100%	99%	100%	100%	100%
Prescriber Notification: Annual 2023	100%	98%	99%	99%	100%	100%	99%	100%	100%
Prescriber Notification: Annual 2024	100%	100%	98%	100%	100%	100%	98%	100%	100%
Prescriber Notification: Annual 2025	99%	100%	99%	100%	100%	99%	99%	100%	100%

Percentages are rounded to the nearest whole number for reporting purposes.
Partially Met (PM) and Black font ≥95% for at least one reporting period, but not all reporting periods
Median TAT for Pre-service denial decision

MY 2025's GAD studies observed the following about timeliness of pre-service denial resolutions and notifications:

- **Record Review Results.** Record reviews assessed compliance with the COMAR requirements for timeliness of pre-service determinations, adverse determination notifications, and adverse determination letters. The following table identifies compliance with denial requirements and compares annual record review results across MCOs. MY 2025's GAD studies observed the following about adverse determinations during review of adverse determination records:
- **Compliance.** In the record review, eight MCOs (ABH, CFCHP, JMS, KPMAS, MPC, MSFC, PPMCO, and WPM) demonstrated 100% compliance with all applicable categories for determination and notification requirements. UHC fell below the compliance score (95%) at 0% for 24-hour prescriber notification of the outcome of a preauthorization request for a covered outpatient drug by telephone or other telecommunication device within 24 hours of receipt, as there was no evidence found in case notes. While there was evidence that prescribers received a copy of the adverse determination letter sent to the enrollee within 24 hours of receipt of the request, there was no evidence that these letters were faxed to the provider within 24 hours of receipt of the preauthorization request.
- **Prior Year Comparison.** When comparing MY 2024 to MY 2025, eight MCOs (ABH, CFCHP, KPMAS, MPC, MSFC, PPMCO, and WPM) demonstrated 100% compliance in all three adverse determination categories. UHC demonstrated 100% compliance with timeframes for determinations and adverse determination notifications; however, there was no evidence that UHC notified prescribers by telephone or other telecommunication device within 24 hours of the outcome of a preauthorization request for a covered outpatient drug in either MY.
- **Trending.** Assessing trends from MY 2023 to MY 2025, eight MCOs (ABH, CFCHP, JMS, KPMAS, MPC, MSFC, PPMCO, and WPM) exceeded the 95% compliance score for all pre-service determination/resolution and notification requirements for record reviews across three consecutive years. While UHC exceeded the compliance score for determination and adverse determination notification timeframes in all three MYs, this was the third MY in a row that UHC did not demonstrate compliance with the requirement for notifying the prescriber of the outcome of a preauthorization request for a covered outpatient drug, by telephone or other telecommunication device, within 24 hours of receipt of the request**.**

Table 26. MY 2025 MCO Annual Adverse Determination Results (Record Review)

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Appropriateness of Adverse Determinations	100%	100%	100%	100%	100%	100%	100%	100%	100%
Compliance with Pre-Service Determination Timeframes	100%	100%	100%	100%	100%	100%	100%	100%	100%
Compliance with Adverse Determination Notification Timeframes	100%	100%	100%	100%	100%	100%	100%	100%	100%
Required Letter Components	100%	**0%** UM	100%	100%	100%	100%	100%	100%	100%
Compliance with Prescriber Notification	100%	NA	100%	100%	100%	100%	100%	**0%** UM	100%

Unmet (UM) <95% for reporting period
Not Applicable (NA)

Qlarant identified specific issues in the record review process that are not identified as metrics in assessing MCO compliance. MY 2025's GAD studies observed the following about adverse determinations during review of pre-service adverse determination records:

- **Compliance.** CFCHP fell below the compliance score (95%) at 0%, as no adverse determination letters noted that a copy was sent to the requesting provider; although case notes indicated a copy of the letter was faxed.

Conclusions

Annual report trends for MYs 2023 to 2025 added context to MCO-reported results for MY 2025 GAD studies. This section includes conclusions from data collected from MCO-reported GAD reports and a sample of grievance, appeal, and adverse determination records. The following section summarizes MCO performance for MY 2025 and identifies notable trends over the three-year assessment period (MYs 2023 to 2025), especially those that are positive for the HealthChoice delivery system.

General Findings

MCOs are making a concerted effort to submit complete GAD reports. MCOs are responsive when contacted and work with Qlarant to remedy errors in reporting. More MCOs are submitting explanation for variances in performance from quarter to quarter, and on revealing the content within the "Other" Codes. Opportunities still exist for all MCOs to identify factors contributing to non-compliance or informed decisions on systemic changes.

MY 2025 Performance

- The nine MCOs processed 6,154 enrollee grievances, 218 provider grievances, 9,477 appeals, and 526,545 PA requests.
- PPMCO was the only MCO that exceeded performance thresholds in all required metrics in the annual record review and in the annual compliance review assessing MCO GAD reports.
- ABH is the only MCO with appeal resolution TAT scores of 100% for three years running.
- Pharmacy services are consistently reported in the service category for grievances, appeals, and pre-service denials. All nine MCOs met resolution and notification compliance requirements for pre-service outpatient pharmacy. All nine MCOs met the TAT for prescriber notification within 24 hours of the decision.
- Based upon MCO reported data, MCOs are resolving prior authorization requests at a rate of >95 to100%.

Notable Trends Comparing MYs 2023, MY 2024, and MY 2025

Grievances

- The median for enrollee grievances per 1,000 is trending downward.
- CFCHP documented the lowest enrollee grievances per year for all three trending years.
- Three MCOs (ABH, UHC, and WPM) have grievances per 1,000 on an upward trend from MYs 2023 to 2025.
- For Category 3: Administrative Provider Grievances, UHC and WPM did not meet resolution timeliness compliance for the trending years.
- This is the third year in a row that UHC did not demonstrate compliance with: Category 2: Non-emergency enrollee grievance resolution timeliness and prescriber notification of the outcome of a preauthorization request for a covered outpatient drug.

Appeals

- Sixty-three percent of the opportunities for improvement are in the record review portion of the MY 2025 GAD studies. Compliance with appeal requirements represents the greatest opportunity for improvement, based upon record review results, which were the lowest in the last three MYs.
- JMS is the only MCO where appeals per 1,000 enrollees declined each year.
- Seven MCOs (except JMS and MSFC) showed incremental increases in enrollee appeals per 1,000 across the trended years. MPC had the most significant increase from MY 2023 to MY 2025, with a difference of 8.57 per 1,000.
- Two MCOs (KPMAS and CFCHP) declined in expedited enrollee appeals each year.
- Two MCOs (PPMCO and CFCHP) demonstrate year-over-year increases in percent of appeals overturned for Action Type 1.
- Pharmacy appeals overturns have increased annually for CFCHP and PPMCO.
- UHC declined in Pharmacy Overturns each year.
- JMS had a significant drop in pharmacy appeals from MY 2024 (84%) to MY 2025 (46%).
- MCOs document minimal changes in reason and service codes over the trending years. The top five appeal service codes align with MY 2025 pre-service denials except for an increase in 4C/Medical Surgical: related to Therapies and 5B/Pharmacy services: Chronic Pain Management denials.

Prior Authorization and Pre-Service Denials

- The percentage of PA requests that come to the MCOs with complete information is consistent over three years and averages 87% to 88%.
- JMS' PA approvals are increasing each year.

- Comparison of the trending years shows an upward trend in pre-service denials per 1,000 enrollees for all MCOs, except UHC.
- MPC has the highest denial rate per 1,000 for MY 2025 and increasing each year from MY 2023.
- KPMAS has the lowest denial rate for the past three years, although the rates have increased over the trending period.
- Two MCOs (CFCHP and WPM) show a rise in OP Pharmacy denials each year.

MCO Compliance

Table 27. MY 2025 MCO Overall Compliance with Regulatory Timeframes (MCO-Reported Results)

Categories	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Enrollee Grievances	M	M	M	**PM**	M	M	M	**PM**	M
Provider Grievances	M	M	M	NA	M	M	M	**UM**	**UM**
Enrollee Appeals	M	**PM**	**PM**	**PM**	M	M	M	M	M
Adverse Determinations	M	**PM**	M	M	M	**PM**	M	**PM**	M
Adverse Notifications	M	**PM**	M	M	M	**PM**	M	**PM**	M
Prescriber Notifications	M	M	M	M	M	M	M	M	M

Unmet (UM) <95% for all applicable metrics within the reporting period
Partially Met (PM) <95 for one or more, but not all applicable metrics within the reporting period
Met (M) = MCO achieves 95% and demonstrates consistent compliance

Table 28. MY 2025 Review Components (Record Review)

Categories	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Enrollee Grievances	M	M	M	M	M	M	M	M	M
Enrollee Appeals	**UM**	**UM**	**UM**	**UM**	**UM**	**UM**	M	M	**UM**
Adverse Determinations	M	M	M	M	M	M	M	M	M
Adverse Notifications	M	M	M	M	M	M	M	M	M
Prescriber Notifications	M	**UM**	M	M	M	M	M	**UM**	M

Unmet (UM) <95% for reporting periods
Met (M) = MCO achieves 95% and demonstrates consistent compliance
NA = Not Applicable

Performance Indicator 1: All timeliness metrics to meet or exceed a 95% compliance score.

This section captures overall MCO compliance scores from quarterly report submissions and annual record review components against MDH's compliance score for MY 2025 (95%).

Enrollee Grievance Resolution Timeliness

- Seven of the nine MCOs met all performance requirements for grievance resolution timeliness, based on MCO reported results. The outliers are KPMAS and UHC.
- Eight MCOs (except ABH) demonstrated compliance in all grievance categories, based upon record reviews.
- Seven MCOs demonstrated compliance in all applicable adverse determination categories based upon record reviews.

Provider Grievance Resolution Timeliness

- Seven MCOs were compliant with provider grievance resolution timeliness. The outliers are UHC and WPM.

Appeal Resolution Timeliness

- Approximately 99% of enrollee appeals in MY 2025 were for Action Type 1.
- Eight MCOs met the timeliness requirement for non-emergency appeals in MY 2025. JMS is the outlier.
- Seven of the nine MCOs met the required appeal resolution time frame for expedited appeals. The outliers are CFCHP and KPMAS.
- Eight MCOs had PA requests approved after appeal, whereas JMS had none.

Pre-Service Denial Resolution and Notification Timeliness

- JMS has the highest PA approval rate at 95%, followed by KPMAS at 91% and MSFC at 89%. These MCOs are above the median of 74%. These MCOs also operate in an employer provider model rather than a network individual or group practice.
- Six MCOs (ABH, JMS, KPMAS, MPC, PPMCO, and WPM) exceeded the 95% compliance requirement for all four pre-service denial timeliness metrics.
- Eight MCOs (except CFCHP) performed at or above the 95% threshold for both resolution and notification timeliness for Standard Pre-Service Medical Denials.
- In the record review, eight MCOs (except UHC) demonstrated 100% compliance with all applicable categories for determination and notification requirements.
- Seven MCOs met timeliness requirements for both resolution and notification for Expedited Pre-Service Medical Denials. The outliers are MSFC and UHC.
- UHC had 72 expedited pre-service medical denials, with a rate of 94%. This is an improvement from the Q3 MY 2025 rate of 91%.

Performance Indicator 2: Proposed appeals overturned percentage >50% overturned, indicating favor to the enrollee.

- MCOs with overturned rates above the 50% threshold (in favor of the enrollee) include: CFCHP (68%), MSFC (56%), PPMCO (51%), UHC (53%) and WPM (54%)
- Compliance with appeal requirements represents the greatest opportunity for improvement, based upon record review results, which were the lowest in the last three MYs.

Data Validity Analysis

Threats to the validity of the MCO-submitted quarterly grievance, appeal, and denial reports continue to be assessed. Limitations in the accuracy of the self-reported MCO data are noted below.

- MCO-reported data has room for error if there is not some form of inter-rater reliability measured across the MCOs in how they are interpreting instructions.
- MCO initial submissions regularly require return to MCOs, due to incomplete submissions or data inconsistencies, causing delays in reporting and validation timeframes.

HealthChoice Quality, Access, and Timeliness

Qlarant identified strengths, improvements, opportunities, and recommendations summarizing aggregate performance across MCOs, based on the results of MY 2025 GAD studies. These strengths, improvements, opportunities, and recommendations correspond to quality and timeliness of services provided to enrollees. 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).

Applicable domains in quality, access, or timeliness correspond to areas of impact during MY 2025 GAD studies and identify positive, negative, or NA assessments of MCO performance.

HealthChoice MCOs' strengths positively impacted ***quality and/or timeliness*** with the following compliance:

- Three MCOs (ABH, MPC and PPMCO) exceeded compliance in all timeliness metrics across all categories (expedited, standard, administrative, and pharmacy) for grievances, appeals, and denials during review of MCO-reported GAD metrics for three MYs in a row.
- Eight MCOs (except UHC) exceeded the 95% compliance score in the record review for all pre-service determination/resolution and notification requirements over the trended years.

HealthChoice MCOs' strengths, improvements, opportunities, and recommendations impacting quality and/or timeliness are individually identified per MCO in Appendix A.

Recommendations

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 the appeal process serves as a timely and effective avenue for enrollees to have recourse.

Because of opportunities identified following the MY 2024 focused review, the table below displays MDH's implementation and planned implementation of the following changes:

Table 29. Implementation of MY 2024 Recommendations

MY 2024 Recommendations	MDH Implementation
Update timeframe requirement for enrollee notice of an adverse determination for a covered outpatient drug to 24 hours from the determination.	Recommendation stands for MY 2025.
Establish CAPs for MCOs who have been non-compliant on the same metrics for the past two years.	Instead of requesting a CAP, Qlarant's teams accountable for SPR and GAD reviews worked directly with individual MCOs to provide technical assistance when data gaps and report errors were identified, and when Qlarant required an explanation of unusual data variances. Any corrective action needed to address non-compliant GAD findings are requested at the time of the annual SPR. MCOs continue to receive performance findings and recommendations with their quarterly reports analysis.
Consider looking at top five service and reason codes by percentages, instead of occurrences of a service code being in the top five.	Analysis shows the outcomes are not that different, especially for the top three categories. Qlarant will continue to monitor and inform MDH of any changes.

MDH Opportunity

Qlarant provides the following recommendations from MY 2025 activities:

- Given greater scrutiny at the federal level on GAD, if not already in place, MDH may want to consider having quarterly GAD meetings with MCOs to brainstorm solutions. Topics could include methods to decrease service denials, reduce administrative burden on the health system, standardize billing and administrative practices and authorization for service routinely appealed, identify errors that could contribute to delays in care, assess disparities (e.g., geographical, race/ethnicity, and literacy) in denials for enrollees less likely to appeal a service, reduce out-of-network denials, and address the pros and cons of information technology and artificial intelligence.
- As recommended in MY 2024, Qlarant recommends that MDH update the requirement for enrollee notice of an adverse determination in response to a pharmacy preauthorization request to 24 hours from the determination to improve consistency among the MCOs and support more timely notification, especially with the provision of 14-calendar days now available for receiving requested information from the prescriber.
- MDH may want to consider a separate approach to address denials for the EPSDT age group. This is particularly important given the move toward managed care for long-term services and supports and Health Sciences and Behavioral Sciences (HSBS) services. Denials in the EPSDT population are important to ensure that enrollees in special needs populations are not missing important services. Service

category 4C/Medical Surgical: related to therapies is increasing in frequency. It is unclear if this category is for adults only. If it includes those under age 21, it would be important to monitor. One strategy might be to separate age groups between those under 21 and adults and create metrics per 1,000 PA requests and per 1,000 children, using each MCO's population numbers for both age groups. This approach could tie in EPSDT and assess-denied services, especially for the special needs populations being denied these services.

MCOs Opportunity

Qlarant provides the following recommendations from MY 2025 activities:

- All MCOs should provide an explanation for changes in performance, especially for any non-compliant metrics for the review period.
- For the past three years, the "Other" category has posted in the top five reason and service categories for enrollee and provider grievances. Many of the elements of these "Other" codes noted in Table 9 could be integrated into existing reason and service categories. This warrants further discussion between Qlarant and the MCOs.
- MCOs with the highest appeals overturned rate may want to reevaluate the services requiring authorization if the appeal will be overturned in the end.

Appendix A: MCO-Specific Summaries

Qlarant summarized MCO-specific results from quarterly assessments and annual record reviews about findings from activities conducted during MY 2025's GAD studies. Each MCO summary includes observations on MCO-specific compliance, trends, comparisons to other MCOs, strengths, improvements, opportunities, and recommendations. Due to the limited impact on access across all MCOs, it has not been included as a category. Qlarant evaluated the impact on quality and timeliness by adopting the following definitions for MY 2025's GAD study:

- **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).

Qlarant did not observe any formal improvements from the previous measurement year for ABH.

Table 30. ABH Strengths, Improvements, and Recommendations

Domain	Aetna Better Health of Maryland	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality and Timeliness	**Trends:** • ABH's results overall have remained positive and consistent year-to-year. • Exceeded compliance in all timeliness metrics in all categories for expedited, standard, administrative and pharmacy) for grievances, appeals and denials for the trended years (2023-2025). • ABH is the only MCO with appeal resolution TAT scores of 100% for three years running.	↑
Quality	**Comparison to Other MCOs:** • Scored above the median for both enrollee and provider grievances per 1,000. • Top member grievances by reason code and service code are consistent with other MCOs with one exception, ABH has a unique Provider Reason code for 3B/Attitude/Service-Administrative Staff. • More than half (54%) of the top Service category are for 9/Other within enrollee grievances. • 4/Finance/Billing continues to be the top Reason code within enrollee grievances. • Recorded the second highest pre-service denial per 1,000 rate for MY 2025. • Appeals per 1,000 enrollees were at the median compared to other MCOs. The percentage of upheld appeals is the second highest of all MCOs with 69% upheld. ABH's top five service categories align with other MCOs, with pharmacy services within the top three. • Percentage of PA requests approved is 66% and those denied 34%, similar to MY 2024. Pre-service denials per 1,000 moved from just above the median.	↓

Domain	Aetna Better Health of Maryland	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality and Timeliness	**Compliance:** *MCO Reports* • Consistently exceeds compliance requirements in all GAD domains with the MCO report requirements. *Record review:* • Met all timeframes for written grievance acknowledgment, resolution, and written resolution. • Met all timeframes for written appeal acknowledgment and written resolution notification. • Met all timeframes for pre-service determination, prescriber notification, and adverse determination notification. • Included required components in all adverse determination letters.	↑
Quality	**Strengths:** • Consistently meets compliance metrics for MCO reports. • Appropriately categorized all grievances. • Writes appeal and adverse determination letters in easy-to-understand language.	↑
Quality and Timeliness	**Opportunities:** *Record Review* • Inappropriately resolved grievances. • Case notes should indicate reasonable attempts to provide enrollees with oral notice of expedited appeal resolution. • Written confirmation of an oral appeal is not required. Two appeal acknowledgment letters included this requirement. This is the second year in a row for this opportunity. *Trends* • Over the past three years, ABH shows a gradual increase in enrollee and provider grievances per thousand.	↓

Domain	Aetna Better Health of Maryland	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality and Timeliness	**Recommendations:** • Retrain grievance team to enable processing of billing/financial grievances without requesting release of protected health information when needing to contact the billing provider. • Retrain staff on regulations prohibiting written confirmation of an oral appeal. • Routinely audit expedited appeal case notes to ensure documentation of reasonable attempts to provide enrollees with oral notification of expedited appeal resolution. • Routinely audit appeal resolution letters to ensure all dates are accurate. One appeal resolution letter included an incorrect date appeal was filed.	↓

Table 31. CFCHP Strengths, Improvements, and Recommendations

Domain	CareFirst Community Health Plan	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality and Timeliness	**Trends:** • Documented the lowest amount of enrollee grievances each year for all trended years. • Declined in the amount of expedited enrollee appeals year-over-year. • Increased in percent of appeals overturned for Action Type 1 each year.	↑
Quality and Timeliness	**Comparison to Other MCOs:** • Enrollee grievances per 1,000 continue to be the lowest of the nine MCOs. The top five reason and service codes for enrollee grievances are similar to the other MCOs. Approximately 90% of CFCHP's service categories are for 4A/Medical Surgical and 8/Vision Services. • Enrollee appeals per 1,000 are the third highest of the MCOs. • Pharmacy services continue as the top appeals service category. • Documented pre-service denials/1,000 enrollees as directly below the median of the MCO range. These metrics met in all quarters of MY 2024. The results for resolution and notification for expedited and outpatient pharmacy denials exceeded the threshold.	↓
Quality and Timeliness	**Compliance:** *MCO Reports:* • Exceeded the threshold (95%) of resolution timeframes for both enrollee and provider grievances. • Met timeframes for resolution and notification of standard pre-service medical denials. *Record Review:* • Met all timeframes for grievance acknowledgment, resolution, and written resolution. • Met all timeframes for written appeal acknowledgment and written resolution notifications. • Met all timeframes for pre-service determinations and adverse determination notifications.	↑
Quality	**Strengths:** • Detailed description of grievance, investigation, and resolution in case notes. • Appropriately categorized and resolved all grievances. • Enrollee adverse determination and appeal resolution letters provide an extremely detailed description of the determination/resolution in easily understandable language.	↑

Domain	CareFirst Community Health Plan	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality and Timeliness	**Improvements:** • Increased resolution TAT for expedited enrollee appeals. • Improved resolution and notification timeframes for standard pre-service medical denials. • Exceeded the compliance score for compliance with grievance acknowledgment letters, which is an improvement over MY 2024, when TAT was at 90%. • Used the appropriate MD Health Choice grievance letter template. In MY 2024, a Medicare Advantage template was used for one acknowledgment letter. • Included the correct resolution timeframe and calculated dates in appeal acknowledgment letters. In MY 2024, two appeal acknowledgment letters for an expedited appeal stated a 30-day timeframe for resolution and the calculated dates were 43 and 45 days after appeal receipt.	↑
Quality and Timeliness	**Opportunities:** *MCO Reports:* • Resolution and notification of standard pre-service medical denials. *Record Review:* • Use the appropriate MD Health Choice appeal letter template. One resolution letter appeared to be for provider claims appeals, as it included the availability of a second level appeal to be heard by the plan CEO. • Grievance acknowledgment letters must include the correct resolution timeframe of five rather than seven calendar days. • Adverse determination letters must include evidence the requesting provider was copied. (Case notes indicate providers received a copy of the adverse determination letter.) • Case notes must indicate a reasonable attempt to provide oral notification of the denial of a request for an expedited appeal resolution. • Case notes are missing documentation of reasonable attempts to provide oral notice of denial of an expedited request for one appeal (83%). *Trends:* • Documented a rise in OP pharmacy denials each year. • Trending downward in resolution and notification timeframes for standard pre-service medical denials.	↓

Domain	CareFirst Community Health Plan	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality and Timeliness	**Recommendations:** • Retrain staff on resolution timeframe for non-emergency medically related grievances. • Retain staff on noting copy of adverse determination letter sent to requesting provider in enrollee adverse determination letters. • Routinely audit a sample of appeal resolution letters to ensure the correct template is used. • Routinely audit case notes for enrollee oral notification of denial of an expedited request.	↓

Table 32. JMS Strengths, Improvements, and Recommendations

Domain	Jai Medical Systems, Inc.	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality	**Trends:** • Documented a low number of appeals per 1,000 for three years. • Declined each year in the number of appeals per 1,000 enrollees; JMS is the only MCO with this trend. • Increased number of PA approvals each year.	↑
Quality	**Comparison to Other MCOs:** • Enrollee grievances per 1,000 were at the low end of the MCO range at 2.36 compared to the highest (18.54). • Enrollee appeals per 1,000 are the second lowest of the MCOs. • Over two-thirds (71%) of enrollee grievances are related to access issues where in MY 2024 the top category was 4/Billing/Financial, consistent with other MCOs. • Reason codes and Service categories align with other MCOs. • Pre-service denials/1,000 are the second lowest of the MCO range. • Compared to the other MCOs, JMS has the lowest PA Requests denied at 5%. JMS has the second highest denial rate for outpatient pharmacy of the other MCOs.	↑
Quality and Timeliness	**Compliance:** *MCO Reports:* • Exceeds the threshold (95%) in TAT compliance for enrollee and provider grievances for all relevant metrics. *Record reviews:* • Met all timeframes for written grievance acknowledgment, resolution, and written resolution. • Met timeframes for standard and expedited appeal resolution notifications. • Met all timeframes for pre-service determinations, prescriber notifications, and adverse determination notifications. • Include all required components in adverse determination letters.	↑

Domain	Jai Medical Systems, Inc.	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality and Timeliness	**Strengths:** • Appropriately categorized and resolved all grievances. • Detailed documentation in case notes of grievance investigation and steps to resolve. • Resolved ninety percent of grievances in less than or equal to five days in all categories for exceptional enrollee service. • In the sample of appeals reviewed, all were resolved the same day as receipt providing exceptional service to enrollees. • Wrote all appeal and adverse determination letters in easy-to-understand language.	↑
Timeliness	**Improvements:** • Met all performance metrics for denial resolution and notification timeliness metrics. This is an improvement from MY 2024.	↑
Quality and Timeliness	**Opportunities:** *Compliance:* • Scored below the threshold on timeliness of resolution of non-emergency appeals. • Did not meet timeframe for standard appeal acknowledgment letters (0%). • Acknowledgment letters sent to enrollees for all standard appeals. *Trends:* • Trending upward in the number of pre-service denials reported per 1,000.	↓
Quality and Timeliness	**Recommendations:** • Routinely audit case notes to ensure acknowledgment letter sent to enrollee for all standard appeals.	↓

Table 33. KPMAS Strengths, Improvements, and Recommendations

Domain	Kaiser Permanente of the Mid-Atlantic States, Inc.	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality and Timeliness	**Trends:** • Reported no provider grievances for the trending years. • Reported the lowest number of appeals per 1,000 across all MCOs for the measured trending years. • Declined in the amount of expedited enrollee appeals each year. • Documented the lowest denial per 1,000 rate for the trending years, though the rates have increased over the three-year period. • Exceeded TAT thresholds in compliance with pre-service determination and notification timeframes in all relevant categories for the past three years.	↑
Quality and Timeliness	**Comparison to Other MCOs:** • Met TAT compliance for Categories 2: Non-emergency Medically Related and 3: Administrative. • Denials rate per 1,000 members remains the lowest of all MCOs. This was also the case in MY 2023 and MY 2024. • One of KPMAS' top service categories in pre-service denials, 11/Long Term Care, continues to be unique to only this MCO. The top denial reasons are in range with other MCOs. Reported compliance with determination and notification timeframes has exceeded TAT thresholds in all relevant categories for the past three years. KPMAS' results for the year remain consistent.	↑

Domain	Kaiser Permanente of the Mid-Atlantic States, Inc.	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Timeliness	**Compliance:** *MCO Reports:* • Met TAT compliance for Categories 2: Non-emergency Medically Related and 3: Administrative. • Did not meet the timeliness threshold for expedited appeals resolution (75%). *Record reviews:* • Met all timeframes for written grievance acknowledgment, resolution, and written resolution. • Met timeframe for appeal acknowledgment. • Met timeframes for enrollee oral notice of expedited appeal resolution (100%). • Met all timeframes for pre-service determinations, prescriber notifications, and adverse determination notifications. • Included all required components in adverse determination letters.	↑
Quality	**Strengths:** • Appropriately categorized and resolved all grievances. • Detailed explanations of adverse determinations and appeal resolutions in easy-to-understand language in enrollee letters.	↑
Quality and Timeliness	**Improvements:** • Increased timeframe compliance for standard non-emergency appeals from MY 2024 (93%) to MY 2025 (98%). • Provided appeal decisions to enrollees in easy-to-understand language, which is an improvement from MY 2024 compliance at 80%.	↑

Domain	Kaiser Permanente of the Mid-Atlantic States, Inc.	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality and Timeliness	**Opportunities:** *Record Review:* • Improve timeframe compliance for standard and expedited appeal resolution notifications. • Appeal acknowledgment letters include accurate dates. (Dates for standard resolution ranged from 28 to 34 calendar days. Date for expedited resolution was stated as 30 calendar days from filing.) • Appeal resolution letters include the correct name of the enrollee in the body of the letter. (The enrollee name referenced in the body of the appeal resolution letter was inconsistent with the enrollee name in the address and salutation in two letters.) *Comparison to Other MCOs:* • Documented the highest number of enrollee grievances per 1,000 among the MCOs, specifically for non-emergency medically related and administrative grievances. • Did not meet compliance with Category 1: Emergency Medically Related grievances (67%) for MY 2025. It is important to note there were only two grievances reported in this category. This is the first non-compliant metric in the past four reporting periods. • Documented two unique appeals service categories, one for Vision and one for LTC. *Compliance: Record Reviews* • Did not meet timeframe compliance for written appeal resolution letters (86%). • Did not meet timeframe compliance for written notice of expedited appeal resolution (0%).	↓
Quality and Timeliness	**Recommendations:** • Routinely audit compliance with timeframes for expedited and standard appeal resolution notifications. • Routinely audit acknowledgment letters for accurate resolution dates and resolution letters for consistent use of correct enrollee name throughout.	↓

Table 34. MPC Strengths, Improvements, and Recommendations

Domain	Maryland Physicians Care	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality and Timeliness	**Trends:** • Met TAT compliance in all applicable GAD MCO reported domains and standard/expedited categories for reporting periods in MY 2023, MY 2024, and MY 2025.	↑
Quality	**Comparison to Other MCOs:** • Documents results generally within the range of the other MCOs. Both enrollee and provider grievances per 1,000 are at the median of the MCO range. Most grievances are administrative. • Documents the second highest number of appeals per 1,000 across the MCOs. • Scored the highest percentage of upheld appeals decisions of MCOs (73%). • Continues to document the highest rate of pre-service denials per 1,000 enrollees across all MCOs.	↓
Quality and Timeliness	**Compliance:** *MCO Reports* • Met TAT compliance in all applicable categories for three consecutive years. *Record reviews:* • Met all timeframes for grievance acknowledgment, resolution, and written resolution. • Exceeded compliance score for enrollee appeal acknowledgment and resolution letters. • Met all timeframes for pre-service determinations, prescriber notifications, and adverse determination notifications. • Included all required components in adverse determination.	↑
Quality and Timeliness	**Strengths:** • Consistently exceeds the required performance metrics. • Grievance investigation and resolution are well documented in case notes. • Writes appeal and adverse determination letters in easy-to-understand language. *Comparison to Other MCOs:* • Consistently exceeds the compliance threshold for all determination and notification TATs for MYs 2023 through 2025.	↑

Domain	Maryland Physicians Care	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality and Timeliness	**Improvements:** • Improved performance on record review by reducing non-compliant metrics from three in MY 2023 to one in 2025. • Exceeded the compliance score for compliance with grievance acknowledgment letters, which is an improvement over MY 2024, when TAT was at 87%.	↑
Quality	**Opportunities:** • Enrollees should receive oral and written notification of the denial of an expedited appeal request. *Trends* • Continues to document the highest denial rate per 1,000 with increases each year. *Record Reviews* • Did not meet compliance with enrollee oral notification of denial of an expedited appeal request (10%); notified provider instead. • Did not meet compliance for providing written notice to the enrollee of denial of an expedited appeal request (90%). No letter was found in the file provided.	↓
Quality	**Recommendations:** • Retrain staff on requirements for enrollee oral and written notifications of denial of an expedited request (COMAR 10.67.09.05 C (3)(b)).	↓

Table 35. MSFC Strengths, Improvements, and Recommendations

Domain	MedStar Family Choice, Inc.	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality	**Comparison to Other MCOs:** • Documented less enrollee and provider grievances per 1,000 than in MY 2024. • Documented a number of appeals per 1,000 enrollees below the median of the MCO range. Pharmacy-related appeals continue as the most prevalent (79%) service category. • Decreased in the number of PA requests denied from MY 2024 (23%) to MY 2025 (11%). MSFC's rate of denials per 1,000 enrollees continues as the third lowest among the MCOs. • Qlarant did not observe any formal trends in performance for MSFC.	↑
Quality and Timeliness	**Compliance:** *MCO Reports:* • Exceeded performance requirements for both determination and notification timeframes for standard pre-service medical denials and outpatient pharmacy denials, and for prescriber notification timeframes. *Record reviews:* • Met all timeframes for written grievance acknowledgment, resolution, and written resolution. • Exceeded timeframe compliance for appeal acknowledgment letters (97%). • Met all timeframes for pre-service determinations, prescriber notifications, and adverse determination notifications. • Included all required components in adverse determination letters.	↑
Quality	**Strengths:** • Continues to educate enrollees and providers on ways to reduce errors in billing. • Appropriately categorized and resolved all grievances. • Grievance, investigation, and resolution were well documented in case notes. • Wrote appeal and adverse determination letters in easy-to-understand language.	↑
Quality	**Improvements:** • All grievances reflected an appropriate resolution, which is an improvement over the MY score of 97%. • Pharmacy preauthorization requests are no longer identified as urgent, as noted in MY 2024; and are now processed in accordance with MCO transmittal No. 225, dated October 3, 2024.	↑

Domain	MedStar Family Choice, Inc.	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality and Timeliness	**Opportunities:** • Improve resolution and notification timeliness for expedited denials. • Include enrollee written notification of standard appeal resolution in all files. • Did not meet requirements for oral and written notice of expedited appeal resolution. Provider requested expedited appeal, but case notes indicated processed as standard with no notes or enrollee notification of downgrade to standard. • Upload appeal records consistent with requirements to include no voids, dismissals, or withdrawals. The sample reviewed included at least six. • Include accurate resolution/notification timeframes in acknowledgment letters for expedited appeals. Three acknowledgment letters incorrectly stated timeframe for processing expedited appeal as 30 calendar days. *Compliance: MCO Reports* • Declined in timeframe compliance for resolution and notification of expedited denials (50%). It is important to note that there was only two expedited preservice medical denials reported for these findings. *Compliance: Record Reviews* • Did not meet compliance with written notification of standard appeal resolution (68%). All non-compliant records were the result of a missing resolution letter. • Did not meet compliance with oral and written notice of expedited appeal resolution (80%).	↓
Quality and Timeliness	**Recommendations:** • Retrain staff on appropriate requirements and documentation for expedited appeal requests. • Audit appeal confirmation letters for expedited appeals to ensure appropriate processing timeframe, • Audit appeal universe provided for record review to ensure specifications are met. • Audit upload of case records to ensure all case records include an appeal resolution letter. • Routinely audit appeal acknowledgment letters to ensure the correct timeframe is identified for expedited appeal resolution/notification**.**	↓

Table 36. PPMCO Strengths, Improvements, and Recommendations

Domain	Priority Partners	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality and Timeliness	**Trends:** • Increased year-over-year in percent of appeals overturned for Action Type 1. • Increased pharmacy appeals overturn each year.	↑
Quality and Timeliness	**Comparison to Other MCOs:** • PPMCO is the only MCO that met and exceeded all required performance metrics in both MCO-reported compliance and medical record review for MY 2025, • Documented enrollee grievances per 1,000 are the second to the lowest of the MCO range for another MY. • Reported 87% of enrollee grievances are for the service 9/Other category. • Continued to report the highest appeals rate per 1,000 enrollees across the MCOs. • Denials per 1,000 enrollees are the third highest of MCOs. In MY 2024, there were no pre-service pharmacy denials reported. In MY 2025, 45% of pre-service denials were for outpatient pharmacy.	↑
Quality and Timeliness	**Compliance:** *MCO Reports:* • Exceeded the 95% performance threshold for both pre-service determination and notification timeframes in all relevant categories. *Record reviews:* • Met all timeframes for grievance acknowledgment, resolution, and resolution letters. • Met all timeframes for appeal acknowledgment and resolution letters and oral notice of expedited appeal resolution. • Met all timeframes for determinations, pharmacy notifications, and adverse determination notifications. • Included all required components in adverse determination letters.	↑

Domain	Priority Partners	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality and Timeliness	**Strengths:** • Met compliance (100%) for all applicable enrollee and provider grievance metrics. • Made significant improvements in the past three years to achieve high performance marks. • Consistent compliance with all timeframe regulatory requirements for grievances, appeals, and adverse determinations. • Appropriately categorized and resolved all grievances. • Wrote appeal and adverse determination letters in easy-to-understand language. • Qlarant did not recommend any formal opportunities or recommendations for PPMCO.	↑
Quality and Timeliness	**Improvements:** • Exceeded the compliance score for compliance with grievance resolution and grievance resolution notification, which is an improvement over MY 2024, when TAT was at 73%. • Appropriately resolved all grievances, which is an improvement over MY 2024 (73%). • No longer includes the assumption of a five-calendar-day mailing timeframe in adverse determination letters, as in MY 2024. • No longer includes claims appeals procedures in adverse determination letters sent to the requesting provider.	↑

Table 37. UHC Strengths, Improvements, and Recommendations

Domain	UnitedHealthcare Community Plans	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality and Timeliness	**Trends:** • Documented an upward trend in grievances per 1,000. • Did not demonstrate compliance with Category 2: non-emergency enrollee grievance resolution timeliness and prescriber notification of the outcome of a preauthorization request for a covered outpatient drug for the third year in a row. • Declined in Pharmacy Overturns each year. • Did not provide documentation in case notes of prescriber notification by telephone or other telecommunication device of review outcome within 24 hours of receipt of the PA request for at least the third year in a row.	↓
Quality	**Comparison to Other MCOs:** • Documented enrollee and provider grievances per 1,000 are at the mid-to-low end of the MCO range. Most grievances are administrative. • Documented 61% of the top service categories as related to 5A/Pharmacy Services and 21% to 4A/Medical/Surgical.	↓
Quality and Timeliness	**Compliance:** *MCO Reports:* • Did not meet the threshold (95%) for resolution timeliness for Category 1: Emergency medically related (0%) or Category 2: Non-emergency Medically Related enrollee grievances (90%). • Did not meet the threshold for timeliness of resolution for provider Category 3: Administrative grievances (80%). • Scored below the threshold (95%) for expedited Pre-service Medical denials resolution and notification timeliness (94%). *Record reviews:* • Did not provide evidence in case records of prescriber notification of the outcome of a preauthorization request for a covered outpatient drug by telephone or other telecommunication device within 24 hours of receipt of the request.	↓

Domain	UnitedHealthcare Community Plans	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality	**Strengths:** *Compliance: MCO Reports:* • Met resolution TAT compliance for administrative enrollee grievances at 100%. • Demonstrated compliance with resolution and notification timeliness for Standard Pre-service Medical Denials and Pre-Service Outpatient Pharmacy denials. *Compliance: Record reviews:* • Met all timeframes for written grievance acknowledgment, resolution, and written resolution. • Met all timeframes for standard and expedited appeal resolution/notification and notification of denial of an expedited appeal request. Appeal acknowledgment letters met the compliance score at 95%. • Demonstrate reasonable attempt to notify enrollee of denial of an expedited appeal request and resolution of an expedited appeal request in case notes. • Met all timeframes for determinations and adverse determinations. • Appropriately resolved all grievances. • Wrote all appeal resolution letters in easy-to-understand language. • Included detailed description of reason for denial and any additional needs in easy-to-understand language in denial letters.	↑
Quality and Timeliness	**Improvements:** • Met the compliance score for timeliness of appeal acknowledgment letters, which is an improvement over MY 2024 (94%). • Written notice of denial of an expedited appeal request met the timeframe, which is an improvement over MY 2024, which was at 67%. • Verbal notification of expedited appeal resolution was met, which is an improvement over MY 2024 at 79%.	↑
Quality and Timeliness	**Opportunities:** • Appropriately categorize all grievances based upon level of urgency. One grievance related to access to prescription refill was miscategorized as administrative rather than non-emergency, medically related. • Document review outcome in case notes of prescriber notification, by telephone or other telecommunication device, within 24 hours of receipt of the PA request.	↓

Domain	UnitedHealthcare Community Plans	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality	**Recommendations:** • Review the criteria for categorizing grievances as emergency and non-emergency medically related with staff. • Retrain staff and routinely audit case notes for pharmacy PA requests to ensure compliance with prescriber notification.	↓

Table 38. WPM Strengths, Improvements, and Recommendations

Domain	Wellpoint Maryland	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality	**Trends:** • Documented a rise in OP Pharmacy denials each year.	↓
Quality	**Comparison to Other MCOs:** • Documented grievance results above the median for both enrollee and provider grievances per 1,000. • Reported one unique reason code (12): Lack of timely MCO response to a service authorization or appeal. • Reported having only Administrative Grievances for both enrollees and providers. • Documented 82% of the reasons for a denial under the NMN-1 category-Full Denial for Non-medically Necessary service.	↓
Quality and Timeliness	**Compliance:** *MCO Reports:* • Exceeded the performance requirement threshold (95%) for pre-service determination and notification timeliness in all required categories. • Met compliance (100%) for TAT of enrollee grievances in Category 3: Administrative. **Record reviews:** • Met all timeframes for written grievance acknowledgment, resolution, and written resolution. • Met timeframes for appeal acknowledgment and resolution/notification letters. • Met timeframes for determinations, prescriber notifications, and adverse determinations. • Included all required components in adverse determination letters.	↑
Quality	**Strengths:** • Fully describe grievance, investigation, and resolution in case notes. • Appropriately categorized and resolved all grievances. • Wrote all appeal and adverse determination letters in easy-to-understand language.	↑
Quality	**Improvements:** • Exceeded the compliance score for compliance with appropriate grievance categorization, which is an improvement over MY 2024 at 87%.	↑

Domain	Wellpoint Maryland	Assessment
Quality or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑ or ↓**
Quality	**Opportunities:** *Compliance: MCO Reports:* • Did not meet the performance threshold (95%) for provider grievances Category 3: Administrative (90%). This metric has not been compliant since Q1 MY 2025. *Compliance: Record reviews:* • Did not meet compliance for oral notice to enrollee of expedited appeal resolution (50%). Demonstrate reasonable attempt to provide enrollee with oral notice of appeal resolution in case notes. • Use appropriate MDH appeal acknowledgment letter template. Provider claims acknowledgment letter template used for two enrollee appeals.	↓
Quality	**Recommendations:** • Routinely audit appeal acknowledgment letters to ensure use of appropriate letter template. • Routinely audit case notes to ensure documentation of reasonable attempts to provider enrollee oral notification of expedited appeal resolution.	↓