Qlarant

Maryland
DEPARTMENT OF HEALTH

Medicaid Managed Care Organization

Grievances, Appeals, & Denials Focused Review Report

Measurement Year 2023

Submitted June 2024

Table of Contents

Grievances, Appeals, & Denials

Focused Review Report

Measurement Year 2023

Introduction

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

Federal regulations require MDH to contract with an external quality review organization (EQRO) to provide annual, independent reviews assessing quality, access, and timeliness of care. The EQRO for MDH is Qlarant. Qlarant's independent review ensures services provided to enrollees meet federal regulations and evaluate quality, access, and timeliness of care through analysis of grievances, appeals, and denials.

HealthChoice emphasizes continuous quality improvement by structuring a comprehensive system that includes problem identification, analysis, corrective action, and reevaluation. The objective is to identify areas for improvement by developing processes and systems capable of profiling and tracking information regarding the care and services received by HealthChoice enrollees. Qlarant conducts quality studies focused on determining MCO compliance with federal and state laws and regulations pertaining to the appropriateness of denials in the service denial reports submitted by each MCO, along with an annual record review.

Assessment of MCO compliance was completed by applying performance standards defined for measurement year (MY) 2023. Quarterly studies of grievances, appeals, and pre-service denials were conducted for the first through third quarters of MY 2023, while the fourth quarter included annual data for MY 2023. The annual record review included enrollee grievances, appeals, and pre-service denials that occurred during MY 2023. The following MCOs were assessed in this report:

- Aetna Better Health of Maryland (ABH)
- CareFirst Community Health Plan (CFCHP)
- Jai Medical Systems, Inc. (JMS)
- Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)
- Maryland Physicians Care (MPC)

- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare Community Plan (UHC)
- Wellpoint Maryland (WPM)

Purpose and Objectives

The purpose of this review is to:

1. Assess MCO compliance with federal and state regulations governing enrollee and provider grievances, enrollee appeals, pre-service authorization requests, and adverse determinations;
2. Facilitate increased compliance within the above areas by illustrating trends and opportunities for improvement; and
3. Ensure that HealthChoice enrollees are not denied access to medically necessary services and supports.

This focused study activity addresses the following:

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

Methodology

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

In addition to quarterly reviews of the reports submitted by the MCOs, Qlarant conducted an annual record review of MY 2023's sample of grievance, appeal, and pre-service denial records. Records were requested from July 1 through October 31, 2023, to allow MCOs an opportunity to address and fully implement several recent regulatory changes noted as incomplete during the Systems Performance Review (SPR) conducted in early 2023. Each MCO provided Qlarant with a listing of grievances, appeals, and pre-service denials for MY 2023. Qlarant selected 35 cases from each listing, using a random sampling approach; and requested each MCO to upload the selected case records to the Qlarant portal. Using the 10/30 rule, an initial sample of ten grievance, ten appeal, and ten denial records were reviewed. If an area of noncompliance was discovered, an additional 20 records were reviewed for noncompliant component(s).

Results of the overall grievance, appeal, and pre-service denial record reviews, including strengths, best practices, and opportunities for improvement, were provided to MDH as a component of each SPR report. Results of the record reviews were also shared with the appropriate staff for each MCO, including technical assistance as needed, to facilitate improved compliance.

Data Validity Analysis

Threats to the validity of the MCO-submitted quarterly grievance, appeal, and denial reports are assessed quarterly. For each quarter of MY 2023, MCOs continued to show improvements in GAD report documentation. In particular, MCOs had fewer report resubmissions and fewer errors within each report. Limitations in the accuracy of the self-reported MCO data are noted below.

- Maryland MCOs' GAD data for MY 2023 consists of three quarterly data submissions and one annual submission. As a result, positive or negative data trends over the quarters were not as easily determined.

- Service and reason codes reported by the MCOs in the category of "Other," increased in MY 2023. These codes do not support the identification and trending of relevant information. Qlarant performed an analysis of the frequency of these "other" codes in March 2024. Findings are noted in the results section of this report.

- In December 2023, CMS revised the timeframes for reporting on the Managed Care Program Annual Report (MCPAR) related to resolved appeals to request 12-month rather than 11-month totals. The measurement year for 2023 considers 12 months of MCO GAD data, while 2022 was considered a calendar year with 11 months of MCO data.

Qlarant will continue to assess data disparities in MY 2024.

Results

This section provides MCO-specific findings from a review of performance against select grievance, appeal, and pre-service denial measures. The data used to inform results came from two sources: MCO-reported quarterly and annual grievance, appeals, and denial data for MY 2023; and an annual record review specific to documentation practices for GAD metrics for a shorter time period: July-October 2023. Findings are displayed in table and graphical format using percentages to reflect compliance against pre-defined performance thresholds as appropriate. Findings are depicted for three consecutive quarters and for the year (MY 2023). In most cases, the results between the quarterly and annual findings are similar. The data also allows for comparisons of MCO performance over time and in relation to peers.

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

Table 1. Review Determinations

Review Determinations	
Met (M)	≥95% for all reporting periods = Met (M)
Partially Met (PM)	≥95% for at least one reporting period but not all reporting periods = Partially Met (PM) Compliance inconsistently demonstrated
Unmet (UM)	<95% for all reporting periods = Unmet (UM) No evidence of compliance
Not Applicable (NA)	Not Applicable – used when information is not available for a category under review

Grievance Results

A grievance is an expression of dissatisfaction about any matter other than an adverse action and is defined in COMAR 10.67.01.01. COMAR 10.67.09.02.C1 describes three categories of grievances:

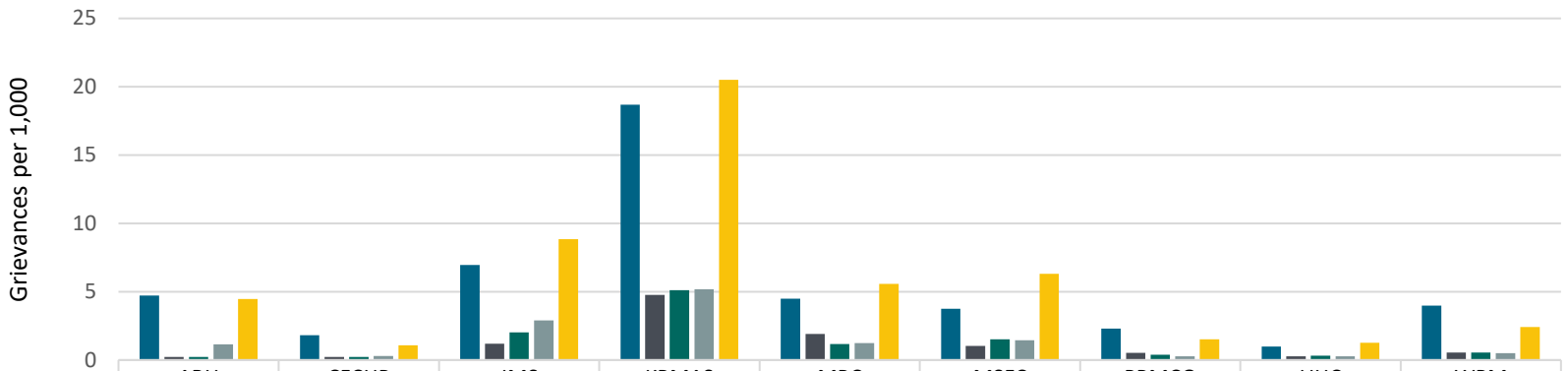
- **Category 1:** Emergency medically related grievances
  - Example: Emergency prescription or incorrect prescription provided
- **Category 2:** Non-emergency medically related grievances
  - Example: Durable Medical Equipment/Disposable Medical Supplies-related complaints about repairs, upgrades, or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

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

- Comparative Statistics
  - Grievances filed per 1,000 enrollees overall and by categories
  - Top 5 enrollee grievance service categories
  - Grievances filed per 1,000 providers overall and by categories
  - Top 5 provider grievance reason categories
- Resolution Timeframes (based upon 95% compliance)
  - Emergency medically related grievances resolved within 24 hours
  - Non-Emergency medically related grievances resolved within 5 days
  - Administrative grievances resolved within 30 days
- Grievance Definitions
  - Must meet the definition of an expression of dissatisfaction about any matter other than an action.
  - May include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships, such as rudeness of a provider or employee or failure to respect the enrollee's rights, regardless of whether remedial action is requested.
- Grievance Documentation:
  - Grievance issue must be fully described in the enrollee record.
- Grievance Determination:
  - Grievance determination must be documented in the enrollee record, appropriately address the grievance issue, and identify steps taken to resolve the issue.
  - Written determination must be forwarded to:
    1. An enrollee who filed the grievance;
    2. Individuals and entities that are required to be notified of the grievance; and
    3. The Department's complaint unit (for complaints referred to the MCO by the Department's complaint unit).

Figure 1 displays a comparison of MCO grievances per 1,000 enrollees for quarterly and annual reviews.

Figure 1. Grievances/1,000 Enrollees



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2022	4.72	1.83	6.96	18.69	4.5	3.76	2.31	0.99	3.98
Q1 2023	0.22	0.22	1.19	4.76	1.91	1.03	0.53	0.27	0.55
Q2 2023	0.23	0.23	2.03	5.11	1.18	1.53	0.39	0.32	0.55
Q3 2023	1.15	0.29	2.91	5.19	1.25	1.46	0.27	0.28	0.51
Annual 2023	4.48	1.08	8.85	20.5	5.57	6.31	1.53	1.26	2.41

Considering all nine MCOs in MY 2023, the median for grievances per 1000 members is 4.48. Four MCOs have grievances per 1000 below the median (CFCHP, PPMCO, UHC, and WPM). ABH is at the median, and MPC falls close to the median. The remaining three MCOs (JMS, KPMAS, and MSFC) have grievances per 1000 greater than the median. CFCHP reports the lowest number of grievances per 1000 (1.08) for the year and KPMAS reports the highest (20.50).

By peer comparison, KPMAS continues to be a major outlier in grievances per 1000 enrollees for all four quarters of MY 2023. Approximately 44% of KPMAS grievances are related to attitude and service. The remaining grievances are distributed evenly across quality of care, inability to schedule appointments, and the “other” category for non-specified reasons. JMS follows KPMAS with the next highest rate of grievances per 1000 enrollees in three of the four quarters, with 79% pertaining to billing/financial issues.

When comparing MY 2023 to MY 2022, it is evident that there are minor differences in the rates of MCOs' enrollee grievances per 1000, yet the variances across MCOs have not changed. MY 2023 grievance reason and service codes are consistent with MY 2022.

The most prevalent reasons for enrollee grievances fall within the following three categories in order of prevalence: attitude/service, access including access to pharmacy for prescription issues, and billing/financial. The top three grievance service categories include Medical Surgical, Pharmacy Services, and Diagnostic/Lab and Radiology.

Several MCOs documented the factors contributing to grievance issues. In some instances, delegated vendors did not follow proper resolution procedures. For one MCO, there was a significant 136% upsurge in pharmacy and prescription-related grievances due to issues with the coordination of benefits; i.e., pharmacy data systems used incorrect insurance carriers when billing. In addition, there was an increase in billing/financial-related grievances as a result of enrollees not providing their ID cards when seeking medical care; this led to providers sending bills directly to the enrollee.

Table 2 displays quarterly and annual comparisons of MCO-reported compliance with resolution timeframes for enrollee grievances. The MDH established compliance threshold for MY 2023 was 95%.

Table 2. MCO Reported Compliance with Enrollee Grievance Resolution Timeframes

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2022	**100%**	**91%**	**100%**	**99%**	**100%**	**85%***	**100%**	**100%**	**100%**
Q1 2023	100%	100%	100%	93%*	100%	100%	100%	88%	100%
Q2 2023	100%	100%	100%	100%	99%*	100%	100%	79%	100%
Q3 2023	100%	100%	100%	100%	100%	100%	99%	80%	100%
Annual 2023	**100%**	**99%**	**100%**	**97%***	**100%**	**100%**	**99%**	**84%***	**98%**

*Average of all three grievance categories (medically-related emergency and non-emergency, and administrative) for the year.
Underlined ≥95% for at least one reporting period but not all reporting periods = Partially Met (PM)
Red font - <95% for all reporting periods = Unmet (UM)

In MY 2023, improvements were made in grievance resolution timeliness. Seven of the nine MCOs (ABH, CFCHP, JMS, MPC, MSFC, PPMCO, and WPM) met grievance resolution timeliness in all three quarters and for the year. By comparison, in MY 2022, only five MCOs (ABH, JMS, MPC, UHC, and WPM) met resolution timeframes in all three quarters and for the year. The majority of the member grievances were administrative in nature. KPMAS and UHC were the two outliers for grievance resolution timeliness.

For MY 2023, KPMAS had 12 emergency medically related grievances that did not meet compliance with the timeliness of resolution. UHC met all relevant resolution timeframes for the most prevalent grievance category, administrative grievances. Approximately two-thirds of UHC's member grievances were administrative and the resolution TAT for these met compliance at 99%. Timeliness metrics did not meet the 95% threshold for

Category 1: Emergency Medically Related (80%) grievances and Category 2: Non-Emergency Member grievances (74%). Category 2 fell below the 95% threshold for each quarter of the year.

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

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

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2022	**0.54**	**6.61**	**0.50**	**0.00**	**0.22**	**1.03**	**0.45**	**0.65**	**5.11**
Q1 2023	0.00	0.00	0.00	0.00	0.07	0.76	0.80	0.18	1.19
Q2 2023	0.00	0.00	0.00	0.00	0.09	0.06	0.72	0.03	1.10
Q3 2023	0.25	0.00	0.00	0.00	0.09	0.58	0.47	0.09	2.14
Annual 2023	**0.36**	**0.10**	**0.08**	**0.00**	**0.24**	**2.12**	**0.37**	**0.61**	**6.85**

The median for provider grievances per 1000 is 0.36. KPMAS has consistently reported the absence of provider grievances in all four quarters for MY 2022 and MY 2023. Excluding KPMAS, provider grievances per 1000 were the highest for WPM (6.85) and lowest for JMS (0.08). The top three reasons for provider grievances are finance/billing, attitude/service, and other.

When comparing MY 2023 to MY 2022, provider grievances per 1000 declined for ABH, CFCHP, JMS, PPMCO, and UHC. The remaining three MCOs (MPC, MSFC, and WPM) had slight increases in provider grievances per 1000.

Table 4 displays quarterly comparisons of MCO-reported compliance with resolution timeframes for provider grievances. The MDH established compliance threshold for MY 2023 was 95%.

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

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2022	**100%**	**85%**	**100%**	**NA**	**100%**	**100%**	**100%**	**100%**	**100%**
Q1 2023	100%	NA	NA	NA	100%	100%	100%	100%	100%
Q2 2023	100%	100%	NA	NA	100%	100%	100%	100%	100%
Q3 2023	100%	100%	100%	NA	100%	100%	100%	100%	100%
Annual 2023	**100%**	**100%**	**100%**	**NA**	**100%**	**100%**	**100%**	**94%**	**92%**

Underlined ≥95% for at least one reporting period but not all reporting periods = Partially Met (PM)
Red font - <95% for all reporting periods = Unmet (UM)

Excluding KPMAS, six of the nine MCOs (ABH, CFCHP, JMS, MPC, MSFC, and PPMCO) met provider grievance resolution timeframes in all three quarters (when data available) and for the year. UHC and WPM the outliers. Both UHC and WPM met compliance in quarters one through three, but not for the year.

When comparing MY 2023 to MY 2022, CFCHP improved provider grievance resolution TAT from 85% in MY 2022 to 100% in MY 2023. UHC and WPM moved from 100% in MY 2022 to 94% and 92% respectively.

Table 5 presents a comparison of the annual grievance record review results across MCOs. Results are based upon a random selection of grievance records during MY 2023. Reviews were conducted utilizing the 10/30 rule.

Table 5. MY 2023 MCO Annual Grievance Record Review Results

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Appropriately Classified	100%	100%	100%	100%	100%	100%	100%	100%	100%
Acknowledgment Letter Timeliness	80%	84%	100%	100%	100%	100%	100%	93%	100%
Issue Is Fully Described	100%	100%	100%	100%	100%	100%	100%	100%	100%
Resolution Timeliness	100%	100%	100%	100%	100%	100%	100%	100%	100%
Resolution Appropriateness	100%	100%	100%	100%	100%	100%	100%	100%	100%
Resolution Letter Timeliness	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%

Red font - <95% for reporting period = Unmet (UM)
NA = Not Applicable

Five MCOs (JMS, KPMAS, MPC, MSFC, and PPMCO) demonstrated 100% compliance in all seven categories. Three MCOs (ABH, CFCHP, and UHC) fell below the 95% compliance threshold for acknowledgment letter timeliness at 80%, 84%, and 93% respectively. WPM incorrectly categorized a non-emergency medically related grievance as administrative although it resolved it within the regulatory timeframe for the appropriate category. In reviewing a sample of UHC grievance records it was discovered that it did not include the comprehensive Language Accessibility Statement in its acknowledgment and resolution letters. In addition to English, only two other languages were included.

When comparing MY 2023 to MY 2022, seven MCOs in MY 2022 (ABH, JMS, KPMAS, MPC, MSFC, PPMCO, and UHC) received a finding of 100% compliance in all seven categories and only two MCOs performed below the threshold (CFCHP and WPM). CFCHP received a finding of Partially Met for both acknowledgment and resolution letter timeliness, received a finding of Partially Met for not including a description of the grievance in 40% of the records reviewed, and a finding of Unmet resulted from CFCHP providing incomplete documentation of grievances in case notes. In

MY 2023, CFCHP made improvements in documentation demonstrating 100% compliance with all components except acknowledgement letter timeliness.

In MY 2022 WPM did not meet the required resolution timeframe with a rate of 90%. WPM also did not categorize all grievances appropriately, scoring 77%. In MY 2023, WPM met compliance in all categories at 100% except for categorizing a grievance appropriately though improvement was made from 77% to 90%.

Appeals Results

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

- Action 1: Denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- Action 2: Reduction, suspension, or termination of a previously authorized service.
- Action 3: Denial, in whole or part, of payment for a service, except for administrative denials of unclean claims.
- Action 4: Failure to provide services in a timely manner (i.e., if the MCO fails to provide services within the timeframes defined by the State in COMAR 10.67.05.07).
- Action 5: Failure of an MCO to act within the required appeal timeframes set in COMAR (i.e., COMAR 10.67.09.05).
- Action 6: The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, or other enrollee financial liabilities.

Appeal results assessed compliance with the following COMAR 10.67.09.05 regulations:

- MCOs may only have one level of enrollee appeal, and enrollees must first appeal to the MCO before requesting a state fair hearing.
- Except for expedited appeals, MCOs shall resolve each appeal and provide notice of a resolution, as expeditiously as the enrollee's health condition requires, within 30 days from the date the MCO receives the appeal unless an extension is requested.
- Expedited appeals shall be resolved as expeditiously as the enrollee's health condition requires, but no later than 72 hours after the MCO receives the appeal.

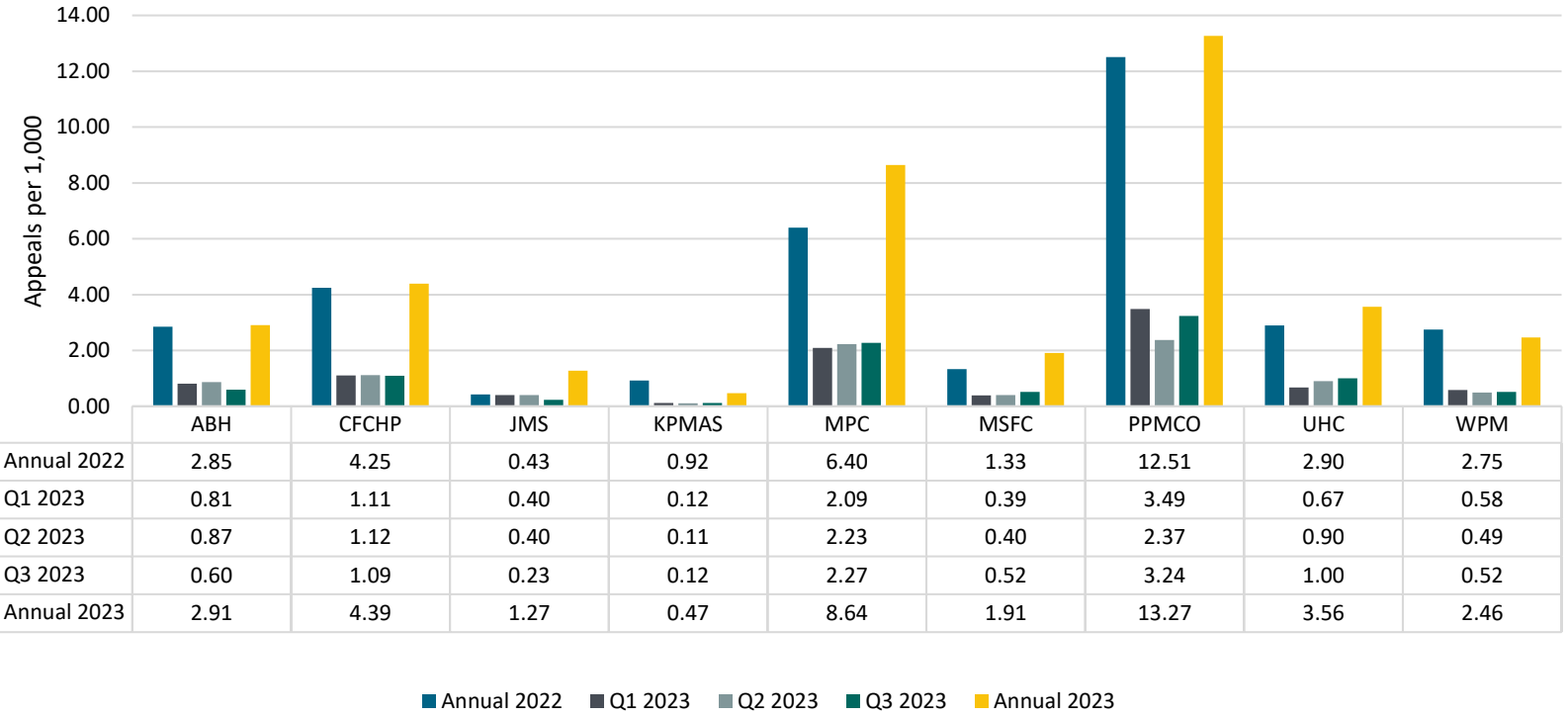
Providers can file an appeal on behalf of an enrollee, with the enrollee's written consent. COMAR previously did not require the provider to seek written authorization before filing an appeal on the enrollee's behalf. In 2020, MDH updated the expedited appeal's 72-hour timeframe to include both the resolution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

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

- Comparative Statistics:
  - Appeals Filed Per 1,000 Enrollees
  - Percentages of Appeals Received from Denials
  - Percentages of Appeals Submitted by Enrollees and by Providers
  - Percentages of Upheld and Overturned Denials
  - Percentages of Overturns by Action Types (1-6)
  - Percentages of Upholds by Action Types (1-6)
  - Top 5 Service Categories
  - Percentages of Expedited Appeals
  - Percentages of Extended Appeals
- Resolution Timeframes (95% threshold)
  - Expedited appeals are required to be completed within 72 hours of receipt. Notification of the appeal decision is required within 24 hours of the decision and within the overall 72-hour timeframe.
  - Non-emergency appeals are required to be completed within 30 days unless an extension is requested of no more than 14 days.
- Appeal Processing: Appeals are to be processed as expeditiously as the enrollee's health requires.
- Notifications of Denial of an Expedited Request
- Appeal Documentation: Appeal decisions are to be documented fully in the enrollee record.
- Decision Made by Health Care Professional with Appropriate Expertise
- Written Notification: The appeal resolution is to be provided to the enrollee in a written letter and must include results in an easily understood language.

Figure 3 provides a quarterly and annual comparison of MCO-reported appeals per 1,000 enrollees.

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



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2022	2.85	4.25	0.43	0.92	6.40	1.33	12.51	2.90	2.75
Q1 2023	0.81	1.11	0.40	0.12	2.09	0.39	3.49	0.67	0.58
Q2 2023	0.87	1.12	0.40	0.11	2.23	0.40	2.37	0.90	0.49
Q3 2023	0.60	1.09	0.23	0.12	2.27	0.52	3.24	1.00	0.52
Annual 2023	2.91	4.39	1.27	0.47	8.64	1.91	13.27	3.56	2.46

Assessment of the nine MCOs appeals data shows the median for appeals per 1000 enrollees is 2.91. Four MCOs (JMS, KPMAS, MSFC, and WPM) have the number of appeals per 1000 below the median of 2.91. ABH is performing at mid-range and the other four MCOs (CFCHP, MPC, PPMCO, and UHC) are above the median.

When comparing MY 2023 to MY 2022, to all other MCOs during the four time periods under review, PPMCO continues to be an outlier in MY 2023 with the highest number of appeals per 1000 (13.27). MPC and CFCHP are second and third in this ranking respectively.
There were no noticeable differences between MY 2022 and MY 2023 findings on the number of appeals reported per 1000 enrollees. PPMCO continues to have the highest appeals per 1000 and KPMAS and JMS continue to document the lowest appeals per 1000 enrollees respectively.
Each MCO reports its top five appeal service categories for each quarter and the year. The top appeal service categories for MY 2023 align with MY 2023 preservice denials data and mimic findings from MY 2022. These service categories are noted below:

- Pharmacy Services and Medical Surgical (tied)
- DME/DMS
- Medical Surgical: related to Therapies
- Diagnostic Lab: Radiology

There were no differences in the top five appeals service categories when comparing MY 2022 to MY 2023.

The primary source of enrollee appeals is due to MCO service authorization decisions, i.e., whether services are denied or approved. Among the nine MCOs, all but KPMAS (45%) indicated that 100% of appeals come from an adverse benefit decision.

Though not a CMS report requirement for MCPAR, MDH monitors denial 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 enrollee. Appeals upheld or overturned are distinguished by the type of adverse decision made. For this study, six types of actions are assessed on a quarterly and annual basis:

Action Type 1 - denial or limited authorization of a requested service, including the type or level of service.
Action Type 2 - reduction, suspension, or termination of a previously authorized service.
Action Type 3- denial in whole or part of a payment for service.
Action Type 4 - failure to provide services in a timely manner.
Action Type 5- failure of an MCO to act within the required appeal time frames set in COMAR.
Action Type 6 -denial of an enrollee request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, or other enrollee financial liabilities.

For MY 2023, the majority of MCOs appeals were Action Type 1.

Table 6 reflects the percentages of upheld and overturned appeals for Action Type 1.

Table 6 MCO Percentages of Overturned versus Upheld Appeals for Action Type 1

MCO	Action Type 1 Overturned	Action Type 1 Upheld
ABH	40%	60%
CFCHP	52%	49%
JMS	68%	32%
KPMAS	19%	81%
MPC	32%	68%
MSFC	66%	34%
PPMCO	48%	52%
UHC	57%	43%
WPM	50%	50%

In MY 2023, the MCO range for overturned appeals is 32%-68%, and the median is 52%. Using the median as a gauge, JMS's overturn rate is the highest among MCOs (68%), followed by MSFC (65%) and KPMAS (64%).

Five MCOs (CFCHP, JMS, MPC, PPMCO, and WPM) had appeals for Action Type 1 only. Though not as many appeals, four MCOs had other action types including Action Type 2 (KPMAS), Action Type 3 (ABH, KPMAS, and MSFC), and Action Type 6 (UHC).

KPMAS had an overturned rate of 50% for Action Type 2. For Action Type 3, the three MCOs' overturned rates were ABH (33%) KPMAS (97%), and MSFC (100%). For Action Type 6, UHC had three appeals and all three were overturned at 100%.

Table 7 displays the ranking of the pharmacy services category by MCO for three quarters and for the year.

Table 7. Ranking of Pharmacy Services Appeal Category on Top Five MCO List

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2022	**1st**	**1st**	**1st**	**N/A**	**2nd**	**1st**	**1st**	**1st**	**2nd**
Q1 2023	1st	1st	1st	N/A	2nd	1st	1st	1st	NA
Q2 2023	2nd	1st	1st	N/A	1st	1st	1st	1st	3rd
Q3 2023	2nd	1st	1st	N/A	1st	1st	1st	1st	1st
Annual 2023	**2nd**	**1st**	**1st**	**N/A**	**1st**	**1st**	**1st**	**1st**	**1st**

NA a designation of N/A implies that there were no pharmacy appeals in the top 5.

When comparing MY 2023 to MY 2022, the MY 2022 GAD findings, Pharmacy Services was the most prevalent appeals service category occupying the top spot in MY 2023.

Five MCOs (CFCHP, JMS, MSFC, PPMCO, and UHC) reported pharmacy as the top appeals service category for MY 2022 and for all three quarters and the year for MY 2023. MPC listed pharmacy as the top service category in two quarters and as second for a quarter. ABH reported pharmacy as the lead in quarter one and then second for quarters two and three. WPM reported pharmacy appeals in the top five for quarter three and third for quarter two.

Quarterly and annual comparisons of MCO-reported compliance with resolution timeframes for enrollee appeals are displayed in Table 8.

Table 8. MCO-Reported Compliance with Enrollee Appeal Resolution/Notification Timeframes

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2022	**100%**	**97%**	**100%**	**88%**	**93%**	**98%**	**100%**	**99%**	**93%**
Q1 2023	100%	100%	100%	100%	100%	50%	99%	98%	94%
Q2 2023	100%	100%	100%	100%	100%	100%	99%	96%	92%
Q3 2023	100%	100%	100%	100%	100%	100%	100%	99%	94%
Annual 2023	**100%**	**100%**	**100%**	**100%**	**96%**	**100%**	**100%**	**98%**	**96%**

Underlined ≥95% for at least one reporting period but not all reporting periods = Partially Met (PM)
Red font - <95% for all reporting periods = Unmet (UM)

Compliance with enrollee appeal resolution timeliness considered two types of appeals, expedited and non-emergency. In instances where performance was different between these appeal types, Table 8 reflects performance as an average of both.

In MY 2023, there were seven MCOs (ABH, CFCHP, JMS, KPMAS, MPC, PPMCO, and UHC) that met compliance with both appeal types for all three quarters and for the year. The remaining two MCOs (MSFC and WPM) fell below the threshold in one or more quarters for one or both types of appeals. For example:

- For the expedited appeal resolution timeframe: MPC's performance fell from 100% in the first three quarters of MY 2023 to 92% for the year. For non-emergency appeals, MPC exceeded compliance with a rate of 99%.
- MSFC had a rate of 50% in Quarter 1 followed by 100% for the remaining three review periods.
- In Quarter 2, UHC was at 91% compliance for expedited appeal resolution only.
- WPM had three non-compliant quarters related to both expedited and non-emergency appeals.

Table 9 provides a comparison of appeal record review results across MCOs. Results are based upon a random selection of appeal records reviewed for MY 2023.

Table 9. MY 2023 MCO Appeal Record Review Results

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Processed Based Upon Level of Urgency	100%	100%	100%	100%	100%	100%	97%	100%	100%
Compliance with Timeframe for Written Appeal Acknowledgment Letter	100%	100%	100%	100%	100%	100%	97%	100%	100%
Compliance with Verbal Notification of Denial of an Expedited Request	N/A	25%	N/A	100%	0%	N/A	100%	100%	75%
Compliance with Written Notification of Denial of an Expedited Request	N/A	100%	N/A	100%	100%	N/A	100%	100%	100%
Compliance with 72-hour Timeframe for Expedited Appeal Resolution Notification	N/A	N/A	100%	100%	N/A	100%	80%	79%	100%
Compliance with Verbal Notification of Expedited Appeal Decision	N/A	N/A	0%	100%	N/A	100%	80%	100%	100%
Compliance with Written Notification Timeframe for Non-Emergency Appeal	100%	100%	100%	100%	100%	100%	100%	100%	100%
Appeal Decision Documented	100%	100%	100%	100%	100%	100%	100%	100%	100%
Decision Made by Health Care Professional with Appropriate Expertise	100%	100%	100%	100%	100%	100%	100%	100%	100%
Decision Available to Enrollee in Easy-to-Understand Language	100%	100%	100%	100%	100%	100%	77%	100%	100%

Red font - <95% for reporting period = Unmet (UM)
NA = Not Applicable

A sample review of MCO appeal records found three MCOs (ABH, KPMAS, and MSFC) demonstrated 100% compliance in all applicable categories.

Three MCOs (CFCHP, MPC, and WPM) fell below the 95% threshold for compliance with verbal notification of the denial of an expedited request at 25%, 0%, and 75% respectively. Two MCOs (PPMCO and UHC) fell below the threshold for compliance with the 72-hour timeframe for expedited appeal resolution notification at 80% and 79%, respectively. Two MCOs (JMS and PPMCO) fell below the threshold for compliance with verbal notification of an expedited appeal resolution at 0% and 80%, respectively.

Pre-Service Denial Results

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

- For standard authorization decisions, the MCO shall make a determination within two business days of receipt of necessary clinical information, but no later than 14 calendar days.
- For expedited authorization decisions, the MCO shall make a determination and provide notice no later than 72 hours after receipt of the request for services.
- For all covered outpatient drug authorization decisions, the MCO shall provide prescriber notice by telephone or other telecommunication device within 24 hours of a prior authorization request.

Additional regulatory requirements specified in COMAR 10.67.09.04 include:

- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested:
    - Shall be made by a healthcare professional who has appropriate clinical expertise in treating the enrollee's condition or disease; and
    - May not be arbitrarily based solely on diagnosis, type of illness, or condition.
- Standard and expedited authorization decisions may be extended up to 14 calendar days under certain specified conditions.
- An MCO shall give an enrollee written notice of any action within the following timeframes:
    - 24 hours from the date of determination for emergency, medically related requests;
    - 72 hours from the date of determination for non-emergency, medically related requests;
    - At least ten days before the action for termination, suspension, or reduction of a previously authorized covered service; and
    - For denial of payment at the time of any action affecting the claim.
- A notice of adverse action shall be in writing and:
    - Be translated for enrollees who speak prevalent non-English languages;
    - Include language clarifying that oral interpretation is available for all languages and how to access it;
    - Be written in easy-to-understand language and format that takes into consideration enrollees with special needs;
    - Be available in alternative formats;
    - Inform enrollees that information is available in alternative formats and how to access those formats; and
    - Contain the following information:
        - The action the MCO has made or intends to make;

- The reasons for the action, including the right for the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the MCO's action;
- The enrollee's right to request an appeal of the MCO's action;
- The procedures for exercising the rights described;
- The circumstances under which an appeal process can be expedited and how to request it;
- The enrollee's right to have benefits continue pending resolution of the appeal;
- How to request that benefits be continued; and
- The circumstances under which the enrollee may be required to pay the costs of the services.

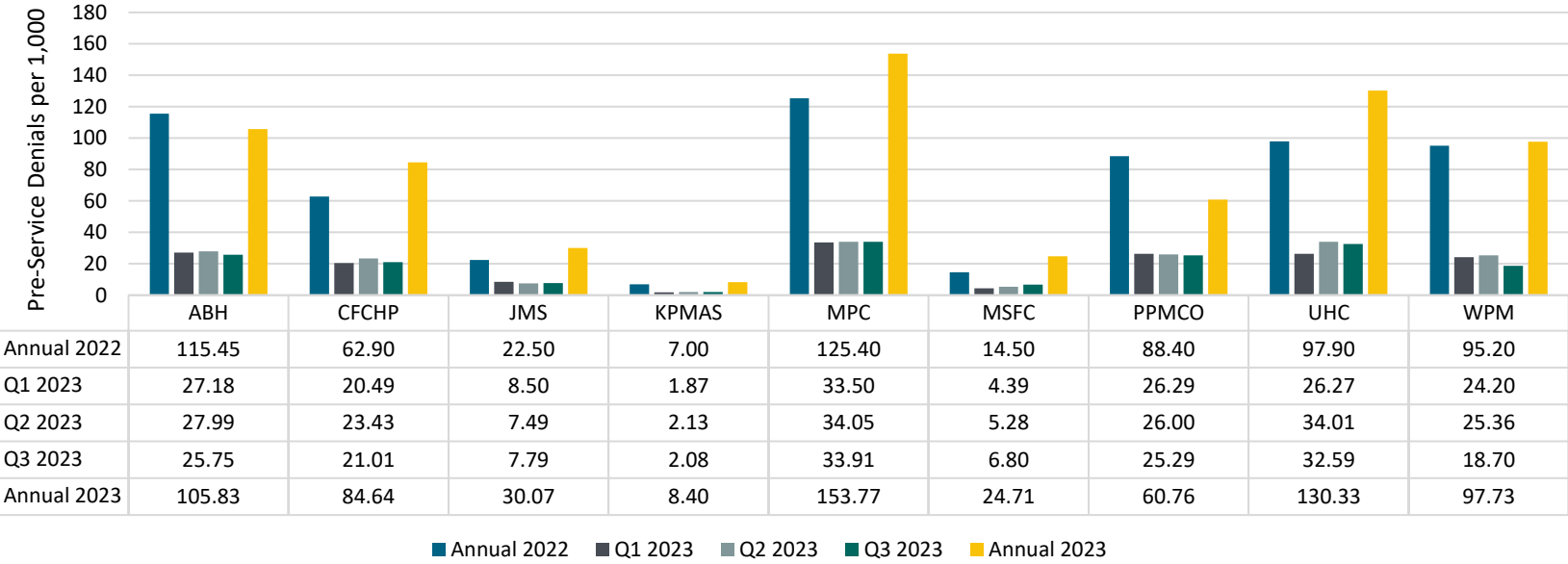
The MCO pre-service denial review encompassed the following comparative statistics and compliance with federal and state laws and regulations:

- Comparative Statistics:
  - Pre-service Denials Rendered Per 1,000 Enrollees
  - Percentages of Prior Authorization Requests with Complete Information
  - Percentages of Prior Authorization Requests Requiring Additional Information
  - Percentages of Prior Authorization Requests Approved
  - Percentages of Prior Authorization Requests Denied
  - Percentages of Pre-Service Denials for Enrollees Under 21
  - Percentages of Pre-Service Denials for Standard Medical, Expedited Medical, and Outpatient Pharmacy
  - Top 5 Service Categories
  - Top 5 Denial Reasons
  - Determination and Notification Turnaround Time Compliance Percentages
  - Prescriber Notification Turnaround Time Compliance Percentages
- Determination timeframe compliance based upon a threshold of 95%:
  - For standard requests within two business days of receipt of necessary clinical information, but no later than 14 calendar days from the date of the initial request.
  - For outpatient pharmacy requests within 24 hours of a prior authorization request.
  - For expedited requests, determination and notice no later than 72 hours after receipt of 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 17 required regulatory components.

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

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



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2022	115.45	62.90	22.50	7.00	125.40	14.50	88.40	97.90	95.20
Q1 2023	27.18	20.49	8.50	1.87	33.50	4.39	26.29	26.27	24.20
Q2 2023	27.99	23.43	7.49	2.13	34.05	5.28	26.00	34.01	25.36
Q3 2023	25.75	21.01	7.79	2.08	33.91	6.80	25.29	32.59	18.70
Annual 2023	105.83	84.64	30.07	8.40	153.77	24.71	60.76	130.33	97.73

When establishing a pre-service denial rate per 1000 enrollees, Qlarant considers two factors. The first is the percentage of prior authorization (PA) requests the MCO approves or denies. For MY 2023, the MCO range for PA requests approved is 66%-93% and for those denied is 7%-34%. Of the PA requests denied, the median across MCOs is 26%. Secondly, Qlarant determines from those PA requests denied, the rate of denials per 1000 enrollees. For MY 2023 of those 7%-34% of PA requests denied, the median for pre-service denials per 1000 members is 84.64.

The rates of pre-service denials per 1,000 enrollees show that MPC has the highest denial rate at 153.77, followed by UHC (130.33), ABH (105.83), and WPM (97.73). CFCHP's rate falls at the median. KPMAS, JMS, and MSFC have few denials in comparison to the other six MCOs. As noted in the MY 2022 GAD annual report, the low number of denials for JMS, KPMAS, and MSFC may be related to an increased understanding of review criteria resulting from common ownership of provider groups that serve a large percentage of their members.

Eight of the nine MCOs' pre-service denial rates per 1000 enrollees have remained consistent between MY 2022 and MY 2023. UHC had the most significant increase within its per 1000 rate, from 97.90 in MY 2022 to 130.33 in MY 2023.

MCOs report their top five denial service categories for the year. For MY 2023, the top five mimic those of MY 2022 though the order of prevalence varies:

- Medical/Surgical
- Pharmacy services
- Diagnostic/Lab: Radiology
- DME/DMS
- Medical/Surgical - Related to Therapies (PT/OT/SLP) tied with Pharmacy Services-Chronic Pain Management

Here are some examples of MCO service and reason code variances in MY 2023:

- KPMAS is the only MCO with no Pharmacy Services in its top five.
- MPC documents that 18% of their denials occurred in the NMN-Other category
- PPMCO indicates Diagnostic/Lab: Radiology, which is 69% of its top five service categories, replaces Pharmacy Services as number one.
- UHC has one unique service category, Inpatient/Admission Hospital Services.

MCOs also report the most prevalent reasons for pre-service denials. For MY 2023, the top four reasons identified are listed below. The remaining reason codes each had one denial only:

- Not Medically Necessary/Full Denial
- Not Medically Necessary/Full Denial/Lack of Complete Clinical Information
- Administrative/Out of Network Provider
- Administrative/Not a Covered Benefit or Service

Table 10 provides a quarterly and annual comparison of the top five MCO-reported pharmacy services denial categories per 1,000 enrollees.

Table 10. Ranking Pharmacy Services Denial Category on Top Five MCO List

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2022	**1st**	**1st**	**1st**	**NA**	**2nd**	**1st**	**1st**	**1st**	**1st**
Q1 2023	1st	1st	1st	N/A	1st	1st	2nd	1st	1st
Q2 2023	1st	1st	1st	N/A	1st	1st	1st	1st	1st
Q3 2023	1st	1st	1st	N/A	2nd	1st	1st	1st	1st
Annual 2023	**1st**	**1st**	**1st**	**N/A**	**1st**	**1st**	**NA**	**1st**	**1st**

NA - Not Applicable/No data reported

Pharmacy Services continues to appear in the top five service category list for denials. KPMAS reported only two pharmacy denials during the four review periods in MY 2023. Of the remaining eight MCOs reporting pharmacy denials, six (ABH, CFCHP, JMS, MSFC, UHC, and WPM) reported Pharmacy Services as the top service category for three quarters and the year. PPMCO reported it as the top service category in quarters two and three, and MPC in two quarters and for the year.

When comparing MY 2023 to MY 2022, in MY 2022, four MCOs (JMS, MSFC. PPMCO, and UHC) reported denials related to Pharmacy Services for Chronic Pain Management within their top five list for the timeframe. In MY 2023, the number of MCOs increased to six, adding CFCHP, and WPM. These six MCOs had this service category in their top five list in at least two or more quarters and for the year. In comparison to MY 2022, when MPC had pharmacy services as second on the service category list for all four review periods, MPC is the one MCO that reported pharmacy services to the top of the list for MY 2023.

The range across MCOs for Pre-Service Outpatient Pharmacy Denials is the widest at 0.2% to 93%. The median is 64%. JMS continues to have the highest denial rate for pre-service outpatient pharmacy (93%), which has consistently been above 90% for the year. CFCHP (82%), MSFC (70%), and PPMCO (76%) have the next highest denial rates. UHC was at the median with 64%. KPMAS documented the lowest number and percentage with only two pharmacy denials (2/0.2%) followed by ABH, MPC, and WPM.

Compliance with COMAR requirements for the timeliness of pre-service determinations was assessed based on self-reporting through MCO submissions of quarterly reports and an annual record review. Quarterly data represented the entire population or a statistically significant sample. Table 11 displays the results of the MCO's reported compliance with pre-service determination timeframes. The MDH-established compliance threshold for MY 2023 was 95%.

Table 11. MCO-Reported Compliance with Pre-Service Determination Timeframes (Quarterly and Annual Reports)

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Compliance with Expedited Pre-Service Determination Timeframes for Medical Denials									
Annual 2022	**99%**	**100%**	**100%**	**100%**	**99%**	**100%**	**98%**	**100%**	**98%**
Q1 2023	100%	100%	NA	100%	100%	100%	98%	100%	95%
Q2 2023	100%	100%	NA	NA	99%	100%	98%	100%	100%
Q3 2023	98%	100%	100%	100%	99%	100%	100%	100%	98%
Annual 2023	**99%**	**100%**	**100%**	**100%**	**99%**	**100%**	**98%**	**100%**	**99%**
Compliance with Standard Pre-Service Determination Timeframes for Medical Denials									
Annual 2022	**98%**	**100%**	**100%**	**92%**	**100%**	**99%**	**99%**	**100%**	**84%**
Q1 2023	99%	100%	100%	98%	100%	98%	100%	100%	99%
Q2 2023	99%	97%	100%	100%	100%	100%	100%	100%	99%
Q3 2023	99%	100%	100%	99%	100%	98%	99%	100%	99%
Annual 2023	**99%**	**99%**	**100%**	**99%**	**100%**	**99%**	**99%**	**100%**	**99%**
Compliance with Outpatient Pharmacy Pre-Service Determination Timeframes for Denials									
Annual 2022	**100%**	**99%**	**99%**	**100%**	**99%**	**98%**	**99%**	**100%**	**100%**
Q1 2023	100%	99%	100%	NA	99%	100%	99%	100%	100%
Q2 2023	100%	100%	97%	NA	99%	100%	99%	100%	100%
Q3 2023	100%	100%	98%	100%	99%	100%	98%	100%	100%
Annual 2023	**100%**	**100%**	**98%**	**100%**	**99%**	**100%**	**99%**	**100%**	**100%**

Underlined ≥95% for at least one reporting period but not all reporting periods = Partially Met (PM)
Red font - <95% for all reporting periods = Unmet (UM)

When comparing MY 2023 to MY 2022, UHC was the only MCO to score 100% on TAT for expedited, standard, and outpatient pharmacy pre-service determinations for each quarter and the year.

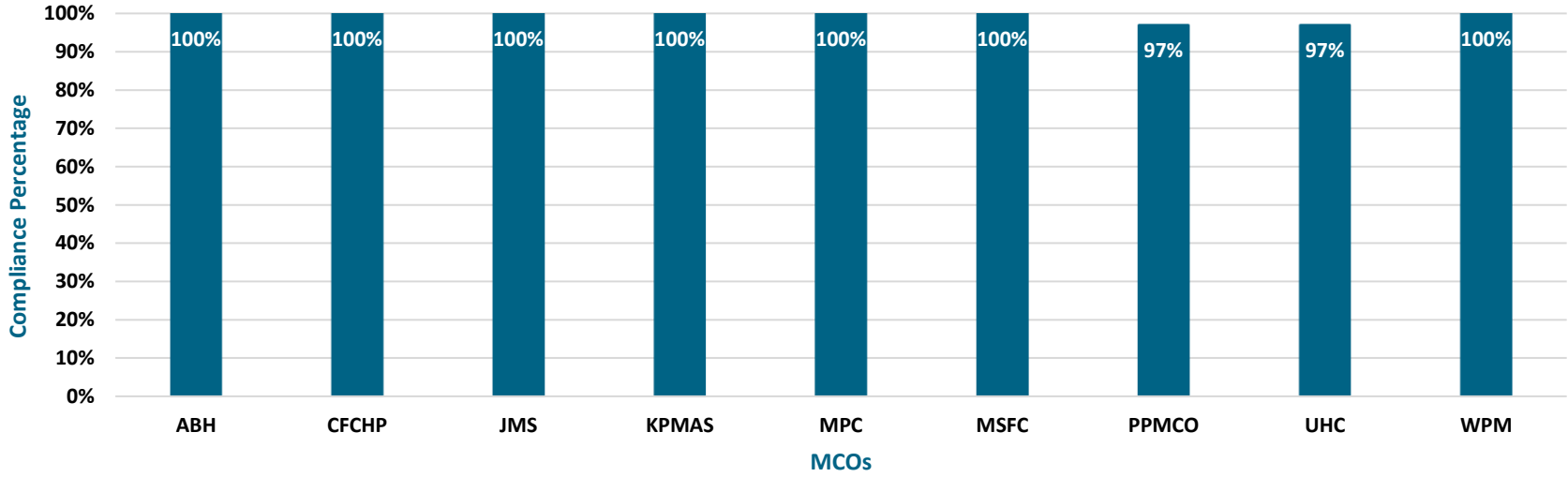
In MY 2023, all nine MCOs met or exceeded the 95% compliance requirement for timeliness of pre-service denial determinations including outpatient pharmacy and prescriber notification by pharmacy within 24 hours of the outcome.

This is an improvement from MY 2022 performance when only six of the MCOs (CFCHP, JMS, MPC, MSFC, PPMCO, and UHC) met or exceeded the compliance threshold for all applicable categories in each of the three quarters and the year.

In MY 2023, WPM made improvements in determination timeliness for expedited and standard pre-service denials. From MY 2022 to MY 2023, WPM increased one percentage point from 98% to 99% with determination timeliness for expedited pre-service denials. For standard pre-service denials, the improvement was 15 percentage points from 84% in MY 2022 to 99% in MY 2023.

Record reviews were conducted to assess compliance with the COMAR requirement for timeliness of pre-service determinations. Results are based upon a random selection of pre-service adverse determination records from MY 2023. Results are highlighted in Figure 5.

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



All MCOs exceeded the 95% compliance threshold for pre-service determination timeframes.

Table 12 provides a comparison of adverse determination record review results across MCOs. Results are based upon a random selection of adverse determination records reviewed for MY 2023.

Table 12. MCO Adverse Determination Records Review Issues

MCO	Issues Identified
JMS	**Pharmacy requests** – Inappropriately categorized one pre-service pharmacy request as "urgent"
MSFC	**Pharmacy requests** - Inappropriately categorized six pre-service pharmacy requests as "urgent"
PPMCO	**Letter Components** - Inconsistent Use of Easy to Understand Language in Enrollee Letters
UHC	**Pharmacy requests** - Inappropriately categorized four pre-service pharmacy requests as "urgent" **Request for additional information** - Additional information did not appear to be requested before denying a preauthorization request for a covered outpatient drug for lack of information. **Language Accessibility Statement**- Incomplete as only two languages in addition to English were included.

Results of MCO-reported compliance with adverse determination notification timeframes, based on the quarterly and annual reports, are highlighted in Table 13.

Table 13. MCO Reported Compliance with Adverse Determination Notification Timeframes

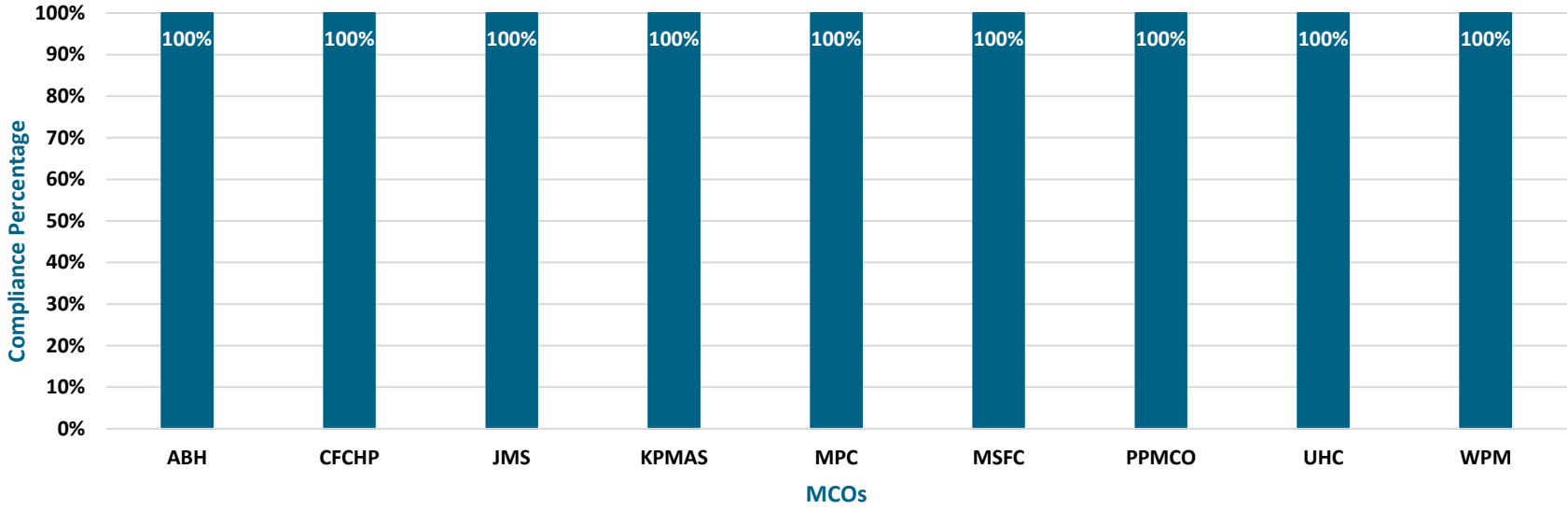
Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Compliance with Expedited Medical Adverse Determination Notification Timeframes									
Annual 2022	**100%**	**100%**	**100%**	**100%**	**98%**	**100%**	**95%**	**100%**	**97%**
Q1 2023	100%	100%	NA	100%	97%	100%	100%	100%	93%
Q2 2023	98%	100%	NA	NA	99%	100%	95%	100%	83%
Q3 2023	93%	100%	100%	100%	99%	100%	100%	100%	98%
Annual 2023	**99%**	**100%**	**100%**	**100%**	**99%**	**100%**	**95%**	**100%**	**96%**
Compliance with Standard Medical Adverse Determination Notification Timeframes									
Annual 2022	**98%**	**100%**	**100%**	**96%**	**99%**	**99%**	**96%**	**100%**	**98%**
Q1 2023	100%	100%	100%	100%	100%	97%	100%	100%	99%
Q2 2023	98%	100%	100%	99%	100%	100%	86%	100%	99%
Q3 2023	97%	100%	93%	100%	100%	98%	99%	100%	100%
Annual 2023	**99%**	**100%**	**98%**	**100%**	**100%**	**99%**	**100%**	**100%**	**99%**
Compliance with Outpatient Pharmacy Adverse Determination Notification Timeframes									
Annual 2022	**100%**	**99%**	**100%**	**100%**	**100%**	**97%**	**100%**	**100%**	**100%**
Q1 2023	100%	99%	100%	NA	100%	100%	100%	100%	100%
Q2 2023	100%	100%	100%	NA	100%	100%	100%	100%	100%
Q3 2023	100%	100%	100%	100%	100%	99%	100%	100%	100%
Annual 2023	**100%**	**99%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Compliance with Prescriber Notification of Outcome within 24 Hours									
Annual 2022	**100%**	**99%**	**99%**	**100%**	**100%**	**98%**	**99%**	**100%**	**100%**
Q1 2023	100%	98%	100%	99%	100%	100%	99%	100%	100%
Q2 2023	100%	96%	99%	98%	100%	99%	99%	100%	100%
Q3 2023	100%	100%	99%	100%	100%	100%	98%	100%	100%
Annual 2023	**100%**	**98%**	**99%**	**99%**	**100%**	**100%**	**99%**	**100%**	**100%**

Underlined ≥95% for at least one reporting period but not all reporting periods = Partially Met (PM)
Red font - <95% for all reporting periods = Unmet (UM)

In MY 2023, all nine MCOs met or exceeded the 95% compliance requirement for timeliness of notification requirements for expedited, standard, outpatient pharmacy including prescriber notification by pharmacy within 24 hours of the outcome. Record reviews were conducted to assess compliance with the COMAR requirement for timeliness of adverse determination notifications. Results are highlighted in Figure 6 and are based upon a random selection of adverse determination records from MY 2023.

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



All MCOs demonstrated 100% compliance with adverse determination notification timeframes.

Table 14 provides a comparison of adverse determination record review results across MCOs. Results are based upon a random selection of adverse determination records from MY 2023.

Table 14. Results of MY 2023 Adverse Determination Record Reviews

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%	97%	97%	100%
Compliance with Adverse Determination Notification Timeframes	100%	100%	100%	100%	100%	100%	100%	100%	100%
Required Letter Components	100%	100%	100%	100%	100%	100%	73%	100%	100%
Compliance with Prescriber Notification	100%	N/A	100%	N/A	N/A	100%	100%	0%	100%

Red font - <95% for reporting period = Unmet (UM)
NA = Not Applicable

Seven MCOs demonstrated 100% compliance in all five categories, as applicable.

PPMCO fell below the compliance threshold of 95% for required letter components as only 73% of adverse determination letters were written in easy-to-understand language. There was no evidence UHC notified prescribers within 24 hours of the outcome of a preauthorization request for a covered outpatient drug.

Corrective Action Plans

As part of the quarterly GAD review process, MCOs that demonstrated noncompliance with one or more timeliness requirements were not placed on a corrective action plan (CAP) in MY 2023. The data validity section, earlier in this report, indicated fewer inconsistencies with the MCOs GAD report submissions. 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 was requested at the time of the annual SPR. The GAD-related standards fall predominantly within 42 CFR Part 438 Subpart D on coverage and authorization of services and quality, Subpart E on enrollee rights, and Subpart F on the MCOs' grievances and appeals systems.

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

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

In the event that a CAP is deemed unacceptable, Qlarant will provide technical assistance to the MCO until an acceptable CAP is submitted. Recognizing the need to provide more real time and meaningful feedback to the MCOs, Qlarant and MDH collaborated to identify key GAD performance metrics that would have the most immediate impact on enrollee care and outcomes. These metrics would not replace MCPAR requirements but would enhance the ability to determine when performance variances exist. Without a performance threshold and benchmark, the MCO oversight is far more subjective and does not allow for valid peer-to-peer comparisons. For example, MDH already uses a performance threshold of 95% for all GAD timeliness requirements. Other performance metrics could be developed using MCO-specific GAD data as well as aligning with CMS' long-term goals for monitoring MCO GAD performance.

Recommendations

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

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

MCOs have shown improvements in reporting and regulatory compliance over the course of MY 2023. Moving forward, MCOs continue to have opportunities to improve, as noted in Table 15, with the timeliness of determination and notification decisions and in documenting GAD appropriately in the enrollee record. CAPs through the SPR process are in place to address MCOs with ongoing issues in demonstrating compliance.

Because of opportunities identified following the MY 2022 focused review, Table 15 displays MDH's implementation and planned implementation of the following changes:

Table 15. Implementation of MY 2022 Recommendations

MY 2022 Recommendations	MDH Implementation
MDH Opportunity: Continue to explore options with Qlarant and the MCOs to reduce the complexity/redundancy of the GAD data collection process. Examples to consider: • Conduct a crosswalk of SPR standards with quarterly GAD reporting data to determine where redundancies can be eliminated. • Consider eliminating the annual GAD record review currently performed as part of the SPR. Align the record review with the quarterly GAD review to provide more real time results. • Identify the most relevant GAD metrics to monitor on a quarterly and annual basis. Metrics should be meaningful data that the MCOs and MDH can act upon to make improvements (i.e., those required by regulatory bodies and those that may adversely affect enrollee access to medically necessary services). These could include for example, all clinically related grievances, denials, and appeals timeliness metrics, denial and appeal rates, decisions to uphold or overturn as well as monitoring appeals and denials. Performance thresholds should be developed for each metric and should be evidence-based or based on historical MCO data.	MDH has completed this crosswalk informally through quarterly discussions with the EQRO. MDH now emphasizes the need for performance improvement on the MCOs' quarterly GAD metrics. By providing real time recommendations to the MCOs, the desire is to reduce the amount of corrective action needed during the annual systems performance review (SPR). MDH agreed to move completion of the GAD Annual Report from September each year to the second quarter of the year. This will align more closely with the annual SPR GAD record review and annual SPR of GAD-related standards. MDH and the EQRO are finalizing a draft of performance metrics unique to grievances, appeals, and denials. Performance thresholds will be developed based on MCO historical GAD data and research from the GAO and CMS. Implementation of metrics and monitoring of MCO performance will begin in review of Q1 2024 GAD data in May 2024.
MDH Opportunity: Convene a meeting with Qlarant and the MCOs to obtain feedback on the GAD process. • Identify systemic barriers hindering the accuracy of data entry and aspects of the process that are working well. • Clarify all performance requirements and expectations.	MDH and EQRO will review the need for this since MCOs have made improvements to the accuracy of GAD data submissions. Performance requirements are communicated to the MCOs on a quarterly basis when GAD data entry errors occur and/or when clarifications on the data are needed.
MDH Opportunity: Initiate a more real time corrective action plan process for GAD. Corrective action plans must be based upon clearly defined performance metrics, such as the 95% threshold MDH currently has in place, to monitor GAD timeliness metrics.	See above.
MDH Opportunity: Consider making GAD a Performance Improvement Project (PIP) that can be structured and consistent in its	MDH will hold off on requesting another MCO PIP at this time.

implementation. The process is familiar to the MCOs and requires ongoing monitoring by the EQRO and MDH.	

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

MDH Opportunity:

- **Pharmacy Preauthorization Requests** - Many MCOs continue to process preauthorization requests for covered outpatient drugs as "urgent", whether or not explicitly requested by the provider. One of the key drivers of this is thought to be MCOs'/pharmacy vendors' Pharmacy Preauthorization forms that include a checkbox for marking the request "urgent". Additionally, based on possible fear of losing NCQA accreditation, MCOs appear to be following NCQA requirements for pharmacy preauthorization requests. Specifically, for Medicaid urgent pre-service pharmacy decisions, NCQA requires the organization to provide electronic or written notification of the decision to members and practitioners within 24 hours of the request. Similarly, for Medicaid non-urgent pre-service decisions, NCQA requires the organization to provide electronic or written notification of the decision to members and practitioners within 24 hours of the request. This extremely short turnaround time appears to minimize requests for additional information to demonstrate medical necessity, which contributes to the high level of adverse determinations and appeals observed over the past few years. There also may be some confusion among MCOs regarding the requirement for notifying the prescriber of the outcome of the preauthorization request for a covered outpatient drug within 24 hours of receipt. While the standards clearly specify the outcome as either approve, deny, or request additional information some MCO staff may be unaware of this. In view of all these issues, Qlarant recommends that MDH clarify the preauthorization requirements for covered outpatient drugs and the expectation that additional information, if needed to demonstrate medical necessity, be requested at the time of submission of the preauthorization request.

- **Expedited Appeals** - In reviewing appeal records, it appears that not all MCOs are aware that a written acknowledgment letter is no longer required for expedited appeals. Since both COMAR (10.67.09.05 (2)) and the Code of Federal Regulations (438.406 (b) (1) require enrollee acknowledgment of an appeal is MDH requiring the enrollee receive oral notification of receipt of an expedited appeal if written acknowledgment is not provided. Qlarant recommends these requirements be clarified and communicated to the MCOs with a copy to Qlarant.

MCO Opportunity:

- **Explaining variances-** Not all MCOs offer an explanation for data variances when submitting GAD quarterly reports. The reports have a place for this in the analysis of data. MCOs should describe any unique changes from the prior quarter or year to help MDH identify aggregate trends or potential issues across MCOs.

- **Describing Other Codes**. All "Other" reason and service categories in the top five should clearly describe what "Other" issues are.

MCO Opportunity: The number of provider grievances continues to be underreported by at least some of the MCOs. It does not appear that all MCOs have an effective process in place for capturing provider grievances, which may be submitted to various departments, such as Provider Relations, Customer Service, Utilization Management, and Care Management. MCOs need to establish a cross-functional workgroup to address the various points of entry and develop a process for aggregating all grievances to support accurate reporting.

Conclusions

This report includes studies of MCO grievance, appeal, and denial quarterly reports for MY 2023. Additionally, a sample of grievance, appeal, and adverse determination records were reviewed for MY 2023.

Conclusions for the GAD review for MY 2023 are drawn primarily from Annual GAD Report data found in Tables 2, 4, 8, 11, and 13, and the annual record review data is found in Tables 5, 9, 12, and 14 and Figures 5 and 6. Table 16 provides a summary of the opportunities identified from a review of these data.

Table 16. Summary of Opportunities for Improvement Identified in the MY 2023 GAD Review

Improvement Opportunities by End of MY 2023	MCO
Compliance with Enrollee Grievance Resolution Timeframes	KPMAS, UHC
Compliance with Provider Grievance Resolution Timeframes	UHC, WPM
Appropriately Classified	WPM
Acknowledgment Letter Timeliness	ABH, CFCHP, UHC
Compliance with Enrollee Appeal Resolution/Notification Timeframes	MPC
Compliance with Verbal Notification of Denial of an Expedited Request	CFCHP, MPC, WPM
Compliance with 72-hour Timeframe for Expedited Appeal Resolution/ Notification	PPMCO, UHC
Compliance with Verbal Notification of Expedited Appeal Decision	JMS, PPMCO
Decision Available to Enrollee in Easy-to-Understand Language	PPMCO
Letter Components – Use of Easy-to-Understand Language in Enrollee Letters	PPMCO
Inappropriate classification of pharmacy requests as “urgent”	JMS, MSFC, UHC
Required Letter Components	PPMCO
Compliance with 24-Hour Prescriber Notification	UHC

Table 17. Comparison of Opportunities for Improvement from MY 2022 to MY 2023

Improvement Opportunities Comparison	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total # Opportunities MY 2022	2	11	0	7	2	0	4	1	8
Total #Opportunities MY 2023	1	2	2	1	3	1	5	6	3
MY 2022 to MY 2023 Comparison	↓	↓	↑	↓	↑	↑	↑	↑	↓

↑ Increase from MY 2022; ↓ Decrease from MY 2022; Ø no change

General Findings

- In MY 2022 there were 34 opportunities for improvement across all nine MCOs. In MY 2023, the number of opportunities dropped to 24.
  - ABH, CFCHP. KPMAS and WPM have improved performance from MY 2022 to MY 2023.
  - JMS, MPC, MSFC, PPMCO, and UHC have more opportunities for improvement in MY 2023 than in MY 2022.

- Of significance for the record reviews:
  - KPMAS had no negative record review findings.
  - CFCHP, JMS, and WPM had two and ABH, MPC, and MSFC had only one.
  - Two MCOs (PPMCO and UHC) account for 50% of the opportunities for improvement, with PPMCO contributing 28% of the opportunities.

- The three most frequent opportunities for improvement were related to timeliness of grievance acknowledgment, documentation in case notes of verbal notification of the denial of a request for an expedited appeal resolution or an expedited appeal resolution, and inappropriate classification of pharmacy requests as "urgent". These issues represent 61% of all identified from the record review.

Other MCO-specific record review findings noted in the Appendices according to MCO.

Enrollee Grievance Resolution Timeliness

- In MY 2022, seven of nine MCO met compliance with enrollee grievance resolution timeliness. Two MCOs (CFCHP and KPMAS) were non-compliant with enrollee grievance resolution timeframes.
- In MY 2023, two MCOs (KPMAS and UHC) were non-compliant with enrollee grievance resolution timeframes
- KPMAS was non-compliant in both MY 2022 and MY 2023.

Provider Grievance Resolution Timeliness

- In MY 2022, eight of nine MCOs were compliant with provider grievance resolution timeframes. CFCHP was the outlier.
- In MY 2023, seven of nine MCOs were compliant with provider grievance resolution timeframes. UHC and WPM were the outliers.

Appeals Resolution Timeliness

- In MY 2022, six of nine MCOs met appeals resolution timeliness. Three MCOs (KPMAS, MPC, and WPM) did not meet timeliness requirements.

Pre-Service Denial Determinations and Notification Timeliness

- In MY 2022, seven of nine MCOs met timeframes for pre-service denials determination and notification timeliness. Two MCOs (KPMAS and WPM) did not meet timeliness requirements.
- In MY 2023, all nine MCOs were complaint.

Appendix A: MCO-Specific Summaries

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

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

- MCO-specific trends
- Comparison to other MCOs
- Compliance
- Strengths
- Improvements
- Opportunities
- Recommendations

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

For this evaluation, Qlarant has adopted the following definitions for quality and timeliness:

- **Quality**, as it pertains to external quality review, is defined as "the degree to which an MCO or Prepaid Inpatient Health Plan increases the likelihood of desired health outcomes of its participants (as defined in 42 CFR 438.320[2]) through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge." ([CMS], Final Rule: Medicaid Managed Care; 42 CFR Part 400, et al. Subpart D– Quality Assessment and Performance Improvement, [June 2002]).

- **Timeliness**, as it relates to utilization management decisions and as defined by the National Committee for Quality Assurance, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care." (2006 Standards and Guidelines for the Accreditation of Managed Care Organizations). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care." (Envisioning the National Health Care Quality Report, 2001).

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

Quality	Timeliness	Aetna Better Health of Maryland	
X		**Trends**	Overall results have remained consistent over the past two years.
X		**Comparison to Other MCOs**	• Member and provider grievances per 1000 remain at the low to middle end of the MCO range. • Appeals per 1000 members were in the low-range compared to other MCOs. • The percentage of upheld appeals remains the second highest of all MCOs with 61% upheld. • Top five service categories align with other MCOs with pharmacy services as one of the top three. ABH exceeded compliance with the expedited and standard/non-emergency resolution TAT at 100% for the year. Appeals per 1,000 are at the bottom end of the MCO range. • Of the PA requests denied, the median across MCOs is 26%. ABH is above the median at 31% • The median for pre-service denials per 1000 members is 84.64. ABH is the third highest at 105.80 • Pre-service outpatient pharmacy denials are mid-range of other MCOs at 53%.
	X	**Compliance**	GAD Reporting: • All timeframes exceeded compliance thresholds for grievance and appeal resolutions, pre-service denial resolutions and notifications, and prescriber notification of outcome. Record review: • Timeframes for grievance resolution and written resolution were met. The timeframe for acknowledgment letters fell below the compliance threshold at 80%. • All timeframes met for appeal acknowledgment and resolution notifications. • All timeframes met for pre-service determinations, prescriber notifications, and adverse determination notifications.
X	X	**Strengths**	• Quarterly and annual self-report GAD reports are consistently error free. • All grievances appropriately categorized and resolved. • Consistently exceeds compliance threshold for timeliness of grievance resolution and grievance resolution notifications. • Consistently exceeds compliance threshold for timeliness of appeal acknowledgment and resolution notifications. • Consistently exceeds compliance threshold for timeliness of prescriber notifications, pre-service determinations, and adverse determination notifications. • Excellent use of easy-to-understand language in appeal resolution notifications.

X		**Improvements**	• Compliance with TATs exceeded the threshold in all categories, which is an improvement over Q3 MY 2023, when expedited pre-service medical denials' notification TAT were at 93%. • Adverse determination notifications written in easy-to-understand language.
	X	**Opportunities**	• Compliance with written grievance acknowledgment timeframe at the MDH established threshold.
X	X	**Recommendations**	• Routinely monitor timeliness of grievance acknowledgment letters. • Review grievance records before submission to ensure no duplicates (#17 was a duplicate of #5 and #12 a duplicate of #15.)

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

Quality	Timeliness	CareFirst Community Health Plan	
X		**Trends**	Overall, CFCHP's results for the year remain fairly consistent.
X	X	**Comparison to Other MCOs**	• Member grievances per 1000 are the lowest of the nine MCOs. • Unique reason and service codes for member grievances include grievances related to Quality of Practitioner Site (5) and LTC rehab or skilled nursing facilities (11) • Access (2) grievances comprised 55% of the total and was the most prevalent reason code versus Billing/Financial (4) for many other MCOs. • Billing/Financial (4) was the sole reason for provider grievances. • Member appeals per 1000 are on the lower end of the MCO range. The majority of appeals (92%) are submitted by providers and appeals upheld and overturned are close to even. • CFCHP falls in the middle of the MCO range with pre-service denials per 1000 members, percentage of PA requests received with complete information is at 90%, and its percentage of PA requests denied is at the end of the range at 31%. Pre-Service Denials for Members Under 21 is one of the lowest of the MCOs. • Pharmacy services has remained the top category for denials at 79% of the top five denials. • Top denial reasons mirror those of the other MCOs.
X	X	**Compliance**	GAD Report: • Timeframes for grievance resolution exceeded the threshold of 95% for member and provider grievances, for both standard and expedited appeals, and for determination and notification of pre-service denials for standard, expedited, and outpatient pharmacy. Record review:

			• Timeframes for grievance resolution and written resolution were met. The timeframe for acknowledgment letters fell below the compliance threshold at 84%. • All timeframes met for appeal acknowledgment and resolution notifications. • Timeframe was met for written notification of the denial of a request for an expedited appeal resolution. • Compliance with a reasonable attempt to provide oral notification of the denial of a request for an expedited appeal resolution was 25%. • All timeframes met for pre-service determinations and adverse determination notifications.
X	X	**Strengths**	• All grievances were appropriately categorized and resolved. • Consistently exceeds compliance threshold for timeliness of grievance resolution and grievance resolution notifications. • Consistently exceeds compliance threshold for timeliness of appeal acknowledgment and resolution notifications. • Consistently exceeds compliance threshold for timeliness of pre-service determinations and adverse determination notifications.
X	X	**Improvements**	• Consistent compliance with timeliness of grievance resolutions and resolution notifications. • Consistent compliance with required content for grievance resolution notifications (description of grievance). • Grievance case notes include documentation of investigation and resolution. • Use of correct template for grievance resolution notifications. • Adverse determination and appeal resolution notifications written in easy-to-understand language.
X	X	**Opportunities**	• Compliance with timeliness of written grievance acknowledgment at the MDH established threshold. • Case notes reflect a reasonable attempt to provide the enrollee with oral notification of denial of a request for an expedited appeal resolution.
X	X	**Recommendations**	• Routinely monitor timeframe compliance with written grievance acknowledgments. • Routinely monitor case notes for documentation of a reasonable attempt to provide the enrollee with oral notification of denial of a request for an expedited appeal resolution. • Review records before submission to ensure all are pre-service requests. Two records (15 and 16) were post-service requests.

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

Quality	Timeliness	Jai Medical Systems, Inc.	
X		**Trends**	JMS' MY 2023 performance has remained consistent over the year.
X	X	**Comparison to Other MCOs**	• Member grievances per 1000 are at the higher end of the MCO range. • JMS is in the middle of the MCO range. • Over two-thirds of member grievances are related to (4) Billing/Financial, consistent with most MCOs. • JMS had only one provider grievance in the year. • The rate of member appeals per 1000 is at the low end of the MCO range. • JMS' overturn rate is the highest among MCOs (68%). • Pre-service denials per 1000 is at the bottom of the range of other MCOs. • JMS continues to have the highest denial rate for outpatient pharmacy, which has consistently been above 90% for the year. • Standard Pre-Service Medical Denials and Pre-Service Denials for Members Under 21 are the lowest of the other MCOs. • Pharmacy services categories (5A and 5B) continue to occupy the top two spots for over a year, which is 94% of JMS' top two service categories.
X	X	**Compliance**	Gad Report: • Grievance resolution TAT compliance for member and provider grievances consistently exceeds the threshold at a reported rate of 100%. • Appeal resolution timeframes for expedited and non-emergency appeals meet compliance at 100%. • JMS met all performance metrics for denial determination and notification timeliness. Record review: • All timeframes for grievance acknowledgment, resolution, and written resolution were met. • All timeframes met for appeal acknowledgment and resolution notifications. • Compliance with a reasonable attempt to provide enrollees with oral notification of an expedited appeal resolution was 0%. • All timeframes met for pre-service determinations, prescriber notifications, and adverse determination notifications.
X	X	**Strengths**	• All grievances were appropriately categorized and resolved.

			• Consistently exceeds compliance threshold for timeliness of grievance resolution and grievance resolution notifications. • Consistently exceeds compliance threshold for timeliness of appeal acknowledgment and resolution notifications. • Consistently exceeds compliance threshold for timeliness of pre-service determinations, prescriber notifications, and adverse determination notifications.
		Improvements	There were no formal opportunities noted in the prior year.
X		**Opportunities**	• Case notes reflect a reasonable attempt to provide the enrollee with oral notification of an expedited appeal resolution. • Pharmacy preauthorization requests are categorized and processed consistent with HealthChoice requirements.
X		**Recommendations**	• Routinely audit case notes for documentation of reasonable attempt to provide enrollee with oral notice of expedited appeal resolution. • Retrain staff as there is no "urgent" category for covered outpatient drug preauthorization requests. All covered outpatient drug preauthorization requests are subject to the same requirements.

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

Quality	Timeliness	Kaiser Permanente of the Mid-Atlantic States, Inc.	
X		**Trends**	Overall, KPMAS' results remain fairly consistent.
X		**Comparison to Other MCOs**	• Member grievances per 1000 remains the highest among the MCOs, specifically for administrative grievances per 1000 and non-emergency grievances per 1000. • Unique member grievance reason code 2A/Access-Unable to Schedule an Appointment. • There were no provider grievances reported for the year • Appeals per 1000 are the lowest of the MCO range. • Only 44% of KPMAS appeals are from denials received versus 100% for other MCOs and 98% of appeals come from members, the highest of the MCOs. • Appeal overturn percentage changed from 50% in Q3 to 64% for the year. • Pre-service denial per 1000 members rate remains the lowest of all MCOs.

			• PA requests received with complete information, the percentage of PA requests approved, the percentage of preservice denials for members under the age of 21, and the percentage of standard pre-service medical denials are at the high end of MCO range. • KPMAS is the only MCO with no (5A) Pharmacy Services in its top five. One of its top service categories, Long Term Care (11) is unique continued.
	X	**Compliance**	GAD Report: • Grievance TAT compliance was met for two of the three applicable categories; compliance with Emergency Medically Related grievances fell to 92% for the year. • All timeframes for expedited and non-emergency resolution of appeals and for pre-service denial determination and notification exceeded 95% threshold. Record reviews: • All timeframes for grievance acknowledgment, resolution, and written resolution were met. • All timeframes were met for appeal acknowledgment and resolution notifications. • All timeframes were met for pre-service determinations and adverse determination notifications.
X	X	**Strengths**	• All grievances were appropriately categorized and resolved. • In records, consistently exceeds compliance threshold for timeliness of grievance resolution and grievance resolution notifications. • Consistently exceeds compliance threshold for timeliness of appeal acknowledgment and resolution notifications. • Consistently exceeds compliance threshold for timeliness of pre-service determinations and adverse determination notifications.
X	X	**Improvements**	• Consistent compliance with expedited appeal resolution notification timeframe. • Consistent compliance with notifying enrollees orally and in writing of the denial of a request for an expedited resolution. • Consistent compliance with pre-service determination timeframes.
X	X	**Opportunities**	• Twelve emergency medically related grievances did not meet compliance with grievance resolution timeliness. TAT fell to 92%. • One appeal resolution letter for a HealthChoice enrollee made multiple references to Optima Health Virginia Medicaid plan coverage and its member handbook.
X	X	**Recommendations**	• Review the 12 emergency medically related grievance cases from MY 2023 to determine what processes are delaying the resolution TAT. • Routinely review appeal resolution letters to ensure language is consistent with the HealthChoice program.

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

Quality	Timeliness	Maryland Physicians Care	
X		**Trends**	None noted. Overall, results have been fairly consistent over the last year.
X		**Comparison to Other MCOs**	• Member and provider grievances per 1000 are at the lower end of the MCO range. • Top member reason and service codes mirror those of the other MCOs. • Appeals per 1000 members are the second highest of the MCOs. • The percentage of upheld appeals is the highest of all MCOs at 68% upheld. • MPC's primary source for appeals (97%) is providers, the second highest of the MCOs. • Pre-service denials per 1000 members' rate continues to be the highest of all MCOs. • Percentage of PA requests approved are in the middle of the MCO range • Pre-service outpatient pharmacy denials fall in the lower third of the MCO range. • As the reason for pre-service denial, 18% occurred in the NMN-Other category.
X	X	**Compliance**	GAD Report: • Timeliness metrics exceeded compliance in all applicable categories for grievances and pre-service denials. • Compliance with standard/non-emergency appeal resolution TAT was reported at 99%. • Compliance with expedited appeal resolution TAT was 92%; it is the first time in the year that it fell below the 95% performance threshold. Record reviews: • All timeframes for grievance acknowledgment, resolution, and written resolution were met. • All timeframes met for appeal acknowledgment and resolution notifications. • Timeframe was met for notification of the denial of a request for an expedited appeal resolution. • Compliance with a reasonable attempt to provide oral notification of the denial of a request for an expedited appeal resolution was 0%. • All timeframes met for pre-service determinations and adverse determination notifications.
X	X	**Strengths**	• All grievances were appropriately categorized and resolved. • Consistently exceeds compliance threshold for timeliness of grievance resolution and grievance resolution notification.

			• Consistently exceeds compliance threshold for timeliness of appeal acknowledgment and resolution notifications in record review. • Consistently exceeds compliance threshold for timeliness of pre-service determinations and adverse determination notifications. • Excellent use of easy-to-understand language in adverse determination notifications.
		Improvements	Could not be determined as no expedited appeals or outpatient pharmacy requests for preauthorization were included in the sample of records reviewed.
X	X	**Opportunities**	• Improve compliance to 95% at a minimum, with expedited appeal resolution TAT. • Documentation of reasonable attempt to provide enrollee with oral notification of denial of an expedited request.
X	X	**Recommendations**	• When referring a member grievance to Provider Relations for investigation it is recommended that MPC request written follow-up from Provider Relations re results of investigation to close the loop. • Retrain G & A staff on requirement for documenting in case notes reasonable attempt to provide enrollee with oral notice of denial of an expedited request. Due to the large number of expedited requests being denied due to failure to meet criteria consider educating providers on criteria for expedited review through blast fax and/or provider newsletter.

Table 23. MSFC Specific Summary: Strengths, Improvements, Recommendations

Quality	Timeliness	MedStar Family Choice, Inc.	
X		**Trends**	Overall MSFC's results have been fairly consistent over time
X		**Comparison to Other MCOs**	• Grievances per 1000 are in the lower third of the MCO range. • Appeals per 1000 remains at the low end of the MCO range. • Appeals overturn rate was 65% for the year. • Pharmacy-related appeals stayed at the top of the service category for the year. • The percentage of PA requests approved remains at the high end of the MCO range. • MSFC's rate of denials per 1000 members is the second lowest for the year. We saw an increase in appeals based on the 24-hour TAT for pharmacy appeals and providers not submitting adequate clinical documents upon initial request for prior authorization. Requests were overturned when clinical documents showing medical necessity were received upon appeal. • The MCO's top service categories are in range with the other MCOs.

			• Pharmacy services (69%) and DME/DMS (13%) assumed the top two service categories for the year. The total PA requests in 2023 decreased P6.26% compared to 2022. This decrease is attributed to the addition of Children's National Medical Center and the removal of pain injections from requiring prior authorization in the 4th Q of 2022. In 2023, MFC saw a 58.75% increase compared to 2022 in total pre-service denials, which is attributed to the increase in requests for weight loss medications, MFC putting the GLP-1's back on authorization starting 7/01/23 due to inappropriate use for weight loss, non-formulary migraine medications, limiting Albuterol fills to a total of 6 in year starting 10/01/23 to encourage use of controller medications and non-formulary requests. For the top 5 service codes, code 2 DME increased by 25.38% in 2023 to 326 from 260 in 2022 and moved from the 3rd most to the second most denied service. This increase is being driven by requests for DME equipment that are longer medically necessary for the member to have, not receiving the clinical to determine medical necessity and not a covered benefit. The top 5 Denial Reason Codes were unchanged in 2023 when compared to 2022, just the total numbers increased due to the higher volume of denials in 2023.
X	X	**Compliance**	GAD Report: • All timeliness metrics for grievances resolution exceeded threshold at 100%. • All timeliness metrics for both the non-emergency and expedited appeals resolution timeframe met the performance threshold for the last three quarters of the year • All timeliness metrics for denials determination and notification timeframes exceeded thresholds for the year. Record review: • All timeframes for grievance acknowledgment, resolution, and written resolution were met. • All timeframes met for appeal acknowledgment and resolution notifications. • Compliance with a reasonable attempt to provide enrollee with oral notification of an expedited appeal resolution was 100%. • All timeframes met for pre-service determinations, prescriber notifications, and adverse determination notifications.
X	X	**Strengths**	• Provides clear understanding of performance variances from quarter to quarter • All grievances were appropriately categorized and resolved. • Consistently exceeds compliance threshold for timeliness of grievance resolution and grievance resolution notifications. • Consistently exceeds compliance threshold for timeliness of appeal acknowledgment and resolution notifications and provides enrollee with oral notification of an expedited appeal resolution.

			• Consistently exceeds compliance threshold for timeliness of pre-service determinations, prescriber notifications, and adverse determination notifications. • Best practice in use of easy-to-understand language for even common terms such as authorization (permission) and denied (not approved) in adverse determination and appeal resolution notifications.
		Improvements	Could not be determined as there were no non-emergency medically related grievances included in the sample of records reviewed.
X		**Opportunities**	Pharmacy preauthorization requests are categorized and processed consistent with HealthChoice requirements.
X		**Recommendations**	Retrain staff as there is no "urgent" category for covered outpatient drug preauthorization requests. All covered outpatient drug preauthorization requests are subject to the same requirements.
X		**Opportunities**	Pharmacy preauthorization requests are categorized and processed consistent with HealthChoice requirements.
X		**Recommendations**	Retrain staff as there is no "urgent" category for covered outpatient drug preauthorization requests. All covered outpatient drug preauthorization requests are subject to the same requirements.

Table 24. PPMCO Specific Summary: Strengths, Improvements, Recommendations

Quality	Timeliness	Priority Partners	
X		**Trends**	Overall, results have been fairly consistent for the year.
X		**Comparison to Other MCOs**	• Member grievances per 1000 fall to the low end of the MCO range. • The majority of appeals (93%) come from members. • The appeal rate per 1000 members is the highest of the MCOs. • Appeal overturn rate stayed in the mid-range. • One new appeal service category was identified: 4D/ Medical/Surgical: Non Pharmacy Pain Management. PA denial requests and denials per 1000 members is at the midpoint of the MCO range. • Standard Pre-Service Medical Denials are at the top of the MCO range. • Pharmacy services (5A) is no longer in the top five service codes for the year. • The top denial service category is now (1B) Diagnostic/Lab: Radiology which is 69% of the top five.
X	X	**Compliance**	GAD Report: • All timeframes met compliance for grievance and appeal resolution, and for timeliness of all pre-service denial determination and notification timeframes.

			Record review: • All timeframes for grievance acknowledgment, resolution, and written resolution were met. • Timeframe compliance for written appeal acknowledgment was 97%, for written expedited appeal resolution and reasonable attempt to provide oral notice of resolution 80%, and for written notification of non-emergency appeal resolution notification 100%. • Compliance with appeal resolution letters in easy-to-understand language was 77%. • Timeframes for prescriber notifications, determinations, and adverse determination notifications exceeded the 95% compliance threshold. • Compliance with adverse determination letters in easy-to-understand language was 73%.
X	X	**Strengths**	• Grievances appropriately categorized and resolved. • Consistently exceeds compliance threshold for timeliness of grievance acknowledgment, resolution, and resolution notifications. • Consistently exceeds compliance threshold for timeliness of appeal acknowledgment and non-emergency appeal resolution notifications. • Consistently exceeds compliance threshold for timeliness of pre-service determinations, prescriber notifications, and adverse determination notifications.
	X	**Improvements**	• Consistent compliance with timeframes for resolution of medically related grievances. • Compliance with timeframe for appeal acknowledgments exceeded the 95% compliance threshold.
X	X	**Opportunities**	• Compliance with timeframe for notification of expedited appeal resolution and reasonable attempt to provide oral notification of expedited resolution at the MDH established threshold. • Appeal resolution and adverse determination notifications written in easy-to-understand language (no undefined medical terms, no use of acronyms).
X	X	**Recommendations**	• Routinely monitor turnaround time for expedited appeal resolution and documentation of reasonable attempt to provide enrollee with oral notification of appeal resolution. • Routinely audit a sample of appeal resolution and adverse determination notifications to ensure written in easy-to-understand language. Retrain staff in the use of easy-to-understand language as this has been an ongoing issue. Perhaps consider developing a library of common terms for use by staff. Use Consumer Advisory Board for feedback. • Review all case records submitted to ensure they are from the year under review. One grievance record (#12) was from 2022.

Table 25. UHC Specific Summary: Strengths, Improvements, Recommendations

Quality	Timeliness	UnitedHealthcare Community Plans	
X		**Trends**	• Overall, UHC's results for the year remain consistent.
X		**Comparison to Other MCOs**	• Member and provider grievances per 1000 are at the low end of the MCO range; administrative grievances per 1000 are the lowest. • Appeals per 1000 are at the lower range of other MCOs. • Appeals overturned stayed toward the mid-range. • Pharmacy services (5A) has remained the top service category consistently for over a year. • PA requests denied is at the top of the MCO range for this metric and pre-service denials per 1000 members is the second highest. • Percentage of PA requests received with complete information is one of the lowest across MCOs. • The top 5 service codes and the top five reason codes have remained constant with the same order of prevalence over the course of the year. Its top service categories are consistent with the other MCOs with one exception, (3) Inpatient/Admission Hospital Services, though there were only three denials for the year. • Pharmacy services continue to be the top category for the quarter. Its denial reasons mirror those of the other MCOs. UHC is the only MCO that has scored 100% compliance in all categories for the year.
X	X	**Compliance**	GAD Report: • For Category 2: Non-Emergency Member grievances, compliance was below 95% each quarter of the year. While not always a downward trend, it is a consistently non-compliant trend. Administrative grievance resolution TAT exceeded compliance at 99%. • Provider administrative grievance resolution typically meets TAT at 100% and for MY 2023, it fell to 94%. • Performance did not meet the 95% for Category 1: Emergency Medically Related (80%) and for Category 2: Non-Emergency Member grievances (74%). For Category 2: Non-Emergency Member grievances, compliance was below 95% each quarter of the year. Record review: • Timeframes for grievance resolution and resolution notification were met. Timeframe compliance for grievance acknowledgment was 93%.

			• Timeframes for appeal acknowledgment and non-emergency resolution notifications were met. The timeframe for written notification of an expedited appeal resolution was 79%. Oral notice of the expedited resolution was fully met. • Compliance with written and oral notice of denial of a request for an expedited appeal resolution was fully met. • Compliance with 24-hour prescriber notification of outcome (approve, deny, request additional info) within 24 hours of receipt of preauthorization request for covered outpatient drug was 0%. • Compliance with pre-service determinations and adverse determinations exceeded the 95% compliance threshold.
X	X	**Strengths**	• Grievances appropriately categorized and resolved. • Consistently exceeds compliance threshold for timeliness of grievance resolutions and resolution notifications. • Consistently exceeds compliance threshold for timeliness of appeal acknowledgment and non-emergency appeal resolution notifications. • Consistently exceeds compliance threshold for oral and timely written notice of denial of a request for an expedited appeal resolution. • Consistently exceeds compliance threshold for timeliness of pre-service determinations and adverse determination notifications.
		Improvements	Improvement noted in the emergency medically related grievance resolution TAT from 67% to 80%. There were no formal opportunities noted in the prior year record review.
X	X	**Opportunities**	• Improve provider administrative grievance resolution TAT back to 100% from 94%. • Improve TAT performance on Category 1: Emergency Medically Related and Category 2: Non-Emergency Member grievances to at least 95%. • Since there were only four Emergency Medically Related grievances for the year, UHC should review each of these cases to determine where processes may have been delayed. • For Category 2: Non-Emergency Member grievances, compliance fell to 74%, and was below 95% for each quarter of the year. As part of its QI Program, UHC should conduct a root cause analysis and an action plan to address this poor performing TAT metric. • Compliance with grievance acknowledgment timeframe at the MDH established threshold. • The appropriate grievance acknowledgment template is used. (The appeal acknowledgment template was used for one grievance.) • The complete Language Accessibility Statement is included with all grievance, appeal, and pre-service adverse determination notifications. (In addition to English only two other languages were included in

			the Language Accessibility Statements accompanying all grievance, appeal, and adverse determination notifications.) • Compliance with timeframe for written notification of expedited appeal resolution at the MDH established threshold. • Compliance with prescriber notification of review outcome of preauthorization requests for covered outpatient drug within 24 hours of receipt of the request. (For outpatient drug requests there was no evidence that additional information was requested. Rather an adverse determination was immediately rendered for lack of information.) • Pharmacy preauthorization requests are categorized and processed consistent with HealthChoice requirements.
x	x	**Recommendations**	• For Category 2: Non-Emergency Member grievances, compliance fell to 74%, and was below 95% for each quarter of the year. As part of its QI Program, UHC should conduct a root cause analysis and an action plan to address this poor performing TAT metric. • Routinely monitor timeframe compliance for grievance acknowledgment notifications. • Routinely monitor timeframe compliance for written notification of expedited appeal resolutions. • Routinely monitor use of appropriate letter template for grievance acknowledgment letters. • Routinely audit a sample of all grievance, appeal, and adverse determination notifications to ensure use of the complete Language Accessibility Statement. • Retrain staff who process pharmacy preauthorization requests on 24-hour prescriber notification requirement. • There was no evidence to suggest that additional information was initially requested for covered outpatient drug preauthorization requests that were denied for lack of information. It is recommended that pharmacy staff be retrained to request this information before an adverse determination is rendered.

Table 26. WPM Specific Summary: Strengths, Improvements, Recommendations

Quality	Timeliness	Wellpoint Maryland	
X		**Trends**	Overall, results have been fairly consistent for the year.
X		**Comparison to Other MCOs**	• Member grievances per 1000 are at the low end of the MCO range. • Provider grievances per 1000 are the highest of all MCOs. • Top member grievance reason codes (6) Participant Education Issue and service codes (6) Substance Abuse, differ from other MCOs. • Member appeals per 1000 falls at the low end of the range. • Appeals overturned rate is 50%. • PA requests approved and pre-service outpatient pharmacy denials are at the lower end of the MCO range. • Pre-service denials per 1000 members is in the middle of the MCO range.
X	X	**Compliance**	GAD Report: • All timeliness metrics met in all applicable categories for member grievances, appeals and pre-service denials. • Provider administrative grievances resolution timeliness did not meet compliance at 92%. Record review: • All timeframes for grievance acknowledgment, resolution, and written resolution were met. • All timeframes were met for appeal acknowledgment and resolution notification, including written notification of denial of a request for an expedited appeal resolution. Case notes demonstrated oral notice of expedited appeal resolution. Oral notice of the denial of a request for an expedited appeal resolution was demonstrated in 75% of the cases. • All timeframes met for pre-service determinations, prescriber notifications, and adverse determination notifications.
	X	**Strengths**	• Consistently exceeds compliance threshold for timeliness of grievance acknowledgment, resolution, and resolution notifications. • Consistently exceeds compliance threshold for timeliness of appeal acknowledgment and written appeal resolution notifications.

			• Consistently exceeds compliance threshold for timeliness of pre-service determinations, prescriber notifications, and adverse determination notifications.
X	X	**Improvements**	• Consistent compliance with timeframes for grievance resolutions. • Consistent compliance with appeal acknowledgment timeframe. • Consistent compliance with expedited appeal resolution notification timeframe and oral notice to the enrollee of the resolution. • Consistent compliance with pre-service determination timeframes.
X		**Opportunities**	• Grievances are appropriately categorized. (One grievance was categorized as administrative when it should have been categorized as non-emergency medically related as it was related to difficulty accessing a prescription. However, the grievance was resolved within the required 5 calendar day timeframe for a non-emergency medically related grievance.) • Case notes consistently document reasonable attempt to provide oral notice to the enrollee of denial of an expedited appeal request. • Correct letter template is used for appeal acknowledgment letters. Four of the 30 records used a standard appeal acknowledgment letter template for an expedited appeal which included a 30 day resolution timeframe rather than 72 hours.
X		**Recommendations**	• Retrain grievance staff on appropriate categorization of grievances and routinely audit to ensure appropriate assignment. • Routinely audit case files to ensure documentation of a reasonable attempt to provide oral notice to the enrollee of denial of an expedited appeal request. • Routinely audit appeal acknowledgment letters to ensure correct template is used. • Audit case records before they are submitted to ensure they include the appropriate records. Grievance records rather than appeal were submitted initially.

Appendix B: Grievance Review Template

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

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

Appendix C: Appeal Review Template

<MCO> Appeals for <X> Quarter<Year> Results & Analysis						
	Current Quarter	**Prior Quarter**	**Qx 202x**	**Qx 202x**	**Status**	**Other MCO Results**
Total Appeals Received in the Quarter						
Total Appeals Resolved in the Quarter						
Appeals/1000 Members						
Member Appeal Sources						
Appeals from Denials Received (#/%)						
Appeals Submitted by Members (#/%)						
Appeals Submitted by Providers (#/%)						
Appeal Outcomes						
Upheld (#/%)						
Overturned (#/%)						
Overturned by Action Type						
Action 1 (#/%)						
Action 2 (#/%)						
Action 3 (#/%)						
Action 4 (#/%)						
Action 5 (#/%)						
Action 6 (#/%)						
Upheld by Action Type						
Action 1 (#/%)						
Action 2 (#/%)						
Action 3 (#/%)						
Action 4 (#/%)						
Action 5 (#/%)						
Action 6 (#/%)						
Top 5 Service Categories						
Category 1						

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

Appendix D: Pre-Service Denial Review Template

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

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