Qlarant

Medicaid Managed Care Organization

2022 Focused Review Report Grievances, Appeals, & Denials

Maryland
DEPARTMENT OF HEALTH

Submitted November 2022

Table of Contents

2022 Grievances, Appeals, & Denials

Focused Review Report

Introduction

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

The Maryland Department of Health (MDH) is required annually to evaluate the quality of care provided to HealthChoice enrollees in HealthChoice managed care organizations (MCOs) [as defined in Code of Federal Regulations (42 CFR Part 438, Subpart D) and Code of Maryland Regulations (COMAR) 10.67.04]. Under the Social Security Act [Section 1932(c)(2)(A)(i)], MDH is required to contract with an external quality review organization (EQRO) to perform an independent annual review of services provided under each MCO contract. This independent review ensures that services provided to enrollees meet the standards set forth in CFR and COMAR regulations governing the HealthChoice Program. MDH contracts with Qlarant to serve as the EQRO.

Qlarant conducts quality studies focused on determining MCO compliance with federal and state laws and regulations pertaining to the appropriateness of denials of service and the handling of grievances and appeals. These studies consist of quarterly evaluations of grievance, appeal, and pre-service denial reports submitted by each MCO, along with an annual record review. Qlarant's 2022 study is the sixth annual focused review conducted for MDH.

Assessment of MCO compliance was completed by applying performance standards defined for the calendar year (CY) 2021. Quarterly studies of grievances, appeals, and pre-service denials were conducted for the third and fourth quarters of 2021 and the first and second quarters of 2022. The annual record review encompassed enrollee grievances, appeals, and pre-service denials that occurred during CY 2021 and gathered during November-December 2021. The nine MCOs evaluated during these timeframes were:

- Aetna Better Health of Maryland (ABH)
- AMERIGROUP Community Care (ACC)
- 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)
- United Healthcare Community Plan (UHC)

Purpose and Objectives

The purpose of this review is to:

- Assess MCO compliance with federal and state regulations governing enrollee and provider grievances, enrollee appeals, pre-service authorization requests, and adverse determinations; and
- Promote increased compliance within these areas to identify trends and opportunities for improvement.

This focused study activity completes the following:

- Validates the data provided by MCOs in the quarterly grievance, appeal, and pre-service denial reports.
- Compares each MCO's performance with their peers.
- Identifies MCO opportunities for improvement and provides recommendations.
- Requests corrective action when an MCO demonstrates consistent noncompliance with one or more review components.

Methodology

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

In addition to quarterly reviews of the reports submitted by the MCOs, Qlarant conducted an annual record review of a sample of CY 2021 grievance, appeal, and pre-service denial records. Records were requested from July 1 through October 31, 2021, 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 2021. Each MCO provided Qlarant with a listing of grievances, appeals, and pre-service denials for this time period. Qlarant selected 35 cases from each listing, using a random sampling approach, and requested each MCO to upload the selected case records to the Qlarant portal. Using the 10/30 rule, an initial sample of 10 grievance, 10 appeal, and 10 denial records were reviewed. If an area of noncompliance was discovered, an additional 20 records were reviewed for the non-compliant component(s).

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

Limitations

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

In addition to the above issues, it appears that enrollee and provider grievances may be underreported by several MCOs. As an example, one MCO recently discovered that grievances resolved and closed by the Customer Service Department were not consistently entered into the complaint and grievance tracking system. A change in workflow resulted in a 140% increase in the number of grievances reported. Another MCO updated its criteria for categorizing some enrollee concerns as grievances, such as failure to receive an identification card or difficulty finding a provider. Implementation of this revised criteria resulted in an over 800% increase in the number of grievances reported.

Based upon these issues and feedback from MCOs, it does not appear that all MCOs have a process in place for quality oversight of these reports or routine auditing of enrollee concerns to ensure appropriate categorization. In the first quarter, formulas were embedded in each of the MCO quarterly grievance, appeal, and pre-service denial forms; however, data quality issues still exist. Technical assistance continued to be provided to individual MCOs, as needed. These combined efforts have achieved some success in decreasing the number of report resubmissions, as highlighted in Figure 1.

Figure 1. Grievance, Appeal, and Denial Report Resubmissions by Quarter

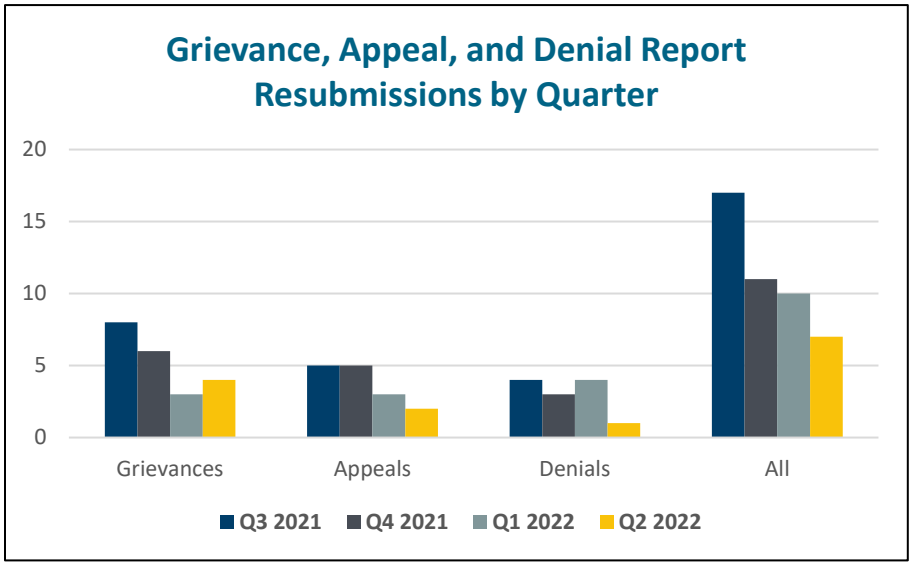


Figure 1 demonstrates that resubmissions of grievance reports were required more frequently than appeals or denials during three of the four quarters. The third quarter resulted in the highest number of required resubmissions. Each subsequent quarter demonstrates a declining number of resubmissions. It should be noted that embedded formulas were included within the reporting forms beginning in the first quarter and, as such, this and the subsequent quarterly numbers must be reviewed with caution.

Additionally, as previously noted, resubmissions were required from two MCOs in the second quarter due to optional services, such as adult dental, being incorrectly included in their reported numbers.

Results

This section provides MCO-specific review results of select grievance, appeal, and pre-service denial measures in table format. Graphical representation is also displayed where applicable. Annual record review results and quarterly reports inform these results and provide comparisons of MCO performance over time and in relation to peers.

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

Table 1. Review Determinations

Review Determinations	
Met (M)	Compliance consistently demonstrated
Partially Met (PM)	Compliance inconsistently demonstrated
Unmet (UM)	No evidence of compliance

Grievance Results

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

- **Category 1**: Emergency medically related grievances
  - 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

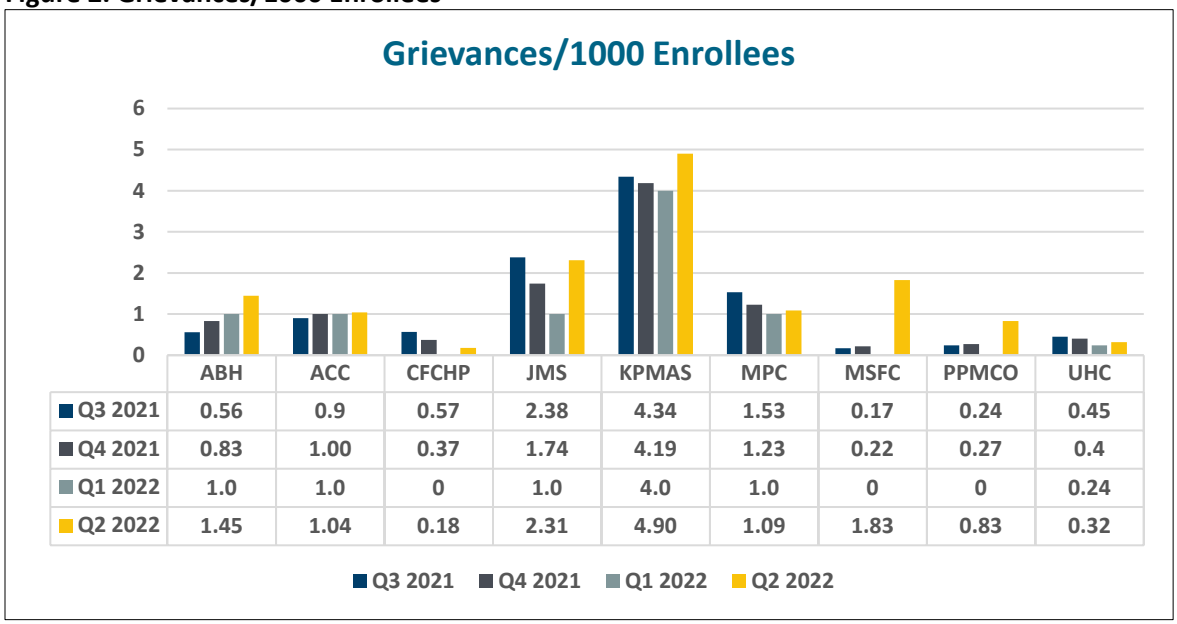
The MCO grievance review encompassed a review of comparative statistics and an assessment of compliance with federal and state laws and regulations as follows:

- Comparative Statistics
  - Grievances filed per 1000 enrollees overall and by categories
  - Top 5 enrollee grievances by reason codes
  - Top 5 enrollee grievances by service codes
  - Grievances filed per 1000 providers overall and by categories
  - Top 5 provider grievance service categories
- Resolution Timeframes (based upon a 90% relaxed compliance threshold for third quarter of 2021 and 95% thereafter)
  - 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 in 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 MDH's complaint unit (for complaints referred to the MCO by the MDH's complaint unit).

Figure 2 displays a comparison of MCO grievances per 1000 enrollees for four quarters.

Figure 2. Grievances/1000 Enrollees



	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2021	0.56	0.9	0.57	2.38	4.34	1.53	0.17	0.24	0.45
Q4 2021	0.83	1.00	0.37	1.74	4.19	1.23	0.22	0.27	0.4
Q1 2022	1.0	1.0	0	1.0	4.0	1.0	0	0	0.24
Q2 2022	1.45	1.04	0.18	2.31	4.90	1.09	1.83	0.83	0.32

KPMAS was a major outlier in grievances per 1000 enrollees for all four quarters for their increased rate of grievances compared to their peers. Attitude/service-related categories represented the majority of KPMAS grievances, consistent with the prior 12-month period. JMS follows with the next highest rate in three of the four quarters, with the majority of their grievances related to billing/financial issues. Both MSFC and PPMCO experienced major spikes in the number of grievances reported for the second quarter. According to MSFC, this spike was related to issuing updated criteria for categorizing some enrollee concerns as grievances. PPMCO created a new workflow after discovering the Customer Service Department was not consistently entering resolved and closed cases into the complaint and grievance tracker system.

Consistent with the prior annual report, billing/financial issues remain the overall service category with the highest percentage of enrollee grievances for all four quarters within the review period. Factors

causing these issues are enrollees failing to present their Medicaid identification card at the time of service, provider billing errors, or MCO enrollment record errors. Billing/financial issues were closely followed by access-related grievances, including pharmacy-prescription issues; and attitude/service-related grievances, including practitioner, administrative staff, and MCO customer service. Similarly, provider grievances throughout the review period were primarily related to billing/financial issues with attitude/service and "other" cited as the next most common sources of grievances. These findings are consistent with the prior review period.

Table 2 displays quarterly comparisons of MCO-reported compliance with resolution timeframes for enrollee grievances. As a result of the COVID-19 public health emergency during CY 2020, the Maryland Managed Care Organization Association requested that MDH relax the compliance threshold for grievance-resolution timeliness. MDH agreed to relax the compliance threshold from 100% to 90% during the COVID-19 public health emergency. Effective July 1, 2021, the COVID-19 state of emergency was lifted. MDH subsequently released new compliance thresholds that increased the relaxed threshold from 90% to 95%. The new compliance thresholds were put into effect as of October 1, 2021, which allowed for a 90-day transition period.

Table 2. MCO Reported Compliance with Enrollee Grievance Resolution Timeframes

Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2021	M	M	M	M	M	M	M	M	M
Q4 2021	M	M	M	M	M	M	M	M	M
Q1 2022	M	M	M	M	M	M	M	PM	M
Q2 2022	M	M	M	M	PM	M	M	PM	M

Green = Met (M), Yellow = Partially Met (PM)

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

Table 3 offers a comparison of MCO-reported grievances per 1000 providers for four quarters.

Table 3. MCO-Reported Grievances/1000 Providers

Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2021	0.09	2.33	2.61	0.29	N/A	0.30	0.70	4.48	0.92
Q4 2021	0.54	2.26	1.60	0.20	N/A	0.23	N/A	0.85	0.57
Q1 2022	0.54	1.73	2.58	0.19	N/A	0.08	0.10	0.83	0.12
Q2 2022	0.11	1.19	3.58	0.19	N/A	0.16	0.00	0.34	0.19

N/A = Not Applicable/No data reported

In general, MCO-reported grievances per 1000 providers have increased during this review period due to improved identification. Additionally, there is a greater variety in the types of grievances being reported. PPMCO was a major outlier for the third quarter, which was attributed to a change in the claims submission process following implementation of a new utilization management system and the MCO contracting with two new vendors. KPMAS has consistently reported the absence of provider grievances. MSFC reported no provider grievances for one of the four quarters.

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

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

Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2021	UM	M	UM	M	NA	M	M	M	M
Q4 2021	M	M	M	M	NA	M	NA	M	M
Q1 2022	M	M	M	M	NA	M	M	M	M
Q2 2022	M	M	M	M	NA	M	M	M	M

Green = Met (M), Red = Unmet (UM), White = NA (Not applicable as the MCO did not receive any provider grievances during the reporting period)

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

Table 5 presents a comparison of the annual grievance record review results across MCOs. Results are based upon a random selection of grievance records during CY 2021. Reviews were conducted utilizing the 10/30 rule.

Table 5. CY 2021 MCO Annual Grievance Record Review Results

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

Green = Met (M), Yellow = Partially Met (PM), White = NA (Not applicable as the MCO did not have a standard for resolution letter timeliness during the reporting period)

Four MCOs (JMS, MPC, MSFC, and PPMCO) received a finding of Met in all seven categories. One category, "Resolution Letter in Easy to Understand Language," was consistently met by all MCOs. Two MCOs (ACC and CFCHP) received a finding of Met or NA in six of the seven categories. CFCHP compliance could not be determined for "Resolution Letter Timeliness," as their grievance policy did not specify a timeframe for written resolution.

Three MCOs (ACC, KPMAS, and UHC) received a finding of Partially Met for "Appropriately Classified." Grievances that were incorrectly categorized were frequently pharmacy related. Three MCOs (ABH, CFCHP, and UHC) received a finding of Partially Met for "Acknowledgment Letter Timeliness." CFCHP met the five-calendar-day timeframe in only 65% of the records reviewed, with outliers ranging from 6 to 14 days. UHC met the timeframe in only 77% of the records reviewed, with outliers ranging from 6 to 31 days. ABH received a finding of Partially Met for "Issue is Fully Described," as the grievance, steps to resolve, and resolution were described in only 83% of the case notes reviewed. KPMAS received a finding of Partially Met for both "Resolution Timeliness" and "Resolution Letter Timeliness," as their grievance policies included notification within the resolution timeframe. All KPMAS grievances, which exceeded the regulatory timeframes, were the result of incorrect categorization. Only one MCO (ABH)

received a finding of Partially Met for "Resolution Appropriateness," as many of the resolutions were limited to either an apology or a determination as to whether the grievance was substantiated.

Appeal Results

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

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

In April 2016, the Centers for Medicare and Medicaid Services (CMS) issued final regulations that revised existing Medicaid managed care rules for contract periods beginning on or after July 1, 2017. As a result, MDH communicated to the MCOs new regulatory requirements for appeal processing with an effective date of January 1, 2018. This date was subsequently revised to dates of services requested on or after February 1, 2018, to allow the MCOs additional time for implementing the new requirements. Updates to COMAR 10.67.09.05, as they relate to MCO-reported appeal results addressed in this report, included the following:

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

Providers can file an appeal on behalf of an enrollee, with the enrollee's written consent. COMAR previously did not require the provider to seek written authorization before filing an appeal on the enrollee's behalf.

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

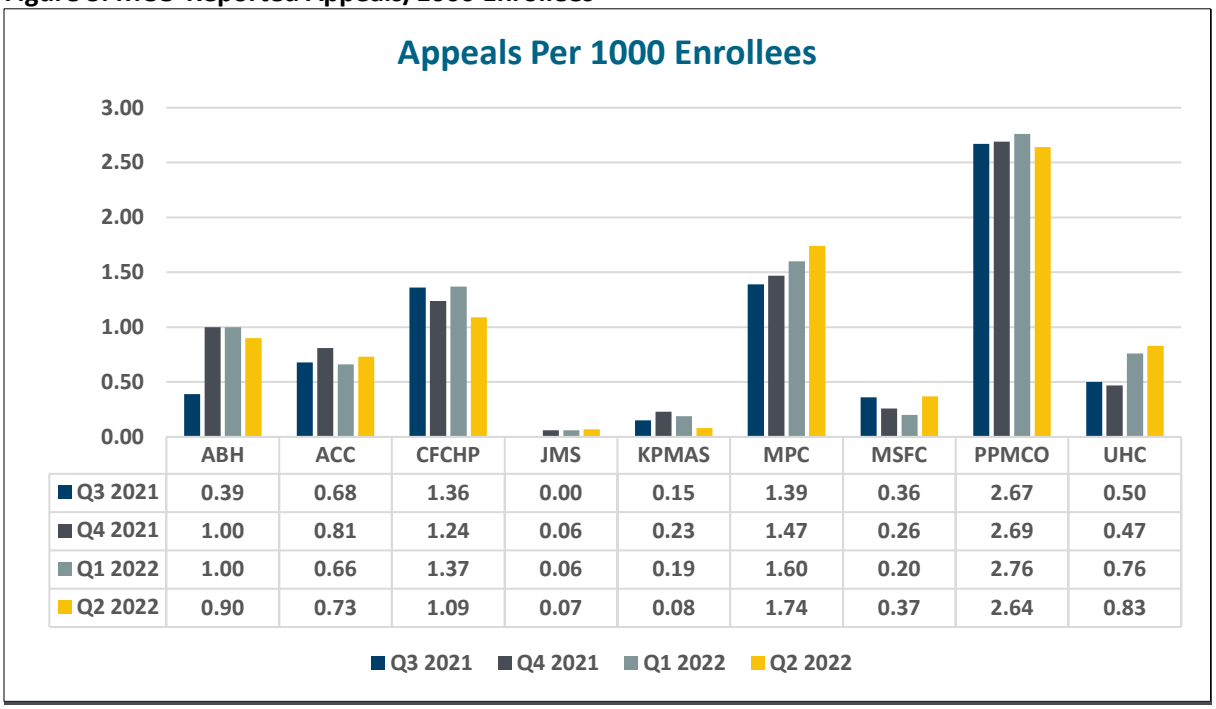
Effective November 13, 2020, CMS amended CFR 42.438.406 (b) (3) to allow oral inquiries seeking to appeal an adverse benefit determination to be treated as appeals. This eliminated the previous requirement for an oral appeal to be followed by a written, signed appeal. The MCO appeal review

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

- Comparative Statistics:
  - Appeals Filed Per 1000 Enrollees
  - Percentages of Appeals Received from Denials
  - Percentages of Appeals Submitted by Enrollees and by Providers
  - Percentages of Upheld and Overturned Denials
  - Percentages of Overturns by Action Types (1-6)
  - Percentages of Upholds by Action Types (1-6)
  - Top 5 Service Categories
  - Percentages of Expedited Appeals
  - Percentages of Extended Appeals
- Resolution Timeframes (100% threshold revised to 95% effective October 1, 2021.)
  - 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 comparison of MCO-reported appeals per 1000 enrollees.

Figure 3. MCO-Reported Appeals/1000 Enrollees



	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2021	0.39	0.68	1.36	0.00	0.15	1.39	0.36	2.67	0.50
Q4 2021	1.00	0.81	1.24	0.06	0.23	1.47	0.26	2.69	0.47
Q1 2022	1.00	0.66	1.37	0.06	0.19	1.60	0.20	2.76	0.76
Q2 2022	0.90	0.73	1.09	0.07	0.08	1.74	0.37	2.64	0.83

In comparison to all other MCOs during the four quarters under review, PPMCO has consistently been an outlier, at the top of the range, in reported appeals per 1000 enrollees. This spike appears to coincide with the initiation of contracts with specialty managed care vendors for utilization review of selected services. Three MCOs (JMS, KPMAS, and MSFC) occupy the lower end of the range, which may be partially attributed to their lower denials per 1000 rate.

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

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

Quarter	ABH*	ACC*	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC*
Q3 2021	1st	1st	1st	N/A	4th	2nd	1st	1st	1st
Q4 2021	1st	2nd	1st	1st	4th	2nd	1st	1st	1st
Q1 2022	1st	2nd	1st	1st	5th	3rd	1st	1st	1st
Q2 2022	1st	1st	1st	1st	N/A	3rd	1st	1st	1st

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

Pharmacy Services was the most frequent service category occupying the top spot for the majority of MCOs throughout the review period for the last three CYs. Six MCOs (ABH, CFCHP, JMS, MSFC, PPMCO, and UHC) reported it as the top service category for all applicable quarters in the review period. ACC reported it in the top spot for two quarters and in the second spot for the remaining two quarters. Pharmacy services occupied either the second or third top spot for MPC. Three MCOs (ABH, ACC, and UHC) also reported appeals related to "Pharmacy Services: Chronic pain management" within their top five list for at least one quarter.

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

Table 7. MCO-Reported Compliance with Enrollee Appeal Resolution/Notification Timeframes

Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2021	M	PM	M	NA	PM	UM	M	M	UM
Q4 2021	PM	PM	M	M	M	M	M	M	M
Q1 2022	M	PM	M	M	PM	PM	PM	M	PM
Q2 2022	M	PM	M	M	M	M	M	M	M

Green = Met (M), Yellow = Partially Met (PM), Red = Unmet (UM), White = Not Applicable (NA)

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

Table 8 provides a comparison of appeal record review results across MCOs. Results are based upon a random selection of appeal records reviewed for CY 2021.

Table 8. CY 2021 MCO Appeal Record Review Results

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

Green = Met (M), Yellow = Partially Met (PM), Red = Unmet (UM), White = Not Applicable (NA)

In CY 2021, eight of the nine MCOs had appeals. JMS reported no appeals during the timeframe for record review. Review of MCO appeal records demonstrated that two MCOs (ACC and MSFC) received a finding of Met in all applicable categories.

All MCOs received a Met finding for "Processed Based Upon Level of Urgency," "Appeal Decision Documented," and "Decision Made by Health Care Professional with Appropriate Clinical Expertise."

Four MCOs (ABH, ACC, MSFC, and PPMCO) received a finding of Met for compliance with the timeframe for sending the enrollee written acknowledgment of appeal receipt. The four remaining MCOs (CFCHP, KPMAS, MPC, and UHC) received a finding of Partially Met.

Denials of requests for an expedited resolution were found within the record sample reviewed from five MCOs (ABH, ACC, CFCHP, KPMAS, and MPC). CFCHP received a finding of Unmet for compliance with verbal notification of denial of an expedited request, as there was no evidence of a reasonable attempt to provide the enrollee with prompt verbal notification of the denial.

Requests for an expedited resolution were available in the record sample reviewed for all applicable MCOs, with the exception of CFCHP. Two MCOs (ABH and PPMCO) provided limited or no evidence of a reasonable attempt to provide the enrollee with verbal notification of the resolution, resulting in a finding of Partially Met and Unmet, respectively. ABH and PPMCO received a finding of Partially Met and KPMAS received a finding of Unmet for compliance with the 72-hour timeframe for resolving and providing the enrollee with written notice of an expedited resolution.

Six of the eight applicable MCOs (ABH, ACC, CFCHP, KPMAS, MSFC, and PPMCO) demonstrated full compliance with sending the enrollee a written resolution for a non-emergency appeal within the required timeframe. MPC received a Partially Met finding as internal routing errors resulted in long delays in processing some appeal requests. UHC received a finding of Partially Met as appeal processing delays occurred as a result of its practice of changing the receipt data of an appeal filed by a provider on behalf of the enrollee to the date of enrollee written consent.

All but one of the eight applicable MCOs (ABH) received a finding of Met for "Decision Available to Enrollee in Easy to Understand Language." ABH received a Partially Met finding, as their resolution letters were not consistently written in plain language.

Pre-Service Denial Results

Actions and decisions regarding services to enrollees and requiring PA by the MCO are defined in COMAR 10.67.09.04. In April 2016, CMS issued final regulations that revised existing Medicaid managed care rules for contract periods beginning on or after July 1, 2017. In response, MDH communicated to the MCOs these new regulatory requirements for services that require PA. The effective date of January 1, 2018, was subsequently revised to dates of services requested on or after February 1, 2018, to allow the MCOs additional time for implementing the new requirements. Updates to COMAR 10.67.09.04 resulting from CMS regulatory changes to PA determination timeframes included the following:

- For standard authorization decisions, the MCO shall make a determination within two business days of receipt of necessary clinical information, but not later than 14 calendar days.

- For expedited authorization decisions, the MCO shall make a determination and provide notice no later than 72 hours after receipt of the request for services.
- For all covered outpatient drug authorization decisions, the MCO shall provide prescriber notice by telephone or other telecommunication device within 24 hours of a PA request.

Additional regulatory requirements specified in COMAR 10.67.09.04 include:

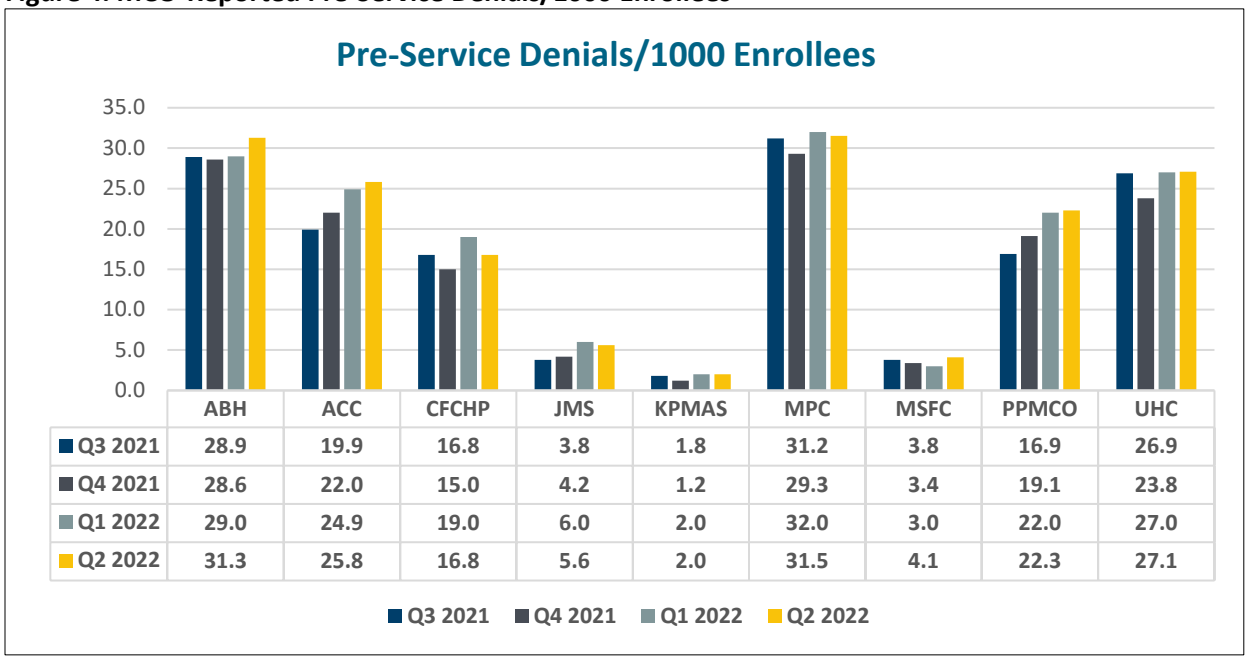
- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested:
    - Shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease; and
    - May not be arbitrarily based solely on diagnosis, type of illness, or condition.
- Standard and expedited authorization decisions may be extended up to 14 calendar days under certain specified conditions.
- An MCO shall give an enrollee written notice of any action within the following timeframes:
    - 24 hours from the date of determination for emergency, medically related requests;
    - 72 hours from the date of determination for non-emergency, medically related requests;
    - At least 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 an easily understood language and format that takes into consideration enrollees with special needs;
    - Be available in alternative formats;
    - Inform enrollees that information is available in alternative formats and how to access those formats; and
    - Contain the following information:
        - The action the MCO has made or intends to make;
        - The reasons for the action, including the right for the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the MCO’s action;
        - The enrollee’s right to request an appeal of the MCO’s action;
        - The procedures for exercising the rights described;
        - The circumstances under which an appeal process can be expedited and how to request it;
        - The enrollee’s right to have benefits continue pending resolution of the appeal;
        - How to request that benefits be continued; and
        - The circumstances under which the enrollee may be required to pay the costs of the services.

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

- Comparative Statistics:
    - Pre-service Denials Rendered Per 1000 Enrollees
    - Percentages of PA Requests with Complete Information
    - Percentages of PA Requests Requiring Additional Information
    - Percentages of PA Requests Approved
    - Percentages of PA Requests Denied
    - Percentages of Pre-Service Denials for Enrollees Under 21
    - Percentages of Pre-Service Denials for Standard Medical, Expedited Medical, and Outpatient Pharmacy
    - Top 5 Service Categories
    - Top 5 Denial Reasons
    - Determination and Notification Turnaround Time Compliance Percentages
    - Prescriber Notification Turnaround Time Compliance Percentages
- Determination timeframe compliance based upon a threshold of 90% during the third quarter of 2021 and 95% compliance thereafter:
    - 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 PA request.
    - For expedited requests, determination and notice no later than 72 hours after receipt of request for service.
- Adverse determination notification timeframe compliance based upon a threshold of 90% during the third quarter 2021 and 95% compliance thereafter:
    - 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 PA request based upon a compliance threshold of 90% during the third quarter of 2021 and 95% compliance thereafter
- Adverse Determinations
    - Must be based upon medical necessity criteria and clinical policies.
    - Must be rendered by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
- Adverse Determination Letters: Must include all 17 required regulatory components.

Figure 4 provides a quarterly comparison of MCO-reported pre-service denials per 1000 enrollees.

Figure 4. MCO-Reported Pre-Service Denials/1000 Enrollees



	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2021	28.9	19.9	16.8	3.8	1.8	31.2	3.8	16.9	26.9
Q4 2021	28.6	22.0	15.0	4.2	1.2	29.3	3.4	19.1	23.8
Q1 2022	29.0	24.9	19.0	6.0	2.0	32.0	3.0	22.0	27.0
Q2 2022	31.3	25.8	16.8	5.6	2.0	31.5	4.1	22.3	27.1

The rates of pre-service denials per 1000 enrollees have varied widely among MCOs, but have generally remained within a narrow range within each MCO throughout the quarters. ABH and MPC have the highest pre-service denial rates among the MCOs. The consistently 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.

Each MCO reports its top five denial service categories for each quarter. Table 9 displays the ranking of the pharmacy services category, by MCO, for each of the four quarters of the review period.

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

Quarter	ABH	ACC	CFCHP	JMS*	KPMAS	MPC	MSFC	PPMCO*	UHC*
Q3 2021	1st	1st	1st	1st	N/A	3rd	1st	2nd	1st
Q4 2021	1st	1st	1st	1st	N/A	3rd	1st	2nd	1st
Q1 2022	1st	1st	1st	1st	N/A	2nd	1st	1st	1st
Q2 2022	1st	1st	1st	1st	N/A	2nd	1st	2nd	1st

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

Pharmacy services continue to appear on the top five service category list of denials for all MCOs except KPMAS. KPMAS only reported three pharmacy denials during the review period. Six MCOs (ABH, ACC, CFCHP, JMS, MSFC, and UHC) reported Pharmacy Services as the top service category for all four quarters in the review period. PPMCO reported it as the top service category in one of the four quarters and in second place in the remaining three quarters. MPC reported it in the second spot for two quarters and in the third place for the remaining quarters. Three MCOs (JMS, PPMCO, and UHC) also reported denials related to “Pharmacy Services: Chronic pain management” within their top five list for all four quarters.

Compliance with COMAR requirements for the timeliness of pre-service determinations was assessed based upon self-report through MCO submissions of quarterly reports and an annual record review. Quarterly data represented the entire population or a statistically significant sample. Table 10 displays the results of the MCO's reported compliance with pre-service determination timeframes. During the COVID-19 public health emergency, the compliance threshold was lowered to 90%. Following the termination of the public health emergency, the MCOs were provided a 90-day period to transition to the prior 95% threshold. The effective date of this change was October 1, 2021, the beginning of the fourth quarter of 2021.

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

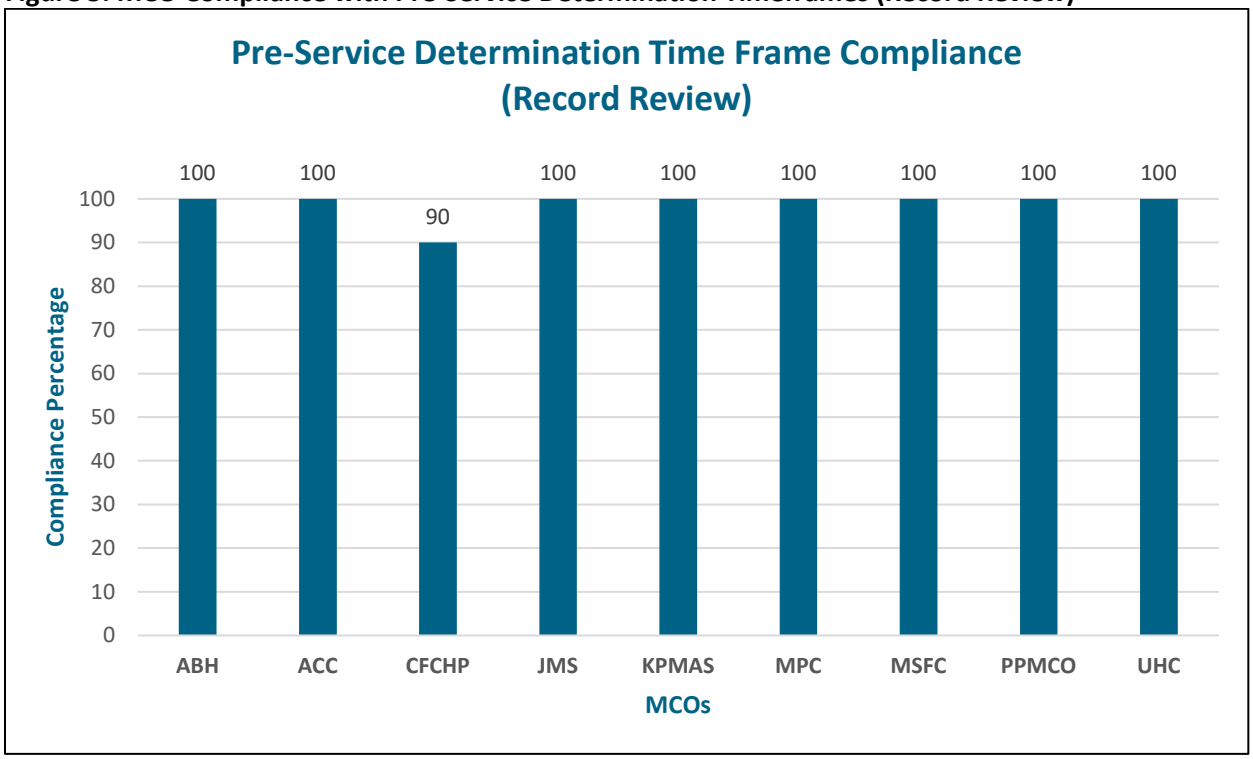
Report Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Compliance with Expedited Pre-Service Determination Timeframes for Medical Denials									
Q3 2021	100%	92%	100%	NA	100%	100%	100%	97%	100%
Q4 2021	100%	70%	100%	100%	100%	100%	NA	100%	100%
Q1 2022	100%	100%	100%	NA	100%	100%	100%	99%	100%
Q2 2022	92%	96%	100%	100%	100%	100%	100%	97%	100%
Compliance with Standard Pre-Service Determination Timeframes for Medical Denials									
Q3 2021	98%	93%	29%	100%	100%	100%	99%	100%	98%
Q4 2021	98%	95%	79%	100%	98%	100%	99%	100%	98%
Q1 2022	97%	98%	99%	100%	96%	100%	99%	99%	100%
Q2 2022	97%	94%	100%	100%	96%	100%	99%	100%	100%
Compliance with Outpatient Pharmacy Pre-Service Determination Timeframes for Denials									
Q3 2021	100%	100%	100%	100%	NA	99%	99%	99%	100%
Q4 2021	100%	100%	99%	99%	100%	100%	100%	97%	100%
Q1 2022	100%	100%	100%	100%	NA	100%	96%	99%	100%
Q2 2022	100%	100%	99%	100%	100%	99%	97%	99%	100%

Green = Met (M), Red = Unmet (UM), White = Not Applicable (NA)

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

Record reviews also were conducted to assess compliance with the COMAR requirement for timeliness of pre-service determinations. Results are based upon a random selection of pre-service adverse determination records from CY 2021. Results are highlighted in Figure 5.

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



A review of the record sample demonstrated that all MCOs met or exceeded the 90% relaxed threshold in place during the sampling timeframe for pre-service determination timeframe compliance.

Table 11 provides a comparison of adverse determination record review results across MCOs. Results are based upon a random selection of adverse determination records reviewed for CY 2021.

Table 11. MCO Adverse Determination Records Review Issues

MCO	Issues Identified
ACC	Letter Components – Incorrect Timeframes and Use of Plain Language in Enrollee Letters

*No other issues were identified in the remaining MCOs.

Results of MCO-reported compliance with adverse determination notification timeframes, based on the quarterly reports, are highlighted in Table 12. In addition to relaxing the compliance threshold for PA determination timeliness during the COVID-19 public health emergency, MDH also reduced the threshold for adverse determination notification timeliness from 95% to 90%. Once the public health emergency was lifted, MCOs were provided with a 90-day transition period to return to the 95% threshold previously in place. October 1, 2021 was the effective date of this change.

Table 12. MCO Reported Compliance with Adverse Determination Notification Timeframes (Quarterly Reports)

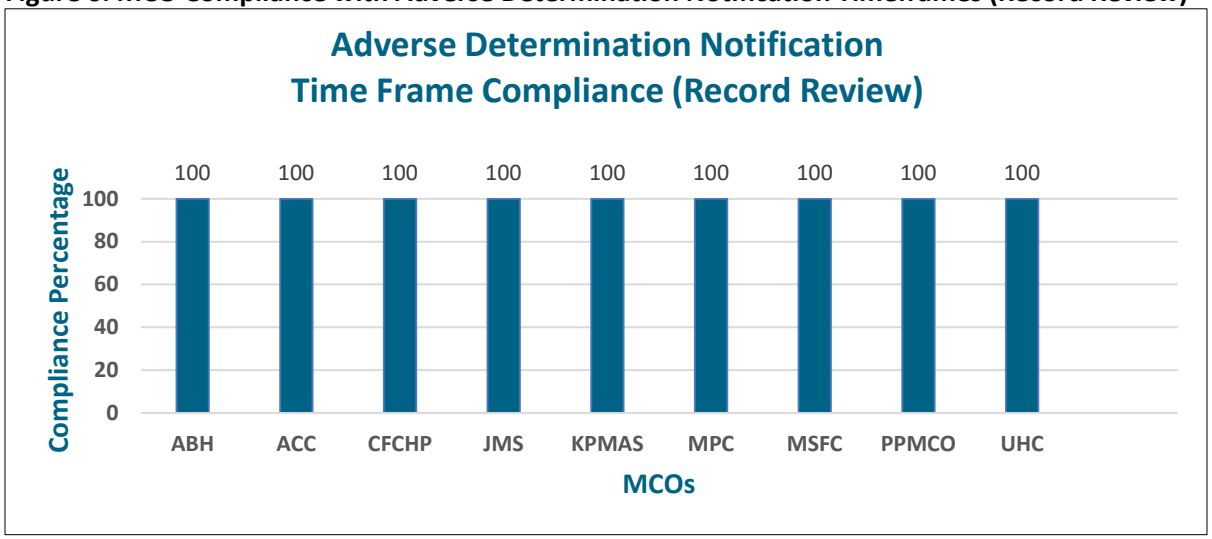
Report Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Compliance with Expedited Medical Adverse Determination Notification Timeframes									
Q3 2021	97%	95%	100%	NA	100%	100%	100%	96%	100%
Q4 2021	100%	93%	100%	100%	100%	100%	NA	100%	97%
Q1 2022	100%	96%	100%	NA	100%	100%	100%	98%	100%
Q2 2022	100%	98%	100%	100%	100%	100%	100%	96%	100%
Compliance with Standard Medical Adverse Determination Notification Timeframes									
Q3 2021	100%	95%	100%	100%	100%	100%	100%	100%	96%
Q4 2021	99%	99%	100%	80%	99%	100%	100%	99%	96%
Q1 2022	98%	98%	100%	100%	91%	100%	99%	99%	100%
Q2 2022	99%	98%	100%	100%	97%	100%	100%	99%	100%
Compliance with Outpatient Pharmacy Adverse Determination Notification Timeframes									
Q3 2021	100%	100%	99%	100%	NA	100%	99%	100%	100%
Q4 2021	100%	100%	98%	100%	100%	100%	100%	100%	100%
Q1 2022	100%	100%	100%	100%	NA	100%	91%	100%	100%
Q2 2022	100%	100%	99%	99%	100%	100%	98%	100%	100%
Compliance with Prescriber Notification of Outcome within 24 Hours									
Q3 2021	100%	100%	99%	100%	100%	100%	100%	98%	100%
Q4 2021	100%	100%	98%	100%	100%	100%	100%	97%	100%
Q1 2022	100%	100%	100%	100%	100%	100%	96%	99%	100%
Q2 2022	100%	100%	100%	100%	100%	100%	98%	99%	100%

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

Review of MCO quarterly reports identified five of the MCOs (ABH, CFCHP, MPC, PPMCO, and UHC) met or exceeded the compliance threshold for all applicable categories. All MCOs met the compliance threshold for outpatient pharmacy prescriber notifications in all four quarters. ACC and JMS were the only two MCOs that did not consistently meet the compliance threshold for the expedited adverse determination notification timeframe, as both fell below the compliance threshold in one of the four quarters. All MCOs except two (JMS and KPMAS) met the compliance threshold for standard requests. Both MCOs fell below the compliance threshold in one quarter. MSFC was the only MCO that did not meet the compliance threshold for the outpatient pharmacy adverse determination notification timeframe.

Record reviews also were conducted to assess compliance with the COMAR requirement for timeliness of adverse determination notifications. Results are highlighted in Figure 6 and are based upon a random selection of adverse determination records from CY 2021.

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



The record review identified all MCOs demonstrated 100% compliance with adverse determination notification timeframes.

Table 13 provides a comparison of adverse determination record review results across MCOs. Results are based upon a random selection of adverse determination records from CY 2021.

Table 13. Results of CY 2021 Adverse Determination Record Reviews

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

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

Eight MCOs demonstrated compliance with all requirements, as applicable. ACC received a finding of Partially Met for "Required Letter Components," as its pharmacy vendor did not utilize the most current adverse determination letter template or explain the reason for the adverse determination and any additional information needed for reconsideration in easy to understand language.

Corrective Action Plans

Corrective action plans (CAPs) are in place for several MCOs, as a result of identified opportunities for improvement:

- Complete documentation of the substance of a grievance, steps to resolve, and resolution in the case record – ABH
- Compliance with timeframe for written acknowledgment of enrollee grievances – UHC
- Compliance with timeframes for written acknowledgment and resolution of enrollee grievances – ABH, CFCHP, KPMAS
- Compliance with timeframes for enrollee grievance resolution – PPMCO
- Grievance resolutions are appropriate and written in easy to understand language – ABH
- Compliance with the timeframes for written adverse determination notifications – ACC
- Compliance with enrollee verbal notification requirement of the denial of a request for an expedited appeal resolution – CFCHP, MPC, PPMCO
- Compliance with timeframe for enrollee written notification of denial of a request for an expedited appeal resolution – PPMCO
- Enrollee appeal resolution letters written in easy to understand language – ABH
- Compliance with adverse determination letters for outpatient pharmacy denials – KPMAS

All quarterly CAPs in effect during the CY 2021 focused review timeframe were successfully resolved and closed as highlighted below:

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

Recommendations

Overall, the MCOs demonstrated fairly strong and consistent results in meeting regulations relating to grievances, appeals, and pre-service denials. This may be attributed to comprehensive and collaborative MCO oversight by MDH and the EQRO. Compliance with regulatory timeframes for written appeal acknowledgment and appeal resolution/notification present the greatest opportunity for improvement. CAPs through the SPR process and MDH oversight are in place to address MCOs with issues in demonstrating compliance. As necessary, MDH has also instituted a quarterly review to assess progress in CAP implementation and related performance measures. Improvement in compliance is expected during the next review annual cycle, as MDH has lowered the appeal timeliness threshold from 100% to 95%.

As a result of opportunities identified following the 2021 focused review, MDH:

- Embedded formulas in the MCO grievance, appeal, and denial quarterly reporting forms to address formula errors impacting data validity.

- Revised the compliance threshold for written acknowledgment of appeal receipt and written resolution/notification from 100% to 95%.
- Added new reporting fields to the MCO quarterly grievance, appeal, and denial reports to support alignment with a new CMS state-reporting template.

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

- **MDH, Continued Opportunity:** Require MCOs to implement routine quality oversight of all grievance, appeal, and denial quarterly report submissions. This is a carryover recommendation from the 2020 and 2021 Annual GAD Reports.
- **MDH, Continued Opportunity:** Explore options to support data quality of MCO quarterly grievance, appeal, and denial reports. This is a carryover recommendation from the 2020 and 2021 Annual GAD Reports. This was partially addressed by embedding formulas in the grievance, appeal, and denial report forms; however, data validity continues to be an issue.
- **MDH, Continued Opportunity:** Cross-check MCO-reported provider grievances with grievances that are submitted to MDH to ensure all grievances are accounted for in MCO report submissions. This is a carryover recommendation from the 2020 and 2021 Annual GAD Reports and is currently on hold until resources are available.
- **MDH, Continued Opportunity:** Consider conducting a focused record review of pharmacy-related denials and appeals to determine key factors underlying the consistently high volume among MCOs. This is a carryover recommendation from the 2020 and 2021 Annual GAD Reports and is currently on hold until resources are available.
- **MDH, Continued Opportunity:** Consider including compliance with timeframes for sending written acknowledgment of grievance receipt, written resolution of grievance, and written acknowledgment of appeal receipt in the quarterly grievance and appeal reports submitted by the MCOs. This supports the inclusion of these requirements in the CY 2021 SPR standards and helps to ensure MCOs are routinely tracking compliance.
- **MCOs, Continued Opportunity:** Cross-train at least one additional staff member on the quarterly grievance, appeal, and denial reports to ensure continuity in the event of staff turnover or absence.
- **MCOs, Continued Opportunity:** Educate appeal staff to process appeals filed by a provider on behalf of an enrollee consistent with the MCO **Transmittal #137 *Processing Appeals Filed by Providers Representing HealthChoice Enrollees (PT22-20)*** issued by MDH on March 16, 2020.
- **MCOs, Continued Opportunity:** The number of provider grievances continues to be under-reported by at least some of the MCOs. It does not appear that all MCOs have an effective process in place for capturing provider grievances, which may be submitted to various departments, such as Provider Relations, Customer Service, Utilization Management, 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. This is a carryover recommendation from the 2020 and 2021 Annual GAD Reports. While several MCOs have shown some improvement in identifying and reporting provider grievances, opportunities for improvements remain among other MCOs.
- **MCOs, New Opportunity:** Conduct a quarterly audit of a sample of enrollee calls to the Customer Service Department to ensure that all grievances are appropriately identified and documented in case notes and any applicable tracking systems.

Conclusions

This report includes studies of MCO grievance, appeal, and denial quarterly reports from the third quarter of 2021 through the second quarter of 2022. Additionally, a sample of grievance, appeal, and adverse determination records was reviewed for CY 2021. Based upon the outcomes of these studies and supplemented by the annual record reviews, most MCOs demonstrated strong and consistent results in meeting the majority of grievance, appeal, and denial requirements. This level of compliance helps to ensure the delivery of quality care and services to HealthChoice enrollees. Below are strengths identified in specific review components where all or a majority of the MCOs were in compliance:

- Appropriate classification and resolution of grievances
- Timely written acknowledgment of receipt of enrollee grievances
- Full documentation of grievance issues
- Timely resolution of enrollee and provider grievances
- Timeliness of grievance resolution letters
- Grievance resolution letters written in easily understood language
- Appeals processed based on the level of urgency
- Appeal decisions made by a health care professional with appropriate expertise
- Appeal decisions are documented and available to the enrollee in easy to understand language
- Timely pre-service determinations
- Timely pre-service adverse determination written notifications
- Timely prescriber notifications of PA review outcome
- Required components in adverse determination letters
- Appropriate adverse determinations, based upon MCO medical necessity criteria and policies

Major opportunities for improvement, where the majority of the MCOs did not meet requirements on a consistent basis, are identified in the following areas:

- Timely written appeal acknowledgment
- Timely resolution/written notification of enrollee appeal resolutions

As noted in the Limitations section, the validity of the data submitted by the MCOs, while much improved, continues to be a challenge, evidencing an ongoing absence of quality oversight. Consequently, the assessment results documented in this report need to be considered with some caution. It is anticipated that subsequent reporting will continue to yield a greater level of confidence in the review outcomes for annual reporting.

Appendix A

MCO-Specific Summaries

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

The MCO-specific results from quarterly assessments and CY 2021 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, Access has not been included as a category in the tables which follow.

For the purpose of 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).

Quality	Timeliness	N/A	Aetna Better Health of Maryland	
		√	**Trends**	• Reported enrollee grievances per 1000 rates demonstrated a steady increase during the review period. • Reported grievances per 1000 providers varied over the four quarters of the review period, with the fourth and first quarters demonstrating the highest rates. • Billing/financial issues have represented the vast majority of provider grievances. • The rate of appeals per 1000 has trended upward overall since the third quarter. • After a slight decrease in the fourth and first quarters, the pre-service denials per 1000 rate rose to its highest level in the second quarter. • Pharmacy services was the top denial and appeal service category for all four quarters.
		√	**Comparison to Other MCOs**	• Enrollee and provider grievances per 1000 are at the lower end of the MCO range. • The appeals per 1000 rate is mid-range. • The denials per 1000 rate is at the high end of the MCO range.
	√		**Compliance**	• Case notes provided a detailed description of grievance, steps to resolve, and resolution in 83% of the records reviewed. • Written acknowledgment of enrollee grievance receipt was evident in 93% of the records reviewed. • Enrollee grievance resolution timeframes were fully Met in all four quarters. Provider grievances were fully Met in three of the four quarters. • Enrollee grievance resolutions were appropriate in 80% of the cases reviewed. • Compliance with the timeframe for written acknowledgment of enrollee appeal receipt was evident in 100% of the records reviewed. • Timeframes for appeal resolution/written notification were Met in three of the four quarters. • Compliance with verbal notification of denial of an expedited appeal request was Met. • Verbal notification of an expedited appeal decision was evident in 70% of the records reviewed. • Appeal resolution letters were written in easy to understand language in 87% of the records reviewed. • Pre-service determination timeframes were consistently Met in three of the four quarters.

				• Adverse determination notification timeframes were consistently Met in all four quarters.
√			**Strengths**	• Consistent compliance in meeting timeframes for resolution of enrollee grievances. • Consistent compliance in meeting the timeframes for adverse determination notifications. • All adverse determination letters were written in plain language and included a detailed explanation of the reason(s) for the determination and any additional information needed for reconsideration.
√	√		**Improvements**	• Consistent compliance in meeting enrollee grievance resolution timeframes. • Consistent documentation of reasonable attempts to provide enrollees with prompt verbal notice of a denial of an expedited appeal resolution. • Adverse determination letters include correct timeframes for appeals and the continuation of benefits.
√	√		**Opportunities**	• Case notes provide a description of the enrollee grievance, steps to resolve, and resolution. • Consistent compliance in meeting timeframe for enrollee written acknowledgment of grievance receipt. • Consistent compliance in meeting provider grievance resolution timeframes. • Enrollee grievance resolutions are appropriate. • Consistent compliance in meeting timeframes for appeal resolution/notification. • Consistent compliance with enrollee verbal notification of an expedited appeal decision. • Appeal acknowledgment and resolution letters are written in plain language, include required and correct content in all fields, and use proper grammar. • Consistent compliance in meeting timeframes for pre-service determinations.
√	√		**Recommendations**	• Retrain grievance staff on appropriate documentation requirements and grievance resolution. • Audit case notes on a routine basis to ensure compliance with documentation standards and appropriate grievance resolution. • Conduct a barrier analysis and implement associated action plans to ensure compliance with all regulatory timeframes for grievances acknowledgment letters, provider grievance resolutions, appeal resolution/notifications, and pre-service determinations. Increase the frequency and scope of monitoring until consistent compliance is demonstrated. • Routinely audit a sample of appeal acknowledgment and resolution/notification letters, including those issued by

				delegated entities, to ensure the completeness and accuracy of content and ease of understanding.

Quality	Timeliness	N/A	AMERIGROUP Community Care	
		√	**Trends**	• Rates of reported grievances per 1000 enrollees have steadily increased over the review period. • Reported provider grievance rates per 1000 demonstrated a quarter-over-quarter decrease during the review period. • Billing/financial issues have represented the vast majority of provider grievances. • Appeal rates per 1000 have varied over the review period from 0.66 to 0.81. • The rates of pre-service denials and appeals per 1000 have demonstrated a quarter-over-quarter increase during the review period. • Pharmacy services was the top pre-service denial category and occupied one of the top two spots for appeals in all four quarters.
		√	**Comparison to Other MCOs**	• Enrollee grievances per 1000 are at the lower end of the MCO range. • The provider grievances per 1000 rate was mid-MCO range for three quarters, while at the top for one. • The appeal rate per 1000 is at the lower end of the MCO range. • The rate of pre-service denials per 1000 is at the higher end of the MCO range.
	√		**Compliance**	• Enrollee and provider grievance resolution timeframes were fully Met in all four quarters. • Compliance with the timeframe for written acknowledgment of enrollee grievance receipt was evident in 100% of the records reviewed. • Compliance with the timeframe for written acknowledgment of enrollee appeal receipt was evident in 100% of the records reviewed. • Compliance with notification requirements for denial of an expedited appeal request and request for an extension was evident in the applicable records reviewed. • Timeframes for appeal resolution/notification were Partially Met in all four quarters. • Pre-service determination timeframes were consistently Met in two of the four quarters. • Adverse determination notification timeframes were consistently Met in three of the four quarters.

√			**Strengths**	• Demonstrated consistent compliance in meeting timeframes for enrollee and provider grievance resolutions. • Demonstrated consistent compliance in meeting timeframes for sending enrollee acknowledgments of grievance and appeal receipt. • Enrollee grievances and steps to resolve were well described in case notes and resolution letters. • All non-pharmacy adverse determination letters provided a detailed explanation of the reason for the determination and any additional information needed for reconsideration.
√	√		**Improvements**	• Consistent compliance with resolving provider grievances within regulatory timeframes.
√	√		**Opportunities**	• Correct categorization of enrollee grievances. • Provider grievances are primarily related to billing/financial issues. • Consistent compliance with timeframes for resolution/notification of enrollee appeals. • Consistent compliance with timeframes for pre-service determinations. • Consistent compliance with timeframes for adverse determination notifications. • Use of the current letter template and plain language in pharmacy adverse determination letters.
√	√		**Recommendations**	• Revise the Member Grievances - MD Policy to specify a timeframe for providing the enrollee with a written resolution of their grievance. • Retrain grievance staff on the appropriate categorization of grievances (emergency medically related, non-emergency medically related, and administrative). • Conduct a barrier analysis and implement associated action plans to ensure compliance with all regulatory timeframes for enrollee appeals, pre-service determinations, and adverse determination notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Work with the pharmacy vendor to ensure the use of the most recent adverse determination letter template and plain language in letters. Routinely audit a sample of adverse determination letters to ensure compliance. • Consider conducting a root cause analysis of billing/financial-related provider grievances to identify opportunities for improvement.

Quality	Timeliness	N/A	CareFirst Community Health Plan	
		√	**Trends**	• The enrollee grievance rate per 1000 has been trending downward for the last three quarters of the review period. • The provider grievance rate has varied considerably over the review period, reaching its highest rate of 3.58 in the last quarter. • Billing/financial issues was the top service category of provider grievances. • The appeal rate per 1000 has varied between a relatively narrow range during the first three quarters, reaching its lowest rate of 1.09 in the last quarter. • The rate of pre-service denials per 1000 has varied between 15.9 and 19.0 during the four quarters of the review period, with the third and second quarter rate at 16.8. • Pharmacy services was the top service category for pre-service denials and appeals in all four quarters of the review period.
		√	**Comparison to Other MCOs**	• The enrollee grievances per 1000 rate is at the lower end of the MCO range; the provider grievances per 1000 rate is at the higher end of the range and was at the top for the last two quarters of the review period. • The appeal rate per 1000 was at the middle of the MCO range during the review period. • The rate of pre-service denials per 1000 is at mid-range.
	√		**Compliance**	• Compliance with the timeframe for written acknowledgment of grievance receipt was evident in 65% of the records reviewed. • Resolution timeframes for enrollee grievances was Met in all four quarters. • The resolution timeframe for provider grievances was Met in three of the four quarters. • Compliance with the timeframe for written acknowledgment of appeal receipt was evident in 87% of the records reviewed. • Appeal resolution/notification timeframes were consistently Met in all four quarters. • Records reviewed did not provide evidence of enrollee verbal notification of denial of an expedited appeal request. • Pre-service determination timeframes were consistently Met in two of the four quarters.

				• Adverse determination notification timeframes were consistently Met during the review period.
√			**Strengths**	• Grievance resolution letters provided a full description of the grievance and the required steps to resolve. • Consistent compliance in meeting enrollee grievance resolution timeframes. • Consistent compliance in meeting enrollee appeal resolution/notification timeframes. • Consistent compliance with adverse determination notification timeframes.
√	√		**Improvements**	• Grievance resolution letters are supported by case notes with full documentation of the grievance and required steps to resolve. • Adverse determination letters provide an explanation of requested service in plain language.
√	√		**Opportunities**	• Consistent compliance with the timeframe for sending enrollees a written acknowledgment of their grievance. • Consistent compliance in meeting resolution timeframes for provider grievances. • Provider grievances are primarily related to billing/financial issues. • Consistent compliance with the timeframe for sending enrollees a written acknowledgment of their appeal. • Consistent compliance in providing an enrollee verbal notification of denial of an expedited appeal request. • Consistent compliance with pre-service determination timeframes.
√	√		**Recommendations**	• Revise Member Grievances Policy to specify a timeframe for providing the enrollee a written resolution of their grievance. • Consider conducting a root cause analysis of billing/financial-related provider grievances to identify opportunities for improvement. • Monitor timeliness of mailing of grievance and appeal acknowledgment letters on a routine basis. • Retrain appeal staff on the requirement for making a reasonable attempt to provide verbal notification of a denial of an expedited appeal request, and routinely audit a sample of cases to ensure compliance. • Ensure an effective process is in place for monitoring compliance with regulatory timeframes for provider grievances and pre-service determinations. Increase the frequency and scope of monitoring until consistent compliance is demonstrated.

Quality	Timeliness	N/A	Jai Medical Systems, Inc.	
		√	**Trends**	• The rate of reported grievances per 1000 enrollees demonstrates an uneven trend with the first and last quarters of the review period, demonstrating a much higher rate than the fourth and first quarters. • Billing/financial issues represented the majority of enrollee grievances in the first three quarters of the review period, with a decline to 46% in the last quarter. • The rate of reported provider grievances per 1000 has remained relatively stable during the review period. • JMS had no appeals in the third quarter and only two in each of the remaining quarters. According to JMS, this is related to the relaxing of requirements for Hepatitis C treatment. • Pre-service denials per 1000 increased in each of the first three quarters of the review period, but declined slightly in the last quarter. • Pharmacy services was the top service category for pre-service denials for all four quarters.
		√	**Comparison to Other MCOs**	• JMS had the second highest enrollee grievance rate per 1000 throughout the review period. • Provider grievances per 1000 were at the low end of the range. • The appeal rate per 1000 is at the bottom of the MCO range. • Pre-service denials per 1000 was at the lower end of the range.
	√		**Compliance**	• Resolution timeframes for enrollee and provider grievances were consistently Met during the review period. • Compliance with sending the enrollee a written acknowledgment of their grievance was evident in all records reviewed. • Appeal resolution/notification timeframes were consistently Met in all applicable quarters. • Pre-service determination timeframes were consistently Met in all quarters. • Adverse determination notification timeframes were Met in three of the four quarters.
√			**Strengths**	• Case notes provided a detailed description of the grievance, steps taken to resolve, and resolution. • All grievance resolution timeframes were consistently Met during the review period.

				• Grievance acknowledgment letters were evident in all records reviewed. • All enrollee grievance letters were written in plain language, with a full description of the grievance and an appropriate resolution. • All appeal resolution/notification timeframes were consistently Met. • All pre-service determination timeframes were consistently Met.
√	√		**Improvements**	• Consistent compliance with pre-service determination timeframes.
√	√		**Opportunities**	• Enrollee grievances are primarily related to billing/financial issues. • Consistent compliance with adverse determination notification timeframes.
√	√		**Recommendations**	• Ensure an effective process is in place for monitoring compliance with all regulatory timeframes for adverse determination notification timeframes. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Consider conducting a root cause analysis of billing/financial-related enrollee grievances to identify opportunities for improvement.

Quality	Timeliness	N/A	Kaiser Permanente of the Mid-Atlantic States, Inc.	
		√	**Trends**	• The reported rate of enrollee grievances per 1000 has remained fairly stable for the first three quarters, with an uptick in the last quarter. • Enrollee grievances relating to attitude/service have represented the majority of KPMAS grievances, ranging from 56% to 58%, with a slight decrease to 48% in the last quarter. • KPMAS has consistently reported the absence of provider grievances. • The appeal rate per 1000 has varied within a narrow range over the four quarters. • The rate of pre-service denials per 1000 was fairly consistent during the review period. • Medical/Surgical pre-service denials remained the top service category for all four quarters.
		√	**Comparison to Other MCOs**	• KPMAS was a major outlier in its enrollee grievances per 1000 rate for all four quarters.

				• KPMAS is the only MCO that has consistently reported no provider grievances. • The appeal rate per 1000 is near the bottom of the MCO range. • The rate of pre-service denials per 1000 was at the bottom of the range of the other MCOs, possibly due to KPMAS' model. • KPMAS reported only three pre-service denials for pharmacy services during the review period.
	√		**Compliance**	• Compliance with the timeframe for written acknowledgment of enrollee grievance receipt was evident in all records reviewed. • Compliance with the resolution timeframes for enrollee grievances was Met in three of the four quarters. • Appeal resolution/notification timeframes were Met in two of the four quarters. • Compliance with the timeframe for written acknowledgment of appeal receipt was evident in 67% of the records reviewed. • KPMAS consistently Met regulatory timeframes for pre-service determinations. • Compliance with adverse determination notification timeframes was not met for outpatient pharmacy in one of the three quarters.
√			**Strengths**	• Enrollee grievance acknowledgment letters were evident in all records reviewed. • Records reviewed demonstrated thorough documentation of grievance, the required steps to resolve, and the resolution in all case notes. • Resolution letters provided a detailed description of the enrollee's grievance and are written in plain language. • Adverse determination letters provided a detailed explanation of the requested service and an explanation of the denial decision in plain language. • Demonstrated consistent compliance in meeting the timeframes for pre-service determinations.
√	√		**Improvements**	• Consistent compliance with sending enrollees a grievance resolution letter. • MDH-approved appeal letter templates are consistently used. • Consistent compliance with verbal and written notification of denial of an expedited appeal request.
√	√		**Opportunities**	• Appropriate categorization of grievances. • Consistent compliance in meeting resolution timeframes for enrollee grievances. • Consistent compliance in meeting the timeframe for written acknowledgment of enrollee appeal receipt.

				• Consistent compliance in meeting enrollee appeal resolution/notification timeframes. • Consistent compliance in meeting the timeframes for adverse determination notifications. • High percentage of attitude/service-related enrollee grievances.
√	√		**Recommendations**	• Consider conducting a root cause analysis of service/attitude-related enrollee grievances to identify opportunities for improvement. • Ensure an effective process is in place for monitoring compliance with all regulatory timeframes for grievance resolutions, appeal acknowledgment letters, appeal resolutions/notifications, and adverse determination notifications. Increase the frequency and scope of monitoring until consistent compliance is demonstrated. • Retrain grievance staff on the assignment of enrollment grievances to the appropriate category (emergency medically related, non-emergency medically related, and administrative).

Quality	Timeliness	N/A	Maryland Physicians Care	
		√	**Trends**	• The enrollee grievances per 1000 rate has demonstrated a slight downward trend during the review period. • The rate per 1000 of provider grievances demonstrated a slight uptick in the last quarter after a downward trend in the prior two quarters. • The rate of appeals per 1000 has increased quarter over quarter during the review period. • Pharmacy Services occupied one of the top five appeal and pre-service denial service category spots for all four quarters. • The rate of pre-service denials per 1000 has varied within a narrow range over the review period.
		√	**Comparison to Other MCOs**	• The enrollee and provider grievances per 1000 rates are at the lower end of the MCO range. • The appeal rate per 1000 is at mid-range. • The rate of pre-service denials per 1000 is at or near the top of the MCO range.
	√		**Compliance**	• Compliance with the timeframe for written acknowledgment of enrollee grievance receipt was evident in all records reviewed. • The resolution timeframes for enrollee and provider grievances were Met in all quarters.

				• MCO demonstrated compliance with the timeframe for written acknowledgment of appeal receipt was evident in 66% of the records reviewed. • Appeal resolution/notification timeframes were Met in two of the four quarters. • The compliance threshold for pre-service determinations and adverse determination notifications was Met for all categories in all four quarters.
√			**Strengths**	• Consistent compliance in meeting timeframes for grievances, pre-service determinations, and adverse determination notifications was identified throughout the review period. • Case notes were very organized and provided a detailed description of the grievance, steps taken to resolve, and resolution. • Appeal resolution letters included a very detailed description of the denied service being requested and an explanation of the decision in plain language. • Adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial and what was needed for approval of the request in plain language.
√	√		**Improvements**	• Appeal resolution letters were written in plain language.
√	√		**Opportunities**	• Consistent compliance with the timeframe for sending enrollee acknowledgment of appeal receipt. • Consistent compliance with timeframes for appeal resolution/notification.
√	√		**Recommendations**	• Ensure an effective process is in place for monitoring compliance with all regulatory timeframes for written appeal acknowledgments and appeal resolution/notification. Increase frequency and scope of monitoring until consistent compliance is demonstrated.

Quality	Timeliness	N/A	MedStar Family Choice, Inc.	
		√	**Trends**	• The enrollee grievances per 1000 rate remained fairly stable until it spiked in the second quarter, following the release of new criteria for categorizing some concerns as grievances. • Attitude/Service-related enrollee grievances ranged from 50% to 61% in the first three quarters of the review period, but demonstrated a sharp decline to 8% in the last quarter.

				• The provider grievance rate per 1000 decreased over the review period, with no grievances reported for the fourth quarter. • The appeal rate per 1000 increased in the second quarter, after demonstrating a downward trend in the prior two quarters. • Pharmacy services was the top appeal and pre-service denial category for all four quarters. • The rate of pre-service denials per 1000 varied slightly during the review period, with a slight increase in the last quarter.
		√	**Comparison to Other MCOs**	• The rate of enrollee grievances per 1000 remained at the low end of the MCO range the first three quarters, but moved to mid-range in the last quarter. • Provider grievances per 1000 remained at the lower end of the MCO range. • The appeals per 1000 rate is at the lower end of the range. • The rate of pre-service denials per 1000 has remained at the low end of the MCO range.
	√		**Compliance**	• Resolution timeframes for enrollee and provider grievances was Met in all applicable quarters. • Written acknowledgments of enrollee grievance and appeal receipt was evident in all records reviewed. • Appeal resolution/notification timeframes were Met in three of the four quarters. • Pre-service determinations and adverse determination notification timeframes Met the compliance threshold in all but one category. Compliance with the outpatient pharmacy determination notification timeframe fell below the threshold in the first quarter.
√			**Strengths**	• Consistent compliance was demonstrated in meeting the resolution timeframes for enrollee and provider grievances in all applicable quarters. • Case notes were well organized and provided a detailed description of the grievance, steps taken to resolve, and resolution. • Acknowledgments of grievance and appeal receipt were sent to enrollees in all the records reviewed. • Detailed case notes provided descriptions of all appeal-related activities and outcomes. • All appeal resolution letters were written in plain language and provided a detailed explanation of the reason for the uphold or overturn decision. • All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial.

√	√		**Improvements**	• Appeal receipt date is not changed to reflect the date of enrollee consent.
√	√		**Opportunities**	• Consistent compliance with appeal resolution/notification timeframes. • Consistent compliance with adverse determination notification timeframes.
√	√		**Recommendations**	• Conduct a root cause analysis and implement associated action plans to ensure consistent compliance with enrollee appeal resolution/notification timeframes and adverse determination notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated.

Quality	Timeliness	N/A	Priority Partners	
		√	**Trends**	• The rate of enrollee grievances per 1000 remained fairly consistent over the first three quarters of the review period, but experienced a dramatic increase in the last quarter as a result of PPMCO discovering not all grievances were documented in the grievance tracker system. • The rate of provider grievances per 1000 steadily decreased over the review period, reversing an earlier spike that was attributed to authorization denials (Evicore and pharmacy related) and claims disputes, over half of which were for lack of ePREP completion. • The rate of appeals per 1000 varied within a narrow range over the four quarters of the review period. • Pharmacy Services was one of the top two service categories for pre-service denials and the top appeal category for all four quarters. • The rate of pre-service denials per 1000 remained relatively stable over the review period, with the exception of a decrease in the fourth quarter.
		√	**Comparison to Other MCOs**	• Enrollee grievances are at or near the bottom of the MCO range. • Provider grievances moved from the top of the range in the third quarter to the lower end of the range in the remaining three quarters. • The appeals per 1000 rate has consistently been at the top of the range. • The rate of pre-service denials per 1000 is at mid-range.
	√		**Compliance**	• Enrollee grievance resolution timeframes were Met in two of the four quarters. • Compliance with resolution timeframes for provider grievances was fully Met in all four quarters.

				• Written acknowledgments of enrollee grievance and appeal receipt were evident in all records reviewed. • Compliance with appeal resolution/notification timeframes was Met in all four quarters. • Review of case notes did not provide evidence of a reasonable attempt to provide the enrollee with verbal notification of an expedited appeal resolution. • Timeframes for pre-service determinations and adverse determination notifications were Met in all four quarters.
√			**Strengths**	• Case notes were well organized, and described the grievance, steps to resolve, and resolution. • Consistent compliance was demonstrated in meeting the resolution timeframe for provider grievances. • Acknowledgments of grievance and appeal receipt were sent to enrollees in all the records reviewed. • Consistent compliance was demonstrated in meeting the resolution/notification timeframes for enrollee appeals. • Consistent compliance was demonstrated in meeting the timeframes for pre-service determinations and adverse determination notifications.
√	√		**Improvements**	• Attitude/Service-related enrollee grievances have been steadily decreasing over the review period. • Consistent compliance with appeal resolution/notification timeframes. • Enrollee consent is documented in the case record when a provider is filing an appeal on behalf of the enrollee. • Appeal resolution letters reflect correct calculated dates, appeal receipt, and resolution dates. • Appeal and adverse determination letters were consistently written in plain language. • Consistent compliance with pre-service determination and adverse determination notification timeframes. • Additional clinical information, if required, was requested within two business days of receipt of a PA request.
√	√		**Opportunities**	• Appropriate categorization of grievances (emergency-medically related, non-emergency medically related, and administrative). • Consistent compliance with enrollee grievance resolution timeframes. • Documentation of reasonable attempt to provide enrollee with verbal notification of expedited appeal resolution.
√	√		**Recommendations**	• Retain staff on the appropriate categorization of grievances. • Conduct a root cause analysis and implement associated action plans to ensure consistent compliance with enrollee grievance resolution timeframes.

				• Retrain appeal staff and conduct routine audits on appeal case documentation requirements, including verbal notification of an expedited resolution.

Quality	Timeliness	N/A	UnitedHealthcare Community Plan	
		√	**Trends**	• The rate of enrollee grievances per 1000 has demonstrated an uneven, but overall downward trend during the review period. • Enrollee and provider billing/financial issues were the top grievance service category for all quarters. • Provider grievances have demonstrated an overall decrease during the review period. • The rate of appeals per 1000 has demonstrated an uneven, but overall downward trend during the review period. • The rate of pre-service denials per 1000 has been relatively stable with the exception of the fourth quarter decrease. • Pharmacy services was the top service category for both appeals and pre-service denials for all four quarters of the review period.
		√	**Comparison to Other MCOs**	• UHC is at the lower end of the MCO range in enrollee grievances per 1000. • The rate of provider grievances per 1000 was at mid-MCO range in the first quarter of the review period, moving to the lower end of the range in the remaining three quarters. • The rate of appeals per 1000 is at the lower end of the MCO range. • The rate of pre-service denials per 1000 is at the higher end of the range.
	√		**Compliance**	• Timeliness of written acknowledgment of enrollee grievance receipt was Met in 77% of the records reviewed. • Compliance with enrollee and provider grievance resolution timeframes was Met in all four quarters. • Timeliness of written acknowledgment of enrollee appeal receipt Met in 67% of the records reviewed. • Compliance with appeal resolution/notification timeframes was Met in two of the four quarters. • Compliance with pre-service determination and adverse determination notification timeframes was Met in all four quarters.
√			**Strengths**	• Consistent compliance with enrollee and provider grievance resolution timeframes was demonstrated in all four quarters.

				• Grievance case records provided a detailed description of the grievance, steps taken to resolve, and resolution. • All enrollee grievance resolution letters fully described the grievance and steps taken to resolve and are in plain language. • Appeal resolution letters provided a very detailed explanation of reasons for the overturn of a denial in addition to uphold decisions in easy to understand language. • Consistent compliance with pre-service determination and adverse determination notification timeframes was demonstrated in all four quarters. • Adverse determination letters included a very detailed explanation of the reason for the denial in plain language, including what is needed to demonstrate medical necessity.
√	**√**		**Improvements**	• Consistent compliance with the resolution timeframes for enrollee and provider grievances.
√	**√**		**Opportunities**	• Appropriate categorization of grievances. • Billing/financial-related enrollee and provider grievances. • Consistent compliance in meeting timeframe for written acknowledgment of receipt of enrollee grievance. • Consistent compliance in meeting timeframe for written acknowledgment of receipt of enrollee appeal. • Consistent compliance with appeal resolution/notification timeframes. • Date of appeal is the date the provider filed on behalf of the enrollee, not the date of enrollee consent.
√	**√**		**Recommendations**	• Conduct a root cause analysis and implement associated action plans to ensure consistent compliance with grievance acknowledgment letters, appeal acknowledgment letters, and appeal resolution/notification timeframes. Increase the frequency and scope of monitoring until consistent compliance is demonstrated. • Consider conducting a root cause analysis of billing/financial-related enrollee and provider grievances to identify opportunities for improvement. • Consider including a more detailed description of the grievance in enrollee acknowledgment letters. • Educate appeal staff on dating appeal receipt as the date the provider filed on behalf of the enrollee.

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					o	
Total Member Grievances Resolved in the Quarter					o	
Grievances/1000 Members					o	
Member Grievances by Category						
Category 1: Emergency medically related (rate/1000)					o	
Category 2: Non-emergency medically related (rate/1000)					o	
Category 3: Administrative (rate/1000)					o	
Top 5 Member Grievances Received by Reason Code						
Reason Code (#/%)					o	
Reason Code (#/%)					o	
Reason Code (#/%)					o	
Reason Code (#/%)					o	
Reason Code (#/%)					o	
Top 5 Member Grievances Received by Service Code						
Service Code (#/%)					o	
Service Code (#/%)					o	
Service Code (#/%)					o	
Service Code (#/%)					o	
Service Code (#/%)					o	
Member Grievances TAT Met (standard 95% compliance)						
Category 1: Emergency medically related (#/%)					o	
Category 2: Non-emergency medically related (#/%)					o	
Category 3: Administrative (#/%)					o	
Total Provider Grievances Received in the Quarter					o	

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

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

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					o	
Total Appeals Resolved in the Quarter					o	
Appeals/1000 Members					o	
Member Appeal Sources						
Appeals from Denials Received (#/%)					o	
Appeals Submitted by Members (#/%)					o	
Appeals Submitted by Providers (#/%)					o	
Appeal Outcomes						
Upheld (#/%)					o	
Overturned (#/%)					o	
Overturn by Action Type						
Action 1 (#/%)					o	
Action 2 (#/%)					o	
Action 3 (#/%)					o	
Action 4 (#/%)					o	
Action 5 (#/%)					o	
Action 6 (#/%)					o	
Upheld by Action Type						
Action 1 (#/%)					o	
Action 2 (#/%)					o	
Action 3 (#/%)					o	
Action 4 (#/%)					o	
Action 5 (#/%)					o	
Action 6 (#/%)					o	
Top 5 Service Categories						
Category 1						
Resolved (#/%)					o	
Upheld (#/%)					o	
Overturn (#/%)					o	
Category 2						

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

Legend

o Neutral

o Met, if applicable

o Negative trend. (Requires explanation from MCO)

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

N/A - Not Applicable

N/R- Not Reported

Bold, red font - corrected reporting errors

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

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

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