Maryland Department of Health

MARYLAND Department of Health

HealthChoice
Maryland's Medicaid Managed Care Program

Delmarva Foundation
A Quality Health Strategies Company

Medicaid Managed Care Organization

2017 Focused Review Report Grievances, Appeals, and Denials

Calendar Year 2017

Submitted by:
Delmarva Foundation
November 2017

Table of Contents

2017 Focused Review Report
Grievances, Appeals, & Denials

Executive Summary

The Maryland Department of Health (MDH) is responsible for evaluating the quality of care provided to Maryland Medical Assistance recipients enrolled in HealthChoice Managed Care Organizations (MCOs). Delmarva Foundation, as the contracted External Quality Review Organization (EQRO), conducts quality studies focused on determining MCO compliance with federal and state laws and regulations pertaining to the handling of grievances and appeals, and the appropriateness of denials of service. These studies consist of quarterly evaluations of grievance, appeal, and pre-service denial results submitted by each MCO and an annual record review. This is the first focus review conducted for the MDH.

Assessment of MCO compliance was completed by applying the systems performance standards defined for Calendar Year (CY) 2016 in the Code of Maryland Regulations (COMAR) 10.09.65. Quarterly studies of grievances, appeals, and pre-service denials were conducted for the third and fourth quarters of 2016, and the first and second quarters of 2017. The annual record review encompassed member grievances, appeals, and pre-service denials that occurred during calendar year 2016. Using the 10/30 rule, an initial sample of 10 grievance, appeal, and denial records were reviewed. If an area of non-compliance was discovered an additional 20 records were reviewed for the non-compliant component. The eight MCOs evaluated during these time frames were:

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

The following section will provide MCO specific review results of select grievance, appeal, and pre-service denial measures in table format. This facilitates comparisons of MCO performance over time and in relation to its peers based on quarterly reports and annual record review results. Data from the third quarter of 2016, was omitted as a result of reporting inconsistencies discovered among the MCOs.

For the purpose of this Executive Summary, the percentage of compliance demonstrated for various components is represented by a review determination of met, partially met, or unmet, as follows:

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

Findings

The following sections include findings for Grievances, Appeals and Pre-Service Denials.

Grievance Findings

A grievance is an expression of dissatisfaction about any matter other than an action and is defined in COMAR 10.09.62.01[58-1]. The regulation describes three categories of grievances:

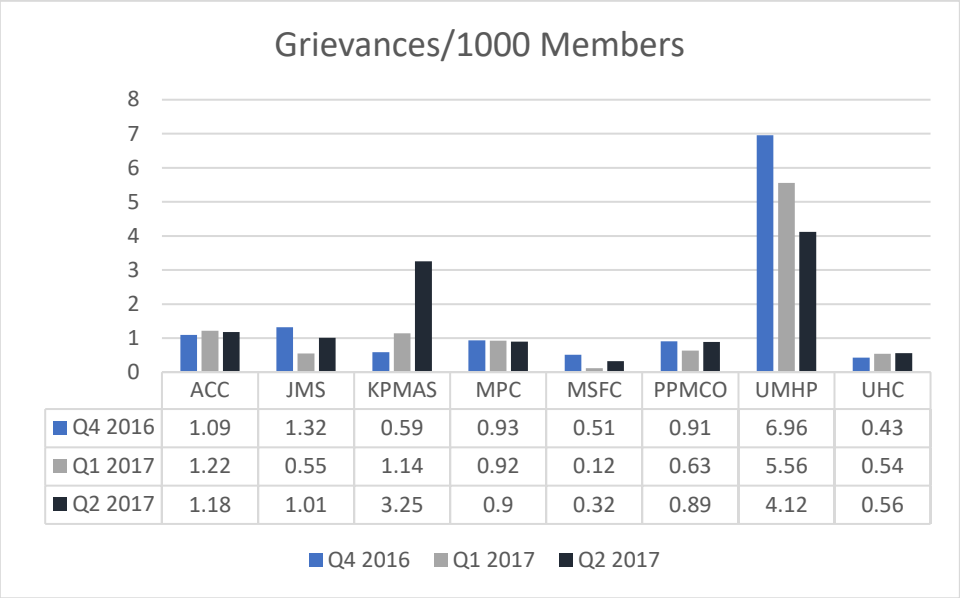
- Category 1: Emergency medically related grievances (24 hours)
  Example: Emergency prescription or incorrect prescription provided
- Category 2: Non-emergency medically related grievances (5 calendar days)
  Example: DME/DMS related complaints about repairs, upgrades, vendor issues, etc.
- Category 3: Administrative grievances (30 calendar days)
  Example: Difficulty finding a network PCP or specialist

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

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

Figure 1 provides a comparison of MCO grievances per 1000 members for three quarters.

Figure 1. Grievances/1000 Members



UMHP was a major outlier in grievances per 1000 members for all three quarters however, this measure has been trending downward since the fourth quarter of 2016. Both KPMAS and UHC demonstrate an upward trend in grievances per 1000 members since the fourth quarter of 2016. This measure falls within a fairly narrow range for the remaining MCOs.

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

Table 1. Grievances/1000 Providers

Quarter	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP*	UHC
Q4 2016	0	0	0	0	0.81	0.13	0.71	0.1
Q1 2017	0	0.21	0.92	0	0	0.2	65.44*	0.1
Q2 2017	0	0.21	0.92	0	0.47	0.5	28.77*	0

***Major outliers in comparison to other MCOs**

Grievances per 1000 providers remains low for the majority of MCOs. For first and second quarters of 2017, UMHP was a major outlier for this measure in comparison to all other MCOs. For Q1 2017, UMHP had 65.44, and Q2 28.77, grievances per 1000 providers compared to less than 1 grievance per 1000 providers on average for all other MCOs.

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

Table 2. Compliance with Member Grievance Resolution Time Frames

Quarter	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP	UHC
Q4 2016	Met	Met	Partially Met	Partially Met	Partially Met	Met	Met	Partially Met
Q1 2017	Met	Met	Partially Met	Met	Partially Met	Partially Met	Met	Partially Met
Q2 2017	Met	Met	Partially Met	Partially Met	Partially Met	Partially Met	Met	Partially Met

Three MCOs (ACC, JMS, and UMHP) met the resolution time frames for member grievances in all three quarters. KPMAS, MSFC, and UHC received a finding of partially met for all three quarters. MPC and PPMCO met the resolution time frames in one of the three quarters.

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

Table 3. Compliance with Provider Grievance Resolution Time Frames

Quarter	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP	UHC
Q4 2016	N/A	N/A	Met	Partially Met	Met	Met	Met	N/A
Q1 2017	N/A	Met	N/A	Met	N/A	Met	Met	Met
Q2 2017	N/A	Met	Met	Met	Met	Met	Met	N/A

All but one MCO met the resolution time frame for provider grievances. MPC received a finding of partially met for the fourth quarter 2016.

Table 4 presents a comparison of grievance record review results across MCOs. Results are based upon a random selection of grievance records reviewed for CY 2016. Reviews were conducted utilizing the 10/30 rule.

Table 4. CY 2016 MCO Grievance Record Review Results

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

All MCO records reviewed demonstrated full explanation of the grievance issue. Two MCOs (ACC and PPMCO) received a finding of partially met for the component addressing appropriate classification of a grievance. Resolution timeliness was met by all MCOs with the exception of MSFC and UMHP. Three MCOs demonstrated an opportunity for improving the appropriateness of the resolution. Four of the MCOs (ACC, PPMCO, UMHP, and UHC) received a finding of met for the resolution letter component. The remainder of the MCOs received a partially met or unmet score due to inconsistent or missing resolution letters within the records reviewed.

Appeal Findings

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

- Action 1: Denial or limited authorization of a requested service, including the type or level of service
- Action 2: Reduction, suspension, or termination of a previously authorized service
- Action 3: Denial, in whole or part, of payment for a service
- Action 4: Failure to provide services in a timely manner
  (i.e., if the MCO fails to provide services within the timeframes defined by the State in COMAR 10.09.66.07)
- Action 5: Failure of an MCO to act within the required appeal time frames set in COMAR

Providers can file appeals on a participant's behalf. Maryland's 1115 waiver has special terms and conditions that do not require the provider to seek written authorization before filing an appeal on the participant's behalf.

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

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

Table 5 provides a comparison of MCO appeals per 1000 members based on MCO quarterly submissions.

Table 5. MCO Appeals/1000 Members

Quarter	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP	UHC
Q4 2016	0.27	0.32	1.1	0.63	0.67	1.89	14.59*	0.64
Q1 2017	0.04	0.16	0.69	0.51	1.01	0.87	5.44*	0.63
Q2 2017	0.04	0.31	1.02	0.39	0.69	0.06	5.13*	0.56

***Major outlier in comparison to other MCOs**

UMHP has consistently been a major outlier in appeals per 1000 members in comparison to all other MCOs. This measure, however, has been trending downward for the past two quarters for the MCO. Appeals per 1000 members falls within a fairly narrow range for the remaining MCOs.

Comparisons of MCO compliance with resolution time frames for member appeals are displayed in Table 6 based on MCO quarterly submissions.

Table 6. MCO Compliance with Member Appeal Resolution Time Frames

Quarter	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP	UHC
Q4 2016	Met	Met	Met	Met	Met	Partially Met	Met	Partially Met
Q1 2017	Met	Met	Partially Met	Met	Met	Partially Met	Met	Partially Met
Q2 2017	Met	Met	Partially Met	Met	Met	Met	Met	Partially Met

Five MCOs (ACC, JMS, MPC, MSFC, and UMHP) consistently met appeal resolution time frames for the three quarters reviewed. KPMAS and PPMCO demonstrated compliance for one quarter. UHC was scored as a partially met for all three quarters.

Table 7 provides a comparison of appeal record review results across MCOs. Results are based upon a random selection of appeal records reviewed for CY 2016. Reviews were conducted utilizing the 10/30 rule.

Table 7. CY 2016 MCO Appeal Record Review Results

Requirement	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP	UHC
Processed Based Upon Level of Urgency	Met	Met	Met	Met	Met	Partially Met	Met	Met
Compliance with Resolution Time Frame for Expedited Appeal	Met	Met	Met	N/A	Met	Partially Met	Met	Met
Compliance with Notification Time Frame for Non-Emergency Appeal	Met	Met	Met	Met	Met	Partially Met	Met	Met
Appeal Decision Documented	Met	Met	Met	Met	Met	Met	Met	Met
Decision Available to Enrollee in Easy to Understand Language	Met	Met	Met	Met	Met	Met	Met	Met

All but one MCO demonstrated compliance with each review component. PPMCO received a score of partially met for the following components: processed based upon level of urgency, compliance with resolution time frame for expedited appeal, and compliance with notification time frame for non-emergency appeals.

Pre-Service Denial Findings

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

- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested:
  - Shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease; and
  - May not be arbitrarily based solely on diagnosis, type of illness, or condition.
- Notices of a decision to deny an authorization shall be provided to the enrollee and the regulation provider within the following time frames:
  - 24 hours from the date of determination for emergency, medically related requests; and
  - 72 hours from the date of determination for nonemergency, medically related requests.
- An MCO shall give an enrollee written notice of any action, except for denials of payment which do not require notice to the enrollee, within the following time frames:
  - At least 10 days before the action for termination, suspension, or reduction of a previously authorized covered service.
- A notice of adverse action shall be in writing and:
  - Be translated for enrollees who speak prevalent non-English languages;
  - Include language clarifying that oral interpretation is available for all languages and how to access it;
  - Be written in an easily understood language and format that takes into consideration enrollees with special needs;
  - Be available in alternative formats; and
  - Inform enrollees that information is available in alternative formats and how to access those formats.

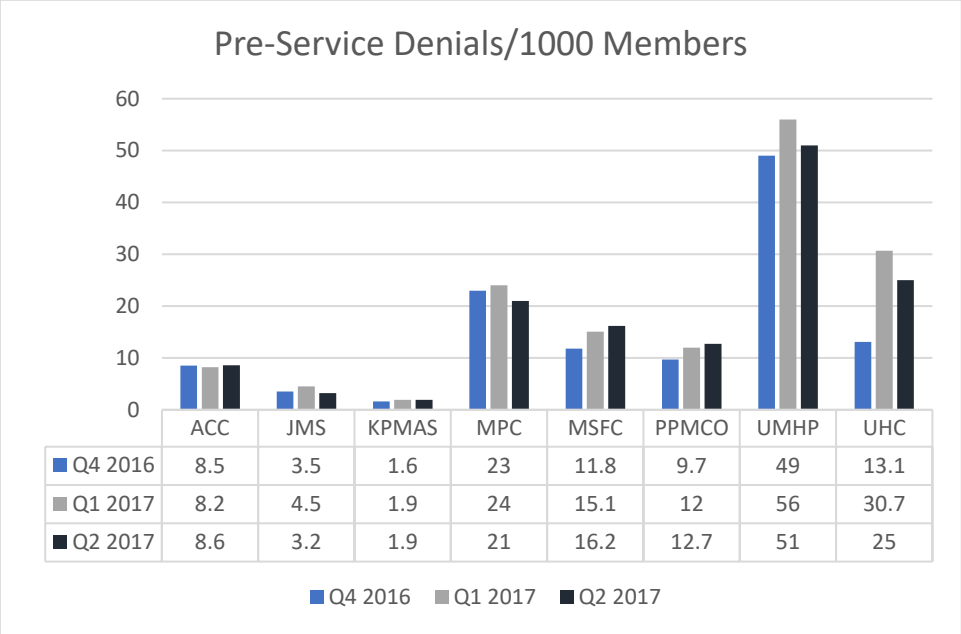
The MCO pre-service denial review encompassed the following comparative statistics and compliance with federal and state laws and regulations:

- Comparative Statistics: Pre-service Denials Rendered Per 1000 Members
- Preauthorization Time Frames: Determinations provided within 2 business days of receipt of necessary clinical information but no later than 7 calendar days from date of initial request based on a compliance threshold of 95%

- Notice of Decision to Deny Time Frames: Initial services provided to enrollee within 24 hours for emergency, medically related requests and not more than 72 hours for non-emergency, medically related requests based upon a compliance threshold of 95%
- Notification Time Frames: For any previously authorized service written notice to enrollee is provided at least 10 days prior to reducing, suspending, or terminating a covered service based upon a compliance threshold of 95%.
- Adverse Determinations
  - Must be based upon medical necessity criteria and clinical policies.
  - Must be rendered by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
- Adverse Determination Letters: Must include all 15 required regulatory components.

Figure 2 provides a comparison of MCO pre-service denials per 1000 members based on MCO quarterly submissions.

Figure 2. MCO Pre-Service Denials/1000 Members



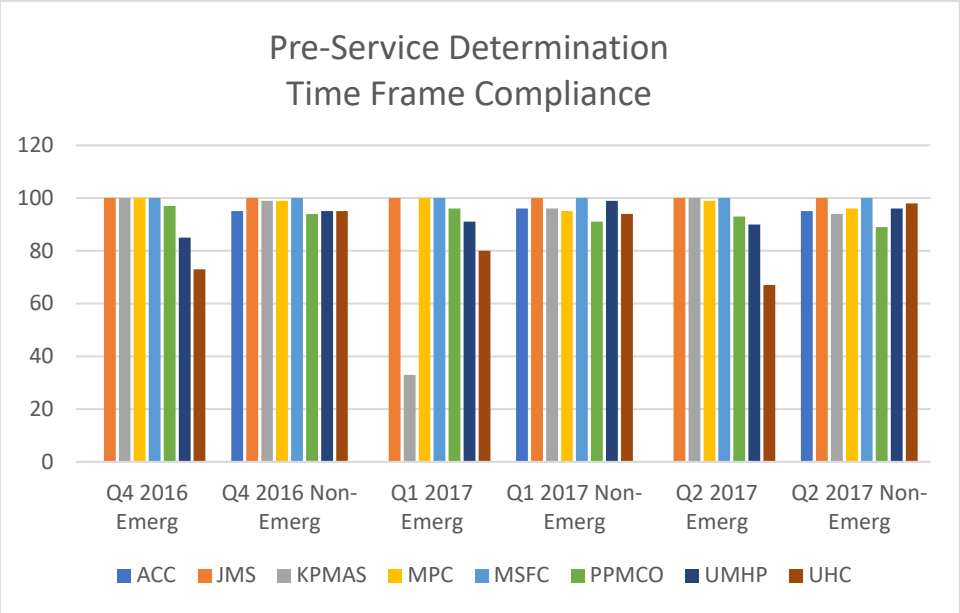
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP	UHC
Q4 2016	8.5	3.5	1.6	23	11.8	9.7	49	13.1
Q1 2017	8.2	4.5	1.9	24	15.1	12	56	30.7
Q2 2017	8.6	3.2	1.9	21	16.2	12.7	51	25

MPC and UMHP were major outliers in comparison to other MCOs' pre-service denials per 1000 members for all three quarters. UHC was an outlier in respect to this measure for the first two quarters of 2017.

Compliance with COMAR requirements for the timeliness of pre-service determinations was assessed based upon MCO submissions of quarterly reports and an annual record review. Quarterly data

represented the entire population or a statistically significant sample. Figure 3 represents results of the MCO's compliance with pre-service determination time frames.

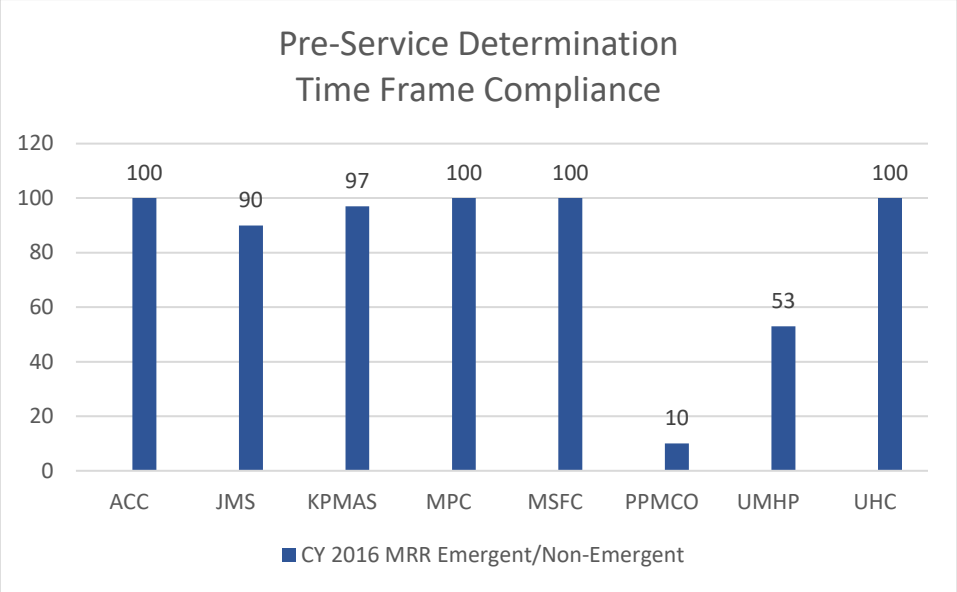
Figure 3. MCO Compliance with Pre-Service Determination Time Frames



Four of the MCOs (ACC, JMS, MPC, and MSFC) met or exceeded the 95% threshold based upon a review of MCO quarterly reports. Overall compliance results for the remaining four MCOs (KPMAS, PPMCO, UMHP, and UHC) ranged from 33% to 94%. ACC did not have any emergent requests for the quarters reviewed.

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

Figure 4. MCO Compliance with Pre-Service Determination Time Frames

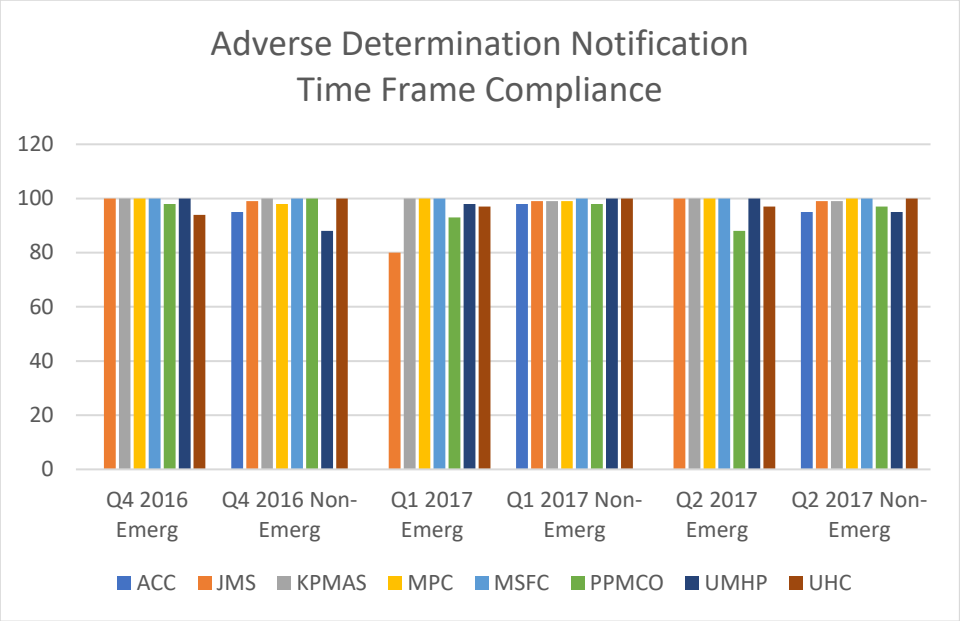


Five of the MCOs (ACC, KPMAS, MPC, MSFC, and UHC) met or exceeded the 95% threshold based upon the annual review of the MCO's records. Overall compliance results for the remaining three MCOs (JMS, PPMCO, and UMHP) ranged from 10% to 90%.

Compliance with COMAR requirements for the timeliness of adverse determination notifications was assessed based upon MCO submissions of quarterly reports and an annual record review. Quarterly data represented the entire population or a statistically significant sample. Record reviews were conducted based upon the 10/30 rule.

Results of compliance with adverse determination notification time frames based on the quarterly reports are highlighted in Figure 5.

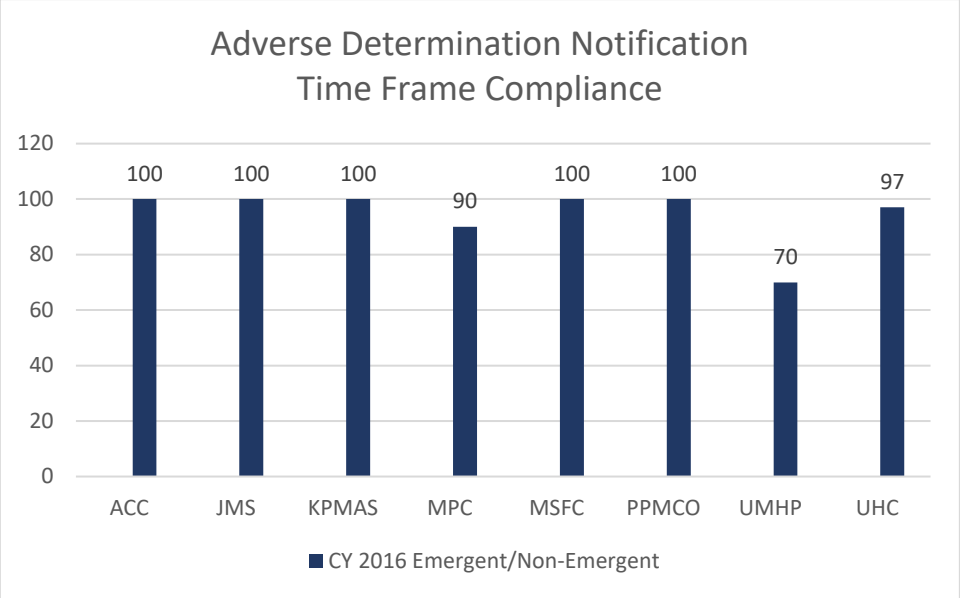
Figure 5. MCO Compliance with Adverse Determination Notification Time Frames



Four of the MCOs (ACC, KPMAS, MPC, and MSFC) met or exceeded the 95% threshold based upon a review of MCO quarterly reports. Overall compliance results for the remaining four MCOs (JMS, PPMCO, UMHP, and UHC) ranged from 80% to 94%. ACC did not have any emergent requests for the quarters reviewed.

Results of compliance with adverse determination notification time frames based on the annual record review of CY 2016 records are highlighted in Figure 6.

Figure 6. MCO Compliance with Adverse Determination Notification Time Frames



Six of the MCOs (ACC, JMS, KPMAS, MSFC, PPMCO, and UHC) met or exceeded the 95% threshold based upon an annual review of the MCO's records. UMHP and MPC results were 70% and 90% respectively.

Table 8 provides a comparison of denial record review results across MCOs for CY 2016. Results are based upon a random selection of denial records. Reviews were conducted utilizing the 10/30 rule.

Table 8. CY 2016 MCO Denial Record Review Results

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

All MCOs demonstrated compliance with the appropriateness of adverse determinations supported by medical necessity criteria and MCO specific clinical policies. Additionally, all MCOs were found to have included all required components in adverse determination letters. Four of the MCOs (ACC, KPMAS, MSFC, and UHC) met or exceeded the 95% threshold for pre-service determinations and adverse determination notifications based on review of a sample of records.

Recommendations

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

Grievance and appeal record reviews surfaced additional opportunities for improvement. As a result, it is recommended that MDH approve new System Performance Review standards relating to the following:

- Written notification of grievance determinations even when a case is closed because of inability to contact the member.
- Documentation of reasonable efforts to provide the member with prompt verbal notice of the denial of an expedited resolution and evidence of a written notice within two calendar days.
- Evidence that appeal decisions are made by health care professionals who have appropriate clinical expertise in treating the member's condition or disease consistent with the MCO's policies and procedures.

CY 2017 Focused Review Report
Grievances, Appeals, and Denials

Introduction

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

The Maryland Department of Health (MDH) is required annually to evaluate the quality of care (QOC) provided to Maryland Medical Assistance enrollees in HealthChoice Managed Care Organizations (MCOs). MDH, pursuant to Title 42, Code of Federal Regulations, 438.204, is responsible for monitoring the QOC provided to MCO enrollees when delivered pursuant to the Code of Maryland Regulations (COMAR) 10.09.65. Under Federal law [Section 1932(c)(2)(A)(i) of the Social Security Act], MDH is required to contract with an External Quality Review Organization (EQRO) to perform an independent annual review of services provided under each MCO contract to ensure that the services provided to the enrollees meet the standards set forth in the regulations governing the HealthChoice Program. MDH contracts with Delmarva Foundation to serve as the EQRO. As a component of this annual review MDH has engaged Delmarva Foundation to perform a focused review of HealthChoice MCO compliance with federal and state laws and regulations pertaining to the handling of grievances and appeals and the appropriateness of denials of service.

Purpose and Objectives

The aim of this review was to twofold: 1) to assess MCO compliance with federal and state regulations pertaining to the handling of member and provider grievances, member appeals, and pre-service authorization requests and adverse determinations and 2) to facilitate increased compliance within these areas. Review objectives addressed the following:

- To ensure the validity of the data provided by MCOs in the quarterly grievance, appeal, and pre-service denial reports.
- To provide an avenue for MCOs to compare their performance on these measures with those of their peers through distribution of quarterly reports.
- To identify MCO opportunities for improvement and provide recommendations to address them.
- To request corrective action when an MCO demonstrates consistent non-compliance with one or more review components.

Methodology

MDH requires all HealthChoice MCOs to submit quarterly Grievance, Appeal, and Pre-Service Denial Reports within 30 days of the close of the quarter on an approved form to Delmarva Foundation. A review tool for each reporting category was developed by Delmarva Foundation and submitted to the MDH for approval. Following validation of the data submitted by the MCOs this template allowed the Delmarva Foundation reviewer to enter data from the MCO reports and to identify areas of non-compliance. Results from other MCOs also were aggregated to allow MCO peer group comparisons. MCO specific trends were identified after three quarters of data was available. Quarterly reports to the MDH included an analysis of MCO data and recommendations, as appropriate. MCOs were provided a separate report of quarterly reviews which included areas for follow up when data issues, ongoing non-compliance, or negative trends were identified.

In addition to quarterly reviews of MCO submitted reports, an annual review was conducted of a sample of case records from CY 2016. Each MCO provided Delmarva Foundation with a listing of grievances, appeals, and pre-service denials for CY 2016. Delmarva Foundation selected 35 cases from each listing using a random sampling approach and requested each MCO upload the selected case records to the Delmarva Foundation portal. The Delmarva Foundation reviewer selected an initial 10 records from each MCO's sample for review. If an area of non-compliance was discovered an additional 20 records were reviewed for the non-compliant component. Results of this record review including strengths, best practices, and opportunities for improvement, as applicable, were provided to the MDH. MCOs also were provided with their results from each of the record reviews. Both reports included peer comparisons for each of the review components.

Limitations

Following the initial assessment of third quarter 2016 reports, Delmarva Foundation identified a number of opportunities for improvement. Upon review, it was discovered that the MCOs were not routinely including required reporting elements from delegated entities in the data they submitted. Additionally, several MCOs included provider administrative (claims) appeals in reporting member appeals. One MCO included other lines of business and excluded requests for a certain category of drugs that required approval from the MDH. Opportunities were also presented to include additional fields in the MCO quarterly reporting templates to facilitate an assessment of compliance with regulatory time frames. As a result, Delmarva Foundation revised all reporting templates and detailed instructions for the MCOs. Upon MDH approval of the recommended revisions, MCOs began using this new format for fourth quarter 2016 reports. While MCO reporting has improved over the last three quarters, approximately half of all submissions still contain calculation and formula errors, incorrect category assignments, and

missing results from delegated entities. Consequently, caution must be exercised in reviewing the results contained in this report.

MCO Specific Findings and Recommendations

MCO specific results from quarterly assessments and CY 2016 record reviews are highlighted in the following grievance, appeal, and pre-service denial sections. Summaries include the following for each MCO, as applicable:

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

Separate report templates listing review components for Grievances, Appeal, and Pre-Service Denials are found in Appendices A, B, and C. Findings are based upon select performance measures trended over time and peer comparisons contained in these reports.

Grievance Summaries

Amerigroup Community Care
OVERVIEW: **Trends:** Results are fairly consistent over three quarters. No negative trends identified. **Comparison with Other MCOs:** Results are generally consistent with all other MCOs. **Compliance:** Resolution time frames were met for all three quarters. **Strengths:** Grievances and their resolution were well documented. Resolutions were appropriate. Compliance with time frames was consistently at 100%. **Best Practices:** Resolution letters are in plain language and describe well the grievance and the resolution. **Opportunities:** Appropriate classification of a grievance.
RECOMMENDATIONS: The MCO may want to consider conducting refresher training for grievance staff to reinforce the difference between a grievance and an inquiry.

Jai Medical Systems
OVERVIEW: **Trends:** Results are fairly consistent over three quarters. No negative trends identified. **Comparison with Other MCOs:** Results are generally consistent with all other MCOs. However, non-emergency medical grievances are at the high end of the range. **Compliance:** Resolution time frames were met for all three quarters. **Strengths:** Grievances and their resolutions are well documented. Compliance with time frames was consistently at 100%. **Opportunities:** There was no evidence that resolution letters were mailed to any member who filed a grievance and others, as appropriate.
RECOMMENDATIONS: The MCO needs to ensure policies and procedures document the COMAR requirement for sending resolution letters to any member who filed a grievance and others, as appropriate. This includes members who the MCO was unable to contact by phone and as a result closed the case.

Kaiser Permanente of the Mid-Atlantic States

OVERVIEW:

Trends: Results are fairly consistent over three quarters. Grievances per 1000 has steadily increased each quarter, however, it appears that the reported number for the second quarter was incorrectly calculated.

Comparison with Other MCOs: Results are generally consistent with all other MCOs.

Compliance: Resolution time frames have not been met for participant grievances for the three quarters reviewed. Compliance with the resolution time frames for provider grievances have been met consistently.

Strengths: Grievances are well documented.

Opportunities: Appropriate classification of a grievance. Full resolution of member grievances including documentation of the response from provider offices reflecting investigation of the grievance and any action to address it. Consistent mailing of resolution letters to any member who filed a grievance and others as appropriate.

RECOMMENDATIONS:

The MCO may want to consider conducting refresher training for grievance staff to reinforce the difference between a grievance and an inquiry. Documentation of follow-up when a member files a grievance against a provider must include results of the investigation and any planned follow-up. Additionally, the MCO needs to ensure its policies and procedures document the COMAR requirement for sending resolution letters to any member who filed a grievance and others as appropriate. This includes members who the MCO was unable to contact by phone and as a result closed the case. It is recommended that the MCO assess the cause(s) of non-compliance with resolution time frames and implement action plans in response to identified opportunities for improvement.

Maryland Physicians Care

OVERVIEW:

Trends: Results are fairly consistent over three quarters. No negative trends identified.

Comparison with Other MCOs: Results are generally consistent with all other MCOs.

Compliance: Resolution time frames have not been met consistently for participant grievances. Time frames for resolution of provider grievances have been met for the last two quarters.

Strengths: Grievances and their resolutions are well documented and resolutions are appropriate.

Opportunities: Consistent mailing of resolution letters to any member who filed a grievance and others, as appropriate. Consistent compliance with resolution time frames for participant grievances.

RECOMMENDATIONS:

The MCO needs to ensure its policies and procedures document the COMAR requirement for sending resolution letters to any member who filed a grievance and others, as appropriate. This includes members who the MCO was unable to contact by phone and as a result closed the case. It is recommended that the MCO assess the cause(s) of non-compliance with resolution time frames and implement action plans in response to identified opportunities for improvement.

MedStar Family Choice

OVERVIEW:

Trends: Results are fairly consistent over three quarters. No negative trends identified.

Comparison with Other MCOs: Results are generally consistent with all other MCOs.

Compliance: Compliance with resolution time frames for participant non-emergency medically related and administrative grievances have not been met for all three quarters. A contributing factor is the low number of grievances. Resolution time frames have been met consistently for provider grievances.

Strengths: Grievances and their resolutions are well documented.

Opportunities: Consistent mailing of resolution letters to any member who filed a grievance and others, as appropriate. Consistent compliance with resolution time frames for participant grievances. Appropriate documentation of receipt date of grievance.

RECOMMENDATIONS:

The MCO needs to ensure its policies and procedures document the COMAR requirement for sending resolution letters to any member who filed a grievance and others, as appropriate. This includes members who the MCO was unable to contact by phone and as a result closed the case. Additionally, the MCO needs to ensure that it consistently meets grievance resolution time frames. Date of grievance receipt needs to reflect date TPA receives grievances, if not sent directly to MCO.

Priority Partners

OVERVIEW:

Trends: Results are fairly consistent over three quarters. No negative trends identified.

Comparison with Other MCOs: Results are generally consistent with all other MCOs.

Compliance: Compliance with resolution time frames for participant grievances has generally been at 100% with exceptions falling slightly short of the threshold at 97% and 98%. All provider grievances met the resolution time frames.

Strengths: Grievances and their resolution are well documented and resolutions are appropriate.

Best Practices: Resolution letters are in plain language and provided in both English and Spanish.

Opportunities: Appropriate classification of a grievance. Consistent compliance with resolution time frames for participant grievances.

RECOMMENDATIONS:

It is recommended that the MCO assess the cause(s) of non-compliance with resolution time frames and implement action plans in response to identified opportunities for improvement. Additionally, the MCO may want to consider conducting refresher training for grievance staff to reinforce the difference between a grievance and an inquiry.

UnitedHealthcare Community Plan

OVERVIEW:

Trends: Results are fairly consistent over three quarters. Billing/financial issues remain the top service category representing over a third to a half of all grievances.

Comparison with Other MCOs: Results are generally consistent with all other MCOs.

Compliance: Compliance with resolution time frames for participant grievances has declined slightly over the past two quarters at 95%. Provider grievances have demonstrated compliance with resolution time frames.

Strengths: Grievances and their resolution are well documented and resolutions are appropriate.

Best practices: Resolution letters are in plain language and are very detailed in describing the grievance and the resolution. UHC also provides a written acknowledgement of each grievance.

Opportunities: Consistent compliance with resolution time frames for participant grievances.

RECOMMENDATIONS:

It is recommended that the MCO assess the cause(s) of non-compliance with resolution time frames and implement action plans in response to identified opportunities for improvement. Additionally, UHC may want to consider analyzing the large percentage of billing/financial grievances to identify any opportunities for improvement.

University of Maryland Health Partners

OVERVIEW:

Trends: Results are fairly consistent over three quarters with two exceptions. Participant grievances per 1000 demonstrates a downward trend and provider grievances decreased approximately 50% from first to second quarter. No negative trends identified.

Comparison with Other MCOs: Results are generally consistent with all other MCOs with two major outliers. Both participant and provider grievances per 1000 exceed the top of the range of all other MCOs.

Compliance: Compliance with resolution time frames was consistently met for all three quarters

Strengths: Grievances and their resolution are well documented and resolutions are appropriate.

Best practices: All members submitting a grievance receive both an acknowledgement letter describing the grievance and the time frame for resolution and a resolution letter.

Opportunities: Appropriate classification of type of grievance (emergency medically related, non-emergency medically related, administrative).

RECOMMENDATIONS:

MCO may want to consider refresher training of grievance staff on appropriate classification of grievances.

Appeal Summaries

Amerigroup Community Care
OVERVIEW: **Trends:** Results are fairly consistent over three quarters. No negative trends identified. **Comparison with Other MCOs:** Results are generally consistent with all other MCOs, however, its appeal rate per 1000 remains slightly below all other MCOs. Second level appeals and partial overturn rates are slightly higher than all other MCOs. **Compliance:** Appeal resolution time frames were consistently met for all three quarters. **Strengths:** 100% compliance with appeal resolution time frames for all three quarters. **Best practices:** Resolution letters are written in plain language and for medical necessity appeals the title and specialization of the Medical Director/designee is included. ACC includes a Maryland Medicaid Appeal Form in all resolution letters when the first level appeal results in an uphold decision. **Opportunities:** Member notification of denial of an expedited appeal request.
RECOMMENDATIONS: ACC must revise its policies/procedures to demonstrate compliance with COMAR which requires the MCO to make reasonable efforts to give the enrollee prompt verbal notice of the denial of an expedited resolution and provide a written notice within 2 calendar days.

Jai Medical Systems
OVERVIEW: **Trends:** Results are fairly consistent over three quarters. No negative trends identified. **Comparison with Other MCOs:** Results are generally consistent with all other MCOs. **Compliance:** Appeal resolution time frames were consistently met for all three quarters. **Strengths:** 100% compliance with appeal resolution time frames for all three quarters. **Best practices:** All resolution letters are in plain language and include the board certification and specialty of the physician who reviewed the appeal. **Opportunities:** None identified.
RECOMMENDATIONS: None at this time. Will continue to monitor performance individually and against MCO ranges to assess potential opportunities for improvement.

Kaiser Permanente of the Mid-Atlantic States

OVERVIEW:

Trends: Results are fairly consistent over three quarters. No negative trends identified.

Comparison with Other MCOs: Results are generally consistent with all other MCOs, however, all appeals are resolved at the first level and the overturn percentage remains at the top of the range.

Compliance: Compliance with resolution time frames for non-emergency appeals was not met in two of the three quarters.

Best practices: Well documented appeal records include detailed appellant's argument for the coverage. All resolution letters are in plain language and include background information detailing appellant's argument and a comprehensive explanation supporting the decision. When a decision results in upholding a denial, the members of the appeal committee involved in making the determination are listed by title and specialty.

Opportunities: None identified.

RECOMMENDATIONS:

KPMAS may want to consider also including the titles and qualifications of the appeal reviewers in resolution letters for overturn decisions.

Maryland Physicians Care

OVERVIEW:

Trends: Results are fairly consistent over three quarters. A downward trend in appeals per 1000 was observed for the three quarters. No negative trends identified.

Comparison with Other MCOs: Results are generally consistent with all other MCOs.

Compliance: Appeal resolution time frames were consistently met for all three quarters.

Strengths: 100% compliance with appeal resolution time frames for all three quarters.

Best practices: Resolution letters are in plain language and include the name and qualifications of the physician who conducted the appeal review.

Opportunities: Appropriate clinical expertise of physicians conducting the appeal review.

RECOMMENDATIONS:

It is recommended that MPC review its Member Appeal Policy and make the necessary operational adjustments to demonstrate appropriate clinical expertise of physicians conducting appeal reviews consistent with the policy language.

MedStar Family Choice

OVERVIEW:

Trends: Results are fairly consistent over three quarters. No other negative trends were identified.

Comparison with Other MCOs: Results are generally consistent with all other MCOs.

Compliance: Appeal resolution time frames were consistently met for all three quarters.

Strengths: 100% compliance with appeal resolution time frames for all three quarters.

Best practices: All resolution letters are in plain language and include the board certification and specialty of the physician who reviewed the appeal.

Opportunities: None identified.

RECOMMENDATIONS:

None at this time. Will continue to monitor performance individually and against MCO ranges to assess potential opportunities for improvement.

Priority Partners

OVERVIEW:

Trends: Results are fairly consistent over three quarters with a notable exception. Appeals per 1000 has declined sharply over the three quarter. No negative trends were identified.

Comparison with Other MCOs: Results are generally consistent with all other MCOs.

Compliance: Full compliance with resolution time frames has been demonstrated only in the second quarter, however, results have generally improved from quarter to quarter.

Best practices: Resolution letters are in plain language and include the qualifications of the physician who made the determination and documentation considered in reviewing the case.

Opportunities: Consistent compliance with determination and notification time frames. Resolution time frame in appeal acknowledgment letters. Consistent field for documenting an appeal as expedited. Documentation supporting denial of an expedited request and notification of the member of the denial. Appropriate clinical expertise of physician conducting the appeal review.

RECOMMENDATIONS:

A CAP is currently in place to address non-compliance with appeal resolution time frames. It is recommended that PPMCO revise appeal acknowledgment letters to identify resolution time frames applicable to the specific appeal. Additionally, it is recommended that PPMCO develop a field within its appeal management system to identify an expedited appeal and include documentation supporting the denial of an expedited request. PPMCO must revise its policies/procedures to demonstrate compliance with COMAR which requires the MCO to make reasonable efforts to give the enrollee prompt verbal notice of the denial of an expedited resolution and provide a written notice within two calendar days. Lastly, PPMCO needs to make the necessary operational adjustments to demonstrate appropriate clinical expertise of physicians conducting appeal reviews.

UnitedHealthcare Community Plan

OVERVIEW:

Trends: Results are fairly consistent over three quarters. There has been a slight downward trend in appeals per 1000. A positive trend was also demonstrated in compliance with resolution time frames. No negative trends were identified.

Comparison with Other MCOs: Results are generally consistent with all other MCOs, however, expedited requests are above the high end of the MCO range.

Compliance: Appeal resolution time frames were not met consistently for the three quarters reviewed.

Best practices: All resolution letters are in plain language and include the board certification and specialty of the reviewer.

Opportunities: Consistent compliance with appeal resolution time frames.

RECOMMENDATIONS:

None at this time. Will continue to monitor performance individually and against MCO ranges to assess potential opportunities for improvement.

University of Maryland Health Partners

OVERVIEW:

Trends: Results are fairly consistent over three quarters. No negative trends identified.

Comparison with Other MCOs: Results are generally consistent with all other MCOs with one major outlier. Appeals per 1000, while declining, is still above the top of the MCO range.

Compliance: Appeal resolution time frames were consistently met for all three quarters.

Strengths: 100% compliance with appeal resolution time frames for all three quarters.

Best practices: All denials upheld on appeal include a comprehensive three-page document, Appeal Rights Description, with the appeal resolution letter. All letters are in plain language.

Opportunities: Specialty of appeal reviewer in all resolution letters.

RECOMMENDATIONS:

UMHP may want to consider including the specialty of the physician reviewer in all clinical appeal resolution letters.

Pre-Service Denial Summaries

Amerigroup Community Care
OVERVIEW: **Trends:** Results are fairly consistent over three quarters. No negative trends identified. **Comparison with Other MCOs:** Results are generally consistent with all other MCOs. **Compliance:** Determination and notification time frames met or exceeded the 95% threshold for all three quarters. **Opportunities:** None identified.
RECOMMENDATIONS: None at this time. Will continue to monitor performance individually and against MCO ranges to assess potential opportunities for improvement.

Jai Medical Systems
OVERVIEW: **Trends:** Results are fairly consistent over three quarters. No negative trends identified. **Comparison with Other MCOs:** Results are generally consistent with all other MCOs. **Compliance:** Determination and notification time frames met or exceeded the 95% threshold for all three quarters with one exception. First quarter non-compliance with the emergent time frame for notification was determined not met due to one outlier case. **Opportunities:** None identified.
RECOMMENDATIONS: None at this time. Will continue to monitor performance individually and against MCO ranges to assess potential opportunities for improvement.

Kaiser Permanente of the Mid-Atlantic States
OVERVIEW: **Trends:** Results are fairly consistent over three quarters. No negative trends identified. **Comparison with Other MCOs:** Results are generally consistent with all other MCOs. Pre-service denials per 1000 are below the range of the other MCOs, possibly due to the MCO's model. **Compliance:** Notification time frames exceeded the compliance threshold for all three quarters. Compliance with determination time frames was not met for emergent requests in the first quarter and non-emergent requests in the second quarter. **Opportunities:** None identified.
RECOMMENDATIONS: None at this time. Will continue to monitor performance individually and against MCO ranges to assess potential opportunities for improvement.

Maryland Physicians Care
OVERVIEW: **Trends:** Results are fairly consistent over three quarters. No negative trends identified. **Comparison with Other MCOs:** Results are generally consistent with all other MCOs. **Compliance:** Determination and notification time frames exceeded the 95% threshold for all three quarters. **Strengths:** 100% compliance with determination and notification time frames for all three quarters. **Opportunities:** None identified.
RECOMMENDATIONS: None at this time. Will continue to monitor performance individually and against MCO ranges to assess potential opportunities for improvement.

MedStar Family Choice
OVERVIEW: **Trends:** Results are fairly consistent over three quarters, however pre-service denials per 1000 are trending up. **Comparison with Other MCOs:** Results are generally consistent with all other MCOs. **Compliance:** Determination and notification time frames were reported at 100% compliance for all three quarters. **Strengths:** 100% compliance with determination and notification time frames for all three quarters. **Opportunities:** None identified.
RECOMMENDATIONS: None at this time. Will continue to monitor performance individually and against MCO ranges to assess potential opportunities for improvement.

Priority Partners
OVERVIEW: **Trends:** Results are fairly consistent over three quarters with some notable exceptions. Pre-service denials per 1000 are trending up although still within the range of the other MCOs. Additionally, compliance with determination and notification time frames has demonstrated a steady decline over the past three quarters. **Comparison with Other MCOs:** Results are generally consistent with all other MCOs. **Compliance:** Consistent compliance with the 95% threshold has only been demonstrated for non-emergent notifications. **Opportunities:** Consistent compliance with determination and notification time frames.
RECOMMENDATIONS: A CAP is currently in place to address non-compliance with determination and notification time frames. Will continue to monitor progress of corrective action and other MCO performance individually and against MCO ranges to assess potential opportunities for improvement.

UnitedHealthcare Community Plan
OVERVIEW: **Trends:** Results are fairly consistent over three quarters. No negative trends identified. **Comparison with Other MCOs:** Results are generally consistent with all other MCOs, however, emergent requests have been at the top of the range of other MCOs for all three quarters reviewed. Pre-service denials per 1000 have been at the mid to top of the range. **Compliance:** Consistent compliance with determination and notification time frames has only been demonstrated for non-emergent notifications. **Opportunities:** Consistent compliance with determination and notification time frames.
RECOMMENDATIONS: A CAP is currently in place to address non-compliance with determination and notification time frames. Will continue to monitor progress of corrective action and other MCO performance individually and against MCO ranges to assess potential opportunities for improvement.

University of Maryland Health Partners
OVERVIEW: **Trends:** Results are fairly consistent over three quarters. No negative trends identified. **Comparison with Other MCOs:** Results are generally consistent with all other MCOs with one exception. Pre-service denials per 1000 are a major outlier exceeding the top of the range of all other MCOs. **Compliance:** Compliance with determination and notification time frames has been met consistently for non-emergent determinations and emergent notifications. Improvement has been demonstrated in the remaining two categories. **Opportunities:** Consistent compliance with determination and notification time frames.
RECOMMENDATIONS: A CAP is currently in place to address non-compliance with determination and notification time frames. Will continue to monitor progress of corrective action and other MCO performance individually and against MCO ranges to assess potential opportunities for improvement.

Conclusions

MCO compliance with federal and state laws and regulations addressing the handling of grievances and appeals and the appropriateness of denials of service was assessed through quarterly quality studies and annual record reviews. Studies commenced with the submission of third quarter 2016 reports. Additionally, a sample of grievance, appeal, and denial records were reviewed for CY 2016. Based upon the outcomes of these studies, supplemented by the annual record reviews, most MCOs demonstrated strong and consistent results in meeting the majority of grievance, appeal, and denial requirements. This level of compliance helps to ensure the delivery of quality care and services to HealthChoice members that also are timely and accessible. In the event opportunities for improvement were identified some positive trends have been observed in the most recent quarter reviewed. Below are strengths identified in specific review components where all, or a majority, of the MCOs were in compliance:

- Appropriateness of adverse determinations
- Required components in adverse determination letters
- Appeals processed based upon level of urgency
- Appeal decisions well documented
- Appeal resolution timeliness
- Appeal decisions available to the enrollee in easy to understand language
- Appropriate classification of grievances
- Grievance issues fully documented
- Grievance resolution appropriate
- Provider grievance resolution timeliness

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

- Member grievance resolution time frames
- Grievance resolution letters
- Pre-service determination and adverse determination notification time frames (CAPs are in place for three MCOs)

As noted in the Limitations section the validity of the data submitted by the MCOs continues to be a challenge after 12 months despite detailed instructions and ongoing technical assistance. Consequently, assessment results documented in this report need to be considered with some caution. Subsequent reporting will yeild a greater level of confidence in the review outcomes for annual reporting.

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

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

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

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

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

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

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

Analysis
Recommendations

Legend

○ Neutral

○ Met, if applicable

○ Negative trend. (Requires explanation from MCO)

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

N/A - Not Applicable

N/R- Not Reported

<MCO> Appeals Record Review for CY 20xx Results & Analysis			
	CY 20xx	Status	Other MCO Results
Processed Based Upon Level of Urgency		O	
Type of Appeal			
Expedited		O	
Non-Emergency		O	
Extended		O	
Compliance with Appeal Time Frames			
Expedited (within 72 hours of request)		O	
Non-Emergency (within 30 calendar days of receipt)		O	
Decision Documented		O	
Decision			
Uphold		O	
Overturn		O	
Decision Available to Enrollee in Easy to Understand Language		O	
Analysis			
Recommendations			
Legend O Neutral O Met, if applicable O Partially met O Not met, if applicable. (May require a CAP) N/A - Not Applicable N/R - Not Reported			

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

Legend

o Neutral

o Met, if applicable

o Negative trend. (Requires explanation from MCO)

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

N/A - Not Applicable

N/R - Not Reported

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