



Maryland HealthChoice Program

Interim Systems Performance Review

Statewide Executive Summary Report

Measurement Year 2025

Submitted August 2026

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Acronym List

Abbreviation	Definition	Specific to MCO?
ABH	Aetna Better Health of Maryland	MCO name
B	Baseline	No
CAHPS	Consumer Assessment of Healthcare Providers and Systems®	No
CAPs	Corrective action plan	No
CFCHP	CareFirst Community Health Plan	MCO name
CFR	Code of Federal Regulations	No
CMS	Centers for Medicare & Medicaid Services	No
COMAR	Code of Maryland Regulations	COMAR
D	Deemed	No
EQR	External quality review	No
GAD	Grievances, appeals, and denials or adverse determinations	No
HealthChoice	Maryland's Medicaid Managed Care Program	No
HEDIS	Healthcare Effectiveness Data and Information Set®	No
JMS	Jai Medical Systems, Inc.	MCO name
KPMAS	Kaiser Permanente of the Mid-Atlantic States, Inc.	MCO name
M	Met	No
MCO	Managed care organization	No
MDH	Maryland Department of Health	No
MPC	Maryland Physicians Care	MCO name
MSFC	MedStar Family Choice, Inc.	MCO name
MwO	Met with Opportunity	No
MY	Measurement year	No
NA	Not applicable	No
NCQA	National Committee for Quality Assurance	No
PM	Partially met	No
PPMCO	Priority Partners	MCO name
SPR	Systems performance review	No
UHC	UnitedHealthcare Community Plan	MCO name
UM	Unmet	No
WPM	Wellpoint Maryland	MCO name

Maryland HealthChoice Program Measurement Year 2025

Statewide Executive Summary Report

Executive Summary

HealthChoice Program Overview

Maryland's Medicaid Managed Care Program, known as HealthChoice, has a comprehensive system of continuous quality improvement, which includes problem identification, analysis, corrective action, and re-evaluation, to identify and address areas for improvement. HealthChoice serves Marylanders on Medicaid by developing processes and systems capable of profiling and tracking information regarding the care received by HealthChoice enrollees. Guiding principles for HealthChoice's operations are to provide quality healthcare that is equitable, patient-focused, prevention-oriented, coordinated, accessible, and cost-effective. HealthChoice emphasizes health promotion and disease prevention and requires managed care organizations (MCOs) to provide health education and outreach services. Utilization of a "medical home" connects each enrollee with a primary care provider of their choice and identifies a PCP responsible for overseeing their medical care by providing preventive and primary care services, managing referrals, and coordinating all necessary care.

External Quality Review

The Maryland Department of Health (MDH) is responsible for evaluating the quality of care provided to eligible HealthChoice enrollees by contracted MCOs. MDH contracts with Qlarant to conduct external quality reviews (EQRs) and to assess compliance with standards governing the HealthChoice program in the Code of Federal Regulations (CFR) Title 42, §438.204 and Code of Maryland Regulations (COMAR) 10.67.04 through the Centers for Medicare & Medicaid Services (CMS) protocols. Qlarant's annual, independent reviews evaluate quality, access, and timeliness of care; assess the structures, processes, and outcomes of each MCO's internal quality program and activities; identify, validate, quantify, and monitor problem areas; and distinguish and promote best practices.

This executive summary report includes performance per assessed standard, observations from review (strengths, improvements, opportunities for improvement, and recommendations), and required corrective action plans (CAPs). No MCOs were exempt from the systems performance review (SPR). The nine HealthChoice MCOs evaluated for measurement year (MY) 2025 were:

- Aetna Better Health of Maryland (ABH)
- CareFirst Community Health Plan (CFCHP)
- Jai Medical Systems, Inc. (JMS)

- Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare Community Plan (UHC)
- Wellpoint Maryland (WPM)

Objectives

Conducting the systems performance review (SPR) provides an annual assessment of the structures, processes, and outcomes of each MCO's internal quality assurance program. Qlarant's review team identifies, validates, quantifies, and monitors problem areas. Then the review team distinguishes and promotes best practices through compliance, or systems, review. Healthcare professionals with experience in managed care and quality improvement systems performed the annual SPR. Team members utilized a combined experience of more than 50 years in managed care and quality improvement systems, 40 years of which are specific to HealthChoice.

COMAR 10.67.04 requires all HealthChoice MCOs to comply with SPR standards and all applicable federal and state laws and regulations. MY 2025's interim desktop review assessed standards scored as baseline in MY 2024's comprehensive review and effectiveness of any CAPs initiated or continued during MY 2025's SPR. Performance standards used to address the MCOs' operational systems were developed through a review of COMAR 10.67.04.03B(1), federal regulations, and guidelines from other quality assurance accrediting bodies, such as the National Committee for Quality Assurance (NCQA). MDH receives an independent assessment of MCO capabilities through the SPR, which can be used to promote accountability and improve quality-related processes and monitoring.

Key Findings

MDH has established the minimum compliance score for all standards at 100%, while the specific components associated with grievances, appeals, and denials (GAD) carry a minimum compliance threshold of 95%. Qlarant assesses CAPs for MCOs not meeting minimum compliance by standard, instead of by individual components or elements.

JMS continues to maintain full compliance at 100%, without required CAPs, for multiple years. CAPs were required to address areas of noncompliance for the remaining eight MCOs, which should improve compliance rates if successfully implemented. The following table identifies the standard associated with CAPs requiring continued monitoring by each MCO on a quarterly basis.

Table 1. MY 2025 Quarterly CAP Monitoring

MCO	Standards	SPR Requirement
CFCHP	7	7: Utilization Review
KPMAS	7, 9	7: Utilization Review, 9: Health Education Plan
MSFC	5, 7, 9	5: Enrollee Rights, 7: Utilization Review, 9: Health Education Plan
PPMCO	5, 7	5: Enrollee Rights, 7: Utilization Review
UHC	5, 7, 9	5: Enrollee Rights, 7: Utilization Review, 9: Health Education Plan
WPM	5, 7	5: Enrollee Rights, 7: Utilization Review

HealthChoice Quality, Access, and Timeliness

MY 2025 SPR provided evidence of each MCO's continuous commitment to ensuring quality healthcare delivery for HealthChoice enrollees. Qlarant identified strengths, improvements, opportunities for improvement, and recommendations summarizing aggregate performance across MCOs. These strengths, improvements, opportunities for improvement, and recommendations correspond to the quality, access, and timeliness of services provided to enrollees. Qlarant adopted the following definitions for MY 2025's interim desktop review:

- MCOs demonstrate **quality** by their ability to demonstrate accountability, assess, and improve performance for systems review standards, and ensure enrollee needs and rights are being met in accordance with systems review standards and MCO-specific policies, procedures, and processes.
- MCOs demonstrate **timeliness** by providing evidence of consistent assessment and performance improvement efforts related to systems review standards.
- MCOs demonstrate **access (or accessibility)** by providing evidence of compliance for Standard 6: Availability and Accessibility.

Applicable domains in quality, access, or timeliness correspond to areas of impact during MY 2025's SPR and identify positive (↑), negative (↓), or NA assessments of aggregate MCO performance. [Appendix C](#) identifies areas of impact for quality, access, or timeliness by MCO and assesses whether MCOs addressed previous annual recommendations. Appendices [A \(Compliance Score Requirements and Standard Descriptions\)](#) and [B \(MCO-Detailed Findings\)](#) define SPR requirements and identify individual MCO results by standards, respectively.

Table 2. HealthChoice Strengths, Improvements, Opportunities for Improvement, and Recommendations

Domain	Strengths, Improvements, Opportunities for Improvement, and Recommendations	Assessment
Quality	Strengths: All MCOs demonstrated the ability to design and implement effective quality assurance systems.	↑
Quality, Access, Timeliness	Improvements: All MCOs continue to make improvements in quality assurance monitoring policies, procedures, and processes while working to provide appropriate levels and types of healthcare services to managed care enrollees.	↑
Quality, Access, Timeliness	Opportunities for Improvement: Qlarant provided MCOs with recommendations for any required CAPs and any applicable opportunities to improve as <i>MwO</i> recommendations. Both <i>MwO</i> and <i>CAP</i> findings will be assessed to achieve <i>Met</i> compliance in the next SPR.	↓
Quality, Access, Timeliness	Recommendations: Qlarant provided informal recommendations in which applicable MCOs should consider addressing to strengthen the quality, access, and timeliness of their managed care programs.	↓

Green and ↑ = positive impact; Pink and ↓ = negative impact with required corrective action; Blue and ↓ = negative impact with informal recommendation.

Interim Systems Performance Review

Measurement Year 2025

Methodology

HealthChoice MCOs received the MY 2025 SPR orientation manual, “Medicaid Managed Care Organization Systems Performance Review Orientation Manual,” prior to the interim review. Contents included:

- Overview of HealthChoice program and SPR
- SPR standards and guidelines, including MY 2025 revisions
- Maryland standards eligible for deeming utilizing National Committee for Quality Assurance’s (NCQA) crosswalk
- MY 2025 Review Timeline
- EQR contacts
- Pre-audit overview and survey
- Pre-audit SPR document list

Review Activities

MY 2025’s interim system’s performance review activities included a pre-audit overview and survey, individual desktop reviews, exit letters, final reports, and CAPs.

Pre-audit Overview and Survey. COMAR 10.67.04 requires all HealthChoice MCOs to comply with SPR standards and all applicable federal and state laws and regulations. Performance standards used to assess the MCOs’ operational systems were developed through a review of COMAR 10.67.04.03B(1), federal regulations, and guidelines from other quality assurance accrediting bodies, such as the NCQA. Qlarant finalized the SPR standards for the orientation manual after considering all comments from each MCO’s review of the draft standards and MDH’s review and approval. MCOs submitted a completed pre-audit survey form and demonstrated efficiency of their healthcare systems by providing documentation identifying continuous quality improvement efforts undertaken by each MCO for these processes.

Individual Desktop Reviews. All documentation previously submitted by the MCOs was reviewed during individual desktop reviews. Effectiveness of any CAPs initiated or continued from the MY 2024’s comprehensive review was additionally evaluated.

Exit Letters. Each MCO received finalized exit letter sharing areas of noncompliance based on initial conclusions of Qlarant’s SPR review team, and indicates, as necessary, a request for additional information not provided during the interim review.

Reports. Additional documents received from the MCOs in response to the exit letters were reviewed against the standard(s) to which they related. Qlarant made appropriate revisions to each MCO’s draft report, documented findings, and levels of compliance for each standard by element and component and submitted draft results of the SPR to MDH for review. Upon MDH’s approval, the MCOs received a final report containing individual review findings and any required CAPs. Feedback provided to MDH and the MCOs sought to improve the care provided to HealthChoice enrollees.

CAPs. After receiving the final report, each MCO responded to Qlarant with the required CAP(s). Each MCO had the opportunity to respond to any other issues contained in the report and request technical assistance with MDH and Qlarant to clarify issues or ask for assistance in preparing a CAP. Qlarant evaluates the content of all CAPs and determines a CAP adequate only if it addresses all required elements and components (timelines, action steps, or documented evidence).

Data Collection and Review

Documentation provided by the MCOs included policies and procedures; committee minutes; program descriptions; annual evaluations; work plans; tracking and monitoring reports; focused studies; delegate reports; population assessments; Healthcare Effectiveness Data and Information Set (HEDIS)[®] and Consumer Assessment of Healthcare Providers and Systems (CAHPS)[®] results; operational performance reports; enrollee handbook and materials; provider manuals, directories, and newsletters; and GAD records.

Each element and component received a determination for meeting compliance with SPR standards and GAD requirements (*Met* or *Met with Opportunity*) or for required CAPs because of not meeting compliance with SPR standards and GAD requirements (*Partially Met* or *Unmet*). Qlarant scores each element or component with equal weight. MCOs were held accountable for standards in their policies and procedures that were more restrictive than what was required by MDH. MDH had the discretion to change a determination to *Unmet* if the element or component received a *Partially Met* determination for more than one consecutive year. Elements or components receiving a *Met with Opportunities* determination should be remedied by the MCO and will be reviewed during the MY 2026 SPR. The table below describes the status for performance evaluations and review inclusions.

Table 3. MY 2025 Validation Review Determinations

Determination	Explanation
<i>Met (M)</i>	MCO achieves compliance with requirements and does not require a CAP. Minimum compliance is scored depending on the type of performance standard, either grievances, appeals, and denials (95%) or all other standards (100%).
<i>Met with Opportunity (MwO)</i>	MCO achieves compliance with requirements and does not require a CAP. Elements and standards scoring a <i>Met with Opportunity</i> demonstrate an opportunity to improve.
<i>Partially Met (PM)</i>	MCO achieves partial compliance and requires a CAP.
<i>Unmet (UM)</i>	MCO does not achieve compliance and requires a CAP.
<i>Baseline (B)</i>	Qlarant reviews and does not score components, elements, or standards with changes during MY 2025.
<i>Deemed (D)</i>	Qlarant does not review components, elements, or standards as the MCO scores minimum compliance (100%) on the applicable National Committee for Quality Assurance (NCQA) standard(s).
<i>Not Applicable (NA)</i>	Qlarant does not review since the component is not applicable.

Non-Duplication Deeming

CMS permits states the opportunity to use information from a private accreditation review, such as an NCQA audit, to meet comparable federal regulations. Using results from a comparable audit allows an opportunity for non-duplication deeming. Non-duplication, as described in EQR protocols and 42 CFR §438.360, is intended to reduce administrative burden on the MCOs. This process eliminates the need to review the deemed regulation as part of the SPR, thus reducing the administrative burden on the MCO. To qualify for deeming, MDH established the following criteria:

- The MCO must be NCQA accredited with Health Plan Accreditation.
- The NCQA accreditation review standards were comparable to applicable standards established through EQR protocols.
- The MCO must provide evidence of the most recent NCQA audit, which includes a 100% assessment of the applicable standards.

Qlarant used the following resource to determine qualifications for deeming during the comprehensive review: NCQA *Medicaid Managed Care Toolkit: Standards Crosswalk, 2023 Health Plan Standards* (Effective July 1, 2023, through June 30, 2024). The following table identifies the elements and components in which MDH permitted deeming for MY 2025's interim review.

Table 4. MY 2025 Non-duplication Deeming Eligibility

System Performance Review Standards	Elements and Components Eligible for Deeming
Standard 1: Systematic Process of Quality Assessment and Improvement	1.3b, 1.3c, 1.3d, 1.3e, 1.3g, 1.3h, and 1.8
Standard 2: Accountability to the Governing Body	No elements/components are eligible for deeming.
Standard 3: Oversight of Delegated Entities and Subcontractors	No elements/components are eligible for deeming.
Standard 4: Credentialing and Recredentialing	4.1 and 4.7
Standard 5: Enrollee Rights	5.3a, 5.6a, and 5.8a
Standard 6: Availability and Accessibility	6.1b, 6.2a, 6.2b, 6.2c, and 6.2d
Standard 7: Utilization Review	7.1a, 7.1b, 7.1c, 7.2a, 7.2b, 7.2c, 7.2d, 7.2f, 7.4a, 7.7b, 7.7c, 7.7d, 7.7f, and 7.7g
Standard 8: Continuity of Care	8.4
Standard 9: Health Education Plan	No elements/components are eligible for deeming.
Standard 10: Outreach Plan	No elements/components are eligible for deeming.
Standard 11: Fraud and Abuse	No elements/components are eligible for deeming.
Standard 12: Disenrollment	No elements/components are eligible for deeming.

Timeline

MY 2025's SPR timeline started in July 2025 by providing MCOs with an opportunity to review and comment on standards, laws, and regulations applying to the upcoming review. Any comments forwarded from MCOs during the 45-day comment period were considered before submission of the orientation manual in September 2025. Desktop reviews were conducted between January and February 2026. After receiving exit letters, MCOs had ten business days to submit any additional information. MCOs received final reports after MDH approved Qlarant's draft reports. Any required CAPs were due within 45 days of receiving final reports. Continued technical assistance occurred until applicable MCOs submitted an acceptable CAP.

Results

MY 2025's interim SPR observed the following about the HealthChoice MCOs' compliance across standards:

- **Standards without Required Corrective Action or Recommended Improvements.** Seven MCOs, except WPM and ABH, met the compliance score of 100% for Standard 12: Disenrollment Requirements and Limitations.
 - ABH met compliance score of 100% for Standard 4: Credentialing and Recredentialing and Standard 5: Enrollee Rights.
 - CFCHP met the compliance score of 100% for Standard 11: Fraud and Abuse and Standard 12: Disenrollment Requirements and Limitations.
 - JMS met the compliance score of 100% for all standards reviewed: Standard 5: Enrollee Rights and Standard 12: Disenrollment Requirements and Limitations.
 - KPMAS met the compliance score of 100% for Standard 5: Enrollee Rights and Standard 12: Disenrollment Requirements and Limitations.
 - MPC met the compliance score of 100% for Standard 5: Enrollee Rights, Standard 8: Continuity of Care and Standard 12: Disenrollment Requirements and Limitations.
 - MSFC met the compliance score of 100% for Standard 12: Disenrollment Requirements and Limitations.
 - PPMCO met the compliance score of 100% for the following standards reviewed: Standard 1: Systematic Process of Quality Assessment and Improvement, Standard 3: Oversight of Delegated Entities and Subcontractors, Standard 8: Continuity of Care, Standard 9: Health Education Plan, and Standard 12: Disenrollment Requirements and Limitations.
 - UHC met the compliance score of 100% for Standard 11: Fraud and Abuse.
 - WPM met the compliance score of 100% for Standard 9: Health Education Plan.
- **Standards with Required Corrective Action and Recommended Improvements.** Qlarant categorized observations about HealthChoice MCOs' compliance across standards by required actions: required follow-up for MY 2026's interim SPR, standards with required improvements only, standards with required corrective action only, and standards with a comprehensive mixed result of *PM*, *UM*, and *MwO* determinations.

Follow Up for MY 2026's SPR: Standards with required CAPs and *MwO* determinations will be reviewed during the MY 2026 interim review. Improvements identified for elements or components receiving *MwO* determinations should be remedied by the applicable MCOs to receive a *Met* determination in the MY 2026 interim review. MCOs identified as requiring corrective action submitted a CAP with proposed detailed actions to correct any identified deficiencies from the review process.

Standards with Required Opportunities Only.

- MSFC was the only MCO with a *MwO* determination, which was for Standard 7.4 (component 7.4c).

Standards with Required Corrective Action Only. Standards 5: Enrollee Rights, 7: Utilization Review, 9: Health Education Plan, 12: Disenrollment Requirements and Limitations required corrective action based on *PM* or *UM* determinations.

- Four MCOs (CFCHP, MSFC, PPMCO, & WPM) are required to submit an annual CAP and four MCOs (MSFC, PPMCO, UHC, and WPM) are required to submit quarterly CAPs for Standard 5: Enrollee Rights.
- Four MCOs (ABH, MPC, PPMCO, & WPM) are required to submit annual CAPs and six MCOs (CFCHP, KPMAS, MSFC, PPMCO, UHC, and WPM) are required to submit quarterly CAPs for Standard 7: Utilization Review.
- Three MCOs (KPMAS, MSFC, and UHC) are required to submit quarterly CAPs for Standard 9: Health Education Plan.
- Two MCOs (ABH and WPM) are required to submit annual CAPs for Standard 12: Disenrollment Requirements and Limitations.

Standards with Mixed Results. Standards with a comprehensive mixed result received a mix of *PM*, *UM*, and *MwO* determinations.

- MSFC will be required to submit an annual CAP for Standard 5: Enrollee Rights as the required improvement for Component 5.7d was not fully implemented during MY 2025 and a quarterly CAP for Component 5.1g as the annual CAP was not implemented in MY 2025. MSFC will be required to submit a quarterly CAP for Standard 7: Utilization Review as the annual CAP was not implemented in MY 2025 for Component 7.8c. Additionally, for Standard 7: Utilization Review, MSFC will be required to demonstrate that it successfully addressed the required improvement for Component 7.4c, which had a *MwO determination*.

Table 5. MY 2025 MCO Opportunity Findings

MCO	MwO and Recommendations	Annual CAPs	Quarterly CAPs
ABH	<i>Recommendation: 9.5c, 12.1a</i>	<i>PM: 7.9c, 12.3</i>	<i>Not Applicable</i>
CFCHP	<i>Not Applicable</i>	<i>PM: 5.7d</i>	<i>UM: 7.7c, 7.7e</i>
KPMAS	<i>Recommendation: 11.4c</i>	<i>Not Applicable</i>	<i>UM: 7.10, 9.3a</i>
MPC	<i>Recommendation: 9.3a</i>	<i>PM: 7.6a</i>	<i>Not Applicable</i>
MSFC	<i>MwO: 7.4c Recommendation: 2.5</i>	<i>PM: 5.7d</i>	<i>UM: 5.1g, 7.8c, 9.3a</i>
PPMCO	<i>Not Applicable</i>	<i>PM: 5.7d UM: 7.8c, 7.9a</i>	<i>PM: 5.1d UM: 5.1g, 5.1h, 7.4c</i>
UHC	<i>Recommendation: 7.4c, 12.3</i>	<i>Not Applicable</i>	<i>PM: 9.3a UM: 5.1g, 5.1h, 7.7e</i>
WPM	<i>Recommendation: 11.4d</i>	<i>PM: 5.7d, 7.6a, 7.8c UM: 12.3</i>	<i>UM: 5.1d, 7.8a, 7.9c</i>

*Note: PM = Partially Met and UM = Unmet

Conclusion

This section includes conclusions drawn from results of MY 2025's interim desktop review. JMS was the only MCO to receive a *Met* determination for all standards reviewed.

MCO Compliance

The following tables compare SPR results across MCOs and the HealthChoice aggregate and identify recommended CAP closures, as compliance was achieved during the MY 2025 review. Appendices [A \(Compliance Score Requirements and Standard Descriptions\)](#) and [B \(MCO-Detailed Findings\)](#) define SPR requirements and identify individual MCO results by standard, respectively.

Table 6. MY 2025 Recommended Met with Opportunity and CAP Closures

MCO	Standard	SPR Requirement	Element or Component
ABH	4, 5, 7, 9	4: Credentialing and Recredentialing, 5: Enrollee Rights, 7: Utilization Review, 9: Health Education Plan	4.4j, 5.1d, 7.2e, 7.4c, 7.7a, 7.8a, 9.5c
CFCHP	5, 7, 11	5: Enrollee Rights, 7: Utilization Review, 11: Fraud and Abuse	5.1g, 7.1c, 7.3a, 7.3b, 7.5b, 7.7a, 11.4c
JMS	5	5: Enrollee Rights	5.8d
KPMAS	5, 11	5: Enrollee Rights, 11: Fraud and Abuse	5.1d, 11.4c
MPC	5	5: Enrollee Rights	5.1g
MSFC	7, 9	7: Utilization Review, 9: Health Education Plan	7.9b, 9.1a
PPMCO	1, 7	1: Systematic Process of Quality Assessment and Improvement, 7: Utilization Review	1.2b, 7.6b, 7.9b
UHC	7, 11	7: Utilization Review, 11: Fraud and Abuse	7.4c, 7.8b, 7.8c, 11.4d
WPM	7, 11	7: Utilization Review, 11: Fraud and Abuse	7.2e, 7.3c, 7.6b, 11.4c

Appendix A: Compliance Score Requirements and Standard Descriptions

This appendix includes each of the SPR standards reviewed for the MY 2025 review.

Element or Component Reviewed	Standard Description
	1: Systematic Process of Quality Assessment and Improvement
1.2	The Quality Assurance Program (QAP)'s written guidelines for the MCO's quality of care studies and related activities require the use of quality indicators.
1.2b	Methods and frequency of data collection are appropriate and sufficient to detect the need for program change.
	2: Accountability to the Governing Body
2.1	There is documentation that the governing body has oversight of the Quality Assurance Program (QAP) and approves the annual quality assurance (QA) Plan/Description and QA Work Plan.
2.5	The governing body takes action when appropriate and directs that the operational QAP be modified on an ongoing basis to accommodate review of findings and issues of concern within the MCO.
	3: Oversight of Delegated Entities and Subcontractors
3.3	There is evidence of continuous and ongoing evaluation of delegated activities, including:
3.3a	Oversight of delegated entities' performance to ensure the quality of the care and/or service provided, through the review of regular reports, annual reviews, site visits, etc.
	4: Credentialing and Recredentialing
4.4	The credentialing process must be ongoing and current. At a minimum, the credentialing process must include:
4.4j	Adherence to the timeframes set forth in the MCO's policies for communication with providers regarding provider applications within the time frames specified in Insurance Article Section 15-112(d).
	5: Enrollee Rights
5.1	The MCO has a system linked to the Quality Assurance Program (QAP) for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04.
5.1a	There are written procedures in place for registering and responding to grievances in accordance with COMAR 10.67.09.
5.1c	The system ensures that the resolution of a grievance is documented according to policy and procedure.
5.1d	The policy and procedure describes the process for aggregation and analysis of grievance data and the use of the data for quality improvement (QI). There is documented evidence that this process is in place and is functioning.
5.1g	The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances within the MDH-established threshold of 95%.

Element or Component Reviewed	Standard Description
5.1h	The MCO ensures enrollees receive written notification of the resolution of all grievances, even if the resolution was provided verbally, within the timeframe documented in the MCO's policy and within the MDH established threshold of 95%.
5.7	The MCO must have an active Consumer Advisory Board (CAB).
5.7a	The MCO's CAB membership must reflect the special needs population requirements.
5.7d	The MCO provides a report on member grievances to the CAB on at least an annual basis, including actions taken to address identified opportunities for improvement.
5.8	The MCO must notify enrollees and prospective enrollees about their nondiscrimination rights.
5.8d	Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.
	7: Utilization Review (UR)
7.1	There is a comprehensive written UR Plan.
7.1c	There is documentation that ensures that utilization determinations made by an individual or entity are not directly influenced by financial incentive or compensation.
7.2	The UR Plan specifies criteria for UR/Utilization Management decisions.
7.2e	There is evidence that UR/Utilization Management staff receive annual training on the interpretation and application of UR/Utilization Management criteria/guidelines.
7.3	The written UR Plan has mechanisms in place to detect over utilization and underutilization of services.
7.3a	Services provided must be reviewed for over and underutilization.
7.3b	UR reports must provide the ability to identify problems and take the appropriate corrective action.
7.3c	Corrective measures implemented must be monitored.
7.4	The MCO maintains policies and procedures pertaining to preauthorization decisions and demonstrates implementation.
7.4c	Time frames for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.
7.5	Adverse determination letters include a description of how to file an appeal and all other required components.
7.5b	Adverse determination letters include all required components.
7.6	The MCO must be compliant with the requirements of COMAR 10.67.09.04 pursuant to notification requirements for preauthorization denials.
7.6a	The MCO maintains policies and procedures pertaining to timeliness of adverse determination notifications in response to preauthorization requests as specified by the State.

Element or Component Reviewed	Standard Description
7.6b	The MCO demonstrates compliance with adverse determination notification time frames in response to preauthorization requests as specified by the State.
7.7	The MCO must have written policies and procedures pertaining to enrollee appeals.
7.7a	The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.02 and COMAR 10.67.09.05.
7.7c	The MCO must adhere to appeal timeframes.
7.7e	Reasonable efforts are made to give the member prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request.
7.8	The MCO must have written policies and procedures pertaining to provider administrative appeals, including but not limited to claims appeals.
7.8a	The MCO's provider appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.03.
7.8b	The MCO's provider appeals policies and procedures must include a provider complaint and appeal process for resolving provider appeals timely. This component is limited to provider administrative appeals. Provider medical necessity appeals are always post-payment. Pre-service medical necessity reviews are enrollee appeals.
7.8c	The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.
7.9	There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.
7.9a	The MCO has a process in place to evaluate the effects of the utilization review program by using enrollee satisfaction, provider satisfaction, and/or other appropriate measures.
7.9b	The MCO demonstrates review of the data on enrollee satisfaction, provider satisfaction, and/or other appropriate data by the appropriate oversight committee.
7.9c	The MCO acts upon identified issues as a result of the review of the data.
7.10	The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.
7.11	The MCO must have written policies and procedures for establishing a corrective managed care plan for enrollee abuse of medical assistance pharmacy benefits consistent with the Department's corrective managed care plan.

Element or Component Reviewed	Standard Description
7.11a	The MCO's policies and procedures regarding corrective managed care plans must include all steps outlined in the regulation.
	8: Continuity of Care
8.6	The MCO has processes in place for coordinating care with the State's behavioral health and substance use vendors and demonstrates implementation of these procedures.
	9: Health Education Plan (HEP)
9.1	The MCO has a comprehensive written HEP, which must include:
9.1a	The education plan's purpose and objectives.
9.3	The MCO's Health Education Program (HEP) must:
9.3a	Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as emergency room utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.
9.5	The MCO must make the education program available to the enrollee population and demonstrate that enrollees have attended. The MCO must provide:
9.5c	Provider evaluations of health education programs.
	11: Fraud and Abuse
11.4	The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address:
11.4c	Evidence of the Compliance Committee's review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate that the MCO contracts with.
11.4d	Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.
	12: Disenrollment Requirements and Limitations
12.1	The MCO may request disenrollment for an enrollee from the HealthChoice program in accordance with federal and state regulations.
12.1a	MCO policies and procedures specify the reasons for which the MCO and the Department may request enrollee disenrollment.
12.1b	The MCO submits to the Department, within thirty (30) days of discovering a discrepancy, a list of Enrollees who are known to the MCO to have reasons to be disenrolled for any reason listed in the referenced COMAR regulations from the HealthChoice Program.
12.2	MCO policies and procedures specify the reasons the MCO is prohibited from requesting enrollee disenrollment.

Element or Component Reviewed	Standard Description
12.3	The MCO policies and procedures specify the methods by which the MCO assures the state that it does not request disenrollment for reasons other than those permitted under the contract.
12.4	The MCO must have policies and procedures for notifying enrollees when, (1) the MCO terminates its contract with the state, and (2) when the MCO is acquired by another entity. In these instances, the MCO must:
12.4a	Provide written notice to the enrollee at least 60 days before the date on which the MCO will exit the HealthChoice Program, or when the MCO is acquired by another entity.
12.4b	Include in the written notice to the enrollee, the name and provider number of the PCP assigned to the recipient and the telephone number of the enrollment broker.

Appendix B: MCO Detailed Findings

This appendix includes detailed findings for elements or components scoring *Met with Recommendations*, *Partially Met*, *Unmet*, and *Met with Opportunity* determinations across applicable MCOs and all standards reviewed for MY 2025's interim review.

Standard 2: Accountability to the Governing Body

The governing body of the MCO is the Board of Directors (BOD) or, where the Board's participation with the QI issues is not direct; a committee of the MCO's senior management is designated. The governing body is responsible for monitoring, evaluating, and making improvements to care.

MSFC Findings

2.5 - The governing body acts when appropriate and directs that the operational QAP be modified on an ongoing basis to accommodate review of findings and issues of concern within the MCO.

This element is Met.

In response to the MY 2024 review, MSFC was required to show in meeting minutes that the governing body is taking an active part in monitoring QIP initiatives, establishing priorities, assessing performance barriers, and developing action plans for improvement. As indicated below, this opportunity for improvement was successfully addressed.

As noted in element 2.1, QIC meeting minutes documented greater detail in addressing successes and barriers of various QIP initiatives. Toward the latter part of 2025, the QIC showed improvement in committee discussion on action steps for addressing metrics performing below required thresholds. For example, in QIC meeting minutes from October 22, 2025, a section is dedicated to Decisions/Actions Needed from the QIC.

RECOMMENDATION: Qlarant recommends MSFC consider a consistent format for subcommittee reports. The section added for Decisions and Action Steps Needed was not consistent in all QIC meeting minutes. This section, or something similar, is useful for establishing follow-up items in subsequent QIC meetings. MSFC should continue refining succinctness of meeting minutes to prioritize metrics needing improvement.

Standard 5: Enrollee Rights

The organization demonstrates a commitment to treating enrollees in a manner that acknowledges their rights and responsibilities.

CFCHP Findings

5.7 - The MCO must have an active CAB.

This element is *Partially Met*.

- 5.7d. The MCO provides a report on member grievances to the CAB on at least an annual basis, including actions taken to address identified opportunities for improvement.

This component is *Partially Met*.

CFCHP provided partial evidence that the MCO provides a report on enrollee grievances to the CAB on at least an annual basis, including actions taken to address identified opportunities for improvement. CFCHP provided CAB meeting minutes for 2025 that included discussions of the enrollee experience and noted areas of enrollee grievances. However, CFCHP did not provide documentation of identified opportunities for improvement within these areas. For example, the CAB summary for April and June 2025 identifies enrollee grievances categorically and descriptively, such as an enrollee identifying concerns with the website being outdated and the availability of nutritionist support. However, CFCHP does not state any opportunities the MCO has identified to address these enrollee concerns.

After initial review, CFCHP presented CAB meeting minutes for December 2025. These meeting minutes included categories of enrollee grievances, such as service quality and Superior Vision misinformation. This information does not coincide with previous reports of grievance discussions and no information on actions taken regarding opportunities for improvement was identified.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, CFCHP must provide clear evidence that the MCO discusses enrollee grievances with the CAB and identifies actions taken to address opportunities for improvement.

MSFC Findings

5.1 - The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04.

This element is Unmet.

- 5.1g.** The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances within the MDH-established threshold of 95%.

This component is Unmet.

In response to the MY 2024 review, MSFC was required to demonstrate consistent compliance with the timeframe for member grievance acknowledgment letters at or above the MDH compliance threshold of 95% on at least a quarterly basis throughout the MY. As indicated below, continued opportunities for improvement exist.

As evidence of compliance, MSFC submitted MDH quarterly GAD reports for the first three quarters of 2025. These reports do not include a field for MCO reporting of compliance with the timeframe for providing the member with written acknowledgment of grievance receipt. No additional documents were submitted to support compliance.

A sample review of ten member grievance records found all demonstrated compliance with the timeframe for written acknowledgment of grievance receipt. Overall compliance was 100%.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of Met in the MY 2026 SPR, MSFC must demonstrate timeframe compliance with sending the member written acknowledgment of grievance receipt at or above the MDH compliance threshold of 95% on at least a quarterly basis throughout the MY.

5.7 - The MCO must have an active Consumer Advisory Board (CAB).

This element is Partially Met.

- 5.7d.** The MCO provides a report on member grievances to the Consumer Advisory Board on at least an annual basis, including actions taken to address identified opportunities for improvement.

This component is Partially Met.

MSFC provided partial evidence that the MCO provides a report on member grievances to the CAB on at least an annual basis, including actions taken to address identified opportunities for improvement. Within *MSFC's Consumer Advisory Board Membership Policy*, it states:

The CAB is responsible for the following:

- a. Collecting enrollees' feedback regarding health plan operations and quality of care*
- b. Reviewing quarterly enrollees' complaints and discussing potential system-wide solutions*
- c. Suggesting ideas for improvement in all areas of operations*
- d. Educating CAB enrollees on navigating through the health care system*
- e. Educating CAB enrollees on relevant health care issues.*

Additionally, within the presented April 2025 CAB meeting minutes, under the section, "*Review of Previous Minutes* (February 2025 Meeting)," it states, "*Review of appeals and grievance process and timeframes.*" However, MSFC did not present the February 2025 CAB meeting minutes that displayed the review of member grievances and/or actions taken toward addressing identified issues.

After the initial review, MSFC submitted the February 2025 meeting minutes. These meeting minutes displayed a list of the 2024 Grievance Statistics and top grievance "*drivers*." It also displayed the 2024 appeal trends and corresponding member roles with the aim of improving their access to care. However, the minutes did not note any opportunities for improvement or interventions developed by the MCO to address identified concerns of "*drivers*" from 2024.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of Met in the MY 2026 SPR, MSFC must present CAB meeting minutes that display discussions of member grievances and any associated opportunities for improvement or interventions developed to address noted concerns.

PPMCO Findings

5.1 - The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04.

This element is Partially Met.

- 5.1d.** The policy and procedure describes the process for aggregation and analysis of grievance data and the use of the data for QI. There is documented evidence that this process is in place and is functioning.

This component is Partially Met.

In response to the MY 2024 review, PPMCO was required to:

- Identify the specific quality committee(s) required to receive complaint and grievance data, on a quarterly basis, in the MCO's *Enrollee Complaints/Grievances Policy*.
- Demonstrate identification of opportunities for improvement, based upon analysis of grievance data and interventions, to address identified opportunities.

The *Enrollee Complaints/Grievances Policy* assigns responsibility to the Complaint & Grievance Department for analyzing trends and determining the form of intervention most appropriate to promote improvements in complaints and grievances and throughout the organization. Aggregate data and analysis related to complaints and grievances are required reporting for the designated quality committees, on a quarterly basis. The policy also identifies other committees and departments that receive an analysis of grievance data and the frequency, as applicable.

According to the Statement of Compliance submitted by PPMCO, the Member Experience Work Group (MEWG) and QAPI Committee received quarterly presentations of grievance data *"to analyze trends and identify opportunities for improvement and develop follow-up actions to address them."*

Minutes from three MEWG meetings held in 2025 included reporting of grievances, by category and subcategory; and identified subcategories trending in a negative direction. Balance billing was consistently identified as the top subcategory under the Billing/Financial category. Several action plans were identified to address provider balance billing:

- Undertake data analysis and root cause identification, including reviewing data for providers that are repeat offenders; identifying provider and enrollee misunderstanding and system coding issues; and identifying any trends related to specific specialties, service types, or geographic regions.

- Educate Customer/Member Services by explaining the Explanation of Benefits and when balance billing of enrollees is appropriate.
- Continue to work with Provider Relations and Network Management to identify providers that are repeat offenders and provide the necessary education, when appropriate.

Minutes from the March 6, 2025, QAPI Committee meeting demonstrated similar reviews of grievance trends, opportunities for improvement, and action plans being implemented to address identified opportunities.

After the initial review, PPMCO provided a response to the MCO's exit letter and submitted the revised *Enrollee Complaints/Grievances Policy*, which identifies the QAPI as the committee that receives and reviews complaint and grievance data quarterly. The folder for 5.1d was empty; therefore, this component remains *Partially Met*.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, PPMCO must identify the specific quality committee(s) required to receive complaint and grievance data, on a quarterly basis, in the MCO's *Member Complaints/Grievances Policy*.

- 5.1g.** The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances within the MDH-established threshold of 95%.
This component is Unmet.

In response to the MY 2024 review, PPMCO was required to:

- Demonstrate compliance with the timeframes for acknowledgment letters and resolutions, by grievance category, at or above the MDH threshold of 95%, for all four quarters of MY 2025.
- Document appropriate grievance resolutions in case notes.

As indicated below, continued opportunities for improvement exist. The *PPMCO Complaint-Grievance Trends Report* indicates timeframe compliance for written grievance acknowledgments, within PPMCO's 72-hour timeframe, exceeded the MDH threshold of 95% for the first three quarters of 2025. No results were provided for the fourth quarter of 2025. Reported compliance for each quarter was based on a percentage capturing the average compliance for the three months within the quarter, rather than the overall percentage of compliance for the quarter. Results may differ between the two approaches as grievance volumes can vary month to month.

As evidence of compliance with grievance resolution timeframes, PPMCO submitted quarterly GAD reports for the first three quarters of 2025, which indicated results were above the MDH threshold of 95% for all three quarters. No results were provided for the fourth quarter of 2025.

A sample review of ten enrollee grievance records found acknowledgment letters were consistently sent within PPMCO's 72-hour timeframe. Overall compliance was 100%. Additionally, 100% compliance was demonstrated in the timeframes for resolution by assigned grievance category (emergency, medically related, non-emergency medically related, and administrative). Appropriate grievance resolutions were documented in case notes of all records reviewed within the sample.

After the initial review, PPMCO submitted additional documentation; however, no documents supported compliance with this component. One document submitted was the *MCO GAD Reporting Annual 2025*, which only provided annual, not quarterly, results for timeframe compliance with grievance resolution. Additionally, this report does not include a field for timeliness of grievance acknowledgment. The other two documents submitted were trend reports, which did not include results for timeframe compliance of grievance acknowledgment letters or resolution. This component therefore remains *Unmet*.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, PPMCO must:

- Demonstrate compliance with the timeframes for acknowledgment letters and resolutions, by grievance category, at or above the MDH threshold of 95% for all four quarters of MY 2026.
- Report compliance as the overall percentage for the quarter, rather than the percentage capturing the average of compliance, for the three months within the quarter.

5.1h. The MCO ensures enrollees receive written notification of the resolution of all grievances, even if the resolution was provided verbally, within the timeframe documented in the MCO's policy and within the MDH established threshold of 95%. **This component is Unmet.**

In response to the MY 2024 review, PPMCO was required to:

- Demonstrate compliance with the MCO's timeframe for grievance resolution letters, at or above the MDH threshold of 95%, for all four quarters of MY 2025.
- Document appropriate resolutions in grievance resolution letters.

As indicated below, continued opportunities for improvement exist.

The PPMCO *Complaint-Grievance Trends Report* indicates timeframe compliance for written grievance resolution, within PPMCO's 72-hour timeframe, exceeded the MDH threshold of 95% for the first three quarters of 2025. No results were provided for the fourth quarter of 2025. Reported compliance for each quarter was based on a percentage capturing the average of compliance for the three months within the quarter, rather than the overall percentage of compliance for the quarter. Results may differ between the two approaches as grievance volumes can vary month to month.

A sample review of ten enrollee grievance records found grievance resolution letters were consistently sent within PPMCO's 72-hour timeframe. Overall compliance was 100%. All letters within the sample reviewed included an appropriate resolution in easy-to-understand language.

After the initial review, PPMCO submitted additional documentation; however, no documents supported compliance with this component. One document submitted was the *MCO GAD Reporting Annual 2025*, which only provided annual, not quarterly, results for timeframe compliance with written grievance resolution. The other two documents submitted were trend reports, which did not include results for timeframe compliance with written grievance resolution. This component therefore remains Unmet.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, PPMCO must:

- Demonstrate compliance with the MCO's timeframe for grievance resolution letters, at or above the MDH threshold of 95%, for all four quarters of MY 2026.
- Report compliance as the overall percentage for the quarter, rather than the percentage capturing the average of compliance, for the three months within the quarter.

5.7 - The MCO must have an active CAB.

This element is Partially Met.

- 5.7d.** The MCO provides a report on enrollee grievances to the CAB on at least an annual basis, including actions taken to address identified opportunities for improvement.

This component is Partially Met.

PPMCO provided partial evidence that the MCO provides a report on enrollee grievances to the CAB, on at least an annual basis, including actions taken to address identified opportunities for improvement. PPMCO provided the *2025 CAB Charter*, which states some responsibilities of the CAB as "*reviews results of consumer satisfaction studies and resolution of consumer grievances.*"

PPMCO also presented a review of the November 12, 2025, CAB meeting relating to enrollee grievances. The presentation displayed grievances for Q2 2025 and noted trending elements for enrollee grievances; however, it did not display any identified opportunities for improvement or actions PPMCO is taking to address these areas.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR review, PPMCO must provide a report on enrollee grievances to the CAB, which includes actions taken to address identified opportunities for improvement.

UHC Findings

5.1 - The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04.

This element is Partially Met.

- 5.1g.** The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances within the MDH-established threshold of 95%.

This component is Unmet.

In response to the MY 2024 review, UHC was required to demonstrate compliance with required timeframes for written grievance acknowledgment and resolutions by category at or above the MDH compliance threshold of 95% on at least a quarterly basis for all four quarters of the MY. As indicated below, continued opportunities for improvement exist.

The *MD Member Appeal, Grievance, and State Fair Hearing Policy* require a grievance acknowledgment letter to be sent to the member within five calendar days of grievance receipt if any grievance takes longer than the regulatory timeframe or five calendar days, whichever is sooner. Resolution timeframes are consistent with regulatory requirements and include notification.

The *Maryland Appeal Compliance Report* provided timeframe compliance by month and by quarter for written grievance acknowledgments and resolutions by grievance category. Compliance with the timeframe for written grievance acknowledgment was reported as 91.7% first quarter, 100% second quarter, and 100% third quarter. No results were provided for the fourth quarter.

Compliance with resolution timeframes by grievance category for the first three quarters of 2025 was reported as follows:

- Emergency, medically related: No grievances were received in the first and third quarters and there was 0% compliance for two grievances received in the second quarter.
- Non-emergency, medically related: 66.7% first quarter and 100% second and third quarters.

- Administrative: 99.1% first quarter and 100% second and third quarters.

A sample review of ten member grievance records, all categorized as administrative, found all met the timeframe for written grievance acknowledgment. Overall compliance with the acknowledgment letter timeframe was 100%.

One grievance in the initial sample related to access to prescription refill was incorrectly categorized as administrative and, as a result, did not meet the regulatory timeframe for resolution. An additional 20 records were reviewed for compliance, and all met the regulatory timeframe. Overall compliance with resolution timeframes was 97%.

After the initial review, UHC submitted the *Maryland Member Compliance Report 2025*, which included fourth quarter data for acknowledgment letter timeliness and compliance with resolution timeframes based upon grievance category. Results by quarter are provided below:

Compliance with the timeframe for written grievance acknowledgment was reported as 91.7% for the first quarter and as 100% for the second through the fourth quarters.

Compliance with resolution timeframes by grievance category was reported as follows:

- Emergency, medically related: No grievances were received during the first, third, and fourth quarters. Compliance for two grievances received in the second quarter was 0%.
- Non-emergency, medically related: 66.7% first quarter, 100% second and third quarters, and 75.0% fourth quarter.
- Administrative: 99.1% first quarter and 100% second, third, and fourth quarters.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of Met in the MY 2026 SPR, UHC must demonstrate compliance with required timeframes for written grievance acknowledgment and resolution by category at or above the MDH compliance threshold of 95% on at least a quarterly basis for all four quarters of the MY.

- 5.1h.** The MCO ensures enrollees receive written notification of the resolution of all grievances, even if the resolution was provided verbally, within the timeframe documented in the MCO's policy and within the MDH established threshold of 95%. **This component is Unmet.**

In response to the MY 2024 review, UHC was required to demonstrate compliance with required timeframes for written grievance resolutions at or above the MDH compliance score of 95% on at least a quarterly basis for all four quarters of the MY. As indicated below, continued opportunities for improvement exist.

The *MD Member Appeal, Grievance, and State Fair Hearing Policy* requires written grievance resolutions be provided to enrollees within the grievance resolution timeframes.

As written resolution is incorporated in the resolution timeframes by grievance category, this component was Unmet as noted in component 5.1g. Overall, UHC fell below the MDH compliance threshold of 95% in the first quarter for non-emergency, medically related grievances and in the second quarter for emergency, medically related grievances. No results were provided for the fourth quarter of 2025 during the initial review.

An initial sample review of ten grievances found that nine grievances met the timeframe for resolution/written notification. One grievance in this sample related to access to prescription refill was incorrectly categorized as administrative and, as a result, did not meet the timeframe for resolution/notification. An additional 20 records were reviewed for compliance, and all met the required timeframes. Overall compliance with resolution/notification timeframes was 97%.

After the initial review, UHC submitted the *Maryland Member Compliance Report 2025*, which included fourth quarter data for resolution timeframes based upon grievance category. As noted in component 5.1g, written resolution is incorporated in the resolution timeframes by grievance category, therefore this component was found to be Unmet. Overall, UHC fell below the MDH compliance threshold of 95% in the first and fourth quarters for non-emergency, medically related grievances and in the second quarter for emergency, medically related grievances.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of Met in the MY 2026 SPR, UHC must demonstrate compliance with required timeframes for written grievance resolutions at or above the MDH compliance score of 95% on at least a quarterly basis for all four quarters of the MY.

WPM Findings

5.1 - The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04.

This element is *Partially Met*.

5.1d. The policy and procedure describes the process for aggregation and analysis of grievance data and the use of the data for QI. There is documented evidence that this process is in place and is functioning.

This component is *Unmet*.

In response to the MY 2024 review, WPM was required to demonstrate it conducts an analysis of grievance data to identify opportunities for improvement and develop action plans to address identified opportunities consistent with the *Member Grievances - MD Policy*. As indicated below, continued opportunities for improvement exist.

The *Member Grievances - MD Policy* indicates the Quality Management Committee (QMC) reviews grievance reports quarterly and annually to identify patterns of grievances.

As evidence of QMC review of enrollee grievances, minutes were reviewed from five QMC meetings held in 2025. In the meetings of March 26th, May 28th, June 25th, and September 24th, there was no evidence of discussion of member grievances. In the July 30th meeting, the top three grievance categories were identified as billing/financial, attitude/service, and access for the second quarter of 2025. It was noted that grievances increased by 19% compared to the first quarter of 2025. Committee discussion focused on providing an update to the corrective action plan from the MY 2024 review, which "*involves conducting a more in-depth analysis of grievances, with the intention of delivering more comprehensive information to the committee*". The need for further collaboration with the health plan was identified in addressing providers who consistently balance bill members and enhancing member education on the prior authorization process. Additionally, it was proposed that access related grievances be analyzed to identify potential patterns. No specific action plans based upon a root cause analysis of the top grievance categories were found in the minutes reviewed.

A slide presentation to the QMC addressing second quarter grievances was submitted for review noting collaboration with Member Services was underway to decrease the number of access-related grievances. The stated goal was to increase first-call resolutions by assisting members in locating providers and scheduling appointments. It is unclear if this initiative was in direct response to an analysis of the root causes underlying access-related grievances.

After the initial review, WPM submitted the *MD Grievance Provider Related Issues Desktop Procedure*, which outlines the process to be used when a grievance involves a provider-related issue. This does not specifically address the root cause(s) underlying the top enrollee grievances, such as billing/financial, attitude/service, and access, and the development of any action plans to address identified opportunities for improvement. The finding of *Unmet* remains unchanged.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, WPM must demonstrate it conducts an analysis of grievance data to identify opportunities for improvement and develop action plans to address identified opportunities consistent with the *Member Grievances - MD Policy*.

5.7 - The MCO must have an active Consumer Advisory Board (CAB).
This element is *Partially Met*.

- 5.7d.** The MCO provides a report on member grievances to the CAB on at least an annual basis, including actions taken to address identified opportunities for improvement.

This component is *Partially Met*.

WPM did not provide clear evidence that the MCO provides a report on member grievances to the CAB on at least an annual basis, including actions taken to address identified opportunities for improvement. It did not provide any documentation regarding CAB meeting minutes or the associated review of member grievances by the CAB.

After the initial review, WPM submitted CAB meeting minutes, dated March 18, 2025, which displayed 2024 member complaints by category; however, they did not address opportunities for improvement or make notes of any actions taken by the MCO to address identified concerns.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, WPM must provide clear evidence that it supplies a report on member grievances to the CAB on at least an annual basis, including actions taken to address identified opportunities for improvement.

Standard 7: Utilization Review

The MCO has a comprehensive Utilization Management program, monitored by the governing body, and designed to systematically evaluate the use of services through the collection and analysis of data in order to achieve overall improvement.

ABH Findings

7.9 - There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the Utilization Review (UR) program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.

This element is *Partially Met*.

- 7.9c.** The MCO acts upon identified issues, as a result of the review of the data.

This component is *Partially Met*.

In response to the MY 2024 review, ABH was required to improve its meeting minutes documentation to explain its criteria for selecting utilization management-related opportunities for improvement identified from the *Provider Satisfaction Survey* results. As indicated below, continued opportunities for improvement exist.

In the January 9, 2025, Quality Management/Utilization Management meeting, the following results from the *MY 2024 Provider Satisfaction Survey* were reported:

The Utilization/Prior Authorization measure rates improved in all seven areas over the previous year and four out of the seven were above the HealthChoice Aggregate rate. Despite this reported improvement, four attributes were identified in the improvement quadrant:

- *Accuracy of claims processing*
- *Overall experience in obtaining prior authorization of outpatient services*
- *Timeliness of obtaining authorization of inpatient services*
- *Overall experience in obtaining authorization of inpatient services*

These attributes were considered unmet needs and were recommended as priority areas for ABH.

Review of subsequent minutes from SIC and QMOC meetings provided limited detail on utilization of management-related action plans to address identified opportunities to improve provider satisfaction.

Internal Action Plans presented as attachments to the July and September QMOC meetings provided additional detail on provider-related initiatives. Specifically, as related to satisfaction with the utilization management process, ABH reported plans to create a limited workgroup to walk through the preauthorization process and provider customer service process - from the providers' perspective to look for gaps, issues, or pain points. A plan for corrections, as needed, would be subsequently developed. No additional details were provided in the meeting minutes reviewed. ABH also identified an initiative to assist providers in transitioning back to preauthorization requirements for over 300 service codes required by MDH; however, this was not related to provider satisfaction survey findings.

After the initial review, ABH submitted its response to the exit letter, stating it "*acknowledges and understands further improvement is needed here to demonstrate that we respond to identified opportunities for improving provider satisfaction with the utilization management process, as evidenced by meeting minutes and provider satisfaction improvement work plans.*"

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, ABH must demonstrate that it responds to identified opportunities for improving provider satisfaction with the utilization management process, as evidenced by meeting minutes and provider satisfaction improvement work plans.

CFCHP Findings

7.7 - The MCO must have written policies and procedures pertaining to enrollee appeals.

This element is *Partially Met*.

7.7c. The MCO must adhere to appeal timeframes.

This component is *Unmet*.

In response to the MY 2024 review, CFCHP was required to demonstrate consistent compliance with timeframes for written enrollee appeal acknowledgment and resolution/notification for expedited appeals, at or above the MDH threshold of 95%, for all four quarters of the MY. As indicated below, continued opportunities for improvement exist.

The *Enrollee Appeals Policy* includes timeframes for written acknowledgment of an appeal and written resolution for standard and expedited appeals that are consistent with regulatory requirements.

As evidence of compliance, CFCHP submitted the *Appeals and Grievances PowerPoint* presentation for Q1-Q3 2025. CFCHP reported that it exceeded MDH's compliance threshold for timeliness of written appeal acknowledgment in the three reported quarters. Timeframe compliance with notification of expedited appeal resolution fell below the compliance threshold for the first quarter of 2025. No compliance results were provided for the fourth quarter of 2025 for either written appeal acknowledgment or resolution notification for expedited appeals.

A sample review of ten appeal records, three expedited and seven standard, found 100% compliance with the timeframes for enrollee written appeal acknowledgment and notification of appeal resolution.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, CFCHP must demonstrate consistent compliance with timeframes for enrollee written appeal acknowledgment and resolution notification for expedited appeals, at or above the MDH threshold of 95%, for all four quarters of the MY.

- 7.7e.** Reasonable efforts are made to give the member prompt verbal notice of denial of expedited resolution and a written notice within two calendar days of the denial of the request.

This component is *Unmet*.

In response to the MY 2024 review, CFCHP was required to demonstrate a reasonable attempt to provide the enrollee with verbal notification of the denial of a request for an expedited appeal resolution and written notification within two calendar days of the denial decision, at or above the MDH threshold of 95%, on at least a quarterly basis throughout the MY. As indicated below, continued opportunities for improvement exist.

The *Member Appeals Policy* requires CFCHP to make a reasonable effort to give the enrollee and treating provider prompt verbal notice and written notice within two calendar days of a denial of a request for an expedited appeal resolution.

As evidence of compliance, CFCHP submitted the *Appeals and Grievances PowerPoint* presentation for Q1-Q3 2025. CFCHP reported that it fell below MDH's compliance threshold for verbal notification of the denial of an expedited request in the first and third quarters at 84% and 94%, respectively. Written notice of the denial of an expedited appeal request fell below the compliance threshold for the first quarter at 88%. No results were provided for the fourth quarter of 2025.

An initial sample review of ten enrollee appeal records found three denials of a request for an expedited resolution. Case notes demonstrated an attempt to provide verbal notification of the denial of an expedited request to the enrollee for two denials and written notification within two calendar days of the denial decision for all three records. Review of an additional 20 records found three denials of an expedited request with all demonstrating verbal notice of the denial of an expedited request to the enrollee. Overall, compliance with the six denied requests for an expedited appeal was 83%, with a reasonable attempt to provide verbal notice of the denial; and 100% with the timeframe for written notice of the denial of an expedited request.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, CFCHP must demonstrate a reasonable attempt to provide the enrollee with verbal notification of the denial of a request for an expedited appeal resolution and written notification within two calendar days of the denial decision, at or above the MDH threshold of 95%, on at least a quarterly basis throughout the MY.

KPMAS Findings

7.10 - The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining

how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an IRO designated by the Department.

This element is Unmet.

In response to the MY 2024 review, KPMAS was required to revise the *Provider Claim Disputes/Appeals Policy - MD* to be consistent with the requirements of COMAR 10.67.13. As indicated below, continued opportunities for improvement exist.

The *Provider Claim Disputes/Appeals Policy - MD* requires KPMAS to enter into a Medical Necessity Case Agreement with the IRO, which has been executed. Upon notification of a case review request from the IRO, KPMAS is required to upload the complete case record within five business days. Any additional case-related documentation requested by the IRO is required to be uploaded within two business days of receipt of the request. If the IRO determines that KPMAS improperly denied, either in whole or in part, a provider's claim on medical necessity grounds, KPMAS is required to reimburse the provider for claims determined to be medically necessary by the IRO, including any interest owed within 60 calendar days of the date of the IRO's adverse decision. Additionally, if the IRO reverses a decision to deny, limit, or delay services, KPMAS is required to pay the fixed case fee within 60 calendar days of the release of the invoice. If payment is not issued within the required timeframe, MDH shall impose penalties based upon the number of delinquencies. KPMAS may file an appeal if it receives an adverse decision from the IRO in accordance with COMAR 10.67.10.02.

Missing from the policy is a documented process to ensure IRO invoices are paid within 60 days, consistent with the COMAR 10.67.13.07C(2).

After the initial review, KPMAS submitted their exit letter response acknowledging and accepting the finding.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of Met in the MY 2026 SPR review, KPMAS must either revise the *Provider Claim Disputes/Appeals Policy - MD* or develop a desktop procedure that documents the process for ensuring IRO invoices are paid within the required 60 calendar days. Additionally, KPMAS must submit evidence that the process has been implemented.

RECOMMENDATION: Qlarant recommends that KPMAS revise the *Provider Claim Disputes/Appeals Policy - MD* to replace DHMH with MDH as it is currently known.

MPC Findings

7.6 - The MCO must be compliant with the requirements of COMAR 10.67.09.04 pursuant to notification requirements for preauthorization denials.

This element is *Partially Met*.

- 7.6a.** The MCO maintains policies and procedures pertaining to timeliness of adverse determination notifications in response to preauthorization requests as specified by the State.

This component is *Partially Met*.

In response to the MY 2024 review, MPC was required to revise the *Pharmacy Prior Authorization Policy* timeframe for enrollee written notice of the determination from 24 hours of receipt of request to 24 hours from the decision, or equivalent language, for consistency with MCO Transmittal No. 225's allowance for this 14-calendar day extension. As indicated below, continued opportunities for improvement exist.

The *Pharmacy Prior Authorization Policy* requires the Pharmacy Benefit Manager to provide written notice of a decision to the enrollee, with a copy to the requesting provider, within 24 hours of the request. In its Statement of Compliance, MPC noted that the MCO transmittal "cites that the 24-hour window is based on the receipt of the request and not the decision. Additionally, NCQA requires the more stringent of the two timeframes. Therefore, the policy was not revised."

MCO Transmittal No. 225, dated October 3, 2024, addresses the timeframe for provider notification of the outcome of a preauthorization request for a covered outpatient drug within 24 hours of receipt. An outcome is either an approval, denial, or request for additional information. This transmittal does not address enrollee notification of the decision. If the provider is allowed up to 14 calendar days to submit information to support an authorization determination, enrollee written notice of the decision could not occur within 24 hours of receipt of the request but rather would be delayed until 24 hours after the determination. For this reason, enrollee written notice of the decision needs to occur 24 hours following the determination rather than within 24 hours of receipt of the preauthorization request.

After the initial review, MPC submitted a draft of the revised *Pharmacy Prior Authorization Policy* based upon feedback from Qlarant. This policy will be reviewed along with MPC's CAP submission. While MPC requested the finding be changed to an *MwO* due to COMAR and NCQA language, the requirement for sending the enrollee an adverse determination letter within 72 hours of an outpatient drug decision was stated in the SPR Standards and Guidelines, and the decision remains a *Partially Met*.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, MPC must revise the *Pharmacy Prior Authorization Policy* timeframe for enrollee written notice of the determination from 24 hours of receipt of request to 24 hours from the decision, or equivalent language, for consistency with MCO Transmittal No. 225's allowance for a 14 calendar day extension if additional information is requested from the provider.

MSFC Findings

7.4 - The MCO maintains policies and procedures pertaining to preauthorization decisions and demonstrates implementation.
This element is *Met*.

- 7.4c.** Timeframes for preauthorization decisions are specified in the MCO's policies, and decisions are made in a timely manner as specified by the State.
This component is *Met with Opportunity*.

In response to the MY 2024 review, MSFC was required to update the *UM Process Policy* to include information from MCO Transmittal No. 225, dated October 3, 2024, which provides up to 14 calendar days including the original 24-hour decision timeframe for a decision about a covered outpatient drug if additional clinical information is requested. As indicated below, this opportunity for improvement was successfully addressed.

The *UM Process Policy* has been updated to include an extension of up to 14 calendar days in the event necessary clinical information requested is not received within 24 hours of receipt of the preauthorization request.

In order to receive a finding of *Met* in the MY 2026 SPR, MSFC must provide additional clarification in the *UM Process Policy* that the 14-day extension for additional clinical information not received within 24 hours of receipt of the request for preauthorization of a covered outpatient drug includes the initial 24-hour timeframe from receipt of the request.

7.8 - The MCO must have written policies and procedures pertaining to provider administrative appeals, including but not limited to claims appeals.
This element is *Unmet*.

- 7.8c.** The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.
This component is *Unmet*.

In response to the MY 2024 review, MSFC was required to demonstrate compliance with provider appeal acknowledgment letters and written resolution at or above the MDH threshold of 95% on at least a quarterly basis throughout the MY. As indicated below, continued opportunities for improvement exist.

The *Provider Appeals Timeliness Report* included compliance results by month and quarter through October 2025. The reported compliance with timeliness of written appeal acknowledgment was incorrectly reported as the percentage of non-compliance rather than the percentage of compliance. On a quarterly basis (corrected) compliance with appeal acknowledgments was demonstrated in the first and second quarters; however, compliance was 44.5% for the third quarter. No results were available for the fourth quarter of the MY.

Compliance with MSFC's timeframe for provider notification of appeal resolution was met in the first quarter; however, performance fell below the 95% compliance threshold during second and third quarters to 80.88% and 68.42%, respectively. No fourth quarter results were provided.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of Met in the MY 2026 SPR, MSFC must demonstrate compliance with provider appeal acknowledgment letters and written resolution at or above the MDH threshold on at least a quarterly basis throughout the MY.

PPMCO Findings

- 7.4** - The MCO maintains policies and procedures pertaining to preauthorization decisions and demonstrates implementation.
This element is *Unmet*.

- 7.4c.** Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.
This component is *Unmet*.

In response to the MY 2024 review, PPMCO was required to demonstrate consistent compliance, at or above the MDH threshold of 95%, for preauthorization determination timeframes and 24-hour prescriber notifications, no less than quarterly for MY 2025. As indicated below, continued opportunities for improvement exist.

The *Utilization Management Quarterly Turnaround Time Report* indicated PPMCO exceeded the MDH compliance threshold of 95% for determination timeframes for approved and denied preauthorization requests for the first three quarters of 2025. No compliance results were provided for the fourth quarter of 2025 during the initial review.

As evidence of compliance with 24-hour prescriber notification of the outcome of a preauthorization request for a covered outpatient drug, PPMCO submitted quarterly GAD reports for the first three quarters of 2025, which demonstrated compliance as exceeding the MDH threshold. No reports were provided for the fourth quarter of 2025 during the initial review.

A sample review of ten enrollee adverse determination records (seven medical and three pharmacy) found 100% compliance with determination timeframes and 24-hour prescriber notifications.

After the initial review, PPMCO submitted the *MCO Preauthorization & Pre-Service Denials Report*, which included only annual results for MY 2025. PPMCO also submitted the *Quarterly Turnaround Time Report*, which reported compliance with determination timeframes as exceeding the 95% threshold for all four quarters of the MY.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, PPMCO must demonstrate consistent compliance, at or above the MDH threshold of 95%, for 24-hour prescriber notifications no less than quarterly for MY 2026.

7.8 - The MCO must have written policies and procedures pertaining to provider administrative appeals, including but not limited to claims appeals.

This element is *Unmet*.

- 7.8c.** The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.
This component is *Unmet*.

In response to the MY 2024 review, PPMCO was required to eliminate the "*expedited*" category for provider administrative (claims) appeals. As indicated below, continued opportunities for improvement exist.

PPMCO did not submit any documentation to support compliance with this component during the initial review.

After the initial review, PPMCO submitted the *Provider Appeals Turnaround Time Report* for each quarter of the MY, which still included an expedited appeal category with one expedited appeal reported for third quarter. This finding, therefore, remains *Unmet*.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, PPMCO must eliminate the "expedited" category for provider administrative (claims) appeals in the MCO's *Provider Appeals Report* for monitoring timeframe compliance.

7.9 - There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the utilization review program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.

This element is *Partially Met*.

- 7.9a.** The MCO has a process in place to evaluate the effects of the utilization review program by using enrollee satisfaction, provider satisfaction, and/or other appropriate measures.

This component is *Unmet*.

In response to the MY 2024 review, PPMCO was required to revise the *Enrollee and Provider Experience with the Utilization Management Process Policy* to identify the "appropriate oversight committee" referenced in this policy. As indicated below, continued opportunities for improvement exist.

The *Enrollee and Provider Experience with the Utilization Management Process Policy* assigns responsibility to the Utilization Management Department for an annual analysis of utilization management-related satisfaction results from the MDH coordinated CAHPS and Provider Satisfaction surveys. An evaluation of these findings is reported to the appropriate oversight committee on an annual basis. The "appropriate oversight committee" continues to be unidentified.

After the initial review, PPMCO submitted the *Enrollee and Provider Experience with the Utilization Management Process Policy*, which has been revised with an effective date of 3/16/2026. Since this revision is outside of the review timeframe, it will be reviewed with PPMCO's CAP submission for this component.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, PPMCO must revise the *Enrollee and Provider Experience with the Utilization Management Process Policy* to identify the "appropriate oversight committee" referenced in this policy.

UHC Findings

7.4 - The MCO maintains policies and procedures pertaining to preauthorization decisions and demonstrates implementation.

This element is *Met*.

- 7.4c.** Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.

This component is *Met*.

In response to the MY 2024 review, UHC was required to:

- Revise the appropriate policy to include content found in MCO Transmittal No. 225, dated October 3, 2024, which allows up to 14 calendar days including the original 24-hour decision timeframe when additional information is requested in response to a preauthorization request for a covered outpatient drug.
- Provide evidence in case notes of fax notification of the outcome of a preauthorization request for a covered outpatient drug within 24 hours of receipt.
- Revise the *Pharmacy TAT* report to replace "*final determination within 24 hours of the decision*" to "*final determination within 24 hours of receipt of preauthorization request*" and add "*determination within 24 hours of receipt of additional information not to exceed 14 calendar days from date of receipt*"; and change faxed notification from "*24 hours from the determination*" to "*24 hours from receipt of the preauthorization request*".
- Revise the *MD Medical TAT Report* to replace "*case closure*" with "*determination*"; clarify the written notification of expedited request is "*within 72 hours of receipt of the preauthorization request*".

The *Initial Review Timeframes Policy* includes state-specific timeframes at the end of the policy. Content from MCO Transmittal No. 225, dated October 3, 2024, has been added to include the 14 days allowed for a provider to submit requested information. This timeframe includes the original 24-hour decision timeframe from receipt of the preauthorization request for a covered outpatient drug.

The *Outpatient Drug and Preauthorization Turn-Around-Time Service Standards Policy* also has been updated to include the requirements outlined in MCO Transmittal No. 225, dated October 3, 2024.

Review of the *MD Medical TAT Report* found the "*case closure*" field has been renamed "*determination*" and written notification of expedited request has been clarified to include "*within 72 hours of receipt of the preauthorization request*".

Review of the *Pharmacy Preauthorization Report* demonstrated that all required changes have been made to the fields for monitoring compliance with determination and notification timeframes for preauthorization requests for covered outpatient drugs.

An initial sample review of ten enrollee adverse determination records (six pharmacy) found no evidence of compliance with the requirement for prescriber notification within 24 hours of receipt of a preauthorization request for a covered outpatient drug via telephone or other telecommunication device. Review of an additional 20 records for compliance found no evidence of prescriber notification for the 12 outpatient pharmacy requests. Overall compliance was 0% (0/18). In the MY 2024 review, UHC reported that the provider notification letter included in case records is faxed to prescribers within 24 hours of receipt of the preauthorization request. However, there is no evidence in case notes that the letters were faxed within 24 hours, and no fax number was included in the letter.

After the initial review, UHC submitted its response to the preliminary exit letter findings noting that currently the case notes section supports the clinical review process for a preauthorization request; however, it does not display the outbound notification date and time stamp within the preauthorization application. For each sample case, UHC reported that an outbound notification to the prescriber can be found in the Notification Date/Time Stamp section of every pharmacy preauthorization request. Review of the Notification Date/Time Stamp section for several sample cases found the status of the outbound fax (resolved-complete), the date and time when the preauthorization response attachment was sent, and the prescriber's fax number.

Review of the *Pharmacy Prior Authorization TAT CY 2025* spreadsheet found UHC exceeded the MDH compliance score for 24-hour fax notification to the provider of the review outcome for all months in MY 2025.

RECOMMENDATION: Qlarant recommends that UHC include the fax cover sheet or the fax number of the provider in the case record to demonstrate a fax was sent to the provider within 24 hours of receipt of the outpatient pharmacy request since UHC reported the preauthorization application does not currently display the outbound notification date and time stamp.

7.7 - The MCO must have written policies and procedures pertaining to enrollee appeals.

This element is *Unmet*.

- 7.7e.** Reasonable efforts are made to give the member prompt verbal notice of denial of expedited resolution and a written notice within two calendar days of the denial of the request.

This component is *Unmet*.

In response to the MY 2024 review, UHC was required to demonstrate compliance with providing an enrollee timely oral notice and written notice of denial of a request for an expedited appeal resolution within two calendar days of the denial. As indicated below, continued opportunities for improvement exist.

In the *Maryland Appeals Notification Expedited to Standard Monitoring* document, UHC reported 100% compliance with oral and written notification to the enrollee when an expedited request was downgraded to standard for the first three quarters of 2025. No compliance results were reported for the fourth quarter of 2025.

A sample review of ten enrollee appeal records found one denial of a request for an expedited resolution with oral and written notice of the downgrade from expedited to standard provided to the enrollee.

After the initial review, UHC submitted the *Maryland Member Compliance Report 2025*, which included fourth quarter results. According to UHC, compliance with the timeframe for providing the enrollee written notice of the downgrade of an expedited appeal request was demonstrated in all four quarters. While UHC demonstrated compliance with a reasonable attempt to provide the enrollee with oral notification of the downgrade of an expedited appeal request within the first three quarters of the MY, in the fourth quarter oral notice of the downgrade was reported in eight of 12 cases, resulting in a compliance rate of 67%.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of **Met** in the **MY 2026 SPR**, UHC must demonstrate compliance with a reasonable attempt to provide oral notification to the enrollee of any downgrade from an expedited to a standard request on at least a quarterly basis for all four quarters of the MY.

WPM Findings

7.6 - The MCO must be compliant with the requirements of COMAR 10.67.09.04 pursuant to notification requirements for preauthorization denials.

This element is *Partially Met*.

- 7.6a.** The MCO maintains policies and procedures pertaining to timeliness of adverse determination notifications in response to preauthorization requests as specified by the State.

This component is *Partially Met*.

In response to the MY 2024 review, WPM was required to revise the *Pharmacy Prior Authorization Policy* to change the timeframe of enrollee notification of an approval or denial from "closed date" to "date of determination". As indicated below, continued opportunities for improvement exist.

The *Pharmacy Prior Authorization Policy* does not specifically address the timeframe for sending an enrollee notice of an adverse determination in response to a preauthorization request for a covered outpatient drug. The *SPR Audit Pharmacy* document shows compliance with adverse determination notifications measured against a timeframe, which is within 24 hours of the decision.

After the initial review, WPM resubmitted the *Pharmacy Prior Authorization Policy*, which, as noted above, does not specifically reference the timeframe for providing the enrollee with a written notice of adverse determination for a covered outpatient drug. The policy does reference the timeframe for enrollee notification of an adverse determination for a medical injectable; however, that does not meet the requirement of this component. The finding of *Partially Met* remains unchanged.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, WPM must specify in its *Pharmacy Prior Authorization Policy* the enrollee adverse determination notification timeframe for covered outpatient drug requests.

- 7.8 -** The MCO must have written policies and procedures pertaining to provider administrative appeals, including but not limited to claims appeals.

This element is *Partially Met*.

- 7.8a.** The MCO's provider appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.03.

This component is *Unmet*.

In response to the MY 2024 review, WPM was required to revise the *Provider Claim Payment Dispute Process Policy* to include the following:

- The MCO's timeframe for sending written notice of appeal resolution to the provider.
- The opportunity for the provider to have their final level of appeal heard by the MCO's CEO, or the CEO's designee.

- Recategorize "*Reconsideration*" as "*Appeal*" which, according to WPM staff, is the first level of a provider claim appeal to be consistent with COMAR 10.67.09.03 language.

As indicated below, continued opportunities for improvement exist.

The *Provider Claim Payment Dispute Process Policy* has been revised to recategorize "*Reconsideration*" as "*Appeal*" which, according to WPM staff, is the first level of a provider claim appeal to be consistent with COMAR 10.67.09.03 language.

There was no evidence that the additional required changes to the policy were implemented. The policy still does not address:

- The MCO's timeframe for written resolution of each level of appeal.
- The opportunity for the provider to have their final level of appeal heard by the MCO's CEO, or the CEO's designee.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, WPM must revise the *Provider Claim Payment Dispute Process Policy* to include the following:

- The MCO's timeframe for sending written notice of appeal resolution to the provider.
- The opportunity for the provider to have their final level of appeal heard by the MCO's CEO, or the CEO's designee.

- 7.8c.** The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution. **This component is *Partially Met*.**

In response to the MY 2024 review, WPM was required to revise the *Provider Claim Payment Dispute Process Policy* to specify the MCO's timeframe for sending the provider a written appeal resolution for each level of appeal which would allow sufficient time for a second-level of appeal if the provider chooses. As indicated below, continued opportunities for improvement exist.

The *Provider Claim Payment Dispute Process Policy* has not been revised to specify the MCO's timeframe for written resolution for each level of appeal.

According to the *Provider Claims Dispute TAT Report Measurement* document, WPM tracks compliance with written appeal resolution within 30 business days of the decision. Results by month through October 2025 were reported as exceeding the MDH compliance threshold of 95%. It is unlikely this timeframe is accurate as only 15 business days at most would be available for processing a second-level appeal (30 business days for the decision, plus 30 business days following the decision for a written resolution, and a minimum of 15 days from the initial decision for the provider to file a second-level appeal).

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, WPM must revise the *Provider Claim Payment Dispute Process Policy* to specify the MCO's timeframe for sending the provider a written appeal resolution for each level of appeal, which would allow sufficient time for a second-level of appeal if the provider so chooses.

7.9 - There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.

This element is *Unmet*.

7.9c. The MCO acts upon identified issues as a result of the review of the data.

This component is *Unmet*.

In response to the MY 2024 review, WPM was required to demonstrate development and implementation of action plans to address utilization management-related opportunities to improve satisfaction based upon CAHPS and Provider Satisfaction Survey results and provide updates to the quality committees at the frequency identified in its *Member Satisfaction Survey Policy* and *Practitioner/Provider Satisfaction Survey Policy*. As indicated below, continued opportunities for improvement exist.

Limited documentation was provided to support WPM in implementing action plans to address utilization management opportunities based upon results from the CAHPS and Provider Satisfaction surveys. According to the *Member Satisfaction Survey Policy*, progress reports are to be presented to the QMC on a quarterly basis and to the corporate Quality Improvement Committee on a semi-annual basis. According to the revised *Practitioner/Provider Satisfaction Survey Policy*, the applicable quality committee is responsible for monitoring the development and reevaluation of the improvement action plan progress and generating progress reports as appropriate, as well as presenting results to the Quality Improvement Committee semi-annually.

Review of QMC minutes from the May and June 2025 meetings did not include any action plans related to CAHPS or Provider Satisfaction Survey results. The minutes from March 26, 2025, meeting identified action plans in response to a decrease in provider satisfaction in obtaining outpatient authorizations. Initiatives included placing an article in the provider newsletter on the use of Availity, which increases the efficiency of completing authorization requests and prompts the provider to include all needed information. Additionally, a complimentary webinar training schedule was expanded for providers and office staff who request and/or submit preauthorization requests. While opportunities for improvements in Getting Needed Care and Getting Care Quickly CAHPS composite measures were identified, there were no specific initiatives identified to address root causes underlying these results. In the July 30, 2025, QMC meeting, it was noted that opportunities for improvement related to MY 2024 CAHPS results will be discussed in CAHPS Workgroup meetings to determine potential interventions. In the September 24, 2025, QMC meeting Getting

Care Quickly and Getting Needed Care were identified as opportunities for improvement. A table with CAHPS Strategic Initiatives did not specifically address utilization management-related opportunities.

After the initial review, WPM submitted minutes from the Maryland Clinical Services Committee meeting of October 15, 2025, which listed utilization management-related initiatives to address opportunities for improving provider satisfaction with the authorization process. There was no evidence of any action plans related to addressing utilization management opportunities related to CAHPS survey results. The finding of *Unmet* remains unchanged.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, WPM must demonstrate development and implementation of action plans to address utilization management-related opportunities to improve satisfaction based upon CAHPS survey results and provide updates to the quality committees at the frequency identified in its *Member Satisfaction Survey Policy*. Additionally, the applicable quality committee and frequency of reporting must be specified in the *Practitioner/Provider Satisfaction Survey Policy*.

Standard 9: Health Education Plan

The MCO must have a comprehensive educational plan and have mechanisms in place to oversee that appropriate health education activities are provided or are available at each provider site. The educational activities must include health education on subjects that affect the health status of the enrollee population.

ABH Findings

9.5 - The MCO must make the education program available to the enrollee population and demonstrate that enrollees have attended. The MCO must provide:

This element is *Met*.

- 9.5c.** Provider evaluations of health education programs.
This component is *Met*.

In response to the MY 2024 review, ABH was required to demonstrate provider feedback related to evaluation of its HEP. As indicated below, this opportunity for improvement was successfully addressed.

Review of three Quality Management/Utilization Management meetings from 2025 affirmed presentation of the annual HEP, Annual HEP Evaluation, and HEP workplan updates. Documented attempts were made to solicit provider feedback on the HEP without

success. A provider did comment in the August 14, 2025, meeting on plans to send new educational mailers to enrollees on colon, lung, and breast cancer screenings. Minutes stated, *“Dr. Isles liked the mailers. She found they were easy to read, visually engaging, and attention grabbing for our members. She also noted the graphics were effective.”*

RECOMMENDATION: It is recommended that ABH consider exploring other options for obtaining provider feedback on the HEP and advise that this feedback is a requirement of the program.

KPMAS Findings

9.3 - The MCO's HEP must:

This element is *Unmet*.

- 9.3a.** Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as emergency room utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.
This component is *Unmet*.

In response to the MY 2024 review, KPMAS was required to include evaluation measures that are more indicative of the health of the enrollee population, such as the impact of health education on Emergency Department utilization, hospital admissions, utilization of preventive health services, and/or clinical measures, such as HbA1c for enrollees with diabetes in its annual evaluation of the impact of the HEP. As indicated below, continued opportunities for improvement exist.

The HEP has been revised to include process and outcome measures in its annual evaluation of the impact of the HEP. Specifically, the HEP includes the following statement in the *“Impact Evaluation Methodology and Reporting”* section:

Annual process and outcomes evaluation of the impact of health education on the health of the enrollee population. Assessment includes utilization, such as urgent care, emergency room, and outpatient/primary care; clinical measures, such as glycemic control (A1c) and depression symptoms (PHQ-9); and preventive care, such as weight loss, tobacco cessation, postpartum visit timeliness, and breastfeeding post-delivery.

KPMAS did not submit an annual evaluation of the impact of the HEP to demonstrate inclusion of these process and outcome measures.

After the initial review, KPMAS indicated in their exit letter response that its *MY 2025 Health Education Plan Annual Evaluation* would not be completed until April 2026 in order to incorporate data for the entire year, which takes approximately three months after the close of the MY due to the claims lag. The finding of *Unmet* therefore remains unchanged.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2026 review, KPMAS must submit an annual evaluation of the impact of the HEP, which includes process and outcome measures identified in its methodology.

MPC Findings

9.3 - The MCO's HEP must:

This element is *Met*.

- 9.3a. Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as emergency room utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.
This component is *Met*.

In response to the MY 2024 review, MPC was required to further explore opportunities to evaluate the effectiveness of the MCO's various health education programs on process and outcome measures through pre- and post-enrollee participation on relevant outcome measures or comparisons to non-participants on selected measures. As indicated below, this opportunity for improvement was successfully addressed.

The *Prevention and Wellness Program Policy* requires MPC to evaluate the effectiveness of the HEP and goals, at least annually. Benchmarks and goals are based on national standards and/or MPC thresholds.

As evidence of compliance, MPC submitted the *2025 Effectiveness of Health Education Analysis*, which focused on evaluating the impact of health education on PCP follow-up visits, postpartum care visits, and increases in statin utilization. Descriptions of each educational initiative and their impact on selected measure(s) follow.

Evaluating the impact of health education on PCP follow-up visits. Diabetic Eye Clinic events were held monthly in Baltimore and included an eye exam with an optometrist. During the event, Prevention & Wellness (P&W) staff provided health education to enrollees on diabetes care, nutrition and fitness, and the importance of attending routine PCP visits to manage their condition. Claims data from PCP visits following the Diabetic Eye Clinic events were used to determine if health education provided during the event on the importance of regular checkups with PCPs made an impact. According to MPC, the American Diabetes Association recommends diabetic enrollees follow-up with their PCP every three to six months for periodic monitoring. The eligible population

was identified as non-compliant enrollees in attendance at the event who had not received a diabetic eye exam in more than 12 months. Data showed that 224 enrollees attended Diabetic Eye Clinics and received health education in 2025. Of those enrollees, 165, or 74%, engaged with a PCP within three months of the event. Results show a 13% increase from 2024 to 2025 in the number of enrollees engaged with a PCP within three months of attending the events.

Evaluating the impact of health education on postpartum care visits. MPC's P&W staff partnered with Holy Cross Hospital to conduct a Baby Shower in Q4 2024 for pregnant women and new moms. During the event, P&W staff provided health education to enrollees, both orally and in writing, in the form of tip sheets on safe exercises and stretches during and after pregnancy, healthy foods safe to consume during pregnancy, the importance of postpartum care visits within three months of delivery, and the importance of immunizations for their babies. Information on the Pacify app was also provided to advise enrollees of its benefits, such as direct and virtual access to licensed healthcare professionals (including lactation consultants, nurses, and doulas). Claims data for postpartum visits following the event were used to determine if health education on the importance of postpartum visits within three months of delivery made an impact. The eligible population was identified as enrollees in attendance who were no more than 32 weeks pregnant. There were five enrollees that fell into the eligible population. Results showed that 100% of the enrollees attending the Baby Shower in the eligible population received timely postpartum visits (within three months of delivery).

Evaluating the impact of health education on increases in statin utilization. MPC's Pharmacy Team implemented a *Medication Therapy Management Program* to improve statin utilization for two HEDIS measures: Statin Therapy for Patients with Cardiovascular Disease (SPC) and Statin Therapy for Patients with Diabetes (SPD). The program includes telephone outreach focused on delivering health education to enrollees in need of statin therapy to improve understanding of their chronic condition(s) and medication adherence. The Pharmacy Team provided health education to address identified enrollee barriers, such as education on enrollees' chronic condition(s), the use of medications to manage their chronic condition(s), how statin therapy medication can improve their condition, and the importance of medication adherence. Pharmacy claims data was used to confirm the refill rates following enrollee health education outreach. A report of pharmacy claims data was pulled for the last 45 days to confirm that the claim was processed and not put back into stock due to the enrollee not picking up the medication. Data showed that from January to June 2025, outreach occurred to 204 enrollees for SPC with 53% of those enrollees filling their medication directly following the outreach and education. Outreach also occurred to 203 enrollees for SPD, resulting in 46% filling their medication directly following the outreach and education.

RECOMMENDATION: Qlarant recommends that MPC consider ramping up health education programs that demonstrate effectiveness in improving process and/or outcome measures for its membership.

MSFC Findings

9.3 - The MCO's HEP must:

This element is **Unmet**.

- 9.3a.** Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as emergency room (ER) utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.

This component is **Unmet**.

In response to the MY 2024 review, MSFC was required to demonstrate it has a written methodology for evaluating the impact of its HEP on process and outcome measures using either comparison groups or comparing individual process or outcome measures pre and post participation in health education activities. As indicated below, continued opportunities for improvement exist.

According to the HEP, MSFC developed several goals to assess the effectiveness of the health education program and activities. Among the calendar year (CY) 2025 goals identified, MSFC measured the impact of health education on health outcomes, such as emergency room visits, medication adherence, improved dilated eye exams for enrollees with diabetes, timeliness of screenings, and tests.

MSFC did not submit an annual evaluation of its HEP that demonstrates the impact of health education activities on identified health outcomes.

After the initial review, MSFC submitted the draft *Health Education Appraisal CY 2025*. This document included the methodology for evaluating the effectiveness of health education programs; however, no evaluations of specific health education programs were included. According to this document, the methodology for program evaluation includes,

Processes and outcome measures, such as knowledge, behavior change and overall impact which include: scheduling and timeliness of appointments, screening and treatment compliance, medication adherence, reduction/elimination of social determinants of health, barriers to healthcare access, emergency room (ER) utilization, avoidable hospital admissions, utilization of preventive services, utilization of resources and educational materials, clinical measures, health outcomes/conditions, disease episodes, missed school and work days, morbidities.

MSFC also submitted the *2024 Health Education Appraisal*, which identified several HEDIS measures for improvement. Initiatives primarily focused on outreach and enrollee incentives with overall HEDIS rates compared to the prior MY.

Neither document submitted met the requirements of this component; therefore, the finding of Unmet remains unchanged.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of Met in the MY 2026 SPR, MSFC must submit an annual evaluation of the HEP, which includes comparative measures of its effectiveness on identified health process and outcome measures for those enrollees participating versus their prior performance on selected measures or that of a group of non-participants.

UHC Findings

9.3 - The MCO's HEP must:

This element is *Partially Met*.

- 9.3a.** Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as emergency room (ER) utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.
This component is *Partially Met*.

In response to the MY 2024 review, UHC was required to demonstrate it evaluates the effectiveness of its HEP on process and/or outcome measures. As indicated below, continued opportunities for improvement exist.

UHC provided the *Maryland 2026 Health Education Program Plan*, which included a section entitled "*Program Evaluation*". Several measures were evaluated; however, it was found that they were not connected to any health education initiative, or comparison data was not used. For example, UHC implemented a standardized transition of care model, including 48-to-72-hour post discharge outreach, medication reconciliation within seven days, PCP follow-up scheduling, a Social Determinants of Health assessment, and high-risk monitoring, which it attributed to reducing the 30-day readmission rate from 27% to 6.3% within 12 months. Additionally, there was no evidence of the success of enrollee outreach and education focused on the completion of the initial health assessment with their care provider through comparison of results to a control group or prior period. Similar findings were found for the targeted outreach and education on the human papillomavirus directed at non-compliant enrollees in three locations. The Well Child Visit Gap Closure limited its evaluation to the percentage of appointments kept also providing no comparison data with either a control group or pre- and post-measures.

After the initial review, UHC requested its *Health Education Program Plan* be reevaluated since it was updated based upon reviewer feedback in response to the MY 2024 submission. It specifically noted that it did identify additional opportunities to evaluate the effectiveness of its HEP through the inclusion of the new enrollee health risk assessment and well-child visit gap closure. According to UHC, because of UHC's Outreach agent explaining the importance of completing the initial health assessment with their care provider, 26% of enrollees completed the care visit and 24% of those completed the visit within the recommended 90 days from the

time of enrollment. To successfully evaluate the effectiveness of this intervention the percentage of new enrollees completing the initial health assessment visit contacted by the Outreach agent could be compared to those new enrollees who completed the initial health assessment visit where there was no contact with the Outreach agent. This approach could also be considered for evaluating the effectiveness of the percentage of well-child visits kept by those contacted and educated on the importance of the visit in comparison to those enrollees where there was no contact by the contracted vendor.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of **Met** in the **MY 2026 SPR**, UHC must further explore opportunities to evaluate the effectiveness of its various health education programs on process and outcome measures based upon pre and post enrollee participation on relevant outcome measures or comparisons to non-participants on selected measures.

RECOMMENDATION: Qlarant recommends that UHC consider evaluating the effectiveness of health education provided through its chronic disease management program by comparing emergency room or inpatient admissions pre- and post-health education or comparing utilization for those in the chronic disease management program with enrollees declining participation. Medication adherence, another program mentioned in UHC's health education program plan, could also be considered for evaluation, comparing pre- and post-adherence for participants. These initiatives provide improved opportunities for evaluation of health education in comparison to those initiatives that are more outreach-focused.

Standard 11: Fraud and Abuse

The MCO maintains a Medicaid Managed Care Compliance Program that outlines its internal processes for adherence to all applicable federal and state laws and regulations, with an emphasis on preventing fraud and abuse. The program also includes guidelines for defining failure to comply with these standards.

KPMAS Findings

11.4 - The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address: This element is **Met**.

11.4c. Evidence of the Compliance Committee's review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate that the MCO contracts with.

This component is **Met**.

In response to the MY 2024 review, KPMAS was required to show evidence of its Compliance Committee's review and approval of each delegate's Compliance Plan and FWA policies and procedures. As indicated below, this opportunity for improvement was successfully addressed.

KPMAS has two delegates: MedImpact as the Pharmacy Benefits Manager (PBM) and Relations Insurance of Florida, the Non-Emergency Transportation vendor. Each quarter, the Compliance Committee reviews and approves these vendors' FWA reports. Annually, the Compliance Committee reviews vendor policies and procedures and Compliance Program Plans.

As evidence of compliance, KPMAS submitted meeting minutes to support oversight of vendors' FWA reports in each of the three quarterly Compliance Committee meetings held in March, July, and September 2025. KPMAS indicated it will submit Q4 MY 2025 Compliance Committee meeting minutes (when available) as evidence of compliance with the requirements of this component.

After the initial review, KPMAS submitted December 2025 (Q4 MY 2025) Compliance Committee meeting minutes reflecting submission of Program Integrity: Fraud, Waste, and Abuse reports from each delegate, the details of which are noted below.

MedImpact's FWA quarterly activity reports from Q3 MY 2025 were reviewed by KPMAS:

- National Special Investigations Unit on October 29, 2025.
- PBM Vendor Management on October 31, 2025.
- Pharmacy Benefits department on November 18, 2025.

The Compliance Committee also reviewed and approved *MedImpact's Compliance Program Description*, a PBM claims review report, annual FWA desk audit findings, and the *PBM's Network Management FWA* program plan.

The KPMAS delegation oversight teams reported to the December Compliance Committee its findings from the November 7, 2025, audit of Relations Insurance FWA quarterly activity reports from Q3 MY 2025 and the delegate's annual *FWA Program Description*, FWA policies and procedures, and upcoding guidelines.

RECOMMENDATION: Qlarant recommends KPMAS consider submitting only the relevant section of the Compliance Committee report if the rest of the report is redacted and improve the clarity of actual dates of committee meetings.

WPM Findings

- 11.4d.** Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.

This component is *Met*.

In response to the MY 2024 review, WPM was required to ensure the Compliance Committee reviews and approves each delegate's FWA activity quarterly. If a *Special Investigations Unit (SIU) Report* is given that addresses delegate oversight of their SIU FWA activity, the name of the delegate and the date of that oversight should be documented in Compliance Committee meeting minutes per component 11.1d. As indicated below, this opportunity for improvement was successfully addressed.

WPM implements a process for continuous oversight of vendor FWA activity. This process touches several different WPM departments. These include: the Vendor Oversight team at the Wellpoint Enterprise level, who perform delegate annual audits and overall vendor contract management, WPM's delegate oversight management team leads, the Wellpoint SIU, and the WPM Compliance Department.

Representatives from WPM's Compliance Department, Compliance Committee, internal vendor oversight management leads, and the SIU meet virtually monthly to monitor FWA activity for both the MCO and WPM's delegated entities (in this case, MTM and Superior Vision). The SIU performs FWA audits, investigations, and analysis of actual and potential FWA. This work is summarized in a Monthly SIU Dashboard as evidenced in SIU dashboards for March, June, September, and November 2025. This monthly data is rolled up into a quarterly report and submitted to the Compliance Committee and reviewed as part of the *SIU/Program Integrity Report*. Slide presentations from the SIU to the Compliance Committee for 2025 support that this process is occurring. FWA data are also reviewed at quarterly Joint Operations Committee (JOC) meetings. WPM's JOC meetings include representatives from WPM's Compliance Department, SIU, and JOC vendor managers and relevant representatives from MTM and Superior Vision. As noted on November 11, 2025, Maryland Medicaid SIU Monthly Dashboard, these quarterly meetings review delegates' FWA activity and any referrals to the SIU.

The quarterly delegate FWA oversight process occurs in several venues, including the Delegation Oversight Committee, the JOC, the monthly SIU meetings, the WPM Compliance Committee, and the QMC.

The Compliance Department and SIU provide FWA activity reports to the Compliance Officer and Compliance Committee. These reports are given, in part, in the form of updates to the compliance work plan and include a standing agenda item in the Compliance Committee meeting minutes dedicated to SIU/Payment Integrity reporting. The Vendor Management section documents oversight of MTM and Superior Vision.

There is evidence of the Compliance Committee's quarterly review and approval of MTM and Superior Vision delegate FWA activity (reported from SIU Dashboards) in the following Compliance Committee meeting minutes:

- Q4 2024 - March 13, 2025
- Q1 2025 - June 12, 2025
- Q2 2025 - September 10, 2025
- Q3 2025 - December 19, 2025

RECOMMENDATION: Qlarant recommends WPM consider enhancing the delegate FWA oversight process. Given the many different touchpoints in the process, it might be helpful to create a process flow diagram to include departments and committees covering whom and from where information is shared. In the Compliance Committee slide decks on Vendor Monitoring and Oversight report headings could include, in addition to Results of Vendor Audits and FWA Plans, Quarterly Vendor FWA Activity Reports. Documented findings should stay away from using the term "No Reports" to imply there were no FWA findings; this statement could also indicate the vendor did not provide FWA data to WPM. It would be clearer to document that, for example, MTM and Superior Vision had no FWA findings for the quarter or investigation for the quarter found no FWA activity to report.

Standard 12: Disenrollment Requirements and Limitations

The provisions for disenrollment apply to all managed care programs whether enrollment is mandatory or voluntary. This includes state contracts with MCO, prepaid inpatient health plan, prepaid ambulatory health plan, primary care case management (PCCM), or PCCM entities. MCO policies and procedures must address the federal and state requirements for enrollee disenrollment when initiated by the Department, the MCO, and the enrollee. Policies and procedures must specify when disenrollment is for cause and without cause, methods for communicating requests for disenrollment, and the timeliness of disenrollment procedures.

ABH Findings

12.1 - The MCO may request disenrollment for an enrollee from the HealthChoice program in accordance with federal and state regulations.
This element is *Met*.

12.1a. MCO policies and procedures specify the reasons for which the MCO and the Department may request enrollee disenrollment.
This component is *Met*.

ABH provided partial evidence that the MCO policies and procedures specify the reasons the MCO and MDH may request enrollee disenrollment. ABH's *Member Disenrollment Policy* states, *Aetna Better Health requests member disenrollment due to:*

- *The enrollee is determined to reside outside of the service area.*
- *The enrollee is determined to be deceased.*
- *Enrollee is determined to be incarcerated.*
- *Medically necessary, continuous institutionalization for a period of more than 90 successive days in a long-term care facility.*
- *Admissions to an intermediate care facility for individuals with intellectual disabilities or persons with related conditions (ICF/IID).*
- *Determined eligible for rare and expensive case management pursuant to COMAR 10.09.69.*
- *The enrollee is 65 years old or older.*
- *The enrollee is eligible to receive Medicare benefits.*
- *Changes to an assistance category and member is not eligible for MCO Enrollment.*
- *The enrollee is not validly enrolled in an MCO.*

However, ABH did not provide evidence in policies and procedures that specify the reasons MDH may request enrollee disenrollment.

After the initial review, ABH provided a copy of the ABH enrollee handbook that noted reasons that Medicaid coverage may end and noted reasons Medicaid can disenroll a member from an MCO.

RECOMMENDATION: Qlarant recommends that ABH consider adding within MCO policies and procedures specific reasons MDH can request enrollee disenrollment.

12.3 - The MCO policies and procedures specify the methods by which the MCO assures the state that it does not request disenrollment for reasons other than those permitted under the contract.

This element is *Partially Met*.

ABH provided partial evidence that the MCO policies and procedures specify the methods by which the MCO assures MDH that ABH does not request disenrollment for reasons other than those permitted under the contract. The *Enrollee Disenrollment Policy* states, “*Aetna Better Health does not process disenrollments unless Maryland Department of Health (MDH), which has the sole authority to disenroll members, has directed or approved the action*”.

The policy continues to state:

The Department and Maryland Health Benefit Exchange (MHBE) are responsible for notifying Aetna Better Health of member disenrollments, reasons for disenrollments and effective dates. Aetna Better Health reconciles the business application system with the enrollment and disenrollment records from the Department.

As detailed below, opportunities for improvement exist.

After the initial review, ABH provided a job aid with documentation regarding the enrollment broker and outlined policy identifying the process for involuntary disenrollments. However, this does not specify the methods by which ABH assures MDH that it does not request disenrollment.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, ABH must specify within policies and procedures the methods by which ABH assures MDH that it does not request disenrollment for reasons other than those permitted under the contract.

RECOMMENDATION: Qlarant recommends ABH to consider adding specific language to ABH's disenrollment policies.

UHC Findings

12.3 - The MCO policies and procedures specify the methods by which the MCO assures the state that it does not request disenrollment for reasons other than those permitted under the contract.

This element is *Met*.

UHC did not provide clear evidence that the MCO policies and procedures specify the methods by which the MCO assures MDH that it does not request disenrollment for reasons other than those permitted under the contract. Review of the presented *Disenrollment Policy* found it did not specify the methods utilized by the MCO to assure MDH it does not request disenrollment for reasons other than those permitted under the contract.

After the initial review, UHC presented compliance in its *Disenrollment Policy*, which prohibits the MCO from requesting enrollee disenrollment based on any of the following:

- *An adverse change in the enrollee's health status.*
- *The enrollee's utilization of medical services (overutilization and underutilization).*
- *An enrollee's diminished mental capacity.*

- *An enrollee's uncooperative or disruptive behavior resulting from his or her special needs. (An exception applies when the enrollee's continued enrollment in the MCO seriously impairs the MCO's ability to furnish services to either this enrollee or other enrollees).*

The policy further states:

Member-facing staff who receive notification of UHC enrollees who are known to have reasons to be disenrolled are required to forward these cases via e-mail to the health plan newborn coordinator at michele_forbes@uhc.com. The newborn coordinator will review the request to confirm that it meets appropriate criteria as follows:

A. Member or authorized representative has indicated one of the following:

- *Enrollee has moved their primary residence out of the UHC service area.*
- *Enrollee has resided in a long-term care facility for more than 90 successive days.*
- *Enrollee has been admitted to an intermediate care facility (ICF) for individuals with intellectual disabilities (IID) or persons with related conditions.*
- *Enrollee is eligible for rare and expensive case management (REM) pursuant to COMAR 10.09.69.*
- *Enrollee is no longer eligible for Medicaid*
- *Enrollee has changed to an assistance category not eligible for MCO enrollment.*
- *Enrollee is deceased.*
- *Enrollee is otherwise not validly enrolled in the health plan.*
- *Enrollee is 65 years of age or older.*
- *Enrollee is eligible to receive Medicare benefits.*
- *Enrollee is an inmate of a public institution, including a State operated institution or facility.*

RECOMMENDATION: Qlarant recommends UHC add specific language to the Disenrollment Policy that identifies the methods by which the MCO assures MDH that it does not request disenrollment for reasons other than those permitted under the contract.

WPM Findings

12.3 - The MCO policies and procedures specify the methods by which the MCO assures the state that it does not request disenrollment for reasons other than those permitted under the contract.

This element is *Unmet*.

WPM did not provide clear evidence that the MCO's policies and procedures specify the methods by which the MCO assures MDH that it does not request disenrollment for reasons other than those permitted under the contract. It did not include language within its *Disenrollment Policy* specifying methods by which it assures MDH that it does not request disenrollment for reasons other than those permitted under the contract.

After the initial review, WPM submitted a copy of the highlighted *Disenrollment Policy*. However, this policy does not contain the specific language by which the MCO assures MDH that it does not request disenrollment for reasons other than those permitted under the contract.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of *Met* in the MY 2026 SPR, WPM must update its *Disenrollment Policy* to specify the methods by which the MCO assures MDH that it does not request disenrollment for reasons other than those permitted under the contract.

Appendix C: MCO Profiles

This appendix includes assessments of MCO performance to identify strengths, improvements, opportunities for improvement, and recommendations; and evaluates compliance in addressing previous recommendations that resulted in the need for corrective action. Identified strengths, improvements, opportunities for improvement, and recommendations correspond to quality, access, and/or timeliness of services delivered to MCO enrollees. Applicable domains for each strength, improvement, or recommendation are identified with an arrow (↑) or ↓ and color-coded cells, indicating a positive or negative impact. Not all domains were impacted by each strength, improvement, or recommendation. Where applicable, recommendations include opportunities for improvement. Assessment outcomes (shown as color-coded cells and ↑ or ↓) identify if the MCO adequately addressed previous MY recommendations. This section includes results per MCO.

ABH

Quality, Access, and Timeliness

Improvements, Opportunities for Improvement, and Recommendations	Assessment
Improvements: - Ensuring that all initial credentialing records include a notice of intent to continue or reject the application process within 30 days of receipt of the initial provider application. (Component 4.4j) - Tracking and trending grievances by category, identifying opportunities for improvement, and taking appropriate action to address identified opportunities, consistent with the MCO's Enrollee Complaint/Grievance Process Policy. (Component 5.1d) - Including a requirement for annual training of Utilization Management staff on the interpretation and application of medical necessity criteria/guidelines in either the Utilization Management Program Description or an appropriate Utilization Management policy. (Component 7.2e) - Revising the Pharmacy Prior Authorization and Formulary Exceptions Policy to include the requirement for notifying the prescriber of the outcome (approve, deny, or request additional information) of the preauthorization request for a covered outpatient drug by telephone or other telecommunication device within 24 hours of receipt of the request. (Component 7.4c) - Removing reference to urgent and non-urgent, as all outpatient drug requests are subject to the same requirements. (Component 7.4c) - Providing evidence of compliance with the timeframe for notifying the prescriber of the outcome of a preauthorization request within 24 hours of receipt, on at least a quarterly basis. (Component 7.4c)	↑

Improvements, Opportunities for Improvement, and Recommendations	Assessment
- Revising the Enrollee Appeals Policy to specify the timeframe for filing an appeal within 60 calendar days from "the date on the MCO's adverse determination letter." (Component 7.7a) - Revising the Provider Appeals Policy to require a written notice of appeal resolution be sent to the provider, regardless of whether the appeal is filed verbally or in writing. (Component 7.8a) - Including a final step in the job aid for timely payment of IRO invoices to identify the process for follow-up with Accounts Payable to ensure payment is issued within the designated timeframe and cross-referencing this job aid in the Provider Appeals Policy. (Component 7.10) - Demonstrating provider feedback related to evaluation of its HEP. (Component 9.5c)	
Opportunities for Improvement: ABH must submit an annual CAP to achieve compliance in MY 2026: - Demonstrate response to identified opportunities for improving provider satisfaction with the utilization management process, as evidenced by meeting minutes and provider satisfaction improvement work plans. (Component 7.9c) - Specify within policies and procedures the methods by which the MCO assures MDH that it does not request disenrollment for reasons other than those permitted under the contract. (Element 12.3)	↓
Recommendations: - Exploring other options for obtaining provider feedback on the HEP and advising that this feedback is a requirement of the program. (Component 9.5c) - Adding within MCO policies and procedures specific reasons MDH can request enrollee disenrollment. (Component 12.1a) - Adding the specific language to ABH's disenrollment policies. (Element 12.3)	↓

Green and ↑ = positive impact; Pink and ↓ = negative impact with required corrective action; Blue and ↓ = negative impact with informal recommendation.

CFCHP

Quality, Access, and Timeliness

Strengths, Improvements, and Opportunities for Improvement	Assessment
Strengths: Routinely monitoring initiatives to address targeted areas of overutilization and underutilization and conducting a root cause analysis when improvement is not achieved, implementing additional or revised interventions as needed. (Component 7.3c)	↑
Improvements: - Demonstrating consistent compliance with grievance acknowledgment letter timeliness. (Component 5.1g) - Providing evidence that all Utilization Management staff members sign an Affirmative Statement, which includes the required content identified in the Affirmative Statement Policy, on an annual basis. (Component 7.1c) - Demonstrating consistent reporting of identified metrics to the Quality Improvement Committee (QIC), consistent with the Health Services Program Description. (Component 7.3a) - Taking appropriate action based upon identified opportunities to improve overutilization and underutilization of healthcare services, as evidenced by reporting to the QIC and consistent with the MCO's Health Services Program Description. (Component 7.3b) - Demonstrating routine monitoring of action plans implemented to address areas of overutilization and underutilization by the QIC, consistent with its Health Services Program Description. (Component 7.3c) - Updating the Pharmacy Prior Authorizations Standard Operating Procedure to include information from MCO Transmittal No. 225, dated October 3, 2024, which provides up to 14 calendar days, including the original 24-hour decision timeframe, for a determination about a covered outpatient drug if additional clinical information is requested. (Component 7.4c) - Revising the Timeliness of Utilization Management Decisions Policy to include all components required in enrollee adverse determination letters. (Component 7.5b) - Revising the Pharmacy Prior Authorizations Standard Operating Procedure to require notifying the enrollee of an adverse determination within 24 hours of the preauthorization determination to support the additional time allowed for a provider to submit requested clinical information, as outlined in the October 3, 2024, MCO No. 225 transmittal. (Component 7.6a) - Revising the Medicaid Member Appeals Policy and Medicaid Member Appeals Standard Operating Procedure to clarify the appeal filing timeframe is 60 calendar days from the date on the notice of adverse determination. (Component 7.7a)	↑

Strengths, Improvements, and Opportunities for Improvement	Assessment
Providing evidence of review and approval of three delegates' (CVS, Superior, and Webb Mason Supply Logic) Compliance Plans at the November 5, 2025, Compliance Committee meeting. (Component 11.4c)	
Opportunities for Improvement: CFCHP must submit an annual CAP to achieve compliance in MY 2026: - Provide clear evidence that the MCO discusses enrollee grievances with the CAB and identifies actions taken to address opportunities for improvement. (Component 5.7d) CFCHP must submit a quarterly CAP to achieve compliance in MY 2026: - Demonstrate consistent compliance with timeframes for written enrollee appeal acknowledgment and resolution/notification for expedited appeals, at or above the MDH threshold of 95%, for all four quarters of the MY. (Components 7.7c) - Demonstrate a reasonable attempt to provide the enrollee with verbal notification of the denial of a request for an expedited appeal resolution and written notification within two calendar days of the denial decision, at or above the MDH threshold of 95%, on at least a quarterly basis throughout the MY. (Component 7.7e)	↓

Green and ↑ = positive impact; Pink and ↓ = negative impact with required corrective action

JMS

Quality, Access, and Timeliness

Improvements	Assessment
Improvements: Providing photographic evidence of postings of notices and taglines when the MCO interacts with enrollees during community events. (Component 5.8d)	↑

Green and ↑ = positive impact

KPMAS

Quality, Access, and Timeliness

Improvements, Opportunities for Improvement, and Recommendations	Assessment
Improvements: - Demonstrating reporting and analysis of Maryland HealthChoice grievance data to the Regional Quality Improvement Committee (RQIC) on a quarterly basis, which included any identified opportunities for improvement and associated action plans. (Component 5.1d) - Eliminating the sole use of goals to determine if an opportunity for improvement exists upon analysis of grievance data. (Component 5.1d) - Eliminating "strive to" verbiage (include special needs members) within the Maryland Consumer Advisory Board Policy and providing evidence of CAB membership, including special needs enrollees. (Component 5.7a) - Updating the MD HealthChoice Pharmacy Service Authorizations Policy to include information from MCO Transmittal No. 225, dated October 3, 2024, which provides up to 14 calendar days, including the original 24-hour decision timeframe, for a determination about a covered outpatient drug if additional clinical information is requested. (Component 7.4c) - Revising the adverse determination notification timeframe in the MD HealthChoice Pharmacy Service Authorizations Policy from 24 hours from receipt of the preauthorization request to the date of determination. (Component 7.6a) - Revising the Provider Claim Disputes/Appeals Policy - MD to specify the timeframe for resolving subsequent levels of provider appeals beyond the initial appeal. (Component 7.8b) - Providing documentation that demonstrates specific initiatives have been implemented to address opportunities for improvement related to results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS)[®] survey. (Component 7.9c) - Providing evidence of its Compliance Committee's review and approval of each delegate's Compliance Plan and Fraud, Waste, and Abuse (FWA) policies and procedures. (Component 11.4c)	↑
Opportunities for Improvement: KPMAS must submit a quarterly CAP to achieve compliance in MY 2026: - Revise the Provider Claim Disputes/Appeals Policy - MD or develop a desktop procedure documenting the process for ensuring IRO invoices are paid within the required 60 calendar days. Additionally, KPMAS must submit evidence that the process has been implemented. (Element 7.10) - Submit an annual evaluation of the impact of the HEP, which includes process and outcome measures identified in its methodology. (Component 9.3a)	↓

Improvements, Opportunities for Improvement, and Recommendations	Assessment
Recommendations: - Revise the Provider Claim Disputes/Appeals Policy - MD to replace Department of Health and Mental Hygiene (DHMH) with MDH (Maryland Department of Health) as it is currently known. (Element 7.10) - Submit only the relevant section of the Compliance Committee report if the rest of the report is redacted and improve the clarity of actual dates of committee meetings. (Component 11.4c)	↓

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MPC

Quality, Access, and Timeliness

Strengths, Improvements, Opportunities for Improvement, and Recommendations	Assessment
Strengths: Developing and implementing an effective methodology for evaluating the impact of health education provided to focus population groups within its membership through selected Healthcare Effectiveness Data and Information Set (HEDIS)[®] measures. (Component 9.3a)	↑
Improvements: - Revising the Enrollee Grievance Policy to identify the timeframe for acknowledgment of receipt of an enrollee grievance. (Component 5.1a) - Demonstrating compliance with the timeframe for written grievance acknowledgment, at or above the MDH compliance threshold of 95%, on at least a quarterly basis throughout MY 2025. (Component 5.1g) - Revising the Pharmacy Prior Authorization Policy to include providing up to 14 calendar days for providers to submit additional information, if needed to make an authorization decision, and ensure consistency with MDH Transmittal No. 225, dated October 3, 2024. (Component 7.4c) - Revising the Corrective Managed Care Program Description to accommodate the designation of a new pharmacy provider if the enrollee moves out of the service area of the current pharmacy and adjusting the timeframe for submitting additional information to 20 days from the date of the notice, rather than the date of the decision. (Component 7.11a) - Adding education of Screening, Brief Intervention, and Referral to Treatment (SBIRT) and Release of Information for Substance Use Disorder (SUD), at a minimum, as content in the provider newsletter and directly on the MPC provider website. (Component 8.6)	↑

Strengths, Improvements, Opportunities for Improvement, and Recommendations	Assessment
Further exploring opportunities to evaluate the effectiveness of MPC's various health education programs on process and outcome measures through pre- and post-enrollee participation on relevant outcome measures or comparisons to non-participants on selected measures. (Component 9.3a)	
Opportunities for Improvement: MPC must submit an annual CAP to achieve compliance in MY 2026: Revise the Pharmacy Prior Authorization Policy timeframe for enrollee written notice of the determination from 24 hours of receipt of request to 24 hours from the decision, or equivalent language, for consistency with MCO Transmittal No. 225's allowance for a 14-calendar day extension if additional information is requested from the provider. (Component 7.6a)	↓
Recommendations: Revise health education programs that demonstrate effectiveness in improving process and/or outcome measures for its membership. (Component 9.3a)	↓

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MSFC

Quality, Access, and Timeliness

Improvements, Opportunities for Improvement, and Recommendations	Assessment
Improvements: - Clearly identifying the Quality Improvement Committee (QIC) as the governing body with authority to make decisions regarding the Quality Improvement Plan (QIP). (Element 2.1) - Showing in QIC meeting minutes that the governing body is taking an active part in monitoring quality improvement (QI) initiatives, establishing priorities, assessing performance barriers, and developing action plans for improvement. (Element 2.5) - Updating the Utilization Management Process Policy to include information from MCO Transmittal No. 225, dated October 03, 2024, which provides up to 14 calendar days including the original 24-hour decision timeframe for a decision about an outpatient drug covered if additional clinical information is requested. (Component 7.4c) - Presenting results of the annual Provider Satisfaction Survey to the QIC consistent with its policy. (Component 7.9b) - Demonstrating its HEP is in place for the entire MY. (Component 9.1a) - Providing clear evidence that the MCO policies and procedures specify the reasons for which the MCO and the Department may request enrollee disenrollment. (Component 12.1a)	↑

Improvements, Opportunities for Improvement, and Recommendations	Assessment
Opportunities for Improvement: MSFC must address the following MwO to achieve compliance in MY 2026: - Provide additional clarification in the Utilization Management Process Policy that the 14-day extension for additional clinical information not received within 24 hours of receipt of the request for preauthorization of a covered outpatient drug includes the initial 24-hour timeframe from receipt of the request. (Component 7.4c) MSFC must submit an annual CAP to achieve compliance in MY 2026: - Present CAB meeting minutes that display discussions of member grievances and any associated opportunities for improvement or interventions developed to address noted concerns. (Component 5.7d) MSFC must submit a quarterly CAP to achieve compliance in MY 2026: - Demonstrate timeframe compliance with sending the member written acknowledgment of a grievance receipt at or above the MDH compliance threshold of 95% on at least a quarterly basis throughout the MY. (Component 5.1g). - Demonstrate compliance with provider appeal acknowledgment letters and written resolution at or above the MDH threshold on at least a quarterly basis throughout the MY. (Component 7.8c) - Submit an annual evaluation of the HEP, which includes comparative measures of its effectiveness on identified health process and outcome measures for those enrollees participating versus their prior performance on selected measures or that of a group of non-participants. (Component 9.3a)	↓
Recommendations: Consider a consistent format for subcommittee reports. The section added for <i>Decisions and Action Steps Needed</i> was not consistent in all QIC meeting minutes. This section or something similar is useful for establishing follow-up items in subsequent QIC meetings. MSFC should continue refining succinctness of meeting minutes to prioritize metrics needing improvement. (Element 2.5)	↓

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PPMCO

Quality, Access, and Timeliness

Improvements and Opportunities for Improvement	Assessment
Improvements: - Reviewing the Quality Assurance Program Improvement (QAPI) Program Description and Work Plan, and the QAPI Program Evaluation in the first quarter of the year to allow for more timely analysis to detect the need for program change. (Component 1.2b) - Demonstrating the QAPI Committee reviews, approves, and documents, in meeting minutes, the committee's quarterly oversight of delegates, as written in policy and the QAPI Committee Charter. (Component 3.3a) - Identifying the specific overutilization and underutilization measures the MCO is addressing through the development of interventions and monitoring the progress of those interventions and how they are impacting the measures they are designed to address. (Component 7.3c) - Removing reference to the assumption of a five-day timeframe for mailing adverse determination notices within the appeal filing timeframe. (Component 7.5b) - Demonstrating compliance with the timeframes for adverse determination notifications, at or above the MDH threshold of 95%, on at least a quarterly basis for MY 2025. (Component 7.6b) - Demonstrating that annual Consumer Assessment of Healthcare Providers and Systems (CAHPS)[®] and Provider Satisfaction Survey results are reviewed annually by the appropriate oversight committee, as specified in the MCO's Member and Provider Experience with the Utilization Management Process Policy. (Component 7.9b) - Educating providers on the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process and Release of Information procedures in any of the following sources: the provider manual, new provider orientation program, the provider website, or in provider newsletters. (Component 8.6) - Demonstrating that the MCO analyzes negative outcomes, such as the increase in emergency room visits following class attendance, to understand the root cause(s); and determines any needed enhancements to class offerings. (Component 9.3a)	↑
Opportunities for Improvement: PPMCO must submit an annual CAP to achieve compliance in MY 2026: - Provide a report on enrollee grievances to the CAB, which includes actions taken to address identified opportunities for improvement. (Component 5.7d) - Eliminate the "expedited" category for provider administrative (claims) appeals. (Component 7.8c)	↓

Improvements and Opportunities for Improvement	Assessment
Revise the Member and Provider Experience with the Utilization Management Process Policy to identify the "appropriate oversight committee" referenced in this policy. (Component 7.9a) PPMCO must submit a quarterly CAP to achieve compliance in MY 2026: - Identify the specific quality committee(s) required to receive complaint and grievance data, on a quarterly basis, in the MCO's Member Complaints/Grievances Policy. (Component 5.1d) - Demonstrate compliance with the timeframes for acknowledgment letters and resolutions, by grievance category, at or above the MDH threshold of 95% for all four quarters of MY 2026. (Component 5.1g) - Report compliance as the overall percentage for the quarter, rather than the percentage capturing the average of compliance, for the three months within the quarter. (Components 5.1g and 5.1h) - Demonstrate compliance with the MCO's timeframe for grievance resolution letters, at or above the MDH threshold of 95%, for all four quarters of MY 2026. (Component 5.1h) - Demonstrate consistent compliance, at or above the MDH threshold of 95%, for 24-hour prescriber notifications no less than quarterly for MY 2026. (Component 7.4c)	

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UHC

Quality, Access, and Timeliness

Improvements, Opportunities for Improvement, and Recommendations	Assessment
Improvements: - Revising the MD Member Appeal, Grievance, and State Fair Hearing Policy to specify the appropriate quality committee(s) responsible for analyzing grievance data to identify opportunities for improvement and developing and monitoring action plans in response to identified opportunities. (Component 5.1d) - Ensuring meeting minutes of the appropriate quality committee(s) reflect identified opportunities and actions taken to address opportunities based upon analysis of grievance data. (Component 5.1d) - Revising the appropriate policy to include content found in MCO Transmittal No. 225, dated October 3, 2024, which allows up to 14 calendar days including the original 24-hour decision timeframe when additional information is requested in response to a preauthorization request for a covered outpatient drug. (Component 7.4c) - Providing evidence in case notes of fax notification of the outcome of a preauthorization request for a covered outpatient drug within 24 hours of receipt. (Component 7.4c)	↑

Improvements, Opportunities for Improvement, and Recommendations	Assessment
- Revising the Pharmacy TAT report to replace "final determination within 24 hours of the decision" to "final determination within 24 hours of receipt of preauthorization request" and add "determination within 24 hours of receipt of additional information not to exceed 14 calendar days from date of receipt"; and change faxed notification from "24 hours from the determination" to "24 hours from receipt of the preauthorization request". (Component 7.4c) - Revising the MD Medical TAT Report to replace "case closure" with "determination"; clarify the written notification of expedited request is "within 72 hours of receipt of the preauthorization request". (Component 7.4c) - Demonstrating compliance with resolution timeframes for provider appeals at or above the MDH compliance threshold of 95% on at least a quarterly basis for all four quarters of the MY. (Component 7.8b) - Demonstrating compliance with timeframes for acknowledgment and written resolution of provider appeals on at least a quarterly basis for all four quarters of the MY. (Component 7.8c) - Clearly documenting the Compliance Oversight Committee's (COC'S) annual review and approval of Fraud, Waste, and Abuse (FWA) policies and procedures and Compliance Plans for each of its delegates. (Component 11.4c) - Clearly documenting review and approval of each delegate's FWA/SIU activities on a quarterly basis in the Compliance Oversight Committee's (COC's) meeting minutes and in relevant Compliance Program policies and procedures. (Component 11.4d)	
Opportunities for Improvement: UHC must submit a quarterly CAP to achieve compliance in MY 2026: - Demonstrate compliance with required timeframes for written grievance acknowledgment and resolution by category at or above the MDH compliance threshold of 95% on at least a quarterly basis for all four quarters of the MY. (Component 5.1g) - Demonstrate compliance with required timeframes for written grievance resolutions at or above the MDH compliance score of 95% on at least a quarterly basis for all four quarters of the MY. (Component 5.1h) - Demonstrate compliance with a reasonable attempt to provide oral notification to the enrollee of any downgrade from an expedited to a standard request on at least a quarterly basis for all four quarters of the MY. (Component 7.7e) - Further explore opportunities to evaluate the effectiveness of its various health education programs on process and outcome measures based upon pre and post enrollee participation on relevant outcome measures or comparisons to non-participants on selected measures. (Component 9.3a)	↓
Recommendations: - Include the fax cover sheet or the fax number of the provider in the case record to demonstrate a fax was sent to the provider within 24 hours of receipt of the outpatient pharmacy request since UHC reported the preauthorization application does not currently display the outbound notification date and time stamp. (Component 7.4c) - Evaluate the effectiveness of health education provided through its chronic disease management program by comparing emergency room or inpatient admissions pre and post health education or comparing utilization for those in	↓

Improvements, Opportunities for Improvement, and Recommendations	Assessment
the chronic disease management program with enrollees declining participation. Medication adherence, another program mentioned in UHC's health education program plan, could also be considered for evaluation comparing pre and post adherence for participants. These initiatives provide improved opportunities for evaluation of health education in comparison to those initiatives that are more outreach focused. (Component 9.3a) • Add specific language to the Disenrollment Policy that identifies the methods by which the MCO assures MDH that it does not request disenrollment for reasons other than those permitted under the contract. (Element 12.3)	

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WPM

Quality, Access, and Timeliness

Improvements, Opportunities for Improvement, and Recommendations	Assessment
Improvements: • Revising the Member Grievances - MD Policy to explicitly address the requirement for documentation of the resolution of a grievance in the member's case record. (Component 5.1c) • Revising the timeframe for written grievance acknowledgment within its Member Grievances - MD Policy to be consistent with the MDH requirement, which allows waiver of the acknowledgment letter only if a grievance is resolved within the regulatory timeframe or within five calendar days whichever is less or its own policy if more stringent. (Component 5.1g) • Demonstrating that utilization management staff participated in annual training on the interpretation and application of utilization management criteria/guidelines, which includes training content and attendees. (Component 7.2e) • Including the role and responsibilities of the Clinical Service Committee in its Over/Under-Utilization of Services Policy. (Component 7.3a) • Demonstrating that action plans to address areas of overutilization and underutilization are presented to the identified committee(s) consistent with its Over/Under-Utilization of Services Policy. (Component 7.3b) • Demonstrating that action plans to address overutilization and underutilization of services are routinely monitored to determine their effectiveness and reported to the committee(s) specified in its Over/Under-Utilization of Services Policy. (Component 7.3c) • Providing compliance results for prescriber notification of the review outcome (approval, denial, or request additional information) by telephone or other telecommunication device within 24 hours of receipt of a preauthorization request for a covered outpatient drug for each quarter of the MY. (Component 7.4c)	↑

Improvements, Opportunities for Improvement, and Recommendations	Assessment
- Updating the Pharmacy Prior Authorization Policy to include information from MCO Transmittal No. 225, dated October 3, 2024, which provides up to 14 calendar days including the original 24-hour decision timeframe for a determination about a covered outpatient drug if additional clinical information is requested. (Component 7.4c) - Demonstrating compliance with adverse determination notification timeframes for medical and pharmacy preauthorization requests no less than quarterly throughout the MY. (Component 7.6b) - Ensuring the Compliance Committee reviews and approves each delegate's fraud, waste, and abuse (FWA) policies and procedures and Compliance/Anti-Fraud Plans at a minimum annually. (Component 11.4c) - Ensuring the Compliance Committee reviews and approves each delegate's FWA activity quarterly. (Component 11.4d)	
Opportunities for Improvement: WPM must submit an annual CAP to achieve compliance in MY 2026: - Provide clear evidence that it supplies a report on member grievances to the CAB on at least an annual basis, including actions taken to address identified opportunities for improvement. (Component 5.7d) - Specify in its Pharmacy Prior Authorization Policy the enrollee adverse determination notification timeframe for covered outpatient drug requests. (Component 7.6a) - Revise the Provider Claim Payment Dispute Process Policy to specify the MCO's timeframe for sending the provider a written appeal resolution for each level of appeal, which would allow sufficient time for a second-level of appeal if the provider so chooses. (Component 7.8c) - Update its Disenrollment Policy to specify the methods by which the MCO assures MDH that it does not request disenrollment for reasons other than those permitted under the contract. (Element 12.3) WPM must submit a quarterly CAP to achieve compliance in MY 2026: - Demonstrate it conducts an analysis of grievance data to identify opportunities for improvement and develops action plans to address identified opportunities consistent with the Member Grievances - MD Policy. (Component 5.1d) - Revise the Provider Claim Payment Dispute Process Policy to include the following: the MCO's timeframe for sending written notice of appeal resolution to the provider and the opportunity for the provider to have their final level of appeal heard by the MCO's CEO, or the CEO's designee. (Component 7.8a) - Demonstrate development and implementation of action plans to address utilization management-related opportunities to improve satisfaction based upon CAHPS survey results and provide updates to the quality committees at the frequency identified in its Member Satisfaction Survey Policy. (Component 7.9c) - Specify the applicable quality committee and frequency of reporting in the Practitioner/Provider Satisfaction Survey Policy. (Component 7.9c)	↓
Recommendations: Enhancing the delegate FWA oversight process. Given the many different touchpoints in the process, it might be helpful to create a process flow diagram to include departments and committees covering whom and from where information	↓

Improvements, Opportunities for Improvement, and Recommendations	Assessment
is shared. In the Compliance Committee slide decks on Vendor Monitoring and Oversight report headings could include, in addition to Results of Vendor Audits and FWA Plans, Quarterly Vendor FWA Activity Reports. Documented findings should stay away from using the term "No Reports" to imply there were no FWA findings; this statement could also indicate the vendor did not provide FWA data to WPM. It would be clearer to document that, for example, Medical Transportation Management Inc. (MTM) and Superior Vision had no FWA findings for the quarter or investigation for the quarter found no FWA activity to report. (Component 11.4d)	

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