C. Technical Approach

14. Enrollee Grievances and Appeals *(Section 24.0 Enrollee Grievances and Appeals)*
Describe the Vendor's proposed Enrollee Grievances and Appeals process, including a summary of methods for the following:

To serve our Kentucky Enrollees, we use the well-established grievances and appeals process that we operate in several states for more than 615,000 Medicaid Enrollees. Our system is structured to offer Enrollees a clear, easily accessible process to address dissatisfaction with Humana, our providers, or our subcontractors. We view grievances and appeals as a critical source of information about the quality of our operations and Enrollee satisfaction. Neither Enrollees nor their legally authorized representatives (LAR) (e.g., parents, guardians, caretakers, etc.) are subject to retaliatory actions if they choose to exercise their grievance and appeal rights. We communicate regularly with our Enrollees, their caregivers, and LARs, treating them fairly and respectfully using the latest cultural competency tools and services. We use data from our grievances, appeals, and Medicaid State Fair Hearings to improve our policies, procedures, and processes, including our quality improvement activities and Enrollee services.

a. Compliance with State and Federal requirements.

We maintain our grievances, appeals, and Medicaid State Fair Hearings standards in compliance with the requirements set forth by federal and State laws and accreditation bodies, including **42 CFR Part 431, Subpart E (Fair Hearings for Applicants and Beneficiaries), 42 CFR 438 Subpart F (Grievance/Complaint System), KRS Chapter 13B, and KRS 205.534(3)(a)**. Our state-of-the-art inventory management system is configured to comply with all applicable regulatory and contractual requirements, along with resolution timeframes and other relevant compliance obligations. Humana will provide DMS with written grievances and appeals policies and procedures for approval prior to implementation in accordance with Section 24.2 of the Draft Medicaid Contract.

We resolved **all standard grievances and appeals** within the required timeframes for **100%** of our Kentucky Medicaid grievances and appeals in 2019.

ENROLLEE GRIEVANCES AND APPEALS PROCESS

Please refer to **Attachment I.C.14-1** for flowcharts detailing our Enrollee grievances and appeals processes.

Enrollee Submission of a Grievance or Appeal

Humana's no wrong door policy enables Enrollees to submit grievances and appeals through the avenue most convenient to them and ensures they are consistently processed and tracked no matter the path that we receive them. Avenues available to Enrollees include calling our Kentucky Medicaid Member Services Call Center, utilizing mail or fax, visiting one of our more than 25 Humana physical locations across the Commonwealth, asking their provider to submit a grievance or appeal on their behalf, speaking with their care manager (if they have one), or speaking to one of our Subcontractors. Member Services Representatives (MSR) offer Enrollees needing assistance additional support in filing a grievance or appeal; Enrollees may also obtain assistance from their care managers. We train associates, providers, and Subcontractors to identify and handle grievances and appeals and emphasize the importance of assisting the Enrollee with filing.

Grievance and Appeal Teams

Our grievances and appeals (G&A) team processes grievances and appeals submitted to us directly from an Enrollee or their LAR. Our G&A team is led by Andrea Harvel, Director of Humana's Resolution team. Ms. Harvel has been with Humana for 30 years and has led our G&A operational teams for the last 13 years. She is

responsible for ensuring that we resolve all grievances and appeals in a fair and timely manner and that we adjust our policies and procedures to avoid future grievances and appeals. Our G&A team and leadership currently has **58 full-time associates with a combined 516 years of experience** and an average tenure of nine years with Humana.

We resolved all standard **grievances** within the required 30-day timeframe for **100%** of our Kentucky Medicaid grievances in 2019.

Grievances that Humana receives from the Department for Medicaid Services (DMS) (as opposed to an Enrollee), are processed by our specialized Critical Inquiry (CI) team. The CI team consists of 18 full-time associates with a combined 190 total years of experience and an average of more than 10 years with Humana. Our CI team is uniquely qualified to fulfill this role, as CI analysts are drawn from internal associates with experience in Humana's operations. We also ensure these associates have strong investigative and writing skills. We provide specialized training to all CI associates regarding the lines of business relevant to their substantive responsibilities and the Enrollee grievance process so they are familiar with every potential source of dispute. We also train the CI associates on Contractual requirements and compliance and provide retraining when there are changes to procedures or as needed based on internal reviews, Contract amendments, and new federal or State regulations.

Our Kentucky-based Enrollee and Provider Complaint, Grievance, and Appeal Coordinator, Andrea Williams, works closely with the G&A and CI teams to review and resolve grievances and appeals and to identify areas for operational improvement based on trend and root cause analysis.

Grievance and Appeal Systems

Our G&A system is built to comply with 42 CFR §438 Subpart F, 907 KAR 17:010, and Section 24 of the Draft Medicaid Contract, as well as other applicable Centers for Medicare and Medicaid Services (CMS) and Department guidelines. **We use our Customer Relationship Management (CRM) tool and a state-of-the-art inventory management system, mhk, for intake and management of our grievances and appeals compliance requirements**. Our system incorporates applicable notice and resolution timeframes and standardized communications that comply with mandatory provisions. Our inventory management system's advanced configurability enables the system to quickly adapt to market and regulatory changes as they occur.

Grievances

Humana's Internal Grievance system is designed to incorporate the requirements in 42 C.F.R. §431.200 and 42 C.F.R. Part 438, Subpart F, along with Section 24 of the Draft Medicaid Contract. Our inventory management system allows the G&A and CI teams to monitor all due dates and turnaround times and includes dashboards that allow associates to accurately track grievances and monitor performance metrics. The G&A and CI teams also leverage business intelligence tools, such as **Clarabridge**, to conduct advanced analytics. Clarabridge has built-in root cause analysis reporting so the G&A and CI teams can quickly identify trends and implement targeted process improvements. In 2019, our most frequently filed grievances were in the categories of billing, dissatisfaction with plan, dissatisfaction with provider, and pharmacy for our Kentucky Medicaid market.

Processing Grievances

Logging Grievances: All grievances submitted by Enrollees are logged by either a G&A associate or an MSR. The associate logs the grievance based on the date Humana (or our Subcontractor) receives it and enters them into our inventory management system. Our system tracks grievances by Enrollee name, description of the grievance, resolution date, expedited status, and other details. Associates and mhk use the date and time of receipt to calculate the resolution due date and timely filing requirements.

Research and Evaluation: Once logged, our inventory management system routes the grievance to a G&A associate who researches the issue, including contacting the provider and other business-area subject matter experts (SME). For example, to thoroughly develop the grievance case file, a G&A associate may work with our clinical team, behavioral health (BH) experts, or pharmacy team to gather information relevant to the case. The

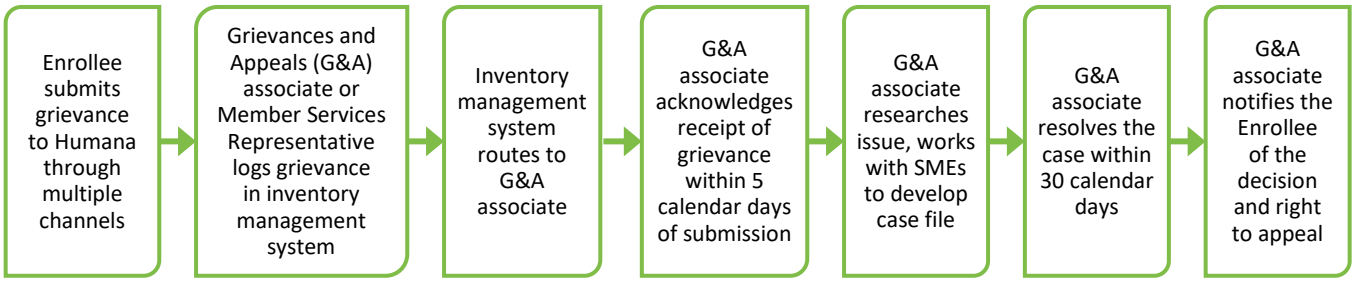
G&A associate compiles a clear case file that is stored on our inventory management system. Following compilation of a thorough case file, the G&A associate evaluates the grievance in consultation with relevant associates and SMEs.

Resolution and Notice: The G&A associate next drafts a decision and resolves the issue within 30 days, in accordance with Section 24.2 of the Draft Medicaid Contract. Upon resolution of the grievance, the G&A associate sends a written resolution to the Enrollee or the Enrollee's LAR (or guardian) as quickly as possible, while considering the Enrollee's health and adhering to the required timeframes. The associate shares the information with the Enrollee's CM, when necessary, to ensure proper follow up.

Processing DMS Inquiries: For all inquiries from DMS, the inventory management system flags the inquiry and routes them to the CI team. The CI team uses a distinct and integrated fast-track process for DMS requests. The CI team logs all inquiry documents into the inventory management system so that they are tracked appropriately and included alongside any other grievances, enabling us to monitor, trend, and conduct root cause analyses on all DMS inquiries.

Our grievance process is summarized below in **Figure I.C.14-1**.

Figure I.C.14-1 Enrollee Grievance Process



For a more detailed flowchart of Humana's enrollee grievances and appeals processes, please refer to **Attachment I.C.14-1**.

Appeals

Similar to our grievance system, Humana's Internal Appeal system is built to comply with 42 C.F.R. §431.200 and 42 C.F.R. Part 438, Subpart F, along with Section 24 of the Draft Medicaid Contract. Our G&A team utilizes the same inventory management system to log and track appeals and Clarabridge to analyze trends and identify opportunities for improvement. In 2019, our most frequently filed appeals were in the categories of pharmacy, outpatient hospital, dental, and durable medical equipment (DME) for our Kentucky Medicaid market.

Logging the Appeal: When an Enrollee submits an appeal, a G&A associate or MSR logs the appeal in our inventory management system. Our inventory management system tracks appeals by expedited status, Enrollee name, description of the appeal, resolution date, and other details. We use date and time of receipt to calculate the resolution due date and timely filing requirements. Our inventory management system flags requests for an expedited appeal and routes these appeals in accordance with our procedures, further described below.

Clinical Input: We ensure appeals are resolved by healthcare professionals with relevant clinical expertise. **Humana's medical directors review all clinically related appeals and all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) appeals**. When our Kentucky Medicaid Medical Director, Dr. Lisa Galloway, or our Kentucky Medicaid Behavioral Health Director, Liz Stearman, are unable to review cases in the necessary timeframes, we rely on our corporate and market-level medical directors to provide input, ensuring that all clinical cases are reviewed with relevant expertise.

Unbiased Evaluation: **We approach every appeal in an objective, unbiased way**. Our inventory management system and G&A policies and procedures ensure that the G&A associates and medical directors who reviewed a

grievance are never involved in the appeals review for the same case. All grievance and appeal files also include the names of associates involved in each level of review to ensure the same decision maker is never involved in the appeals review.

Upon receipt of an appeal, a G&A associate assembles a case file, which includes the original claim or authorization denial, additional information submitted with the appeal, and supporting documentation. The G&A associate reviews the relevant information and consults with SMEs and appropriate clinical associates within Humana to develop and issue a resolution within 30 days in accordance with Section 24.2 of the Draft Medicaid Contract.

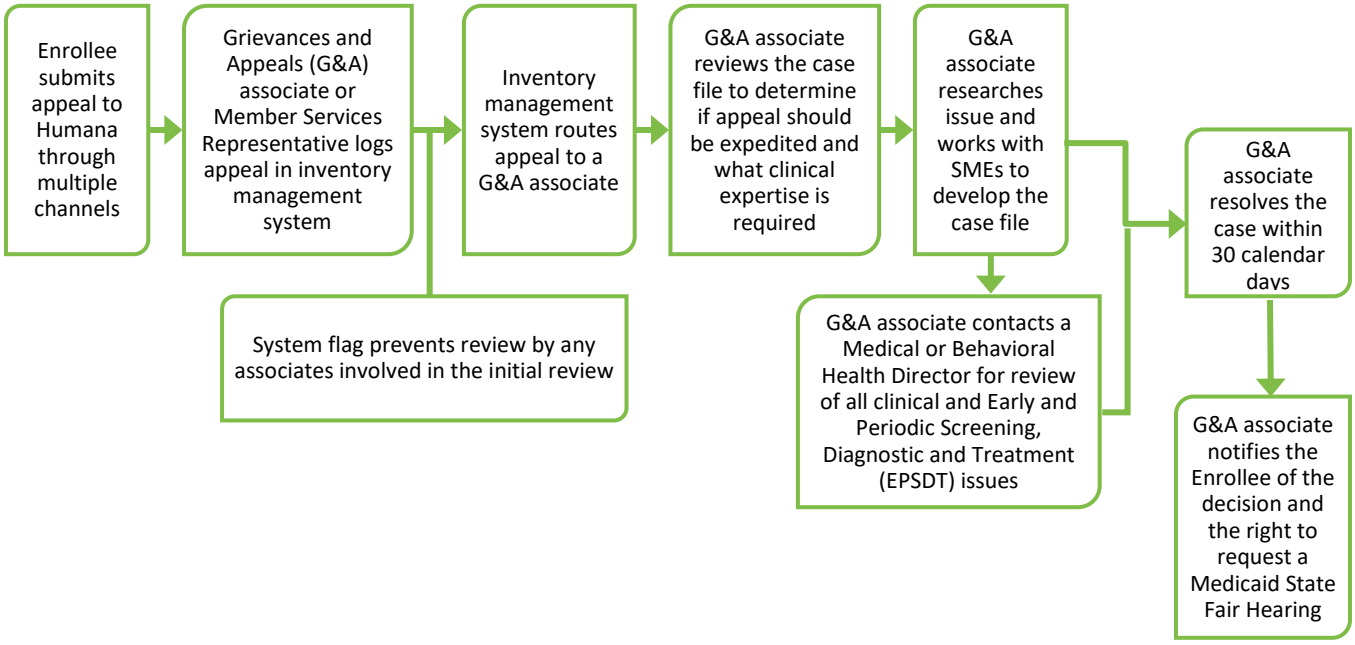
We resolved all standard **appeals** within the required 30-day timeframe for **100%** of our Kentucky Medicaid appeals in 2019.

Resolution and Notice: Following resolution of the appeal, an associate will send a disposition notice in compliance with the required timeframes, which may include a 14-day extension if the Enrollee or their LAR requests one. We also send a copy of the notice to the Enrollee's CM, when applicable, so that they may assist the Enrollee in requesting a Medicaid State Fair Hearing if the Enrollee so chooses. The notice of disposition includes:

- The right to request a Medicaid State Fair Hearing and how to request one
- The circumstances under which the Enrollee may continue to receive benefits pending a Medicaid State Fair Hearing and how to request these benefits
- If our action is upheld in a Medicaid State Fair Hearing, the Enrollee may be liable for the cost of any services furnished while the appeal was pending
- All items defined in Section 24 of the Draft Medicaid Contract will be included in Humana's notice of disposition

Our appeals process is summarized below in **Figure I.C.14-2**.

Figure I.C.14-2 Enrollee Appeals Process



For a more detailed flowchart of Humana's Enrollee grievances and appeals processes, please refer to **Attachment I.C.14-1**.

Expedited Appeals
As discussed in greater detail in sub-question I.C.14.b of this response, Enrollees or their providers may request an expedited appeal or a G&A associate may classify an appeal as expedited if following the standard resolution timeframe could seriously jeopardize the Enrollee's life or health. The G&A associate assigned the expedited appeal reviews the case file and information submitted with the expedited appeal, consults with one of our medical or BH directors to review and resolve the expedited appeal. We resolve each expedited appeal and supply notice as quickly as the Enrollee's health condition requires and no later than 72 hours after receipt of request for services, including holidays and weekends, in accordance with federal regulation 42 CFR 438.

OVERSIGHT OF G&A PROCESSES, POLICIES, AND PROCEDURES TO ENSURE COMPLIANCE WITH FEDERAL AND STATE REQUIREMENTS

Humana employs an Enterprise Risk Management (ERM) framework that provides structure and accountability for our local (market-based) monitoring activities as well as our corporate oversight functions. Our local and corporate monitoring teams use a single system, our Enterprise Solution Point (ESP) system, to track, monitor, and identify risk issues from mitigation to resolution, allowing for a seamless sharing of information and identification of risk areas. ERM is a systematic process that enables our managers to strategically identify potential risk events that may affect us and provide a structured framework to manage that risk. Compliance with federal and State requirements are central sources of risk.

In Kentucky, our Medicaid Operations team, led by our Kentucky Chief Operating Officer (COO), Samantha Harrison, owns and drives resolution of all market-level risks. Our Medicaid Operations team includes our Member 360 and Provider 360 Committees, which monitor our grievances and appeals, trends, and opportunities for improvement.

Our Medicaid Operations team is supported by corporate resources such as our **Contract Management Unit** (CMU). The CMU is responsible for monitoring sources of guidance and then summarizing and communicating this guidance to Humana associates responsible for CMS and State Medicaid agency Contract requirements. Examples of sources of this guidance are listed below:

- CMS Transmittals and Memoranda
- State Medicaid Agency Transmittals and Memoranda
- Health Plan Management System (HPMS) Memoranda
- Managed Care and Prescription Drug Benefit Manuals
- The Federal Register and Code of Federal Regulations
- The United States Code
- Commerce Clearing House Publications
- American Health Insurance Plan Mailings

Upon Contract award, the CMU conducts an initial review, examining the impact of all rules, regulations, and Contract requirements on our policies, processes, and procedures. This review includes all required Enrollee information materials, as well as guidance around grievances, appeals, and Medicaid State Fair Hearings. **The CMU distributes this information to all impacted departments, including the G&A and CI teams so that policies and procedures can be revised in accordance with all current regulations and Contract requirements. The G&A and CI teams are responsible for updating their policies and procedures to reflect changes in federal and State requirements with CMU monitoring these updates in the ESP platform until they are complete**.

Along with the CMU, Humana's **Operational Risk Management** (ORM) team works collaboratively with operational business areas to implement new or revised CMS and State Medicaid agency metrics and non-metrics. The ORM team also validates, collects, and uploads evidence of compliance with metrics and Humana-termed "non-metrics" to ESP. Humana classifies non-metrics as pieces of guidance or compliance that cannot be measured, such as "grievance response language must be written in terms easily understood by an Enrollee."

This classification allows Humana to measure qualitative in addition to quantitative compliance. Specifically, the ORM team is responsible for the following tasks:

- Assessing CMS and State Medicaid agency guidance and identifying new or revised metrics and non-metrics
- Seeking clarification from Regulatory Compliance or the legal team as necessary
- Gathering impacts (if any) from the identified business areas
- Facilitating the implementation of a new or revised metric and/or non-metric as needed
- Obtaining regular updates of the implementation status
- Collecting and storing evidence of compliance with the metric and/or non-metric within ESP

ORM has processes that measure and monitor compliance performance specific to CMS and State Medicaid agency Contract requirements using multiple dashboards that track and trend data.

During performance of the Contract, our **Regulatory Compliance** (RC) team is responsible for overseeing the operational and administrative effectiveness of Humana's compliance program. Through an effective system of routine monitoring, auditing, and identification of compliance risks, the RC team can effectively monitor adherence to State and federal requirements. This system includes extensive risk-based assessments of key administrative and operational functions, internal monitoring and auditing, and as appropriate, engagement of external monitoring and auditing to evaluate Humana's compliance with these requirements and the overall effectiveness of the compliance program. The RC team works closely with many internal departments and documents compliance deficiencies identified and corrective actions taken in ESP. Our RC associates, specifically our full-time dedicated Kentucky Chief Compliance Officer (CCO), Kimberly Myers, has responsibility for oversight and monitoring of compliance with federal, Commonwealth, and Contract requirements.

Grievance and Appeal Audits
Humana's National Quality Assurance (NQA) department conducts 10 audits per G&A associate per month to ensure adherence to relevant guidelines, regulations, and internal policies and procedures. When a variance is identified, NQA sends a report to the individual associate, team lead, and supervisor for review. At the end of each month, NQA aggregates a report of the month's performance to review the quality performance of each G&A associate and the department as a whole. These audits guide associate trainings and drive process improvements.

b. Process for Expedited Review.

Enrollees may file expedited appeals either orally or in writing in the same manner as a standard grievance or appeal with no additional follow up required. Our MSRs act as advocates for our Enrollees through the grievances and appeals process, assuring Enrollees receive adequate representation when seeking an expedited appeal in accordance with Section 22.1 of the Draft Medicaid Contract. Enrollees or their providers may request an expedited appeal or a G&A associate may classify an appeal as expedited if following the standard resolution timeframe could seriously jeopardize the Enrollee's life or health. Enrollees may also file an expedited grievance if Humana takes an extension on an appeal and the Enrollee disagrees. In 2019, the most frequent requests for expedited appeals were in the categories of pharmacy, inpatient services, outpatient services (including pain management, DME, genetic testing, physical therapy, and home health), psychiatric, and dental for our Kentucky Medicaid market.

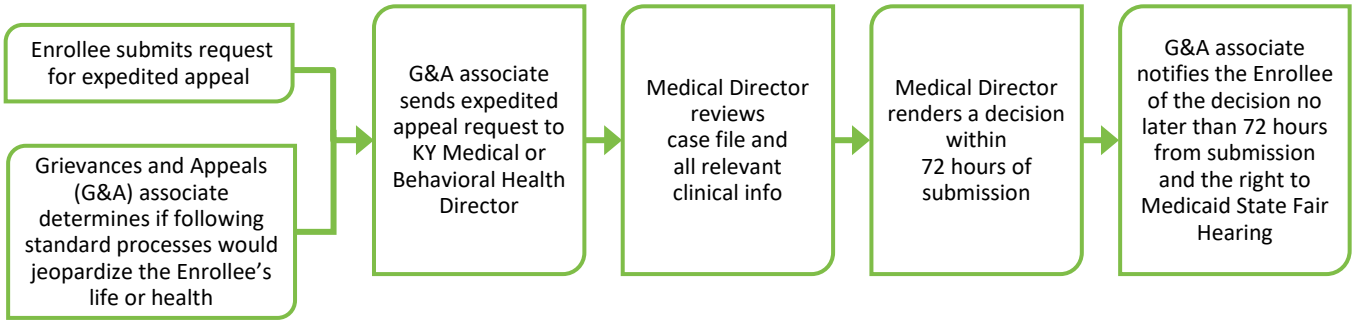
The G&A associate receiving the expedited appeal will log the appeal in our inventory management system and inform the Enrollee of the time limits available to present evidence and allegations of fact or law and that the Enrollee may present the information in person and/or in writing. The inventory management system automatically routes the appeal to a G&A associate, flagging it for expedited review.

Following receipt of an expedited appeal, a G&A associate initiates an expedited review, researches the initial denial, and obtains necessary supporting documentation.

Medical Director Review of All Expedited Appeals

G&A associates send all expedited appeal requests to our Kentucky Medical Director (or Kentucky Behavioral Health Director, if applicable), ensuring that clinical expertise informs the decision. If the Kentucky Medical Director, Dr. Lisa Galloway, is unavailable, we have a process in place to ensure another Medical Director is available to complete the review so that the appeal is resolved within the contractually required timeframes and in accordance with our written policies and the automated tracking in our inventory management system. Our expedited appeals process is summarized below in **Figure I.C.14-3**.

Figure I.C.14-3 Enrollee Expedited Appeal Process



For a more detailed flowchart of Humana's Enrollee grievances and appeals processes, including expedited appeals, please refer to **Attachment I.C.14-1**.

We resolve each expedited appeal and supply notice as quickly as the Enrollee's health condition requires and **no later than 72 hours after receipt of request for services**, including holidays and weekends, in accordance with federal regulation 42 CFR 438. Our G&A associates assemble the previous case, case file, applicable facts, medical records, CM notes, and the Enrollee's Health Risk Assessment (if applicable) to allow for a complete assessment from one of Humana's medical directors. Following a decision, we supply written notice of disposition of the expedited appeal, including notice of the right to file an Expedited Medicaid State Fair Hearing, and make reasonable efforts to supply notice of disposition immediately and in accordance with the information described in the Appeals section above.

If the services have already been rendered or if the case does not meet expedited criteria, we handle the case as a standard appeal. We verbally notify the Enrollee the same day and supply written notice to the Enrollee and the Enrollee's CM that includes an explanation that we will automatically transfer and process the request under the standard appeal timeframe and that the Enrollee may file an expedited grievance if they disagree with the decision. Humana will also inform the Enrollee of the right to resubmit the request with support from the treating provider. We will explain that if the provider indicates that applying the standard review process could seriously jeopardize the Enrollee's life or health, we will automatically expedite the request if the service has not been rendered. We also inform the Enrollee's CM of the status so that the CM may support the Enrollee in arranging services and submitting additional information if necessary.

c. Involvement of Enrollees and their caregivers in the process.

Enrollees and their caregivers are assisted through each step of the grievances and appeals process by Humana's MSRs, G&A associates, and CI associates, as well as the Enrollee's CM. Humana's MSRs and CMs assist Enrollees with filing a grievance or appeal, educate the Enrollee and their caregiver on Enrollee rights and the G&A process, and connect the Enrollee to appropriate language and interpretation services, as necessary. Our MSRs act as advocates for our Enrollees through the grievances and appeals process, assuring Enrollees receive adequate representation, and are often our Enrollees' first point of contact in the G&A process.

Enrollee Story Spotlight:
An Enrollee recently called Humana's Member Services Call Center to complain that she could not fill her prescription due to a lost ID card and expressed concern about an upcoming medical appointment. The Enrollee expressed interest in dis-enrolling from our plan due to her high medication costs. Our MSR listened to the Enrollee and then assisted the Enrollee with getting prescriptions through her plan benefits, re-ordering an ID card, and providing her with relevant information in preparation for her upcoming appointment. At the end of the call, the MSR documented the call, filed an oral grievance, and transferred the case to our G&A department in order to obtain a complete resolution for the Enrollee.

Once a grievance or appeal is filed, our G&A associates contact the Enrollee or their caregiver to communicate updates and gather additional information, if necessary.

There are multiple ways an Enrollee or the Enrollee's caregiver or LAR can be involved in the grievances and appeals process. For example, a caregiver can submit a grievance or appeal on the Enrollee's behalf when proper documentation is supplied or on file with us. Humana has implemented processes to ensure that no matter how the Enrollee submits, whether in person, by phone, in writing by the Enrollee or the Enrollee's caregiver or LAR, through DMS, or through a Subcontractor, that we adequately and efficiently address every grievance and appeal. We also ensure that we communicate actions taken and outcomes to Enrollees. Our Enrollee Handbook and website include instructions on how to file a grievance or an appeal.

Language and Assistance Services
We ensure our Enrollees and their caregivers receive assistance resolving any barriers such as language, culture, disability, or literacy. **Our cultural competency tools and services include an interactive voice response (IVR) system that can identify when a caller is struggling to communicate either because of disability or language and then transfer them directly to an MSR to ensure communication between the Enrollee, their caregiver, and our associate**. For the hearing-impaired, we provide a teletype (TTY/TDD) line to ensure smooth communication between the Enrollee and the Humana associate. Humana will connect an Enrollee or their caregiver to oral interpretation services in **200 languages, video interpretation in 24 languages, including American Sign Language (ASL)**, and translated written materials of vital documents based on threshold languages. We conduct language tests for our bilingual associates to ensure proficiency. We ensure we provide resources in the languages most prevalent across Kentucky's population, including Spanish, Chinese, German, Vietnamese, and Arabic.

Humana's Concierge Service for Accessibility works proactively to supply auxiliary aids that ensure effective access and communication with our Enrollees who may have a disability, are non-English speaking, or have other barriers preventing access to care. Humana also provides additional accommodations for any Enrollee with special needs and their caregiver or LAR who is unable to follow the standard process. For example, should an Enrollee have difficulty writing because of physical impairment, literacy challenges, or language barriers, Humana MSRs, associates at Humana Neighborhood Locations, and CMs assist in writing and filing grievances and appeals. Enrollees can self-refer to this service, be referred by their provider or CM, or be identified by an MSR. The Concierge Service for Accessibility identifies challenges that Enrollees may have in accessing services and works to resolve them before they become barriers. Once an Enrollee accesses the Concierge Service for Accessibility, a Concierge Service for Accessibility associate periodically checks in with the Enrollee throughout their enrollment with Humana to see if they require additional support such as assistance with filing a grievance or appeal.

d. Tracking grievances and appeals received by type and trending results for use in improving operations.

TRACKING GRIEVANCES AND APPEALS BY TYPE

Our proprietary CRM consolidates all information about Enrollees in one single platform to allow associates from across our business functions to view a comprehensive picture of our Enrollees, including language and communication preferences, designated Primary Care Provider, and grievances and appeals initiated by the Enrollee. Our inventory management tool, mhk, overlays our CRM and is a state-of-the-art tool to support resolution of grievances and appeals and facilitate data analysis, trending, and root cause analysis.

Our systems are configured to comply with programmatic performance requirements, which allow us to track relevant deadlines, including the 30-day timeframe for resolution of grievances and appeals, flag cases at risk, and adhere to programmatic obligations while compiling a full and complete record. Humana's grievances and appeals system generates daily, quarterly, and annual reports, which our Member Services Call Center, G&A team, and CI team continuously review to ensure timely and appropriate resolution and to identify emerging or recurring trends that warrant root cause analysis.

The G&A team also utilizes a dashboard that generates detailed information on each grievance and appeal. The dashboard includes an open inventory of cases arranged by nature of case, due date, Enrollee name, case type, and status (e.g., standard, expedited). We also log disposition type and disposition date. The G&A team **conducts monthly and quarterly root cause analysis**, which they report to the Kentucky Quality and Member Access Committee (QMAC), the Kentucky Quality Improvement Committee (QIC) and corporate level quality committees.

TRENDING RESULTS FOR USE IN IMPROVING OPERATIONS

Our grievance and appeal system includes a comprehensive oversight component to detect patterns of grievances and appeals with built-in mechanisms to improve our processes. Our G&A and CI teams use our inventory management tools within mhk to pull real time data and ensure adherence to relevant timeframes. We also have business intelligence tools, including a Grievances and Appeals Dashboard that provide detailed information on grievances, appeals, and Medicaid State Fair Hearings. The Dashboard allows our associates and leadership to analyze patterns and trends to recommend business process improvements.

Clarabridge, an analytics platform used by our G&A team, is a highly effective means of capturing what Enrollees, their caregivers, and providers are saying. This industry-recognized text analytics solution organizes Enrollee information and interactions to gain insight into pain points and areas of dissatisfaction. Using natural language processing and smart filtering, Clarabridge enables us to capture and understand Enrollee issues in their own terms, allowing us to prioritize G&A data based on Enrollee sentiment, effort, and confusion. This sentiment tool scores how Enrollees use language, coding them green and red to denote positive and negative feedback. G&A data can be sorted in a variety of ways, including provider number and case/topic of the grievance or appeal. Clarabridge categorizes and presents data in dashboards and other visual tools to allow for in-depth analysis. Our Resolution Reporting team, comprising experts in root cause analysis, enter new data into Clarabridge at least weekly with the dashboards and analytic tools automatically updated within 24 to 48 hours. We use Clarabridge to perform root cause analysis across our grievances and appeals to inform opportunities for associate training and operational improvement.

OVERSIGHT AND MONITORING

We have a multi-pronged approach to oversight and monitoring of grievances and appeals to identify improvements in operations. Our G&A and CI teams conduct monthly and quarterly root cause analysis for grievances and appeals. Both teams report status, trends, and patterns of grievances, appeals, and Medicaid State Fair Hearings to our **Kentucky QIC**, co-chaired by our Kentucky Medicaid Medical Director, Dr. Lisa

Galloway, and our Kentucky Quality Improvement Director, Audra Summers. The Kentucky QIC provides operational oversight for the quality improvement program activities, recommends policy decisions, and oversees the Kentucky-market Quality Improvement program and measurement of quality activities on a regular basis. Specifically, the Kentucky QIC will review data to determine trends and follow up with relevant departments to identify areas for improvement and develop initiatives. Both our Kentucky and corporate QIC provide guidance and input into the proposed improvements or suggest alternative action.

The G&A team also presents monthly and quarterly root cause analysis to our **Member 360 Committee**, which convenes all Medicaid operational areas within Humana. The Kentucky Medicaid Member 360 Committee's goal is to identify ways to improve the Enrollee experience. The committee meets monthly to review all metrics applicable to Enrollees, including grievances and appeals data, and provides a forum for review of Enrollee-related metrics, root cause analysis, process improvement opportunities, and escalation of Enrollee concerns. At each meeting, the committee reviews total grievances and appeals received, number overturned, number upheld, and the top overturned appeal reasons and grievance issues. The committee has the opportunity to provide insight and identify opportunities for improvement on provider or Enrollee education. In preparation for the monthly meetings, the internal G&A team thoroughly reviews data and identifies trends and process improvement opportunities.

Additionally, we include G&A issues we need to address with Subcontractors through the Subcontractor's assigned Relationship Manager and via **Joint Operations Committee** (JOC) meetings. Held monthly with our Subcontractors, these meetings provide an opportunity to address Subcontractor needs, such as additional training, that Humana can provide to avoid future issues. We hold our Subcontractors to the same contractually required timeframes that our internal processes follow and incorporate these requirements in our contractual agreements with our Subcontractors. As part of our JOC meetings, we track and trend grievances and appeals to ensure Subcontractor compliance with all applicable rules and regulations. We hold our Subcontractors accountable by utilizing performance penalties as a result of any G&A noncompliance.

The G&A team also participates in cross-departmental operational forums such as the **Process Council**. As the governing body for Humana's Resolution team, the Process Council connects Humana's overall business goals and strategies with the performance of individual processes.

Led by Melissa Perraut, Humana's Clinical Pharmacy Lead, our **Medicaid Pharmacy Benefit Management (PBM) Oversight Committee** reviews all pharmacy related appeals monthly, reviewing the top drugs related to appeals and overturned decisions and conducting root cause analyses. All operational areas within Humana, including the G&A team, are invited to the Medicaid PBM Oversight Committee meetings monthly to help inform process improvement.

e. Reviewing overturned decisions to identify needed changes.

REVIEWING OVERTURNED DECISIONS

Humana has processes in place to ensure that when decisions are overturned they are reviewed to see if changes are needed. Our G&A and CI teams conduct monthly and quarterly root cause analysis for grievances and appeals. Both teams report status, trends, and patterns of overturned decisions to our **Kentucky QMAC**, led by Bryan Kennedy, Culture & Community Engagement Director, and co-chaired by one of our Enrollees. Our Kentucky QIC oversees our Kentucky Medicaid Quality Management and Quality Improvement and the measurement of quality activities on a regular basis. Specifically, the Kentucky QIC will review data to determine trends and follow up with relevant departments to identify areas for improvement and develop initiatives. The Kentucky QIC then shares these with our corporate QIC. The Kentucky QIC provides operational oversight for Quality Management and Quality Improvement activities and recommends internal policy decisions. Both our Kentucky and corporate QIC provide guidance and input into the proposed improvements or suggest alternative action.

As outlined in sub-question I.C.14.d of this response, the G&A team also presents monthly and quarterly root cause analysis to our **Member 360 Committee**, which convenes all Medicaid operational areas within Humana. At each meeting, the committee reviews total grievances and appeals received, number overturned, number upheld, and the top overturned appeal reasons and grievance issues. The committee has the opportunity to provide insights and identify opportunities for improvement on provider or Enrollee education. The committee meets monthly to review all metrics applicable to Enrollees, including overturned decisions, and provides a forum for review of Enrollee-related metrics, root cause analysis, process improvement opportunities, and escalation of Enrollee concerns, with the ultimate goal of improving the Enrollee experience. In preparation for these meetings, the internal G&A team thoroughly reviews the data and identifies trends and process improvement opportunities.

Additionally, we include G&A issues we need to address with Subcontractors via JOC meetings and through the Subcontractor's assigned Relationship Manager. Held monthly with our Subcontractors, these meetings provide an opportunity to address Subcontractor needs, such as additional training, that Humana can provide to avoid future issues.

The G&A team also participates in cross-departmental operational forums such as the **Process Council**. The Process Council connects Humana's overall business goals and strategies with the performance of individual processes and is the governing body for Humana's Resolution team.

Our **Medicaid PBM Oversight Committee** reviews all pharmacy related appeals monthly, reviewing the top drugs related to appeals and overturned decisions and conducting root cause analyses. All operational areas within Humana, including the G&A team, are invited to the Medicaid PBM Oversight Committee meetings monthly to help inform process improvement.

IMPROVEMENTS MADE AS A RESULT OF REVIEW

In recent years, Humana has identified and implemented several operational improvements in response to grievances and appeals data trends in overturned decisions that helped to expose processes requiring adjustments.

For example, our G&A team initiated an additional step in the Medicaid State Fair Hearing procedure, where a Medical Director performs a courtesy review of all Medicaid State Fair Hearings. This ensures that the initial decision provided by the G&A department was accurate and verifies that any additional information provided for the hearing does not change the outcome of the case.

Through this mechanism, the G&A team identified an opportunity to add additional quality oversight of our Medicaid Fair Hearings by implementing an internal auditing process, which **audits 100% of cases**. Humana's National Quality Auditors (NQA) perform these audits on all Medicaid State Fair Hearing cases to verify that we process each case according to the policies and procedures put in place to ensure Contractual compliance. We provide results of the audits to the supervisors and the Medicaid State Fair Hearing associates on a weekly basis. In addition to this quality control, Humana also added internal compliance metrics to monitor adherence to Contract requirements, including changes that may occur through a Contract amendment. We use our inventory management tool that includes comprehensive, built-in dashboards to monitor the compliance of Medicaid State Fair Hearing cases in real time. We also capture and monitor these cases daily in a dashboard.

By using data to inform improvements, we can more easily identify barriers. Understanding the structure of internal areas also helps us make our processes more efficient and reduce the number of overturned decisions. These improvements strengthen Humana's grievances and appeals system and allow it to meet both DMS requirements and the high standards of Humana's Medicaid Enrollee-centered approach.