C.14 Enrollee Grievances and Appeals

REQUIREMENT: RFP Section 60.7.C.14
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:
a. Compliance with State and Federal requirements.
b. Process for Expedited Review.
c. Involvement of Enrollees and their caregivers in the process.
d. Tracking grievances and appeals received by type and trending results for use in improving operations.
e. Reviewing overturned decisions to identify needed changes.

Molina's tightly managed Enrollee grievances and appeals process for the Kentucky Medicaid program will support Enrollees in exercising their rights and resolve Enrollee concerns as quickly as possible. *Our average resolution from initiation is 11 days for grievances and 9 days for appeals.*

Molina is committed to continuous improvement in all areas of our business, especially around Enrollee experience. Enrollee grievances and appeals provide valuable feedback about our Enrollees' experiences with our staff, providers, and the services we provide. During onsite focus groups we held with Medicaid Enrollees in Kentucky, we learned about what worked and what needs to be improved. For example, participants expressed concerns about accessing healthcare and services, the quality of information provided by MCOs, and poor customer service. Our proposal includes solutions to address these concerns. Molina's end-to-end processing of grievances and appeals offers a "no wrong door" approach and ensures Enrollee voices are heard. ***We respond swiftly and appropriately, and information is used throughout Molina to improve the services we provide.*** Moreover, our 'Enrollee Advocate' approach offers Enrollees a single Molina staff person who follows the grievance or appeal from beginning to resolution to make sure Enrollee needs are met and concerns are addressed.

Assisting Enrollees in the Process

Molina will support Enrollees in exercising their rights by:

- Helping them prepare and submit Grievances and Appeals, or file a request for a State Fair Hearing
- Providing 24/7 oral interpretation for Enrollees who are non-English speaking, TTY/TDD and relay services for Enrollees who are deaf or hard of hearing, and materials in alternate formats for Enrollees who have vision impairments or low vision
- Offering written translation of materials

As part of a quality healthcare program, Enrollees must be able to easily file grievances and appeals to address any dissatisfaction they may have with Molina, including any displeasure they have regarding quality, services, and outcomes of care. ***We will train all our staff and providers on our Grievances and Appeals process and how to help Enrollees exercise their rights in support of Molina's "no wrong door" approach.***

We will maintain high-quality standards in all aspects of services, including a streamlined process to effectively and efficiently address, resolve, and report Enrollee grievances and appeals in full compliance with Commonwealth and federal laws and regulations and NCQA standards. Our tightly managed process will allow Molina to meet, and often exceed, goals and performance standards. For example, in 2019, the average turnaround time across our affiliated Medicaid health plans was 11 days for grievances and 9 days for appeals, well in advance of the Department's requirement to resolve grievances within 30 days from initiation.

We will build Kentucky-specific time frames and processing requirements into our HIPAA-compliant grievance and appeals workforce system. Our system is time-tested, proven, and reliable and is used successfully at our 14 affiliated Medicaid health plans to collect, store, access, track, and analyze grievances and appeals information in support of our affiliate's Medicaid programs. The system will house all of Molina's Kentucky Medicaid Enrollee grievances and appeals information, including date and time stamps. All grievances and appeals (both open and closed/resolved) will automatically "map" from our core claims administration system and our customer relationship management (CRM) system to the grievances and appeals system, which will assign a unique case number to every case. Enrollee information from our core claims administration system will be auto-populated in the case as well as related call notes. Each Enrollee case will be assigned to a specific Enrollee Resolution Team coordinator in keeping with our "Enrollee Advocate" approach. The Enrollee Resolution Team coordinator will be responsible for ensuring the grievance or appeal is resolved within regulatory time frames.

We will also adhere to NCQA's rigorous accreditation requirements, ensuring each Enrollee or their caregiver / authorized representative receives prompt, personalized attention. Molina will educate our Kentucky Medicaid Enrollees and their families/caregivers on Enrollee rights to file a grievance or appeal and request a State Fair Hearing and how Molina will help them in the process.

Molina will employ various communication tools and methods to meet the diverse needs and preferences of our Enrollees. We will inform our Kentucky Medicaid Enrollees about our Grievances and Appeals process through:

- New Enrollee orientation sessions at our community-based Molina One-Stop Help Centers
- Toll-free Call Center
- New Enrollee Welcome Kit
- Enrollee website
- Enrollee Handbook
- Molina's Guide to Accessing Quality Healthcare that will be sent annually to all Enrollees. This user-friendly guide will provide valuable information on Molina's programs and services, including how to file a grievance and appeal

Bringing a Local Approach to Grievances and Appeals

Molina will establish regional Quality and Member Access Committees (QMACs) across the Commonwealth. Our QMACs will help us solicit and capture Enrollee feedback and recommendations that reflect the nuances of each region. They will provide a forum for open dialogue on issues related to the services Molina provides, including our handling of grievances and appeals, and how we can improve them.

Each of these resources will explain how Molina can meet the needs of Enrollees who are non-English speaking (through 24/7 oral interpretation and written translation), deaf or hard of hearing (through TTY/TDD and relay services), or have vision impairments or low vision (through alternative formats including Braille, audio, and large print). Our written materials will include taglines in the top 15 non-English languages, explaining the availability of oral and written interpretation and how to request such services in accordance with Contract requirements.

Comprehensive, well-organized, documented policies and procedures will guide our processing of Kentucky Medicaid Enrollee grievances and appeals to ensure compliance with the notice, timelines, rights, and procedures detailed in applicable Commonwealth and federal laws and regulations as well as Department and CMS requirements. We will submit our written Grievances and Appeals process to the Department for approval before implementation.

We have thoroughly reviewed the requirements contained in Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 24, Enrollee Grievances and Appeals, and we will meet or exceed them.

PROPOSED ENROLLEE GRIEVANCES AND APPEALS PROCESS

Enrollees are not always able to act as their own advocate; therefore, we recognize the importance of our role in serving as the "Enrollee Advocate." Molina will ensure Enrollees, or their caregiver / authorized representative, can file grievances and appeals. This can be done orally by calling our toll-free Call Center, in writing, fax, email, or through our secure Enrollee Web portal. Whether submitted orally, in writing, or by electronic communications, we will assist them through each step of the process, ensuring they understand any time frames that may apply, and the availability of alternative communication methods.

Our Kentucky-based Enrollee Resolution Team will oversee all Enrollee grievances and appeals. While we will strive for "first call resolution" for grievances received by our Call Center, we recognize it is not always possible. If a grievance is resolved by a customer service representative from Molina's Call Center, the case in the system will indicate it is closed. If the case remains open, our Enrollee Resolution Team staff will be alerted to actively work on the case and resolve the grievance for the Enrollee. We will acknowledge the grievance in writing and send an acknowledgement letter and expected date of resolution to the Enrollee within five business days of our receipt of the grievance.

GRIEVANCES

Molina's Kentucky Medicaid Enrollees or their authorized representatives will be able to file a grievance by telephone, in writing, or electronically. Our Kentucky-based Enrollee Resolution Team will review the grievance and resolve it as quickly as possible and within Department requirements. The Enrollee Resolution Team will partner with other Molina departments to resolve grievances, as indicated. For example, Kentucky Medicaid Enrollee grievances related to a potential quality of care or service issue will be promptly forwarded to our Quality Improvement and Provider Services departments, respectively. Each department will follow stringent written protocols, including provider outreach, as appropriate. Grievances and appeals that involve Medical Necessity Determinations, Denials, or expedited resolution of clinical issues will be reviewed by healthcare professionals (registered nurses and licensed physicians) with appropriate clinical expertise.

A Solid Record of Timely Resolution of Grievances and Appeals

In 2019, the average turnaround time across our affiliated Medicaid health plans was:

- 11 days for grievances
- 9 days for appeals

Enrollee Resolution Team coordinators will ensure the substance of the grievance is fully documented and investigated and Enrollees are notified, as appropriate. ***We will resolve all Kentucky Medicaid program grievances as expeditiously as possible and no later than 30 calendar days from receipt.*** We will send the Enrollee or their caregiver / authorized representative a resolution letter that includes all information considered in the investigation of the grievance, findings, and conclusions based on the investigation and the disposition of the grievance. Grievances of urgent matters that require expedited resolution will be identified at the time of intake and processed accordingly.

Exhibit C.14-1 illustrates Molina's proposed process for handling Enrollee grievances for the Kentucky Medicaid program.

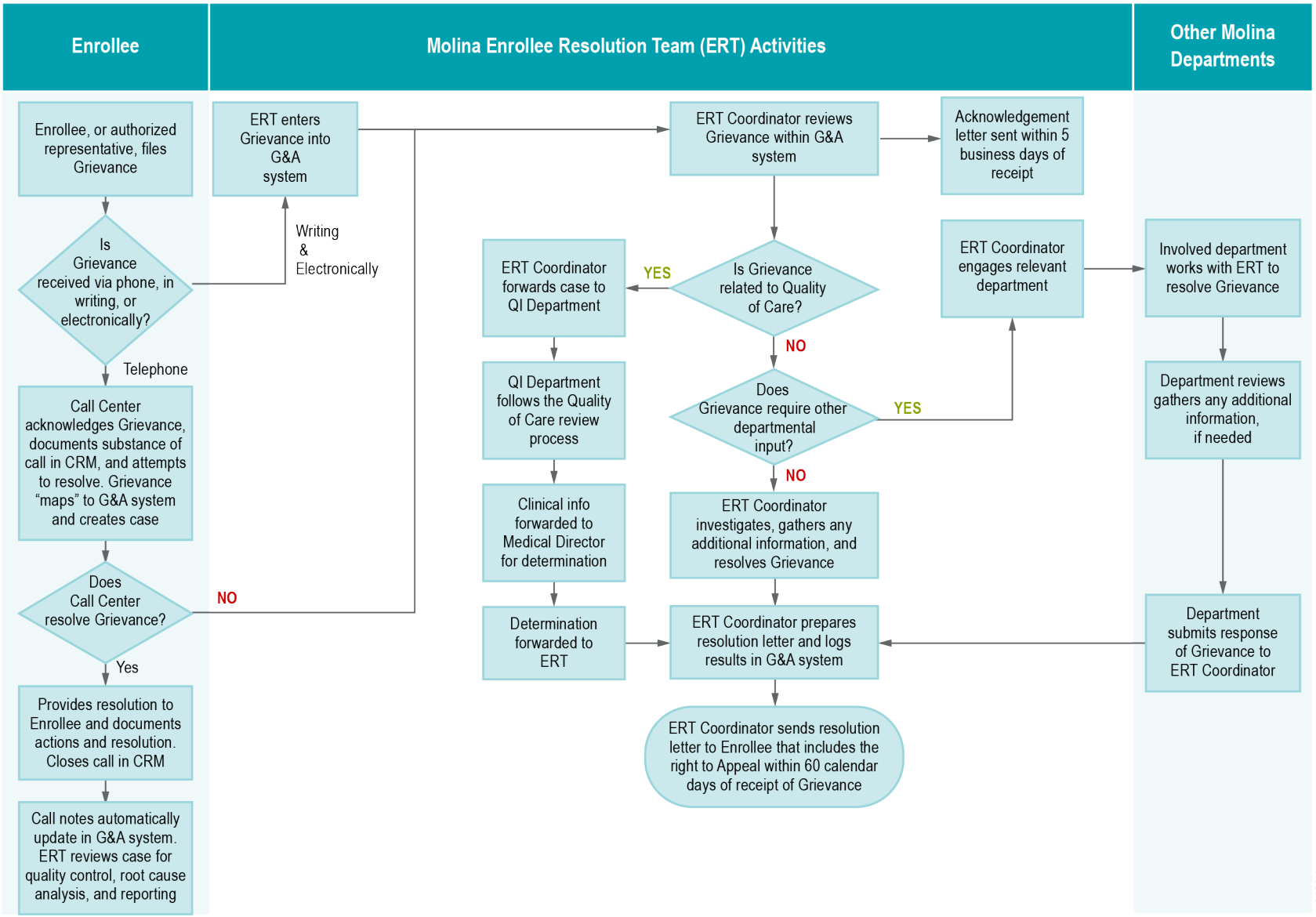

Exhibit C.14-1. Molina's Grievances Process will Ensure Timely and Appropriate Resolution

APPEALS

Our Kentucky Medicaid Enrollees and their caregivers and authorized representatives will be able to file appeals orally or in writing within 60 calendar days of receiving an Adverse Benefit Determination or a decision by Molina related to covered services, services provided, or the payment for a service. Oral appeals must be followed by a written appeal signed by the Enrollee or their caregiver / authorized representative within 10 calendar days; however, the date of the oral request will be considered the date of receipt to establish the earliest possible filing date for filing the appeal. We will send Enrollees a written acknowledgement letter confirming receipt of the appeal and expected date of resolution within five business days of Molina's receipt. An Enrollee Resolution Team coordinator will contact the Enrollee or caregiver / authorized representative and explain the appeals process, gather pertinent information, and answer any questions.

Enrollees and their authorized representatives will have the opportunity to present evidence, testimony, and allegations of fact or law, examine their case notes, and receive copies of the documentation related to their appeal. We will ensure that individuals who make decisions have not participated in previous levels of review or decision-making by checking the name of the original reviewer in the system.

We will resolve standard appeals and provide written notice within 30 calendar days of our receipt. We will resolve any appeals that meet the requirements for expedited review within three business days of our receipt.

Molina may extend the resolution time frame for an appeal up to 14 calendar days if an Enrollee or caregiver / authorized representative requests an extension or if we demonstrate (to the satisfaction of the Department) a need for additional information and how the delay is in the Enrollee's interest. If the time frame is extended based on a request by Molina, we will make reasonable efforts to give the Enrollee prompt oral notice and provide written notice within two business days explaining the reason for the delay.

We understand Enrollees will have the right to request the continuation of benefits while appeals are pending under the following conditions:

- The Enrollee or their caregiver / authorized representative files an appeal with Molina on or before the later of the following: within 60 days from the date of the Adverse Benefit Determination; within 10 business days after the notice of the adverse action is mailed; or within 10 business days after the intended effective date of the action, whichever is later.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The time period covered by the original authorization has not expired.
- The Enrollee or caregiver / authorized representative requests an extension of services.

If the request for continuation of benefits meets the conditions, Molina will continue to provide benefits to an Enrollee in accordance with Contract requirements and Commonwealth and federal laws and regulations.

Molina will provide the Enrollee a written letter notifying them of the appeal decision. If the decision is not in their favor, the letter will provide their right to request a State Fair Hearing. If requested, the Enrollee Resolution Team coordinator will assist the Enrollee and explain that if they would like a State Fair Hearing, they must file a written request with the Department, including the reason for the request and the date of service or the type of service denied. The coordinator also will inform the Enrollee that the request must be postmarked or filed within 120 calendar days from the date of Molina's adverse decision

letter (which provided the appeal decision). The coordinator will inform the Enrollee that the Department must receive Molina's documentation supporting the adverse decision no later than five calendar days from the date Molina receives a notice from the Department that a request for a State Fair Hearing has been filed.

Exhibit C.14-2 illustrates Molina's proposed process for handling Enrollee appeals for our Kentucky Medicaid program.

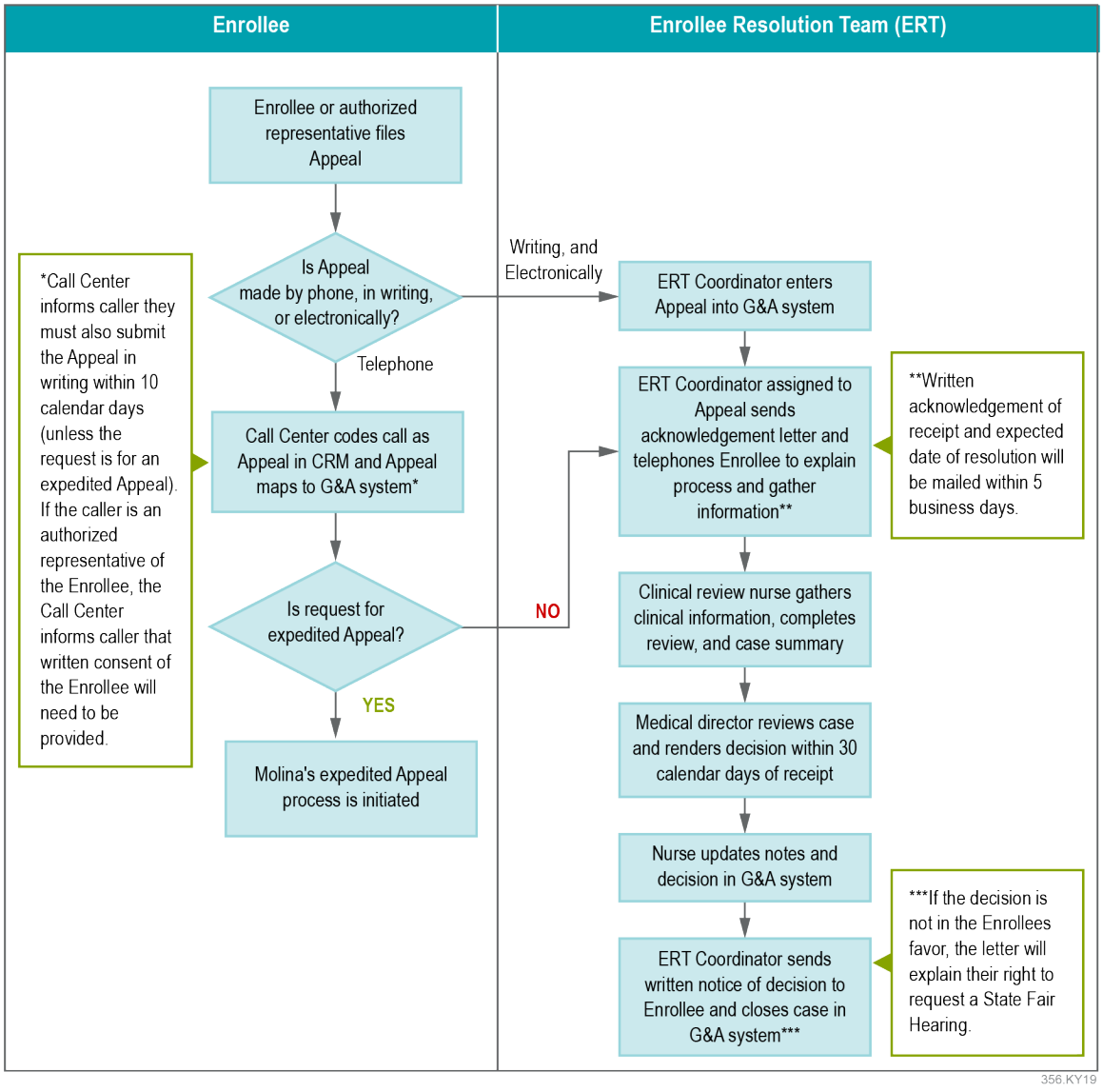

Exhibit C.14-2. Overview of Molina's Appeals Process

a. COMPLIANCE WITH STATE AND FEDERAL REQUIREMENTS

Molina's policies and procedures will comply with the notice, timelines, rights and procedures in 42 CFR § 438 subpart F, 907 KAR 17:010, and other applicable CMS and Department requirements. Our proposed Kentucky-based chief compliance officer and vice president of government contracts will closely monitor proposed changes in Commonwealth and federal laws and regulations, including those that relate to the Grievances and Appeals process. They will work closely with the Enrollee Resolution Team to implement any necessary changes to Molina's policies and procedures.

Our Kentucky-based Enrollee Resolution Team will perform weekly quality audits and review monthly summary reports to ensure all processes and written communications comply with the Kentucky Medicaid program Contract, Commonwealth and federal laws and regulations, and NCQA standards.

We will generate and submit monthly reports to the Department of Enrollee grievances and appeals activities in accordance with Contract requirements. We have carefully reviewed the reporting requirements and are confident in our ability to provide timely and accurate information.

We have thoroughly reviewed the requirements contained in Draft Contract, Section 24.2, Enrollee Grievance and Appeal Policies and Procedures, and we are confident in our ability to meet them. Table C.14-1 summarizes how Molina will meet and comply with these requirements.

Table C.14-1. Complying with State and Federal Requirements

Contract Requirement (Section 24.2)	How Molina Will Meet and Comply with the Requirement
A. Provide the Enrollee the opportunity to present evidence, testimony and allegations of fact or law, in person as well as in writing. The Contractor shall inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals and expedited Appeals as specified in 42 C.F.R. 438.408(b) and (c).	Molina policy specifies the Enrollee or their authorized representative will have the opportunity to present evidence, testimony, and allegations of fact or law related to an appeal in person or in writing. Our Kentucky Medicaid Enrollee Handbook will explain this information. This information also will be provided in the written acknowledgement that Molina will send the Enrollee upon receipt of an appeal.
B. Provide the Enrollee and the Enrollee's representative the Enrollee's case file, including Medical Records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor, or at the direction of the Contractor, in connection with the Appeal of the Adverse Benefit Determination. This information shall be provided, upon request, free of charge and sufficiently in advance of the resolution timeframe for Appeals as specified in 42 C.F.R. 438.408(b) and (c).	Upon receipt of a request by the Enrollee or their authorized representative, Molina's Enrollee Resolution Team will provide the Enrollee with all written documentation requested related to their appeal case, free of charge. Molina will send the requested information to the Enrollee within three business days of our receipt of the request. In the event the case information would not be received by the Enrollee within at least three business days before the appeal resolution date, Molina will expedite the request.
C. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.	Our policy ensures all information submitted by the Enrollee or their representative, as well as the requesting provider, will be reviewed and considered part of the appeal case evidence documentation without regard to whether the information was submitted or considered in the initial Adverse Benefit Determination.
D. Consider the Enrollee, the Enrollee's representative, or the legal representative of the Enrollee's estate as parties to the Appeal.	Our policies stipulate the Enrollee, Enrollee representative, or the legal representative of the Enrollee's estate will be considered parties to the appeal.

Contract Requirement (Section 24.2)	How Molina Will Meet and Comply with the Requirement
E. A process for evaluating patterns of grievances for impact on the formulation of policy and procedures, access and utilization.	Molina will analyze grievances and appeals information at least monthly to determine trends in both volume and certain grievance types. This analysis will identify areas to improve the Enrollee experience. Quarterly analyses will be presented at various committees comprising other Molina departments. Once opportunities are identified, there may be a smaller work group formed to address the issue. For example, a work group may be formed to address a trend in transportation or provider access and availability grievances. Such work groups may include representatives from various Molina departments to address the issue and design and implement improvements.
F. Procedures for maintenance of records of grievances separate from medical case records and in a manner that protects the confidentiality of Enrollees who file a grievance or Appeal.	Every case will be identified as either a grievance or appeal and will be assigned a unique case number in Molina's grievances and appeals system. Therefore, grievances can be separated from appeals, as needed. Cases will be identified by their case number, not Enrollee name. The grievances and appeals system will only be accessible to individuals who are required to have access for their role at Molina. All documents associated with cases will be maintained in the secure grievances and appeals system, and files will be maintained for 10 years following the final decision by Molina, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.
G. Ensure that a grievance or an Appeal is disposed of and notice given as expeditiously as the Enrollee's health condition requires but not to exceed thirty (30) Days from its initiation. If the Contractor extends the timeline for an Appeal not at the request of the Enrollee, the Contractor shall make reasonable efforts to give the Enrollee prompt oral notice of the delay and shall give the Enrollee written notice, within two (2) Days, of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file another grievance if he or she disagrees with that decision. Additionally, if the Contractor fails to resolve an Appeal within this thirty (30) Day timeframe, the Enrollee is deemed to have exhausted the Contractor's internal Appeal process and may initiate a State Fair Hearing.	Molina will ensure all grievances and appeals are disposed of expeditiously and no later than 30 calendar days from initiation. Though uncommon, if it is deemed necessary for Molina to request to extend the timeline for an appeal, Molina policy requires the Enrollee Resolution Team make reasonable efforts to give the Enrollee prompt oral notice of the delay. Within two business days, we will provide the Enrollee written notice of the reason for Molina's decision to extend the time frame. We also will inform the Enrollee of their right to file another grievance if he or she disagrees with the decision. Molina policy also stipulates that if an appeal decision is not made within this 30-calendar-day time frame, the Enrollee will be deemed to have exhausted our internal appeal process and may request a State Fair Hearing.
H. Ensure individuals and subordinates of individuals who make decisions on grievances and Appeals were not involved in any prior level of review.	Molina policy will prohibit individuals and subordinates of individuals involved in any prior level of review from making decisions on grievances and appeals. We also will provide this information to the Enrollee in the appeal decision letter.
I. If the grievance or Appeal involves a Medical Necessity determination, Denial or expedited resolution or clinical issue, ensure that the grievance and Appeal is heard by healthcare professionals who have the appropriate clinical expertise.	Molina policy will ensure grievances and appeals that involve Medical Necessity Determinations, Denials, or expedited resolution or clinical issues are reviewed by healthcare professionals (licensed nurses and physicians) with appropriate clinical expertise.

Contract Requirement (Section 24.2)	How Molina Will Meet and Comply with the Requirement
J. Process for informing Enrollees, orally and/or in writing, about the Contractor's Grievance and Appeal Process by making information readily available at the Contractor's office, by distributing copies to Enrollees upon Enrollment; and by providing it to all Subcontractors at the time of contract or whenever changes are made to the Grievance and Appeal Process.	We will mail all new Enrollees, guardians, or authorized representative a confirmation letter and Welcome Kit within five business days of Molina's notification of a new Enrollee. Welcome Kits will be available in English, Spanish, and each prevalent non-English language and alternative formats. The Welcome Kit will include an Enrollee Handbook explaining important plan benefits information. This information also will be available on Molina's Kentucky Medicaid program website and provided to Molina's network providers. This information will be included in the Provider Manual. We will provide updates to both Enrollees and providers if the information should change.
K. Assist Enrollees in filing a grievance if requested or needed including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability.	We will provide over-the-phone oral interpreter services in all non-English languages. We also will provide alternative methods of phone communication, including TTY/TDD and relay services.
L. Include assurance that there will be no discrimination against an Enrollee solely due to the Enrollee filing a grievance or Appeal.	Molina policy will strictly prohibit discrimination against an Enrollee solely on the basis of the Enrollee or their authorized representative filing a grievance or appeal with Molina.
M. Include notification to Enrollees in the Enrollee Handbook regarding how to access the Cabinet's ombudsmen's office regarding grievances, Appeals and hearings.	Molina's Enrollee Handbook will include a description of the Cabinet's Office of the Ombudsman and how to contact the office by phone, online, and mail. This information also will be provided to the Enrollee in grievances and appeals disposition letters.
N. Provide oral or written notice of the resolution of the grievance in a manner to ensure ease of understanding.	Enrollee notices will be written at or below a sixth-grade reading level, determined by the Flesch–Kincaid Index, and meet the requirements contained in Draft Contract, Section 22.6, Enrollee Information Materials. We will write all Enrollee materials in accordance with Plain Language Guidelines and established criteria to ensure cultural sensitivity and readability. Oral notices will be provided in a clear manner. Molina's staff training will include communicating with Enrollees in a manner that respects their cultural background and beliefs. All our customer service representatives and Enrollee Resolution Team members will participate in mandatory company cultural diversity training to promote an understanding of cultural beliefs and traditions specific to the Kentucky population.
O. Provide for an Appeal of a grievance decision if the Enrollee is not satisfied with that decision.	Our policy will specify that an Enrollee has the right to file an appeal if the Enrollee is not satisfied with a grievance decision. This information will be provided to the Enrollee in the grievance resolution letter.
P. Provide for continuation of services, in accordance with 42 C.F.R. 438.420, while the Appeal is pending.	Molina's policy for continuation of services will be in accordance with 42 CFR 438.420.

Contract Requirement (Section 24.2)	How Molina Will Meet and Comply with the Requirement
Q. Provide expedited Appeals relating to matters which could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function.	Molina policy will ensure prompt identification of expedited appeals to ensure an expedited review if required. Upon receipt of a request for an expedited appeal, we will perform a clinical review to determine if a standard appeal would seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. We will render a decision if the request warrants an expedited review within 24 hours of our receipt.
R. Provide that oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals to establish the earliest possible filing date for the Appeal and must be confirmed in writing.	Molina policy will ensure any oral request for an appeal of an Adverse Benefit Determination is considered the date of oral receipt to establish the earliest possible filing date for the appeal. Enrollees will be informed at the time of the oral request that written confirmation must be received in follow-up to the oral request.
S. Not require an Enrollee or an Enrollee's representative to follow an oral request for an expedited Appeal with a written request.	Molina policy will allow Enrollees or their representative to make an oral request for an expedited appeal. Upon receipt of an oral request for an expedited appeal, we will not require a follow-up request in writing. Our Enrollee Handbook also will explain that Enrollees can telephone our Call Center to request an expedited appeal.
T. Inform the Enrollee of the limited time to present evidence and allegations of fact or law in the case of an expedited Appeal.	Upon the determination that a request for expedited review of an appeal decision meets criteria for expedited review, we will make reasonable effort to reach the Enrollee (or their representative) by telephone to explain the limited time they have to provide evidence and allegations of fact or law. Molina makes at least three telephone attempts to ensure Enrollees have every opportunity to provide information.
U. Acknowledge receipt of each grievance and Appeal.	We will acknowledge grievances and appeals in writing and send an acknowledgement letter and expected date of resolution to the Enrollee within five business days of receipt.
V. Provide written notice of the Appeal decision in a format and language that, at a minimum, meet the standards described in 42 C.F.R. 438.10 and for notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.	Molina will provide Enrollees a written notice of the appeal decision in a manner and format that is easily understood and readily accessible by the Enrollee in compliance with 42 CFR 438.10. For expedited appeals, we will attempt to provide prompt oral notification to Enrollees by telephone.
W. Provide for the right to request a hearing under KRS Chapter 13B.	For appeals with a decision to uphold the Adverse Benefit Determination, the written notice to Enrollees will explain their right to request a State Fair Hearing. If the Enrollee requires assistance, Molina will assist the Enrollee.
X. Allows a Provider or a representative to file a grievance or Appeal on the Enrollee's behalf as provided in 907 KAR 17.010.	Our Enrollee Resolution Team and customer service representatives will inform a provider or authorized representative the Enrollee's written consent is required for the specific action that is being requested (or if the subject of a State Fair Hearing). Molina policy will also include this information, as specified in 907 KAR 17.010.

Contract Requirement (Section 24.2)	How Molina Will Meet and Comply with the Requirement
Y. Notifies the Enrollee that if a Service Authorization Request is denied and the Enrollee proceeds to receive the service and Appeal the Denial, if the Appeal is in the Contractor's favor, that the Enrollee may be liable for the cost as allowed by 42 C.F.R. 438.420(d).	Molina will notify the Enrollee with the continuation of benefits information related to an appeal that involves the termination, suspension, or reduction of previously authorized services. For a denial of a new Service Authorization Request, Molina's appeal acknowledgement letter will inform the Enrollee they may be liable for the cost of services if the appeal upholds the denial. Enrollees also will be notified if they proceed to receive the denied requested service and the State Fair Hearing is in Molina's favor, the Enrollee may be liable for the cost. This information will be provided in the appeal decision letter when the internal appeal has upheld the denial.

b. PROCESS FOR EXPEDITED REVIEW

Upon receipt of a request for an expedited appeal, a Molina registered nurse will conduct a clinical review of the request to determine if criteria for an expedited review are met. As indicated, the nurse will review the case with Molina's medical director for additional clinical input. An expedited review is warranted if the time frame for a standard appeal resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

We will determine if the request for expedited review of an appeal meets criteria for expedited review within 24 hours of our receipt. If it does, we will make reasonable effort to reach the Enrollee (or their representative) by telephone to explain the limited time they have to provide evidence and allegations of fact or law. Molina will make at least three telephone attempts to ensure Enrollees have every opportunity to provide information.

If we determine a case does not meet expedited review criteria and deny a request for expedited resolution of an appeal, we will transfer the appeal request to the 30-calendar-day time frame for standard resolution. The 30-day period will begin on the date of Molina's receipt of the original request for an appeal. We also will provide Enrollees with prompt oral notice of the denial (e.g., attempt to reach the Enrollee by telephone). We will follow up with a written notice within two calendar days of the denial. Enrollees will have the right to file a grievance related to the denial to expedite an appeal request.

Molina will review and make determinations on requests for appeals that meet the expedited criteria as expeditiously as an Enrollee's physical or mental health condition allows, but no later than three business days after we receive the request for appeal (unless an extension is made in accordance with requirements). We will attempt to provide prompt oral notification to Enrollees related to appeal determinations via telephone. We will send written resolution to Enrollees or their authorized representative at the time of the decision. If the appeal determination upheld the original denial, the resolution letter will include the Enrollee's right to a State Fair Hearing.

Exhibit C.14-3 illustrates Molina's proposed process for handling requests for expedited appeals for our Kentucky Medicaid program operations.

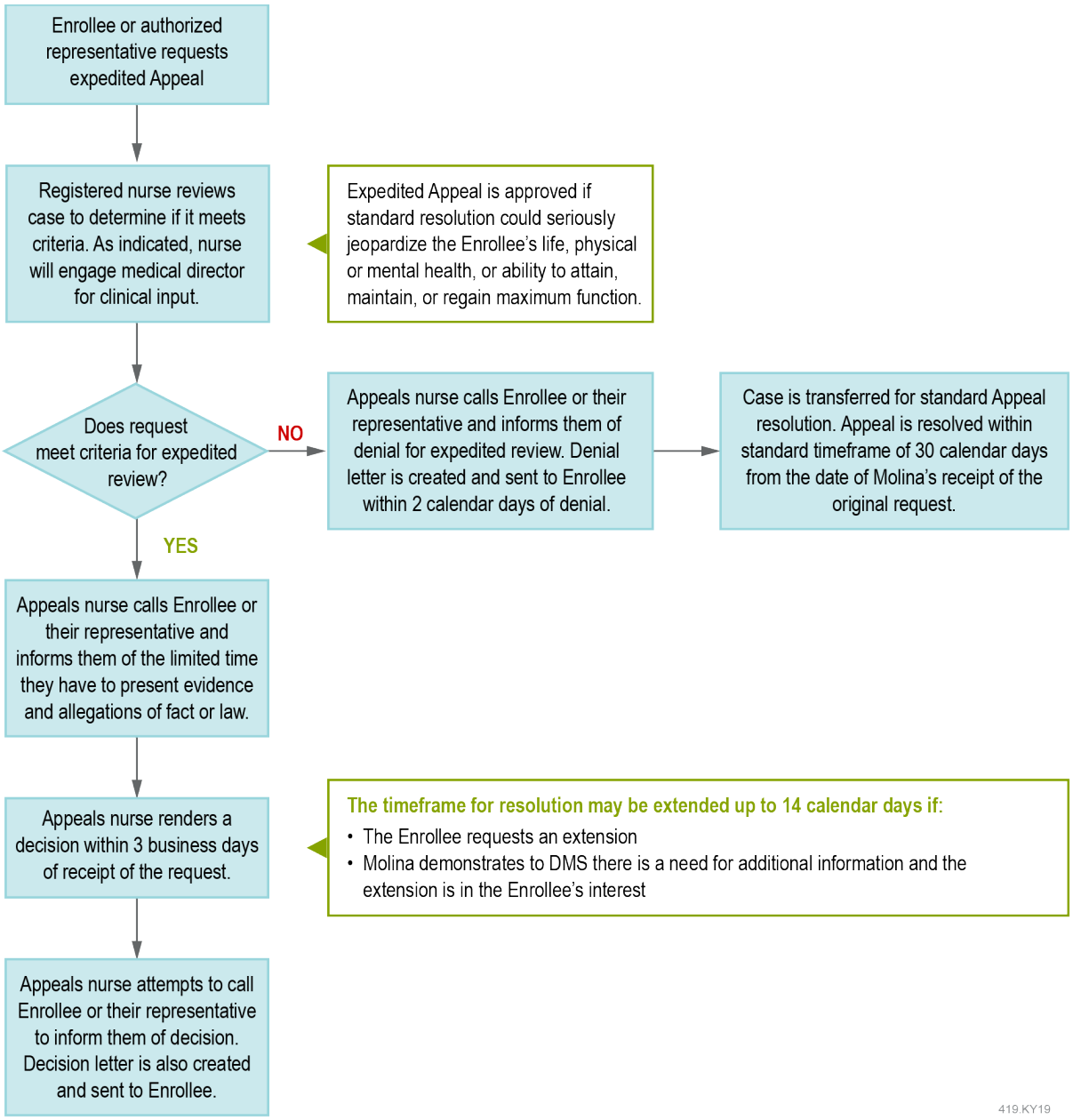

Exhibit C.14-3. Molina's Expedited Appeals Process

c. INVOLVEMENT OF ENROLLEES AND THEIR CAREGIVERS

Enrollees, their caregivers, or Enrollees' authorized representatives (with the Enrollee's written consent) will be able to file a grievance or appeal verbally or in writing with Molina. Our Kentucky-based Enrollee Resolution Team coordinators, customer service representatives, and care managers will be available to assist in filing a grievance or appeal, as requested. ***Enrollees, their caregivers, and authorized representatives also will be able to receive in-person assistance at one of our community-based Molina One-Stop Help Centers.***

We will offer Enrollees, caregivers, and authorized representatives who are non-English speaking over-the-phone oral interpreter services in all non-English languages and provide TTY/TDD and relay services for those who are deaf or hard of hearing.

While providers cannot serve as an authorized representative for grievances, they may file an appeal on behalf of an Enrollee. Except for expedited appeal requests by an Enrollee's provider, an Enrollee's written consent is required for any authorized representative acting on their behalf. We will inform Enrollees of the limited time available to provide this information, in cases of expedited reviews. The Enrollee, the caregiver / authorized representative, the provider (acting on behalf of the Enrollee with the Enrollee's written consent), or the legal representative of a deceased Enrollee's estate will be included as part of the appeal. ***Molina's appeals process will provide the opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records considered during the appeals process.***

In addition to providing a written acknowledgement letter of Molina's receipt of the appeal, our Enrollee Resolution Team coordinator will call the Enrollee (or their caregiver / authorized representative) upon receipt of the appeal and explain the process and answer any questions they may have. The coordinator also will gather any additional information related to the appeal that should be considered part of the review. Molina's clinical reviewer (a registered nurse) will reach out to providers for any additional clinical documentation that should be considered. ***The Enrollee Resolution Team coordinator will be available to the Enrollee and their caregiver / authorized representative throughout the appeal process.*** If an Enrollee, caregiver, or authorized representative would like to appear in person to discuss the appeal, Molina's Enrollee Resolution Team coordinator will assist them and arrange for an in-person, virtual, or telephone meeting.

d. TRACKING AND TRENDING GRIEVANCES AND APPEALS

Molina's grievances and appeals workforce system will track and trend grievances and appeals data from initial receipt through final resolution. We will use grievances and appeals data as part of our standard metrics and data analyses to measure effectiveness and drive improvement activities for our Kentucky Medicaid program operations.

Internally, we will categorize and track grievances and appeals in accordance with NCQA standards (as illustrated in Exhibit C.14-4) to identify opportunities for improvement and implement appropriate interventions.

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Exhibit C.14-4. Grievances and Appeals Tracking and Trending Categories

In addition to grievances and appeals data, Molina will leverage other sources of information to identify trends and institute improvements, including our Quality and Member Access Committee and Provider Advisory Workgroup.

In addition to the five NCQA standard categories, our grievances and appeals system includes the category of "Other." This category allows us to conduct in-depth analyses of grievances. Grievances are automatically mapped to the first level of category based on core claims administration system "C" codes and include the reason for the dissatisfaction. For example, if an Enrollee calls regarding a provider bill, the Call Center customer service representative will select an Enrollee call code with a "C—Billing Issue" that automatically maps to the "Billing and Financial Issues" category in the system. From there, the next level of root cause will be selected, such as "co-pay," "medical records charge," or "provider bill." This process will provide additional data to determine the types of billing grievances. Our grievances and appeals system also captures appeals data, such as type of service and appeal decision.

Daily, our Grievances and Appeals leadership team will use our sophisticated Grievances and Appeals Interactive Dashboard to gauge inventory by age, assignment loads, case routes, current status, and more. The dashboard will provide near real-time data to support prompt decision-making and optimize timeliness of response and resolution. Exhibit C.14-5 provides a screenshot of the dashboard.

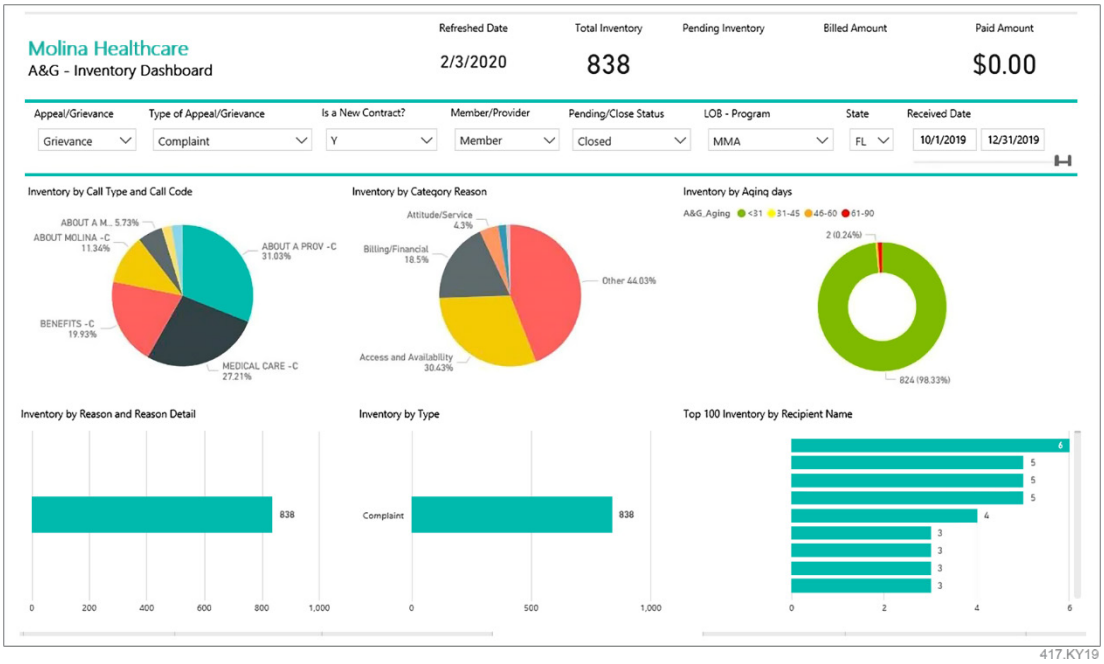

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Exhibit C.14-5. Our Dashboard Provides Key Information to Drive Success

We will track volume and turnaround-time metrics monthly and adjust as indicated. We will conduct root cause analysis to a third and even fourth level of specificity. Molina's comprehensive review and response process will ensure appropriate, effective, and timely actions are taken to resolve root cause errors. Our Root Cause Analysis team will detect root causes of errors across Molina systems through ongoing review and analysis; drive change across the enterprise to identify and implement systemic improvements; and oversee and maintain improvements by ensuring appropriate controls and responses are in place. This rigorous process will allow us to track and trend data internally and identify opportunities for improvement to increase Enrollee and provider satisfaction with Molina as part of our outcomes-based process model. We will track appeal outcomes and share the data with our clinical staff as part of ongoing feedback to improve services and the Enrollee experience.

Trending Data to Improve Operations

We will analyze grievances and appeals data for our Kentucky Medicaid program at least monthly to proactively identify any issues that need to be addressed and escalated, as appropriate. Quarterly, our Grievances and Appeals team will review reports to identify trends and track information for internal operational monitoring. Annually, Molina's Quality Improvement Committee will identify trends based on appeals and grievances categories to discuss opportunities for improvement, address barriers, and plan quality improvement interventions, as indicated. We also will evaluate general trends related to access and availability and determine if there are any provider access issues that warrant further investigation. If so, the information will be presented to Molina's Kentucky-based Provider Network and Provider Services teams.

Molina will continually review data to identify opportunities for improvement. We will engage various Molina departments and committees and share data and reports on trends for review and appropriate action. Figure C.14-6 details our process for tracking and trending data on grievances.

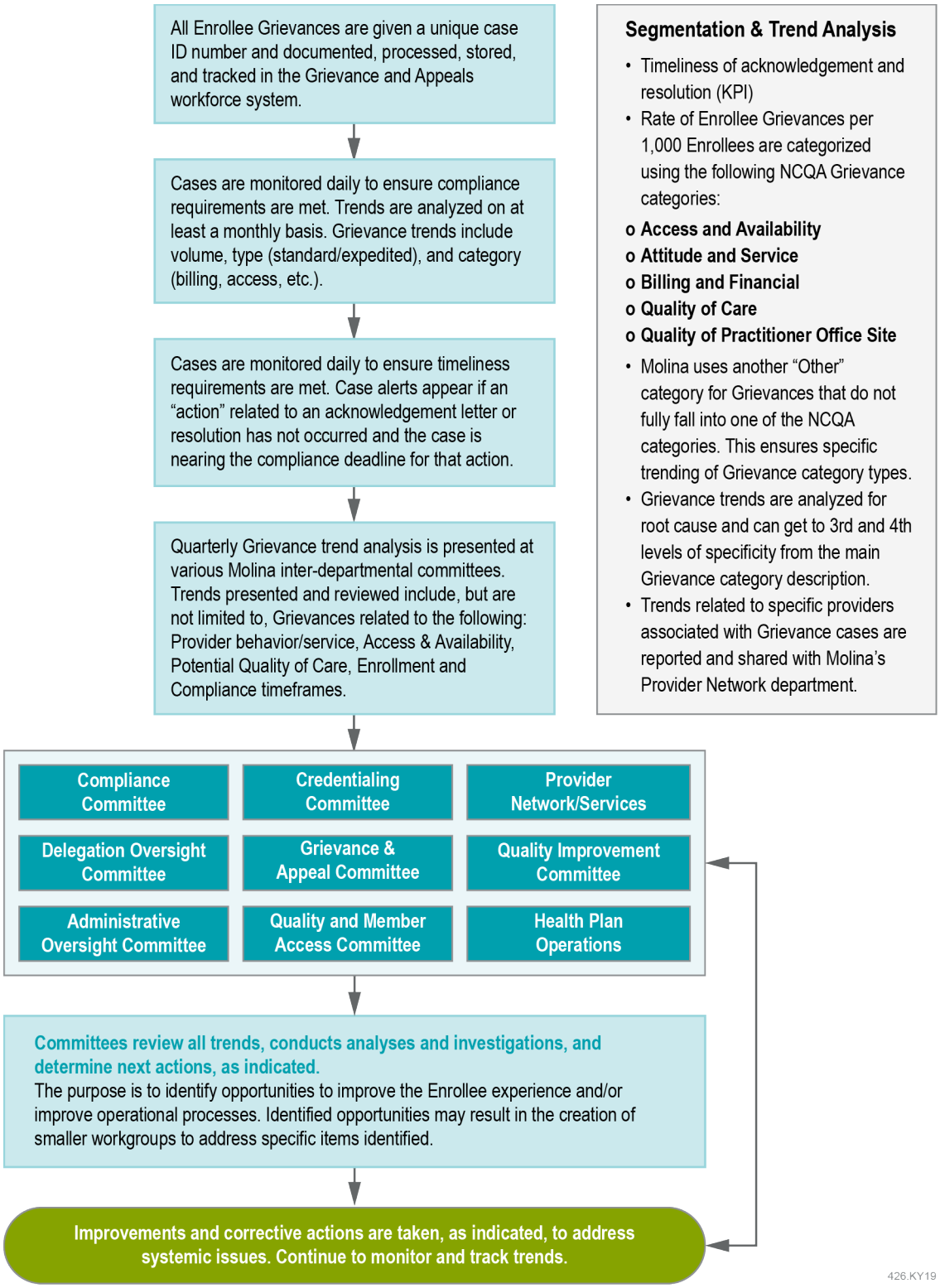

Exhibit C.14-6. Tracking and Trending Data on Grievances to Improve Outcomes

e. REVIEWING OVERTURNED DECISIONS TO IDENTIFY NEEDED CHANGES

As part of our ongoing data analysis, we will review appeals decisions, including overturned decisions, quarterly for our Kentucky Medicaid program operations to identify trends that may indicate necessary changes in our policies, processes, or how we interact with our Enrollees and providers. Our Quality Improvement department will review appeals data on such elements as type of service (e.g., MRI, braces, wheelchair), original reviewer (the person who originally denied the service), and type of decision (e.g., upheld, overturned).

For example, one of our affiliate Medicaid health plan's quarterly trend analyses indicated an uptick in overturned appeal decisions. The plan's Grievances and Appeals team conducted a root cause analysis and discovered that many of the decisions were overturned following a provider's submission of additional documentation during the appeal process to support their request. In collaboration with the Healthcare Services department, solutions were designed and implemented to address the issue and consequently reduce the volume of overturned decisions. This included conducting targeted training to providers on supplying all relevant clinical information with requests for prior authorization at the time of submission. In addition, the Healthcare Services department revised their process to have utilization management nurses make additional attempts to reach providers when clinical information or clarification is needed to render a determination on the service request. The health plan closely monitored overturned decisions following implementation of the targeted training and confirmed a significant decrease in appeals and overturned decisions.

All decisions to overturn the original decision will be reviewed and shared with the Healthcare Services Committee to determine if a change in process or criteria should be made. Quarterly, our Grievances and Appeals team will review trends to identify opportunities for improvement, implement improvement initiatives and activities, and monitor data to confirm improvement. Ultimately, our goal is to review outcomes data on appeals to address any areas where we can improve our Enrollees' access to services and remove barriers to them receiving appropriate and needed care.

We also will carefully review information on grievances. For example, a Molina affiliated health plan noted a trend in Enrollee grievances relating to their ID cards, indicating they were not sturdy enough. After consulting with the Health Plan Operations Committee, the card stock was upgraded to a more durable material.

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