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.

Because of our interactive end-to-end process that includes experienced professional staff, our **resolution compliance rate for all issue types across all national plans for 2018 is 99.5%**.

We currently process enrollee grievances and appeals for Medicaid health plans in 31 states plus the District of Columbia. We deliver high quality services to enrollees through our streamlined grievances and appeals processes and our knowledgeable member services center, while engaging individuals in their own health care by delivering easy-to-use solutions. In each of the state Medicaid programs we serve, we have developed innovative systems and processes with an integrated organizational structure (e.g., collaboration between grievances and appeals, compliance and quality management through quality committees) that allow us to track our handling and resolution of enrollee grievances and appeals. Tracking information allows us to learn trends in filing grievances and appeals, and we continuously use this information to improve our services to avoid our enrollees having to reach the filing process. This also allows us to comply with contract requirements and continue to provide high-quality services to our enrollees. Our approach will educate Kentucky enrollees on what they can do to file a grievance or appeal and provide them with a simple, well-supported process through our member services center.

We confirm our enrollee grievances and appeals system complies with 42 C.F.R., Part 438, Subpart F, all applicable federal and state laws, regulations and policies; and all requirements in Attachment C – Draft Medicaid Managed Care Contract, Section 24.0. Enrollee Grievances and Appeals. It comprises all elements required by DMS, including enrollee grievance process, appeal process, expedited review and resolution procedures, State Fair Hearing process and when applicable, external review procedures. We will update our policies and procedures with Kentucky-specific requirements in Attachment C – Draft Medicaid Managed Care Contract, Section 24.2 Enrollee Grievance and Appeal Policies and Procedures, and submit for review to DMS. We will bring to Kentucky established systems, processes and organizational structure to evaluate grievances and appeals data as part of a continuous quality improvement process for the enrollees we serve.

Our streamlined, structured enrollee complaints, grievances and appeals process gives enrollees recourse to resolve their issues in a supportive, professional, consistent and timely manner. Our Kentucky based enrollee and provider complaint, grievance and appeal coordinators will support the enrollees through their process. Enrollees will have the opportunity to present evidence, testimony and allegations of fact or law, in person and in writing. We will then resolve issues as quickly as an enrollee's condition requires, not exceeding contractual and legal limits, and in accordance with the requirements in Section 24.0. The triage team receives and enters all enrollee grievances and appeals into our Escalation Tracking System (ETS). During triage, we determine the type of issue (grievance or appeal) and issue priority (e.g., standard or expedited).

Enrollee Grievances Process

Individuals, their authorized representative, or a provider, acting on behalf of the enrollee, with written permission from the individual, can file a grievance with us by calling our member services center or by mailing a grievance to us.

We enter the data into our system and capture relevant data as required by DMS. We enter written (date-stamped upon receipt) and oral grievances into ETS, enter the date of receipt and create a case file. Using ETS, we log and track their name and identification number, date grievance received and grievance acknowledgement, grievance description, staff assigned for disposition, the disposition, disposition and notification date, date of resolution and description of resolution.

If an individual files a grievance orally, acknowledgement of receipt is apparent. We acknowledge receipt of written grievances in writing, not to exceed 10 calendar days, unless the enrollee or provider requests an expedited resolution.

Our ETS queues the grievance to a resolution analyst (RA) for investigation and resolution. We date stamp and incorporate into the case file information received during the resolution process. Resolution analysts have excellent communication skills, strong written and verbal skills, sound deductive reasoning skills, and extensive knowledge of federal and Commonwealth laws, regulations and policies. They use these skills to provide prompt resolution of the grievance, including investigating all pertinent facts related to resolving the grievance. Unless the grievance involves a denial based upon lack of medical necessity or otherwise involves clinical issues, the RA researches and resolves the grievance.

The RA may enlist the help of other internal departments (e.g., clinical) if subject matter expertise is needed. If the matter requires review by another internal department, the RA requests that a designated subject matter expert in the department address specific issues necessary to resolve the grievance. The RA may contact the individual or their provider to obtain additional information necessary to resolve the grievance. Upon completion of this process, the RA issues a written Notice of Disposition. We will communicate the disposition of a grievance in compliance with Section 24.2. We send a written Notice of Disposition that includes the actions we took to investigate and resolve the grievance.

Enrollee Appeals Process

The utilization management (UM) team sends a Notice of Adverse Benefit Determination (NABD) to the individual. This NABD communication is the starting point for an appeal. It includes rights and instructions to submit appeals within the specified timeline and the expectations of the process. A Notice of Appeal Resolution (NAR) is sent after an appeal determination. It includes rights and instructions to submit a State Fair Hearing. The NAR letter includes a clear explanation and basis for the adverse determination as required in Section 24.2.

If an enrollee receives an NABD, they have the right to appeal. We will accept appeals in writing or orally and treat oral inquiries seeking to appeal an action as an appeal. An individual or their authorized representative and provider, with written consent, can file an appeal on their behalf. Except for expedited appeals, the individual or their authorized representative must submit the oral appeal in writing within 10 calendar days of the call. We acknowledge the receipt of an appeal in writing, not to exceed 10 calendar days, unless we receive a request for an expedited resolution. We do not take punitive action against a provider who supports an enrollee's appeal or requests an expedited resolution.

Our ETS queues the appeal to a RA for investigation and resolution. The RA provides each individual a reasonable opportunity to present evidence and allegations of fact or law in person and in writing. The RA informs the enrollee of the limited time available in cases involving expedited resolution. We date stamp and incorporate into the case file information received during the resolution process. We provide individuals an opportunity to examine the appeal file, including medical records and other documents considered during the resolution process.

The RA may enlist the help of other internal departments (e.g., clinical) if subject matter expertise is needed. If the matter requires review by another internal department, the RA requests that a designated subject matter expert in the department address specific issues necessary to resolve the appeal. The RA may contact the individual or their provider to obtain additional information necessary to resolve the appeal.

For clinical appeals, the RA assembles relevant background information from our prior authorization and claims systems, obtains relevant clinical information, and forwards the matter to a medical director or other health care professional who has appropriate clinical expertise to review the matter. Only medical directors or other health care professionals with the appropriate clinical expertise, and those not involved in previous levels of review or decision-making, review appeals. Upon completion, the RA issues a written NAR for both expedited and standard appeals resolutions. In the case of an expedited appeal, the RA also provides oral notice of our decision. Following is our streamlined grievances and appeals process.

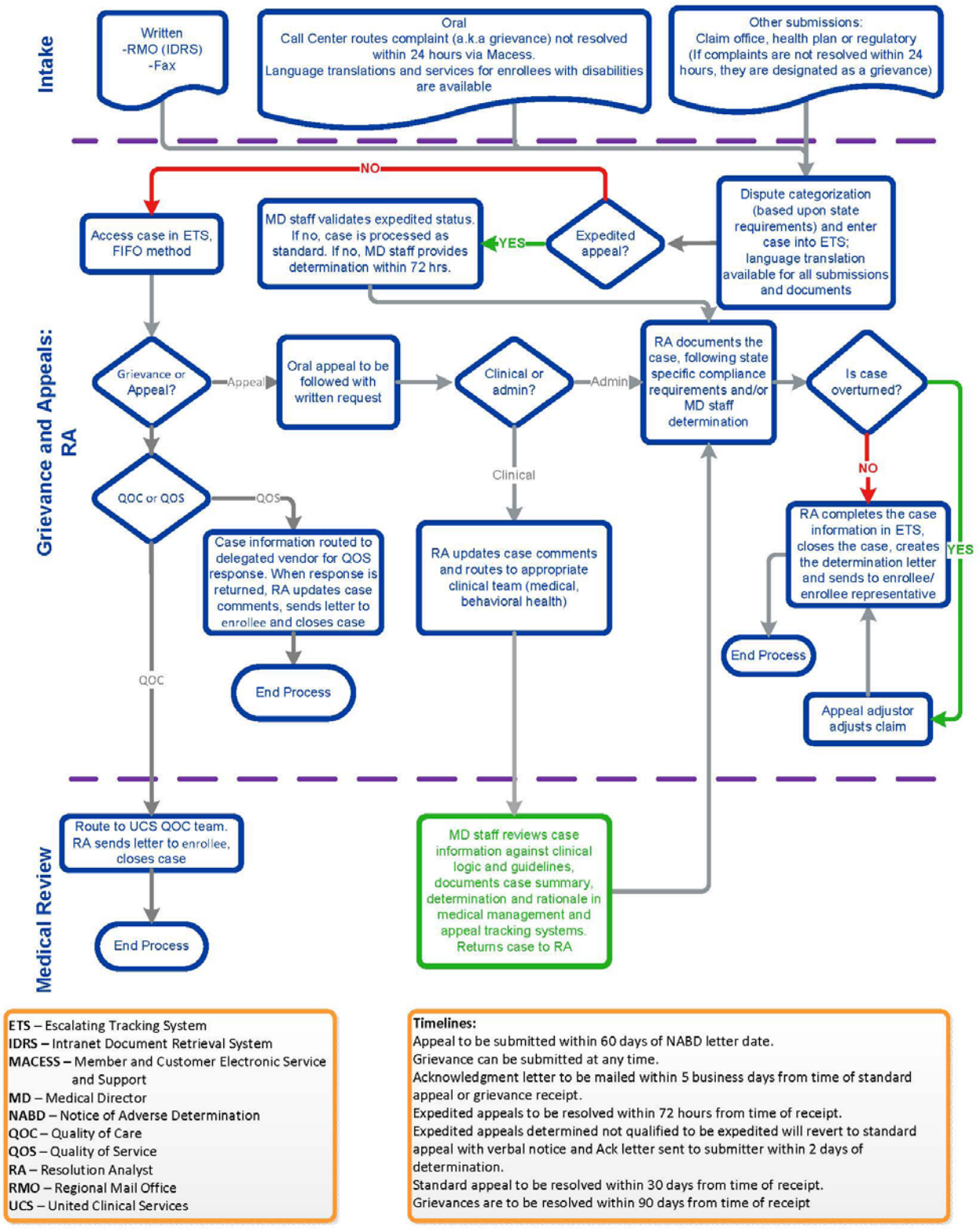

Figure 7. Our structured enrollee grievances and appeals process gives enrollees recourse to have their issues resolved in a professional, consistent and timely manner and verifies we resolve enrollee complaints, grievances and appeals as quickly as an enrollee's condition requires, not exceeding contractual and legal limits.

b. Process for Expedited Review.

When it comes to issues that may seriously jeopardize an enrollee's life, health or ability to attain, maintain or regain maximum function, we are committed to providing high quality solutions. We provide expedited appeals review and resolution timely and efficiently to confirm the safety of our enrollees. Our expedited review and resolution of the appeals process complies with Section 24.2, including resolving the request within 72 hours of receipt unless this time frame is extended pursuant to 42 C.F.R. 438.408(c). Our expedited grievance review process includes the following steps:

- An enrollee, the enrollee's authorized representative or provider acting on the enrollee's behalf, requests an expedited appeal review by calling our member services center.
- We forward the expedited appeals request to a medical director to review and determine if the request meets the criteria for expedited review (e.g., the practitioner's actions or skills are being questioned or a delay in referral or authorization process that resulted in a clinical problem).
- If our medical director determines the expedited review request **does** meet the criteria for expedited review:
  - The expedited appeal is queued to our RA for investigation and resolution.
  - We provide oral notice of our decision within 72 hours and issue a written Notice of Disposition. The Notice of Disposition contains the results of the resolution process, including the legal citations or authorities supporting the determination along with the date it was completed.
- If our medical director determines the expedited appeal **does not** meet the criteria for expedited review:
  - We make every effort to contact the enrollee and provide prompt oral notice of our decision.
  - We follow up with a written notice of denial of expedited resolution within 2 days that explains that we will transfer the appeal to our standard appeal process and informs the enrollee of their right to file a grievance in response to our decision.

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

When enrollees first call the member services center to file a grievance or appeal, our MSAs are available to try to mitigate any initial issues and avoid filing a grievance or appeal if at all possible. If the issue continues on to filing, then our grievances and appeals team makes the process of filing as simple as possible for our enrollees and their caregivers or representatives (e.g., enrollee's provider). *Advocate4Me* MSAs can assist the enrollee to simplify the process, including preparing and submitting a written complaint, grievance or appeal. Care coordinators, enrollee advocates, community health workers, and our quality team help enrollees write and file complaints, grievances and appeals. We will continue monitoring the enrollee's issue through to resolution. This

Our award-winning member service approach — known as ***Advocate4Me***® — is staffed by in-state MSAs empowered to address the needs of our enrollees and creating a simple compassionate individual experience. Our MSAs act quickly to resolve issues through a single telephone line for both medical and behavioral health calls. Building upon our national framework and proven capabilities, we deploy a member services approach that addresses individuals' needs in a culturally appropriate, Kentucky-specific manner to make sure enrollees feel engaged in their health care experience.

commitment creates an environment where enrollees feel engaged in their health care, and view us as a resource and affords us the opportunity to resolve their issues with as little dissatisfaction as possible. If the enrollee chooses to have a representative file on their behalf, they must sign an Authorization of Representation that we will keep on file. Involvement from the enrollee or their caregiver or representative involves:

- Filing of appeals (either expedited or standard) must be submitted within 60 calendar days from the date of initial denial. If the appeal is received in writing, it must be on our provided standard form. If we do not receive this information within 10 days, we withdraw the request.
- Submitting expedited appeals orally by calling our member services center and speaking to one of our MSAs.
- Submitting complaints or grievances orally to member services center or in writing to the regional mail office.

Advocate4Me MSAs can serve enrollees in their choice of primary language. Our MSAs have access to our interpretive services, which provide translators for over 240 languages, as needed. An enrollee who is hard of hearing can use our toll-free telecommunications relay service, and enrollees with impaired vision can request that an MSA read the materials aloud.

Grievance and Appeals Enrollee and Caregiver Assistance

Jeremy was required to have a medical test to qualify for a waiver. He was told the copay was covered by his Medicaid plan, though after he had the test, the Medicare copay portion was denied. The provider billed Jeremy for the copay balance. Jeremy's mother (with permission to appeal on his behalf) called our member services center disputing that Jeremy was told a service was covered, yet it had been denied after the service was performed. The MSA offered to forward their appeal directly to the grievances and appeals team to address their case. Jeremy's mother accepted and the case was routed to the grievances and appeals team.

As part of the process, the grievances and appeals RA called the provider with a request for additional information. Upon receipt of this additional information, the service was confirmed as approved and the RA was able to resolve and close Jeremy's case, sending a resolution letter to the provider to cease billing Jeremy.

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

We view grievances and appeals as an opportunity to ascertain issues and trends that allow us to make continual quality improvements to the way we provide care and services to our enrollees. We have relationships in place with designated accountable owners, clearly organized processes and a structure that involves all areas of the organization including the Quality Assurance and Performance Improvement (QAPI) program, UM and compliance while providing senior level accountability. In addition to confirming the appropriate and timely processing and resolution of enrollee grievances or appeals, our grievances and appeals governance team collaborates with other internal departments, such as compliance and QAPI, to monitor the reasons that enrollees are filing grievances or appeals and our handling and resolution of grievances and appeals.

Our QAPI department is the central area for receiving potential quality issues and coordinating improvement activities. They serve as a critical interface between enrollees, their representatives, practitioners, the Commonwealth, other regulators, and internal departments that perform grievances and appeals activities, such as the member services center and our *Advocate4Me* team. The QAPI conducts quality investigations and analyses related to grievances and appeals, identifying trends necessitating further evaluation and education.

Using our grievances and appeals database, ETS, our QAPI program collaborates with our grievances and appeals team, compliance department, UM program and *Advocate4Me* team to collect, review, analyze and trend grievances and appeals data to:

- Confirm compliance with Kentucky requirements for processing grievances and appeals
- Assess enrollee satisfaction and identify opportunities for improvement
- Identify and resolve potential quality-of-care issues with network providers
- Identify issues with other aspects of our operations (e.g., claims processing) that may be causing an unnecessary increase in the number of grievances and appeals filed
- Identify opportunities for improvement in our operations

An example of where we tracked trends was with our New York health plan, when we noticed a high amount of post-service appeals related to provider groups who worked out of clinics in five hospitals run by the city of New York. While these hospitals were participating in our network, the physicians were non-participating. This created dissatisfaction for enrollees and access to care challenges for the membership. To solve this problem, we worked with the network management team to pursue a contract with the affected physicians. After we contracted, credentialed, and loaded these providers into our system, we were able to reduce appeals, overturn rates significantly, and improve both enrollee access and enrollee and provider satisfaction. Over a 2-year span, we saw a **93% reduction in appeals** for the groups before and after contracting. Before contracting, there were 3,811 appeals for the year, which drastically declined to 247 appeals for the year after contracting and run out.

e. Reviewing overturned decisions to identify needed changes.

In compliance with requirements in Attachment C – Draft Medicaid Managed Care Contract, Section 24.3 State Fair Hearings for Enrollees, an enrollee can request a State Fair Hearing if they are not satisfied with an adverse benefit determination. We review decisions overturned in State Fair Hearings through our Quality Improvement Committee (QIC), Service Quality Improvement Subcommittee (SQIS), Provider Advisory Council (PAC) and Healthcare Quality and Utilization Management (HQUM). To make certain we meet regulatory policies, the QIC reviews each case and offers feedback from other departments regarding the case determination to improve operational processes, share information with the appropriate parties, and provide for consistent and consensus State Fair Hearing case resolution.

A local State Fair Hearing coordinator attends each meeting and presents the cases, providing a brief synopsis of the cases and what direction the cases are taking. The SQIS, PAC and HQUM conduct a root cause analysis and barrier assessments to provide insight into issues with our grievances and appeals, review processes of our operations and implement action plans. We base action plans on the root cause analysis that address and refine our grievances and appeals review process and any other operational processes, as needed and put remediation plans in place, if appropriate. The compliance officer and director of claims help facilitate identified operational changes; our clinical services also reviews and determines root cause for remediation.

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