SECTION S – MEMBER GRIEVANCES AND APPEALS

S.1 Provide a flowchart (marked as Chart C) and comprehensive written description of your member Grievance and Appeals process, including your approach for meeting the general requirements and plan to:
o Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the member's primary language and that reasonable assistance will be given to members to file a Grievance or Appeal;
o Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and
o Ensure that an expedited process exists when taking the standard time could seriously jeopardize the member's health. As part of this process, explain how you will determine when the expedited process is necessary. Include in the description how data resulting from the Grievance system will be used to improve your operational performance.

Louisiana Healthcare Connections (LHCC) has established, implemented, and maintains fully developed, member-centric Grievance and Appeals processes, procedures, policies, and notices that comply fully with all regulatory and statutory requirements, including RFP Section 13, Member Grievance and Appeals; 42 CFR Part 438, Subpart F; and all other contractual, regulatory and NCQA requirements. In addition, LHCC's member Grievance and Appeals written policies and procedures have been reviewed and approved by the Louisiana Department of Health and Hospitals (DHH), and LHCC will not modify those policies without prior written approval from DHH.

LHCC promotes and maintains an internal function dedicated to the identification and prompt resolution of oral and written Grievances and member Appeals. Our policies and procedures govern the resolution of inquiries, Grievances, and Appeals, and encompass expedited review, external review, and access to the State's Fair Hearing system. LHCC maintains, and will continue to maintain, written policies and procedures clearly describing the Grievance and Appeals process. We ensure that the Grievance and Appeals System policies and procedures, and all notices, are available in the member's primary language in accordance with the requirements 42 CFR §438.10(c),(d), and Section 12 of the RFP, and that reasonable assistance is provided to members to file a Grievance or Appeal. We further ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review, and that an expedited process is followed when taking the standard time could seriously jeopardize the member's health. We also use the data resulting from the Grievance System to improve operational performance.

Grievance and Appeals System

Authority and Roles. The LHCC Board of Directors has final authority over, and responsibility for, the Grievance and Appeals process, and has delegated operational oversight and implementation to LHCC's Grievance and Appeals Committee. The Grievance and Appeals Committee reviews all complaints, Grievances and Appeals, including provider complaints handled by subcontractors under a delegated arrangement, to identify trends or issues requiring follow-up or improvement.

The Grievance and Appeals Coordinator (GAC) is responsible for ensuring all aspects of the process are documented, and that complaints, Grievances and Appeals are routed, processed, tracked, resolved, and reported per DHH requirements. The Clinical Appeals Coordinator (CAC) manages and processes requests for peer-to-peer, member and provider Appeals, tasks cases to an appropriate physician reviewer for determination, and ensures that the member or provider has received appropriate and timely "due process" from LHCC. The Customer Services Representative (CSR) answers incoming calls to our Member call center. When a member calls with a problem or a specific concern, the CSR attempts to resolve the member's concerns. If the CSR is unable to resolve the member's concern, he or she documents the member's concern/Grievance in the Member Relationship Management (MRM)

system and sends notification (referral) to the appropriate queue (e.g., the Grievance queue). In addition, all LHCC staff are trained on the Grievance and Appeals process and its importance, member and provider rights, and how to assist members and providers in filing Complaints/Grievances and Appeals.

LHCC uses three technology tools to manage our Grievance and Appeals processes, including our leading edge systems, our Member Relationship Management System (MRM), and TruCare:

- **Member Relationship Management System (MRM).** Using leading *Customer Relationship Management technology*, LHCC's management uses MRM to oversee our Grievance and Appeals process, including using it to view both the inventory of all outstanding Grievances and Appeals, and ensuring that all timeframes are being met for any open Grievance or Appeal case. Our enterprise-based secure Grievance and Appeals Workflow and Documentation System module of our MRM system enables auditable workflow as an Appeal or Grievance moves to completed resolution through formal DHH and Federal compliant steps and protocols.
- **TruCare.** LHCC Grievance and Appeal staff use TruCare to track Appeals by member that include a clinical component. TruCare is LHCC's member-centric health management platform for collaborative care coordination and case, behavioral health, disease, and utilization management.
- **SharePoint.** LHCC Grievance and Appeal staff use SharePoint to provide a central location for documenting, tracking, and reporting member Grievance and Appeal data, and to facilitate monitoring of the Grievance resolution process and timeframes.

Subcontractors. LHCC holds all subcontractors, including US Script, Inc.® (US Script), Cenpatico STRS, and OptiCare Managed Vision, Inc. (OptiCare) responsible for compliance with member Grievance and Appeal requirements. LHCC monitors its subcontractors, including through Joint Operations Committee meetings conducted at least quarterly to ensure that they comply with all DHH requirements. The vendor is supervised and held accountable by Vendor Oversight on a monthly/quarterly basis, which includes the reporting of grievances at the vendor/Plan level. The quarterly meetings also include the sharing of member and provider experiences (including Grievances reported at the Plan level). Subcontractors are also required to provide all materials explaining their services in the members' primary language, and to arrange for, and provide translators on, an as-needed basis. In order for subcontractors to comply with this requirement, LHCC provides subcontractors with a member eligibility file, which includes the member's primary language. LHCC provides this information to subcontractors prior to the contract start date, and on a monthly basis thereafter. The Cultural and Linguistic Appropriate Service (CLAS) Committee also provides subcontractors with analytical reports related to the primary language of the members they are serving.

Reasonable Assistance to Members. LHCC believes that members should have their concerns and issues heard and addressed as soon as possible. We ensure prompt resolution by providing assistance to members in filing Grievance and Appeals, educating members about the process, providing responsive customer service and immediate resolution whenever possible, and ensuring HIPAA compliant communications.

In all cases, the member has access to LHCC assistance in filing member inquiries, Grievances, Appeals, or requests for State Fair Hearings. LHCC provides personal assistance to any member needing support in any stage of the complaint/Grievance process, including completing forms and communication assistance, such as translation, toll-free numbers with adequate TTY/TDD and interpreter capability, or alternative formats for materials. LHCC provides instructions related to filing a plan-level Appeal or a State Fair Hearing to the members, providers, and other authorized representatives filing Grievances on behalf of a member, including providing the required State Fair Hearing Form and the appropriate authorization forms.

We also educate our members about how to contact LHCC's Customer Services Department if they have an inquiry or concern, and about the Grievance and Appeal process in the Member Handbook, on the LHCC Member Portal, and at least annually in our Member Newsletters. A member's authorized representative may contact LHCC at any time with an inquiry on behalf of the member. They may contact LHCC orally, in writing, by mail, facsimile (fax), electronic mail, through the LHCC Member Portal, or by dialing the LHCC toll-free Customer Services Helpline.

We take pride in our responsive customer service, and attempt to resolve the issue or inquiry for the caller at the time of the call. LHCC trains all LHCC staff members to identify, document, and route verbal or written issues or inquiries to the appropriate personnel, although most individuals and members call the Customer Services Helpline with their initial inquiry. We refer all members who are dissatisfied with LHCC or our subcontractors in any respect to our CSRs and/or our GAC who are authorized to review and respond to Grievances and Appeals, and have the authority to require corrective action. When responding to inquiries, CSRs utilize help screens and other system documentation to assist members with addressing issues and providing information to the member's satisfaction.

LHCC ensures that communication with designated representatives on behalf of members is HIPAA compliant, and that there is written consent from the member for a representative to act on behalf of the member, as outlined in LHCC policy and procedure. Our GAC or CAC confirms the member has given written consent. When appropriate, the GAC supplies a consent form for the member to complete and return.

Information to Members in Member's Primary Language. LHCC makes Grievance and Appeal System policies and procedures (and all notices) available in easily understandable formats in the member's primary language. LHCC writes all materials at a 6th grade reading level in easy-to-understand language and, upon request, provides materials in the member's primary language or in an alternative format for members who are hearing or vision impaired. LHCC includes a statement in the Member Handbook, Member Newsletters, and all complaint/Grievance correspondence and notices in English, Spanish, and Vietnamese that provides the member with a telephone number to call if they require translation services or would like to have the material provided to them in their native language. In addition, LHCC's Customer Services Representatives give a number for translation services to members who telephone the call center. At no cost to the member, LHCC provides translation services and documents in the member's native language or in an alternative format.

LHCC also educates members about the Grievance and Appeal System policy and procedures and their rights through our Member Handbook, Member Newsletters, Member Portal, and during telephonic and face-to-face interactions with members. We provide information in these documents and interaction that includes, but is not limited to information on how to file a complaint or Grievance; how LHCC will address the complaint or Grievance; and how LHCC will receive, track, review, and report all inquiries, Grievances, and Appeals. We also provide information on the DHH Medicaid State Fair Hearing process and the procedures involved, including the rights of members and providers to access a Fair Hearing after exhausting LHCC's internal Appeal process. We also include information regarding the State Fair Hearing process in the Notification of Adverse Determination letter. We make all forms and all related policies, procedures, and timeframes regarding Grievances, Appeals, and State Fair Hearings available to members upon written or verbal request, on our Member Portal, provided to the member by staff when informing members of their rights, and provided verbally and/or in writing in applicable situations, such as initiation of disenrollment by LHCC and decisions resulting in an adverse action.

Information to Providers and Subcontractors. LHCC provides all required information to providers and subcontractors on our Member Grievance Policy and Procedures at the time of contracting, and ongoing in the Provider Manual, Provider Newsletters, Provider Portal, our website, during Provider Training, and on an individual basis as needed.

Appropriate Expertise. The GAC will ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise, and are not involved in any previous level of review or decision-making at any time. As determined by DHH, a physician with appropriate clinical expertise reviews Appeals of a denial based on lack of medical necessity, Grievances regarding denial of expedited Appeals, or Grievance or Appeals involving clinical issues. This individual is a clinical peer of the same or similar specialty who is not a subordinate of the individual who makes the initial adverse determination (and who is not involved in the initial determination or any prior decision-making). Similarly, individuals with appropriate expertise review and decide upon Grievances or Appeals involving nonclinical issues, including, but not limited to transportation, Customer Services, or LHCC's office hours. These individuals are not involved in the initial determination or any prior decision-making, and are not a subordinate to the individual who made the initial adverse determination.

Member Grievance Process

A member Grievance is any member expression of dissatisfaction about any matter other than an Action (described below). Possible concerns identified as Grievances may include, but are not limited to the quality of care or services provided to a member and aspects of interpersonal relationships, such as the rudeness of a provider or employee, or failure to respect the member's rights.

Receiving the Grievance. Members, authorized representatives acting on a member's behalf, and providers may file a Grievance via fax, orally (by using our toll-free or TTY/TDD number), in person, or in writing. LHCC provides members reasonable timeframes to file a Grievance; within 30 calendar days of the date on the notice of action or inaction.

Fax Receipt. The GAC checks the fax queue several times daily for Grievances, then retrieves them and immediately records their receipt in the SharePoint documentation system (SharePoint). LHCC uses SharePoint to provide a central location for documenting, tracking, and reporting member Grievances by category, and to facilitate monitoring of the Grievance resolution process and timeframes. After recording the Grievance in SharePoint, the GAC creates a "case" in the MRM, and attaches accompanying documentation. LHCC's Grievance and Appeals staff use the enterprise-based secured Grievance and Appeals Workflow and Documentation System module of our MRM system to manage all Grievance and Appeals cases. Our Grievance and Appeal System enables auditable workflow as an Appeal or Grievance moves to completed resolution through formal DHH and Federal compliant steps and protocols. LHCC management can view both the inventory of all outstanding Grievances and Appeals, and ensure that all timeframes are being met for any open Grievance or Appeal case.

Mail Receipt. LHCC staff immediately date stamp mailed Grievances and deliver them twice daily to the GAC who records their receipt in the SharePoint Grievance log. The GAC then creates a "case" in MRM and attaches accompanying documentation.

Oral Receipt. Staff receiving Grievances orally acknowledge the Grievance, document the substance of the Grievance, and attempt to resolve it immediately. The staff document resolution details for informal Grievances, which are defined as those received orally and resolved immediately to the satisfaction of the member, representative, or provider. If the Grievance is not resolved, the receiving staff forwards the Grievance and the documentation to the GAC through MRM, where cases for all Grievances are created, stored, and queued for follow up. Upon receiving the Grievance, the GAC enters it into SharePoint. SharePoint is used to track, analyze, and filter data, including member Grievances, member and provider Appeals, peer to peer requests, and State Fair Hearings. This data includes trending volume, State and NCQA categories, process time, service type, and Appeal determination. The SharePoint system also serves as a database to track and trend analytics for Quality Improvement processes which relate to internal and external customers, and is used to generate required Grievance and Appeals reports.

Referral or Resolution. The GAC reviews the Grievances in the MRM queue daily, and determines whether any of the Grievances in the queue should be expedited. For non-expedited Grievances, the GAC confirms that they are Grievances and completes and sends an acknowledgement letter, which includes a description of the Grievance procedures and resolution timeframes, within five business days and determines whether further action is needed to arrive at a resolution. If the GAC determines that the Grievance was resolved at the point of intake and no further action is needed, the GAC updates the case in the MRM and in SharePoint, completes the resolution letter, and mails it to the complainant within 90 calendar days of receipt of the Grievance. The GAC then documents the resolution in the MRM, closes the case, and records the case resolution in SharePoint. If the GAC determines that the case requires further action and includes a clinical or quality of care component, the GAC refers the case for investigation to the QI Department via MRM queue and email. If the case does not involve a clinical or quality of care component, the GAC refers the case to the appropriate Department for investigation.

Investigation and Resolution. Under the direction of the Quality Management (QM) Director and Quality Improvement (QI) Manager, the GAC conducts an initial review, which may include contacting the member for additional information or clarification of the issue and gathering applicable documentation from other LHCC departments. For example, the GAC may obtain the assistance or input of the member's Case Manager, or the Provider Services Department if the matter involves an LHCC provider.

The GAC forwards clinical issues, including Grievances filed as a result of a service denial, to the Medical Management Department for investigation, or review by a physician or other appropriate clinician. If the Grievance involves a quality of care issue, the GAC forwards the Grievance to the QM Department for review, resolution, and inclusion in the quality of care investigation process. The GAC forwards matters involving privacy concerns or potential fraud and abuse to the Program Integrity Officer for resolution. The Program Integrity Officer also determines whether the issue should be forwarded to DHH, and accordingly reports suspected concerns related to fraud, abuse, waste, neglect, and overpayment issues to DHH immediately upon discovery.

After completing the investigation, the appropriate LHCC staff documents the results and sends them to the GAC who reviews the case, updates it in MRM and SharePoint, completes and mails the Notice of Action, and closes the case in MRM and SharePoint.

Member Grievance Flowchart. Please see the following flowchart that illustrates the steps in the member Grievance process: *Chart C1: Member Grievance Process*

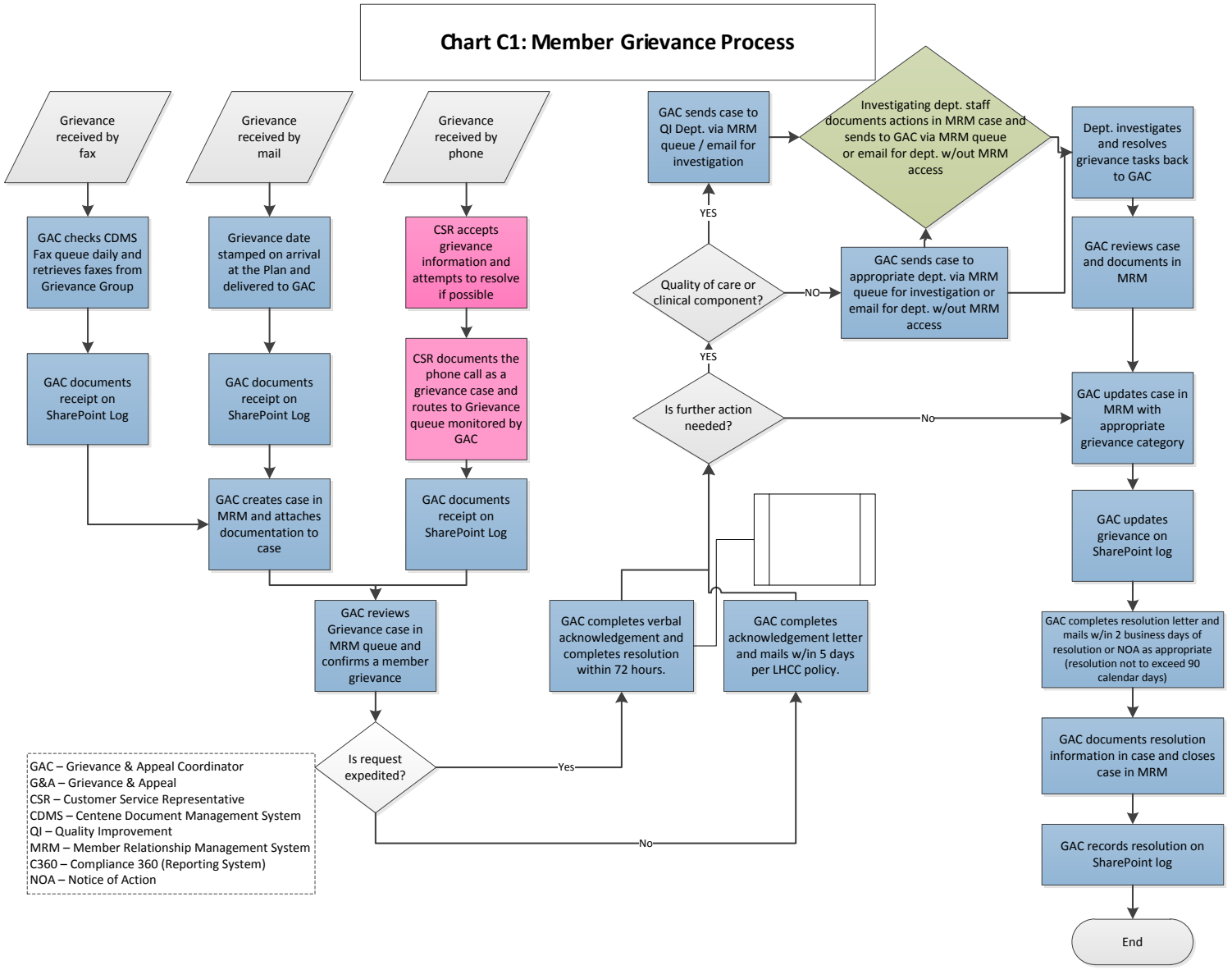


Chart C1: Member Grievance Process
Grievance received by fax
Grievance received by mail
Grievance received by phone
GAC checks CDMS Fax queue daily and retrieves faxes from Grievance Group
Grievance date stamped on arrival at the Plan and delivered to GAC
CSR accepts grievance information and attempts to resolve if possible
GAC documents receipt on SharePoint Log
GAC documents receipt on SharePoint Log
CSR documents the phone call as a grievance case and routes to Grievance queue monitored by GAC
GAC creates case in MRM and attaches documentation to case
GAC documents receipt on SharePoint Log
GAC reviews Grievance case in MRM queue and confirms a member grievance
Is request expedited?
Yes
No
GAC completes verbal acknowledgement and completes resolution within 72 hours.
GAC completes acknowledgement letter and mails w/in 5 days per LHCC policy.
GAC sends case to QI Dept. via MRM queue / email for investigation
Investigating dept. staff documents actions in MRM case and sends to GAC via MRM queue or email for dept. w/out MRM access
YES
Quality of care or clinical component?
NO
GAC sends case to appropriate dept. via MRM queue for investigation or email for dept. w/out MRM access
YES
Is further action needed?
No
Dept. investigates and resolves grievance tasks back to GAC
GAC reviews case and documents in MRM
GAC updates case in MRM with appropriate grievance category
GAC updates grievance on SharePoint log
GAC completes resolution letter and mails w/in 2 business days of resolution or NOA as appropriate (resolution not to exceed 90 calendar days)
GAC documents resolution information in case and closes case in MRM
GAC records resolution on SharePoint log
End
GAC – Grievance & Appeal Coordinator
G&A – Grievance & Appeal
CSR – Customer Service Representative
CDMS – Centene Document Management System
QI – Quality Improvement
MRM – Member Relationship Management System
C360 – Compliance 360 (Reporting System)
NOA – Notice of Action

Standard Member Appeal Process

An Appeal is defined as a request for the review of an Action taken by a health plan. The definition of an Action includes:

- Denial or limited authorization of a requested service, including the type or level of service
- Reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner, including failure to act within required timeframes.

Value-added services are not Medicaid funded and, as such, are not subject to Appeal and Fair Hearing rights. Therefore, a denial of these services will not be considered an Action for the purposes of Grievances and Appeals.

LHCC's parent company, Centene Corporation (Centene), and its affiliated health plans maintain an excellent record of meeting Grievance and Appeal resolution timeframes. In 2013 LHCC met the timeframes for 100 percent of Grievances, and 99.45 percent for member Appeals. We recognize that failure to provide services in a timely manner also constitutes an Action. LHCC also recognizes that failure to issue a timely determination for standard and expedited Appeals will be deemed as an approval, as of the date upon which the final determination should have been made.

In 2013 LHCC met the timeframes for 100% of Grievances, and 99.45% for member Appeals.

Receiving the Appeal. LHCC provides members reasonable timeframes to file an Appeal; within 30 calendar days of the date on the Notice of Action/Denial Letter, and within 10 calendar days when the Appeal involves requesting continuation of benefits. A member's authorized representative or provider may, with the written consent of the member, file an Appeal orally or in writing on behalf of the member. LHCC receives Appeals by fax, mail, telephone, or in a face-to-face conversation.

Fax Receipt. The GAC retrieves Appeals daily that are received by fax, and immediately records the date and time of receipt in SharePoint. The GAC then tasks the Appeal review to the CAC via the TruCare system. The GAC entry on the SharePoint log also triggers another alert to the CAC reviewer as a reminder.

Mail Receipt. LHCC staff date stamp Appeals received by mail, record them in SharePoint, and deliver them daily to the CAC.

Oral Receipt. LHCC staff who receive an Appeal, or an inquiry seeking to Appeal, an action by telephone acknowledge it, accept the Appeal information, and create a case in the MRM. LHCC staff also assist members with filling out Appeal forms if requested. LHCC considers the oral receipt date as the initial receipt date of the Appeal.

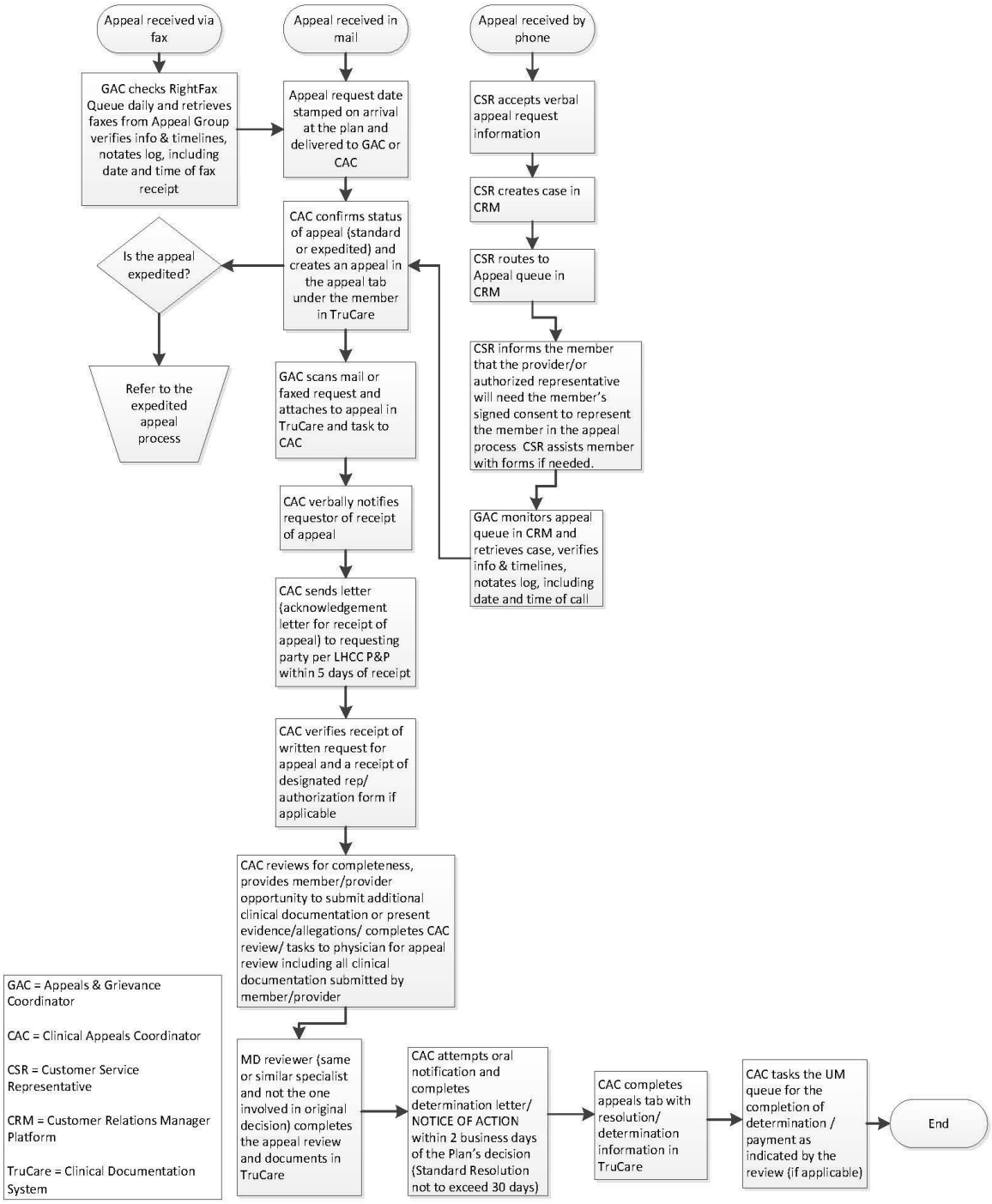
Review and Resolution. The GAC monitors the MRM for Appeals and forwards those in the system to the CAC. The CAC confirms the status and completeness of all of the Appeals received on that day. For those Appeals that are complete and validated against all DHH requirements, the CAC acknowledges them in writing or orally, as appropriate, and refers them to a physician for review. If any Appeal is not complete, the CAC returns the Appeal to the GAC for completion. The physician reviewer completes the review, documents the decision in the system, and notifies the CAC who then completes the verbal notification within 24 hours and mails the resolution letter to the appellant within 2 days of the decision. The CAC then documents the decision in the TruCare platform and initiates any follow-up action that results from the decision (e.g., payment, including for disputed services the member received while the Appeal was pending). TruCare is LHCC's member-centric health management platform for collaborative care coordination and case, behavioral health, disease, and utilization management, and it is also used to track Appeals that include a clinical component.

As part of the Appeal process, LHCC provides members with a reasonable opportunity to present, in person as well as in writing, evidence and allegations of fact or law. LHCC also provides the member or member's representative the opportunity to examine the case file, including medical records and any other documents considered during the Appeals process. LHCC includes the member, member's representative, or legal representative of a deceased member's estate as parties to the Appeal.

Standard Appeal Process Flowchart. Please see the following flowchart that illustrates the steps in the standard Appeal process: *Chart C2: Standard Appeal Process*

CHART C2: STANDARD APPEAL PROCESS

Louisiana Healthcare Connections Standard Appeal Process Flow



Revised 9.2.14

Expedited Member Appeal Process

A member, or the member's authorized representative or provider (acting on behalf of the member with the member's written consent), may request an expedited Appeal of an Action while pursuing the standard Appeals process if a delay could seriously jeopardize the member's life or health, or the ability to attain, maintain, or regain maximum function. LHCC informs the member of the limited time available to the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited Appeals.

The GAC or CAC immediately gathers supporting documentation for expedited Appeal requests, and forwards all information to the LHCC Medical Director (MD). The MD consults with another physician, with the same or similar specialty as indicated, who was not involved in any previous level of review. Prior to issuing an adverse determination, the MD, or his or her representative, contacts the requesting provider to obtain any additional information the provider or member wishes the MD to consider.

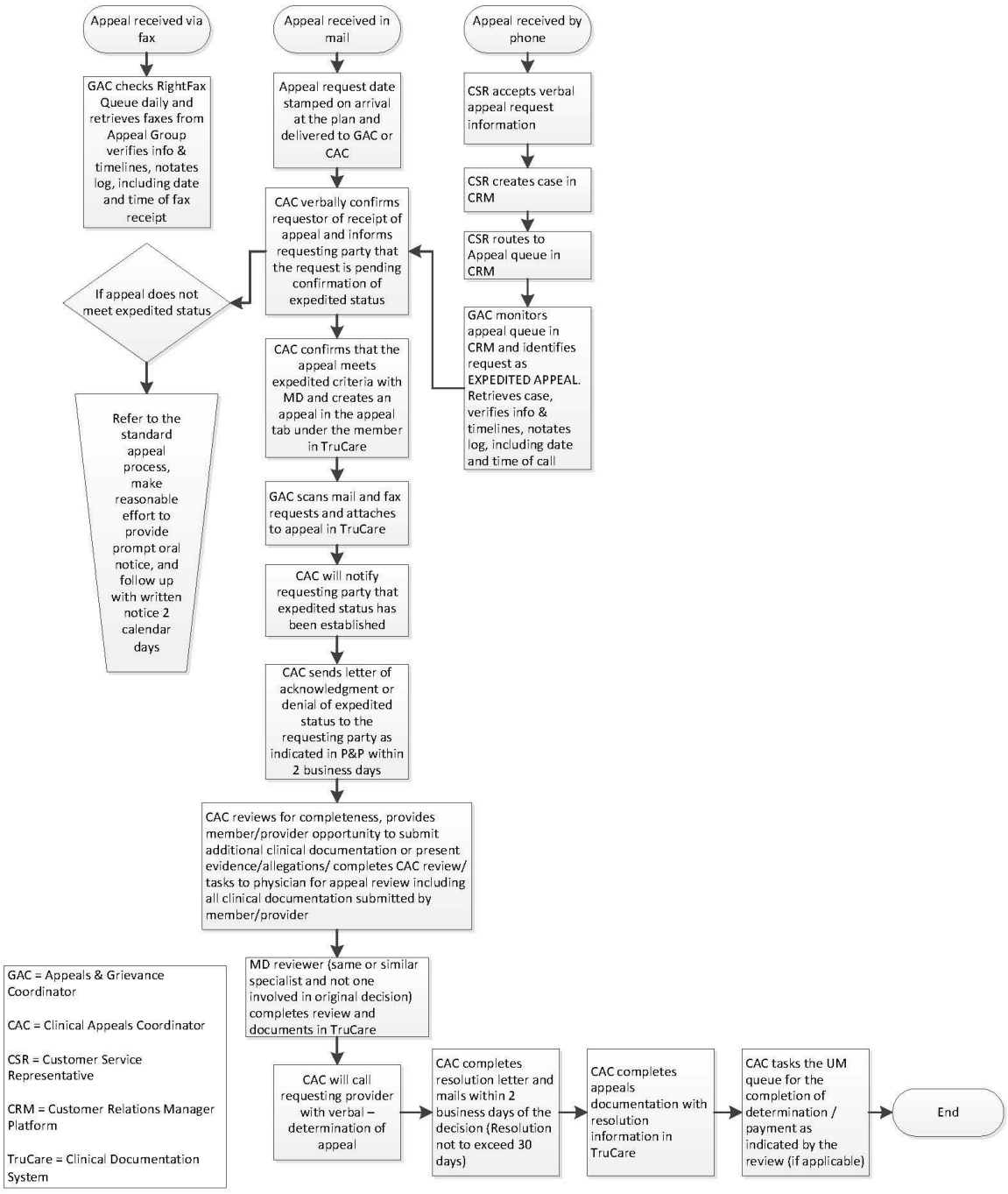
For requests related to an ongoing emergency or denial of a continued hospitalization, the MD will render a decision within 24 hours or sooner as the member's condition requires. For other types of requests, the MD will render a decision within 72 hours of receiving the request or sooner, as the member's condition requires. An oral expedited Appeal request does not require written notification, rather, the MD or CAC provides prompt verbal notice of all decisions to the provider and member. The CAC then follows up with written notification within two days of the expedited decision.

If a request for an expedited Appeal is denied, the CAC transfers the Appeal to the standard resolution process and makes reasonable efforts to promptly notify the member by telephone of the denial, which is followed by a written notice within two days. Although denial of a request for expedited Appeal resolution does not constitute an Action or require a Notice of Action, LHCC affords the member the right to file a Grievance in response to the decision.

Expedited Appeal Process Flowchart. Please see the following flowchart that illustrates the steps in the expedited Appeal process: ***Chart C3: Expedited Appeal Process***

CHART C3: EXPEDITED APPEAL PROCESS

Louisiana Healthcare Connections Expedited Appeal Process Flow



Revised 9.2.14

LHCC Response Time Exceeds Requirements

LHCC exceeds all contractual and regulatory timelines and requirements for acknowledgement and resolution of Grievances and Appeals. For example, in calendar year 2013, LHCC averaged:

- 16 calendar days from member Grievance receipt to resolution—14 days less than the standard
- 13 calendar days from standard member Appeal receipt to resolution—17 days less than the standard
- 22 calendar days from standard provider Appeal receipt to resolution—8 days less than the standard
- 24 hours from expedited member Appeal receipt to resolution—48 hours less than the standard
- 48 hours from expedited provider Appeal receipt to resolution—24 hours less than the standard.

LHCC does not create barriers to timely due process, and ensures none exist, in compliance with RFP Section 13. In addition, in 2012 and 2013, LHCC experienced no reversal of decisions Appealed to the State Fair Hearing level.

Acknowledgement and Resolution Timeframes. LHCC resolves Appeals as quickly as the member's condition requires. For example, a member who was due for a needed injection of Olanzapine in less than 72 hours was very stressed, and per US Script, the member did not try the PDL recommendations. The member was taking several psychiatric medications, and the provider did not send the list of medications that were tried, and failed in the past, with the original authorization form as required. When the CAC nurse received the request, she immediately reached out to the provider for a record of medications which were tried and failed for this member. The CAC nurse gathered the necessary documentation and presented the documentation to the plan-level pharmacists for review. With her quick response, she was able to have the expedited request resolved within 24 hours.

LHCC resolves Appeals and notifies the member and provider no later than 30 calendar days of receipt for standard Appeals, and 72 hours of receipt for expedited Appeals. LHCC extends the resolution timeframe for up to 14 calendar days if the member requests the extension, or if the delay is in the best interest of the member and the member agrees to the extension. We also provide the member with written notification of the reason for the delay for extensions not requested by the member.

Notice of Resolution. The GAC will provide written notice of the Appeal resolution to the member and the provider within 2 business days of the decision, not to exceed 30 days following receipt of the Appeal. Adverse Appeal resolution notices will include, but are not limited to the results of the resolution process and the date it was completed; the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending and how to make the request; and a statement that advises the member that the member may be held liable for the cost of those benefits if the hearing decision upholds LHCC's action.

If the member (or his/her designated representative) requests a State Fair Hearing, LHCC ensures all supporting documentation is forwarded to the Louisiana Division of Administrative Law within seven calendar days from the date LHCC receives the written hearing request.

Continuation of Benefits. LHCC continues a member's benefits through the Appeal resolution process (until the final decision by LHCC or the State Fair Hearing decision is issued) if the member filed the Appeal within 10 days of the Notice of Action, or the intended effective date of a proposed action and the Appeal involves *all* of the following:

- Termination, suspension, or reduction of a previously authorized course of treatment
- Services ordered by an authorized provider
- Original period covered by the original authorization has not expired
- The member requested an extension of benefits.

If these conditions are met, LHCC continues benefits throughout the Appeal process. The services remain in place until at least one of the following occurs; the member withdraws the Appeal, the Appeal decision is rendered and the member does not request a continuance within the designated timeframe pending a hearing, State Fair Hearing Officer issues an adverse decision, the original authorization time period expires, or authorization service limits are met.

Using Data to Improve Processes and Operational Performance

LHCC recognizes that complaint, Grievance, and Appeals data are a valuable source of information about member/provider satisfaction with LHCC's services, policies, procedures, and processes, and the effectiveness and efficiency of our Grievance and Appeals processes. Our processes and integrated Managed Information System (MIS) components, described above, enable us to collect, track, identify, trend, and aggregate complaint, Grievance, and Appeal data for effective monitoring and reporting, as well as for improving operational performance. All components of our integrated MIS are fully compliant with State and federal security regulations, including HIPAA and HITECH, and all MIS system components support our compliance with State and federal privacy regulations.

Tracking Grievances. Grievances are categorized within MRM under standard categories identified in LHCC's contract, or defined by the current DHH reporting guide. Current categories include:

- Quality of Care
- Accessibility of Office
- Attitude/Service of Staff
- Quality of Office Building
- Timeliness
- Benefit Limitations/Exclusions
- Billing and Financial Issues
- Clinical Criteria Not Met—Durable Medical Equipment
- Clinical Criteria Not Met—Inpatient Admissions
- Clinical Criteria Not Met—Medical Procedure
- Prior or Post Authorization
- Lack of Information from the Provider
- Level of Care Dispute
- Pharmacy
- Not a State Plan Service
- Other (Narrative)

LHCC further defines these broad categories by sub categories to delineate and trend issues while monitoring and tracking resolution timeframes. LHCC maintains records of all Grievances and Appeals in accordance with DHH requirements.

Using Grievance System Data to Improve Operational Performance. On at least a monthly basis, the LHCC GAC compiles all Grievance data into a Member Grievance Report, which the GAC reviews to identify trends. The GAC submits any identified trends which are specific to a department or service to the appropriate department for review and corrective action.

The GAC also submits this data monthly to DHH with the information as required, and also promptly forwards any adverse decisions to DHH for further review/action upon request by DHH or the member.

LHCC aggregates our Grievance System data so appropriate staff and our internal quality committees can review the results to analyze and prioritize corrective action and/or quality improvement initiatives. The GAC and Quality Improvement (QI) Director review metrics reports monthly to identify emerging

trends and concerns, Appeals procedures, processes, and policies, and together initiate prompt corrective action. Examples of key actionable metrics from aggregated data are:

- Grievance/Appeal acknowledgment, resolution, and notice within timeframe
- Grievance/Appeal (and expedited): number per 1,000 enrollees
- Appeals: percentage upheld
- Actions: percentage overturned

In addition to the metrics above, the GAC reviews a sampling of resolutions to ensure compliance and consistency. LHCC tracks all Grievance System activity by categories, which helps us to identify operational and provider performance improvement opportunities. For example, categorized Grievance System data helps LHCC to identify and implement plan-wide, departmental, or provider/subcontractor corrective action, such as to address network gaps, issues with appointment availability, wait times, provider compliance, improvements to written materials, additional provider or staff training, and business process improvements.

LHCC also presents a report at the quarterly Grievance and Appeals Committee meeting and the Quality Assessment Performance Improvement Committee for their review and analysis. The analysis performed on these data by the Quality Improvement Committee, which is composed of departmental leaders and network physicians, enables LHCC to initiate quality improvement efforts to improve program operations, quality of the services we provide to members, and member satisfaction.

LHCC uses trending information to inform policies, procedures, and processes affecting members and providers, and necessary changes to provide optimal service to members.

Finally, LHCC has committed to supporting Six Sigma certification of a number of employees in 2015, and using these resources to improve LHCC's Grievance and Appeals processes and procedures with information generated by the Grievance and Appeals System.

Specific examples of how data generated by the Grievance and Appeals System has been used recently to improve services is provided below:

***Improved Access to ADHD Medications*.** LHCC received 20 Appeals for denial of pharmacy services (17% of the overall total) during the first quarter of 2014, noting a trend of increased Appeal requests for medication denials related to step therapy edits required by plan guidelines for treating ADHD. The Director of Pharmacy and the Medical Director brought the pharmacy statistics, and related Appeal trending, for ADHD medications to LHCC's Pharmacy and Therapeutics Committee (P&T) for review. The P&T Committee made adjustments to the current pharmacy guidelines and removed, and otherwise revised, certain step therapy edits for drugs treating ADHD in order to provide more rapid access to ADHD medications to our members. This change became effective September 1st, and its effect will be monitored to ensure that the goal of providing more rapid access to ADHD medications is achieved.

***Improved Transportation Services*.** We recognize that transportation is an important service. When analyzing 2013 Grievance data, LHCC identified complaints regarding the rude/unprofessional behavior of transportation providers clearly as the most significant causes for member dissatisfaction leading to Grievances. Within the Attitude/Service of Staff category, "Rude/unprofessional provider or staff members" represented 18.9% (32/169) of the total Grievances for 2013. Overall, all complaints regarding providers represented the vast majority of the Attitude/Service Grievances, when including complaints against the transportation vendor.

In response to these complaints, and an April 2013 audit of the vendor, we terminated the transportation vendor and contracted with a new vendor on June 1, 2013. This second vendor merged with another company on August 1, 2013, which is the transportation vendor for Centene plans in several states, in addition to Louisiana. In November 2013, after conducting an audit of this transportation vendor,

Centene issued a Corrective Action Plan (CAP) to improve the quality of the vendor's services and their responsiveness to member needs. Centene and LHCC are closely monitoring the transportation vendor's implementation of the CAP to ensure that services to members improve.

***Improved Access to Pharmacy Services*.** Approximately 75% of the Appeals we received in 2013 were related to access to pharmacy services. Pharmacy related Appeals make up over 99% (452/453) of the "Access" category, making pharmacy issues the overwhelming focus of member Appeals in 2013. The high volume of pharmacy Appeals is believed to be related to the transition from traditional Fee-For-Service (FFS) Medicaid to Managed Medicaid under Bayou Health when the pharmacy benefit was carved in on November 1, 2012. The providers and members were not accustomed to, and may not have completely understood, the stricter preferred drug list (PDL) limits, prior authorization, and other requirements that are part of managed care.

To address the pharmacy issues identified by the Appeals and improve pharmacy access for our members, LHCC worked with US Script on improving authorization processes and analyzing our PDL. We have also focused efforts on educating providers and members about the PDL and authorization requirements. We are monitoring Grievances and Appeals and claims to measure success on improving access, and are working with US Script to analyze our PDL and our authorization processes on an ongoing basis.