ATTACHMENT D
Member Grievances and Appeals
And Provider Complaints and Appeals

1.0 Member Grievances and Appeals

1.1 Member Grievance System
The CONTRACTOR must develop, implement, and maintain a member grievance system that complies with the requirements in applicable Federal and State laws and regulations, including 42 CFR §431.200, 42 CFR Part 438, Subpart F, "Grievance System," and the provisions of Kansas Statute 40-3228 relating to grievance procedures.
1.1.1
The grievance system must include a grievance process, an appeal process, and access to the State's fair hearing system. Any grievance system requirements apply to all three components of the grievance system not just to the grievance process. Members may access the Office of Administrative Hearings (OAH) State Fair Hearing process at any time except when an expedited appeal is requested. Members must exhaust the CONTRACTOR's expedited appeal process prior to accessing the expedited State Fair Hearing process. The procedures must be the same for all members and must be reviewed and approved in writing by the State or its designee. Modifications and amendments to the member grievance system must be submitted for the State's approval at least 30 days prior to the implementation.
1.1.2
The CONTRACTOR shall establish a grievance system including written policies and procedures that meet the following requirements:
1.1.2.1
provides Members reasonable assistance in completing forms and other procedural steps, not limited to providing interpreter services and toll-free numbers with TeleTypewriter/Telecommunications Device (TTY/TDD) and interpreter capability;
1.1.2.2
acknowledges receipt of each grievance and appeal;
1.1.2.3
ensures that decision makers on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the Member's condition or disease if any of the following apply:
1.1.2.3.1
an appeal of a denial based on lack of medical necessity;
1.1.2.3.2
a grievance regarding denial of expedited resolution of an appeal;
1.1.2.3.3
any grievance or appeal involving clinical issues;
1.1.2.4
provides the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a subcontract:
1.1.2.4.1
the Member's right to a State Fair Hearing, how to obtain a hearing, and right to representation at a hearing;
1.1.2.4.2
the Member's right to file grievances and appeals and their requirements and timeframes for filing;
1.1.2.4.3
the availability of assistance in filing;
1.1.2.4.4
the toll-free numbers to file oral grievances and appeals;
1.1.2.4.5
the Member's right to request continuation of benefits (as defined in 42 C.F.R. § 438.420(b)(1)) during an appeal or State Fair Hearing; if the CONTRACTOR's Action in a State Fair Hearing is upheld, the Member may be liable for the cost of any continued benefits;

1.1.2.4.6
any State-determined provider appeal rights to challenge the failure of the organization to cover a service.
1.1.3
The CONTRACTOR must maintain records of all grievances and appeals received as noted below

1.2 Member Grievance Process
1.2.1
The CONTRACTOR must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting and resolving grievances by members or their authorized representatives through the grievance process. For purposes of this section**,** an "authorized representative" is any person or entity acting on behalf of the member and with the Member's written consent. A provider may be an authorized representative. The grievance process shall ensure the following:
1.2.1.1
The grievance procedure must be the same for all Members under this Contract.
1.2.1.2
The Member or Member's authorized representative may file a grievance either orally or in writing.
1.2.1.3
Members or their designee may file a grievance either orally or in writing;
1.2.1.4
The timeframe within which a Member must file a grievance is 180 days;
1.2.1.5
The CONTRACTOR may require others who are not Members or their designees to initiate the process with a written request;
1.2.1.6
The CONTRACTOR shall dispose of each grievance and provide notice, as expeditiously as the Member's health condition requires within 30 business days from the day the CONTRACTOR receives the grievance
1.2.3
The State may, in its reasonable discretion, grant a written extension if the CONTRACTOR demonstrates good cause but in no case may that extension result in a disposition of the grievance to exceed 60 days from the day the CONTRACTOR receives the grievance.
1.2.4
Unless the State has granted a written extension as described above, the CONTRACTOR is subject to remedies, including liquidated damages if Member grievances are not resolved by the timeframes indicated herein.
1.2.5
The CONTRACTOR must resolve 98% of grievances within 30 days from the date the grievance is received. The CONTRACTOR must resolve 100% of the grievances within 60 days from the date the grievance is received. The CONTRACTOR is subject to remedies, including liquidated damages, if the grievances are not resolved within the established timeframes. Please see ATTACHMENT G.
1.2.5.1
All decisions shall be in writing.
1.2.5.2
The CONTRACTOR must also inform Members how to file a grievance directly with the State, once the Member has exhausted the CONTRACTOR's grievance process.
1.2.6
The CONTRACTOR must designate an officer of the CONTRACTOR who has primary responsibility for ensuring that grievances are resolved in compliance with written policy and within the required timeframe. The CONTRACTOR must have a routine process to detect patterns of grievances. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the grievances.
1.2.7
The CONTRACTOR's grievance procedures must be provided to Members in writing and through oral interpretive services. A written description of the CONTRACTOR's grievance procedures must be available in the prevalent non-English language identified by the State, at no more than a 6th grade reading level. The CONTRACTOR must include a written description of the grievance process in the

Member handbook. The CONTRACTOR must maintain and publish in the Member handbook, at least one (1) local and one (1) toll-free telephone number with TTY/TDD and interpreter capabilities for making grievances. The CONTRACTOR's process must require that every grievance received in person, by telephone, or in writing must be acknowledged and recorded in a written record and logged with the following details:

1.2.7.1
Date;

1.2.7.2
Identification of the individual filing the grievance;

1.2.7.3
Identification of the individual recording the grievance;

1.2.7.4
Nature of the grievance;

1.2.7.5
Disposition of the grievance (i.e., how the CONTRACTOR resolved the grievance);

1.2.7.6
Corrective action required; and

1.2.7.7
Date resolved.

1.2.8
The CONTRACTOR is prohibited from discriminating or taking punitive action against a Member or his/her representative for making a grievance.

1.2.9
If the Member makes a request for disenrollment, the CONTRACTOR must give the Member information on the disenrollment process and direct the Member to the State's fiscal agent. If the request for disenrollment includes a grievance by the Member, the grievance will be processed separately from the disenrollment request, through the grievance process.

1.2.10
The CONTRACTOR will cooperate with the State's fiscal agent and the State or its designee to resolve all Member grievances. Such cooperation may include, but is not limited to, providing information or assistance to internal CONTRACTOR grievance committees.

1.2.11
The CONTRACTOR must provide designated Member advocates to assist Members in understanding and using the CONTRACTOR's grievance system. The CONTRACTOR's Member advocates must assist Members in writing or filing a grievance and monitoring the grievance through the CONTRACTOR's grievance process until the issue is resolved.

1.3 Notices of Action for Medicaid Members

1.3.1
The CONTRACTOR must notify the Member, in accordance with Kansas Statutes and Federal regulations at 42 CFR 438.404 whenever the CONTRACTOR takes an action. The notice shall be in writing. It must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All Members must be informed that information is available in alternative formats and how to access those formats. The notice must, at a minimum, include any information required by Kansas Statute that relates to a managed care organization's (MCO) notice of action and any information required by 42 CFR §438.404 as well as 42 CFR 431 Subpart E, including but not limited to:

1.3.1.1
The dates, types and amount of service requested (if the action pertains to a service authorization request);

1.3.1.2
The action the CONTRACTOR has taken or intends to take;

1.3.1.3
The reasons for the action (If the action taken is based upon a determination that the requested service is not medically necessary, the CONTRACTOR must provide an explanation of the medical basis for the

decision, application of policy or accepted standards of medical practice to the individuals medical circumstances, in its notice to the Member.);

1.3.1.4
The Member's right to file an appeal through the CONTRACTOR's appeal process within 30 days of the notice of action;
1.3.1.5
The procedures by which the Member may appeal the CONTRACTOR's action;
1.3.1.6
The circumstances under which expedited resolution is available and how to request it
1.3.1.7
The circumstances under which a Member may continue to receive benefits pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services;
1.3.1.8
The date the action will be taken;
1.3.1.9
A reference to the CONTRACTOR policies and procedures supporting the CONTRACTOR's action;
1.3.1.10
An address where written requests may be sent and a toll-free number that the Member can call to request the assistance of a Member representative, file an appeal, or request a fair hearing;
1.3.1.11
In the event of a State Fair Hearing, that:
1.3.1.11.1
The Member may represent him/herself or be represented by a provider, a friend, a relative, legal counsel or another spokesperson;
1.3.1.11.2
The specific regulations that support, or the change in Federal or State law that requires, the action; and
1.3.1.11.3
An explanation of the individual's right to an evidentiary hearing if one is available or a State Fair Hearing, or in cases of an action based on a change in law, the circumstances under which a hearing will be granted.
1.3.2
Timeframes for notice of action pertaining to Standard Service Authorization Denial:
1.3.2.1
CONTRACTOR shall give notice as expeditiously as the Member's health condition requires, which may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to fourteen additional calendar days, if the Member or the provider requests an extension; or the CONTRACTOR justifies a need for additional information and how the extension is in the Member's interest (upon the State's approval).
1.3.2.3
If the CONTRACTOR extends the timeframe, the CONTRACTOR shall give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the Member's health condition requires and not later that the date the extension expires.
1.3.3
Timeframes for notice of action pertaining to termination, suspension or reduction of services:
1.3.3.1
The CONTRACTOR shall give notice at least 10 calendar days before the date of the action when the action is a termination, suspension, or reduction of previously authorized T-XIX-covered services, except:
1.3.3.1.1
If probable fraud and abuse has been verified, the period of advanced notice is shortened to five (5) calendar days;
1.3.3.1.2
If one of the following events occurs, the period of advanced notice is shortened to the day of the Action:
1.3.3.1.2.1

The death of a recipient;
1.3.3.1.2.2
A signed written Member statement requesting service termination or giving information requiring termination or reduction of services (where the Member understands that this shall be the result of supplying that information);
1.3.3.1.2.3
The recipient's admission to an institution where he/she is ineligible for further services;
1.3.3.1.2.4
The recipient's address is unknown and mail directed to him has no forwarding address;
1.3.3.1.2.5
The recipient has been accepted for T-XIX services by another local jurisdiction;
1.3.3.1.2.6
The recipient's physician prescribes the change in the level of care; or
1.3.3.1.2.7
The previously authorized service is substituted with a higher level of service.
1.3.4
Timeframes for Notice of Action: Untimely Service Authorization Decision:
1.3.4.1
If service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations, such untimely service authorizations constitute a denial and are adverse actions.
1.3.5
Timeframes for Notice of Action pertaining to Denial of Payment:
1.3.5.1
The CONTRACTOR shall give notice to the provider and Member on the date of action when the action is a denial of payment. Notice is not required to the Member when the action is due to the provider's failure to adhere to contractual requirements and there is no action against the Member.
1.3.6
Timeframes for Notice of Action pertaining to Expedited Service Authorization Denial:
1.3.6.1
For cases in which a provider indicates, or the CONTRACTOR determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the CONTRACTOR shall make an expedited authorization decision and provide notice of action as expeditiously as the Member's health condition requires and no later than three (3) business days after receipt of the request for service. The CONTRACTOR may extend the three (3) business days time period by up to 14 calendar days if the Member requests an extension, or if the CONTRACTOR justifies a need for additional information and how the extension is in the Member's interest (upon the State's approval)

1.4 Medicaid Standard Member Appeal Process
1.4.1
The CONTRACTOR must develop, implement and maintain an appeal procedure that complies with State and Federal laws and regulations, including 42 CFR§ 431.200 and 42 CFR Part 438, Subpart F, "Grievance System." The appeal procedure must be the same for all Members. The Member or provider may file an appeal either orally or in writing; however, an oral request to appeal shall be followed by a written, signed, appeal. The CONTRACTOR shall ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing upon receipt of the written, signed appeal, unless the Member or the provider requests expedited resolution. When a Member or his/her authorized representative expresses orally or in writing requests review of an action, the CONTRACTOR must regard this as a request to appeal an action.
1.4.2
A Member must file a request for an appeal with the CONTRACTOR within 30 days from receipt of the notice of the action.
1.4.3
The Contractor shall provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The CONTRACTOR shall allow the Member and the Member's representative the opportunity, before and during the appeal process, to examine the Member's case file,

including clinical records, and any other documents and records. The CONTRACTOR must inform the Member of the time available for providing this information and that, in the case of an expedited resolution, limited time will be available.

1.4.4

The CONTRACTOR must have policies and procedures in place outlining the officer's role in an appeal of an action. The officer must have a significant role in monitoring, investigating and hearing appeals.

The CONTRACTOR must have a routine process to detect patterns of appeals. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the appeals.

1.4.5

The CONTRACTOR's appeal procedures must be provided to Members in writing and through oral interpretive services. A written description of the appeal procedures must be available in the prevalent non-English language identified by the State, at no more than a 6th grade reading level.

1.4.6

The CONTRACTOR must include a written description of the appeals process in the Member handbook. The CONTRACTOR must maintain and publish in the Member handbook at least one (1) local and one (1) toll-free telephone number with TTY/TDD and interpreter capabilities for requesting an appeal of an action.

1.4.7

All appeals must be recorded in a written record and logged with the following details:

1.4.7.1

Date notice is sent;

1.4.7.2

Effective date of the action;

1.4.7.3

Date the Member or his or her representative requested the appeal;

1.4.7.4

Date the appeal was followed up in writing;

1.4.7.5

Identification of the individual filing;

1.4.7.6

Nature of the appeal; and

1.4.7.7

Disposition of the appeal, and notice of disposition to Member.

1.4.8

The CONTRACTOR must send a letter to the Member within five (5) business days acknowledging receipt of the appeal request.

1.4.9

In accordance with 42 CFR§ 438.420(b), the CONTRACTOR must continue the Member's benefits currently being received by the Member, including the benefit that is the subject of the appeal, if all of the following criteria are met:

1.4.9.1

The Member or his or her representative files the appeal timely, meaning on or before the later of the following: within 10 days of the MCO mailing the notice of action or the intended effective date of the MCO proposed action;

1.4.9.2

The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

1.4.9.3

The services were ordered by an authorized provider;

1.4.9.4

The original period covered by the authorization has not expired; and

1.4.9.5

The Member requests an extension of the benefits.

1.4.10

If, at the Member's request, the CONTRACTOR continues or reinstates the Member's benefits while the appeal is pending either at the CONTRACTOR or the State Fair Hearing, the benefits must be continued until one (1) of the following occurs:

1.4.10.1
The Member withdraws the appeal;

1.4.10.2
The Member does not request a fair hearing within 10 days from when the CONTRACTOR mails an adverse CONTRACTOR decision;

1.4.10.3
A State Fair Hearing officer issues a hearing decision adverse to the Member or

1.4.10.4
The authorization expires or authorization service limits are met.

1.4.11
If the authorization period has expired or the authorized units of service are exhausted, Members or their designee may request an extension of services. Such extensions are considered a new request for services, however; and the CONTRACTOR is not obligated to continue services if such new request is denied.

1.4.12
In accordance with 42 CFR§ 438.420(d), if the final resolution of the appeal is adverse to the Member and upholds the CONTRACTOR's action, then to the extent that the services were furnished to the enrollee while the appeal was pending to comply with the Contract continuation of benefits requirements, the CONTRACTOR may recover such costs from the Member.

1.4.13
The CONTRACTOR shall consider the Member's representative, or an estate representative of a deceased Member as parties to the appeal. A Member may seek a State Fair Hearing if the Member is not satisfied with the CONTRACTOR's decision in response to an appeal.

1.4.14
The CONTRACTOR shall resolve 95%of appeals and provide notice, as expeditiously as the Member's health condition requires within 14 calendar days from the date the CONTRACTOR receives the written appeal, and 100% shall be resolved within 30 calendar days;

1.4.14.1
the CONTRACTOR may extend the initial 14 calendar day timeframe by up to 14 calendar days if the Member requests the extension;

1.4.14.2
the CONTRACTOR may extend the initial 14 calendar day timeframe by up to 14 calendar days, with approval by the State, when the CONTRACTOR shows that there is need for additional information and how the delay is in the Member's interest. The CONTRACTOR shall notify the Member of the reason for the extension, and

1.4.15
The CONTRACTOR is subject to remedies, including liquidated damages, if at least 98% of Member appeals are not resolved within 30 days of receipt of the Appeal by the CONTRACTOR. Please see ATTACHMENT G. The CONTRACTOR must designate an officer who has primary responsibility for ensuring that appeals are resolved in compliance with written policy and within the 30-day time limit.

1.4.16
The CONTRACTOR shall provide written notice of appeal resolution. The written appeal resolution notice shall include:

1.4.16.1
the results and date of the appeal resolution;

1.4.16.2
for decisions not wholly in the Member's favor:

1.4.16.2.1
the right to request a State Fair Hearing within 30 days;

1.4.16.2.2
how to request a State Fair Hearing;

1.4.16.2.3

the right to continue to receive benefits (pursuant to 42 CFR 438.420) pending a hearing;
1.4.16.2.4
how to request the continuation of benefits in a timely manner; and
1.4.16.2.5
notice that if the CONTRACTOR's action is upheld in a hearing, the Member may be liable for the cost of any continued benefits;
1.4.16.3
that in the State Fair Hearing the Member may represent him/herself or use legal counsel, a relative, a friend, or a spokesperson;
1.4.16.4
the specific regulations that support, or the change in Federal or State law that requires, the action, and
1.4.16.5
an explanation of the individual's right to request an evidentiary hearing if one is available or a State Fair Hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted.
1.4.16.6
Any other information required by Kansas Statute that relates to a managed care organization's notice of disposition of an appeal.
1.4.17
If the CONTRACTOR or State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CONTRACTOR must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires.
1.4.18
If the CONTRACTOR or State Fair Hearing officer reverses a decision to deny authorization of services and the Member received the disputed services while the appeal was pending, the CONTRACTOR is responsible for the payment of services.
1.4.19
The CONTRACTOR is prohibited from discriminating or taking punitive action against a Member or his/her representative for making an appeal.

1.5 Expedited Medicaid Member Appeals
1.5.1
In accordance with 42 CFR §438.410, the CONTRACTOR must establish and maintain an expedited review process for appeals, when the CONTRACTOR determines (for a request from a Member) or the provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life or health. The CONTRACTOR must follow all appeal requirements for standard Member appeals as set forth in this ATTACHMENT except where differences are specifically noted. The CONTRACTOR must accept oral or written requests for expedited appeals.
1.5.2
No additional Member follow-up is required. The CONTRACTOR shall inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.
1.5.3
Members must exhaust the CONTRACTOR's expedited appeal process before making a request for an expedited fair hearing.
1.5.4
After the CONTRACTOR receives the request for an expedited appeal, it must dispose each expedited appeal and notify the Member of the outcome of the expedited appeal, as expeditiously as the Member's health condition requires, within three (3) business days, except that the CONTRACTOR must complete investigation and resolution of an appeal relating to an ongoing emergency or denial of continued hospitalization not later than one (1) business day after receiving the Member's request for expedited appeal is received.
1.5.5
Except for an appeal relating to an ongoing emergency or denial of continued hospitalization, the timeframe for notifying the Member of the outcome of the expedited appeal may be extended up to 14

calendar days if the Member requests an extension or the CONTRACTOR shows (to the satisfaction of DHCF, upon DHCF's request) that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, the CONTRACTOR must give the Member written notice of the reason for delay if the Member had not requested the delay. In addition to written notice, the CONTRACTOR must also make reasonable efforts to provide oral notice. The CONTRACTOR is prohibited from discriminating or taking punitive action against a Member or his/her representative for requesting an expedited appeal. The CONTRACTOR must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a Member's request.

1.5.6

If the CONTRACTOR denies a request for expedited resolution of an appeal, it shall:

1.5.6.1

transfer the appeal to the standard timeframe for an appeal, and

1.5.6.2

make reasonable efforts to give the Member prompt oral notice of the denial and give a written notice within two (2) calendar days.

1.5.7

This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.

1.5.8

If the decision is adverse to the Member, the CONTRACTOR must follow the procedures relating to the appeal resolution notice described above. The CONTRACTOR is responsible for notifying the Member of his/her right to access an expedited fair hearing from OAH. The CONTRACTOR will be responsible for providing documentation to the State and the Member, indicating how the decision was made, prior to OAH's expedited fair hearing.

1.6 Access to Fair Hearing for Medicaid Members

1.6.1

The CONTRACTOR must inform Members that they have the right to access the fair hearing process at any time during the appeal system provided by the CONTRACTOR. In the case of an expedited fair hearing process, the CONTRACTOR must inform the Member that he/she must first exhaust the CONTRACTOR's internal expedited appeal process prior to filing an expedited fair hearing. The CONTRACTOR must notify Members that they may be represented by an authorized representative in the fair hearing process.

1.6.2

If a Member requests a fair hearing, the CONTRACTOR will complete the OAH request for fair hearing, and submit the form electronically to the appropriate fair hearings office, within five (5) calendar days of the Member's request for a fair hearing.

1.6.3

Within five (5) calendar days of notification that the fair hearing is set, the CONTRACTOR will prepare an evidence packet for submission to the State fair hearings staff and send a copy of the packet to the Member. The evidence packet must comply with the State's fair hearings requirements.

1.6.4

The State OAH is responsible for the State Fair Hearing. The State must reach its decisions within the specified timeframes:

1.6.4.1

Standard resolution: within 90 days of the date the enrollee filed the appeal with the CONTRACTOR if the enrollee filed initially with the CONTRACTOR (excluding the days the enrollee took to subsequently file for a State Fair Hearing) or the date the enrollee filed for direct access to a State Fair Hearing.

1.6.4.2

Expedited resolution (if the appeal was heard first through the CONTRACTOR appeal process): within three (3) working days from agency receipt of a hearing request for a denial of a service that:

1.6.4.2.1

Meets the criteria for an expedited appeal process but was not resolved using the CONTRACTOR's expedited appeal timeframes, or

1.6.4.2.2

Was resolved wholly or partially adversely to the enrollee using the CONTRACTOR's expedited appeal

timeframes.
1.6.5
The State is a party to the State Fair Hearing and may be represented by the CONTRACTOR. The Member or the Member's estate is also a party and may be represented.
1.6.6
The CONTRACTOR must ensure that any Member dissatisfied with determination denying a beneficiary's request to transfer plans/disenroll is given access to a State Fair Hearing.

1.7 Member Advocates
1.7.1
The CONTRACTOR must provide Member advocates to assist Members. Member advocates must be physically located within Kansas unless an exception is approved by the State. Member advocates must inform Members of the following:
1.7.1.1
Their rights and responsibilities,
1.7.1.2
The grievance process,
1.7.1.3
The appeal process,
1.7.1.4
Covered services available to them, including preventive services, and
1.7.1.5
Non-capitated services available to them.
1.7.2
Member advocates must assist Members in writing grievances and appeals and are responsible for monitoring the grievances and appeals through the CONTRACTOR's Grievance System.
1.7.3
Member advocates are responsible for making recommendations to management on any changes needed to improve either the care provided or the way care is delivered. Member advocates are also responsible for helping or referring Members to community resources available to meet Member needs that are not available from the CONTRACTOR as Medicaid covered.
1.7.4
Member enrollment information must include how Members can contact Member advocates by phone, e-mail, or letter.

2. 0 Provider Complaints and Appeals

2.1 Provider Complaints
2.1.1
Medicaid CONTRACTORs must develop, implement, and maintain a system for tracking and resolving all Medicaid provider complaints. Within this process, the CONTRACTOR must respond fully and completely to each complaint and establish a tracking mechanism to document the status and final disposition of each provider complaint. The CONTRACTOR must resolve provider complaints within 30 days from the date the complaint is received. The CONTRACTOR is subject to remedies, including liquidated damages, if at least 98% of provider complaints are not resolved within 30 days of receipt of the complaint by the CONTRACTOR. Please see ATTACHMENT G.
2.1.2
CONTRACTORs must also resolve provider complaints received by the State no later than the due date noted upon the State's notification. The State will generally provide CONTRACTORs 10 business days to resolve such complaints. If a CONTRACTOR cannot resolve a complaint by the due date indicated on the notification form, it may submit a request to extend the deadline. The State may, in its reasonable discretion, grant a written extension if the CONTRACTOR demonstrates good cause.
2.1.3
Unless the State has granted a written extension as described above, the CONTRACTOR is subject to remedies, including liquidated damages if provider complaints are not resolved by the timeframes indicated herein.

2.2 Provider Appeals

2.2.1

CONTRACTORs must develop, implement, and maintain a system for tracking and resolving all Medicaid provider appeals related to claims payment or other contracting issues including removal from the CONTRACTOR's provider network. Within this process, the CONTRACTOR must respond fully and completely to each Medicaid provider's appeal and establish a tracking mechanism to document the status and final disposition of each provider's appeal.

2.2.1

For claims payment issues, Medicaid CONTRACTORs must contract with physicians who are not network providers to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeal. The determination of the physician resolving the dispute must be binding on the CONTRACTOR and the provider. The physician resolving the dispute must hold the same specialty or a related specialty as the appealing provider. The State reserves the right to amend this process to include an independent review process established by the State for final determination on these disputes.