EXHIBIT G

COMPLAINT, GRIEVANCE, AND DHS FAIR HEARING PROCESSES

A. General Requirements

1. The CHC-MCO must obtain the Department's prior written approval of its Complaint, Grievance, and Fair Hearing policies and procedures.

2. The CHC-MCO must have written policies and procedures for registering, responding to, and resolving Complaints and Grievances as they relate to the MA population and must make these policies and procedures available to Participants upon request.

3. The CHC-MCO must maintain an accurate written record of each Complaint and Grievance and the actions taken by the CHC-MCO to resolve each Complaint and Grievance. The record must include at least the following:
    a. The name of the Participant on whose behalf the Complaint or Grievance was filed;
    b. The date the Complaint or Grievance was received;
    c. A description of the reason for the Complaint or Grievance;
    d. The date of each review or review meeting;
    e. The date of resolution of the Complaint or Grievance and how the Complaint or Grievance was resolved; and
    f. A Copy of any documents or records reviewed.

    The CHC-MCO must provide the record of each Complaint and Grievance and the actions taken by the CHC-MCO to resolve each Complaint and Grievance to the Department and CMS upon request.

4. The CHC-MCO must submit a log of all Complaint and Grievance decisions in a format specified by the Department and must include review of the Complaint and Grievance processes in its QM and UM programs as outlined in Exhibit F Quality Management and Utilization Management Program Requirements.

5. The CHC-MCO must have a data system to process, track, and trend all Complaints and Grievances.

6. The CHC-MCO must designate and train sufficient staff as reported in the Operating Procedures Report (OPS) 11 Provider Education, to be responsible for receiving, processing, and responding to Participant Complaints and Grievances in accordance with the requirements specified in this Exhibit.

7. CHC-MCO staff performing Complaint and Grievance reviews must have the necessary orientation, clinical training, and experience to make an informed and impartial determination regarding issues assigned to them.

8. The CHC-MCO must provide information about the Complaint and Grievance process to all Providers and subcontractors when the CHC-MCO enters into a contract or agreement with the Provider or subcontractor.

9. The CHC-MCO may not use the timeframes or procedures of the Complaint or Grievance process to avoid the medical decision process or to discourage or prevent a Participant from receiving Medically Necessary care in a timely manner.

10. The CHC-MCO must require that anyone who participates in making the decision on a Complaint or Grievance was not involved in and is not a subordinate of an individual who was involved in any previous level of review or decision-making on the issue that is the subject of the Complaint or Grievance.

11. The CHC-MCO may not charge Participants a fee for filing a Complaint or a Grievance.

12. CHC-MCOs must permit both a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a Complaint or Grievance. If a Complaint or Grievance is received by a CHC-MCO from a representative on behalf of the Participant that does not include the Participant's authorization the CHC-MCO must contact the Participant to obtain authorization.

13. The CHC-MCO must allow the Participant and the Participant's representative to have access to all relevant documentation pertaining to the subject of the Complaint or Grievance free of charge and sufficiently in advance of the time frame for resolution of the Complaint or Grievance outlined in this Exhibit.

14. The CHC-MCO must maintain the following information in the Participant's case file:
    a. Medical records;
    b. Any documents or records relied upon or generated by the CHC-MCO in connection with the Complaint or Grievance, including any Medical

Necessity criteria used to make a decision or information on coverage limits relied upon to make a decision; and

c. Any new or additional evidence considered, relied upon, or generated by the CHC-MCO in connection with the Complaint or Grievance.

15. The CHC-MCO must ask the Participant if the Participant needs interpreter services. The CHC-MCO must provide language interpreter services at no cost when requested by a Participant. The CHC-MCO must include in the Complaint or Grievance record documentation that the Participant was asked if the Participant needed an interpreter and if an interpreter was provided.

16. The CHC-MCO must accept Complaints and Grievances from individuals with disabilities which are in alternative formats including: TTY/Videophone/TDD for telephone inquiries and Complaints and Grievances from Participants who are deaf or hearing impaired; Braille; tape; computer disk; and other commonly accepted alternative forms of communication. The CHC-MCO must make its employees who receive telephone Complaints and Grievances aware of the speech limitations of Participants with disabilities so they treat these individuals with patience, understanding, and respect.

17. The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant. This includes but is not limited to:
    a. Providing qualified sign language interpreters for Participants who are deaf or hearing impaired;
    b. Providing information submitted on behalf of the CHC-MCO at the Complaint or Grievance review in an alternative format accessible to the Participant filing the Complaint or Grievance. The alternative format version must be supplied to the Participant at or before the review, so the Participant can discuss and/or refute the content during the review; and
    c. Providing personal assistance to a Participant filing the Complaint or Grievance who has other physical limitations in copying and presenting documents and other evidence.

18. The CHC-MCO must offer Participants the assistance of a CHC-MCO staff member throughout the Complaint and Grievance processes at no cost to the Participant.

19. The CHC-MCO must provide Participants with a toll-free number to file a Complaint or Grievance, request information about the Complaint or Grievance process, and ask any questions the Participant may have about the status of a Complaint or a Grievance.

19. The CHC-MCO must, at a minimum, hold in-person reviews of Complaints and Grievances at one location within each of its zones of operation. If a Participant requests an in-person review, the CHC-MCO must notify the Participant of the location of the review and who will be present at the review, using the template specified by the Department.

20. The CHC-MCO must ensure that any location where it will hold in-person reviews is physically accessible for persons with disabilities.

21. The CHC-MCO must notify the Participant when the CHC-MCO fails to decide a first level Complaint or a Grievance within the time frames specified in this Exhibit, using the template specified by the Department. The CHC-MCO must mail this notice to the Participant one (1) day following the date of the decision (day 31).

22. The CHC-MCO must notify the Participant when it denies payment after a service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program, using the template specified by the Department. The CHC-MCO must mail this notice to the Participant on the day the decision is made to deny payment.

23. The CHC-MCO must notify the Participant when it denies payment after a service or item has been delivered because the service or item provided is not a Covered Service for the Participant, using the template specified by the Department. The CHC-MCO must mail this notice to the Participant on the day the decision is made to deny payment.

24. The CHC-MCO must notify the Participant when it denies payment after a service or item has been delivered because the CHC-MCO determined that the service or item was not Medically Necessary, using the template specified by the Department. The CHC-MCO must mail this notice to the Participant on the day the decision is made to deny payment.

25. The CHC-MCO must notify the Participant when it denies the Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities using the template specified by the Department. The CHC-MCO must mail this notice to the Participant on the day the decision is made to deny payment.

26. If a Participant continued to receive services at the previously authorized level because the Participant filed a Complaint, Grievance, or Fair Hearing to dispute a decision to discontinue, reduce, or change a service that the Participant has been receiving within ten (10) days from the mail date on the written notice of decision, the CHC-MCO must pay for the services pending resolution of the Complaint, Grievance, or Fair Hearing.

27. The CHC-MCO must use all templates specified by the Department, which are available in DocuShare. The CHC-MCO may not modify the templates. The CHC-MCO must follow the instructions in the templates for including detailed, specific information related to the Complaint or Grievance.

B. Complaint Requirements

Complaint: A dispute or objection regarding a particular Provider or the coverage operations, or management of a CHC-MCO, which has not been resolved by the CHC-MCO and has been filed with the CHC-MCO or with PID's Bureau of Managed Care (BMC), including but not limited to:

- a denial because the requested service or item is not a Covered Service; which does not include BLE;
- the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department;
- the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames;
- a denial of payment by the CHC-MCO after a service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program;
- a denial of payment by the CHC-MCO after a service or item has been delivered because the service or item provided is not a Covered Service for the Participant; or
- a denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.

The term does not include a Grievance.

1. First Level Complaint Process

a. A CHC-MCO must permit a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a first level Complaint either in writing or orally. The CHC-MCO must commit oral requests to writing if not confirmed in writing by the Participant and must provide the written Complaint to the Participant or Participant's representative for signature. The signature may be obtained at any point in the process, and failure to obtain a signed Complaint may not delay the Complaint process.

b. If the first level Complaint disputes one of the following, the Participant must file a Complaint within sixty (60) days from the date of the incident complained of or the date the Participant receives written notice of a decision:

   - a denial because the service or item is not a Covered Service;
   - the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department;
   - the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames;
   - a denial of payment after the service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program;
   - a denial of payment after the service or item has been delivered because the service or item provided is not a Covered Service for the Participant; or
   - a denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities,

   For all other Complaints, there is no time limit for filing a first level Complaint.

c. A Participant who files a first level Complaint to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving on the basis that the service or item is not a Covered Service must continue to receive the disputed service or item at the previously authorized level pending resolution of the first level Complaint, if the first level Complaint is made verbally, hand delivered, faxed, submitted via secure web portal, or

post-marked within ten (10) days from the mail date on the written notice of decision.

d. Upon receipt of the Complaint, the CHC-MCO must send the Participant and Participant's representative, if the Participant has designated one in writing, a first level Complaint acknowledgment letter using the template specified by the Department. The first level Complaint acknowledgement letter must be sent no later than three (3) business days after the receipt of the Complaint.

e. The first level Complaint review for Complaints **not involving a clinical issue** must be conducted by a first level Complaint review committee, which must include one or more employees of the CHC-MCO who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

f. The first level Complaint review for Complaints **involving a clinical issue** must be conducted by a first level Complaint review committee, which must include one or more employees of the CHC-MCO who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. The first level Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the first level Complaint.

g. A committee member who does not personally attend the first level Complaint review meeting may not be part of the decision-making process unless that member actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.

h. The CHC-MCO must afford the Participant a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.

i. The CHC-MCO must give the Participant at least ten (10) days advance written notice of the first level Complaint review date, using the template specified by the Department. The CHC-MCO must be flexible when scheduling the review to facilitate the Participant's attendance. If the Participant cannot appear in person at the review, the CHC-MCO must provide an opportunity for the Participant to communicate with the first level Complaint review committee by telephone or videoconference.

j. The Participant may elect not to attend the first level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Participant was present. All Complaint review meetings must be recorded and transcribed and the recording and transcription must be maintained as part of the Complaint record.

k. If a Participant requests an in-person first level Complaint review, at a minimum, a member of the first level Complaint review committee must be physically present at the location where the first level Complaint review is held and the other members of the first level Complaint review committee must participate in the review through the use of videoconferencing.

l. The decision of the first level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Participant or the Participant's representative without regard to whether such information was submitted or considered in the initial determination of the issue.

m. Prior to the start of the first level Complaint review meeting, the Participant must be told that the testimony will be recorded. If the Participant agrees to the testimony taken by the Complaint review committee (including the Participant's comments) being recorded, the testimony must be recorded and transcribed verbatim and maintained as part of the Complaint record. If the Participant objects to the testimony being recorded, the Participant's objection must be documented in the Complaint record and the first level Complaint review meeting must proceed without the testimony being recorded.

n. The first level Complaint review committee must complete its review of the Complaint as expeditiously as the Participant's health condition requires.

o. The first level Complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Complaint record.

p. The CHC-MCO must send a written notice of the first level Complaint decision, using the template specified by the Department, to the Participant, Participant's representative, if the Participant has designated one, service Provider and prescribing Provider, if applicable, within thirty (30) days from the date of receipt of the Complaint unless the time frame for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Participant.

q. If the Complaint disputes one of the following, the Participant may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review:

- a denial because that the service or item is not a Covered Service;
- the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department;
- the failure of the CHC-MCO to decide the Complaint or Grievance within the specified time frames;
- a denial of payment by the CHC-MCO after the service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program;
- a denial of payment by the CHC-MCO after the service or item has been delivered because the service or item provided is not a Covered Service for the Participant; or
- a denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.

The Participant or Participant's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the CHC-MCO's first level Complaint decision.

The Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an external review in writing with PID's BMC within fifteen (15) days from the date the Participant receives written notice of the CHC-MCO's first level Complaint decision.

For all other Complaints, the Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a second level Complaint either in writing or orally within forty-five (45) days from the date the Participant receives written notice of the CHC-MCO's first level Complaint decision.

2. Second Level Complaint Process

a. A CHC-MCO must permit a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a second level Complaint either in writing or orally for any Complaint for which a Fair Hearing and external review is not available.

b. Upon receipt of the second level Complaint, the CHC-MCO must send the Participant and Participant's representative, if the Participant has designated one in writing, a second level Complaint acknowledgment letter using the template specified by the Department. The second level Complaint acknowledgement letter must be sent no later than three (3) business days after the receipt of the second level Complaint.

c. The second level Complaint review for Complaints **not involving a clinical issue** must be performed by a second level Complaint review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

d. The second level Complaint review for Complaints **involving a clinical issue** must be conducted by a second level Complaint review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. The second level Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the second level Complaint.

e. At least one-third of the second level Complaint review committee members may not be employees of the CHC-MCO or a related subsidiary or Affiliate.

f. A committee member who does not personally attend the second level Complaint review may not be part of the decision-making process unless that member actively participates in the review by telephone or videoconference and has the opportunity to review all information introduced during the review.

g. The CHC-MCO must afford the Participant a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.

h. The CHC-MCO must give the Participant at least fifteen (15) days advance written notice of the second level review date, using the template specified by the Department. If the Participant cannot appear in person at the review, the CHC-MCO must provide an opportunity for the Participant to communicate with the second level Complaint review committee by telephone or videoconference. The CHC-MCO must be flexible when scheduling the review to facilitate the Member's attendance.

i. The Participant may elect not to attend the second level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Participant was present. All second level Complaint review meetings must be recorded and transcribed verbatim and the recording and transcription must be maintained as part of the second level Complaint record.

j. If a Participant requests an in-person second level Complaint review, at a minimum, a member of the second level Complaint review committee must be physically present at the location where the second level Complaint review is held and the other members of the second level Complaint review committee must participate in the review through the use of videoconferencing.

k. The decision of the second level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Participant or the Participant's representative without regard to whether such information was submitted or considered previously. The decision of the second level Complaint review committee must be based solely on the information presented at the review.

l. Prior to the start of the second level Complaint review meeting, the Participant must be told that the testimony will be recorded. If the Participant agrees to the testimony taken by the second level Complaint review committee (including the Participant's comments) being recorded, the testimony must be tape-recorded and transcribed verbatim and maintained as part of the second level Complaint record. If the Participant objects to the testimony being recorded, the Participant's objection must be documented in the second level Complaint record and the second level Complaint review meeting must proceed without the testimony being recorded

m. The second level Complaint review committee must complete its review of the second level Complaint as expeditiously as the Participant's health condition requires.

n. The CHC-MCO must send a written notice of the second level Complaint decision, using the template specified by the Department, to the Participant, Participant's representative, if the Participant has designated one in writing, service Provider, and prescribing Provider, if applicable, within forty-five (45) days from the date of receipt of the second level Complaint.

o. The Participant or the Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization of the representative to be involved and/or act of the Participant's behalf, may file in writing a request for an external review of the second level Complaint decision with PID's BMC within fifteen (15) days from the date the Participant receives the written notice of the CHC-MCO's second level Complaint decision.

3. **External Complaint Process**

a. If a Participant files a request directly with PID's BMC for an external review of a Complaint decision that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving on the basis that the service or item is not a Covered Service, the Participant must continue to receive the disputed service or item at the previously authorized level pending resolution of the external review, if the request for external review is hand-delivered or post-marked within ten (10) days from the mail date on the written notice of the CHC-MCO's first or second level Complaint decision.

b. Upon the request of PID's BMC, the CHC-MCO must transmit all records from the CHC-MCO's Complaint review to PID's BMC within thirty (30) days from the request in the manner prescribed by PID's BMC. The Participant, the Provider, or the CHC-MCO may submit additional materials related to the Complaint.

4. **Expedited Complaint Process**

a. The CHC-MCO must conduct expedited review of a Complaint if the CHC-MCO determines that the Participant's life, physical or mental health, or

ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process or if a Participant or Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, provides the CHC-MCO with a certification from the Participant's Provider that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process. The certification must include the Provider's signature.

b. A request for an expedited review of a Complaint may be filed in writing via mail, by fax, secure web portal, orally, or by email

c. Upon receipt of an oral or written request for expedited review, the CHC-MCO must inform the Participant of the right to present evidence and testimony and make legal and factual arguments in person as well as in writing and of the limited time available to do so.

d. If the Provider certification is not included with the request for an expedited review and the CHC-MCO cannot determine based on the information provided that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process, the CHC-MCO must inform the Participant that the Provider must submit a certification as to the reasons why the expedited review is needed. The CHC-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within seventy-two (72) hours of the Participant's request for expedited review, the CHC-MCO must decide the Complaint within the standard time frames as set forth in this Exhibit, unless the time frame for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Participant. If the CHC-MCO decides that expedited consideration within the initial or extended time frame is not warranted, the CHC-MCO must make a reasonable effort to give the Participant prompt oral notice that the Complaint is to be decided within the standard time frame and send a written notice within two (2) business days of the decision to deny expedited review, using the template specified by the Department.

e. A Participant who files a request for expedited review of a Complaint to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving on the basis that the service or item is not a Covered Service must continue to receive the disputed service or item at the previously authorized level pending resolution of the Complaint, if the request for expedited review is made orally, hand delivered, faxed,

emailed, submitted via secure web portal, or post-marked within ten (10) days from the mail date on the written notice of decision.

f. Expedited review of a Complaint must be conducted by a Complaint review committee that includes a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. If the Complaint is related to dental services, the expedited Complaint review committee must include a dentist. Other appropriate providers may participate in the review, but the licensed physician must decide the Complaint. The members of the expedited Complaint review committee may not have been involved in and not be the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

g. Prior to the start of the expedited Complaint review meeting, the Participant must be told that the testimony will be recorded. If the Participant agrees to the testimony taken by the Complaint review committee (including the Participant's comments) being recorded, the testimony must be recorded and transcribed verbatim and maintained as part of the Complaint record. If the Participant objects to the testimony being recorded, the Participant's objection must be documented in the Complaint record and the expedited review meeting must proceed without the testimony being recorded.

h. The CHC-MCO must issue the decision resulting from the expedited review in person or by phone to the Participant, the Participant's representative, if the Participant has designated one in writing, service Provider and prescribing Provider, if applicable, within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Participant's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited complaint has been extended by up to fourteen (14) days at the request of the Participant. In addition, the CHC-MCO must mail written notice of the decision to the Participant, the Participant's representative, if the Participant has designated one in writing, the Participant's service Provider, and prescribing Provider, if applicable, within two (2) business days of the decision, using the template specified by the Department.

i. The Participant or the Participant's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the CHC-MCO's expedited Complaint decision.

j. The Participant, or the Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for

the representative to be involved and/or act on the Participant's behalf, may file a request for an expedited external Complaint review with the CHC-MCO within two (2) business days from the date the Participant receives the CHC-MCO's expedited Complaint decision. A Participant who files a request for an expedited Complaint review that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Complaint review.

k. A request for an expedited external Complaint review may be filed in writing via mail, by fax, secure web portal, orally, or by email

l. The CHC-MCO must follow PID's BMC guidelines relating to submission of requests for expedited external Complaint reviews.

m. The CHC-MCO may not take punitive action against a Provider who requests expedited resolution of a Complaint or supports a Participant's request for expedited review of a Complaint.

C. Grievance Requirements

Grievance: A request to have a CHC-MCO or utilization review entity reconsider a decision concerning the Medical Necessity and appropriateness of a Covered Service. A Grievance may be filed regarding a CHC-MCO's decision to 1) deny, in whole or in part, payment for a service or item; 2) deny or issue a limited authorization of a requested service or item, including a determination based on the type or level of service or item; 3) reduce, suspend, or terminate a previously authorized service or item; 4) deny the requested service or item but approve an alternative service or item; and 5) deny a request for a BLE.

The term does not include a Complaint.

1. Grievance Process

a. A CHC-MCO must permit a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a Grievance either in writing or orally. The CHC-MCO must commit oral requests to writing if not confirmed in writing by the

Participant and must provide the written Grievance to the Participant or the Participant's representative for signature. The signature may be obtained at any point in the process, and the failure to obtain a signed Grievance may not delay the Grievance process.

b. A Participant must file a Grievance within sixty (60) days from the date the Participant receives written notice of decision.

c. A Participant who files a Grievance to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the request for review of the Grievance is made orally, hand delivered, faxed, submitted via secure web portal, or post-marked within ten (10) days from the mail date on the written notice of decision.

d. Upon receipt of the Grievance, the CHC-MCO must send the Participant and Participant's representative, if the Participant has designated one in writing, a Grievance acknowledgment letter using the template specified by the Department. The Grievance acknowledgement letter must be sent no later than three (3) business days after receipt of the Grievance.

e. A Participant who consents to the filing of a Grievance by a Provider may not file a separate Grievance. The Participant may rescind consent throughout the process upon written notice to the CHC-MCO and the Provider.

f. In order for the Provider to represent the Participant in the conduct of a Grievance, the Provider must obtain the written consent of the Participant and submit the written consent with the Grievance. A Provider may obtain the Participant's written permission at the time of treatment. The CHC-MCO must assure that a Provider does NOT require a Participant to sign a document authorizing the Provider to file a Grievance as a condition of treatment. The written consent must include:

    i. The name and address of the Participant, the Participant's date of birth and identification number;

    ii. If the Participant is legally incompetent, the name, address, and relationship to the Participant of the person who signed the consent;

iii. The name, address, and CHC-MCO identification number of the Provider to whom the Participant is providing consent;

iv. The name and address of the CHC-MCO to which the Grievance will be submitted;

v. An explanation of the specific service or item which was provided or denied to the Participant to which the consent will apply;

vi. The following statement: "The Participant or the Participant's representative may not submit a Grievance concerning the service or item listed in this consent form unless the Participant or the Participant's representative rescinds consent in writing. The Participant or the Participant's representative has the right to rescind consent at any time during the Grievance process.";

vii. The following statement: "The consent of the Participant or the Participant's representative shall be automatically rescinded if the Provider fails to file a Grievance or fails to continue to prosecute the Grievance through the review process.";

viii. The following statement: "The Participant or the Participant's representative, if the Participant is legally incompetent, has read, or has been read, this consent form, and has had it explained to his/her satisfaction. The Participant or the Participant's representative understands the information in the Participant's consent form."; and

ix. The dated signature of the Participant, or the Participant's representative, and the dated signature of a witness.

g. The Grievance review must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.

h. At least one-third of the Grievance review committee may not be employees of the CHC-MCO or a related subsidiary or Affiliate.

i. The Grievance review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. If the Grievance is related to dental services, the

Grievance review committee must include a dentist. Other appropriate providers may participate in the review, but the licensed physician must decide the Grievance.

j. A committee member who does not personally attend the Grievance review may not be part of the decision-making process unless that member actively participates in the review by telephone or videoconference and has the opportunity to review all information introduced during the review.

k. The CHC-MCO must afford the Participant a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.

l. The CHC-MCO must give the Participant at least ten (10) days advance written notice of the review date, using the template specified by the Department. The CHC-MCO must be flexible when scheduling the review to facilitate the Participant's attendance. If the Participant cannot appear in person at the review, the CHC-MCO must provide an opportunity for the Participant to communicate with the Grievance review committee by telephone or videoconference.

m. The Participant may elect not to attend the Grievance review meeting, but the meeting must be conducted with the same protocols as if the Participant was present. All Grievance review meetings must be recorded and transcribed verbatim and the recording and transcription must be maintained as part of the Grievance record.

n. If a Participant requests an in-person Grievance review, at a minimum, a member of the Grievance review committee must be physically present at the location where the Grievance review is held and the other members of the Grievance review committee must participate in the review through the use of videoconferencing.

o. The decision of the Grievance review committee must take into account all comments, documents, records, and other information submitted by the Participant or the Participant's representative without regard to whether such information was submitted or considered in the initial determination of the issue. The decision of the Grievance review committee must be based solely on the information presented at the review.

p. Prior to the start of the Grievance review meeting, the Participant must be told that the testimony will be recorded. If the Participant agrees to the testimony taken by the Grievance review committee (including the

Participant's comments) being recorded, the testimony must be recorded and transcribed verbatim and a written transcription prepared and maintained as part of the Grievance record. If the Participant objects to the testimony being recorded, the Member's objection must be documented in the Grievance record and the Grievance review meeting must proceed without the testimony being recorded..

q. The Grievance review committee must complete its review of the Grievance as expeditiously as the Participant's health condition requires.

r. The CHC-MCO must send a written notice of the Grievance decision, using the template specified by the Department, to the Participant, Participant's representative, if the Participant has designated one in writing, service Provider and prescribing Provider, if applicable, within thirty (30) days from the date the CHC-MCO received the Grievance, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) days at the request of the Participant.

s. The Participant may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review.

   The Participant or Participant's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the CHC-MCO's Grievance decision.

   The Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for a representative to be involved and/or act on the Participant's behalf, may file a request with the CHC-MCO for an external review of a Grievance decision by a certified review entity (CRE) appointed by PID's BMC. The request must be filed in writing or orally within fifteen (15) days from the date the Participant receives the written notice of the CHC-MCO's Grievance decision.

2. External Grievance Process:

a. The CHC-MCO must process all requests for external Grievance review. The CHC-MCO must follow the protocols established by PID's BMC in meeting all time frames and requirements necessary in coordinating the request and notification of the decision to the Participant, Participant's representative, if the Participant has designated one in writing, service Provider, and prescribing Provider.

b. A Participant who files a request for an external Grievance review that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the external Grievance review, if the request for external Grievance review is made orally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of the CHC-MCO's Grievance decision.

c. Within five (5) business days of receipt of the request for an external Grievance review, the CHC-MCO must notify the Participant, the Participant's representative, if the Participant has designated one in writing, the Provider if the Provider filed the request for the external Grievance, and PID's BMC that the request for external Grievance review has been filed.

d. The external Grievance review must be conducted by a CRE not affiliated with the CHC-MCO.

e. Within two (2) business days from receipt of the request for an external Grievance review, PID's BMC will randomly assign a CRE to conduct the review and notify the CHC-MCO and assigned CRE of the assignment.

f. Within two (2) business days of receipt of notice of the assignment of the CRE, the CHC-MCO must notify the Participant, using the template as suggested by PID's BMC, of the name and contact information of the assigned CRE.

g. If PID's BMC fails to select a CRE within two (2) business days from receipt of a request for an external Grievance review, the CHC-MCO may designate a CRE to conduct a review from the list of CREs approved by PID's BMC. The CHC-MCO may not select a CRE that has a current contract or is negotiating a contract with the CHC-MCO or its Affiliates or is otherwise affiliated with the CHC-MCO or its Affiliates.

h. The CHC-MCO must forward all documentation regarding the Grievance decision, including all supporting information, a summary of applicable issues, and the basis and clinical rationale for the Grievance decision, to the CRE conducting the external Grievance review. The CHC-MCO must transmit this information within fifteen (15) days from receipt of the Participant's request for an external Grievance review.

i. Within fifteen (15) days from receipt of the request for an external Grievance review by the CHC-MCO, the Participant or the Participant's representative, or the Participant's Provider, may supply additional information to the CRE conducting the external Grievance review for consideration. Copies must also be provided at the same time to the CHC-MCO so that the CHC-MCO has an opportunity to consider the additional information.

j. Within sixty (60) days from the filing of the request for the external Grievance review, the CRE conducting the external Grievance review must issue a written decision to the CHC-MCO, the Participant, the Participant's representative, PID's BMC and the Provider (if the Provider filed the Grievance with the Participant's consent), that includes the basis and clinical rationale for the decision. The standard of review must be whether the service or item is Medically Necessary and appropriate under the terms of this Agreement.

k. The external Grievance decision may be appealed by the Participant, the Participant's representative, or the Provider to a court of competent jurisdiction within sixty (60) days from the date the Participant receives notice of the external Grievance decision.

3. Expedited Grievance Process

a. The CHC-MCO must conduct expedited review of a Grievance if the CHC-MCO determines that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process or if a Participant or Participant representative, with proof of the Participant's written authorization for a representative to be involved and/or act on the Participant's behalf, provides the CHC-MCO with a certification from the Participant's Provider that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. The certification must include the Provider's signature.

b. A request for expedited review of a Grievance may be filed either in writing via mail, by fax, via secure web portal, by email, or orally.

c. The expedited review process is bound by the same rules and procedures as the Grievance review process with the exception of timeframes, which are modified as specified in this section.

d. Upon receipt of an oral or written request for expedited review, the CHC-MCO must inform the Participant of the right to present evidence and testimony and make legal and factual arguments in person as well as in writing and of the limited time available to do so.

e. If the Provider certification is not included with the request for an expedited review and the CHC-MCO cannot determine based on the information provided that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process, the CHC-MCO must inform the Participant that the Provider must submit a certification as to the reasons why the expedited review is needed. The CHC-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within seventy-two (72) hours of the Participant's request for expedited review, the CHC-MCO must decide the Grievance within the standard time frames as set forth in this Exhibit unless the time frame for deciding the Grievance has been extended by up to fourteen (14) days at the request of the Participant. If the CHC-MCO decides that expedited consideration with the initial or extended time frame is not warranted, the CHC-MCO must make a reasonable effort to give the Participant prompt oral notice that the Grievance is to be decided within the standard time frame and send a written notice within two (2) business days of the decision to deny expedited review, using the template specified by the Department.

f. A Participant who files a request for expedited review of a Grievance to dispute a decision to discontinue, reduce or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the request for expedited review of a Grievance is made verbally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of decision.

g. Expedited review of a Grievance must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.

h. At least one-third of the expedited Grievance review committee may not be employees of the CHC-MCO or a related subsidiary or Affiliate.

i. The expedited Grievance review committee must include a licensed physician in the same or similar specialty that typically manages or consults

on the service or item in question. If the Grievance is related to dental services, the expedited Grievance review committee must include a dentist. Other appropriate providers may participate in the review, but the licensed physician must decide the Grievance.

j. Prior to the start of the expedited Grievance review meeting, the Participant must be told that the testimony will be recorded. If the Participant agrees to the testimony taken by the Grievance review committee (including the Participant's comments) being recorded, the testimony must be recorded and transcribed verbatim and a written transcription prepared and maintained as part of the Grievance record. If the Participant objects to the testimony being recorded, the Participant's objection must be documented in the expedited Grievance record and the expedited Grievance review meeting must proceed without the testimony being recorded.

k. The CHC-MCO must issue the decision resulting from the expedited review in person or by phone to the Participant, to the Participant's representative if the Participant has designated one in writing, to the service Provider, and to the prescribing Provider within either forty eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Participant's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Grievance has been extended by up to fourteen (14) days at the request of the Participant. In addition, the CHC-MCO must mail written notice of the decision to the Participant, to the Participant's representative, if the Participant has designated one in writing, to the service Provider, and to the prescribing Provider, if applicable, within two (2) business days of the decision, using the template specified by the Department.

l. The Participant or the Participant's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the CHC-MCO's expedited Grievance decision.

m. The Participant, or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an expedited external Grievance review with the CHC-MCO within two (2) business days from the date the Participant receives the CHC-MCO's expedited Grievance decision. A Participant who files a request for an expedited external Grievance review to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Grievance review.

n. A request for an expedited external Grievance review may be filed in writing via mail, by fax, via secure web portal, orally, or by email

o. The CHC-MCO must follow PID's BMC guidelines relating to submission of requests for expedited external reviews.

p. The CHC-MCO may not take punitive action against a Provider who requests expedited resolution of a Grievance or supports a Participant's request for expedited review of a Grievance.

D. Department's Fair Hearing Requirements

Fair Hearing: A hearing conducted by the Department's Bureau of Hearings and Appeals (BHA) or a Department designee.

1. Fair Hearing Process

a. A Participant or Participant's representative must file a Complaint or Grievance with the CHC-MCO and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If the CHC-MCO fails to provide written notice of a Complaint or Grievance decision within the time frames specified in this Exhibit, the Participant is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.

b. The Participant or the Participant's representative may request a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the CHC-MCO's first level Complaint decision or Grievance decision for any of the following:

i. the denial, in whole or part, of payment for a requested service or item based on lack of Medical Necessity;

ii. the denial of a requested service or item because the service or item is not a Covered Service;

iii. the reduction, suspension, or termination of a previously authorized service or item;

iv. the denial of a requested service or item but approval of an alternative service or item;

v. the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department;

vi. the failure of a CHC-MCO to decide a Complaint or Grievance within the specified time frames;

vii. the denial of payment after a service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program;

viii. the denial of payment after a service or item has been delivered because the service or item is not a Covered Service for the Participant;

ix. the denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.

c. The request for a Fair Hearing must include a copy of the written notice of decision that is the subject of the request unless the CHC-MCO failed to provide written notice of the Complaint or Grievance decision within the time frames specified in this Exhibit. Requests must be sent to:

Department of Human Services
OLTL/Forum Place 6th Floor
Complaint, Grievance and Fair Hearings
P.O. Box 8025
Harrisburg, Pennsylvania 17105-8025

d. A Participant who files a request for a Fair Hearing that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

e. Upon receipt of the request for a Fair Hearing, BHA or the Department's designee will schedule a hearing. The Participant and the CHC-MCO will receive notification of the hearing date by letter at least ten (10) days before the hearing date, or a shorter time if requested by the Participant. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.

f. The CHC-MCO is a party to the hearing and must be present. The CHC-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. BHA's decision is based solely on the evidence presented at the hearing. The absence of the CHC-MCO from the hearing will not be reason to postpone the hearing.

g. The CHC-MCO must provide Participants, at no cost, with records, reports, and documents, relevant to the subject of the Fair Hearing.

h. BHA will issue an adjudication within ninety (90) days of the date the Participant filed the first level Complaint or the Grievance with the CHC-MCO, not including the number of days before the Participant requested the Fair Hearing. If BHA fails to issue an adjudication within ninety (90) days of receipt of the initial request of the first level complaint or grievance, less the time it took the Participant to request a Fair Hearing, the CHC-MCO must comply with the requirements at 55 Pa. Code § 275.4 regarding the provision of interim assistance upon the request for such by the Participant. When the Participant is responsible for delaying the hearing process, the time limit by which BHA must issue the adjudication prior to interim assistance being afforded will be extended by the length of the delay attributed to the Participant.

i. BHA's adjudication is binding on the CHC-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Participant may appeal to Commonwealth Court within thirty (30) days from the date of the BHA adjudication or from the date of the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the CHC-MCO.

2. Expedited Fair Hearing Process

a. A Participant or the Participant's representative may file a request for an expedited Fair Hearing with the Department either in writing or orally.

b. A Participant must exhaust the Complaint or Grievance process prior to filing a request for an expedited Fair Hearing.

c. BHA will conduct an expedited Fair Hearing if a Participant or a Participant's representative provides the Department with a signed written certification from the Participant's Provider that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Fair Hearing process or if the Provider provides testimony at the Fair Hearing which explains why using the usual time frames would place the Participant's health in jeopardy.

d. A Participant who files a request for an expedited Fair Hearing to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for an expedited Fair Hearing is made verbally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of decision.

e. Upon the receipt of the request for an expedited Fair Hearing, BHA or the Department's designee will schedule a hearing.

f. The CHC-MCO is a party to the hearing and must be present. The CHC-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The absence of the CHC-MCO from the hearing will not be reason to postpone the hearing.

g. The CHC-MCO must provide the Participant, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing.

h. BHA has three (3) business days from the receipt of the Participant's oral or written request for an expedited review to process final administrative action.

i. BHA's adjudication is binding on the CHC-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Participant may appeal to Commonwealth Court within thirty (30) days from the date of adjudication or from the date of the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the CHC-MCO.

E. Provision of and Payment for Service or Item Following Decision

1. If the CHC-MCO, BHA, or the Secretary reverses a decision to deny, limit, or delay a service or item that was not furnished during the Complaint, Grievance, or Fair Hearing process, the CHC-MCO must authorize or provide the disputed service or item as expeditiously as the Participant's health condition requires but no later than seventy-two (72) hours from the date it receives notice that the decision was reversed. If the CHC-MCO requests reconsideration, the CHC-MCO must authorize or provide the disputed service or item pending reconsideration unless the CHC-MCO requests a stay of the BHA decision and the stay is granted.

2. If the CHC-MCO, BHA, or the Secretary reverses a decision to deny authorization of a service or item, and the Participant received the disputed service or item during the Complaint, Grievance, or Fair Hearing process, the CHC-MCO must pay for the service or item that the Participant received.

   If a Participant requests both an external appeal/review and a Fair Hearing, and if the decisions rendered as a result of the external review and Fair Hearing are in conflict with one another, the CHC-MCO must abide by the decision most favorable to the Participant. In the event of a dispute or uncertainty regarding which decision is most favorable to the Participant, the CHC-MCO will must submit the matter to DHS' the Department's Grievance and Appeals Coordinator for review and resolution.