Changes to the Complaint and Grievance Processes

Scope: This Provider Alert, which is effective September 1, 2018, applies to all providers in all HealthChoices contracts.

Purpose: To alert all providers to the key changes to the complaint and grievance processes, which are in accordance with federal and state changes to Medicaid managed care regulations, as stated in Appendix H of the HealthChoices Behavioral Health Program Standards and Requirements (HC BH PSR) published July 1, 2018. This alert gives an overview of the most important changes. For details and comprehensive information about these processes, refer directly to the HC BH PSR, Appendix H at [http://www.dhs.pa.gov/cs/groups/webcontent/documents/communication/p_004161.pdf](http://www.dhs.pa.gov/cs/groups/webcontent/documents/communication/p_004161.pdf)

The following change applies to both Complaints and Grievances

(1) “The BH-MCO must allow the Member or the Member’s representative if the Member has provided the BH-MCO with written authorization that indicates that the representative may be involved and/or act on the Member’s behalf access to all relevant documents pertaining to the subject of the Member’s Complaint or Grievance, including any new or additional evidence considered, relied upon, or generated for the Complaint or Grievance review and, if an Investigator was assigned, any information obtained as part of the investigation. The BH-MCO may not charge Members or their representatives for copies of the documentation.” (p. 3)

The following changes apply only to Complaints

(2) “The BH-MCO must afford the Member a reasonable opportunity to present testimony and evidence and make legal and factual arguments, in person as well as in writing. The BH-MCO must allow the Member or anyone the Member chooses to present the Member’s position to the Complaint review committee.” (p. 9)

(3) “The Member must be provided the opportunity to appear before the Complaint review committee. The BH-MCO must be flexible when scheduling the Complaint review to facilitate the Member’s attendance. The Complaint review must be conducted at a time and place that is convenient for the Member. If the Member cannot appear in person at the Complaint review, the BH-MCO must provide an opportunity for the Member to communicate with the Complaint review committee by telephone or videoconference.” (p. 10)
(4) “The Complaint review committee may ask individuals who attend the Complaint review in person, by telephone, or by videoconference questions related to the subject of the Complaint.” (p. 10)

(5) “The Member may elect not to attend the Complaint review meeting, but the meeting must be conducted with the same protocols as if the Member was present.” (p. 10)

(6) “If the Member’s Provider did not file the Complaint, the Member’s Provider may participate in the Complaint review only if the Member consents to the Provider being present at the Complaint review. The BH-MCO must document the Member’s consent in the Complaint record.” (p. 10)

(7) A Complaint decision letter must be sent to the Member or the Member’s representative within 30 days of the date the Complaint was filed with the BH-MCO (p. 11).

(8) Complaints due to a denial of services or payment after a service has been delivered, or due to missed time frames for providing a service or rendering a decision must be filed within 60 calendar days from the date of the incident complained of or the date the Member receives written notice of a decision. These types of Complaints will have only one level of BH-MCO Complaint review available to the member, followed by the opportunity to request an External Complaint Review within 15 calendar days of receiving the decision letter, a Fair Hearing within 120 calendar days of receiving the decision letter, or both if he/she is not satisfied (p. 12).

(9) Complaints due to “a member’s dissatisfaction with the BH-MCO or a Provider” can be filed at any time and there will continue to be two levels of review available to the Member. When a level two Complaint is filed within 45 calendar days of the Member receiving the level one Complaint Decision, then the level two Complaint decision letter must be mailed to the member within 45 calendar days of the level two request. After the level two Complaint decision, the Member can request an External Complaint Review within 15 calendar days if he/she is still not satisfied (p. 12).

Regarding Complaints, Community Care recommends that providers have a robust, visible, and accessible internal process for resolution of member complaints within their organizations so that, whenever possible, complaints can be resolved quickly and effectively with minimal disruption to the relationship between member and provider.
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The following changes apply only to Grievances

(10) “The Member or Member’s representative (if designated) must file a Grievance within 60 Days from the date the Member receives written notice of decision.” (p. 20)

(11) All Grievance Review committees will include three people: 1) a psychologist or psychiatrist with the credentials to deny the service being reviewed (this doctor must not be the one who denied the service, nor be his/her subordinate), 2) someone who does not work for the BH-MCO, and 3) a Member/Family representative or another BH-MCO staff person depending on the availability of Member/Family representatives (p. 22).

(12) A Grievance decision letter must be sent to the Member or the Member’s representative within 30 days of the date the Grievance was filed with the BH-MCO.

(13) There will be only one level of BH-MCO Grievance review available to Members, followed by the opportunity to request an External Grievance review within 15 calendar days of receiving the decision letter, a Fair Hearing within 120 calendar days of receiving the decision letter, or both if he/she is not satisfied (p. 25).

Regarding Grievances, Community Care recommends that whenever possible, the prescriber or provider is available to consult with the Community Care Professional Advisor reviewing his/her service request for medical necessity.

The following are reminders of existing requirements regarding Complaints and Grievances

(14) “The BH-MCO must require Network Providers to display information about how to file a Complaint or a Grievance and the Complaint and Grievance process at all Network Provider offices.” (p.1)

(15) “The BH-MCO must require Network Providers to display a notification that Members will not incur a fee for filing Complaints or Grievances at any level of the process at all Network Provider offices.” (p.1)

Reference: HealthChoices Behavioral Health Program Standards and Requirements, Appendix H