PerformCARE®	Policy and Procedure
Name of Policy:	Dissatisfaction Complaint
Policy Number:	QI-043
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Quality Improvement
Related Stakeholder(s):	All departments
Applies to:	Associates
Original Effective Date:	10/01/01
Last Revision Date:	01/03/20
Last Review Date:	02/18/21
Next Review Date:	02/01/22

Policy: PerformCare has established a fair and uniform process for Members to resolve dissatisfaction complaints at the lowest administrative level consistent with the *HealthChoices Requirements for Behavioral Health Managed Care Organizations*. Attachment 1 in this policy lists all General Requirements of Appendix H, with which PerformCare will remain in full compliance.

Purpose: To ensure all Members have access to an organized process to address dissatisfaction complaints.

Definitions: **Complaint:** A dispute or objection regarding a participating healthcare provider or the coverage, operations, or management of PerformCare, which has not been resolved by PerformCare and has been filed with PerformCare or with Pennsylvania's Department of Health (DOH) or Insurance Department. PerformCare recognizes two types of complaints: 6-Criteria and Dissatisfaction.

6-Criteria Complaint: A complaint involving, but not limited to, any of the following:

a. a denial because the requested service is not a covered service;
b. failure of PerformCare to meet the required timeframes for providing a service;
c. failure of PerformCare to decide a complaint or grievance within the specified timeframes;
d. a denial of payment after a service(s) has been delivered because the service(s) was provided without

authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

e. a denial of payment after a service(s) has been delivered because the service(s) is not a covered benefit;
f. a denial of a request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities; or

Dissatisfaction Complaint: A complaint related to a Member's dissatisfaction with PerformCare or a Provider.

Consumer Representative: An individual/parent/guardian who has received or is currently receiving services with PerformCare. This person has completed the necessary training related to the dissatisfaction complaint process through PerformCare, This person will also meet the following criteria to serve as a member of a review committee:

a. If the dissatisfaction complaint involves mental health services for an adult, the consumer representative must be an adult who has previously received or is currently receiving mental health services.
b. If the dissatisfaction complaint involves substance use services for an adult, the consumer representative must be an adult who has previously received or is currently receiving substance use services.
c. If the dissatisfaction complaint involves mental health services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has previously received or is currently receiving mental health services. The consumer representative may also be an individual who has previously received or is currently receiving mental health services.
d. If the dissatisfaction complaint involves substance use services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has previously received or is currently receiving substance use services. The consumer representative may also be an individual who has received or is currently receiving substance use services.

External Review: A review conducted by an independent utilization review entity not directly affiliated with PerformCare and in response to an appeal by a PerformCare Member.

Program Standards and Requirements (PS&R): Commonwealth of Pennsylvania Department of Human Services Health Choices Behavioral Health Program – Program Standards and Requirements.

Acronyms: **C&G:** Complaint and Grievance
DOH: Department of Health
PSR: Program Standards and Requirements

Procedure: 1. First Level Dissatisfaction Complaint Process:

1.1. There is no time frame for filing a dissatisfaction complaint, provided PerformCare was the payer of the service.

1.2. Any PerformCare Associate can take the initial details of a Member and/or Authorized representative initiated dissatisfaction complaint. A Complaint and Grievance (C&G) Coordinator will conduct further outreach to the Member to provide notification of the Member's rights through the process and seek any clarification that may be necessary.

1.3. PerformCare Members (or an authorized representative) may file a dissatisfaction complaint either orally or in writing. If filed orally, the request will be committed to writing and provided to the Member or the Member's representative for signature. The signature may be obtained at any point in the process. Failure to obtain a signed request for dissatisfaction complaint will not delay the dissatisfaction complaint process.

1.4. Within 5 business days of receipt of a dissatisfaction complaint, PerformCare will send the Member and the Member's representative, if designated, an acknowledgment letter.

1.5. Each dissatisfaction complaint will be investigated by the C&G Department.

1.6. Each first level dissatisfaction complaint (involving a clinical issue or non-clinical issue) will be reviewed by a first level dissatisfaction complaint review committee comprised of one or more individuals who have not participated in the matter under review. No one with previous involvement in this issue may become involved in the decision making of the first level dissatisfaction complaint. No committee members will be a subordinate of any previous decision-maker.

1.7. For dissatisfaction complaints involving a clinical issue, at least one member of the committee will meet the qualifications required of an individual who makes medical necessity decisions as described in Section C.3 of the *PSR Appendix AA*. This same individual will render the final decision for the first level dissatisfaction

complaint, after taking into consideration input from any other review committee members.

1.8. At least 2 calendar days prior to the review meeting, all committee members will receive a dissatisfaction complaint information packet for review. Committee members are expected to review (but not discuss) the information in advance of the meeting. All dissatisfaction complaint materials will be properly discarded upon conclusion of the meeting.

1.9. The Member will be afforded a reasonable opportunity to be present during the first level dissatisfaction complaint review. All attendees/participants of the review meeting will conduct themselves in a professional, respectful, and impartial manner.

- 1.9.1. PerformCare will be flexible when scheduling the review to facilitate the Member's attendance. The meeting will be conducted at a time and place that is convenient for the Member. Teleconference will also be presented as an option.
- 1.9.2. The Member may elect not to attend the review meeting. If the Member does not attend, the meeting will be conducted with the same protocols as if the Member was present.
- 1.9.3. The Member and/or anyone of the Member's choosing may present information related to the first level dissatisfaction complaint. Providers may attend the review meeting only with the Member's consent.
- 1.9.4. Individuals not directly involved with the first level dissatisfaction complaint may attend the review meeting for training purposes, with prior consent from the Member.

1.10. PerformCare's investigator must attend the review to present the issues of the dissatisfaction complaint. This investigator may not be involved in the decision made by the committee.

1.11. The review committee must complete its review of the first level dissatisfaction complaint and render a decision no more than 30 calendar days from receipt of the first level dissatisfaction complaint. The Member may request a one-time extension of 14 calendars days.

1.12. Upon a decision being rendered, the review committee will prepare a summary of the issues presented, the decisions made by the committee, and the rationale for those decisions. Within 30 calendar days from receipt of

the first level dissatisfaction complaint, PerformCare will send a written notice of its decision to the Member, the Member's representative (if applicable), and the targeted provider, unless the timeframe has been extended by up to 14 calendar days at the Member's request. Both the summary and the letter will be maintained as part of the dissatisfaction complaint record.

1.13. The review committee may also recommend provider follow-up. Referrals will be submitted to the appropriate PerformCare department(s) with the expectation for completion within 30 calendar days. PerformCare staff will document completion of the follow-up as part of the dissatisfaction complaint record.

2. Second Level Dissatisfaction Complaint Process:
   2.1. A second level dissatisfaction complaint may be filed within 45 calendar days from the date the Member receives written notices of the first level dissatisfaction complaint decision.
   2.2. Within 5 business days of receipt of request, PerformCare will send the Member and the Member's representative, if designated, an acknowledgment letter.
   2.3. Each second level dissatisfaction complaint will be investigated by the C&G Department.
   2.4. Each second level dissatisfaction complaint review will be performed by a committee comprised of three or more individuals who have not participated in the matter under review. No one with previous involvement in this issue may become involved in the decision making of the dissatisfaction complaint. No committee member will be a subordinate of any previous decision-maker.
   2.5. At least one-third of the second level dissatisfaction complaint review committee may not be an employee of PerformCare or a related subsidiary or affiliate.
   2.6. At least 20% of PerformCare's second level dissatisfaction complaint review committees in a year must include a consumer representative.
   2.7. For dissatisfaction complaints involving a clinical issue, at least one member of the committee will meet the qualifications required of an individual who makes medical necessity decisions as described in Section C.3 of the *PSR Appendix AA.* This same individual will render the final decision for the second level dissatisfaction complaint, after taking into consideration input from any other review committee members.
   2.8. A committee member who does not personally attend

the second level dissatisfaction complaint review meeting may not be part of the decision-making process unless that person actively participates in the review by telephone and has the opportunity to review all information presented at the meeting.

2.9. At least 2 calendar days prior to the review meeting, all committee members will receive a dissatisfaction complaint information packet for review. Committee members are expected to review (but not discuss) the information in advance of the meeting. All dissatisfaction complaint materials will be properly discarded upon conclusion of the meeting and deliberation.

2.10. During the second level dissatisfaction complaint review, the Member will be afforded a reasonable opportunity to be present and the right to comment and provide testimony on any document, record, and other information submitted or presented during the dissatisfaction complaint review. All attendees/participants of the review meeting will conduct themselves in a professional, respectful and impartial manner.

- 2.10.1. PerformCare will be flexible when scheduling the second level dissatisfaction complaint review to facilitate the Member's attendance. The meeting will be conducted at a time and place that is convenient for the Member. Teleconference will also be presented as an option.
- 2.10.2. The Member will be given at least 10 calendar days advance written notice of the review date, with an option to waive should the Member wish to have the meeting sooner.
- 2.10.3. The Member may elect not to attend the review. If the Member does not attend, the meeting will be conducted with the same protocols as if the Member was present.
- 2.10.4. The Member and/or anyone of the Member's choosing may present information related to the second level dissatisfaction complaint. Providers may only attend the review meeting with the Member consent.
- 2.10.5. Individuals not directly involved with the second level dissatisfaction complaint review may attend the meeting for training purposes, with prior consent from the Member.

2.11. A PerformCare staff person must attend the review meeting to present the issues of the second level dissatisfaction complaint. This presenter may not be present for the deliberation by the committee or involved with in the decision made by the committee.
2.12. A Facilitator must attend the review meeting for coordination purposes and to ensure the meeting and deliberation follow *PSR Appendix H standards*. This facilitator will also be responsible for recording the meeting and deliberation.
2.13. The decision of the second level dissatisfaction complaint review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative (if designated) without regard to whether such information was submitted or considered previously. Upon completion of the meeting, the committee will deliberate and will base its decision solely upon the materials and testimony presented during the review.
2.14. The review meeting and the committee's deliberation of the decision will be recorded. The meeting and deliberation will be transcribed. Both the recording and the transcription will be maintained in the second level dissatisfaction complaint record.
2.15. The second level dissatisfaction complaint review committee will render a decision no later than 45 calendar days from receipt of the second level dissatisfaction complaint.
2.16. Upon a decision being rendered, the review committee will prepare a summary of the issues presented, the decisions made by the committee, and the rationale for those decisions. Within 45 calendar days, PerformCare will also send a written notice of its decision to the Member, the Member's representative (if applicable) and the targeted provider. Both the summary and the letter will be maintained as part of the dissatisfaction complaint record.
2.17. The review committee may also recommend provider follow-up. Referrals will be submitted to the appropriate PerformCare department(s) with the expectation for completion within 30 calendar days. PerformCare staff will document completion of the follow-up as part of the second level dissatisfaction complaint record.

3. External Review of Second Level Dissatisfaction Complaint Review Decision:

3.1. A request for an external review of the second level dissatisfaction complaint may be made within 10 calendar days from the date the Member receives the written notice of PerformCare's written decision of the second level dissatisfaction complaint. This request may be filed with either Pennsylvania's Department of Health (DOH) or Pennsylvania's Insurance Department.

3.2. Upon the request of either DOH or Pennsylvania's Insurance Department, all records from the first and second level reviews will be submitted to the appropriate department by PerformCare within 30 calendar days from the request and in the manner requested by that department. Additional materials may be submitted by the Member, the healthcare provider, and/or PerformCare.

3.3. DOH and Pennsylvania's Insurance Department will determine the appropriate agency for the review.

Related Policies: *QI-042 6-Criteria Complaint Policy*
QI-044 Grievance Policy
168.114 Retention of Records Policy

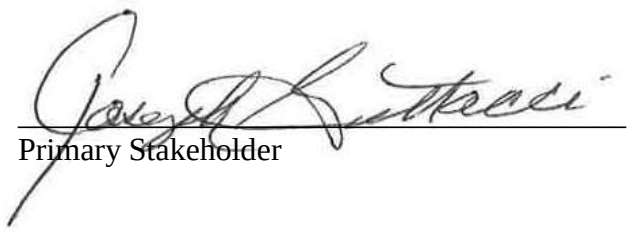
Related Reports: None

Source Documents and References: *Commonwealth of Pennsylvania Department of Human Services HealthChoices Behavioral Health Program – Program Standards and Requirements (PSR)*

Superseded Policies and/or Procedures: *CC-CG-001 Complaint Policy*
QI-CG-001 Complaint and Grievance Policy

Attachments: *Attachment 1 General Requirements for Complaint, Grievance, and Fair Hearing Processes*

Approved by:



Primary Stakeholder

PerformCARE®

QI-043 Attachment 1

General Requirements for Complaint, Grievance, and Fair Hearing Processes

1. PerformCare must have written policies and procedures for registering, responding to, and resolving Complaints and Grievances (at all levels) as they relate to the MA population.
2. All complaint, grievance, and fair hearing policies and procedures developed by PerformCare must be approved in writing by the Department prior to their implementation.
3. Complaint and Grievance processes must be fair, easy to understand, easy to follow, easily accessible and respectful of the Member's rights.
4. PerformCare policies and procedures regarding Member Complaints and Grievances must be provided to Members in written form:
    a. Upon enrollment into the BH-MCO,
    b. Upon Member request, and
    c. At least 30 Days before a Department-approved change becomes effective.
5. PerformCare 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.
6. PerformCare may not charge Members a fee for filing a Complaint or Grievance.
7. PerformCare 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.
8. PerformCare must operate a toll-free telephone service for Members to use to file complaints and grievances and to follow up on Complaints and Grievances filed by Members. The phone service must be operated 24 hours a day, 7 Days a week by appropriately trained staff. Voice mail or recorded messages are not allowed. PerformCare must provide Members with the number of the toll-free telephone service.
9. PerformCare must designate and train sufficient staff to be responsible for receiving, processing, and responding to Member Complaints and Grievances in accordance with the requirements in Appendix H.
10. Anyone involved in the complaint and grievance processes must receive training in the areas related to their responsibility at least annually or more frequently, if needed. This includes all PerformCare staff as well as County and Consumer Representatives who participate in review committees.
11. All County and PerformCare staff involved in the Complaint and Grievance processes and all review committee members must have the necessary orientation, knowledge, and experience to make a determination about assigned issues and must analyze information and resolve disputed issues in a fair and nondiscriminatory manner.

12. All review committee proceedings shall be conducted in a manner that is informal and impartial to avoid intimidating the Member or the Member's representative.

13. PerformCare's Director of Quality Improvement and Supervisor of Complaints and Grievances are responsible for the overall coordination, implementation, and management of the complaint and grievance processes. Complaint and Grievance Coordinators and Supervisor are responsible for the day-to-day operation and administration of the process, including the provision of information and instructions to Members.

14. PerformCare must maintain an accurate log of all Complaints and Grievances, which includes, at a minimum:
    a. Identifying information about the Member
    b. A description of the reason for the Complaint or Grievance
    c. The date the Complaint or Grievance was received
    d. The date of the review or review meeting (if applicable)
    e. The decision
    f. The date of the decision
    g. If the second level Complaint review committee or the Grievance review committee included a consumer representative

    PerformCare must provide the log to the Department or CMS upon request.

15. PerformCare must retain all Complaint and Grievance records, which must include a copy of any document reviewed by the review committees and the Complaint or Grievance log, for 10 years from the date the Complaint or Grievance was filed.

16. PerformCare must allow the Member or Member's representative (if the Member has provided PerformCare 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. PerformCare may not charge Members or their representatives for copies of the documentation.

17. PerformCare must obtain and document all consents and authorizations from Member or Representative through the Complaint or Grievance process.

18. PerformCare must ensure that there is a link between the Complaint and Grievance processes and the Quality Management and Utilization Management programs.

19. PerformCare may not use the time frames or procedures of the complaint or grievance process to avoid the medical decision process or to discourage or prevent a Member from receiving medically necessary care in a timely manner.

20. PerformCare must accept complaints and grievances from Members who have disabilities and which may be given in alternative formats including: TTD/TTY; Braille; recording; or computer disk; and other commonly accepted alternative

forms of communication. PerformCare staff who receive telephone complaints and grievances must be aware of the speech limitation of some Members who have disabilities so they treat these Members with patience, understanding, and respect.

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

22. PerformCare must provide language interpreter services when requested by a Member at no cost.

23. PerformCare must offer Members the assistance of a PerformCare staff throughout the complaint and grievance processes at no cost. PerformCare staff cannot have been involved in and cannot be a subordinate of anyone who was involved in any previous level of review or decision-making on the issue that is the subject of the complaint or grievance.

24. PerformCare 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 anyone who was involved in any previous level of review or decision-making on the issue that is the subject of the complaint or grievance.

25. Upon receipt of a complaint or grievance, PerformCare must offer to provide Members with names and contact information of advocacy organizations available to assist Members.

26. If the outcome of a Member's complaint or grievance indicates that a corrective plan of action and/or follow-up is needed to address quality of care concerns, PerformCare must implement the corrective plan of action and/or follow-up.

27. If a Member continued to receive services at the previously authorized level because the Member filed a Complaint, Grievance, or Fair Hearing to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving within one calendar day from the mail date on the written notice of decision if acute inpatient services were being discontinued, reduced, or changed or within 10 calendar days from the mail date on the written notice of decision if any other services were being discontinued, reduced, or changed, PerformCare must pay for the services pending resolution of the Complaint, Grievance, or Fair Hearing.

28. PerformCare must provide written notification to Member when PerformCare:
    a. fails to decide a first level complaint or a grievance within the time frames specified in Appendix H- this notice must be mailed to the Member 1 calendar day following the date the decision was to be made
    b. denies payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program- this notice must be mailed to the Member on the day that the decision is made to deny payment
    c. denies payment after a service(s) has been delivered because the service(s) provided is not a covered service(s) for the Member- this notice must be mailed to the Member on the day that the decision is made to deny payment
    d. denies payment after a service(s) has been delivered because PerformCare determined that the emergency room service(s) was not medically necessary- this notice must be mailed to the Member on the day the decision is made to deny payment
    e. denies the Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities- this notice must be mailed to the Member on the day the decision is made to deny payment

29. PerformCare must include **Attachments 10a and 10b** of *Appendix H* when sending a letter or notice to a Member and a Member's representative if the Member has provided PerformCare with written authorization that indicates that the representative may be involved and/or take action on the Member's behalf.