PerformCARE®	Policy and Procedure
Name of Policy:	Administrative Complaint Policy
Policy Number:	QI-051
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Quality Improvement
Related Stakeholder(s):	All departments
Applies to:	Associates
Original Effective Date:	07/18/25
Last Revision Date:	05/09/25
Last Review Date:	07/18/25
OMHSAS Approval Date:	07/18/25
Next Review Date:	07/01/26

Policy: The Administrative Complaint Policy outlines PerformCare's procedures for addressing Member specific and non-Member specific concerns and how they will be processed outside of the formal Complaint process.

Purpose: Identify steps for receiving, collaborating, and addressing Member-specific and non-Member-specific concerns.

Definitions: **Administrative Complaint:** A dispute, objection or concern conveyed to the Primary Contractor and its BH-MCO that requires an investigation by the Primary Contractor and its BH-MCO due to allegations of misconduct, violation of laws or regulations, or other issues related to the provision of behavioral health services. The dispute, objection or concern may be conveyed to the Primary Contractor and its BH-MCO anonymously, by an individual who is not a Member, or by a Member or the Member's representative who is not seeking to file a Complaint. The dispute, objection or concern that requires an investigation can also result from the withdrawal of a Complaint by a Member or their representative. An Administrative Complaint does not include a Complaint filed by a Member or the Member's representative, which is reviewed in accordance with the Member Complaint process outlined in Appendix H. PerformCare recognizes 3 types of Administrative Complaints:

Anonymous Complaint: (1) Concerns that are raised by a Member who wants to remain anonymous or by someone who is not authorized to act on behalf of a Member; or (2) concerns that are not Member specific and are considered more an anonymous tip.

Informal Complaint: Dissatisfaction concerns raised by a Member or Authorized Representative with a request for a more immediate

resolution, by means and timeframes outside of the formal Complaint process.

Withdrawn Complaint: A formal Complaint that has been withdrawn by a Member or an Authorized Representative and that PerformCare determines additional actions steps are warranted.

Administrative Complaint Committee: Committee designated to review Withdrawn Complaints and Anonymous Complaints to determine if all concerns have been addressed and/or if there are any additional actions steps warranted. The committee will be comprised of a Manager or Director for each of the following PerformCare Departments: Quality Improvement, Clinical, Member Services, Provider Relations, and Compliance.

Complaint: A dispute or objection regarding a network provider or the coverage, operations, or management policies of PerformCare, which has not been resolved by PerformCare and has been filed with PerformCare or with PID. 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 Network Provider.

Investigation: The systematic gathering of information to form a cohesive picture of a given situation, problem, or allegation, which will then be used to make an informed decision about that given situation, problem, or allegation.

Acronyms:
C&G: Complaints and Grievances
CCM: Clinical Care Manager
MSS: Member Services Specialist
PID: Pennsylvania Insurance Department

QI: Quality Improvement
QOCC: Quality of Care Counsel
SIU: Special Investigations Unit

Procedure: **1. General**

1.1. Administrative Complaint concerns can be received verbally or in writing.

1.2. Concerns received by any PerformCare Associate outside of the C&G Department (or by a representative of a Primary Contractor) are documented in detail and forwarded to C&G for review and continued processing.

1.3. Once received, PerformCare's C&G Department reviews the available options for addressing the concerns with the person who expressed them.

1.4. For concerns that are Member-specific, C&G will follow the steps for an Informal Complaint as outlined below in Section 2.

1.5. Formal Complaints that have been withdrawn at the request of the Member or Authorized Representative are reviewed to determine whether any additional action steps are warranted before being considered fully resolved. These Withdrawn Complaints are reviewed and processed using the steps outlined in Section 3 of this policy.

1.6. Concerns that are not Member-specific, that are expressed by someone who requests to remain anonymous, or that are voiced by someone other than the Member and without consent from the Member are investigated as an Anonymous Complaint and documented using the steps outlined in Section 4 of this policy.

1.7. Concerns that are determined to not have enough detail and/or are about something outside of the scope of PerformCare such as but not limited to the healthcare system, laws, and/or regulations cannot be investigated by PerformCare. When possible, the person who has expressed the concerns will be given contact information for resources who may be able to offer additional support or guidance. The source of information could come from C&G, MSS, and/or CCM.

1.8. At any point during the Administrative Complaint Process, C&G will collaborate with other PerformCare Departments as necessary for concerns that may require additional actions steps.

1.9. Referrals will be made as appropriate to other committees including, but not limited to, QOCC, SIU, and/or Credentialing.

1.10. The goal is to resolve all Administrative Complaints within 60 calendar days. Some cases involving unique or extenuating circumstances may require additional time for resolution, as determined by the C&G Supervisor, or designee.

1.11. Administrative Complaints will be documented, tracked, trended, and analyzed as applicable.

2. **Informal Complaint**
    2.1. If the Member chooses the Informal Complaint Process, they are informed that a formal Complaint can be opened upon request, at any time through the process.
    2.2. Verbal consent is obtained from the Member to proceed with the Informal Complaint as well as consent for the provider/PerformCare Associate to contact the Member directly as needed. If the Member does not provide consent, a C&G Coordinator will function as the liaison.
    2.3. The C&G Coordinator initiates outreach with other PerformCare Departments and/or PerformCare providers as needed, based on the Member's identified concerns.
    2.4. Any identified PerformCare Departments and/or providers will expedite action steps to assist in the remediation of the Member's concerns.
    2.5. Upon completion of the action steps, the identified PerformCare Department and/or provider will report the outcome of the action steps to the C&G Coordinator.
    2.6. The C&G Coordinator will outreach to the Member, discuss the outcome/resolution, and document the Member's level of satisfaction.
        2.6.1. After two unsuccessful attempts to contact, an Unable to Contact Letter is sent to the Member.
        2.6.2. If the Member expresses satisfaction, the Informal Complaint is considered resolved.
        2.6.3. If the Member expresses dissatisfaction, the option to file a formal Complaint is offered, and initiated when requested.

3. **Withdrawn Complaint**
    3.1. After sending written confirmation to the Member, confirming their request to withdraw their formal Complaint, the C&G Coordinator will outreach to the provider/PerformCare Department to notify them that (a) the formal Complaint has been withdrawn and (b) the Complaint will be reviewed by the Administrative Complaint Committee to determine any additional action steps that may be warranted before the concerns can be considered fully resolved.
        3.1.1. If a complaint is withdrawn prior to the Provider Response being received, the C&G Coordinator will also inform the provider they are required to submit their Provider Response.
        3.1.2. Once the Provider Response has been received, the C&G Coordinator will move forward with steps required to present to the committee.

3.2. The C&G Coordinator will prepare all required documents and present the details of the Withdrawn Complaint to the Administrative Complaint Committee for determination of any additional steps.

3.3. Within 2 business days, an Administrative Complaint Outcome Letter will be sent to the provider to relay the outcome of the Administrative Complaint Committee's review.

3.3.1. If it is determined that no further action is needed, the concerns are considered fully resolved.

3.3.2. If the committee determines additional action steps are required, all future steps will be completed, documented, and tracked as a Withdrawn Complaint within the Administrative Complaint Process.

4. Anonymous Complaint

4.1. Within 5 business days of receiving an Anonymous Complaint, a C&G Coordinator outreaches to the provider/PerformCare Department and submits to them a written Notification of Administrative Complaint. This document describes the concerns voiced and instructs the provider to (a) complete an internal review based on the details received and (b) submit a Provider Response documenting the actions taken to review and/or address the concerns and the outcome of those actions.

4.2. Once the Provider Response is received, C&G will prepare all required documentation and present the details of the Anonymous Complaint to the Administrative Complaint Committee for determination of any additional steps.

4.3. Within 2 business days, an Administrative Complaint Outcome Letter will be sent to the provider/PerformCare Department to relay the outcome of the Administrative Complaint Committee's review.

4.3.1. If it is determined that no further action is needed, the concerns are considered fully resolved.

4.3.2. If the committee determines additional action steps are required, all future steps will be completed, documented, and tracked as an Anonymous Complaint within the Administrative Complaint Process.

Related Policies: *QI-043 Dissatisfaction Complaint Policy*
QI-042 6-Criteria Complaint Policy
QI-047 Complaint and Grievance Referrals Regarding Corporate Compliance Issues
168.114 Record Retention Policy

Related Reports: None

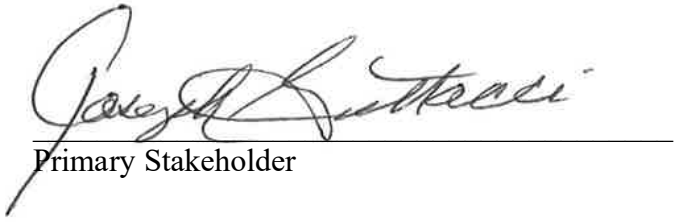
Source Documents and References:

PS&R
C&G Intake Assessment
Administrative Complaint Assessment
Informal Complaint Assessment
Follow-up for Complaints & Grievances Assessment
PerformCare Desktop Process for Informal Complaints
PerformCare Desktop Process for Administrative Complaint Committee

Superseded Policies and/or Procedures: *QI-048 Informal Complaint Policy*

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

Approved by:



Primary Stakeholder

PerformCARE®

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 calendar 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. Voicemail or recorded messages are not allowed. PerformCare must provide Members with the number of the toll-free telephone service.
9. All PerformCare staff who interact with Members must receive training on complaints and grievances, including how to record a complaint or grievance and how to provide the information staff receive to designated complaint and grievance staff for processing. This training must occur at least once per calendar year.
10. All county and PerformCare staff involved in the complaint and grievance processes, and all review committee members, must receive training in the areas related to their responsibility at least once per calendar year.
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 (or designee) are responsible for the overall coordination of the complaint and grievance processes, 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, grievance, or fair hearing
    c. The date the complaint, grievance, or fair hearing was received
    d. The date of the review, review meeting, of hearing (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

15. PerformCare must retain all complaint and grievance records, which must include a copy of any document reviewed by the complaint or grievance review committees and the complaint or grievance log, for 10 years from the date the complaint or grievance was filed. PerformCare must provide the record of each complaint and grievance to the Department, PID, and CMS upon request.

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 ensure that there is a link between the complaint and grievance processes and the Quality Management and Utilization Management programs.

18. 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.

19. PerformCare must accept complaints and grievances from Members who have disabilities which are in alternative formats including: TTD/TTY for telephone inquiries and complaints and grievances from Members who are deaf or hearing impaired; Braille; recording; or computer disk; and other commonly accepted alternative forms of communication. PerformCare must make its employees who receive telephone complaints and grievances aware of the speech limitation of

some Members who have disabilities, so they treat these Members with patience, understanding, and respect.

20. 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.

21. PerformCare must provide language interpreter services when requested by a Member at no cost to the Member.

22. PerformCare must offer Members the assistance of a PerformCare staff throughout the complaint and grievance processes at no cost. The 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.

23. 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.

24. 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.

25. If the decision 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 and document the actions taken in the complaint or grievance record or include in the record where documentation of the action or follow-up can be found.

26. 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 15 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.

27. PerformCare must notify the Member when PerformCare fails to decision a first level complaint or grievance within the timeframes specified in Appendix H. PerformCare must mail this notice to the Member 1 day following the date the decision was made.

28. PerformCare must notify the Member when it 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 using the Notice for Payment Denial Because the Service was Provided Without Authorization by a Provider Not Enrolled in the Pennsylvania Medical Assistance Program template. PerformCare must mail this notice to the Member on the day that the decision is made to deny payment.

29. PerformCare must notify the Member when it denies payment after a service(s) has been delivered because the service(s) provided is not a covered service(s) for the Member, using the Notice for Payment Denial Because the Service Was Not a Covered Service for the Member template. PerformCare must mail this notice to the Member on the day that the decision is made to deny payment.

30. PerformCare must notify the Member when it denies payment after a service(s) has been delivered because PerformCare determined that the emergency room service(s) was not medically necessary, using the Notice for Denial of Payment After a Services(s) Has Been Delivered Because the Emergency Room Service(s) Was Not Medically Necessary template. PerformCare must mail this notice to the Member on the day the decision is made to deny payment.

31. PerformCare must notify the Member when it denies the Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities, using the Notice for Denial of Request to Dispute Financial Liability template. PerformCare must mail the notice to the Member on the day the decision was made to deny the request to dispute a financial liability.

32. PerformCare must include the Non-Discrimination Notice and Language Assistance Services templates when sending a letter or notice to a Member and 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.

33. PerformCare must use the templates supplied by the Department. PerformCare may not modify the templates. PerformCare must follow the instruction in the templates for including detailed, specific information related to the complaint or grievance.