Community HealthChoices

COMPLAINTS & GRIEVANCES

COMMUNITY HEALTHCHOICES (CHC) is Pennsylvania's mandatory managed care program for individuals who are eligible for both Medicaid and Medicare (dual eligibles), older adults, and individuals with physical disabilities.

CHC offers protection to participants

if they disagree with the CHC managed care organization's (CHC-MCO) decisions to deny, decrease, or approve a service or item different than the service or item requested, or if a participant is dissatisfied with the CHC-MCO or a provider, the participant can file a complaint or grievance. The process for filing a complaint or grievance is detailed in the participant handbook for each CHC-MCO. Because there are timeframes related to filing a complaint or grievance, it is important the participant does not delay in taking action.

WHO CAN FILE A COMPLAINT OR GRIEVANCE?

A complaint or grievance can be filed by a:

- Participant
- Participant's representative
- Provider

» If filed by a representative or a provider, the participant must provide written consent for the representative or provider to be involved or act on the participant's behalf.

Complaints and grievances can be filed orally or in writing.

- If in writing, the complaint or grievance can be mailed or faxed to the CHC-MCO.
- A participant can write a letter or use a complaint/grievance request form.

COMPLAINT

A complaint is an unresolved dispute or objection filed with the CHC-MCO regarding a participating health care provider or the coverage, operations or management of the CHC-MCO. For example, a complaint may be filed about the following:

- A denial because the requested 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 of Human Services (department).

TIMEFRAME

If pertaining to one of the following, the complaint must be filed within 60 days of the date of the incident or the date the participant receives notice of a decision:

- A denial because the service or item is not covered;
- 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 timeframes;
- A denial of payment after the service or item has been delivered;
- A denial of a participant's request to dispute a financial liability.

For all other complaints, there is no time limit for filing. From the date the complaint was received, The CHC-MCO has 30 days to decide the complaint and send written notice of the decision to the participant.

Participants who file a complaint to dispute a decision to deny previously covered services must continue to receive the disputed service at the previously authorized level pending resolution of the complaint if the complaint is filed within 10 days of the date of the notice of decision.

GRIEVANCES

A grievance is a request to reconsider a plan's decision that a service or item is not medically necessary. A grievance may be filed regarding the CHC-MCO's decision to:

- Deny, in whole or in part, payment for a service or item;
- 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;
- Reduce, suspend, or terminate a previously authorized service or item;
- Deny the requested service or item, but approve an alternative service or item;
- Deny a request for a Benefit Limit Exception.

TIMEFRAME

Participants who file a grievance to dispute a decision to discontinue, reduce, or change a service or item that they have been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the grievance if the grievance is filed within 10 days of the date of the notice of decision. All grievances must be filed within 60 days from the date the participant receives written notice of the CHC-MCO's decision about the medical necessity and appropriateness of a covered service. The CHC-MCO has 30 days to decide on a grievance and send written notice to the participant.

EXPEDITED REVIEW
OF A COMPLAINT/GRIEVANCE

If a participant's health could be harmed by waiting 30 days for a decision, the participant can ask the CHC-MCO for a faster review. The CHC-MCO must conduct an expedited review if a participant submits a letter from the participant's doctor explaining why waiting the usual amount of time for a decision could harm the participant's health, or if the CHC-MCO determines that waiting the usual amount of time for a decision could harm the participant's health. The CHC-MCO must issue a decision within either 48 hours of receiving the provider letter, or 72 hours of receiving the request for expedited review, whichever is shorter.

FAIR HEARINGS

A hearing conducted by the department's Bureau of Hearings and Appeals (BHA) or a representative designated by the department.

PROCESS FOR A FAIR HEARING REQUEST

Participants must first go through the CHC-MCO complaint or grievance process. The CHC-MCO will decide on the complaint/grievance and send a notice of the decision to the participant. If a participant still has concerns, they may request a fair hearing with BHA — not all complaints may be the subject to a fair hearing. If the complaint is about one of the reasons listed under the "Timeframes" of the "Complaints" section of this fact sheet, the participant may request a fair hearing and/or an external complaint review by the Department of Health or the Insurance Department. A participant may request a second-level complaint with the CHC-MCO after receiving a notice of decision on the first-level complaint.

- **Standard Fair Hearing**

  The participant, or the participant's representative, may request a fair hearing within 120 days from the mailing date on the written notice of the CHC-MCO's first-level complaint or grievance decision. Participants may submit standard fair hearing requests to the Office of Long-Term Living (OLTL) in writing. Participants must submit the following information:

  - » Signed fair hearing request form or letter;
  - » The reason the participant is asking for a fair hearing; and
  - » A copy of the CHC-MCO's decision notice.

  BHA will issue a decision within 90 days of the date the participant filed for a first-level complaint or grievance, not including the number of days between the date on the written notice of the CHC-MCO's first-level complaint or grievance decision and the date the participant requested a fair hearing.

- **Expedited Fair Hearing**

  BHA will conduct an expedited fair hearing if a participant, or participant's representative, provides the department with a signed, written certification from the participant's provider that indicates 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 presents testimony at the fair hearing which explains why using the usual timeframes would place the participant's health in jeopardy. A request for an expedited fair hearing may be filed in writing or orally.

- **External Review**

  An external review is a review of the record by a doctor chosen by the Pennsylvania Department of Health. The external reviewer must issue a decision within 60 days of the request for external review.

  - » Requests for an external review must be filed within 15 days from the date on the grievance decision.
  - » Participants can ask for an external review and a fair hearing at the same time. If either is decided in the participant's favor, the CHC plan must approve the service.
  - » Participants who file a request for an external grievance review that disputes a decision to discontinue, reduce, or change a service or item that they have been receiving must continue to receive the disputed service or item at the previously authorized level, pending resolution of the external grievance, if the request for external grievance review is filed within 10 days of the date of the CHC-MCO's grievance decision.
  - » Participants can also request an external review of a second-level complaint.