How to make a complaint to your MA mangaged care plan

A Factsheet for Consumers

A complaint is a dispute or objection about a participating provider, or about the coverage, operations, or management of the plan.

Examples of **complaints** include:

- You are unhappy with the quality of care you received
- You cannot find a specialist in the plan's network who can meet your needs
- Your health plan denies a service saying it is not a covered benefit under Medicaid
- You have not received a service your plan has already approved
- Your plan did not decide a complaint or grievance within the specified time frames
- Your plan denied payment after a service was delivered because it was provided without authorization by a provider not enrolled in the MA program
- Your plan denied your request to dispute financial liability

This fact sheet describes the process for filing a complaint with your plan, and what to do if you are not satisfied with the complaint outcome.

Step 1: Ask for a Complaint

Call Member Services and tell them about your complaint. Or write down your complaint and send it to your plan to the attention of your plan's complaints and grievances department by mail or fax.

Some complaints have time constraints. In some circumstances, you must make a complaint within **60 days**. Generally, these are complaints about actions or inactions of your plan (see examples above). You may file all other complaints at any time.

After you file a complaint, you should get a complaint acknowledgement letter from your managed care plan. This should include information about the first level complaint process. You may ask to see any information the plan has about your complaint. You may also send additional information to the plan about your complaint. Your plan should send you **10 days** advanced written notice of your complaint review. You may (but are not required to) attend the complaint review in person or by phone. If you want to attend, you can do so in person or by phone.

You should receive a decision notice within **30 days** of the date you filed the complaint.

Don't like the decision of your First Level Complaint Review? You can appeal!

Some issues are eligible for appeal by external review and fair hearing these are:

- Denial because the service or item is not covered by your plan
- Failure of plan to decide the complaint within the specified time frame
- Denial of payment by plan after the service or item has been delivered because it was provided by provider not enrolled in MA program
- Denial of payment by plan after it has been delivered because it is not a covered service
- Denial of members request to dispute financial liability

*If your issue is mentioned above, skip the next step and go straight to **Step 3 and 4**.*

*If your issue is not mentioned above, you can still request a Second Level Complaint. Go to **Step 2** to learn more about that process.*

Step 2: Ask for a Second Level Complaint

In some cases, an external review and fair hearing are NOT applicable. In these cases, you may ask for a second level complaint within **45 days** of the date you received the first level complaint decision notice.

To request a second level complaint, call member services and tell them you want to make the second level complaint or write to them attention complaints and grievances and send by mail or fax.

After you file the second level complaint, you should get a letter from your managed care plan telling you that they received the complaint. This should include information about the second level complaint process.

You may ask to see any information the plan has about your complaint. You may also send additional information to the plan about your complaint.

The plan must send you advance written notice of the second level complaint review. You may attend the complaint review in person or by phone.

The plan must send you a written notice of their decision within **45** days of the date they received your complaint.

Step 3: Ask for an External Complaint Review

If you do not agree with the decision of the complaint review, you may have the right to an external complaint review. You must ask for an external complaint review within **15 days** of the date you received the complaint decision.

You must send your request for external review of your complaint to the PA Department of Health Bureau of Managed care and/or the Pennsylvania Insurance Department at the addresses below:

Pennsylvania Department of Health
Bureau of Managed Care
Health and Welfare Building, Room 912
625 Forster Street
Harrisburg, PA 17120
Telephone Number: 1-888-466-2787

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
Telephone Number: 1-877-881-6388

The Department of Health and/or Pennsylvania Insurance Department will get a file from your managed care organization. You may also send them any information that may help with their decision.

A decision letter will be sent to you. This letter will tell you the reasons for the decision and what you can do if you do not agree with the decision.

Step 4: Ask for a Fair Hearing

If you do not agree with the decision of the complaint review, you can ask for a fair hearing. You must ask for a fair hearing within **120 days** from the date on the first level complaint decision. This request must be in writing.

Under *Health Choices*, send your request to:

Department of Human Services

OMAP – HealthChoices Program
Complaint, Grievance, and Fair Hearings
PO Box 2675
Harrisburg, PA 17105

Under *Community Health Choices*, send your request to:

Department of Human Services
OLTL – Community Health Choices
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105

Under your *Behavioral Health Plan*, send your request to:

Department of Human Services
Office of Mental Health and Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17105
Fax: 717-772-7827

You should include a copy of the written notice of decision with your request. You will receive a notice with the date and time of your hearing once it is scheduled. You must be part of the hearing either in person or by phone, or the hearing will be dismissed. The Bureau of Hearings and appeals will hold your hearing and issue a decision in about **60-90 days** from when you filed the first level complaint.

The hearing *decision is binding* unless it is reversed by the Secretary of Human Services through a process called Reconsideration. You and your plan both have the right to request Reconsideration by the Secretary within **15 days** of the date of the hearing decision.

Important Note: *If your life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the normal complaint review process*, you may be eligible for an expedited review process. Be sure to specify that you are requesting an "expedited review". This request will need to be accompanied by a provider certification. The timeframes are shorter for this type of review and plans are expected to respond more quickly to your complaint.