Section: Customer Services	Policy Name: **Medicare Member Grievance**	Policy Number: **MHL 06.07**
Owner: **Customer Service Manager**	Reviewed By: **Sarah Ameter**	Total Pages: **10**
Required By: ☒ **BBA** ☒ **MDHHS** ☒ **NCQA** ☐ **Other (please specify):**	Final Approval By: Sarah Ameter	Date Approved: Aug 2, 2022
Application: ☒ **SWMBH Staff/Ops** ☐ **Participant CMHSPs** ☐ **SUD Providers** ☐ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☐ **Medicaid** ☐ **Other (please specify):** ☐ **Healthy Michigan** ☐ **SUD Block Grant** ☐ **SUD Medicaid** ☒ **MI Health Link**	Effective Date: **1/1/2015**

Policy: All verbal or written grievances received at Southwest Michigan Behavioral Health (SWMBH) will be investigated and resolved in a consistent and timely manner, in accordance with the guidelines outlined in Section 42 of The Code of Federal Regulations, Part 422, Subpart M- Grievances, Organization Determinations and Appeals and Part 438, Subpart F: Grievance System and Appeal System. The grievance process meets all Centers for Medicare and Medicaid Services (CMS) guidelines, and National Committee of Quality Assurance (NCQA) standards. An expedited process will be implemented whenever a complaint or grievance has been determined to be of an urgent clinical nature. All grievances will be monitored, tracked and trended in a central database maintained by the Member Service Department.

Purpose: SWMBH is committed to ensuring that members can freely voice grievances, and recommend changes in care or services, without the fear of reprisal or unreasonable interruption of services. The grievance system for Medicare members promotes the resolution of the members concerns while supporting and enhancing the overall goal of improving care under standards of best practice.

Scope: Member Services

Responsibilities: SWMBH Member Services department shall ensure compliance with the standards and guidelines outlined in this policy and guiding documents.

Definitions:

A. Adverse Benefit Determination: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a Covered Service; (ii) the reduction, suspension, or

termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner, as defined by the State; (v) the failure of the Integrated Care Organization (ICO) to act within the required timeframes for the standard resolution of Grievances and Appeals; (vi) for a resident of a rural area with only one ICO, the denial of an Enrollee's request to obtain services outside of the Network; or (vii) the denial of an Enrollee's request to dispute a financial liability.

B. Appeal: As defined in 42 CFR 438.400(b). A request for review of a ICO or Prepaid Inpatient Health Plan's (PIHP) decision that results in any of the following actions: (1)The denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a properly authorized and covered service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of an Entity to act within the established timeframes for grievance and appeal disposition; (6) For a resident of a rural area with only one ICO Integrated Care Organization, the denial of a member's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network. Effective no later than January 1, 2018, a Medicaid-based Appeal is defined as a review by the ICO of an Adverse Benefit Determination.

C. Authorized Representative: An individual appointed by an enrollee or other party, or authorized under State or other applicable law, to act on behalf of an enrollee or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of an enrollee or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules described at 42 CFR Part 405.

D. Grievance: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.

E. Grievance System: The system that provides the processes to handle appeals and grievances, as well as the processes used to collect and track information about grievances and appeals.

F. Quality of Care: The extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people centered. A quality of care complaint may be filed through the Medicare health plan's complaint process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare health plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

G. Quality Improvement Organization (QIO): As set forth in Section 1152 of the Social Security Act and 42 CFR Part 476, an organization under contract with CMS to perform utilization and quality control peer review in the Medicare program or an organization designated as QIO-like by CMS. The QIO or QIO-like entity provides quality assurance and utilization review.

H. Reconsideration: The first level in the appeals process which involves a review of an adverse organization determination by a Medicare health plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the Medicare health plan or CMS.

I. Independent Review Entity (IRE): An independent entity contracted by CMS to review appeal decisions made by the plan. An IRE can review plan dismissals. Reviews the case if SWMBH partially or fully denies coverage for an item/service that is covered by Medicare only or by Medicare and Medicaid upholding the original determination. SWMBH will automatically forward the case for review to the IRE.

Standards and Guidelines:

Federal regulations require that Southwest Michigan Behavioral Health, as an organization that serves Medicare beneficiaries, to establish meaningful complaint and grievance procedures for members. SWMBH provides written information about grievance processes to members and/or their representatives, at the time of initial enrollment, upon involuntary disenrollment initiated by the ICO, upon denial of a member's request for expedited review of an organization determination or appeal, upon a member's request, and annually thereafter. Written information provided outlines the grievance procedures available to them, how to access them and the difference between adverse benefit determination appeals and grievances.

A. Distinguishing Between a Grievance and Adverse Benefit Determination Appeal

1. If a member addresses two or more issues in one grievance, then each issue should be processed separately and simultaneously (to the extent possible) under the proper procedure. At times both the grievance and adverse benefit determination appeal procedures may need to be utilized when there is both a grievance, as well as an appeal of an adverse benefit determination.
2. Upon receipt, the facts surrounding a complaint from a member, or member's authorized representative, will determine whether the grievance or adverse benefit determination appeals process should be initiated. This review ensures routing the identified matter to the appropriate process and facilitates timely processing.
3. If the complaint is about an adverse benefit determination, it will be rerouted to the adverse benefit determination appeal process and be subject to SWMBH MI Health Link (MHL) Policy 06.08: Medicare Member Adverse Benefit Determination Appeal.
4. If the complaint is about dissatisfaction with anything other than an adverse benefit determination or coverage, it will be processed as a grievance and will be subject to this policy.

B. The SWMBH grievance system provides Medicare members:

1. A process for addressing issues that do not involve authorization determinations.
2. A process for promptly distinguishing between a grievance and an appeal of an adverse benefit determination and informing the member that the grievance is subject to its grievance procedures or adverse benefit determination appeal procedures, orally or in writing, and facilitating the appropriate process.
3. A procedure for investigating, resolving and documenting member grievances.
4. A method to ensure that all members receive written information about the grievance processes available to them.

C. Medicare members have rights available to them in accordance with the provisions of 42CFR, Subpart M, and PIHP contractual requirements, including the right to:

1. Have grievances against SWMBH, or providers, heard and resolved in a timely manner and in accordance with Medicare guidelines.
2. Provide any information or evidence concerning the grievance orally or in writing.
3. An expedited process when a grievance has been determined to be of an urgent clinical nature.

4. A process to file, and have grievances resolved, in a culturally competent manner, including accommodations for members with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds.
5. The right to request quality of care grievance data from Medicare Health Plans.
6. The right to file a quality of care grievance with a QIO.
7. The right to request an expedited organization determination, or an extension, as described in the Medicare Managed Care Manual, and, if the request is denied, the right to receive a written notice that explains the member's right to file an expedited grievance.
8. The right to a written notice from a Medicare Health Plan of its own decision to take an extension on a request for an organization determination that explains the reasons for the delay and explains the member's right to file an expedited grievance if he or she disagrees with the extension.

D. Member Authorized Representatives

1. Individuals who represent members may either be appointed or authorized to act on behalf of the member in filing a grievance, requesting an initial determination, or in dealing with any of the levels of the adverse benefit determination appeals process, as defined in the Medicare Managed Care Manual and 42 CFR, Part 422, Subpart M.
2. A member may appoint any individual (such as a relative, friend, advocate, an attorney, or any physician) to act as his or her representative.
3. Alternatively, a representative (surrogate) may be authorized by the court or act in accordance with State law to act on behalf of a member. A surrogate could include, but is not limited to, a court appointed guardian, an individual who has Durable Power of Attorney, or a health care proxy, a person designated under a health care consent statute, or an executor of an estate.
4. To be appointed by a member, both the member making the appointment and the representative accepting the appointment (including attorneys) must sign, date, and complete a representative form (Form CMS-1696 Appointment of Representative or other equivalent written notice).
5. An "equivalent written notice" is one that:
    a. Includes the name, address, and telephone number of member and the individual being appointed;
    b. Includes the member's Health Insurance Claim Number (HICN) [or Medicare Identifier, or plan (ID) Number];
    c. Includes the appointed representative's professional status or relationship to the party;
    d. Contains a statement that the member is authorizing the representative to act on his or her behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative;
    e. Is signed and dated by the member making the appointment; and
    f. Is signed and dated by the individual being appointed as representative and is accompanied by a statement that the individual accepts the appointment.
    g. Includes a written explanation of the purpose and scope of the representation
6. Due in part to the incapacitated or legally incompetent status of a member, a surrogate is not required to produce a representative form. Instead, he or she must produce other appropriate legal papers supporting his or her status as the member's authorized representative.
7. Either the signed representative form for a representative appointed by a member, or other appropriate legal papers supporting an authorized representative's status, must be included with

each request for a grievance, organization determination, or an adverse benefit determination appeal.

8. A representative form is valid for one year from the date it has signatures for both the member and the representative, unless revoked. If the member would like the same individual to continue serving as a representative after one year, they must reappoint that person by submitting a new representative form. A form is valid for the life of a grievance, coverage request, or appeal if the grievance, coverage request, or appeal was received within one year of the date a representative form is signed by both the member and representative. If the representative form is maintained and accessible, a photocopy of the signed representative form is not required to be filed with future grievances, coverage requests, or appeals made on behalf of the member in order to continue representation. If the plan uses a representative form that is on file for requests, it must include a copy when sending a case file to higher level adjudicators, if applicable.
9. For grievances, requests for organization determinations, or adverse benefit determination appeals submitted either without a representative form or with a defective representative form – SWMBH will inform the member and purported representative, in writing, that the grievance, coverage determination, or appeal is not valid until documentation is provided. For expedited requests, SWMBH will ensure that expedited requests are not inappropriately delayed. When a request for a grievance, organization determination, or reconsideration of an adverse benefit determination is filed by a person claiming to be a representative, but the representative does not provide appropriate documentation upon SWMBH's request, SWMBH must make, and document, its reasonable efforts to secure the necessary documentation. SWMBH will not issue a decision until or unless such documentation is obtained. SWMBH is not required to undertake a review until or unless such documentation is obtained but may choose to begin the review while continuing efforts to obtain the representative documentation. The time frame for acting on a grievance, organization determination, or appeal begins when the representative documentation is received.
10. For Grievances and coverage requests, if SWMBH does not receive the documentation by the conclusion of the Grievance time frame, plus extension, SWMBH may dismiss the grievance on the grounds that a valid request was not received. SWMBH will notify the member and the person asserting representative status of the dismissal in writing. The dismissal notice should explain that reason(s) for the dismissal, how the invalid request can be cured, and that the request will be processed if the enrollee or representative submits a properly executed form.
11. A provider, physician, or supplier may not charge a member for representation in filing a grievance, coverage request, or appeal. Administrative costs incurred by a representative during the appeals process are not reasonable costs for Medicare reimbursement purposes.
12. Unless otherwise stated in the rules described in 42 CFR, Subpart M of part 422, the representative has all of the rights and responsibilities of a member in filing a grievance, obtaining an coverage request, or in dealing with any of the levels of the appeals process.
13. All notices or other correspondence intended for the member must be sent to the member's representative instead of to the member. SWMBH may send notices or correspondence to both the representative and the member but is not required to do so.

E. Grievance Categories

1. Grievance categories will align with NCQA Quality Management and Performance Improvement Grievance categories.

a. Quality of Care
b. Access
c. Attitude and Service
d. Billing and Financial Issues
e. Quality of Practitioner office site

F. Assistance for Grievance Process

1. Members shall receive reasonable assistance in completing any forms or other procedural steps, including interpreter services and toll-free numbers with TTY/TDD and interpreter capability. This also includes assistance that includes auxiliary aides and services upon request.
2. Written materials shall be in an easily understood language and format, and members shall be notified that written materials are available to them in alternative formats, including other prevalent languages other than English, and oral interpretation is also available. Documentation shall also include how to access such assistance.
3. Written materials, including notices, shall be translated for members who speak prevalent languages.
4. Language services will be provided to members requesting assistance through bilingual staff or interpreter services, face-to face or telephonically, including but not limited to:
   a. Filing a grievance or appeal
   b. Notification and/or correspondence regarding the grievance or appeal
5. All steps in the grievance and appeals processes shall be provided within the scope of, and maintain compliance with, SWMBH MHL Policy 06.04: Limited English Proficiency.

G. Filing a Grievance

1. Members and/or a member's authorized representative (as defined by 42 CFR Part 422, Subpart M, and Medicare Managed Care Manual), may express their grievances orally or in writing.
2. Members can make a complaint at any time.
3. SWMBH shall acknowledge the receipt of the grievance:
   a. In writing when the grievance is submitted in writing.
   b. In writing when the grievance is regarding quality of care.
   c. Verbally or in writing for other grievances filed verbally.
4. Grievances may be referred and handled by the department/organizations listed, but not limited to:
   a. Office of Recipient Rights
   b. Compliance Department
   c. Quality/Integrity Program
   d. Utilization Management
   e. Michigan Department of Health and Human Services (MDHHS)
   f. Independent Review Organization (IRE)
   g. Quality Improvement Organization (QIO)

H. Standard Complaint/Grievance Resolution

1. SWMBH will maintain written records of all Grievance activities.
2. SWMBH will promptly issue a full investigation of the grievance as expeditiously as the member's case requires and based on the member's health status.

3. SWMBH will research and document all issues relevant to the grievance including any aspects of clinical care involved, including all actions taken.
4. SWMBH will ensure that all comments, documents, records, and other information submitted by the member or their representative will be taken into account, regardless if the information was used in the initial review, as applicable.
5. SWMBH shall provide members with a reasonable opportunity, sufficiently in advance of the resolution, to present evidence and argue their case, and inform the member of this timeframe at the time the grievance is filed.
6. Any testimony provided by the member or member's representative will be considered by the Individual making the decision on the grievance, and new information that was not considered in the initial determination of the grievance, shall be considered when resolving the grievance.
7. SWMBH notify all concerned parties upon completion of the investigation of the grievance as expeditiously as the case requires, based on the member's health status, but no later than 30 calendar days after the date SWMBH receives the oral or written grievance.
8. In clinically urgent situations, members and/or authorized representatives will be notified orally, or in writing, of the resolution within 24 hours after receipt of the grievance.
9. SWMBH may extend the 30-calendar day timeframe by up to 14 calendar days if the member or authorized representative requests the extension or SWMBH justifies a need for additional information and documents and how the delay is in the interest of the member. If the timeframe is extended, SWMBH will make reasonable efforts to give the member prompt oral notice of the delay. In addition, within two days SWMBH will give the member written notice of the reason for the extended timeframe and inform he member of the right to file a grievance if he or she disagrees with a that decision.
10. Grievances will be resolved by SWMBH staff at appropriate decision-making levels, who are not involved in the substance of the grievance and were not involved in previous levels of review or decision making, nor a subordinate of any such individual.
11. Grievance regarding the denial of an expedited resolution of an appeal or involves clinical issues, will be processed by a health care professional who has the appropriate clinical expertise, as determined by MDHHS, in treating the member's clinical condition or disease.
12. Grievances that are submitted orally may be responded to either orally or in writing, unless the member or authorized representative, requests a written response or the grievance raises a quality of care issue. Verbal resolutions must be documented in the grievance record with the date and time of the resolution call.
13. Members, or their authorized representative, will be notified of any appeal options applicable.
14. All grievances related to quality of care, regardless of how the grievance is filed, will be responded to in writing and will include the member's right to both the grievance and appeals process, as well as a description of the member's right to file a written complaint with the Quality Improvement Organization (QIO).
15. A member may submit a written withdrawal request for a grievance any time before the decision is mailed. SWMBH may accept verbal withdrawals for both written and verbal grievances received from a member. SWMBH will clearly document in the system that the member does not want to proceed with the grievance procedures. SWMBH may but is not required to send written

confirmation of that withdrawal to the member within 3 calendar days of receiving the withdrawal request.

16. If the member submits a quality of care grievance verbally or in writing but later decides to withdraw the grievance, SWMBH is still required to investigate the quality of care grievance; however, SWMBH is not required to notify the member of the outcome of the grievance since they decided not to pursue the grievance.
17. SWMBH's notice to the member of the disposition/resolution of the Grievance:
    a. Must meet the requirements of 42 CFR 438.408(d)(1);
    b. Be produced in a matter, format, and language that can be easily understood;
    c. Be made available in prevalent languages, upon request; and
    d. Include information, in the most commonly used languages, about how to request translation services and alternative formats.

I. Expedited Grievance Resolution

1. SWMBH shall respond to a member's grievance within 24 hours if:
    a. The grievance involves SWMBH's decision to invoke an extension relating to an organization determination or reconsideration.
    b. The grievance involves SWMBH's refusal to grant a member's, or member's authorized representative, request for an expedited organization determination under 422.570 or reconsideration under 422.584.
    c. Upon determination that there is a clinical urgency to resolve the grievance expeditiously.
2. When written notification is required for expedited grievances, SWMBH may initially provide verbal notification of its decision and must deliver written confirmation of its decision within 3 calendar days of the verbal notification.

J. Record Keeping

1. SWMBH will track and maintain records of all grievances received both orally and in writing, and will ensure documentation of the following information, at minimum:
    a. A general description of the reason for the Grievance;
    b. The date received;
    c. The date of each review, or if applicable, the review meeting;
    d. The resolution of the Grievance;
    e. The date of the resolution;
    f. Name of the covered person for whom the Grievance was filed.

K. Quality Improvement Organization (QIO)

1. Members will be provided written information at the time of initial enrollment and annually thereafter, of the "Quality of Care" complaint process available under QIO process as described in §1154(a)(14) of the Social Security Act.
2. All grievances regarding quality of care, must be responded to in writing and include a description of the member's rights to file the grievance with the QIO, including contact information for the appropriate QIO to which the member may submit his or her quality of care grievance. (Ch. 13 p.20)
3. Under section 1154(a)(14) of the Social Security Act, the QIO must review beneficiaries' written complaints about the quality of services they have received under the Medicare program. This process is separate and distinct from SWMBH's complaint procedures. For quality of care issues, an enrollee may file a complaint with SWMBH; file a written complaint with the QIO, or both.

4. SWMBH will cooperate in resolving any complaint submitted to the QIO.

L. Grievance Reporting Requirements

1. SWMBH's Member Services Department shall report grievances received regarding behavioral health, substance use disorders and intellectual/developmental disabilities, to:
   a. The SWMBH MI Health Link Committee and Quality Assurance and Performance Improvement (QAPI) Department on a quarterly basis.
   b. Each contracted ICO as required in each ICO/PIHP contract, via SWMBH's QAPI department.
   c. Other parties as required through contractual obligations and/or regulatory requirements.

M. Regulatory Complaints Process

1. Regulatory complaints may be received from the State primarily through the Ombudsman's office or from CMS through the Complaint Tracking Module (CTM) of the Health Plan Management System (HPMS).
2. Complaints received through CTM will be processed according the CMS assigned issue level:
   a. "Immediate" within two (2) calendar days
   b. "Urgent" within seven (7) calendar days
   c. "Non-Urgent" within thirty (30) calendar days
3. Processing of all other regulatory complaints will follow the grievance or appeal process timeframes depending on complaint classification unless the regulatory body stipulates a different timeframe for the complaint.
4. Within one (1) calendar day of receipt of a regulatory complaint the facts surrounding the complaint will be reviewed to determine whether the grievance, coverage determination or appeals process should be initiated.
5. SWMBH will ensure that all regulatory agencies are aware of any regulatory complaints filed as necessary.
6. All regulatory complaints will be identified as a regulatory complaint, processed and tracked in the appeal and grievance database to allow for comprehensive trending of all received complaints regardless of origination. As specified in CMS Part C Reporting and Technical Specifications regulatory complaints will not be included in regulatory reporting.

References:

A. SWMBH MI Health Link Policy 6.4: Limited English Proficiency
B. SWMBH MI Health Link Policy 6.8: Medicare Member Adverse Benefit Determination Policy
C. NCQA Standard: RR2 Policies and Procedures for Complaints and Appeals; QI5 Member Experience
D. MI Health Link 3-Way Contract: 2.10 Enrollee Grievance
E. Code of Federal Regulations: 42CFR 438: Subpart F, 42CFR 422: Subpart M, 42CFR 405
F. Medicare Managed Care Parts C&D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

Attachments: None

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
3	1/1/20	SWMBH	Updated per Medicare Managed Care guidelines	Heather Woods
4	8/20/21	Standards and Guidelines: F2	Edit wording to clarify language assistance	Heather Woods
5	7/15/22	Annual Review	No Changes	Heather Woods

MHL 06.07 Medicare Member Grievance

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