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CMS REVISES PROCEDURES FOR FILING COMPLAINTS AGAINST MEDICARE PROVIDERS

Last month, the Institute of Medicine (IoM) issued a report recommending that responsibility for handling and resolving Medicare beneficiaries' complaints and appeals regarding quality of care be removed from Quality Improvement Organizations (QIOs).[1] Setting out the principle that beneficiary complaints "be reviewed under a contract that recognizes the beneficiary as the primary client," IoM identified state survey agencies (SAs) as one potential site for complaint investigations.[2]

State survey agencies already have responsibility for handling complaints by beneficiaries and others about alleged non-compliance with federal and state requirements by Medicare-certified providers, suppliers, skilled nursing facilities, and CLIA-certified laboratories. The procedures that state survey agencies and CMS Regional Offices use to receive and resolve these complaints were issued (and became effective) March 17, 2006 as a revision to the State Operations Manual (SOM).[3]

Under the revised SOM, state survey agencies are expected to:

- Have written policies and procedures and response timelines;
- List the complaint telephone number in local directories;
- accept oral, written, and anonymous complaints; and
- "Ensure the privacy and anonymity of every complainant."[4]

SAs collect comprehensive information from complainants about their concerns, including their "expectation/desire for resolution/remedy, if appropriate".[5] Specific information must also be given to complainants, including the state's procedures, anticipated timeframe for investigating the complaint, information about other appropriate agencies, and an "SA contact name and number for follow-up by the complainant".[6]

SAs must promptly review complaints, conduct "**unannounced** onsite investigations of reports alleging noncompliance," and inform the CMS Regional Office (RO) or the State Medicaid Agency, or both, "any time certification requirements are found to be out of compliance [emphasis in original]".[7] SAs may not delegate these functions.[8]

The timing of the SA's investigation of a complaint depends on the seriousness of the complaint. SAs must review immediate jeopardy allegations within two or five days (depending on the provider type); non-immediate jeopardy allegations, within 45 days for most providers; and other allegations of noncompliance, at the next onsite survey.[9]

The SA or RO that conducts the complaint investigation must provide a **written report of the investigation findings to the complainant**, including a summary of investigative methods used, dates of investigation, explanation of the SA's process, summary of findings, follow-up action to be taken, and, as appropriate, referral information to other agencies.[10]

SAs are also required to "manage and investigate", as complaints, any referrals they receive from the office of the coroner, quality improvement organizations, law enforcement, the ombudsman's office, and protection and advocacy systems.[11]

The SA must conduct an **exit conference** with the provider and document all deficiencies that were found, using a form expressly for this purpose (Form CMS-2567).[12]

Sections of the new Chapter address nursing home complaints (§5300), procedures for deemed providers (providers presumed to comply with federal standards of care because of their accreditation status) and suppliers (§§5100-5170, pages 21-32), procedures for non-deemed providers (providers that must undergo a survey by a state regulatory agency), excluding nursing homes (§5200, pages 32-34), nursing homes (§5300, pages 34-45), Emergency Medical Treatment and Labor Act (EMTLA) (§5400, pages 46-62), and CLIA-certified laboratories (§5500, pages 62-75). Some sections in the Chapter address complaints against all providers; other sections, complaints against deemed or non-deemed providers; other sections, nursing homes only.

In light of the comprehensive complaint investigation procedures set out in the SOM, state survey agencies would appear to be a reasonable and logical option for handling all complaints about quality of care by Medicare providers. At the very least, any agency that takes on the QIOs' complaint handling responsibilities should be required to use these procedures. And, as the IoM recommended, whoever handles complaints should see beneficiaries as their "primary client."

The two-page memorandum and 91-page Chapter are available at http://new.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=ascending&itemID=CMS060362.

The prepublication version of the 338-page IoM report may be read on-line for free, at http://darwin.nap.edu/books/0309101085/html/; copies of the final report may be purchased at http://www.nap.edu/catalog/11604.html.

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[1] Institute of Medicine, *Medicare's Quality Improvement Organization Program; Maximizing Potential* 10 (Recommendation 4) (Mar. 2006).
[2] *Id.* 90.
[3] "State Operations Manual (SOM) Chapter 5, Complaints," S&C-06-12 (Mar. 22, 2006) (Memorandum from Thomas E. Hamilton, Director, Survey and Certification Group, to State Survey Agency Directors).
[4] (§5010, pages 7-8)
[5] (§5010.1, page 9)
[6] (§5010.2, page 9)
[7] (§5000.2, page 7)
[8] *Id.*
[9] (§5075, pages 14-19).
[10] (§5080.1, pages 20-21).
[11] (§5010, page 7)
[12] (§5080.2, page 21)