Medicare Minute Teaching Materials – December 2019
Complaints, Grievances, and Beneficiary Resources

1. What is a grievance?
A grievance is a formal complaint that you file with your plan. If you are dissatisfied with your Medicare Advantage or Part D prescription drug plan for any reason, you can choose to file a grievance. A grievance is different from an appeal, which is a request for your plan to cover a service or item that it has denied.

You may wish to file a grievance if your plan provides poor customer service or you face administrative problems. Some additional examples of issues that might lead you to file a grievance include:

- Your plan fails to return a coverage determination or appeal decision on time
- Your plan fails to expedite a coverage determination or appeal
- You experience poor quality of care from an in-network provider (see number 3)
- You experience poor customer service from a plan representative
- You are asked to pay an incorrect copayment amount
- You are involuntarily disenrolled from your plan
- There is a change in premiums or cost-sharing
- You receive inadequate written communications from your plan
- You experience marketing abuse (see number 7)

In some cases, you may want to file both an appeal and a grievance.

To file a grievance, send a letter to your plan's Grievance and Appeals department. Visit your plan's website or contact them by phone for the address. You can also file a grievance with your plan over the phone, though it is recommended to send your complaints in writing. When you contact your plan with an issue, they should be able to assess whether you are filing a grievance, appeal, coverage request, or some combination of those things. To be safe, submit your grievance in writing with clear language indicating that it is a grievance. If you are filing both an appeal and a grievance, be sure to state that clearly as well. Be sure to send your grievance to your plan within 60 days of the event that led to the grievance.

Your plan must investigate your grievance and get back to you within 30 days. If you made your grievance in writing, the plan must respond to you in writing. If you make your request over the phone, your plan may respond verbally or in writing, unless you specifically request that the response be in writing. If your request is urgent, your plan must get back to you within 24 hours. If you have not heard back from your plan within this time, you can check the status of your grievance by calling your plan or 1-800-MEDICARE.

2. When should I file a complaint about my plan with Medicare?
In some cases, if you have an issue with your Medicare Advantage or Part D prescription drug plan that has not been resolved through the grievance process, or if you want to make Medicare aware of other issues, you can file a complaint at 1-800-MEDICARE. Medicare uses a system called the Complaint Tracking Module (CTM) to handle beneficiary concerns with Medicare health and drug plans. You might want to call Medicare to make a formal complaint in order to escalate an issue to Medicare's attention. For example, if a plan fails to respond

to appeals according to Medicare's specified deadlines, preventing you from accessing medically necessary services, you should call 1-800-MEDICARE to make a complaint.

The Centers for Medicare & Medicaid Services (CMS), the government agency that oversees the Medicare program, use information from the complaint tracking module in setting Medicare Advantage and Part D plan star ratings each year. Star ratings measure how well Medicare Advantage and Part D plans perform. Medicare scores how well plans perform in several categories, including quality of care and customer service. Ratings range from one to five stars, with five being the highest and one being the lowest. Making a complaint to Medicare about a problem is a way to make sure that plan is held accountable.

3. What should I do if I have a concern about the quality of care I have received?
If you have a concern about the quality of care you receive from a Medicare provider, your concern can be handled by the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) for your area. The BFCC-QIOs are made up of practicing doctors and other health care experts. Their role is to monitor and improve the care given to Medicare enrollees. BFCC-QIOs review complaints about the quality of care provided by:

- Physicians
- Inpatient hospitals
- Hospital outpatient departments
- Hospital emergency rooms
- Skilled nursing facilities (SNFs)
- Home health agencies (HHAs)
- Ambulatory surgery centers
- Hospice providers

Examples of situations that you might wish to file a quality of care complaint about include:

- A medication mistake
- Contracting an infection during a stay in a facility
- Receiving the wrong care or treatment
- Running into barriers to receiving care

Two ways that the BFCC-QIO might review this complaint are:

- **Immediate advocacy:** Immediate advocacy is an informal process used by the BFCC-QIO to quickly resolve a concern or complaint. This process starts when you, a family member, or an advocate gives the BFCC-QIO permission to address the concern or complaint. The BFCC-QIO will then contact your provider. If your provider agrees to participate in the resolution of the issue, the BFCC-QIO will work with both you and your provider to resolve the issue. If your provider declines to participate, you will be able to file a written complaint. Immediate advocacy can take place when the complaint is unrelated to the clinical quality of health care, or when it is related to the clinical quality of healthcare, but does not rise to the level of being a significant quality of care concern. For example, immediate advocacy could

be used to address complaints about a hospital staff's poor communication. In cases when immediate advocacy is used, the issue should be resolved within no more than two business days. This process is not available if you wish to remain anonymous.

- **Quality of care complaints:** If you have concerns related to the quality of clinical care that you have received, you can file a complaint with the BFCC-QIO so they can review the case. You can do this by calling your QIO or submitting a written complaint. When the BFCC-QIO gets your complaint, they should call you to ask clarifying questions about your complaint and to get the contact information for your provider. A physician of matching specialty will review the medical record to determine whether the care provided met the medical standard of care. The review process can take up to a few months, at which point you and your doctor will be notified by phone and in writing. In cases when the BFCC-QIO finds a very serious and/or repeated failure to meet professional standards of care, they can recommend that the Office of the Inspector General (OIG) impose sanctions on the provider. Sanctions can include corrective action plans, fines, or exclusion from the Medicare program.

Livanta and KEPRO are currently the two BFCC-QIOs that serve the entire country. To find out which BFCC-QIO serves your state or territory and how to contact them, visit www.qioprogram.org/contact or call 1-800-MEDICARE

If you have a Medicare Advantage Plan, you can choose to make complaints about the quality of care you receive through your plan's grievance process, through the BFCC-QIO, or both. If you file a grievance with your plan (see number 1) about the quality of care you receive, the plan should inform you of your right to file a complaint with the BFCC-QIO.

4. What should I do if I have a complaint about my durable medical equipment supplier?
Durable medical equipment (DME) suppliers should have processes in place to handle complaints from Medicare beneficiaries. If you have a complaint, contact your DME supplier and tell them what your complaint is or ask where you can send a written complaint. Within five calendar days, your supplier must let you know they got your complaint and that they are investigating it. Within 14 calendar days, the supplier should send you the result of your complaint and their response in writing.

If your supplier does not handle the complaint appropriately or does not respond in time, you can also call 1-800-Medicare to file a complaint

5. What should I do if I have a complaint about my dialysis or kidney transplant center?
End-stage Renal disease (ESRD) Networks can handle many of the complaints that you might have about dialysis or kidney transplant care. An ESRD Network is made up of all the Medicare-approved ESRD facilities in a geographic area. Each ESRD Network has an ESRD Network Organization. The ESRD Network Organizations monitor and improve the quality of care given to people with ESRD.

Complaints you might have about your ESRD facility include:

- The facility staff does not treat you with respect
- Your dialysis shifts conflict with your work hours, and the facility will not let you change your shift

- Your facility is not providing you with, or helping you access, a medication that they are responsible for providing to you
- You made complaints to your facility and they were not addressed.

If you have these kinds of concerns, you can raise them to your facility, by requesting a patient care meeting at your facility or following your facility's formal complaint process. You can also contact your ESRD Network office to start the Network grievance process. The ESRD Network can handle these grievances in several ways:

- **Confidential consultation:** A conversation with someone at the Network about your care.
- **Immediate advocacy:** A way for the ESRD Network to work with you and your facility to resolve an issue. Immediate advocacy must be completed in seven days.
- **Quality of care review:** A larger scale review if you feel that your concerns involve poor care to you and/or other patients. This review might include a review of medical records and can take up to 60 days.
- **Referral:** In some cases, your Network might identify another agency that can help you resolve your issue. In this case, the Network should provide you with the contact information of that organization.

To find contact information for your ESRD Network Organization, call 1-800-MEDICARE or visit www.esrdnetworks.org.

In cases when your complaint is related to claims of abuse, unsafe conditions, or poor quality of care, you may want to file a complaint with your State Survey Agency. Call 1-800-MEDICARE for the contact information of your State Survey Agency. This information is also available at www.cms.gov.

6. What should I do if I suspect that a provider is committing Medicare fraud or abuse?
Medicare fraud occurs when someone knowingly deceives Medicare to receive payment when they should not, or to receive higher payment than they should. **Medicare abuse** involves billing Medicare for services that are not covered or are not correctly coded, when the provider has unknowingly and unintentionally misrepresented the facts to obtain payment. Some common examples of Medicare fraud or abuse are:

- Billing for services or supplies that were not provided
- Providing unsolicited supplies to beneficiaries
- Misrepresenting a diagnosis, a beneficiary's identity, the service provided, or other facts to justify payment
- Prescribing or providing excessive or unnecessary tests and services
- Violating the participating provider agreement with Medicare by refusing to bill Medicare for covered services or items and billing the beneficiary instead
- Offering or receiving a kickback (bribe) in exchange for a beneficiary's Medicare number
- Requesting Medicare numbers at an educational presentation or in an unsolicited phone call

You can watch out for fraud by keeping a calendar of all of your medical appointments and comparing it with your Medicare statements (Medicare Summary Notices (MSNs) if you have Original Medicare and Explanations of Benefits (EOBs) if you have Medicare Advantage) and bills from your providers. If something does not seem right—for example, if you see in your MSN that your provider billed Medicare for an office visit

on a day when you did not see them—you should first contact your provider. Call your doctor or their billing office and let them know about the problem in case it was a billing error. If your doctor does not fix the error or if you continue to suspect fraud or abuse, you can call:

- Your **Senior Medicare Patrol (SMP):** Your SMP can help you identify Medicare fraud, abuse, and errors, and can help you report fraud or attempted fraud to the correct authorities. Contact information for your SMP is on the last page of this document.
- The **Office of the Inspector General** fraud hotline: If the Inspector General's staff determines that your complaint is worth further study, the complaint will be sent to the appropriate agency for review. The complaint resolution process usually takes at least six months. The hotline number is 1-800-HHS-TIPS (1-800-447-8477).

7. What should I do if a plan is engaging in inappropriate or misleading marketing?
Insurance companies selling Medicare health and drug plans must follow certain rules when promoting their products. These rules are meant to prevent plans from presenting misleading information about a plan's costs or benefits, also known as marketing fraud. Medicare plans are allowed to conduct certain activities. For instance, companies can market their plan through direct mail, radio, television, and print advertisements. Agents can visit your home if you invite them for a marketing appointment. However, insurance agents cannot:

- Call you if you did not give them permission to do so
- Visit you in your home, nursing home, or other place of residence without your invitation
- Provide a gift or prize worth more than $15 per person
- Disregard federal and state consumer protection laws for telemarketing, the National Do-Not-Call registry or do-not-call-again requests
- Market their plans at educational events or in health care settings (except in common areas)
- Sell you life insurance or other non-health products at the same appointment unless you request information about such products
- Use the term "Medicare-endorsed" or suggest that their plan is a preferred Medicare plan
- Imply that they are calling on behalf of Medicare

Additionally, you are being misled if an agent from an insurance company says that you:

- Must sign up for a Medicare Advantage Plan to get Medicare drug coverage
- Will pay a higher Part B premium unless you sign up for a certain plan (some plans help pay your Part B premium or charge additional premiums, but your Part B premium will not increase based on your coverage choices)
- Must invite a plan representative to your home to get information about the plan or to enroll
- Can switch back to Original Medicare at any time if you are dissatisfied, without providing information about enrollment periods
- Will receive additional benefits that are actually Medicare-covered services
- Will receive additional benefits, such as dental or vision, that are actually covered by other insurance you have or are eligible for (such as Medicaid)
- Will lose your Medicaid benefits unless you sign up for a certain plan

If a plan representative engages in any of these behaviors, save any documented proof of this interaction, you can contact your SMP program. Your SMP can help you identify and report Medicare fraud, abuse, errors, and misleading marketing (see numbers 6 and 7). SMPs provide individualized assistance and help refer Medicare fraud, abuse, errors, and misleading marketing to the proper authorities. You can also call 1-800-MEDICARE.

8. What other resources are available to me as a Medicare beneficiary?
If you experience issues with your Medicare enrollment or with accessing services, or if you need help understanding your benefits, these resources are available:

State Health Insurance Assistance Program (SHIP): If you have questions about Medicare, call your local SHIP for assistance. Contact information for your SHIP is on the last page of this document. SHIPs can help with:

- Enrolling in Medicare Part A and B for the first time
- Medicare Advantage and Part D prescription drug plan selection and enrollment
- Eligibility screenings and enrollment in programs for people with limited incomes, like the Medicare Savings Programs, Extra Help, and State Pharmaceutical Assistance Programs
- Questions about what items and services are covered by Medicare
- Appealing denials of coverage by Original Medicare or your Medicare Advantage or Part D prescription drug plan
- Understanding how to file a grievance with a plan
- Questions about coordination of benefits between Medicare and other types of insurance, like supplemental policies, Medicaid, and retiree coverage
- Knowing your rights under Medicare

Senior Medicare Patrol (SMP): Your SMP can help you identify and report Medicare fraud, abuse, errors, and misleading marketing (see numbers 6 and 7). SMPs provide individualized assistance and help refer Medicare fraud, abuse, errors, and misleading marketing to the proper authorities. Contact information for your SMP is on the last page of this document.

The Social Security Administration: If you are enrolling in Medicare Part A and/or Part B for the first time, you need to do so through the Social Security Administration (SSA). You can reach the SSA by visiting your local office or calling the SSA helpline at 1-800-772-1213. SSA can also provide information about:

- Extra Help, a federal program that helps people save money on prescription drugs
- Your Medicare Parts A and B enrollment history
- Your Part B late enrollment penalty, if you have one
- Employment programs for people receiving Medicare due to disability

1-800-MEDICARE: Medicare can provide you information about enrollment and coverage rules in general, and about your own Medicare enrollment and claims information. Call Medicare for information about:

- Your current enrollment and enrollment history in Medicare Advantage or Part D prescription drug plans
- Costs and coverage of items and services covered under Original Medicare

- Claims that have been submitted to Medicare for your care, and to get a copy of your Medicare Summary Notice (MSN).
- To make a complaint about a Medicare private plan (see number 2) or a durable medical equipment supplier (see number 5)
- How to have your question or concern sent to the Medicare beneficiary ombudsman, if your question or concern is not resolved by speaking to a 1-800-MEDICARE representative.

Your local department of social services (LDSS): If you need help finding out if you qualify for Medicaid or would like to apply, call your LDSS to learn about eligibility and to apply.

Long-term care ombudsman: Each state has an ombudsman to assist residents of that state with finding and affording quality long-term care. The long-term care ombudsman also responds to complaints about long-term care facilities. You can find your ombudsman by visiting www.ltcombudsman.org.

Health insurance Marketplace: If you are not eligible for Medicare and need to enroll in health insurance through the Marketplace, you can get more information and enroll by visiting https://www.healthcare.gov/.

SHIP case study
Donnie recently had a hospital stay that was covered by his Medicare Advantage Plan. He felt that there were some problems with the quality of care that he received—he didn't think that the hospital staff checked on him often enough, and he thinks that this might have gotten in the way of his recovery. He already reported the hospital to his state's department of health, but wants to know if there are other steps he can take to hold the hospital accountable.

What should Donnie do?
- Donnie should call his State Health Insurance Assistance Program (SHIP) for advice about this situation.
    - If Donnie does not know how to reach his SHIP, he can call 877-839-2675 or visit www.shiptacenter.org.
- The SHIP counselor can tell Donnie that for a complaint related to quality of care received from a Medicare Advantage provider, he can report his concern to his plan, to the BFCC-QIO, or to both.
    - If Donnie wishes to file a grievance with his plan, the SHIP counselor can help Donnie write a brief complaint and can direct him to call his plan to find out where to send the grievance. The plan should respond to the grievance within 30 days.
        - The SHIP counselor can also tell Donnie that if his plan does not respond to this grievance in a timely fashion, he can call 1-800-MEDICARE to file a complaint.
    - If Donnie wishes to file a quality of care complaint with the BFCC-QIO, the SHIP counselor can help Donnie determine whether his BFCC-QIO is Livanta or KEPRO, and can help him find information about where to call or send a written complaint to.
        - The QIO will contact Donnie for more information about his complaint. He should be prepared to provide information about why he is complaining and about how the QIO can contact the hospital.

SMP case study

Esther got an Explanation of Benefits (EOB) from her Medicare Advantage Plan showing that a doctor submitted claims to her plan for services she received last month. She is confused, because she only saw the provider once, but the EOB lists three different dates of service. She is concerned that this incorrect information might get in the way of her plan covering services that she needs in the future.

What should Esther do?

- Esther can call her Senior Medicare Patrol (SMP) for advice about what to do next.
  - If Esther doesn't know how to reach her SMP, she can call 877-808-2468 or visit www.smpresource.org
- The SMP will tell Esther that she should contact her provider to let them know about the mistake that she found on her EOB and to ask them to clarify or correct it.
- If Esther's provider is unresponsive or unwilling to correct the error, Esther may want to report this incident as possible Medicare fraud. The SMP can help Esther report it to the proper authorities.
- The SMP can remind Esther to continue keeping track of her health care appointments and checking her Medicare statements and medical bills against a calendar of those appointments. If Esther suspects fraud, abuse, or errors on the part of her providers, she can call the SMP again.

Local SHIP Contact Information	Local SMP Contact Information
SHIP toll-free: **SHIP email:** **SHIP website:** **To find a SHIP in another state:** Call 877-839-2675 or visit www.shiptacenter.org.	**SMP toll-free:** **SMP email:** **SMP website:** **To find an SMP in another state:** Call 877-808-2468 or visit www.smpresource.org.

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