SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on two things:

1. Whether your problem is about benefits covered by Medicare or Medi-Cal (Medicaid). If you would like help deciding whether to use the Medicare process or the Medi-Cal (Medicaid) process, or both, please contact Member Services. (Telephone numbers are on the back cover of this booklet.)

2. The type of problem you are having:
   o For some types of problems, you need to use the process for coverage decisions and making appeals.
   o For other types of problems, you need to use the process for making complaints.

These processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” or “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.
SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your State Health Insurance Assistance Program (SHIP). This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (http://www.medicare.gov).

You can get help and information from Medi-Cal (Medicaid)

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<tr>
<th>Your County</th>
<th>Agency Name</th>
<th>Call</th>
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<tbody>
<tr>
<td>Los Angeles County</td>
<td>Department of Public Social</td>
<td>(877) 597-4777</td>
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<td>Services</td>
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Source: Care1st TotalDual Plan (HMO SNP) Evidence of Coverage  
Chapter 9, Sections 1, 2, 3 and 11
SECTION 3  To deal with your problem, which process should you use?

Section 3.1 Should you use the process for Medicare benefits or Medi-Cal (Medicaid) benefits?

Because you have Medicare and get assistance from Medi-Cal (Medicaid), you have different processes that you can use to handle your problem or complaint. Which process you use depends on whether the problem is about Medicare benefits or Medi-Cal (Medicaid) benefits. If your problem is about a benefit covered by Medicare, then you should use the Medicare process. If your problem is about a benefit covered by Medi-Cal (Medicaid), then you should use the Medi-Cal (Medicaid) process. If you would like help deciding whether to use the Medicare process or the Medi-Cal (Medicaid) process, please contact Member Services. (Telephone numbers are on the back cover of this booklet.)

Source:  Care1st TotalDual Plan (HMO SNP) Evidence of Coverage
Chapter 9, Sections 1, 2, 3 and 11
The Medicare process and Medi-Cal (Medicaid) process are described in different parts of this chapter. To find out which part you should read, use the chart below.

<table>
<thead>
<tr>
<th>Is your problem about Medicare benefits or Medi-Cal (Medicaid) benefits?</th>
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<tr>
<td>(If you would like help deciding whether your problem is about Medicare benefits or Medi-Cal (Medicaid) benefits, please contact Member Services.)</td>
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<tr>
<td><strong>My problem is about Medicare benefits.</strong> Go to the next section of this chapter, <a href="#">Section 4, “Handling problems about Medicare your benefits.”</a></td>
<td><strong>My problem is about Medi-Cal (Medicaid) benefits.</strong> Skip ahead to <a href="#">Section 12 of this chapter</a>, “Handling problems about your Medi-Cal (Medicaid) benefits.”</td>
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Source: Care1st TotalDual Plan (HMO SNP) Evidence of Coverage
Chapter 9, Sections 1, 2, 3 and 11
SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 5 of this chapter.

Section 11.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.
If you have any of these kinds of problems, you can “make a complaint”

**Quality of your medical care**
- Are you unhappy with the quality of the care you have received (including care in the hospital)?

**Respecting your privacy**
- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

**Disrespect, poor customer service, or other negative behaviors**
- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services has treated you?
- Do you feel you are being encouraged to leave the plan?

**Waiting times**
- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan?
  - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

**Cleanliness**
- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?

**Information you get from us**
- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

*The next page has more examples of possible reasons for making a complaint*
Possible complaints
(continued)

These types of complaints are all related to the **timeliness** of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-10 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a “fast response” for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

**Section 11.2** The formal name for “making a complaint” is “filing a grievance”

**Legal Terms**
- What this section calls a “complaint” is also called a “grievance.”
- Another term for “making a complaint” is “filing a grievance.”
- Another way to say “using the process for complaints” is “using the process for filing a grievance.”

Source: Care1st TotalDual Plan (HMO SNP) Evidence of Coverage
Chapter 9, Sections 1, 2, 3 and 11
Section 11.3  Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- Usually, calling Member Services is the first step. If there is anything else you need to do, Member Services will let you know. You can call Member Services at 1-800-544-0088 (TTY users should call 1-800-735-2929) from 8:00 p.m., seven days a week.

- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.

  **Mail your written grievance to:**
  Care1st Health Plan
  Member Services
  601 Potrero Grande Drive, Second Floor
  Monterey Park, CA 91755

  You may also fax it to us at 1-323-889-2105

  Or you may deliver it to Care1st Health Plan
  Member Services
  601 Potrero Grande Dr., Second Floor
  Monterey Park, CA 91755

  We will acknowledge receipt of your written grievance within five days of receiving it. We will conduct a review of your issues. We may request your medical records as part of our review. We will mail you a response to your complaint within thirty days of receiving your complaint. We must address your grievance as quickly as your case requires based on your health status, but no later than thirty days after receiving your complaint. We may extend the time frame by up to fourteen days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

  You may request an expedited grievance if you disagree with our decision to not conduct an expedited organization/coverage determination, as well as an expedited reconsideration/redetermination. We must resolve your expedited grievance within 24 hours.
**Step 2: We look into your complaint and give you our answer.**

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.

- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

### Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about **quality of care**, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4,
of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.