- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

SECTION 10 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 4 of this chapter.

Section 10.1 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"

Complaint	Example
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? o 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?

Complaint	Example
Timeliness (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 4-9 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 coverage decision" or a "fast 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 10.2 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."**

Section 10.3 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. Please call Member Services at **1-877-299-9062 (TTY users, call 711).** Member Services is available from 7 a.m. to 8 p.m. Pacific Time, seven days a week from October 1 to February 14. (After February 15 your call will be handled by our automated phone system Saturdays, Sundays and holidays. When leaving a message, please include your name, number and the time that you called, and a Member Services representative will return your call the next business day.)

- **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.

- **You, the member, your authorized representative, your legal representative or any other provider may file a complaint.** You must make a complaint within 60 calendar days from the date of the event or incident that caused you to make a complaint. If you miss the deadline, you may still make a complaint and request an extension of the time frame. Your request must be in writing and include the reason you did not make a complaint on time.

  - You can **mail** your complaint to:
    Moda Health Plan, Inc.
    Attn: Medicare Appeal and Grievance Unit
    P.O. Box 40384
    Portland OR, 97240-0384

    Or **fax** your complaint to:
    503-412-4003
    Attn: Medicare Appeal and Grievance Unit

    You may also make your complaint **in person** at:
    Moda Health Plan, Inc.
    601 SW Second Ave.
    Suite 700
    Portland OR, 97204

  - If you **call** Member Services at 1-877-299-9062, (TTY users call 711), from 7 a.m. to 8 p.m. Pacific Time, Monday through Friday, they will record the complaint and repeat back to you the complaint as written, to confirm the accuracy. The complaint will be noted with the time and the date. If you mail, fax or deliver your complaint, the received date will be noted on your letter.

- If your complaint was filed orally, we will send an acknowledgement letter to you confirming that we received your complaint. You may be asked to provide additional information, which will be requested in the letter, before we can make a decision. We have 30 calendar days starting from the date the complaint was received to make a decision on your complaint. Sometimes we may need more time to make a decision on your complaint. If we need more time, you will receive a letter requesting the extra time and telling you why we need more time to make a decision. When we have made a decision, you will receive a letter explaining our decision. If you don't agree with our decision and your complaint is about quality of care, the letter will include your right to file a quality of care grievance with the Quality Improvement Organization (QIO) in Oregon. To find the name, address and phone number of the QIO for Oregon, look in Chapter 2, Section 4 of this booklet.

- We must address your complaint as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we find a need for additional information and the delay is in your best interest.

- If we turn down your request for a "fast" coverage determination, a "fast" organization determination, a "fast" redetermination or a "fast" appeal and you have not yet received the drug or service, or if we extend the time frame for a "fast" coverage determination, a "fast" organization determination, a "fast" redetermination or a "fast" appeal when you have not yet received the drug or service, you have the right to file a "fast" complaint. Indicate clearly on your request you would like a **"FAST COMPLAINT REQUEST"**. You may file a "fast" complaint by **phone (call 1-866-796-3221), fax, or in person as listed above**. We will respond to your "fast" complaint in writing within 24 hours of receipt of your "fast" complaint.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.

- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint."** If you have a "fast complaint," it means we will give you **an answer within 24 hours**.

Legal Terms
What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

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 decide to take extra days, we will tell you in writing.
- **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 10.4 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.

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about Moda Health HMO directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.