CALIFORNIA HEALTH ADVOCATES

Medicare Advantage: If You Have Problems with Your Medicare Advantage Plan

Medicare Advantage (MA) plans are Medicare-approved health plans offered by private insurance companies. Just as Medicare beneficiaries in the Original Medicare program have the right to file appeals and grievances, Medicare beneficiaries enrolled in MA plans have the same rights. Each MA plan is required to include information about these complaint processes in its membership materials. They must also have this information available online for every plan member. Enrollees can also request printed copies. This fact sheet outlines the steps to take to file an appeal or grievance. It also includes a table outlining the time frames for each step of the appeals process. For more information about Medicare Advantage Plans, see our online Medicare Topics section on Medicare Advantage at cahealthadvocates.org.

Appeal or Grievance

As an enrollee, you have the right to file a complaint if you have problems with your MA plan. You can also appoint someone else – a family member, friend, caregiver or doctor – to be your representative in a complaint. The appointment must be in writing, signed and dated. You may use the Appointment of Representative form at cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.

There are 2 kinds of complaints: appeals and grievances. You can file an appeal if your MA plan decides not to provide or pay for a service or item that you think it should provide or pay for. Two examples of such situations:

- If your MA plan refuses or fails to give you treatment in a timely manner that you feel should be covered by the plan.
- If your MA plan discontinues services you believe are still medically necessary.

A grievance is a complaint about a plan's operations, activities, or behavior of its employees or providers. Examples of such situations:

- If getting an appointment is difficult, or if you have to wait a long time for one to be scheduled.
- If a plan's provider or employee is rude to you or treats you disrespectfully.
- If you are involuntarily disenrolled even though you have been paying the monthly premiums on time.

MA plans are required to have written procedures in place that inform all plan members about the grievance process, including specific time frames for each step and instructions for how to file a grievance. Grievances must be transmitted in a timely manner to the appropriate decision-making levels within the MA plan. The plan must also promptly take appropriate action, including a full investigation, if necessary. The person filing the complaint must be notified in writing of the investigation's results, if the grievance is related to quality of care issues.

Note: In addition to filing appeals or grievances, if the quality of care for a Medicare-covered service is in question, you can also complain to your QIO (Quality Improvement Organization), which in California is Livanta. To reach Livanta about a quality of care issue, call 1-877-588-1123 or 1-855-887-6668 (TDD for the hearing impaired).

Five Levels of Appeal

Organization Determination. If you ask your MA plan to provide or pay for a service or item that you think should be covered or continued,

the plan's response or decision is called an organization determination. If the plan decides not to cover or continue a service or item, it must tell you in writing the reason(s) for the denial, and how to appeal the organization determination.

1. Request for Reconsideration. If your MA plan denies all or part of your request to provide or pay for a service or item, you can request a reconsideration. A plan may, upon reconsideration, change its decision and provide the item or service. But if the plan still decides not to provide or pay for the item or service, it automatically sends your appeal for external review by MAXIMUS Federal Services. At this point, the plan is not required to notify you that is forwarding the appeal to Maximus. However, Maximus does notify you when it receives your forwarded case.

Note: If your MA plan dismisses your request, it will not automatically send your appeal for external review. A dismissal is not a denial since the plan does not review the substance of the appeal. A plan can dismiss an appeal for procedural reasons, such as an appeal was not filed timely, or the representative was not properly authorized, or the plan does not have jurisdiction. If your plan dismisses your request, it must notify you in writing and explain your right to request an external review of the dismissal within 60 days of the dismissal notice.

2. External Review by Independent Review Entity. The Centers for Medicare and Medicaid Services (CMS) contracts with MAXIMUS Federal Services (medicareappeal.com) to be the national Independent Review Entity (IRE) that reviews denials from MA plans.

If MAXIMUS disagrees with the MA plan, MAXIMUS will send a letter to you and the plan about its decision and tell the plan to provide or pay for the service or item.

If MAXIMUS agrees with the MA plan, MAXIMUS will send you a letter about its decision and information about the next level of appeal.

3. Administrative Law Judge (ALJ). If you want to appeal MAXIMUS' decision, the amount in controversy must be $180 or more (in 2023) for a hearing with an ALJ. After hearing your case, the ALJ will send a written decision to you, the MA plan, and MAXIMUS. If the ALJ rules in your favor, MAXIMUS will send a letter to your MA plan telling the plan to provide or pay for the service or item. The MA plan can appeal this decision by asking for a review by the Medicare Appeals Council, the next level of appeal.

Or, if the ALJ agrees with the MA plan, you can request a review by the Medicare Appeals Council. Information about where to send the request should be in the ALJ's decision notice. ALJ hearings are usually held by video teleconference or over the telephone, as there are only 4 offices nationwide for in-person hearings. If you can show "good cause," a request for an in-person hearing may be granted at the ALJ's discretion.

4. Medicare Appeals Council. The Medicare Appeals Council does not review every case it receives. If the Council decides not to review your case, you or the plan may ask for a review by a Federal court. If the Medicare Appeals Council reviews your case and agrees with the MA plan, you may ask for a Federal court review if the amount in controversy is $1,850 or more in 2023.

5. Federal Court. To appeal a Medicare Appeals Council's decision, you may file a lawsuit in Federal district court if the amount in controversy is $1,850 or more in 2023. This is the last level of appeal.

Note: You should seek legal advice before appealing to an ALJ, Medicare Appeals Council, or Federal court. Your local HICAP office can generally refer you to local legal assistance programs.

Expedited Appeals

Many medical conditions require immediate attention when a service has been denied or terminated. If you believe that waiting for a decision from the plan within the standard 14-day period would put your life, health or ability to regain maximum function in serious jeopardy, you may file an expedited appeal.

If your doctor requests an Expedited Appeal, the MA plan must review the case within 72 hours. This doctor does not need to be your assigned doctor (primary care physician), nor does the doctor need to be a member of your MA plan's network.

However, if you or your representative (and not a doctor) requests an Expedited Appeal, the MA plan can choose to grant your request for an expedited appeal and decide the appeal within 72 hours, or deny your request for an expedited appeal and process the appeal within the standard 14-day period.

Note: You may also file a grievance if the plan denies your request for an Expedited Appeal. You may file a grievance at any time. The grievance process addresses complaints outside of the formal appeals process.

Fast Track Appeals

You have the right to request a fast track appeal by contacting California's Quality Improvement Organization (QIO), Livanta, in the following situations:

- You are being discharged from the hospital but you are not medically ready to leave, or you have not received clear discharge instructions; or
- You are receiving care from a skilled nursing facility, home health agency, hospice or comprehensive outpatient rehabilitation facility and receive notice that those services will end soon but you need those services to continue.

Call Livanta at 1-877-588-1123 or 1-855-887-6668 (TDD for the hearing impaired); https://livantaqio.com/en/states/california.

Medicare Advantage Appeals Timetable

Organization Determination – If you request a service or item to be covered or continued, the plan must notify you of its determination as expeditiously as your health condition requires, but no later than the time period required depending on whether it is a standard or expedited request.

Standard – If the plan decides not to cover or continue the requested service or item, the plan must notify you in writing within 14 days of receiving your request. In the notice, the plan must state the reason(s) for the denial and how to appeal the decision. If the plan doesn't cover a requested Part B drug, they must notify you within 72-hours.	**Fast decision** – The plan must notify you of its decision within 72 hours if it determines that your health or life could be seriously harmed by waiting for a decision in the standard 14-day period. For Part B-covered drugs, the plan must notify you within 24 hours.

1. Reconsideration by the Plan – You have 60 days from the date of notice of the organization determination to request a reconsideration by the plan. This is the 1st level of appeal.

Standard – For a *service* request, the plan has 30 days from the receipt of the request for reconsideration to notify you of its decision.	**Expedited request** – The plan has 72 hours from the receipt of the request for reconsideration to notify you of its decision.

For a *payment* request, the plan has 60 days from the receipt of the request for reconsideration to notify you of its decision. For a *Part B-covered drug* request, the plan has 7 days to notify you of its decision.	For Part B-covered drugs, the plan has 72 hours from the receipt of the request for reconsideration to notify you of its decision.

If upon reconsideration the plan does not change its decision, it automatically sends your case file to an Independent Review Entity.

2. Review by MAXIMUS Federal Services (Independent Review Entity). This is the 2nd level of appeal. MAXIMUS will notify you in writing when it has your case file. You have the right to send MAXIMUS information about your case. If you decide to send MAXIMUS information, they must receive it within 10 days after the date you receive MAXIMUS' notice that they have your case file.

Standard – For a *service* request, MAXIMUS has 30 days to notify you of its decision. For a *payment* request, MAXIMUS has 60 days to notify you of its decision. For a *Part B-covered drug* request, the plan has 7 days to notify you of its decision.	**Expedited request** – MAXIMUS has 72 hours to notify you of its decision. For Part B-covered drugs, MAXIMUS has72 hours to notify you of its decision.

MAXIMUS must send a written decision to you and the plan. If MAXIMUS agrees with the plan, the decision letter from MAXIMUS should include instructions about the next level of appeal.

3. Administrative Law Judge (ALJ) – You have 60 days from the date of MAXIMUS' decision letter to request a hearing with an ALJ if the amount in controversy is $180 or more. This is the 3rd level of appeal.

The ALJ office will schedule a hearing and inform you of the time and place of the hearing. (Most hearings are held by video teleconference or phone). The ALJ will make a decision based on your case file and information presented at the hearing. The ALJ must send a written decision to you, the plan and MAXIMUS.

If the ALJ agrees with the plan, you may request a review by the Medicare Appeals Council. If the ALJ disagrees with the plan, the plan may request a review at the next level.

4. Medicare Appeals Council – You have 60 days from the date of the ALJ's written decision to request a review by the Medicare Appeals Council. This is the 4th level of appeal.

The Medicare Appeals Council does not review every case it receives. If it decides not to review a case, or if it does review your case and decides against you, you may ask for a review at the next level.

5. Federal Court – You have 60 days from the date of the Medicare Appeals Council's written decision to request a review by a Federal court if the amount in controversy is $1,850 or more. This is the 5th and last level of appeal.

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This fact sheet contains general information and should not be relied upon to make individual decisions. If you would like to discuss your specific situation, call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides free and objective information and counseling on Medicare and can help you understand your specific rights and health care options. You can call **1-800-434-0222** to make an appointment at the HICAP office nearest you.

Note: Online access to all CHA fact sheets on Medicare and related topics is available for an annual subscription. See cahealthadvocates.org/fact-sheets/.