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Participant Grievance and Appeals Process: Chapter 8

All of us at AltaMed PACE share responsibility for your care and your satisfaction with the services you receive. Our grievance procedures are designed to enable you or your representative to express any concerns or dissatisfaction you have so that we can address them in a timely and efficient manner. You also have the right to appeal any decision about our failure to approve, furnish, arrange for or continue what you believe are covered services or to pay for services that you believe we are required to pay.

The information in this Chapter describes our grievance and appeals processes. You will receive written information of the grievance and appeals processes when you enroll and annually after that. Any time you wish to file a grievance or an appeal, we are available to assist you. If you do not speak English, a bilingual staff member or translation services will be available to assist you.

You will not be discriminated against because a grievance or appeal has been filed. AltaMed PACE will continue to provide you with all the required services during the grievance or appeals process. The confidentiality of your grievance or appeal will be maintained throughout the grievance or appeal process and information pertaining to your grievance or appeal will only be released to authorized individuals.

Grievance Procedure

Definition: A grievance is defined as a complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of Participant care. A grievance may include, but is not limited to:

- The quality of services an AltaMed PACE Participant receives in

the home, at the AltaMed PACE Center or in an inpatient stay (hospital,

- rehabilitative facility, skilled nursing facility, intermediate care facility or residential care facility);
- Waiting times on the telephone, in the waiting room or exam room;
- Behavior of any of the care providers or program staff;
- Adequacy of center facilities;
- Quality of the food provided;
- Transportation services; or
- A violation of a Participant's rights.

How to File a Grievance

The information below describes the grievance process for you or your representative to follow should you or your representative wish to file a grievance.

1. You can verbally discuss your grievance either in person or by telephone with AltaMed PACE Program staff, a Senior Care Advocate, your assigned Social Worker, or the Center Manager of the center you attend. The staff person will make sure that you are provided with written information on the grievance process and that your grievance is documented on the Grievance Report Form. You will need to provide complete information of your grievance so the appropriate staff person can help to resolve your grievance in a timely and efficient manner. If you wish to submit your grievance in writing, please send your written grievance to the address listed on the front page of this booklet.

2. You may also contact our AltaMed PACE Senior Care Advocate or Social Worker directly to receive assistance in filing a grievance. For

the hearing impaired (TTY/ TDD), please call (800) 735-2922. Our AltaMed PACE Senior Care Advocate or Social Worker will provide you written information on the grievance process.

3. The staff person who receives your grievance will help you document your grievance (if your grievance is not already documented) and coordinate investigation and action. All information related to your grievance will be held in strict confidence and will not be disclosed to program staff or contract providers, except where appropriate to process the grievance. No reference that you have elected to file a grievance with AltaMed PACE will appear in your medical record.

4. You will be sent a written acknowledgement of receipt of your grievance within five (5) calendar days. Where necessary, the AltaMed PACE Senior Care Advocate will acknowledge your grievance by telephone and will clarify information provided on the Grievance Report Form or will obtain and document additional facts related to your grievance. Investigation of your grievance will begin immediately to find solutions and take appropriate action.

5. The AltaMed PACE staff will make every attempt to resolve your grievance within thirty (30) calendar days of receipt of your grievance. If you are not satisfied with that resolution, you and/or your representative have the right to pursue further action.

6. In the event resolution is not reached within thirty (30) calendar days, you or your representative will be notified in writing of the status and estimated completion date of the grievance solution.

Expedited Review of Grievances

If you feel your grievance involves a serious or imminent threat to your

health, including, but not limited to potential loss of life, limb or major bodily function, severe pain or violation of your Participant rights, we will expedite the review process to a decision within seventy-two (72) hours of receiving your written grievance and request for expedited review. In this case, you will be immediately informed by telephone of the receipt of your request for expedited review.

Resolution of Grievances

7. Upon AltaMed PACE's completion of the investigation and reaching a final resolution of your grievance, you will receive written notification that will provide you with a report describing the reason for your grievance, a summary of actions taken to resolve your grievance, and options to pursue if you are not satisfied with the resolution of your grievance.

Grievance Review Options

If after completing the grievance process or after participating in the process for at least thirty (30) calendar days, you or your representative are still dissatisfied, you or your representative may pursue a second level review through the AltaMed Corporate Leadership Team. Please Note: If you feel that waiting thirty (30) calendar days represents a serious health threat, you and/or your representative need not complete the entire grievance process nor wait thirty (30) calendar days to pursue the options described below.

1. Participant and/or his/her representative may request a second level review from the AltaMed PACE Corporate Leadership Team, which may include the Social Work Functional Manager, an AltaMed PACE VP, Medical Director, or others as assigned.

2. The second level review team will analyze the information provided

to assess whether the initial grievance was addressed effectively and to determine whether all options and alternatives have been explored. The second level review team will return a final decision in writing within ten (10) business days.

AltaMed PACE's Internal Procedures

AltaMed PACE will assure that every grievance is handled in a uniform manner and that there is communication among the different individuals who are responsible for reviewing or resolving grievances. In addition, AltaMed PACE will maintain appropriate documentation, so the information can be utilized in AltaMed PACE's Quality Improvement Plan. This process ensures that all Participant concerns are addressed and resolved.

Appeals Process

Definition: An appeal is a Participant's action taken with respect to the PACE organization's **non-coverage of, or nonpayment for, a service,** including denials, reductions or termination of services.

When AltaMed PACE decides not to cover or pay for a service you want, you may take action to change our decision. The action you take — whether verbally or in writing is called an "appeal." You have the right to appeal any decision about our failure to approve, furnish, arrange for or continue what you believe are covered services or to pay for services that you believe we are required to pay.

You will receive written information on the appeals process when you enroll and annually after that. You will also receive this information and necessary appeals forms whenever AltaMed PACE denies, defers or modifies a request for a service or request for payment.

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Standard and Expedited Appeals Processes: There are two (2) types of appeals processes: standard and expedited. Both of these processes are described below.

If you request a **standard appeal**, your appeal must be filed within one-hundred-and eighty (180) calendar days of when your request for service or payment of service was denied, deferred or modified. This is the date which appears on the Notice of Action for Service or Payment Request. (The 180-day limit may be extended for good cause.) We will respond to your appeal as quickly as your health requires, but no later than thirty (30) calendar days after we receive your appeal.

If you believe that your life, health or ability to get well is in danger without the service you want, you or any treating physician may ask for an expedited appeal. If the treating physician asks for an expedited appeal for you, or supports you in asking for one, we will automatically make a decision on your appeal as promptly as your health requires, but no later than seventy-two (72) hours after we receive your request for an appeal. We may extend this time frame up to fourteen (14) days if you ask for the extension or if we justify to the Department of Health Care Services the need for more information and how the delay benefits you.

If you ask for an **expedited appeal** without support from a treating physician, we will decide if your health condition requires us to make a decision on an expedited basis. If we decide to deny you an **expedited appeal**, we will let you know within seventy-two (72) hours. If this happens, your appeal will be considered a standard appeal.

Please Note: AltaMed PACE will continue to provide the disputed service(s) if you choose to continue receiving the service(s) until the appeals process is completed. If our initial decision to NOT cover or reduce services is upheld, you may be financially responsible for the

payment of disputed service(s) provided during the appeals process.

The information below describes the appeals process for you or your representative to follow should you or your representative wish to file an appeal:

1. If you or your representative has requested a service or payment for a service and AltaMed PACE denies, defers or modifies the request, you may appeal the decision. A written "Notice of Action of Service or Payment Request" (NOA) will be provided to you and/or your representative which will explain the reason for the denial, deferral or modification of your service request or request for payment.

2. You can make your appeal either verbally, in person or by telephone, or in writing with AltaMed PACE Program staff of the center you attend. The staff person will make sure that you are provided with written information on the appeals process, and that your appeal is documented appropriately. You will need to provide complete information of your appeal so the appropriate staff person can help to resolve your appeal in a timely and efficient manner. You or your representative may present or submit relevant facts and/or evidence for review, either in person or in writing to your assigned AltaMed PACE center. If more information is needed, you will be contacted by the Senior Care Advocate or Social Worker who will assist you in obtaining the missing information.

3. If you wish to make your appeal by telephone, you may contact our Senor Care Advocate or Social Worker at the number designated on the front page of this Handbook, Monday through Friday from 8:00 AM to 5:00 PM, to receive assistance in filing an appeal. For the hearing impaired (TTY/TDD), please call 1(800) 735-2922.

4. If you wish to submit your appeal in writing, please ask a staff person for an appeal form. Please send your written appeal to the Social Work Supervisor at your assigned AltaMed PACE center.

5. You will be sent a written acknowledgement of receipt of your appeal within five (5) calendar days for a standard appeal. For an expedited appeal, we will notify you or your representative within one (1) business day by telephone or in person that the request for an expedited appeal has been received.

6. The reconsideration of AltaMed PACE's decision will be made by a person(s) not involved in the initial decision-making process in consultation with the Interdisciplinary Team. We will ensure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services you requested.

7. Upon AltaMed PACE's completion of the review of your appeal, you or your representative will be notified in writing of the decision on your appeal. As necessary, and depending on the outcome of the decision, AltaMed PACE will inform you and/ or your representative of other appeal rights you may have if the decision is not in your favor. Please refer to the information described below:

The Decision on Your Appeal

If we decide fully in your favor on a **standard appeal** for a request for service, we are required to provide or arrange for services as quickly as your health condition requires, but no later than thirty (30) calendar days from when we received your request for an appeal. *If we decide fully in your favor on a request for payment*, we are required to make the requested payment within sixty (60) calendar days after receiving your request for an appeal.

*If we do not decide fully in your favor on a **standard appeal*** or if we fail to provide you with a decision within thirty (30) calendar days, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (see Additional Appeal Rights, below). We also are required to notify you as soon as we make a decision and also to notify the federal Centers for Medicare and Medicaid Services and the Long-Term Care Division, DHCS. We will inform you in writing of your **external appeal** rights under the Medicare or Medi-Cal Program, or both. We will help you choose which to pursue if both are applicable.

We also will send your appeal to the appropriate external program for review.

*If we decide fully in your favor on an **expedited appeal***, we are required to obtain the service or provide you the service as quickly as your health condition requires, but no later than seventy-two (72) hours after we received your request for an **appeal**.

If we do not decide fully in your favor on an expedited appeal or fail to notify you within seventy-two (72) hours, you have the right to pursue an external appeal process under either Medicare or Medicaid **(see Additional Appeal Rights)**. We are required to notify you as soon as we make a decision that is not fully in your favor and also to notify the Centers for Medicare and Medicaid Services and the Long-Term Care Division, DHCS. We will let you know in writing of your **external appeal** rights through the Medicare or Medi-Cal Program, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

Additional Appeal Rights under Medi-Cal and Medicare

If we do not decide in your favor on your appeal or fail to provide you a decision within the required timeframe, you have additional appeal

rights. Your request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program.

The Medicare program contracts with an "Independent Review Organization" to provide external review on appeals involving PACE programs. This review organization is completely independent of our AltaMed PACE organization.

The **Medi-Cal program** conducts their next level of appeal through the State hearing process. If you are enrolled in Medi-Cal, you can appeal if AltaMed PACE wants to reduce or stop a service you are receiving. Until you receive a final decision, you may choose to continue to receive the disputed service. However, you may have to pay for the service(s) if the final decision is not in your favor.

If you are enrolled in both **Medicare and Medi-Cal**, we will help you choose which appeals process you should follow. We also will send your appeal to the appropriate external program for review.

If you are not sure which program you are enrolled in, ask us. The Medicare and Medi- Cal external appeal processes are described below.

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Medi-Cal External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medi-Cal only**, and choose to appeal our decision using Medi-Cal's external appeals process, we will send your appeal to the California Department of Social Services. At any time during the appeals process, you may request a State hearing through:

California Department of Social Services State Hearings Division

P.O. Box 944243, Mail Station 19-37

Sacramento, CA 94244-2430

Telephone: 1-800-743-8525

Fax: (916) 651-2789

TTY: 1-800-952-8349

If you choose to request a State hearing, you must ask for it within ninety (90) days from the date of receiving the Notice of Action (NOA) for Service or Payment Request from AltaMed PACE.

You may speak at the State hearing or have someone else speak on your behalf such as someone you know, including a relative, friend or attorney. You may also be able to get free legal help. We will provide you with a list of Legal Services offices in Los Angeles County and Orange County at the time that we deny, modify or defer a service or payment of a service, if you would like legal services assistance.

If the Administrative Law Judge's (ALJ) decision is in your favor of your appeal, AltaMed PACE will follow the judge's instruction as to the timeframe for providing you with services you requested or payment for services for a standard or expedited appeal.

If the ALJ's decision is not in your favor of your appeal, for either a

standard or an expedited appeal, there are further levels of appeal, and we will assist you in pursuing your appeal.

Medicare External Appeals Process

If you are **enrolled in both Medicare and Medi-Cal OR Medicare only**, and choose to appeal our decision using Medicare's external appeals process, we will send your appeal to Medicare's Independent Review Organization for you. Medicare currently contracts with MAXIMUS to impartially review appeals. MAXIMUS will contact us with the results of their review. MAXIMUS will either maintain our original decision or change our decision and rule in your favor. You may request a hearing through:

MAXIMUS Federal Services
Medicare Managed Care & PACE Reconsideration
Project 3750 Monroe Avenue, Suite 702
Pittsford, NY 14534-1302
Telephone: (585) 348-3300

Expedited and Standard Appeals Process

You can request an expedited external appeal if you believe your health would be jeopardized by not receiving a specific service. In an expedited external review, we will send your appeal to MAXIMUS as quickly as your health requires. MAXIMUS must give us a decision within seventy-two (72) hours after they receive the appeal from us. MAXIMUS may ask for more time to review the appeal, but they must give us their decision within fourteen (14) calendar days.

You can request a standard external appeal if we deny your request for non-urgent services or do not pay for a service. For a standard external appeal, you will receive a decision on your appeal no later than thirty (30) calendar days after you request the appeal.

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If MAXIMUS's decision is in your favor for a standard appeal, the action will be as follows:

If you have requested a service that you have not received, we will provide you with the service you asked for as quickly as your health condition requires; -OR-

If you have requested payment for a service that you have already received, we will pay for the service within sixty (60) calendar days for either a standard or expedited.

If MAXIMUS's decision is not in your favor for either a standard or expedited appeal, there are further levels of appeal, and we will assist you in pursuing your appeal.