AltaMed PACE
A community of caring for more than 25 years

CHAPTER 8
PARTICIPANT GRIEVANCE AND APPEALS PROCESS

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 to deny, reduce, or stop 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. Any time you wish to make a grievance or file 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 never be discriminated or retaliated against, nor be made to be afraid of discrimination or retaliation, because you have made a grievance or filed an appeal. {AltaMed PACE} will continue to provide you with all of your 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

A grievance is a complaint, made either in writing or verbally, expressing dissatisfaction with the delivery of your services or the quality of your care regardless of whether you are requesting any action be taken as a result. Grievances may be between you and AltaMed PACE, or between you and one of your other service providers through the PACE program. You will receive written information of the grievance process when you enroll and at least annually thereafter. A grievance may include, but is not limited to:

- The quality of services you receive in your home, at the PACE center or in an inpatient stay (hospital, rehabilitative facility, skilled nursing facility, intermediate care facility or residential care facility);
- Care provided by a specialist or other contract provider or other care provider (including personal care aides) **20**
- 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;
- A violation of your rights; and
- Discrimination by any PACE center staff, contracted providers, and/or contracted provider staff
- Failure to provide trans-gender inclusive healthcare **20**

Submission of Grievances

A grievance can be made by you, your family member or caregiver, or your designated representative. The information below describes the grievance submission process.

1. You can verbally discuss your grievance either in person or by telephone with PACE program staff of the center you attend, or with any AltaMed PACE contracted provider, including your driver, and the providers who care for you in your home. If you discuss your grievance with a contracted provider, they will let an AltaMed PACE staff person know the details of your complaint. The staff person will make sure that your grievance is documented. You will need to provide complete information of your grievance so the appropriate staff person can respond and 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:
   Center Manager, Your Designated PACE Center Address.

   While not required, you may request a Grievance Report form

to use when submitting a written grievance.

You may also contact our Senior Care Advocate/PACE Social Worker at designated PACE Center phone number to receive assistance in filing a grievance. For the hearing impaired (TTY/TDD), please call 800-735-2922. Our Senior Care Advocate/PACE Social Worker will assist you with your grievance submission.

2. The staff member who receives your grievance will coordinate the investigation when the cause of your issue not already known, and an investigation of your grievance will be conducted to find solutions and take appropriate action. All information related to your grievance will be kept strictly confidential, including from other AltaMed PACE staff and contracted providers when appropriate. Please note, if you do not wish to be notified of the grievance resolution, let AltaMed PACE know at the time you make your grievance. AltaMed PACE will still investigate, but AltaMed PACE will note your wishes and will not send you any further notifications. No reference that you have elected to file a grievance with AltaMed PACE will appear in your medical record. **20**

3. AltaMed PACE will continue to furnish all required services to you during the grievance process.

4. AltaMed PACE staff will take action to resolve your grievance as quickly as your case requires, but no later than thirty (30) calendar days after receipt of your grievance.

Resolution of Grievances

1. AltaMed PACE will notify you of the resolution of your grievance as quickly as your case requires, but no later than three (3) calendar days after the date we resolve your grievance.

2. 2AltaMed PACE will notify you either verbally or in writing based on your preference. The exception is for grievances related to quality of care, for which we will always provide written notification of the grievance resolution.

3. The notification AltaMed PACE provides will include a summary of your grievance, what steps we have taken to investigate the grievance, what we found as a result of our investigation, what actions we have taken or are going to take to resolve the issue, and when you can expect those actions to occur.

4. AltaMed PACE may withhold notification of the grievance resolution if the individual who submitted the grievance specifically requests not to receive the notification, and the AltaMed PACE has documented this request in writing. The AltaMed PACE is still responsible for complying with all other requirements. **20**

Grievance Review Options

1. If you are not satisfied with the resolution, please let us know so that we can continue to work towards a resolution that is acceptable. AltaMed Corporate Second Level Review: you may request review of your grievance and resolution by AltaMed PACE corporate leadership. 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 10 business days of the receipt of request for a second level review. **20**

2. You also have the option of contacting 1-800-MEDICARE (1-800-633-4227) to make a complaint related to the quality of your care or the delivery of a service.

3. If you have Medicare and your grievance is related to Medicare covered services, you, your family or caregiver, or your designated representative have the right to file a written complaint with the quality improvement organization (QIO). If you submit a complaint to the QIO, AltaMed PACE must cooperate with them to resolve the complaint. This information will also be included in the resolution notification you receive if you have submitted your grievance to AltaMed PACE as an additional option available to you.

Medicare QIO – Livanta

https://www.livantaqio.cms.gov/en
1-877-588-1123
1-855-887-6668 (TYY) 20

4. In the event that AltaMed PACE is unable to provide a satisfactory resolution, you are entitled to pursue your grievance with the DHCS, by contacting:

   Health Consumer Alliance
   Medicare Medi-Cal Ombudsman Program
   www.healthconsumer.org
   Telephone: 1-888-804-3536
   TTY: 1-877-735-2929

AltaMed PACE AltaMed PACE assures that every grievance is handled in a consistent manner and that there is communication among the different individuals who are responsible for reviewing or resolving grievances. In order to ensure all participant concerns are addressed and resolved, AltaMed PACE will document, track, and maintain records related to all processing requirements for grievances received both orally and in writing. PACE will aggregate and analyze the information collected for purposes of its internal quality improvement program.20

Appeals Process

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 we have made to deny, reduce, or stop what you believe are covered services or to pay for services that you believe we are required to pay.

You will receive written information of the appeals process when you enroll, at least annually after that, and any time that the Interdisciplinary Team denies a request for services or for payment of services.

Standard and Expedited Appeals Processes: There are two 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, reduced, or stopped. This is the date that 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 or stay well is in danger without the service you want, you or any treating physician may ask for an **expedited appeal**. We will automatically decide on your appeal as quickly as your health requires, but no later than seventy-two (72) hours after we receive your request for an expedited appeal. We may extend this time frame up to fourteen (14) calendar 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.

*Note: If you have Medi-Cal and the reason for your appeal is that **AltaMed PACE** decided to reduce or stop service(s) you were receiving, you may choose to request to continue receiving the disputed service(s) until the appeals process is completed. If our initial decision to reduce or stop 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 AltaMed PACE denies a service or payment for a service that you or your representative has requested, reduces, or stops a service you were already receiving, you may appeal the decision. A written notification will be provided to you and/or your representative that will explain the reason for the denial of your

service request or request for payment, and you will also receive verbal notification.

2. You can make your appeal either verbally, in person or by telephone, or in writing with your PACE center's staff. 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. If more information is needed, you will be contacted by Senior Care Advocate/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 Senior Care Advocate/Social Worker at number designated on the front page of this Handbook, Monday through Friday from 8:00 AM to 5:00 PM, to request an appeal form and/or 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:

   Your Designated PACE Center's
   address shown at the front of this
   handbook.
   Attention: Social Work Supervisor

5. You will be sent a written acknowledgement of receipt of your appeal within five (5) business days for a **standard** appeal. For and **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 decision will be made by a person(s) not involved in the initial decision-making process in consultation with the Interdisciplinary Team and who does not have a stake in the outcome of your appeal. You and anyone

helping with your appeal may present or submit relevant facts and/or evidence for review, in person as well as in writing.

7. Once AltaMed PACE completes the review of your appeal, you and 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 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, we are required to provide or arrange for services as quickly as your health condition requires. **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 <u>do not</u> decide fully in your favor, we will provide you with written notification that will include the specific reason(s) for the denial, why the service would not improve or maintain your overall health, your right to appeal the decision, and a description of your external appeal rights through either the Medicare or Medi-Cal program **(see Additional Appeal Rights, below).** We also are required to notify the federal Centers for Medicare and Medicaid Services and the California Department of Health Care Services.

AltaMed PACE organization must maintain, aggregate, and analyze information on appeal proceedings and use this information in the organization's internal quality improvement program. **20**

Additional Appeal Rights under Medi-Cal and Medicare

If AltaMed PACE makes a decision that is not fully in your favor, you have additional appeal rights called external appeal rights. An external appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program. If you are enrolled

in both **Medicare and Medi-Cal**, you may choose which appeals process you wish to use. If you are not sure which program you are enrolled in, ask us. We can explain how the processes differ, and whether one would be more appropriate. The external appeal may only be made to one or the other (Medicare or Medi-Cal), but not both. We also will send your appeal on to appropriate external program for review if you would like.

The Medicare and Medi-Cal external appeal processes are described below.

Medi-Cal External Appeals Process

The **Medi-Cal program** conducts their next level of appeal through the State hearing 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: 1-800-952-5253
Fax: (916) 229-4410
TTY: 1-800-952-8349

If you choose to request a state hearing, you must ask for it within ninety (90) calendar days from the date of the decision by the third-party reviewer 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 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. 20

If the decision is not in your favor of your appeal, there are further levels of appeal, and we will assist you in pursuing your appeal.

Medicare External Appeals Process

The **Medicare program** contracts with an "Independent Review Entity" (IRE) to provide external review on appeals involving PACE programs. This review entity is completely independent of our AltaMed PACE.

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 the IRE to impartially review your appeal. A written request for reconsideration must be filed with the IRE within sixty (60) calendar days from the date of the decision by the impartial reviewer of the internal appeal. The IRE will contact us with the results of their review. The IRE will either maintain our original decision or change our decision and rule in your favor.

For more information regarding the appeals process or to request forms, please AltaMed PACE call the AltaMed PACE Senior Care Advocate or Social Workers at the designated phone number on the front page of this handbook Monday through Friday 8:00 AM to 5:00 PM. For TTY/TDD 1 (800) 735-2922.