COMPLAINT PROCEDURES

In an exception to the State of Louisiana licensing requirement for Adult Day Health Care (ADHC), a Program of All-Inclusive Care for the Elderly (PACE) organization shall utilize the federal PACE complaints/grievances processes.

As required by 42 Code of Federal Regulations (CFR) 460.120 the PACE organization must have established process to resolve written or oral complaints/grievances expressing dissatisfaction with service delivery or the quality of care provided from PACE recipients, family members, and their representatives. There must be a formal written process to evaluate and resolve medical and nonmedical grievances by recipients, family members, or representatives. Upon enrollment and at least annually the recipient must be given written information on the grievance process. The PACE organization must continue to furnish all required services to the recipient during the grievance process. The PACE organization must discuss and provide to the recipient in writing specific steps and timeframes for response that will be taken to resolve the recipient's grievance.

All personnel (employees and contractors) who have contact with recipients should be aware of and understand the basic procedures for receiving and documenting grievances in order to initiate the appropriate process for resolving recipient concerns.

At a minimum the grievance process must include:

- How to file a grievance;
- Documentation of the grievance:
    - Date the grievance was received;
    - Nature of the grievance;
    - Letter of reference to timeframes/resolution;
    - Date of resolution of grievance; and
    - Date of notification of resolution provided to the recipient;
- Response to and resolution of the grievance in a timely manner; and
- Maintenance of the recipient's confidentiality throughout the process of the grievance and thereafter to prevent unauthorized access.

Internal Appeals Process

Complaints concerning denial of services or service coverage must be handled as appeals. In accordance with 42 CFR 460.122 the PACE organization must have a formal written internal appeals process, with specified timeframes for response, to address non-coverage of, or nonpayment for, a service including denials, reductions, or termination of services.

The recipient must receive written information on the appeals process at enrollment, at least annually thereafter and whenever the interdisciplinary team (IDT) denies a request for services or payment. The PACE organization's responses to and resolution of the appeal must be no later than 30 calendar days after the organization receives an appeal.

The PACE organization's internal appeal process must include but not limited to:

- Timely preparation and processing of a written denial of coverage or payment;
- How a recipient files an appeal;
- Documentation of a recipient's appeal;
- Appointment of an appropriately credentialed and impartial third party who was not involved in the original action and who does not have a stake in the outcome of the appeal to review the recipient's appeal;
- Responses to and resolution of, appeals expeditiously as recipient's health condition requires, but no later than 30 calendar days after the organization receives the appeal; and
- Maintenance of confidentiality of appeals.

An expedited internal appeals process should be available for situations of urgency when the PACE recipient believes not having the service would place his/her life or ability to function is in jeopardy. The PACE organization must respond no later than 72 hours after it receives the appeal. The PACE organization may extend the 72 hour timeframe by up to 14 calendar days for either of the following reasons:

- The recipient requests an extension; or
- The PACE organization justifies with the State administrating agency (SAA) the need for additional information and how the delay is in the interest of the recipient.

An appeal decision will be given to the recipient in writing. If after the internal appeal process, the PACE recipient is not satisfied with the determination, then an external appeal to Medicaid or Medicare may be requested and the PACE organization must forward the appeal to the appropriate external entity.

External Appeals Process

A PACE organization must inform a recipient in writing of his or her appeal rights under Medicare or Medicaid managed care or both, assist the recipient in choosing which to pursue if both are applicable, and forward the appeal to the appropriate external entity.

PACE organization shall submit proposed denial of enrollment determinations of applicants for health and safety reasons and all involuntary disenrollment determinations of recipients to OAAS RO for review prior to notifying applicants/recipients of such adverse decisions.

Medicaid eligible recipients who appeal through Medicaid shall be heard by the Health and Hospitals Section of the Division of Administrative Law (DAL) within the timeframes applicable to processing Medicaid appeals, except in cases where federal PACE requirements require a more expeditious decision.

The OAAS RO must prepare the Summary of Evidence (SOE) for appeals in which OAAS RO has made any adverse action determination that is appealed by the applicant/recipient.

If the initial or reassessment MDS-HC (involuntary disenrollment) determined the applicant/recipient does not meet nursing facility level of care the PACE organization must notify the OAAS RO to request a final determination review of all enrollment data, including the MDS-HC. The OAAS RO will ensure the accuracy of the enrollment data and make the final determination regarding nursing facility level of care. OAAS RO shall be responsible for assuring that all avenues of eligibility have been explored prior to determining that an individual does not meet the required nursing facility level of care or meet deemed eligibility for continuation of services. OAAS RO shall notify the PACE organization of the final determination. When the PACE applicant/recipient does not meet nursing facility level of care the OAAS RO must prepare the Summary of Evidence (SOE) for appeals. OAAS RO must issue a denial letter and appeal rights to the recipient and copy the PACE organization. The PACE organization must provide the applicant with any referral sources that may be indicated.

If involuntary disenrollment is approved the PACE organization will follow their written appeals process. The PACE organization must provide recipients with reasonable advanced notice of disenrollment and applicable referrals and recommendations for alternate healthcare options.
The PACE organization must continue to furnish all needed services until the recipient is back in the Medicare/Medicaid (If eligible) fee-for-service systems as specified in 42 CFR 460.166.

The PACE organization must prepare the SOE in preparation for any appeals in which the PACE organization has made any adverse action determination that was appealed by the applicant/recipient.

For a Medicaid recipient the PACE organization must continue to furnish the disputed services until issuance of the final determination by the DAL is issued if the following conditions are met:

- The PACE organization is proposing to terminate or reduce services currently being furnished to the recipient; and

- If a timely appeal is not filed, services will be terminated effective at the end of the month in which the denial notice was issued.

Reporting

The PACE organization must maintain, aggregate, and analyze information on grievance proceedings and appeals information. This information must be used in the PACE organization's internal quality assessment and performance improvement (QAPI). The QAPI program must include mechanisms to receive and address recipient and care giver complaints and grievances and, when necessary, take appropriate corrective action(s).

The PACE organization must report grievances and appeals quarterly through the Health Plan Management System (HPMS) as indicated in the PACE program agreement.