GRIEVANCES/COMPLAINTS

The Program of All-Inclusive Care for the Elderly (PACE) provider must utilize the Federal PACE complaints/grievances processes.

NOTE: The Department, may conduct unannounced complaint investigations on all ADHCs, including those with accredited status.

A grievance is a complaint, either written or oral, that is expressing dissatisfaction with service delivery or the quality of care provided.

PACE providers must:

- Have an established formal written process to evaluate and resolve medical and non-medical grievances by beneficiaries, family members, or representatives;
- Take appropriate corrective actions in response to grievances/complaints, when necessary;
- Provide written information regarding their grievance process upon enrollment and at least annually;
- Continue to provide all required services to the beneficiary during the grievance process;
- Discuss and provide to the beneficiary in writing, the specific steps and timeframes for response that will be taken to resolve the beneficiary's grievance; and
- Maintain, aggregate and analyze the information on grievance proceedings and include this information in the Quality Assessment and Performance Improvement (QAPI) program.

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

At a minimum, the grievance process must include the following in written procedures:

- 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 beneficiary;

- Response to and resolution of the grievance in a timely manner; and
- Maintenance of the beneficiary'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. An appeal is when an action is taken by the PACE provider regarding non-coverage of, or non-payment for, a service, which includes denials, reductions, and terminations.

The PACE provider must have a formal written internal appeals process, with specified timeframes for response, to address non-coverage of, or non-payment for, services, including denials, reductions, and terminations.

The beneficiary must receive written information on the appeals process at enrollment and, at least annually thereafter and whenever the interdisciplinary team (IDT) denies a request for services or payment.

The PACE provider's responses to and resolution of the appeal must be no later than 30 calendar days after the PACE provider receives the appeal.

The PACE provider's internal appeal process must include, but is not limited to, the following:

- Timely preparation and processing of a written denial of coverage or payment as provided in 42 CFR 460.104;
- How a beneficiary files an appeal;
- Documentation of a beneficiary'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 beneficiary's appeal;

- Responses to and resolution of, appeals expeditiously as beneficiary's health condition requires, but no later than 30 calendar days after the PACE provider receives the appeal; and

- Maintenance of confidentiality of appeals.

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

- The beneficiary requests an extension; or

- The PACE provider justifies with LDH/OAAS the need for additional information and how the delay is in the interest of the beneficiary.

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

External Appeals Process

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

The PACE provider must submit proposed denial of enrollment determinations of applicants for health and safety reasons and all involuntary disenrollment determinations of beneficiaries to OAAS RO for review prior to notifying applicants/beneficiaries of such adverse decisions.

Medicaid eligible beneficiaries who appeal through Medicaid must be handled by the Louisiana Department of Health (LDH) 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/beneficiary.

If the initial or re-assessment interRAI (involuntary disenrollment) determined the applicant/beneficiary does not meet nursing facility level of care, the PACE provider must notify the OAAS RO to request a final determination review of all enrollment data, including the RAI Assessment. The OAAS RO will ensure the accuracy of the enrollment data and make the final determination regarding nursing facility level of care. OAAS RO is 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 must notify the PACE provider of the final determination. When the PACE applicant/beneficiary 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 beneficiary and copy the PACE provider and LDH/OAAS. The PACE provider must provide the applicant with any referral sources that may be indicated.

If involuntary disenrollment is approved the PACE provider will follow their written appeals process. The PACE provider must provide beneficiaries with reasonable advanced notice of disenrollment and applicable referrals and recommendations for alternate healthcare options.

The PACE provider must continue to furnish all needed services until the beneficiary is back in the Medicare/Medicaid (If eligible) fee-for-service systems as specified in 42 CFR 460.166.

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

For a Medicaid beneficiary the PACE provider 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 provider is proposing to terminate or reduce services currently being provided to the beneficiary; 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 provider must report grievances and appeals quarterly through the Health Plan Management System (HPMS), as indicated in the PACE program agreement.