

PARTICIPANT GRIEVANCE and APPEAL PROCESS

PARTICIPANT GRIEVANCE PROCESS

All of us at Sutter SeniorCare PACE share the responsibility for assuring that you are satisfied with the care you receive. We understand that disability and illness can cause unhappiness, dissatisfaction, and permanent limitations that no one can resolve. We also understand that there are sometimes areas of dissatisfaction that require our attention and response. We encourage you to express any grievances at the time any dissatisfaction occurs, including any violation of your rights as a participant.

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

- The quality of services a PACE participant receives in the home, at the PACE Center or in an inpatient stay (hospital, rehabilitative facility, skilled nursing facility, intermediate care facility or residential care facility);
- Waiting times on the phone, 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; and
- A violation of a participant's rights

SeniorCare does not discriminate against a participant because a grievance has been filed. SeniorCare will continue to furnish you with all required services during the grievance process as well as maintain confidentiality throughout the grievance process and release information only to authorized individuals.

If you do not speak English, a bilingual staff member or volunteer will be found to facilitate the grievance process. The grievance procedure is outlined below.

Grievance Procedures

Filing a Grievance

- a. You and/or your designated representative may express dissatisfaction with the services delivered or quality of care furnished by speaking or writing to your SSC social worker; manager of nursing, manager of home health/home care or center manager at:
444 North 3rd Street, Suite 150, Sacramento, CA 95811
Phone: 1-833-560-7223; Fax: 1-916-229-4410
- b. The Participant/Designated Representative Grievance form and a copy of the grievance procedures are available to you and/or your designated representative upon request. SSC will provide assistance to you the PACE participant and /or your representative in filing a grievance if needed.
- c. If you voluntarily disenroll from SSC due to a complaint/grievance, your social worker will discuss the grievance process and provide guidance for filing a grievance if you and/or your designated representative choose to do so. The discussion with you and/or your designated representative will be documented in your medical record.
- d. You and/or your designated representative may express the grievance verbally or in writing:
 - o You and/or your designated representative may submit a written grievance using the Participant/Designated Representative Grievance form, which is provided by the staff member to whom you and/or your designated representative present the grievance.

If you and/or your designated representative choose to express your grievance verbally or in writing to any of the staff members listed in step (a) above, the staff member receiving the grievance, summarizes it on the appropriate section of the Grievance Report.

The SeniorCare center manager will send written acknowledgement of receipt of the grievance within five days to you and/or your designated

representative). The SeniorCare center manager will then investigate and take action as appropriate. At any time during the grievance process you and/or your designated representative can involve the SeniorCare Administrator.

The grievance should be resolved within 30 days from the date your grievance was received by SeniorCare. Following resolution of the grievance, SeniorCare will send to you and/or your designated representative a letter describing the grievance, the resolution of the problem, the basis for the resolution and the review process available, if you and/or your designated representative) are still dissatisfied.

If the grievance is about medical care:

- You and/or your designated representative has the right to request a review by a member of SeniorCare's Medical Advisory Board (MAB). The MAB membership includes impartial community physicians.

If you or your designated representative requests a review by a member of the MAB, the center manager refers the grievance to the medical director and administrator for investigation and resolution to your satisfaction and/or to the satisfaction of your designated representative. The medical director or the administrator forwards the grievance to the MAB chairperson. If the grievance involves the medical director, it is forwarded to the medical director's clinical supervisor, the Vice President and Chief Medical Officer of Sutter Health Sacramento Sierra Region..

- The chairperson or other designee sends written acknowledgement of receipt of the grievance to you and/or your designated representative within five days of receiving the grievance.
- An impartial member of the MAB investigates the grievance, finds solutions and takes appropriate actions.
- Every attempt is made to resolve the grieving party's grievance within 30 calendar days from the date the grievance is filed. The center manager sends written notification to you or your

designated representative describing the resolution and the review options available if dissatisfaction continues.

- If the grievance is pending and cannot be resolved within 30 calendar days from the date the grievance was filed the center manager makes certain that:
- The quality assurance coordinator and administrator are involved in the process and you and/or your designated representative is notified by letter of the status of the grievance and given an estimated completion date of the resolution.
- The written notice includes a statement that you and/or your designated representative, acting on your behalf may exercise your rights under Medi-Cal (see Grievance Review Options below).

The Department of Health Care Services, Long Term Care Division is provided with a copy of the letter.

Expedited Review of Grievances

1. If the grievance involves a serious or imminent health threat to you, including, but not limited to, severe pain, potential loss of life, limb or major bodily function or when your rights have allegedly been violated, the center manager will expedite the internal review process to reach a decision within 72 hours of receiving the grievance.
2. You and/or your representative must inform the center manager of your request either verbally or in writing and you will receive assistance by the center manager to document the grievance in writing prior to resolution.
3. As soon as possible, but no later than one business day after you and/or your designated representative files an expedited grievance, the center manager must inform you and/or your representative by telephone or in person that the grievance has been received and describe the steps that will be taken to resolve the grievance.
4. The center manager must inform you and/or your designated representative both verbally and in writing of your right to notify the Department of Health Care Services (DHCS) and California Department of Social Services of the grievance.

5. The center manager will notify you and/or your designated representative in writing of the resolution of the expedited grievance. If the resolution is not possible within 72 hours, the written notification will include the reason for the delay and the timeframe for when the grievance will be resolved.

Grievance Review Options

If, after completing the grievance process, or participating in the process for at least 30 calendar days, you and/or your designated representative are still dissatisfied, you and/or your designated representative have the option to pursue the steps described below. However, if the grievance involves an imminent and serious threat to your health, it is not necessary to complete the entire grievance process or wait 30 calendar days to pursue the steps given below.

- If you are covered by Medi-Cal only or Medi-Cal and Medicare, you and/or your designated representative is entitled to pursue the grievance with the Department of Health Care Services by contacting or writing to:

Ombudsman Unit

Medi-Cal Managed Care Division

Department of Health Care Services

P.O. Box 997413, MS 4412

Sacramento, California 95899-7413

1-888-452-8609

TTY: 1-800-735-2922

- At any time during the grievance process, whether your grievance is resolved or unresolved, you and/or your designated representative may request a State hearing from the California Department of Social Services by calling or writing to:

California Department of Social Services

State Hearings Division

P.O. Box 944243, MS 19-37

Sacramento, CA 94244-2430

1-800-743-8525

TTY: 1-800-952-8349 (hearing-impaired number)

Fax: 1-916-229-4410

You and/or your representative may speak at the State hearing or have someone else speak on your behalf such as a relative, friend, or an attorney. You may also be able to get free legal help. If you would like legal assistance, please talk with your Sutter SeniorCare social worker for a list of Legal Services offices in Sacramento County.

PARTICIPANT APPEALS PROCESS FOR NON-COVERAGE OR NON-PAYMENT OF A SERVICE

As a member of Sutter SeniorCare PACE, you have a right to appeal any treatment decision made by SeniorCare or our contract providers, including decisions not to authorize or pay for items and services. You will receive written information about appeals when you enroll, annually and whenever SeniorCare denies a request for service or payment.

SeniorCare does not discriminate against a participant because an appeal has been filed. During the appeal process, SeniorCare will continue to furnish you with all required services. However, you may be liable for the costs of the contested services if the determination regarding the appeal is not made in your favor.

SeniorCare will also maintain confidentiality throughout the appeals process and release information only to authorized individuals.

DEFINITIONS

Appeal: An appeal is defined as 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. Depending on

the urgency of the appeal the process resolution may be a standard or expedited.

- **Standard Appeal:** Is a review process for response to and resolution of appeals as expeditiously as the participant's health requires, but no later than 30 days after receipt of the appeal.
- **Expedited Appeal:** An expedited appeal is required when the participant or the physician believes that the participant's life, health or ability to regain maximum function would be seriously jeopardized, without the provision of the service in dispute. The timeframe for resolution of an expedited appeal is 72 hours from time of receipt of the appeal. The 72 hour time frame may be extended up to 14 calendar days for either of the following reasons:
 - The participant requests the extension
 - Sutter SeniorCare requests and justifies to the state administering agency the need for additional information and how the delay is in the best interest of the participant.

Coverage Decision: Is the approval or denial of health Services by Sutter SeniorCare based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the contract with the enrolled participant.

Disputed health care service: Means any health care service eligible for payment under the enrolled participant contract with Sutter SeniorCare that has been denied, modified or delayed by a decision of Sutter SeniorCare due to the finding that the service is not medically necessary.

Medically necessary: Means reasonable medically necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

Representative: means a person who is acting on behalf of or assisting a Sutter SeniorCare/PACE participant, and may include, but is not limited to, a family member, a friend, a Sutter SeniorCare/PACE employee, or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator or Guardian.

Appeal Procedure

Filing an Appeal

1. Once a decision is made by SSC Interdisciplinary team to deny, defer or modify a service or denial of payment is made both verbally and in writing using the Notice of Action for Service or Payment Request (Attachment 54), the participant has the right to appeal the decision.

Sutter SeniorCare PACE

444 North 3rd Street, Suite 150

Sacramento, California 95811

1-833-560-7223

1-916-393-1112 (hearing impaired number)

2. Participants and/or the designated representative can request an appeal of a decision to deny coverage or payment verbally or in writing using the Appeal for Reconsideration of Denial (Attachment 119). The participant and or his/her representative have up to 180 calendar days after a denial of service or payment. The 180 day limit may be extended for good cause by SSC. Participants and/or the designated representative are directed to present appeals to the SSC administrator. If the administrator is not available, the request for an appeal is made to the participant's social worker or center manager who immediately refers it to the administrator
3. SSC will provide assistance to the PACE participant and/or his representative in filing a grievance if needed.
4. The participant and/or his representative can file either a Standard Appeal or expedited Appeal, depending on the urgency of the case.

Sutter SeniorCare PACE's Review of Your Appeal

1. The SeniorCare Administrator will send written acknowledgement of receipt of the appeal within 5 days to you (or your designated representative).
2. Once we receive your request for an appeal, SeniorCare will make certain that your request for re-consideration (appeal) of a decision is reviewed by a person or persons that were not involved in the initial decision-making process. We will insure that this is an impartial person (or persons) who are appropriately qualified to make a decision regarding the necessity of the service(s) at issue. If it is a medical decision, it will be considered by an impartial third party who is appropriately qualified (credentialed).
3. If it is a Standard Appeal as defined above, we will notify you of our decision regarding your appeal no later than 30 days after the date your appeal was received.
4. If it is an Expedited Appeal as defined above, we will make a decision within 72 hours unless the timeframe is extended for reasons as described above.

Sutter SeniorCare PACE's Decision on Your Appeal

- If we decide fully in your favor on a Standard Appeal for a request for a service, we must give permission for you to receive the service elsewhere or we will provide you the service as quickly as your health condition requires, but no later than 30 calendar days from the date we received your request for an appeal.
- If we decide fully in favor on a request for payment, we must make the requested payment within 60 calendar days after receiving your request for an appeal.
- If we do not decide in your favor on a Standard Appeal, either in whole or in part, or if we fail to provide you with a decision within the proper time frame, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (see Additional Appeals Rights). We are also required to notify you if we make a decision that is not fully in your favor and also notify the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS). When we inform you of the decision

(within 30 days of receipt of the request for an appeal), we will also inform you in writing of your appeal rights under Medicare or Medi-Cal or both. We will help you choose which to pursue if both are applicable. We will also send your appeal on to the appropriate government office.

- If we decide in your favor on an Expedited (fast) Appeal, we must give permission for you to receive the service or provide you the service as quickly as your health condition requires, but no later than 72 hours after we received your request for an appeal.
- If we do not decide in your favor on an Expedited Appeal, either in whole or in part, or fail to notify you within the appropriate 72 hour timeframe, you have the right to pursue an external appeal process under either Medicare or Medi-Cal (see Additional Appeals Rights). We are required to notify you as soon as we make a decision that is not fully in your favor and also notify the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS). We will inform you in writing of your appeal rights under Medicare and Medi-Cal or both. We will help you choose which to pursue if both are applicable. We will also send your appeal to the appropriate entity.

1. Medi-Cal external appeals process

- a. Your Sutter SeniorCare social worker or designated staff will assist you and/or your representative with the external appeals process as needed, including assistance with choosing either Medicare or Medi-Cal external appeals process or both and with sending the appeal to the appropriate government office.
- b. If you are enrolled in both Medi-Cal and Medicare or Medi-Cal only and chose to appeal the Sutter SeniorCare decision using the Medi-Cal external appeals process, you and/or your representative may request a fair hearing from the State Department of Social Services by contacting:

California Department of Social Services

State Hearings Division

744 P Street, Mail Station 9-17-37

Sacramento, CA 95814

1-800-743-8525

TTY: 1-800-952-8349

Fax: 1-916-229-4410

If you receive a Notice of Action (NOA) informing you that the treatment you have been receiving must be stopped or reduced, and if you and the treating provider want to continue this treatment, then you must ask for a State hearing within 10 days after the NOA is postmarked or personally delivered to you or before the effective date of action you are disputing.

2. Medicare external appeals process

- a. If you are enrolled in both Medicare and Medi-Cal or Medicare only, you and/or your representative may choose to appeal using Medicare's external process. Medicare currently uses the Center for Health Dispute Resolution (MAXIMUS Federal Services), an independent review organization, to impartially review appeals involving PACE programs like Sutter SeniorCare.
- b. The Sutter SeniorCare administrator sends the appeals case file to MAXIMUS Federal Services for their review:

MAXIMUS Federal Services Medicare Managed
Care and PACE Reconsideration Project
50 Square Drive, Suite 210
Victor, NY 14564
1-(585) 425-5210

1-800-356-8151

Email: medicareappeal@MAXIMUS.com

Web Site: www.medicareappeal.com

- c. When MAXIMUS Federal Services has made a decision, MAXIMUS Federal Services contacts SSC with the results of the review. MAXIMUS Federal Services either upholds the SSC original decision or rules in favor of the participant.
- d. There is an expedited and a standard Medicare external appeals process

- A participant can request an expedited Medicare external appeal if the participant believes his/her health would be jeopardized by not receiving a specific service. In an expedited external appeal, SSC sends the participant's case file to MAXIMUS Federal Services as quickly as the participant's health requires. MAXIMUS Federal Services must give SSC a decision within 72 hours after they receive the information. If MAXIMUS Federal Services asks for more time to review the appeal, they must give SSC their decision within 14 calendar days.
 - A participant can request a standard Medicare external appeal if SSC denies the request for non-urgent services or for nonpayment of a claim for services. For a standard external appeal, SSC provides the participant with a decision regarding the appeal in no later than 30 calendar days after the request the appeal.
 - If MAXIMUS Federal Services decides in favor of the participant for an expedited appeal, SSC must provide or authorize provision of the service as quickly as the participant's health requires.
 - If MAXIMUS Federal Services decides in the participant's favor for a standard appeal
 - If the participant requested a service not yet received, SSC must provide the service requested as quickly as the participant's health condition requires.
 - If the participant requested payment for a service already received, SSC must pay for the service.
 - If MAXIMUS Federal Services does not decide in favor of the participant for either a standard or an expedited appeal, there are further levels of appeal the participant may pursue. SSC social workers assist participants in pursuing appeals further.
1. If MAXIMUS Federal Services' decision is in your favor for a standard appeal:
- If you have requested a service that you have not received, we must give you the service you requested as quickly as your health condition requires.
 - If you have requested payment for a service that you have already received, we must pay for the service.

If MAXIMUS Federal Services' decision is not in your favor for either a Standard or an Expedited Appeal, there are further levels of appeal and SeniorCare staff can assist you in pursuing your appeal further if you choose to do so.