myPlace Health

myPlace PACE Provider Manual

Effective July 24, 2024

Table of Contents

SECTION 1

Introduction and General Information

WELCOME!
We are pleased to welcome you to myPlace Health as a contracted provider. We appreciate your participation in fulfilling our mission to enable seniors to live the independent lives they deserve.

myPlace Health is an integrated care delivery organization that specializes in providing personalized care and coverage to older adults who wish to remain safely living in their homes and communities for as long as possible, rather than living in a nursing facility. We pursue our mission through the myPlace PACE model, which relies on a trusted network of providers that collaborate to provide care for our participants.

PURPOSE AND USE OF THIS PROVIDER MANUAL
This Provider Manual is intended to support you and your staff in working with myPlace PACE participants, including adherence to myPlace policies and procedures required by the myPlace PACE Provider Service Agreement. Your myPlace PACE Provider Service Agreement is entered into with Prosper Services LLC ("myPlace Health"), on behalf of itself and its affiliates myPlace Greater LA PACE Inc. and myPlace South LA PACE Inc. (both doing business as "myPlace PACE").

The information provided in this Provider Manual is intended to be informative and supplement the myPlace PACE Provider Service Agreement as our network providers navigate participation in the myPlace PACE program. Unless otherwise specified in the myPlace PACE Provider Service Agreement, the information contained in this Provider Manual shall supplement but will not replace or supersede your myPlace PACE Provider Service Agreement. In the event of any discrepancy between the Provider Manual and the myPlace PACE Provider Service Agreement, the terms of the myPlace PACE Provider Service Agreement shall govern.

This Provider Manual is subject to change and will be updated periodically in response to changes in regulatory requirements and operational systems and processes. myPlace PACE will make reasonable efforts to notify providers of changes to this Provider

Manual. In the event of a material change to the Provider Manual, myPlace PACE will make all reasonable efforts to notify providers in advance of such changes through mediums such as bulletins, newsletters, mailings, and other outreach. In such cases, the most recently published information shall supersede all previous information and be considered the current directive. The manual is not intended to be a complete statement of all myPlace Health and myPlace PACE policies or procedures. Other policies and procedures not included in this Provider Manual may be posted on our website or published in other communications.

myPlace PACE values our relationship with you, your staff, and your organizations. We welcome and encourage your feedback and suggestions regarding this Provider Manual and your relationship with our organization. If you require clarification or have questions or comments about your role as a participating network provider for myPlace PACE, please contact our Provider Service Department.

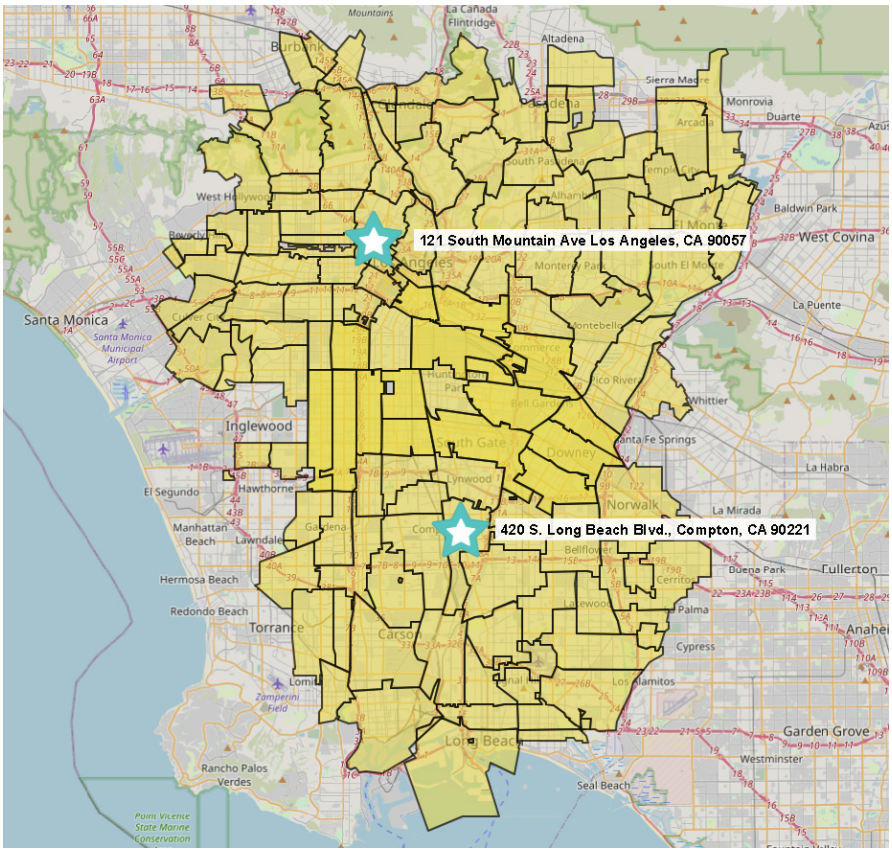
WHAT IS PACE?

PACE (Program of All-Inclusive Care for the Elderly) is a Medicare and Medicaid waiver program in the State of California that provides a full spectrum of health and social services to a frail and elderly population. A central goal of PACE is to enable individuals who are at risk of moving into a nursing home to continue to live safely in their homes and communities. To be eligible to enroll as a myPlace PACE participant, an individual must be:

- A resident of the myPlace PACE service area (see zip codes list below)
- Age 55 and older
- Eligible for nursing home level of care (NFLOC) based on criteria established by the State of California
- Eligible for Medi-Cal only; eligible for both Medi-Cal and Medicare; or enrolled only with Medicare and willing to pay
- Able to live safely in the community with the services provided by myPlace PACE

SERVICE AREA AND LOCATIONS

myPlace PACE is approved to serve selected zip codes in the Los Angeles County area.



Zip Codes List for the myPlace Greater LA Service Area

90001	90018	90036	90058	90230	90278	90660	90747	90840	91502
90002	90019	90037	90059	90232	90280	90701	90755	91006	91506
90003	90020	90038	90061	90280	90301	90702	90802	91007	91602
90004	90021	90039	90062	90240	90302	90703	90803	91030	91608
90005	90022	90040	90063	90241	90303	90706	90804	91101	91731
90006	90023	90041	90065	90242	90304	90710	90805	91104	91732
90007	90026	90042	90067	90245	90305	90712	90806	91105	91733
90008	90027	90043	90068	90247	90501	90713	90807	91106	91754
90011	90028	90044	90071	90248	90502	90715	90808	91108	91755
90012	90029	90045	90201	90249	90503	90716	90810	91201	91770
90013	90031	90046	90211	90250	90504	90717	90813	91203	91775
90014	90032	90047	90212	90255	90506	90723	90814	91204	91776
90015	90033	90048	90220	90260	90606	90744	90815	91205	91780
90016	90034	90056	90221	90262	90640	90745	90822	91206	91801
90017	90035	90057	90222	90270	90650	90746	90831	91210	91803

myPlace PACE Contact Information

Topic	Contact Information
Referrals To refer your patients to join us or to refer any others who may be eligible for myPlace PACE, or to find out more about who qualifies and the enrollment process.	Referrals@myPlaceHealth.com p: (833) 883-2888 f: (833) 883-2887
Administration General information about us, including locations and contact information for myPlace PACE Care Centers, verification of participant eligibility status, primary care provider information, or referral status.	GreaterLA@myPlaceHealth.com p: (213) 800-8880 f: (213) 800-8881
Scheduling myPlace PACE Services Inquiries about sending a participant to receive myPlace PACE services, coordination with the PACE interdisciplinary team, scheduling transportation, or other services coordinated by myPlace PACE.	GreaterLA@myPlaceHealth.com p: (213) 800-8880 f: (213) 800-8881
Authorizations and Records Requests Authorizations for referrals to another in-network provider, referrals to non-participating providers, or to request services such as prescriptions, home care services, labs, DME, or other services.	RecordsGLA@myPlaceHealth.com p: (213) 800-8880 f: (213) 800-8881
Quality Management Information and inquiries regarding quality of care oversight, quality assurance policies and procedures, provider office on-site inspections, and provider reporting requirements.	GreaterLA@myPlaceHealth.com p: (213) 800-8880 f: (213) 800-8881
Provider Relations Inquiries regarding general program information, policies and procedures, provider publications, contract status and inquiries, adding providers to an existing contract, or provider demographic changes.	Network@myPlaceHealth.com Contract@myPlaceHealth.com p: (213) 800-8882
Claims Claims submission, claims payment, and status of claims	Claims@myPlaceHealth.com p: (213) 800-8884 f: (213) 800-8885
Compliance Information and inquiries regarding fraud, waste, or abuse; compliance with CMS and Medi-Cal regulations; and other Compliance related matters.	Regulatory@myPlaceHealth.com p: (213) 800-8886
Eligibility Verification Inquiries regarding benefits, eligibility status, eligibility requirements and enrollment process.	p: (213) 800-8889

SECTION 2

Participant Eligibility and Benefits

Persons enrolled with myPlace PACE are called "participants." The myPlace PACE interdisciplinary team assesses all potential participants prior to enrollment and verifies, in conjunction with the California Department of Health Care Services (DHCS), that all participants meet program requirements.

After enrollment, myPlace PACE becomes the sole coordinator of services and each participant's care is planned and directed by the myPlace PACE interdisciplinary team. Our care focuses on preventive services, functional maintenance, coordination of services, access to services, quality, and regulatory compliance. Periodic assessments by the myPlace PACE interdisciplinary team aligns service delivery with a care plan that is customized for each participant.

myPlace PACE covers a full range of services, including primary care, adult day health care, home care, inpatient services, acute care through local hospitals, nursing home care through local providers, drugs, laboratory tests, diagnostics, durable medical equipment, and more when authorized by the interdisciplinary team.

Eligibility Verification

Upon enrollment in myPlace PACE, each participant is assigned a unique ID number and receives a myPlace PACE identification card that identifies the participant's name and ID number. This card identifies the participant as a myPlace PACE participant and should be presented to physicians and other providers when seeking healthcare services.

If a myPlace PACE participant requests service and is unable to present an identification card, please contact myPlace PACE Provider Relations. Please have ready the participant's date of birth and first and last name.

Illustrative Identification Card

Program Benefits
myPlace PACE benefits for participants include all Medicare and Medi-Cal covered services in addition to specific additional services myPlace PACE provides to maintain and improve the participant's health. Services provided by PACE include, but are not limited to, primary care (including doctor, dental and nursing services), prescription drugs, adult day health care, home and personal care services, nutrition services, and hospital and nursing home care, if needed. Transportation to and from the center and all off-site medical appointments is also provided.

Deductibles, Copayments, and Coinsurance
There are no deductibles, copayments, or coinsurance for myPlace PACE participants to access the services you are contracted to provide.

SECTION 3

Care Management and Utilization Management

myPlace PACE Care Management Program, Interdisciplinary Team and Individual Plan of Care

The core of the myPlace PACE Care Management Program is the myPlace PACE Interdisciplinary Team (IDT). The IDT is responsible for:

- Establishing each participant's individual plan of care (ICP), and maintaining and updating the ICP as the participant receives care and for any change in health status and/or diagnoses
- Coordinating and directing appropriate care for participants, referring participants for second opinions as necessary, and consulting with contracted specialty and ancillary providers
- Tracking and following up on clinical outcomes from referrals made to contracted specialty and/or ancillary providers including, but not limited to, coordination with assigned myPlace PACE PCP regarding treatment plan follow up, medication regimen, and ongoing care requirements to ensure continuity and coordinated delivery of care
- Providing prescription drug consultation through myPlace PACE pharmacy resources to ensure appropriate use of approved medications and use of the pharmacy drug benefit

The IDT is responsible for the initial and ongoing assessment of each participant's care needs documented in the individual participant's Individual Care Plan (ICP). The designated myPlace PACE primary care provider is a member of the IDT and engages the participant with frequent care services to proactively manage the participant's unique health needs. The ICP focuses on maintaining and improving the participant's functional health status as well as preventive services. A comprehensive assessment of participant health, social and emotional status is performed that will be used to establish the ICP which is based on the elicited goals of the participant. Evaluations will include:

- Medical status including physical, cognitive, nutritional, behavioral, and psychosocial status
- Medications used and prescribed
- Current existing treatment and treatment needs
- Participant and caregiver preferences for care, language preference, and cultural preferences

- Family and social support resources and status
- Environment assessment including home/community and safety situation
- Vision, hearing and dental status

The ICP is updated as applicable care delivery services are provided or new problems are identified that impact a participant's health and wellbeing. Periodic assessment and update to the ICP by the IDT keeps the ICP and service delivery on track. The IDT conducts a periodic re-assessment and revises the ICP at the following time periods:

- At least every 6 months, including an annual assessment
- Upon the identification of a significant change in the participant's condition
- Upon request by the participant or the participant's caregiver

Care Delivery Service Locations

Services provided to participants may be delivered in various locations including the myPlace Health Care Center, in a participant's home, and at contracted network provider office locations. Primary care services and other services such as those listed above may be provided at the myPlace Health Care Center.

Request for Services

Once enrolled, each participant's care is planned and directed by the myPlace PACE IDT. Program regulations dictate that myPlace PACE must authorize all non-emergency services before they are rendered. Providers who render emergency services must notify myPlace PACE within 24 hours or the next business day after the service has been rendered.

Requests for authorization of services or referral to another provider for services are made through completion and submission of consult notes to myPlace PACE. Once submitted, requests for authorizations or referrals will be funneled through the IDT for a decision. All authorizations and referral decisions will be sent via mail to the requesting provider.

Authorization requests are considered based on medical necessity, benefit coverage, and assessment of the participant in alignment

with the participant's ICP. Failure to follow these procedures may result in delayed authorization or claims processing or an adverse determination for insufficient information.

Prior authorization approval is based upon clinical documentation that supports medical necessity for the requested item or service. Requests for referrals to other providers (e.g., specialists, lab, DME) must be to a myPlace PACE contracted provider. A list of myPlace PACE contracted providers can be accessed from our Provider Services team. If the desired provider for a referral is not in the myPlace PACE contracted network, please contact the Provider Services team to discuss the possibility of a single case agreement or adding that provider to the myPlace PACE network.

Emergency and Urgent Care Services

Emergency services do not require prior authorization. If appropriate, providers should contact myPlace PACE if emergent care is needed. myPlace PACE will have a provider on staff 24/7 to respond to emergent situations.

Providers who render emergency services must notify myPlace PACE within 24 hours or the next business day after the service has been rendered.

Urgently needed services are defined as those conditions which require immediate medical attention due to unexpected illness or injury. Urgent Care Services are defined in 42 CFR 405.400 as services furnished within 12 hours in order to avoid the likely onset of an emergency medical condition.

Authorization Approval Communication

Routine Authorization requests will be processed within 14 calendar days of receipt by myPlace PACE. Urgent Authorization requests will be processed within 2-7 business days of receipt.

All Authorization approval notifications will include a myPlace issued authorization number and specify services approved, name of approved provider of service, approved service units and a timeline to complete the approved service.

Scheduling Outpatient Service Appointments
myPlace PACE is responsible for scheduling all appointments for participants. After Authorization for services is approved and communicated with the requesting provider, a myPlace Health representative will contact the provider office directly to schedule an appointment for the participant.
Please refrain from scheduling appointments directly with participants or their family members to avoid confusion and no-shows. To schedule an appointment, please contact myPlace PACE. To facilitate effective care services, delivery providers should make their best effort to schedule appointments within 30 calendar days for routine services, 7 calendar days for urgent requests, and no more than 2 business days for STAT requests.

Inpatient Services and Discharge Planning
myPlace Health staff in coordination with the myPlace PACE IDT is responsible for working with clinicians and hospital staff to authorize inpatient services and to plan and manage discharge planning for all participants.

Transportation Services
myPlace PACE benefits include non-emergency transportation services. myPlace PACE is responsible for scheduling transportation on behalf of all myPlace PACE participants. The transportation program will accommodate both ambulatory and non-ambulatory participants in a safe manner.

Please contact myPlace PACE to schedule transportation for a myPlace PACE participant.

Pharmacy Services
myPlace PACE provides prescription drug benefits covered through the Medicare Part D program. myPlace PACE IDT is responsible for managing the participant's care including prescription drugs. A myPlace PACE pharmacist may make recommendations for drug therapy which will be reviewed by the primary care physician and IDT, and subsequently ordered by the participant's myPlace PACE primary care physician as appropriate. Financial responsibility for unauthorized drugs and medications ordered by providers outside of myPlace PACE will not be accepted by myPlace PACE except in the case of an emergency.

SECTION 4

Provider Billing and Claims Payment

myPlace PACE will process claims for reimbursement for services rendered in accordance with all applicable regulatory requirements, including applicable requirements from CMS (Centers for Medicare and Medicaid Services) for Medicare and California DHCS (Department of Health Care Services) for Medi-Cal. These claims typically are for services provided by contracted providers under a myPlace PACE Provider Services Agreement or services provided by non-contracted providers. Delegated entities that have been delegated to perform claims activities on behalf of myPlace PACE must also comply with requirements applicable to myPlace PACE including the requirements set forth in this Section.

Payment of a claim for services provided to a myPlace PACE participant is dependent on the specific compensation terms in the provider's contract and the subject to following:

- Participant is eligible at the time of service (Providers are required to verify participant eligibility at the time of service to ensure Participant is enrolled and eligible in myPlace PACE. Evidence of a myPlace PACE ID card is not sufficient to verify Participant eligibility at time of service.)
- Services provided are covered services under the participant's evidence of coverage
- Services provided are medically necessary as determined by myPlace PACE
- Services were prior authorized by myPlace PACE as required in the provider's contract with myPlace PACE and this Provider Manual
- Provider's billed charges for authorized services as submitted on the claim
- Applicable coding or other adjustments of payments based on coding edits

A provider contracted with myPlace PACE who receives reimbursement for services rendered to myPlace PACE participants must comply with all federal laws, rules, and regulations applicable to individuals and entities receiving federal funds, including without limitation Title VI of the Civil Rights act of 1964, Age Discrimination

Act of 1975, Americans with Disability Act, and Rehabilitation Act of1973.

Claims Submission

For the most efficient processing of your claims, we recommend you submit claims electronically. The claim must contain all required data elements. Incomplete or incorrect claims will be rejected and returned to the Provider. Medical records must be submitted related to each claim. All claims (electronic and paper) must include:

- Participant (member) name
- Participant address
- Participant's myPlace PACE ID
- Participant's birth date
- Place of service (use standard CMS HCFA location codes)
- ICD-10 diagnosis code(s)
- HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS) code(s) and modifiers, where modifiers are applicable
- Units, where applicable (e.g., anesthesia claims require minutes)
- Date of service (a date range cannot be accepted, even though some claim forms contain From/To formats)
- Prior authorization (PA) number, if applicable
- NPI
- Federal tax ID number or physician social security number
- Signature of physician or supplier

Electronic Claims

myPlace PACE strongly encourages providers to submit claims electronically. Electronic claims submission is no cost to the provider and helps facilitate timely disposition of claims in accordance with regulatory requirements.

Electronic claims must be submitted via a clearinghouse using the HIPAA Compliant 837 Version 5010 transaction set format. myPlace PACE's clearinghouse partner is Smart Data Solutions (SDS). If you do not have a clearinghouse, or have been unsuccessful in submitting claims to the clearinghouse, please contact our Provider Services team.

Paper Claims
Paper claims may be mailed to:
myPlace Health
C/O Peak TPA
PO Box 21631
Eagan, MN 55121

EDI Payer ID: 27034

Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form. Paper claims must be submitted on current CMS standard forms, including:

- UB-04 for hospital services claims
- CMS-1500 for physician services claims and all other claims except pharmacy (i.e., DME, lab/X-ray, transportation, ancillary services, etc.)

Detailed instructions for completing each form type are available at these websites:

- CMS 1500 Form: www.nucc.org
- UB-04 Form: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf

All claims must conform to CMS clean claim requirements and claim submission guidelines including those set forth in the Medicare Claims Processing Manual and in accordance with prevailing Correct Coding Initiatives (CCI) Edits. We cannot accept handwritten claims, SuperBills or photocopied forms. Claims submitted without all required information will be returned (paper submission) or denied (electronic submission). Providers should promptly respond to requests for additional information and/or records in order to facilitate prompt payment and resolution of claims.

myPlace PACE encourages providers to submit all claims within ninety (90) days of date of service to facilitate prompt payment. Unless otherwise stated in a provider's Agreement with myPlace PACE, however, claims must be submitted within 120 days from the date of discharge or completion of service.

Claims Adjudication and Payment

myPlace PACE follows standard claims processing procedures and applicable state and/or federal laws, rules and regulations with respect to the timeliness of claims processing and payment of Clean Claims. Unless defined otherwise in a provider's contract with myPlace PACE, a "Clean Claim" means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim. (See 42 U.S.C. 1395u). It does not include a claim from a provider who is known to be under investigation for fraud or abuse, a claim under review for medical necessity or a claim for which there is no authorization or the claim does not match the services authorized by myPlace PACE prior authorization.

myPlace PACE processing procedures and edits may include, without limitation, automated systems applications or manual processes which identify, analyze and compare the amounts claimed for payment with the diagnosis codes and which analyze the relationships among the billing codes used to represent the services provided to Participants. These automated systems or manual processes may result in an adjustment of the payment to the Provider for the services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these automated systems or manual processes by submitting a timely request for reconsideration to myPlace PACE. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a noncovered service.

myPlace PACE understands that eligibility for healthcare coverage can vary based on each member's unique circumstances. As a result, our reimbursement framework accommodates this variability, ensuring a fair and equitable reimbursement process for providers. Claims reimbursement is determined by the member's eligibility status, with payments structured based on either Medicare or Medi-Cal rates, depending on the member's active coverage.

Incomplete or Pended Claims
myPlace PACE shall pend, reject or deny incomplete claims as well as claims for which information necessary to determine payer liability has been requested. Pended claims will be held awaiting receipt of additional information in writing within the time frames set forth in applicable regulations.

If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the
following information with an unlisted CPT/HCPCS procedure code on the claim form:

- A full, detailed description of the service provided.
- A report, such as an operative report or a plan of treatment.
- Any information that would assist in determining the service rendered (For example, 84999 is an unlisted lab code that requires additional explanation.)

Drug injections that do not have specific J code (J3490 thru J3999) and any assigned HCPCS J code that is not listed on the Medicare fee schedule require the NDC number, name of the drug and the dosage administered to the patient. The unit of measure billed must be defined.

Rejected vs. Denied Claims
myPlace PACE may *reject* claims that are not able to be processed (not a Clean Claim) due to missing or invalid required information. Rejected claims do not have Appeal rights. The provider must correct and resubmit the claim timely for further adjudication.

myPlace PACE will *deny* a claim if myPlace PACE determines that all or some portion of the claim is not payable due to claims requirements noted in this Manual, and, in such a case, no payment is applied to the denied claim item(s). Denied claims cannot be resubmitted for payment but may be appealed (see below).

Checking Claims Status
Providers can check the status of a claim through the following methods:

- On-line via myPlace PACE's Provider Portal (Details to be published soon)

- Calling or emailing the myPlace PACE Claims Team (See Contact Information table above)

Provider Claims Disputes and Appeals
Payment disputes and Appeals processes for contracted providers are governed by the terms of the contract between the provider and myPlace PACE. If your claim is adjusted, denied, or contested, myPlace PACE will provide a written explanation of the specific reasons for the action taken and direct the provider to access information regarding the provider dispute resolution process.

If the provider does not agree with the decision of the processed claim, you will have 60 days after receipt of the written determination of the claim to submit a dispute or 365 calendar days from the date of service or discharge to file a claim appeal.

If the provider was denied authorization or reimbursement due to not obtaining a required prior authorization, then providers have 180 calendar days from the date of service or discharge to file a claim appeal.

Overpayment and Recovery
Providers are required to report any payments made to them by myPlace PACE to which they are not entitled as well as to return any overpayment to myPlace PACE no later than sixty (60) days after the date on which the overpayment was identified and to notify myPlace PACE in writing of the reason for the overpayment.

If myPlace PACE determines that it has made an overpayment to a provider, it will make a claim for such overpayment by sending written notification to the provider that has received the overpayment. Providers have thirty (30) days from the receipt of the notice of the overpayment to contest or reimburse the overpayment.

Whether the provider is notified of an overpayment by myPlace PACE or discovers such overpayment independently, the provider must mail the refund check along with a copy of the notification or other supporting documentation to myPlace PACE Claims Department (see Contact Information table above).

If myPlace PACE does not receive payment within the required timeframe, the overpayment amount may be deducted from future claims payments.

myPlace PACE follows both State and Federal regulations regarding audits for both overpayments and underpayments. Under federal regulations, CMS has the authority to conduct audits at any time and to review claims data for up to 6 years from the data of service to identify overpayments or other errors. CMS may also recover overpayments for up to 6 years from the date of payment, unless state laws provide for a longer or shorter time frame.

Per California state laws, the time frame for recovery of overpayments by a PACE (Program of All-Inclusive Care for the Elderly) program is governed by state law. California law allows PACE programs to recover overpayments made to providers or members for up to 4 years from the date of payment.

Coordination of Benefits and Third Party Liability

Coordination of Benefits is the procedure used to process health care payments for a participant with one or more insurers providing coverage. myPlace PACE, and delegated entities for claims activities, must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits. (See 42 CFR 422.108 and MMCM, Chapter 4, Section 130). Prior to claims submission, providers must identify if any other payer has primary responsibility for payment and bill that payer prior to billing myPlace PACE (or its delegate). When a balance is due after receipt of payment from the primary payer, a claim should be submitted to myPlace PACE (or its delegated entity) for payment consideration. The claim should include information verifying the payment amount received from the primary payer as well as a copy of the primary payer's explanation of payment statement. Upon receipt of the claim, myPlace PACE (or its delegate) will review its liability using the coordination of benefits rules and/or the Medicare/Medicaid "crossover" rules—whichever is applicable.

All claims payments to providers are subject to retrospective review to determine if any third party liability exists and recovery where such liability is determined to exist. myPlace PACE may use

a vendor to conduct retrospective review on its behalf for third party liability and recovery purposes.

If a claim is denied for coordination of benefits (COB) information needed, the provider must submit the primary payer's explanation of benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 90 calendar days from the primary payer's EOB date. If a copy of the claim and EOB is not submitted within the required time frame, the claim will be denied for timely filing.

No Balance Billing

Participant balance billing is strictly prohibited. myPlace PACE payments to providers are considered payment in full, less any copays, coinsurance, or deductibles – which are the financial responsibility of the Participant. Providers are prohibited from seeking additional payment from Participants for any other unpaid balances. Providers that engage in balance billing may be subject to sanctions by myPlace PACE, CMS, DHCS, and other regulatory agencies.

Please note that providers may seek payment from a Participant for a covered service that is NOT Medically Necessary or for a non-covered service ONLY IF provider obtains written informed consent from the participant and/or legal authority for the participant stating financial responsibility for the specific services prior to services being rendered.

If a copayment, coinsurance, and/or deductible amount collected from a Participant at the time of service exceeds the Participant cost share, the provider is required to refund the overpaid amount within fifteen (15) calendar days. Providers shall not apply overpayments to outstanding balances.

To ensure compliance with Participant balance billing restrictions, myPlace PACE requires providers to investigate and resolve Participant balance billing cases within fifteen (15) calendar days of receipt, whether from myPlace PACE, a Participant, or another party. Providers are also required to cooperate with myPlace PACE to resolve any Participant balance billing issues that arise.

SECTION 5

Provider Rights and Responsibilities

Provider Responsibilities

All providers are expected to follow all laws, rules, regulations, and contract requirements and conduct business in an ethical manner. myPlace PACE expects all providers to adhere to the following:

- Providers will always act in the best interests of myPlace PACE Participants including protection of Participant's rights and sensitivity to cultural diversity and to honor participants' beliefs. Providers are expected to foster staff attitudes and interpersonal communication styles that respect participants' cultural backgrounds.
- Providers will avoid conflicts of interest. Where potential conflicts exist, providers are expected to disclose the conflict to myPlace PACE to collaboratively work to resolve such conflict.
- Providers will treat participants with dignity, respect and fairness. Participants will not be discriminated against based on race, color, religion, gender, sexual orientation, age, disability, or any other protected characteristic.
- Providers will protect the confidentiality of participant information and any confidential information of myPlace PACE.
- Providers will report any known or suspected instances of unethical or illegal behavior and will not retaliate against any staff participant who in good faith reports any such concern.
- Provider shall report timely any suspected non-compliance, fraud, waste or abuse myPlace PACE Compliance hotline (see Contact Information table above).
- Provider is expected to always understand and adhere to their myPlace PACE contract provisions.
- Provider is expected to check the government sanction and exclusion databases monthly to ensure that they, their employees, and their subcontractors are not excluded from participating in government programs. There are companies that provide monitoring services or you can monitor by going to the government sites (www.sam.gov and http://exclusions.oig.hhs.gov/). Providers need to keep documentation of this monthly monitoring activity. My Place PACE may ask for this documentation as proof the monitoring is being performed.

- Provider will provide culturally and linguistically appropriate services to participants, Interpretation and translation services are to be provided to participants at no cost.

Care Delivery and Medical Records

Provider must submit all progress notes to myPlace PACE within 72 hours of care delivery and same day if the provider is recommending any immediate and/or urgent changes to a patient's treatment regimen. This can be supplemented by a direct phone conversation with the primary care provider and/or alternate if the situation warrants.

All medical records may be sent to myPlace PACE at:
EMAIL: RecordsGLA@myPlaceHealth.com
FAX: 213 800 8881

Participant Eligibility for Continuity of Care Services

If myPlace PACE intends to terminate a provider's contract with myPlace PACE, or is notified of a provider's intent to terminate, myPlace PACE IDT will evaluate any participants under the care of the terminating provider to determine qualification for continuity of care with the terminating provider. myPlace PACE is responsible for notifying eligible participants that they have the right to request to continue to see the terminated provider for continuation of care if the participant meets continuity of care criteria and provider can provide continuity of care services. myPlace PACE will make the determination about whether the participant may continue treatment with the terminating provider.

Criteria for Assessment and Approval of Continuity of Care Services

The service must be 1) covered by myPlace PACE benefits; 2) Participant is in active treatment for certain conditions or have been authorized for treatment or procedures to be performed by the terminating provider, and 3) treatment can be safely provided under one of the following conditions within the defined time frame:

- For acute conditions (a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration), the duration of the condition.

- For serious chronic conditions (a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and does either of the following: (i) persists without full cure or worsens over an extended period of time, and (ii) requires ongoing treatment to maintain remission or prevent deterioration), a duration not to exceed 12 months from the date of the provider's termination.
- For a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less), the duration of the condition until and/or unless the participant begins end of life care .
- If the participant received authorization for surgery (or other procedure) and scheduled the surgery (or other procedure) within 180 days of the date of the provider's termination, myPlace PACE may request that the provider continue to provide the service.

Provider Responsibility for Continuity of Care

Provider is responsible for Continuity of Care of eligible myPlace PACE participants in the event of termination of provider's contact as required by California Health and Safety Code, Section 1373.96. Provider is responsible for providing continuing care under the following conditions:

- Provider's termination or non-renewal was voluntary and not for reasons related to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the California Business and Professions Code, or fraud or other criminal activity.
- Provider is subject to the same contractual terms and conditions of the original contract, including but not limited to, credentialing, hospital privileges, utilization review, peer review, and quality assurance requirements.
- Provider accepts the payment rates and methods which are described in the Provider's contract with myPlace PACE.

If contractor cannot comply with the contractual terms and conditions described in this Provider Manual and the provider's contract with myPlace PACE, then provider must provide written notice and explanation to our Provider Services team no later than forty-five dates prior to the termination of provider's contract. In

such case or if contractor is unable to comply due to retirement, disability, death, or a move out of the service area, myPlace PACE will not approve the request from the participant for the continuation of care services and seek to identify an alternative provider for our participants' care. Provider agrees to fully cooperate with myPlace PACE and the participant to transition of Participant's care in the event Provider is not providing continuity of care services.

Provider and Provider Staff Training and Compliance

All providers must adhere to required training and compliance activities including the following:

- Provider shall review this myPlace PACE Provider Manual and other myPlace PACE policies and procedures provided by myPlace PACE to provider; these documents may be updated at any time and are subject to change.
- Provider is required to provide compliance and fraud, waste, and abuse training for all staff and annually document training in staff files
- Provider shall complete all required compliance training and submit evidence of initial and annual compliance training upon request by myPlace PACE.
- Provider shall send written notice to myPlace PACE within five (5) calendar days of any legal, governmental or other action initiated against Provider.

Reporting Unusual Incidents or Occurrences

Providers will report to myPlace PACE any unusual incidents, injuries, or occurrences at or in provider's office. An unusual incident or injury is one that threatens the welfare, safety, or health of any participant and that is not consistent with provider's routine operation or patient care practices. An unusual occurrence is a fire, explosion, epidemic outbreak, poisoning, catastrophe, major accident, or like event that occurs in or on the premises of provider's office or facility which threatens welfare, safety or health of Contractor's patients, employees, or visitors**.**

Record Keeping, Record Submission, and Records Inspection

All Providers must maintain, and provide to myPlace PACE, upon request, all information related to the quality and quantity of services provided to Participants under the myPlace PACE

Provider contract. This includes but is not limited to all written documentation of care and services provided, including dates of services, time records, invoices, contracts, vouchers, or other official documentation evidencing in proper detail the nature and propriety of the services provided.

Provider is required to maintain books and records, including Participant medical records, pertaining to actions performed pursuant to Provider's contract with myPlace PACE performed by the Provider. Documentation shall be in a form consistent with and in compliance with provisions of all applicable state and federal laws. For PACE-funded services, records must be retained for a minimum of ten (10) years after termination of services as specified in Provider's Contract or from the date of completion of any audit, whichever is later.

Changes to Provider's Contact and Practice Information
Provider must notify myPlace PACE of any changes in address, telephone number, or other contact information, such as email address or contract administrator name. Provider agrees to make best efforts to submit changes at least thirty (30) days prior to the effective date of any changes. All changes should be submitted to our Provider Services team (see Contact Information table).

HIPAA and Privacy
Provider must comply with all privacy under the Health Insurance and Portability Act (HIPAA) privacy regulations with regard to any protected health information (PHI) of participants. This information includes all medical and care-related services provided to current and past participants. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) providers are responsible to keep PHI secure including paper records and emails, and should be protected against theft. The law also requires you to only share PHI with the participant's consent in all but a limited number of situations.

Any loss, theft, misuse, or accidental disclosure of PHI must be reported, immediately upon first knowledge, to the myPlace PACE Compliance Department (see Contact Information table). myPlace Health will make a determination if such information may need

to be reported to the any regulatory agency under the breach notification requirements.

There are government resources available to assist you to understand your obligations, including:
- http://www.hhs.gov/ocr/privacy/index.html
- http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative- Simplification/HIPAAGenInfo/index.html

Fraud, Waste, and Abuse

myPlace PACE has established and proactively enforces a comprehensive compliance program that investigates allegations of fraud, waste and abuse on the part of Providers and participants. myPlace PACE is required to report to California DHCS all suspected fraud, waste or abuse (FWA).

Providers must abide by all applicable fraud, waste, and abuse state and federal law, including laws and regulations designed to prevent or ameliorate fraud, waste, and abuse including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), the Anti-Kickback Statute (section 1128B(b)) of the Act). (See 42 CFR 422.504(h)(1)), Title VI of The Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act and all other laws applicable to recipients of federal funds from which payments to Providers under Provider's contract with myPlace PACE are made in whole or in part, and all applicable Medicare laws, regulations, reporting requirements, and CMS instructions.

In addition to federal and state statutes, myPlace PACE and all myPlace PACE employed and contracted providers may be subject to other legal requirements concerning the reporting of credible fraud, waste, or abuse allegations. The following describes provider's obligations with respect to eliminating fraud, waste, and abuse and provides education and other resources for providers.

- *Fraud* is defined as an intentional deception, false statement or misrepresentation made by an individual with knowledge that the deception could result in unauthorized benefit to that individual or another person. Claims submitted for services not provided are considered fraudulent.

- *Waste* is defined as failing to control costs or using Medicare or Medicaid funds to pay for services that are not determined to be necessary.
- *Abuse* is defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business or medical practices. The primary difference between fraud and abuse is "intent". Poor recordkeeping, lack of understanding of care responsibilities or reporting obligations may result in an investigation for abuse.

Examples of fraud, waste, and abuse:

- Billing for procedures not performed
- Physician kick-backs for referrals
- Authorizing and/or billing for services not medically necessary (e.g., acute inpatient instead of observation, advance life support ambulance services instead of basic life support ambulance services)
- Certifying terminal illness when criteria is not met
- Obtaining benefits without medical necessity e.g., glucose test strips, incontinence supplies, enterals) and reselling
- Billing for services that do not meet CPT/revenue code descriptions
- Falsifying information in a medical record / claim
- Improper bundling/coding of charges
- Misrepresentation by a Participant/provider to seek benefits
- Unsupported risk adjustment data (including encounter data) submitted to CMS
- Inaccurate Prescription Drug Event (PDE) and Direct/Indirect
  - Remuneration (DIR)
- Incorrect Low Income Premium Subsidy for Employer Group Waiver Plans
- Improper Opioid Prescription/Dispensing
- Incorrect enrollment into MA plans, Part D plans, and other government programs
- Investigation Process and Overpayment Recovery

myPlace PACE reviews all reports of fraud, waste and abuse. Allegations and investigative findings may be reported to appropriate regulatory and law enforcement agencies. In addition to reporting, myPlace PACE may take corrective action, including but not limited to, recovery of overpayments.

Provider Responsibilities to address Fraud, Waste and Abuse
In order to meet regulatory requirements, providers are required to be diligent and immediately report suspected fraud, waste, and abuse, including, but not limited to:

- Watching for suspicious activity and red flags; and
- Immediately reporting suspected fraud, waste, and abuse that affects myPlace

PACE or myPlace PACE participants or retaliation for making such a report.

Providers may submit FWA reports to myPlace PACE Compliance (see Contact Information table). All reports will be kept confidential to the extent possible and in accordance with applicable law. Providers may also report directly to the Federal Department of Health and Human Services (HHS) or the Office of the Inspector General (OIG):

By Phone: (800) HHS-TIPS or (800) 447-8477
By E-Mail: HHSTips@oig.hhs.gov
By Mail: Office of the Inspector General HHS TIPS Hotline, P.O. Box 23489, Washington, DC 20026

Cooperate with myPlace PACE Investigations, Resolve Issues, and Protect Your Employees from Retaliation

- Providers must cooperate with myPlace PACE's investigation of potential fraud, waste and abuse including timely responding to requests for medical records and other information;
- Providers must cooperate with any corrective action requested by myPlace PACE to resolve reports of potential fraud, waste, and abuse (including return of overpayments);
- Providers must cooperate with referrals to law enforcement and/or regulatory agencies, the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), DHCS; and
- Providers must not retaliate against employees who act lawfully in furtherance of an action under the false claims acts, including investigation for, initiation of, testimony for, or assistance in an action filed, or to be filed under the false claims acts. Retaliation includes, but is not limited to, discharge, demotion, suspension, threats, harassment, or any

other manner of discrimination against the employee in the terms and conditions of employment.

Compliant Policies, Procedures, and Practices

In addition to the Provider Responsibilities described in this section, myPlace PACE contracted providers are responsible for:

- Establishing and maintain appropriate policies, procedures, and practices – update regularly to address trends in fraud, waste, and abuse (e.g., prescription drug abuse and hospice enrollment fraud)
- Striving for accuracy and excellence in service, coding, and billing
- Documenting participant medical records properly and accurately (e.g., do not up-code, do not bill for services not rendered/not Medically Necessary, unbundle services, do not submit duplicate billing, etc.)
- Safeguarding privacy
- Maintaining records accurately and timely

Provider Roles and Responsibilities

In addition to the Provider Responsibilities described in this section, myPlace PACE contracted providers are responsible for the following:

- Providing medical services to participating within the scope of their license
- Setting appointments for services within 14 days of request or within 2 business days for services requested on an urgent basis
- Providing only services that are authorized by myPlace PACE and covered under myPlace PACE benefits
- Communicating findings and outcomes of the visit or service to participant's myPlace PACE PCP, including recommendations for further diagnostic procedures or therapy
- Coordinating laboratory and X-ray request(s) with the myPlace PACE IDT
- Contacting the participant's myPlace PACE PCP if a referral to another specialist or testing and services beyond those authorized are recommended

Participant Grievance Procedures
Provider must adhere and cooperate in the Participant Grievance Procedures described in Section 10 of the Provider Manual.

Provider Dispute Resolution Process
myPlace PACE manages a dispute resolution process to address and resolve administrative, operational, contractual, and payment disputes from contracted and non-contracted providers in a timely, fair, and cost-effective manner. myPlace PACE makes best efforts to resolve provider disputes on a timely basis with the mutual satisfaction of all parties.

Providers should report any administrative, operational, contractual, or claims/payment concerns, issues, or disputes in writing to our Provider Services team (see Contact Information table). Disputes must be filed within 365 calendar days of myPlace PACE's action, or in the case of inaction, within 365 calendar days after the time for contesting or denying claims has expired.

Provider disputes can be submitted to our Provider Services team (see Contact Information table above). When filing a dispute, the following information must be included:

- The provider's name and identification number (i.e., NPI)
- The provider's contact information, including address, telephone number, and fax number of the provider's contact person
- An explanation of the dispute or issue, including any relevant attachments, documentation, and supplemental information
- The name, ID number, and date of service of the myPlace PACE participant for disputes involving a service provided to a specific participant

Cultural and Linguistic Services
Cultural and linguistic competence among health care providers is essential to the care satisfaction of participants. The goal of the myPlace PACE cultural and linguistic services program is to ensure the participants, both with and without limited English proficiency, have access to quality health care and services that are culturally and linguistically appropriate.

myPlace PACE participants have rights to language assistance services provided by myPlace PACE and contracted providers. Interpretation and translation services may be provided to participants at no cost. myPlace PACE provides collateral and materials to participants in various languages.

Contractors will provide culturally and linguistically appropriate services to participants. myPlace PACE can support with language assistance upon request at no cost to the participant. For assistance with interpretation or translation services for the participants, a participant or provider can contact myPlace PACE IDT (see Contact Information table above).

SECTION 6

Network Participation and Credentialing

Credentialing and Recredentialing Requirements

Provider participation in myPlace PACE's provider network requires contractors to comply with the myPlace PACE credentialing requirements prior to providing services to myPlace PACE participants and complete the recredentialing process every three years thereafter. Network providers may fulfill this requirement through an attestation. Please contact our Provider Services team for more details.

Adding or Deleting Providers from Existing Provider Contract

Contractor shall immediately notify myPlace PACE of new associated providers and the termination of any provider's status as an associated provider under the myPlace PACE Provider Service Agreement. Send notification of additions or deletions of associated providers to our Provider Services team.

SECTION 7
Quality Assurance

Quality Improvement, Oversight and Review
myPlace PACE maintains a thorough Quality Management Plan that includes both internal and external review processes. This program monitors quality issues through chart audits, grievance reports, statistical information and other data sources, and develops and implements changes to enhance program quality and effectiveness. A willingness to cooperate with and participate in this review process is expected of all providers.

myPlace PACE also has an Ethics Committee composed of leading members of the medical, legal and lay communities. This committee's primary responsibility is to review and assist with formulating policy on ethical issues and review individual participant cases as required.

myPlace PACE Medical Advisory Committee is composed of myPlace PACE staff, and various community physicians with an interest and background in geriatrics and/or long-term care. This committee is ultimately responsible for all medical quality assurance activities, establishing standards for all quality assurance activities, establishing standards for all contract providers, and approving all contracted services.

In order to comply with CFR 42§460.120, §460.132(c)(3) and CFR §460.136(c)(1), myPlace PACE (and all PACE Organizations) must require contracted providers to participate in the development and implementation of quality improvement activities and to be informed of the outcomes of these activities.

To fulfill these requirements, myPlace PACE requests the following from Contracted Providers:

- Promptly report any complaints by the participant, their caregiver, or designated representative, expressing dissatisfaction with service delivery or the quality of care furnished

- Promptly report any falls experienced by our participants (falls are defined as the sudden, unintentional, descent of the body to the floor/ground, or another object),

- Promptly provide reports of any participant that has been sent emergently to the Emergency Room and/or Hospital or have an adverse reaction to treatment

- Provide a designated email address to receive:

    - Invitations to the quarterly Quality Improvement Committee meeting, and

    - Materials related to quality improvement activities and their outcomes.

SECTION 8

Participant Rights and Responsibilities

PACE Participant Bill of Rights

myPlace PACE provides high quality health care services so participants may remain as independent as possible. This includes providing covered items and services and other services determined to be necessary by the interdisciplinary team across all care settings. Participants are made aware of their rights and responsibilities at the time of enrollment and at least annually thereafter.

A copy of the myPlace PACE participant's Bill of Rights is located in the Appendix of this document.

Participant Appeal and Grievance Process

myPlace PACE ensures the participant, or the participant's representative, is able to express his/her concerns or dissatisfaction with services and quality of care delivered by myPlace PACE staff or contract providers. The Appeal and Grievance procedures enable myPlace PACE to address complaints in a timely and efficient manner when they arise and allow for a systematic resolution.

myPlace PACE Appeals Policy and myPlace PACE Grievance Policy are attached in the Appendix to this Provider Manual.

SECTION 9

Definitions

- **myPlace Heath** means Prosper Services LLC (doing business as "myPlace Health"), which is the parent organization to myPlace PACE
- **myPlace PACE** means myPlace Greater LA PACE Inc. and myPlace South LA PACE Inc. (both doing business as "myPlace PACE"), which are subsidiaries of myPlace Health that operate PACE (Program of All-Inclusive Care for the Elderly) programs.
- **Provider** means the individual provider, provider group, or provider organization that has signed an agreement with myPlace PACE to participate in the myPlace PACE provider network to provide covered services.
- **Interdisciplinary Team (IDT)** means the team of myPlace PACE healthcare professionals responsible for coordination and authorization of all participant care provided by myPlace PACE.
- **Participant** means any individual enrolled in a myPlace PACE benefit program and is entitled to receive Covered Services.

APPENDIX 1

Appeals Policy

Purpose: To provide for responses to, and resolution of appeals as expeditiously as the participant's health condition requires, while maintaining confidentiality, in accordance with regulatory and contractual requirements.

Policy: myPlace PACE is committed to ensuring that a participant, a participant's representative, or a treating provider has the right to appeal myPlace PACE's decision to deny, defer or modify a particular care-related service or its decision not to pay for a service received by a participant.

myPlace PACE will handle all appeals in a respectful manner and will maintain the confidentiality of a participant's appeal throughout the appeals process and after the appeals process is completed. Information pertaining to appeals will not be disclosed to program staff or contract providers, except where appropriate to resolve the appeal.

Contract providers are accountable for all appeal procedures established by myPlace PACE. myPlace PACE will monitor contracted providers for compliance with this requirement on an annual basis or on an as needed basis.

Definitions:

- **Appeal:** a participant's action taken with respect to the PACE organization's noncoverage of, or nonpayment for a service including denials, reductions, or termination of services. A request to initiate, modify or continue a service will first be processed as a service determination request under §460.121 before the PACE organization can process an appeal. An appeal may be filed verbally, either in person or by telephone or in writing.
- **Standard appeal:** is a standard review process for response to, and resolution of, appeals as expeditiously as the participant's health requires, but no later than 30 calendar days after the PACE organization receives an appeal.
- **Expedited appeal:** occurs when a participant believes that his or her life, health, or ability to regain or maintain maximum

function could be seriously jeopardized, absent provision of the service in dispute. The PACE organization will respond to the appeal as expeditiously as the participant's health condition requires, but no later than 72 hours after it receives the appeal.

- **Extended appeal:** The 72-hour timeframe may be extended by up to 14 calendar days for either of the following reasons:
  - The participant requests the extension.
  - The PACE organization justifies to the State administering agency the need for additional information and how the delay is in the interest of the participant.
- **Disputed health care service:** any health care service eligible for payment under the enrolled participant's contract with myPlace PACE that has been denied, modified, or delayed by a decision of myPlace PACE in whole or in part due to the finding that the service is not necessary.
- **Necessary** or **Necessity:** reasonable and 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:** a person who is acting on behalf of or assisting a participant, and may include, but is not limited to, a family member, a friend, a PACE employee, or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

General Information:

- The Quality Director has primary responsibility for maintenance of the procedures, review of operations, and utilization of any patterns of appeals to formulate policy changes and procedural improvements in the administration of the plan.
- myPlace PACE will continue to furnish the participant with all services at the frequency provided in the current plan of care during the appeals process.
- myPlace PACE will not discriminate against a participant solely on the grounds that an appeal has been filed.
- myPlace PACE will ensure that a participant is able to access and participate in the appeals process by addressing the linguistic and cultural needs of its participants, as well as the

needs of participants with disabilities. myPlace PACE will ensure the following:

- If the person filing the appeal does not speak English, a bilingual staff member will be available to facilitate the process. If a staff person is not available, translation services/ interpreter will be made available.
- All written materials describing the appeal process are available in all languages required for the myPlace PACE service area.
- myPlace PACE maintains a toll-free number for the filing of appeals.

- myPlace PACE will provide written information about the appeal process to a participant and/or their representative upon enrollment, at least annually thereafter, and whenever the interdisciplinary team denies, defers, or modifies a request for services or refuses to pay for a service. Information includes, but is not limited to:
  - Procedures for filing an appeal, including participant's external appeal rights under Medicare and Medicaid (in California, Medi-Cal).
  - Telephone numbers for the filing of appeals received.
  - Location where written appeals may be filed.
- Any method of transmission of appeals information from one myPlace PACE staff to another shall be done with strictest confidence, in adherence with HIPAA regulations.
- myPlace PACE will assist the participant in choosing which external appeals process to pursue if both are applicable and forward the appeal to the appropriate external entity.

Procedure

The appeal process is available to any participant, their representative or treating provider who disputes denial of payment for a service, or the denial, deferral, or modification of a service by the primary care physician (PCP) or any member of the interdisciplinary team (IDT) who is qualified to make referrals. A participant or their representative may submit the request to myPlace PACE either verbally, by telephone, in person, or in writing.

A. Filing an Appeal

1. An appeal for denial, deferral or modification of a service or payment for a service may be filed verbally or in writing.

- **a.** A participant and/or their representative may verbally request an appeal by speaking to the Program Director, Center Director, Social Worker, or any member of the IDT.
- **b.** At the time of denial or at any time upon request, myPlace PACE provides a participant and/or their representative with an "**Appeal for Reconsideration of Denial**" form (see Attachment 3). The participant and/or his/ her representative completes the form, which constitutes a written request to appeal a myPlace PACE decision.
- **c.** The Social Worker will assist the PACE participant and/ or their representative in filing an appeal in the event assistance is required.

2. An appeal may be filed as a **"standard appeal"** or an **"expedited appeal"**, depending on the urgency of the case:

- **a.** A **standard appeal** may be filed verbally or in writing with any myPlace PACE staff within 180 calendar days of a denial of service or payment. The 180 calendar-day limit may be extended for good cause by myPlace PACE.
- **b.** An **expedited appeal** may be filed verbally or in writing to myPlace PACE if the participant or a treating physician believes that the participant's life, health, or ability to regain maximum function would be seriously jeopardized without provision of the service in dispute. In the case of an expedited appeal, the Quality Director will immediately contact the Medical Director.

3. The Quality Director will notify the appropriate myPlace PACE individual based on the nature of the appeal:

- **a.** Appeals related to disputed health care services should be directed to the Medical Director.
- **b.** Appeals related to disputed health care services or payment issues should be directed to the Program Director or their designee.

4. For myPlace PACE participants enrolled in Medi-Cal, the myPlace PACE IDT will continue to furnish the disputed service if the following conditions are met:

- **a.** myPlace PACE is proposing to terminate or reduce services currently being furnished to the PACE participant.
- **b.** The participant requests continuation of the service with the understanding that they may be liable for the cost of the contested service if the determination is not made in favor. (Reference the "**Appeal for Reconsideration of Denial**" for participant's decision.)

5. If the above conditions are met, myPlace PACE will not discontinue the disputed service for which an appeal has been filed until the appeals process has concluded.

B. Documentation of Receipt of Appeal

- All appeals expressed either verbally and/or in writing, will be documented on the day that it is received or as soon as possible after the event or events that precipitated the appeal, in an **Appeal Log** (Attachment 7).
- Appeals are then documented on the **Appeal for Reconsideration of Denial Form** (Attachment 3) by the participant, their representative or by a treating provider, on behalf of the participant. Complete information will be provided so that the appeal can be resolved in a timely manner.
- If insufficient information is received, the Quality Director will take all reasonable steps to contact the participant, their representative, or other appropriate parties to the appeal to obtain missing information to resolve the case within the designated timeframes for an expedited and standard appeal.

C. Acknowledgement of Receipt of Appeal

- The Medical Director or Program Director will acknowledge a standard appeal in writing using the **Acknowledgement of Receipt of Appeal Form** (Attachment 4) within five (5) working days of the initial receipt of appeal by myPlace PACE.

- Expedited appeals will be acknowledged within one (1) business day by telephone or in person - whereby the Quality Director will inform the participant or their representative that their request has been received and along with an explanation of the participants additional appeal rights.

D. Determination and Notification of an Appeal

When the IDT receives a request it will make its decision and notify the participant or their designated representative of its decision to approve, deny, defer, or modify the request as expeditiously as the participant's condition requires, but no later than 72 hours or 3 calendar days after the date the IDT receives the participant's request.

myPlace PACE will give all parties involved in the appeal appropriate written notification of the decision to approve or deny the appeal.

- **Favorable Decision:** when the decision of an appeal is **in favor of a participant** that is, the decision to deny, defer, or modify a service or payment of a service is reversed, the following applies:
  - **a.** Program Director or designee provides a written response to the participant and/or representative, sent by mail, within 30 calendar days of receiving a standard appeal or sooner if the participant's health condition requires using the **Notice of Appeal Resolution** (Attachment 5).
  - **b.** myPlace PACE will provide authorization to get the disputed service or provide the service as quickly as the participant's health condition requires, but no later than 30 calendar days from the receipt of the request for a standard appeal.
  - **c.** For an expedited appeal, myPlace PACE will provide the participant permission to obtain the disputed service or provide the service as quickly as the participant's health condition requires, but no later than 72 hours from the receipt of a request for an expedited appeal.
  - **d.** If the decision to deny payment for a service is reversed by myPlace PACE, then payment will be made within 60 calendar days of receiving the participant's or representative's request for a standard or expedited appeal.

- **Partially or Fully Adverse Decision:** when the decision of an appeal is **not in favor of the participant** that is, the decision to deny, defer or modify provision or payment of a service is upheld, or if the participant is not notified of the decision within the specified time frame for a standard or expedited appeal, the Quality Director will do the following:
    - **a.** Notify in writing, at the time the decision is made, and within 30 calendar days from the date of the request for a standard appeal and within 72 hours for an expedited appeal using the **Notice of Appeal Decision** (Attachment 6).
        1. The participant and/or their representative
        2. Health Plan Management System (HPMS)
        3. Long-Term Care Division, Department of Health Care Services
    - **b.** Notify the participant and/or their representative in writing of their appeal rights through the Medicare or Medi-Cal program depending on the participant's eligibility using the **Information for Participants about the Appeal Process** (Attachment 2).
    - **c.** Offer to assist the participant or participant's representative in choosing which external appeal route to pursue (if desired) and to assist in preparation of appeal.
    - **d.** Forward the appeal to appropriate external entity.

- myPlace PACE will have an expedited appeals process for situations in which the participant believes that his or her life, health, or ability to regain or maintain maximum function could be seriously jeopardized, absent provision of the service in dispute

- **Expedited Appeal:** For an expedited appeal supported by a physician, the myPlace PACE IDT will decide as promptly as the participant's health condition requires, but no later than 72 hours after receipt of the request for appeal.
    - If a participant's request for expedited appeal is not supported by a physician, the myPlace PACE Medical Director will decide if the participant's health situation requires deciding within 72 hours. If the participant's health does not warrant an expedited appeal process, the myPlace PACE Medical Director notifies the participant within 72 hours that the appeal will be treated as a standard appeal.

- The Program Director or designee will provide the participant and/or their representative and the Department of Health Care Services with a written statement of the final disposition or pending status of an expedited appeal within 72 hours of receipt of an appeal.
- In the event the 72-hour timeframe will be extended, myPlace PACE will provide justification to the DHCS for need of the extension. myPlace PACE will notify participant both verbally and in writing of the pending status and reason for the delay in resolving the appeal. The participant will be notified of the anticipated date by which the appeal decision will be determined.

- **Extensions:** The interdisciplinary team may extend the 72-hour timeframe for review and notification by up to 5 calendar days if either of the following occur:
  - The participant, or other requestor including the designated representative or participants caregiver requests the extension.
  - The extension is in the participant's interest because the interdisciplinary team needs additional information from an individual not directly employed by the PACE organization that may change the interdisciplinary team's decision to deny a service. The interdisciplinary team will document the circumstances that led to the extension and demonstrate how the extension is in the participant's best interest.
- **Notice of Extension:** When the interdisciplinary team extends the timeframe, it will notify the participant or their designated representative either orally or in writing. The notice will explain the reason(s) for the delay and will be issued as expeditiously as the participant's condition requires, but no later than 24 hours after the IDT decides to extend the timeframe.
- **Opportunity to submit evidence:** All individuals involved with the appeal, including the participant or their representative, will be given written notice of the appeals process and reasonable opportunity to present evidence or submit relevant facts for review to myPlace PACE, either verbally or in writing.

E. Documentation Requirements

myPlace PACE will give all parties involved in the appeal appropriate written notification of the decision to approve or deny the appeal.

- **Notice of a favorable decision.** Notice of any favorable decision will explain the conditions of the approval in understandable language.
- **Notice of partially or fully adverse decisions.** A myPlace PACE notice of any denial will:
  - **a.** State the specific reason(s) for the denial.
  - **b.** Explain the reason(s) why the service would not improve or maintain the participant's overall health status.
  - **c.** Inform the participant of his or her right to appeal the decision.
  - **d.** Describe the external appeal rights under §460.124.

At the same time a decision is made, myPlace PACE will also notify the following:

- CMS
- The State Administering Agency

- Notification of the denial, deferral or modification of service or denial of payment is made 1) verbally in person or by telephone, and 2) in writing, using the **Notice of Action for Service Request (NOA) Form** (Attachment 1).
- An IDT member will document in the medical record that a denial, deferral or modification of service or denial or payment has been made, using '**Denial of Service'** in the title of the progress note.
- myPlace PACE will notify the participant in writing of their right to appeal the denial for reconsideration by myPlace PACE and of their external appeal rights, using the **Information for Participants about the Appeals Process** notice (Attachment 2).
- If the interdisciplinary team fails to provide the participant with timely notice of the resolution of the request or does not furnish the services required by the revised plan of care, this failure constitutes an adverse decision, and the participant's request will be automatically processed by myPlace PACE as an appeal.

F. Reconsideration of Decision for Service Request or Payment of a Service

An appeal will be reviewed by an appropriate credentialed and impartial third-party or committee. An appropriate third-party reviewer or member of a review committee will be an individual who meets the following criteria:

- Appropriately credentialed in the field(s) or discipline(s) related to the appeal.

myPlace PACE will utilize qualified and credentialed third party reviewers or committee to review these appeals.

An impartial third-party will meet the following criteria:

- Was not involved in the original action.
- Does not have a stake in the outcome of the appeal.

The distribution of written or electronic materials to the third-party reviewer or committee will explain the following:

a. Services will be provided in a manner consistent with the requirements in §460.92; Required Services and §460.98; Service Delivery.

b. The need to make decisions in a manner consistent with how determinations under section 1862(a)(1)(A) of the Act are made.

c. The rules in §460.90(a) PACE benefits under Medicare and Medicaid that specify that certain limitations and conditions applicable to Medicare or Medicaid or both benefits do not apply.

H. External Review Options for Appeal / Medi-Cal External Appeal Process

1. This option for external appeal is available to participants enrolled in Medi-Cal, that is, “Medi-Cal only” or “both Medi-Cal and Medicare”. If the participant and/or representative chooses to appeal using the Medi-Cal external appeal process, the Social Worker will assist the participant and forward the appeal to:

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
Facsimile: (916) 229-4410
TDD: 1-800-952-8349

2. myPlace PACE will not discontinue services for which an external appeal has been filed until the external appeal process has concluded. However, if myPlace PACE's initial decision to deny, discontinue or reduce a service is upheld, the participant may be financially responsible for the cost of the disputed service provided during the external appeal process.

3. If a participant and/or their representative want a state hearing, he or she will ask for it within 90 calendar days from the date of the NOA (Attachment 1). A participant and/or their representative may speak at the State hearing or have someone else speak on the participant's behalf, including a relative, friend or an attorney.

- **a.** For legal assistance, the participant and/or their representative may be able to get free legal help. To facilitate this, the Quality Director will provide a listing of *"Legal Services Listing"* to the participant and/or their representative (Attachment 8).
- **b.** myPlace PACE is required to provide written position statements whenever notified by DHCS that a participant has requested a state hearing. The myPlace PACE Quality Director will make testimony at State hearings whenever notified by DHCS of the scheduled time and place for a state hearing.
- **c.** If the Administrative Law Judge (ALJ) decision is in favor of the participant's appeal, myPlace PACE will follow the judge's instruction as to the timeline for provision of services to the participant or payment for services for a standard or expedited appeal.
- **d.** If the ALJ's decision, adopted by the Director as final, is not in favor of the participant's appeal, the participant may request a re-hearing with the Director within 30 calendar days after receiving the final decision.

e. Within one year after receiving notice of the Director's final decision, the participant may file a petition with the superior court, under the provisions of Section 1094.5 of the Code of Civil Procedure.

4. The following option for external appeal is available to participants enrolled in Medicare, that is, "Medicare only" or "both Medicare and Medi-Cal":

a. A Medicare enrollee may choose to appeal myPlace PACE's decision using Medicare's external appeals process. myPlace PACE will send the appeal to the current contracted Medicare appeals entity.

b. The contracted Medicare appeals entity maintains a standard and expedited appeal process. Standard appeals will be resolved within 30 calendar days after filing of the appeal; expedited appeals will be resolved with 72 hours (with a possible 14 calendar day extension).

c. The contracted Medicare appeals entity will contact myPlace PACE with the results of the review. The contracted Medicare appeals entity will either maintain myPlace PACE's original decision or change myPlace PACE's decision and rule in the participant's favor.

d. If the contracted Medicare appeals entity's decision is not in the participant's favor, there are further levels of external appeal, and if requested by the participant and/or representative, the Social Worker will assist a participant in further pursuing the appeal.

I. Documentation, Tracking, Analysis and Reporting

1. All appeals related information shall be marked "confidential."

2. All Appeal-related information and correspondence, including the appeals log will be stored in locked cabinets in the Quality Director.

3. The **Appeals Log** (Attachment 7) will contain, at a minimum, the following information:

a. Name and telephone number of the staff person recording the appeal

b. Date the appeal was filed

c. Participant's and/or her/her representative's name and/or person filing the appeal
d. Description of the appeal
e. Action taken
f. Description and date of the final resolution.

4. myPlace PACE will submit a summary of all grievances in the quarterly report to the DHCS, Long Term Care Division and Centers for Medicare and Medicaid Services. The DHCS appeals summary is due 45 calendar days from the date of the end of the reporting quarter.
5. A written summary of appeals including number, type, location, and disposition are reported to the Quality Management Team, Quality Improvement Committee and the myPlace PACE Board of Directors on a quarterly basis.
6. Records of all appeals will be held confidentially and made available as needed to State and Federal agencies upon request.
7. myPlace PACE shall maintain in its files, copies of all appeals, the responses and recording of log for ten (10) years from the date the appeal was filed.
8. To ensure timeliness and accuracy in the appeals process, myPlace PACE shall perform regular audits of the appeals log and files to ensure they correspond with other data reporting systems (i.e., HPMS reports).
9. Recordkeeping: myPlace PACE will establish and implement a process to document, track, and maintain records related to all processing requirements for service determination requests received both orally and in writing. These records will be available to the interdisciplinary team to ensure that all members remain alert to pertinent participant information.
10. Analyzing appeals information: myPlace PACE will maintain, aggregate, and analyze information on appeal proceedings and use this information in the organization's internal quality improvement program. Quality Director is responsible for maintaining, aggregating, and analyzing information related to appeals to identify trends or patterns. On a quarterly basis, this information will be forwarded to myPlace PACE IDT staff.

J. Annual Review

The appeals process will be reviewed with participants and/or their representative, contract providers and all employees of myPlace PACE on an annual basis. The myPlace PACE Social Worker will be responsible for performing this review with participants and their representatives. The myPlace PACE Network Coordinator will be responsible for ensuring this review occurs with contract providers. The PACE Program Director will ensure this review occurs with all employees of myPlace PACE.

APPENDIX 2

Grievance Policy

Purpose:

To provide for resolution of medical and non-medical grievances within thirty (30) calendar days while maintaining confidentiality, in accordance with regulatory and contractual requirements.

Policy:

myPlace PACE is committed to assuring that PACE participants are satisfied with the service delivery or quality of care they receive. myPlace PACE has an established grievance process to address participants' concerns or dissatisfaction about services provided, provision of care, or any aspect of the PACE program.

myPlace PACE will handle all grievances in a respectful manner and will maintain the confidentiality of a PACE participant's grievance throughout and after the grievance process is completed and information pertaining to grievances will only be released to authorized individuals.

Contract providers are accountable for all grievance procedures established by myPlace PACE. myPlace PACE will monitor contracted providers for compliance with this requirement on an annual basis or on an as needed basis.

Definitions:

- **Grievance:** 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:
  - 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
- violation of a participant's rights.

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

General Information:

1. The Executive Director in collaboration with the Director of Quality has primary responsibility for maintenance of the procedures, review of operations, and utilization of any emergent patterns of grievances to formulate policy changes and procedural improvements in the administration of the plan.

2. myPlace PACE will continue to furnish the PACE participant with all services at the frequency provided in the current plan of care during the grievance process.

3. myPlace PACE will not discriminate against a PACE Participant solely on the grounds that a grievance has been filed.

4. To ensure PACE participants, have access to and can fully participate in the grievance process, myPlace PACE will ensure the following:

a. If the person filing the grievance does not speak English, a bilingual staff member will be available to facilitate the process. If a staff person is not available, translation services/ interpreter will be made available.

b. All written materials describing the grievance process are available in the appropriate languages for the myPlace PACE service area.

c. myPlace PACE participants may report grievances by calling myPlace PACE.

d. Persons requiring the use of a Telephone Relay Service may report grievances to myPlace PACE by calling the TTY line.

5. myPlace PACE will provide written information about the grievance process to a PACE participant and/or his/her representative upon enrollment, annually, and upon request. Information includes, but is not limited to:

a. Procedures for filing grievances including:

- Information on telephone numbers for the filing of grievances received in person or by telephone. myPlace PACE participants may report grievances by calling myPlace PACE. Persons requiring the use of a Telephone Relay Service may report grievances to myPlace PACE by calling the TTY line.
- Information on the location where written grievances may be filed, if filing by mail, can be found in the enrollment handbook:

  myPlace Health Greater LA PACE Inc.
  Attn: Director of Quality
  121 South Mountain View Ave, Los Angeles, CA 90057
  Los Angeles, CA, 90057

b. Information on External Review Options, including a PACE participant's right to request a State Hearing covered under Medi-Cal.

6. Any method of transmission of grievance information from one myPlace PACE staff to another shall be done with strictest confidence, in adherence with HIPAA regulations.

Procedure and Explanation

Explaining the grievance process. myPlace PACE will discuss with and provide to the participant in writing the specific steps, including timeframes for response, that will be taken to resolve the participant's grievance.

a. Filing of Grievances

1. A PACE participant and/or his/her representative, may voice a grievance to PACE program staff in person, by telephone or in writing to a PACE location. If the participant does not want to participate in the grievance process or the participant wishes to remain anonymous, the grievance will still be submitted and analyzed with this information noted on the form.

2. Any myPlace PACE staff member can assist the PACE participant and/or his/her representative in filing a grievance in the event assistance is required.
3. The Grievance Report Form (Attachment #1) is available from myPlace PACE Quality Improvement Associates or other PACE staff. The Social Worker will provide the PACE participant and/or his/her representative with a report form if requested (either in person, by telephone, or in writing).
4. In addition to the Grievance Report, the Social Worker will provide the PACE participant and/or his/her representative with "Information for Participants about the Grievance Process" (Attachment #2).

b. Documentation of Grievances

1. All grievances expressed either orally and/or in writing, will be documented on the day that it is received or as soon as possible after the event or events that precipitated the grievance, in the PACE Participant Grievance Log (Attachment #6).
2. Grievances submitted in writing are documented on the "Grievance Report" Form (Attachment #1) by the PACE participant and/or his/her representative. The Quality Improvement associate will assist with the completion of the Grievance Report, if necessary. Grievances received either in person or by telephone are documented on the "Grievance Report" form by the myPlace PACE staff person.
3. Complete details of the grievance must be documented so that the grievance can be resolved within thirty (30) calendar days. In the event of insufficient information, the Quality Improvement Associate will take reasonable efforts to obtain the missing information in order to resolve the grievance within the specified timeframes.
4. All information related to a PACE participant's 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 a PACE participant has elected to file a grievance with myPlace PACE will appear in the medical record.
5. It is the responsibility of the Quality Improvement Associate and all PACE staff to ensure confidentiality is maintained,

documentation is complete and accurate, and grievance process is implemented and completed according to Policies and Procedures.

c. Acknowledgement, Notification, and Initial Investigation of Grievance

1. All PACE staff receiving a participant grievance will notify the Quality Improvement Associate within one working day of receipt of the grievance.
2. The Quality Improvement Associate responsible for coordinating the investigation, designating the appropriate staff member(s) to take corrective actions, and reporting the grievance to the interdisciplinary team.
3. The Quality Improvement Associate will acknowledge receipt of the PACE participant's grievance in writing, within five (5) calendar days of receipt of the grievance (Attachment #3, *Receipt of Grievance)* and document this step in the Grievance Log. When necessary, the Quality Improvement Associate will acknowledge receipt of the grievance by telephone. We will discuss with and provide to the participant in writing the specific steps, including timeframes for resolution of grievance.
4. The Quality Improvement Associate notifies the management or supervisory staff responsible for the services or operations which are the subject of the grievance.
5. Grievances related to medical quality of care will be immediately submitted to the myPlace PACE Medical Director by the Quality Improvement Associate for appropriate action.
6. When grievances related to services provided by a myPlace PACE contracted service provider arise, the Quality Improvement Associate notifies the contracted service provider.
7. When a grievance involves a violation of a PACE participant's rights, the Quality Improvement Associate will notify the myPlace PACE Executive Director immediately to begin investigation of the grievance.

d. Resolution of Grievances

1. myPlace PACE will resolve grievances within thirty (30) calendar days from the day the grievance is received. The Quality Improvement Associate will make reasonable efforts to contact the PACE participant and/or his/her representative by telephone or in person to advise him/her of the outcome of the grievance investigation and determine his/her satisfaction or dissatisfaction with the outcome of the investigation.
2. The Quality Improvement Associate will send written notification of the resolution of the grievance to the PACE participant and/or his/her representative (Attachment #4, *Letter for Resolved Grievance*)
3. In the event resolution is not reached within thirty (30) calendar days, the participant and/or his/her representative will be notified in writing of the status and estimated completion date of the grievance resolution. (Attachment # 5*, Letter for Pending Grievance)*
4. The Quality Improvement Associate will document all steps of the grievance resolution in the PACE Participant Grievance Log. This will include how the PACE participant and/or his/her representative was notified and, whether or not he/she was satisfied or dissatisfied with the outcome.

e. Expedited Review of Grievances

1. In the event the grievance involves a serious or imminent health threat to a PACE participant, including, but not limited to, severe pain, potential loss of life, limb or major bodily function or when a participant's rights have allegedly been violated, the
2. Quality Improvement Associate will expedite the review process to a decision within 72 hours of receiving the Participant's grievance.
3. The PACE participant and**/**or his/her representative will inform the Quality Improvement Associate or other PACE staff of his/her request either verbally or in writing. While the PACE participant may file a verbal grievance, he/she should be assisted, as necessary, by the Quality Improvement Associate to document the grievance in writing prior to resolution.

4. If the PACE participant files an expedited grievance during weekend hours (4:30 p.m. Friday to 8:00 a.m. Monday), Program Staff will immediately contact an authorized supervisor of the program (Medical Director, Program Director) to investigate the grievance with the PACE participant and/or his/her representative. This individual will notify the Quality Improvement Associate at the start of normal business hours of the status of the grievance.
5. As soon as possible but no later than one business day after the PACE participant files an expedited grievance, the Quality Improvement Associate informs the PACE participant and/or his/her representative by telephone or in person of the receipt of the grievance for expedited review and describes the steps that will be taken to resolve the grievance.
6. The PACE participant and/or his/her representative are informed both verbally and in writing of their right to notify the Department of Health Care Services (DHCS) and California Department of Social Services of the grievance (as described below under Grievance Review Options).
7. The Quality Improvement Associate will expedite the internal review process to reach a decision within 72 hours of receiving the grievance.
8. The Quality Improvement Associate will notify the PACE participant and/or his/her representative in writing of the resolution of the expedited grievance. The PACE participant will be notified verbally and in writing if resolution is not possible within 72 hours. The written notification for delay will include the reason for the delay and the timeframe for when the grievance will be resolved.

f. Grievance Review Options

1. After a PACE participant has completed the grievance process (as described above) or has participated in the grievance process for at least thirty (30) calendar days and he or she is dissatisfied with the resolution of the grievance, the Participant may pursue other steps.
   a. Note: If the situation represents a serious health threat, the Participant and/or his/her representative need not complete the entire grievance process nor wait thirty (30) calendar days to pursue to steps described below.

2. If the Participant is eligible for Medi-Cal only or for Medi-Cal and Medicare, he or she 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
Mail Station 4412
Sacramento, CA 95899-7413
Telephone: 1-888-452-8609
TTY: 1-800-735-2922

3. At any time during the grievance process, whether the grievance is resolved or unresolved, per California State law, the PACE Participant and/or his/her representative may request a State hearing from the California Department of Social Services by contacting or writing to:

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
Facsimile: (916) 229-4410 T
DD: 1-800-952-8349

4. If a PACE participant and/or his/her representative wants a state hearing, he or she must ask for it within 90 calendar days from the date of the resolution letter (Attachment #4, *Letter for Resolved Grievance*). A PACE participant and/or his/her representative may speak at the State hearing or have someone else speak on the PACE participant's behalf, including a relative, friend or an attorney.

5. For legal assistance, the PACE participant and/or his/her representative may be able to get free legal help. To facilitate this, the Quality Improvement Associate will provide a listing of Legal Services Offices to the Participant or his/her representative (Attachment #7)

6. myPlace PACE is required to provide written position statements whenever notified by DHCS that a PACE participant has requested a state hearing. The myPlace PACE will designate staff the Quality Improvement Associate or other PACE staff, as necessary, to provide testimony at State hearings whenever notified by DHCS of the scheduled time and place for a state hearing.

g. Documentation, Tracking, Analysis and Reporting

1. All grievances related information shall be marked "confidential."
2. All grievance information and details of verbal correspondence will be documented by the Quality Improvement Associate in the Participant Grievance Log and stored in locked cabinets in the Quality Improvement office.
3. The Quality Improvement Associate is responsible for maintaining, aggregating, and analyzing information related to grievances. On a quarterly basis, this information will be forwarded to the Quality Improvement Committee (i.e., part of the quality program) and will be reported to the myPlace PACE Board of Directors.
4. A written summary of grievances including number, type, location, and disposition are reported to the Quality Improvement Committee and myPlace PACE Board of Directors on a quarterly basis.
5. myPlace PACE will submit a summary of all grievances in the quarterly report to the DHCS, Long Term Care Division and CMS. The grievance summary is due 45 calendar days from the date of the end of the reporting quarter.
6. The Quality Improvement Associate will maintain, aggregate, and analyze grievance data and identify any trends or patterns. This information will be used by the myPlace PACE internal quality improvement program. Analyzing Grievance Information will include the following:
    a. Grievance information will be documented using myPlace PACE electronic grievance file system located in appropriate SharePoint folder.
    b. The QI Department is responsible for maintaining, aggregating, and analyzing all information on grievance proceedings. This information will be used in the myPlace PACE's internal quality improvement program.

c. A written summary of grievances including number, type, location, and disposition are reported on a quarterly basis by the QI Department to the myPlace PACE QI Committee, interdisciplinary teams, leadership, and to myPlace PACE's Board of Directors.
d. The QI Department and QI Committee will review grievances and identify any trends or patterns for quality improvement, incorporating this information into the annual quality plan.
e. Records of all grievances will be held confidential and made available as needed to State and Federal agencies upon request.
f. myPlace PACE shall maintain in its files, copies of all grievances, the responses to them, and logs of grievances for a period of 10 years from the date the grievance was filed.

7. Records of all grievances will be held confidentially and made available as needed to State and Federal agencies upon request.
8. myPlace PACE shall maintain in its files, copies of all grievances, the responses to them, and logs recording them for a period of six 6 years from the date the grievance was filed.
9. To ensure timeliness and accuracy in the grievance process, myPlace PACE shall perform regular audits of the grievance log and files to ensure they correspond with other data reporting systems (i.e., HPMS reports).

h. Annual Review

1. The grievance process will be reviewed with PACE participants and/or his/her representative, contract providers and all employees of myPlace PACE on an annual basis. The evaluation is conducted by the myPlace PACE Director of Quality Improvement, in collaboration with the PACE Medical Director, Director of Clinical Services, Director of Provider Relations and the Quality Improvement Committee.
2. The evaluation includes:
a. An analysis of administrative and organizational practices related to grievance recording and management.

b. An evaluation of the quality of the grievance management system throughout the period.

c. An evaluation of the extent to which the grievance management system meets the needs of the area and the population being served.

3. The Annual Review is presented to the myPlace PACE Executive Director, the Quality Improvement Committee, and Board of Directors for review and approval.

4. The annual program review is shared with staff and contractors in whole or in part, as appropriate, for learning and is disseminated in a variety of ways including but not limited to: staff meetings and in-service training, IDT meetings including daily briefings and I&A meetings, staff newsletters and memorandums.

APPENDIX 3

Bill of Rights

Explanation of Rights

The Program of All-Inclusive Care for the Elderly, also called PACE, is a special program that combines medical and long-term care services in a community setting.

When you join a PACE program, you have certain rights and protections. myPlace Health, as your PACE program, must fully explain and provide your rights to you or someone acting on your behalf in a way you can understand at the time you join.

PARTICIPANT RIGHTS

myPlace Health is dedicated to providing you with quality health care services so you may remain as independent as possible. Our staff is committed to treating each and every participant with dignity and respect and ensuring that all participants are involved in planning for their care and treatment. As a myPlace Health participant, you have the following rights.

You have the right to be treated with respect.

You have the right to be always treated with dignity and respect, to have all your care kept private, and to get compassionate, considerate care. You have the right to:

- Get all your health care in a safe, clean environment and in an accessible manner.
- Be free from harm; this includes physical or mental abuse, neglect, physical punishment, being placed by yourself against your will, excessive medication, and any physical or chemical restraint that is used on you for discipline or convenience of staff and that you do not need to treat your medical symptoms or to prevent injury.
- Be encouraged to use your rights in myPlace Health.
- Get help, if you need it, to use the Medicare and Medicaid complaint and appeal processes and your civil and other legal rights.

- Be encouraged and helped in talking to myPlace Health staff about changes in policy and services you think should be made.
- Use a telephone while at the myPlace Health Center.
- You do not have to do work or services for myPlace Health.

You have a right to protection against discrimination.

Discrimination is against the law. Every company or agency that works with Medicare and Medicaid must obey the law. They cannot discriminate against you because of your:

- Race or ethnic origin
- Religion
- Age
- Sex
- Mental or physical disability
- Sexual orientation
- Source of payment for your health care (for example, Medicare or Medicaid)

If you think you have been discriminated against for any of these reasons, contact a staff member at myPlace Health help you resolve your problem.

If you have any questions, you can call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

You have a right to information and assistance.

You have the right to get accurate, easy-to-understand information and to have someone help you make informed health care decisions. You have the right to:

- Have someone help you if you have a language or communication barrier so you can understand all information given to you.
- Have myPlace Health interpret the information into your preferred language in a culturally competent manner, if your first language is not English and you can't speak English well enough to understand the information being given to you.

- Get marketing materials and a copy of the myPlace Health participant rights in English and in any other frequently used language in your community or in Braille, if necessary.
- Get a written copy of your rights from myPlace Health. myPlace Health must also post these rights in a public place in the PACE Center where it is easy to see them.
- Be fully informed, in writing, of the services offered by myPlace Health; this includes telling you which services are provided by contractors instead of the myPlace Health staff. You must be given this information before you join, at the time you join, and when you need to make a choice about what services to receive.
- To have the enrollment agreement fully explained in a manner that you understand.
- Look at, or get help to look at, the results of the most recent review of myPlace Health —federal and state agencies review all PACE programs.
- To contact 1-800-MEDICARE for information and assistance, including to make a complaint related to the quality of care or the delivery of a service.

You also have a right to review how myPlace Health plans to correct any problems that are found at inspection.

You have a right to a choice of providers.

You have the right to choose a health care provider within myPlace Health's network and to get quality health care. Women have the right to get services from a qualified women's health care specialist for routine or preventive women's health care services. You have the right to reasonable and timely access to specialists within myPlace Health's network as determined by your health condition and consistent with current clinical practice guidelines.

You also have the right to receive care across all care settings, up to and including placement in a long-term care facility when the PACE organization can no longer maintain you safely in the community.
To disenroll from the program at any time and have such disenrollment be effective the first day of the month following the

date the PACE organization receives the participant's notice of voluntary disenrollment as set forth in § 460.162(a).

You have a right to access emergency services.

You have the right to get emergency services when and where you need them without the approval of myPlace Health. A medical emergency is when you think your health is in serious danger, when every second counts. You may have a bad injury, sudden illness, or an illness quickly getting much worse. You can get emergency care anywhere in the United States.

You have a right to participate in treatment decisions.

You have the right to fully participate in all decisions related to your health care. If you cannot fully participate in your treatment decisions or you want to have someone you trust help you, you have the right to choose that person to act on your behalf. You have the right to:

- Have all treatment options explained to you in a language you understand, to be fully informed of your health status and how well you are doing, and to make health care decisions; this includes the right not to get treatment or take medications. If you choose not to get treatment, you must be told how this will affect your health.
- Have myPlace Health help you create an advance directive (an advance directive is a written document that says how you want medical decisions to be made in case you cannot speak for yourself); you should give it to the person who will carry out your instructions and make health care decisions for you.
- Participate in making and carrying out your plan of care; you can ask for your plan of care to be reviewed at any time.
- Request a reassessment by the interdisciplinary team.
- Be given advance notice, in writing, of any plan to move you to another treatment setting and the reason you are being moved.

You have a right to have your health information kept private.

You have the right to talk with health care providers in private and to have your personal health care information kept private as protected under state and federal laws. This includes automated health information such as information contained in an electronic medical record. You also have the right to look at and receive copies of your medical records.

There is a patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used.

Your written consent will be obtained for the release of information to persons not otherwise authorized under law to receive it. If you have any questions about this privacy rule, call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

You have a right to file a complaint.

You have a right to complain about the services you receive or that you need and don't receive; the quality of your care; or any other concerns or problems you have with myPlace Health. You have the right to a fair and timely process for resolving concerns with myPlace Health. You have the right to:

- Receive a full explanation of the complaint process.
- Be encouraged and helped to freely explain your complaints to myPlace Health staff and outside representatives of your choice. You must not be harmed in any way for telling someone your concerns; this includes being punished, threatened, or discriminated against.
- Appeal any treatment decision by myPlace Health staff or contractors.

You have a right to leave the program.

If, for any reason, you do not feel that myPlace Health is what you want, you have the right to leave the program at any time and have such disenrollment be effective the first day of the month following the date myPlace Health receives your notice of voluntary disenrollment.

Additional Help

If you have complaints about myPlace Health, think your rights have been violated, or want to talk with someone outside about your concerns, call or contact the California Department of Health Care Services at:

Ombudsman Unit
Medi-Cal Managed Care Division
Department of Health Care Services
P.O. Box 997413, Mail Station 4412
Sacramento, CA 95899-7413
Telephone: 1-888-452-8609
TTY: 1-800-735-2922

Or call 1-800-MEDICARE or 1-800-633-4227 to get the name and phone number of someone in your State Administering Agency.

