Provider Manual

January 2022

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Using This Provider Manual

This Provider Manual is meant to assist you in working with our participants within the framework of WelbeHealth PACE's policies and procedures. Familiarizing yourself with and adhering to the procedures outlined in this manual is required by our Agreement will help ensure a mutually beneficial, productive relationship in caring for our participants.

The information provided in this manual is intended to be informative and to assist Providers in navigating the various aspects of participation with the WelbeHealth PACE program. Unless otherwise specified in the Provider Agreement, the information contained in this manual is not binding upon WelbeHealth PACE and is subject to change. WelbeHealth PACE will make reasonable efforts to notify Providers of changes to the content of this manual.

This manual may be updated at any time and is subject to change. In the event of an inconsistency between information contained in this manual and the Provider Agreement between you or your facility and WelbeHealth PACE, the Agreement shall govern.

In the event of a material change to the Provider Manual, WelbeHealth PACE will make all reasonable efforts to notify you in advance of such changes through Provider bulletins, Provider newsletters, and other mailings. 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 WelbeHealth PACE Plan policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially targeted communications.

GENERAL INFORMATION

What is WelbeHealth PACE?

WelbeHealth brings PACE (Program of All-Inclusive Care for the Elderly) to California to unlock the full potential of our most vulnerable seniors. WelbeHealth was founded by mission-driven physicians to bring PACE to underserved communities. Its leadership team includes exemplary PACE operators and seasoned healthcare innovators that share top-tier expertise in senior care and a passion for helping seniors reach their full potential.

PACE is a national program sponsored by the Federal government through Medicare and the State governments through Medicaid. A central goal of PACE programs is to enable individuals who are at risk for moving into a nursing home to continue to live safely in their homes and communities. To be eligible to enroll as a WelbeHealth PACE participant, an individual must be:

- 55 years of age or older
- Eligible for nursing home level of care based on criteria established by the State of California
- Eligible for Medicaid or have Medicare and be willing to pay privately
- Able to live safely in the community with the services provided by the PACE program
- A resident of the WelbeHealth PACE service area (the ZIP codes listed below and highlighted in pink in the map below).

Program Locations and Service Areas

Program	Address	Service Area Zip Codes
Sierra PACE	582 E Harding Way, Stockton, CA 95204	95202, 95203, 95204, 95205, 95206, 95207, 95209, 95210, 95212, 95215, 95219,95220, 95231, 95236,95237, 95240, 95242, 95258, 95304, 95307, 95316, 95320, 95326, 95328, 95330, 95336, 95337, 95350, 95351, 95354, 95355, 95356, 95357, 95358, 95361 (Stanislaus only), 95366, 95367, 95368, 95376, 95377, 95380 (Stanislaus only), 95382, 95385 (Stanislaus only)
Sequoia PACE	1649 Van Ness Ave, Fresno, CA 93721	93202, 93223, 93230, 93235, 93242, 93245, 93274, 93277, 93291, 93292, 93606, 93608, 93609, 93611, 93612, 93615, 93616, 93618, 93619, 93624, 93625, 93626, 93627, 93630, 93631, 93636, 93637, 93638, 93640, 93646, 93648, 93650, 93651, 93652, 93654, 93656, 93657, 93660, 93662, 93666, 93668, 93673, 93675, 93701, 93702, 93703, 93704, 93705, 93706,

		93710, 93711, 93720, 93721, 93722, 93723, 93725, 93726, 93727, 93728, 93730
Pacific PACE	50 Alessandro Place, Suites A20, Pasadena, CA 91105	90046, 90068, 91001, 91011, 91020, 91030, 91040, 91046, 91101, 91103, 91104, 91105, 91106, 91201, 91202, 91203, 91206, 91207, 91208, 91210, 91214, 91331, 91352, 91501, 91502, 91504, 91505, 91506, 91601, 91602, 91605, 91606, 91608
Coastline PACE	1220 E 4th Street, Long Beach, CA 90802	90045, 90066, 90094, 90230, 90232, 90245, 90254, 90266, 90274, 90275, 90277, 90278, 90291, 90292, 90293, 90501, 90502, 90503, 90505, 90701, 90703, 90710, 90715, 90716, 90717, 90731, 90732, 90744, 90745, 90755, 90802, 90803, 90804, 90806, 90807, 90808, 90810, 90813, 90814, 90815, 90831

The PACE model of care is built around an interdisciplinary team (IDT) approach which includes diverse perspectives working together on behalf of each individual. The IDT consists of a a primary care physician, nurse, social worker, physical therapist, occupational therapist, recreational therapist, dietician, center director, transportation coordinator, personal care worker, and home care coordinator. The members of the IDT meet regularly to comprehensively support the needs of each individual through bi-annual assessments and care planning.

When a participant is enrolled in WelbeHealth PACE, their insurance transitions to WelbeHealth for coverage of all care and services. Services are available 24 hours a day, 7 days a week, and 365 days a year. Many services such as meals, recreational therapy, physical therapy, and Adult Day Health Care can be provided in WelbeHealth PACE centers. Services that are not provided at the centers will be provided in the home or by our network of contracted providers, such as you, in consultation with our IDT.

The PACE program provides the same benefits that Medicare and Medicaid provide to its participants at no cost and at the discretion of the IDT as well as additional benefits when deemed necessary for the participant. Core benefits include:

Medical Care	**Community-Based Services**
• Physician Care • Nursing • Prescription Medications • Dentistry	• Rehabilitation Therapies ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy

• Podiatry
• Optometry
• Audiology
• All Medical Specialty
• Labs, X-ray
• Dialysis
• Hospital Care
• Emergency and Urgent Care
• Short-term Rehab and Long-term Care
	• Engagement Programs
	  ▪ Socializing with others
	  ▪ Music, cultural events and games
	  ▪ Stimulating cognitive activities
	  ▪ Group exercise activities
	• Nutritional Support
	  ▪ Nutrition counseling
	  ▪ Meals on center days
	• Transportation
	  ▪ Rides to and from the WelbeHealth PACE Center
	• Social Services
	  ▪ Connections to community resources
	  ▪ Medi-Cal and Medicare benefits support
	  ▪ Counseling and psychological services
	  ▪ Guidance and support for participants and caregivers
	• In-Home Services
	  ▪ Skilled Home Health (nursing, wound care, medication administration, etc.)
	  ▪ Safety Assessment and Equipment
	  ▪ Personal care (bathing, dressing, grooming, etc.)
	  ▪ Chore services (meal preparation, light housekeeping, laundry, etc.)

Contact Information

Contact Information	**Phone Numbers and Website Addresses**
WelbeHealth General Information	Website: www.welbehealth.com
Provider Relations	(650) 336-0300 providers@welbehealth.com
Scheduling	(650) 336-0300 WelbeHubRequest@welbehealth.com
Authorizations	Fax: (209) 729-5854
Claims	P.O. Box 30760 Tampa, Florida 33630 Electronic payor ID - WBHCA

WELBEHEALTH PROVIDER PORTAL

About

We have introduced a better system to help you do business with us. The WelbeHealth Provider Portal allows you to quickly get the answers you need so you can save valuable time and get better documentation and visibility.

With the WelbeHealth Provider Portal, you can:

- Check eligibility
- Submit prior authorization requests and check status
- Submit claims and check reimbursement status

How to register

Visit https://welbehealth.quickcap.net/ select "First Time User" and follow the prompts to request an account. The WelbeHealth Provider Relations Team will receive the request and create a Username and Password that will be distributed back to the requestor along with a Provider Portal User Guide within 5 business days. For questions, please reach out to providers@welbehealth.com

PARTICIPANT SCHEDULING AND TRANSPORTATION

Scheduling & Transportation

WelbeHealth PACE is responsible for scheduling and arranging transportation to and from all provider encounters on behalf of all WelbeHealth PACE participants. To ensure access to care and safety for our participants, WelbeHealth PACE provides non-emergency medical transportation. These services include not only transportation to and from WelbeHealth PACE centers, but also to doctor's appointments and other healthcare facilities in the community. The transportation program is designed to accommodate both ambulatory and non-ambulatory participants in a safe manner.

- Once a referral order is sent via fax, a WelbeHealth representative from our Central Scheduling Team will reach out to your office directly to schedule an appointment.
- Please refrain from scheduling appointments directly with participants or their family members to avoid confusion and no-shows.
- If you need to schedule a follow-up appointment or other service, please contact WelbeHealth PACE at (650) 336-0300 or email WelbeHubRequest@welbehealth.com.
- We ask that our partners make best effort to schedule PACE participants within 30 calendar days for routine matters, 7 calendar days for urgent requests, and 2 business days for STAT requests.

BILLING AND REIMBURSEMENT

Eligibility for Payment

Every WelbeHealth PACE participant receives an insurance identification card that will detail the participant's name and identification number. This card identifies them as a WelbeHealth PACE participant and should be presented to physicians and other Providers when seeking healthcare services. If a WelbeHealth PACE participant is requesting service and is unable to present an identification card, please contact WelbeHealth PACE Provider Services at (650) 336-0300.

Providers should contract WelbeHealth in the case that emergent care is needed. We have a nurse on staff 24/7 to respond to emergent situations. Regardless of whether a participant has an identification card, Providers should verify participant eligibility at the time of service to ensure s/he is enrolled in WelbeHealth PACE. Failure to do so may affect claims payment.

Payment terms are defined in provider contracts with WelbeHealth PACE. The amount of payment for services provided is affected not only by the terms in the contract, but also by the following:

- Participant's eligibility at the time of service
- Whether services provided are covered services
- Whether services provided are medically necessary
- Whether services were without the prior approval of WelbeHealth PACE, if prior approval is required
- Amount of the Provider's billed charges
- Adjustments of payments based on coding edits described below

A Provider who receives reimbursement for services rendered to WelbeHealth 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 of 1973.

Nothing contained in the provider Agreement or this Manual is intended by WelbeHealth PACE to be a financial incentive or payment which directly or indirectly acts as an inducement for Providers to limit medically necessary services.

WelbeHealth PACE applies the CMS site-of-service payment differentials in its fee schedules for CPT codes based on the place of treatment (physician office services versus other places of treatment).

Coding Edits: WelbeHealth PACE will process Provider claims that are accurate and complete in accordance with WelbeHealth PACE's normal claims processing procedures and applicable state and/or federal laws, rules and regulations with respect to the timeliness of claims processing. Such claims processing procedures and edits may include, without limitation, automated systems applications 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 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 by submitting a timely request for reconsideration to WelbeHealth PACE (please see the Provider Claims Reconsideration section of this Manual for more information). 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.

Pass-Through Billing: WelbeHealth PACE prohibits pass-through billing. Pass-through billing occurs when the ordering Provider requests and bills for a service, but the service is not performed by the ordering Provider or those under their direct employment. Provider agrees that services related to pass-through billing will not be eligible for reimbursement from WelbeHealth PACE and Provider shall not bill, charge, seek payment or have any recourse against WelbeHealth PACE or Participants for any amounts related to the provision of pass-through billing.

Claims Submission

Providers are responsible for submitting a clean claim for each participant served in order to receive payment. A clean claim is free from errors and contains all of the following:

Participant Information:

- Participant full name
- Participant ID number
- Date of birth

Service Information:

- Date(s) of service (date range or individual days)
- Service/HCPCS/Revenue code/Modifier
- Diagnosis code
- Number of units (number of days in service period or units of provided service)
- Unit rate/Billed amount

Provider Information:

- Provider name
- Provider address
- Provider Tax Identification Number (TIN)
- National Provider Identifier (NPI)

All providers are required to bill encounters ninety days (90) after the service date, but no later than one hundred and twenty days (120) after the service date, or as indicated in the provider contract.

Electronic Claims

All encounters when possible should be submitted electronically. Our payer ID is WBHCA. WelbeHealth PACE accepts electronic claim submissions for professional (837P), institutional (837I) and (837D) dental. Contact your clearinghouse to initiate the process to forward WelbeHealth PACE claims to Change Healthcare and RelayHealth.

Paper Claims

Your paper claims must be submitted on typed, redlined CMS-1500 or UB-04 claim forms and mailed to:

WelbeHealth PACE
P.O. Box 30760
Tampa, Florida, 33630-3760

Failure to send claims to this address, may result in delayed claims processing and/or rejected claims. Please ensure that all your claims are submitted timely, are complete and all required data elements are present, are correct, and valid for the service date to avoid delays in claims processing or denial of your claims.

Payment of Claims

WelbeHealth PACE shall process all Clean Claims within thirty (30) calendar days of receipt. A Clean Claim means one which can be processed without obtaining additional information from the provider of the service or from a third party. 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 via the authorization.

Payment for services rendered is subject to verification that:

- The participant was enrolled in WelbeHealth PACE at the time the service was provided;
- The service was delivered to the patient (cancelled services are not eligible for payment); and,
- The Provider was compliant with WelbeHealth PACE Prior Authorization policies at the time of service.

Claims that are not clean may be denied. Provider agrees that in the event of a denial of payment for services rendered to Participants, that Provider shall not bill, charge, seek payment or have any recourse against Participant, Medicare, or Medicaid for such services.

Medicare and Medicaid will not be responsible for claims for the participant while they are enrolled as a participant of WelbeHealth PACE. All claims for services provided to WelbeHealth PACE participants must be submitted to WelbeHealth PACE.

If you have questions concerning claim status, adjustment or requests for claim review please contact Provider Services at (650) 336-0300.

Electronic Funds Transfer (EFT)

We offer Electronic Funds Transfer capabilities to allow direct deposit reimbursements. To register, complete an EFT form (located at https://welbehealth.com/partner/) and submit with a voided check to providers@welbehealth.com.

Utilization Management and Prior Authorization

WelbeHealth PACE maintains a "Right Care, Right Place, Right Time" Program to evaluate medical necessity and manage the quality and cost of health care services delivered to participants. All services are evaluated either prospectively, concurrently, or retrospectively to determine medical necessity based on standard criteria. This program is designed to ensure that:

- Services are medically necessary, consistent with the assigned participant's diagnoses, and are delivered at appropriate levels of care.
- Services are provided by WelbeHealth PACE contracted Providers and that the utilization review staff is notified immediately to discuss the use of non-contracted Providers based on services that are not available through contracted Providers.
- Hospital admissions and length of stay are justified.
- Services are not over-utilized or under-utilized.
- Continuity and coordination of care is monitored.
- Guidelines, standards, and criteria set by governmental and other regulatory agencies are adhered to as appropriate. WelbeHealth PACE utilizes standard criteria, such as InterQual Criteria, National Coverage Decisions, the Medicare Benefit Policy Manual, Local Coverage Determinations and current literature to assess all requests for determination of medical necessity. All criteria are reviewed by the Quality Improvement Committee on an annual basis.
- New technology is evaluated based on Medicare and Medicaid reviews and review of studies that determine its application and effectiveness.
- There is coordination of thorough and timely investigations and responses to Provider Appeals (see Provider Appeals section).

All non-emergency services provided to WelbeHealth PACE participants, outside the scope of the initial diagnosis, require prior authorization from WelbeHealth PACE. With that said, any service initially ordered by WelbeHealth PACE employed providers is automatically authorized – the order number is the authorization number.

If you need to request prior authorization for follow-up visits or additional services, please submit a prior authorization request. Authorization requests should be submitted through the Provider Portal or via fax with an authorization request form and clinical documentation to

(209) 729-5854. Authorizations submitted via the portal will be reviewed by our Utilization Management department within five (5) business days.

Please visit our website at https://welbehealth.com/partner/ to for a copy of the Authorization Request Form and to view the Prior Authorization List sorted by service type, place of service, and CPT/HCPC code.

Prior authorization is based upon the clinical documentation that supports medical necessity for the requested item. If you have questions concerning prior authorizations, please contact Provider Services at (650) 336-0300.

Urgent and Emergency Care

WelbeHealth PACE provides coverage for the treatment of an emergency medical condition, which is defined by CMS as a condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual in serious jeopardy
- Serious impairment to bodily functions or
- Serious dysfunction of any bodily organ or part

Inpatient and outpatient emergency health services are covered both inside and outside of the WelbeHealth PACE service area. Prior authorization is not required for emergency care. In the event of an emergency, WelbeHealth PACE instructs its participants to seek immediate care, or call 911 for assistance. WelbeHealth PACE will not deny payment if an WelbeHealth PACE contracted health care Provider instructs a participant to seek emergency services.

Enrollment in WelbeHealth PACE includes coverage for post-stabilization care, defined as non-emergency services needed to ensure the participant remains stabilized after an emergency. In the post-stabilization period, providers should only provide services authorized by WelbeHealth PACE. Unauthorized services will not be paid by WelbeHealth PACE unless it is an emergency or WelbeHealth PACE fails to respond to an authorization request within one hour of being contacted for urgently needed or post-stabilization services.

Urgently needed services are defined as those conditions which require immediate medical attention due to unexpected illness or injury. Fevers, abdominal pain, nausea and vomiting and difficulty urinating are some examples of situations requiring urgently needed services.

Urgent care services are covered for participants. Providers must notify WelbeHealth PACE within 24 hours or the next business day of providing emergency or urgent services to an WelbeHealth PACE participant, or if the participant is admitted to a hospital.

Participants are encouraged to always carry their WelbeHealth PACE identification card and to notify WelbeHealth PACE should they need urgent or emergency care.

Provider Responsibilities

The government expects WelbeHealth PACE and all our contractors and providers to follow all laws, rules, regulations, and contract requirements and conduct business in an ethical manner. This means:

- Providers will always act in the best interests of our program participants, including the protection of participants' rights.
- Providers will avoid conflicts of interest. Where potential conflicts exist, providers are expected to disclose the conflict to WelbeHealth PACE and work with us to successfully resolve it.
- 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 WelbeHealth PACE.
- Providers will obey all laws, rules, regulations, and contract requirements.
- 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 and all suspected non-compliance to WelbeHealth compliance hotline. Provider shall act to resolve deficiencies, ethical and services issues and non-compliant practices in coordination with the WelbeHealth Compliance Officer.
- Provider shall submit evidence of initial and annual compliance training upon request from WelbeHealth.

Providers are expected to have written policies and procedures that guide staff in complying with regulatory and contractual requirements. Staff should also be trained annually on compliance and fraud, waste and abuse. WelbeHealth PACE may ask for copies of these training records.

Providers are obligated to review the WelbeHealth PACE policies and procedures attached within the Provider Manual. These documents may be updated at any time and are subject to change.

Providers are 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 service 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. WelbeHealth PACE may ask for this documentation as proof the monitoring is being performed.

- Provider is expected to understand and adhere to the contract provisions at all times.
- Provider is required to provide compliance and fraud, waste and abuse training for all staff and annually document training in staff files.
- Validate monthly that employees have not been listed on the Office of Inspector General exclusion list. http://oig.hhs.gov/fraud/exclusions.asp Provider shall

immediately notify WelbeHealth PACE if they as a provider or any of their employees appear on the exclusion list.

- WelbeHealth PACE shall provide a global authorization upon initial referral of a participant to contracted Providers. Provider shall render services necessary as it relates to the participant's diagnosis. If additional needs arise outside of the scope of the initial diagnosis, the provider is expected to contact the participant's Care Team to obtain an additional authorization.
- Written notice of any change in the type, scope or location of delivery of services shall be provided to WelbeHealth PACE at least ninety (90) days prior to the effective date of the change.
- Provider must only bill for services actually provided. Submitting claims for services that were not provided – even if authorized – is illegal (fraud).
- Provider shall send written notice to WelbeHealth PACE within five (5) days of any legal, governmental or other action initiated against Provider.
- Provider shall notify WelbeHealth PACE's Provider Management Department at providers@welbehealth.com of any changes in address, telephone number, or other contact information, such as email address or contract administrator name.
- WelbeHealth PACE expects providers to demonstrate 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.

Record Keeping, Record Submission, and Records Inspection

All Network Providers must maintain and upon request furnish to WelbeHealth PACE all information requested by WelbeHealth PACE related to the quality and quantity of services provided through their contract. This includes 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. Network providers should submit progress notes to WelbeHealth PACE within 72 hours of care delivery and same day if the provider is recommending any changes to a patient's treatment regimen.

Provider shall maintain books and records, including Participant medical records, pertaining to actions performed pursuant to this Contract by the Provider 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 this Contract or from the date of completion of any audit, whichever is later.

Participant rights

When enrolled in a PACE program, participants have certain rights and protections. The PACE program must fully explain these rights to all participants or someone acting on their behalf in a way that they can understand at the time they join. As a Provider, you have the responsibility to respect every participant's rights. Please see attached for an overview of the PACE participants' rights.

HIPAA

Based on the services you provide on behalf of WelbeHealth PACE you may be provided with protected health information (PHI). This information includes all medical and care-related services you provide. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) you are responsible to keep this information secure. Information must not be left out where anyone can read it, 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 to WelbeHealth PACE's Compliance Department and may also need to be reported to the government under the breach notification requirements.

There are government resources available to assist you to understand your obligations. These include:

- http://www.hhs.gov/ocr/privacy/index.html
- http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/index.html

Please contact our Provider Relations Department or Compliance Department if you have questions or concerns about HIPAA.

WelbeHealth PACE is concerned with protecting participant privacy and is committed to complying with the Health Insurance and Portability Act (HIPAA) privacy regulations. Generally, covered health plans and covered Providers are not required to obtain individual participant consent or authorization for use and disclosure of Protected Health Information (PHI) for treatment, payment and health care operations. Activities such as: care coordination, reviewing the competence of health care professionals, billing/claims management, and quality improvement fall into this category. If you have further concerns, please contact Provider Services at (650) 336-0300.

Individuals should be notified in writing or e-mail if that is their preferred method of contact, and be provided with basic information about the breach, such as:

- When the breach happened, when the event was discovered, and a brief statement about what happened
- What type of PHI was breached
- Things that the individual can do in order "to protect themselves from potential harm resulting from the breach"
- What corrective actions and investigation the covered entity is doing to prevent future breaches and mitigate losses; and contact information for the individual to use in case of any questions.

In addition to disclosure accounting, the individual is also entitled to receive a copy of his or her electronic health record, if they request; this information may be sent to the individual, or another person designated by individual.

Fraud, Waste, and Abuse

WelbeHealth PACE operates a comprehensive compliance program that actively investigates allegations of fraud, waste and abuse on the part of Providers and participants. WelbeHealth PACE is required to report to DHCS all suspected fraud, waste or abuse (FWA).

- 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.

The following are some examples of fraudulent, abusive, and unacceptable practices that are prohibited by WelbeHealth PACE:

- Submission of false information for the purpose of obtaining greater compensation than that to which the Provider is legally entitled (i.e. up coding or unbundling of charges)
- Billing for services not rendered or billing in advance of care
- Knowingly demanding or collecting any compensation in addition to claims submitted for covered services (except where permitted by law)
- Ordering or furnishing inappropriate, improper, unnecessary or excessive care services or supplies
- Failing to maintain or furnish, for audit and investigative purposes, sufficient documentation on the extent of care and services rendered to participants
- Offering or accepting inducements to influence participants to join the plan or to use or avoid using a particular service
- Submitting bills or accepting payment for care, services or supplies rendered by a Provider who has been disqualified from participation in the Medicare or Medicaid programs

Providers must comply with federal laws and regulations designed to prevent fraud, waste and abuse, but not limited to, applicable provisions of federal criminal law, the False Claims Act, the anti-kickback statute, and the Health Insurance Portability and Accountability Act administrative simplification rules, applicable state and federal law, including, but not limited to, 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 this Agreement are made in whole or in part, and all applicable Medicare laws, regulations, reporting requirements, and CMS instructions.

Confirmed cases of fraud and abuse are reported to the appropriate state agency. Providers who suspect fraud, waste and abuse on the part of another Provider or a participant should

contact the WelbeHealth PACE Compliance Hotline at compliance@welbehealth.com. Remember, you may report anonymously as WelbeHealth PACE abides by a zero-tolerance against non-compliance. All contacts will be treated confidentially.

Quality Management

WelbeHealth PACE strives to deliver outstanding services so participants can achieve their goals and desired outcomes. Delivering quality care is a strategic objective and is driven each year by the Annual Quality Plan.

- WelbeHealth PACE conducts formal QI projects as defined and approved by state and federal agencies. Required projects to meet CMS and DHCS contract requirements
    - WelbeHealth PACE strategically selects meaningful projects that will benefit the participants
- Measures and evaluates the quality of the Care Management activities to improve the participants' experience.
    - Participant Satisfaction Survey
    - Care Management process monitoring
    - Regulatory audit readiness/corrective action planning
    - Practice Guidelines
    - Consumer and Provider input to Quality Plan
- Integrate other organizational plans with the Quality Program

WelbeHealth PACE encourages its network providers to communicate feedback on how we can continue with our strong tradition of delivering quality care.

Gifts and Entertainment

As we operate a federally-funded program and in order to avoid even the appearance of improper conduct, WelbeHealth PACE discourages providers and vendors from offering gifts to our staff and participants. WelbeHealth PACE limits vendor gifts to staff to $20 per employee per year and $100 across all employees per year. Gifts include business meetings over meals or coffee, physical gifts, gift certificates, and tickets to sporting and other entertainment events. Financial support to attend conferences or seminars would be a legitimate business expense and would not be considered a gift. It is our hope that this policy will eliminate real or imagined bias by regarding selection of providers for participant services. Providers who may be in doubt of what is considered an acceptable or unacceptable item should ask Provider Relations for clarification and assistance.

Utilization Management and Prior Authorization

WelbeHealth PACE maintains a "Right Care, Right Place, Right Time" Program to evaluate medical necessity and manage the quality and cost of health care services delivered to participants. All services are evaluated either prospectively, concurrently, or retrospectively to determine medical necessity based on standard criteria. This program is designed to ensure that:

- Services are medically necessary, consistent with the assigned participant's diagnoses,

and are delivered at appropriate levels of care.

- Services are provided by WelbeHealth PACE contracted Providers and that the utilization review staff is notified immediately to discuss the use of non-contracted Providers based on services that are not available through contracted Providers.
- Hospital admissions and length of stay are justified.
- Services are not over-utilized or under-utilized.
- Continuity and coordination of care is monitored.
- Guidelines, standards, and criteria set by governmental and other regulatory agencies are adhered to as appropriate. WelbeHealth PACE utilizes standard criteria, such as InterQual Criteria, National Coverage Decisions, the Medicare Benefit Policy Manual, Local Coverage Determinations and current literature to assess all requests for determination of medical necessity. All criteria are reviewed by the Quality Improvement Committee on an annual basis.
- New technology is evaluated based on Medicare and Medicaid reviews and review of studies that determine its application and effectiveness.
- There is coordination of thorough and timely investigations and responses to Provider Appeals (see Provider Appeals section).

All non-emergency services provided to WelbeHealth PACE participants, outside the scope of the initial diagnosis, require prior authorization from WelbeHealth PACE. With that said, any service ordered by WelbeHealth PACE employed providers is automatically authorized – the order number is the authorization number. If you need to request prior authorization for a outside the scope of the initial diagnosis, please notate the additional service request on the clinical case notes and fax it to the respective market location for review and approval.

Prior authorization is based upon the clinical documentation that supports medical necessity for the requested item. If you have questions concerning prior authorizations, please contact Provider Services at (650) 336-0300.

Urgent and Emergency Care

WelbeHealth PACE provides coverage for the treatment of an emergency medical condition, which is defined by CMS as a condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual in serious jeopardy
- Serious impairment to bodily functions or
- Serious dysfunction of any bodily organ or part

Inpatient and outpatient emergency health services are covered both inside and outside of the WelbeHealth PACE service area. Prior authorization is not required for emergency care. In the event of an emergency, WelbeHealth PACE instructs its participants to seek immediate care, or call 911 for assistance. WelbeHealth PACE will not deny payment if an WelbeHealth PACE contracted health care Provider instructs a participant to seek emergency services.

Enrollment in WelbeHealth PACE includes coverage for post-stabilization care, defined as non-emergency services needed to ensure the participant remains stabilized after an

emergency. In the post-stabilization period, providers should only provide services authorized by WelbeHealth PACE. Unauthorized services will not be paid by WelbeHealth PACE unless it is an emergency or WelbeHealth PACE fails to respond to an authorization request within one hour of being contacted for urgently needed or post-stabilization services.

Urgently needed services are defined as those conditions which require immediate medical attention due to unexpected illness or injury. Fevers, abdominal pain, nausea and vomiting and difficulty urinating are some examples of situations requiring urgently needed services.

Urgent care services are covered for participants. Providers must notify WelbeHealth PACE within 24 hours or the next business day of providing emergency or urgent services to an WelbeHealth PACE participant, or if the participant is admitted to a hospital.

Participants are encouraged to always carry their WelbeHealth PACE identification card and to notify WelbeHealth PACE should they need urgent or emergency care.

NETWORK PARTICIPATION

How to Become a Network Provider

If a potential provider is interested in joining the WelbeHealth PACE Provider Network, email us at providers@welbehealth.com.

WelbeHealth PACE considers requests for contracting based on the following criteria:

- The proposed provider's mission and vision complement the WelbeHealth PACE mission
- The provider is committed to serving participants consistent with the PACE model of care
- The provider meets applicable licensing and/or certification standards applicable to the services to be provided.
- The provider is willing and able to sign and adhere to all components of a contract with WelbeHealth PACE including, but not limited to:
- Agree to WelbeHealth PACE rate
- Follow contractual requirements related to authorizations and billing
- Maintain ongoing communications with WelbeHealth PACE staff
- Meet or exceed quality assurance expectations set by WelbeHealth PACE

Updating Services or Providers in Existing Network Provider Organizations

If you are a current WelbeHealth PACE contracted provider and you are interested in adding services to your existing contract or otherwise amending or terminating that contract, please email us at providers@welbehealth.com.

Credentialing

WelbeHealth PACE's credentialing process enables us to contract with qualified health care providers and to meet the requirements of our contracts with the Centers for Medicare & Medicaid Services (CMS) and the California Departments of Health Care Services (DHCS). The credentialing process ensures that providers are properly educated, trained, and accessible to

WelbeHealth PACE's participants.

Although WelbeHealth PACE delegates some credentialing activities to recognized credentialing programs, WelbeHealth PACE always retains the right and the obligation to accept or reject the recommendations of our credentialing delegates. WelbeHealth PACE reviews these credentialing programs on an annual basis.

Information acquired through the credentialing and re-credentialing processes is considered confidential, and WelbeHealth PACE staff and credentialing delegates who have access to the files are responsible for ensuring the information remains confidential, except as otherwise provided by law. WelbeHealth PACE may deny or restrict participation, terminate participation, or take other action in accordance with the provider's written agreement with WelbeHealth PACE and our credentialing policies and procedures.

Initial Credentialing

Each practitioner, facility or ancillary Provider must complete a standard application form when applying for initial participation in the WelbeHealth PACE Network. This application may be a state-mandated form or a standard form created by or deemed acceptable by WelbeHealth PACE for practitioners, facilities and ancillary practitioners. The Council for Affordable Quality Healthcare ("CAQH"), a universal credentialing data source is utilized. CAQH is building the first national provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals, and practitioners. To learn more about CAQH, visit their web site at www.CAQH.org.

WelbeHealth PACE will verify those elements related to an applicant's legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the one hundred and eighty (180) calendar-day period prior to the Credentialing Committee making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, WelbeHealth PACE will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These lists represent minimum verification requirements.

Practitioners (Providers)

- National Provider Identification number
- License to practice in the state(s) in which the practitioner will be treating Covered Individuals
- Current DEA registration (for relevant practitioners)
- Proof of education (evidence of graduation from applicable professional school and completion of residency or other post-graduate training as applicable)
- Malpractice claims history
- Malpractice insurance
- Board certification (for relevant practitioners)
- Clinical history
- Work history
- Exclusions and sanctions

- Medicare Opt-Out

Facility and Ancillary (Health Delivery Organizations)

- Good standing with State and Federal government
- CMS/DHCS Certification (if applicable)
- Proof of Accreditation (if applicable)
- Most recent Survey (if applicable)
- Certificate of Insurance
- State License

Re-credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or facility and ancillary practitioner's licensure, sanctions, certification, and/or performance information (including, but not limited to, malpractice experience) that may reflect on the practitioner's, facility or ancillary professional's conduct and competence. This information is reviewed to assess whether practitioners, facility and ancillary providers continue to meet WelbeHealth PACE's credentialing standards.

During the re-credentialing process, WelbeHealth PACE will review verification of the credentialing data as described in the tables under Initial Credentialing unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements. All applicable practitioners and HDOs in the network within the scope of WelbeHealth PACE's Credentialing Program are required to be re-credentialed every three (3) years unless otherwise required by contract or state regulations.

To support certain credentialing standards between the re-credentialing cycles, WelbeHealth PACE has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General (OIG)
- System for Award Management (SAM)
- National Practitioner Data Bank (NPDB)

Professional Medical Advisory Committee

The Professional Medical Advisory Committee will delegate to a designated credentialing committee the responsibility of approving providers and facilties who do not meet the requirements of a clean file. The purpose of the group is to:

- Provide guidance to the WelbeHealth PACE Medical Director, Quality Improvement Committee, and the Board of Directors on the Quality Improvement (QI) Plan and results,
- Review and advise WelbeHealth PACE Board on medical and dental policies and procedures,
- Evaluate QI medical and dental data, and

- Review provider credentialing packets for approval (or withholding).

Quality Improvement Plan and Policies

The policies and procedures attached directly impact provider processes over the course of business with WelbeHealth PACE. These documents may be updated at any time and are subject to change. In the event of a material change to these documents, WelbeHealth PACE will make all reasonable efforts to notify you in advance of such changes through Provider bulletins, Provider newsletters, and other mailings. In such cases, the most recently published information shall supersede all previous information and be considered the current directive. Other policies and procedures not included in this manual may be posted on our website or published in specially-targeted communications.

Please note that the sample Pacific PACE Quality improvement plan and policies are attached here are applicable to all WelbeHealth market affiliates.

Pacific PACE

QUALITY IMPROVEMENT PLAN

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The Quality Improvement (QI) Program at Pacific PACE is designed and organized to support the mission, values and goals of Pacific PACE.

I. Purpose

A. The Pacific PACE data-driven QI Program is designed to promote quality services and achieve desired outcomes for all PACE enrollees through systematic, objective, ongoing monitoring and evaluation of data that identifies the program's strengths and areas for improvement.

II. Goal

A. The goal of the QI Program is to accurately assess current performance and to improve future performance of PACE for clinical and non-clinical services.

III. Objectives

- To ensure effective, timely and safe delivery of care;
- To immediately address problems that directly or potentially threaten the health and safety of a participant
- To oversee contracted provider performance including compliance with participant rights and service provision requirements;
- To ensure that all PACE staff and contracted providers are educated and involved with the development and implementation of the QI activities, and are aware of the results of these activities;
- To ensure that each employee and contracted employee understands their role in the QI program including upholding participant rights;
- To involve participants and caregivers in the quality improvement activities;
- To monitor participant/caregiver satisfaction and to incorporate consumer feedback into program improvements;
- To ensure the accuracy and completeness of all data used for outcome monitoring and reporting;
- To ensure compliance with CMS and the State of California contractual and regulatory requirements including all areas of the participant Bill of Rights.

IV. Quality Improvement Process

A. The Pacific PACE quality improvement process assesses the quality of program services, identifies and prioritizes opportunities for program improvement, organizes subcommittees or task forces to develop and implement program improvements, and uncovers root causes and selects interventions to improve quality in all program areas.

B. The improvement cycle includes collecting baseline data, identifying the problem, planning the improvement, implementation of interventions, measurement of the results of the interventions and analysis of outcomes, resulting in a continuous improvement process.

C. Pacific PACE shall develop an annual QI Plan that shall:

- Identify areas in which to improve or maintain the delivery of services and patient care;
- Set priorities for quality improvement, considering the prevalence and severity of identified problems and give priority to improvement activities that

affect clinical outcomes;
- Develop and implement plans of action to improve or maintain quality of care; and
- Document and disseminate the results of the quality assessment and improvement activities to the PACE staff and subcontractors.

D. The annual QI Plan shall be presented to the Board for approval and revised if necessary.

E. Pacific PACE has adopted the PDCA (Plan, Do, Check, Act) model for quality improvement:

i. Plan

- Find a process to improve
- Organize to improve it
- Clarify knowledge
- Understand variation
- Select an improvement

ii. Do

- Pilot the Improvement

iii. Check

- Measure the results of the intervention
- Analyze outcomes

iv. Act

- Standardize the improvement or start over
- Develop and implement mechanisms for sustaining the improvement with appropriate measurement

V. Quality Improvement Program Oversight and Structure

A. **The Pacific PACE Board of Directors** has ultimate oversight responsibility for the QI Plan, and the annual evaluation of the prior year's QI Plan. The Medical Director shall present the QI Plan to the Board annually. At each regular Board meeting the Medical Director shall review the outcomes of quality improvement activities with the Board. The Board votes to approve both the plan for the upcoming year and evaluation of prior year's plan.

B. **The Medical Director** shall have overall responsibility for the QI Program at Pacific PACE.

C. **The Executive Director** shall provide direction to the QI Coordinator and QI Program implementation at Pacific PACE.

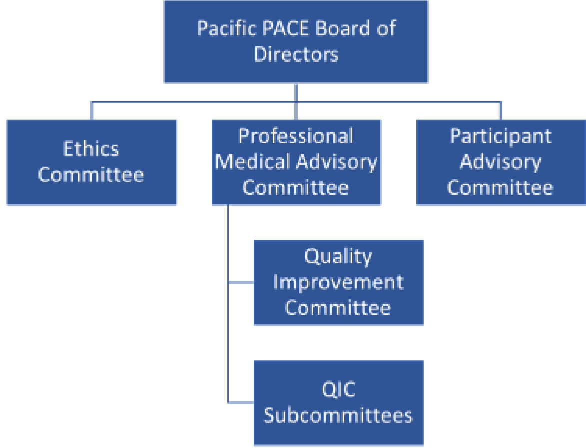
D. **The QI Coordinator** shall be responsible for the implementation, monitoring and evaluation of the QI Program, including development of QI reports and the tracking, analysis and trending of data to be used in assessing the quality of Pacific PACE services.

E. **The Ethics Committee** shall provide guidance to the Pacific PACE Board of Directors and staff on ethical dilemmas.

F. **Participant Advisory Committee (PAC)** shall be established to provide advice to the governing body on matters of concern to participants. The PAC shall report directly to the Pacific PACE Board of Directors.

G. **The Professional Medical Advisory Committee (PMAC)** shall assist the Pacific PACE Board of Directors provide medical oversight and provides guidance to the Quality Improvement Committee.

H. **Pacific PACE** will create QI subcommittees and task forces to improve specific clinical or administrative processes identified as critical to participants, caregivers or PACE operations.



VI. Implementation of the Quality Improvement Plan

A. Responsibility for QI: The Medical Director, Executive Director and QI Coordinator with assistance from the QI Committee shall be responsible for:

- Developing mechanisms for collecting and evaluating program information, identifying problems, formulating recommendations, disseminating information, implementing corrective actions, and evaluating the effectiveness of action taken;
- Reviewing the QI Plan annually and making recommendations concerning the formulation, revision or implementation of the policies governing both clinical and non-clinical services including, but not limited to, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications and program evaluation;
- Providing technical assistance regarding individual service problems;

- Participating in program evaluation;
- Participating in the development and ongoing review of written policies and procedures and standards of participant care and quality management;
- Reviewing the adequacy and effectiveness of quality management and utilization activities;
- Developing mechanisms for evaluating responsiveness of the grievance process;
- Collecting and analyzing information about voluntary and involuntary disenrollments;
- Ensuring that all PACE staff and contracted providers are involved in the development and implementation of the QI Plan;
- Facilitating the formation of QI subcommittees or task forces to address specific quality improvement initiatives;
- Reviewing customer service satisfaction reports, grievances, appeals and disenrollment reports and initiating action to increase satisfaction;
- Reviewing reports of participant incidents and employee accidents and initiate action to improve participant and employee safety and to reduce risk;
- Immediately addressing and then correcting any identified problem that may threaten the health and safety of participants or employees;
- Reviewing hazard surveillance reports and responding as necessary to ensure a safe environment for employees and participants;
- In coordination with management, setting priorities for quality improvement considering prevalence and severity of identified problems and giving priority to improvement activities that effect clinical outcome;
- Continuously monitoring progress toward goals and applying improvement and problem-solving processes as necessary to ensure satisfactory outcomes;
- Developing and providing reports of QI activities to be distributed to PACE stakeholders;
- Developing an annual QI Plan that addresses findings of the previous year and seeks to improve its weakest areas and maintain its strongest.

B. Quality Data Sources

i. At a minimum, the QI Plan shall use standard data measures specified by CMS and the state administering agency and those developed by organizations, such as the National PACE Association. Based on the measures selected, aggregated outcome data shall be reviewed for trends, patterns and opportunities for improvement. Variations in the outcomes shall be evaluated from both the program and the individual participant viewpoints. When adverse practice variations are identified, a plan shall be developed and implemented to identify more effective practices whenever possible. The QI Coordinator and Medical Director, with assistance of the QIC and subcommittees when needed, shall develop methodologies and audit tools to be used for periodic monitoring to ensure that quality improvement measures are sustained over time.

ii. Because the process of service delivery in a PACE program requires the interdisciplinary team (IDT) to identify participant problems, determine appropriate treatment outcomes, select interventions, and evaluate the outcomes of care for all participants, the IDT is in a unique position to provide PACE management with structured feedback on the performance of the program and suggest ways in which performance can be improved. Quality improvement initiatives and activities shall be developed to respond to the feedback and suggestions from the IDT.

C. Staff Training

i. All new employed and contracted staff shall be trained on the QI program during initial orientation and annually or as particular issues of quality arise. Staff shall be made aware of results and outcomes of the QI program activities and studies though presentations to staff and QI program reports. Participation in QI by staff shall be emphasized during training.

D. Urgent QI Issues

i. Policies, procedures or practices that are found by any member of the Pacific PACE staff to threaten the immediate health and safety of participants or staff shall be immediately reported by that individual to the Executive Director, Medical Director and QI Coordinator. The QI Coordinator shall consult with appropriate staff and be responsible for developing an appropriate corrective plan within 24 hours. Urgent corrective measures shall be discussed immediately during IDT meetings and when appropriate with participants. Policies and procedures shall be amended to ensure the health and safety issues identified have been resolved. The plan shall include an explanation of the problem, who shall be responsible for implementing the corrective plan, the time frame for each step of the plan, and an evaluation process to determine effectiveness. The management team of Pacific PACE shall be informed of the issues and the corrective plan.

E. Participant Involvement in QI

i. Pacific PACE shall encourage PACE participants to participate in quality improvement activities. Opportunities include the Participant Advisory Committee, the Participant Council, and presentations by Pacific PACE staff for participants on results and outcomes of the QI program activities and studies including but not limited to grievances, appeals, participant and caregiver surveys and informal feedback by participants and caregivers.

F. Contracted Provider Involvement in QI

i. Pacific PACE shall provide opportunities and encourage contracted staff to participate in the QI program. The PMAC will include least 2 contracted providers and contracted providers may be invited to participate in other QI subcommittees and task forces, asked to provide specific QI data about their organizations and made aware of results and outcomes of the QI program activities and studies through the QI program reports.

VII. Methodology Established to Measure Performance

A. Utilization of PACE services

i. To ensure that participants receive the appropriate level of care, Pacific PACE shall use its own utilization data to compare with other PACE sites across the country through DataPACE 3, a database of PACE organizations across the country, administered through the National PACE Association. The data shall identify unusually high or low utilization of services including use of homecare services, center attendance, emergency care, inpatient hospitalization, and nursing home. This information shall be gathered quarterly by the QI Coordinator and provided to the QIC and the appropriate QI subcommittees. The information shall assist the organization in evaluating utilization as it relates to quality of care and the fiscal well-being of the organization. Identified problems shall be evaluated, recommendations developed and corrective actions taken to address inappropriate over or under utilization.

B. Caregiver and participant satisfaction

i. Pacific PACE shall conduct participant satisfaction surveys for each participant through a contract with Vital Research who developed the I-SAT Measurement program for PACE. All active participants including those who are in the hospital, nursing homes, or are home bound shall be invited to participate. In the event the participant is not able to answer the questions, a designated representative shall be asked to complete the survey process. In addition, a separate caregiver satisfaction survey shall be administered, at least annually, to all current family caregivers.

ii. Results of the survey shall be presented to the Board of Directors, management, the Professional Medical Advisory Committee, the Participant Advisory Committee, staff and participants.

iii. If participants are not satisfied with their care during the discipline specific reassessment process the interdisciplinary team (IDT) member shall inform them of their right to and offer to file a grievance.

iv. Participant satisfaction shall also be monitored through the grievance data and from feedback of the Participant Advisory Committee.

v. Identified dissatisfaction trends shall be addressed through the Plan, Do, Check and Act methodology, regardless of the source of information.

C. Measures derived from participant assessment data

i. Pacific PACE shall collect data and measure outcomes related to physiological well-being, functional status, cognitive status, mental health, social/behavioral functioning, and quality of life. The IDT shall collect this data during initial assessments of new enrollees and reassessments of enrolled participants. The following are examples of outcome data collected during assessments:

- Physiological: Tinetti balance assessment tool or other falls risk assessment tools
- Functional: Barthel Index of activities of daily living
- Cognitive status: SLUMS, or other cognitive assessment tool
- Social/behavioral functioning: Geriatric Depression Score (GDS).

ii. The QI Coordinator shall be responsible for compiling the results of the data collected. This data is used to determine if individual and organization-level outcomes are achieved as compared to a previous time period.

iii. Results shall be reviewed semi-annually by the by QI Coordinator, QIC and relevant QI subcommittees. When problems are identified action plans shall be developed implemented, and outcomes shall be presented and evaluated.

D. Effectiveness and safety of staff-provided and contracted services

i. Clinical

a. Pacific PACE shall ensure the safety and effectiveness of services provided by staff and contractors including competency of clinical staff, promptness of service delivery and achievement of treatment goals and outcomes. Competency of employed or contracted staff shall be assessed through review of licenses and or certifications upon time of hire and through the discipline-specific competency assessment process conducted by the contracted agency. In addition, Pacific PACE shall conduct facility reviews of medical and dental service sites as part of the credentialing and re-credentialing procedures.
b. Pacific PACE shall test the competency of its clinical and direct care staff upon employment, annually thereafter or more often when a need is identified. The testing will demonstrate that all direct care staff have the skills and knowledge necessary to safely provide care and achieve the desired outcomes for participants.
c. Training shall be provided to staff as needed to improve skills and knowledge, as new techniques are introduced and as new staff are hired.
d. Outcomes of competency testing shall be collected and the data will be used to identify and address staff training needs.
e. All medical providers shall be credentialed at the time of initial contract agreement and according to re-credentialing procedures.
f. Service delivery shall be monitored during regular IDT care planning and briefing meetings, through the annual participant and caregiver survey, annual staff survey and feedback during other meetings such as the Participant Council.
g. Medical Records shall be reviewed at quarterly for completeness. The QIC shall review a random sampling of records. The QI Coordinator, with assistance from the Medical Director and/or QIC, will select quality indicators for each review and establish thresholds for quality measures.

ii. Non-Clinical

a. Safety shall be measured for non-clinical areas such as transportation, physical plant and safety in the home. The data will be collected through incident reports, and ongoing safety assessments for transportation, the participant's home environment and physical plant.
b. Vans shall be inspected daily, pre and post trip. Home safety assessments shall be conducted at initial assessment and during reassessments and when information from home care providers identifies a problem. Plant safety inspections shall be done monthly by the designated Safety Officer and results of those inspections, in addition to the reports of any safety uses by those

responsible in each department to inspect daily, will be provided to the QI Coordinator. Problems shall be addressed as soon as identified within each area.

c. Areas identified as having trends related to safety issues shall be addressed through action plans using the Plan, Do, Check and Act methodology.

E. Grievances and Appeals

i. Pacific PACE shall continuously monitor outcomes related to participants' grievances and appeals. Participants shall be informed about the grievance and appeal process upon denial of enrollment, enrollment, annually, when a service complaint is made by a participant or caregiver and upon denial of payment or coverage of a service. All participants and caregivers shall be encouraged to use the grievance and appeals process as an opportunity for program improvement. All grievances and appeals shall be recorded, analyzed and trended by the QI Coordinator. The QI Coordinator has the overall responsibility to ensure timely processing of grievance resolutions, timely coordination of appeals processing and the identification of quality improvement opportunities.

ii. The Grievances and Appeals process applies to all clinical and non-clinical areas.

F. High Risk Areas

i. To reduce risks to health and safety Pacific PACE shall monitor the following clinical outcomes:

- Abuse
- Adverse drug reactions
- Adverse outcomes
- Burns
- Deaths
- Emergency room visits
- Equipment-related occurrences
- Falls with injury
- Falls without injury
- Fires/other disasters
- Food-borne outbreak
- Immunizations- pneumococcal and influenza
- Infectious disease outbreak
- Medication administration errors (without an Adverse Effect)
- Medication related occurrence
- Motor vehicle accidents
- Pressure injury
- Suicide attempt/suicide
- Unexpected deaths

ii. The information shall be collected, tracked, analyzed and trended quarterly the QI Coordinator and Medical Director with guidance from the QIC and PMAC, and reported to the Board of Directors, management, staff and State and Federal

regulators as required. Areas identified as needing improvement shall be addressed through the Plan, Do, Check and Act methodology.

iii. Pacific PACE will report incidents as outlined in the most recent guidelines as issued by Centers for Medicare and Medicaid Services (CMS).

VIII. Clinical and Professional Practice Standards

A. Pacific PACE may use the following resources in developing clinical practice guidelines and professional practice standards.

- National PACE Association Primary Care Model Practices
- American Geriatrics Society
- American College of Physicians,
- OSHA guidelines
- CDC recommendations

B. Additionally, Pacific PACE shall set internal standards on outcomes to be measured based on the following:

- Internally established baseline for nursing home utilization shall be <6% of total capitated days
- Internally established baseline for hospital bed-days utilization shall be <3500/1000/annum
- Internally established baseline for customer satisfaction shall be 85% or greater excellent rating
- Internally established care goals for frequently encountered diagnoses as determined by the Medical Director

C. Professional practice standards for clinical staff shall be based on sources such as the Academy of Nutrition and Dietetics, American Nurses Association, American Therapeutic Recreation, American Physical Therapy Association, and the American Occupational Therapy Association as a benchmark for professional standards of practice. The Medical Director and QI Coordinator shall be responsible for identifying practice standards that do not meet the criteria of these sources and shall create action plans to bring all professional standards into compliance.

IX. Standardized Quality Measures

A. Pacific PACE shall meet the levels of quality performance established by CMS and the State of California on the following standardized quality measures (see attachment HPMS PACE Quality Data Table (QIC-RP-02-A01)):

- Abuse
- Appeals
- Adverse drug reactions
- Adverse outcomes
- Burns
- Elopement
- Emergency room visits
- Enrollment (census, new enrollments, disenrollments, total deaths,

enrollment denials)
- Equipment-related occurrences
- Falls with injury
- Falls without injury
- Fires/other disasters
- Food-borne outbreak
- Grievances
- Immunizations- pneumococcal and influenza
- Infectious disease outbreak
- Media-related event
- Medication administration errors (without an Adverse Effect)
- Medication related occurrence
- Motor vehicle accidents
- Pressure injury
- Restraint use
- Suicide attempt/suicide
- Unexpected deaths

B. The data elements shall be collected, tracked, analyzed and trended quarterly by QI Coordinator and Medical Director with guidance from the QIC and PMAC and outcomes reported to the Board of Directors, management and staff, including the IDT.

C. When problems are identified action plans shall be developed using the Plan, Do, Check and Act methodology.

D. As required by CMS, Pacific PACE shall submit this data and any corresponding root cause analyses (RCA) quarterly via HPMS.

X. Data Integrity

A. Pacific PACE staff shall submit accurate data and will verify the integrity of the data through auditing of its data collection sources and systems.

B. The QI Coordinator shall select several indicators each quarter and an independent person, selected by the QIC, shall audit samples of data from original source documents (hospital claims, ER visits, infection logs, etc.) to verify the accuracy and completeness of the data. An audit tool to assist the independent reviewer in assessing the accuracy of the data shall be developed by the QI Coordinator with assistance from other staff.

C. Any issue with accuracy of data shall be directed to the QI Coordinator, the QIC and Executive Director. Problems with data integrity will be resolved through action plans based on the Plan, Do, Check and Act methodology.

D. The QI Coordinator shall be responsible for analyzing the results of the data integrity assessment outcomes and incorporate the outcome data and plans in its QI reports to the QIC, PMAC and Board.

XI. Quality Improvement Committee Descriptions

A. **The Ethics Committee** shall assist Pacific PACE by: reviewing the ethical dimensions of medical and non-clinical decisions on behalf of the participants; providing guidance to Pacific PACE's Board of Directors on medical-ethical issues; assisting in the development of procedures in documenting advance directives; helping to address ethical dilemmas, including end of life issues and implementation of the Patient Self-Determination Act; and providing needed staff training around ethical issues and concerns. Through this committee, Pacific PACE will be able to receive guidance regarding its QI Program and the ethical issues faced by the organization.

   The Ethics committee membership shall include the Executive Director, Medical Director, Clinic Supervisor, Center Manager, a primary care physician, as well as representation from some of the following disciplines: experts in law; medical ethics; pastoral care; social work; adult protective services and/or other relevant disciplines. The committee shall meet semiannually and as needed and report through the Executive Director to the Pacific PACE Board of Directors.

B. **The Participant Advisory Committee** (PAC) shall be established to provide advice to the governing body on matters of concern to participants. The PAC shall report directly to the Pacific PACE Board of Directors. The Pacific PACE Board of Directors shall appoint a representative from the board as the PAC Liaison and will attend all PAC meetings. Participants and participants' representatives shall constitute a majority of the membership. Other membership shall include the QI Coordinator, the Board member PAC liaison and advocates for older adults representing the service area. The PAC Liaison shall report the PAC issues, ideas and recommendations to the Board and present a copy of the minutes. The PAC Liaison shall report the Board's response to the PAC at its next regular meeting. QI Coordinator shall report a summary of the PAC meetings and outcomes annually as part of the QI Plan Evaluation. The PAC is intended to help improve service delivery within the PACE program through increased consumer feedback and recommendations within the QI structure. This committee shall meet on a quarterly basis and be facilitated by the QI Coordinator or designee.

   i. The function of the PAC is to:

      a. Advise the Pacific PACE administration on areas of consumer satisfaction and quality of care
      b. Review participant satisfaction survey results, and generate suggestions based on the results
      c. Advise the Executive Management Team and the Board on matters of concern to participants and caregivers
      d. Advise Pacific PACE staff in matters related to the quality of services, including but not limited to:

         - Transportation Services
         - Clinical and Medical Services
         - Home Care Services
         - Dietary Issues
         - Organizational Improvement issues
         - Contracted Services
         - Services provided by members of the Interdisciplinary team

e. Assist Pacific PACE identify and address participant needs and concerns, particularly regarding quality of care
f. Help interpret Pacific PACE's philosophy and purpose within the community
g. Help facilitate the dissemination of relevant information to participants and their caregivers
h. To review the Participant Council minutes and make recommendations based on the suggestions of that Council.
i. Evaluate data collected pertaining to quality outcome measures.
j. Address the implementation of and results from the QI Plan.

C. **Professional Medical Advisory Committee (PMAC)** shall assist the Pacific PACE Board provide medical oversight by: reviewing provider credentialing packets for approval (or withholding), reviewing and advising Board on medical and dental policies and procedures, evaluating QI medical and dental data, providing guidance to the QIC and the Board on the QI Plan and results.

   PMAC membership shall include the Pacific PACE Medical Director, QI Coordinator, at least 2 contracted medical specialists, 1 dentist, at least 1 community public health professional. The Pacific PACE Board of Directors shall appoint the chair of the PMAC. The committee shall meet semiannually and as needed and report through the Medical Director to the Pacific PACE Board of Directors.

D. **The Quality Improvement Committee (QIC)** shall be responsible for developing the annual QI Plan, guiding the implementation of planned activities and creating opportunities for staff participation in the QI process. The committee shall meet at least quarterly and more often if needed to review critical indicators such as adverse participant outcomes, concerns about over or under utilization of services or other clinical areas that may pose a serious threat to participant health or safety. The Medical Director shall serve as QIC chair. Members of the QIC shall at least include the Medical Director, Executive Director, QI Coordinator, Center Manager, Clinic Supervisor, Home Care Coordinator, Transportation Coordinator, Rehabilitation representation. Additional disciplines to be included as appropriate to agenda.

E. **Quality Improvement Subcommittees** shall be established to address specific quality issues such as infection and exposure control, utilization, safety, emergency preparedness, etc. Members of the QI subcommittees may include members of the interdisciplinary team, other PACE staff and contracted providers. The goals of the QI subcommittees shall be to take actions to improve care and incorporate actions into standard of practice.

F. **The Participant Council** shall be established to create an opportunity for participants to provide feedback on issues. The Participant Council shall be held quarterly at the Pacific PACE facility and shall be facilitated by the Social Worker or designee. Days of the months shall be rotated so all participants shall have an opportunity to attend. Additional members of the interdisciplinary team and staff may be invited to this meeting based on the comments and issues brought forth by the participants. Minutes shall be taken at each meeting by a staff member participating in the meeting and provided to the QI Coordinator who shall forward to the PAC and QIC for review.

XII. Additional Quality Assessment Activities

A. Pacific PACE shall identify additional QI activities. Pacific PACE shall identify QI activities in each service area including but not limited to, social services, recreation, rehabilitation, clinical services, transportation, dietary, medical records and in-home services for development of quality improvement projects. The projects shall be based on input from the Participant Council, Customer Satisfaction Surveys, the Participant Advisory Committee, Clinical outcomes and analysis of other data.

B. Pacific PACE shall furnish data and information in the manner and at the time intervals specified by CMS and DHCS pertaining to participant care activities and outcomes.

C. Pacific PACE shall report inpatient and outpatient encounter data and any other data required by CMS to develop a risk adjustment methodology for PACE. Pacific PACE shall evaluate and report participant care statistics, inpatient and outpatient encounter data and all other data required or requested by CMS or DHCS. Pacific PACE shall capture all standard ICD 10 codes and use most recent adopted CPT and DRG coding.

XIII. Confidentiality

A. All data related to quality improvement activities shall be maintained in a confidential manner. Only individuals directly involved in monitoring and evaluation activities or individuals representing accreditation, certification and other review entities shall be permitted access to all QI documents. The Executive Director of Pacific PACE shall determine any exceptions.

____________________________ ______________

Executive Director Approval Date

____________________________ _______________

Pacific PACE Board Chair Approval Date

PARTICIPANT BILL OF RIGHTS AND RESPONSIBILITIES

Pacific PACE

Participant Bill of Rights and Responsibilities

PARTICIPANT RIGHTS

At Pacific PACE, we are dedicated to providing you with quality health care services so that you may remain as independent as possible. Our staff seeks to affirm the dignity and worth of each Participant by assuring the following rights:

Respect and Non-Discrimination

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

You have the right to:

- Be treated in a respectful manner that honors your dignity and privacy.
- Receive care from professionally trained staff.
- Know the names and responsibilities of the people providing your care.
- Know that decisions regarding your care will be made in an ethical manner.
- Receive comprehensive health care provided in a safe and clean environment and in an accessible manner.
- Be free from harm, including unnecessary physical or chemical restraints or isolation, excessive medication, physical or mental abuse or neglect, and hazardous procedures.
- Be encouraged to use your rights in the PACE program.
- Receive reasonable access to a telephone at the center, both to make and receive confidential calls, or to have such calls made for you if necessary.
- Not have to do work or services for the PACE Program.
- Not be discriminated against in the delivery of PACE services based on race, ethnicity, national origin, religion, sex, age, sexual orientation, mental or physical disability or source of payment.

Information Disclosure

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

You have the right to:

- Be fully informed, in writing, of your rights and responsibilities and all rules and regulations governing participation in Pacific PACE.
- Be fully informed, in writing, of the services offered by Pacific PACE, including services provided by contractors instead of Pacific PACE staff. You must be given this information before enrollment, at enrollment, and at the time your needs necessitate the disclosure and delivery of such information, in order for you to make an informed choice.
- A full explanation of the Enrollment Agreement and an opportunity to discuss it.
- Have an interpreter or a bilingual provider available to you if your primary language is not English.
- Examine the results of the most recent federal or state review of Pacific PACE and how Pacific PACE plans to correct any problems that are found at inspection.

Confidentiality

You have the right to talk with health care providers in private and have your personal health care information kept private as protected under state and federal laws.

You have the right to:

- Speak with health care providers in private and have all the information, both paper and electronic, related to your care kept confidential within required regulations. Be assured that your written consent will be obtained for the release of medical or personal information or photographs or images to persons not otherwise authorized under law to receive it. You have the right to limit what information is released and to whom it is released to.
- Be assured that your health record will remain confidential.

- Review and copy your medical records and request amendments to those records and have them explained to you.
- Be assured of confidentiality when accessing Sensitive Services such as Sexually Transmitted Disease (STD) and HIV testing.

If you have any questions, you may call the Office for Civil Rights toll-free at 1-800-368-1019. TTY users should call 1-xxx-xxx-xxxx.

Choosing Your Provider

You have the right to:

- Choose your own primary care provider and specialists from the Pacific PACE provider panel.
- Request a qualified specialist for women's health services or preventive women's health services.
- Initiate the disenrollment process at any time.

Emergency Care

You have the right to:

- Receive health care services in an emergency without prior approval from the Pacific PACE Interdisciplinary Team.

Treatment Decisions

You have the right to:

- Participate in the development and implementation of your care plan. If you cannot fully participate in your treatment decision you may designate a health spokesperson to act on your behalf.
- Have all treatment options explained to you in a language you understand and acknowledge this explanation in writing.
- Be fully informed of your health status and make your own health care decisions.
- Refuse treatment or medications and be informed how this may affect your health.
- Request and receive complete information about your health and functional status by the Pacific PACE Interdisciplinary Team.
- Request a reassessment by the Pacific PACE Interdisciplinary Team at any time.
- Receive reasonable advance notice, in writing, if you are to be transferred to another treatment setting for medical reasons or for your welfare or the welfare of other Participants. Any such actions will be documented in your health record.
- Have our staff explain advance directives to you and to establish one on your behalf, if you desire.

Exercising Your Rights

You have the right to:

- Assistance to exercise civil, legal and participant rights, including Pacific PACE grievance process, the Medi-Cal State hearing process and the Medicare and Medi-Cal appeals processes.

- Voice your complaints and recommend changes in policies and services to our staff and to outside representatives of your choice. There will be no restraint, interference, coercion, discrimination or reprisal by our staff if you do so.
- Appeal any treatment decision made by Pacific PACE or our contractors through our appeals process and request a State hearing.
- Leave the program at any time.

If you feel any of your rights have been violated or you are dissatisfied and want to file a grievance or an appeal, please report this immediately to your social worker or call our office during regular business hours at {PACE Program telephone number } or our toll free line at {PACE Program telephone number}.

If you would like to talk to someone outside of Pacific PACE about your concerns you may contact 1-800-MEDICARE (1-800-633-4227) or 1-888-452-8609 (Department of Health Care Services Office of the Ombudsman)

Please refer to other sections of your Pacific PACE *Member Enrollment Agreement Terms and Conditions* booklet for details about Pacific PACE as your sole provider; a description of Pacific PACE services and how they are obtained; how you may obtain emergency and urgently needed services outside Pacific PACE's network; the grievance and appeals procedure; conditions for disenrollment; and a description of premiums, if any, and payment of these.

PARTICIPANT RESPONSIBILITIES

We believe that you and your caregiver play crucial roles in the delivery of your care. To assure that you remain as healthy and independent as possible, please establish an open line of communication with those participating in your care and be accountable for the following responsibilities:

You have the responsibility to:

- Cooperate with the Interdisciplinary Team in implementing your care plan.
- Accept the consequences of refusing treatment recommended by the Interdisciplinary Team.
- Provide the Interdisciplinary Team with a complete and accurate medical history.
- Utilize only those services authorized by Pacific PACE.
- Take all prescribed medications as directed.
- Call the Pacific PACE physician for direction in an urgent situation.
- Notify Pacific PACE within 48 hours or as soon as reasonably possible if you require emergency services out of the service area.
- Notify Pacific PACE in writing when you wish to initiate the disenrollment process.
- Notify Pacific PACE of a move or lengthy stay outside of the service area.
- Pay required monthly fees as appropriate.
- Treat our staff with respect and consideration.
- Not ask staff to perform tasks that they are prohibited from doing by PACE or agency regulations.
- Voice any concerns or dissatisfaction you may have with your care.

Policies and Procedures

Participant Grievance Process

Title	Grievance Process
Domain	Quality and Compliance
Section	Grievance and Appeals
Policy Number	QIC-GA-01
Revision Dates	12-8-17
Attachments	Information for Participants about the Grievance Process (Attachment QIC-GA-01-A01) Grievance Report (Attachment QIC-GA-01-A02) Grievance Log (Attachment QIC-GA-01-A03) Acknowledgement Receipt of Grievance Letter (Attachment QIC-GA-01-A04) Resolved Grievance Letter (Attachment QIC-GA-01-A05) Pending Grievance Letter (Attachment QIC-GA-01-A06) Legal Services List (Attachment QIC-GA-01-A07)
Reg. Citations	42 CFR §460.120

General Information

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

Pacific PACE must 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.

Pacific PACE will handle all grievances in a respectful and confidential manner throughout and following the grievance process. Information pertaining to grievances will not be disclosed to program staff or contract providers -- except where appropriate to process the grievance -- and will only be released to authorized individuals. Also, no reference that a PACE participant has elected to file a grievance with Pacific PACE will appear in the medical record.

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

Contract providers are accountable for all grievance procedures established by Pacific PACE. Pacific PACE will monitor contracted providers for compliance with this requirement on an annual or as needed basis. Pacific PACE will not discriminate against a PACE Participant for filing a grievance.

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

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

Scope: All staff.

Definitions:

1. A **grievance** is defined as 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:
   - The quality of services a PACE participant receives in the home, at the PACE Center or in an inpatient stay (hospital, rehabilitative facility, skilled nursing facility, intermediate care facility or residential care facility);
   - Waiting times on the phone, in the waiting room or exam room;
   - Behavior of any of the care providers or program staff;
   - Adequacy of center facilities;
   - Quality of the food provided;
   - Transportation services; and
   - A violation of a participant's rights
2. **Representative** means a friend, family member or caregiver that you have designated to act on your behalf or a person legally identified as power of attorney for health care, conservator or guardian.

Procedures

I. Ensuring Access to Grievance Process

A. Pacific PACE will provide written information about the grievance process to a participant and/or his/her representative upon enrollment, annually and upon request. The written information on grievances is provided in the *Information for Participants about the Grievance Process* that includes, but is not limited to:
   i. Location and contact information for filing a grievance;
   ii. Types of grievances;
   iii. Procedures for filing a grievance;
   iv. Grievance rights including participant's right to request a State Hearing covered under Medi-Cal.

B. The grievance process will be reviewed with PACE participants and/or their representatives and all employees of Pacific PACE annually.

C. In order to ensure PACE participants have access to and can fully participate in the grievance process, Pacific PACE will ensure the following:
   i. 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, interpreter services will be made available.
   ii. All written materials describing the grievance process are available in the following languages: English and Spanish.
   iii. Pacific PACE maintains a toll-free number (**xxx-xxx-xxxx**) for the filing of grievance.
   iv. Pacific PACE maintains a TYY/TDD number (**xxx-xxx-xxxx**) for the filing of grievance.

II. Filing of Grievances

A. A PACE participant and/or their representative, may voice a grievance to a Pacific PACE staff in person, by telephone or in writing to a PACE location.

B. Any Pacific PACE staff member can assist the PACE participant and/or their representative in filing a grievance in the event assistance is required.

C. The *Grievance Report* is available from the Quality Improvement Department or Pacific PACE intranet. The Social Worker or designee will provide the PACE participant and/or his/her representative with a report if requested (either in person, by telephone, or in writing).

D. In addition to the *Grievance Report*, the Social Worker or designee will provide the PACE participant and/or his/her representative with the *Information for Participants about the Grievance Process* document.

III. Documentation of Grievances

A. 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*, by the QI Coordinator.

B. Grievances submitted in writing are documented on the *Grievance Report* by the PACE participant and/or his/her representative. The Quality Improvement (QI) Coordinator or designee 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* by a Pacific PACE staff person.

C. Complete details of the grievance must be documented so that the grievance can be resolved within 30 calendar days. If there is insufficient information, the QI Coordinator or designee will take reasonable efforts to obtain the missing information to resolve the grievance within the specified timeframes.

IV. Acknowledgement, Notification and Initial Investigation of Grievance

A. Program Staff who receive participant a grievance will notify the QI Coordinator or designee within 1 working day of receipt of the grievance.

B. The QI Coordinator or designee is responsible for coordinating the investigation, designating the appropriate staff member(s) to take corrective actions, and reporting the grievance to the interdisciplinary team.

C. The QI Coordinator or designee will acknowledge receipt of the PACE participant's grievance in writing, within 5 calendar days of receipt of the grievance using the *Acknowledgment Receipt of Grievance Letter,* and document this step in the *Grievance Log.* When necessary, the QI Coordinator or designee will acknowledge receipt of the grievance by telephone.

D. The QI Coordinator or designee notifies the management or supervisory staff responsible for the services or operations which are the subject of the grievance.

E. Grievances related to medical quality of care will be immediately submitted to the Medical Director by the QI Coordinator or designee for appropriate action.

F. When grievances related to services provided by a Pacific PACE contracted provider arise, the QI Coordinator or designee notifies the contracted provider's office.

G. When a grievance involves a violation of a PACE participant's rights, the QI Coordinator or designee will notify the Director immediately to begin investigation of the grievance.

V. Resolution of Grievances

A. The QI Coordinator is responsible for coordinating the investigation, designating the appropriate staff member(s) to take corrective actions, completing a detailed plan of resolution, and documenting the outcome in the electronic health record and grievance log.

B. Pacific PACE will resolve grievances within 30 calendar days from the day the grievance is received.

C. Upon receipt of the grievance, the QI Coordinator will:
   i. Create an entry in the Grievance Log noting the date of the grievance, the date the grievance was submitted to QI, and a description of the grievance.
   ii. Immediately notify the Executive Director and appropriate supervisor.
   iii. Immediately notify the Medical Director for grievances related to medical quality of care.

D. The QI Coordinator or designee 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.

E. The QI Coordinator or designee will send written notification of the resolution of the grievance to the PACE participant and/or his/her representative, *Resolved Grievance Letter*.

F. In the event resolution is not reached within 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, *Pending Grievance Letter.*

G. The QI Coordinator or designee 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 he/she was satisfied or dissatisfied with the outcome.

VI. Expedited Review of Grievances

A. 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 QI Coordinator or designee will expedite the review process to a decision within 72 hours of receiving the Participant's grievance.

B. The PACE participant and/or his/her representative will inform the Pacific 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 QI Coordinator or designee to document the grievance in writing prior to resolution.

C. If the PACE participant files an expedited grievance during weekend hours (5:00 p.m. Friday to 8:00 a.m. Monday), Pacific PACE Staff will immediately contact an authorized supervisor of the program (Medical Director or Program Director) to investigate the grievance with the PACE participant and/or his/her representative. This individual will notify the QI Coordinator or designee at the start of normal business hours of the status of the grievance.

D. As soon as possible, but no later than one business day after the PACE participant files an expedited grievance, the QI Coordinator or designee 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.

E. 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).

F. The QI Coordinator or designee will expedite the internal review process to reach a decision within 72 hours of receiving the grievance.

G. QI Coordinator or designee 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.

VII. Additional Grievance Review Options

A. After a PACE participant has completed the grievance process (as described above) or has participated in the grievance process for at least 30 calendar days and he or she is dissatisfied with the resolution of the grievance, the Participant may pursue other steps.

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 30 calendar days to pursue to steps described below.

B. 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

C. 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 94244-24
Telephone: 1-800-952-5253
Fascimile: (916) 229-4410
TDD: 1-800-952-8349

D. 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 *Resolved Grievance Letter*. 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.

E. If the participant and/or representative have questions or concerns regarding Pacific PACE home health services, the Pacific PACE should inform the participant and/or representative that the State of California has established a confidential toll-free telephone number to receive questions or complaints about home health services. The telephone number of the Sacramento Licensing and Certification District Office is: 800-554-0354, Monday through Friday, from 9 a.m. to 5 p.m. This information is contained in the *Information for Participants about the Grievance Process* document.

F. For legal assistance, the PACE participant and/or his/her representative may be able to get free legal help. To facilitate this, the QI Coordinator or designee will provide a *Legal Services List* offices to the participant or his/her representative.

G. Pacific PACE is required to provide written position statements whenever notified by DHCS that a PACE participant has requested a State hearing. The Pacific PACE will designate staff Medical Director or Program Director to make testimony at State hearings whenever notified by DHCS of the scheduled time and place for a State hearing.

VIII. Record Maintenance

A. All grievances related information shall be marked “confidential”.

B. All Grievance-related information and details of verbal correspondence will be documented by QI Coordinator or designee in the Participant *Grievance Log* and stored in locked cabinets in the PACE Center or secure electronic systems.

C. Records of all grievances will be held confidentially and made available as needed to State and Federal agencies upon request.

D. Pacific PACE shall maintain in its files copies of all grievances, the responses to them, and logs recording them for a period of 6 years from the date the grievance was filed.

IX. Monitoring and Oversight

A. Responsibility:
   i. The Pacific PACE Executive Director has overall responsibility for PACE operations, including the development and maintenance of the grievance procedure.
   ii. Pacific PACE QI Coordinator is responsible for ensuring confidentiality and implementation of all activities specified in the grievance procedure.
   iii. The Pacific PACE Medical Director has overall responsibility for the *QI plan*.

B. The QI coordinator will record, aggregate, analyze and prepare reports for inclusion in the QI program (see *Pacific PACE QI Plan*).

C. Grievances are reviewed at least quarterly according to the *QI Plan*.

D. Pacific PACE shall submit Grievance data to DHCS and CMS as required.

Compliance and Enforcement

All management personnel are responsible for enforcing this policy. All individuals must comply with this policy. Individuals who violate this policy are subject to discipline up to and including termination from employment in accordance with Pacific PACE Disciplinary Policies.

Approved by (name and title): ______________________________

Date: ______________________________

Provider Appeals Process

Title	Provider Appeal Process
Domain	Administration
Section	Network and Vendors
Policy Number	ADM-NV-03
Revision Dates	04/02/2018
Attachments	N/A
Reg. Citations	State Contract, Exhibit A, Attachment 7

General Information

Policy: All providers have the opportunity to appeal WelbeHealth PACE decisions related to authorization, denial of services, or the processing, payment or nonpayment of a claim.

Purpose: To ensure that all WelbeHealth PACE contracted providers receive appropriate compensation for services rendered and promote the continuing availability of a robust provider network to meet the needs of WelbeHealth PACE participants.

Scope: All clinical providers and provider entities who are providing care to participants of WelbeHealth PACE.

Procedures

X. Written Notice

A. If Pacific PACE denies or modifies a provider's request to authorize services or a claim for payment, a written notice of the decision is provided to the provider along with information regarding the provider's right to appeal the decision.

XI. **Provider Appeal**

A. For appeals regarding authorization or payment of a claim for services rendered to Pacific PACE participants, providers are directed as follows:

i. Within 30 calendar days of the denial, the provider may initiate an appeal by providing Pacific PACE with written information identifying the claim and specifically describing the disputed action. The appeal must be on the contracted provider's letterhead and contain the following information to identify the claim:

Participant name
Provider name
Dates of service
Charges denied/underpaid
Grounds for appeal
Supporting documentation for the grounds on which the provider is appealing

ii. The appeal should be submitted to:

P.O. Box 30760
Tampa, Florida 33630
Attn: Health Plan Services

B. The WelbeHealth PACE Health Plan Services Manager or designee will acknowledge receipt of the appeal within 5 calendar days of receipt.

C. The WelbeHealth PACE Health Plan Services Team will:
   i. Collaborate with the Medical Director to determine if the appeal relates to a medical decision or a payment issue.
   ii. Review the appeal and sends a written report of its conclusions and reasons to the provider within 30 calendar days from the acknowledged receipt of the appeal.

XII. Maintenance of Records

A. Records of all appeals are maintained by WelbeHealth PACE for seven years.

Compliance and Enforcement

All management personnel are responsible for enforcing this policy. All individuals must comply with this policy. Individuals who violate this policy are subject to discipline up to and including termination from employment in accordance with WelbeHealth PACE Disciplinary Policies.

Approved by (name and title): ______________________________

Date: ______________________________