1333 Bush Street
San Francisco, CA 94109
415/292-8888
TTY: 711

INFORMATION FOR PARTICIPANTS ABOUT THE APPEALS PROCESS

When On Lok PACE decides not to cover or pay for a service you want, you may take action to change our decision. The action you take—whether verbally or in writing—is called an "**appeal**." You may make your appeal by calling 415-292-8895, or our toll-free telephone number at 1-888-996-6565 (TTY: 711), or writing to our Health Plan Services Department (1333 Bush Street, San Francisco, CA 94109).

Below is a description of our appeals process. We have provided the definition of an appeal, the process for standard and expedited appeals, the types of decisions that can be made on an appeal, and finally, what happens once a final decision is made.

Definition: An appeal is a participant's action taken with respect to our organization's decision not to cover, or not to pay for, a service, including denials, reductions, or termination of services.

You will receive written information on the appeals process when you enroll and annually after that, as well as whenever On Lok PACE denies a request for services or payment. You have the right to file an appeal if we deny, defer, or modify your request for a service or payment for a service. You may file your appeal either verbally or in writing. The reconsideration of our decision will be made by a person(s) not involved in the initial decision-making process. We will ensure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services at issue. You or your representative may present or submit relevant facts and/or evidence for review, either in person or in writing to us.

Standard and Expedited Appeals Processes: There are two types of appeals processes: standard and expedited appeals processes. We describe both of these processes below.

If you request a **standard appeal**, your appeal must be filed within one hundred and eighty (180) calendar days of when your request for service or payment of service was denied, deferred, or modified. This is the date which appears on the "Notice of Action for Service or Payment Request" (NOA). (The 180-day limit may be extended for good cause.) Within five (5) calendar days of receiving your appeal, On Lok PACE will acknowledge in writing that the appeal has been received. We will issue a decision on your appeal as quickly as your health requires, but no later than thirty (30) calendar days after we receive your appeal.

If you believe that your life, health, or ability to get well is in danger without the service you want, you or any primary care provider may ask for an **expedited appeal**. If any primary care provider asks for an expedited appeal for you, or supports you in asking for one, we will automatically make a decision on your appeal as promptly as your health requires, but no later than seventy-two (72) hours after we receive your request for an appeal. We may extend this time frame up to fourteen (14) days if you ask for the extension or if we justify to the California Department of Health Care Services the need for more information and how the delay benefits you.

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If you ask for an **expedited appeal** without support from a treating primary care provider, we will decide if your health condition requires us to make a decision on an expedited basis. If we decide to deny you an **expedited appeal**, we will let you know within seventy-two (72) hours. In this case, your appeal will be considered a standard appeal.

Note: On Lok PACE will continue to provide the disputed service(s) if you choose to continue receiving the service(s) until the appeals process is completed. If your initial decision to NOT cover or reduce services is upheld, you may be financially responsible for the payment of disputed service(s) provided during the appeals process.

The information below describes the appeals process for you or your representative to follow should you or your representative wish to file an appeal:

1. If you or your representative has requested a service or payment for a service and On Lok PACE denies, defers, or modifies the request, you may appeal the decision. A written "*Notice of Action for Service or Payment Request*" (NOA) will be provided to you and/or your representative which will explain the reason for the denial, deferral, or modification of your service request or request for payment.

2. You can make your appeal either verbally, in person or by telephone, or in writing with any member of the interdisciplinary team of the center you attend. The staff person will make sure that you are provided with written information on the appeals process and your appeal is documented on the appropriate form. You will need to provide complete information of your appeal so the appropriate staff person can help to resolve your appeal in a timely and efficient manner. You or your representative may present or submit relevant facts and/or evidence for review, either in person or in writing, to us at the address listed below. If more information is needed, you will be contacted by our Health Plan Services Department or a member of the interdisciplinary team of the center you attend who will assist you in obtaining the missing information.

3. If you wish to make your appeal by telephone, you may contact our Health Plan Services Department at **415-292-8895**, or our toll-free telephone number at **1-888-996-6565 (TTY: 711)**, to request an appeal form and/or to receive assistance in filing an appeal.

4. If you wish to submit your appeal in writing, please ask a staff person for an appeal form. Please send your written appeal to:

   On Lok PACE
   Health Plan Services Department
   1333 Bush Street
   San Francisco, CA 94109

5. You will be sent a written acknowledgement of receipt of your appeal within five (5) working days for a standard appeal. For an expedited appeal, we will notify you or your representative within one (1) working day by telephone or in person that the request for an expedited appeal has been received.

6. The reconsideration of the On Lok PACE decision will be made by a person(s) not involved in the initial decision-making process in consultation with the interdisciplinary team. We will ensure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services you requested.

7. Upon the On Lok PACE completion of the review of your appeal, you or your representative will be notified in writing of the decision on your appeal. As necessary and depending on the outcome of the decision, On Lok PACE will inform you and/or your representative of other appeal rights you may have if the decision is not in your favor. Please refer to the information described below.

The Decision on your Appeal:

If we decide fully in your favor on a **standard appeal** for a request for ***service***, we are required to provide or arrange for services as quickly as your health condition requires, but no later than thirty (30) calendar days from when we received your request for an appeal. ***If we decide fully in your favor*** on a request for ***payment***, we must make the requested payment within sixty (60) calendar days after receiving your request for an appeal.

If we do not decide in your favor on a **standard appeal**, or if we fail to provide you with a decision within thirty (30) days, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (**see Additional Appeal Rights below**). We also are required to notify you as soon as we make a decision that is not fully in your favor and to notify the federal Centers for Medicare and Medicaid Services and the California Department of Health Care Services. We will inform you in writing of your appeal rights under Medicare or Medi-Cal managed care, or both. We will help you choose which to pursue if both are applicable. We will also send your appeal to the appropriate review.

If we decide fully in your favor on an **expedited appeal**, we must give permission for you to get the service or give you the service as quickly as your health condition requires, but no later than seventy-two (72) hours after we received your request for an appeal.

If we do not decide in your favor on an **expedited appeal** or fail to notify you within seventy-two (72) hours, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (**see Additional Appeal Rights below**). We also are required to notify you as soon as we make a decision that is not fully in your favor and to notify the federal Centers for Medicare and Medicaid Services and the California Department of Health Care Services. We will inform you in writing of your appeal rights under Medicare or Medi-Cal managed care, or both. We will help you choose which to pursue if both are applicable. We will also send your appeal to the appropriate review.

Additional Appeal Rights Under Medi-Cal, Medicare, or the California Department of Managed Health Care (DMHC)

If we do not decide in your favor on an appeal or fail to provide a decision to you within the required time frame, you have additional appeal rights. Your request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program, or both, or the California Department of Managed Health Care.

The Medicare program contracts with an "independent review organization" to provide external review on appeals involving PACE programs. This review organization is completely independent of our PACE organization.

The Medi-Cal program conducts their next level of appeal through the State's fair hearing process. If you are enrolled in Medi-Cal, you can appeal if your requested service or payment for service is denied, deferred, modified, delayed, reduced, or stopped. Until you receive a final decision, you may choose to continue to receive these services. However, you may have to pay for these services if the decision is not in your favor.

If you are enrolled in both **Medicare and Medi-Cal**, we will help you choose which appeals process you should follow. We are required to send your appeal to the appropriate review.

If you are not sure if you are enrolled in Medicare or Medi-Cal, or both, ask us. The Medicare and Medi-Cal external appeals processes are described below.

Medi-Cal External Appeals Process

If you are enrolled in **both Medi-Cal and Medicare OR Medi-Cal only**, and choose to appeal our decision using Medi-Cal's external appeals process, we will send your appeal to the California Department of Social Services. You may request a fair hearing at any time during the appeals process up until ninety (90) days from the date of the decision through:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430
Telephone: 1-800-952-5253
Fax: 833-281-0905
TTY: 1-800-952-8349

If you choose to request a State fair hearing, you must ask for it within ninety (90) days from the date of receiving the "Notice of Action for Service or Payment Request" (NOA) from On Lok PACE.

You may speak at the State hearing or have someone else speak on your behalf such as someone you know, including a relative, friend, or attorney. You may also be able to get free legal help. We will provide you with a list of legal services offices in the county where you live at the time that we deny, defer, or modify a service or payment of a service.

If the Administrative Law Judge's (ALJ) decision is in your favor of your appeal, On Lok PACE will follow the judge's instruction as to the time frame for providing you with services you requested or payment for services for a standard or expedited appeal.

If the ALJ's decision is not in your favor of your appeal, for either a standard or an expedited appeal, there are further levels of appeal, and we will assist you in pursing your appeal.

Medicare External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medicare only,** you may choose to appeal using Medicare's external appeals process. We will send your case file to the appropriate Medicare independent review organization for you. Medicare currently contracts with C2C Innovative Solutions, Inc. and Maximus Federal Services to impartially review appeals involving PACE programs like us. The Medicare independent review organization will contact us with the results of their review. The Medicare independent review organization will either maintain our original decision or change our decision and rule in your favor.

You may contact C2C Innovative Solutions, Inc. for Medicare Part D drug appeals through:

C2C Innovative Solutions, Inc.
P.O. Box 45309
Jacksonville, FL 32232-5309
Telephone: 833-919-0198
Fax: 833-710-0580

You may contact Maximus Federal Services for all other PACE service appeals through:

Maximus Federal Services
PACE Appeal Project
3750 Monroe Avenue, Suite 702
Pittsford, New York 14534-1302
Telephone: 585-348-3300
Fax: 585-425-5292

Standard External Appeal

You can request a **standard external appeal** if we deny your request for a non-urgent service or do not pay for a service. For a standard external appeal, you will get a decision on your appeal within the following time frames:

- Seven (7) calendar days after the Medicare independent review organization receives your appeal for a Medicare Part D drug, or thirty (30) calendar days after the Medicare independent review organization receives your appeal for a service that is not a Medicare Part D drug.

- Fourteen (14) calendar days after the Medicare independent review organization receives your appeal for payment of a Medicare Part D drug, or sixty (60) calendar days after the Medicare independent review organization receives your appeal for payment of a service that is not a Medicare Part D drug.

The Medicare independent review organization may ask for more time to review an appeal for a service that is not a Medicare Part D drug, but they must give their decision to us within fourteen (14) calendar days.

If the Medicare independent review organization's decision is in your favor for a standard appeal:

If you have requested a service that you have not received, we must provide the service as quickly as your health condition requires, but no later than: (a) seventy-two (72) hours after we receive the decision for a Medicare Part D drug, or (b) fourteen (14) calendar days after we receive the decision for a service that is not a Medicare Part D drug.

OR

If you have requested payment for a service that you have already received, we are required to pay for the service within thirty (30) calendar days after we receive the decision.

Expedited External Appeal

You can request an **expedited external appeal** if you believe your health would be jeopardized by not receiving a specific service. In an expedited external appeal, we will send your case file to the Medicare independent review organization as quickly as your health requires. The Medicare independent review organization must give a decision to us within seventy-two (72) hours after they receive the appeal. The Medicare independent review organization may ask for more time to review an appeal for a service that is not a Medicare Part D drug, but they must give their decision to us within fourteen (14) calendar days.

If the Medicare independent review organization's decision is in your favor for an expedited appeal:

We must provide the service or arrange for you to receive the service as quickly as your health condition requires, but no later than: (a) twenty-four (24) hours after we receive the decision for a Medicare Part D drug, or (b) seventy-two (72) hours after we receive the decision for a service that is not a Medicare Part D drug.

If the Medicare independent review organization's decision is <u>not</u> in your favor for either a standard or an expedited appeal, there are further levels of appeal, and we will assist you in pursuing your appeal.

<u>California Department of Managed Health Care Independent Medical Review (IMR) Process</u>

The California Department of Managed Health Care operates an Independent Medical Review ("IMR") process for those health care service plan enrollees who are NOT enrolled in Medicare (one is "enrolled in Medicare" if one is enrolled in both Medicare and Medi-Cal or is enrolled in Medicare only). If you are eligible for an IMR, On Lok PACE will provide you with a separate written description of your rights under this program.

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **415-292-8895** or **1-888-996-6565** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you

may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online."