VOANS Senior CommUnity Care PACE

Manual for Service Providers to Senior CommUnity Care

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Volunteers of America National Services is a national, nonprofit, faith-based organization of nearly 2,700 paid employees.

Volunteers of America National Services (VOANS) is a wholly owned subsidiary of Volunteers of America, Inc. (VOA). In addition to helping older adults achieve their highest levels of health and independence in affordable housing, senior living communities and through community-based services, VOA and VOANS are dedicated to helping those in need rebuild their lives and reach their full potential.

In 2022, Volunteers of America's National Service's ministry of service touched the lives of almost 34,000 people in 38 states and Puerto Rico.

Since 1896, VOA has supported and empowered America's most vulnerable groups, including veterans, at-risk youth, people returning from prison, homeless individuals and families, people with disabilities and those recovering from addictions.

Nationally, Volunteers of America touches the lives of more than 2.5 million people each year in over 400 communities across 46 states and Puerto Rico, with nearly 16,000 employees.

Provided here is a link to the 2022 Impact Report for Volunteers of America National Services.

Volunteers of America National Services 2022 Impact Report

Company

Welcome Message

Important Contacts

Position / Description	Name	Number
VOANS Senior CommUnity Care of North Carolina	Main Facility Line Main Fax Line	919-425-3000 919-425-3004
Enrollment Specialist Department	Mae Kokulo Destiny Alston Tory Engram	919-425-3040 919-425-3031 919-425-3055
Executive Director	Jane Venick	919-425-3022
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Provider Relations Representative	Lorna Ward	612-409-7305
Quality and COmpliance		Performance_Excellence@voa.org

1970'S

The PACE model of care began in the early 1970s, when the Chinatown-North Beach community of San Francisco saw pressing needs for long-term care services for families whose elders had immigrated from Italy, China and the Philippines. Dr. William L. Gee, a public health dentist, headed the committee to investigate solutions. The committee hired Marie-Louise Ansak in 1971. They, along with other community leaders, formed On Lok Senior Health Services, a nonprofit corporation with a mission to create a community-based system of care. “On Lok” is Cantonese for "peaceful, happy abode."

In 1979, On Lok received a four-year Department of Health and Human Services grant to develop a consolidated model of delivering care to persons with long-term care needs. On Lok piloted a new financing system utilizing Medicare and Medicaid dollars applied to a capitated payment model. In 1989, federal legislation extended On Lok’s financing system to 10 demonstration programs in other parts of the country. In 1990, the first Programs of All-inclusive Care for the Elderly (PACE) received Medicare and Medicaid waivers to operate the program. The Balanced Budget Act of 1997 established the PACE model as a permanently recognized provider type under both Medicare and Medicaid. In 1999, interim federal regulations were adopted, and in 2006, the final regulations were passed. By 2019, 130 PACE programs were operational in 31 states, serving over 50,000 participants. For additional information, visit the National PACE Association website: www.npaonline.org

Volunteers of America National Services (VOANS), a subsidiary of Volunteers of America, Inc., is an affordable housing developer and senior healthcare provider with operations nationwide and in Puerto Rico. VOANS has a long-established national presence as a quality provider of both housing and health care. The two business lines were merged to provide the financial and administrative strength needed to support these complex businesses in 1997. VOANS serves a wide variety of clients facing challenges due to income, age, physical or mental disability, with a special focus on seniors. The dramatic projected increase in the number of older adults in the United States who are living longer with fewer resources, coupled with the emergence of managed healthcare, has created a demand for providers that can efficiently and skillfully integrate affordable housing, healthcare and other supportive services. VOANS is one of the few organizations with a proven track record in both serviced enriched affordable housing and senior care, thus it is uniquely positioned to take advantage of the increasing opportunities to leverage strengths from each business line

To PACE

The Program of All-Inclusive Care for the Elderly, or PACE, is a Medicare and Medicaid program, regulated by the Centers for Medicare and Medicaid Services (CMS) for older adults and nursing home eligible people over age 55 who wish to remain living in the larger community instead of transitioning to a nursing home environment. This program provides community-based care and services to people who would otherwise need nursing home level of care. PACE was created as a way to provides flexibility in meeting the health care needs of the frailest individuals, while enabling them to continue living in the community.

CMS, in conjunction with each State's Administering Agency for PACE, oversees the program to ensure compliance with Federal regulations.
See Federal Regulations:
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-E/part-460

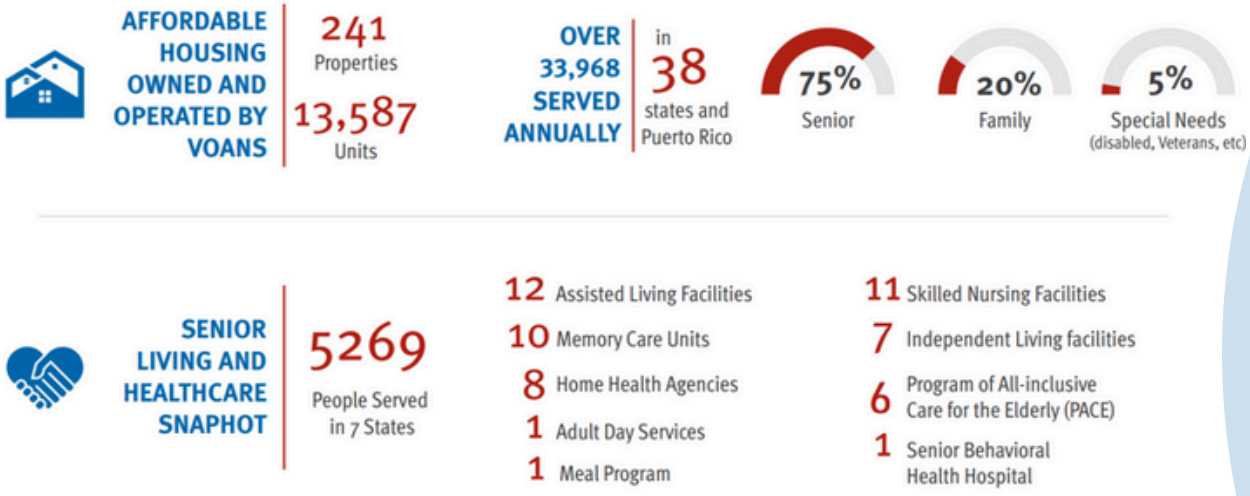
PACE provides comprehensive medical, social and long-term care services using an interdisciplinary team approach. Services are provided at the PACE Center and in the homes of registered participants. PACE provides all of the care and services covered by Medicare and Medicaid, as well as additional medically-necessary care, as authorized by the interdisciplinary team. The program also provides services not covered by Medicare and Medicaid. PACE provides coverage for prescription drugs, physician care, transportation, home care, primary health care, specialty care, hospital stays and nursing home stays whenever necessary.

Vision

A world where all people live in safety with social, emotional and physical wellbeing, spiritual fulfillment, justice and hope.

Mission

The mission of VOANS Senior CommUnity Care PACE is to enhance the quality of life and independence for aging adults by providing services, which will help them remain in their home and in their communities.



Benefit

PACE provides its participants with a full array of health, social and long-term care services. Medical assistance is available 24 hours a day, 7 days a week, year-round. Participants may receive services at the PACE Adult Day Health Center, in their home or in other settings necessary to manage their needs. Upon enrollment participants select their primary care and specialist physicians from the PACE network.

As a PACE participant, seniors no longer have to deal individually with their different health care providers.The PACE Interdisciplinary Team (The IDT) provides care management & coordination of care. The IDT, working with the participant, family, caregivers and providers, develops a personalized plan of care that best meets the unique needs of the individual participant.

This plan is updated every six months or more frequently if the needs or health status changes for the participant.

PACE Services:

Participants receive all health care services from PACE and, when approved, from its contracted providers. Participants visit the PACE Center on average two to three times a week.

PACE Center Services:

- Recreation and socialization
- Transportation to and from the PACE Center and to and from medical appointments
- Primary care in the PACE Clinic
- Rehabilitation services such as , Occupational Therapy (OT), Physical Therapy (PT) and other therapies when needed, in the rehabilitation center
- Nutritious hot meals & snacks
- Visits with the social worker
- Personal care

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

- Medical care
- Personal care
- Prescription drugs
- Social Services
- Audiology
- Dentistry
- Optometry
- Podiatry
- Home Health care
- Adult Day Health
- Hospital care

- Transportation
- Physical Therapy
- Occupational Therapy
- Recreational Therapy
- Speech Therapy
- Skilled Nursing
- Care
- Nutritional Counseling
- Meals
- DME

Primary Medical Care:
While at the center, participants may see PACE Primary Care Provider (PCP) or nurses for urgent care, routine care, physical examinations, immunizations, preventive health care, and consultations. The PACE Primary Care Physician (PCP), on behalf of the IDT, coordinates each participant's health care needs with specialists.

It is important to note that it is the responsibility of the PCP to authorize and pre-approve all services that are provided by the PACE specialty providers.

It is important to establish a communication process at the initiation of any new provider relationship in all settings. The PACE clinic staff will schedule the participant's appointments with medical specialists and arrange transportation to and from these appointments. The PACE organization appreciates that all required forms are completed and returned to the PACE program in a timely manner.

Other medical services include:

- Nursing Care, including skilled home care
- Social Work Services, Physical, Occupational and Speech Therapies
- Ambulance Services
- Emergency coverage anywhere in the United States
- Urgent care and Post Stabilization Care needed outside the PACE service area
- Dietary counseling for participants
- Medication - PACE is a Medicare Part D provider
- Vision Care and eyeglasses
- Psychiatry/Psychotherapeutic Services
- Audiology Evaluation and hearing aides
- Podiatry
- Dental Care
- Durable medical equipment

Services Provided in Participant's Home:
PACE will provide home care services directly or through a contracted vendor. Services are initiated after a home visit and home safety assessment, where home care needs are evaluated. The PACE organization will provide all necessary medical/adaptive equipment in the home if approved and authorized by the IDT. Services provided in the home may include homemaker/chore services, home-delivered meals, personal care, nursing services, medical equipment installation and servicing.

Nursing Facility Care: Participants admitted to a nursing home are still under the care of PACE, who continues to manage all health services and coordinate with nursing home staff. PACE staff will provide physical and occupational therapies prescription and medication management, physician and nurse services, and other services necessary as determined by the IDT. It will be necessary for PACE staff providing services in the Nursing Home to document in the Nursing Facility Care medical records.

Hospitalizations: When a participant is hospitalized, the PACE staff continues to coordinate care through the primary care physician. The PACE Primary Care Physician will coordinate with hospitalists (where appropriate) and the hospital discharge planner to develop a discharge plan for the PACE participant.

Hospital Outpatient: PACE authorizes for all contracted outpatient services. The PACE staff will schedule participants for outpatient services such as lab work, x-rays, medical equipment, surgical services, behavioral health, substance abuse treatment, etc. as deemed necessary by the IDT.

Services for End Stage Renal Disease (ESRD): PACE contracts with providers for treatment of ESRD when the IDT authorizes the services.

End-of-Life Care: PACE provides End-of-Life services.

Participant

Enrollment Process

Eligibility:
To be eligible for the PACE program, participants must:

- Live within the service areas.
- Be 55 years of age or older.
- Be certified to meet the state's criteria for a nursing home level of care.
- Be able to live safely in the community, with the help of PACE services, at the time of enrollment.

Referrals:
Potential participants are sometimes referred by their physician and sometimes they call directly. Referring physicians or agencies or interested seniors may contact the PACE Outreach Coordinator and Intake Coordinator, or may call the center directly. Potential enrollees and their families may also contact PACE directly to apply for enrollment

Enrollment Process:
The enrollment process begins following a participant referral or inquiry. After receiving a referral, the PACE Enrollment Specialist meets with the potential participant to explain the program, verify that the person lives in the PACE service area and is age 55 years or older. Before deciding to enroll, the potential participant is invited to visit the PACE Center.

PACE staff then meet with the potential participant to complete the discipline- specific assessments and initiate the process for determining nursing facility level of care.

If the applicant is deemed to be safe in the community with PACE services by the IDT, the care plan is developed and presented to the participant & his or her caregiver. The PACE staff then meet with the potential participant and assess if the person can live safely in the community with PACE services

Medicaid:
Part of the enrollment process may include application for Medicaid. If the enrollee is not paying privately, then the Medicaid authorization must be provided prior to initiating PACE service. Medicaid approvals are done according to the state's process and are not under the control of the PACE organization.

Funding Sources:
PACE is funded primarily by Medicare and Medicaid. The majority of enrollees are dually eligible for Medicare and Medicaid, though some may be eligible for Medicaid only or may pay privately.

There are no out-of-pocket charges if participants qualify for both Medicare and Medicaid or Medicaid only.

PACE organizations receive a monthly (per member, per month) capitated payment from Medicare and/or Medicaid that must cover all costs of care for all participants, regardless of setting. There is no fee for service and participants enrolled in PACE may not be enrolled in any other programs. PACE takes full risk its participants' health care needs.

Participant's

Bill of Rights & Responsibilities

The PACE organization is dedicated to providing its participants quality health care services. Upon enrollment into a PACE program, Participants have certain rights and protections. The PACE program must fully explain these rights to all participants and/ or someone acting on they're behalf, in a way that they can understand at the time of their enrollment, As part of our contracted network, all providers must be knowledgeable about and uphold the Participant Rights.

All contracted providers are responsible for promptly notifying PACE if a participant's rights have been violated or if a participant or their caregiver has indicated that the participant's rights have been denied. It is also part of the contracted providers responsibility to educate their staff and those that work with PACE Participants on the Participant's Rights.

It is the responsibility of all Contracted Providers to respect every Participant's rights. All PACE Participants have the following rights:

- the right to be treated with respect
- the right to protection against discrimination
- the right to understand how services will change if you elect to receive palliative care, comfort care, or end of life services.
- the right to revoke or withdraw the consent to receive palliative care, comfort care, or end of life services.
- the right to information and assistance
- the right to a choice of providers
- the right to access emergency services
- the right to participate in treatment decisions
- the right to have their health information kept private
- the right to file a complaint
- the right to leave the program

You can find a more detailed explanation of the Participant's Right' in Attachment 5.

Plan of Care

Each PACE participant has a written plan of care developed by the IDT in collaboration with the participant and their caregiver at the time of enrollment. The plan of care is the framework on which all services are provided by both the PACE staff and its contracted providers. Unlike other programs, all care remains the responsibility of the IDT and PACE staff, regardless of the setting in which the service is provided. PACE staff must therefore work closely with its contracted providers to ensure that the care plan is unanimously understood and carried out.

Development of the Plan of Care:
At time of enrollment, the following IDT members conduct an initial assessment of the participant: Primary Care Physician, Registered Nurse, Social Worker, Physical Therapist, Occupational Therapist, Recreational Therapist, Dietitian and Home Care Coordinator.

It is essential that participants and or caregivers be part of the plan of care (POC) process. To accomplish this, IDT members gather input regarding participant and/or caregiver preferences and goals from the participant during their assessments. This information is documented, reported and incorporated into the POC process.When all assessments are complete an IDT Care Plan meeting is held. The assessment findings are presented and a person-centered, problem specific (not diagnosis specific) plan of care is developed. Reassessments and an update of the care plan are done at a minimum of every six months and more often if needed. Contracted providers actively involved in participant care are invited and encouraged to participate.

PACE Medical Specialists and Other Contracted Health Care Providers: PACE contracts with medical specialists,nursing homes, hospitals and other health care providers to supplement the direct services provided by PACE staff at the Center and at home.
Communication between the PACE program staff and its contracted providers are essential to coordinating care across all settings as mandated by CMS for all PACE organizations.

As a provider you are entitled to a copy of the participants' Plan of Care, please request this from your local SCC PACE Executive Director

Interdisciplinary Team (The IDT)

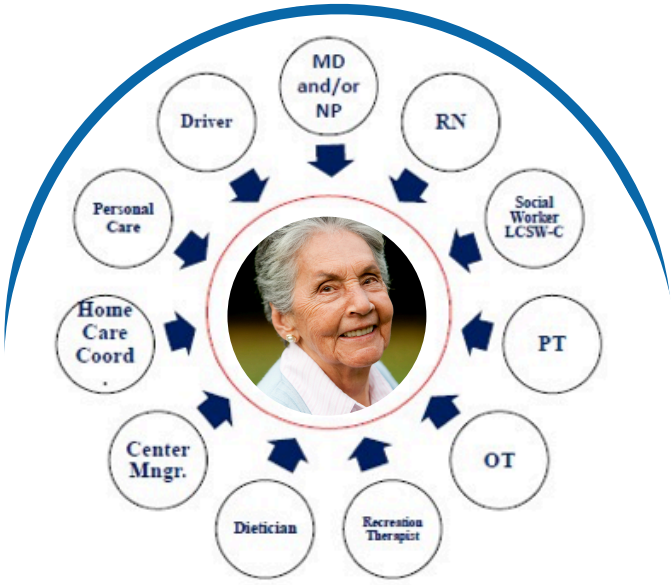
The IDT is the care management mechanism for PACE. It is the collective responsibility of the IDT to assess, coordinate and provide the medical, social, long-term care and support services needed for each participant. All services must be pre-approved by the PACE IDT. Emergency services are an exception and do not require pre-approval. The responsibilities of the IDT are to:

- Complete an initial assessment on each participant at the time of enrollment.
- Conduct periodic assessments on each participant.
- Develop a plan of care for each participant to address all medical, physical, emotional, and social needs while taking into account the participant's preferences for care and modifying the care plan as the participant's needs change.
- Review and approve services for each participant. Only services approved by the IDT and included in the participant's plan of care will be approved for payment, except for emergency services, which do not require approval.
- Coordinate 24-hour care delivery.
- To solicit and/or respond to pertinent input from other team members, participants and caregivers.
- To document changes in a participant's condition in the electronic medical record.

Daily IDT Meetings:
The IDT conducts daily meetings to discuss participant needs and issues. The agenda includes at a minimum; on call report, hospital and nursing home admission and discharge up dates, service requests, new issues/concerns, announcements, new enrollments and other information needing attention by the IDT. Contracted providers are encouraged to be part of this communication process. The IDT is comprised of the following individuals:

- Primary Care Provider
- Registered Nurse
- Master's-Level Social Worker
- Physical Therapist
- Occupational Therapist
- Recreational Therapist or Activity Coordinator
- Dietitian
- PACE Center Manager
- Home Care Coordinator
- Driver (or representative)
- Personal Care Attendant

*IDT Meeting Call in Procedures:
To arrange to participate in an IDT daily meeting or a care plan meeting contact the Center Director.



Records

PACE organization must have one comprehensive medical record for each participant. The record includes:

- Appropriate identifying information
- Documentation of all services furnished, directly or by contracted providers
- IDT assessments, reassessments, care plans
- Treatments and response to treatments
- Progress notes
- Laboratory, radiology, and other tests reports
- Medication records
- Hospital discharge summaries, when applicable
- Reports of contact with family and other informal supports
- The PACE Enrollment Agreement
- Physician Orders
- Disenrollment information
- Advance Directives (if applicable)

All health care providers who provide direct care to participants while at the PACE center are expected to document their visit/encounters in the medical records. All medical specialists who provide services to participants are expected to provide recommendations/ reports that will become part of the participant's individualized medical record. In the event that a participant is placed in a higher level of care setting (Nursing Home, Assisted Living, etc.), it is the responsibility of any IDT member or PACE clinician to document a visit or encounter with a participant in the facility's medical record in addition the PACE comprehensive medical record. All records are protected by HIPAA regulations.

Grievance and Appeals Process

Feedback is critical to PACE, and a driver for the Quality Assessment & Improvement Program. Grievances (complaints) are expected and viewed as positive. Each PACE program must maintain a grievance log that identifies grievances and the PACE response and resolution to those grievances. Grievances are tracked, analyzed and trended. The information is used to improve quality of care. The PACE staff and partnership team view contracted providers as partners in this process and expect that grievances voiced to our contracted providers are part of the grievance process in all settings.

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

It is the responsibility of contracted providers to communicate to the PACE organization any participant concerns or complaints so that the PACE organization can resolve the issue. Please contact the PACE Quality and Compliance Manager to report the grievance. Please read the Grievance policy and procedure (See Attachment 3 for additional information)

An Appeal is defined as a participant's action taken with respect to the PACE organization's non-coverage of, or nonpayment for a service, including denials, of requests for services, reductions, or terminations.

Please read the Appeals policy and procedure. (See Attachment 4 for additional information)

Quality Reporting

PACE organizations are required to report all incidents involving participants and staff and track this information as part of its quality program. Serious incidents, as defined by CMS, as requiring a Root Cause Analysis, are also considered "Level II". PACE must initiate the Root Cause Analysis within 3 business days of the incident.

All PACE contracted providers are required to report any incident that meets the Level II category, as defined below, within 24 hours. PACE can be reached 24 hours a day, seven days a week.

(See Attachment 2 for additional information)

CMS defines the following as Level II

- Falls with fracture or requiring hospitalization
- Abuse or neglect
- Unexpected deaths including suicide or suicide attempts
- Infectious disease outbreaks
- Pressure injuries and burns
- Adverse outcomes including adverse drug reactions
- Medication errors resulting in death, injury or hospitalization
- Elopement

Staff & Contracted Providers

Competency testing is required for all staff and contracted staff providing direct care to PACE participants. Staff must be legally authorized (licensed, certified, registered) to practice in the State in which they provide services and only practice within the scope of service for which they are licensed, certified or registered.

Health Status Requirements:
All staff and contracted staff providing direct care to PACE participants must be medically cleared and determined free of communicable diseases. All immunizations must be up to date before providing direct participant care. Each contracted provider must provide evidence of competency, medical clearance and immunization status for all of its employees providing direct care to PACE participants. Immunizations are based on the Center for Disease Control Recommendations for Health Care Workers. Proof of up-to-date immunization (or declination) for:

- Two step TB testing
- Hepatitis B
- Seasonal Influenza

Required Training:
All PACE staff and contractors must be oriented to the following information and provide proof of training. All of the required training information, that has an asterisk *, will be provided by the PACE organization. All other training information must be conducted by the contracted provider and the contracted provider must provide proof of training.

- Role of the PACE Team*
- Organizational Chart to identify leadership, IDT members & support staff*
- Standards of care and conduct
- Quality Assessment & Improvement Program*
- Reviewed List of Contracted Providers*
- OSHA-Mandated Training, including:
  - Standard Precautions
  - Waste management
  - Blood Borne Pathogens/Infection Control
  - Life Safety – Emergency and Disaster Planning
- Participant Safety
- Care of the Elderly
- Training on medical equipment used
- Body Mechanics
- Medical Documentation
- PACE Grievance and Appeals policies*
- PACE Service Determination Request Policies*
- Incidents with or without injury/Level II Reporting*
- HIPAA and Confidentiality
- PACE Participant Rights*
- Enrollments and Disenrollment Policies and Procedures*

Primary Care Provider Requirements

Community-Based Primary Care Providers designated by the PACE Participant serve as part of the PACE Interdisciplinary Team (IDT) as required by law. (42 CFR §460.102). As part of the PACE IDT, the primary care provider must provide these services:

Assessments:
Comprehensive Physical Assessments shall be provided as set forth in 42 CFR §460.104:

- At enrollment of the PACE Participant
- Every 6 months
- Any time there is a change in the Participant's health status
- At the request of the Participant or Participant's representative

SCC PACE will schedule assessments and provide all appropriate medical history and medical records. Following the assessment, the medical record of the community-based provider will be forwarded to the PACE program in a format agreed upon by both PACE and the provider within 14 days of services being provided.

IDT Meetings:
The primary care provider shall participate in the PACE IDT meeting on a regular basis at intervals agreed upon by the IDT in order to consolidate the assessment of the Participant into a single plan of care. The provider may attend in person or via teleconferencing.

Episodic Care:
The primary care provider shall provide episodic care to the Participant:

- As early in the course of the illness or condition as possible
- The need may be identified by the Participant, SCC PACE staff or the primary care provider. Issues identified by the PACE staff will be assessed with an initial nursing evaluation will be performed and used to triage the health concern and findings communicated to the provider.

Assure Coverage:
The primary care provider shall assure coverage for medical care of the Participant in the hospital or nursing home setting and assuring that there is continuity in the plan of care when Participant is transferred.

Oversee Usage:
The primary care provider shall oversee a Participant's use of medical specialists in coordination with the PACE team except when urgent care is required and outside the scope of practice of the primary care provider. Coordination of care by specialists will be through a consultation request process established with SCC PACE. Quality Improvement Activities
The primary care provider shall participate in quality improvement activities (42 CFR §460.136) as agreed upon with the SCC PACE Director of Quality Improvement and Compliance.

Mission and Philosophy:
The primary care provider shall uphold the mission and philosophy of SCC PACE in regard to providing quality care in a cost-effective manner through coordination and collaboration with the PACE IDT.

Emergent and Urgent Care Policies:
The primary care provider shall comply with SCC PACE policies provided to the provider relative to emergency and urgent medical services 42 CFR §460.100.

Medicare Part B Services:
In providing services, the primary care provider shall comply with the qualifications, requirements and conditions under 42 C.F.R. §410.20 and applicable Kentucky law and regulations.

Oversight & Monitoring Requirements for Contracted Providers:
It is the responsibility of the PACE organization to assure that quality services are provided in all settings whether they are provided directly by the PACE organization staff or by contracted providers.

The PACE organization must assure that all PACE staff and contracted providers meet all CMS requirements. In the event that the PACE organization identifies any quality/safety issues, those concerns will promptly be brought to the attention of the contracted provider. It is the expectation of the PACE organization that all contracted providers will work cooperatively to remedy identified issues and concerns.

Leadership Team

The Leadership Team guides the operation of the organization, and oversees the delivery of quality services to participants. The Leadership Team is comprised of: Chief of Community Healthcare, Executive Director, PACE Center Director, Medical Director, Quality Manager and Director of Business Operations.

PACE Medical Director: The Medical Director has the overall responsibility for the Quality Improvement Program and the Primary Care Services. This position serves as the liaison with community-based physicians and other medical professionals providing care to PACE participants.

PACE Staff: The PACE staff provides the core PACE services and ensure that the participants' needs are being met:

PACE Center Director: The PACE Center Director manages the day-to-day operations and services provided by all PACE staff and facilitates the interdisciplinary team.

Primary Care Staff: The physician and nurse practitioners provides care that meets the medical needs of the participants. The PCP works in the clinic, visit participants in hospitals and nursing homes, visit participants in their own homes and is on call for needed services after hours.

Registered Nurses: Registered Nurses focus on the health status and care of participants, both in the clinic and in the home. Nurses conduct skilled nursing assessments; provide direct skilled care, oversee medication administration, participate in care planning and manage the clinic and home care service delivery.

PACE Adult Day Health Center Staff: PACE Center staff include Certified Nursing Assistants' (CNA), Personal Care Attendant, Dietary Aides, and Activity Aides. The Center staff provides personal care; assists with activities, preparation and delivery of meals, toileting, transfers, ambulation; and transporting participants to and from the clinic or other areas of the center, such as rehab or visits to the social worker. In general Adult Day Health Center staff support the participants throughout their daily activities at the PACE Center.

Home Care Coordinator: A registered nurse oversees the provision of skilled nursing care and personal care in the home setting.

Therapists and Therapy Aides: Physical Therapists, Occupational Therapists, Recreational Therapists, and Therapy Aides work with participants to provide a comprehensive program of therapy at the Center and, when necessary, in the home.

Registered Dietician: The Registered Dietician is responsible for assessing each participant's nutritional needs and developing nourishing, palatable, well-balanced menus that meet the daily nutritional and special dietary needs of each participant. Dieticians also provide nutritional education to participants and caregivers.

Social Worker: A Masters Level Social Worker assesses each participant's psychosocial needs, and collaborates with IDT, staff, participants and caregivers in meeting the overall needs of each participant. The Social Worker may provide direct counseling; assist with financial, housing or family issues; and support both participants and caregivers in meeting their health care goals and remaining in the community.

Transportation Manager, Drivers and Van Escorts: The Transportation Manager must manage the transportation of all participants to and from the Center daily, to medical appointments, delivery of supplies to the home, and provide transportation for recreational activities. The Transportation Coordinator also trains and supervises all Drivers. Drivers are responsible for the door through door transportation and must be competent in managing equipment on the vans including wheel chair lifts, and safety harnesses, be able to safely transfer participants, know all emergency procedures and work in cooperation with van Escort Aides. Escort Aides assist the Driver in transfers, seating participants in the van, communications with the office while the van is in motion and managing all participant assistance in door through door services.

Receptionist: The Receptionist is stationed at the main entry of the PACE Center and is responsible for greeting all visitors and assuring that all visitors are signed in upon entry and announced prior to proceeding into the Center. The Receptionist is responsible to ensure that participants leaving the building unescorted and attempting to "elope" are stopped as quickly as possible. He or she will follow all procedures for notifying PACE staff and sound any alarms. The Receptionist answers the main incoming line and directs calls to other staff members.

Provider Relations

Representative

VOANS Senior CommUnity Care, PACE has a Provider Relations Representative servicing certain regions across the US. The Provider Relations Representative (PRR) bridges the gap between you as the provider and VOANS Senior CommUnity Care PACE.

The PRR will support you in a full range of provider relations & service interactions with VOANS Senior CommUnity Care. The PRR will establish and maintain strong communication channels with providers by overseeing any investigating research that may need to be done on your behalf and following through to provider resolution.

Support:
The PRR can assist you with financial research and analysis by coordinating communication and collaboration with participating parties in regard to the following:

- PACE Team
- Contracting
- Credentialing
- Claims concerns such as provider appeals and status; denials; and contracted reimbursement

Communication:
The PRR will meet with contracted providers, facilities, and/or their staff to educate and orient them regarding VOANS Senior CommUnity Care policies, protocols and initiatives.
Means of education conducted via:

- Telephone
- Virtual meetings
- On-site meetings
- Quarterly workshops

If you have any questions that do not pertain to any of the above scenarios please reach out to your local VOANS Senior CommUnity Care, PACE Team.

VOANS Senior CommUnity Care CMS Marketing Regulations: PACE staff are prohibited from engaging in certain practices when marketing PACE

- Discrimination of any kind, except that marketing may be directed to individuals eligible for PACE by reason of their age.
- Activities that could mislead or confuse potential participants, or misrepresent the PACE organization, CMS or the State Administering Agency.
- Gifts or payments to induce enrollment.
- Contracting outreach efforts to individuals or organizations whose sole responsibility involves direct contact with the elderly to solicit enrollment.
- Unsolicited door-to-door marketing.

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 PACE Disciplinary Policies.

Improvement

The PACE Quality Improvement and Compliance Manager tracks, analyzes and trends information on clinical and non-clinical program services. Their findings are then provided to the Governing Body, the Leadership Team, the Quality Improvement Committee, staff and contracted providers.

The Quality Program is intended to promote quality services and to achieve desired outcomes for all participants enrolled in the program through systematic, objective, ongoing monitoring and evaluation of data that identifies the program's strengths and areas for needed improvement while maintaining adherence to the highest ethical standards and in compliance with applicable federal and state laws, rules, regulations, and procedures in a timely and effective manner. As part of the Quality Program, SCC will have committees with community input and contracted providers are encouraged to participate. See Attachment 2 for the Quality Program.

As a provider of VOANS Senior CommUnity Care PACE Participants, you are expected to maintain privacy consistent with Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Any loss, theft, misuse, or accidental disclosure of Protected Health Information (PHI) must be reported to SCC PACE's Quality and Compliance Department and may also need to be reported to the government under the breach notification requirements.

HIPAA Breach:
Participants and SCC should be notified in writing of the following information if there is a HIPAA breach:

- 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 Participant can do to protect themselves from potential harm resulting from the breach.
- What corrective actions and investigations the entity is doing to prevent future breaches and mitigate losses.
- Who to contact for additional information and to request an entitled copy of his/her health record.

PACE Provider and Network Information:
This section provides information for maintaining network privileges and sets forth expectations and guidelines for PCPs, specialists, and facility providers. Please note that, in general, the responsibilities and expectations outlined in this section pertain to all contracted PACE providers, including behavioral health providers, personal care, long-term services, and support providers (LTSS) Becoming a PACE Provider, VOANS Senior Community Care of maintains and adheres to all applicable state and federal laws and regulations, Medicaid requirements. VOANS Senior Community Care PACE, will align with CMS requirements on a long-term model for credentialing to meet the Department of Health and Human Services and CMS standards. All providers enrolled with VOANS Senior Community Care PACE must also be enrolled in Medicare and Medicaid.

Examples of Participating PACE Provider Network Types are included but not limited to the following:

- Primary Care Providers (PCPs)
- Physician Specialists
- Long-Term Services and Support (LTSS) Providers
- Home Health Agencies
- Community-Based Residential Alternatives
- Behavioral Health Providers
- Ancillary and Hospital Providers
- Allied Health Providers
- Acute Care Providers
- Other Safety Net Providers and Community Partners
- Federally Qualified Health Centers (FQHCs)
- Rural Health Centers (RHCs)
- County Health Department
- Nurse Practitioners
- Transportation Providers
- Social Work services
- Nutritional counseling
- Recreational Therapy
- Personal care and supportive services
- Educational and recreational services
- Congregate meals
- Durable medical equipment
- Respiratory therapy and oxygen
- Dental
- Pharmacy
- Dialysis
- Alcohol and substance abuse services

Provider Enrollment Through the uniform credentialing process, the Enrollment Department will screen and enroll and periodically revalidate all contracted PACE providers. PACE, Senior Community Care is prohibited from employing or contracting with providers excluded from participation in federal health care programs under the Social Security Act.

Disclosure Requirements:
PACE is prohibited from using, disclosing, or sharing provider enrollment/credentialing information for any purpose other than use in PACE Managed Care without the express, written consent of the provider, CMS, and the State Administering Agency.

Credentialing and Re-credentialing:

PACE, at the department's direction, will not make a quality determination or use independent credentialing quality standards to evaluate providers. PACE will consider providers that are active with the state's Department of Health and Human Services and CMS as being acceptable for network inclusion subject to completion of the PACE provider contracting process.
PACE will make independent screening, enrollment, or credentialing determinations as required per CMS standards and will not request the submission of additional documentation from any provider. However, as part of the contracting process, PACE may collect roster information including all data elements required for claims payment and directory purposes. After the Provider's initial Credentialing, PACE will evaluate a contracted provider's continued eligibility for contracting by re-credentialing the provider. PACE's process will occur no less frequently than every three years consistent with CMS' provider credentialing policy and procedures unless otherwise notified by CMS or the state's agency.

Provider Enrollment through the uniform credentialing process, the Department will screen and enroll and periodically revalidate all contracted PACE providers. Disclosure Requirement, PACE is prohibited from using, disclosing, or sharing provider enrollment/credentialing information for any purpose other than use in PACE Managed Care without the express, written consent of the provider, CMS, and the State Administering Agency.

Enrollment:

Each provider must be enrolled in the Medicare and Medicaid programs. The Medicare and Medicaid Departments will ensure that the applicants meet all program requirements and qualifications. Based on state and federal requirements:

- Federal and state application fees
- Training Fingerprinting Site visits
- Criminal background checks
- Federal database checks
- Verification of provider certification license and accreditation

PACE's Role and Responsibilities:

- PACE will accept provider screening, enrollment, credentialing, and verified information from the State Administering Agency.
- PACE may collect or request information from providers for contracting purposes only.
- PACE will not request any additional credentialing information from a provider without the State department's written prior approval.
- PACE will not solicit or accept any provider credentialing or verified information from any other source except as permitted by the State Administering Agency.
- PACE may execute a network provider contract, pending the outcome of department screening, enrollment, and revalidation, by up to specified number of days but must terminate a network provider immediately upon notification from the State's Department of the Office of the Inspector General (OIG) that the network provider cannot be enrolled, or the expiration of a specified period of days period without enrollment of the provider, and notify affected participants.

Ongoing Sanction Monitoring:

To support certain credentialing standards between the re-credentialing cycles, PACE has established an ongoing monitoring program. PACE 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, PACE will review periodic listings/reports every three years. The various monitoring sources used are including but are not limited to the following:

- Office of the Inspector General (OIG)
- Federal Medicare/Medicaid reports
- State licensing boards/agencies
- Any other information received from sources deemed reliable by CMS

and Submission

Senior CommUnity Care, PACE use to process our claims, these are the preferred submission methods:

- Electronic Claim Submission

Please submit using:
Payer ID: VNSPC
Support: Clearinghouse

- Direct Entry using the Provider Portal:

Direct Entry using the Provider Portal – www.SCCPACEproviders.org

**Claim status inquires or questions about your claims should be directed to Senior CommUnity Care Claims Department at claims@voa.org

Provider Appeals:
Disagree with a Claim Decision?

Appeals must be submitted timely per your contract. if you are not contracted with PACE Senior CommUnity Care default to Medicare guidelines; 120 days from initial determination. To initiate a claim dispute/appeal using any of the following methods:

- Corrected Claim entered through your Clearinghouse with its corresponding corrected claim identifier
- PDR entry via the Provider Portal

For written appeals, utilize the PACE Appeal letter located on under our Provider Resources on our Provider Website www.SCCPACEProviders.org. Complete the appeal letter in its entirety, including the reasons for the disagreement, and attach supporting documentation. Email the completed appeal form to the claims email or fax noted above and include "Claim Appeal" in the subject line

Clean Claims:
Senior CommUnity Care knows it's important to you that your office gets paid promptly. To reduce payment delays, have your office submit "clean claims." A clean claim is a claim that is received in a timely manner and includes all the information Senior CommUnity Care need to process it for payment. Unless otherwise required by law or regulation, clean claims include all of the following:

- Detailed and descriptive medical and patient data.
- A corresponding PACE reference number or authorization number.
- All the data elements of the UB-04 or CMS-1500 forms (including but not limited to participant number, National Provider Identifier (NPI), date(s) of service, and a complete and accurate breakdown of services).
- Submitting claims timely per your contract or if no contract is active, timely filing will default to Medicare guidelines.
- In addition, a clean claim:
  - Doesn't involve the coordination of benefits
  - Has no defect or error (including any new procedures with no CPT* codes, experimental procedures, or other circumstances not contemplated at the time of execution of your agreement) that prevents timely adjudication.

Benefits for automobile/no-fault are not covered under the PACE program. These will need to be submitted to your correct carrier for processing.

Coding:
As changes to coding are published by nationally recognized coding entities, Senior CommUnity Care will update our internal systems and practices, as appropriate. Updates may include the assignment/reassignment of codes to service groupings and/or other updates that are consistent with PACE policies and applicable law. Until any updates are complete, services may be subject to the standards and coding set for the prior period. The rates and compensation under your agreement are subject to PACE coding/claim edit policies, procedures, and practices (e.g., DRG assignment), which may be updated from time to time, and which may consider actual services performed and the setting in which they are provided.

Audits:
PACE Billed Charges Audit:
The purpose of an audit is to review the itemized bill against the claim, authorized services, and medical records. This audit policy is used on claims where Senior CommUnity Care pay a percentage of billed dollars (charges). In addition, the audits identify items that may not have been ordered by PACE or were not supported in the medical records. You as a vendor may be selected for an audit to verify the accuracy of billing policies.

If PACE performs an audit and determines there are questionable charges being submitted, PACE will reach out to notify you that an audit is being performed and may ask you to provide additional documentation for the services being billed. Audits may cause a delay in your reimbursement until the findings are complete.

Prepay Review:
Senior CommUnity Care may review our participant's medical records before certain claims are processed. This review includes but is not limited to, itemized bills or more specific detail for claims contracted on a percentage-of-charges basis. The review may result in payment being denied for duplicate charges and errors in billing.

Overpayment Recovery:
Overpayment notifications are typically sent within 24 months of the payment issue date. A different time frame may be used if applicable by law and/or if fraud or other intentional misconduct by the provider occurs. For Medicare plans, overpayment notifications are typically sent within 36 months of the payment issue date. Medicare and Medicaid time frames are subject to change in order to comply with regulatory or legislative requirements.

Attachment #1:

Role of PACE Team

PACE organizations must establish an IDT at each center to comprehensively assess and meet the individual needs of each participant and assign each participant to an IDT functioning at the PACE center that the participant attends. The IDT is responsible for the initial and periodic assessments, plan of care, and coordination of 24-hour care delivery. Each team member is responsible for:

(1) regularly informing the IDT of the medical, functional, and psychosocial condition of each participant

(2) remaining alert to pertinent input from other team members, participants, and caregivers; and

(3) documenting changes of a participant's condition in the participant's medical record consistent with documentation policies established by the medical director.

Additionally, IDT members must serve primarily PACE participants. As part of the initial assessment, eight of the eleven IDT members (Primary Care Provider, Registered Nurse, Master's Level Social Worker, Physical Therapist, Occupational Therapist, Home Care Coordinator, Dietitian, and Recreational Therapist or Activity Coordinator) evaluate the participant in person, at appropriate intervals and develop a discipline-specific assessment of the participant's health and social status. At the recommendation of individual team members, other professional disciplines (e.g., Speech-Language Pathology, Dentistry, or Audiology) may be included in the comprehensive assessment process.

Quality Improvement Plan

The Senior CommUnity Care Quality Program is designed and organized to support the organization's mission, values, and goals. It is collaborative and interdisciplinary to improve organizational performance and maintain compliance with regulatory and other requirements.

Senior CommUnity Care Mission Statement

Our mission is to enhance the quality of life and independence for frail, older adults by providing services that will help them stay in their community and in their own residence.

Purpose

The Quality Program is intended to promote quality services and to achieve desired outcomes for all participants enrolled in the program through systematic, objective, ongoing monitoring and evaluation of data that identifies the program's strengths and areas for needed improvement while maintaining adherence to the highest ethical standards and in compliance with applicable federal and state laws, rules, regulations, and procedures in a timely and effective manner.

Goal and Objectives

The goal of the Quality Program is to assess current performance accurately and to improve future performance of PACE for clinical and non-clinical services with the following objectives:

- To deliver services that are effective, timely, and safe.
- To continually evolve a system that efficiently and effectively promotes performance improvement throughout the organization.
- To plan improvement based on input from our participants and families, community partners, current research, and experience.
- To use performance measures and quality indicators to evaluate performance, processes, and outcomes. Measures include safety, clinical, financial efficiency, and service.
- To maintain a Quality Program that monitors processes and outcomes and captures events that require root cause analysis, peer review, or other corrective action.
- To develop and adhere to processes that assure compliance with all regulatory and oversight agencies.
- To provide education to all staff the assure compliance with all regulatory requirements.
- Maintain effective systems to prevent, detect, and correct instances of non-compliance with applicable federal and state laws, rules, regulations, and procedures in a timely and effective manner
- To provide education, support, consultation, and guidance to administration and clinical staff in monitoring, evaluating, and implementing processes.
- To monitor the effectiveness of the Quality Program and make revisions as necessary.
- To encourage staff engagement, at all levels, in the culture of quality.

Values

- Safety – To foster a positive environment and work ethic to ensure the health, safety, and well-being of all participants.
- Timeliness – To provide services striving to reduce unnecessary and potentially harmful delays in the provision of care
- Effectiveness – To provide services based on scientific, best practice, and evidence-based standards that align with the participant's health goals.
- Efficiency – We seek to be fiscally responsible and promote an environment and work process that reduces waste, both overuse, and misuse of resources.
- Equitability – We will seek to provide care to all participants in alignment with their health goals and not be based on age, gender, race, ethnicity, national origin, religion, sexual orientations, disability, socioeconomic status, or geographical location.
- Patient-centeredness – We strive to provide care that is respectful of and responsive to participant preferences, needs, and values.
- Service Excellence – We strive to respond to our internal and external customer's needs in a professional manner
- Teamwork – We work together to efficiently complete our tasks, striving to eliminate barriers between departments, services, disciplines, and job classifications.

Quality Program Structure

Performance Monitoring Plan

Senior CommUnity Care will develop an annual Performance Monitoring Plan that will:

- Identify areas to improve or maintain the delivery of services and participant care
- Set priorities for performance improvement efforts
- Develop and implement plans of action to improve or maintain quality of care
- Develop and implement plans of action to ensure that Senior CommUnity Care operates in compliance with state and federal regulations and contractual requirements.
- Monitor participant and caregiver satisfaction with program services to develop and implement plans of action to address those issues not meeting expectations
- Document and distribute the results of the Quality Program to Senior Community Care staff, participants, and contracted providers

Board of Directors

The Senior CommUnity Care Board of Directors has oversight and approval of the Performance Monitoring Plan. The Quality and Compliance Department shall present the Performance Monitoring Plan annually and provide the Board of Directors with outcomes and performance of the plan during regular board meetings.

Executive, Medical, Center, and Clinical/Nursing Directors

Senior CommUnity Care's Executive, Medical, Center, and Nursing Directors shall have overall responsibility for oversight of the Quality Program, reviewing and monitoring of utilization management, and implementing staff education whenever necessary.

Quality and Compliance Department

The Quality and Compliance Department will work closely with the Discipline and Departmental Mastery Teams, Medical Records Department, and Infection Control for data collection, examination, and reporting of findings necessary for quality projects or for identification of possible quality issues, which will be reported to the Quality and Compliance Committee.

Ethics Committee

Senior CommUnity Care shall establish an Ethics Committee. This committee will assist Senior CommUnity Care by:

- Reviewing the ethical dimensions of medical and non-clinical decisions on behalf of the participants
- Providing guidance to Senior CommUnity Care's Governing Body 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
- Providing needed staff training around ethical issues and concerns

Through this committee, Senior CommUnity Care will be able to receive guidance regarding its Quality and Compliance Program and the ethical issues faced by the organization. The committee and committee membership shall include the Executive Director, Medical Director, Center Director, Clinical/Nursing Director, a Primary Care Provider, as well as representation from some of the following disciplines: medical ethics; pastoral care; social work; adult protective services; experts in law and/or other relevant disciplines. The committee shall meet semiannually or as needed and report through the Executive Director to the Senior CommUnity Care Board of Directors.

Discipline and Department Mastery Teams

Senior CommUnity Care will support consistent operational excellence through a series of discipline-specific mastery teams with the following objectives:

1. Identifies and maintains monthly metrics to measure the effectiveness of discipline-specific performance and compliance to PACE regulations, contract requirements, and standards of practice
2. Based on monthly metrics, identifies best practices to be populated across the discipline across all Senior CommUnity Care PACE Organizations
3. Assure discipline at each PACE Organization is compliant with PACE regulations and VOANS Policies, Procedures, and Standards of Practice
4. Maintains consistent orientation and discipline-specific training programs and materials considering any state-specific requirements that must be incorporated and included
5. Maintains consistent discipline-specific policies and procedures considering any state-specific requirements that must be incorporated and included
6. Identify and promote educational opportunities for Senior CommUnity Care PACE Organization staff supporting the Interdisciplinary Team
7. Reviews discipline-specific systems and practices to assure consistent processes and outcomes
8. Create and maintain a peer review system to provide feedback and input to improve discipline-specific performance, outcomes, and results
9. Recommend and coordinate discipline-specific activities for recognition days, weeks, or months and throughout the year as special circumstances indicate.

Teams consist of representatives from each PACE Organization and are organized into the following categories: Primary Care; Clinical/Nursing/Home Care/Personal Care; Social Work/Behavioral Health/Chaplaincy; Rehab (PT, OT, ST); Recreational Therapy; Nutrition; Day Center/IDT Facilitation; Transportation; Medication/Pharmacy; Medical Records, Quality and Compliance; Enrollment; Marketing Communications

Quality and Compliance Committee

The Senior CommUnity Care Quality and Compliance Committee shall assist the management team with regulatory compliance, assurance of high-quality care, and ethical behavior. The committee is responsible for developing the annual and continuously updated Quality Work Plan and Compliance Work Plan, guiding the implementation of planned activities, and creating opportunities for staff participation in the process. The committee will review the effectiveness of the Quality Work Plan and the Compliance Work Plan by responding to data trends, critical quality issues, and critical compliance issues to ensure that programs provide high-quality care that complies with State and Federal regulations. The committee will meet at least quarterly and review data outlined, collected, and reported in the Performance Monitoring Plan and reported activities from the QI teams. However, the committee may meet more frequently, if necessary, to address areas of non-compliance. The Quality and Compliance Committee will be chaired by the Quality and Compliance Manager at each program. It will include, at a minimum, the Medical Director, the Executive Director, the Center Directors, the Clinic/Nursing Director, and others that are felt to be necessary, including the Business Services Director, the Marketing and Community Relations Manager, and the Medication Department Lead.

Safety Committee

The Senior Community Care Safety Committee is committed to providing a work environment that is safe, healthful, and regulatory compliant. The committee will be comprised of representatives from both front-line to management. The members will work to identify and recommend solutions to hazards that may lead to an unsafe environment. The Safety Committee is responsible for conducting the Environmental Audits of the Day Center and Transportation department. The Quality and Compliance Department will have a representative at these monthly meetings for any collaboration needed with the Quality Work Plan or the Compliance Work Plan.

Quality Improvement Teams

Quality Improvement (QI) Teams shall be established to address specific Quality Improvement Projects. Members of the QI Teams will include relevant, interdisciplinary staff and contracted providers and should encourage overall staff participation. Each QI Team will establish a Team Lead with the overall responsibility for the team and its goals and will be the contact person between the Quality and Compliance Committee and the QI Team.

Quality Improvement Process

The Senior CommUnity Care quality improvement process is a problem-solving method that assesses the quality of program services, identifies and prioritizes opportunities for program improvement, uncovers root causes, organizes teams to develop and implement program improvements, and selects interventions to improve quality in all program areas.

Senior CommUnity Care uses an approach to clinical and service quality improvement consistent with scientific principles. (PDSA). Our approach has four key processes:

1) Measurement of data collection and analysis to assess organizational performance in the quality of patient care, delivery systems, and customer service. Data will be collected from multiple sources throughout the organization and on a variety of important functions. Examples would be internal databases, safety program reviews, participant/family surveys, medical records, occurrence reports, participant feedbacks, service requests, and appeals.
2) Analysis and assessment of the data, which may include comparing performance to reference databases, clinical practice guidelines, to similar organizations and benchmarks, to the expectations of our participants, staff, or community providers. The assessment process is to identify and prioritize opportunities for improvement.
3) Improvement of care and organizational processes based on the data analysis.
4) Reassessment of results of improvement interventions and analysis of outcomes, resulting in a continuous improvement process.

Performance Improvement Model
When opportunities for improvement are identified through data collection and analysis and prioritized by the Quality Committee, the Systematic Problem Solving or A3 methodology is used to make the improvement. The approach includes the following steps:

1) Define the problem
2) Explain the background, context, or importance
3) Breakdown the problem (current condition or state)
4) Set a target (goal condition or state)
5) Analyze the root cause of the problem
6) Identify, develop, and implement countermeasures – providing accountability in roles and target dates for implementation
7) Evaluate results – adopt, adapt, or abandon
8) Standardize
9) Follow up

The Systematic Problem Solving, or A3, improvement process model is an effective and efficient blending of the PDSA (Plan-Do-Study-Act) and Six Sigma DMAIC (Define-Measure-Analyze-Improve-Control).

Improvement Opportunities
When analysis reveals an opportunity for improvement, the decision to act will depend on:
· The impact on participant safety, care, and outcomes
· The impact on participant satisfaction
· The scope and extent of the process in question
· The relevance to the organization's mission and strategic plan
· High risk, problem-prone processes or one where variation has historically been a problem
· The extent to which the process improvement is a requirement of regulatory or oversight bodies
· Available resources

The Quality and Compliance Committee reviews and prioritizes performance improvement goals. When opportunities for improvement are identified, the committee may initiate individual Quality Improvement Projects or QI Teams. While Senior CommUnity Care strongly encourages quality improvement suggestions from all organizational levels, both internal and external, the Quality and Compliance Committee shall be responsible for initiating the Quality Improvement Project or QI Team based on the criteria above.

Quality Indicators

Indicators are developed to measure and monitor the performance and stability of processes used in delivering participant care services and the associated outcomes. Indicators objectively measure processes and outcomes based on current knowledge and clinical experience and may include industry standards, professional guidelines, or other applicable benchmarking. Special attention shall be given to developing indicators for those processes and/or outcomes that are high risk, high volume, tend to be problem-prone, and/or offer opportunities for improvement. Quality indicators are established with an organizational-wide view.

The Senior CommUnity Care Quality Indicators and Goals provide the Board of Directors, Leadership Team, Quality and Compliance Committee, and QI Teams an effective, high-level view of the overall performance of the organization as well as defining Senior CommUnity Care's annual quality goals. Indicators, at a minimum, will cover the following key quality elements:

Utilization

To ensure participants receive the appropriate level of care, Senior CommUnity Care collects, analyzes, and monitors its internal utilization data. This data is benchmarked against national PACE or industry benchmarks as appropriate. Areas of unusually high or low utilization of particular services including use of homecare services, center attendance, emergency care, inpatient hospitalization, and nursing home utilization. This information shall be gathered monthly for analysis of the impact and need for action and intervention. If problems or concerns are identified, the issue will be evaluated, action plans will be developed and implemented, and outcomes monitored to improve performance.

Participant and Caregiver Satisfaction

At least annually, or more frequently as determined by the Quality and Compliance Committee, Senior CommUnity Care shall survey participants and caregivers to assess the level of satisfaction with PACE services and program outcomes. The survey results shall be tabulated and analyzed by the Quality Department. The information obtained shall be used to identify areas of opportunity for improved services and to ensure continuous improvement in the level of care and participant satisfaction. The results will be presented to the Board of Directors, Quality and Compliance Committee, Leadership Team, and Participant Advisory Committee. Participant satisfaction shall also be monitored through grievance and appeals, as well as feedback from the Participant Advisory Committee. If problems or concerns are identified, the issue will be evaluated, action plans will be developed and implemented, and outcomes monitored to improve performance.

Data Collected During Participant Assessment

Senior CommUnity Care 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 Interdisciplinary Team (IDT) collects this data during initial assessments of new enrollees and reassessments of enrolled participants. Senior CommUnity Care is committed to performance improvement in the area of participant outcomes. Data collected from quality improvement activities, as determined by the Quality and Compliance Committee, in the area of participant outcomes will be analyzed against comparative data programs, such as DataPACE3 (National PACE Association), and other appropriate sources. If problems or concerns are identified, the issue will be evaluated, action plans will be developed and implemented, and outcomes monitored to improve performance.

Effectiveness and Safety of Direct and Contracted Services

Senior CommUnity Care shall ensure the safety and effectiveness of services provided by its staff and contracted providers, including the competency of clinical staff, timeliness of service delivery, and the achievement of treatment goals and outcomes. Competency of employed or contracted services shall be assessed through review of licenses and/or certifications upon time of hire and through discipline-specific competency assessment process conducted by Senior CommUnity Care or the contracted agency. Senior CommUnity Care shall evaluate the competency of its clinic and direct care staff (including contracted staff) upon employment, annually, and more frequently if the 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.

Training will be provided to staff as needed to improve skills and knowledge, as new techniques and technologies are introduced, and as new staff are hired. Outcomes of competency testing shall be collected, and the data will be used to identify and address staff training needs.

Service delivery is monitored through various venues:the annual participant and caregiver survey, feedback from all staff, participants, and families, plan of care reviews, and formal meetings, such as the Participant Advisory Council. If problems or concerns are identified, the issue will be evaluated, action plans will be developed and implemented, and outcomes monitored to improve performance.

Safety of other clinical and non-clinical areas, such as physical plant, home environment, and transportation, shall be monitored by Senior CommUnity Care. The data is collected through incident reports, Level II events, and other ongoing safety assessments for these areas. Transportation vehicles will be inspected daily before and after participant use. Home safety will be assessed during the participant's initial assessment and each reassessment and when information from home care identifies a problem. Physical plant safety will be assessed and reviewed monthly in accordance with Senior CommUnity Care policies. If safety problems or concerns are identified in these or any other areas, the issue will be evaluated, action plans will be developed and implemented, and outcomes monitored to improve performance, as appropriate.

Non-Clinical

Senior CommUnity Care monitors outcomes related to participant grievances and appeals. Participants are informed about the grievance and appeal process upon enrollment and annually thereafter. All participants and caregivers are encouraged to utilize the grievance and appeal process should the need arise. All grievances and appeals are monitored and tracked on an ongoing basis by the Quality and Compliance Department to ensure the timely resolutions of participant requests, incidents, appeals, and feedback and to identify potential areas of performance improvement.

Participant satisfaction with non-clinical areas is assessed at least annually as part of the participant and caregiver satisfaction survey and through feedback from the Participant Council and Participant Advisory Committee meetings. If problems or concerns are identified, the issue will be evaluated, action plans will be developed and implemented, and outcomes monitored to improve performance.

Regulatory Compliance Process

Prevent

Senior CommUnity Care's Quality and Compliance Department will provide all employees with education on participant rights including the rights of expressing the desire for a service through Service Determination Requests, the right to appeal a decision related to decreasing or not covering a service through the appeals process, and the right to express dissatisfaction by utilizing the grievance process. In addition to this education, Senior CommUnity care will also provide education to employees on the importance of reporting any unusual incidents to the Quality and Compliance Department for investigation. These incidents include, but are not limited to:

- Medicare Part D Fraud, Waste, and Abuse
- Participant Abuse or Neglect
- Certain medical conditions such as adverse events, falls with injury, pressure ulcers, and 2nd degree or higher burns
- Any, and all, unusual incidents that are not expected in the day to day operations of Senior CommUnity Care.

Employees will also be educated that Senior CommUnity Care has a zero-tolerance policy for intimidation or retaliation against any Senior CommUnity Care employee or participant, member of the Board of Directors, or first-tier, downstream, or related entity (FDR) that, in good faith, reports real or apparent unusual incidents. Employee education will happen at least at initial hire and annually. Opportunities for additional education will be evaluated on an ongoing basis.

Senior CommUnity Care establishes policies, procedures, and guidelines to ensure the consistency and alignment of operational functions and delivery of services. Policies, procedures, and guidelines are designed to ensure compliance with governing laws, rules, regulations statutes, codes, and contractual requirements; establish clinical best practices; give guidance for decision-making; and streamline processes. Employees are educated on and expected to follow all Senior CommUnity care policies and procedures.

Detect

To ensure that Senior CommUnity Care is operating in a regulatory compliant manner, all employees will be expected to report all unusual incidents to the Quality and Compliance Department. The Quality and Compliance Department will investigate, or assist in the investigation of, all incidents to determine the scope, if any, of non-compliance with regulations, contract requirements, and/or standards of practice. The results of the investigation will be use to develop corrective actions as needed.

Internal auditing and monitoring will be conducted to detect other potential areas of non-compliance with regulations and fraud, waste, and abuse. The purpose of internal auditing is to evaluate Senior CommUnity Care against the regulatory standards set forth by CMS or the State Administering Authority.

The Senior CommUnity Care Compliance Program is designed to be dynamic and operate as a continual feedback system where compliance risk directs monitoring and auditing activities and the establishment or evaluation of current compliance controls or other corrective actions. The results of monitoring and auditing activities as well as assessment of reported or detected compliance issues and subsequent corrective actions loop back to affect risk ratings for that compliance element and, in turn, subsequent compliance monitoring and auditing activities. In this way, areas of higher compliance risk are monitored and audited more comprehensively and with greater frequency than areas with lower compliance risk.

This system is initially established using the framework of the current CMS PACE audit protocol to establish Senior CommUnity Care's Auditing and Monitoring Work Plan, but is designed to be dynamic and responsive to changes affecting the organizations compliance with federal and state laws, regulations, contractual obligations, and other requirements. The results of compliance monitoring and auditing, reported incidence and issues of program noncompliance or potential FWA as well as changes to organizational policy and procedure, establishment of mitigating compliance controls, and changes to governing laws, regulations, and requirements are intended to feedback and effect the risk assessment of any compliance area or element and subsequent monitoring and auditing activities and/or the establishment of mitigating compliance controls.

Utilizing this feedback mechanism, the Auditing and Monitoring Work Plan defines internal and external monitoring and auditing activities. The Auditing and Monitoring Work Plan will be reviewed by Senior CommUnity Care on at least a quarterly basis and updated based on these factors in a manner to promote ongoing compliance.

At a minimum, internal audits will include, but are not limited to the following areas:

- Assessments and Plan of Care
- Complete and Accessible Medical Record
- Emergency Care
- Emergency Equipment
- Home Care
- Infection Control Standards
- Personnel Records
- Processing of Service Determination Requests, Appeals, and Grievances
- Provision of Services Across All Care Settings
- Required Notification of Participant Rights
- Safe Transportation
- Wound Care

Correct

The results of incident investigations and internal audits will determine the scope of any corrective action measures needed to correct identified areas of non-compliance. The Quality and Compliance Department will assist in developing the Corrective Action Plans. Corrective Action Plans will include:

- Specific Regulatory Requirement
- Root Cause Analysis
- Specific Changes to be Implemented
- Responsible Party
- Length of Time to Fully Implement
- Effectiveness Evaluation Plan
- Ongoing Auditing or Monitoring for Continued Compliance

Document

The results of all auditing and monitoring activities and associated Corrective Action Plans will be documented in the SCC Auditing and Monitoring Work Plan and will be available for review by the Executive Teams, the Board of Directors and state and federal oversight bodies as needed.

Implementation of the Quality Program

Responsibilities of the Quality and Compliance Committee

Senior CommUnity Care's Quality and Compliance Committee, with the assistance of the Quality and Compliance Manager, is responsible for:

- Developing mechanisms for collection and evaluating program information, identifying problems, formulating recommendations, disseminating information, assists with implementation of corrective actions and quality improvements, and evaluating the effectiveness of actions taken;
- Reviewing the Performance Monitoring Plan, Quality Work Plan, and the Compliance Work Plan annually and making recommendations concerning the formulation, revision, or implementation of policies governing both clinical and non-clinical services;
- Providing technical assistance regarding individual service problems;
- Participating in the development and ongoing review of written policies and procedures and standards of participant care, quality management, and compliance with regulatory requirements;
- Maintaining clear, effective lines of communication necessary for the operation of the Quality Program and supporting a culture of quality and compliance;
- Reviewing the adequacy and effectiveness of quality management and utilization activities;
- Developing mechanisms for evaluating responsiveness to the grievance process;
- Collecting and analyzing information about voluntary and involuntary disenrollment;
- Ensuring that all Senior CommUnity Care staff and contracted providers are involved in the Quality Program and are provided quality and compliance training and education as defined by organizational policy or resultant from quality improvement or corrective action activities;
- Facilitating the formation of QI Teams to address specific quality improvement opportunities;
- 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 initiating action to improve employee and participant safety and mitigate risks;
- Immediately addressing and 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;
- Establishing and maintaining an effective system to prevent, detect, and correct instances of non-compliance with regulatory requirements and potential Fraud, Waste, and Abuse issues;
- Providing routine oversight of contracted providers and First-Tier, Downstream, and Related (FDR) parties to ensure compliance with applicable regulations, policy, and contractual requirements.
- In coordination with other members of the Leadership Team, setting priorities for performance improvement considering prevalence and severity of identified problems and giving priority to improvement activities that affect clinical outcomes;
- Continuously monitoring progress toward goals and applying improvement and problem-solving processes as necessary to ensure satisfactory outcomes;
- Developing an annual Quality Work Plan and Compliance Work Plan that addresses findings of the previous year and seeks to improve the weakest areas and maintain the strongest areas;
- Assuring compliance with educational requirements as outlined by regulation and state contracts or resulting from metrics and quality improvement or corrective action activities.

Staff and Contracted Provider Involvement in Quality Improvement

All new staff shall be trained on the quality improvement process and plan during initial orientation and annually thereafter, or as particular quality issues arise. Employees at all levels are encouraged to participate in performance and quality improvement activities as appropriate and necessary. Also, staff are encouraged to participate by offering suggestions and recommendations for quality improvement projects through their involvement in event reviews, performance improvement initiatives, departmental meetings, and other formal and informal means.

As part of the contracted provider orientation, Senior CommUnity Care will provide an overview of the Quality Program and provide opportunities and encourage contracted staff to participate in the quality improvement process. Contracted providers may be invited to participate in QI Teams, asked to provide specific quality-related data about their organizations, and made aware of quality outcomes through reports of the Quality and Compliance Committee and QI team findings and outcomes.

Participant Involvement in the Quality Improvement

Senior CommUnity Care encourages participants and their caregivers to be involved in the quality improvement process and activities. Opportunities for participant input are provided through the Participant Advisory Committee (PAC), information gained from the grievance process, participant and caregiver surveys, and informal feedback from participants and caregivers.

The PAC shall be established to provide advice to the Board of Directors on matters of concern to participants. The PAC shall report directly to the Senior Community Care Board of Directors. Participants and participants' representatives shall constitute the majority of the membership. Other members shall include members of the Quality and Compliance Department, a Board of Directors-PAC liaison, and advocates for older adults representing the service area. The Board of Directors-PAC liaison shall report the PAC issues, ideas, and recommendations to the Board of Directors and present a copy of the meeting minutes. The Board of Directors-PAC liaison shall report the Board of Directors' response to the PAC at the next regular meeting. The PAC is intended to help improve service delivery with the PACE program through increased consumer feedback and recommendations with the Quality Improvement structure. This committee shall meet on a quarterly basis and be facilitated by the Quality and Compliance Department. The function of the Participant Advisory Committee (PAC):

· To advise Board of Directors and Leadership Team on areas of participant satisfaction and quality of care,

- To review participant satisfaction survey results and generate suggestions based on the results,
- To advise the Leadership Team and the Board of Directors on matters of concern to participants and caregivers,
- To advise staff in matters related to the quality of services including, but not limited to:

o Transportation Services
o Clinical and Medical Services
o Home Care Services
o Dietary Issues
o Organizational Improvement Issues
o Contracted Services
o Services Provided by IDT Members
o To assist SCC to identify and address participant needs and concerns, particularly with regard to the quality of care,
o To help interpret Senior Community Care's philosophy of purpose within the community, and
o To help facilitate the dissemination of relevant information to participants and their caregivers.

Grievance Policy and Procedure

Policy

- Process to resolve grievances
  - VOANS Senior CommUnity Care, PACE will have a formal written process to evaluate and resolve medical and nonmedical grievances by participants, their family members or representatives.
- Notification to participants
  - Upon enrollment and at least annually thereafter, VOANS Senior CommUnity Care, PACE will provide to participants written information on the grievance process.
- Minimum requirements
  - VOANS Senior CommUnity Care, PACE grievance process must include written procedures for the following:
    - How a participant files a grievance.
    - Documentation of a participant's grievance.
    - Response to, and resolution of, grievances in a timely manner.
    - Maintenance of confidentiality of a participant's grievance.
- Continuing Care during the grievance process
  - VOANS Senior CommUnity Care, PACE will continue to furnish all required services to the participant during the grievance process.
- Explaining the grievance process
  - VOANS Senior CommUnity Care, PACE will discuss with and provide to the participant in writing the specific steps, including timeframes for response, that will be taken to resolve the participant's grievance.
- Analyzing grievance information
  - VOANS Senior CommUnity Care, PACE will maintain, aggregate and analyze information from its grievance process and use that information in the organization's internal quality improvement program.

Procedure:

- Roles and Responsibilities:
  - All VOANS Senior CommUnity Care, PACE staff are responsible for working with the participant to resolve the issues and concerns and to assist the participant to submit grievance forms.
  - VOANS Senior CommUnity Care, PACE staff must inform the participant of his or her right to send their concern directly to the Department of Medicaid Services if the participant does not wish to work with VOANS Senior CommUnity Care, PACE to resolve the issue(s).
  - The Quality and Compliance (QAC) Department is responsible for initiating the grievance process when mechanisms of communication to VOANS Senior CommUnity Care, PACE using the phone, mail, or other non-direct means are utilized.
  - The QAC Department is responsible for maintaining, aggregating, and analyzing information related to grievances for integration into the organization's quality improvement program.
- Grievance Process:
  - Filing of Grievance
    - § Any VOANS Senior CommUnity Care, PACE participant or his/her representative may provide a grievance to any staff member at any time, either in person, by telephone, or in writing.
    - § Participant Documented Grievance - The VOANS Senior CommUnity Care, PACE Grievance Form will be available for participant use at all times. Assistance filling out the VOANS Senior CommUnity Care, PACE Grievance Form will be provided if requested.

§ VOANS Senior CommUnity Care, PACE Staff Documented Grievance - VOANS Senior CommUnity Care, PACE staff receiving a verbal or written concern will immediately document the information on the VOANS Senior CommUnity Care, PACE Grievance Form and verbally verify the information documented with the participant including the participant's desire to engage the grievance process.

§ If the participant does not want to participate in the grievance process, the grievance must still be submitted with this information noted on the form.

- On many occasions, participant concerns will be immediately resolved to the satisfaction of the participant by VOANS Senior CommUnity Care, PACE staff. These concerns, regardless of their severity, must still be documented on the Grievance Form and follow the grievance process.

§ Once the issue is documented by either participant/representative and provided to VOANS Senior CommUnity Care, PACE staff or documented by VOANS Senior CommUnity Care, PACE staff directly, the VOANS Senior CommUnity Care, PACE Grievance Form will be immediately scanned and emailed to the VOANS Senior CommUnity Care, PACE QAC Department. The original form will be placed in the QAC Department mailbox.

§ Once received, electronic copies of the VOANS Senior CommUnity Care, PACE Grievance Form will be shared internally within the QAC Department and, as appropriate, a copy will be provided to the appropriate Center Manager.

§ The QAC Department and/or Center Manager will refer the Grievance Form to the appropriate department head/discipline lead for resolution. The receiving department head/discipline lead is responsible for investigating and, if possible, resolving the issue and communicating this information to the QAC Department in a timely manner.

§ If more than one department is named in the grievance, the issue will be referred to the Center Manager, or designee, so that overall coordination within departments occurs.

§ As determined above, the individual ultimately responsible for the resolution to the grievance must investigate and gather all information necessary to analyze the grievance and to determine a resolution.

§ Every effort will be made to resolve the grievance in the best interests of the participant in accordance with VOANS Senior CommUnity Care, PACE policies and procedures.

o Documentation of Grievance

§ Participant Documented Grievance - The VOANS Senior CommUnity Care, PACE Grievance Form will be available for participant use at all times. Assistance filling out the VOANS Senior CommUnity Care, PACE Grievance Form will be provided if requested.

§ VOANS Senior CommUnity Care, PACE Staff Documented Grievance - VOANS Senior CommUnity Care, PACE staff receiving a verbal or written concern will immediately document the information on the VOANS Senior CommUnity Care, PACE Grievance Form and verbally verify the information documented with the participant including the participant's willingness to engage the grievance process.

§ Documentation of investigation findings and resolution to participant grievance issues will be documented electronically by the investigating department head/discipline lead or the QAC Department within the grievance file.

o Response and Resolution of Grievance:

§ The VOANS Senior CommUnity Care, PACE staff person or designee who receives the complaint will be responsible for discussing with the participant and/or representative the process for resolving the grievance issue.

§ On many occasions, participant concerns will be immediately resolved to the satisfaction of the participant by VOANS Senior CommUnity Care, PACE staff. These concerns, regardless of their severity, must still be documented on the Grievance Form and follow the grievance process.

§ The QAC Department will inform the participant, in writing, of VOANS Senior CommUnity Care, PACE's resolution to the grievance issue within 30 calendar days of the date of the original filing of the Grievance Form.

§ If the participant/representative is satisfied with the resolution of the issue, the issue will be considered resolved. Issues in which no resolution can be made to the satisfaction of the participant/representative will be referred to VOANS Senior CommUnity Care, PACE's Executive Director.

§ In the event of an unfavorable decision to the participant, a form letter will be provided to the participant with information about how to file a complaint to the Kentucky Department of Medicaid Services. The complainant will be notified that they can take further action by notifying the QAC Department in writing no later than thirty (30) calendar days after the date of final action taken on the Grievance if they would like to appeal to Medicaid/Medicare.

§ If the participant or representative is dissatisfied with the outcome of the internal decision or wishes to bypass the internal Grievance process, the participant and/or representative may request a fair hearing by contacting the Department for Medicaid Services, Division of Policy and Operations.

o Assurance of Appropriate Process

§ To ensure that the appropriate organizational policy and process is followed and that participant needs are being most appropriately addressed, reviewed grievance forms may be redirected to the appropriate process within the organization (e.g. service request, appeal, Level II).

- Examples, for clarification only:

o Participant grievance stating the need for additional homecare hours would be redirected as service request.

o Participant grievance expressing dissatisfaction with IDT decision would be redirected to appeal.

o Participant grievance reporting theft would be redirected to Level II.

§ This redirection shall be done only at the discretion of the QAC Department and will be documented within the grievance file and communicated to the participant/ representative.

§ Redirection of participant grievance shall follow organizational policy for the process in which it has been redirected and is thus exempt from further requirements of this policy.

o Grievance Related to Protected Health Information:

§ If the Grievance is related to the use or disclosure of Protected Health Information (PHI) or compliance with privacy policies, the Grievance will be sent to the VOANS Senior CommUnity Care, PACE Compliance Officer and QAC Department. The Compliance Officer will document the receipt of participant's complaint, any investigation undertaken, and the resolution of the issue. The Compliance Officer will seek to resolve the participant's complaint following the appropriate time frames associated with grievance. The privacy complaint and any documentation will be maintained for ten (10) years. The Compliance Officer will also inform the participant of his or her right to submit a written privacy complaint directly to the Office for Civil Rights in the U.S. Department of Health and Human Services. The Compliance Officer or QAC Department will help the participant file this complaint or will provide them with the necessary information to do so.

o Grievance Related to Discrimination:

§ If the grievance is related to discrimination based on classes protected under federal or state law, the grievance will be routed to VOANS Senior CommUnity Care, PACE's designated Civil Rights Coordinator for investigation and resolution. VOANS Senior CommUnity Care, PACE's designated Civil Rights Coordinator will, in addition to investigating and resolving the participant grievance, will provide to the participant information on their right to and how to file a civil rights complaint with the US Department of Health and Human Services, Office of Civil Rights and will help facilitate this process if desired by the participant.

§ VOANS Senior CommUnity Care, PACE will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or languages assistance services respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of materials for individuals with low vision, or assuring barrier-free location for the proceedings. The Privacy Officer will be responsible for such arrangements.

o Grievances Related to Personnel Issues

§ Grievances related to personnel issues will be communicated by the QAC Department to both the VOANS Senior CommUnity Care, PACE Executive Director and Human Resources department.

o Analyzing Grievance Information

§ Grievance information will be documented using VOANS Senior CommUnity Care, PACE's electronic grievance file system.

§ The QAC Department is responsible for maintaining, aggregating, and analyzing all information on grievance proceedings. This information will be used in the VOANS Senior CommUnity Care, PACE's internal quality improvement program.

§ A written summary of grievances including number, type, location and disposition are reported on a quarterly basis by the QAC Department to the VOANS Senior CommUnity Care, PACE QAC Committee, interdisciplinary teams, leadership, and to VOANS Senior CommUnity Care, PACE's Board of Directors.

§ The QAC Department and QAC Committee will review grievances and identify any trends or patterns for quality improvement, incorporating this information into the annual quality plan.

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

§ VOANS Senior CommUnity Care, PACE shall maintain in its files, copies of all grievances, the responses to them, and logs of grievances for a period of 10 years from the date the grievance was filed.

- Education

o All VOANS Senior CommUnity Care, PACE employees and contractors that have contact with VOANS Senior CommUnity Care, PACE participants will be provided education regarding the basic procedures for receiving and documenting participant grievance information in order to initiate the appropriate process for resolving participant concerns.

Attachment #4:

Appeals Policy

Participant Appeals:

- Notification of Participants
  - Upon enrollment, at least annually thereafter, and whenever the interdisciplinary team denies a service determination request for payment VOANS Senior CommUnity Care, PACE will give a participant written information on the appeals process.
- Minimum Requirements
  - At minimum, VOANS Senior CommUnity Care, PACE's appeals process shall include written procedures for the following:
    - § How a participant or their designated representative files an appeal, including procedures for accepting oral written appeal requests.
    - § Documentation of a participant's appeal.
    - § Review of an appeal by an appropriate third part reviewer or committee. An appropriate third-party reviewer or member of a review committee must be an individual who meets all of the following:
      - § Is appropriately credentialed in the field(s) or discipline(s) related to the appeal.
      - § An impartial third party who meets both of the following:
        - i. Was not involved in the original action.
        - ii. Does not take a stake in the outcome of the appeal.
  - The distribution of written or electronic materials to the third-party reviewer or committee that, at a minimum, will explain all of the following:
    - § Services must be provided in a manner consistent with the requirements in 42 CFR 460.92 (Required Services) and 42 CFR 460.98 (Service Delivery).
    - § The need to make decisions in a manner consistent with how determinations are made under section 1862(a)(1)(A) of the Social Security Act (PACE benefits under Medicare and Medicaid).
    - § The rules in 42 CFR 460.90(a) that specify that certain limitations and conditions applicable to Medicare or Medicaid or both benefits do not apply.
  - Responses to, and resolution of, appeals as expeditiously as the participant's health condition requires, but no later than 30 calendar days after VOANS Senior CommUnity Care, PACE receives the appeal.
  - Maintenance of confidentiality of appeals.

- Opportunity to Submit Evidence
  - VOANS Senior CommUnity Care, PACE will give all parties involved in the appeal a reasonable opportunity to present evidence related to the dispute, in person, as well as in writing.

- Service Furnished During Appeals Process
  - During the appeals process, VOANS Senior CommUnity Care, PACE shall meet the following requirements:
    - § For a Medicaid participant, continue to furnish the disputed services until issuance of the final determination if the following conditions are met:
    - § VOANS Senior CommUnity Care, PACE is proposing to terminate or reduce services currently being furnished to the participant.
    - § The participant requests continuation with the understanding that he or she may be liable for the costs of the contested services if the determination is not made in his or her favor.

§ Continue to furnish the participant all other required services, as specified in subpart of F of 42 CFR 460

- Expedited appeals process:

o VOANS Senior CommUnity Care, PACE will have an expedited appeal process for situations in which the participant believes that his or her life, health, or ability to regain or maintain maximum function could be seriously jeopardized, absent provision of the service dispute.

o Except as provided by section II(e)(iii) of this policy, VOANS Senior CommUnity Care, PACE will respond to the appeal as expeditiously as the participant's health condition requires, but no later than 72 hours after it received the appeal.

o VOANS Senior CommUnity Care, PACE may extend the 72-hour timeframe by up to 14 calendar days for either of the following reasons:

§ The participant requests the extension.

§ VOANS Senior CommUnity Care, PACE justifies to the State administering agency the need for additional information and how the delay is in the interest of the participant.

· Notification. VOANS Senior CommUnity Care, PACE will give all parties involved in the appeal appropriate written notification of the decision to approve or deny the appeal.

o Notice of Favorable Decision. Notice of any favorable decision must explain the conditions of the approval in understandable language.

o Notice of Partially or Fully Adverse Decisions

§ Notice of any denial must:

§ State the specific reasons(s) for the denial;

§ Explain the reason(s) why the service would not improve or maintain the participant's overall health status;

§ Inform the participant of his or her right to appeal the decision; and

§ Describe the external appeal rights under 42 CFR 460.124.

§ At the same time the decision is made, VOANS Senior CommUnity Care, PACE must also notify the following:

§ CMS.

§ The State administering agency.

o Actions Following a Favorable Decision. VOANS Senior CommUnity Care, PACE will furnish the disputed service as expeditiously as the participant's health condition requires if a determination is made in favor of the participant on appeal.

o Analyzing appeals information. VOANS Senior CommUnity Care, PACE will maintain, aggregate and analyze information on appeal proceedings and use this information in the organization's internal quality improvement program.

- Additional Appeal Rights Under Medicare or Medicaid. VOANS Senior CommUnity Care, PACE will inform a participant in writing of his or her appeal rights under Medicare or Medicaid managed care, or both, assist the participant in choosing which to pursue if both are applicable, and forward the appeal to the appropriate external entity.

o Appeal Rights under Medicare. Medicare participants have the right to a reconsideration by an independent review entity.

§ A written request for reconsideration must be filed with the independent review entity within 60 calendar days from the date of the decision by third-party reviewer.

§ The independent outside entity must conduct the review as expeditiously as the participant's health condition required but must not exceed the deadlines specified in the contract.

§ If the independent review conducts a reconsideration, the parties to the reconsideration are the same parties described in this policy, with the addition of [INSERT LOCATION].

o Appeal Rights under Medicaid. Medicaid participants have the right to a State Fair Hearing.

o Appeal Rights for Dual Eligible Participants. Participants who are eligible for both Medicare and Medicaid have the right to external review by means of either the Independent Review Entity or the State Fair Hearing process.

- Additional State Requirements
  - o Appeal Rights for Dual Eligible Participants. Participants who are eligible for both Medicare and Medicaid have the right to external review by means of either the Independent Review Entity or the State Fair Hearing process.VOANS Senior CommUnity Care, PACE will establish procedures to comply with any additional requirements defined by the State administering agency.

- Procedure:
  - o General Appeals Process
    - § Upon submission of an appeal by a participant/designated representative, the VOANS Senior CommUnity Care, PACE staff person receiving the appeal will assist the participant in completing the VOANS Senior CommUnity Care, PACE Appeals Form, if needed, to identify the contested benefit(s)/service(s) and attempt to have the participant/designated representative sign the VOANS Senior CommUnity Care, PACE Appeals Form.
    - § The VOANS Senior CommUnity Care, PACE staff person receiving the appeal will immediately forward the VOANS Senior CommUnity Care, PACE Appeal Form and any other documents to the Quality and Compliance Department.
    - § The Quality and Compliance Department is responsible for processing the appeal and facilitating the appeal process within the designated timeframes and ensuring that all disputed or contested services are continued to be provided to the participant until final determination of the appeal is completed.
    - § The Quality and Compliance Department will provide the participant/designated representative with written acknowledgment of the receipt of the appeal within three (3) business days from the submission.
    - § The Quality and Compliance Department, in collaboration with the Executive Director and other selected professionals, will utilize an appropriately credentialed and impartial third-party review team, which does not consist of VOANS Senior CommUnity Care, PACE employees, to review the participant's appeal.
    - § The third-party review team will respond to and resolve a participant/designated representative appeal as expeditiously as the participant's health condition requires but no later than thirty (30) calendar days after the Quality and Compliance Department receives the appeal.
    - § The participant/designated representative will be allowed to present their point of view, testimony, and/or evidence to the reviewing third party either in person, by phone, or in writing. If the participant/designated representative wishes to provide further information to the reviewing third party, it will be indicated on the VOANS Senior CommUnity Care, PACE Appeal Form and signed by the participant/designated representative.
    - § The third-party review team may request additional information from the Quality and Compliance Department and coordinate interviews if needed. They will use their professional judgment and experience to determine whether they agree with the participant or the original IDT decision.
    - § The appeal record will be completed by the Quality and Compliance Department at the time of the determination either in favor of the participant, overturning the original IDT decision, or adverse to the participant, sustaining the original IDT decision.
    - § Appeal Decisions

  - o The Third-Party reviewer will notify the participant/designated representative the outcome of the appeal, both verbally and in writing.
    - § Determination in favor of the participant:
      - If a determination is made in favor of the participant on appeal and overturning the original IDT decision, VOANS Senior CommUnity Care, PACE will furnish the disputed service or payment as expeditiously as the participant's health condition requires and not to exceed five (5) business days to initiate implementation of service.
      - Exception: The service is not available from an external contractor. The participant/designated representative will be notified verbally and in writing.

- Documentation of implementation or continuation of services shall be provided to the Quality and Compliance Department to be kept as part of the appeal record.
- The participant shall be informed, in writing, of the determination of the appeal in their favor indicating the initiation, restoration, continuation, or payment for services, as appropriate.
- Ongoing services provided to a participant based on a favorable appeal decision will continue to be provided to the participant for at least 90 days at which time the IDT may further review the appropriateness of providing the service according to its normal processes.

o Determination adverse to the participant:

§ For a determination that is wholly or partially adverse to the participant, sustaining the original IDT decision, Senior CommUnity Care will notify the Center for Medicare and Medicaid Services (CMS) and the State Authorizing Authority (SAA) at the time of the decision in addition to any monthly or quarterly reporting.

§ The denial of appeal letter to participant/designated representative will include information on further Medicare and Medicaid appeal rights.

§ The Quality and Compliance Department will act as a resource for the participant/designated representative to answer any questions, offer any assistance in choosing which process to pursue under the additional Medicare and Medicaid appeal rights, and facilitate this process as appropriate.

§ A copy of the appeal denial letter will be provided to the Quality and Compliance Department to be kept as part of the appeal record.

- Expedited Appeals Process

o Situations in which a participant/designated representative believes that his or her life, health, or ability to regain or to maintain maximum function could be seriously jeopardized, absent provision of the service in dispute, will be processed as an expedited appeal.

o Expedited appeals will follow the same requirements as general appeals with the following modifications to the process:

§ The third-party review team will respond to and resolve the participant/designated representative's appeal as expeditiously as the participant's health condition requires, but no later than seventy-two (72) hours after the Quality and Compliance Department receives the expedited appeal.

§ The Quality and Compliance Department may extend the seventy-two (72) hour timeframe by up to fourteen (14) calendar days if:

- The participant requests the extension, OR
- If the Quality and Compliance Department can justify to the SAA the need for additional information and how the delay is in the interest of the participant.

§ The participant/designated representative will be notified verbally of receipt of the appeal and the final determination of the appeal will be communicated to the participant/designated representative both verbally and in writing.

§ In the event of an expedited appeal decision in favor of the participant, overturning the original IDT decision, VOANS Senior CommUnity Care, PACE] will furnish the disputed service or payment as expeditiously as the participant's health condition requires and not to exceed seventy- two (72) business hours to initiate implementation of service.

- Exception: The service is not available from an external contractor. The participant/designated representative will be notified verbally and in writing.
- Additional Appeal Process Under Medicaid or Medicare

o The Quality and Compliance Department acts as a resource for any participant/designated representative to answer any questions, offer any assistance in choosing which process to pursue under additional Medicare and Medicaid appeal rights, and facilitate this process as appropriate.

- The specific available appeals process for a participant is determined by whether the participant is enrolled in Medicaid, Medicare, or both.
- Medicaid external appeal process:
  - The participant/designated representative may engage the Medicaid external appeal process in appeal to VOANS Senior CommUnity Care, PACE's internal appeal decision, in lieu of VOANS Senior CommUnity Care, PACE internal appeal process, or concurrently to VOANS Senior CommUnity Care, PACE's internal appeal decision.
  - To request a Fair Hearing through the Medicaid external appeal process, contact the Health Services Administrative Hearings Branch in your state.
- Medicare external appeals process through an Independent Review Entity (IRE).
  - A participant/designated representative may file an appeal with Medicare's IRE only after first having engaged VOANS Senior CommUnity Care, PACE's internal appeal process and after receiving an adverse appeal decision.
  - After receiving an adverse appeal decision, if a participant/designated representative elects to engage Medicare's IRE, VOANS Senior CommUnity Care, PACE will:
  - Send the participants appeal to Medicare's IRE, MAXIMUS, for impartial review of the appeal.
  - MAXIMUS Federal Services PACE Appeal Project, 3750 Monroe Ave. Ste. 702, Pittsford, New York, 14534-1302, Telephone: 585-348-3300 www.medicareappeal.corn
  - MAXIMUS maintains a standard and expedited appeals process.
  - Standard appeals will be resolved within thirty (30) calendar days after an adverse decision or filing of the appeal.
  - MAXIMUS will contact VOANS Senior CommUnity Care, PACE with the results of the review.
  - MAXIMUS will either maintain VOANS Senior CommUnity Care, PACE's original decision or overturn VOANS Senior CommUnity Care, PACE's decision and rule in the participant's favor.

§ Analyzing Appeal Information

- The Quality and Compliance Department is responsible for maintaining, aggregating, and analyzing all information on appeal proceedings. This information will be used in the VOANS Senior CommUnity Care, PACE's internal quality assessment and performance improvement program.
- A written summary of appeals including number, type, location, and disposition are reported on a quarterly basis by the Quality and Compliance Department to the VOANS Senior CommUnity Care, PACE Quality Committee, interdisciplinary teams, leadership, and to VOANS Senior CommUnity Care, PACE's Board of Directors.
- The Quality and Compliance Department and Quality Committee will review appeals and identify any trends or patterns for quality improvement, incorporating this information into the annual quality plan.
- Records of all appeals will be held confidential and made available as needed to State and Federal agencies upon request.
- VOANS Senior CommUnity Care, PACE shall maintain in its file's copies of all appeals, the responses to them, and logs of appeals for a period of 10 years from the date the appeal was filed.

§ Compliance and Monitoring

- The Quality and Compliance Department will review the Service Determination Log, and Participant Appeal log at least monthly for compliance with the provisions of this policy.
- Non-compliance findings by the Quality and Compliance Department will be reported to VOANS Senior CommUnity Care, PACE's Executive Director, who will be responsible for taking corrective action as necessary.

§ Education

- All VOANS Senior CommUnity Care, PACE employees and contractors that have contact with VOANS Senior CommUnity Care, PACE participants will be provided education regarding the basic procedures for receiving and documenting participant appeals in conjunction with education regarding participant rights.

Attachment #5:

Participants Rights

Participant's Bill of Right and Responsibilities

The Program of All-Inclusive Care for the Elderly, also called PACE, is a special program that combines medical and long-term care services in a community setting. When you join a PACE program, you have certain rights and protections. Senior CommUnity Care must fully explain your rights to you or someone acting on your behalf in a way you can understand at the time you join. At Senior CommUnity Care, 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:

You have the right to be treated with respect.

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 get all of your health care in a safe, clean environment.
- To be free from harm. This includes physical or mental abuse, neglect, physical punishment, being placed by yourself against your will, and any physical or chemical restraint that is used on you for discipline or convenience of staff and that you do not need to treat your medical symptoms or to prevent injury.
- To be encouraged to use your rights in the PACE program.
- To get help, if you need it, to use the Medicare and Medicaid complaint and appeal processes, and your civil and other legal rights.
- To be encouraged and helped in talking to Senior CommUnity Care staff about changes in policy and services you think should be made.
- To use a telephone while at the Day Center.
- To not have to do work or services for Senior CommUnity Care.

You have a right to protection against discrimination

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

- Race / Ethnic Origin
- Religion
- Age
- Sex
- Sexual orientation
- Mental or physical ability
- Source of payment for your health care (for example, Medicare or Medicaid)

If you think you have been discriminated against for any of these reasons, contact a staff member at the Senior CommUnity Care to help you resolve your problem. If you have any questions, you can call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

You have a right to information and assistance

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

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

- To get marketing materials and participant rights in English and in any other frequently-used language in your community. You can also get these materials in Braille, if necessary.
- To get a written copy of your rights from the PACE program.
- Senior CommUnity Care must also post these rights in a public place in the Day Center where it is easy to see them.
- To be fully informed, in writing, of the services offered by Senior CommUnity Care. This includes telling you which services are provided by contractors instead of Senior CommUnity Care staff. You must be given this information before you join, at the time you join, and when there is a change in services.
- To look at, or get help to look at, the results of the most recent review of Senior CommUnity Care. Federal and State agencies review all PACE programs. You also have a right to review how Senior CommUnity Care plans to correct any problems that are found at inspection.

You have a right to a choice of providers:
You have the right to choose a health care provider within the Senior CommUnity Care network and to get quality health care. You have the right:

- If you are a woman, to get services from a qualified women's health care specialist for routine or preventive women's health care services.
- To have reasonable and timely access to in-network specialists based on your health condition and in line with current clinical guidelines.
- To receive necessary care in all care settings, up to and including placement in a long-term facility if we can no longer help you live safely in the community.

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

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

- To have all treatment options explained to you in a language you understand, to be fully informed of your health status and how well you are doing, and to make health care decisions. This includes the right not to get treatment or take medications. If you choose not to get treatment, you must be told how this will affect your health.
- To have Senior CommUnity Care help you create an advance directive. An advance directive is a written document that says how you want medical decisions to be made in case you cannot speak for yourself. You should give it to the person who will carry out your instructions and make health care decisions for you.
- To participate in making and carrying out your plan of care. You can ask for your plan of care to be reviewed at any time.
- To be given advance notice, in writing, of any plan to move you to another treatment setting and the reason you are being moved.

You have a right to have your health information kept private:
You have the right to talk with health care providers in private and to have your personal health care information kept private as protected under State and Federal laws. You also have the right to look at and receive copies of your medical records.
There is a new patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used. If you have any questions about this privacy rule, call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

You have a right to file a complaint:
You have a right to complain about the services you receive or that you need and don't receive, the quality of your care, or any other concerns, or problems you have with Senior CommUnity Care. You have the right to a fair and timely process for resolving concerns with Senior CommUnity Care program. You have the right:

- To a full explanation of the complaint process.
- To be encouraged and helped to freely explain your complaints to Senior CommUnity Care staff and outside representatives of your choice. You must not be harmed in any way for telling someone your concerns. This includes being punished, threatened, or discriminated against.
- To contact 1-800-Medicare for information or to make a complaint.
- To appeal any treatment decision by Senior CommUnity Care, staff, or contractors.

You have a right to leave the program:
If, for any reason, you do not feel that the PACE program is what you want, you have the right to leave the program at any time.

Service Determination Request Policy

Service Determination Requests:
A participant request to initiate, modify or continue a service will first be processes as a service determination request and will follow VOANS Senior CommUnity Care, PACE's Service Determination Request (SDR) Policy before VOANS Senior CommUnity Care, PACE will process an appeal in accordance with this policy. SCC will ensure that participant service requests are processed and reviewed consistent with CMS requirements.

POLICY:

- I. Written Procedures. SCC will have formal written procedures for identifying and processing service determination requests (SDR).
- What is an SDR:

§ Requests that constitute an SDR. Except as provided by II(b) of this policy, the following requests constitute SDRs:

i. A request to initiate a service.

ii. A request to modify an existing service, including to increase, reduce, eliminate, or otherwise change a service.

iii. A request to continue coverage of a service that SCC is recommending be discontinued or reduced.

§ Requests that do not constitute an SDR. Requests to initiate, modify, or continue as service do not constitute an SDR if the request is made prior to completing the development of the initial plan of care.

- Who can make an SDR. Any of the following individuals can make an SDR:

§ The participant.

b. The participant's designated representative.
c. The participant's caregiver.

- Method for making and SDR. An individual may make an SDR as follows:

§ Either orally or in writing.

§ To any employee or contractor of SCC that provides direct care to a participant in the participant's residence, the PACE center, or while transporting participants.

- Processing an SDR.

§ Except as provided in section V(b) below, SCC will bring an SDR to the interdisciplinary team (IDT) as expeditiously as the participant's condition requires, but no later than 3 calendar days from the time the request is made.

§ If a member of the IDT is able to approve the service determination request in full at the time the request is made SCC:

i. Must fulfill all of the following:

1. Notice of the decision to approve a service determination request requirement specified in section X(i) below.
2. Effectuation requirements specified in section XI below.
3. Recordkeeping requirements specified in paragraph XIII below.

ii. Is not required to process the SDR in accordance with paragraphs sections VI through IX, X(b), or XII below.

- Who must review an SDR. The full IDT will review and discuss each SDR and decide to approve, deny, or partially deny the request based on that review.
- IDT decision making. The IDT will consider all relevant information when evaluating a service determination request, including, but not limited to, the findings and results of any reassessments required in section VIII below, as well as the criteria specified in 42 CFR 460.92(b).

- Reassessments in response to a service determination request.

§ If the IDT expects to deny or partially deny a service determination request, the appropriate members of the IDT, as identified by the IDT, will conduct an in-person reassessment before the IDT makes a final decision. The team members performing the reassessment must evaluate whether the requested service is necessary to meet the participant's medical, physical, emotional, and social needs.

§ The IDT may conduct reassessments prior to the approving and SDR, either in-person or through use of remote technology, if the team determines that a reassessment is necessary.

- Notification timeframe. Except as provided in IX(a) below, when the IDT receives an SDR, it must make its decision and notify the participant or their designated representative of its decision as expeditiously as the participant's condition requires, but no later than 3 calendar days after the date the IDT receives the request.

§ Extensions. The IDT may extend the timeframe for review and notification by up to 5 calendar days if either of the following occurs:

i. The participant or other requestor listed in section III of this policy requests the extension.

ii. The extension is in the participant's interest because the IDT needs additional information from an individual not directly employed by SCC that may change the IDT's decision to deny a service. The IDT must document the circumstances that led to the extension and demonstrate how the extension is in the participant's best interest.

§ Notice of extension. When the IDT extends the timeframe, it will notify the participant or their designated representative in writing. The notice must explain the reason(s) for the delay and must be issued as expeditiously as the participant's condition requires, but no later than 24 hours after the IDT decides to extend the timeframe.

- Notification requirements

§ Notice of decisions to approve a service determination request. If the IDT makes a determination to approve a service determination request, it will provide the participant or the designated representative with either an oral or written notice of the determination. Notice of any decision to approve a service determination request will explain the conditions of the approval in understandable language, including when the participant may expect to receive the approved service.

§ Notice of decisions to deny a service determination request. If the IDT decides to deny or partially deny a service, it will provide the participant or the designated representative with both oral and written notice of the determination. Notice of any denial will:

i. State the specific reason(s) for the denial, including why the service is not necessary to maintain or improve the participant's overall health status, taking into account the participant's medical, physical, emotional, and social needs, and the results of the reassessment(s) in understandable language.

ii. Inform the participant or designated representative of his or her right to appeal the decision under 42 CFR 460.122.

iii. Describe the standard and expedited appeals processes, including the right to, and conditions for, obtaining expedited consideration of an appeal of a denial of services as specified in 42 CFR 460.122.

iv. For a Medicaid participant, inform the participant of both of the following, as specified in 42 CFR 460.122(e)(1):

1. His or her right to continue receiving disputed services during the appeals process until issuance of the final determination.
2. The conditions for continuing to receive disputed services.

- Effectuation requirements. If the IDT approves a service determination request, in whole or in part, SCC will provide the approved service as expeditiously as the participant's condition requires, taking into account the participant's medical, physical, emotional, and social needs. The IDT will explain when the participant may expect to receive the service in accordance with section X(a) of this policy.

- Effect of failure to meet the processing timeframes. If the IDT fails to provide the participant with timely notice of the resolution of the request or does not furnish services required by the revised plan of care, this failure constitutes an adverse decision and the participant's request must be automatically processed by SCC as an appeal in accordance with 42 CFR 460.122.
- Recordkeeping. SCC will establish and implement a process to document, track, and maintain records related to all processing requirements for service determination requests received both orally and in writing. These records will be available to the IDT to ensure that all members remain alert to pertinent participant information.