Participant Grievance / Appeal Procedure

Your LIFE Provider and their staff share the responsibility for assuring that you are satisfied with the care you receive. You are **ENCOURAGED** to express any complaints you have at the time and place any dissatisfaction occurs. Per federal regulations for the program, your complaints or dissatisfaction with the program or its decisions are identified as either grievances or appeals. Those processes are described below.

Grievance Procedure

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

•Discuss your grievance with any staff member. Give complete information so that appropriate staff can help to resolve your concern in a timely manner.

•The staff that receives your grievance will discuss with you and provide in writing the specific steps including time frames for response that will be taken to resolve your grievance. The grievance will be reported to the LIFE health team within 5 working days.

•If a solution is found by the staff and agreed to by you and/or your family/caregiver within 5 working days of making the grievance, the grievance is resolved.

•If you are not satisfied with the solution, the staff will send a written report to the Executive Director (clinical complaints will be reviewed by qualified clinical personnel) for review, to be completed within 5 working days.

•Immediately after review (but within 5 working days), a copy of a written report will be sent to you and/or your family/caregiver.

•If you are still dissatisfied with the results, you may submit a request in writing within 30 days to ask for a review by LIFE's Plan Advisory Committee (PAC).

•The PAC will send written acknowledgment of receipt of the grievance within 5 working days to you, investigate, find a solution, and take appropriate actions.

•The PAC will send you a copy of a report containing a description of the grievance, the actions taken to resolve the grievance and the basis for such action. The PAC has 30 working days from the day the grievance is filed with the PAC to complete its report and send it to you.

•If the decision is not in your favor, a copy of the report will be forwarded immediately to CMS and the Department.

Appeal Procedure

The definition of an appeal is action taken by you with respect to your disagreement with our non-coverage of or non-payment for a service, denial of enrollment, or your involuntary disenrollment from the program.

You will be notified in writing if your LIFE Provider:

•will not cover or pay for a service that you are receiving or requesting.

•is denying enrollment into LIFE.

•is initiating an involuntary disenrollment from LIFE.

The notice will instruct you on how to appeal the decision if you do not agree with the decision. You must request an appeal within 30 days of the date the notice was sent to you. An involuntary disenrollment for non-compliance with your care plan or conditions of participation, engaging in disruptive or threatening behavior, failing to pay or make satisfactory arrangements to pay, or being out of the service area for more than 30 days without prior approved arrangements, will automatically be considered an appeal.

•Confirmation of receipt of your request for appeal will be sent to you within 24 hours of receipt of your request.

•Your LIFE Provider will continue to furnish disputed services until a final determination is made if you appeal within 30 days of the notice to you.

•If your LIFE Provider is proposing to terminate or reduce services that you are currently receiving; and

• If you agree that you will be liable for the costs of the disputed services if the appeal is not resolved in your favor.

•An independent review entity will review your appeal and you will be notified in writing of the date and time of that review to have an opportunity

to present evidence related to your dispute.

•You will receive a written report of the independent review entity's review within 30 days of receipt of your appeal. That report will describe the appeal, actions taken, and outcome of the review.

•If your appeal is resolved in your favor, your LIFE Provider will provide or pay for the disputed service right away.

•If the decision is not in your favor, a copy of the written report from the independent review entity will be forwarded immediately to CMS and the Department. You will also be notified in writing of your additional appeal rights under Medicare, or Medical Assistance through the State Fair Hearing Process. Your LIFE Provider will assist you with your appeal.

•If you believe that your life, health, or ability to regain function would be seriously jeopardized if you do not receive the service in question, you can request in writing that your LIFE Provider speed up the appeal process. This is called an expedited appeal. In that case you will receive the outcome of the appeal within 72 hours of receipt of your appeal.