Franciscan PACE
A Ministry of Franciscan Missionaries of Our Lady Health System

Participants have the right to file grievances and appeals. Grievances can be expressed at any time and will be kept confidential, with services continuing while the issue is resolved. If dissatisfied with decisions related to enrollment, disenrollment, or payment for services, participants can file an appeal, which will also be kept confidential. The grievance and appeals processes ensure that participants' concerns are addressed fairly and thoroughly.

Grievance Process

Upon enrollment and annually thereafter, participants are informed of their rights and the grievance process. The grievance process at Franciscan PACE ensures that participants, their families, designated representatives, and caregivers have a safe and structured way to express dissatisfaction with any aspect of care or service delivery. Grievances may be submitted orally or in writing and can involve any individual or entity associated with Franciscan PACE. The process is designed to be non-retaliatory and accessible, promoting transparency and accountability in service delivery.

You can file a grievance for the Franciscan PACE program here:

Franciscan PACE Baton Rouge
7436 Bishop Ott Drive, Baton Rouge, LA 70806
Phone: (225) 490-0604
Fax: (225) 490-0354

Franciscan PACE Lafayette
515 South College Road, Lafayette, LA 70503
Phone: (337) 470-4500
Fax: (337) 470-4515

All grievances are documented within 72 hours of receipt, including the date, nature of the complaint, and resolution details. The Franciscan PACE Quality Manager oversees the documentation and ensures that the information is used to support continuous quality improvement. Confidentiality is strictly maintained throughout the process, and all staff are trained annually on the confidentiality policy. Investigations are conducted thoroughly, and resolutions are provided within 30 calendar days. Participants are notified of the outcome within three days of resolution, and written responses are required for grievances related to quality of care.

If a participant or their representative is dissatisfied with the resolution, they may escalate the grievance to the Franciscan PACE Executive Director within 30 days. The Executive Director will attempt to resolve the issue using available program resources, including the Ethics and Quality Committees. If the issue remains unresolved, a further review can be requested from the Program Director, who may also consult these resources. This escalation process ensures that participants have multiple avenues for seeking fair and thorough resolution of their concerns.

Franciscan PACE maintains detailed records of all grievances and uses this data to identify trends and areas for improvement. The Franciscan PACE Quality Manager aggregates and analyzes grievance data, which is shared with the Leadership Team and Interdisciplinary Team (IDT) to develop action plans for addressing recurring issues. These efforts are part of the organization’s broader quality improvement program. Additionally, the grievance process is reviewed annually with all stakeholders, including participants, caregivers, contract providers, and employees, to ensure continued effectiveness and transparency.

Appeals Process

The appeals process at Franciscan PACE ensures that participants have the right to challenge decisions related to non-coverage or non-payment of services, as well as involuntary disenrollment. Appeals can be initiated by the participant or their designated representative and must follow a service determination request. Participants are informed of their appeal rights upon enrollment, annually, and whenever a denial occurs. Appeals are handled confidentially, and staff and contracted providers are required to follow strict confidentiality protocols. Appeals may be submitted during or outside of center hours, with on-call staff responsible for forwarding after-hours requests.

You can file an appeal for the Franciscan PACE program here:

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Once an appeal is submitted—within 14 calendar days of the denial notice—it is documented and reviewed based on the participant's medical, emotional, and social needs. Participants and their representatives may present evidence in person or in writing. If the appeal is urgent and the participant's health could be at risk, an expedited review is conducted within 72 hours, with a possible extension of up to 14 days if justified. During the appeal, Franciscan PACE continues to provide all required services and may continue disputed services for Medicaid participants upon request.

If the appeal is not resolved internally, it may be reviewed by a Third-Party Reviewer or committee that is impartial and appropriately credentialed. This may include staff from a sister site, a designated review committee, or external medical professionals. All parties involved receive written notification of the decision. If the appeal is approved, services are provided promptly. If denied, participants are informed of their rights to further appeal under Medicare or Medicaid and are assisted in selecting the appropriate path. All appeals are documented and reviewed quarterly by the Quality Committee to identify trends and improve care.

Participants also have additional appeal rights under Medicare and Medicaid. Medicare participants may request reconsideration by an independent review entity within 60 days of the decision. Medicaid participants may request a State Fair Hearing within 30 days, and if requested within 10 days, may continue receiving disputed services during the process. Dual-eligible participants may choose either appeal route. All appeal data is maintained, analyzed, and incorporated into the Franciscan PACE Quality Improvement program, with trends reported quarterly to the Franciscan PACE Quality Committee, Management Team, and Interdisciplinary Team to guide improvements in care and service delivery.

Appointment of a Representative

According to Medicare guidelines, an appointed representative is a person who can act on your behalf to request an exception, appeal or grievance. This person can be a relative, friend, advocate, doctor, or anyone else whom you trust to act on your behalf. To appoint a representative, complete the CMS-1696 form located below:

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.html