GRIEVANCE SYSTEM POLICY AND PROCEDURE

In this document, CCC is referenced in place of CCC and CHA.

CONTENTS

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1 PURPOSE

1.1 This policy establishes standards for Cascade Health Alliance's (CHA's) Grievance System.

2 SCOPE

2.1 This policy applies to all members covered by Oregon Health Plan (OHP) through CHA regarding grievances, appeals and hearing related to denials of physical, behavioral, dental and Non-Emergent Medical Transportation (NEMT) services. This policy also applies to individual representing these members, which may include the member's provider(s).

3 POLICY STATEMENT

3.1 This policy demonstrates CHA's obligation and commitment to upholding the rights of our members and providers. CHA's policy is that no member, provider, or their representatives will be discouraged from using any aspect of the grievance process or encouraged to withdraw a grievance request already filed.

3.2 This policy is supported by the following:

3.3 *Grievance Procedure PP2003.01*

3.3.1 A grievance is a member's/representative's/provider's/other's expression of dissatisfaction to CHA or to a participating provider about any matter other than an appeal or contested case hearing. Grievances are a complaint expressed as a concern, problem, dissatisfaction with quality of care provided, issue of interpersonal relationship (i.e. provider or employee rudeness), or a failure to respect a member's rights.

3.4 *Appeal Procedure PP2003.02*

3.4.1 An appeal is a member's/representative's/provider's request to review the denial or limited authorization of a requested service including:

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3.4.1.1 Determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit;

3.4.1.2 Reduction, suspension or termination of a previously authorized service; failure to provide services in a timely manner, as defined by Oregon Health Authority (OHA).

3.4.1.3 Failure to act within the timeframes provided in Code of Federal Regulations (CFR) § 438.408 (b)(1) and (2) regarding the standard resolution of grievances and appeals;

3.4.1.4 Residents of a rural area with only one Medicaid managed care organization in the denial to obtain services out of network, under CFR § 438.52(b)(2)(ii).

3.5 *Hearing/Contested Case Hearing Procedure PP2003.03*

3.5.1 A hearing/contested hearing is a member's/representative's course of action right to a meeting with OHA when CHA upholds an adverse benefit determination upon completion of a requested appeal.

3.6 *Notice of Action/Adverse Benefit Determination Application PP2003.04*

3.6.1 A Notice of adverse benefit determination (NOABD) is a notification to a requesting provider and written notice to the member of any decision by CHA to deny service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. NOABDs must meet the requirements of 42 CFR § 438.404.

4 PROCEDURE

4.1 Inquiries relating to Grievances, Appeals and/or Hearings may be directed to CHA. CHA's office is located at 2909 Daggett Avenue, Suite 225 in Klamath Falls, OR 97601. The local phone number is (541) 883-2947 and the toll-free number is (888) 989-7846.

4.2 CHA utilizes an enrollee/member handbook approved by the state that:

4.2.1 Includes the member's right to file grievances, appeals and/or hearings.

4.2.2 Includes the requirements and timeframes for filing a grievance, appeal or hearing.

4.2.3 Includes information on the availability of assistance in the filing process for grievances.

4.2.4 Includes information on the provision of explanation of how CHA accepts, processes and responds to grievances.

4.2.5 Includes information on the availability of assistance in the filing process for appeals.

4.2.6 Includes the member's right to request a state fair hearing after CHA has made a determination on a member appeal which is adverse to the member.

4.2.7 Specifies that, when requested by the member, benefits that CHA seeks to reduce or terminate will continue if the member files an appeal or a request for state fair hearing within the time frames specified for filing, and the member may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the member.

4.3 CHA will make its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices available in the Spanish language, per *Enrollee Rights Policy PP7006* and OAR 410-141-3300.

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4.4 CHA will keep grievance, appeal and hearing forms available and accessible to members at CHA's office located at the address listed in 4.1. The following forms are available to members:

4.4.1 OHP Complaint Form (OHP 3001)

4.4.2 MCE and Appeal Form (OHP 3302 & OHP 3302 SP)

4.4.3 Hearing Request Form (MSC 0443)

4.4.4 Notice of Hearing Rights (OHP 3030)

4.5 CHA will keep all healthcare information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in 45 CFR § 164.501 and include providing member assurance of confidentiality in all written, oral and posted material in Grievance System.

5 RESPONSIBILITIES

5.1 The Utilization Review Committee will:

5.1.1 Review this policy annually.

5.2 The Chief Compliance Officer (CCO) will:

5.2.1 Designate an Appeals and Hearings Coordinator.

5.2.2 Oversee and aid the Appeals and Hearings Coordinator in the execution of this instruction and procedure.

5.2.3 Submit reviewed policy to the OHA Contract Administration Unit no later than January 31st.

5.2.4 Submit any significant changes to the OHA Contract Administration Unit prior to formal adoption of the policy.

5.2.5 Submit the policy to the OHA Contract Administration Unit anytime said policy is requested by OHA.

5.2.6 Provide to all providers and subcontractors, at the time they enter into a subcontract, the following Grievance, Notice of Action/Adverse Benefit Determination (NOABD), Appeal and Contested Case Hearing procedures and timeframes:

5.2.6.1 Member's right to file grievances and appeals and their requirements and timeframes for filing, per Oregon Administrative Rule (OAR) 410-141-3230 and applicable Oregon Health Plan (OHP) forms Notice of Action Benefit Denial (OHP 2405), OHP 3001 and Denial of Medical Services Appeal & Hearing Request Form (OHP 3302).

5.2.6.2 Member's right to a Contested Hearing, how to obtain a hearing and representation rules at a hearing, per OAR 410-141-3230 and applicable forms OHP 3030 & OHP 3302.

5.2.6.3 The availability of assistance in filing of grievances and appeals, per OAR 410-141-3230 (9)(a-d).

5.2.6.4 The toll-free numbers to file oral grievances and appeals.

5.2.6.5 Members right to request continuation of benefits (COB) during an Appeal or Contested Case Hearing filing, and notification that the member may be held liable for the cost of COB if the appealed denial is upheld, per OAR 410-141-3250.

5.2.6.6 Provider appeal rights to challenge a denial or limitation of a requested service by CHA.

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5.3 The Appeals and Hearings Coordinator will:

5.3.1 Report directly to the CCO.

5.3.2 Execute this policy in coordination with the above referenced CFRs and OARs.

5.3.3 Execute the Grievance System as established in this document and appendices.

5.3.4 Advise members of their right to file grievances and appeals and their requirements and timeframes for filing, per OAR 410-141-3230 and applicable forms OHP 2405, OHP 3001 and OHP 3302.

5.3.5 Advise members of their right to request and obtain a Contested Case Hearing and the requirements and timeframes for filing a hearing, per OAR 410-141-3230 and applicable forms OHP 2405, OHP 3030 & OHP 3302.

5.3.6 Document grievances, appeals and hearings in a log as specified in 42 CFR § 438.416 that complies with OAR 410-141-3255 that is consistent with contractual requirements.

5.3.7 Complete all required quarterly reporting of grievances, appeals and hearings, as specified in OHA Contract.

5.3.8 Maintain annual logs of all appeals and grievances for 10 years.

Compliance, Monitoring and Review

5.4 This policy will be reviewed on an annual basis and submitted for approval as necessary. This annual review must incorporate any changes in applicable laws, regulations, and other program requirements that have occurred and have not already been updated.

Reporting

5.5 Grievance System data shall be logged together and submitted to OHA Quality Assurance and Contract Administration. Each log will be accompanied by a trend analysis report. The log and report are due to OHA no later than 45 days following the end of a quarter.

Records Management

5.6 Team Members must maintain all records relevant to administering this policy and procedure in a recognized CCC record management system.

6 RELATED LEGISLATION AND DOCUMENTS

6.1 42 Code of Federal Regulation 438.10, 438.404, 438.408 - 438.416, and 438.52

6.2 45 Code of Federal Regulations 165.501

6.3 Complaint Form (OHP 3001)

6.4 Denial of Medical Services Appeal & Hearing Request Form (OHP 3302)

6.5 Hearing Request Form (MSC 443)

6.6 Notice of Action Benefit Denial (OHP 2405)

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6.7 Notice of Hearing Rights (OHP 3030)

6.8 Enrollee Rights Policy PP7006

6.9 CHA 2018 Member Handbook

6.10 Oregon Administrative Rule 410-141-3230, 410-141-3246, 410-141-3250, 410-141-3255 and 410-252-3300

6.11 Oregon Health Authority – Coordinated Care Organization Contract #143110-11

7 FEEDBACK

7.1 Team Members may provide feedback about this document by emailing policyfeedback@cascadecomp.com.

8 APPROVAL AND REVIEW DETAILS

Approval and Review	Details
Advisory Committee to Approval	Utilization Review Committee
Next Review Date	9/17/2018

9 APPENDICES

9.1 APPENDIX 1: Grievance Procedure

9.2 APPENDIX 2: Appeal Procedure

9.3 APPENDIX 3: Hearing/Contested Case Hearing Procedure

9.4 APPENDIX 4: Notice of Action/Adverse Benefit Determination Application

9.5 APPENDIX 5: Appeal Workflow

9.6 APPENDIX 6: Hearing Workflow

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GRIEVANCE PROCEDURE

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1 PURPOSE

1.1 Established standards applicable to Cascade Health Alliance (CHA) member's filing of grievances in the *Grievance System PP2003*.

1.2 Individuals filing a grievance will not be discouraged from using any aspect of the grievance process or encouraged to withdraw a grievance request already filed.

2 PROCEDURE

2.1 To assure CHA members obtain quality services and care from providers, allied health professionals and subcontracted healthcare organizations.

2.2 To correct deficiencies in services and organizational processes for all members of CHA. CHA will maintain written policies and procedures conforming to Code of Federal Regulations (CFRs) and Oregon Administrative Rules (OARs) listed under Related Legislation and Documents identifying how CHA acknowledges receipt, disposition, documentation and reporting of each grievance from member and/or their representatives.

2.3 Grievances may be clinical or non-clinical.

2.4 Upon receipt of a grievance, CHA shall obtain documentation of all relevant facts concerning issues, including considering all comments, documents, records and other information submitted by the member or their representative.

2.5 CHA will analyze all grievances in the context of quality improvement pursuant to OAR 410-141-3200 and OAR 410-141-3230.

2.6 CHA ensures that grievance and appeal decision makers of adverse benefit determinations are not involved in any previous level of review or decision-making, as well as not subordinates of any individual who was involved in a previous level of review or decision-making.

2.7 Upon receipt of grievance, CHA ensures staff and any consulting experts making decisions on the grievance are not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any member.

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2.8 CHA ensures that decision makers on grievances of adverse benefit determinations consider all comments documents, records and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefi8t determination.

2.9 CHA will address each aspect of the grievance and explain the reason for the decision to the requesting party.

2.10 CHA will give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance. This includes, but is not limited to:

2.10.1 Providing Certified or Qualified Health Care Interpreter services;

2.10.2 Providing toll-free numbers that have adequate TTY/TTD and Certified or Qualified Health Care Interpreter capability;

2.10.3 Assistance from qualified community health workers, qualified peer wellness specialists or personal health navigators to participate in processes affecting the member's care and services;

2.10.4 Free interpreter services or other services to meet language access requirements where required in 42 CFR §438.10;

2.10.5 Reasonable accommodation or policy and procedure modifications as required by any disability of the member.

2.11 CHA will respond in writing, notice of grievance resolution, to all grievances as expeditiously as member's health condition requires, within state-established timeframes not to exceed 30 days from the day CHA receives the grievance. In addition to written responses, CHA may also respond orally.

2.11.1 Notice of grievance resolution shall comply with OHA's formatting and readability standards in OAR 410-3300 and 42 CFR §438.10;

2.11.2 Notice of grievance resolution will be written in language that is sufficiently clear so that a layperson can understand the notice and make an informed decision about appealing the grievance resolution.

2.12 CHA will notify members who are dissatisfied with the disposition of a grievance that they may present their grievance to the Department of Human Services Client Services Unit or the Oregon Health Authority (OHA) Ombudsperson.

Retaliation

2.13 CHA will protect individuals who file grievances from retaliation consistent with *Compliance Policy PP2001*.

2.14 Members will not be discouraged or encouraged to withdraw, or use the filings of a grievance, in any retaliatory manner consistent with *Compliance Policy PP2001*.

2.15 CHA will not request disenrollment of a member for request and use of the Grievance System.

2.16 CHA and its providers/subcontractors will cooperate with the DHS Governor's Advocacy Office, the OHA Ombudsperson and hearing representatives in all activities related to member grievances, including providing all requested written materials.

Provision of Provider Education

2.17 CHA will educate all staff who have contact with potential members to be fully informed of policies and OHA's rules applicable to enrollment, disenrollment, appeal policies and interpreter services, including which providers' offices have bilingual capacity.

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2.18 CHA will provide information specified in 42 CFR § 438.414 to all providers and subcontractors at the time they enter into a contract.

Confidentiality

2.19 CHA will safeguard the member's right to confidentiality of information about grievances. CHA will monitor procedures to ensure that information concerning a member's grievance is kept confidential, consistent with appropriate use or disclosure as treatment, payment or health care operations of CHA, as defined in 45 CFR § 164.501.

2.20 CHA and any practitioner whose authorizations, treatments, services, items, quality of care or requests for payment are alleged to be involved in the grievance have a right to use this information, without a signed release from the member for purposes of resolving the grievance, maintaining the grievance log and health oversight by OHA.

2.21 CHA will request an authorization for release of information from the member regarding the grievance if further communication with other individuals is necessary to resolve the grievance.

3 RESPONSIBILITIES

3.1 The Chief Compliance Officer (CCO) will:

3.1.1 Designate an Appeals and Hearing Coordinator and oversee this staff member's position.

3.1.2 Elevate grievances to the Compliance Committee and/or Medical Director as necessary.

3.2 The Appeal and Hearing Coordinator will:

3.2.1 Be responsible for receiving, processing, directing, responding, reporting and recordkeeping of grievances consistent with the CFRs and OARs as listed in Related Legislation and Documents for grievances that relate to a contractual issue.

3.2.2 Refer complaints that do not address CHA's contractual issues to the Director of Quality Management.

3.2.3 Send acknowledgement of a grievance within five business days of receipt.

3.2.4 Send notification of determination/decision regarding grievance within five business days of said determination.

3.2.5 Send one notification regarding grievance receipt and determination if determination is made within five business days of receipt of grievance.

3.3 CHA members, member representatives, representative of a deceased member's estate, providers and others:

3.3.1 May file a grievance at any time either orally or in writing to CHA or to OHA.

3.3.2 Grievance may be written on Complaint Form (OHP 3001) or on member paper.

3.3.3 A provider/subcontractor, acting on behalf and with written consent of the member, may file a grievance but may not act as the member's authorized representative.

3.3.4 Will receive notification of grievance determination/decision from CHA within five business days of said determination.

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Compliance, Monitoring, and Review

3.4 The Appeals and Hearings Coordinator will monitor the completeness and accuracy of the grievance log on a quarterly basis.

3.5 Monitoring of grievances shall include a review of completeness, accuracy, timeliness of the documentation and compliance with receipt, disposition and documentation of grievance.

3.6 This appendix will be reviewed at least annually and will be updated as process changes necessitate.

Reporting

3.7 All grievances that a member chooses to resolve through another process, and that CHA is notified of, will be noted in a grievance log.

3.8 CHA will maintain records and a log of all member grievances in an electronic format, check monthly for completeness and accuracy and report them in a consistent format as designated by CHA/OHA, compliant with OAR 410-141-3255.

3.9 CHA grievance log will include at a minimum:

- 3.9.1 Member's name and CHA/OHA ID number;
- 3.9.2 Date reported;
- 3.9.3 The grievance and the nature of the grievance;
- 3.9.4 Documentation of the review or investigation, resolution and reasons for the decision;
- 3.9.5 Dates of written decisions and correspondence with the member;
- 3.9.6 Disposition & date of disposition;
- 3.9.7 A separate record for each corresponding grievance.
- 3.9.8 Total number of grievances and categorization of the grievance per OHA direction.

3.10 CHA will keep a copy of authorizations for release of information and include them in the member's records.

3.11 CHA will report to OHA any grievances that arise as related to racial, ethnic, gender, religion, sexual orientation, socioeconomic status, cultural or linguistic service requests or disability status to support the improvement of health equity.

3.12 Each grievance will be recorded and maintained by CHA in a manner accessible to the state and available upon request to CMS.

3.13 CHA will retain all grievance related records for ten years.

3.14 Analysis of grievances will be conducted on a quarterly basis and sent to OHA no later than 45 days following the end of a quarter.

- 3.14.1 OHA is responsible to review the policy and procedures for compliance with requirements as part of the State quarterly strategy; to monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System; and ensure a consistent response to complaints of violations of consumer rights and protections.

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3.15 Grievance and Appeal Log will be submitted to OHA on a quarterly basis no later than 45 days following the end of a quarter.

4 RELATED LEGISLATION AND DOCUMENTS

4.1 42 Code of Federal Regulations (CFR) 438.10, 438.400, 438.402, 438.406, 438.408, 438.414 and 438.416

4.2 45 Code of Federal Regulations 165.501

4.3 Complaint Form (OHP 3001)

4.4 Compliance Policy PP2001

4.5 Grievance System Policy PP2003

4.6 Member Rights Policy PP7006

4.7 CHA 2018 Member Handbook

4.8 Oregon Administrative Rules (OAR) 410-141-3200, 410-141-3230, 410-141-3235 and 410-141-3255

4.9 Oregon Health Authority – Coordinated Care Organization Contract #143110-11

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Cascade Health Alliance, LLC

cascade comprehensive care, inc.

APPEAL PROCEDURE

CONTENTS

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1 PURPOSE

1.1 Established standards applicable to Cascade Health Alliance (CHA) member's filing of an appeal of a service denial or limitation in the *Grievance System Policy PP2003*.

1.2 Establishes and corrects deficiencies in services and organizational processes for all members of CHA. CHA will maintain written policies and procedures conforming to Oregon Administrative Rule (OAR) 410-141-3245, identifying how CHA acknowledges the receipt, disposition, documentation, and reporting of each appeal from members and/or their representatives.

1.3 Ensure that members are informed of denial of services or service coverage and rights to appeal or request a Contested Case Hearing.

1.4 Ensures individuals filing an appeal will not be discouraged from using any aspect of the appeal process or encouraged to withdraw an appeal already filed.

1.5 Ensures there is only one level of appeal for enrollees, per OAR 410-141-3245.

1.6 Ensures the adjudication of appeals and the appeals process is not delegated, per OAR 410-141-3230.

1.7 Ensures CHA members are informed of denial of services or service coverage and their rights to appeal denials.

1.8 Ensures that decision makers on appeals of adverse benefit determinations are individuals with appropriate clinical expertise, as determined by the state, in treating the member's condition or disease:

1.8.1 If the decision involves an appeal of denial based on lack of medical necessity;

1.8.2 If the decision involves a grievance regarding denial of expedited resolution of an appeal

1.8.3 If the decision involves a grievance or appeal involving clinical issues.

1.9 CHA ensures that each appeal is transmitted timely to staff having authority to act on it and that the appeal is investigated and resolved in accordance with OAR 410-141-3230 (5)(b).

2 PROCEDURE

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2.1 A written *Notice of Action/Adverse Benefit Determination (NOABD) PP2003.04* will be mailed to the member when CHA takes any "action," including but not limited to denying or limiting service authorizations in amount, duration, or scope that is less than requested, reducing, suspending, discontinuing, or terminating a previously authorized service.

2.1.1 All denial of service or service coverage change/action shall be conveyed in writing as an NOABD to inform the member which service is denied, or limited, as well as convey the basis of denial/limitation and the member's right to file an appeal and/or hearing.

2.2 A member, their representative, or provider, with the member's consent, who disagrees with a NOABD, has the authority to file an appeal, per OAR 410-141-3245 (1) and Code of Federal Regulation (CFR) § 438.408 (b)(1)(2).

2.3 CHA will provide members, and/or representative, the member's case file (including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the appeal of the adverse benefit determination.

2.3.1 CHA will provide the member, and/or representative, the member's case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions.

2.4 CHA will analyze all appeals in the context of quality improvement pursuant to OAR 410-141-3200 and OAR 410-141-3230.

2.5 Upon receipt of an appeal, CHA ensures that appeal decision makers, and any consulting experts, are not involved in any previous level of review or decision-making, as well as not subordinates of any individual who was involved in a previous level of review or decision-making.

2.6 Upon receipt of an appeal, CHA ensures staff and any consulting experts making decisions on the appeal are not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any member.

2.7 IF CHA should delegate the appeal process to a subcontractor, CHA will:

2.7.1 Ensure the subcontractor meets the requirements consistent with the rule and OAR 410-141-3025 through 410-141-3255;

2.7.2 Monitor the subcontractor's performance on an ongoing basis;

2.7.3 Perform a formal compliance review at least once a year to assess performance, deficiencies or areas for improvement;

2.7.4 Ensure the subcontractor takes corrective action for any identified area of deficiencies that need improvement.

2.8 Appeals must be requested no later than 60 days from the date of the NOABD, per CFR § 438.402 (2)(ii).

2.9 Standard appeal reviews must be completed within 16 days of CHA's receipt of appeal, per OAR 410-141-3245 (3).

2.9.1 CHA may extend the timeframe for processing an appeal by up to 14 calendar days if the member's requests the extension, or if CHA shows there is need for additional information and that the delay is in the member's interest (upon state request).

2.9.2 If CHA extends the timeline for a standard appeal not at the request of the member, it will:

2.9.2.1 Make reasonable efforts to give the member prompt oral notice of the delay;

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2.9.2.2 Give the member written notice, within two calendar days, of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he/she disagrees with that decision;

2.9.2.3 Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

2.10 CHA will respond to standard review by sending a written Notice of Action Resolution (NOAR) within 16 days of receipt of appeal, CHA may also relate determination to member orally.

2.10.1 The NOAR will be written in a format and language that, at a minimum, meets applicable notification standards;

2.10.2 Includes the results of the appeal resolution; and

2.10.3 Includes the date of the appeal resolution.

2.11 CHA will notify the requesting provider and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

2.12 Expedited appeals may be filed orally or in writing and are approved when taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function, per CFR § 438.410.

2.13 CHA ensures that punitive action is not taken against a member or provider who requests an expedited appeal.

2.14 Expedited appeal timeframes may be extended up to 14 days.

2.14.1 Member, or member's provider, may request extension, orally or in writing, with validation as to why it is in their best interest to do so.

2.14.2 CHA may request extension if there is satisfaction to Oregon Health Authority (OHA) that there is need for additional information and how the delay is in the member's best interest.

2.15 CHA shall complete the review of the expedited appeal in a timeframe that is no longer than 72 hours after CHA received the appeal.

2.16 If CHA denies a request for expedited resolution of an appeal, it must transfer the appeal to the standard timeframe of no longer than 30 calendar days from the day CHA received the appeal, with a possible 14-day extension, per OAR 410-141-3246.

2.17 If CHA denies a request for an expedited appeal, they will:

2.17.1 Make reasonable efforts to give the member prompt oral notice of the denial and follow-up within two days with a written notice;

2.17.1.1 The written notice must state the right of a member to file a grievance with CHA if he/she disagrees with that decision.

2.18 If CHA provides an expedited appeal but denies the service or items requested in the expedited appeal, CHA will inform the member of the right to request an expedited administration hearing and send the member an approved NOAR, Contested Case Hearing Request and Information forms, per OAR 410-141-3247.

2.19 If CHA extends the timeline for processing an expedited appeal not at the request of the member, it will:

2.19.1 Make reasonable efforts to give the member prompt oral notice of the delay;

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2.19.2 Give the member written notice, within two calendar days, of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he/she disagrees with that decision;

2.19.3 Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

2.20 Continuation of benefits (COB) requests must be made within 10 calendar days after CHA sends the NOABD while the appeal is pending. The benefits must be continued until the appeal is completed or the member withdraws the appeal, per CFR § 438.420.

2.20.1 CHA may, consistent with the state's usual policy on recoveries and as specified in CHA's contract, recover the cost of continued services furnished to the member while the appeal or state fair hearing was pending the final resolution of the appeal or state fair hearing upholds the adverse benefit determination.

2.21 CHA will provide member a reasonable opportunity to present evidence and testimony and make legal and factual arguments in person as well as in writing in advance of the resolution timeframe for appeals, as specified in CFR § 438.406 (4) and CFR § 438.408 (4)(5).

2.21.1 CHA will inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for standard appeals in the case of a request for expedited appeals resolution.

2.22 Individuals requesting an appeal orally will be informed that a written appeal is still required, per OAR 410-141-3245 (4)(a-c).

2.22.1 If an oral appeal is not followed by a written appeal request within the appeal timeframe, the appeal shall expire, per CFR § 438.402 (3)(ii) and OAR 410-141-3245 (6)(a).

2.23 Individuals will not be discouraged from using any aspect of the appeal process or encouraged to withdraw an appeal already filed.

2.24 Provider may request reconsideration of denial by Medical Director.

Retaliation

2.25 CHA will protect individuals who file appeals from retaliation consistent with *Compliance Policy PP2001*.

2.26 Members will not be discouraged from or encouraged to withdraw, or use the filings of an appeal, in any retaliatory manner consistent with *Compliance Policy PP2001*.

2.27 CHA will not request disenrollment of a member for request and use of the Grievance System.

2.28 CHA and its providers/subcontractors will cooperate with the Department of Human Services (DHS) Governor's Advocacy Office, the OHA Ombudsperson and hearing representatives in all activities related to member appeals, including providing all requested written materials.

Provision of Provider Education

2.29 CHA will educate all staff who has contact with potential members to be fully informed of policies and OHA's rules applicable to enrollment, disenrollment, appeal policies and interpreter services, including which providers' offices have bilingual capacity.

2.29.1 CHA will provide information, specified at CFR § 438.414 (g)(2)(xi), to all providers and subcontractors at the time they enter into a contract.

Confidentiality Statement
This Procedure along with all attachments hereto shall be considered
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Confidentiality

2.30 CHA will safeguard the member's right to confidentiality of information about grievances by implementing and monitoring written policies and procedures that ensure that information concerning a member's appeal is kept confidential, consistent with appropriate use or disclosure as treatment, payment or health care operations of CHA, as defined in 45 CFR 164.501.

2.31 CHA and any practitioner whose authorizations, treatments, services, items, quality of care or requests for payment are alleged to be involved in the grievance have a right to use this information, without a signed release from the member for purposes of resolving the grievance, maintaining the grievance log and Health oversight by the OHA.

2.32 CHA will request an authorization for release of information from the member regarding the appeal if further communication with other individuals is necessary to resolve the appeal.

3 RESPONSIBILITIES

3.1 The Chief Compliance Officer (CCO) will:

3.1.1 Designate an Appeals and Hearing Coordinator and oversee and monitor the Grievance System.

3.2 The Appeal and Hearing Coordinator will:

3.2.1 Be responsible for receiving, processing, directing, responding, reporting and recordkeeping of appeals consistent with the CFRs and OARs listed in Related Legislation and Documents.

3.2.2 Advise members of their right to appeal and request CHA review a NOABD.

3.2.3 Provide information regarding the ability of providers and authorized representative to appeal on behalf of a member, as well as provide information regarding the manner in which CHA accepts, processes and responds to appeals, per OAR 410-141-3230.

3.2.4 Provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing of appeal, including reasonable accommodation and free interpreter services, per CFR § 438.10 and OAR 410-141-3230.

3.2.5 Obtain documentation of all relevant facts concerning appeal issues, including considering all comments, documents, records and other information submitted by the member or their representative without regard to whether the information was submitted or considered in the initial adverse determination.

3.2.6 Send acknowledgement of appeal to member within five business days of CHA's receipt of appeal, exception in case of response to expedited appeal that would require acknowledgment of appeal, per OAR 410-141-3230 (5)(a).

3.2.7 Send expedited resolution of an appeal within 72 hours of receipt of response and with written notice to affected parties in a timeframe that is no longer than 3 days after CHA receives the appeal.

3.2.7.1 Make reasonable efforts to call the member and the provider to relate expedited appeal resolution within 72 hours after receiving the request.

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3.2.8 Send standard resolution, NOAR, of an appeal to member and affected parties, no more than two days after appeal resolution is delivered and within 16 days from the date CHA received the appeal.

3.2.9 Send written COB resolution on an appeal to the member within 72 hours after receiving the request. Member may be called as well.

3.2.10 Advise members who are dissatisfied with the disposition of an appeal that they have a right to request a Contested Case Hearing per the Administrative Procedures Act. This includes member's representative, legal representative of deceased member's estate or provider.

3.3 CHA members, member representatives, representative of a deceased member's estate, providers or others:

3.3.1 May file an appeal at any time either orally or written to CHA or to OHA.

3.3.2 Appeal may be written on the Oregon Health Plan (OHP) Denial of Medical Services Appeal & Hearing Request Form (OHP 3302) or on member paper.

Compliance, Monitoring and Review

3.4 The Director of Quality Management will monitor the completeness and accuracy of the appeal log on a quarterly basis.

3.5 Monitoring of grievances shall include a review of completeness, accuracy, timeliness of the documentation and compliance with receipt, disposition and documentation of grievance.

3.6 This appendix will be reviewed at least annually and will be updated as process changes necessitate.

Reporting

3.7 CHA will maintain records and a log, in a central location, of all member appeals in an electronic format, check monthly for completeness and accuracy and report them in a consistent format as designated by CHA/OHA, compliant with OAR 410-141-3255.

3.7.1 Record of each appeal will be accurately maintained in a manner accessible to the state and available upon request to CMS.

3.8 CHA appeals and hearing log will include at a minimum:

3.8.1 Member's name and Medical Care ID number;

3.8.2 Notice of Adverse Benefit determination;

3.8.3 The date and nature of the appeal, and if it was filed in writing or orally;

3.8.4 Whether COB was requested and provided;

3.8.5 Records of the review or investigation at each level of the appeal;

3.8.6 Resolution and resolution date of the appeal;

3.8.7 All written decisions and copies of all correspondence with all parties to the appeal;

3.8.8 Disposition and date of disposition;

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3.8.9 Separate record of each appeal will be maintained in the log;

3.8.10 Total number of appeals categorization of the appeals per OHA direction.

3.9 CHA will keep a copy of authorizations for release of information and include them in the member's records.

3.10 CHA will report to OHA any appeals that arise as related to racial, ethnic, gender, religion, sexual orientation, socioeconomic status, cultural or linguistic service requests or disability status to support the improvement of health equity.

3.11 CHA will retain all appeal related records for ten years.

3.12 Analysis of appeals will be conducted on a quarterly basis and sent to OHA no later than 45 days following the end of a quarter.

3.12.1 OHA is responsible to review the policy and procedures for compliance with requirements as part of the State quarterly strategy; to monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System; and ensure a consistent response to complaints of violations of consumer rights and protections.

3.12.2 Grievance and Appeal Log will be submitted to OHA on a quarterly basis no later than 45 days following the end of a quarter.

4 RELATED LEGISLATION AND DOCUMENTS

4.1 42 Code of Federal Regulations (CFR) 438.10, 437.210, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420 and 438.424

4.2 45 Code of Federal Regulations 165.501

4.3 Compliance Policy PP2001

4.4 Denial of Medical Services Appeal & Hearing Request Form (OHP 3302)

4.5 Grievance System Policy PP2003

4.6 Enrollee Rights Policy PP7006

4.7 CHA 2018 Member Handbook

4.8 Notice of Action/Adverse Benefit Determination Policy

4.9 Oregon Administrative Rules (OAR) 410-141-3200, 410-141-3230, 410-141-3235, 410-141-3240, 410-141-3245, 410-141-3246, 410-141-3247, 410-141-3250 and 410-141-3255

4.10 Oregon Health Authority – Coordinated Care Organization Contract #143110-11

Confidentiality Statement
This Procedure along with all attachments hereto shall be considered
Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

Cascade Health Alliance, LLC

cascade comprehensive care, inc.

HEARING/CONTESTED CASE HEARING PROCEDURE

CONTENTS

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Terms not defined in the DEFINITIONS section of this document may be found in the CCC Glossary.

1 PURPOSE

1.1 Established standards applicable to Cascade Health Alliance (CHA) member's request of a hearing in the *Grievance System Policy PP2003*.

1.2 Ensure that members are informed of denial of services or service coverage and rights to appeal or request a contested case hearing.

1.3 Individuals requesting a hearing will not be discouraged from using any aspect of the appeal and hearing process or encouraged to withdraw a hearing already requested.

2 PROCEDURE

2.1 To ensure CHA members are informed of denial of services or service coverage and their rights to appeal denials and request contested case hearings.

2.2 To correct deficiencies in services and organizational processes for all members of CHA. CHA will maintain written policies and procedures conforming to Oregon Administrative Rule (OAR) 410-141-3245, identifying how CHA acknowledges the receipt, disposition, documentation, and reporting of each appeal and hearing from members and/or their representatives.

2.3 A member, their representative, or provider, with the member's consent who received a written Notice of Appeal Resolution/Adverse Benefit Determination (NOAR/ABD) is upheld, has the right to request a hearing with Oregon Health Authority (OHA), per OAR 410-141-3247 (3).

2.3.1 A member's provider may request a hearing about an action affecting the provider. The provider shall resolve an appeal with CHA before requesting a hearing. As stated in OAR 410-141-3245, in addition to the member, a provider with the member's written consent may file an appeal with CHA if:

2.3.1.1 There is a disagreement with an adverse benefit determination;

2.3.1.2 The provider is contesting the failure of CHA to act within the timeframes provided in Code of Federal Regulations (CFR) § 438.408 (b)(1(2) regarding the standard resolution of grievances and appeals.

2.3.1.3 CHA will approve or deny the appeal within 30 days and provide the provider with a NOAR.

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2.3.1.4 The provider appealing for reasons set forth in OAR 410-120-1560 Provider Appeals shall file a hearing request with OHA no later than 30 days from the date on CHA's written NOAR, unless the provider is completing the appeal on behalf of the member, pursuant to OAR 410-120-1560.

2.3.2 When member sends the contested case hearing request to CHA after CHA has already completed the initial plan appeal, in accordance with OAR 410-141-3247 (9), CHA will:

2.3.2.1 Date-stamp the hearing request with the date of receipt; and

2.3.2.2 Submit the following required documentation to OHA within two business days:

2.3.2.2.1 A copy of the hearing request, Notice of Action/Adverse Benefit Determination (NOABD) and NOAR;

2.3.2.2.2 All documents and records CHA relied upon to take its action, including those used as the basis for the initial action or the NOAR, if applicable, and all other relevant documents and records OHA requests as outlined in OAR 141-410-3245.

2.3.3 If member files a request for an appeal or hearing with OHA prior to filing said request with CHA, OHA will transfer the request to CHA and provide notice of the transfer to the member, per OAR 410-141-3247 (8), CHA will then complete the following:

2.3.3.1 Review the request immediately as an appeal of the NOABD if appeal not already processed.

2.3.3.2 Approve or deny the appeal within 16 days and provide the member with a written NOAR.

2.3.4 Should CHA fail to adhere to the notice and timing requirements of CFR § 438.408, OHA may consider that the member has exhausted CHA's appeal process and may initiate a contested case hearing.

2.4 CHA will analyze all hearings in the context of quality improvement pursuant to OAR 410-141-3200 and OAR 410-141-3230.

2.5 Hearings must be requested no later than 120 days from the date of the NOAR, per OAR 410-141-3247 (2).

2.5.1 A request for a contested hearing made prior to requesting an appeal from CHA will be forwarded by OHA to CHA for appeal review, per OAR 410-141-3247 (4).

2.5.1.1 Cases where OHA determines CHA failed to act within required timelines listed above would be an exception, per OAR 410-141-3247 (4).

2.5.1.1.1 In cases such as above, CHA shall receive notice of OHA's decision to allow the member access to a contested case hearing under Administrative Procedures Act for failure to adhere to the notice and timing requirements in CFR § 438.408.

2.5.1.1.2 When a member files a hearing request with OHA prior to completion of an appeal or expedited appeal with CHA, OHA shall follow procedures outlined in CFR § 438.408.

2.6 The parties to a contested case hearing, per OAR 410-141-3247 (13), include the following:

2.6.1 CHA and the member or member's representative requesting hearing; or

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2.6.2 CHA and the member's provider.

2.7 OHA shall refer the hearing request along with the NOABD or NOAR to the Office of Administrative Hearing (OAH) for hearing. Contested case hearings are requested using Oregon Health Plan (OHP) Denial of Medical Services Appeal & Hearing Request Form (OHP 3302) or Hearing Request Form (MSC 443), or other OHA approved appeal or hearing requested forms.

2.8 A member or provider who believes that taking time for a standard resolution of a request for a contested case hearing could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function may request an Expedited contested case hearing, per OAR 410-141-3247 (2).

2.8.1 Member may not request an expedited contested case hearing without first filing an appeal or expedited appeal with CHA. When a member files a hearing request prior to completion of a CHA appeal or expedited appeal, OHA shall follow procedures set forth in OAR 410-141-3247.

2.8.2 Expedited hearings are requested using OHP 3302 or MSC 443, or other OHA approved appeal or hearing request forms.

2.8.3 CHA shall submit relevant documentation to OHA within two working days of any decision of an expedited appeal. OHA shall decide within two working days from the date of receiving the medical documentation applicable to the request whether the member is entitled to an expedited contested case hearing.

2.8.3.1 If OHA denies a request for an expedited contested case hearing, OHA shall:

2.8.3.1.1 Handle the request for a contested case hearing in accordance with OAR 410-120-1860; and

2.8.3.1.2 Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two days with a written notice.

2.8.4 If a member requests an expedited hearing, OHA shall request documentation from CHA, and CHA shall submit relevant documentation including clinical documentation to OHA within two working days, per OAR 410-141-3248 (7).

2.9 A member who may be entitled to continuing benefits (COB) may request and receive COB in the same manner and same amount while an appeal or contested case hearing is pending, per OAR 410-141-3250 (1).

2.10 CHA will notify the requesting provider and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

2.11 CHA may, consistent with the state's usual policy on recoveries and as specified in CHA's contract, recover the cost of continued services furnished to the member while the appeal or state fair hearing was pending the final resolution of the appeal or state fair hearing upholds the adverse benefit determination.

2.12 To be entitled to COB, the member shall complete a CHA appeal request or an OHA contested hearing request, per OAR 410-141-3250, for COB no later than:

2.12.1 The 10th day following the date of the NOABD or the NOAR; and

2.12.2 The effective date of the action proposed in the notice, if applicable.

2.13 CHA will continue the member's benefits if:

2.13.1 The member or his/her representative file the appeal or administrative hearing request timely;

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2.13.2 The appeal or administrative hearing request involves the termination, suspension, or reduction of a previously authorized services;

2.13.3 The services were ordered by an authorized provider

2.13.4 The period covered by the original authorization hasn't expired; and

2.13.5 The member timely files for COB

2.14 COB benefits, per OAR 410-141-3250 (1)(A-D), shall continue until:

2.14.1 Unless the member requests a contested case hearing with COB, no later than 10 days following the date of the NOAR, a final appeal resolution resolves the appeal;

2.14.2 A final order resolves the contested case;

2.14.3 The time period or service limits of a previously authorized service have been met; or

2.14.4 The member withdraws the request for a hearing.

2.15 For determinations to overturn denials prior to actual hearing, CHA will prepare send an Amended NOAR to the member, provider and OHA.

2.15.1 CHA will make reasonable attempts to contact the member by phone to relate the overturned denial and issuance of Amended NOAR.

2.15.2 OHA will contact the member regarding the Amended NOAR to inquire if they intend to withdraw the hearing request based on approval of services.

2.15.2.1 OHA will notify CHA if, and when, the hearing is being withdrawn by the member.

2.16 For reversed appeal and hearing resolution services, per OAR 410-141-3250 (2):

2.16.1 Not furnished while the appeal or hearing is pending, if CHA or ALJ reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, CHA shall authorize or provide the disputed service(s) promptly and as expeditiously as the member's health condition requires but not later than 72 hours form the date it receives notice reversing the determination;

2.16.2 Furnished while the appeal or hearing is pending, if CHA or ALJ reverses a decision to deny authorization of service(s), and the member received the disputed service(s) while the appeal was pending, CHA or OHA shall pay for those services in accordance with OHA policy and regulations.

2.17 OAH shall issue a final order or OAH shall resolve the case ordinarily within 90 days from the date CHA receives the member's request for appeal. This does not include the number of days the member took to subsequently file a contested case hearing, per OAR 410-141-3247 (15).

2.18 For services not furnished while the appeal or hearing is pending, per OAR 410-141-3247 (15)(a), if CHA or the Administrative Law Judge (ALJ) reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, CHA will authorize or provide the disputed service(s) promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it received notice reversing the determination.

2.18.1 For services furnished while the appeal or hearing is pending, if CHA or the ALJ reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, CHA or OHA shall pay for those services in accordance with OHA policy and regulations.

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Retaliation

2.19 CHA will protect individuals who request hearings from retaliation consistent with *Compliance Policy PP2001*.

2.20 Members will not be discouraged or encouraged to withdraw, or use the requests of a hearing, in any retaliatory manner consistent with *Compliance Policy PP2001*.

2.21 CHA will not request disenrollment of a member for request and/or use of the Grievance System.

2.22 CHA and its providers will cooperate with the DHS Governor's Advocacy Office, the OHA Ombudsperson and hearing representatives in all activities related to member hearings, including providing all requested written materials.

Provision of Provider Education

2.23 CHA will educate all staff who has contact with potential members to be fully informed of policies and OHA's rules applicable to enrollment, disenrollment, appeal and hearing policies and interpreter services, including which providers' offices have bilingual capacity.

2.24 CHA will provide information specified at CFR § 438.414 (g)(2)(xi), to all providers and subcontractors at the time they enter into a contract.

Confidentiality

2.25 CHA will safeguard the member's right to confidentiality of information about grievances by implementing and monitoring written policies and procedures that ensure that information concerning a member's appeal is kept confidential, consistent with appropriate use or disclosure as treatment, payment or health care operations of CHA, as defined in 45 CFR 164.501.

2.26 CHA and any practitioner whose authorizations, treatments, services, items, quality of care or requests for payment are alleged to be involved in the grievance have a right to use this information, without a signed release from the member for purposes of resolving the grievance, maintaining the grievance log and Health oversight by the OHA.

2.27 CHA will request an authorization for release of information from the member regarding the hearing if further communication with other individuals is necessary to resolve the hearing.

3 RESPONSIBILITIES

3.1 The Director Of Quality Management will:

3.1.1 Designate an Appeals and Hearing Coordinator and oversee and monitor the Grievance System.

3.1.2 Attend contested case hearings as deemed necessary.

3.2 The Appeal and Hearing Coordinator will:

3.2.1 Be responsible for receiving, processing, directing, responding, reporting and recordkeeping of hearings consistent with the Codes of Federal Regulations and Oregon Administrative Rules listed in Related Legislation and Documents.

3.2.2 Advise members of their right to request a hearing, using Notice of Hearing Rights (OHP 3030), regarding an appeal resulting in upheld NOABD once the Notice of NOAR has been written and issued under the Administrative Act, per OAR 410-141-3230 (2)(b), OAR 410-141-3247 (1), CFR § 438.400 (a)(3), CFR § 438.402 (c), and CFR § 438.404.

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3.2.3 Provide information regarding the ability of providers and authorized representative to request a hearing on behalf of a member, as well as provide information regarding the manner in which CHA accepts, processes and responds to appeals, per OAR 410-141-3230.

3.2.4 Provide members with any reasonable assistance in completing forms and taking other procedural steps related to a hearing, including reasonable accommodation and free interpreter services, per CFR § 438.10 and OAR 410-141-3230.

3.2.5 Obtain documentation of all relevant facts concerning appeal and hearing issues, including taking into account all comments, documents, records and other information submitted by the member or their representative without regard to whether the information was submitted or considered in the initial adverse determination, and distribute to OHA if needed.

3.2.6 Distribute hearing date and time notification, according to OHA, and hearing packet to CHA parties as necessary.

3.3 CHA members, member representatives, representative of a deceased member's estate, providers and others:

3.3.1 May request a contested case hearing after receiving written notice, NOABD, from CHA that an adverse benefit determination was upheld in an appeal, per OAR 410-141-3247 (3) and CFR § 438.408 (2)(f)(1).

3.3.1.1 May request a hearing using OHP 3302 or MSC 443 no later than 120 days from the date of the NOAR, per OAR 410-141-3245 (14).

3.3.1.2 May not request a hearing without first filing an appeal with CHA, per OAR 410-141-3247 (2) and CFR § 438.408 (2)(f)(1).

3.3.2 Will not be discouraged from using any aspect of the hearing process or encouraged to withdraw an appeal already filed.

3.4 The Medical Director will:

3.4.1 Be responsible for presenting CHA's case at hearing and testifying on behalf of CHA for all behavioral health and physical health care.

3.5 P & R Dental Group, or Dental Designee will:

3.5.1 Be responsible for testifying on behalf of CHA for all dental hearings. [Include brief statement/s that identify to whom (i.e. specific departments vendors, organizations, or providers) and to which parts of the CCC policy applies. Specify exclusions to clarify scope if needed.]

Compliance, Monitoring and Review

3.6 The Director of Quality Management will monitor the completeness and accuracy of the appeal log on a quarterly basis.

3.7 Monitoring of grievances shall include a review of completeness, accuracy, timeliness of the documentation and compliance with receipt, disposition and documentation of grievance.

3.8 This appendix will be reviewed at least annually and will be updated as process changes necessitate.

Reporting

Confidentiality Statement
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3.9 CHA will maintain records and a log of all member hearings in an electronic format, check monthly for completeness and accuracy and report them in a consistent format as designated by CHA/OHA, compliant with OAR 410-141-3255.

3.10 CHA appeals and hearing log will include at a minimum:

3.10.1 Member's name and Medical Care ID number;

3.10.2 Date of notice;

3.10.3 The date and nature of the appeal;

3.10.4 Whether COB was requested and provided;

3.10.5 Resolution and resolution date of the appeal;

3.10.6 Disposition and date of disposition;

3.10.7 Separate record of each appeal and hearing will be maintained in the log;

3.10.8 Total number of appeals categorization of the appeals per OHA direction.

3.11 CHA will keep a copy of authorizations for release of information and include them in the member's records.

3.12 CHA will retain all hearing related records for ten years.

3.13 Analysis of hearings will be conducted on a quarterly basis and sent to OHA no later than 45 days following the end of a quarter.

3.13.1 OHA is responsible to review the policy and procedures for compliance with requirements as part of the State quarterly strategy; to monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System; and ensure a consistent response to complaints of violations of consumer rights and protections.

3.13.2 Grievance and Appeal Log will be submitted to OHA on a quarterly basis no later than 45 days following the end of a quarter.

3.14 CHA will maintain records and a log, in a central location, of all member appeals and hearings in an electronic format, check monthly for completeness and accuracy and report them in a consistent format as designated by CHA/OHA, compliant with OAR 410-141-3255.

3.14.1 Record of each hearing will be accurately maintained in a manner accessible to the state and available upon request to CMS. Hearings records will include at a minimum:

3.14.1.1 A general description of the reason for the appeal, grievance or hearing;

3.14.1.2 The date received;

3.14.1.3 The date of each review or, if applicable, reviewing meeting;

3.14.1.4 Resolution information for each level of the appeal, grievance or hearing;

3.14.1.5 The date of the resolution at each level applicable;

3.14.1.6 The name of the covered person for whom the appeal, grievance or hearing was filed.

4 RELATED LEGISLATION AND DOCUMENTS

Confidentiality Statement
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4.1 42 Code of Federal Regulations (CFR) 438.4004, 438.10, 438.210, 438.230, 438.400, 438.402, 438.404, 438.408, 438.414, 438.416 and 438.420

4.2 45 Code of Federal Regulations 165.501

4.3 Compliance Policy PP2001

4.4 Denial of Medical Services Appeal & Hearing Request Form (OHP 3302)

4.5 Grievance System Policy PP2003

4.6 Hearing Request Form (MSC 443)

4.7 Enrollee Rights Policy PP7006

4.8 CHA 2018 Member Handbook

4.9 Notice of Hearing Rights (OHP 3030)

4.10 Oregon Administrative Rules (OAR) 410-120-1560, 410-120-1860, 410-141-3200, 410-141-3225, 410-141-3230, 410-141-3240 and 410-141-3245 - 410-141-3255

4.11 Oregon Health Authority – Coordinated Care Organization Contract #143110-11

Confidentiality Statement
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Cascade Health Alliance, LLC

cascade comprehensive care, inc.

NOTICE OF ACTION/ADVERSE BENEFIT DETERMINATION APPLICATION AND PROCEDURE

CONTENTS

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Terms not defined in the DEFINITIONS section of this document may be found in the CCC Glossary.

1 PURPOSE

1.1 Established standards applicable to Cascade Health Alliance (CHA) member's filing of an appeal of a service denial or limitation in the *Grievance System Policy PP2003*.

1.2 Define and provide requirements of Notice of Adverse Benefit Determination (NOABD.

1.2.1 Adverse benefit determination is defined as any of the following:

1.2.1.1 The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

1.2.1.2 The reduction, suspension, or termination of a previously authorized service;

1.2.1.3 The denial, in whole or in part, of payment for a service;

1.2.1.4 The failure to provide services in a timely manner, as defined by the State;

1.2.1.5 The failure of CHA to act within the timeframes provided in 42 CFR § 434.408 (b)(1)(2) regarding the standard resolution of grievances and appeals;

1.2.1.6 For a resident of a rural area with only one Managed Care Organization (MCO), the denial of a member's request to exercise his /her right, under § 438.52 (b)(2)(ii), to obtain services outside the network;

1.2.1.7 The denial of a member's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other member financial liabilities.

2 REQUIREMENTS

2.1 When CHA has made or intends to make an adverse benefit determination, CHA will mail a written Notice of Action/Adverse Benefit Determination (NOABD) letter that is on OHA's formatting and readability standards in OAR 410-141-3300 and §438.10 and be written in language that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an appeal.

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2.2 The NOABD includes the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. This includes medical necessity criteria, and any processes, strategies, or evidentiary standard used in setting coverage limits.

2.3 The NOABD explains the member's right to request an appeal of CHA's adverse benefit determination, including information on exhausting CHA's one level of appeal.

2.4 The NOABD explains the member's right to request a state fair hearing after receiving notice that the adverse benefit determination is upheld upon appeal and explains the procedures for exercising member rights to appeal.

2.5 The NOABD explains the circumstances under which an appeal process can be expedited and how to request it.

2.6 The NOABD explains the member's right to have benefits continue, continuation of benefits (COB), pending the resolution of the appeal.

2.6.1 To be entitles to COB, the member must complete a CHA appeal request or an Authority contested case hearing request for COB no later than the 10th day following the date of the NOABD and the effective date of the action proposed in the NOABD.

2.7 The content of the NOABD meets requirements of OAR 410-141-3240, including but not limited to:

2.7.1 Date of the notice;

2.7.2 CHA's name and contact information for additional information or assistance in completing the process;

2.7.3 Member name, address and Medical Care ID number;

2.7.4 Name of member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD) or behavioral health professions, as applicable;

2.7.5 Service requested or previously provided and the adverse benefit determination that CHA made or intends to make, including whether CHA is denying, terminating, suspending or reducing a service or denial of payment;

2.7.6 Date of service or date service was requested by the provider or member;

2.7.7 Name of the provider who performed or requested the service;

2.7.8 Effective date of the adverse benefit determination if different from the date of the notice;

2.7.9 Whether CHA considered other conditions such as co-morbidity factors if the service was below the funding line on the Prioritized List of Health Services;

2.7.10 Clear and thorough explanation of the specific reasons for the adverse benefit determination, including reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the notice that includes, but is not limited to:

2.7.10.1 The item requiring prior authorization but not authorized;

2.7.10.2 The services or treatment requested not meeting medically necessary or medically appropriate criteria as defined in OAR 410-120-000;

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2.7.10.3 The service specifically not a covered service or that does not meet requirements based on the Prioritized List of Health Services;

2.7.10.4 The service or item in an emergency care setting that does not qualify as an emergency service;

2.7.10.5 The person not a member at the time of the service or not a member at the time of the requested service;

2.7.10.6 Except in the case of an Indian-Health Care Provider (HCP) serving an Indian (AI/AN) member of CHA, the provider not on CHA's panel;

2.7.10.7 CHA's denial of member's disenrollment request and findings that there is no good cause for the request.

2.8 The NOABD references appropriate forms, Hearing Request form (MSC 443), Notice of Hearing Rights (OHP 3030) and The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302), for completion when requesting appeal or hearing.

3 PROCEDURE & TIMEFRAMES

3.1 CHA will mail the NOABD for termination, suspension or reduction of services at least 10 days before the date the adverse benefit determination takes effect, per §431.211. In §431.213 and §431.214, exceptions related to advance notice include:

3.1.1 CHA may mail the notice no later than the date of adverse benefit determination if:

3.1.1.1 CHA has factual information confirming the death of a member;

3.1.1.2 CHA received a clear written statement signed by the member stating he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;

3.1.1.3 CHA can verify that the member has been admitted to an institution where the member is no longer eligible for OHP services;

3.1.1.4 CHA is unaware of the member's whereabouts and received returned mail directed to the member from the post office indicating no forwarding address and OHA has no other address;

3.1.1.5 CHA verifies another state, territory, or commonwealth accepted the member for Medicaid services;

3.1.1.6 CHA verifies the transfer or discharge of a member from a facility will occur in an expedited fashion;

3.1.1.7 The member's PCP, PCD or behavioral health professional prescribed a change in the level of health services; or

3.1.1.8 The NOABD involves an adverse determination with regard to preadmission screening requirements of section 1919 (e)(7) of the Act.

3.2 CHA may shorten the period of advance notice to 5 days before the date of action if CHA has facts indicating that the action should be taken because of probable fraud by the Member. Whenever possible, these facts should be verified through secondary sources.

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3.2.1 For denial of payment, at the time of any action affecting the claim.

3.2.2 For standard prior authorizations that deny a requested service or that authorize a service in amount, duration, or scope that is less than requested, CHA will provide a Notice of Action letter as expeditiously as the Member's health condition requires and within 14 calendar days of receiving the request.

3.3 CHA may extend 14 calendar day NOABD timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the member or provider requests extension.

3.4 If CHA extends 14 calendar day NOABD timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days CHA justifies (to OHA upon request) a need for additional information and explain how the extension is in the member's best interest.

3.5 If CHA extends the timeframe, a written notice of the reason for the decision to extend the timeframe and inform the member of their right to file a complaint if he or she disagrees with that decision. CHA will issue and carry out its prior authorization determination as expeditiously as the member's health condition requires and not later than the date the extension expires.

3.6 If CHA extends 14 calendar day NOABD timeframe for standard authorization decisions that deny or limit services, it will issue and carry out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

3.7 For cases in which a provider indicates, or CHA determines, that following the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, CHA will make an expedited service authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service.

3.7.1 CHA may extend 72 hour expedited service authorization decision time period by up to 14 calendar days if the member requests an extension, or if CHA justifies (to the state agency, upon request) a need for additional information and how the extension is in the member's interest.

3.7.2 CHA will give notice on the date that the timeframes expire, when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations.

Records Management

3.8 Team Members must maintain all records relevant to administering this policy and procedure in a recognized CCC record management system.

3.9 CHA's record of each grievance or appeal will be accurately maintained in a manner accessible to the state and available upon request to Center for Medicare and Medicaid Services (CMS).

4 RELATED LEGISLATION AND DOCUMENTS

4.1 42 Code of Federal Regulations (CFR) 438.210, 438.404, 438.410 and 438.416

4.2 Oregon Administrative Rules (OAR) 410-141-3240

4.3 Enrollee Rights Policy PP7006

4.4 CHA 2018 Member Handbook

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