Name:	**Grievance, Appeal, Administrative Hearing Policy**
Date of Origin:	**10/23/2002**
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Scheduled Review Date:	**08/16/2024**

I. POLICY

Capitol Dental Care (CDC) is committed to member satisfaction. In order that members have a positive care experience and to ensure that their rights are protected, CDC has implemented multiple systems to ensure that grievances and appeals are handled in a confidential, unbiased, professional, timely manner and that practices are consistent with all applicable OHP and federal rules and regulations.

CDC members, members' representatives, and/or a provider acting on behalf of the member with written consent have the right to engage in the grievance system to resolve concerns that they may have with CDC, its providers, or any of its subcontracted or otherwise downstream or associated entities. The grievance may be filed with CDC or the Authority orally or in writing. If the grievance is filed with the Authority, it shall be promptly forwarded to CDC.

CDC's Appeals and Grievances Manager is primarily responsible for management of the grievance system (outlined below) as well as appeals and administrative hearings. The Member Services team assists in this effort by making sure that the Appeals and Grievances Manager receives the proper information and that members are appropriately placed in contact with her.

Efforts made to resolve a grievance often include communicating with the grieving party and coordinating with appropriate departments to obtain member information consistent with CDC confidentiality policies and other federal rules and regulations, such as HIPAA and HITECH. CDC maintains the same confidentiality and security standards in reporting the grievance data to OHA, CCOs, and other entitled entities.

CDC will ensure and monitor that its participating providers and subcontractors comply with the Grievance and Appeal System requirements in accordance with applicable law and the applicable provisions of its contracts.

CDC will also provide to all Participating Providers and Subcontractors, at the time they enter into a Subcontract, written notification of procedures and timeframes for Grievances, Notice of Adverse Benefit Determination, Appeals, and Contested Case Hearings, and shall provide all of its Participating Providers and other Subcontractors written notification of updates to these procedures and timeframes within five (5) Business Days after approval of such updates by OHA.

CDC, its subcontractors, and its participating providers will not:

a) Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution

or supports a member's appeal;
b) Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
c) Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.

The following forms will also be made available in all CDC administrative offices and in those physical, behavioral, and oral health offices where CDC has delegated responsibilities for appeal, hearing request, or grievance involvement, CDC shall have the following forms available:

1) OHP Complaint Form (OHP 3001);
2) CDC appeal forms (OHP 3302; OR approved facsimile);
3) Hearing request form Request to Review a Health Care Decision (OHP 3302) or (MSC 443) and Notice of Hearing Rights (OHP 3030)

If CDC were to delegate any other portion of the grievance and appeal process to a subcontractor, CDC will, in addition to the general obligations established under OAR 410-141-3505, do the following:

1) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3875 through 410-141-3915;
2) Monitor the subcontractor's performance on an ongoing basis;
3) Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and
4) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.

The Members literacy and language of preference (including accommodations such as alternate formats) were considered in the development of this process and policy.

II. GRIEVANCE PROCEDURES

Grievance Definition
Any expression of dissatisfaction, expressed verbally or in writing.

Receipt of Grievances through Provider
Grievances that are expressed in the dental office may be reported by the office staff or provider, at times, on behalf of the member. In other instances, the member is given information by the office to call CDC and work with its staff to reach a resolution.

All PCD / Dental Office are in possession of CDC's contact information and have been informed to share this information with a member, whenever a member would like to discuss a grievance.

Providers may file a grievance on behalf of the member with the member's written consent, and can also be submitted anonymously without fear of retaliation.

Receipt of Grievances through Member Services

CDC may become aware of members' grievances in a variety of ways and through a variety of people. No matter the source or the form of the information, CDC will work to resolve all members' grievances and will ensure that they are accurately captured and tracked.

CDC staff will provide assistance to members with a grievance or appeal, including letting them know that their concern has been recorded as a grievance, and can also be submitted anonymously. This includes, but is not limited to providing Certified or Qualified Health Care Interpreter services and toll-free numbers that have adequate TTY/TTD and Certified or Qualified Health Care Interpreter capability.

1) 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) Free interpreter services or other services to meet language access requirements where required in 42CFR §438.10;
3) Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and
4) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.

Grievances are often expressed verbally. CDC employees and providers are encouraged to resolve grievances within their authority level, as quickly and fully as possible. Verbal grievances may be resolved with a verbal response, but a written response is also made.

A grievance can be made in whatever language or form of communication that is used by the member (or the member's representative), and CDC will communicate in like manner. If the member has advised CDC that they will be using a representative, CDC will work with the representative to resolve the grievance.

All grievances are logged in the Clinical Integration Manager (CIM) system in the member's file. Grievances reported through another process, such as direct contact with the OHP Client Services Unit will also be logged.

Verbal grievances are logged in CIM. The CIM record states who filed the grievance; the member's identification number, address, and phone number; details of the grievance; the name of the related provider or clinic if applicable; what the member's desired resolution is; and the date the grievance was made.

This is often performed by the CDC Appeals and Grievances Manager; however, all members of the Member Services team are able to identify and capture the details of a grievance.

Any issues that are not resolved over the phone while speaking with the member, i.e., "one-phone-call resolutions," are handled by the Appeals and Grievances Manager, the Call Center Supervisor, or the Director of Member Services. Further investigation may require contacting the member and/or the provider as well as requesting and reviewing clinical or billing records. For grievances involving a provider or clinic, CDC may notify them of the concern so that they have an opportunity to participate in an unbiased manner in the resolution of the grievance.

It is also necessary, at times, for CDC staff, including the Appeals and Grievances Manager, the Director of Member Services, the Dental Director, or the Compliance Officer to discuss a particular grievance with the provider or office in order to coach and correct so that similar grievances are preempted.

Written grievances are largely processed in the same manner as verbal grievances. The documentation is delivered directly to the Appeals and Grievances manager, though. From that point, the same procedure is followed as outlined above.

If a grievance is received in writing, an answer must be delivered in writing. CDC may also provide a verbal resolution to the member in addition to the written response.

Upon receipt of a grievance, CDC shall:

a. Within five business days, resolve or acknowledge receipt of the grievance to the member and the member's provider where indicated;
b. Give the grievance to staff with the authority to act upon the matter;
c. Obtain documentation of all relevant facts concerning the issues;
d. Ensure staff and any consulting experts making decisions on grievances are:
    i. Not involved in any previous level of review or decision making nor a subordinate of any such individual;
    ii. Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the grievance involves clinical issues or if the member requests an expedited review. Health care professionals shall make decisions for the following:
        1. (ii) A grievance regarding denial of expedited resolution of an appeal or involves clinical issues.
    iii. Taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered ;
    iv. Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.
        1. If the decision involves a grievance regarding denial of expedited resolution of an appeal.
        2. If the decision involves a grievance or appeal involving clinical issues.

Resolving Grievances

An initial response is made within 5 business days of receipt of a grievance that serves one of two purposes:

(1) The response can inform the member that their grievance has been resolved, indicating and explaining the outcomes.
    - CDC refers to these as "resolution" letters.

- No further communications are required about this grievance.

(2) The response can inform the member that additional time (up to 30 days from the date of receiving the grievance) will be required to resolve their grievance, including the reason why the delay is necessary.
    - CDC refers to these as "acknowledgment" letters.
    - Another letter is sent within 30 days of the receipt of the grievance, which explains the resolution of the grievance and the outcomes.
        - CDC also refers to these as "resolution" letters.

Responses to grievances address each aspect of the grievance and the associated outcomes; they also explain the reason for CDC's decision or actions. Responses also inform members of any applicable due process rights.

The reasons why additional time may be required to resolve the grievance can vary but often include the time to secure pertinent information in the possession of a third party, e.g., chart notes or x-rays, and the time to discuss the facts with the provider or office. Another reason can be that the Dental Director may need to review the particular issue and cannot perform the review in the typical timeframe.

Regardless of whether the grievance can be resolved within 5 days or requires additional time—CDC resolves each grievance as expeditiously as the member's health requires (at minimum, within the stated timeframes).

Grievance Documentation

In addition to the information stored in the CIM system (as detailed above), information relating to all member grievances is maintained in the Grievance Log, which includes but is not limited to the following:

- Member CCO
- Member name
- Member ID number
- Date of receipt of grievance
- Grievance type
- Date of resolution
- Number of days to resolution
- Provider name
- Clinic name
- Description of grievance
- Description of resolution
- Whether an extension was required
- Whether the grievance dealt with an issue of health equity
    - Such issues are reported to the CCOs, which then report to OHA.

Grievance files are maintained for all grievance issues, which contain all pertinent information, including notes, communications with the member, communications with the provider, etc.

CDC will keep accessible all documentation, logs and other records for the Grievance and Appeal System whether in paper, electronic, or other form. These records will be retained indefinitely or for a minimum of ten years.

CDC staff who participate in the identification, capturing, documenting, and resolving of grievances will:

- Not have been involved in any previous level of review or decision making and
- Have the necessary clinical expertise to treat the member's condition if the grievance is based on clinical issues or determinations.
    - CDC shall note the credentials of the reviewer early in the review in order to determine that the appropriate level of clinical provider was involved in making the decision.

Grievance Elevation to OHP Client Services Unit (CSU)
If a member is dissatisfied with the resolution of their grievance, the member may elevate their grievance to OHP Client Services Unit (CSU) (800-273-0557) or to the OHA's Ombudsman office (503-947-2346 or 877-642-0450). This information will be included in all grievance resolution letters.

CDC will fully cooperate with any investigation involving one or both of these organizations (including supplying all requested records and information) and will consider implementing any recommended actions in response to that investigation.

Grievance Monitoring
The CDC Quality Improvement Committee (QIC) meetings include review of all grievances that have been received since the previous meeting. A copy of the Grievance Log is supplied to the Committee, including the appropriate level of detail (excluding PHI or other confidential information), for review. Analysis of grievances will be incorporated into the quarterly data provided to OHA under contract.

Any and all grievances that relate to quality of care are discussed one by one by the Committee. A determination will be made for each quality of care grievance as to whether any additional actions are required beyond that which CDC has already taken in relation to the issue.

Grievance data is analyzed for trends or other concerns. Recommendations, projects, trainings, studies, corrective action plans, etc. may result from these analyses in order to improve the quality of CDC's services delivery system.

At times, the QIC may request an update at a future meeting for a grievance that has been reviewed. If this is the case, the Appeals and Grievances Manager will prepare such for the Committee's information.

Grievance Reporting
Grievance data is reported to the CCOs on a quarterly basis, as required by Exhibit I of the CCO contract. CDC uses the State template for this reporting and submits it timely for each

CCO. Any accompanying samples are also sent with the grievance data.

Any additional reporting requirements that come from CDC's contracts with the CCOs or other sources will be completed and delivered timely and accurately.

Member and Provider Education Regarding Grievances
CDC's Member Handbook will inform members of the grievance system procedures. This includes making them aware of their right to file a grievance, instructions on how to proceed, contact information for the appropriate parties, etc. This information is also found on CDC's website, outside of the Member Handbook, but a link to the Member Handbook is available through the website as well.

CDC's Provider Manual (given to providers at time of contracting) contains similar information as the Member Handbook and informs providers of members' rights to file a grievance about any expression of dissatisfaction that the member may have relating to CDC's delivery of services/administration of benefits. CDC providers are also informed that they may not discourage a member from filing a grievance or encourage a member from withdrawing a grievance that has been filed. This is also true of filing an appeal or a hearing request. Relatedly, providers may not retaliate against a member (including requesting their disenrollment) for using the grievance and appeal system.

CDC staff will also inform members of their right to file a grievance and help them in doing so if the member expresses dissatisfaction or concern with their experience.

III. THE APPEAL PROCESS INVOLVING NOTICES OF ADVERSE BENEFIT DETERMINATION

Notice of Adverse Benefit Determination
A Notice of Adverse Benefit Determination (NOABD) is a document that is given to a member when a benefit determination is made that negatively impacts the member. A determination can be defined as an action or the absence of an action, so long as the effect thereof is adverse to the member.

Adverse benefit determinations may include but are not limited to the following:

- 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;
- the reduction, suspension, or termination of a previously authorized service;
- the denial, in whole or in part, of payment for a service. This excludes any claim that is not a clean claim. Clean claim is defined as one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity;
- the failure to provide services in a timely manner, pursuant to 410-141-3515;
- the failure to act within the timeframes provided in 410-141-3875 through 410-141-

3895 regarding the standard resolution of grievances and appeals;
- for a resident of a rural area, the denial of an enrollee's request to exercise their right, under § 438.52(b)(2)(ii), to obtain services outside the network;
- and/or the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

NOABDs will contain at a minimum the following elements:
- the date the letter was mailed;
- CDC's name, address, and phone number;
- The name of the provider who performed or requested the service;
- the name of the member's Primary Care Dentist, and the name of the requested service provider. If the member has not been assigned a practitioner because they enrolled with CDC within the last 30 days, the NOABD will state PCD provider assignment has not occurred;
- the member's name, date of birth, address, and member ID number;
- the date of the service or the date the member or provider requested the service;
- the effective date of the NOABD if different from the date of the notice (pre-service); Effective date (date claim denied) of the adverse benefit determination if different from the date of the notice (post-service);
- toll-free number for TTY/TTD for hearing impaired
- information regarding the ability to access interpreter services free of charge to the member
- a description of and explanation of the service(s) requested or previously provided and an explanation of the adverse action that CDC has taken or intends to take, including whether denying, terminating, suspending, or reducing service or denying payment in whole or in part;
    - a clear and thorough description of the specific reason for the action, which could include the following examples:
        - Treatment is not covered.
        - The item requires pre-authorization and was not pre-authorized.
        - The individual was not a CDC member at the time of the service or is not a CDC member at the time of a requested service.
    - whether CDC considered any other conditions of the member including, but not limited to, co-morbidity factors if the requested service was below the OHP Prioritized List of Health Services funding line of covered services, and other services pursuant to 410-141-3820 and 410-141-3830; statement of intent governing the use and application of the Prioritized List to requests for health care services; and other coverage for services addressed in the State 1115(a) Waiver;
- Diagnosis and procedure codes submitted with the authorization request, including a description in plain language if denying a requested service because of line placement on the Prioritized List or the diagnosis and procedure code do not pair on the Prioritized List.
- references to specific sections of the statutes and/or OARs to the highest level of

specificity relating to each reason and specific circumstance identified for the action; and
- the right to request any records or other materials that were used in making the determination.

NOABDs will advise the member at a minimum of the following:
- The member's right to be provided reasonable access to/ and copies of all documents/records/other information relevant to the adverse determination. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used by the CDC in setting coverage limits or making the adverse benefit determination. These are available upon request and free of charge..
- The member's right or, if the member provides their written consent as required under OAR 410-141-3890(1), the provider's right to file an appeal within 60 days of the adverse determination with CDC, including information on exhausting the one level of appeal, and the procedures to exercise that right. This includes the member's or the provider's right to request a contested case hearing with OHA within 120 days of receiving a Notice of Appeal Resolution (NOAR) or when CDC fails to meet appeal timeframes in OAR 410-141-3890 and 410-141-3895.
    - Circumstances under which an appeal and contested case hearing may be expedited and how to request expedited status (pre-service). The member, their representative, or their provider may request expedited status of an appeal, and the procedures to exercise that right.
    - Continuing benefits means a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending pursuant to 410-141-3910.
    - An explanation to the member that there are circumstances under which an appeal process or contested case hearing can be expedited and how the member or the member's provider may request it but that an expedited appeal and hearing will not be granted for post-service denials as the service has already been provided (post-service).
- The member's right to continued benefits pending the resolution of the appeal or contested case hearing, including how to request the continuation and the circumstances under which the member might be required to pay for the services.
    - Continuing benefits means a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending pursuant to 410-141-3910.
- CDC's contact information, including telephone number and physical address and the ability to communicate with CDC for additional information.

Note: The provider cannot bill the member for a service rendered unless the member signed an OHP Agreement to Pay form (OHP 3165 or 3166) (post-service denial).

Timeframes

NOABDs are sent to members according to prescribed timeframes (by federal or state law as well as contractual obligations):

- If relating to the termination, reduction, or suspension of a previously authorized Medicaid-covered service, CDC will notify the requesting provider and send the NOABD to the member within 10 calendar days of the determination's effective date.
    - Exceptions include:
        - The member provides a signed, clearly written statement that they no longer desire services or CDC is provided with information that requires termination or reduction of services. The notice from the member must indicate that they understand that the result of supplying the information will terminate or reduce the requested services.
            - CDC will also provide a clear statement advising the member that the information was received and that it caused the termination or reduction of requested services.
        - CDC verifies that the member has been admitted to an institution where they are ineligible for covered services from the provider.
        - The member's whereabouts are unknown, the post office returns mail without a forwarding address, and OHA has no other address for the member.
        - CDC establishes the fact that another State, territory, or commonwealth has accepted the member for Medicaid services.
        - A change in the level of care is prescribed by the member's provider.
        - The effective date of the determination will occur in fewer than 10 calendar days (in accordance with 42 CFR 483.15(c)(4)), which provides exceptions to the 30 day notice requirements of 483.15(b)(4)(i), related to discharges or transfers and long-term care facilities.
        - CDC has factual information confirming the member has passed away.
    - CDC may also shorten the period of advance notice to 5 calendar days before the effective date of the determination if CDC has facts indicating that an action should be taken because of probable fraud by the CDC member. Whenever possible, these facts should be verified through secondary sources.

- If relating to the denial of payment, the NOABD must be sent at the time the determination is made that affects the member's clean claim.

- For standard prior authorizations for services not previously authorized that deny a requested service or that authorize a service in an amount, duration, or scope that is less than requested, CDC must notify the requesting provider and mail the NOABD to the member as expeditiously as the member's health condition requires and in all cases within 14 calendar days following receipt of the request for the service, except that:
    - Some requests may require more time to produce a determination. If that is the case (or if the member, member's representative or provider requests an extension), the NOABD may be sent within an additional 14 calendar days of the receipt of the request.
        - Upon request CDC must justify to OHA/the CCOs that this is necessary and in the member's best interest, within five days of the request.

- For cases in which a provider indicates, or CDC determines, that following the standard

authorization timeframe could seriously jeopardize the member's life or health or member's ability to attain, maintain or regain maximum function, CDC must make an expedited authorization decision. For expedited service requests, a decision must be made and notice provided thereof as quickly as the member's health condition requires, but not later than 72 hours after receipt of the request for service which period of time is determined by the time and date stamp on the receipt of the request.

- If additional information is required (or if the member or provider requests an extension), the NOABD may be sent within 14 days of the expedited request.
  - Upon request CDC must justify to OHA/the CCOs that this is necessary and in the member's best interest. CDC must provide its justification for any request to OHA via Administrative Notice.
  - If CDC meets the criteria to extend the 14 calendar day NOABD timeframe, the member will receive written notice of the reason for the extension. CDC will make reasonable effort (including as necessary multiple calls at different times of day) to give the member oral notice of the reason for the decision to extend the timeframe; and inform the member of the right to file a grievance if they disagree with that decision.
  - CDC must issue and carry out its prior authorization determination as expeditiously as the member's health condition requires, and no later than the date the extension expires..

- If the extension criteria is met, CDC must:
  - Give the member written notice of the reason for the decision to extend the timeframe;
  - Make reasonable effort (including multiple calls at different times of the day) to give the member oral notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision; and
  - Issue and carry out its determination as expeditiously as the member's health or mental health condition requires, but no later than the date the extension expires.

- For untimely standard or expedited authorization decisions, on the date that the timeframes expire.
  - Untimely decisions are those not reached within the timeframes specified above and specified in 438.210(d) [which constitutes a denial and is thus an adverse benefit determination].
  - Such failures constitute a denial and is therefore an adverse action by definition, and an NOABD must be sent to the member, accordingly.

- Service authorization decisions for outpatient drugs include a practitioner administered drug (PAD).
  - When CDC has made or intends to make an adverse benefit determination for an initial outpatient drug request and is in receipt of CDC's standard information collection tools for prior authorization, within 24 hours, CDC must issue a written NOA/NOABD to the member and telephonic or electronic notice to the

prescribing practitioner, and when known to CDC, the pharmacy if the drug is denied or partially approved.

- If additional documentation needs to be requested from the prescribing practitioner in order to render a decision, this must not delay a decision to approve or deny the drug as expeditiously as the member's health requires and no later than 72 hours.
- The 72-hour window for a coverage decision begins with the initial date and time stamp of a prior authorization request for a drug.
- If the requested additional documentation is not received within 72 hours from the date and time stamp of the initial request for prior authorization, CDC must issue a written NOABD to the member and telephonic or electronic notice to the prescribing practitioner, and when known to CDC, the pharmacy.

IV. APPEAL PROCEDURES

Appeal Requests
Members may make an appeal request of an adverse determination made by CDC either verbally or in writing. Expedited appeal requests may be made in the same fashion.

Providers or authorized representatives, acting on behalf of the member and with the member's written consent, may file appeal requests in the same manner mentioned above. It is important to note that CDC will not take any form of punitive action against a provider who supports a member's appeal or who requests an expedited resolution.

With respect to actions taken regarding appeals, references to a 'member' include, as appropriate, the member, the member's representative, and the representative of a deceased member's estate. A separate notice will be sent to each individual who falls within this definition.

CDC will review and consider all documentation submitted by the member or on the member's behalf by one of the parties mentioned above when making benefit determinations, regardless of whether such information was considered when making the initial determination.

Adjudication of appeals in a member appeals process may not be delegated to a Subcontractor.

Request Process
Appeal requests must be received no later than 60 calendar days from the date on the NOABD. Members are instructed in the NOABD to contact CDC to begin the appeal process.

The Appeals and Grievances Manager will mainly be responsible for the appeal resolution. Other individuals who may be involved with the appeals process include the Director of Member Services, the Dental Director, other Member Services representatives, etc.

When the member is assigned to a CCO, CDC will coordinate with the CCO to resolve the appeal—as the CCO is the final adjudicator of appeals in those instances. CDC will often present its suggested determination and supporting documents to the CCO so that it may make

its own independent determination.

CDC staff who act on appeals will comply with the following:

- Will not have been involved in any previous level of review or decision making and will not be subordinate to any reviewer involved in the initial review of the request;
- Will have clinical expertise necessary to treat the member's condition if the appeal is based on medical appropriateness or clinical issues.
    - CDC shall note that the credentials of the reviewer early in the review in order to determine that the appropriate level of clinical provider was involved in making the decision. In addition, this reviewer shall review all denials from an expedited resolution of an appeal or a grievance.

Appeal requests are forwarded to the Appeal and Grievances Manager with a received date, which is documented in the CIM system under the member's file as well as in the Appeals Log. The Appeals and Grievances Manager then coordinates and facilitates the appeal to an informed determination within the appropriate statutory timeframes—which includes the following:

- CDC shall resolve each appeal as expeditiously as the member's health condition requires and **no later than sixteen (16) days** from the day CDC receives the appeal.
    - Where requested, a member may be granted an extension of up to 14 additional days; or if CDC shows that there is a need for additional information.
        - As part of this request, CDC must justify to OHA/the CCO that the delay is necessary and in the member's best interest. This applies to both standard and expedited appeal requests.

- If CDC extends the timeframes, it shall, for any extension not requested by the member,
    - Make reasonable efforts (including as necessary multiple calls as different times of day) to give the member prompt oral notice of the delay.
    - Give the member a written notice of the reason for the delay **within two (2) calendar days**. This notice must be sent, whether the appeal request is standard or expedited.
        - The notice will inform the member of the right to file a grievance if he or she disagrees with that decision.
    - Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.
    - A member may file a grievance for CDC's decision to extend the timeframe.

- CDC staff will provide assistance with inquiries related to NOABDs and the appeals/hearing process, including how to begin those processes. This also includes providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capacity.

- CDC shall ensure that the member is given reasonable opportunity, in person and in

writing, to present evidence and testimony and make legal and factual arguments. CDC shall inform the member sufficiently in advance of the resolution time frame for appeals. This holds for both standard and expedited appeals.

- CDC shall ensure that the member is given an opportunity before and during the appeals process to examine any dental/medical records or other pertinent documents considered during the appeal process. The member is notified of his or her right to submit documents or other information pertinent to the appeal.

- CDC will provide the member and his or her 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 CDC (or at the direction of CDC) in connection with the appeal of the adverse benefit determination. CDC will provide the member and his or her representative the member's case file free of charge and sufficiently in advance of the resolution timeframe for standard appeal resolutions.

- For denied requests for expedited resolution of an appeal, CDC shall make reasonable efforts (including as necessary multiple calls at different times of day) of the denial, and follow-up within two days with a written notice. The denied expedited appeal would be transferred to the standard process. The MCE shall resolve the appeal no later than 16 days from the day the MCE receives the appeal with a possible 14 day extension. The written notice must state the right of a Member to file a grievance with the MCE if he or she disagrees with that decision.

- CDC will handle appeals in a confidential manner, including the storage and communication of member information.

- CDC may extend the timeframe for processing an expedited appeal by up to 14 calendar days:
    1. If the member requests the extension; or
    2. If CDC (to the satisfaction of OHA upon its request) shows that there is need for additional information and that the delay is in the member's interest.

- If CDC extends the timeline for processing an expedited appeal not at the request of the member, it must:
    1. Make reasonable efforts to give the member prompt oral notice of the delay (including as necessary multiple calls at different times of day).
    2. Give the member written notice, within 2 calendar days, of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if they disagree with that decision.
    3. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

Notice of Appeal Resolution

Once a decision is reached, a written notice is sent to the CDC member called a Notice of Appeal Resolution (NOAR), including the following:

- Date of appeal request
- Date of NOAR
- Date of NOABD sent previously
- CDC member's name and identification number
- Description of the adverse determination being appealed
- The appeal decision and an explanation thereof
- Whether continuing benefits was requested and provided
- References to applicable rules governing the appeal decision
- Toll free number for TTY/TTD for hearing impaired
- The contact and telephone number for additional information
- Information regarding accessing interpreter services
- Notice of CDC member's rights to an administrative hearing
- Copy of the OHA forms "Notice of Hearing Rights" and "Appeal and Hearing Request"

The written Notice of Appeal Resolution shall be in a format approved by the Authority. The notice shall contain, as appropriate, the same elements as the notice of action/adverse benefit determination, as specified in OAR 410-141-3885, in addition to:

1) The results of the resolution process and the date CDC completed the resolution; and
2) For appeals not resolved wholly in favor of the member:
   (a) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;
   (b) The right to request a contested case hearing or expedited hearing with the Authority and how to do so;
   (c) The right to request to continue receiving benefits while the hearing is pending and how to do so; and
   (d) An explanation that the member may be held liable for the cost of those benefits if the hearing decision upholds CDC's adverse benefit determination;
   (e) Copies of the appropriate forms:
      i. Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or
      ii. The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.
      iii. Notice of CDC member's rights to an administrative hearing
      iv. Information regarding accessing interpreter services

Note: OHA recommends the use of the OHP 3302 over forms MSC 443 and OHP 3030. Use of the 443 & 3030 will not be considered a finding at this time.

In the case where a member is assigned to a CCO, the CCO will send the NOAR to the member.

Confidentiality
CDC shall keep all healthcare information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in federal and state requirements, and include providing member assurance of confidentiality in all written, oral, and posted material in grievance and appeal processes.

Documents Available
Grievance and appeal forms are made available and accessible to members (OAR 410-141-3875). In all CDC offices (including dental and administrative), the following forms will be made available to members upon request:

1) OHP Complaint Form (OHP 3001);
2) CDC's appeal forms;
3) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or
4) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.

Expedited Appeal Requests

CDC's system for expedited review is in place for member and providers to have access to a expedited review process for oral and written appeals.

CDC will resolve each expedited appeal request and provide notice as expeditiously as the member's health condition requires, **within seventy-two (72) hours** from the time that the approved expedited request was made, and no later than the date the extension expires.

- CDC shall make an expedited decision for cases in which a provider indicates or CDC determines that following the standard appeal timeframe could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function, for all oral and written appeals.

If CDC determines (upon request from the member or the Provider) that taking the time for a standard resolution could seriously jeopardize the CDC member's life, health, or ability to attain, maintain or regain maximum function, it will approve the request for an expedited appeal, for all oral and written appeals.

Upon receipt of an expedited appeal, CDC shall within one business day acknowledge receipt of the expedited appeal to the member and the member's provider where indicated, both orally and in writing.

The timeline for an expedited Appeal requested orally shall begin when there is established contact made between the Member and Contractor.

When CDC determines to uphold its initial adverse determination at the resolution of an expedited appeal, CDC informs the member of the right to request an expedited hearing in the NOAR letter. Included with the letter are copies of the appropriate OHA documentation/forms

to begin that process.

CDC makes every effort to accommodate the member's request for an expedited appeal; however, there are circumstances where a determination is made that an expedited appeal is not in the best interest of the member. This may occur where the need for additional, difficult-to obtain documentation is required. In such a case, the appeal is processed in accordance with the standard timeframe outlined above.

CDC shall provide written notice, and make reasonable efforts (including as necessary multiple calls at different times of day) to provide oral notice, of the resolution or denial of an expedited appeal.

CDC will not take any punitive action against a member that has requested an expedited resolution in the appeal process (or a provider who has made the request on behalf of a member).

A request for an expedited hearing for a service that has already been provided (post-service) to the member will not be granted.

Continuation of Benefits Pending Appeal or Administrative Hearing

To be entitled to continuing benefits, the member shall complete a CDC appeal request or an Authority contested case hearing request form and check the box requesting continuing benefits by:

A. The tenth day following the date of the notice of adverse benefit determination or the notice of appeal resolution; or
B. The effective date of the action proposed in the notice, if applicable.

A Member is also able to request a continuation of benefits verbally if they call in to request an appeal or hearing.

CDC must continue the member's benefits during the appeal and hearing process if:

- The CDC member, their representative, or the provider files a timely request for an appeal or a hearing;
- The request involves the termination (including the expiration of a previously approved course of treatment or provision of services), suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- The Member timely files for continuation of benefits.
    - Timely files means filing on or before the later of the following: within 10 days after the date of the NOABD; or the intended effective date of the Action proposed in the NOABD.

If the member's benefits are continued as outlined above, the benefits must be continued until one of the following occurs:

1. The member withdraws the appeal or hearing request;
2. Ten days pass after CDC mails the NAOR, unless the member has requested an administrative hearing with continuation of benefits within the 10-day timeframe;
3. A final order is issued at hearing that is adverse to the member;

CDC must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires (but no later than 72 hours from the date it receives notice reversing the determination) if the services were not furnished while the appeal was pending and if CDC or state fair hearing officer reverses a decision to deny, limit, or delay services.

Benefits furnished while the hearing is pending:

1. CDC will pay for disputed services received by the member while the appeal was pending, unless state policy and regulations provide for the state to cover the cost of such services, when CDC or state fair hearing officer reverses a decision to deny authorization of the services.

If the final resolution of the appeal or administrative hearing is adverse to the CDC member, i.e., upholds CDC's action—CDC may recover the cost of the services furnished to the member while the appeal or hearing was pending, to the extent that they were furnished solely because of the requirements of this section and the applicable statutes and rules.

CDC's communications with providers regarding preauthorization's, denials, and their related statuses help providers understand the process for continuation of benefits as outlined above. All providers are copied on NOABDs, NOARs, and hearing outcomes.

If continuation of benefits occurs, CDC alerts claims processing to reverse preauthorization denials and to pay related claims when presented.

Appeals Monitoring

CDC reports appeals data to the CCOs on a quarterly basis as part of the Exhibit I deliverable. This information is analyzed for trends or troubling outcomes. The Quality Improvement Committee reviews this information from time to time as well.

V. ADMINISTRATIVE HEARING

Request for Expedited Administrative Hearing

Members have the right to request an administrative hearing after completing the appeals process as outlined above. CDC will allow providers, or authorized representatives, acting on behalf of the member to request a contested case hearing.

The member shall file a hearing request with the Authority using form MSC 0443 or any other Authority-approved appeal or hearing request form. OHA prefers use of 3302 when issuing an NOAR.

"Member." With respect to actions taken regarding grievances, appeals, and hearings references to a "member" include, as appropriate, the member, the member's representative, and the representative of a deceased member's estate. With respect to CDC's notification requirements, a separate notice must be sent to each individual who falls within this definition.

CDC provides OHA/the CCOs copies of all pertinent materials up to that point, including the NOABD and NOAR within 2 business days of standard requests. OHA notifies involved parties of the hearing date.

If a member sends the contested case hearing request to CDC after CDC has already completed the initial plan appeal, CDC shall:

(a) Date-stamp the hearing request with the date of receipt; and
(b) Submit the following required documentation to the Authority within two business days:
    (A) A copy of the hearing request, notice of action/adverse benefit determination, and notice of appeal resolution;
    (B) All documents and records CDC relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records the Authority requests as outlined in detail in OAR 141-410-3890.

If the member, or provider, believes that taking the time for a standard resolution of a request for an administrative hearing could seriously jeopardize their life or health or ability to attain, maintain or regain maximum function may request an expedited hearing. CDC will submit relevant documentation to OHA within, as nearly as possible, 2 working days for a decision as to the necessity of an expedited Administrative Hearing. OHA shall decide within, as nearly as possible, 2 working days from the date of receiving the documentation applicable to the request, whether the member is entitled to an expedited hearing.

If OHA denies the request for an expedited hearing, it must:

- Handle the request for Administrative Hearing in accordance with OAR 410-141-0264; and
- Make reasonable efforts to give the member prompt verbal notice of the denial and follow up within 2 calendar days with a written notice.

If an administrative law judge (ALJ) reverses a decision made by CDC to deny, limit, or delay services that were not furnished while an appeal was pending—CDC will authorize or provide the disputed services to the member as promptly and as expeditiously as the member's health condition requires but **no later than seventy-two (72) hours** of the ALJ's decision.

In the case that CDC fails to adhere to notice and timing requirements, the member is deemed to have exhausted the appeals process, and the member may initiate a contested case hearing.

Monitoring Administrative Hearing Process
CDC maintains a Hearing Log, incorporating similar information to the Appeals Log.

CDC reports hearings data to the CCOs on a quarterly basis as part of the Exhibit I deliverable. This information is analyzed for trends or troubling outcomes. The Quality Improvement Committee reviews this information from time to time as well.

V. Additional Information

In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsperson or hearing representatives, CDC, and participating providers shall cooperate in ensuring access to all activities related to member appeals, hearing requests, and grievances including providing all requested written materials in required timeframes.

CDC shall provide information to members regarding the following:

1) An explanation of how CDC shall accept, process, and respond to grievances, appeals, and contested case hearing requests;
2) Member rights and responsibilities; and
3) How to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP.

CDC's Grievance, Appeal, and Hearing Policy are specifically designed to be culturally and linguistically responsive. The policy complies with state and federal laws. See 410-141-3735(6); 410-141-3875 through 410-141-3915.

In compliance with Title VI of the Civil Rights Act and ORS Chapter 659A, CDC shall review and report to the Oregon Health Authority, as outlined in the CDC-OHA contract, complaints that raise issues related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status, and other identity factors for consideration in improving services for health equity. CDC provides written notice to Members of CDC's nondiscrimination policy and process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance with all Applicable Laws including Title VI of the Civil Rights Act and ORS Chapter 659A.

CDC's notice of grievance resolution shall comply with OHA's formatting and readability standards in OAR 410-141-3585 and 42 CFR §438.10. CDC shall write the notice in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the grievance resolution.

CDC shall promptly cooperate with any investigations and resolution of Grievance by either or both OHP Client Services Unit or OHA's Ombudsman as expeditiously as the affected Member's health condition requires, and within required timeframes.

CDC shall 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 prevalent non-English languages in its particular service area.

CDC will include language access taglines in prevalent non-English languages in 18-point font which explains:

1. The availability of written translation or oral interpretation to understand the information provided, how to request auxiliary aids and services for members who have limited English proficiency or a disability, as well as alternate formats at no cost, and
2. The toll-free and TTY/TDY telephone number of CDC's member/customer service unit.

CDC and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal, or hearing may use this information without the member's signed release for purposes of:

1) Resolving the matter; or
2) Maintaining the grievance or appeals log as specified in 42 CFR 438.416.
3) If CDC needs to communicate with other individuals or entities not listed above to respond to the matter, CDC shall obtain the member's signed release and retain the release in the member's record.

Parties to a Contested Case Hearing include:

(1) The Member and their Representative (A provider would be considered the member's representative if that provider requested the contested case hearing on behalf of the member);
(2) CDC; and
(3) The legal representative of a deceased Member's estate.

Expedited hearings are requested using Authority form MSC 443 or other Division approved appeal or hearing request forms. OHA prefers that CDC issue the 3302 form with the NOAR.

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

CDC only has one level of appeal for members, and members shall complete the appeals process prior to requesting a contested case hearing.

Upon receipt of an oral or written appeal, CDC shall:

1) Obtain documentation of all relevant facts concerning the 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 benefit determination.
2) Ensure staff and any consulting experts making decisions on the appeal are:
    a. Not involved in any previous level of review or decision making nor a subordinate of any such individual.
    b. Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the appeal involves clinical issues or if the

member requests an expedited review.

3) Ensure staff and any consulting experts making decisions on the appeal are:
    a. Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.
4) The timeline for an expedited Appeal requested orally shall begin when there is established contact made between the Member and Contractor.

If the member files a request for an appeal or hearing with OHA prior to the member filing with CDC, OHA shall transfer the request to CDC and provide notice of the transfer to the member. CDC shall:

1) Review the request immediately as an appeal of CDC's notice of adverse benefit determination;
2) Approve or deny the appeal within 16 days and provide the member with a notice of appeal resolution.

Upon receipt of an appeal, CDC shall, within five business days, resolve or acknowledge receipt of the appeal to the member and the member's provider where indicated. CDC will assign the appeal to staff with the authority to act upon the matter.

In sending NOABDs and NOARs, CDC must use an Oregon Health Authority (OHA) approved form unless the member is a dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in Oregon's NOABD.

CDC uses easily understood language and format. OHA defines "easily understood" as 6th grade reading level or lower using the Flesch-Kincaid readability scale. CDC uses a minimum 12-point font or large print (18 point).

In the NOABD, CDC includes a language access tagline in 18-point font which explains:

1. The availability of written translation or oral interpretation to understand the information provided, how to request auxiliary aids and services for members who have limited English proficiency or a disability, as well as alternate formats at no cost, and
2. The toll-free and TTY/TDY telephone number of CDC's member/customer service unit.

Taglines must also be located at the beginning of the member handbook for the ease of the member.

In the NOABD, CDC includes a language access statement with the 24 translated languages in at least 12-point font. CDC also includes its Nondiscrimination Statement.

CDC will also provide copies of the following forms to members when it issues an NOABD:

1. The Health Systems Division Service Denial Appeal and Hearing Request form (OHP

3302) or approved facsimile (OHA preferred form); or
2. Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030).

CDC must cause its participating providers and subcontractors to comply with the Grievance and Appeal System requirements set forth in Exhibit I.

CDC gives members timely and adequate NOABD in writing consistent with requirements in OAR 410-141-3885 and in 438.10.

When CDC makes an adverse benefit determination, CDC must notify the requesting provider and give the member and the member's representative a written NOABD.

CDC must provide copies of the following forms to members when it issues an NOABD:
1) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile (OHA preferred form); or
2) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030).

CDC must retain and keep accessible all notices of adverse determination and any documentation, logs and other records for adverse benefit determinations whether in paper, electronic, or other form for a minimum of 10 years. CDC must communicate these policies and procedures to subcontractors.

In addition, CDC will document and maintain a record, in a central location for each grievance and appeal. CDC's record of each grievance and appeal will be accurately maintained in a manner accessible to the state and available upon request to CMS. The record shall include, at a minimum:

(1) A general description of the reason for the Appeal or Grievance and the supporting reasoning for its resolution;
(2) The Member's name and ID;
(3) The date Contractor received the Grievance or Appeal filed by the Member, Subcontractor, or Provider;
(4) The NOABD;
(5) If filed in writing, the Appeal or Grievance;
(6) If filed orally, documentation that the Grievance or Appeal was received orally;
(7) Records of the review or investigation at each level of the Appeal, Grievance, or Contested Case Hearing, including dates of review;
(8) Notice of resolution of the Grievance or Appeal, including dates of resolution at each level;
(9) Copies of correspondence with the Member and all evidence, testimony, or additional documentation provided by the Member, the Member's Representative, or the Member's Provider as part of the Grievance, Appeal, or Contested Case Hearing process; and
(10) All written decisions and copies of all correspondence with all parties to the Grievance, Appeal, or Contested Case Hearing.

VI. Revision Activity

Modification Date	Change or Revision and Rationale	**Effective** Date of Policy Change
04/15/2005	Annual Update	04/15/2006
10/01/2006	Annual Update	10/01/2006
12/09/2008	Annual Update	12/09/2008
12/01/2010	Annual Update	12/01/2010
01/01/2012	Annual Update	01/03/2012
10/11/2014	Guidance update from community partner	10/15/2014
12/03/2014	Annual Review/Update	12/03/2014
06/22/2016	Guidance/audit update from community partner	6/22/2016
1/4/2018	Updated to reflect that the CCO is the final adjudicator of all appeals.	1/4/2018
1/18/2018	Updated to reflect new timeframes	1/18/2018
1/4/2019	Annual Review, update to formatting and editing of content	1/3/2020
1/28/2020	Several revisions/additions in response to HSAG audit findings	2/5/2020
2/28/2020	Update information	2/28/2020
3/1/2021	Update information	3/1/2021
7/22/2022	OHA Evaluation Review Updates	7/22/2022
8/16/2023	Reviewed	8/16/2023

VII. Affected Departments:

All CDC Administrative Staff
All CDC Providers

VIII. References:

CDC Member Service Guide
CDC Provider Services Guide
CDC Notice of Adverse Benefit Determination
CDC Notice of Appeal Resolution
OAR 410-141-0260 through 410-141-0266
CDC Pre-Authorization Policy and Procedures
CDC Confidentiality Policy and Procedures
OAR 410-141-3875
CFR 438.402 | CFR 438.406 | CFR 438.228
OHA Health Plan Services Contract Exhibit I