CORPORATE POLICY & PROCEDURE

Department: Clinical Engagement	Policy Name: Grievances Policy Number: CE01
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Line of Business: ☐ All	
☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Newton Creek	☐ Physician eHealth Services
☐ UHA Community Activities	☐ Umpqua Health Network
☐ Professional Coding and Billing Services	☐ ACE Network
Signature: F Douglas Carr, MD Approved By: F. Douglas Carr, MD, Chief Medical Officer	Date: 8/10/2020

POLICY STATEMENT

Umpqua Health Alliance (UHA) has internal grievance procedures under which members, a member's representative, or providers acting on their behalf, may challenge an adverse benefit determination. UHA shall maintain its policies in accordance with the Coordinated Care Organization (CCO) Contract between UHA and the Oregon Health Authority (OHA, Authority, or State), OAR 410-141-3835 through 410-141-3915, and 42 CFR §§ 438.400 through 438.424. This policy applies in conjunction with related policies for adverse benefit determinations, appeals, hearings, and member services.

PURPOSE

To provide all members with a meaningful, confidential process to file a grievance.

RESPONSIBILITY

Member Services
Clinical Engagement

DEFINITIONS

Adverse Benefit Determination: The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service or the denial of payment for a service; failure to provide services in a timely manner, as defined by the State; the failure of UHA to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network if they are a resident of a rural area with only one managed care organization; and the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance,

and other member financial liabilities.

Appeal: A request by a UHA member or a member's representative to review an adverse benefit determination. For purposes of this policy, an appeal also includes a request by OHA to review an adverse benefit determination.

Clinical Advisory Panel: A panel comprised of practicing doctors and other health care experts.

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievances include the member's right to dispute an extension proposed by the UHA to make an authorization decision.

Grievance System: The overall system that includes grievances and appeals handled at UHA and access to the OHA administrative hearing process.

Member Representative: A person who can make Oregon Health Plan (OHP) related decisions for a member who lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the principal's manner of communicating if those persons are available. A member representative may be, in the following order of priority, a person who is designated as the member's health care representative as defined in Oregon Revised Statutes (ORS) 127.505(13) (including an attorney-in-fact or a court-appointed guardian), a spouse, or other family member as designated by the member, the Individual Service Plan Team (for members with developmental disabilities), parent or legal guardian of a minor below the age of consent, a Department of Human Services (DHS) or OHA case manager or other DHS or OHA designee. For members in the care or custody of DHS Children, Adults, and Families (CAF) or Oregon Youth Authority (OYA), the member representative is DHS or OYA. For members placed by DHS through a Voluntary Child Placement Agreement (SCF form 499), the member representative is his or her parent or legal guardian.

Timely Filing (as it applies to continuation of benefits): Means filing no later than the 10th day following the adverse benefit determination or the notice of appeal resolution, or by the effective date of the proposed adverse benefit determination.

PROCEDURES

1. UHA provides members with written information regarding the grievance process:
    a. Upon initial enrollment to OHP via the Client Handbook;
    b. Upon initial enrollment to UHA via the Member Handbook (also see policies MS3 - Member Rights and MS9 – Member Handbook);
    c. Upon denial of a request for service;
    d. Upon discontinuance of a previously authorized service;
    e. When UHA extends the timeframe of a service authorization, or fails to meet the required timeframe; and
    f. At any time upon request.
2. UHA will ensure all staff who have contact with members or potential members are fully informed of UHA's Grievance policy.
3. UHA requires all participating providers and subcontractors to comply with the Grievance and appeal system requirements set forth in the CCO Contract (Exhibit I).
    a. UHA will provide every provider and subcontractor at the time it enters into a contract or subcontract its OHA approved written procedures for its Grievance and Appeals System.
    b. UHA will provide all of its participating providers and subcontractors with written notification of updates to these procedures and timeframes within five (5) business days after approval of such updates by OHA.
4. UHA will provide members with oral information regarding the grievance and appeal process upon request, or when a member or representative expresses concern or dissatisfaction.
5. UHA will make its grievance forms including those listed in OAR 410-141-3875(11) available and accessible to its members in all administrative offices. If a member expresses that they need assistance in filling out any forms, requests a notice in a different language or format (e.g. auxiliary aids), or would like a qualified or certified interpreter, they may contact UHA Member Services for assistance by going to the office, calling the standard phone number, or by using the TTY or TTY toll free phone number; all contact information is posted on UHA's public website (MS5 – Requests for Interpreter or Alternative Format).
6. Member grievance and appeals resolution process will protect the anonymity of complaints and protect callers from retaliation.
7. UHA will ensure members that all information concerning a member's grievance will be kept confidential.
    a. UHA and any practitioner whose services, items, quality of care, authorization, treatment, or request for payment is alleged to be involved in the grievance, have a right to use this information, without a signed release from the member, for

purposes of:
   i. UHA resolving the grievance;
   ii. For purposes of maintaining the appropriate logs; and/or
   iii. For health oversight purposes by OHP.
   b. If UHA must release any information related to the grievance to any other person or party, UHA will ask the member to sign an authorization to release information prior to disclosing such information. Without a signed authorization, some information cannot be released which may restrict UHA's investigation.
8. A member grievance or appeal may be received in writing or orally, or have a provider or an authorized representative with written consent file on the member's behalf either to UHA or to the State. Any time a member expresses dissatisfaction or concern they are informed of their right to file a grievance and how to do so at any time for any matter other than an Adverse Benefit Determination. UHA, its subcontractors, and its participating providers may 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.
9. If the member files a grievance with OHA, OHA will then forward promptly to UHA for handling.
10. The Appeal & Grievance Coordinator is responsible for receiving, processing, directing, and responding to grievances. Upon receipt of a grievance, UHA obtains 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.
11. UHA will acknowledge receipt of a grievance to the member within five (5) working days, as part of the notifications below.
   a. Each grievance is investigated and resolved as expeditiously as the member's health condition requires and within the following timeframes:
      i. For standard disposition of a grievance, within five (5) working days from the date of receipt, UHA will make a decision and notify the member; or
      ii. Within five (5) working days notify the member in writing that a delay of up to 30 calendar days from the date of receipt is necessary to resolve the grievance. If a delay is needed to resolve the grievance UHA shall specify

the reasons the additional time is necessary. An extension up to 30 calendar days may also occur at the member's request.

12. UHA ensures that the individuals who make decisions on grievances follow all requirements in OAR 410-141-3875 MCE Grievance and Appeals System General Requirements.
13. UHA will ensure that any staff or consulting experts making decisions on the grievance are:
    a. Not involved in any previous level of review or decision making nor a subordinate of such individual with respect to the grievance;
    b. 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 also make decisions pertaining to a grievance regarding denial of expedited resolution of an appeal or involves clinical issues; and
    c. 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.
14. If UHA's failure to meet a required timeframe for review precipitated the grievance, UHA will work with the member and provider(s) to coordinate care and address the original request as appropriate.
15. A written response will be provided whether the member filed their grievance orally or in writing. The notice of grievance resolution shall:
    a. Address each aspect of the member's grievance and the reason for UHA's decision.
    b. Comply with OHA's formatting and readability standards in OAR 410-141-3585 and 42 CFR § 438.10. UHA shall write the notice in the preferred language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the grievance resolution.
    c. UHA's notice advises all affected members that they have the right to present their grievance to OHP Client Services Unit (CSU) or OHA's Ombudsperson by telephone. Such telephone numbers shall be included in the notice of grievance resolution and are as follows:
        i. For CSU: 800-273-0557, and
        ii. For OHA's Ombudsperson: 503-947-2346 or toll free at 877-642-0450.
16. All grievances are placed in Clinical Engagement's quarterly grievance log. This log is reviewed quarterly for quality improvement purposes and submitted to the State to

review as part of the State quality strategy. Categories and service types are applied consistent with Exhibit I of the CCO Contract deliverables.

17. Data from grievances may also be utilized to identify and report, as needed, trends impacting members, UHA, its subcontractors, or its participating providers. Information is also reported to multiple committees for review.
18. In compliance with Title VI of the Civil Rights Act and ORS Chapter 659A, UHA reviews and reports to the OHA, as outlined in the CCO 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.
19. Grievance documentation shall be accurately maintained in a manner accessible to the state and available to CMS upon request for 10 years (CCO Contract Exhibit I, Section 9 and CO23 – Record Retention & Destruction Policy).
20. UHA annually reviews and updates its grievance systems policies and procedures and its member notifications. Written notification of updates to these procedures and timeframes within 5 business days after approval of such updates by OHA.

Subcontracted Entities

1. If UHA delegates the grievance process to a subcontractor, it must:
    a. Provide to OHA all subcontracts for grievance services to be approved prior to such subcontracts being implemented (CCO Contract Exhibit B, Part 3, Section 14(c)(4).
    b. Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3835 through 410-141-3915 and 42 CFR §§ 438.400 through 438.424;
    c. Monitor the subcontractor's performance on an ongoing basis;
    d. Perform a formal compliance review annually to assess performance, deficiencies, or areas for improvement, including but not limited to, updates to the grievance systems policies and procedures and its member notifications; and
    e. Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.
    f. Data collected by subcontractors and participating providers are included in UHA's analysis of grievance system data provided to OHA consistent with contractual requirements (see procedure #16-17 above).
2. Subcontractors must also comply with the following guidelines:
    a. Maintain a log according to the criteria specified by OHA and submit to UHA

no later than 21 days after the end of each quarter.

b. Grievance resolution notices (as applicable) will be sent by the subcontractors on UHA's behalf. Copies of notices issued will be submitted to UHA no later than 21 days after the end of each quarter.

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
Clinical Engagement	Grievances	SOP-CE01-1	7/24/19	1
Clinical Engagement	Grievance Log Quarterly Reporting	SOP-CE01-2	7/23/19	1