CORPORATE POLICY & PROCEDURE

	Policy Name: CE01 - Grievance Appeals and Hearings
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Line of Business: ☐ All ☒ Umpqua Health Alliance ☐ Umpqua Health - Newton Creek	☐ Umpqua Health Management ☐ Umpqua Health Network
Approved By: Quality Improvement Committee, Douglas Carr (Medical Director)	Date: 03/25/2024

POLICY STATEMENT

Umpqua Health Alliance (UHA) has internal grievance and appeal procedures under which members, a member's authorized representative, or providers acting on their behalf, may file a complaint or appeal 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) and State and Federal laws, OAR 410-141-3835 through 410-141-3915, OAR 410-120-1860 and 42 CFR § 438.400 through 438.424. This policy applies in conjunction with related policies for adverse benefit determinations, member services, provider network, and compliance. Policies and procedures are designed to be culturally and linguistically responsive.

PURPOSE

UHA strives to ensure all Grievance and Appeals System policies and procedures are culturally and linguistically responsive to advance health equity, improve quality, and help eliminate health care disparities through the implementation of Culturally and Linguistically Appropriate Service (CLAS) standards within our governance, leadership, workforce, communications, and continuous improvement. To provide all members with a meaningful, confidential process to file a grievance and/or appeal an adverse benefit determination.

RESPONSIBILITY

Clinical Engagement

DEFINITIONS

Adverse Benefit Determination (ABD): 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 (A payment denied solely because the claim does not meet the definition of a "clean claim" at 42 CFR § 447.45(b) is not an adverse benefit determination); the failure to provide services in a timely manner pursuant to OAR 410-141-3515; the MCE's failure to act within the timeframes provided in OAR 410-141-3875 through 410-141-3895 regarding the standard resolution of grievances and appeals; for a resident of a rural area with only one MCE, the denial of a member's request to exercise their legal right under 42 CFR § 438.52(b)(2)(ii) to obtain services outside the network; or 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 authorized 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.

Contested Case Hearing: A hearing before the Authority under the procedures of OAR 410-141-3900 and 410-120-1860.

Continuing benefits: A continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending, pursuant to OAR 410-141-3910.

Clean claim: Means 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.

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.

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 Association (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. For the purpose of this policy, references to "member" may also include "member representatives." This may also include the legal representative of a deceased member's estate. 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 person's 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.

Member: With respect to actions taken regarding grievances and appeals, references to a "member" include, as appropriate, the member and/or the provider or the member's authorized representative with written consent, and the legal representative of a deceased member's estate. With respect to UHA notification requirements, a separate notice must be sent to each individual who falls within this definition.

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

UHA, Subcontractor and Provider Responsibility

1. Participating providers and subcontractors are to comply with UHA's Grievance and Appeal System requirements as outlined in this policy, the CCO Contract, OAR 410-141-3875 through OAR 410-141-3915, OAR 410-120-1860, 42 CFR §438.400 through 438.424 and the Member and Provider Handbooks.
2. A member grievance or appeal may be received orally or in writing 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 or if applicable an appeal. 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 grievance or appeal;
    b. Encourage the withdrawal of a grievance, appeal, or hearing request already filed;
    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.

3. Member grievance and appeals resolution process will protect the anonymity of complaints and protect callers from retaliation.
4. Participating providers and subcontractors receive written notification of procedures and timeframes for grievances, Notice of Adverse Benefit Determination (NOABD), appeals, and contested case hearings at the time of entering into a contract with UHA via provider orientation and training (PN6 – Provider Orientation & Training). This information is also available on the UHA website.
5. Participating providers and other subcontractors receive written notification of updates to these procedures and timeframes within five (5) business days after approval of such updates by OHA.
6. UHA monitors the compliance of subcontractors, including its Provider Network, with all grievance and appeal requirements.
7. In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsperson or hearing representatives, UHA, subcontractors, 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.

Member Rights

1. UHA provides appeal information to members in accordance with the CCO Contract, Exhibit B, Part 3, Sec. 4, Exhibit I, Preamble, Sec. 1, (b) (1) (2) (e) (1) (10) and, at a minimum, members are advised of their rights and responsibilities as mentioned in the *UHA, Subcontractor and Provider Responsibility* above. Additionally, the ABD notices and Appeal and Hearing Request form (OHP 3302) provides information on member's rights and the process for appealing. These rights include, but are not limited the right to:
    a. File an appeal within sixty (60) days from the date on the NOABD;
    b. File a grievance with UHA and/or OHA for any matter other than an ABD;
    c. Request a contested case hearing with either UHA or OHA within one hundred and twenty (120) days from the date on the Notice of Appeal Resolution (NOAR), when the ABD is upheld, or the date that OHA deems that the member has exhausted the appeals process, or except where UHA fails to adhere to the notice or timing requirements in 42 CFR §438.408. In which case member is deemed to have exhausted the grievance and appeals system process and the member may request a contested case hearing;
    d. Have an attorney or member authorized representative present at the contested case hearing and the availability of free legal help through Legal Aid Services and Oregon Law Center, including the telephone number of the Public Benefits Hotline, 1-800-520-5292, TTY 711; and

e. The right to continuation of benefits pending an appeal or contested case hearing as stated below.

Grievance and Appeal System Overview

1. UHA's Grievance and Appeal System complies with the terms and conditions of Ex. I of the CCO contract, is culturally and linguistically appropriate, and complies with Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act, Title III of the American with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973.
2. UHA shall provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or hearing requests. Reasonable assistance includes but is not limited to:
    a. Assistance from certified community health workers, peer wellness specialists, or personal health navigators to participate in processes affecting the member's care and services;
    b. Free qualified interpreter services or other services to meet language access requirements where required in 42 CFR §438.10;
    c. Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities;
    d. Reasonable accommodation or policy and procedure modifications as required by any disability of the member;
    e. When CCO identifies that a member has an Authorized Representative, the CCO should assist the member with completion of the Authorized Representative form; and
    f. All such contact information is posted on UHA's website, is provided in the Member Handbook, and is on the Member ID card (MS5 – Requests for Interpreter or Alternative Format).
3. UHA will provide an information to members regarding how UHA shall accept, process, and respond to grievances, appeals, and contested case hearing requests, including requests for expedited review of grievances, appeals and hearings and the timeframes associated. This information includes how to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP and the member's rights and responsibilities.
    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;
f. At any time upon request; and
g. When a member or authorized representative expresses concern or dissatisfaction.

4. A grievance or appeal can be completed by going to the Customer Care (administrative) office, calling the standard phone number, or by using the TTY or TTY toll free phone number.
    a. Contact information is posted on UHA's website, in the Member Handbook, Provider Handbook and is on the Member ID card.
    b. Grievance and appeal forms are available and accessible to members in all administrative offices, including where services are delegated (physical, behavioral, and oral health as applicable) per OAR 410-141-3875. These forms include, but are not limited to:
        i. OHP Complaint Form (OHP 3001);
        ii. UHA appeal form (OHP 3302; OR approved facsimile);
    c. Additionally, the OHP 3302 form is provided to the member at the time of the ABD and can be mailed to the member again upon request and is available on UHA's website.
5. Parties of the grievance, appeal and/or hearing include:
    a. The member;
    b. The member's authorized representative;
    c. A provider acting on behalf of a member, with written consent from the member; or
    d. The legal representative of a deceased member's estate; and
    e. UHA.
6. UHA will ensure all staff who have contact with members or potential members are fully informed of UHA's appeal and grievance policy. In accordance with OAR 410-141-3875:
    a. UHA staff and consulting experts, or any individuals who make decisions on appeals, are 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;
    b. Not involved in any previous level of review or decision making nor a subordinate of such individual with respect to the grievance or appeal;
    c. Are health care professionals with appropriate clinical expertise in treating the member's condition or disease, when deciding any of the following:
        i. An appeal of a denial that is based on lack of medical necessity;
        ii. A grievance regarding denial of expedited resolution for a grievance or service authorization appeal; and/or

iii. A grievance or appeal that involves clinical issues.

d. Give the grievance or appeal to staff with the authority to act upon the matter.

i. In accordance with OAR 943-005-0060 (2-3), appeals and grievance coordinator (non-discrimination coordinator) is responsible for receiving discrimination complaints 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. They will then send the complaint to the Director of Equity and Inclusion (DEI) to resolve. The DEI will work with the compliance department and if needed, engage in legal counsel. The resolution will be given back to the appeals and grievance coordinators to communicate the findings with the member.

7. Consistent with confidentiality requirements, UHA shall ensure its staff designated to receive appeals or grievances begins to obtain documentation of the facts concerning the appeal or grievance upon receipt.
    a. Decision makers will take into account all comments, documents, records, and other information submitted by the member or their authorized representative, regardless to whether such information was previously submitted or, for appeals, were considered in the initial ABD;
    b. For cases in which a provider indicates, or UHA determines, that following the standard appeal (or hearing) timeframe could seriously jeopardize the member's life or physical or mental health or ability to attain, maintain, or regain maximum function, UHA will investigate, resolves, and provide notice as expeditiously as the member's health condition requires and within the standard or expedited appeal timeframes.
    c. Provides members a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments as specified in 42 CFR §438.406(b)(4) and OAR 414-141-3875.
    d. Inform the member of the limited amount of time available to present evidence and argument sufficiently in advance of the resolution timeframe for both standard and expedited appeals as specified in OAR 410-141-3875 and OAR 410-141-3895.
8. Upon request, members are provided with a copy of their case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by UHA (or at the direction of UHA) in connection with the appeal of the ABD. This information is provided free of charge and sufficiently in advance of the resolution timeframes as specified in 42 CFR §438.408 (b) and (c).
9. UHA shall keep all healthcare information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in federal, state, and CCO Contract

requirements, including providing member assurance of confidentiality in all written, oral, and posted material in grievance and appeal processes.

a. UHA and any practitioner whose services, items, quality of care, authorizations, treatments, or requests for payment is alleged to be involved in the grievance, appeal, or hearing have a right to use this information for purposes of UHA resolving the grievance or appeal, or for purposes of maintaining the appropriate logs as specified in 42 CFR 438.416 without a signed release from the member.
b. If the UHA needs to communicate with other individuals or entities not listed in subsection (a) above to respond to the matter, UHA shall obtain the member's signed release and retain the release in the member's record.

10. All grievance and appeal system and member communications related thereto shall comply with all of the format, accessibility and readability requirements as specified in the CCO Contract, OAR and CFR regulations, specifically in in OAR 410-141-3585 and 42 CFR § 438.10.
    a. UHA written notices use easily understood language and format, in the preferred language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the grievance resolution.
    b. Are made available in the prevalent non-English languages in our particular service area and are available in formats noted in (2) of this section for members with disabilities. UHA will also accommodate requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested See policy (MS4 – Written Notices to Members).
        i. Alternate formats shall be provided and may include but are not limited to braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide.
        ii. Alternative formats, auxiliary aids and services and interpreter services are available upon request at no cost.
    c. Notices are culturally and linguistically appropriate and are sensitive to people with disabilities or reading limitations, including those whose primary language is not English.
    d. UHA addresses health literacy issues by preparing informational materials at a 6th grade reading level, incorporating graphics, and utilizing alternate format materials for potential members and using a minimum 12-point font or large print (18 point).
    e. They will advise all affected members that they have the right to present their grievance to OHP Client Services Unit (CSU) or OHA's Ombudsperson by telephone.

f. They include an insert of UHA's nondiscrimination policy statement and process to report a complaint of discrimination. All members will be treated fairly regardless of age, color, ethnicity, race, disability, gender, identity, marital status, national origin, race, religion, sex and sexual orientation, etc. in accordance with all Applicable Laws including 42 CFR §§438.100 (b)(2)(3) and (d)), Title VI of the Civil Rights Act and ORS Chapter 659A (see policy MS2 – Nondiscrimination of Members).
    i. The nondiscrimination policy statement must meet requirements outlined in the Nondiscrimination Statement Evaluation Checklist and are approved by OHA. The Nondiscrimination Statement Evaluation Checklist can be found at https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-QA-Materials.aspx.
g. They include language access taglines in prevalent non-English languages in 18-point font which explains:
    i. 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
    ii. The toll-free and TTY/TDY telephone number of the MCE's member/customer service unit.
h. A separate notice is sent to each individual within the definition of "Member".

Grievances

1. Upon receipt of a grievance, UHA shall comply with grievance process and timing requirements in OAR 410-141-3875, 410-141-3880 and 42 CFR 438.408 as well as 42 CFR §438.406.
2. A member grievance may be received orally or in writing or have a provider or an authorized representative with written consent, file on the member's behalf, either to UHA or to the OHA. 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 ABD.
    a. If the member files a grievance with OHA, OHA will then forward promptly to UHA for handling.
3. 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 authorized representative, without regard to whether the information was submitted or considered in the initial adverse benefit determination or resolution of grievance.
4. UHA will resolve or acknowledge receipt of a grievance to the member and the member's provider where indicated, within five (5) working days, as part of the notifications below.

5. The grievance is given to staff with the authority to act upon the matter. Each grievance is investigated and resolved as expeditiously as the member's health condition requires and within the following timeframes:
    a. 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 in their preferred language that a decision on the grievance has been made and what that decision is; or
    b. 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.
        i. 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.
6. 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.
7. When informing members of the decision, UHA may provide the decision related to oral grievances orally but shall also, provide a written response 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 format, accessibility requirements and readability standards in Exhibit I of the CCO Contract, 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. Advise 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;
        ii. For OHA's Ombudsperson: 503-947-2346 or toll free at 877-642-0450.
            1. UHA shall promptly cooperate and cause its subcontractor to promptly cooperate with any investigations and resolution of a grievance by either or both DHS' Client Services Unit and OHA's Ombudsperson as expeditiously as the affected member's health condition requires, and within timeframes set forth in or required by the CCO contract.
8. If a grievance is related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one CCO to another CCO as defined in OAR 410-141-3850, UHA shall log the grievance and work with the receiving or sending MCE to ensure continuity of care during the transition.

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Member Appeals

1. UHA has only one level of appeal for members. Members are required to complete the appeals process before requesting a contested case hearing. Standard or expedited member appeals can be filed orally or in writing to express disagreement with an ABD.
    a. A request for a contested case hearing made without previous use of the appeal procedures may be forwarded to UHA to review as an appeal prior to the hearing.
2. A member, their representative, legal representative of a deceased member's estate, a subcontractor, or a provider with the member's written consent, may file an appeal orally or in writing with UHA to:
    a. Express disagreement with an ABD; or
    b. Contest the failure of UHA to act within the timeframes provided in 42 CFR § 438.408(a) regarding the standard resolution of grievances and appeals.
3. The member shall file the appeal with UHA no later than 60 days from the date of notice on the ABD. Upon receipt of an appeal, 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, without regard to whether the information was submitted or considered in the initial adverse benefit determination or resolution of grievance.
4. The date of an oral appeal request will establish the filing (received) date as the date of the oral request. The timeline for an expedited Appeal requested orally shall begin when there is established contact made between the Member and UHA.
    a. If after a provider or representative files an appeal without the member's signature, within the appeal timeframe, the appeal shall expire.
5. UHA will attempt to resolve or acknowledge the receipt of all member appeals as follows:
    a. Standard appeals in writing to the member, authorized representative and/or the member's provider where indicated, within five (5) business days of receipt.
    b. Expedited appeals orally and in writing within one (1) business day of receipt.
6. UHA will resolve standard appeals and provides written notice of the disposition, as expeditiously as a member's health condition requires and no later than sixteen (16) days from the received date of the appeal.
7. For expedited resolution of an appeal and notice to affected parties, UHA will complete the review as expeditiously as the health condition requires or in a timeframe that is no longer than seventy-two (72) hours after receipt when as the member or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function as set forth in OAR 410-141-3890 (8), (4) and OAR 410-141-3895 (3).

   a. Make reasonable efforts (including as necessary multiple calls at different times of day) to call the member and the provider to tell them of the resolution within seventy-two (72) hours after receiving the request; and
   b. Mail written confirmation of the resolution to the member within three (3) days.
8. The timeframe for standard and expedited appeals may be extended by up to fourteen (14) days if:
   a. The member requests the extension; or
   b. UHA shows to the satisfaction of the OHA, upon its request, that there is need for additional information and how the delay is in the member's interest.
9. If UHA extends the timeframes, but not at the request of the member, it shall:
   a. Give the member a written notice and make reasonable effort to give the member oral notice of the reason for the delay.
   b. Within two (2) days, give the member written 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.
   c. Resolves the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.
10. All appeals that are granted extensions are resolved no later than the expiration date of the extension.
11. If UHA denies a request for an expedited appeal, the appeal will transfer to the timeframe for standard resolution in accordance with OAR 410-120-1860. UHA will:
   a. Resolve the appeal no later than sixteen (16) days from the received date with a possible fourteen (14) day extension.
   b. Make reasonable efforts to give the member prompt oral notice of the denial (including as necessary multiple calls at different times of day).
   c. Follow-up with a written notice within two (2) days.
      i. The written notice will include the member's right to file a grievance if they disagree with the decision.
12. If UHA approves a request for expedited appeal but denies the services or items requested in the expedited appeal, UHA will:
   a. Make reasonable effort to provide oral notice; and
   b. Inform the member of their right to request an expedited contested case hearing and will send the member a Notice of Appeal Resolution (NOAR), Hearing Request and Information forms as outlined in OAR 410-141-3875.
13. If UHA fails to adhere to the notice and timing requirements in OAR 410-141-3875 through 410-141-3895 and 42 CFR § 438.408, the member is considered to have exhausted UHA's appeals process. In this case, the member may initiate a contested case hearing.

Notice of Appeal Resolution

1. UHA will make reasonable effort to provide the member with oral notice of the resolution.
2. The member will also be notified in writing of the resolution of the appeal by means of the Notice of Appeal Resolution (NOAR).
3. The NOAR is consistent with the notice requirements of 42 CFR § 438.404 and OAR 410-141-3885, and OHA accessibility requirements and readability standards in OAR 410-141-3585, 42 CFR §§ 438.408, and 438.10.
    a. Written in language sufficiently clear that a layperson could understand the notice and make an informed decision (about appealing and following the process for requesting a hearing if applicable).
    b. The process for requesting a hearing if applicable:
        i. The rules that govern representation at a hearing.
        ii. The right to have an attorney or member representative present, and the availability of free legal help through Legal Aid Services and Oregon Law Center, including the telephone number of the Public Benefits Hotline 1-800-520-5292, TTY711.
4. Contains, as appropriate, the same elements as the Notice of Adverse Benefit Determination, as specified in OAR 410-141-3885, in addition to:
    a. The results of the resolution process;
    b. The date the resolution was completed.
5. If a portion of the request was overturned, UHA would indicate in the NOAR details of those services that had a favorable outcome.
6. For appeals not resolved in favor of the member (upheld or overturned partial), the NOAR will include:
    a. Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the NOAR relied upon to deny the appeal.
    b. The right of the member to request a standard or expedited contested case hearing with OHA within one hundred and twenty (120) days from the date of the NOAR and how to do so, which includes sending the Appeal and Hearing Request (OHP 3302) available on the OHA Website at: https://www.oregon.gov/oha/HSD/OHP/Pages/Forms.aspx.
    c. The right to continue to receive benefits pending a contested case hearing and how to do so;
        i. Information explaining that if the ABD is upheld in a contested case hearing, the member may be liable for the cost of any continued benefits (see Continuation of Benefits below).
    d. Includes a copy of the Appeal and Hearing Request form (OHP 3302).

7. If the original ABD is overturned, UHA will issue a notice of appeal resolution within the required timeframes and must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, with Care Coordination assistance as deemed appropriate by Contractor or as requested by the Member or the Member Representative, but no later than (72) hours from the date of notice reversing the determination. UHA must promptly correct the ABD taken up to the limit of the original request or authorization.

Contested Case Hearings

1. A member or authorized representative acting on behalf of the member may request a contested case hearing with OHA after receiving notice that an appeal to UHA has been upheld or, in the case of UHA failing to adhere to the notice and timing requirements in 42 CFR §438.408, in which case the member is deemed to have exhausted the grievance and appeals system process and may request a contested case hearing.
2. Hearing requests (standard and expedite) should be filed to the Authority. They can be requested orally, in writing, or online. When submitted in writing, it must be filed using the Service Denial Appeal and Hearing Request form (OHP 3302) or any other Authority-approved appeal or hearing request form no later than 120 days from the date of the MCE's notice of appeal resolution (NOAR), when UHA's ABD is upheld, or the date that OHA deems that the member has exhausted UHA's appeals process.
3. If a participating provider filed an appeal on behalf of the member, the participating provider is allowed to request should be submitted to the OHA and can be requested orally, in writing, or online.
4. If the member files a request for an appeal or hearing with the OHA prior to the member filing with UHA, the OHA shall transfer the request to UHA and provide notice of the transfer to the member. UHA will review the appeal request immediately and respond within 16 days with a NOAR.
5. If a member sends the contested case hearing request to UHA after the initial plan appeal, or upon receipt of a request for a contested case hearing from OHA, UHA will immediately transmit the request to OHA with the following:
    a. Date-stamp the hearing request with the date of receipt; and
    b. Submit the following required documentation to OHA within two (2) business days of member's request for a contested case hearing:
        i. Copies of the contested case hearing request, NOABD and NOAR; and
        ii. All of the documentation that was relied upon to make its decisions, including those used to make the initial decision, including those used as the basis for the initial action or the NOAR, if applicable, and all other relevant documents

and records the OHA requests as outlined in detail in OAR 141-410-3890, OAR 410-141-3900, and OAR 410-141-3905.

6. Information regarding the member used for administrative hearings is handled in confidence.
    a. OHA, the member, their representative, or the legal representative of a deceased member's estate, UHA, and any practitioner whose authorization, treatment, services, items, or request for payment is involved in the administrative hearing have a right to use this information for purposes of resolving the administrative hearing without a signed release from the member.
    b. OHA may also use this information for health oversight purposes and for other purposes authorized or required by law.
    c. The information may also be disclosed to the Office of Administrative Hearings and the administrative law judge assigned to the administrative hearing and to the Court of Appeals if the UHA member seeks judicial review of the final order.
    d. OHA will ask the member to authorize a release of information regarding the administrative hearing to any other individual.
7. The hearing will be scheduled through the Office of Administrative Hearings.
8. UHA has a system in place to ensure its members and providers have access to expedited review for UHA action by requesting an expedited contested case hearing. If a member or provider believes that taking the time for a standard resolution of a contested case hearing could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function may request an expedited contested case hearing, as described in OAR 410-141-3905. A request for an expedited hearing for a service that has already been provided (post-service) to the member will not be granted.
    a. The MCE shall submit relevant documentation to the Authority within two (2) working days of any decision of an expedited appeal. The Authority shall decide within two working days from the date of receiving the relevant documentation applicable to the request whether the member is entitled to an expedited contested case hearing.
9. OHA will resolve a contested case hearing ordinarily within ninety (90) days from the date UHA 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 request. The final order is the final decision of OHA.
10. If UHA or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal or contested case hearing was pending, UHA will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date UHA receives the decision reversing the ABD.

Continuation of Benefits

1. A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount as previously authorized while an appeal or contested case hearing is pending.
2. To be entitled to continuing benefits, the member shall submit an oral request or complete an appeal request (OHP 3302), or an OHA contested case hearing request form and check the box requesting continuing benefits by:
    a. Within ten (10) days after the date of the NOABD; or
    b. The intended effective date of the action proposed in the NOABD.
3. UHA will continue COB to the member's benefits if:
    a. The member or member's authorized representative timely files the appeal or contested case hearing request;
    b. The appeal or contested case hearing request involves the termination, suspension, or reduction of previously authorized services;
    c. An authorized provider ordered the services;
    d. The period covered by the original authorization has not expired; and
    e. The member timely files for continuation of benefits.
4. If at the member's request, UHA continues or reinstates the member's benefits while the appeal or hearing is pending pursuant to 42 CFR § 438.420(c), the benefits will be continued until one of the following occurs:
    a. The member withdraws the appeal;
    b. UHA issues an NOAR;
    c. The member does not request a contested case hearing and continuation of benefits within ten (10) days from the date of notice;
    d. The member withdraws their request for contested case hearing; or
    e. A final contested case hearing decision is upheld.
5. If the final resolution of the appeal or contested case hearing upholds the ABD, UHA will recover from the member the cost of the services furnished to the member while the appeal or hearing was pending, to the extent that they were furnished.
6. If UHA or the Administrative Law Judge reverses a decision to deny, limit, or delay services furnished, and the member received the disputed services while the appeal was pending, UHA or the state shall pay for those services in accordance with the OHA policy and regulations.
7. Should the administrative hearing decision uphold UHA's ABD, UHA may recover the cost of service furnished to the member while the hearing is pending pursuant to 42 CFR § 431.230(b), to the extent that they were furnished solely because of the requirements of Exhibit I, Section 6 of the CCO Contract.

Record Keeping and Quality Improvement

1. UHA will document and maintain a record of all member grievances and appeals in accordance with OAR 410-141-3890, OAR 410-141-3915, OAR 410-141-3875, and 42 CFR §438.416. UHA will fully and timely comply with all records requests. UHA shall fully and promptly comply with OHA monitoring and oversight.
2. UHA will retain and keep accessible all documentation, logs and other records for the Grievance and Appeal System whether in paper, electronic, or other form for a minimum of 10 years (CO23 – Record Retention & Destruction Policy). Records will include at a minimum:
    a. A general description of the reason for the appeal or grievance and the supporting reasoning for its resolution;
    b. Member name;
    c. OHP Member ID;
    d. The date the member, member's authorized representative, subcontractor or provider filed the grievance or appeal;
    e. The NOABD;
    f. If filed in writing, the appeal or grievance;
    g. If filed orally, documentation that the grievance or appeal was received orally;
    h. Records of the review or investigation at each level of the appeal, grievance, or contested case hearing;
    i. Notice of resolution of the grievance or appeal, including dates of resolution at each level;
    j. Copies of correspondence with the member and all evidence, testimony, or additional documentation provided by the member, the member's authorized representative, or the member's provider as part of the grievance, appeal, or contested case hearing process; and
    k. All written decisions and copies of all correspondence with all parties to the grievance, appeal, or contested case hearing.
3. The appeal and grievance coordinator are responsible for monitoring both appeals and grievances for completeness, accuracy, and timeliness of documentation, compliance with policies and procedures, and compliance with Oregon Health Plan rules.
4. All grievances and appeals shall be documented in writing on the Grievance and Appeal Log and is consistent with OHA requirements as directed below. This log is reviewed quarterly for quality improvement purposes and submitted quarterly to OHA review as part of the State quality strategy. Categories and service types are applied consistent with Exhibit I of the CCO Contract deliverables.
5. Data from appeals and grievances are utilized to identify and report, as needed, trends impacting members (Health Equity, Social Determinates of Health, barriers to care, etc.),

UHA, its subcontractors, or its participating providers. This data includes, but is not limited to, race/ethnicity, language, and disability (REALD), sexual orientation and gender identity (SOGI), complaint sources, member and provider feedback, etc.

6. G&A collaborates with multiple groups for continuous monitoring and improvement planning, including UHA's Clinical Advisory Panel (CAP), Quality Improvement Committee (QIC), Provider Network Workgroup, Benefit Alignment Workgroup, Utilization Management Workgroup, Member Engagement and Health Equity Committee and the Community Advisory Council.
7. In compliance with Title VI of the Civil Rights Act, ACA Section 1557, 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.
8. UHA strives to ensure all Grievance and Appeals System policies and procedures are culturally and linguistically responsive to advance health equity, improve quality, and help eliminate health care disparities through the implementation of Culturally and Linguistically Appropriate Service (CLAS) standards within our governance, leadership, workforce, communications, and continuous improvement.

Subcontracted Entities

1. If UHA delegates part of the grievance process to a subcontractor or participating provider, UHA will:
    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. Validate that performance of the subcontractor or participating provider meets the requirements of the CCO Contract, OAR 410-141-3505, OAR 410-141-3835 through 410-141-3915, and 42 CFR § 438.400 through 438.424;
    c. Monitor the subcontractor's or participating provider's performance on an ongoing basis;
    d. Perform a formal compliance review of the subcontractor or participating provider at least annually to assess performance, deficiencies, and areas for improvement, including but not limited to, updates to the appeals and grievance systems policies and procedures and its member notifications;
    e. Require the subcontractor or participating provider to take corrective action for any identified areas of deficiencies that need improvement. UHA will document all monitoring and corrective action activities for subcontractors; and

f. Include data collected by subcontractors or participating providers in the analysis of UHA's Compliance Committee, consistent with contractual requirements for CCO Quality Improvement.

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. Notice of appeal and grievance resolutions 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.
3. For hearings, subcontractors will forward all documentation to OHA and UHA and coordinate schedules to be available as expert witness during the hearing process.
4. UHA does not delegate to a subcontractor or participating provider the adjudication of an appeal in accordance with OAR 410-141-3875.
5. If delegated, in part or in full, monitoring of any grievance and appeal system to a subcontractors or participating providers, UHA will submit records of such monitoring to OHA, federal, state, and OHA contracted auditors, upon request.
   a. Such subcontractor or participating provider records shall provide evidence of compliance, as required under 42 CFR §438.230, OAR 410-141-3835 through 410-141-3915, and 42 CFR §§438.400 through 438.424 and the CCO Contract.
   b. The records submitted will include any corrective actions initiated as a result of subcontractor or participating provider monitoring, up to and including termination of subcontractor or participating provider. All records requested will be submitted to OHA, via Administrative Notice, no later than fourteen (14) days following receipt of the request or in a timeframe established by the requesting entity.

<u>OHA Review and Approval</u>

1. UHA will annually review, and if necessary, update its grievance and appeal system, policies and procedures related thereto, and member notice templates. These will be provided to OHA's Contract Administrator, via Administrative Notice, with the grievance and appeal system for review and approval by January 31.
2. Within five (5) business days, if any changes are made to the approved grievance and appeal system, policies and procedures related thereto, member notice templates, and any other documents to be provided to members regarding the grievance and appeal system, be provided to OHA's Contract Administrator with Administrative Notice that identifies proposed changes with particularity and when applicable includes the revised grievance and appeal system or any other documents relating thereto.
3. After the request of OHA, including but not limited to requests in connection with or following a quarterly review, or to requests in connection with or following a contested case

hearing, UHA shall provide OHA, via Administrative Notice, the grievance and appeal system, policies and procedures related thereto, member notice templates, or any other documents to be provided to members regarding the grievance and appeal system, to OHA for compliance review.

4. In the event OHA, CMS, or EQRO determine the grievance and appeal system member template notices do not comply with Applicable Laws, or with the terms and conditions of UHA and OHA contract, UHA will revise such member template notices within thirty (30) days of notification and submit them to OHA, via Administrative Notice, for review and approval or disapproval.
5. UHA will obtain OHA approval of member materials included in the grievance and appeal system, policies and procedures related thereto, member notice templates, and any other documents to be provided to members regarding the grievance and appeal system prior to implementing and providing such materials to members.
6. Within thirty (30) days of receipt of the grievance and appeal system or changes to the approved grievance and appeal system, policies and procedures related thereto, member notice templates, or any other documents to be provided to members regarding the grievance and appeal system, OHA will provide UHA's Contract Administrator with Administrative Notice of OHA's approval or disapproval of the grievance and appeal system.
    a. OHA will notify UHA within the same thirty (30) day period if additional time is needed for review.
    b. OHA may disapprove of all or part of the grievance and appeal system based on any failure to comply with the contract and any other the Applicable Laws.
        i. In the event OHA does not approve the grievance and appeal system, UHA shall follow the process set forth in Sec. 5, Ex. D of the CCO Contract.
        ii. Upon approval, the grievance and appeal system, policies and procedures related thereto, member notice templates, and any other documents to be provided to members regarding the grievance and appeal system, are to be included in the Member Handbook, Provider Handbook and our UHA's website. UHA will also communicate these policies and procedures to subcontractors.
7. Within forty-five (45) days after the end of each calendar quarter, UHA will provide to OHA, via Administrative Notice, the following documentation (which shall include any and all documentation required to be held and maintained by the subcontractors):
    a. A Grievance and Appeal Log in a format provided by OHA and available at on the CCO Contract Forms website;
    b. Samples of NOABD and corresponding prior authorization documentation. UHA's prior authorization template shall include, at a minimum:
        i. Date of the request for the service;

ii. The diagnosis codes, including but not limited to medical, dental, behavioral, and transportation billing codes, submitted;
iii. CPT or HCPCS (treatment) codes being requested;
iv. Any comorbid diagnosis codes that the provider may list on the authorization request;

c. OHA will randomly select samples from the Grievance and Appeal Log for the corresponding quarter for review. The sample size per quarter is a minimum of twenty samples and a maximum of samples numbering up to ten percent (10%) of the number of NOABDs issued during the quarter. Contractor shall submit records for the samples selected by OHA in the manner directed by OHA in its request no later than fourteen (14) days following receipt of OHA's request;
   i. All NOABDs for Applied Behavioral Analysis and Hepatitis C for the previous calendar quarter; and
   ii. Any other related documentation requested by OHA.
d. The Grievance System Report to OHA via Administrative Notice in a format provided by OHA, which is available on the CCO Contracts Forms website.
   i. UHA will use data collected from its own and its subcontractors' monitoring of the grievance and appeal system, including the grievance and appeal data reported by the subcontractors in the Grievance and Appeal logs to analyze such system.
   ii. UHA will demonstrate how the data used maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to members.

8. UHA will comply with all grievance and appeal records requests from OHA, CMS, EQRO, and any of their designees. They will be submitted, in accordance with such request, records to OHA's Contract Administrator, no later than fourteen (14) days following the receipt of a request, except where a request is related to a contested case hearing, in which case UHA shall submit required documentation within twenty-four (24) hours for an expedited hearing and two (2) days for a non-expedited hearing.
9. UHA is responsible for collecting and submitting the grievance and appeal records maintained in part or in full by subcontractors. UHA shall revise grievance and appeal systems or guidebooks (or both), within thirty (30) days of notification by CMS, OHA, or EQRO of non-compliance with the CCO Contract, and applicable federal, and State laws.
   a. If OHA does not approve of the grievance and appeal system or guidebooks, UHA shall follow the process set forth in Sec. 5, Ex. D of the CCO Contract.
10. UHA will review for completeness and accuracy the data collected from the grievance and appeal systems, on a monthly basis, and provide the results of such review to OHA, federal, state, and OHA contracted auditors upon request.

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Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
Health Plan Operations	Grievances & Appeal System Handbook	NA	3/1/21	1
Health Plan Operations	UM & Service Authorization Handbook	NA	8/9/20	1