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EOCCO Medicaid Member Grievances and Appeals Policy

I. Policy Statement and Purpose

Eastern Oregon Coordinated Care Organization (EOCCO) provides an internal procedure for members or their representatives to voice or submit and obtain timely resolution of their complaints and appeals. EOCCO will inform providers and subcontractors, at the time they enter into a contract, written notifications of procedures and timeframes for Grievances, NOABDs, Appeals, and Contested Case Hearings. Written notification of updates to any procedures and time frames will be supplied to providers and subcontractors within five business days after approval of such updates by The Oregon Health Authority (OHA). EOCCO processes physical health, behavioral health, oral health and non-emergent transportation grievances and appeals. EOCCO is the final adjudicator of all appeals. EOCCO, the subcontractor and its participating providers may not 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, encourage the withdrawal of a grievance or appeal or hearing already filed or 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. This policy applies to EOCCO, EOCCO's subcontractors and participating providers. All member communications are written in a format and language that may be easily understood by the member.

This policy and the procedures outlined are designed to be culturally and linguistically responsive. The appeal and grievance processes are simple, accessible, and understandable to the member. EOCCO

takes into consideration the member's literacy and language preference when developing the policy and procedures. The policy and procedures comply with the State and Federal guidelines.

The grievance and appeal system information, which must comply with the requirements set forth in the rules and contract, shall be included in all of EOCCO's member and provider handbooks, and on the website. Written materials, including provider directories, member handbooks, appeal and grievance notices, and all denial and termination notices are made available in the prevalent non-English languages in its particular service area and be available in formats for members with disabilities. EOCCO will 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, offer oral interpretation to understand information provided, information about how to request auxiliary aids and services for members who have limited English proficiency or a disability, as well as other formats at no cost. The EOCCO Grievance and Appeal System policies and procedures comply with State and Federal laws.

II. Definitions

A. **Adverse Benefit Determination:** A 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; the denial, in whole, or in part, of a payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure to act within the timeframes regarding the standard resolution of grievances and appeals (42 CFR §438.408(b)(1) and (2)); the denial of a request by a member residing in a rural area to exercise his or her right to obtain services outside the network (42 CFR §438.52(b)(2)(ii)); or the denial of a request by a member to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

B. **Contested Case Hearing:** A hearing requested by a Medicaid member or representative (including provider) with the member's written consent regarding an appeal decision by EOCCO that has denied benefits for requested services, payment of a claim or terminated, discontinued or reduced a course of treatment or any other adverse benefit determination. The hearing request must be filed with the OHA hearings unit no later than 120 days following the date of the EOCCO written appeal decision.

C. **Appeal:** A request by a Medicaid member, the provider or the member's authorized representative, acting on behalf of the member and with the members written consent, for review of an EOCCO adverse benefit determination. An appeal must be filed no later than 60 days following the date of the EOCCO notice of adverse benefit determination. EOCCO conducts 1 level of appeal for members. Members must complete the appeals process prior to requesting a contested case hearing.

D. **Grievance:** An expression of dissatisfaction to the state, EOCCO or a provider from a member, the members provider, or authorized representatives, acting on behalf of the member and with the member's written consent, to request a grievance and/or about any matter not involving an adverse benefit determination, appeal, or contested case hearing. A grievance can be filed at any time with EOCCO or OHA. Grievances may involve 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 CCO to make an authorization decision. A grievance can be filed at any time orally or in writing.

E. **Expedited Appeal:** An expedited review is when EOCCO determines upon request from the Medicaid member that taking the time for a standard resolution could seriously jeopardize the Medicaid member's life, health or ability to attain, maintain or regain maximum function. An expedited appeal request is automatically accepted when the provider makes the request on behalf of the member or supports the member's request.

F. **Notice of Adverse Benefit Determination:** A written notice to the member of a denial or limitation by EOCCO of a requested covered service; a reduction, discontinuation or termination of previously authorized services; or a denial of claims payment or other adverse benefit or claims determination, in whole or in part in which the member is liable. The notice of adverse benefit determination includes the member's right to file an appeal and information on how to file an appeal.

G. **Oregon Health Authority Health Systems Division:** The Oregon Health Authority Health Systems Division administers the Oregon Health Plan, the state's Medicaid and Children's Health Insurance Program, and contracts with coordinated care organizations (CCOs), mental health programs and others to support community-based health services. OHA enrolls Medicaid providers and offers services and support to Medicaid members.

H. **Representative:** A representative is an individual who can make Medicaid-related decisions for a member who is not able to make such decision themselves. In this policy a representative also includes the member's provider. A provider or the members authorized representative, with the member's written consent, has the authority to file an appeal, grievance, or contested case hearing with EOCCO. EOCCO considers the member, the member's representative, or the legal representative of a deceased member's estate as parties to an appeal. A representative is allowed to request an appeal, file a grievance, or request a state fair hearing request. With respect to actions taken regarding appeals, references to a "member" include, as appropriate, the member, the member's representative, and the representative of the deceased member's estate. Also , with respect to EOCCO's notification requirements, a separate notice must be sent to each individual who falls within this definition.

III. Procedure

A. Timely Filing of Grievances and Appeals

1. A member, members provider or authorized representative acting on behalf of the member, as state law permits, must file an appeal within 60 calendar days from the date on the adverse benefit determination notice.. EOCCO will not consider appeals received beyond the time limit. There is no timeline for filing a grievance. There is only one level of appeal for members and all members shall complete the appeal process with EOCCO prior to requesting a contested case hearing.

B. Receiving Grievances/Appeals

1. Grievances/appeals can be received in the following methods:

a. Written/US Postal Service: Grievances/appeals received through the US Postal Service are processed daily and routed, upon receipt, to the appeal

unit.

b. In person at all physical, behavioral, oral health, administrative offices and all offices where EOCCO has delegated responsibilities for appeal, hearing request or grievance involvement, all offices have the following forms available in English and in the prevalent non-English languages in its particular service area: OHP Complaint Form (OHP 3001), Hearing request form (MSC 443), and Notice of Hearing Rights (OHP 3030); or The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302).

c. Facsimiles: Delivered to the appeal staff as received.

d. Email: Grievances/appeals received at OHA and/or a CCO are forwarded to EOCCO for handling via secure email. Grievances/appeals received in any business area are forwarded, upon receipt, to the appeal staff.

e. Telephone Grievance:

i. When a member calls with an expression of dissatisfaction, the EOCCO representative, attempts to resolve the issue at the initial contact. If the EOCCO representative resolves the issue to the member's satisfaction, the EOCCO representative documents the issue and resolution and the documentation is referred to the appeal staff for grievance tracking and analysis. The appeal staff send a letter to the member that explains the resolution.

ii. If the EOCCO representative is unable to resolve the member's grievance at the initial contact, the EOCCO representative documents the member's grievance/appeal and sends to the appeal staff for handling. The appeal staff work to resolve the issue and send a letter to the member that explains the resolution.

2. The EOCCO representative gives the member the option to file standard or expedited appeals orally or in writing to express disagreement with an adverse benefit determination. They also can write or file a grievance orally. If the member chooses to write the grievance/appeal and they did not receive a form, the EOCCO representative mails the member the EOCCO complaint form if requested. EOCCO also accepts grievances/appeals written on the OHP Complaint Form 3001.

3. The EOCCO representative gives the member reasonable assistance in completing the forms and taking other procedural steps related to filing the grievance/appeal. This includes but is not limited to providing Certified or Qualified Health Care Interpreter services and toll free numbers that have adequate TTY/TDD for the hearing impaired at no charge to the member, and Certified or qualified Health Care Interpreter capability.

a. 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;

b. Free interpreter services or other services to meet language access

requirements where required in 42CFR §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; and

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.

4. If the member is filing an oral appeal (not an expedited appeal):
    a. The member may file an appeal orally. Oral inquiries seeking to appeal an adverse benefit determination are treated as appeals.
    b. The EOCCO representative records the grievance/appeal in the member's own words on the EOCCO grievance form, and communicates the following to the member:
        i. Repeats back to the member the grievance/appeal as recorded to confirm accuracy.
        ii. The grievance/appeal is investigated through the EOCCO appeal process.
5. If the appeal or grievance is filed by any representative besides the member, written consent is needed to respond to the representative. Written consent will be stored with the file. See section K.
6. Sufficiently in advance of the resolution timeframe, the EOCCO representative informs the member of the limited time to submit evidence and testimony, in person and in writing, to support their case and make legal and factual arguments in the case of an expedited appeal resolution.
7. If the member requests an appeal or hearing with OHA prior to the completion of the appeal, OHA transfers the request to EOCCO for processing. EOCCO reviews the request immediately and processes according to the appeal process outlined in this document. Approve or deny the appeal within 16 days and provide the member with a notice of appeal resolution.
8. EOCCO complies with the state and federal civil rights laws and does not treat people unfairly in any of its programs or activities because of a person's: age, color, disability, gender identity, marital status, national origin, race, religion, sex and sexual orientation.
9. If a member feels that they have been discriminated against or treated unfairly for any of the above reasons, members can contact the following:
    a. Oregon Health Authority (OHA) Civil Rights, Web:http://http://www.oregon.gov/OHA/OEI, Email: OHA.PublicCivilRights@state.or.us, Phone: (844) 882-7889, 711 TTY, Mail: Office of Equity and Inclusion Division, 421 SW Oak St., Suite 750, Portland, OR 97204.

b. EOCCO, Chief Compliance Officer, 601 SW Second Ave., Portland, OR 97204, Email: compliance@eocco.com, complaint_form.pdf (eocco.com), Customer Service Department 1-888-788-9821, 711 TTY.

c. Bureau of Labor and Industries Civil Rights Division, 800 NE Oregon St. Suite 1045, Portland, OR 97323, Email: crdemail@boli.state.or.us, Phone: (971) 673-0764.

d. U.S. Department of Health and Human Services Office for Civil Rights, Web: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, Email: OCRComplaint@hhs.gov, Phone: (800) 368-1019, (800) 537-7697 (TDD).

10. EOCCO will review and report to OHA complaints that raise issues related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, cultural or linguistically appropriate service requests, disability status, and other identity factors for consideration in improving services for health equity.

C. Logging Grievances/Appeals

1. The EOCCO representative enters the grievance/ appeal into the appropriate processing system. If the grievance/appeal is not yet resolved, the resolution date, resolution time and resolution will be added when the information becomes available.

D. Notification of Receipt of Grievance/Appeal

1. EOCCO sends the member an acknowledgment letter within five business days of receipt of the grievance.
2. The letter communicates the following:
    a. Notifies the member that a decision on the grievance has been made and what the decision is; or
    b. The grievance has been received and is being investigated;
    c. A delay is necessary to resolve the grievance and that the member will receive a written decision within 30 calendar days from the date of receipt of the grievance. The letter specifies the reason(s) for the delay.
    d. The complainant is asked to complete the enclosed form(s), if it is needed to investigate the grievance.
3. For appeals, EOCCO sends the member, member's authorized representative and/or the member's provider, where indicated, an acknowledgement letter or resolves the case within five business days of receipt for standard appeals and within 1 business day for expedited appeals. Expedited appeals will also be acknowledged orally within 1 business day.
    a. The letter and call informs the complainant that the appeal will be resolved within 16 calendar days for standard appeals or 72 hours for expedited appeals of receipt or as expeditiously as the member's health condition requires. The receipt date for oral filings of appeals is the date the oral appeal is received.

b. The member is informed that the timeframe for resolution may be extended up to 14 days if the member requests the extension or if EOCCO cannot resolve the written appeal within 14 calendar days of receipt, and satisfactorily shows (if requested by OHA) the need for additional information and how the delay is in the member's interest. EOCCO will make reasonable efforts (including as necessary multiple calls to the member at different times of the day) to give the member prompt oral notice of the delay. EOCCO will provide the member written notice within 2 calendar days, explaining the delay and that EOCCO reaches a decision and informs the member in writing within 14 days of receipt of the extension. This letter will also inform the member of the right to file a grievance if he or she disagrees with that decision. EOCCO will resolve the appeal as expeditiously as the member's health condition requires and not later than the date the extension expires.

    i. If EOCCO fails to meet the required time frames for processing an appeal or an oral appeal that have received an extension, the member is deemed to have exhausted the CCO's appeal process and the member may initiated a contested case hearing.

c. The member or the member's representative is provided the opportunity to present evidence and allegations of fact or law related to the issues in dispute in person or in writing, if he or she chooses.

d. The member is provided the opportunity to examine the member's file, including medical records and any other documents or records to be considered during the appeals process.

e. All appeals and grievances are responded to in writing. In addition, they may also be responded to orally.

E. Request for Standard Appeal

1. EOCCO will resolve each appeal as expeditiously as the member's health condition requires.
2. The member is given reasonable opportunity to present evidence and allegations of fact or law in person or in writing and make legal and factual arguments. The member must be informed of this sufficiently in advance of the resolution timeframe for appeals.
3. EOCCO will resolve standard appeal within 16 days of receiving the member's written appeal.
4. If EOCCO needs to extend the timeline for the appeal, not at the request of the member, the following will take place:

    a. EOCCO will make reasonable efforts to give the member prompt oral notice of the delay.

    b. Within 2 days of oral notice, EOCCO sends a written notice with the reason for the decision to extend the timeframe and informs the member of the right to file a grievance.

c. Resolve the appeal no later than the date of the expiration of the extension.

F. Request for Expedited Appeal

1. In the case of clinical urgency, the member may request an expedited appeal.
2. EOCCO resolves expedited appeals and provides notice as expeditiously as the member's health condition requires, not to exceed 72 hours after EOCCO receives the expedited appeal request or applicable extension.
3. The timeline for an expedited appeal requested orally shall begin when there is established contact made between the member and EOCCO.
4. The member is given reasonable opportunity to present evidence and allegations of fact or law in person or in writing and make legal and factual arguments. The member is informed of the limited time available in advance of the resolution timeframe for appeals.
5. For member requests, the medical or dental director will review the request and determine whether it qualifies as an expedited appeal. If the provider requests the expedited appeal, the request to expedite is automatically accepted.
6. If EOCCO denies the request for an expedited appeal:
    a. The appeal is transferred to the standard timeframe of no longer than 16 days from the day EOCCO receives the appeal with possible 14-day extension.
    b. Makes a reasonable effort to give the member verbal notice of the denial this includes as necessary multiple calls at different times of the day and then follows up with a written confirmation within two days.
    c. Informs the member of the right to file a grievance if the member disagrees with the decision.
7. If EOCCO grants an expedited appeal, EOCCO:
    a. Coordinates the resolution of the appeal and makes reasonable effort to provide the member oral notice, this includes as necessary multiple calls at different times of the day, and written notice no later than 72 hours after EOCCO receives the expedited appeal.
    b. Makes reasonable effort to provide the member with oral notice. If the decision is not wholly in favor of the member, the written notice adheres to the notification requirements set forth in Section III. G of this policy and procedure.
    c. Extension or if EOCCO cannot resolve the appeal within 72 hours of receipt, and satisfactorily shows the need for additional information and how the delay is in the member's interest. EOCCO makes reasonable effort to give the member verbal notice of the delay and the reason for the delay and follows up with a letter explaining the delay within 2 days and that EOCCO will reach a decision and inform the member in writing within 72 hours plus 14 days of receipt of the expedited appeal. The letter will also inform the member of their right to file a grievance about this decision. If

the decision is not wholly in favor of the member, the written notice adheres to the notification requirements.

8. EOCCO makes reasonable efforts to call the member and provider to tell them of the resolution within 72 hours of receiving the request and mails written confirmation of the resolution to the member within three days.

G. Investigation

1. Consistent with the confidentiality requirements, EOCCO coordinates the review and requests all records and documentation regarding the grievance/appeal, including, but not limited to, practitioner office records, ambulatory records, inpatient medical records, and any relevant information regardless of whether the information was submitted during the initial adverse benefit determination. All information is used to make the final determination. Each action taken on the case file are documented in the case notes and stored with the final file.
    a. If written consent is required, but not returned, EOCCO follows up with the member or the member's representative.
2. EOCCO gathers additional information, as needed, from the complainant as well as from the Medicaid plan wording, claims, user's procedure manual (UPM), medical necessity criteria, utilization management notes from the operating system, and Oregon Administrative Rules.
3. If EOCCO has a question regarding the appropriate Oregon Administrative Rules to cite in the appeal resolution letter, the AC will consult with the appropriate leadership for the business area.
4. The person(s) making the decision on a grievance/appeal may not have been involved in any previous level of review or decision making, must not be a subordinate of any individual involved with making the determination of the prior review and must not receive incentivized compensation to deny, limit, or discontinue services. Please refer to the EOCCO Conflict of Interest policy. If the appeal of a denial is based on lack of medical appropriateness or if an appeal involves clinical issues, healthcare professionals with the appropriate level of training and expertise to evaluate the services or issues in dispute makes the decision on the appeal, as determined by the state in treating the member’s condition. For example, if the initial decision was made by a registered nurse, the case is directed to the medical director. The reviewer takes into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination to make their determination.
5. Clinical review is required for all medical necessity appeals, grievances regarding the denial of expedited resolution of an appeal and grievances that involve clinical issues such as quality of care concerns.
6. When necessary, the medical consultant reviews the grievance/appeal and any additional information against established criteria and makes a decision about each element of the grievance/appeal. The medical consultant determines the following:
    a. Whether appropriate clinical protocols and guidelines were followed.

b. Whether there was no effect on the complainant's health status, there was an adverse effect upon the complainant's health status, but this was remedied, or the complainant's health status was seriously affected.

7. If at the member's request EOCCO continues or reinstates the member's benefits while the appeal is pending the benefits must be continued until one of the following occurs:
    a. The member withdraws the appeal; or
    b. The member does not request a contested case hearing within 10 days from when EOCCO mails an adverse decision; or
    c. A contested case hearing decision adverse to the member is made
8. When an appeal request is not timely, the AC will respond and advise the member why the appeal is not timely and further appeal rights will be provided.

H. Effectuation
1. If EOCCO or OHA overturn the original decision to deny, terminate, or suspend a service, and if the service(s) have not been furnished, EOCCO will:
    a. As expeditiously as the member's health condition requires but no later than the applicable turnaround time for the standard or expedited request; or
    b. As expeditiously as the member's health condition requires but no later than 72 hours from the date the notice is received from OHA if a contested case hearing request is filed with OHA and EOCCO's decision is overturned.

I. Notification Requirements
1. All appeals and grievances are resolved with a written resolution letter to the member or the member's representative. The resolution is written in language that is sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the grievance resolution. All written communication is sent in the member's preferred language. The AC works to accommodate the communication to account for a member with a disability or with limited English proficiency. Written notification requirements that are included with the written resolution to complainants are as follows:
    a. Appeals and grievances are resolved and responded to as expeditiously as the member's health condition requires.
    b. EOCCO translates required written material into the prevalent non-English languages identified in its CCO enrollment or upon request. See the EOCCO Interpreter Services policy for details.
    c. EOCCO resolves a grievance within 30 days of receipt if a decision was not possible within five business days of receipt.
    d. EOCCO resolves an appeal within 16 days of receipt. If a delay is necessary due to the need for additional information, EOCCO sends the member a letter explaining the reason for the delay, that a decision will be

reached within 30 days of receipt of the appeal, and the member's right to file a grievance about this decision.

e. The decision on each element of the member's grievance/appeal and the reasons for EOCCO' decision(s). The letter includes the results of the resolution process, the date it was completed, the date the member filed the appeal and effective date of the decision.

f. 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.

g. 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

h. In decisions made by the EOCCO staff, an explanation of who made the appeal decision (i.e., nurse, medical director).

i. Grievance responses include the right to file a grievance with the Department of Human Services ombudsman's office by writing to 500 Summer Street NE, Salem, OR 97310 or by calling 503-947-2346 or toll free at 877-642-0450. They may also contact the OHP Client Services Unit (CSU) toll free at 800-273-0557.

j. EOCCO and their subcontractors shall promptly cooperate with any investigations and resolution of the 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.

k. In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsperson or hearing representatives, EOCCO, 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.

l. If the member indicates that they no longer want to file a complaint or that they would like to withdraw their complaint, the AC will send a written response to the member letting them know that we will no longer investigate the concern.

m. The decision letter must 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.

n. If the member indicates that they no longer want to file a complaint or that they would like to withdraw their complaint, the AC will send a written response to the member letting them know that we will no longer investigate the concern.

o. For appeal decisions not wholly in favor of the member

    i. The particular Oregon state statutes and rules relied upon to reach the decision(s) to deny the appeal;

    ii. The right to request a contested case hearing with OHA (expedited hearing if the appeal decision is expedited) and how to do so. EOCCO encloses forms OHP 3030 (Notice of Hearing Rights) and OHP 3302 (Administrative Hearing Request) with the written resolution;

    iii. The right to request to receive benefits while the hearing is pending and how to make the request;

    iv. That the member may be held liable for the cost of those benefits if the hearing decision upholds EOCCO's decision.

    v. EOCCO continues the member's benefits when requested if the member or member's representative files the appeal timely, within 10 calendar days after EOCCO mails the notice of appeal resolution or the intended effective date of EOCCO' proposed adverse benefit determination. In addition the request must:

        1. Involve the termination, suspension, or reduction of a previously authorized course of treatment;

        2. Involve services that were ordered by an authorized provider;

        3. Pertain to the original period covered by the original authorization that has not expired; and

        4. The member, member’s representative or the provider, with the member’s written consent, timely files for continuation of benefits. Timely filing means filing on or before the later of the following within 10 days after the date of the Notice of Adverse Benefit Determination (NOABD), or the intended effective date of the action proposed in the NOABD.

        5. Include the member's request for extension of benefits.

    vi. If at the member's request EOCCO continues or reinstates the member's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of the following occurs:

        1. The member withdraws the appeal or request for state fair hearing; or

2. The member fails to request a state fair hearing within 10 days from the date of the Notice of Appeal Resolution; or
3. A state fair hearing decision adverse to the member is made

vii. The member's right to the continuation of benefits pending an administrative hearing:
    1. If the member or their representative requests that EOCCO continue or reinstates their benefits while the appeal is pending and
    2. The notice of appeal resolution is adverse to the member, the benefits continue pending the administrative hearing.

viii. If EOCCO overturns a decision to deny, limit or delay a benefit:
    1. EOCCO corrects the adverse benefit determination taken up to the limit of the original request or authorization, retroactive to the date the adverse benefit determination was taken, even if the member has lost eligibility or the benefit package has changed after the date the adverse benefit determination was taken.
    2. If the service has not been furnished while the appeal is pending and EOCCO has decided to authorize the services following the appeal, EOCCO will authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. EOCCO will notify the member and member's representative (if applicable) both orally and in writing, and notify the provider in writing, of the available services and how to access them, and enter the authorization into the system or adjust the encounter data claim representing the service.
    3. EOCCO may recover the cost of continued services furnished to the member while the appeal that is pending if the final resolution of the appeal or state fair hearing, upholds the EOCCO adverse benefit determination.

ix. If the member received the disputed services while the appeal was pending, EOCCO pays for the services per the plan provisions.

x. All response letters include a nondiscrimination statement.

xi. For post-service denials, response letters include an explanation

to the member that an expedited hearing will not be granted.

J. Monitoring/Reporting and Evaluation

1. Monitoring
    a. EOCCO leadership monitors the following:
        a. Decisions about all elements of each grievance/appeal as necessary.
        b. Timeliness of letters acknowledging receipt of grievances/ appeals.
        c. Timeliness of resolution within the mandated timeframes.
        d. Timeliness of 14-day extension letter, when applicable.
2. Reporting and Evaluation
    a. The following grievances are forwarded to the credentialing coordinator for placement in practitioner's credentialing files:
        a. Quality of care
        b. Professional relations/communications
        c. Physical access
        d. Physical appearance
        e. Adequacy of waiting- and examining-room
        f. Safety
3. EOCCO presents quarterly and annually grievance/appeal reports to EOCCO Quality Improvement Committee (QIC) on the following:
    a. Number of grievances/appeals obtained from Access database
    b. Completeness and accuracy
    c. Persistent or significant grievances/appeals
    d. Timeliness of receipt, disposition, and resolution
    e. Trends
4. Courtney Valenzuela with the EOCCO QIC reviews the reports and analyze issues raised by members in grievances and appeals and their resolution and makes recommendations for improvements, as necessary.
5. Annually, the EOCCO QIC reviews the grievance/appeal process and recommend process improvement, as appropriate.
6. At least annually, the grievance and appeal reports are presented to the EOCCO Governance Board. Quarterly, EOCCO incorporates the analysis of the grievances and appeals to OHA using the OHA-prescribed reporting form.
    a. This includes grievances 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.

7. All the report race, ethnicity, language, and disability (REALD) data comes on the eligibility files from the Oregon Health Authority and is stored in Facets under the subscriber application. Monthly, a report is generated of all appeals and grievances by category and the member associated REALD data. If stratification shows that populations are being affected at a higher rate than others, a focused review is triggered.

K. Integration of dental care organizations (DCOs) with coordinated care organizations (CCOs)

1. EOCCO integrates with two DCOs; Advantage Dental and ODS Community Health. The handling of appeals and grievances follow our standard processing guidelines as listed above. This section outlines the steps taken to coordinate the review with the appropriate DCO.

    1. Dental grievances related to Advantage Dental members are reviewed and processed by Advantage Dental. The EOCCO appeal team will notify Advantage Dental of a new grievance within 24 hours of it being received. The grievances are sent to one of the above contacts via secure email (see section B).
    2. All grievance and appeal notices shall comply with OHA's formatting and readability standards in OAR 410-141-3585 and 42 CFR 438.10.
    3. Advantage Dental will complete the grievance review and provide the recommended resolution for grievances to EOCCO (the review will include a copy of all related documents and the proposed resolution letter). EOCCO will review and approve the DCO to mail the resolution.
    4. EOCCO requires a minimum of four calendar days to review and mail the resolution letter. Advantage Dental will send the completed appeal/ grievance to EOCCO as follows:
        a. Appeals will be completed within 12 calendar days of receipt.
        b. Expedited appeals will be completed within 48 hours of receipt.
        c. Grievances will be completed within 26 calendar days of receipt if a decision was not possible within five business days of receipt.
    5. EOCCO will forward administrative hearing documentations to Advantage Dental as necessary. EOCCO and a representative from the Advantage Dental will participate in cases reviewed by the Administrative Law Judge.
    6. Advantage Dental will submit all the grievance and appeal logs on the CCO approved logs from the OHA. The logs are due to EOCCO within 21 days after the quarter ends.
        a. For information on delegate oversight please see the EOCCO Subcontractor Monitoring and Oversight policy. EOCCO ensures the subcontractor meets the requirements consistent with this rule and OAR 410 141 3525; (a) Monitor the subcontractor's

performance on an ongoing basis; (b) Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and (c) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement. All corrective action activity for subcontractors are documented.

7. Dental grievances related to ODS members are reviewed and processed by EOCCO.
8. All dental appeals are handled by EOCCO.

L. Statement of Confidentiality

1. All information and documentation received or created by EOCCO that includes PHI shall be maintained in a confidential manner in accordance with state and federal privacy laws. EOCCO will provide member assurance of confidentiality in all written, oral, and posted material in grievance and appeal processes. If PHI is to be used for purposes other than as required for treatment, payment and/or operations, or as required by federal or state law, an authorization will be obtained from the individual.

M. Storage

1. Following resolution, the supporting documentation of grievances/appeals whether in paper, electronic or other form, are stored for a minimum of 10 years in EOCCO's document storing system. This includes all information found in section C.
2. Appeal and grievance case files are maintained in a manner accessible to the state and CMS.
3. Case files are recorded into the Access database for internal and external reporting and are saved indefinitely. This includes all information found in section C.
4. All appeals/grievances are kept confidential.
5. EOCCO will document and maintain a record, in a central location for each grievance and appeal. The record of each grievance and appeal must be accurately maintained in a manner accessible to the state and available upon request to CMS. The record shall include, at a minimum:
    a. A general description of the reason for the Appeal or Grievance and the supporting reasoning for its resolution;
    b. The Member's name and ID;
    c. The date Contractor received the Grievance or Appeal filed by the Member, Subcontractor, or Provider;
    d. The NOABD;
    e. If filed in writing, the Appeal or Grievance;
    f. If filed orally, documentation that the Grievance or Appeal was received orally;
    g. Records of the review or investigation at each level of the Appeal, Grievance, or Contested Case Hearing, including dates of review;

h. Notice of resolution of the Grievance or Appeal, including dates of resolution at each level;

i. 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

j. All written decisions and copies of all correspondence with all parties to the Grievance, Appeal, or Contested Case Hearing

N. Release of information

1. Information can be shared between providers and EOCCO for the purpose of authorizations, treatments, services, items, quality of care, or requests for payment related to the grievance, appeal, or contested case hearing without the member's signed consent. This information is also for the purpose of resolving the matter or maintaining the grievance or appeals log.
2. If EOCCO needs to communicate with other individuals or entities not listed above, EOCCO shall obtain the member's signed consent and maintain it in the file record.
3. EOCCO will provide the member (or the member's representative with appropriate documentation) a copy of their appeal file when requested free of charge. The case file provided may include medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the CCO (or at the direction of the CCO) in connection with the appeal of the adverse benefit determination. This information is provided sufficiently in advance of the resolution timeframe for appeals.

O. Contracts and handbooks

1. EOCCO must ensure and monitor its participating providers and subcontractors comply with the Grievance and Appeal system requirements in accordance with applicable law and the applicable provisions of the OHS contract.
2. Written notification of updates to any procedures and time frames will be supplied to providers and subcontractors within five business days after approval of such updates by The Oregon Health Authority (OHA).
3. EOCCO informs providers and subcontractors, at the time they enter into a contract, about the member's right to request continuation of benefits that the CCO seeks to reduce or terminate during an appeal or state fair hearing filing, if filed within the allowable timeframes, although the member may be liable for the cost of any continued benefits while the appeal or state fair hearing is pending if the final decision is adverse to the member.
4. EOCCO informs providers and subcontractors, at the time they enter into a contract, about:

a. Member grievance, appeal, and fair hearing procedures and timeframes as specified in 42 CFR 438.400 through 42 CFR 438.424 and described in the Grievance and Appeals section of this State Guide.

b. The member's right to file grievances and appeals and the requirements

and timeframes for filing.

c. The availability of assistance to the member with filing grievances and appeals.

5. EOCCO makes 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. EOCCO provides information to members regarding the following: Member rights and responsibilities
6. EOCCO provides information to members regarding the following:
    a. An explanation of how MCEs shall accept, process, and respond to grievances, appeals, and contested case hearing requests;
    b. Member rights and responsibilities; and
    c. How to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP.
7. EOCCO utilizes an member handbook approved by the state that:
    a. Includes the member's right to file grievances and appeals.
    b. Includes the requirements and timeframes for filing a grievance or appeal.
    c. Includes information on the availability of assistance in the filing process for grievances.
    d. Includes information on the availability of assistance in the filing process for appeals.
    e. Includes the member's right to request a state fair hearing after the CCO has made a determination on a member's appeal which is adverse to the member.
    f. Specifies that, when requested by the member, benefits that the CCO seeks to reduce or terminate will continue if the member files an appeal or a request for state fair hearing within the timeframes specified for filing, and that the member may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the member.

P. Staff Training

1. All EOCCO representatives and subcontractors who receive and respond to Medicaid grievances/appeals receive periodic in-services on the EOCCO grievance/appeal process. Training is designed to ensure staff respond appropriately to members, collect adequate information, document information appropriately and understand grievance/appeal and appeal procedures. Representatives who receive and respond to grievances/appeals are monitored on an ongoing basis by their supervisors as part of the review process.
2. Community Mental Health Programs (CMHP) receive on-going training on grievances and appeals during Behavioral Health Network Compliance/QI Meetings.

IV. Related Policies & Procedures, Forms and References

42 CFR §438.400 through §438.424

EOCCO Conflict of Interest Policy

EOCCO Language Access and Effective Communication Policy

EOCCO Medical Management Program and Clinical Decisions Policy

EOCCO Notice of Adverse Benefit Determination Policy

EOCCO OHA Contested Case Hearings Policy

OAR 410-120-1860

OAR 410-141-3715 through 410-141-3915

OHA Form 3001

OHA Form 3030

V. Affected Departments:

Medicaid Medical and Dental Customer Service

Medicaid Services

Healthcare Services

Quality Programs

Attachments

image1.jpg

Approval Signatures

Step Description	Approver	Date
EOCCO QIC Policy Subcommittee	Becky Miller: GOBHI Policy Analyst	04/2024
	Mica Shattuck: Supervisor, Appeals & Grievances	04/2024

Applicability

EOCCO

References

Behavioral Health, Dental, Medical, NEMT, Pharmacy, Quality Programs