Medicaid Grievance and Appeals System – Grievances, Appeals and Hearings

State(s):	LOB(s):
☐ *Idaho* ☐ *Montana* ☒ *Oregon* ☐ *Washington* ☐ *Other:*	☐ *Commercial* ☐ *Medicare* ☒ *Medicaid* ☐ *PSA*

Government Policy

This Policy outlines the requirements and actions of how PacificSource Community Solutions (PCS) will accept, process and respond to appeals, grievances, and contested hearings in line with Oregon Administrative Rules (OAR), Federal Regulation, and Contract Requirements. Specific regulations are outlined in the applicable regulation section of this policy.

This policy is subject to approval by the Oregon Health Authority (OHA) and must either be submitted or attested to annually, as directed by OHA, or anytime thereafter upon a significant change.

Procedure: Grievances, Appeals and Hearings

1) The definitions utilized in this policy are included in the definition subsection, below.
2) PCS has an Authority approved Grievance and Appeal System in place for members. PCS creates and implements written processes and procedures, which comply with the requirements set forth in rules and contract and includes such documentation in its member and provider handbooks. Grievance and Appeals requirements include the following:
    a. Member rights to file a grievance at any time for any matter other than an adverse benefit determination.
    b. Member rights to appeal and request a review of a notice of adverse benefit determination by PCS, including the ability of providers and authorized representatives to appeal on behalf of a member;
    c. Member rights to request a contested case hearing regarding a PCS adverse benefit determination once the plan has issued a written notice of appeal resolution (NOAR) under the Administrative Procedures Act.
    d. An explanation of how PCS shall accept, acknowledge receipt, process, and respond to grievances, appeals, and contested case hearing requests within the required timeframes.
    e. Compliance with grievance and appeals requirements as part of state quality strategy and to enforce a consistent response to complaints of violations of consumer rights and protections.
3) Specific to the appeals process (standard and expedited), PCS policies:
    a. Are consistent with confidentiality requirements, and ensure PCS' staff designated to receive appeals begin to obtain documentation of the facts concerning the appeal upon receipt.
    b. Provide the member a reasonable opportunity to present evidence and testimony and make legal and factual arguments in person as well as in writing.
        i. PCS informs members of this sufficiently in advance of the resolution timeframe for appeals.

c. Ensure that PCS informs the member of the limited time available for review sufficiently in advance of the resolution timeframe;
d. Support that PCS provides the member, and their representative, the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by PCS (or at the direction of PCS) in connection with the appeal of the adverse benefit determination at no charge and sufficiently in advance of the standard resolution timeframe for appeals.
e. Ensure documentation of appeals, in an appeals log, maintained by PCS that complies with OARs and is consistent with contractual requirements.

4) PCS provides information to members regarding the following:
   a. An explanation of how PCS accepts, processes, and responds to grievances, appeals, and contested case hearing requests, including requests for expedited review of grievances and appeals;
   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.
5) Grievance and Appeal System policies and procedures comply with state and federal laws.
   a. PCS has adopted and maintains compliance with grievances and appeals process timelines in Federal Regulation and OARs.
   b. PCS develops policies and procedures that are specifically designed to be culturally and linguistically responsive.
6) Upon receipt of a grievance or appeal, PCS will:
   a. Within five business days, resolve or acknowledge receipt of the grievance or appeal to the member and/or the member's provider where indicated.
      i. To account for weekends, the PacificSource appeal system calculates acknowledgement timelines as 7 calendar days across lines of business. When the 7th day falls on a weekend or holiday, the due date is moved to the last business day ***before*** it is due. This assures compliance with the 5-business day requirement.
   b. Give the grievance or appeal to staff with the authority to act upon the matter.
   c. Obtain documentation of all relevant facts concerning the issues.
   d. Ensure staff and any consulting experts making decisions on grievances or appeals are:
      i. Not involved in any previous level of review or decision making nor a subordinate of any such individual.
      ii. Health care professionals with appropriate clinical expertise in treating the member's condition or disease when the grievance involves clinical issues or if the member requests an expedited review. Health care professionals make decisions for the following:
         1. An Appeal of a denial that is based on a lack of medical necessity or involving clinical issues.
         2. If the decision involves a grievance regarding denial of expedited resolution of an appeal.
         3. If the decision involves a grievance or appeal involving clinical issues.
   e. Take into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination (ABD) or resolution of grievance;
   f. Not receive incentivized compensation for utilization management activities.
      i. PCS does this by ensuring that individuals or entities who conduct utilization management activities are not structured in a way that provides incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.
7) PCS analyzes all grievances, appeals, and hearings in the context of quality improvement activity pursuant to state regulation.
8) PCS keeps all health care information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in federal, state and CCO Contract requirements.

a. This includes providing member assurance of confidentiality in all written, oral, and posted material in grievance and appeal processes.

9) The following pertains to the release of a member's information:
    a. PCS and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal, or hearing may use this information without the member's signed release for purposes of:
        i. Resolving the matter; or
        ii. Maintaining the grievance or appeals log as specified in federal regulations.
        iii. If PCS needs to communicate with other individuals or entities not listed in subsection (a) above to respond to the matter, PCS will obtain the member's signed release and retain the release in the member's record.
10) PCS gives members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to:
    a. Providing Certified or Qualified Health Care Interpreter services and toll-free numbers that have adequate TTY/TTD and Certified or Qualified Health Care Interpreter capability.
    b. 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.
    c. Free interpreter services or other services to meet language access requirements where required in Federal Regulation.
    d. Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities.
    e. Reasonable accommodation or policy and procedure modifications as required by any disability of the member.
    f. When PCS identifies that a member has an Authorized Representative, PCS will assist the member with completion of the Authorized Representative form.
11) PCS considers members' literacy and language of preference (including accommodations such as alternative formats) in the development of processes and the development of the policies.
12) PCS, its subcontractors, and its participating providers will not:
    a. Discourage a member from using any aspect of the grievance, appeal, or hearing process.
    b. Take punitive action against a provider who requests an expedited resolution or supports a member's appeal.
    c. Encourage the withdrawal of a grievance, appeal, or hearing request already filed.
    d. 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.
13) In all administrative offices and in those physical, behavioral, and oral health offices where PCS has delegated responsibilities for appeal, hearing request, or grievance involvement, PCS makes available and accessible for use to members grievance and appeal forms. This includes the following:
    a. OHP Complaint Form (OHP 3001)
    b. CCO appeal forms (OHP 3302 or approved facsimile)
    c. Appeal and Hearing Request form: Request to Review a Health Care Decision (OHP 3302).
14) In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsperson or hearing representatives, PCS, subcontractors and participating providers cooperate in ensuring access to all activities related to member appeals, hearing requests, and grievances. This includes providing all requested written materials in required timeframes as expeditiously as the affected member's health condition requires.
15) If, at the member's request, PCS continues or reinstates the member's benefits while the appeal or administrative hearing is pending, the benefits shall continue pending administrative hearing pursuant to state regulations.
16) Adjudication of appeals in a member grievance and appeals process will not be delegated to a subcontractor. In situations where PCS is responsible for a portion of the appeal process,

decision making will not be done by a PCS employee.

a. When PCS delegates any other portion of the grievance and appeal process to a subcontractor, in addition to the general obligations established under state regulation regarding the use of subcontractors, PCS does the following:
    i. Ensures the subcontractor meets the requirements consistent with state regulation.
    ii. Monitors the subcontractor's performance on an ongoing basis.
    iii. Performs a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement.
    iv. Ensures the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.
    v. Retains and keeps accessible all subcontractor documentation, logs, and other records for the Grievance and Appeal System whether in paper, electronic, or other form for a minimum of 10 years.
    vi. Communicates these policies and procedures to subcontractors.
    vii. Regularly monitors its subcontractors' compliance and take any necessary corrective action.
    viii. Documents and retains all monitoring and corrective action activities for subcontractors.

17) Nondiscrimination Policy Statement, in accordance with all applicable laws including Title VI of the Civil Rights Act, ACA Section 1557, and ORS Chapter 659A, is optional to include with each Grievance and Appeal System notice.
    a. PCS does not include the Nondiscrimination Policy Statement with each Grievance and Appeal System notice.
    b. PCS does include a Language Access Statement with each Grievance and Appeal System notice.
18) PCS and its providers comply with applicable state and federal civil rights laws. It will not treat people unfairly in any of its programs or activities because of a person's:
    a. Age;
    b. Color;
    c. Disability;
    d. Marital status;
    e. National origin, primary language, and proficiency of English language;
    f. Race;
    g. Religion;
    h. Sex, sex characteristics, sexual orientation, gender identity, and sex sterotype;
    i. Pregnancy and related conditions; or
    j. Health Status and need for services.
19) If member feels they were treated unfairly for any of the above reasons the member can contact any of the following (Contact information must be included verbatim):
    a. CCO: PCS Civil Rights Coordinator
    Web: www.communitysolutions.PCS.com/Member/DocumentsAndForms
    Phone: (888) 977-9299, TTY 711
    Email: crc@PCS.com
    Mail: PO Box 7068
    Springfield, OR 97475-0068
    b. Oregon Health Authority (OHA) Civil Rights
    Web: 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
    c. Bureau of Labor and Industries Civil Rights Division
    Phone: (971) 673-0764
    Email: crdemail@boli.state.or.us

Mail: Bureau of Labor and Industries Civil Rights Division
800 NE Oregon St.,
Suite 1045, Portland, OR 97232

d. U.S. Department of Health and Human Services Office for Civil Rights (OCR)
Web: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Phone: (800) 368-1019, (800) 537-7697 (TDD)
Email: OCRComplaint@hhs.gov
Mail: Office for Civil Rights
200 Independence Ave. SW, Room 509F, HHH Bldg.
Washington, DC 20201

CCO Grievance Process Requirements

1) A member and, with the written consent of the member, a provider or an authorized representative acting on the member's behalf, may file a grievance at any time. Grievances may be filed either orally or in writing.
    a. A grievance may be filed with PCS or OHA.
    b. If a grievance is filed with OHA, it shall be promptly forwarded to PCS.
2) Required notifications will go to all individuals who meet the definition of a member for grievances.
3) PCS will resolve each grievance and provide notice of the disposition as expeditiously as the member's health condition requires but no later than the following timeframes:
    a. Standard Resolution for Grievances: Within five (5) Business Days from the date of PCS receipt of the Grievance, PCS provides written notice to the Member of one of the following:
        i. A notice outlining the decision on the Grievance that has been made and what that decision is.
        ii. That there will be a delay in PCS' decision, of up to 30 days.
            1. The written notice will specify why the additional time is necessary.
            2. PCS' decision will not exceed thirty (30) calendar days from the date of the receipt of the member Grievance.
4) PCS' and all subcontractor's notices of grievance and appeal system shall comply with OHA's formatting and readability standards in state and federal regulation.
    a. PCS and subcontractors will write the notice in language sufficiently clear that a layperson could understand the notice and make an informed decision.
        i. This includes translating notices for members who speak prevalent non-English languages.
        ii. OHA defines "easily understood" as 6th grade reading level or lower using the Flesch-Kincaid readability scale.
        iii. PCS will use a minimum 12-point font for notices, or 18-point font for large print.
5) PCS shall ensure that the individuals who make decisions on grievances follow all requirements in OAR 410-141-3875, "MCE Grievances & Appeals: Definitions and General Requirements".
6) When informing members of a PCS' decision, PCS:
    a. May choose to respond to grievances orally but will, in all instances, respond to all member grievances in writing with a notice of grievance resolution.
        i. Responses both orally and in writing will be in the member's preferred language.
        ii. The language for the notice of Grievance resolution to the Member will be sufficiently clear that a layperson could understand the disposition of the Grievance.
    b. Will address each aspect of the member's grievance and explain the reason for the decision.

    c. Will include in each notice of resolution to the member that is not in favor of the member, or for members who are dissatisfied with the disposition of a grievance, that they may present their grievance to:
        i. The Department of Human Services (Department) Client Services Unit (CSU) toll free at 800-273-0557; or
        ii. The Authority's Ombudsperson at 503-947-2346 or toll free at 877-642-0450.
7) In compliance with Title VI of the Civil Rights Act, Section 1557 of the ACA, and ORS Chapter 659A, PCS reviews and reports to the Authority, as outlined in the CCO contract, member complaints that raise issues related to race, color, national origin (including, without limitations, linguistic characteristics of a national group), religion, sex (including sex characteristics, pregnancy, and related conditions, gender identity, sexual orientation, sex stereotypes, sex assigned at birth, or gender otherwise recorded), age, socioeconomic status, culturally or linguistically appropriate service requests, disability status, health status, country of origin, and other identity factors for consideration in improving services for health equity.
    a. PCS has at least one designated individual responsible for receiving and resolving 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.
    b. The name and contact information for the designated individual will be communicated to members in the Nondiscrimination Statement.
8) If PCS receives a grievance 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, PCS logs the grievance and works with the receiving or sending CCO to ensure continuity of care during the transition.
9) PCS allows Members to file a grievance (after receiving notice that an adverse benefit determination is upheld).
10) PCS allows providers, or authorized representatives, acting on behalf of the Member and with the Member's written consent, to request an appeal, file a grievance, or submit a state fair hearing request.
11) PCS gives Members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes but is not limited to:
    a. Providing Certified or Qualified Health Care Interpreter services and toll-free numbers that have adequate TTY/TTD and Certified or Qualified Health Care Interpreter capability.
    b. 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.
    c. Free interpreter services or other services to meet language access requirements where required in Federal regulation.
    d. 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
    e. Reasonable accommodation or policy and procedure modifications as required by any disability of the member.
12) PCS does not discourage any Member from using any aspect of the Grievance and Appeal System. PCS also does not:
    a. Encourage any Member to withdraw a Grievance, Appeal, or Contested Case Hearing request that has already been filed.
    b. Use the filing or resolution of a Grievance, Appeal, or Contested Case Hearing request as a reason to retaliate against a member or as a basis for requesting Member Disenrollment.
    c. Take punitive action against a Provider who requests an expedited resolution or supports a Member's Grievance or Appeal.

CCO Appeal Requirements

1) A member, provider, or authorized representative, acting on behalf of the member, with the member's written consent, may file a standard or expedited appeal orally or in writing with PCS to:
    a. Express disagreement with an adverse benefit determination; or
    b. Contest PCS' failure to act within the timeframes provided in Federal regulation regarding the standard resolution of grievances and appeals.
2) Required notifications go to all individuals who meet the definition of a member for both expedited and standard appeals.
3) PCS allows the member, provider or authorized representative acting on behalf of the member, as state law permits, to file an appeal with PCS within 60 calendar days from the date on the adverse benefit determination.
    a. DSNP members will have 65 days from the date of adverse benefit determination notice per Medicare guidelines.
4) PCS facilitates only one level of appeal for members, and members will complete the appeals process with PCS prior to requesting a contested case hearing.
5) Upon receipt of a standard appeal, PCS, within five (5) business days, resolves or acknowledges receipt of the appeal to the member and/or the member's provider where indicated.
6) PCS resolves each appeal and provides notice, as expeditiously as the member's health condition requires, within the state-established timeframes.
    a. For standard resolution of an appeal and notice to the affected parties, PCS has established a timeframe that is no longer than 16 days from the day PCS receives the appeal:
    b. If PCS fails to adhere to the notice and timing requirements in Federal regulation for either standard or expedited appeals, the member is considered to have exhausted PCS' appeals process. In this case, the member may initiate a contested case hearing.
    c. PCS permits extension of the timeframes noted above by up to 14 days if:
        i. The member requests the extension; or
        ii. PCS can show upon request, to the satisfaction of OHA, that there is need for additional information and how the delay is in the member's interest.
    d. If PCS extends the timeframes but not at the request of the member, PCS will:
        i. Make reasonable efforts to give the member prompt oral notice of the delay, including as necessary multiple calls at different times of day;
            1. PCS defines adequate outreach as 3 attempts to contact the member at different times of day.
        ii. Within two calendar 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.
        iii. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.
7) A member, authorized representative, or the provider on the member's behalf may request an appeal either orally or in writing directly to PCS for any notice or failure to act within the timeframes provided in Federal regulation regarding the standard resolution of appeals.
    a. PCS shall ensure oral requests for appeal of a notice are treated as appeals to establish the earliest possible filing date without the need for written follow-up.
    b. The member shall file the appeal with PCS no later than 60 days from the date on the notice.
8) Parties to the appeal include, as applicable:
    a. The member; or
    b. Member's authorized representative; or
    c. Provider acting on behalf of a member, with written consent from the member; or
    d. Legal representative of a deceased member's estate; and
    e. PCS

9) A separate notice must be sent to each individual identified as party to the appeal or who meets the definition of "member".
10) PCS resolves each standard appeal in time period defined above in section (6). PCS shall provide the member with a notice of appeal resolution as expeditiously as the member's health condition requires, within state-established timeframes, or within 72 hours for matters that meet the requirements for expedited appeals in State regulation.
11) If PCS or an Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, PCS authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.
12) If PCS or an Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, PCS or the state shall pay for those services in accordance with OHA policy and regulations.
13) The written notice of appeal resolution is provided in a format approved by OHA. The notice will contain, as appropriate, the same elements as the NOABD, as specified in State regulation, in addition to:
    a. The date the member filed the appeal with PCS
    b. The results of the resolution process and the date PCS completed the resolution;
    c. The effective date of the appeal decision; and
    d. For appeals not resolved wholly in favor of the member:
        i. 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.
        ii. The right of the member to request a standard or expedited contested case hearing with the Authority within 120 days from the date of PCS' Notice of Appeal Resolution and how to do so;
        iii. The right to continue to receive benefits while the hearing is pending and how to do so; and
        iv. Information explaining that if PCS' adverse benefit determination is upheld in a hearing, the member may be liable for the cost of any continued benefits.
        v. Copies of appropriate forms including the "Appeal and Hearing Request" (OHP 3302) or an approved facsimile;
        vi. Explanation to the member that an expedited hearing will not be granted for post-service denials.
    e. For appeals resolved partially or wholly in favor of the member an explanation that the member may now access those benefits that were denied and how to do so.

Expedited CCO Appeal Requirements

1) PCS established and maintains an expedited review process for all oral and written appeals, when taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. PCS takes into consideration:
    a. If the request is appropriate when requested from the member;
    b. If the request is made by the member's provider, or indicated in supporting documentation.

2) Upon receipt of an expedited appeal, PCS acknowledges receipt within one business day.
    a. Acknowledgment is provided to the member and the member's provider where indicated, both orally and in writing.
3) PCS resolves each expedited appeal and provide notice, as expeditiously as the member's health condition requires, within state-established timeframes. These timeframes will not exceed 72 hours after PCS receives the expedited appeal request.
4) The timeline for an expedited appeal requested orally shall begin when there is established

contact made between the member and PCS.

5) For expedited appeals, PCS will:
    a. Inform the member of the limited time available for receipt of materials or documentation for the review.
    b. Make reasonable efforts to call the member and the provider to tell them of the resolution within 72 hours after receiving the request.
    c. Mail written confirmation of the resolution to the member within three days.
    d. Extend the timeframes by up to 14 days if:
        i. The member requests the extension; or
        ii. PCS shows (to the satisfaction of OHA, upon its request) that there is need for additional information and how the delay is in the member's interest.
    e. If PCS extends the timeframes not at the request of the member, PCS will:
        i. Make reasonable efforts, including as necessary multiples calls at different times of day, to give the member prompt oral notice of the delay.
        ii. Within two calendar 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 they disagree with that decision.
        iii. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.
6) PCS will provide written notice and make reasonable efforts including as necessary multiple calls at different times of day to provide oral notice, of the resolution of an expedited appeal.
7) If PCS denies a request for expedited resolution of an appeal, the appeal will be transferred to the standard timeframe, PCS will:
    a. Resolve the appeal no later than 16 days from the day PCS receives the appeal with a possible 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, and follow-up within two days with a written notice.
    c. State the right of a member to file a grievance with PCS if he or she disagrees with that decision in the written notice.
8) If PCS provides an expedited appeal but denies the services or items requested in the expedited appeal, PCS shall inform the member of the right to request an expedited contested case hearing and shall send the member a Notice of Appeal Resolution, in addition to Hearing Request and Information forms as set forth in State regulation.

Contested Case Hearings Requirements

1) PCS will allow members to file contested case hearing requests, after receiving notice that an adverse benefit determination is upheld.
    a. PCS will allow providers or authorized representatives acting on behalf of the member request a contested case hearing.
    b. Contested case hearings are conducted pursuant to OAR 410-120-1860 except as otherwise provided in OAR 410-141-3890. Processes for expedited contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures.
    c. If a provider files an appeal on behalf of a member, as permitted in State regulation, the provider may subsequently request a contested case hearing on behalf of the member in accordance with the procedures in this rule;
    d. A provider that filed an appeal on the provider's own behalf for reasons set forth State regulation, shall file a hearing request with the Authority no later than 30 days from the date of PCS' notice of appeal resolution.
        i. Appeals brought on the provider's own behalf are not subject to this rule, which governs appeals brought by member or by a provider on the member's behalf but are governed by state Regulation.
2) The member may not proceed to a hearing without first completing an appeal with PCS and

receiving written notice that PCS adverse benefit determination is upheld, subject to any exceptions listed in section (3) below:

a. The member shall file a hearing request with the Authority using Appeal and Hearing Request: Request to Review a Healthcare Decision form (OHP 3302) or any other Authority-approved appeal or hearing request form no later than 120 days from the date of PCS' notice of appeal resolution. OHA prefers use of 3302 when issuing an NOAR.
b. The Authority shall consider the request timely with the exception as noted for expedited hearing requests in State regulation.
c. If the member sends a contested case hearing request directly to the Authority and the Authority determines that the member qualifies for a contested case hearing, PCS immediately submits the required documentation to the Authority's Hearings Unit following their request.
d. If the member files a request for an appeal or contested case hearing with the Authority prior to the member filing an appeal with PCS, and if the request does not satisfy section (3) below, the Authority shall transfer the request to PCS and provide notice of the transfer to the member. PCS will:
    i. Review the request immediately as an appeal of PCS' notice of adverse benefit determination;
    ii. Approve or deny the appeal within 16 days and provide the member with a notice of appeal resolution.
e. If a member sends the contested case hearing request to PCS after PCS has already completed the initial plan appeal, PCS will:
    i. Date-stamp the hearing request with the date of receipt; and
    ii. Submit the following required documentation to OHA within two (2) business days:
        1. A copy of the hearing request, notice of action/adverse benefit determination, and notice of appeal resolution.
        2. All documents and records PCS relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records OHA requests as outlined in detail in State regulation.

3) If, after a member properly files an appeal, PCS fails to adhere to the notice and timing requirements in Federal regulation, OHA may consider the member to have exhausted PCS' appeals process for purposes of requesting a contested case hearing.
    a. OHA notifies PCS of their decision to allow the member access to a contested case hearing.
4) To compute any period of time prescribed in OAR chapter 410, divisions 120 and 141 that is applicable to timely filing of requests for hearing. PCS utilizes the method outlined in State regulation which indicates:
    a. Documents sent by U.S. Postal Service are considered filed on the postmarked date. Regular mail is assumed to be received unless proven otherwise.
    b. Documents sent by fax or hand-delivered are considered filed when received.
    c. If other filing methods are allowed, OHA or judge decides when they are considered filed.
    d. Time calculations considers the following:
        i. The start day of the time period is not counted.
        ii. The last day is counted unless the office is closed, then it extends to the next open day.
        iii. Office closures include weekends and legal holidays.
    e. Due to operational conflicts, the procedures needing revision, and the expense of doing so, the provisions in OAR 137-003-0520(9) and 137-003-0528(2) that allow hearing requests to be treated as timely based on the date of postmark do not apply to CCO member contested case hearing requests.
5) The parties to a contested case hearing include the following:
    a. The member;

b. Member's authorized representative;
c. Provider acting on behalf of a member as an authorized representative, with written consent from the member; or
d. Legal representative of a deceased member's estate; and
e. PCS

6) The Authority shall refer the hearing request along with the adverse benefit determination or notice of appeal resolution to the Office of Administrative Hearings (OAH) for hearing. Contested case hearings are requested using Authority form OHP 3302 or other Authority-approved appeal or hearing request forms.
7) The Authority shall issue a final order, or the Authority shall resolve the case ordinarily within 90 days from the date PCS receives the member's request for appeal. The 90-day count does not include the days between the date PCS issued a notice of appeal resolution and the date the member filed a contested case hearing request.
8) For reversed appeal and hearing resolution services:
    a. For services not furnished while the appeal or hearing is pending.
        i. If PCS or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, PCS will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination;
    b. For services furnished while the appeal or hearing is pending.
        i. If PCS or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, PCS or the state will pay for those services in accordance with the Authority policy and regulations.

Expedited Contested Case Hearings

1) PCS has a system in place to ensure its members and providers have access to expedited review for PCS' actions by requesting an expedited contested case hearing.
2) Contested case hearings are conducted pursuant to State regulations. Processes for expedited contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures.
3) A request for an expedited hearing for a service that has already been provided (post-service) to the member will not be granted.
4) A member, or provider, who believes that taking the time for a standard resolution of a request for a contested case hearing could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function may request an expedited contested case hearing.
5) The member may not request an expedited contested case hearing without first completing an appeal or expedited appeal with PCS.
    a. This requirement is subject to the exception in State regulation which indicates:
        i. If, after a member properly files an appeal, and PCS fails to adhere to the notice and timing requirements in Federal Regulation, the Authority may consider the member to have exhausted the CCO's appeals process for purposes of requesting a contested case hearing.
        ii. The Authority shall notify PCS of the Authority's decision to allow the member access to a contested case hearing.
    b. When a member files a hearing request prior to completion of a PCS appeal or expedited appeal, the Authority shall follow procedures set forth in OAR 410-141-3900.
6) Expedited hearings should be submitted to the OHA and can be requested orally, in writing, or online. A member may use Service Denial Appeal and Hearing Request form (OHP 3302), or other Division approved appeal or hearing request forms.

7) If a member, member representative, or the provider requests an expedited contested case hearing, the authority shall request documentation from PCS. PCS will submit relevant and clinical documentation to the Authority within two working days. 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.
8) If the Authority denies a request for an expedited contested case hearing, the Authority shall:
    a. Handle the request for a contested case hearing in accordance with OAR 410-120-1860; and
    b. Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two days with a written notice.
9) If a member requests an expedited hearing, the Authority shall request documentation from PCS, and PCS shall submit relevant documentation including clinical documentation to the Authority within two working days.

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 while an appeal or contested case hearing is pending:
    a. To be entitled to continuing benefits, the member can request continuation of benefits by phone, letter, fax, or by using the Review of Health Care Decision form and check the box requesting continuing benefits by:
        i. The tenth day following the date of the notice of adverse benefit determination or the notice of appeal resolution; or
        ii. The effective date of the action proposed in the notice, if applicable.
    b. PCS will continue the member's benefits if all of the following conditions are met:
        i. The appeal or contested case hearing involves the termination, suspension, or reduction of previously authorized services.
        ii. The services were ordered by an authorized provider.
        iii. The period covered by the original authorization has not expired.
        iv. The member or member's representative files the Appeal or Contested Case Hearing request timely.
            1. Providers are prohibited from requesting continuation of benefits on behalf of a member.
        v. The member timely files for continuation of benefits. For the purposes of a Continuation of Benefits request timely filing means filing on or before the later of the following:
            1. Within 10 days after the date of the NOABD; or
            2. The intended effective date of the Action proposed in the NOABD.
    c. In determining timeliness, delay for good cause as defined in State regulation is not counted;
    d. If, at the member's request, PCS continues or reinstates the member's benefits while the appeal or state fair hearing is pending, the benefits will be continued until one of the following occurs:
        i. The member withdraws the request for appeal or contested case hearing;
        ii. The member fails to request a Contested Case Hearing and continuation of benefits within 10 calendar days from the date of the NOAR letter; or
        iii. A final Contested Case Hearing decision adverse to the member is issued.
2) PCS may, consistent with the state's usual policy on recoveries and as specified in the PCS contract, recover the cost of continued services furnished to the member while the appeal or state fair hearing was pending if the final resolution of the appeal or state fair hearing upholds PCS' adverse benefit determination.

3) For reversed appeal and hearing resolution services:
    a. When benefits are not furnished while the appeal or Contested Case Hearing is pending:
        i. PCS will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours after the decision is reversed.
        ii. PCS will take the following steps:
            1. Notify the member, the member's representative (if applicable) both orally and in writing and the member's provider in writing of the available services and how to access them;
            2. Enter the prior authorization into the system and/or adjust the encounter data claim representing the service.
                a. PacificSource defines adjustment of encounter data claim to be when the change is made in the claims adjudication system and is ready for processing. A claim is considered paid regardless of whether a check has been issued because the system will issue a payment on the next payment cycle.
    b. When benefits are furnished while the appeal or Contested Case Hearing is pending:
        i. PCS will pay for the disputed services that were received by the member during this time.
        ii. In certain situations, state policy and regulations may provide that the state cover the cost of services.
    c. When the ALJ reverses PCS' decision to deny authorization of services, PCS can file written exceptions or present argument to the Proposed and Final Order within ten working days after the date the Proposed Order is issued by the ALJ (see OAR 410-120-1860). If written exceptions are filed the Order does not become a Final Order on the 11th work day and the services shall not be provided until the Final Order is issued by the OHA. Once a Final Order is issued and if the decision remains overturned the services shall be authorized or provided to the member within 72 hours of PCS receiving the final order.

Grievance and Appeals System Recordkeeping

1) PCS maintains records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the state quality strategy as stated in Federal Regulation and in alignment with contractual requirements.
2) PCS will document and maintain a record, in a central location for each grievance and appeal.
3) PCS record of each grievance and appeal will be accurately maintained in a manner accessible to the state and available upon request to CMS. The record will include, at a minimum:
    a. A general description of the reason for the grievance or appeal and the supporting reason for its resolution.
    b. The member's name and at a minimum the OHA ID number
    c. The date PCS received the grievance or appeal filed by the member, subcontractor, or provider.
    d. Notice of Adverse Benefit Determination.
    e. If filed in writing, the appeal or grievance.
    f. If an oral filing was received, documentation that the appeal or grievance 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 appeal or grievance, 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 representative, or the member's provider as part of the appeal, grievance, or contested case hearing process; and

j. All written decisions and copies of all correspondence with all parties to the appeal, grievance, or contested case hearing.

4) PCS 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 ten (10) years.
5) PCS must review the log monthly for completeness, accuracy, and compliance with required procedures.
6) PCS will submit for the Authority's review the Grievance and Appeals Log, samples of Notices of Adverse Benefit Determination, and other reports as required under PCS contract.
7) PCS will conduct an analysis of its Grievances in the context of quality improvement activity, consistent with State regulation. The Grievance System Report and Grievance and Appeals Log shall be forwarded to the PCS Quality Improvement committee to comply with the Quality Improvement standards as follows:
    a. Review of completeness, accuracy, and timeliness of documentation.
    b. Compliance with written procedures for receipt, disposition, and documentation; and
    c. Compliance with applicable OHP rules.
8) PCS appeal and grievance data is gathered by race/ethnicity, language and disability (REALD) and Sexual Orientation and Gender Identity (SOGI). This process is performed by the Analytics department.

Participating Providers and Subcontractors

1) PCS ensures and monitors to ensure that its participating providers and subcontractors comply with the Grievance and Appeal System requirements in accordance with the applicable law and the applicable provisions within contract.
2) PCS provides to all participating providers and subcontractors, at the time they enter into a subcontract, written notification of procedures and timeframes for grievances, notices of adverse benefit determination, appeals, and contested case hearings as set forth in Exhibit I and provides all of its participating providers and other subcontractors written notification of updates to these procedures and timeframes within five (5) business days after approval of such updates by OHA.
3) PCS shall ensure and regularly monitor its subcontractors' compliance and take any necessary corrective action. PCS must document all monitoring and corrective action activities for subcontractors.

Appointment of Representative

1) A member may appoint any individual to act as his or her representative during the grievance or appeal process.
    a. An Appointment of Representative form is available and provided to plan members upon notification to the plan that someone else is filing on their behalf.
    b. Both the member and the appointed representative must sign the form.
    c. Alternatively, if the member has appointed a Power of Attorney for Healthcare or a legal guardian, that individual may act as the authorized representative in the grievance process.
2) Supporting documentation to validate the basis in which an individual acts as a member representative in the grievance process will be maintained in the case record.
3) Parents/legal guardians may submit a grievance in the matter of a minor child without requiring an Appointment of Representative form.

Confidentiality

1) The plan maintains all grievance and appeal information confidential in accordance with HIPAA Privacy Rules. The plan and any provider whose authorizations, treatments, services, items, quality or care, or requests for payment are alleged to be involved in the grievance

have a right to use this information without a signed release from the member for purposes of resolving the grievance, maintaining the grievance log, and for health oversight purposes by the Division.

2) If the member or any other individual requests that their information be released to others, the plan will ask the member to provide a signed release of information. Except as provided in OAR 410-141-3260, or as otherwise authorized by all other applicable confidentiality laws, the plan will request an authorization for release of information from the member if the plan needs to communicate with other individuals in the resolution of the grievance.
3) In the case of a minor, the signature should be from someone authorized to act on their behalf, such as a parent or legal guardian. This documentation will be part of the case file and maintained in the member's electronic records.

Definitions

Adverse Benefit Determination[1] - Any of the following, consistent with the regulations listed below in the applicable regulation section of this document:

1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit;
2) The reduction, suspension or termination of a previously authorized service;
3) 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" is not an adverse benefit determination.
4) The failure to provide services in a timely manner per OAR regulation.
5) PCS's failure to act within the timeframes provided in OAR regulation regarding the standard resolution of grievances and appeals;
6) For a resident of a rural area with only one CCO, the denial of a member's request to exercise their legal right to obtain services outside the network; or
7) 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 review of an adverse benefit determination by PCS, or PCS acting within its scope as a delegated entity/subcontractor under state regulation and contract. An appeal includes a request from the Authority for review of a notice.

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

Contract – The General Provisions together with all Exhibits, Exhibit attachments, and Reference Documents and any amendments (including restatements) that makeup the agreement between the State of Oregon and a CCO to provide health services to eligible members. The State of Oregon acts by and through the Oregon Health Authority.

Delegated Entity – The entity or person to which the authority is given by PacificSource to perform certain functions. Delegated Entities encompass subcontractors and First Tier, Downstream and

Related Entities (FDR). Alternately delegated entity can refer to the functions that PacificSource performs on behalf of another organization.

Federal Law and Regulation – Includes the Code of Federal Regulations (CFR) and any other Federal statutes or laws.

Grievance- a member's expression of dissatisfaction to PCS or the Authority 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. A Grievance also includes a member's right to dispute an extension of time proposed by PCS to make an authorization decision;

Member - "Member" With respect to actions taken regarding grievances, appeals and contested case hearings, includes, as appropriate, the member, the member's representative, and the representative of a deceased member's estate.

Notice of Appeal Resolution (NOAR)- the notice issued to a member to communicate the resolution/decision made on an appeal request.

Notice of Adverse Benefit Determination (NOABD)- the notice issued to a member to communicate an adverse benefit determination. The notice must meet all requirements found at 42 CFR 438.44.

State regulation - Oregon state regulations include Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OARs).

Appendix

Policy Number: [Policy Number]

Effective: 1/1/2022 **Next review:** 7/31/2026

Policy type: Government

Author(s):

Depts: Appeals and Grievance

Applicable regulation(s): Oregon Administrative Rules (OARs) 410-120-1560; 410-120-1860; 410-141-3260; 410-141-3505; 410-141-3515; 410-141-3520; 410-141-3585; 410-141-3735; 410-141-3835; 410-141-3850; 410-141-3875[1]; 410-141-3880; 410-141-3885; 410-141-3890; 410-141-3895; 410-141-3900; 410-141-3905; 410-141-3910; 410-141-3915; 137-003-0520; 137-003-0528; 943-005-0010; 943-005-0060; 42 CFR § 438.1, 438.10, 438.100; 438.228; 438.400(b);438.402; 438.406; 438.408; 438.410; 438.414; 438.416; 438.420; 438.424(a)(b); 438.52(b)(2)(ii). 42 CFR § 447.45(b); 45 CFR § 92.8(c);160; 164. Title VI of the Civil Rights Act, Affordable Care Act (ACA) Section 1557

External entities affected: [External Entities Affected]

Approved by: