

Secretary of State
Certificate and Order for Filing
TEMPORARY ADMINISTRATIVE RULES
A Statement of Need and Justification accompanies this form..

I certify that the attached copies* are true, full and correct copies of the TEMPORARY Rule(s) adopted on [upon filing] by the
Date prior to or same as filing date

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division) 410
Agency and Division Administrative Rules Chapter Number

Cheryl Peters, 500 Summer St Ne, Salem, OR 97301 503-945-6527
Rules Coordinator Address Telephone

to become effective [11/1/2012] through [4/29/2013].
Date upon filing or later

A maximum of 180 days including the effective date.

RULE CAPTION

Amend Coordinated Care Organizations rules to include the Authority's intent for member's options to file a grievance or complaint.

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

List each rule number separately, 000-000-0000.

Secure approval of new rule numbers (Adopted rules) with the Administrative Rules Unit prior to filing

AMEND: OAR 410-141-3260

Stat. Auth.: ORS 414.32 & 414.615, 414.635, 414.651

Other Auth.:

Stats. Implemented: ORS 414.32 & 414.615, 414.635, 414.651

RULE SUMMARY

This rule establishes that the grievance and appeal process is available for Authority Members to file as a result of the Authority Member being transferred from their current Coordinated Care Organization (CCO) to a new CCO for their covered services. CCOs will improve health, increase the quality, reliability, availability and continuity of care, as well as to reduce costs. CCOs will provide medical assistance recipients with health care services that are supported by alternative payment methodologies that focus on prevention and that use patient-centered primary care homes, evidence-based practices and health information technology to improve health and reduce health disparities. The Authority needs to amend these rules to ensure the Authority's intent for member choice and notification to align closely with those outlined in Senate Bill 201. This rule change needs to be in effect as soon after August 1, 2012 as possible, the start date of CCO implementation.

Authorized Signer

Printed name

Date

*With this original and Statement of Need, file one photocopy of certificate, one paper copy of rules listed in Rulemaking Actions, and electronic copy of rules. ARC 940-2005

STATEMENT OF NEED AND JUSTIFICATION

A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division)
Agency and Division

410

Administrative Rules Chapter Number

In the Matter of: The temporary amendment of OAR 410-141-3260.

Rule Caption: Amend Coordinated Care Organizations rules to include the Authority's intent for member's options to file a grievance or complaint. (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

Statutory Authority: ORS 414.32 & 414.615, 414.635, 414.651

Other Authority:

Stats. Implemented: ORS 414.32 & 414.615, 414.635, 414.651

Need for the Temporary Rule(s): This rule establishes that the grievance and appeal process is available for Authority Members to file as a result of the Authority Member being transferred from their current Coordinated Care Organization (CCO) to a new CCO for their covered services. CCOs will improve health, increase the quality, reliability, availability and continuity of care, as well as to reduce costs. CCOs will provide medical assistance recipients with health care services that are supported by alternative payment methodologies that focus on prevention and that use patient-centered primary care homes, evidence-based practices and health information technology to improve health and reduce health disparities. The Authority needs to amend these rules to ensure the Authority's intent for member choice and notification to align closely with those outlined in Senate Bill 201. This rule change needs to be in effect as soon after August 1, 2012 as possible, the start date of CCO implementation.

Documents Relied Upon, and where they are available: SB 201 and OARs 410-141-0080 available <http://www.leg.state.or.us/lreg> and <http://arcweb.sos.state.or.us/pages/rules/access/index.html>

Justification of Temporary Rule(s): This rule establishes that there is a grievance and appeal process available for Authority Members to file as a result of the Authority Member being transferred from their current Coordinated Care Organization (CCO) to a new CCO for their covered services. See rule 410-141-3080 that establishes a process for the Authority to inform Authority Members 90 days in advance of them being transferred from their current Coordinated Care Organization (CCO) to a new CCO for their covered services. The Authority needs to amend these rules to ensure the Authority's intent for member choice and notification to align closely with those outlined in Senate Bill 201. This rule change needs to be in effect as soon after August 1, 2012 as possible, the start date of CCO implementation.

Authorized Signer

Printed name

Date

410-141-3260

Grievance System: Grievances, Appeals and Contested Case Hearings

- (1) This rule applies to requirements related to the grievance system, which includes appeals, contested case hearings, and grievances. For purposes of this rule and OAR 410-141-3261 through 410-141-3264, references to member means a member, member's representative and the representative of a deceased member's estate.
- (2) The CCO must establish and have an Authority approved process and written procedures, for the following:
- (a) Member rights to appeal and request a CCO's review of an action;
 - (b) Member rights to request a contested case hearing on a CCO action under the Administrative Procedures Act; and
 - (c) Member rights to file a grievance for any matter other than an appeal or contested case hearing;
 - (d) An explanation of how CCOs shall accept, process, and respond to appeals, hearing requests, and grievances;
 - (e) Compliance with grievance system requirements as part of the state quality strategy and to monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure consistent response to complaints of violations of consumer right and protections.
- (3) Upon receipt of a grievance or appeal, the CCO must:
- (a) Acknowledge receipt to the member;
 - (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 that staff making decisions on the grievance or appeal are:
 - (A) Not involved in any previous level of review or decision-making; and
 - (B) Health care professionals, as defined in OAR 410-120-0000, with appropriate clinical expertise in treating the member's condition or disease if the grievance or appeal involves clinical issues or if the member requests an expedited review.
- (4) The CCO must analyze all grievances, appeals, and hearings in the context of quality improvement activity pursuant to OAR 410-141-3200 and 410-141-3260.
- (5) CCOs must keep all information concerning a member's request confidential, consistent with appropriate use or disclosure as the terms treatment, payment, or CCO health care operations, are defined in 45 CFR 164.501.
- (6) The following pertains to release of a member's information:
- (a) The CCO 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:

(A) Resolving the matter; or

(B) Maintaining the grievance or appeals log.

(b) If the CCO needs to communicate with other individuals or entities, not listed in subsection (a), to respond to the matter, the CCO must obtain the member's signed release and retain the release in the member's record.

(7) The CCO must provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or hearing requests. Reasonable assistance includes, but is not limited to:

(a) Assistance from 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;

(c) 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.

(8) The CCO and its participating providers may not:

(a) Discourage a member from using any aspect of the grievance, appeal, or hearing process;

(b) Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or

(c) Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.

(9) In all CCO administrative offices and in those physical, behavioral, and oral health offices where the CCO has delegated response to the appeal, hearing request or grievance, the CCO must make the following forms available:

(a) Grievance forms;

(b) Appeal forms;

(c) Hearing request forms (DHS 443); and

(d) Notice of hearing rights (DMAP 3030).

(10) A member's provider:

(a) Acting on behalf of and with written consent of the member, may file an appeal;

(b) May not act as the member's authorized representative for requesting a hearing or filing a grievance.

(11) The CCO and its participating providers must cooperate with the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsman and hearing representatives in all activities related to member appeals, hearing requests, and grievances including providing all requested written materials.

(12) If the CCO delegates the grievance and appeal process to a subcontractor, the CCO must:

(a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3261 through 410-141-3264;

(b) Monitor the subcontractor's performance on an ongoing basis;

(c) Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and

(d) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.

(13) CCO's must maintain yearly logs of all appeals and grievances for seven calendar years with the following requirements:

(a) The logs must contain the following information pertaining to each member's appeal or grievance:

(A) The member's name, ID number, and date the member filed the grievance or appeal;

(B) Documentation of the CCO's review, resolution, or disposition of the matter, including the reason for the decision and the date of the resolution or disposition;

(C) Notations of oral and written communications with the member; and

(D) Notations about appeals and grievances the member decides to resolve in another way if the CCO is aware of this.

(b) For each calendar year, the logs must contain the following aggregate information:

(A) The number of actions; and

(B) A categorization of the reasons for and resolutions or dispositions of appeals and grievances.

(14) The CCO must review the log monthly for completeness and accuracy, which includes but is not limited to timeliness of documentation and compliance with procedures.

(15) A member or a member's provider may request an expedited resolution of an appeal or a contested case hearing if the member or provider believes taking the standard time of resolution could seriously jeopardize the member's:

(a) Life, health, mental health or dental health; or

(b) Ability to attain, maintain or regain maximum function.

(16) 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 must complete a hearing request or request for appeal, requesting continuing benefits, no later than:

(A) The tenth day following the date of the notice or the notice of appeal resolution; and

(B) The effective date of the action proposed in the notice, if applicable.

(b) In determining timeliness under section (3)(a) of this rule, delay caused by circumstances beyond the control of the member is not counted.

(c) The benefits must be continued until:

(A) A final appeal resolution resolves the appeal, unless the member requests a hearing with continuing benefits, no later than ten days following the date of the notice of appeal resolution;

(B) A final order resolves the contested case;

(C) The time period or service limits of a previously authorized service have been met; or

(D) The member withdraws the request for hearing.

(17) The CCO shall review and report to the Authority complaints that raise issues related to racial or ethnic background, gender, religion, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status and other identity factors for consideration in improving services for health equity.

(18) If a CCO receives a complaint or 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 for reasons defined in OAR 410-141-3080 (15) the CCO shall log the complaint/grievance and work with the receiving/sending CCO to ensure continuity of care during the transition.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2), 65, HB 3650

Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3261