OREGON HEALTH PLAN

Managed Care Entities

Instructions for submitting

Grievance and Appeal Log

and Grievance System Report



**OREGON HEALTH PLAN**

**Coordinated Care Organizations**

Instructions for submitting Grievance and Appeal Log and

Grievance System Report as required by CCO contract Exhibit I

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# Introduction

The instructions in this document are intended to provide technical assistance guidance to Managed Care Entities (MCEs) for reporting grievance and appeal information to OHA. Use these instructions with the terms and conditions in Exhibit I of the MCEs current contract with OHA, to fulfill grievance and appeal reporting requirements.

# Background

The current Oregon Health Plan 1115 Waiver requires OHA to submit quarterly reports about MCE grievances and appeals to the Centers for Medicare & Medicaid Services (CMS). OHA posts these reports on the OHA website at <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/2017-2022-Quarterly-Annual-Reports.aspx>.

Consistent and timely reporting of grievances and appeals is important to identify trends and implement interventions to address problem areas.

# Federal requirements

## 42 CFR §438.228 Grievance and appeal system.

The State must ensure, through its contracts that each MCO, PIHP, and PAHP has in effect a grievance and appeal system that meets the requirements of subpart F.

## 42 CFR §438 Subpart F Grievance and appeal system

### §438.402   General requirements

The grievance and appeal system. Each MCO and PIHP and PAHP must have a grievance and appeal system in place for enrollees.

### §438.66   State monitoring requirements.

(a) General requirement. The State agency must have in effect a monitoring system for all managed care programs.

(b) The State's system must address all aspects of the managed care program, including the performance of each MCO, PIHP, PAHP, and PCCM entity (if applicable) in at least the following areas:

(2) Appeal and grievance systems.

(c) The State must use data collected from its monitoring activities to improve the performance of its managed care program, including at a minimum:

(2) Member grievance and appeal logs.

# State requirements

## Oregon Administrative Rule (OAR) 410-141-3230 through 410-141-3255

### OAR 410-141-3230

(2) MCE’s shall establish and have an Authority-approved process and written procedures for compliance with grievance and appeals requirements . . .

## MCE contract Exhibit I

Contractor shall establish internal Grievance procedures under which Members, or Providers acting on their behalf, may challenge any action. Contractor shall maintain its Grievance System in accordance with this exhibit, OAR 410-141-3225 through 410-141-3255 and 42 CFR 438.400 through 438.424.

# Definitions

| Term | Definition |
| --- | --- |
| Adverse Benefit Determination (ABD) | OAR 410-141-3000 (3) The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service or the denial of payment for a service. See OAR 410-141-3240 for a member enrolled in an MCE. |
| Appeal | 42 CFR §438.400(b)Appeal means a review by an MCO, PIHP, or PAHP of an adverse benefit determination. |
| Contested Case Hearing | OAR 410-120-0000 (56) A proceeding before the Authority under the Administrative Procedures Act when any of the following contests an adverse determination, action, or as it relates to an MCE enrollee, an adverse benefit determination:  (a)A client or member or their representative;  (b)A member of an MCE after resolution of the MCEs appeal process;  (c)An MCE member’s provider; or  (d)An MCE. |
| Grievances/ Complaints | 42 CFR 438.400(b) Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. |
| Grievance and Appeal System | OAR 410-141-3000 (36) The overall system that includes:  (a) Grievances to an MCE on matters other than actions;  (b) Appeals to an MCE on actions; and  (c) Contested case hearings through the state on actions and other matters for which the member is given the right to a hearing by rule or statute. |
| Managed Care Entity (MCE)  (This term is being used in place of CCO) | OAR 410-141-3000 (48) As stated in 42 CFR 457.10, an entity that enters into a contract to provide services in a managed care delivery system including but not limited to managed care organizations, prepaid health plans, and primary care case managers. |

# General information

Exhibit I of the current MCE contract lists all Grievance and Appeal reporting requirements. MCEs must email quarterly reports to the OHA Contract Administration Unit at: [CCO.MCODeliverableReports@dhsoha.state.or.us](mailto:CCO.MCODeliverableReports@dhsoha.state.or.us)) no later than 45 calendar days from the end of each calendar quarter:

* Grievance and Appeal Log
* Grievance System Report

The report templates are at <http://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx>.

State and federal rules have two main requirements for MCEs:

1 – Maintaining grievance and appeal records (recordkeeping) in a central location within the MCE;

2 – Reporting grievances and appeals to OHA.

# Recordkeeping requirements

## 42 CFR §438.3 Recordkeeping requirements.

(u) MCOs, PIHPs, and PAHPs must retain, and require subcontractors to retain, as applicable, the following information: enrollee grievance and appeal records in §438.416 […] for a period of no less than 10 years.

## 42 CFR §438.416 Recordkeeping requirements:

(a) The State must require MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.

The CFR further states, “(c) the records “must be accurately maintained in a manner accessible to the state and available upon request to CMS.”

## OAR 410-141-3255 - Grievance and Appeals System Recordkeeping

(1) Each MCE shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures [. . .]

(2) MCE’s must maintain yearly logs of all appeals and grievances for ten years with the following requirements:

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

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

(B) Documentation of the MCE’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 MCE is aware of this;

(E) The log must contain a general description of the reason for an appeal.

(b) For each 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.

# Reporting requirements

OHA does not ask MCEs to report all the information they must keep on record as described above in the Recordkeeping Requirements. Instead, MCEs must report grievances and appeals each quarter as required in the MCEs current contract with OHA in the Grievance and Appeal Log that is posted on the OHA Reporting website.

OHA reports grievance and appeal summary data to the Centers for Medicare and Medicaid Services (CMS) in the quarterly 1115 Waiver Report. The 1115 Waiver Report is a contractual agreement between the OHA and CMS. The specific data to be reported to CMS is detailed in the Waiver contract. OHA uses MCE reports to give CMS a “snapshot” of all complaints MCEs received and resolved in the quarter.

# Instructions for Grievance and Appeal Logs

Every quarter, each MCE must submit one Grievance and Appeal Log and one Grievance System Report.

Use only the templates posted at <http://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx>. MCEs may not change the templates or use different templates.

If you have questions or concerns about how to complete the templates, or submitting to the OHA, please email [HSD.QualityAssurance@dhsoha.state.or.us](mailto:HSD.QualityAssurance@dhsoha.state.or.us).

## Tab 1 -Table of Contents

This worksheet links to all other worksheets in the template. (The other worksheets also link back to the Table of Contents worksheet.)

## Tab 2 – Setup

Information entered on this worksheet auto-populates the other worksheets, so that you only need to enter it once for the entire workbook. Choose the correct year and reporting period.

For the enrollment number, use the numbers from your MCE’s 834 information. The enrollment number is an average over the three months of the quarter.

# Grievance Log:

## Tab - 3 - Grievance Log

List all oral and written grievances/complaints received during the quarter. This includes all grievance/complaints collected from MCEs and their sub-contractors for all Medicaid members enrolled in a plan, regardless of other insurance coverage (Medicare, Private Insurance, etc.)

NOTE: Logs will appear blank and will expand as data is entered. Press “Tab” at the end of each line to expand the worksheet.

Record each grievance/complaint on separate lines that can be identified by a grievance type code.

Reporting is based on the date the grievance/complaint was received.

“Resolved” means: when all aspects of the complaint have been resolved and the member has been notified.

Column A Client ID – Enter the member’s 8-digit alphanumeric Oregon Health ID number. Do not enter an MCE or provider ID number.

NOTE: The MCE must keep both the client name **and** client ID in their records, however, in the log submitted to OHA, the MCE only needs to report the clients Oregon Health ID number.

Column B Receipt Date – Enter the date the MCE received the grievance/complaint (either orally, or in writing).

Column C Grievance Type - Enter the category type code from the table on Tab 5 (Grievance Type Codes). For example, enter “A” for Access followed by “k” for “Female or male provider preferred, but not available).” This column is a data verified column, so only the correct format can be entered. There is also a drop-down available in the column, with a list of all the codes.

Column D Service Type – Enter the appropriate number from the table on Tab 5 (Grievance

Type Codes). For example, enter code “10” for issues related to Mental Health.

Column E Date of Resolution – Enter the date the MCE resolved the grievance/complaint. Use the MM/DD/YY format.

NOTE: OAR 410-141-3235(2)(a) requires MCEs to notify members of grievance decisions within five business days of receiving the complaint. Section (2)(b) of this rule requires MCEs to notify members in writing if there will be a delay, and why a delay is needed. MCEs can extend the time up to 30 days.

Leave Column E blank if the grievance is not resolved by the end of the quarter. Use the “View Outstanding” filter to track grievances that were not resolved by

the end of the quarter. Follow the instructions below on how to report “Outstanding” grievances/complaints in the next quarter.

Column F Provider - This column is not required under the requirements for reporting data to OHA, however it is a recordkeeping requirement.

Column G Clinic – This column is not required under the requirements for reporting data to OHA, however it is a recordkeeping requirement.

Column H Resolution - For the reporting requirement, a brief summary of the resolution is acceptable. Full resolutions are required for recordkeeping purposes.

Column I # of Days to Resolution – This field is an auto calculation which counts the number of days between the dates in Columns B and Column E.

Column J Outstanding – This field will auto calculate based on whether there is a date in Column E. If there is not a date in Column E follow the instructions below for reporting “Outstanding grievances/complaints in the next quarter.”

## Tab - 4 - Grievance Summary Totals

This worksheet auto calculates all grievances/complaints entered on the Grievance Log, by Grievance Type. Use the data on this summary sheet to fill out the Grievance System Report.

## Tab – 5 - Grievance Type Codes

This chart shows the approved reason codes entered In Tab 3 Column C in the Grievance Log. Enter Service Type Codes in Column D.

# Appeal Log

## Tab - 6 - Appeal Log

Enter all appeals that were received in the quarter and all NOABDs associated with the appeal. This means, the appeal dates in column G are dates within the current reporting quarter. The NOABDs listed in column C may have dates that are prior to the current reporting quarter.

NOTE: Logs will appear blank and expand as data is entered. Press “Tab” at the end of each line to expand the worksheet.

Column A Client ID – Enter the member’s 8-digit alphanumeric Oregon Health ID number. Do not enter an MCE or provider ID number.

NOTE: The MCE must keep both the client name **and** client ID in their records, however, in the log submitted to OHA, the MCE only needs to report the clients Oregon Health ID number.

Column B Date of Request of Service/Item – Enter the date the MCE received the request from the provider.

Column C Date of NOABD – Enter the date of the NOABD or Explanation of Benefit (EOB) that is associated with the appeal in column G. EOBs must meet the same requirements as the NOABD requirements. The NOABD date may be from a previous quarter.

Column D Action Category - The action categories are requirements that are described in CFR §438.400(b)(1-7). An action category must be listed for each NOABD. Column D is a data verified field and will only accept the approved format. There is also a drop-down list with the categories. The list of categories can also be found on Tab – 9 NOABD Categories.

Column E Subcategories – the subcategories are described in OAR 410-141-3240(1)(c)(J). Use subcategories only when the NOABD is reported in Action category a, c and f . There is a drop- down list with a list of the sub-categories. The list can also be found on Tab – 9 NOABD Categories.

Column F Service Type – Enter the type of service from the categories listed on Tab- 9 the NOABD Categories. There is a drop – down list with the categories.

Column G Date of Appeal – Enter the date that the appeal was received.

Column H CCO Extension – Enter a “Y” if the timeframe for this appeal was extended.

Column I Expedited Granted – Enter a “Y” if the request to expedite the appeal process was granted.

Column J Denied Service Upheld – Enter a “Y” if the denial was upheld.

Column K Overturned at Appeal – Enter a “Y” if the denial was overturned during the appeal process.

Column L Partial Denial - Enter a “Y” if the denial only partially denied the entire request.

Column M Date Member Withdrew – Enter the date the member withdrew. Entering a date in Column M (and leaving Column Q blank) will not show as “Outstanding” when filtered.

Column N Dismissed Late Filing – Enter a “Y” if the appeal was dismissed due to the member filing past the required timeframe.

Column O Invalid Waiver – Enter a “Y” if the appeal was overturned because the provider did not have the member sign an approved Waiver, or agreement similar to form OHP 3165, as described in OAR 410-141-3395(6.c), 410-141-3420 (5) and 410-120-1280 (3.h).

Column P Continuing Benefits Provided – Enter a “Y” if benefits were continued during the appeal process.

Column Q Date of NOAR - Enter the date the Notice of Appeal Resolution was sent to the member. Leave blank if the appeal is outstanding at the end of the quarter. The “View Outstanding” filter can be used to track appeals that were not resolved by the end of the quarter.

# Notices of Adverse Benefit Determination (NOABDs)

MCEs must report the TOTAL number of NOABDs issued during the quarter. This means every time the MCE or a subcontractor sends an NOABD letter to a Medicaid member it must be included in the TOTAL for the quarter. This includes all NOABDs from MCEs and their sub-contractors for all Medicaid members enrolled in a plan, regardless of other insurance coverage (Medicare, Private Insurance, etc.) Report the following:

* All pre- and post-service notices,
* All notices for Hepatitis C Direct-Acting Antiviral (DAA) medication, and
* All notices for Applied Behavior Analysis.

## Tab 7 - NOABD Log

List all NOABDs issued during the quarter. The NOABD Log auto calculates to Tab 8, the NOABD-Appeal Summary page. The totals will populate Column B, lines 4 – 9 into the correct Action Categories. Note: Logs will appear blank and will expand as data is entered.

Column A Client ID – Enter the member’s 8-digit alphanumeric Oregon Health ID number. Do not enter an MCE or provider ID number.

NOTE: The MCE must keep both the client name **and** client ID in their records, however, in the log submitted to OHA, the MCE only needs to report the clients Oregon Health ID number.

Column B Date of Request of Service/Item – Enter the date the MCE receives the request from the provider.

Column C Date of NOABD – Enter the date of the NOABD or Explanation of Benefit (EOB). EOBs must meet the same requirements as the NOABD requirements.

Column D Action Category - The action categories are requirements that are described in CFR §438.400(b)(1-7). An action category must be listed for each NOABD. Column D is a data verified field and will only accept the approved format. There is also a drop-down list with the categories. The list of categories can also be found on Tab 9 the NOABD Categories.

Column E Sub-categories – the subcategories are described in OAR 410-141-3240(1)(c)(J). Use subcategories only when the NOABD is reported in category a, c and f of the Action Categories. There is a drop-down list with the sub-categories listed. The list can also be found on TAB 9 the NOABD Categories.

Column F Service Type – Enter the type of service from the categories listed on Tab 9 the NOABD Categories. There is also a drop-down menu with the list of Service Types.

Column G # Days between request and NOABD – this is an auto calculation.

Column H CCO Extension - Enter a Y if there was an extension.

Column I Services previously authorized – Enter a Y if services were previously authorized- this means a 10 day notice is required prior to services being reduced, terminated, or suspended.

Column J Expedited Granted – Enter a Y if the NOABD was expedited.

## Tab 8 - NOABD -Appeal Summary

MCEs must report all NOABDs and appeals that were issued during the quarter. Data from Tab 6, The Appeal Log and Tab 7, the NOABD Log will auto calculate to Columns B, C and D into the correct a- f categories.

## Tab 9 - NOABD Categories

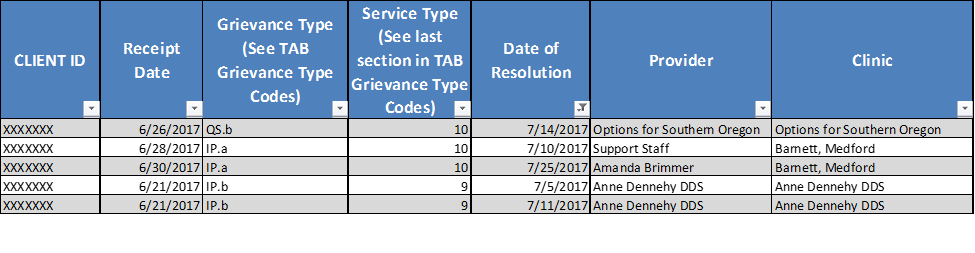
This chart shows the Action Categories, Sub Categories and Service Codes.

# Reporting outstanding grievances and appeals

When grievances and appeals are not resolved by the time the quarterly data is submitted they are considered “outstanding.” This does not mean the MCE is out of compliance; however, OHA does require that the resolution dates of the outstanding items be submitted in the following quarter. OHA has added new worksheets for reporting outstanding items. To complete the worksheets:

* Open the previous quarter’s Grievance and Appeal Log. Use the “View Outstanding” filter to view outstanding items.
* Fill in the dates of resolution for each item that is outstanding from the previous quarter.
* Copy and paste the filtered rows from the previous quarter’s worksheet into the appropriate “Grievance or Appeal Log Outstanding” worksheets for the current quarter.
* This will complete the reporting of outstanding items from the previous quarter. (see the picture below that shows only the outstanding grievances and the dates of the resolutions.)



Reminder – the MCE must maintain records in a central location – submitting the dates of resolution for all Outstanding grievances and appeals to show the grievance or appeal has been finalized is a requirement of maintaining records. If not completed in the following quarter, the MCE must explain in the Grievance System Report why the grievance or appeal was not resolved within the required timeframe.

# Instructions for completing the Grievance System Report

Oregon must provide narrative that describes trends in the Grievance and Appeal System for the quarter, and interventions to address concerns identified during the quarter. MCEs provide this information in the Grievance System Report. The Grievance System Report is a demonstration of how the MCE uses Grievance and Appeal System data to maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided.

Data from the Grievance and Appeals Reporting Tool can be used to fill out the Grievance System Report. The Enrollment number on the Grievance System Report should match the number used in the Reporting Tool.

Grievances/Complaints – The data for this chart is found on Tab 4 of the Grievance and Appeal Log, Grievance Summary Totals. The narrative should follow the suggestions found directly below the chart.

Notice of Adverse Benefit Determinations – Fill out this chart and provide narrative following the instructions directly below the chart. Data for this chart is found on Tab 8 of the Grievance and Appeal Log, NOABD-Appeal Summary.

Appeals – Fill out the chart using data from the Reporting Tool Appeals Log. Provide narrative following the instructions directly below the chart. Data for this chart is found on Tab 8 of the Grievance and Appeal Log, NOABD-Appeal Summary.

Additional Narrative - Please also provide the additional narrative requested.