OREGON HEALTH PLAN
Coordinated Care Organizations

Instructions for submitting Exhibit I Deliverables Grievance and Appeal Log and Grievance System Report

Contents

Introduction

The instructions in this document are intended to provide technical assistance guidance to coordinated care organizations (CCOs) on how to meet the requirements for submitting quarterly reporting of the Grievance System. These instructions are to be used with the terms and conditions required in Exhibit I of the current CCO contract.

Background

The current Oregon Health Plan (OHP) 1115 Waiver[1] requires the Oregon Health Authority (OHA) to report quarterly on the Grievance and Appeal System that each CCO has in place across Oregon. Consistent and timely reporting on the Grievance and Appeal System is important to identify trends and provide interventions to alleviate problem areas. The published reports are posted on the OHA 1115 Waiver website: http://www.oregon.gov/oha/HPA/HP-Medicaid-1115-Waiver/Pages/Quarterly-Annual-Reports.aspx

Federal and State Requirements

42 CFR 438 Subpart D Quality Assessment and Performance Improvement § 438.228 Grievance systems. 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 of this part.

42 CFR 438 Subpart F Grievance System §438.402 General requirements[2]
The grievance and appeal system. Each MCO and PIHP and PAHP must have a grievance and appeal system in place for enrollees.

OAR 410-141-3230 through 410-141-3255[3]
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 . . . .

CCO 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 410-3225 through 410- 141-3255 and 42 CFR 438.400 through 438.424.

The Managed Care Entity (MCE) Service Authorization and Grievance System Timelines, which became effective January 1, 2018 are posted here: http://www.oregon.gov/oha/HSD/OHP/Tools/MCE%20Authorization%20and%20Grievance%20System%20Timelines.pdf

[1] http://www.oregon.gov/oha/HPA/HP-Medicaid-1115-Waiver/Pages/Waiver-Renewal.aspx
[2] http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8
3 http://www.oregon.gov/oha/HSD/OHP/Pages/Policy-OHP.aspx

Definitions[4]

Term	Definition
Adverse Benefit Determination Notice4 (Formally the Notice of Action. For 2018 OHA will use the term NOA-ABD for reporting purposes.)	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	means a request for review of a notice of action/adverse benefit determination (CCO Contract Ex A, Definitions). OAR ~~410-120-0000 (24)~~410-141-3240 ~~A request for review of an adverse determination, action or as it relates to an MCE 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)[5] ~~-~~Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Oregon Health Authority 2017 – 2022 1115 Waiver[6]: Any written or verbal complaint by an enrollee or consumer, or the enrollee's representative, regarding the enrollee's quality and access of care, individual or system abuse or neglect, issues related to the health plan's compliance with the Medicaid Program rules, billing complaints related to rights and limitations as provided by 42 CFR §438 and complaints related to eligibility and/or enrollment.
Grievance System	OAR 410-141-3000 (34) 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 is how CCOs are referred to in the Oregon Administrative Rules (OARs)	OAR 410-141-3000 (46) As stated in 42 CFR 457.10[7], 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.

[4] http://www.oregon.gov/oha/HSD/OHP/Policies/141rb020918.pdf
[5] http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8
[6] http://www.oregon.gov/oha/HPA/HP-Medicaid-1115-Waiver/Pages/Waiver-Renewal.aspx

[7]https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=3ef6b1511310b0f7bc63896d433313ff&mc=true&r=PART&n=pt42.4.457#se42.4.457_110

Types of Review Available to MCE members

	MCE Appeal	OHA Hearing	MCE Grievance
MCO denial or limited authorization of requested service	X	X	
MCO reduction, suspension or termination of previously authorized service	X	X	
MCO denial of payment for a service in whole or in part	X	X	
MCO failure to provide services in timeframe established by state	X	X	
MCO failure to resolve grievances or appeals in timeframe established by state	X	X	
MCO denial of request to obtain services outside network	X	X	
Enrollee dissatisfaction about quality of care or services provided			X
Provider or MCO employee failure to respect enrollee rights			X
MCO denial of enrollee request for expedited appeal			X
Other matters about which enrollee is dissatisfied that are not subject to MCO appeal			X

*It is important to note that many MCE actions, or inactions, that might be characterized as "quality" issues, such as delays in treatment, are in fact adverse actions affecting Medicaid benefits and thus are subject to the notice and hearing requirements of appeals.

OHA Reporting Information

General Instructions:

The CCO contract Exhibit I provides detailed information about the requirements for the Grievance System, including the quarterly reporting requirements. The following reports are due to the OHA Contract Administration Unit no later than 45 calendar days from the end of each calendar quarter:

- ✓ Grievance and Appeal Log
- ✓ Grievance System Report
- ✓ 20 random samples of Notices of Adverse Benefit Determinations (NOA-ABDs)
- ✓ all Notices for ABA
- ✓ all Notices for Hepatitis C

The Contract Administration Unit e-mail address is: CCO.MCODeliverableReports@dhsoha.state.or.us

The Grievance and Appeal Log and the Grievance System Report reporting tools are available at: http://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx

There are two major components that are required by state and federal rules:

1 – Maintaining grievance and appeal records in a central location within the CCO;

2 – Reporting grievances and appeals to OHA.

Requirements for Maintaining Records
42 CFR 438.416 Recordkeeping and reporting requirements: 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 that 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 Managed Care Entity (MCE) shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures. . . ."
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.

Requirements for Reporting Data to OHA
CCO quarterly data reported to the OHA is not all of the information needed to meet the "maintaining records" requirement in the CFR, OAR and CCO Contract.

Reporting grievances and appeals to the OHA are a requirement of the CCO Contract. OHA reports on the Grievance System 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 and what is reported to CMS is detailed in the Waiver contract.

Quarterly reports the OHA submits to CMS are a "snapshot" of what was received and resolved in each calendar quarter.

The Grievance and Appeal Log listed in the CCO Contract Exhibit I has been developed based on the federal and state recordkeeping guidelines as listed on page 4 under the Requirements for Maintaining Records and page 5 under Requirements for Reporting Data to OHA.

Grievance and Appeal Logs

OHA requires one Grievance and Appeal Log and Grievance System Report per CCO using the current template posted at: http://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx
Please do not make changes to the templates as standardized reporting is very important.
Please contact Quality Assurance staff if there are questions, or concerns about filling out and submitting the quarterly reports.

Grievance and Appeal Logs

Tab - 1 **Table of Contents** - this worksheet allows quick access to all worksheets in the reporting tool. Each worksheet has a quick link back to the Table of Contents worksheet.

Tab - 2 **General Instructions** -- this worksheet provides general instructions for the Grievance and Appeal Logs and the Grievance System Report.

Tab - 3 **Setup** – information entered on this worksheet auto populates the other Worksheets. Information only needs to be entered once for the entire workbook. Select the correct year and reporting period. For the enrollment number, CCOs will use their enrollment numbers from the 834 information. The enrollment number is an average over the three months of the quarter.

Grievance Log:

Tab - 4 **Grievance Log Dictionary** - the dictionary provides a quick reference for the Grievance Log. The dictionary shows each column and a brief description of how the log should be filled out.

Tab - 5 **Grievance Log** – the General Instructions on Tab 2 provides the definition of "what is a grievance/complaint." Include all oral and written grievances/complaints. This includes all grievances/complaints collected from CCOs and their sub-contractors. NOTE: Logs will appear blank and will expand as data is entered.
Record each grievance/complaint on separate lines that can be identified by a grievance type code. Reporting is based on the received date of the grievance/complaint.
Resolved means: when all aspects of the complaint have been resolved and the member has been notified.

Column A Client ID – this is the Oregon Health Plan (OHP) identification number. Enter the member's Medicaid number. Do not enter a CCO or provider ID number.

NOTE: For the "Maintaining Records" requirement, the name and the ID number of the member must be recorded on CCO records. For the "Reporting Data" requirement, only the member's ID number is submitted.

Column B Receipt Date – this is the date the grievance/complaint was received either orally, or in writing.

Column C Grievance Type - Enter the type code from the table of categories and sub-categories on Tab 6 Grievance Type Codes. Enter the main category code (for example, "A" for Access) followed by the specific type (for example, "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 with all of the codes listed.

Column D Service Type - Use the appropriate number from the table on TAB 6 Grievance Type Codes. Service Type codes are listed at the end of the Grievance Type codes. Example: enter code "10" for issues related to Mental Health.

Column E Date of Resolution – Enter the date the CCO resolves the grievance/complaint using this format: MM/DD/YY.

NOTE: Timeframes for grievances/complaints is five business days from the MCE's receipt of the grievance/complaint. A written notice must be sent to the member if there is a delay in the MCE's resolution. The notice must specify the reason for the delay. The extension can be up to 30 days. OAR 410-141-3235(2)

If the grievance has not been resolved at the end of the quarter, leave Column E blank. The "View Outstanding" filter on the Grievance Log can be used to track the grievances that were outstanding at the end of the quarter. Follow the instructions below on how to report "Outstanding" grievances/complaints in the next quarter. The MCE Grievance Process Requirements are in OAR 410-141-3235

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

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

Column H Resolution - For the reporting data to OHA requirement a brief summary of the resolution is acceptable.

Column I # of Days to Resolution – This field is an auto calculation and is based on the time between the date in Column B and Column E.

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

Reporting OUTSTANDING grievances/complaints

The following quarter, filter the Grievance Log from the previous quarter to show the grievances/complaints that were outstanding in the previous quarter. Fill in the resolution date of the "Outstanding" grievances. Submit as a separate document, a copy of the filtered Grievance Log from the previous quarter, with just the "Outstanding" grievances showing and their resolution dates. (see the picture below that shows only the outstanding grievances and the dates of the resolutions.)

View Outstanding | View Resolved | View All

CLIENT ID	Receipt Date	Grievance Type (See TAB Grievance Type Codes)	Service Type (See last section in TAB Grievance Type Codes)	Date of Resolution	Provider	Clinic
XXXXXXX	6/26/2017	QS.b	10	7/14/2017	Options for Southern Oregon	Options for Southern Oregon
XXXXXXX	6/28/2017	IP.a	10	7/10/2017	Support Staff	Barnett, Medford
XXXXXXX	6/30/2017	IP.a	10	7/25/2017	Amanda Brimmer	Barnett, Medford
XXXXXXX	6/21/2017	IP.b	9	7/5/2017	Anne Dennehy DDS	Anne Dennehy DDS
XXXXXXX	6/21/2017	IP.b	9	7/11/2017	Anne Dennehy DDS	Anne Dennehy DDS

Reminder – the CCO must maintain records in a central location – submitting the dates of resolution for all Outstanding Grievances meets the requirement. For grievances that are not completed in the following quarter, an explanation will need to be given in the Grievance System Report as to why they were not resolved within the required timeframe.

Tab - 6 **Grievance Type Codes** – This chart shows the approved reason codes that are entered In Tab 5 - Column C in the Grievance Log. Service Type Codes are entered into Column D.

Tab - 7 **Grievance Summary** - This worksheet auto calculates all of the grievances entered on the Grievance Log, by Grievance Type. Nothing needs to be entered into this worksheet. Data on this summary sheet can be used to fill out the Grievance System Report.

Appeal Log

Tab - 8 **Appeal Log Dictionary** - the dictionary provides a quick reference for the Appeal Log. The dictionary shows each column and a brief description of how the log should be filled out.

Tab - 9 **Appeal Log** – Enter all appeals that were received in the quarter and all NOA-ABDs associated with the appeal. This means, the dates in column G are dates within the current reporting quarter. The NOA-ABDs listed in column C may have dates that are prior to the date of the appeal. NOTE: Logs will appear blank and will expand as data is entered.

Column A Client ID – this is the Oregon Health Plan (OHP) identification number. Enter the member's Medicaid number. Do not enter a CCO or provider ID number.

NOTE: For the "Maintaining Records" requirement, the name and the ID number of the member must be recorded on CCO records. For the "Reporting Data" requirement, only the member's ID number is submitted.

Column B Date of Request of Service/Item – Enter the date the provider requested the service. This is the date the provider requested the service, not when the CCO receives the request. The member has not yet received the service.

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

Column D ~~Action~~ ABD Category ~~–~~ The action categories are requirements that are described in CFR 438.400(b)(1-6). Each Appeal must have an ~~action~~ ABD category. Column D is a data verified field and will only accept the approved format. There is also a drop down list with the appropriate categories. The list of categories can also be found on Tab – 14 ~~NOA~~ ABD-~~Appeal~~ Categories.

Below are ~~descriptions of each Action~~ ABD Categories~~:~~ ~~based on the federal or state requirements:~~

a) 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. Use this category for a service that was either partially, or completely, denied (42 CFR 438.400(b)(1).

EXPLANATION: A member or member's doctor requests a service and your MCE determines that the member:

- *cannot have the service;*
- *can have the service, but not the number or in the amount of the service requested (ex. A member requests 10 PT visits, but is only granted 5 PT visits or, a member requests 3 month supply of a medication, but they are only granted a 1 month supply);*
- *the service requested is for a setting that the MCE believes is not appropriate (ex. A member requests to have a dental procedure in a hospital, but the MCE decides the member does not meet MCE criteria for a hospital dental procedure);*
- *requested a service that is determined by the MCE to be experimental, investigative, or not medically necessary;*
- *was/is not eligible for OHP at the time services were/are requested;*
- *requested a service that is not a covered service; or*
- *record is missing information necessary for the MCE to approve the requested service.*

This reporting log includes 5 sub-categories to help you to further classify ABD. You will use the 1-5 sub-categories to say more about why this ABD was made.
The MCE must send the member a letter (NOABD) explaining why the member may not have the service.

b) Denial of a member's request to obtain services outside the managed care entity panel. Use this category when the MCE is denying a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network (42 CFR 438.400(b)(6).

EXPLANATION: When an MCE does not agree (approve) to let a member access services outside of the MCE provider network, this is an adverse benefit determination. The MCE must send the member a letter (NOABD) explaining why. You will use the 1-5 sub-categories to say more about why this ABD was made by the MCE.

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c) Termination, suspension, or reduction of previously authorized covered services. Use this category when a service that was previously authorized is being reduced, suspended, or terminated by your MCE (42 CFR 438.400(b)(2).. These reasons are the 1 – 5 sub-categories that are required in Column E.

EXPLANATION: When an MCE stops or decreases a service a member is already receiving, this is an adverse benefit determination. The MCE must send the member a letter (NOABD) explaining what services have been stopped or decreased. This notice must be sent at least 10 days before the change will take effect ('advance notice'). You will use the 1-5 sub-categories to say more about why this ABD was made by the MCE.

d) Failure to act within the standard grievance and appeal resolution timeframes provided in CFR 438.408(b)(1)&(2). Report any adverse benefit determinations issued by the MCE because the MCE failed to resolve a grievance or an appeal within the timelines required in the Contract and OAR (42 CFR 438.400(b)(5).CFR 438.408(c)(3) Appeals that are reported in this category are not reported in any other category.

EXPLANATION; If the MCE fails to resolve a standard appeal within the required timeframes, this is an adverse benefit determination. The MCE must send the member a letter (NOABD) explaining why the appeal was not resolved within the Contract and OAR timeframes. The member is considered to have exhausted the MCE appeals process and may request a hearing with OHA.
If the MCE fails to resolve a grievance within the required timeframes, this is an adverse benefit determination. The MCE must send the member a letter (NOABD) explaining why the grievance was not resolve within Contract and OAR timeframes.

e) Failure to provide services in a timely manner, as defined by the State. Use this category for adverse benefit determinations issued by the MCE because the MCE failed to adhere to provide services within Contract and OAR definiens timeframes (42 CFR 43.8400(b)(5). Appeals that are reported in this category are not reported in any other category.

EXPLANATION: When a member had to wait longer than standard, urgent or emergency timeframes in MCE Contract and OAR to get health care or receive a service, this is an adverse benefit determination. The MCE must send the member a letter (NOABD) explaining why services could not be provided in the required timeframes.

f) Denial of payment at the time of any action affecting the claim. Use this category if the ABD is issued by the MCE to deny of payment for a service (42 CFR 438.400(b)(3).

EXPLANATION: a member has already received a service, but the MCE determines that it cannot pay for the service; this is an adverse benefit determination. The MCE must send the member a letter (NOABD) explaining why it cannot pay for the service. You will use the 1-5 sub-categories to say more about why this ABD was made by the MCE.

g) Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. Use this category for ABD issued by the MCE to deny a member's request to dispute a financial liability (42 CFR 438.400(b)(7).

*EXPLANATION: A member received a bill for services that they believe the MCE should have paid for, but didn't. If the MCE investigates and determines that the member signed a 'agreement to pay form' and the member **is** required to pay, the MCE must send the member a letter (NOABD) explaining why.*

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~~a) Denial or limited authorization of a requested service. Use this category to report when an appeal is filed for a service that was denied, either partially, or completely denied. Reasons for the denials are to be clearly and thoroughly explained in the NOA ABD as outlined in OAR 410-141-3240(c)(J)(i-viii). These reasons are the 1 – 5 sub-categories that are required in Column E.~~

~~b) Single managed care entity service area, denial to obtain services outside the managed care entity panel. Use this category when an appeal was filed for the denial of a service that was requested outside of the CCO provider network. CFR 438.52(b)(2)(ii).~~

~~c) Termination, suspension, or reduction of previously authorized covered services. Use this category when an appeal was filed for a service that was previously authorized is being reduced, suspended, or terminated. Reasons for the denial must be clearly and thoroughly explained in the NOA ABD as outlined in OAR 410-141-3240(c)(J)(i-viii). These reasons are the 1 – 5 sub-categories that are required in Column E.~~

d) ~~Failure to act within the timeframes provided in CFR 438.408. Report any Appeals that were dismissed because the CCO failed to adhere to the timelines as required in the federal rule and the member was considered to have exhausted the CCOs appeals process. The member can then initiate a state hearing. CFR 438.408(c)(3) Appeals that are reported in this category are not reported in any other category.~~

~~e) Failure to provide services in a timely manner, as defined by the State. Report any Appeals that were dismissed because the CCO failed to adhere to the timelines as required in OAR 410-141-3245(3)(a) and the member was considered to have exhausted the CCOs appeals process. The member can then initiate a state hearing. Appeals that are reported in this category are not reported in any other category.~~

~~f) Denial of payment at the time of any action affecting the claim. Use this category if the Appeal is for a denial of payment for a service. Reasons for the denial must be clearly and thoroughly explained in the NOA ABD as outlined in OAR 410-141-3240(c)(J)(i-viii). These reasons are the 1 – 5 sub-categories that are required in Column E.~~

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Column E Subcategories – the subcategories are described in OAR 410-141-3240(1)(c)(J). Sub-categories are used to provide additional information about the ABD. ~~-~~Use subcategories only when the ~~Appeal~~ ABD is ~~reported~~ in category a, c and f of the ~~Action~~ ABD Categories.

Below are descriptions of each Sub Category based on the federal or state requirements:

(1) Treatment is not a covered service - The service [is] specifically not a covered service or [is a service] that does not meet requirements based on the Prioritized List of Health Services; OAR 410-141-3240(1)(c)(J)(iii).

(2) Requires PA and was not preauthorized - The item requiring prior authorization but was not authorized; OAR 410-141-3240(1)(c)(J)(i).

(3) The service is not medically appropriate - The services or treatment requested does not meeting medically necessary or medically appropriate criteria as defined in OAR 410-120-000. OAR 410-141-3240(1)(c)(J)(ii).

(4) The service or item was received in an emergency care setting and does not qualify as an emergency service; OAR 410-141-3240(1)(c)(J)(iv).

(5) The Provider is not on the Contractor's panel and prior approval was not obtained (if such prior approval would be required under OHP rules.) - Except in the case of an Indian Health Care Provider (HCP) serving an Indian (AI/AN) member of the CCO and the provider is not on the contractor's panel. OAR 410-141-3240(1)(c)(J)(vi).

Column F Service Type – Enter the type of service from the categories listed on Tab 14 the NOA-ABD-Appeal Categories.

Column G Date of Appeal – Enter the date that the appeal was received.
Column H CCO Extension – Enter a "Y" if this 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. By entering a date in Column M, will leave a blank in Column R, however it will not be included in the "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. OAR 410-141-0420, states this: 4. ……Before providing a non-covered service, the provider shall complete and have the member sign an Authority 3165, or facsimile, as described in OAR 410-120-1280.

CCO contract Exhibit B – Statement of Work – Part 4 – Providers and Delivery System #10 (a) (5) - Subcontract Requirements describes the CCOs responsibility to ensure Subcontractors and Providers do not bill Medicaid members for services that are not covered under this Contract unless there is a full written disclosure or waiver (also referred to as agreement to pay) on file signed by the Member, in advance of the service being provided, in accordance with OAR 410-141-0420.

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 on the Appeal Log can be used to track appeals that were outstanding at the end of the quarter.

Reporting OUTSTANDING Appeals

The following quarter, filter the Appeal Log from the previous log to show the appeals that were outstanding in the previous quarter. Fill in the resolution date of the appeals. Submit as a separate document, a copy of the Appeal Log from the previous quarter with just the "Outstanding" appeals showing and their resolution dates. (see the example below)

View Outstanding | View Completed | View All

	NOA-ABD Associated with the Appeal					Appeals										
Client ID	Date of Request of Service / Item	Date of NOA-ABD (or EOB - See Dictionary for instructions)	Action Category	Sub Category	Service Type	Date of Appeal Request	CCO Extension Y/N	Expedited Granted Y/N	Denied Service Upheld Y/N	Overturned at Appeal Y/N	Partial Denial Y/N	Date Member Withdrew Appeal	Dismissed Late Filing Y/N	Invalid Waiver Y/N	Continuing Benefits Provided Y / N	Date of NOAR
XXXXXX	7/6/2017	7/6/2017	a	1		7/24/2017	N	N		Y					N	8/10/2017
XXXXXX	7/10/2017	7/20/2017	a	1		7/29/2017	N	N	Y						N	8/7/2017

Reminder – the CCO must maintain records in a central location – submitting the dates of resolution for all "Outstanding" appeals meets the requirement. For appeals that are not completed in the following quarter, an explanation will need to be given in the Grievance System Report as to why they were not resolved within the required timeframe.

Tab 10 **NOA-ABD -Appeal Summary Dictionary** – the dictionary provides a quick reference for the Appeal Log. The dictionary shows each column and a brief description of how the log should be filled out.

Tab 11 **NOA-ABD -Appeal Summary** - CCOs must report all NOA's/ABDs and appeals that were issued during the quarter. Data from Tab 9, The Appeal Log and Tab 13, the NOA-ABD Log will auto calculate to Column B into the correct a- f categories.

Adverse Benefit Determination Notices (NOA-ABDs)
CMS implemented new rules around managed care that went into effect January 1, 2018 which changes the name of the Notice of Action (NOA) to Adverse Benefit Determination (ABD). OHA has decided to refer to the acronym as NOA/ABD and may eventually drop the NOA portion of the acronym.

The TOTAL of all NOAs-ABDs that were issued during the quarter are required to be reported. This means every time a NOA-ABD letter is sent to the member, it must be included in the TOTAL for the quarter. This includes all pre and post service and includes all HEP-C and ABA NOA-ABDs. OAR 410-141-3225(9)(d).

Tab 12 **NOA-ABD Dictionary** - the dictionary provides a quick reference for the NOA - ABD Log. The dictionary shows each column and a brief description of how the log should be filled out.

Tab 13 **NOA-ABD Log** – List all NOA-ABDs that were issued during the quarter. The

NOA-ABD Log auto calculates to Tab 11, the NOA-ABD-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.

Tab 14 **NOA-ABD-Appeal Categories** - This chart shows the Action Categories that are described on page 8 and 9 of this document. Action Categories, Sub Categories and Service Codes are entered on the following Tabs:

- ✓ Tab 9 – Appeal Log Columns D, E and F;
- ✓ Tab 11 - NOA-ABD-Appeal Summary Column B rows 4 – 9;
- ✓ Tab 11 – NOA – ABD – Appeal-Summary Column B rows 14 – 19 are auto calculated from Tab 9 – Appeal Log;
- ✓ Tab 13 - NOA-ABD Log Columns D, E and F.

Instructions for Completing the Grievance System Report

Oregon must also provide narrative that describes trends in the Grievance System for the quarter, and interventions to address concerns identified during the quarter. CCOs provide this information in the Grievance System Report. The Grievance System Report is a demonstration of how the CCO uses Grievance 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 7 Grievance Summary Totals.
The narrative should follow the suggestions found directly below the chart.

Notice of Action/Adverse Benefit Determination – Fill out this chart and provide narrative following the instructions directly below the chart.

Appeals – Fill out the chart using data from the Reporting Tool Appeals Log. Provide narrative following the instructions directly below the chart.

Hearings Narrative – Please provide a brief analysis of those Appeals that went to a Contested State Hearing process.

Additional Narrative - Please also provide the additional narrative requested.