POLICY AND PROCEDURE

POLICY NAME: Grievance System: Grievances, Appeals, Contested Case Hearings	**POLICY ID:** OR.QMI.111
BUSINESS UNIT: Quality Improvement	**FUNCTIONAL AREA:** Appeals and Grievances
EFFECTIVE DATE: 6/2016	**PRODUCT(S):** OHP Medicaid
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REGULATOR MOST RECENT APPROVAL DATE(S):	

PURPOSE:

To outline the Member Grievance and Appeals System that meets all Federal and State regulatory requirements, including a grievance and appeal process. It identifies how Trillium staff identifies, responds to, resolves, and reports member grievances and appeals. It includes procedures for the Contested Case Hearing (hearing) process if members feel the appeal finding is unacceptable regarding their care or service.

SCOPE:

Trillium Community Health Plan Quality Management (Trillium) (QM), Medical Management and Member Service departments. This Policy applies to the Lane/Douglas/Linn county OHP service area, and to the Multnomah/Washington/Clackamas county OHP service area.

DEFINITIONS:

Adverse Benefit Determination: 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. The reduction, suspension, or termination of a previously authorized service or the denial, in whole or part, of payment for a service. The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner, as defined by the State. The failure of the CCO to act within the timeframes provided in OAR's 410-141-3875 through 410-141-3895 and 42 CFR § 438.408 (a) regarding the standard resolution of grievances and appeals. For a resident of a rural area with only one CCO, the denial of a member's request to exercise his or her right under CFR 438.52(b)(2)(ii), to obtain services outside the network. 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 by the CCO of an Adverse Benefit Determination.

Clinically Urgent: Need for medical care or treatment with respect to which application of time periods for making non-urgent care decisions could result in serious jeopardy to life or health of member or member's ability to regain maximum function, based on a prudent layperson's judgment; or in opinion of practitioner with knowledge of member's medical condition would subject member to severe pain not adequately managed without care or treatment requested.

External Review: Formal request by a member for independent review of an adverse decision by Trillium, which are conducted by the OHA.

Expedited Appeal: Request for urgent review of an adverse determination.

Grievance: Any expression of dissatisfaction to the CCO or OHA about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care of 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 may also include the member's right to dispute an extension proposed by the CCO to make an authorization decision.

HRSN: "Health-Related Social Needs" and "HRSN" each means the unmet climate-related needs that contribute to an individual's poor health and are a result of underlying social and structural determinants of health.

Grievance Resolution Dispute: Request to change an adverse decision made regarding grievance, including denial of change of Practitioner, Provider, Clinical Specialist, Community Health Worker, or Behavioral Health Care Coordinator. Request to change a denial of access to; Complex Case Management Program, Clinical Specialist, Community Health Worker, or Behavioral Health Care Coordinator. NCQA defines this as an appeal to a grievance.

Member: Person insured or otherwise provided coverage by Trillium. For purpose of this procedure, a reference to member means a member, member's representative, or representation of a deceased member's estate.
Member Representative: A person with legal authority to make healthcare decisions on behalf of the member.
Oregon Health Authority: State of Oregon government agency that oversees Oregon Health Plan.

Pre-Service Appeal: A request to change an adverse determination for medical or behavioral healthcare or services requiring approval, in whole or in part, in advance of member obtaining care or services.

Post-Service Appeal: Request to change an adverse determination for medical or behavioral healthcare services already received by the member.

Same-or-Similar Specialist: A clinical peer who holds an active, unrestricted license to practice medicine, or a health professional who is board-certified, if applicable, and who is of the same-or-similar health care profession and has similar credentials and licensure and appropriate training and experience as those who typically treat the condition or health problem in question in the appeal. To be considered same or similar specialist, the reviewing specialists training and experience must meet the following criteria: Includes treating the condition; Includes treating complications that may result from the service or procedure; Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate. Pharmacists are not considered same or similar specialists for the purpose of deciding appeals.

POLICY:

Trillium maintains a procedure for the receipt and prompt resolution of all grievances, appeals and hearings that complies with all applicable State and Federal laws, rules and contract requirements. This policy and procedure includes Health Related Social Needs (HRSN) services.Trillium's Grievance and Appeal System is designed to be culturally and linguistically responsive to the member's needs by considering the member's culture, literacy and language preference (including accommodations such as alternate formats) during the grievance, appeals and contested case hearings processes. Trillium investigates and documents the content and substance of grievances and appeals, including all clinical care aspects involved, according to applicable statutory, regulatory, and contractual provisions and Trillium's policies and procedures. Trillium provides resolution and notification of such resolution as expeditiously as the member's condition warrants but no later than timeframes as outlined in this policy. Trillium does not structure compensation in a manner that incentivizes an individual or entity to deny, limit or discontinue medically necessary service to any member. To ensure Trillium's Grievance and Appeal process is simple, accessible, and understandable to members, Trillium analyzes and monitors grievance and appeals by race, ethnicity, language, and disability. Any indication of in-equity or in-accessibility is addressed as appropriate.

PROCEDURE:

A. General Requirements

1. Trillium's Grievance and Appeal System is included in all Member Handbooks, the Provider Manual, and on the Trillium website.
2. Upon enrollment, Trillium notifies Members of: their rights and responsibilities; the procedures for requesting, processing and resolving member grievances, appeals and hearings; and, how to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP. The notification explains specific instructions about how to contact Trillium's Member Services Department.
3. The following individuals must be included, as appropriate, as parties to a grievance or an appeal or contested hearing:
    a. Trillium.
    b. Member.
    c. Member's representative.

i. If a Member would like an authorized representative, the Member must complete the Member Authorized Representative Designation Form or provide other written documentation authorizing the person to act on their behalf. If the Member chooses to elect an authorized representative, the Member's written consent is required before Trillium can process the request. Once the Authorized Representative Designation Form is received, the resolution time clock begins.

d. Legal representative of a deceased member's estate.
e. Provider and/or provider's subcontractor, with member's written consent.

4. Trillium provides 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. 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 42CFR §438.10;
   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.
   f. When Trillium identifies that a member has an Authorized Representative, Trillium will assist the member with completion of the Authorized Representative form, as needed.
5. Trillium provides members the following for filing a grievance or an appeal:
   a. Toll-free numbers, including TTY/TTD.
   b. Free interpreter services.
   c. Documents in alternate formats and languages other than English.
   d. Rules that govern representation at the hearing.
   e. Right to have an attorney or member representative at the hearing and the availability of free legal help through Legal Aid Services and Oregon Law Center.
6. Trillium, its subcontractors and its participating providers ensure that:
   a. Members are not discouraged from using any aspect of the complaints, appeal or hearing process;
   b. Members are not encouraged to withdraw a complaint, appeal or hearing request already filed; and,
   c. Use of the filing or resolution of a complaint, appeal or hearing request is not used as a reason to retaliate against member or to request member disenrollment.
   d. Punitive action is not taken against providers who request an expedited resolution of a grievance or who support a member's grievance or appeal.
7. Trillium administrative office and in those physical, behavioral, and oral health offices where Trillium has delegated responsibilities for appeal, hearing request, or grievance involvement shall have available the Oregon Health Plan Complaint Form (OHP 3001) and the Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.
8. Trillium and contracted providers cooperate with OHA, CMS, the External Quality Review Organization, 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 in required timeframes.
   a. Requests for records are submitted to OHA's Contract Administrator within the following timelines:
      i. Non-Hearing related: no later than 14 days following receipt of the request,
      ii. Expedited Hearing: within 24 hours; and,
      iii. Non-expedited hearing: within 2 days.
9. Trillium meets the following requirements when handling grievances and appeals:
   a. Resolve or acknowledge receipt of each grievance and appeal to the member, authorized representative and/or the member's provider, where indicated, within 5 business days.
   b. Document the substance of the grievance and appeal and actions taken.
   c. Investigate the substance of the grievance and appeal and consistent with confidentiality requirements obtain documentation regarding the facts of the case upon receipt, including any aspect of clinical care.
      i. If a grievance could be a potential Quality Of Care (QOC) issue, the grievance case is investigated and resolved as a QOC grievance and a QOC referral is routed to the QI QM Department designee for investigation within 1 (one) business day of the grievance being

received. See Policy CC.QI.17 for more information on QOC grievances and practitioner review.

d. Document the actions taken to address the grievance and appeal.
e. Ensure that upon receipt of a grievance or appeal, it is forwarded to staff who are given authority to act upon the matter.
f. Ensure staff and any consulting experts who make decisions on grievances and appeals are:
    i. Not involved in any previous level of review or decision-making and are not the subordinate of the person involved in the initial review or decision-making.
    ii. Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.
    iii. Healthcare professionals with appropriate clinical expertise (same or similar specialty) in treating the member's condition for cases involving:
        1. Appeal of a denial that is based on lack of medically appropriate services.
        2. Grievance regarding denial of expedited resolution of an appeal.
        3. Grievance or appeal that involves clinic issues.
    iv. Taking into account all comments, documents, records and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial decision. The organization documents when members fail to submit relevant information by the specified deadline.
g. Ensure all written notices sent to members are culturally and linguistically appropriate, written in a format and language that may be easily understood by the member. Written notices include:
    i. Nondiscrimination Notice (see Attachment #1)
        1. The nondiscrimination notice provided to members contains both Trillium's nondiscrimination policy and the process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, gender identity or disability status in accordance with all applicable laws including Title VI of the Civil Right Act, ACA Section 1557 and ORS Chapter 659A. ; Nondiscrimination Policy Statements meet requirements outlined in the Nondiscrimination Statement Evaluation Checklist and are approved by OHA. The Nondiscrimination Statement Evaluation Checklist can be found at https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-QA-Materials.aspx and,
    ii. Notice of Language Assistance.

B. Reporting and Logging Requirements

1. Trillium monitors and ensures that its providers and subcontractors comply with grievance and appeal system requirements in accordance with applicable laws and applicable contract provisions.
2. Trillium maintains records of grievances and appeals and reviews the information as part of Trillium's ongoing monitoring of procedures as well as updates and revisions to the state quality strategy. The Quality Improvement Committee (QIC) reviews analyses of grievances, appeals and hearings and recommends opportunities for improvement. Grievance system analyses includes:
    a. Compliance with applicable state, federal or other regulatory requirements including turnaround times;
    b. Member race, ethnicity, language, and disability (REAL - D) data;
    c. Top drivers; and,
    d. Trends and improvement opportunities.
3. Trillium documents and maintains a record in a central location for each grievance and appeal. Grievance and appeal records 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 OHP ID number;
    c. The date the member, or member's representative, or provider filed the grievance or appeal;
    d. Notice of Adverse Benefit Determination;
    e. If filed in writing, the grievance or appeal.
    f. If a verbal filing was received, documentation that the grievance or appeal was received verbally.

g. Records of the review or investigation at each level of the grievance or appeal or Contested Case Hearing, including dates of review;
h. Notice of resolution of the grievance or appeal, including date of resolution for each level;
i. Copies of correspondence with the member and all evidence, testimony, or additional documentation provided by the member, member's representative, or the member's provider as part of the grievance, appeal or contested case hearing; and,
j. All written decisions and copies of all correspondence with all parties to the grievance or appeal or contested case hearing.

4. Trillium, including subcontractors if delegated, retains and keeps accessible all documentation, logs and other records for the Grievance and Appeal system whether in paper, electronic or other form for a minimum ten (10) years. These are kept in a manner accessible to the state and available upon request to CMS.
5. Trillium submits to the OHA Contract Administration Unit within 45 days of the end of each calendar quarter and upon request:
   a. The OHA approved Grievance and Appeal Log;
   b. The OHA approved Grievance System Report;
   c. A sample of 20 Notice of Adverse Benefit Determinations; and,
   d. All Notice of Adverse Benefit Determinations for ABA and Hepatitis C issued in the reporting quarter.
6. Trillium incorporates analysis of grievances and appeals including member race/ethnicity, language and disability (REAL-D) data, as required by CCO contract in the context of quality improvement activity into the quarterly grievance system reporting.
7. Trillium staff review and monitor the records and log at least monthly for completeness and accuracy, which includes but is not limited to timeliness of documentation and compliance with regulations.
8. Trillium provides grievance system policies, procedures, and member notice templates to regulatory bodies annually and within 5 business days of request for review and approval. Upon any changes to the approved policies, procedures, and member notice templates Trillium resubmits the changes for approval.
   a. Trillium revises and corrects all deficiencies identified by CMS, OHA, or EQRO and resubmits corrected documentation within 30 days of notification or as outlined in administrative notice of such deficiency.

C. Protected Health Information

1. Trillium keeps all healthcare information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in federal, state and CCO contract requirements, and include providing member assurance of confidentiality in all written, oral and posted material in grievance and appeal processes.
2. The following pertains to the release of member's information:
   a. Trillium 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 42 CFR 438.416.
      iii. If Trillium needs to communicate with other individuals or entities not listed in subsection (a) to respond to the matter, Trillium shall obtain the member's signed release and retain the release in the member's record.

D. Delegation of Grievance System

1. Trillium does not delegate adjudication of appeals.
2. If Trillium delegates grievances to a subcontractor, Trillium:
   a. Ensures the subcontractor meets the requirements consistent with the grievance system regulations and OAR 410-141-3875 through 410-141-3915.
   b. Monitors the subcontractor's performance on an ongoing basis.
   c. Performs a formal compliance review at least annually to assess performance, deficiencies or areas for improvement and
   d. Ensures subcontractor takes corrective action for any of these areas identified as deficient or needing improvement.
   e. Documents all monitoring and corrective action activities.

3. Trillium provides to providers and subcontractors, at the time they enter into a subcontract, written notification of the grievance, Notice of Adverse Benefit Determination, appeal, and contested case hearing procedures and timeframes as set forth in Ex. I, including the following (a)-(f). Trillium 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.
    a. Member's right to a hearing, how to obtain a hearing and representation rules at a hearing.
    b. Member's right to file a grievance and/or appeal and their requirements and timeframes for filing.
    c. The availability of assistance in filing.
    d. The toll-free numbers, including TTY/TTD, and interpreter capabilities to file oral grievances and appeals.
    e. Member's right to request continuation of benefits during an appeal or a hearing and, if the contractor's action is upheld in a hearing, the member may be liable for the cost of continued benefits.
    f. Any state-determined provider appeal rights to challenge the failure of the organization to cover a service.

E. Member Grievance Process

1. In compliance with Title VI of the Civil Rights Act and ORS chapter 659A, Trillium reviews and reports to the Authority grievances that raise issues related to racial or ethnic background, gender identity, religion, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status, violation of civil rights and other identity factors for consideration in improving services for health equity.
2. Trillium processes member grievances related to continuing benefits during their transition from one health plan to another to ensure continuity of care.
3. Who can file a grievance:
    a. Member.
    b. Member's authorized representative.
    c. Provider and/or provider's subcontractor acting on behalf of the member with the member's authorization and written consent.
4. Grievances may be filed at any time orally or in writing by fax, mail or email with Trillium, OHA, or a delegated subcontractor of Trillium.
    a. When Trillium receives grievances related to services provided by subcontractors who are delegated grievance processing, Trillium forwards the grievance to subcontractor upon receipt.
    b. If the grievance is filed with the Authority, it shall be promptly forwarded to Trillium to address in accordance with Trillium's grievance and appeal system.
5. Trillium acknowledges verbal grievances upon receipt.
6. Taking into account the member's health condition, Trillium notifies the member of the grievance decision, addressing each aspect of the grievance and reason for the decision, within the following timeframes:
    a. Within 5 business days from receipt date.
    b. Extension: If additional time is needed to resolve the grievance, Trillium acknowledges receipt of the grievance and notifies the member within 5 business days that there will be a delay, including the reason additional time is necessary, and provides resolution within 30 calendar days from receipt date.
    c. Grievances determined to be clinically urgent in nature, by an appropriately licensed professional, are resolved within 72 hours.
7. Trillium responds in writing to all grievances, including those received verbally.
8. Notice of grievance resolutions:
    a. Contains the decision, addressing each aspect of the grievance and reason for the decision.
    b. Are written in a language sufficiently clear that a layperson can understand the notice and make an informed decision about requesting a second level grievance review; and,
    c. Comply with OHA's formatting and readability standards as outlined in OAR 410-141-3585 and 42 CFR 438.10. "Easily understood' is 6th grade reading level or lower using the Flesch-Kincaid readability scale and use of minimum 12 point font or for large print, 18 point font.
    d. Contain 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 the grievance to the Oregon Health Plan Client Services Unit (CSU) toll free at 1-800-273-0557 or the OHA Ombudsman at 1-503-947-2346 or toll free at 1-877-642-0450.

9. Grievance resolution dispute rights are provided to members, as appropriate.

F. Second Level Grievance Review (Grievance Appeal)

1. Members unsatisfied with the resolution of their grievance may request a second level grievance review, if applicable.
   a. Trillium must receive grievance resolution dispute requests within 60 calendar days from the grievance resolution notification.
      i. Requests can be received verbally or in writing.
      ii. Requests received more than 60 calendar days after the grievance resolution are be handled as a new grievance.
   b. Trillium investigates and obtains any necessary documentation related to the issues of the case.
      i. If grievance is clinical in nature, an appropriate health care professional is involved in the decision making. (outlined in section 9)
   c. Acknowledgement/Resolution of second level grievance review follows the same timeliness standards as an initial grievance (outlined in section E.5 above).
   d. Notice of second level grievance review is provided to the member in writing and contains the decision, addressing each aspect of the grievance and reason for the decision. If Trillium cannot resolve a grievance within the timeframe stated in policy, or cannot notify the member of the final decision for legal or statutory reasons, Trillium notifies the member that the grievance was received and investigated.
   e. The member is provided information on how to submit their grievance to the appropriate regulatory body for further review, if desired.

G. Additional Requirements

1. Written notification informs members that they may present the grievance to Oregon Health Plan Client Services Unit (CSU) or Oregon Health Authority's (OHA) Ombudsman at any time.
2. Written notification of updates to Trillium's Grievance, Appeals, and Hearings procedures and time frames are given to providers within five business days after approval of such updates by OHA.
3. Trillium cooperates with the investigation and resolution of the Grievance by CSU or OHA Ombudsman, including providing all requested records.

H. Appeals Process

1. Who can file an appeal:
   a. Member.
   b. Member's authorized representative.
   c. Legal representative of a deceased member's estate.
   d. Provider and/or provider's subcontractor acting on behalf of the member with the member's authorization and written consent.
   e. The Oregon Health Authority (OHA) with a request to review an action that is in a hearing process.
2. Member may request standard or expedited appeals verbally or in writing to express disagreement with an adverse benefit determination:
   a. Trillium uses the verbal appeal receipt date to establish earliest possible filing date.
3. Appeals must be filed within 60 calendar days from the date of the notice of adverse benefit determination.
   a. Appeals filed untimely are invalid and dismissed for late filing.
4. For a standard appeal, Trillium sends an Appeal Acknowledgement letter within 5 business days of the receipt of the appeal request.
5. Members have only one level of internal appeal.
6. Members must exhaust internal appeal processes prior to requesting a Contested Case Hearing.
7. Should Trillium fail to adhere to the notice and timing requirements within OAR and state contract, the member is deemed to have exhausted the internal appeal process and may initiate a Contested Case Hearing.
8. During the appeal review process, Trillium:
   a. Provides the member reasonable opportunity, to present evidence and testimony and make legal and factual arguments in person as well as in writing.
      i. In the case of a standard and expedited appeals, Trillium informs the member of the limited time available for this sufficiently in advance of the resolution timeframe.

b. Upon request, provides the member or the member's authorized representative with the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon or generated by Trillium in connection with the appeal at no charge and sufficiently in advance of the resolution timeframe of the appeal.
c. Documents the substance of the appeal to include the Member's reason for appealing the previous decision, and additional clinical or other information provided with the appeal request.
d. Fully investigates and documents the content of the appeal including all aspects of clinical care involved, without giving deference to the denial decision.
    i. Members have the opportunity to submit information relevant to the appeal. All information is taken into account regardless of whether the information was submitted or considered in the initial determination.
    ii. Any additional information required to review the appeal request is requested at this time and that request is documented in the clinical documentation system. If no additional information is available or submitted by the specified deadline, per the Provider or the Member, it is documented in the clinical documentation system.
    iii. Trillium documents actions taken including but not limited to previous denial or appeal history, follow-up activities associated with the denial and conducted before the current appeal.

9. Trillium resolves the appeal, and provide 'Notice of Appeal Resolution' (OHP Form 2406), as expeditiously as the member's health condition requires and within the following timeframes:
    a. Standard pre-service and post-service appeal resolution is within 16 calendar days from the date received.
    b. Expedited appeal resolution within 72 hours from the date appeal was received.
        i. Trillium provides oral notification to the member and the provider within the 72-hour timeframe.
        ii. Written confirmation of decision is provided within 3 calendar days of the oral notification.
        iii. For services not provided while the appeal is pending and if Trillium reverses a decision to deny, limit, or delay services, Trillium will provide the services or pay for the services or both in accordance with OAR 410-141-3910, as expeditiously as the members health condition requires. This includes entering the prior authorization or adjusting claims, as applicable. In addition to the notification process outlined in this policy, Trillium makes reasonable effort to give the member (or representative, if applicable) and/or provider of the service (the party most appropriate to ensure coordination or fulfillment of the service) prompt verbal notice of the reversal (including as necessary multiple calls at different times of day). Notification is provided in writing, of the available services and how to access them in the 'Notice of Appeal Resolution'.
    c. Extensions:
        i. Trillium may extend the time frames, both standard and expedited, by up to 14 calendar days if:
            1. The Member requests the extension; or
            2. Trillium 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.
        ii. For any extension not requested by the member, Trillium:
            1. Makes reasonable effort to give member prompt verbal notice of the reason for the delay (including as necessary multiple calls at different times of day);
            2. Notifies the member in writing within 2 days of the reason for the decision to extend the appeal timeframe and inform the member of their right to file a grievance if they disagree with that decision;
            3. Resolves the appeal as expeditiously as the member's health condition requires but no later than the date the extension expires.

10. An expedited review process for pre-service appeals is available when Trillium determines the Member request or the Provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life, health or ability to attain, maintain, or regain maximum function. Expedited reviews are granted for all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility. Post-service appeal requests are not eligible for expedited review.
    a. Upon receipt of an expedited appeal request, Trillium acknowledges receipt of appeal orally and in writing within 1 business day, and determines if expedited request is granted or denied. The

timeline for an expedited appeal requested orally shall begin when there is established contact made between the member and Trillium.

i. If granted, Trillium:
    1. Informs the member sufficiently in advance of the resolution timeframe of the appeal of the limited time available for receipt of materials or documentation for the review.
    2. Makes reasonable effort to call the member and the provider to tell them of the resolution, within 72 hours after receiving the request (including as necessary multiple calls at different times of day); and,
    3. Mails written confirmation of the resolution within 3 days.
    4. Informs the member of their right to request an expedited hearing in the event Trillium denies the requested services or items.

ii. If denied, Trillium:
    1. Transfers the appeal to the 16-day timeframe for standard resolution.
    2. Makes reasonable efforts to give the member and requesting provider prompt verbal notice of the denial (including as necessary multiple calls at different times of day) and follow-up within two days with a written notice, to include Member right to file a grievance if they disagree with the decision.

b. If Trillium fails to adhere to the notice and timing requirements for extension of the appeal resolution timeframe, the member may initiate a hearing.

I. Notifications

1. Trillium notifies members and their representative's using the state approved Notice of Action/Adverse Benefit Determination when informing members of denied benefit determination and Notice of Appeal Resolution when informing members of appeal resolutions.
    a. As defined in OHA contract, references to a "member" include, as appropriate, the member, the member's representative, and the representative of a deceased member's estate. With respect to notification requirements, a separate notice is sent to each individual who falls within this definition.
    b. Notices are written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and follow the process for doing so.
    c. Notices are written in the member's preferred language as identified in member enrollment demographic data. As per OR.MRKT.102, grievance and appeal notification templates are translated into prevalent languages and readily available for distribution. Trillium accommodates requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested.
    d. The Notice contains a complete explanation of the reason for the denial in plain language and terms specific to the member's condition, that does not include abbreviations or acronyms that are not defined, health care codes that are not explained, or medical jargon that a layperson would not understand.
2. Trillium Notice of Action/Adverse Benefit Determination informs members about:
    a. The member or the member's authorized representatives rights and instructions on how to:
        i. Request internal appeal.
        ii. Request expedited appeal.
        iii. Request hearing, including the right to request an expedited hearing, in the event that taking the time for standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
        iv. Submit comments, documents or other information relevant to the appeal.
    b. How to request an appeal extension.
    c. How to request continued coverage of services pending the outcome of an appeal and/or hearing.
    d. How to request an appeal/hearing representative.
3. All Notice of Appeal Resolution letters inform members about:
    a. The same elements as the notice of action/adverse benefit determination, as appropriate.
    b. The date the member filed the appeal.
    c. Results of the resolution process and date it was completed.
    d. The effective date of the appeal decision.
    e. Titles and qualifications, including specialties, of individuals participating in the appeal review.
    f. 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.

g. For appeals not resolved wholly in favor of the member:
    i. Reason for the resolution and a reference to the particular benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, and particular sections of the statutes and rules involved for each reason identified in the NOAR relied upon to deny the appeal.
    ii. Informs the member or the member's representative that the criteria used to the make the decision is available upon request.
    iii. Right to request a hearing and right to an expedited hearing and how to do so;
        1. Copies of the Health Systems Division Service Denial Appeal and Hearing Request Form (OHP 3302) are included with each NOAR;
    iv. Right to request continuation of benefits pending the outcome and how to do so;
    v. An explanation that the member may be held liable for costs of any continued benefits if adverse benefit decision is upheld.
4. The written Notice of Appeal Resolution shall be in a format approved by the Authority.
5. The elements contained in an adverse benefit determination are listed in OAR 410-141-3885 and in Trillium policy OR.MM.121 Denial Notices.

J. Contested Case Hearing (Hearing) Process

1. Who can file an hearing request:
    a. Member;
    b. Member's representative
    c. Member's provider if the action affects the provider.
2. Include as parties to the hearing:
    a. The member and representative (a provider will be considered the member's representative if that provider requested the contested case hearing on behalf of the member)
    b. Trillium
    c. Legal representative of a deceased member's estate
3. Filing guidelines
    a. A hearing can only be requested after notification of an adverse appeal decision is received or if Trillium fails to adhere to the notice and timing requirements for extension of the appeal resolution timeframe.
    b. A hearing request must be filed with the authority using the Service Denial Appeal and Hearing Request Form (OHP 3302) or any other Authority approved appeal and hearing request form within 120 calendar days from date of Trillium's Notice of Appeal Resolution.
        i. The Authority prefers the use of OHP 3302 when issuing an NOAR.
        ii. If untimely, the Authority determines if there is good cause for late filing.
    c. The request should be filed with the Authority.
        i. If filed with Trillium, Trillium submits the date stamped request upon receipt to the Authority with the following information:
            1. If case has already been appealed, Trillium submits to the Authority within two business days:
                a. Notice of action/Adverse Benefit Determination;
                b. Notice of appeal resolution;
                c. All documents and records relied upon to take action, including those used as the basis for the initial action and all other relevant documents;
                d. All other documents requested as outlined in OAR 410-141-3890.
        ii. If filed with the Authority and an appeal review has not occurred, upon receipt of the appeal from the Authority, Trillium:
            1. Processes the appeal immediately;
            2. Approves or denies the appeal within 16 days; and,
            3. Provides the member with a notice of appeal resolution letter.
    d. A member, member's representative, or provider who believes that taking the time for standard resolution of a hearing could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function may request an expedited hearing. A request for an expedited hearing for a service that has already been provided (post service) to the member will not be granted.
        i. Expedited hearings should be submitted to the Authority and can be requested orally, in writing or online.
        ii. If expedited hearing is requested:

1. Trillium submits all relevant documentation to Authority within two business days.
2. Authority determines if an expedited hearing will be granted within two business days from the date of receipt of the medical documentation.
3. If expedited request is denied, the Authority sends written notice within two calendar days and make reasonable effort to call the member.

4. Provider requests for a hearing with Authority:
   a. Only requests regarding an action that affects the provider are permitted.
   b. To be valid, the provider must have completed an appeal with Trillium, and requested a hearing no later than 30 days from the date of the notice of appeal resolution.

K. Effectuation of Hearing Decisions

1. The Authority provides Trillium with written notice resolving the hearing within 90 calendar days from the hearing receipt date, whichever comes first.
2. If the hearing judge or Trillium reverses the appeal decision:
   a. Trillium will provide the services or pay for the services or both in accordance with OAR 410-141-3910. Trillium authorizes and provides the disputed service promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date notice revising the decision is received. This includes entering the prior authorization or adjusting claims, as applicable.
   b. Trillium will also make reasonable efforts to give the member, or representative and/or provider of the service (the party most appropriate to ensure coordination or fulfillment of the service) prompt verbal notice of the reversal of an appeal decision, including as necessary multiple phone calls at different times of day. Notification is provided in writing, of the available services and how to access them in the amended "Notice of Appeal Resolution".
   c. Trillium authorizes payment of the services within 30 calendar days, if services were already furnished.

L. 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 hearing is pending.
2. To be entitled to continuing benefits, the member shall submit an oral request or by, letter, fax, or by using the Review of health Care Decision form by:
   a. The tenth day following the date of the notice of adverse benefit determination or the notice of appeal resolution; or,
   b. The effective date of the action proposed in the notice, if applicable.
3. Trillium continues the member's benefits if all of the following occur:
   a. The member or member's representative, or provider (with the member's written or oral consent), files an appeal or hearing request timely;
   b. The request involves the termination, suspension, or reduction of a previously authorized service;
   c. The services were ordered by an authorized provider;
   d. The period covered by the original authorization has not expired; and,
   e. The member timely files for continuation of benefits, defined as filing on or before the later of the following:
      i. Within 10 days after the date of the NOABD; or,
      ii. The intended effective date of the Action proposed by the NOABD.
4. If, at the member's request, Trillium continues or reinstates benefits while the appeal or hearing is pending, the benefits must be continued until one of the following occurs:
   a. The member fails to request a hearing and continuation of benefits within 10 calendar days after the date of the Notice of Appeal Resolution.
   b. The member withdraws the appeal or request for hearing;
   c. A final order adverse to the member resolves the hearing.
5. Member responsibility for services furnished while the appeal or hearing is pending. If the final resolution of the appeal or hearing is adverse to the member, that is, upholds Trillium's adverse benefit determination, Trillium may recover the cost of services furnished to the member while the appeal and hearing was pending, to the extent they were furnished solely because of the requirements of this policy.

6. If the final appeal or hearing decision is to reverse Trillium's decision to deny, limit or delay services, Trillium pays for disputed services provided while the appeal or hearing is pending in accordance with State policy and regulations.
    i. For services not provided while the hearing is pending and if Trillium or a state fair hearing officer reverses a decision to deny, limit, or delay services, Trillium authorizes and provides the disputed service promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date notice revising the decision is received. This includes entering the prior authorization or adjusting claims, as applicable. In addition to the notification process outlined in this policy, Trillium makes reasonable effort to give the member (or representative, if applicable) and/or provider of the service (the party most appropriate to ensure coordination or fulfillment of the service) prompt verbal notice of the reversal (including as necessary multiple calls at different times of day). Notification is provided in writing, of the available services and how to access them in the 'Notice of Appeal Resolution'.
7. When the ALJ reverses the CCO's decision to deny authorization of services, MCE 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 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 the MCE receiving the Final Order.

REFERENCES:

42 Code of Federal Regulations (CFR): 431.230, 438.10, 438.228, 438.3, 438.330, 438.358, 438.400 through 438.424
45 Code of Federal Regulations (CFR): 164.501

Section 1557 Affordable Care Act (ACA)
Title VI of Civil Rights Act
Title III of the Americans with Disabilities Act
Section 504 of the Rehabilitation Act of 1973

National Committee for Quality Assurance (NCQA) 2020 Health Plan Standards and Guidelines: ME 7, UM 8&9

Oregon Administrative Rule (OAR)
410-141-3500, 410-141-3515, 410-141-3520, 410-141-3525, 410-141-3580, 410-141-3585, 410-141-3735, 410-141-3820, 410-141-3830, 410-141-3835, 410-141-3875, 410-141-3880, 410-141-3885, 410-141-3890, 410-141-3895, 410-141-3900, 410-141-3905, 410-141-3910, 410-141-3915

OR.MRKT.102 Member Communication Translation/Alternate Format

OR.MM.121 Denial Notices

ATTACHMENTS:

Attachment #1: Trillium Non-Discrimination Notice Version OHP-TRIL-23 S1704 10/24/2023

Do you think Trillium Community Health Plan (Trillium) has treated you unfairly?
Trillium must follow state and federal civil rights laws. It cannot treat people unfairly in any of its programs or activities because of a person's:

- Age
- Color
- Gender identity
- Marital status
- Race
- Religion
- Sexual orientation
- Health Status

- Disability
- National Origin
- Sex
- Need for services

You have a right to enter, exit, and use buildings and services. You have the right to get information in a way you understand. Trillium will make reasonable changes to policies, practices, and procedures by talking with you about your needs.

To report concerns, get help filing a complaint or to get more information, please contact Member Services at 541-485-2155; Toll Free: 1-877-600-5472; TTY: 1-877-600-5473, Monday through Friday, 8:00 a.m. to 5:00 p.m. You can leave a message at other times, including weekends and federal holidays. We will return your call the next business day. The call is free.

If you believe you have been discriminated against, you may also contact:
Levi Welbourne, Senior Manager, Grievance & Appeals
555 International Way, Building B
Springfield, OR 97477
Phone: 541-485-2155
Toll-free 1-877-600-5472 (TTY 711)
Email: grievances@trilliumchp.com
Web: www.trilliumohp.com/members/oregon-health-plan/for-members/member-satisfaction.html

You have a right to file a civil rights complaint with these organizations:

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

Oregon Health Authority (OHA) Civil Rights

Web: www.oregon.gov/OHA/EI
Email: OHA.PublicCivilRights@odhsoha.oregon.gov
Phone: (844) 882-7889, 711 TTY
Mail: Office of Equity and Inclusion Division, 421 SW Oak St., Suite 750, Portland, OR 97204

Bureau of Labor and Industries Civil Rights Division
Phone: (971) 673-0764
Email: boli_help@boli.oregon.gov
Mail: Bureau of Labor and Industries Civil Rights Division, 800 NE Oregon St., Suite 1045, Portland, OR 97232

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED

		& PUBLISHED
Ad Hoc Review	Policy templated updated per CC.COMP.22 Added *Expedited reviews are granted for all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.*	3/21/24
Ad Hoc Review	Added to pg 1 Policy section: This policy and procedure includes Health Related Social Needs (HRSN) services. Added HRSN to definitions.	3/13/24
Annual Review	Added to pg 16 Section I #3 *The date the member filed the appeal.* And *The effective date of the appeal decision.* Added to pg 4 #9a *authorized representative and/or* Added Section L #3 *or provider (with the member's written or oral consent)* Added Pg 20 *(or representative, if applicable)* Added Pg 13 added *This includes entering the prior authorization or adjusting claims, as applicable.* Added *Notification is provided in writing, of the available services and how to access them in the 'Notice of Appeal Resolution'.* Added J #3b changed *adverse appeal decision* to *Notice of Appeal Resolution* Added pg 18 J d member's representative. Pg 19 changed Authority *contested case hearing request form* to *Review of Health Care Decision form*. Added *in writing*. Pg 19 L #2 removed *member shall submit an oral request or complete an appeal request or an Authority contested case hearing request form and check the box requesting continuing benefit.* Replaced with *or by, letter, fax, or by using the Review of health Care Decision form* Pg 19 Section L added *This includes entering the prior authorization or adjusting claims, as applicable.* K 2a added *Trillium authorizes and provides the disputed service promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date notice revising the decision is received. This includes entering the prior authorization or adjusting claims, as applicable.* K 2b added *or representative and/or provider of the service (the party most appropriate to ensure coordination or fulfillment of the service).* Removed *and requesting provider.* Added *as necessary*. Added *notification is provided in writing of the available services and how to access them in the amended "notice of appeal resolution".* L 6 i. Removed this entire section as it is now covered in K 2b. *For services not provided while the hearing is pending and if Trillium or a state fair hearing officer reverses a decision to deny, limit, or delay services, Trillium authorizes and provides the disputed service promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date notice revising the decision is received. This includes entering the prior authorization or adjusting claims, as applicable. In addition to the notification process outlined in this policy, Trillium makes reasonable effort to give the member (or representative, if applicable) and/or provider of the service (the party most appropriate to ensure coordination or fulfillment of the service) prompt verbal notice of the reversal (including as necessary multiple calls at different times of day). Notification is provided in writing, of the available services and how to access them in the 'Notice of Appeal Resolution'.* Pg 19. Added *When the ALJ reverses the CCO's decision to deny authorization of services, MCE 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 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 the MCE receiving the Final Order.* Pg 3 f added *When Trillium identifies that a member has an Authorized Representative, Trillium will assist the member with completion of the Authorized Representative form, as needed.* Pg 5 #4, Added *", including subcontractors if delegated,"*	2/13/24
Ad hoc Review	Revisions made based on OHA 2024 Medicaid Contract changes. H.9.iii Removed *Trillium authorizes the disputed service promptly and as expeditiously as the member's health condition requires, with Care Coordination assistance as deemed appropriate by Trillium or as requested by the member or member representative, but no later than 72 hours from the date notice revising the decision is received.* Replaced with *Trillium will provide the services or pay for the services or both in accordance with OAR 410-141-3910.* K.2.a Removed *Trillium authorizes the disputed services promptly and as expeditiously as the member's health condition requires, with Care Coordination assistance as deemed appropriate by Trillium or as requested by the member or member representative, but no later than 72 hours from the date that Trillium receives notice reversing the determination.*	11/7/23

	Replaced with *Trillium will provide the services or pay for the services or both in accordance with OAR 410-141-3910.* L.4.a. Removed *Trillium send the Notice of Appeal Resolution.* Replaced with *the date of the notice of appeal resolution.* Updated Non-Discrimination Notice to reflect most recent version. OHP-TRIL-23 S1704 10/24/23 Removed 410-141-3881 from references (OAR retired). Added reference 410-141-3525.	
Ad hoc Review	A.6 Added *its subcontractors and its participating providers* A.g.i.1 added *Nondiscrimination Policy Statements meet requirements outlined in the Nondiscrimination Statement Evaluation Checklist and are approved by OHA. The Nondiscrimination Statement Evaluation Checklist can be found at* https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-QA-Materials.aspx B.3.b added OHP H.9.iii. added *For services not provided while the appeal is pending and if Trillium reverses a decision to deny, limit, or delay services, Trillium authorizes the disputed service promptly and as expeditiously as the member's health condition requires, with Care Coordination assistance as deemed appropriate by Trillium or as requested by the member or member representative, but no later than 72 hours from the date notice revising the decision is received.* *iv. In addition to the notification process outlined in this policy, Trillium makes reasonable effort to give the member and/or provider of the service (the party most appropriate to ensure coordination or fulfillment of the service) prompt verbal notice of the reversal (including as necessary multiple calls at different times of day).* I.5 added *The elements contained in an adverse benefit determination are listed in OAR 410-141-3885 and in Trillium policy OR.MM.121 Denial Notices.*	6/27/23
Ad Hoc Review	Revisions made based on OHA 2023 Medicaid Contract Changes K.2a added *with Care Coordination assistance as deemed appropriate by Trillium or as requested by the member or member representative* K.2b added *Trillium will also make reasonable efforts to give the member and requesting provider prompt verbal notice of the reversal of an appeal decision, including multiple phone calls at different times of day.* Updated Non-Discrimination Notice to reflect most recent version OHP-TRIL-22 11.3.22	11/17/22
Ad hoc Review	Revisions made based on OHA G&A Policy Review: Under Policy: *, rules and contract requirements* A.3a. , Added *as appropriate,* A.3g Added *or contested hearing* A.7 Removed *Trillium, contracted provider offices, and subcontractors delegated appeals and grievances make* A.7 Added *Trillium administrative office and in those physical, behavioral, and oral health offices where Trillium has delegated responsibilities for appeal, hearing request, or grievance involvement shall have* A.9a Added *appeal to the member and the member's provider, where indicated,* A.9f Added *staff and any consulting experts* A.9g Added *(see Attachment #1), gender identity, ', ACA Section 1557'* B.1 Added *Trillium monitors and ensures that its providers and subcontractors comply with grievance and appeal system requirements in accordance with applicable laws and applicable contract provisions.* B.1 changed to B.2 B.3a Added *and the supporting reason for its resolution;, or Contested Case Hearing, including dates of review,* B.3g Added *or Contested Case Hearing, including dates of review;* B.3i Removed *documentation* B.3i Added *evidence, testimony, or additional documentation*, and *provider as part of the grievance, appeal or contested case hearing;* and *as part of the grievance, appeal or contested case hearing*	07/13/22

	B.4 Added *retains and keeps accessible all documentation, logs and other records for the Grievance and Appeal system whether in paper, electronic or other form for a minimum ten (10) years. These are kept* C.1 *Removed 45 CFR 164.501* C.1 Added *federal, state and contract requirements,* D.2a Added *and OAR 410-141-3875 through 410-141-3915.* D.2c Removed *ensures* D.2c Added *Ensures* D.2e *Documents all monitoring and corrective action activities.* D.2e Added *Documents all monitoring and corrective action activities.* D.3 Added *written notification of*, *Notice of Adverse Benefit Determination,*, *contested case* D.3 Added *as set forth in Ex. I, including the following (a)-(f). Trillium 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* E.4b Added *If the grievance is filed with the Authority, it shall be promptly forwarded to Trillium to address in accordance with Trillium's grievance and appeal system.* E.8b Added *"Easily understood' is 6th grade reading level or lower using the Flesch-Kincaid readability scale and use of minimum 12 point font or for large print, 18 point font.* E.8d Added *Contain notice* F Added *(Grievances Appeal)* for clarity H.2 Added *standard or expedited* and *to express disagreement with an adverse benefit determination:* H.2 Removed *an* H.8 Added *In the case of a standard and expedited appeals,* H.8 Removed *In the case of an expedited appeal,* H.9c.ii.1 Added *(including as necessary multiple calls at different times of day)* H.10a Added *The timeline for an expedited appeal requested orally shall begin when there is established contact made between the member and Trillium.* H.10a.i.2 Added *(including as necessary multiple calls at different times of day)* H.10a.ii.2 Added *(including as necessary multiple calls at different times of day)* I.1.a Added *as appropriate,* and *With respect to notification requirements, a* I.3.a Added *The same elements as the notice of action/adverse benefit determination, as appropriate.* I.3.d.ii Removed *of the state Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030)* I.3.d.ii.1 Added *of the Health Systems Division Service Denial Appeal and Hearing Request Form (OHP 3302)* I.4 Added this section. Added *The written Notice of Appeal Resolution shall be in a format approved by the Authority.* J.2 Added *(a provider will be considered the member's representative if that provider requested the contested case hearing on behalf of the member)* J.3.c Added *relied upon to take action, including those used as the basis for the initial action and all other relevant documents* J.3.c Removed *included in the file* J.3.d Added *as outlined in OAR 410-141-3890.* J.3.d *A request for an expedited hearing for a service that has already been provided (post service) to the member will not be granted.* Attachments. Added Attachment #1	
Ad Hoc Review	Revisions made based on OHA feedback. Policy added "Trillium's Grievance and Appeal System is designed to be culturally and linguistically responsive to the member's needs by considering the member's culture" and last sentence of paragraph. Procedure A.2. added "and, how to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP." Procedure A.4. added a.-e. Procedure A.8. added "in required timeframes" Procedure A.9.c. added "consistent with confidentiality requirements" Procedure A.9.g.i.1. added 1. Procedure E.3. added 3.a.-3.c. Procedure E.8. added 8.a.-8.c. Procedure E.9. added toll-free phone numbers for OHP CSU and OHP Ombudspersons Procedure H.2.b. removed b. regarding completion of Appeal form after receipt of verbal appeal to align with updated CFR requirements. Procedure I.1.a. added a. Procedure I.1.c. added "Trillium accommodates requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested." Procedure I.3.c.i. added "and particular sections of the statutes and rules involved for each reason identified in the NOAR relied upon to deny the appeal."	06/08/2021

	Procedure I.3.c.ii. added ii. "and right to an expedited hearing and how to do so; 1. Copies of the state Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030) are included with each NOAR;" Procedure J.3.b. added "with the authority using the Authority Administrative Hearing Request form (MSC 0443) or any other Authority approved appeal and hearing request form." Procedure J.3.d. added "may request an expedited hearing." Procedure L.3. added "the member or member's representative files an appeal or hearing quest timely," Procedure L.7. added "and if Trillium or a state fair hearing officer reverses a decision to deny, limit, or delay services,"	
Annual Review	Annual Review Policy added "Trillium considers member's literacy and language preference…." Procedure A. added number 1. Shifting all other lines down one number. Procedure A. added "and responsibilities" Procedure A.6. added "Oregon Health Plan Complaint Form (OHP 3001) and the" Procedure B. re-wrote Reporting and Logging Requirements to remove duplicate information. Procedure I. added "and their representative" and "and "Notice of Appeal Resolution when informing members of appeal resolutions." Procedure I.1.b.added Procedure J.3.c. and d. re-wrote to align with OAR requirements. Procedure L. re-wrote to align with OAR requirements. Updated references	02/25/2021
Ad hoc Review	Revised the scope to include updated service areas Procedure G.2. added notification to provider requirements Procedure H.8.d added punitive action is not taken against providers Procedure L.4.a. and b. updated to reflect updated OAR	02/08/2021
	Procedure B.2.a. added "date received" Procedure E.6. added "including those received verbally" Updated Adverse Benefit Determination definition Updated Grievance definition	8/13/2020
	Corrected grammar and formatting Updated Same-or-similar specialist definition Procedure A.4.c. added "in alternate formats and" Procedure A.4.e. added "through Legal Aid Services and Oregon Law Center" Procedure A.8.c. added "I" additional QOC process information Procedure B.5. added "within 5 business days" Updated OARs and Policies in Reference section	3/31/2020
Annual Review	Updated formatting and organization of text. Corrected OAR and NCQA references. Updated text in Procedure A.1. added "their rights to and the procedures". Procedure: B.5. to include correction process of OHA identified documentation deficiencies. Procedure H.12.a. added "acknowledges receipt,"	2/18/2020
	Revised and updated to reflect new OAR and clarified NCQA language re: including medical director information in the decision letter.	10/8/2019
	Removed duplication language; reorganized policy; removed language re: member ability to request a hearing at the same time they request an appeal for urgent situations; clarified definitions.	7/18/2019
	Updated language, revisions for grammatical errors, addition of regulation language clarified by NCQA and OHA, updated reference.	6/20/2019
Annual Review	Update and added additional information which reflects clarification in language.	2/15/2019
Annual Review	Review and update to revised OARs.	2/23/2018
Annual Review	Revisions including minor grammatical errors and addition of regulation language clarified by CMS ensure individuals who make decision on grievances and appeals take into account information provided by member.	2/21/2017
Annual Review	Mid-year revision; minor grammatical changes	10/31/2016

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.