OHP Member Appeals and Hearings

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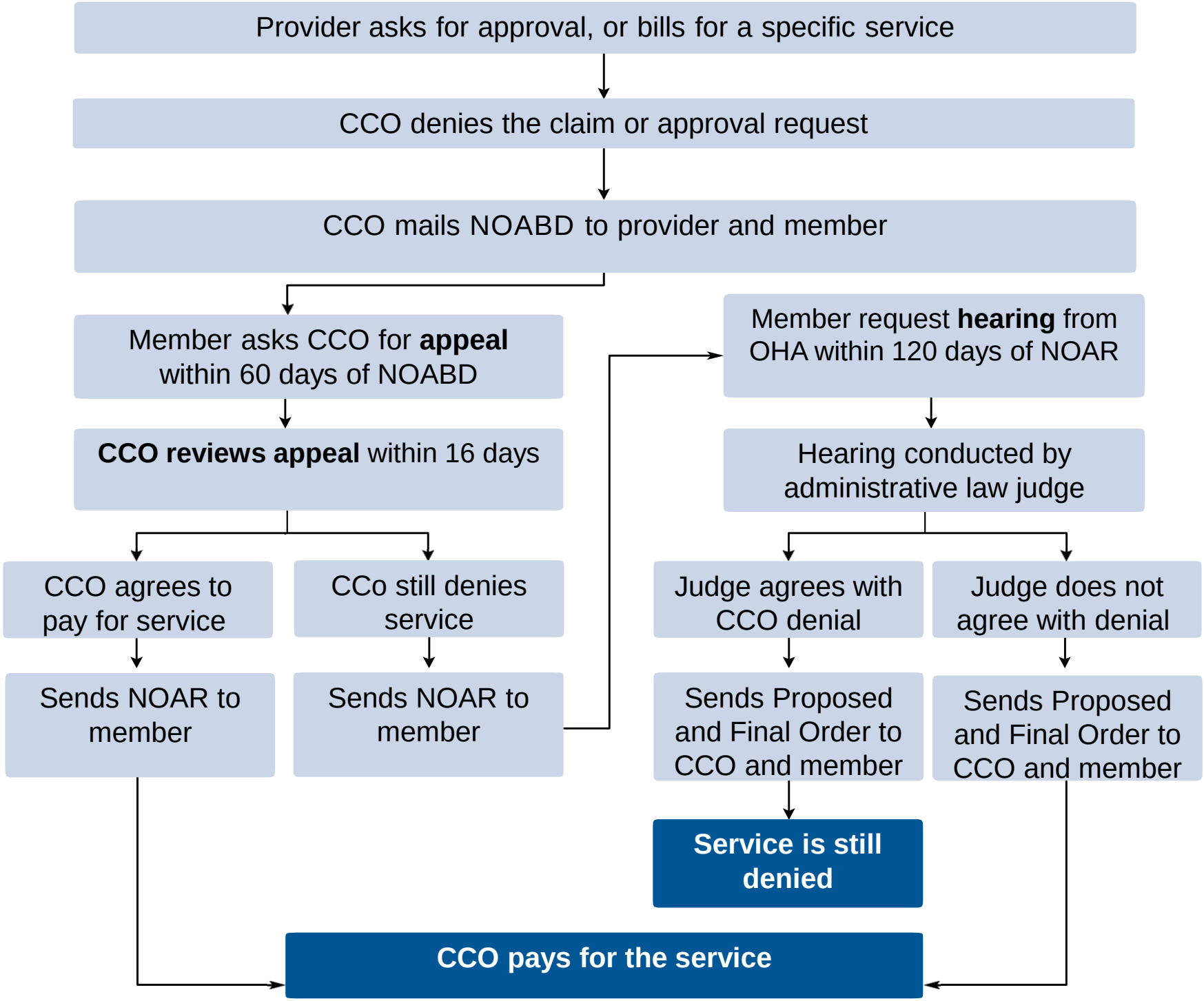
Oregon Health Authority

Federal Protections for Medicaid Members

- CCOs may not have more than one level of appeal
- Members have right to expedited appeal and hearings process if waiting puts member's life, health or ability to function in danger
- Right to request State fair hearing if adverse benefit determination is upheld or CCO does not make decision within required timeframes
- State may offer and arrange for external medical review if certain conditions are met:
  - Must be optional and at no cost
  - Must not be required before or used in place of State fair hearing
  - Must be independent of State and managed care entity
  - Must not extend grievance & appeal timeframes or disrupt continuation of benefits

CCO Member Appeals Process

1. Provider asks for prior approval (PA) or submits service claim
2. CCO denies PA or service claim
3. CCO mails Notice of Adverse Benefit Determination (NOABD) to provider and member
4. Member request appeal from CCO within 60 days of NOABD
5. CCO reviews appeal within 16 days, sending a Notice of Appeal Resolution (NOAR) to member indicating whether service paid or not
6. If appeal results in continued denial, member can request hearing from OHA within 120 days of NOAR
7. Administrative law judge holds hearing then notifies CCO & member of decision by sending Proposed and Final Order

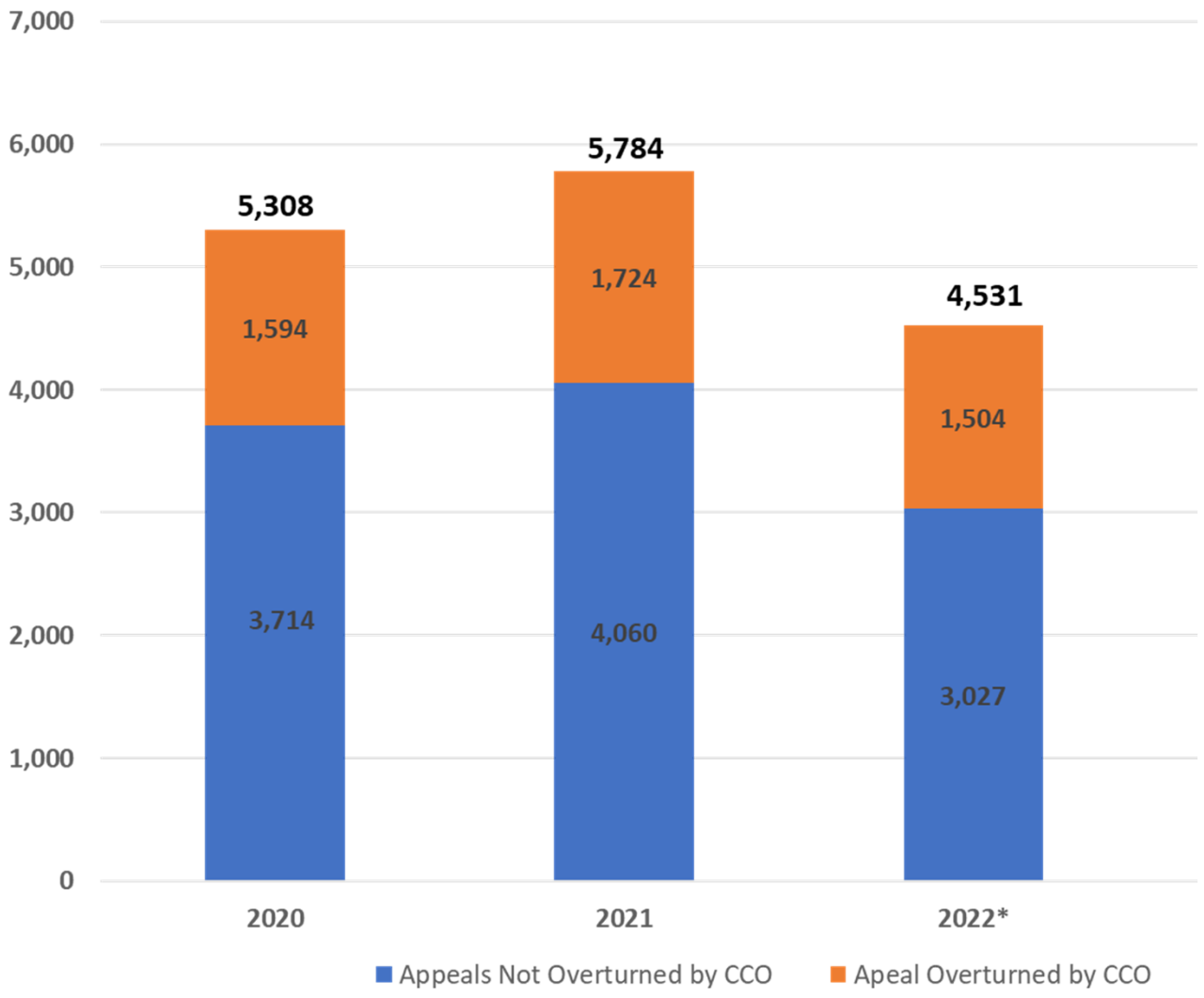

Provider asks for approval, or bills for a specific service
CCO denies the claim or approval request
CCO mails NOABD to provider and member
Member asks CCO for **appeal** within 60 days of NOABD
CCO reviews appeal within 16 days
CCO agrees to pay for service
CCo still denies service
Sends NOAR to member
Sends NOAR to member
Member request **hearing** from OHA within 120 days of NOAR
Hearing conducted by administrative law judge
Judge agrees with CCO denial
Judge does not agree with denial
Sends Proposed and Final Order to CCO and member
Sends Proposed and Final Order to CCO and member
Service is still denied
CCO pays for the service

OHA Oversight of CCO Grievance & Appeals

- Annual review of Grievance & Appeals System Policies & Procedures
- Annual review of Grievance & Appeals Member Notice templates
- Quarterly collection and bi-annual review of sample Notices of Adverse Benefit Determination
- Quarterly review Grievance & Appeals System log
- Annual review of Member Handbooks containing Grievance & Appeals System details.

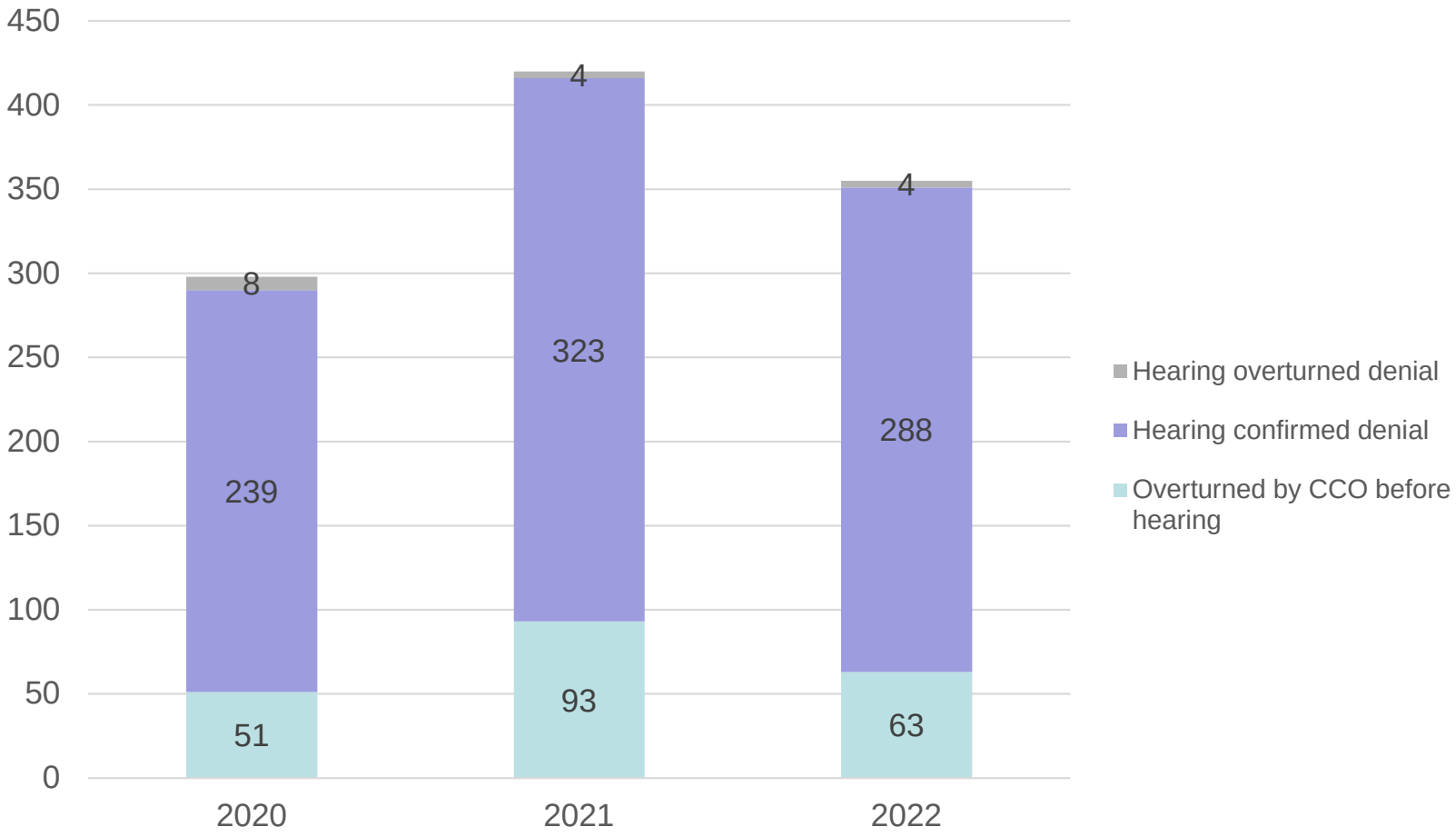
OHA also submits a quarterly report to the Centers for Medicare and Medicaid Services (CMS)

CCO Appeals



* - 2022 data through third quarter

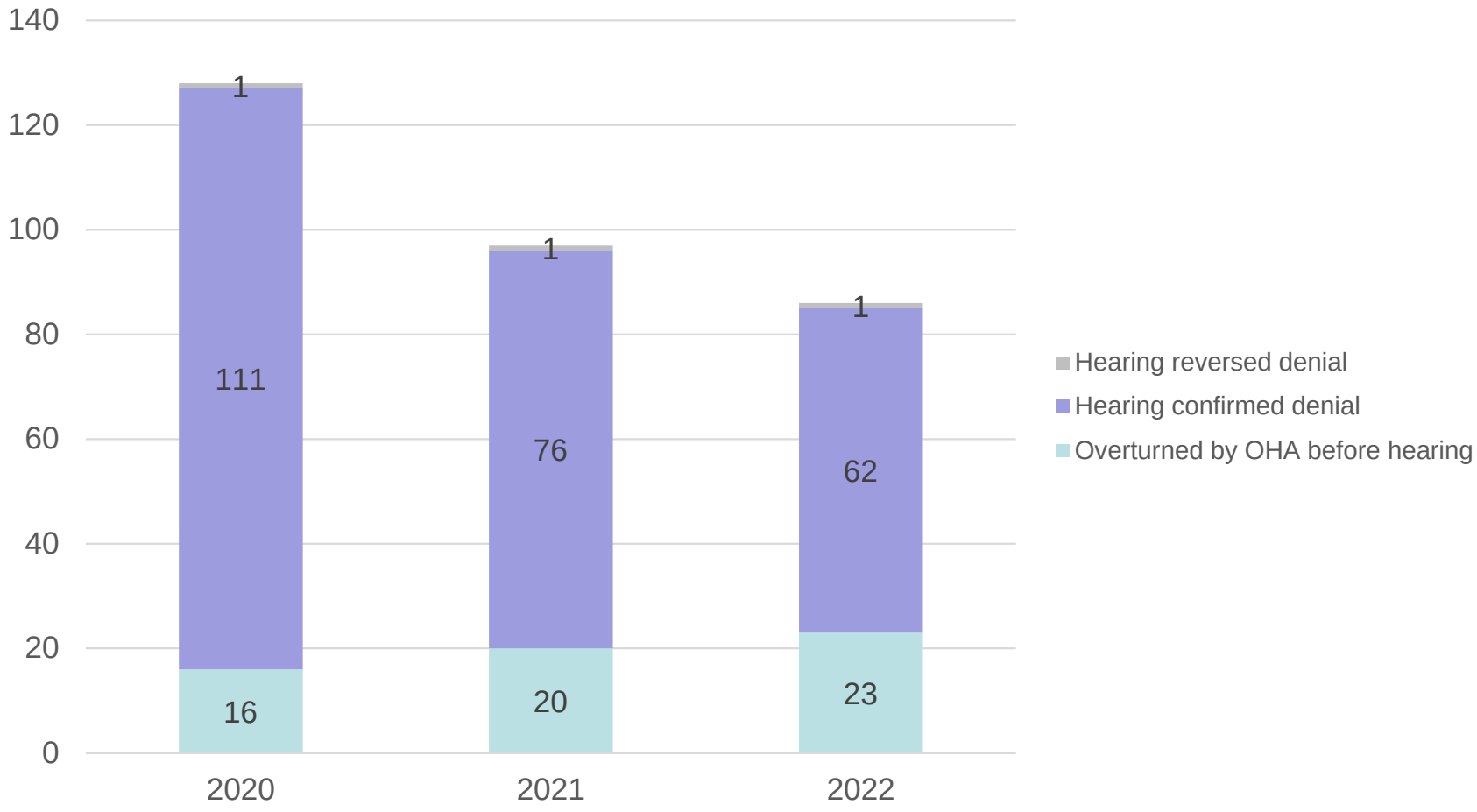
Hearings: CCO Members



Requests for hearings denied:

- 2020: 941 (844 for not completing CCO appeals process)
- 2021: 462 (420 for not completing CCO appeals process)
- 2022: 396 (327 for not completing CCO appeals process)

Hearings: Fee-For-Service Members



Requests for hearings denied:

- 2020: 22
- 2021: 22
- 2022: 24

Recent Change - EPSDT

- EPSDT = Early Periodic Screening Diagnostic Treatment
- Historically, Oregon Health Plan only covered services on prioritized list of conditions and treatments
- Effective January 1, 2023, EPSDT requires CCOs to cover all medically appropriate and medically necessary service for members under 21 years old

Can CCO's require prior authorization for EPSDT services not on prioritized list? No

- Prior authorization must be conducted on a case-by-case basis
- Prior authorization can't be required for any EPSDT screening services

Can CCO's use automatic denial for EPSDT services not on prioritized list? No

- Prioritized list can't be used as basis for denying service under EPSDT
- Service must be reviewed individually for medical appropriateness and medical necessity prior to a denial