PLAN OPERATIONS	Advantage Dental From DentaQuest			
	Policy and Procedure			
	Policy Name:	**Enrollee Grievance and Appeals**	Policy ID:	**PLANCG-24**
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PURPOSE

To establish Dental Care Organization's (DCO's) policy on how to process, respond to and resolve grievances and appeals by CCO enrollees and potential enrollees ("enrollees"). The DCO Grievance and Appeal System complies with the requirements set forth in the Oregon Administrative Rules, and partner contracts. Information about the DCO grievance and appeals system is included in the CCO Member Handbooks. This policy aims to receive and resolve grievances and appeals in a manner that is fair, efficient, and confidential and takes into account the needs, rights and responsibilities of the involved parties in compliance with state and federal laws.

POLICY

The following procedures are for use in all grievances and appeals filed with the DCO, whether oral or written. The DCO shall afford enrollees and potential enrollees, including enrollees and potential enrollees that are aged, blind, disabled having complex medical needs, or Special Health Care Needs, the full use of the procedures and shall cooperate in the Oregon Health Authority (OHA) hearings process. Any hearing requests made outside of DCO's grievance and appeal process or without previous use of DCO's grievance and appeal process shall be reviewed by DCO grievance and appeal process upon notification by OHA.

DCO shall inform enrollees both orally and in writing about DCO's grievance and appeal procedures. This shall be done through enrollee materials distributed at the time of enrollment in DCO and through communications with the Member Services Department. The DCO shall assure the enrollee of the confidentiality in the grievance and appeal process in the materials and communications provided. Potential enrollees and enrollees shall also be able to access information about DCO's grievance and appeals process on the DCO website or the CCO member handbook, or through communication with the DCO enrollee services department.

Every enrollee will be provided with reasonable assistance with the appeals and grievance process. This assistance may include help with filling out forms, steps in filing, availability of interpreter services, auxiliary aids, and toll-free numbers that have adequate TTY/TTD interpreter capacity. Assistance may also include aid from qualified community health workers, qualified peer wellness specialists, or personal health navigators to participate in processes affecting the member's care and services; as well as reasonable accommodation or policy and procedure modifications as required by any disability of the member. If the DCO identifies that an enrollee has an authorized representative, the DCO shall assist the enrollee with completion of the Authorized Representative form.

The DCO, its subcontractors, and its participating providers will not:

- Discourage an enrollee from filing a grievance, appeal, or hearing request or take punitive action against a provider who requests an expedited resolution or supports an enrollee's appeal;
- Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
- Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against an enrollee or to request enrollee disenrollment.

DESIGNATED STAFF FOR GRIEVANCE AND APPEALS PROCESS

DCO has designated the following staff responsible for the grievance and appeals in the grievance and appeals process:

A. Vice President of Clinical Services: The Vice President of Clinical Services or their designee(s), who are licensed dentists, shall be responsible for review and oversight of the written and oral grievance and appeal process.
B. Grievances and Appeals Department: The DCO's Grievances and Appeals Department shall be responsible for receiving, processing and responding to enrollee grievances and ensuring that all grievances are managed, documented, and reported according to written procedure. After completion of an investigation by the Grievances and Appeals Department, and review by the Vice President of Clinical Services or their designee(s), who are licensed dentists, the Grievances and Appeals Department shall review and reply in writing to the enrollee within required timeframes for grievance and appeals processing.
C. Grievances and Appeals Department will prepare an analysis of all grievances, both written and verbal, for review by the Quality Assurance and Performance Improvement Committee.
D. Peer Review and Credentialing Committee: The committee reviews the DCO grievance process annually for appropriate modifications. The committee review and approval of the process will be reflected in the committee meeting minutes. This committee is the final approval on the decisions of all grievances and appeals.
E. Quality Assurance and Performance Improvement Committee: This committee reviews all trend data regarding appeals. The committee reviews an analysis of all the grievances filed including analysis of grievance trend data. The committee reviews all grievances and appeals and the minutes of the committee meetings shall reflect this.

Individuals who make decisions on Grievances and Appeals are individuals who were not involved in any previous level of review or decision-making with respect to the Grievance or Appeal and were not a subordinate of an individual involved in any previous level of review or decision-making with respect to the Grievance or Appeal. The DCO shall ensure staff and any consulting experts making decisions on grievances and appeals are 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 enrollee. The DCO shall also ensure staff and any consulting experts making decisions on grievances and appeals follow all requirements in OAR 410-141-3875 MCE Grievance and Appeals System General Requirements.

CONFIDENTIALITY OF GRIEVANCE AND APPEALS PROCESS

DCO shall keep all information concerning an enrollee's grievance or appeal confidential. The staff is trained and notified of this at the time of employment. All information concerning an enrollee's grievance or appeal is kept confidential, except that the Coordinated Care Organization (CCO) and OHA have a right to this information without a signed release from the enrollee. The DCO 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 enrollee's signed release for purposes of resolving the matter; or maintaining the grievance or appeals log. DCO shall assure enrollees that grievances and appeals are handled in confidence consistent with ORS 411.320, 42 CFR 431.300, the HIPAA Privacy Rules, and other applicable federal and state confidentiality laws and regulations.

In the event the DCO needs to communicate with other external individuals or entities for reasons outside of those permitted or required by applicable privacy laws, including but not limited to HIPAA; the DCO shall obtain the enrollee's signed release and retain the release in the enrollee's record.

DEFINITIONS

- **"Adverse Benefit Determination"** means 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. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" is not an adverse benefit determination. . The failure to provide services in a timely manner, as defined by the State. The failure to act within applicable timeframes regarding the standard resolution of grievances and appeals. For a resident of a rural area with only one DCO, the denial of an enrollee's request to exercise his or her right to obtain services outside of the network. The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.
- **Appeal"** means a request by an enrollee or enrollee's representative for review of an Adverse Benefit Determination.
- **"Contested Case Hearing"** means a hearing before the OHA under the procedures of OAR 410-141-3900 (Grievances & Appeals: Contested Case Hearings) and 410-120-1860 (Contested Case Hearing Procedures).
- **"Continuing benefits"** means a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending. For continuing benefits, an enrollee who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending in determining timeliness, delay for good cause as defined in OAR 137-003-0528 is not counted. If the DCO continues or reinstates benefits at the enrollee's request, while the appeal or hearing is pending, the benefits must be continued until one of the following occurs: the enrollee fails to request a hearing and continuation of benefits within 10 calendar days after the DCO sends the notice of appeal resolution; the enrollee withdraws the appeal or request for hearing; a final order resolves the hearing.
- "**Enrollee**" With respect to actions taken regarding grievances, appeals, and hearings references to a 'enrollee' include, as appropriate, the enrollee, the enrollee's representative, family members and caregivers with hearing impairments or limited English proficiency who need to understand the enrollee's condition and care, and the representative of a deceased enrollee's estate. With respect to DCO notification requirements, a separate notice must shall be sent to each individual who falls within this definition.
- **"Grievance"** means an expression of dissatisfaction by an enrollee or enrollee's representative about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. grievance also includes an enrollee's right to dispute an extension of time proposed by the DCO to make an authorization decision.
- **"Grievance and appeal system"** means the processes the DCO implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.
- **"Limited English proficient (LEP)"** means potential enrollees, enrollees, the enrollee's representatives, family members and caregivers with hearing impairments or limited English proficiency who need to understand the enrollee's condition and care who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.
- **"Member"** With respect to actions taken regarding grievances, appeals and hearings, references to a 'member' include, as appropriate, the member's representative, family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care, and the

representative of a deceased member's estate. With respect to DCO notification requirements, a separate notice must shall be sent to each individual who falls within this definition.

- **"Prevalent"** means a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.
- **"Readily accessible"** means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

"State fair hearing" means the process adopted and implemented by the Department of Human Services, in compliance with Federal regulations and State rules relating to Medicaid Fair Hearings. The appeal process with the DCO must be completed before a fair Hearing is requested.

PROCEDURE

GRIEVANCE PROCESS

The enrollee or their representative may make a grievance either orally or in writing through DCO's internal grievance process, or may contact the State to file a grievance. To file a grievance with the State directly, the enrollee can call OHP Client Services at 800-273-0557 or can fill out and mail the OHP Complaint Form (OHP 3001), which can be found at OHP.Oregon.gov under Complaints and Appeals. Providers or other enrollee representatives must have the enrollee's written consent in order to file a grievance on their behalf. There is no timeline for submission of an enrollee grievance. In accordance with this policy, all contracted providers are required to report any enrollee grievance to the DCO. Contracted providers may also refer the enrollee to file a grievance directly with the DCO.

A. The DCO ensures all grievance reporting is completed according to Oregon Administrative Rules to meet quality assessment and performance improvement goals.

B. The DCO Grievance and Appeal System process is simple, accessible, and understandable to the enrollee. The enrollee's literacy and language of preference is considered in the development of G&A process/procedures. The DCO's Grievance and Appeal System policies and procedures are specifically designed to be culturally and linguistically responsive. The DCO shall review and report to the (OHA and/or applicable CCO) any grievances that raise issues related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service request, disability status, and other identity factors.

C. Upon receipt of a grievance, the DCO shall:
    a. Within five business days, resolve or acknowledge receipt of the grievance to the enrollee and the enrollee's provider where indicated;
    b. Give the grievance to staff with the authority to act upon the matter;
    c. Obtain documentation of all relevant facts concerning the issues;
    d. Ensure staff and any consulting experts making decisions on grievances are:
        i. Not involved in any previous level of review or decision making nor a subordinate of any such individual;
        ii. Health care professionals with appropriate clinical expertise in treating the enrollee's condition or disease, if the grievance involves clinical issues or if the enrollee requests an expedited review. Health care professionals shall make decisions for the following:
            1. A grievance regarding denial of expedited resolution of an appeal or involves clinical issues.
            2. Taking into account all comments, documents, records, and other information submitted by the enrollee without regard to whether the information was submitted or considered;

e. 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 enrollee.
    i. If the decision involves a grievance regarding denial of expedited resolution of an appeal.
    ii. If the decision involves a grievance or appeal involving clinical issues.

D. Credentials of the reviewer are documented clearly in the review process in order to determine that the appropriate level of clinical provider was involved in making the decision.

E. DCO shall make available grievance forms (OHP 3001, MSC 443, OHP 3030, OHP 3302 and MCE appeal forms) in all administrative offices and in all dental offices where staff have been designated to respond to grievances. Enrollees have the right to register a grievance in the following manner:

1) Through the Provider/Staff:
    a) An enrollee or their representative may relate any incident or concern to a provider or other staff orally or in writing to express disagreement with an adverse benefit determination.
    b) The provider or staff shall direct the enrollee to the Grievances and Appeals Department or Member Services Department, who are designated to receive grievances as identified in the DCO's welcome packet. If the grievance is received by the provider orally or in writing the provider should submit the grievance/grievance information to the Grievances and Appeals Department by fax at 1-541-516-4342.

2) Through the DCO Internal Grievance Process:
    a) Enrollees may choose to utilize DCO's internal grievance procedure. If the enrollee files a grievance to DCO's Member Services, the Member Services Representative (MSR) shall inform the enrollee of the grievance process. The MSR shall:
        i. Attempt to resolve the grievance over the phone as a one-call resolution; or
        ii. File an oral grievance on behalf of the enrollee; or
        iii. Mail an OHA grievance form (OHP 3001) to the enrollee

    All oral and one-call resolution grievances will be sent to the Grievances and Appeals Department for documentation and additional follow up as needed.
    b) The Grievances and Appeals Department will work with the enrollee to resolve all grievances and notify the enrollee as expeditiously as the enrollee's health conditions require but no later than 5 business days from the date of receipt of the grievance. Grievances and Appeals Department will ensure that adequate processing time is available for response translation if needed within the required timeframe. If more time is needed, the DCO's shall notify the enrollee that the DCO decision will not exceed thirty (30) calendar days from the date of the receipt of the enrollee Grievance, and the reason additional time is necessary.
    c) The DCO's decision will not exceed thirty (30) calendar days from the date of the receipt of the enrollee Grievance, and the reason additional time is necessary.
    d) If it is determined by the DCO that the grievance is regarding a denial of services, the grievance will immediately be transferred to the appeals process.
    e) If the enrollee does not wish to attempt to resolve the grievance through the use of DCO's internal grievance process, they shall be notified that the enrollee has the right to seek resolution through the Department of Human Services (Department) Client Services Unit or the OHA's Ombudsperson.

F. Resolution: The DCO may provide its decision related to oral grievances orally but shall also, in call instances respond to oral grievances in writing, within the timelines described above, but no later than 30 calendar days from the date of receipt of the enrollee grievance. Grievances and Appeals Department will

ensure that adequate processing time is available for response translation if needed within the required timeframe. The DCO shall respond in writing to written grievances. Written responses shall be sufficiently clear that a layperson could understand the disposition of the grievance and make an informed decision about appealing the grievance resolution. Both oral and written responses shall be made in the enrollees preferred language and shall address each aspect of the grievance and explain the reason for the decision. Included in each notice of resolution to the enrollee that is not in favor of the enrollee, or for enrollees who are dissatisfied with the disposition of a grievance, is notification that they may present the Grievance to OHP Client Services Unit (CSU) toll free at 800-273-0557 or OHA's Ombudsman at 503-947-2346 or toll free at 877-642-0450. Each notice of resolution shall also include the DCOs Nondiscrimination Policy Statement.

G. In the event that the DCO receives a service authorization request for pharmaceutical services, the DCO shall notify the prescribing provider to resubmit to the CCO who is responsible for a coverage decision.

NOTICE OF ACTION AND APPEAL PROCESS

A. Appeal of Notice of Action Benefit Denial. Notice of Action Benefit Denial letters are sent as set forth in the Notice of Action Benefit Denial Policy and the Pre-Authorization Policy. An enrollee, enrollee's representative, or provider with enrollee's written consent may appeal a Notice of Action Benefit Denial orally or in writing through the DCO Appeal process to express disagreement with an adverse benefit determination. The DCO has only one level of appeal for enrollees. The enrollee must go through DCO's Appeal process before requesting an OHA Administrative Hearing. Enrollees also have the right to file an appeal on the basis of the DCO's failure to meet the State timeframes regarding standard resolution of grievances and appeals.

1) Standard Appeal through DCO Appeal Process:

a) **Deadline to File Appeal:** Enrollee must file an appeal with DCO no later than 60 calendar days from the date on the Notice of Action Benefit Denial. Any appeal received by DCO will be promptly transferred to the Grievances and Appeals Department to begin the appeal process. Enrollee can file an appeal directly with DCO, either orally or in writing by contacting DCO Enrollee Services.
Oral inquiries seeking to appeal a Notice of Action Benefit Denial are treated and processed as an appeal. Oral appeal timeframes shall begin when there is established contact made between the enrollee and a DCO representative. If the enrollee leaves a voice mail message with the DCO indicating that they wish to appeal a denial, the DCO shall make reasonable efforts (multiple calls at different times of day) to reach the enrollee by phone to get the details of the service they wish to appeal. The DCO shall document each attempt to reach the enrollee (date(s) and time(s)) by phone and make note on the date they establish contact with the enrollee and are able to attain the appeal information needed to process the appeal.

b) **Present Evidence:** Enrollee shall have a reasonable opportunity to make legal and factual arguments, present evidence, and allegations orally, in person, or in writing. Enrollees have an opportunity, before and during the appeal process, to examine the enrollee's file, including medical records and any other documents or records to be considered during the appeal process.

c) **Parties to Appeal:** Parties to the appeal may include the DCO, Coordinated Care Organization (CCO), enrollee or enrollee's representative; a provider acting on behalf of a member, with written consent from the member, DCO or the legal representative of a deceased member's estate.

d) **Response to Appeal:** Upon receipt of a standard appeal, the DCO shall,

1. Within five business days, resolve or acknowledge receipt of the appeal to the enrollee and the enrollee's provider where indicated;
2. Give the appeal to staff with the authority to act upon the matter;

3. Obtain documentation of all relevant facts concerning the issues;
4. Ensure staff and any consulting experts making decisions on appeals are:
    a. Not involved in any previous level of review or decision making nor a subordinate of any such individual;
    b. Health care professionals with appropriate clinical expertise in treating the enrollee's condition or disease, if the appeal involves clinical issues or if the enrollee requests an expedited review. Health care professionals shall make decisions for the following:
        i. An appeal regarding denial of expedited resolution of an appeal or involves clinical issues.
    c. Taking into account all comments, documents, records, and other information submitted by the enrollee without regard to whether the information was submitted or considered in the initial adverse benefit determination;
    d. 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 enrollee. The DCO shall ensure that decision makers on appeals of adverse benefit determinations are individuals with appropriate clinical expertise, as determined by the state, in treating the enrollee's condition or disease:
        i. If the decision involves an appeal of a denial based on lack of medical necessity.
        ii. If the decision involves an appeal involving clinical issues.

e) The DCO shall inform the enrollee of the limited time available for receipt of materials or documentation sufficiently in advance of the resolution timeframe for both standard and expedited appeals for the review. The DCO shall resolve all appeals as expeditiously as the enrollee's health condition requires and no later than the expiration date of the extension. The DCO shall provide the enrollee and their representative the enrollee's case file (including medical records, other documents and records), and any new or additional evidence considered, relied upon, or generated by the DCO (or at the direction of the DCO) in connection with the appeal of the adverse benefit determination. The DCO shall provide the enrollee and their representative the enrollee's case file free of charge and sufficiently in advance of the resolution timeframe for standard appeal resolutions.

f) **Resolution of Appeal:** DCO must provide a written Notice of Appeal Resolution to the enrollee. For standard resolution of an appeal, the DCO shall establish a timeframe that is no longer than 16 days from the day the DCO receives the appeal The written Notice of Appeal Resolution shall be in a format approved by the OHA. The written Notice of Appeal Resolution must include, as appropriate, the same elements as the notice of action/adverse benefit determination, as specified in OAR 410-141-3885 in addition to: the date the enrollee filed the appeal with the DCO, the results of the appeal and the date it was completed, and the effective date of the appeal decision. If the resolution was not in the enrollee's favor, the notice must also include the reasons for the resolution and a reference to the statutes and rules involved for each reason relied upon to deny the appeal. The written notice must state the right of an enrollee to file a grievance with the DCO if he or she disagrees with that decision. The notice must also inform the enrollee of their right for a contested hearing or expedited hearing with OHA, how to request one, and attach the Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) The notice must state the enrollee's right to receive benefits while the hearing is pending, how to make the request, and that the enrollee will be liable for those benefits if the hearing upholds DCO's decision. For appeals

resolved partially or wholly in favor of the enrollee the notice must include an explanation that the enrollee may now access those benefits that were denied and how to do so.

g) **No Retaliation:** A provider will not be subject to punitive action for requesting an expedited resolution or for supporting an enrollee's request for an appeal or expedited resolution.

h) **Continuation of Benefits:** To be entitled to continuing benefits, the member shall complete a DCO appeal request or an OHA contested case hearing request form and check the box requesting continuing benefits by either the tenth day following the date of the notice of adverse benefit determination or the notice of appeal resolution; or by the effective date of the action proposed in the notice, if applicable. When an enrollee requests an appeal or hearing by telephone, the enrollee may request continuation of benefits verbally. DCO shall continue the enrollee's benefits if: (1) the appeal or contested hearing request involves the termination, suspension or reduction of a previously authorized covered service; (2) the covered services were ordered by an authorized provider; (3) the original period covered by the original authorization has not expired; and (4) the enrollee, enrollee's representative or provider, with the enrollee's written or oral consent, timely files for continuation of benefits. For purposes of this paragraph, "timely" means the filing was on or before the later of: (1) within 10 days after the DCO mailed the Notice of Action or (2) the intended effective date of the DCO's proposed action. If the DCO receives a grievance related to an enrollee's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one DCO/CCO to another DCO/CCO as defined in OAR 410-141-3850, the DCO shall log the grievance and work with the receiving or sending DCO/CCO to ensure continuity of care during the transition

i) **Duration of Benefits:** If, at the enrollee's request, the DCO continues or reinstates the enrollee's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of the following occurs: (1) the enrollee withdraws the appeal or request for hearing; (2) The enrollee fails to request a state fair hearing and continuation of benefits within 10 calendar days from the date of the Notice of Appeal Resolution letter; (3) a contested hearing decision is adverse to the enrollee.

j) **Enrollee's responsibilities for services furnished while the appeal is pending:** If the final resolution of the appeal is adverse to the enrollee (i.e. upholds the DCO's decision to deny the service), the DCO may recover from the enrollee the cost of the services furnished to the enrollee while the appeal was pending.

k) **Services while an appeal is pending**:

i. Services Furnished: If DCO or a contested hearing reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the DCO will for those services in accordance with the Authority policy and regulations.

ii. Services Not Furnished: If DCO or a contested hearing reverses a decision to deny, limit or delay services and those services were NOT provided while the appeal was pending, then DCO shall authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires. . The DCO must take the following steps;

i. Notify the enrollee, the enrollee's representative (if applicable) both orally and in writing and the enrollee's provider in writing of the available services and how to access them;

ii. Enter the prior authorization into the system or adjust the encounter data claim representing the service.

l) **Failure to act within timeframes:** If the DCO fails to adhere to the notice and timing requirements resolution of appeals, the enrollee is considered to have exhausted the appeals process. In this case, the enrollee may request a hearing through OHA.

m) **Extended timeframe**: The DCO may extend timeframes by up to 14 days if:

i. The enrollee requests the extension; or

ii. The DCO shows to the satisfaction of the Authority upon its request that there is need for additional information and how the delay is in the enrollee's interest.

iii. If the DCO extends the timeframes but not at the request of the enrollee, the DCO shall:

a. Make reasonable efforts (including as necessary multiple calls at different times of day) to give the enrollee prompt oral notice of the delay;

b. Within two (2) days, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if the enrollee disagrees with that decision;

c. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

3) Contested Hearing through OHA:

a) If an enrollee is unsatisfied with DCO's resolution of the appeal, the enrollee may request a contested hearing or expedited hearing with OHA (after receiving notice that an adverse benefit determination is upheld). The request must be made within 120 calendar days from the date on the Notice of Appeal Resolution. DCO must retain a complete record of the appeal for more than 120 days so that if the enrollee requests a hearing, the record can be submitted to the OHA Hearing Unit within 2 business days. A request for an expedited hearing for a service that has already been provided (post-service) to the enrollee will not be granted.

b) If the enrollee files a request for a contested hearing or expedited hearing through OHA without first requesting an appeal through DCO, OHA will transfer the request to the DCO and provide notice of the transfer to the enrollee. The DCO will complete the appeal process within 16 days and provide a Notice of Appeal Resolution.

c) If a provider filed an appeal on behalf of an enrollee, the provider may subsequently request a hearing on behalf of the enrollee. Appeals brought on the provider's own behalf are not subject to this rule, which governs appeals brought by enrollee or by a provider on the enrollee's behalf but are governed by OAR 410-120-1560

d) If the enrollee sends the hearing request to the DCO after the DCO has already completed the appeal, the DCO will date-stamp the hearing request with the date of receipt; and submit within two business days to OHA a copy of the hearing request, the Notice of Adverse Benefit Determination and Notice of Appeal Resolution and all documents and records the DCO relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records the OHA requests as outlined in detail in OAR 141-410-3890.

e) Parties to the hearing may include the DCO, Coordinated Care Organization (CCO), enrollee or enrollee's representative; a provider acting on behalf of a member, with written consent from the member, DCO or the legal representative of a deceased member's estate.

f) Enrollees have the right to have an attorney or representative present at the hearing and can access free legal help through Legal Aid Services and Oregon Law Center. Information can be accessed from the Public Benefits Hotline (1-800-520-5292, TTY 711).

g) The enrollee has no less than 90 calendar days and no more than 120 calendar days from the date of the DCO's, notice of resolution to request a State fair hearing.

h) **Continuation of Benefits:** To be entitled to continuing benefits, the member shall complete a DCO appeal request or an OHA contested case hearing request form and check the box requesting continuing benefits by either the tenth day following the date of the notice of adverse benefit determination or the notice of appeal resolution; or by the effective date of the

action proposed in the notice, if applicable. When an enrollee requests an appeal or hearing by telephone, the enrollee may request continuation of benefits verbally. DCO shall continue the enrollee's benefits if: (1) the enrollee or the enrollee's representative files the appeal or contested hearing request timely; (2) the appeal or contested hearing request involves the termination, suspension or reduction of a previously authorized covered service; (3) the covered services were ordered by an authorized provider; (4) the original period covered by the original authorization has not expired; and (5) the enrollee timely files for continuation of benefits. For purposes of this paragraph, "timely" means the filing was on or before the later of: (1) within 10 days after the DCO mailed the Notice of Action or (2) the intended effective date of the DCO's proposed action. If the DCO receives a grievance related to an enrollee's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one DCO/CCO to another DCO/CCO as defined in OAR 410-141-3850, the DCO shall log the grievance and work with the receiving or sending DCO/CCO to ensure continuity of care during the transition.

i) **Duration of Benefits:** If, at the enrollee's request, the DCO continues or reinstates the enrollee's benefits while the contested case hearing is pending, the benefits must be continued until one of the following occurs: (1) the enrollee withdraws the appeal or request for hearing; (2) The enrollee fails to request a state fair hearing and continuation of benefits within 10 calendar days from the date the DCO sends the Notice of Appeal Resolution letter; (3) a contested hearing decision is adverse to the enrollee;

j) **Services furnished while the hearing is pending:** If the final resolution of the hearing is adverse to the enrollee (i.e. upholds the DCO's decision to deny the service), the DCO may recover from the enrollee the cost of the services furnished to the enrollee while the appeal was pending. . If a decision to deny authorization of services is reversed and the enrollee received the disputed services while the appeal was pending, the DCO or the Authority shall pay for those services in accordance with the Authority policy and regulations.

k) **Services not furnished while the hearing is pending:**
If a decision to deny, limit or delay services that were not furnished while the appeal/hearing was pending, is reversed, the DCO shall authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. The DCO must take the following steps;
    a. Notify the enrollee, the enrollee's representative (if applicable) both orally and in writing and the enrollee's provider in writing of the available services and how to access them;
    b. Enter the prior authorization into the system or adjust the encounter data claim representing the service.

l) Any party to the hearing 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 enrollee within 72 hours of the DCO receiving the Final Order.

2) **Expedited Appeal through DCO Appeal Process:**
   a) **Deadline to File Appeal:** Deadline to File Appeal: The DCO has established and maintains an expedited review process for all oral and written appeals for when the DCO determines (for a request from the enrollee) or when the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The enrollee must file an appeal with DCO no later than 60 calendar days from the date on the Notice of Action Benefit Denial. Any appeal received by DCO will be promptly transferred to the Grievances and Appeals Department to begin the appeal process. Enrollee can file an appeal directly with DCO, either orally or in writing by contacting DCO Member Services. Oral inquiries seeking to appeal a Notice of Action Benefit Denial are treated and processed as an appeal. Oral appeal timeframes shall begin when there is established contact made between the enrollee and a DCO representative. If the enrollee leaves a voice mail message with the DCO indicating that they wish to appeal a denial, the DCO shall make reasonable efforts (multiple calls at different times of day) to reach the enrollee by phone to get the details of the service they wish to appeal. The DCO shall document each attempt to reach the enrollee (date(s) and time(s)) by phone and make note on the date they establish contact with the enrollee and are able to attain the appeal information needed to process the appeal.
   b) **Present Evidence:** Enrollee shall have a reasonable opportunity to make legal and factual arguments, present evidence, and allegations orally, in person, or in writing. Enrollees have an opportunity, before and during the appeal process, to examine the enrollee's file, including medical records and any other documents or records to be considered during the appeal process.
   c) **Parties to Appeal:** Parties to the expedited appeal may include the DCO; Coordinated Care Organization (CCO); enrollee or enrollee's representative; a provider acting on behalf of an enrollee, with written consent from the enrollee, DCO or the legal representative of a deceased enrollee's estate.
   d) **Response to Appeal:** Upon receipt of an expedited appeal, the DCO shall:
      (1) Acknowledge receipt of the expedited appeal to the enrollee and the enrollee's provider where indicated, both orally and in writing within one business day;
      (2) Obtain documentation of all relevant facts concerning the issues;
      (3) Ensure staff and any consulting experts making decisions on appeals are:
         (a) Not involved in any previous level of review or decision making nor a subordinate of any such individual;
         (b) Health care professionals with appropriate clinical expertise in treating the enrollee's condition or disease, if the appeal involves clinical issues or if the enrollee requests an expedited review. Health care professionals shall make decisions for the following:
            (i) An appeal regarding denial of expedited resolution of an appeal or involves clinical issues.
            (ii) Taking into account all comments, documents, records, and other information submitted by the enrollee without regard to whether the information was submitted or considered in the initial adverse benefit determination;
         (c) 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 enrollee.

   The DCO shall inform the enrollee of the limited time available for receipt of materials or documentation sufficiently in advance of the resolution timeframe for both standard and expedited appeals for the review. The DCO shall resolve all appeals as expeditiously as the enrollee's health condition requires and no later than the expiration date of the extension. The DCO shall provide the enrollee and their representative the enrollee's case file (including medical records, other documents and records), and any new or additional evidence considered, relied upon, or generated by the DCO

(or at the direction of the DCO) in connection with the appeal of the adverse benefit determination. The DCO shall provide the enrollee and their representative the enrollee's case file free of charge and sufficiently in advance of the resolution timeframe for standard appeal resolutions.

e) **Expedited Resolution:** If the enrollee requests expedited resolution of the appeal and such request is granted, upon receipt of an expedited appeal, the DCO shall acknowledge receipt of the expedited appeal to the enrollee and the enrollee's provider where indicated, both orally and in writing within one business day. DCO shall resolve the appeal as expeditiously as the enrollee's health condition requires and make reasonable efforts to call (including as necessary multiple calls at different times of the day) the enrollee and provider with notice of the resolution no later than 72 hours after DCO receives the appeal. The DCO shall inform the enrollee of the limited time available for receipt of materials or documentation sufficiently in advance of the resolution timeframe for both standard and expedited appeals for the review. The DCO will mail written confirmation of the resolution to the enrollee within 72 hours. This timeframe may be extended as described above in paragraph (d). If DCO denies enrollee's request for expedited resolution, DCO will transfer the appeal to the time frame for standard resolutions. The DCO shall resolve the appeal no later than 16 days from the day the DCO receives the appeal with a possible 14 day extension.
The DCO may extend the timeframe for processing an expedited appeal by up to 14 calendar days: 1) If the member requests the extension; or 2) If the DCO (to the satisfaction of OHA upon its request) shows that there is need for additional information and that the delay is in the member's interest. If the DCO extends the timeline for processing an expedited appeal not at the request of the member, the DCO will make reasonable efforts to give the member prompt oral notice of the delay (including as necessary multiple calls at different times of day) and give the member written notice, within 2 calendar days, of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if they disagree with that decision. The DCO shall resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. The expedited review process applies to both written and oral appeals. Oral appeal timeframes shall begin when there is established contact made between the enrollee and a DCO representative. A request for an expedited appeal for a service that has already been provided (post-service) to the enrollee will not be granted. The DCO shall transfer the appeal to the timeframe for standard resolution.

f) **Resolution of Appeal**: The DCO shall make reasonable efforts (including as necessary multiple calls at different times of day) to provide oral notice, of the resolution of an expedited appeal and follow-up within two days with a written notice. The written notice must state the right of an enrollee to file a grievance with the DCO if he or she disagrees with that decision. The written Notice of Appeal Resolution shall be in a format approved by the OHA. The written Notice of Appeal Resolution must include, as appropriate, the same elements as the notice of action/adverse benefit determination, as specified in OAR 410-141-3885 in addition to: the date the enrollee filed the appeal with the DCO, the results of the appeal and the date it was completed, and the effective date of the appeal decision. If the resolution was not in the enrollee's favor, the notice must also include the reasons for the resolution and a reference to the statutes and rules involved for each reason relied upon to deny the appeal. The notice must also inform the enrollee of their right for a contested hearing or expedited hearing with OHA, how to request one, and attach the Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) The notice must state the enrollee's right to receive benefits while the hearing is pending, how to make the request, and that the enrollee will be liable for those benefits if the hearing upholds DCO's decision. For appeals resolved partially or wholly in favor of the enrollee the notice must include an explanation that the enrollee may now access those benefits that were denied and how to do so.

g) **No Retaliation:** A provider will not be subject to punitive action for requesting an expedited resolution or for supporting an enrollee's request for an appeal or expedited resolution.

h) **Continuation of Benefits:** To be entitled to continuing benefits, the enrollee shall complete a DCO appeal request or an OHA contested case hearing request form and check the box requesting continuing benefits by either the tenth day following the date of the notice of adverse benefit determination or the notice of appeal resolution; or by the effective date of the action proposed in the notice, if applicable. When an enrollee requests an appeal or hearing by telephone, the enrollee may request continuation of benefits verbally. DCO shall continue the enrollee's benefits if: (1) the appeal or contested hearing request involves the termination, suspension or reduction of a previously authorized covered service; (2) the covered services were ordered by an authorized provider; (3) the original period covered by the original authorization has not expired; and (4) the enrollee, enrollee's representative or the provider, with the enrollee's written or oral consent, timely files for continuation of benefits. For purposes of this paragraph, "timely" means the filing was on or before the later of: (1) within 10 days after the DCO mailed the Notice of Action or (2) the intended effective date of the DCO's proposed action. If the DCO receives a grievance related to an enrollee's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one DCO/CCO to another DCO/CCO as defined in OAR 410-141-3850, the DCO shall log the grievance and work with the receiving or sending DCO/CCO to ensure continuity of care during the transition

i) **Duration of Benefits:** If, at the enrollee's request, the DCO continues or reinstates the enrollee's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of the following occurs: (1) the enrollee withdraws the appeal or request for hearing; (2) The enrollee fails to request a state fair hearing and continuation of benefits within 10 calendar days from the date the DCO sends the Notice of Appeal Resolution letter; (3) a contested hearing decision is adverse to the enrollee.

j) **Enrollee's responsibilities for services furnished while the appeal is pending:** If the final resolution of the appeal is adverse to the enrollee (i.e. upholds the DCO's decision to deny the service), the DCO may recover from the enrollee the cost of the services furnished to the enrollee while the appeal was pending.

k) **Services while an appeal is pending:**
   i) Services Furnished: If DCO or a contested hearing reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the DCO will pay for those services in accordance with the Authority policy and regulations.
   ii) Services Not Furnished: If DCO or a contested hearing reverses a decision to deny, limit or delay services and those services were NOT provided while the appeal was pending, then DCO shall authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires. The DCO must take the following steps;
      (1) Notify the enrollee, the enrollee's representative (if applicable) both orally and in writing and the enrollee's provider in writing of the available services and how to access them;
      (2) Enter the prior authorization into the system or adjust the encounter data claim representing the service.

4) Expedited Hearing through OHA:

a) **Request for Expedited Hearing.** The DCO has a system in place to ensure its enrollees and providers have access to expedited review for MCE's action by requesting an expedited contested case hearing. If an enrollee is unsatisfied with DCO's resolution of the appeal, the enrollee may request an expedited contested hearing with OHA (after receiving notice that an adverse benefit determination is upheld). Expedited hearings are requested using OHA form MSC 443 or other OHA-approved appeal or hearing request forms. An enrollee, or provider, who believes that taking the time for a standard resolution of a Contested Case Hearing could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function may request an expedited Contested Case Hearing as described in OAR 410-141-3905. DCO will retain a complete record of the appeal for more than 120 days so

that if the enrollee requests a hearing, the record can be submitted to the OHA Hearing Unit within 2 business days. A request for an expedited hearing for a service that has already been provided (post-service) to the enrollee will not be granted.

b) If the enrollee files a request for an expedited hearing through OHA without first requesting an appeal through DCO, OHA will transfer the request to the DCO and provide notice of the transfer to the enrollee. The DCO will complete the appeal process within 16 days and provide a Notice of Appeal Resolution.

c) If a provider filed an appeal on behalf of an enrollee, the provider may subsequently request a hearing on behalf of the enrollee. Appeals brought on the provider's own behalf are not subject to this rule, which governs appeals brought by enrollee or by a provider on the enrollee's behalf but are governed by OAR 410-120-1560

d) DCO will submit relevant information to OHA within two working days about an expedited appeal decision. OHA shall decide within two working days from the date of receiving the relevant documentation applicable to the request whether the enrollee is entitled to an expedited contested case hearing.

e) Parties to the hearing may include the DCO; Coordinated Care Organization (CCO); enrollee or enrollee's representative; a provider acting on behalf of an enrollee, with written consent from the enrollee, DCO or the legal representative of a deceased enrollee's estate.

f) Enrollees have the right to have an attorney or representative present at the hearing and can access free legal help through Legal Aid Services and Oregon Law Center. Information can be accessed from the Public Benefits Hotline (1-800-520-5292, TTY 711).

g) The enrollee has no less than 90 calendar days and no more than 120 calendar days from the date of the DCO's, notice of resolution to request a State fair hearing.

h) **Services furnished while the hearing is pending:** If the final resolution of the hearing is adverse to the enrollee (i.e. upholds the DCO's decision to deny the service), the DCO may recover from the enrollee the cost of the services furnished to the enrollee while the appeal was pending. If a decision to deny authorization of services is reversed and the enrollee received the disputed services while the appeal was pending, the DCO or the Authority shall pay for those services in accordance with the Authority policy and regulations.

i) **Services furnished while the hearing is pending:**
If a decision to deny, limit or delay services that were not furnished while the appeal/hearing was pending, is reversed, the DCO shall authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. The DCO must take the following steps;

   a. Notify the enrollee, the enrollee's representative (if applicable) both orally and in writing and the enrollee's provider in writing of the available services and how to access them;
   b. Enter the prior authorization into the system or adjust the encounter data claim representing the service.

j) Any party to the hearing 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 enrollee within 72 hours of the DCO receiving the Final Order.

5) **External Medical Review**
   a. External medical review. The State may offer and arrange for an external medical review if the following conditions are met.
      i. The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing.
      ii. The review must be independent of both the State and the DCO.
      iii. The review must be offered without any cost to the enrollee.
      iv. The review must not extend any of the required timeframes and must not disrupt the continuation of benefits.

6) **Appeal review and decision making:** The appeal will be reviewed by the DCO's Vice President of Clinical Services or their designee(s), who are licensed dentists; who are responsible for internal review and with the authority to make a final clinical or administrative decision at the DCO level. Individuals who make decisions on appeals will be individuals who: (a) were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; (b) if deciding on clinical necessity or clinical issues, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease; and (c) take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

7) **DCO Cooperation with Investigations:** In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the OHA's Ombudsperson or hearing representatives, the DCO, subcontractors, and participating providers shall cooperate in ensuring access to all activities related to enrollee appeals, hearing requests, and grievances including providing all requested written materials in required timeframes.

APPEAL AND GRIEVANCE LOG

A. The DCO shall document and maintain a record, in a central location for each grievance and appeal. The DCO's record of each grievance and appeal will be accurately maintained in a manner accessible to the state and available upon request to CMS. The record shall include:
   i. A general description of the reason for the Appeal or Grievance and the supporting reasoning for its resolution;
   ii. The Enrollee's name and at a minimum OHP ID#;
   iii. Primary Care Dentist (PCD) name
   iv. Type of grievance or appeal,
   v. The date Contractor received the Grievance or Appeal filed by the Enrollee, Subcontractor, or Provider;
   vi. The disposition of the grievance
   vii. The NOABD;
   viii. If filed in writing, the Appeal or Grievance;
   ix. If filed orally, documentation that the Grievance or Appeal was received orally;
   x. Records of the review or investigation at each level of the Appeal, Grievance, or Contested Case Hearing, including dates of review;

xi. Notice of resolution of the Grievance or Appeal, including dates of resolution at each level;
xii. Copies of correspondence with the Enrollee and all evidence, testimony, or additional documentation provided by the Enrollee, the Enrollee's Representative, or the Enrollee's Provider as part of the Grievance, Appeal, or Contested Case Hearing process; and
xiii. All written decisions and copies of all correspondence with all parties to the Grievance, Appeal, or Contested Case Hearing.

For appeals the following information should be included:

i. the date of the NOABD,
ii. The date of the appeal,
iii. The nature of the appeal,
iv. Whether continuing benefits were requested and provided,
v. The resolution and date of resolution of the appeal.

B. DCO shall monitor the written log on a monthly basis for receipt, disposition and documentation of all written and oral grievances and appeals. Review of grievances and appeals shall contain the following components: completeness, accuracy, timeliness of documentation and compliance of plan procedures for handling grievances and appeals.

C. DCO shall maintain current grievances and appeals and previous year grievances and appeals on file in office with all other grievances and appeals being sent to storage to maintain for length of 10 years to permit evaluation subject to the DCO's record retention policy. DCO shall retain and keep accessible all documentation, logs and other records for the Grievance and Appeal System whether in paper, electronic, or other form for a minimum of 10 years.

D. DCO shall communicate these policies and procedures to subcontractors.

E. In the event the DCO delegates any elements of the Grievance process, the DCO shall regularly monitor its subcontractors' compliance and take any necessary corrective action. The DCO shall document all monitoring and corrective action activities for subcontractors. The DCO will not delegate adjudication of appeals in a member appeals process to a Subcontractor.

COMPLIANCE

The DCO requires its providers to comply with the grievance and appeal system requirements set forth in this policy and procedure. In addition to providing its participating providers and subcontractors, with written notification of procedures and timeframes for grievances, NOABDs, appeals and hearings upon initial contracting, the DCO shall also provide all of its providers and other subcontractors with written notification of updates to these procedures and timeframes within five (5) business days after approval of such updates by OHA.

DCO Peer Review and Credentialing Committee reviews the grievances and appeals for quality of care issues, access issues, etc. and looks for any trends. If the Committee sees discrepancies or concerns in any of the audit results they request additional information or verification of the information or process of the audit and request the DCO to review ways to improve the audit results if an improvement is needed. The DCO utilizes the Grievance and Appeal log and resulting reports to collect and track information on the effectiveness of the DCO grievance process. The DCO data on grievance and appeals is gathered by race, ethnicity, language, and disability and reviewed by the DCO Quality Assurance and Performance Improvement Committee on a bimonthly basis. The DCO conducts analysis of its Grievances in the context of Quality Improvement activity, and incorporate the analysis into the quarterly data provided to OHA under this Contract.

If the DCO delegates any of its responsibilities under this policy and procedure to a third party, the DCO shall communicate the grievance and appeal system requirements set forth in this policy and procedure. The DCO shall monitor the third party's compliance with the delegated responsibilities and the third party's performance, deficiencies, or areas for improvement. The DCO shall perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and upon identification of deficiencies, or areas for improvement, the DCO shall cause the third party to take corrective action. The DCO shall retain and keep accessible all subcontractor documentation, logs and other records for delegated responsibilities for a minimum of 10 years, to include all documentation of monitoring and corrective action activities. At the current time, the DCO does not delegate any responsibilities to third parties.

TOLL FREE NUMBERS TO FILE A GRIEVANCE OR APPEAL

- Enrollee Services: 866-268-9631

REFERENCES

42 CFR 438.10 Information requirements
42 CFR 438.100
42 CFR 438.228
42 CFR 438.400-424
OAR 410-141-3875 - 3915
OAR 410-141-3580 MCE Member Relations: Potential Member Information
OAR 410-141-3585 MCE Member Relations: Education and Information

FORMS AND OTHER RELATED DOCUMENTS

OHP Grievance Form (OHP 3001)
Appeal and Hearing Request form (OHP 3302)
Notice of Hearing Rights (OHP 3030)
Administrative Hearing Request (MSC 443)
PLANCG-81Transitions of Care
MCE appeal forms

Revision History

Date:	Description
07/31/2012	Approval and adoption.
06/06/2014	Updates based on annual review.
02/23/2015	Updates based on annual review.
02/23/2016	Updates based on annual review.
10/19/2016	Updates based on CCO partner audit findings.
02/14/2017	Updates based on annual review.
07/12/2017	Updates based on CCO partner audit findings.
03/12/2018	Updates based on annual review.
04/23/2019	Updates based on annual review.
12/05/2019	Conversion to revised policy and procedure format and naming convention.

01/06/2020	Updates based on CCO partner audit findings.
05/20/2020	Updates based on CCO partner audit findings.
06/18/2021	Updates based on annual review.
11/08/2021	Updates based on annual review.
05/19/2022	Updates based on CCO partner audit findings.
08/12/2022	Updates based on OHA audit findings.
12/20/2022	Updates based on CCO partner audit findings.
12/31/2022	Updates based on annual review.
03/28/2024	Updates based on annual review.