Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: GA-001	**TITLE:** Grievance System
DEPARTMENT: Quality Management	**APPROVED BY:** President/CEO
EFFECTIVE DATE: 01/31/2016	**LAST REVISION DATE:** 05/20/2024
REVIEW DATES: 01/18/2017, 01/29/2018, 03/08/2018, 08/02/2018; 01/16/2019, 04/20/2022, 05/11/1023, 02/25/2024	
APPLIES TO: Yamhill Community Care, Providers and Subcontractors	

DEFINITIONS:

Word or Acronym	Definition
Action/Adverse Benefit Determination (ABD)	1. The denial or limited authorization of a requested covered service, including determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service; 3. The denial in whole or in part of payment for a service. This excludes any claim that is not a clean claim. Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity 4. For the member who resides in a rural service area where the Coordinated Care Organization (CCO) is the only CCO, the denial of a request to exercise their right under 42 CFR 438.52 to obtain covered services outside the provider network; or 5. The failure to provide services in a timely manner pursuant to OAR 410-141-3515; 6. The failure of the CCO to act within the time frames as provided in OARs 410-141-3875through 410-141-3895 regarding the standard resolution of grievance and appeals; or 7. 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 request by a member or representative to review an Action/Adverse Benefit Determination as defined in this policy.
Complaint	Any expression of dissatisfaction distinct from an action. Complaints may also be called grievances and both terms are used interchangeably.

Complaint Appeal Rights	Complaint appeal rights apply to adverse decisions that affect members' ability to receive benefit coverage, access to care, access to services or payment for care of services as related to complaints (expression of dissatisfaction). Appeals regarding actions are handled through the Appeals process.
Final Order	The Final Order is the written notification and outcome of a contested case hearing.
Grievance	A member or member's representative expressions of dissatisfaction to Yamhill Community Care, a subcontractor, or practitioner about any matter other than an Action, as defined above. • Grievances may also be called complaints, concerns, problems, or issues by the member or member's representative. • The expression may be in whatever form of communication or language that is used by the member or member's representative but must state the reason for the dissatisfaction. For the purpose of this policy and those relating to the grievance system the terms complaint and grievance are used interchangeably. Examples of grievances are: • Problems making appointments • Problems finding a provider near a member's area • Not feeling respected or understood • Treatment members were not sure about, but got anyway • Bills for services members did not agree to pay • Disputes on YCCO extension proposals to make authorization decisions
Member/Enrollee	An individual enrolled under the Coordinated Care Organization Yamhill Community Care Organization for their Oregon Health Plan (Medicaid) coverage. Includes the member or member's representative, attorney, or provider (with specific written authorization from the member), and representative of a deceased members estate. With respect to YCCO notification requirements, a separate notice will be sent to each individual who falls within this definition.
Notice of Action/Adverse Benefit Determination (NOABD/Notice)	A Notice of Action/Adverse Benefit Determination is a written notification to the member that documents when an action is intended or taken, including, but not limited to denials or limiting prior authorization of a requested covered service(s) in an amount, duration, or scope that is less than requested, or reductions, suspension, discontinuation or termination of a previously authorized service, or any other Action. The notice is in written format, as described in OAR 410-141-3885.
Parties to a Contested Case Hearing	When a hearing is requested, the parties involved can be one of the following: The CCO and member and the member's representative; or the CCO and the legal representative of a deceased member's estate requesting a hearing.
Parties to an Appeal	When an appeal is requested, the parties involved can be one of the following: the CCO and member or member's representative; or the CCO and the provider acting on behalf of a member (with written consent from the member); or the CCO and the legal representative of a deceased member's estate.

Subcontractor	An individual or entity that has a contract with an MCE that relates directly or indirectly to the performance of the MCE's obligations under its contract with the State. A Participating Provider is not a Subcontractor solely by virtue of having entered into a Participating Provider agreement with an MCE.

POLICY:

Yamhill Community Care (YCCO) and subcontractors comply with all applicable federal, state, contractual rules and regulations.

YCCO does not delegate or permit any subcontractor to perform final adjudication of appeals this process remains wholly the responsibility of YCCO.

This policy and procedure are an overview of the YCCO grievance system, additional procedural information is located in the subject's specific policy and procedure.

YCCO utilizes the same grievance and appeal process for all currently eligible or eligible at the time-of-service YCCO members for their covered physical health, oral health, behavioral health, health-related social needs, and transportation care. This is inclusive of grievances (complaints), adverse benefit determinations, and appeals.

YCCO grievance and appeal system information is included in the member handbook, provider handbook and on the YCCO website.

Members are provided information regarding the following, this may be provided via YCCO Customer service, website, or member handbook:

- Rights to and how to file a grievance, appeal, or contested case hearing;
- Explanation on how YCCO accepts, processes, and responds to grievances, appeals, and contested case hearing requests;
- Member rights and responsibilities; and
- How to file a hearing through the state's eligibility hearings unit related to the member's current eligibility with the Oregon Health Plan (OHP).

YCCO keeps all healthcare information concerning a member's request confidential, consistent with appropriate use or disclosure per federal and state rules and OHA OHP Health Plan Services Coordination Care Organization Contract requirements. YCCO ensures members confidentiality in all written, oral, and posted materials in the grievance and appeal processes.

Assurances through the Grievance System

Members are provided with a simple, accessible, and understandable grievance and appeal process through YCCO. Members and/or Providers are assured the following through the grievance system:

- Grievances, complaints, appeals, and contested case hearings are kept confidential and have a timely and appropriate resolution.
- Written notice of any adverse benefit determinations referred to as a Notice of Action/Adverse Benefit Determination (NOADB or Notice).
- YCCO Members have access to a robust process for handling grievances, complaints, appeals, and contested case hearings regarding the services they receive from YCCO.
- Members, with the written consent of the member, a provider, or an authorized representative, may file a grievance at any time either orally or in writing on behalf of a member.
- Grievances may be filed directly with YCCO or with the Authority. If filed with the Authority, it will be forwarded to YCCO promptly.

- YCCO ensures member grievances and appeals are processed in accordance with Oregon Administrative Rule (OAR) 410-141-3875 through 410-141-3910.
- With the exception of final adjudication of all appeals, all grievances issuing denials, appeal, and contested case hearing processes are subcontracted functions with appropriate oversight.
- YCCO members are informed that they have a right to file a grievance, appeal, or contested case hearing orally or in writing and may have a member representative of their choice. The member or member's representative may also withdraw an appeal or contested case hearing request at any time.
- A member, member's representative, a representative of a deceased member's estate, or a member's provider acting on behalf of and with written consent of the member may file a grievance or appeal and request a contested case hearing. No punitive action will be taken against any provider who files a grievance, appeal, request a contested case hearing or request expedited resolution of an appeal on behalf of a member.
- YCCO will include in each notice of resolution with the determination not found in favor of the member 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.
- If YCCO fail to adhere to the notice and timing requirements in 42 CFR 438.408, the member is considered to have exhausted the CCO's appeal process. In this case, the member may initiate a contested case hearing.
- That YCCO, subcontractors, and its participating providers may not:
    - Discourage member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member'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 a member or to request member disenrollment.
- Safeguard the member's right to confidentiality of information about grievance or appeal, except where the sharing of information is allowed for the purposes of treatment, payment or health care operations as defined in 42 CFR 164.501. The following pertains to the release of the member's information:
    - YCCO 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 the information without the member's signed release for purposes of:
        - Resolving the matter; or
        - Maintaining the grievance or appeals log as specified in 42 CFR 438.416.
    - If YCCO needs to communicate with other individuals or entities not listed above to respond to the matter, YCCO will obtain the member's signed release and retain the release in the member's record.
- Safeguard member's anonymity for protection against retaliation in the member grievance and appeal resolution process.
- YCCO provides member assurance of confidentiality in all written, oral, and posted material in the grievance and appeal process.
- No incentivized compensation for utilization management activities by ensuring that individual(s) or entities who conduct utilization management activities are not structures so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any member.
- In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authorities Ombudsman and hearing representatives, YCCO, subcontractors, and participating providers will cooperate in ensuring access to all

activities related to member's appeals, hearing requests, and grievances including providing all requested written materials in required timeframes.
- Ensure members receive continuing benefits when requested and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending.

Health Equity & Civil Rights

YCCO complies with requirements of Title II and III of the Americans with Disabilities Act, Title VI of Civil Rights Act, Section 504 of the Rehabilitation Act and Section 1557 of the Patient Protection and Affordable Care Act in addition to all associated State and Federal rules and regulations. YCCO assures communication and delivery of covered services to members with diverse cultural and ethnic backgrounds including cultural health beliefs and practices. Communication and delivery of covered services (including the grievance system) provides certified or qualified healthcare interpreters for members who have difficulty communicating due to medical condition, disability, or limited English proficiency, or where no adult is available to communicate in English, or there is no telephone and providing access to auxiliary aids and services at no charge to the member. Services are provided to members with disabilities in the most integrated setting appropriate to the needs of those members. YCCO as a whole, subcontractors, and facilities are prepared to meet the special needs of members who require accommodations because of a disability or limited English proficiency. The YCCO grievance and appeal system process is designed to be simple, accessible, and understandable to all members. All written grievance system information will be provided with the following guidelines:

- Easily understood language (sufficiently clear that a layperson can understand the notice and make an informed decision), at a 6th grade reading level or lower using the Flesh-Kincaid readability scale and format;
- Font size no smaller than 12 points;
- Be available in alternative formats and through the provisions of auxiliary aids and services in an appropriate manner that takes into consideration with special needs of enrollees or potential enrollees with disabilities or limited English proficiency;
- Include a large print tagline in 18 pt. font in all prevalent non-English languages, that explains availability of written translation or oral interpretation to understand the information provided, and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats at no cost. Tag line also includes toll-free and TTY/TDY telephone number of YCCO customer service. Large print means printed in a font no smaller than 18 points.
- Toll free customer service telephone number to call for assistance in interpretation of the letter or notice with no charge access to interpretation including sign language or to request a copy in an alternate language or format.

YCCO utilizes the OHA templates for YCCO NOABDs and NOARs, and other OHA approved member notices and includes a language access statement with the 8 translated languages and nondiscrimination information with these notices. Grievance system forms and letters are readily available in English and Spanish and can be translated in any language or format the member request including braille and large print at no charge to the member. Members also have access to Customer Service and Grievance staff for assistance in submitting a grievance or appeal in addition to clarification on a notice they may have received. All notices contain information on how to request information in an alternate language or format. Request received in any language other than English receive all correspondence and communication in the language requested. at no charge to the member
YCCO follows state and federal civil rights laws, we do not treat people unfairly in any of our programs or activities because of a person's:

1. Age,
2. Color,
3. Disability,
4. Gender Identity,

5. Marital Status,
6. National Origin,
7. Race,
8. Religion,
9. Sex; and
10. Sexual Orientation

All members have a right to enter, exit and use buildings and services. They also have the right to get info in a way that is best for them. This includes free interpretation services and receiving written material in other formats (large print, audio, braille, etc.). YCCO will make reasonable changes to policies, practices, and procedures by talking with members about their needs.

If members feel they are being or were treated unfairly for any of the reasons above, they can contact any of the following:

1. YCCO

Contact the YCCO Compliance Officer to report a concern or get more information.

- Phone (toll-free): 1-855-722-8205 or TTY 711
- Email: complaints@yamhillcco.org
- Website: www.yamhillcco.org
- Mail: Yamhill Community Care Organization
  Attn: Compliance Officer
  PO Box 490
  Salem, OR 97304

  Members can put a complaint in writing via mail, email, or fax YCCO a letter. Member can use the YCCO complaint form it is on our website at https://yamhillcco.org/members/documents-and-forms/ and send it to YCCO. Members are not required to use a form and can write a letter or email.

2. Oregon Health Authority (OHA) Civil Rights

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

3. Bureau of Labor and Industries Civil Rights Division

- Phone: (971) 673-0764 711 TTY
- Web: https://www.oregon.gov/boli/civil-rights/Pages/default.aspx
- Email: boli_help@boli.oregon.gov
- Mail: Bureau of Labor and Industries Civil Rights Division
  800 NE Oregon St., Suite 1045
  Portland, OR 97232

4. U.S. Department of Health and Human Services Office for Civil Rights (OCR)

- Phone: (800) 368-1019, (800) 537-7697 (TDD)
- Web: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
- Email: OCRComplaint@hhs.gov
- Mail: Office for Civil Rights
  200 Independence Ave. SW, Room 509F, HHH Bldg.
  Washington, DC 20201

YCCO provides members of the nondiscrimination policy notice that contains the process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance with all applicable laws including but not limited to Title VI of the Civil Rights Act and ORS Chapter 659A. This information is provided in various locations including but not limited to the member handbook and YCCO website at https://yamhillcco.org/about-us/anti-discrimination-notice/. The nondiscrimination policy notice is also an attachment included with NOABDs, NOARs and other grievance system notices. The YCCO nondiscrimination notice meets all requirements outlined in the OHA nondiscrimination statement evaluation checklist and must be approved by OHA. The nondiscrimination statement evaluation checklist can be found at https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-QA-Materials.aspx.

Written materials, including provider directories, member handbooks, appeal and grievance notices, and all denial and termination notices are made available in the YCCO prevalent non-English languages in the YCCO service area and available in formats per section 5 of OAR 410-141-3585 for members with disabilities. YCCO will accommodate requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested.

Grievance System Process, Policy and Rights Awareness and Sharing

Contracted providers, and subcontractors are made aware and provided written notification of member's grievance, notice of adverse benefit determination, appeal and contested case hearing procedures and timeframes. In the event that the procedures are updated YCCO will provide written notification within 5 business days once OHA approval has been obtained. Including the following:

- The member's right to request a state fair hearing (contested case hearing), after YCCO has made a determination on members appeal that is adverse to the member, information how a member can obtain a hearing and representation rules at a hearing;
- Member's right to file grievances and appeals with the requirements and timeframes for filing;
- The availability of assistance to members with filing of grievances, appeals and contested case hearings, toll-free numbers to file oral grievances and appeals;
- A statement on the members right to request continuation of benefits and how to request they be continued during the appeal and contested case hearing processes. The statement will also state if the action is upheld the member may be liable for the cost of any continued benefits; and
- The provider appeal rights to challenge the failure of YCCO to cover a service.

Providers, and subcontractors are supplied at the time of subcontract YCCO's approved written Grievance System policy and procedures and timeframes for grievances, NOABDs, appeals, and contested case hearings. And to ensure compliance at the time of contract and upon approval from OHA will provide written notification of the updated policy and procedures within 5 business days of the OHA approval notification.

Staff who have potential contact with members are informed of the grievance system policies.

Assistance

Members are provided with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or contested case hearing requests. Reasonable assistance includes, but not limited to:

- 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;
- Providing free certified and qualified interpreter services to meet language access requirements where required in 42 CFR 438.10;

- Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and certified and qualified interpreter capabilities; and
- Reasonable accommodation or policy and procedure modifications as requested by any disability of the member.
- Forms, notices, and correspondence (included but not limited to the member handbook, provider directory, and grievance system forms and correspondence) provided in the members prevalent non-English language and alternative format such as Braille and larger font in the event that the member's eligibility file flags an alternative language or format need YCCO will sent information in the member's preferred format and/or language.
- The YCCO toll-free telephone number that the member can call to file grievances or appeals by phone.
- In the event that YCCO identifies that a member has an authorized representative, YCCO will assist the member with completion of the Authorized Representative form.

YCCO's grievance system provides the member with the following:
- Toll-free telephone numbers that they can use to file a grievance or appeal by phone with the assistance of a Customer Service Representative;
- Availability of assistance in the filing process as well as an explanation of the grievance system process;
- The rules that govern representation at the hearing; and
- The right to have an attorney or member representative present at the hearing and the availability of free legal help through Legal Aid Services and Oregon Law Center, including the telephone number of the Public Benefits Hotline, 1(800)520-5292, TTY 711.

YCCO administrative office and in physical, behavioral, and oral health subcontractor offices. The following forms will be available:
- OHP Complaint form (OHP 3001); and
- Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile;

These forms must be available in prevalent non-English languages for the YCCO service area as well as in other formats upon request.

Electronic Communication
Electronic communication will not be utilized for a direct member notice related to adverse action or any portion of the grievance, appeals, contested case hearings or any other member rights or member protection process.

Health Information Systems (HIS)
When HIS are utilized, the systems will be maintained and meet all CCO/OHA Contract requirements, 42 CFR438.242 and section 1903(r)(1)(F) of PPACA and will collect, analyze, integrate, and report data that can provide information on areas listed in the CCO/OHA contract.

Complaint or Grievance
A member or member's representative expressions of dissatisfaction to YCCO or practitioner about any matter other than an Action, (see definitions).
- Grievances may also be called complaints, concerns, problems, or issues by the member or member's representative.
- The expression may be in whatever form of communication or language that is used by the member or member's representative but must state the reason for the dissatisfaction.

For the purpose of this policy and those relating to the grievance system the terms complaint and grievance are used interchangeably.

- YCCO members are informed that they have a right to file a grievance regarding any dissatisfaction about any matter other than an action (see definitions). Examples of grievances are:
    - Problems making appointments or getting a ride
    - Problems finding a provider near a member's area
    - Not feeling respected or understood by providers, provider staff, drivers or YCCO
    - Treatment members were not sure about, but got anyway
    - Bills for services members did not agree to pay or
    - Disputes on YCCO extension proposals to make authorization decisions
    - Driver or vehicle safety
- Members are instructed how to submit their concern in writing via the YCCO member handbook, website or verbally when speaking to any YCCO customer service, employee, or any employee of a subcontractor.
- Inquiries and/or eligibility questions are not considered a grievance. Examples include questions regarding co-pays, how to change providers, sending a new member packet and clarifying eligibility for healthcare services.
- There is no timeline for submission of a grievance.
- Grievance is handled in confidence consistent with OARs, HIPAA Privacy Rules and other federal and state confidentiality laws and regulations.
- Compliance with CFR and OAR notification and resolution timeframes. Specific timelines listed in Grievance policy.
- Grievances may receive oral responses in addition to a written response in the preferred language in both instances. All grievances will receive written responses, and all will meet OHA formatting and readability standards per OAR 410-141-3585 and 42 CFR 438.10 and provided in the member's preferred language. Resolution letters will be written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the grievance resolution.
- Grievances are acknowledged.
- Grievances are given to the appropriate staff with the authority to act upon it.
- Obtain documentation of all relevant facts concerning the grievance or appeal. This includes taking into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether the information submitted or considered in the initial adverse benefit determination or resolution of the grievance.
- Ensure that staff making decisions on the grievance and appeal are:
    - Not involved in any previous level of review or decision-making not a subordinate of any such individual;
    - Healthcare professional, with appropriate clinical expertise in treating the member's condition or disease if the grievance or appeal involves clinical issues or if the member requests an expedited review. Health care professionals shall make decisions for the following:
        - Appeal of a denial based on lack of medically appropriate service or involvement of clinical issues or
        - Grievances regarding denial of expedited resolution of an appeal or involvement of clinical issues.
- Obtain the member's authorization by a signed release of information regarding the grievance or appeal prior to speaking with other individuals regarding the grievance or appeal information, or before any information related to the grievance or appeal is disclosed. The release must be retained in the member's record.
    - The subcontractor and any other provider whose authorizations, treatments, services, items, quality care, or requests for payment are involved in an appeal or contested case hearing may use information without the member's signed

release for the purposes of resolving the matter or maintaining the grievance and appeals log.

Notice of Adverse Benefit Determination (NOABD or Notice)
YCCO NOABDs meet the following requirements:

- Notice of Adverse Benefit Determination and Notice of Appeal Resolution meet readability standards, alternative format availability as well as language format requirements found in the OHA Core Contract, 410-141-3580, 410-141-3585 and 42 CFR 438.410;
- Written notice must be translated for members who speak prevalent non-English languages at no charge to the member, as defined in 42 CFR 438.10(c);
- Notices must include language clarifying that oral interpretation is available for all languages including sign language and how to access it at no charge to the member;
- NOABDs will be written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the adverse benefit determination and following the process for requesting an appeal;
- Content requirements per 42 CFR 438.404 and OAR 410-141-3885 including clear and thorough explanation of the specific reason for the adverse benefit determination with reference to specific statutes and rules to highest level of specificity;
- Include a statement that member has right to request the services that are being denied pending resolution of the appeal and that the member may be responsible for the cost of those services if the outcome of the appeal upholds the notice of action.
- Provides information on rights to and what to do to ask for appeal and time frame to do so, after appeal resolution a contested case hearing or where CCO failed to meet appeal timeliness outlined in OAR 410-141-3885 and procedures for exercising rights;
- Describes how to obtain a copy of the denied request file at no cost. Including all documents, records, and other information relevant to the member's adverse benefit determination which includes any processes, strategies, or evidentiary standard used by the CCO in setting coverage limits or making the benefit determination;
- Follow timeliness requirements for specialized service authorization or type via oral and written methods for any service request by the member or members representative outlined in OAR 410-141-3885; and
- Copy of notice will be sent to the requesting provider.

Appeals (Standard and Expedited)
An appeal occurs when a member, member's representative, representative of a deceased member's estate or provider representing the member makes an oral or written request for an action be reviewed. The appeal process takes into account all comments, documents, records, and other information submitted by the member without regard if the information was submitted or considered in the initial adverse benefit determination. YCCO ensures the following:

- Delegate's process and make the initial determination on appeals however the decision is then provided to YCCO for final adjudication. YCCO is the final adjudicator of all appeals.
- Member shall file an appeal with CCO no later than 60 days from date on the notice.
- Appeals can be submitted both orally and in writing. Oral requests for appeal utilize the filing date as the date the oral request was received. Oral and written appeals are processed in the same manner.
- All Grievance System member notices including but not limited to the Notice of Adverse Benefit Determination (NOABD) and Notice of Appeal Resolution (NOAR) meet readability standards, alternative format availability as well as language format requirements found in the OHP Core Contract, OAR 410-141-3580, OAR 410-141-3585, and 42 CFR 438.404 and 42 CFR 438.10.
- NOAR must be translated for members who speak prevalent non-English languages, as defined in 42 CFR 438.10.

- Notices must include language clarifying that oral interpretation is available for all languages and how to access it.
- Content requirements per OHP Health Plan Services Contract, 42 CFR 438.404 and OARs 410-141-3875 through 410-141-3900 including clear and thorough explanation of the specific reason for the adverse benefit determination with reference to specific statutes and rules to highest level of specificity.
- NOAR will be written in language that is sufficiently clear that a lay person could understand the notice and make an informed decision.
- Appeals are handled in confidence consistent with OARs, HIPAA Privacy Rules and other federal and state confidentiality laws and regulations.
- Compliance with CFR and OAR notification and resolution timeframes. Specific timelines listed in appeal policy.
- Appeals are acknowledged.
- Appeals are given to the appropriate staff with the authority to act upon it.
- Obtain documentation of all relevant facts concerning the grievance or appeal. This includes taking into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether the information submitted or considered in the initial adverse benefit determination or resolution of the grievance.
- Ensure that staff making decisions on the appeal are:
    - Not involved in any previous level of review or decision-making not a subordinate of any such individual;
    - Healthcare professional, with appropriate clinical expertise in treating the member's condition or disease if the grievance or appeal involves clinical issues or if the member requests an expedited review. Health care professionals shall make decisions for the following:
        - Appeal of a denial based on lack of medically appropriate service or involvement of clinical issues or
        - Grievances regarding denial of expedited resolution of an appeal or involvement of clinical issues.
- Obtain the member's authorization by a signed release of information regarding the grievance or appeal prior to speaking with other individuals regarding the grievance or appeal information, or before any information related to the grievance or appeal is disclosed. The release must be retained in the member's record.
- The subcontractor and any other provider whose authorizations, treatments, services, items, quality care, or requests for payment are involved in an appeal or contested case hearing may use information without the member's signed release for the purposes of resolving the matter or maintaining the grievance and appeals log.

Contested Case Hearings (Standard and Expedited)

YCCO has a system in place in accordance with OHP Health Plan Services Contract OAR 410-141-3905 through 410-141-3910, 137-003-0501 through 137-003-0700 and OAR 410-120-1860 to ensure members and providers have access to appeal for CCO's action by requesting a contested case hearing.

- Member may not request a hearing without first filing an appeal with YCCO.
- Hearings must be filed on form OHP 3302 or approved facsimile with the Authority no later than 120 days from the date on the Notice of Appeal Resolution (NOAR). Expedited hearings can be requested on OHP 3302 or other Division approved appeal or hearing request forms.
- Member may request a hearing prior to receipt of NOAR when CCO failed to meet appeal timeliness outlined in OAR 410-141-3890-410-141-3895 and procedures for exercising rights.
- When member request a hearing with OHA prior to filing an appeal with YCCO it shall be forwarded to YCCO for review, except when YCCO failed to adhere to appeal timing requirements.

- Once a hearing is received by YCCO they shall follow all hearing request standards noted in OARs 410-141-3905 through 410-141-3910. Specific hearing procedures can be found in the hearing policy.
- In the event that a member requests a hearing prior to filing an appeal and YCCO had not failed in appeal timing requirements OHA will forward the request and YCCO will:
    - Review the request immediately as an appeal.
    - Approve or deny the appeal within the 16 days and provide the member with a NOAR.
- When a hearing results in the overturning of a denial and services have not been provided YCCO should authorize the services or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the decision.
- For services that have been furnished that are overturned through the hearing process YCCO or the state shall pay for the services in accordance with the Authority policy and regulations.

Continuation of Benefits

During the appeal and/or contested case hearing process members have the right to request the services that are being denied pending resolution of the appeal and/or hearing to continue. Continuing benefits means a continuation of benefits in the same manner and same amount while and appeal or contested case hearing is pending per OAR 410-141-3910.

- Members must be provided a statement on the NOABD and NOAR that they have the right to request to continue to receive the services that are being denied pending resolution of the appeal or contested case hearing and that they may be held responsible for the cost of the services continued if the outcome of the appeal or hearing upholds YCCO's NOABD denial. The statement includes how to request the benefits be continued including that the request must be made before the 10th day following the notice date and include an effective date of action proposed in notice if applicable.
- When an appeal or hearing results in the overturning of a denial and services have not been provided YCCO should authorize the services or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the decision.
- For services that have been furnished that are overturned through the appeal or hearing process YCCO or the state shall pay for the services in accordance with the Authority policy and regulations.
- If the final resolution of the appeal or contested case hearing upholds YCCO's adverse benefit determination, YCCO may recover from the member the cost of the services furnished to the member while the appeal or hearing was pending per 42 CFR 431.230 to the extent that they were furnished solely because of the appeal or hearing and per the requirements of the OHP Health Plan Services Contract. Benefits may be requested and received in the same manner and same amount as previously authorized while appeal or hearing is pending. Benefits shall continue as stated below.

Benefit shall continue when:

- The member or member representative file the appeal or hearing request timely*;
- The appeal or hearing request involves the termination, suspension, or reduction of a previously authorized service;
- The Services were ordered by an authorized provider;
- The period covered by the original authorization has not expired; and
- The member timely files for continuation of benefits.

*Timely means filing on or before the later of the following:

- Within 10 days of Notice or
- Intended effective date of the action proposed in the notice.

If member's request continuation of benefits and YCCO continues or reinstates them the benefits will be continued per 42 CFR 438 until one of the following:

- Member withdraws the appeal or hearing; or
- Member does not request the hearing within 10 days from when YCCO mails the NOAR on member's appeal; or
- An adverse hearing decision to the member is made; or
- OHA issues an adverse appeal decision to the member; or
- The authorization expires or the authorization service limits are met.

PROCEDURE:

Final Adjudication of Grievances and Appeals

YCCO retains responsibility of final adjudication of appeals and will not delegate this process.

- When YCCO receives a request for reconsideration of a grievance or denial, Yamhill Community Care will review the case and make a determination.
- Following review by YCCO, the Medical Director may either review and make a determination on the case or may seek external peer review for content knowledge.
- The external review provides consultation for YCCO to make a decision which is final.
- If the decision is in favor of the member, YCCO will ensure adjudication of payment to the provider within 30 days when the final adjudication is for an appeal.

Quality Improvement

YCCO addresses the analysis of grievances in the context of quality improvement activity, consistent with OAR 410-141-3875 and 410-141-3525 incorporating analysis into contract deliverables. Collection of grievances and appeals and the analysis of their data assist in improving the experience and quality of care provided to YCCO members.

- CCO shall monitor the data collected from the grievance system by the CCO and subcontractors internally on a monthly basis for completeness and accuracy.
- At minimum, analysis will include:
    - Review of completeness
    - Accuracy
    - Timeliness of documentation
    - Compliance with timeliness for receipt, disposition and documentation of complaints and appeals.
- Trending of complaint categories:
    - Access
    - Interaction with provider or plan
    - Member rights
    - Quality of service
    - Quality of clinical care
    - Payment issues
- A Grievance System Report, in an OHA acceptable format along with the OHA formatted grievance and appeal log will be submitted to OHA Contract Administration Unit 45 days following end of each calendar quarter. In addition to the report and log a sample of notice of adverse benefit determinations and all notices for ABA and Hepatitis C.
- YCCO shall review and report to the Authority, as outlined in the OHP Health Plan Services Contract, complaints raised on issues related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status, and other identity factors for consideration in improving services for health equity.
- YCCO gathers data from the grievance system by race/ethnicity, language, disability (REALD), and sexual orientation and gender identity (SOGI) and incorporates this information into the Grievance System Report, Transformation and Quality Strategy (TQS) projects and other auditing and reporting to determining if there are issues or barriers within the healthplan system relating to REALD. This data is utilized to assist

in processes, including the grievance system, and projects as well as inform the health equity plan.
- YCCO Health Services staff review grievances relating to ICC members, issues involving case management and to determine if members have additional needs. This information depending on the nature may be shared with subcontractors in the Care Management meetings as well as the YCCO Utilization Management Committee.
- YCCO analyzes REALD data related to all facets of the grievance system (grievance, NOABDs and appeals) for language, race and disability information is compared to previous months and/or quarters to determine if there are any barriers to access, inequality in NOABDs, as well as use of the grievance system with additional analysis being developed as more data is introduced into the tracking system. Analysis is shared with appropriate committees for follow up if applicable.
- YCCO utilizes the Consumer Advisory Counsel to provide feedback on the grievance system in development and revisions to the grievance process.
- YCCO utilizes data related to member literacy, language spoken and preferred, alternative formats derived from improvement projects that can be gathered from the TQS, equity plans, and other reporting structures as well as member feedback to inform revisions to the grievance process and in policy development.

Reporting & Compliance
- Inclusion of the grievance system in the QAPI program evaluation.
- YCCO ensures and monitors participating providers and subcontractors compliance with the Grievance System requirements in accordance with all applicable laws and the OHA OHP Health Services Contract. This is done through audits and review of compliance reports.
- YCCO Compliance Committee and Quality and Clinical Advisory Panel (QCAP) maintain responsibility for regularly scheduled review of the reporting of member grievance and/or appeals as appropriate and as follows:
    - Compliance and delegation oversight review of the quarterly reporting- Follow-up action plans may be required for subcontractors based on the trending and analysis of the complaint and appeals quarterly report.
    - Review of quarterly reporting analysis for trends and applicable quality improvement initiatives.
- OHA grievance and appeals log reporting, sample Notices and summary as per contract.
- Ad hoc reports as requested.
- Complete auditing and monitoring to ensure subcontractors meet the general obligations under OAR 410-141-3505 and the requirements consistent with applicable OAR 410-141-3835 through 410-141-3915 by:
    - Performing a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement;
    - Performing review of any providers that filed on behalf of a member to ensure that no punitive action was taken against them; and
    - Ensure subcontractor takes corrective action for any identified areas of deficiencies that need improvement.
- Annually review and as necessary update Grievance System policies and procedures.
- Annually review and as necessary update Grievance System member notices which will be submitted to OHA per current guidelines for approval prior to use.
- Within 5 business days after request from OHA in addition to quarterly review or in connection with a contested case hearing, YCCO will provide OHA via administrative notice Grievance System policy and procedures, member notice templates or any document regarding the Grievance System. If not in compliance YCCO will review within 30 days of notice by OHA, CMS or EQRO and resubmit with changes for approval. Approval will be obtained prior to implementation.
- The YCCO nondiscrimination notice meets all requirements outlined in the OHA nondiscrimination statement evaluation checklist and must be approved by OHA. The

nondiscrimination statement evaluation checklist can be found at https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-QA-Materials.aspx.

Record Keeping

- YCCO will maintain yearly logs and all appeals and grievance files for ten (10) calendar years with the following minimum requirements:
    - Member's name and and at a minimum OHP ID number.
    - Date the member, member representative or provider on behalf of a member filed the grievance or appeal and date received.
    - Nature of the request with general description of the appeal or grievance and supporting reasoning for its resolution.
    - If filed in writing, copy of the appeal or grievance.
    - If filed orally, documentation that the grievance or appeal was received orally.
    - NOABD if applicable.
    - Documentation of review, resolution, investigation at each level of the appeal, grievance, or contested case hearing and/or disposition of the matter, including dates of review, reason for the decision and the date of the resolution or disposition.
    - Notations of oral and written communications with the member, member representative or provider on behalf of the member.
    - Notations about appeals and grievance the member decides to resolve in another way if YCCO is aware of this.
    - Whether continuation of benefits was requested and provided.
    - Notice of resolution, including the dates of resolution at each level.
    - Additional documentation provided by the member, the member's representative, or the member's provider.
    - All written decisions and copies of all correspondence with all parties on all grievances, appeals and contested case hearings.
- For each calendar year, the log must contain the following aggregate information:
    - The number of actions.
    - A categorization of the reasons for and resolutions of dispositions of appeals and grievances.
- YCCO will document, maintain, and retain records in a central location on all grievances and appeals in accordance with OARs 410-141-3875, 410-141-3890 and 410-141-3915 and 42 CFR 438.416 for a minimum of 10 years whether in paper, electronic, or other form.
- YCCO will retain and keep accessible all subcontractor documentation, logs, and other records for the Grievance and Appeal System whether in paper, electronic, or other forms for a minimum of 10 years.
- All records will be accurately maintained in a manner accessible to the state and available upon request from CMS.
- YCCO will fully and timely comply with all records requests.
- YCCO will fully and promptly comply with all OHA monitoring and oversight.

COMPLIANCE & OVERSIGHT:

YCCO monitors the compliance of its subcontractors, including its provider network, with all grievance and appeal system requirements including adverse benefit determination requirements in accordance with applicable law and the applicable provisions of its contract with OHA.

YCCO will monitor and ensure subcontractors are compliant by:

1. Subcontractors will review the grievance system log monthly for completeness and accuracy, which includes but is not limited to timeliness of documentation and compliance with procedures.
2. Subcontractors will provide a quarterly complaint, grievance, appeals and contested case hearing log and analysis report to YCCO within 20 days of the end of each

calendar quarter. Data is combined from the various subcontractors and then utilized in the YCCO analysis of the grievance system quarterly reporting to OHA. Recorded in this log, subcontractors will demonstrate the following:
    a. Grievance log indicates:
        i. All grievances received in the allotted time frame;
        ii. Issue of the grievance including who/what the issue is pertaining to with all documentation used to resolve the issue;
        iii. Days to resolve issue; and
        iv. Notification of resolution date and letter information.
3. Appeal and Hearing log indicates:
    a. All appeals and hearings received;
    b. Appeal and hearing issue;
    c. Days to resolve issue; and
    d. Notification dates including extensions.
4. Other reporting as indicated:
    a. Submit a random sample of ten (10) Notices written during the reporting quarter.
    b. subcontractor shall review and report to YCCO complaints that raise issues related to racial or ethnic background, gender, religion, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status and other identity factors for consideration in improving services for health equity.
    c. Ad hoc reports as requested
5. Ensuring Policies and Procedures are updated and collected biennially or when subcontractor's review/revision date is updated.
6. Documentation that indicates the process for claim payment and preauthorization denials when appeal is overturned.
7. Insurance that subcontractor meets the requirements consistent with OAR 410-141-3875 through 410-141-3915.
8. Ongoing monitoring of performance.
9. Perform, document, and retain all formal compliance monitoring and reviews at least annually to assess performance, deficiencies, or areas for improvement and take necessary corrective action. All improvement or corrective action plan activities will be monitored and documented.
10. Insurance that subcontractors take corrective action for any identified areas of deficiencies that need improvement.

REFERENCES:

OARs 410-141-3735; 410-141-3875 through 410-141-3915; 137-003-0501 through 137-003-0700 , 410-141-3505, 410-141-3520, 410-120-1860; 410-141-3580,410-141-3585; 943-005-0010; and 943-005-0060
42 CFR 438.1, 438.100, 431.230; 438.10; 438.228; 438.242; 438.402, 438.406; 438.404 through 438.424 and 438.52
45 CFR 160, 164
Health Insurance Portability and Accountability Act of 1996
Health Insurance Portability and Accountability Act Privacy and Security Rules
Title II and III of the Americans with Disabilities Act
Title VI of Civil Rights Act
Section 504 of the Rehabilitation Act
Section 1557 of the Patient Protection and Affordable Care Act
OHA OHP Health Plan Services Coordination Care Organization Contract

RELATED POLICIES & DOCUMENTS:

QA-007 Subcontractor Oversight

GA-001 Grievance System
GA-003 Denial, Appeals and Contested Case Hearings
CMPL-001 Fraud, Waste, Abuse and Compliance Plan
CMPL-008 Member Protected Health Information
CMPL-011 Incident Response and Breach Notification
ENR-001 Member Rights, Protections and Responsibilities
ENR-002 Member Non-Discrimination ADA
YCCO Member Handbook
YCCO Provider Handbook
Final Adjudication Visio Roadmap

LOG OF REVISION

DATE	REVISION	BY WHOM
12/16/16	• Change in owner of approval to Seamus McCarthy • Update to language to Notice definition • Removed language- Acknowledge receipt of the GRIEVANCE or appeal to the member, action not required per OAR	JRoe, Quality Assurance Specialist
1/18/2017	Approved	SMcCarthy, CEO Interim
01/23/2018	Change to current format, policy updates	JRoe, QA Specialist
01/29/2018	Approved	SMcCarthy, President/CEO
3/08/2018	Updated OAR reference and formatting changes	JRoe, Quality Assurance Specialist
03/08/2018	Approved	SMcCarthy, President/CEO
07/02/2018	Policy reformatting, clarifications with additions from new rules and OHA feedback, contract section I-9, and definition updates	JRoe, Quality Assurance Specialist
08/02/2018	Approved	SMcCarthy, President/CEO
08/22/2018	Additional policy reformatting and clarifications of previous edits	JRoe, Quality Assurance Specialist
08/29/2018	Approved	SMcCarthy, President/CEO
01/16/2019	Additional policy clarifications from OHA feedback from new rules, contract section I-9	JRoe, Quality Assurance Specialist
01/16/2019	Approved	SMcCarthy, President/CEO
10/15/2019	Updated policy with 2020 OHA Contract requirements on written notification of all complaints and continuation of benefit cost recovery when adverse determination is upheld.	JRoe, QA Specialist
08/01/2020	OAR updates, bullet formatting for ease of reading and policy clarification, oral appeal clarification.	JRoe, QA Specialist
02/27/2021	OAR & OHA Health Plan Services Contract updates, clarification of internal processes.	JRoe, Benefit Administration Supervisor
04/09/2022	Formatting and subcontractor clarification updates only, no content change	JRoe, Benefit Administration Supervisor
04/20/2022	Annual review for contract, rule, and regulation updates.	JRoe, Benefit Administration Supervisor

06/26/2022	Additional grievance system policy review and updates per OHA feedback.	JRoe, Benefit Administration Supervisor
05/11/2023	Annual review for contract, rule, and regulation updates.	JRoe, Health Plan Operations Manager
02/25/2024	Annual review for contract, rule, and regulation updates	JRoe, Health Plan Operations Manager
05/21/2024	Clarification of grievance system process to specify only one process for all YCCO members.	JRoe, Health Plan Operations Manager

OHA APPROVAL LOG

DATE	METHOD OF APPROVAL (SharePoint/CCO and MCO Deliverable)
07/29/2021	OHA approval received via administrative notice
07/19/2022	OHA approval received via administrative notice
05/18/2023	OHA approval received via administrative notice
02/29/2024	OHA Attestation submitted via deliverable portal