Yamhill Community Care

GA-002 Member Complaints and Grievances | Version 1.2

Policy

Public

Effective: April 23, 2025

Approved By: Jill Roe

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0.0 Header

POLICY NUMBER: GA-002	**TITLE:** Member Complaints and Grievances
DEPARTMENT: Quality Management	**APPROVED BY:** President/CEO
EFFECTIVE DATE: 01/31/2016	**LAST REVISION DATE:** 03/24/2025
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, 05/20/2024	
APPLIES TO: Yamhill Community Care, Providers, and Subcontractors	

1.0 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 • 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 Adverse Benefit Determination (Notice)	A Notice of 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.

2.0 Policy

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

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 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

For 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.

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 ensures member grievances are processed in accordance with Oregon Administrative Rule (OAR) 410-141-3875 through 410-141-3910.

There is no timeline for submission of member grievance. A grievance may be oral or a written communication that addresses issues with any aspect of YCCO operations, activities, or conduct that pertains to the availability, delivery, or quality of care including utilization review decisions that are believed to be averse to the member. Members are instructed or their rights to and how to submit their concern in writing via the YCCO member handbook, website or verbally when speaking to any YCCO or OHA. 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.

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 may also require 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, subcontractors, providers, and facilities are prepared to meet the special needs of members who require accommodations because of a disability or limited English proficiency.

All written grievance system information will be provided with the following guidelines:

- Easily understood language, at a 6^{th} 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 at no charge to the member, include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. 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 provides members of the nondiscrimination policy and process to report a complaint of discrimination 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/. Information on the entities a member can file a complaint with is located in the GA-001 Grievance System Policy.

YCCO has at least one individual responsible to receiving and resolving discrimination complaints related to color, national origin (including, without limitation, the linguistic characteristics of a national group), religion, sex (including sex characteristics, pregnancy and related conditions, racial or ethnic background, gender identity, sexual orientation, sex stereotypes, sex assigned at birth, or gender otherwise recorded), age, socioeconomic status, culturally or linguistically appropriate service requests, disability status, health status, country of origin, and other identity factors for consideration in improving services for health equity. This information is noted in the YCCO Nondiscrimination Notice. The contact information for the designated individual is included in the nondiscrimination notice.

Assistance
Members are provided with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances. 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.
- 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.
- Providing free certified and qualified interpreter services at no charge to the member 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 at no charge to the member.
- Reasonable accommodation or policy and procedure modifications as requested by any disability of the member.
- The YCCO toll-free telephone number to receive assistance in filing their request orally.

Grievance System Process, Policy and Rights Awareness and Sharing
YCCO, and 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.

Grievances are handled in confidence consistent with Health Insurance Portability and Accountability Act, HIPAA Privacy Rules, and other federal and state privacy/confidentiality laws and regulations. The member must authorize disclosure or release of information if there is a need to discuss the complaint with other providers that are not involved with the grievance to resolve the issue. Members are notified, via the member handbook, that the Oregon Health Authority Health Systems Division has the right to grievance information without a signed release from the member.

YCCO staff and partners follow compliance policies; acting on or reporting (when applicable) suspicions of fraud, waste or abuse, provider license actions which pertain to the potential for fraudulent billing practices, grievances which indicate possible sexual impropriety to a member, alteration of medical records (identified through medical record review), and member grievances pertaining to inability to access services with allegations of discrimination.

YCCO addresses the analysis of grievances in the context of quality improvement activity, consistent with OAR 410-141-3520 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.

In compliance with 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 and ORS Chapter 659A, YCCO shall review and report to the Authority, as outlined in the OHA CCO Contract, complaints raised on issues related to color, national origin (including, without limitation, the linguistic characteristics of a national group), religion, sex (including sex characteristics, pregnancy and related conditions, racial or ethnic background, gender identity, sexual orientation, sex stereotypes, sex assigned at birth, or gender otherwise recorded), age, socioeconomic status, culturally or linguistically appropriate service requests, disability status, health status, country of origin, and other identity factors for consideration in improving services for health equity.

Grievances received related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one CCO to another for YCCO shall log the grievance and work with the receiving or sending CCO to ensure continuity of care during the transition.

3.0 Procedures

Review Guidelines
When a member files a grievance, it will be given to the appropriate staff with the authority to act upon it. Insurance that staff making decisions on the grievance are:

- Not involved in any previous level of review or decision-making not a subordinate of any such individual;
- Not 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.
- 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:
    - Grievances regarding denial of expedited resolution of an appeal or involvement of clinical issues.

The review will include the following:

- Upon receipt, in accordance with confidentiality requirements, YCCO will obtain documentation of the facts concerning the complaint.
    - Documentation of the grievance and action taken.
    - Investigation of the complaint, including any aspect of clinical care involved. 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.

Receipt and Documentation
Upon receipt of a grievance, YCCO will resolve or acknowledge receipt to the member and the member's provider were indicated within 5 business days.

The individual who received the grievance should resolve the grievance, if at all possible, if individual does not have the authority to act on the matter, they will forward it to the appropriate staff that does have the authority to act on the matter. Additionally, the grievance requires further investigation, it is referred to the appropriate staff that can act on the matter and resolve the grievance. Grievances are always forwarded and resolved by the appropriate staff that have the authority to act on the matter. Health care professionals with appropriate clinical expertise in treating the member's condition or disease if grievance involves clinical issues or if the member requests an expedited review. Health care professionals shall make decisions for:

- Grievance regarding denial of expedited resolution of an appeal; or
- Grievance involves clinical issues.

The appropriate staff will not be involved in any previous level of review or decision making.

YCCO is responsible for entering a member grievance into the appropriate grievance log system.

- Staff shall determine the member's name, identification number, provider involved, and nature of the grievance in addition to any actions taken from the person filing the grievance. This information will be entered in the Complaint Log:
    - Document receipt of grievance with date and time.
    - When a member makes a complaint, the member will be asked to consent verbally to the release of information regarding the grievance to individuals who are not directly involved in the grievance. Staff shall ensure confidentiality of the complaint unless member provides consent to release of information.
        - If a verbal release of information is given, release should be documented in the complaint log.
        - If a member refuses to give consent, the grievance will be entered in the complaint log anonymously and will be used for trending purposes.
- Establishment of the facts concerning the grievance. Obtain all documentation of the relevant facts concerning the issues, taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination or resolution of grievance.

Additional Review of Oral and Written grievance

For Grievances sent directly to DHS Governor's Advocacy Office, OHP Client Services Unit or OHA Ombudsman. Once YCCO is notified of the grievance, cooperation will be given to the investigation and resolution, including providing all requested records as expeditiously as the affected member's health condition requires, and within required timeframes.

Resolution and Notification Timeframes
Resolution

- Appropriate staff review the grievance and if necessary, forward the grievance to the appropriate manager or clinical individual for further review.
- Grievances shall be resolved, and notice provided to the member as expeditiously as the member's health condition requires.
- Grievance resolution may be provided orally but will also, in all instances, be in a written notification. The language for the notice of grievance resolution to the member shall be sufficiently clear that a layperson could understand the disposition of the grievance.
- Standard resolution of grievances in five (5) business days from the date of YCCO's receipt of the grievance.
    - If unable to resolve a grievance within the five days, written notification will be provided to member explaining the reason for the delay.
    - The notification must be sent within five (5) business days and will include the reason for the delay. This will extend the time frame for resolution to 30 days.
    - All complaints with extensions are required to be resolved within 30 days of receipt.
    - Complaint resolution may be provided in the member's preferred language orally in addition to a written response.
    - All complaints will receive a written response in the member's preferred language.
- Resolution shall include the following:
    - Address each aspect of the grievance and explain what the decision is and the reason for the decision; and
    - Notifies member or member representative for each notice of resolution that is not in favor of the member or for members who are dissatisfied with the disposition of the grievance that they may present their 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.
    - Complaint resolution may be provided in the member's preferred language orally in addition to a written response.
    - All grievances will receive written responses;
    - Written notice must be translated for members who speak prevalent non-English languages, as defined in 42 CFR 438.10(c);
    - Written acknowledgement and responses meet readability standards, alternative format availability as well as language format requirements found in the OHP Health Plan Services Contract, OAR 410-141-3585, and 42 CFR 438.10. 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.

Members are notified if dissatisfied with the disposition of the grievance may present their complaint to the DHS Department Client Services Unit or OHA Ombudsman 503-947-2346/877-642-0450.

Monitoring of Oral and Written Grievance

- The complaint log documents the member, the date of the grievance, the nature of the grievance, the resolution of the grievance, and the date of the resolution.
- When necessary, a file will be maintained with the review of the grievance, investigation, and resolution. This will include all written decisions and copies of the correspondence with the member or member representative.
- Documentation shall be retained for ten years.
- Appropriate staff will review the grievance log monthly for receipt, disposition, and documentation of grievance. Information to be reviewed for completeness may include:
    - Evidence a 5-day notice was sent to member or member representative of the complaint resolution.
    - Documentation in writing to the member that a delay of up to 30 days from the date the grievance was received.
    - Documentation of the reason the additional time was necessary.
    - Documentation of a written response to the grievance.
- Any Contested Case Hearing requests related to the grievance.
- Providers will receive information about the nature of the member grievance when prior release of information is given as feedback to providers and to improve patient care.
- Appropriate staff will monitor the completeness and accuracy of the written log monthly and includes timeliness of documentation, compliance with written procedures for receipt, disposition, and documentation of grievance and appeals, and compliance with Oregon Health plan rules.

Rights of Individuals to File Complaints Regarding Disclosure of Information

- Individuals have the right to submit a complaint to YCCO's Compliance Officer if they believe that YCCO has improperly used or disclosed their protected information or if they have concerns about the privacy policies and procedures of YCCO and the compliance with such policies and procedures.
    - If the information involved is PHI, individuals also have the right to submit a complaint to the Secretary of Health and Human Services.
    - YCCO may not intimidate, threaten, coerce, discriminate against, take other retaliatory action against any individual who is exercising any right or participation by the individual in any process established under the HIPAA Privacy rules, including the filing of a complaint, testifying, assisting, participating in an investigation, compliance review, proceeding or hearing under the HIPAA Privacy rules, or opposing any act or practice made unlawful by the HIPAA Privacy regulations provided that the individual or person has a good faith belief that the practice that they opposed is unlawful and that the manner of the opposition is reasonable and does not involve a disclosure of PHI in violation of the HIPAA Privacy rules. YCCO may not require individuals to waive their rights to file a complaint with the Secretary of Health and Human Services under 45 CFR 160.306 as a condition of the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits.

3.1 Record Keeping

- YCCO will maintain yearly logs and all appeals and grievance file for ten (10) calendar years with the following requirements:
    - Member's name and 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 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 the 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 and maintain records on all grievances and appeals in accordance with OARs 410-141-3875, 410-141-3890 and 410-141-3915 and 42 CFR 438.416.
- 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.

4.0 Compliance & Oversight

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 partners 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. Other reporting as indicated:

a. 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.

b. Ad hoc reports as requested.

4. Ensuring Policies and Procedures are updated and collected biennially or when subcontractor's review/revision date is updated.

5. Documentation that indicates the process for claim payment and preauthorization denials when appeal is overturned.

6. Insurance that subcontractor meets the requirements consistent with OAR 410-141-3875 through 410-141-3915.

7. Ongoing monitoring of performance.

8. Perform formal compliance reviews at least annually to assess performance, deficiencies, or areas for improvement.

9. Insurance that subcontractors take corrective action for any identified areas of deficiencies that need improvement.

4.1 YCCO Compliance

- YCCO will analyze all grievance, appeals, and hearing data in the context of quality improvement activities pursuant to OAR 410-141-3875 and 410-141-3525.
- 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.
- Tracking and reporting of grievances are conducted with oversight by the Medical Director and the Quality and Clinical Advisory Panel (QCAP). YCCO compliance and Quality and Clinical Advisory Panel (QCAP) maintains responsibility for regularly scheduled review and reporting of member grievance and/or appeals as follows:
    - Compliance and delegation oversight quarterly- Follow-up action plans may be required for subcontractors based on the trending and analysis of the complaint and appeals quarterly report.
- Address analysis of grievances in context of quality improvement activities and incorporate analysis into contract deliverables.

5.0 References

OAR 410-141-3735; 410-141-3875 through 410-141-3915, 943-005-0060
Health Insurance Portability and Accountability Act of 1996
Health Insurance Portability and Accountability Act Privacy and Security Rules
42 CFR 164.501
45 CFR 431.228, 431.230; 438.10; 438.242; 438.402; 438.404 through 438.424 and 438.52
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
OHP Health Plan Services Contract

6.0 Related Policies &Documents

QA-007 Subcontractor Oversight
GA-001 Grievance System
GA-003 Denial, Appeals and Contested Case Hearings
CMPL-001 Prevention and Detection of Fraud, Waste and Abuse
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

7.0 Log of Revision

DATE	REVISION	BY WHOM
01/25/2018	Update to current format and content corrections	JRoe, QA Specialist
01/29/2018	Approved	SMcCarthy, President/CEO
02/01/2018	Update content regarding disclosure complaints	JRoe, QA Specialist
02/26/2018	Approved	SMcCarthy, President/CEO
07/13/2018	Policy reformatting, clarifications with additions from new rules and OHA feedback, contract section I-9, and definition updates	JRoe, QA 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
10/15/2019	Updated policy with 2020 OHA Contract requirements on written notification of all complaints.	JRoe, QA Specialist
08/01/2020	Formatting bullets to enhance policy clarification, OAR updates.	JRoe, QA Specialist
02/27/2021	OAR & OHA Health Plan Services Contract updates, clarification of internal processes.	JRoe, Benefit Administration Supervisor
07/29/2021	OHA approval received via administrative notice	JRoe, Benefit Administration Supervisor
04/09/2022	Formatting and subcontractor clarification updates only, no content change	JRoe, Benefit Administration Supervisor
04/20/2022	OHA annual grievance system policy review for contract, rule, and regulation updates.	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

03/24/2025	Annual review for contract, rule, and regulation updates. Including change in required languages, NDN updates, and clarifications to ensure the policy relays documentation correctly.	JRoe, Health Plan Operations Manager

8.0 OHA Approval Log

DATE	METHOD OF APPROVAL (SharePoint/CCO and MCO Deliverable)
07/29/2021	OHA approval received via administrative notice
06/13/2022	OHA approval received via administrative notice
05/18/2023	OHA approval received via administrative notice
02/29/2024	OHA Attestation submitted via deliverable portal
03/25/2025	OHA Attestation submitted via deliverable portal