Yamhill Community Care

GA-003 Denials, Appeals, and Contested Case Hearings | Version 1.2

Policy

Public

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POLICY NUMBER: GA-003	**TITLE:** Denials, Appeals, and Contested Case Hearings
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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. A payment denied solely because the claim does not meet the definition of a "clean claim" at CFR 447.45(b) is not an adverse benefit determination; 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; 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.

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.
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 (NOADB/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.

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

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 has only one level of appeal and ensures members have access to a robust process for handling appeals regarding the services they receive. Members shall complete the appeal process prior to requesting a contested case hearing. YCCO appeals and contested case hearings are kept confidential and have a timely and appropriate resolution.

A member, their representative, or a subcontractor/provider with the member's consent, who disagree with the Notice of Adverse Benefit Determination (Notice), has the authority to file an appeal.

YCCO ensures that no punitive action is taken against any provider who request an expedited resolution or supports a member's appeal by YCCO.

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.

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;
- Forms 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; and
- Reasonable accommodation or policy and procedure modifications as requested by any disability of the member.
- 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.
- The YCCO toll-free telephone number that the member can call to file the appeal by phone.

Notice of Adverse Benefit Determination and Notice of Appeal Resolution meet readability standards as well as language format requirements found in the OHP Health Plan Services Contract, OAR 410-141-3585 and 42 CFR 438.10. Written notice must be translated for members who speak prevalent non-English languages, as defined in 42 CFR 438.10(c), and notices must include language clarifying that oral interpretation is available for all languages and how to access it. When appropriate a copy will be provide to the provider or clinic who provided or is requesting the services.

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. 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;
- 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 utilizes the OHA templates for YCCO NOABDs and NOARs, and other OHA approved member notices. OHA approved notices include language access statement in the top Oregon 15 translated languages. YCCO ensures each member receives a mailed copy of the current nondiscrimination information at least annually. YCCO does not require staff to include a copy of the current nondiscrimination notice with grievance system 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 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/. The Information on the entities a member can file a complaint with is located in the GA-001 Grievance System Policy.

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.

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

- Easily understood language, at a 6th grade reading level or lower using the Flesh-Kincaid readability scale and format;
- Font size no smaller than 12 point;
- 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 point; and
- The YCCO Customer Service toll-free and TTY/TDY telephone number that the member can call to file the appeal by phone.

YCCO utilizes the OHA templates for YCCO NOABDs and NOARs, and other OHA approved member notices OHA approved notices include a language access statement in the top Oregon 15 translated languages. YCCO ensures each member receives a mailed copy of the current nondiscrimination information at least annually. YCCO does not require staff to include a copy of the current nondiscrimination notice with grievance system notices

Members are provided one level of appeal and contested case hearing rights. Prior to a contested case hearing the appeal process must be completed. The member is to have considered to have exhausted the appeal process if YCCO fail to adhere to notice and timing requirements.

3.0 Procedures

Notice of Adverse Benefit Determination
YCCO NOABD & NOARs will 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, OARs 410-141-3580, 410-141-3585 and 42 CFR 438.410;
- Written notice must be translated for members who speak prevalent non-English languages, 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 CCO Contract Exhibit I, 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 to continue 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, the notice explains that to be entitled to the continuation of benefits the request must be made no later than the tenth day following the date of the notice and the effective date of the action proposed in the notice if applicable.
- 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, the member, and the member's representative.
- Notices will be on Authority approved forms unless member is dually eligible member of affiliated Medicare or Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporated required information fields in the Oregon's Notice.

NOABD's will include the following with a copy sent to the provider requesting the services:

1. Date of the notice;
2. YCCO or subcontractor (if applicable) name, address, and telephone number;
3. Name of member primary care provider (PCP), primary care dentist (PCD) or behavioral health (BH) professional if member has an assigned provider or most specific information available if a member is not assigned to a provider due to clinic/facility model. If member has not been assigned a provider due to enrollment within the last 30 days, NOABD should state PCP, PCD, BH provider assignment has not occurred;
4. Member name, address, date of birth, and Oregon Health Plan identification number;
5. Description and explanation of the service(s) requested or previously provided, and explanation of the adverse benefit determination made or intends to make, including whether it is denying, terminating, suspending, or reducing a service or payment for a service in whole or in part;
6. Pre-service: Date of the service or date the member or provider requested the service and name of the provider;
7. Post-service: Date the service was provided, and the name of the provider who performed or requested the service;
8. Effective date of the action if different from the date of the notice
    a. Pre-service: effective date of the NOABD
    b. Post-service: effective date is the date claim denied on the adverse benefit determination if different from the date of the notice (post-service);
9. Pre-service: Date service was requested by the provider or member. Post-service: date the service was provided;
10. Pre-service: Diagnosis and procedure codes submitted with the authorization request, including a description in plain language. For services that do not include a procedure code a description of the requested service.
11. Post-service: Diagnosis and procedure codes submitted with the claim or authorization request, including a description in plain language. For services that do not include a procedure code a description of the requested service.

Pre-service: Whether consideration of other conditions considered including but not limited to co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services pursuant to OARs 410-141-3820 and 410-141-3830;

12. Post-service: Whether consideration of other conditions considered including but not limited to co-morbidity factors if the condition was below the funding line on the OHP Prioritized List of Health Services, pursuant to OARs 410-141-3820 and 410-141-3830.

13. Clearly and thoroughly explain specific reasons for the action including reference to the specific sections of the statutes and rules to the highest level of specificity for each reason and specific circumstance identified in the notice that includes but is not limited to:

    a. Treatment not a covered service or does not meet requirements based on the Prioritized List of Health Services;

    b. Description of review for medical necessity/appropriateness for members under 21;

    c. Prior authorization was required but was not authorized;

    d. Service or treatment request not medically necessary or medically appropriate criteria as defined OAR 410-120-0000;

    e. Service or item received in an emergency care setting and does not qualify as an emergency service;

    f. Person not a member at the time of request or time service was received;

    g. Except in the case of an Indian Health Care Provider serving an Indian member of YCCO, the provider not on the YCCO panel;

    h. Prior authorization was not obtained (except as allowed in OAR 410-141-3835); or

    i. Disenrollment request is denied as findings that there is not good cause for the request;

14. When additional information is required, the member should be informed attempts were made to obtain additional information from the provider.

15. Reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the NOABD;

16. Member's right or if the member provides written consent as required under OAR 410-141-3890, the provider's right to file an oral or written appeal, including information on exhausting YCCO's one level of appeal and procedures on how to file and the time frames required to do so (appeal must be received within 60 days of the NOABD);

17. YCCO has 16 days to review and resolve the appeal from date of receipt with a possible extension of 14 days. If an extension is needed, the plan will call and send a letter to the member within 2 calendar days. Reassure member that their appeal will be resolved as soon as their health requires and that they can file a grievance if they do not agree with the extension.

18. Member's right or the provider's right to request a contested case hearing with OHA only after YCCO's NOAR or YCCO failed to meet appeal timelines (hearing must be received within 120 days after issuance of the NOAR or where the CCO failed to meet appeal timelines) per OARs 410-141-3890 and 410-141-3895, and the procedures to on how to file a hearing;

19. An explanation of circumstances under which the member or member's provider may request expedited resolution of an appeal and expedited contested case hearing are available and how to request one (pre-service) or explanation to the member that there are circumstances under which an appeal process or contested case hearing can be expedited and how the member or member's provider may request it but that an expedited appeal and hearing will not be granted for post-service denials as the service has already been provided (post-service);

20. A statement that the member has 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 the member may be responsible for the cost of those service if the outcome of the appeal upholds the action. The statement includes how to request the benefits be continued, including that the request must be made before the 10th day following the date of NOABD and include an effective date of action proposed in notice if applicable. Continuing benefits means a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending pursuant to OAR 410-141-3910;

21. Right to be provided, upon request, free of charge reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes strategies, or evidentiary standards used in setting coverage limits or making the adverse benefit determination; and

22. Statement that the provider cannot bill the member for a service rendered unless the member signed and OHP Agreement to Pay form (OHP 3165 or 3166)(post-service denial);

23. Language clarifying that oral interpretation is available for all languages and how to access it.

24. Enclosure line. Include all required forms (OHP 3302)

25. Inclusion of the names of providers and authorized representative if applicable copied on the notice (CC line).

When YCCO makes an adverse benefit determination, YCCO will notify the requesting provider and give the member and the member's representative a written NOABD.

YCCO used the Authority approved form with the exception for dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice will be used with the incorporated required information fields in the Oregon's NOABD.

The following forms must be included with the notice as appropriate:

- Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302);
- Nondiscrimination Notice; and

Timeframes
For actions affecting previously authorized services the notice must be mailed at least 10 calendar days before the date of action. This includes a termination, suspension, or reduction of previously authorized Medicaid-covered services.

With the exception in which the NOABD must be mailed by the date of the action when any of the following occur:

- Receipt of factual information confirming the death of the member.
- All notices sent by YCCO, as a result of the receipt of a clear, written statement signed by the member that they no longer wish or desire the service(s) should advise the member of the information received and that such information caused the termination or reduction of the requested services.

- All notices must be in writing and include a clear statement that advises the member of the information received and that such information caused the termination or reduction of the requested services.
- YCCO verifies that the member has been admitted to an institution where they are ineligible for OHP covered services from YCCO.
- The member's whereabouts are unknown with receipt of a notice from the post office indicating no forwarding address and OHA has no other address.
- YCCO verifies another state, territory or commonwealth has accepted the member for Medicaid services.
- The member's PCP, PCD, or Behavioral Health professional prescribe a change in the level of health services.
- The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919€ (7) of the SSA for Long Term Care (LTC) and Long-Term Psychiatric Care (LTPC) admissions; or
- For adverse benefit determinations for LTC and LTPC transfers, the safety or health of the individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a member has not resided in the LTC or LTPC for 30 days. The member will be transferred or discharged from a long-term care facility in less than 10 days, which provides exceptions to the 30 days' notice requirements of § 483.15(c)(4) of this chapter.

Notice may be mailed as few as 5 days before the adverse benefit determination when there are facts indicating that the adverse benefit determination should be taken because of probable fraud on part of the member and the facts have been verified, whenever possible, through a secondary resource.

Claim payment denial notice must be mailed at the time of any adverse benefit determination affecting a clean claim.

Services Not Previously Authorized
For actions affecting services not previously authorized and that deny or limit the amount, duration, or scope of services:

- Notice must be sent as expeditiously as the member's health condition requires but no later than 14 calendar days following the date of receipt of the request for service., which period of time shall be determined by the time and date stamp on the receipt of the request.
    - Time frames may be extended by up to 14 calendar days if:
        - Member or member's representative, or provider request the extension;
        - YCCO can show (to satisfaction of the Division Hearing Unit upon its request) that there is need for additional information and how the extension is in the member's best interest.
- If timeframe is extended, YCCO will make reasonable effort to give the member oral notice (including multiple calls at different times of the day)or the reason for the decision to extend the time frame and a written notice is sent to the Member providing the reason why the extension is needed, and to inform the Member of the right to file a grievance if they disagree with that decision. A decision must be made, and notice provided as expeditiously as the enrollee's health or mental health condition requires but no later than the date the extension expires.

Services Not Previously Authorized with Expedited Review Granted

For actions affecting services not previously authorized where expedited review has been granted, YCCO will make an expedited authorization decision and provide notice:

- Notice must be sent as expeditiously as the member's health condition requires but no later than 72 hours after receipt of the request for service, which period of time shall be determined by the time and date stamp on the receipt of the request.

Timeframe can be extended up to 14 additional calendar days if:

- Time frames may be extended by up to 14 calendar days if:
    - Member or member's representative, or provider request the extension;
    - YCCO can show (to satisfaction of the Division Hearing Unit upon its request via Administrative Notice) that there is need for additional information and how the extension is in the member's best interest.
- If timeframe is extended, YCCO will make reasonable effort to give the member oral notice including as necessary multiple calls at different times of day) or the reason for the decision to extend the time frame and a written notice is sent to the Member providing the reason why the extension is needed, and to inform the Member of the right to file a grievance if they disagree with that decision. A decision must be made, and notice provided as expeditiously as the enrollee's health or mental health condition requires but no later than the date the extension expires.

Expedited cases in which a provider indicated, or YCCO determines, that following the standard authorization timeframe could seriously jeopardize the member's life or health or member's ability to attain, maintain or regain maximum function, YCCO must make an expedited authorization decision.

NOABD – Pharmacy
The following NOABD requirements apply to all outpatient drugs, including a practitioner administered drug (PAD). All prior authorization request will have one of the following take place within 24 hours:

- Written, telephonic or electronic communication of approval of the drug as requested to the member, and prescribing provider, and when known to YCCO, the pharmacy, or
- Written NOABD of the drug to the member and telephonic or electronic notice to the prescribing provider, and when known to the pharmacy if the drug is denied or partially approved; or
- Written, telephonic, or electronic request for additional documentation to the prescribing provider when the prior authorization request lacks the YCCO standard information collection tools such as prior authorization forms or other documentation necessary to render a decision; or
- Written, telephonic, or electronic acknowledgment of receipt of the prior authorization request that gives an expected timeframe for a decision. An initial response indicating only acceptance of a request shall not delay of decision to approve or deny the drug within 72 hours. The 72-hour window for a coverage decision begins with the initial date and time stamp of a prior authorization request for a drug and the need for additional information will not delay a decision to approve or deny the drug as expeditiously as the member's health requires and not later than 72 hours.

Additional information requests, YCCO will identify and notify the prescribing provider
of the documentation required to make a coverage decision and comply with the following timeframes. Once received YCCO issues a decision as expeditiously as the members condition required but no later than 72 hours. If the request is not received within 72 hours from the date of the initial request for prior authorization a written NOABD is sent to the member and telephonic or electronic notice to the prescribing provider and if known the pharmacy. Notification requires:

- Approved as requested receive notification to the member, prescribing provider, and if known the pharmacy telephonically or electronically; or

Denied or partially approved, a written NOABD is issued to the member, and telephonic or electronic notice to the prescribing provider, and when known the pharmacy.

Prior Authorization Timeliness
If a Prior Authorization determination can't be made within the timelines and extension was given, a Notice of Adverse Benefit Determination constituting a denial must be mailed to the member prior to the last date of the extension period.

Noncompliance of NOABD Timeframes
Standard and/or expedited service authorization decision not reached within the specified timeframes per 42 CFR 438.210(d) it will constitute a denial, YCCO will mail the NOABD on the date the timeframe expires.

Appeal Processing (Standard and Expedited)
Consistent with confidentiality requirements, YCCO staff designated to receive appeals begins to obtain documentation of the facts concerning the appeal upon receipt. Upon receipt of the appeal, YCCO will, within 5 business days, resolve, or acknowledge receipt of the appeal to the member, authorized representative and/or the member's provider where indicated.

- Appeals must be received no later than 60 days from the date on the NOABD.
- Members or provider, with member's written consent, or authorized representative acting on behalf of the member, as state law permits, may file an appeal regarding a disagreement with an adverse benefit determination or to contest the failure of YCCO to act within timeframes for standard resolution of grievances and appeals.
- All standard appeals will be acknowledged in writing within 5 business days of receipt, expedited acknowledged orally and in writing within 1 business day.
- Appeals may be initiated orally or 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.
- Appeals include request from the Authority for review of a notice.
- Standard appeals will be resolved, and notice provided as expeditiously as the member's health condition requires and no later than 16 days from the date of receipt.
- Expedited appeals will be resolved, and notice provided as expeditiously as the member's health condition requires and no later than 72 hours from the date of receipt. Expedited appeals requested orally time frame will begin when there is established contact made between YCCO and the member.

Insurance of the following throughout the appeal process by those processing, reviewing, and making decisions on appeal outcomes:

- Obtain and take into account documentation of all relevant facts concerning the issues, including all comments, documents, records, and other information submitted by the member or the representative without regard to whether the information was submitted or considered in the initial adverse benefit determination or resolution of a grievance.
- Ensure staff that are given appeals have the authority to act upon the matter;
- Ensure the individual who made the initial decision on the appeal is not involved in any previous level of review or decision making nor a subordinate of any such individual and is a health care professional with the appropriate

physical health, behavioral health (which includes mental health and substance use disorders), and oral health clinical expertise, as determined by OHA, to treat the member's condition or disease.

- 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.
- The following situations require the review of a health care professional with the appropriate clinical expertise to treat the member's condition or disease:
    - An appeal of a denial that is based on lack of medical appropriateness;
    - A grievance regarding the denial of an expedited resolution of an appeal;
    - A grievance or appeal involving clinical issues.

Oral inquiries seeking to appeal an "action" are treated as appeals in order to establish the earliest possible filing date.

Standard Appeal Time Frame Extension
YCCO may extend the 16-day timeframe up to 14 days if:

- The member requests the extension; or
- YCCO shows (to the satisfaction of OHA, upon its request) that there is need for additional information and how the delay is in the member's best interest.

When an extension takes place YCCO will:

- Make reasonable efforts to give the member prompt oral notice of the delay (multiple calls at different times of day).
- 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 the decision.

Resolve the appeal and provide notice as expeditiously as the member's health condition requires and no later than the date the extension expires.

Appeals Received at OHA
Members have the right to submit an appeal and/or hearing request directly to OHA. If a request for an appeal or hearing is sent to OHA prior to the member filing with YCCO, OHA will transfer the request to YCCO and provide notice of the transfer to the member. Upon receipt YCCO will:

- Review the request immediately as an appeal of the YCCO NOABD.
- Approve or deny the appeal within 16 days and provide the member with a NOAR.

Members have the right to:

- Provide information for the appeal (in person and in writing, and ability to make legal and factual arguments
- Examine their case file which may include medical records;
- Have access to a toll-free number that the member can use to file an appeal or receive help with filing the appeal;
- Avail themselves of a legal representative if desired.
- Insured that they are informed about the appeal process in advance of the resolution for standard and expedited appeals and the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments in the case of an expedited appeal resolution.

Parties to the Appeal
The following YCCO considers parties to the appeal:

- The member;
- Member representative;
- Provider acting on behalf of a member with written consent from the member;
- YCCO; and
- The legal representative of a deceased member's estate.

Member Definition Reminder
With respect to actions taken regarding appeals, references to a member include, as appropriate, the member, member representative, and the representative of a deceased member's estate.

With the respect to YCCO notification requirements, a separate notice must be sent to each individual who falls within this definition.

Final Adjudication of the Appeal
YCCO appeal process provides final adjudication on all appeals and contested case hearings by YCCO.

Continuing Benefits Insurance
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.

Evidence and Testimony
Members are provided reasonable opportunity to present evidence and testimony and make legal and factual arguments in person as well as in writing:

- YCCO shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for standard appeals and in the case of a request for expedited appeals resolution;
- YCCO shall provide the member or member representative the member's case file, including medical records, other documents, and records, and any new or additional evidence considered, relied upon, or generated by YCCO in connection with the appeal of the adverse benefit determination at no charge and sufficiently in advance of the standard resolution timeframe for standard and expedited appeal resolutions.

Expedited Appeals
Members or providers may file an expedited appeal orally or in writing. For cases in which a provider indicates, or YCCO determines, that following the standard appeal timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

Expedited notice of appeal resolutions requires YCCO to make a reasonable effort to provide an oral notice (multiple calls different times of day) followed by the written NOAR. Oral notice should include the NOAR information that will be in the written follow up. Expedited appeals will be resolved in 72 hours.

Expedited Request Denial

If expedited appeal request is denied, the following should take place:

- Determination and documentation that denial of an expedited appeal and taking time for a standard resolution could not seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function as set forth in 410-120-1860.
- Transfer the appeal to the standard time frame in accordance with the OHP Health Plan Services Contract with resolution taking place in 16 days from receipt of the appeal with a possible 14-day exception, with the date of receipt the same as when received as an expedited request;
- Make a reasonable effort to notify the member orally of the denial of the request;
- Follow up with a written notice within 2 calendar days;
    - Written notice must state the right of the member to file a grievance with YCCO if they disagree with the denial for their request of an expedited appeal.
- Resolve the appeal and provide notice as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
- Forward the denial decision along with the written notice to the member to YCCO the day it was sent to the member, so we know which timeline is being followed for the appeal.

Expedited Appeal Time Frame Extensions

- YCCO may extend the 72-hour expedited time frame by up to 14 calendar days if the member requests an extension, or if the CCO justifies (to the state agency, upon request) a need for additional information and how the extension is in the member's interest.
- If additional information is required to resolve an expedited appeal not at the request of the member YCCO will:
    - Make reasonable efforts to give the member prompt oral notice of the delay (multiple calls different times of day).
    - Provide the member with written notice of the delay within 2 calendar days. The notice will include:
        - Reason for the decision to extend the timeframe; and
        - Provide the member with their right to file a grievance if they disagree with the decision.
- Resolve the appeal and provide notice as expeditiously as the member's health condition requires and no later than the date the extension expires.

Expedited Request Accepted but Results in Denial

If Expedited appeal is accepted but results in a denial, member will be informed of the right to an expedited contested case hearing and will be sent the notice of appeal resolution (NOAR) with contested case hearing information and appropriate forms. Within two working days YCCO will submit all relevant documentation to the Authority.

Notice of Appeal Resolution (NOAR) Elements for Standard and Expedited Appeals

YCCO utilizes the OHA NOAR template. All NOARs will be in writing on YCCO letterhead and will include all elements listed in the NOABD as specified in OAR 410-141-3885 and OHP Health Plan Services Contract Exhibit Iin addition to:

1.Date of the notice;

2.YCCO name, address, and telephone number;

3. Name of member primary care provider (PCP), primary care dentist (PCD) or behavioral health (BH) professional if member has an assigned provider or most specific information available if a member is not assigned to a provider due to clinic/facility model. If member has not been assigned a provider due to enrollment within the last 30 days, NOABD should state PCP, PCD, BH provider assignment has not occurred;
4. Member name, date of birth and Oregon Health Plan identification number;
5. Service requested and appeal resolution, whether it is denied, terminating, suspending, or reducing a service or payment and date the decision was made;
6. Date of the service or date the member requested the service;
7. Name of the provider who performed or requested the service;
8. Effective date of the appeal decision;
9. The results of the resolution process and the date YCCO completed the resolution;
10. Whether consideration of other conditions as co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services;
11. Copy to the requesting provider if any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested;
12. For appeals not resolved wholly in favor of the member:
    a. Clearly and thoroughly explain specific reasons for the resolution and a reference to the specific sections of the statutes and rules pertaining to each reason;
    b. Member's right to a contested case hearing, how to request one and will include the Health Systems Division Service Denial Appeal and Hearing Request Form (OHP 3302) or approved facsimile; ;
    c. An explanation of circumstances under which the member may request expedited hearing and how to request one; and
    d. A statement that the member has the right to request to continue to receive the services (continuation of benefits) that are being denied pending resolution of the contested case hearing, information on how to request continuation of benefits and the time frame in which this must be done;
    e. Information on member responsibility for the cost of those service if the outcome of the hearing upholds the action.
    f. For appeals resolved partially or wholly in favor of the member an explanation that the member may now access those benefits that were denied and how to do so.

Appeal Time Frames:

Category	**Timeframes**		**Possible Extension**	**Notices**
	Days for YCCO Action	Days for Member to File		

Standard Appeals	Expeditiously as the member's condition allows but no longer than 16 days from receipt.	60 days from date of the Adverse benefit determination	Up to 14 days if member request extension or the need for additional information and how the delay is in the best interest of the member (this delay must meet the satisfaction of OHA and be shown upon its request)	Acknowledgement of receipt or resolution within 5 business days; NOAR within 16 days; Extension notification within 2 days (with reasonable effort of oral notification -multiple calls different times of day); If extension given NOAR as expeditiously as the member's condition allows and no later than the date extension expires no more than 30 days Oral notification to member and provider via phone if denial is overturned. (reasonable effort of multiple calls different times of day)
Expedited Appeals	Expeditiously as the member's condition allows but no longer than 72 hours	60 days from date of the Adverse benefit determination	Up to 14 days if member request extension or the need for additional information and how the delay is in the best interest of the member (this delay must meet the satisfaction of OHA and be shown upon its request)	Acknowledgement of receipt orally (reasonable effort of multiple calls different times of day) and in writing within 1 business day; NOAR Expeditiously as the member's condition allows but no longer than 72 hours and orally(reasonable effort of multiple calls different times of day) as soon as possible; If extension notification within 2 days reasonable effort of oral notification – multiple calls different times of day. If extension NOAR NOAR as expeditiously as the member's condition allows and no later than the date extension expires no more than14 days Oral notification to member and provider via phone if denial is overturned. (reasonable effort of multiple calls different times of day)

If YCCO fails to adhere to required time frames for processing appeals, the member is deemed to have exhausted the YCCO appeal process and the member may initial a contested case hearing.

3.1 Contested Case Hearing (Standard and Expedited)

In the event the appeal resolution is not wholly in favor of the member, the member, the member's representative or the representative of a deceased member's estate has the right to file a contested case hearing (hearing) request with YCCO or the OHA within 120 days from the date of the NOAR upholding an adverse benefit determination or in the case that YCCO fails to adhere to the notice and timing requirements in 42 CRF 738.408 the Authority may consider the member exhausting YCCOs appeal process and may initiate a hearing. Hearings are requested using the Service Denial Appeal and Hearing Request form (OHP 3302) or any other Authority-approved hearing request form.

Upon request from the Authority YCCO will forward the entire appeal file within 2 business days.

Parties to the Hearing
The following are the parties to the contest case hearing:

- The member;
- Member representative (a provider would be considered a member's representative if the provider requested the contested case hearing on behalf of the member;
- YCCO; and
- The legal representative of a deceased member's estate.

Right to an Attorney
Members have the right to have an attorney present at the contested case 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.

Expedited Hearing Request
Member or providers who believe that taking the time for a standard resolution of a contested case hearing could seriously jeopardize the member's life or health or ability to maintain or regain maximum function may request an expedited hearing and the Authority shall follow the process as described in OAR 410-141-3905. Expedited hearings can be requested orally, in writing, or online. Expedited hearing request for a service that has already been provided (post-service) to the member will not be granted.

Members, member representatives, or providers requesting an expedited contested care hearing, the Authority shall request documentation from YCCO, YCCO will submit relevant and clinical documentation to the Authority within 2 working days. The Authority shall decide within 2 working days from the date of receiving the relevant documentation applicable to the request whether the member is entitled to and expedited hearing.

Expedited Appeal Decisions

- Once any expedited appeal decision is determined all relevant documentation shall be submitted to the Authority within two working days of the decision.

- The authority shall decide within two working days from the date of receiving the medical documentation applicable to the request whether the member is entitled to an expedited contested case hearing.

Hearing Request Prior to Appeal Process
Upon receipt of the Contested Case Hearing request from the Authority, YCCO will review file to determine if an appeal has taken place, if no appeal was received prior to the hearing request, an appeal will be initiated immediately and YCCO will conduct the appeal process as stated above. YCCO will approve or deny the appeal within 16 days and provide the member with a NOAR. The completed file is then forwarded to the Authority immediately following the appeal determination.

Hearing Request Sent to YCCO by Member
If the member submits a contested case hearing request directly to YCCO after the initial appeal has been completed, YCCO will date stamp the hearing request and immediately transmit it to OHA with a copy of the NOAR.

The following should take place and be sent to the Authority within 2 business days:

- YCCO should submit the hearing request with the following required documentation:
    - NOABD/NOA
    - NOAR
    - Member's Name and OHP ID number;
    - All documents and record relied upon to take the 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 Authority requests as outlined in detail in OAR 410-141-3890;
    - Date and nature of the appeal;
    - Whether continuing benefits were requested and provided and resolution and date of resolution of the appeal.

Evidence and Testimony
Members are provided reasonable opportunity to present evidence and testimony and make legal and factual arguments in person as well as in writing:

- YCCO shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for standard hearings and in the case of a request for expedited hearing resolution;
- YCCO shall provide the member the member's case file, including medical records, other documents, and records, and any new or additional evidence considered, relied upon, or generated by YCCO in connection with the appeal of the adverse benefit determination at no charge and sufficiently in advance of the standard resolution timeframe for appeal.

The final order is the final decision of OHA in the contested case hearing process.

Category	**Timeframes**		**Possible Extension**	**Notices**
	Days for YCCO Action	Days for Member to File		

Standard Contested Case Hearing	90 days from date the member files appeal YCCO has 2 business days to submit to the Authority all records from appeal	120 days from date of YCCO appeal resolution	None	Final Order within 90 days
Expedited Contested Case Hearing	YCCO has 2 business days to submit to the Authority all records from appeal	120 days from date of YCCO appeal resolution		Final Order within 2 business days, if expedited hearing is declined As expeditiously as member's health condition requires with typical limits from 3 to 7 days for completions, oral notification as soon as possible

3.2 Appeal or Hearing Authorizations and Payments

- If YCCO or the Administrative Law Judge reverses the decision to deny, limit or delay services not furnished to the member during the appeal or hearing process, YCCO will promptly authorize 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 of the reversing of the decision to deny, limit, or delay services. YCCO must take the following steps:
    - Notify the member, the member's representative (if applicable) both orally and in writing and the member's provider in writing of the available services and how to access them;
    - Enter the prior authorization into the system or adjust the encounter data claim representing the service.
- When the ALJ reverses YCCO's decision to deny authorization of services, YCCO can file written exceptions or present argument to the proposed and final order within 10 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 11^{th} workday and the services shall not be provided until the final order is issued by OHA. Once a final order is issued and if the decision remains overturned the services shall be authorized or provided to the member within 72 hours of YCCO receiving the final order.
- If YCCO or the Administrative Law Judge reverses the decision to deny authorization of the services benefits furnished to the member during the hearing process YCCO shall pay for the services while the appeal was pending unless the state policy and regulations provide for the state to cover the cost of the services.

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.

- Members must be provided a statement on the NOABD and NOAR 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.
- Benefits that have not been provided while the appeal is pending and YCCO had decided to authorize services following review of the appeal, YCCO should authorize the services or provide the disputed services promptly and as expeditiously as the member's health condition requires. YCCO must take the following steps:
    - Notify the member, the member's representative (if applicable) both orally and in writing and the member's provider in writing of the available services and how to access them;
    - Enter the prior authorization into the system or adjust the encounter data claim representing the service.
- Benefits that have been furnished while the appeal is pending and YCCO has decided to authorize services following the review of the appeal, 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 and 438.420 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, member's representative, with the member's written or oral consent 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, whichever is later.

To be entitled to continuing benefits, the member can request continuation of benefits by phone, letter, fax, or by using the OHP 3302 Review of Health Care Decision form and checking the box requesting continuing benefits by:

- The 10^{th} day following the date of the NOABD or the NOAR or
- Effective date of the action proposed in the notice, if applicable.

If at the member's request continuation of benefits and YCCO continues or reinstates them while the hearing is pending pursuant to 42 CFR 438.420 the benefits must be continued until one of the following:

- Member withdraws the appeal or hearing; or

- Member doesn't request the hearing and continuation of benefits within 10 days from the date of the NOAR on member's appeal; or a state fair hearing decision adverse to the member is issued.

3.3 Record Keeping

- YCCO will maintain yearly logs and all appeals and grievances for ten (10) calendar years with the following requirements:
    - Member's name and ID number, date the member filed the grievance or appeal, and nature of the request.
    - 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. 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, all notations and correspondence.
    - 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.
- Per OAR 410-141-3915 YCCO shall maintain a complete record for each appeal included in the log for no less than 10 years to include:
    - Records of the review or investigation
    - Resolution including all written decisions and copies of correspondence with the member and all evidence, testimony, or additional documentation provided by the member, the member's representative, or the member provider as part of the appeal process.
- 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 monitors the compliance of its subcontractors, including its provider network, with all 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 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. Appeal and Hearing log indicates:
        i. All appeals and hearings received;
        ii. Appeal and hearing issue;
        iii. Days to resolve issue; and
        iv. Notification dates including extensions.
3. 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.
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.

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

5.0 References

OAR 410-141-3735; 410-141-3835; 410-141-3875 through 410-141-3915; 410-141-3280; 410-141-3515; and 410-120-0000
42 CFR 164.50; 42 CFR Subpart F 438.400; 438.402-438.414; 42 CFR 438.10; 438.52; 438.420; 438.424; 438.210; 447.45; 431.213-214; 483.15

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
Section 1919 & Section 1927 of the Social Security Act
OHA 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
Final Adjudication Visio Roadmap

7.0 Log of Revision

DATE	REVISION	BY WHOM
01/25/2018	Update to new format and content	JRoe QA Specialist
01/29/2018	Approved	SMcCarthy, President/CEO
03/08/2018	Update OAR reference and adjudication process	JRoe, Quality Assurance Specialist
07/27/2018	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	Update to NOABD requirements and cost recovery when adverse determination is upheld through appeal or hearing.	JRoe, QA Specialist
08/01/2020	Bullet reformatting for content clarification, appeal acknowledgment notification, 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 policy 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
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
07/08/2022	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