Provider Handbook

2020

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Welcome to Yamhill Community Care (YCCO)!

The YCCO Vision Statement

"A unified health community that celebrates physical, mental, emotional, spiritual, and social well-being."

The YCCO Mission Statement

"Working together to improve the quality of life and health of Yamhill Community Care Organization members by coordinating effective care."

The YCCO 10 Guiding Principles

1. Health Education
2. Accountability
3. Innovation
4. Evidence-Based Clinical Care
5. Transparency
6. Shared Responsibility
7. Member Empowerment
8. Wellness Promotion
9. Equity
10. Stewardship

Our Partners

YCCO has partnerships with several organizations to provide the best care to our members.

The YCCO partners:

Performance Health Technology
Providence Plan Partners
Yamhill County Health and Human Services
Capitol Dental Care
WellRide/First Transit

The YCCO provider manual is a resource that contains information on your responsibilities as a YCCO network provider, health plan benefit information and required policies and procedures. Should you be contracted with one of our partners you may be held to additional standards contained through their contracting process and an additional provider manual or handbook.

YCCO Contact Information

Telephone Numbers:

Customer Service: 503-488-2800
855-722-8205
TTY/TDD: 800-735-2900 or 711

Administrative Office: 503-376-7420

Administrative Office Fax: 503-376-7436

Addresses

Administrative Office:
807 NE Third Street
McMinnville, OR 97128

Mailing Address:
PO Box 5490
Salem, OR 97304

Administrative Office Email: info@yamhillcco.org

YCCO Website: www.yamhillcco.org

Eligibility Verification

Each YCCO member receives a Member Identification Card. Information on the card will help explain the patient's eligibility, indicates the Primary Care Provider or Clinic, with the appropriate telephone numbers for YCCO Customer Service, Preauthorization and Pharmacy information. As well as how to reach our Dental Care Organization, Capitol Dental, Behavioral Health at Yamhill County Health and Human Services and our non-emergent medical transportation agency WellRide.

Please remember that Member Identification Card is not a guarantee of eligibility. The Health Plan has no mechanism for retrieving the Member Identification Card when the member is no longer eligible. Please utilize Customer Service, MMIS or the CIM3 Portal to verify current eligibility.

It is the responsibility of the provider to verify a patient is eligible on the date of service and that you or your clinic is the primary care provider. The provider assumes full financial risk of serving a patient not confirmed as eligible for the service provided on the date of service.

You can verify eligibility via MMIS or the CIM3 Portal. If you do not have access to CIM contact Customer Service at 855-722-8205.

You can also call YCCO Customer Service to verify eligibility at 855-722-8205.

Coordination of Benefits

Situations may arise in which charges for a member's health care services are the responsibility of a source other than the Plan. The following is a list of situations that a YCCO member may encounter:

- Workers' Compensation
- Liability Auto Insurance
- Third Party Payer

Coordination of Benefits ensures that the appropriate insurers are held responsible for the cost of a member's health care and is one of the factors that can help hold down premiums and overall health care costs. Always ask members if they have additional insurance coverage or when being seen for an injury, if this injury is related to a work or auto accident.

Member Primary Care Provider (PCP) Assignment

All YCCO members have a primary care provider (PCP) who manages their medical needs. Members are assigned to PCP clinics or offices. Members are not assigned to individual practitioners unless the practitioner has a solo practice.

PCPs are automatically assigned when the member enrolls with YCCO. Auto assignment is based on where the member lives.

Members have 30 days from the date of enrollment to change their PCP assignment.

Changing PCPs

Members can call Customer Service within the first 30 days of their enrollment with YCCO to select a new PCP. PCPs can help a member select their clinic as the PCP by calling Customer Service.

After their first 30 days with their CCO, members may change their PCP no more than twice in a six-month period. Exceptions will be made for members who have had a change of residence or who have been discharged from their PCP clinic.

PCP assignments become effective the day they are requested. However, newly assigned PCPs may not know about their assignments until they download their member roster. Members receive an ID card from YCCO when they enroll and any time, they change their PCP, when they change their name, benefits or household members.

Access to Care

YCCO assures the established provider network can serve the expected enrollment in the service area and the network of providers is sufficient in number, mix and geographic distribution and to offer an appropriate range of preventative, primary care, specialty, and long-term service supports for physical, dental and behavioral health. The network will have adequate access and if a participating provider is not available within the network accommodations will be made for out of network coverage.

YCCO assures the network and services provided by the network are sufficient to deliver accessible, high quality, culturally and linguistically appropriate services to Members. Review of providers, network composition, capacity, utilization and other data is done at minimum annually or when a significant change to the network occurs. These reviews assure the appropriate range of preventive, primary care, and specialty services. If through this review, a disparity is identified, YCCO activity works to address the gap through contracting and other strategies.

Urgent, Emergency and Post-Stabilization Services

YCCO does not:

- Require prior authorization for urgent and emergency services, members may access these services 24 hours a day, 7 days a week.
- Limit what constitutes an emergency medical condition on the basis of lists of diagnosis or symptoms.

- Hold members liable for payment of subsequent screening and treatment need to diagnose the specific condition or stabilize the patient.
- Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's PCP, of the member's screening and treatment within 10 days of the presentation for emergency services.
- Deny payment for treatment obtained under either of the following circumstances:
    - A member had an emergency medical or dental condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition or emergency dental condition.
    - A representative of YCCO instructs the member to seek emergency services.

The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge. Based on this determination, YCCO is liable for payment.

Post-stabilization services are covered and paid for in accordance with 42 CFR 422.113 as follows:

- YCCO is responsible for post-stabilization care services obtained within or outside the YCCO network that are pre-approved by an in-network provider or other YCCO representative.
- YCCO limits charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if her or she had obtained the services through the YCCO network. For cost-sharing purposes, post-stabilization care services begin upon inpatient admission.

Additional information on urgent, emergency and post-stabilization services is located in the YCCO Emergency, Urgent and Post-Stabilization Services Policy and Procedure.

Crisis Management

YCCO and/or partners have monitoring systems that provide for mental health emergency, including post-stabilization care services and urgent services for all members on a 24-hour 7 day-a-week basis consistent.

- YCCO ensures that an emergency response system is provided for members who need immediate, initial or limited duration response for potential behavioral health emergency situations or emergency situations that may include behavioral health conditions, including:
    - Screening to determine the nature of the situation and the person's immediate need for Covered Services;

    - Capacity to conduct the elements of a Behavioral Health Assessment that are needed to determine the interventions necessary to begin stabilizing the crisis situation;
    - Development of a written initial services plan at the conclusion of the Behavioral Health Assessment;
    - Provision of Covered Services and Outreach needed to address the urgent or crisis situation;
    - Linkage with the public sector crisis services, such as Mobile Crisis Services and diversion services.
- The crisis management system must include the necessary array of services to respond to behavioral health crises, which may include crisis hotline, 24-hour mobile crisis team, walk-in/drop-off crisis center, crisis apartment/respite and short-term stabilization unit capabilities.
- YCCO will ensure access to mobile crisis services for all members in accordance with OAR 309-019-105, and 309-019-0300 through 309-019-0320 included below to promote stabilization in a community setting rather than arrest, presentation to an emergency department, or admission to an acute care facility.

Additional information on urgent, emergency and post-stabilization services is located in the YCCO Emergency, Urgent and Post-Stabilization Services Policy and Procedure.

Appointment Availability and Scheduling

YCCO and delegates require participating providers to meet state standards for timely access to care and services considering the urgency of the member's need for services. Providers should have an after-hours call-in system adequate to triage urgent care and emergency calls from members.

- Calls should be returned appropriate to the member's condition but in no event more than 30 minutes after receipt. If information is not adequate to determine if the call is urgent, the call shall be returned within 60 minutes in order to fully assess the nature of the call. If information is adequate to determine the call may be emergent in nature, the call shall be returned immediately.
- All network provider's hours of operation are not fewer than the hours of operation offered to non-OHP members.
- Services included in the plan are available 24 hours a day, 7 days a week, when medically appropriate.
- Scheduling and rescheduling of member appointments are appropriate to the reason for, and urgency of the visit.
- Members shall be seen, treated, or referred within the following timeframes:
    - Emergency care-Immediately or referred to an emergency department depending on the member's condition;
    - Urgent care-Within 72 hours or as indicated in initial screening, in accordance with OAR 410-141-0140 (telephone or face-to-face evaluation, capacity to conduct elements of an assessment, course of

action at conclusion of assessment, provision for services and/or referral and provision for notification to other providers);

- Well care-Within 4 weeks or within the community standard;
- Emergency dental (oral) care-Seen or treated within 24 hours;
- Urgent dental (oral) care-Within one or two weeks or as indicated in initial screening in accordance with OAR 410-123-0160;
- Routine dental (oral) care-Within an average of eight weeks and within 12 weeks or the community standard, whichever is less, unless there is a documented special clinical reason which would make access longer than 12 weeks appropriate;
- Non-Urgent behavioral health treatment-Seen for an intake assessment within 2 weeks from date of request.
- Pregnant women and IV drug users must be provided with an immediate assessment and intake.
- Members with opioid use disorders must be provided with an assessment and intake within 72 hours.
- Veterans and their families must be provided with an immediate assessment and intake.
- Member requiring medication assisted treatment must be provided with an assessment and induction no more than 72 hours with efforts to provide care as soon as possible documented and consideration given to providing ICC services as applicable under OAR 410-141-3170. Additionally YCCO must also:
  - Assistance in navigating health care system and utilize community resources such as hospitals, peer support specialist, and the like as needed until assessment and induction can occur;
  - Ensure providers provide interim services daily until assessment and induction can occur and barriers to medication removed. Daily services may include using community resources. And in no event will YCCO or provider require member to follow a detox protocol as a condition of providing these members with assessment and induction;
  - Assessment will include a full physical as well as a bio-psycho-social spiritual assessment and prescribe and deliver any necessary medication taking into consideration the results of such assessment and the potential risks and harm to the member in light of the presentation and circumstances; and
  - Provide no less than 2 follow up appointments to such members within 1 week after the assessment and induction.

Providers should apply the same standards to their YCCO members (including hours of operation) as they do to their commercially insured or private pay patients. All appointment availability standards are required and may be monitored for adherence to the standards.

Non-Scheduled Walk-Ins

- Provider procedures for triaging walk-ins must include the following actions:
- When a member walks in without an appointment, office staff record the
- member's demographic information (name, address, etc.) and presenting
- problem and send this information to the triage nurse or provider.
- The triage nurse or provider performs a preliminary assessment of the
- member's condition.
    - Members with **emergent** conditions are seen immediately and/or referred for transport to the nearest hospital.
    - Members with **urgent** conditions are seen within two hours, depending on the severity of the condition, and/or referred for transport to the nearest hospital.
    - Members who present with a non-urgent condition are scheduled for an appointment as medically appropriate.

YCCO Member Rights and Responsibilities

YCCO and all in-network providers, contractors and sub-contractors comply with any applicable federal and state laws that pertain to member rights all observe and protect those rights. Members are treated with respect and with due consideration for his or her dignity and privacy and the same as non-members or other patients who receive services equivalent to covered services.

All YCCO OHP Members have the following rights and responsibilities
Member Rights:

- Treatment with respect and with due consideration for their dignity and privacy and the same as non-members or other patients who receive services equivalent to covered services;
- Treatment by participating providers the same as other people seeking health care benefits to which they are entitled;
- Freedom to choose a coordinated care organization (CCO) as permitted in OAR 410-141-3700, a primary care provider (PCP) or service site and to change those choices as permitted in OAR 410-141-3590;
- To refer themselves directly to mental health, chemical dependency or family planning services without getting a referral from a PCP or other participating provider;
- To have a friend, family member, or advocate present during appointments and at other times as needed with clinical guidelines;
- To be actively involved in the development of the member's treatment plan;
- To be given information about the member's condition and covered and non-covered services to allow an informed decision about proposed treatments;
- To consent to treatment or refuse services and be told the consequences of that decision, except for court ordered services;
- To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;
- To have written materials explained in a manner that is understandable to a member;

- To receive necessary and reasonable services to diagnose the presenting condition;
- To receive covered services under OHP that meet generally accepted standards of practice and is medically appropriate;
- To obtain covered preventative services;
- Access to urgent and emergency services 24 hours a day, seven days a week as described in OAR 410-141-3835, OHP CCO emergency and urgent care services;
- Referrals to specialty providers for medically appropriate services;
- A clinical record maintained that documents conditions, services received, and referrals made;
- Access to one's own clinical record unless restricted by statute;
- To transfer a copy of the member's clinical record to another provider;
- Right to execute a statement of wishes for treatment including the right to accept or refuse medical, surgical, chemical dependency, or mental health treatment and the right to execute advance directive and powers of attorney for health care;
- To receive written notice before a denial of or change in a benefit or service level is made unless such notice is not required by federal or state regulations;
- Information on how to make a complaint or appeal with YCCO or request an administrative hearing with the Authority and receive a response per OAR 410-141-3875 - 410-141-3910;
- To exercise his or her rights without adverse treatment by the CCO, its network providers, or the State Medicaid agency.
- To receive interpreter services as defined in OAR 410-141-3515; and
- Timely appointment cancellation notices.
- Require, and cause YCCO in-network providers to require, that members receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition, preferred language, and ability to understand.

Member Responsibilities:

- To choose or help with assignment to a CCO as defined in OAR 410-141-0060, OHP enrollment requirements and a PCP or service site;
- To treat the CCO, providers and clinic staff with respect;
- To be on time for appointments made with providers and to call in advance either to cancel if unable to keep the appointment or if the member expects to be late;
- Seek periodic health exams and preventative services from a PCP or clinic;
- Use of a PCP or clinic for diagnostic and other care except in case of an emergency;
- To obtain a referral to a specialist from their PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;
- Use of urgent and emergency services appropriately and notification to the CCO within 72 hours of an emergency;
- Providing accurate information for inclusion in their clinical record;
- Assistance to the provider or clinic to obtain clinical records from other providers that may include signing an authorization for release of information;
- To ask questions about conditions, treatments, and other issues related to the member's care that is not understood;
- To use information to make informed decisions about treatment before it is given;
- Assist the provider in creation of a treatment plan;
- Follow prescribed agreed upon treatment plans;

- Advise the provider that the member's health care is covered under OHP before services are received and, if requested, to show the provider the OHP coverage identification form or card;
- Notification to OHA worker of a change of address or phone number;
- To tell the OHA worker if any family member becomes pregnant and notify the worker of the birth of the member's child;
- Notification to the OHA worker if any family members move in or out of the household;
- To tell the OHA worker if there is any other insurance available;
- Payment for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;
- To pay the monthly OHP premium on time if a premium is required;
- Assistance to the CCO in pursuing any third-party resources available and to pay the CCO the amount of benefits it paid for any recovery received from that injury;
- To bring issues, complaints or grievances to the attention of the CCO; and
- To sign an authorization for release of medical information so that OHA and the CCO can get information that is pertinent and needed to respond to an administrative hearing request in an effective efficient manner.

American Disabilities Act (ADA), Cultural Considerations & Non-Discrimination

YCCO promotes the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

YCCO including all partners, staff and network providers comply with applicable Federal civil rights laws and do not discriminate against, exclude or treat people differently based on race, color, ethnicity, national origin, age, language, physical or mental disability, religion, sex, sexual orientation, and gender identity or expression.

All YCCO and partner network providers will provide effective, equitable, understandable, and respectful quality care and services, including, without limitation, free-of-charge certified or qualified oral and sign language interpreters to all members, and accessible health and healthcare services for individuals with disabilities in accordance with Title III of ADA. Including but not limited to physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities such as street level access or accessible ramp into the facility and wheelchair access to offices, exam room(s), restrooms and equipment; providing information in the manner in which the member understands including written materials in alternative formats, and interpretation.

Understanding the demographics of the population served and how those demographics are reflected in the staff and providers in the agency serving them is an

important component of discrimination and equitable provision of service. Providers will be expected to collect REAL+D demographics (race, ethnicity, age, language and disability) about their YCCO member population and staff according to REAL+D requirements of House Bill 2134.

YCCO participates in the state's efforts to promote delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Including but not limited to the following:

- Procedures for communicating with members who have difficulty communicating due to a medical condition or living in a household where there is no adult available to communicate in English or there is no telephone;
- Certified or qualified interpreter services by phone or in person;
- Coordinated care services which are culturally appropriate, i.e. demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the members care; and

Compliance with the requirements of the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, Age Discrimination Act of 1975, Rehabilitation Act of 1973 and all amendments to those acts and all regulations declared thereunder.

YCCO will insure that all YCCO staff, partners and network providers have implicit bias; structural barriers and systemic oppression; CLAS (culturally and linguistically appropriate services including language access, interpretation, and health literacy); Adverse Childhood Experiences and historical trauma; ADA and accessibility; and REAL+D (race, ethnicity, age, language and disability) training.

Additional information on ADA and non-discrimination may be found in the YCCO Member Non-Discrimination/ADA Policy and Procedure.

Interpretation Services

All contracted providers must make interpretation services available to YCCO members. Interpretation must be available during and after hours for consultation and provision of care. Interpretation can be provided by certified or qualified staff, or by a certified or qualified interpretation service either on site or over the telephone. Interpretation should *not* be provided by a member of the patient's family or ad hoc interpreter.

Bilingual staff as Interpreters

Qualified staff must be designated by the provider office as an individual who will provide oral language or sign language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the provider's office that they are:

- Proficient is speaking and understanding both English and at least one other spoken language or sign language, including any necessary specialized vocabulary, terminology and phraseology and

- Is able to effectively, accurately, and impartially communicate directly with individuals who use sign language or with limited English proficiency in their primary languages.

If the staff member does not meet the above criteria (example: interpretation is not part of the staff member's job duties) then the bilingual staff member can only provide interpretation services if there is an emergency involving imminent threat to the safety or welfare of an individual or public.

Passport To Languages
YCCO coordinates and pays for interpretation services for members' medical appointments for covered services through our preferred vendor, Passport to Languages (PTL). To arrange for an interpreter to be present during an appointment or for telephone interpretation you can call PTL at 503-297-2707or request services via the PTL their website http://www.passporttolanguages.com you must submit request at least **2 working days prior** to your appointment date. PTL's Customer Service staff sends a fax or email to the provider's office to confirm that interpreter arrangements are complete.

For urgent needs (fewer than 48 hours' notice), call PTL's Customer Service department at 503-297-2707 to arrange for an interpreter.

YCCO's vendor Passport to Languages does not offer the following services:
• Appointment reminders*
• Scheduling or rescheduling appointments*
• Relaying test results*
• Registration for procedures/admissions*
• Telephonic services less than 10 minutes in duration*

*These services must be provided by all providers in a culturally competent manner including providing to those with limited English proficiency. It is the responsibility of the clinic or provider to offer appropriate communication in the language the Member prefers at all points of contact and information sharing.

Advance Directives & Declaration of Mental Health Treatment

Members, under federal and Oregon law, have rights concerning their medical and mental health care, including the right to accept or refuse medical or surgical treatment and the right to formulate an advance directive or declaration for mental health treatment. Providers are required to have written policies concerning these rights with implementation of the rights of members with a clear and precise statement of limitation per CFR 42 Subpart I 489.102 and OAR 410-141-3300. Advance Directives and Declaration of Mental Health Treatment forms can be found on the following links:
https://www.oregon.gov/oha/PH/ABOUT/Documents/Advance-Directive.pdf
https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/le9550.pdf

Seclusion and Restraint

YCCO ensures members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation specified in federal regulations on the use of restraints and seclusion.

Transportation for OHP Members

Non-Emergent Medical Transportation (NEMT)
NEMT program provides free-non-urgent rides, mileage reimbursement, LIFT service and bus tickets (and in some cases bus passes) to covered appointments for YCCO members who have no other transportation options. Members are asked to schedule their ride two days in advance, although same-day transportation may also be available.

YCCO WellRide

Toll-free: 844-256-5720 TTY/Oregon Relay Service: 711
Hours of operation: 7:30 a.m.-6 p.m., Monday-Friday
WellRide's call center is closed on New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day and Christmas Day.

Emergency Transportation
Emergency ground or air ambulance transportation, when medically-necessary, is a member benefit. Transportation required to return a member to the service area to obtain continuing care after a medical emergency also is covered. The PCP should discuss appropriate use of ambulance transportation with the member during the initial visit in the context of member responsibility for proper use of emergency services. Return transportation is considered Non-Emergency Medical Transportation, discussed above.

Traditional Health Workers

At Yamhill Community Care, we strive to make our community a great place to live in. We know that a healthy lifestyle isn't just about seeing your doctor occasionally. There are many other different ways to improve the way you live. Yamhill CCO's Community Health Hub is a group of people focused on finding our members the services they need.
For more information please see our flyer CHW flyer
Click here to download a form for referring your patient to these resources. Community Health Hub Referral Form
Below are some of the resources our Community Health Hub can direct members to:
Community Health Workers: CHWs meet CCO members wherever they're at, working with them to navigate their care and access resources to successfully manage their own health and well-being.

Persistent Pain Program: The PPP is an 8-week class combining pain management education and movement therapy.
Diabetes Prevention Program: Yamhill Community Care offers the National Diabetes Prevention Program. Groups meet for 16 weekly sessions and six-monthly follow-up meetings with a trained lifestyle coach.
Project ABLE: Project ABLE partners peer specialists with people who need support getting healthier, both mentally and physically.
Provoking Hope: Provoking Hope utilizes peer support to help people, especially families, who have encountered difficulty with drug or alcohol use.
SNACK Program: The Student Nutrition and Activity Clinic for Kids pairs Linfield College interns with children up to age 18 who work with them and their families to make healthy lifestyle changes.
Champion Team: Champion Team is a consumer-run organization developed to promote personal growth, recovery and wellness for adults in Yamhill County with mental health and/or co-occurring addiction challenges.
Health and Wellness Workshops: These workshops are peer-led and offer a space to learn about managing chronic conditions like diabetes, pain, asthma, and heart disease.
Multi-Disciplinary Team: This team brings together as many members of a care team as possible, including doctors, caregivers, behaviorists, etc., to coordinate the needs and services of a member.

Member Grievance System

Assurances through the Grievance System

Members and/or Providers are assured the following through the grievance system:

- Grievances, complaints, appeals, and contested case hearings are kept confidential and have a timely and appropriate resolution.
- Written notice of any adverse benefit determinations referred to as a Notice of Action/Adverse Benefit Determination (NOADB or Notice).
- YCCO Members have access to a robust process for handling grievances, complaints, appeals, and contested case hearings regarding the services they receive from YCCO.
- Members, with the written consent of the member, a provider or an authorized representative, may file a grievance at any time either orally or in writing on behalf of a member.
- Grievances may be filed directly with YCCO or with the Authority. If filed with the Authority it will be forwarded to YCCO promptly.
- YCCO ensures member grievances and appeals are processed in accordance with Oregon Administrative Rule (OAR) 410-141-0260 through 410-141-0266 and 410-141-3875 through 410-141-3915.
- With the exception of final adjudication of all appeals, all grievances issuing denials, appeal, and contested case hearing processes are delegated functions with appropriate oversight.
- YCCO members are informed that they have a right to file a grievance, appeal or contested case hearing orally or in writing and may have a member

representative of their choice. The member or member's representative may also withdraw an appeal or contested case hearing request at any time.

- A member, member's representative, a representative of a deceased member's estate, or a member's provider acting on behalf of and with written consent of the member may file a grievance or appeal and request a contested case hearing. No punitive action will be taken against any provider who files a grievance, appeal, request a contested case hearing or request expedited resolution of an appeal on behalf of a member.
- YCCO will include in each notice of resolution with the determination not found in favor of the member that they may present the grievance to OHP Client Services Unit (CSU) toll free at 800-273-0557 or OHA's Ombudsman at 503-947-2346 or toll free at 877-642-0450.
- If YCCO fail to adhere to the notice and timing requirements in 42 CFR 438.408, the member is considered to have exhausted the CCO's appeal process. In this case, the member may initiate a contested case hearing.
- That YCCO, its delegates, subcontractors, and its participating providers may not:
    - Discourage member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;
    - Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
    - Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.
- Safeguard the member's right to confidentiality of information about grievance or appeal, except where the sharing of information is allowed for the purposes of treatment, payment or health care operations as defined in 42 CFR 164.501. The following pertains to the release of the member's information:
    - YCCO and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal or hearing may use the information without the member's signed release for purposes of:
        - Resolving the matter; or
        - Maintaining the grievance or appeals log as specified in 42 CFR 438.416.
    - If YCCO needs to communicate with other individuals or entities not listed above to respond to the matter, YCCO will obtain the member's signed release and retain the release in the member's record.
- Safeguard member's anonymity for protection against retaliation in the member grievance and appeal resolution process.
- No incentivized compensation for utilization management activities by ensuring that individual(s) or entities who conduct utilization management activities are not structures so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any member.

- Cooperate with the Department of Human Services Governor's Advocacy Office, the Authorities Ombudsman and hearing representatives in all activities related to member's appeals, hearing requests, and grievances including all requested written materials.
- 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.
- All written grievance system information will be provided with the following guidelines:
    - Easily understood language 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;
    - 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.

YCCO will not take punitive action against any provider who requests an expedited (fast) resolution or supports a member's grievance or appeal.

Grievance System Process, Policy and Rights Awareness and Sharing
As a contracted provider, delegate and/or subcontractor you have are responsible for ensuring Members have access to grievance, appeal and contested case hearing processes and be aware of procedures and timeframes. Including:

- The member's right to a contested case hearing, how to obtain a hearing and representation rules at a hearing;
- Member's right to file grievances and appeals with the requirements and timeframes for filing;
- The availability of assistance to members with filing of grievances, appeals and contested case hearings, toll-free numbers to file oral grievances and appeals;
- Member right to continuation of benefits during the appeal and contested case hearing processes and if the action is upheld in a contested case hearing, the member may be liable or the cost of any continued benefits; and
- The provider appeal rights to challenge the failure of YCCO to cover a service.

When a provider files an appeal on behalf of a member, the provider may subsequently request a contested case hearing on behalf of the member in accordance with the procedures in OAR 410-141-3900.

YCCO's approved written Grievance System policy and procedures are provided to ensure compliance at the time of contract. A copy is added to this handbook. Please note policies are subject to change when changes take place with the OHA CCO

Contract or through Oregon and Federal Law. These policies will be updated as appropriate, contact YCCO to insure you have the most recent version. For more information on this system, Members and Providers can contact Customer Service at 1-855-722-8205 for assistance.

Grievance System Time Frame Filing & Resolution Standards

Category	**Timeframes**		**Possible Extension**	**Notices**
	Days for YCCO Action	Days for Member to File		
Grievance	5 business days or Expeditiously as the member's condition allows.	Any time	Up to 30 days	Resolution letter within 5 business days; Written delay notification within 5 business days from receipt with an explanation for the reason of the delay; Resolution letter within 30 days of receipt when delayed.
Standard Appeals	16 days or Expeditiously as the member's condition allows.	60 days from date of the Notice of 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; NOAR within 16 days; Extension notification within 2 days (with reasonable effort of oral notification); If extension given NOAR within 30 days
Standard Contested Case Hearing	90 days from date the member files appeal 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	2 business days to submit to the Authority	120 days from date of YCCO		Final Order within 2 business days, if expedited hearing is declined

Case Hearing	all records from appeal	appeal resolution		As expeditiously as member's health condition requires with typical limits from 3 to 7 days for completions, oral notification as soon as possible

Provider Rights and Responsibilities

All obligations of the Participating Practitioner Agreement, general principles, responsibilities, and procedural protocol set forth in the preceding sections of the manual apply when serving YCCO members.

In addition, YCCO is required to meet contract requirements specified by the Oregon Health Authority (OHA) for Coordinated Care Organizations. The delivery of medical services to YCCO must conform to OHA policies, procedures, rules and interpretations in the following order of precedence:

1) Federal law, regulation and waivers granted OHA by CMS to operate the Oregon Health Plan;
2) Oregon state law;
3) Oregon Administrative Rules (410-141-3000, 410-141-0000) and OHA General Rules and the administrative rules (410-120-0000) set forth in the relevant Provider Guides (e.g., Medical-Surgical Services Billing and Procedures Guide);
    a. http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_120.html
4) Any other duly promulgated rules issued by OHA and other offices and divisions within the Department of Human Resources necessary to administer the OHP. Call OHA for Oregon Health Plan training, which OHA makes available to providers and their staff. (This training is not specific to YCCO training is available through the Providence Health Assurance Plan Provider Relations Department. YCCO training is available through YCCO.)

OHA furnishes individually enrolled OHA providers with the OHA Provider's Handbook for Medical-Surgical Services and the CMS-1500 Billing Guide and any current OHA Service Guide(s) specific to the provider's category of service. The documents establish service and billing procedures and are to be used in conjunction with the current OHA General Rules and Oregon Health Plan Administrative Rules. To order OHA forms/publications and to determine OHA provider enrollment status, go to the OHA website.

Providers have the right to:

- Receive information from the Health Plan regarding treatment and utilization patterns for the members they serve and know how they as providers compare with their peers.

- Disagree with Health Plan review and/or decisions that affect the treatment or care of members, or that endangers their professional standing as participating providers, and be heard through a formal appeal process.
- Be reviewed and evaluated by a panel of their peers on issues of clinical practice.
- Be treated courteously by Health Plan members.
- Be supported by the Health Plan in educating members about their responsibilities.
- Expect prudent and responsible fiscal management of Health Plan business.
- Expect prudent and responsible fees for provider services.
- Have timely and accurate adjudication of claims for services rendered.
- Receive timely payment from the Health Plan.
- Be informed of Health Plan administrative rules, policies, and standards of practice.

Providers have the responsibility to:

- Provide competent, compassionate and individualized quality care to Health Plan members within the scope of their practice and profession.
- Provide care in a manner that is respectful and considerate of the members' unique needs.
- Be knowledgeable of the Health Plan's administrative rules, policies and standards of practice.
- Be informed of member rights and responsibilities and respect these rights and responsibilities.
- Provide information so that a member can give informed consent for member treatment. Fully disclose to the member treatment options not covered by the Plan that may be of benefit to the member. Obtain consent from an appropriate surrogate if the member is unable to participate in decision-making.
- Give priority to clinical and scientific considerations over financial considerations.
- Adhere to the Health Plan's Clinical Practice Guidelines or, where the provider judges the standards not to be in an individual member interest, advocate another treatment option to the Plan.
- Encourage and assist members to make advance directives and assure that directives are honored to within the confines of state law.
- Educate and encourage members to maintain health and to use preventive and early- intervention services.
- Keep confidential all communications and records related to care, except in the case of persons who have a need to know because they are participating in the delivery of care, in Medical Management and Quality Management activities, or in resolution of claims or grievances.
- Maintain confidentiality of information about individual members. Provide information to employers only when permission of the member is obtained. Follow federal and state privacy regulations, including maintaining an Accounting for Disclosures database which tells members if their health information has been disclosed inappropriately as required by federal and state regulations.
- Be courteous when discussing Health Plan policy or procedures with Plan employees or representatives.

- Pursue continuing medical education.
- Issue denial notices or notify the Health Plan of a denial, when either a service or referral is not approved.
- Bill and Appeal within timely filing.
- Bill electronically whenever possible.
- Educate and encourage members to use the Plan's resources prudently.
- Utilize appropriately the resources allocated by the Plan.
- Treat members without regard to the provider's financial gain or loss, when the treatment is appropriate and necessary.
- Participate in the collection of outcome data and quality assurance data.
- Speak out and resist if peers, purchasers or the Plan is pursuing unethical practices.
- Protect patient rights while maintaining a professional approach in discussing the Plans policies and procedures.
- Abide by policies and procedures of the Plan that are a result of collaborative deliberation of the Plan and its physician leadership.

Provider Relations

The Provider Relations (PR) Representative assigned to your geographic area is your direct link to YCCO. The PR representative can assist you in the following ways:

- Provide YCCO policies and procedure information to office staff.
- Provide education to office staff to gain access to PH Tech CIM3 portal.
- Answer questions about your Participating Practitioner Agreement and clarify information contained in this manual.
- Act as your liaison for other Health Plan issues.

Office staff may contact their PR representative to schedule office visits.

Contact YCCO Customer Service at 855-722-8205 for information about Provider Relations

CIM3-The YCCO Provider Portal

CIM3 is the portal used by the YCCO network. If you do not have access to CIM contact Customer Service at 855-722-8205.

. Use CIM3 to:

- Verify patient benefits
- View patient roster
- Access medical policies
- Submit referrals and prior authorizations
- View existing referrals
- Get claims information
- Get explanation of payment (EOP)
- See PCP Quality Reports

- Read newsletters
- Stay updated

You may have additional provider portals to access provider information and tools based on your provider type and the services you provide. Provider Relations can assist you with this information.

Credentialing & Contracting

YCCO and Delegated Partners follow all OHA CCO Contract, State and Federal Rules and has guidelines for all aspects of the credentialing and re-credentialing process, including appropriate verifications, SAM & OIG screenings, credentialing decisions, adverse actions, process timeframes and notifications. YCCO will ensure that all practitioners/providers have the legal authority and appropriate training, certification, license and experience to provide care to members prior to participation with the coordinated care organization and that the process will be followed for all licensures and by any entities that perform the process on YCCO's request or behalf. The YCCO QA-002 Credentialing Process Policy and Procedure provides additional information pertaining to YCCO credentialing.

Credentialing and contracting may be a delegated function and held by one of our delegated partners, below is a list of the partners, their contact information and the provider types they work with.

Physical Health
Telephone: 503-488-2800

Dental Health
Telephone: 503-585-5205
Email: Providers@capitoldentalcare.com

Behavioral Health
Telephone: 503-474-6884
Email: yccocredentialing@co.yamhill.or.us

Non-Emergent Medical Transportation
Telephone: 844-256-5720

Once a provider has met all requirements for network participation and a contract is issued and signed the provider will receive the appropriate Delegated Partner Provider Manual/Handbook as well as the YCCO Provider Handbook.

Performance Monitoring

The reappraisal process includes the following components, as available, which are reviewed as part of the recredentialing profile at least every three years:

- Profiles on the utilization of resources.
- Adverse outcomes/sentinel event cases.
- Member complaints.
- Access and site visit audit results.
- Medical record documentation audit results.
- Quality Bonus/Preventive Health Measure rates.

Data is compared to the thresholds as established by the CQC. If the practitioner exceeds any threshold, the practitioner will be referred to the CQC for review and recommendation. Practitioner Performance Reviews that result in the recommendation of probation or other disciplinary process will be implemented per policy and tracked by the Quality and Medical Management Department and the CQC.

Covering Providers and On-Call Arrangements

YCCO and delegates require participating providers to meet state standards for timely access to care and services considering the urgency of the member's need for services. Providers should have an after-hours call-in system adequate to triage urgent care and emergency calls from members. It is essential that members be able to reach the PCP/PP or on-call practitioner at any time. The provider must have a system in place that allows a patient to be evaluated telephonically by a live person. The evaluator will be able to give the patient clinical advice or to facilitate contact with another individual who has that ability. Additional information related to appointments is located under the Availability of Appointments and Scheduling section.

Communication Among Providers/Care Coordination

In the interest of providing quality and efficient patient care, practitioners should communicate the results of any treatment, including the annual gynecological exam to the members PCP/PP. This allows the PCP/PP to maintain complete patient records and fulfill the responsibilities of care coordination and consultation. Each member has a PCP or primary care team that is responsible for coordination of care and transitions.

YCCO coordinates physical health, behavioral health, intellectual and developmental disability and ancillary services:
Between settings of care including appropriate discharge planning for short and long-term hospital and institutional stays that reduce duplication of assessment and care planning activities.
With services members receive from other coordinated care organizations, fee-for-service Medicaid, the community and social support providers.

Filing Claims

YCCO will be billed for all services provided to Health Plan members regardless of primary or secondary position. All bills for service to YCCO members should be submitted directly to YCCO. Members should only receive a bill or statement when there is a patient responsibility portion remaining after payment.

Claims for YCCO members should be submitted electronically whenever possible.

Paper claims can be mailed to:
Yamhill Community Care Claims
PO Box 5490
Salem OR 97304

YCCO accepts electronic claims through various vendors, for more information contact your Provider Relations Representative or YCCO Customer Service

Information Required for Filing Claims
To ensure timely claims processing, all claims must be submitted on a CMS 1500 form (formerly a HCFA 1500 form); or, for facilities, on a UB-92 form. Information on the claim form must be printed in black ink with a standard 10- or 12-point type face. Place required information only in the appropriate field and be sure to align tie form so that each item is properly located within the box.

The list below includes general categories of information necessary for claims processing. If any of this information is missing from your claim, it could be delayed or returned to you.

1. Patient's full name and date of birth.
2. Patient's PHP/PHA member number (including the identifying suffix).
3. Subscriber's full name and relationship to patient.
4. Group number or name.
5. Information about other insurance coverage.
6. ICD-10 CM codes (code to the highest level of specificity).
7. Description of any accident circumstances.
8. CPT or HCPCS codes for services performed (use current year codes).
9. Place service codes per CMS guidelines (use list effective 8/01 available on the CMS website).
10. Itemized changes, by date of service (only one service per line).
11. Provider's name, UPIN #, TIN# and financial address (Box 33)
12. Name and address of facility where services where rendered (Box 32 on HCFA)

Overpayment

YCCO is committed to ensuring the appropriate adjudication of claims. However, when overpayments of claims occur, YCCO will recover the overpayment in the most efficient and cost effective way for YCCO and the provider.

YCCO has a mechanism in-place for network providers to report receipt of an overpayment. The provider is required to notify the plan and return the full amount of the overpayment within 60 calendar days after the date on which the overpayment was identified and provide in writing the reason for the overpayment. In the event YCCO

makes an overpayment to a provider, YCCO will recover the full amount of the overpayment from the provider.

Coordination of Benefits

When a member is eligible for more than one health plan at the same time, the health plans coordinate their payments to avoid overpayment of claims. YCCO and the OHA collects information about other insurance coverage that members may have. If our records indicate that a member has a primary insurance other than YCCO, we must receive a copy of the Explanation of Payment Benefits (EOB) from the primary carrier with your billing. Members should not receive a bill for remaining balances unless the services were not a covered benefit or until both the primary and secondary have processed and paid the claim. If you are unsure of primary coverage, please call customer service.

Third Party Liability

If the diagnosis or treatment on a billing suggests that a third party may be liable for the charges, we will investigate this prior to claims payment. Please provide accident information with your billing.

Timely Claims Submission

Claims must be submitted on a timely basis. OHA requires that providers submit all claims within 120 days (4 months) of the date of service. The member **cannot** be billed for these services if the provider does not file timely. We may choose to waive the timely filing rule for Medicaid if a claim meets one of the following criteria and proof is submitted:

- Newborns
- Medicare coverage
- Other insurance coverage
- Maternity-related expenses
- Claims denied by Workers' Compensation
- Claims processed or adjusted after retroactive eligibility changes

If a Provider disagrees with the way a claim was paid, YCCO must be notified within 180 days of payment or denial of the claim.

Billing a Member

OHP/YCCO does not collect co-payments for services provided to our members. Providers are prohibited from billing a YCCO member for Medicaid covered services.

Members may only be billed if all of the following criteria are met:

- The service is not covered by Medicaid;
- All reasonable covered treatments have been tried or member is aware of reasonable covered treatments, but selects a treatment that is not covered; and
- Member and provider have completed an OHP Client Agreement to Pay for Health Services form (OHP 3165).

The OHP Client Agreement to Pay for Health Services form (OHP 3165) can be found on the OHA website at:
https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/he3165.pdf

If the client accepts financial responsibility for a non-covered service, payment is a matter between the provider and the client subject to the requirements of OAR 410-120-1280.

Discharge and Disenrollment of Members

- **Discharge**: A member is removed from the care of his or her assigned PCP.
- **Disenrollment**: A member is removed from his or her health plan.
- **Verbal abuse**: Abusive language that contains a menacing tone with the intent of threat and is often accompanied by physical and language clues.

Requirements
Although there are general Oregon Health Authority (OHA) guidelines for discharging a member from a PCP, YCCO is responsible for establishing specific discharge policies and procedures. YCCO must follow the guidelines established by the OHA regarding disenrolling members from the plan.

YCCO's philosophy is to encourage members and their providers to resolve complaints, problems and concerns at the clinic level. However, before discharging a member or requesting that a member be disenrolled from YCCO, the PCP must request YCCO's involvement to help resolve the problem or concern.
For guidelines for disenrolling or discharging a member for specific scenarios, please review the procedures in **Appendix A**.

If clinic management decides to discharge the member, a letter must be sent to the member informing him or her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. Fax a copy of the discharge letter to 503-376-7436 Attn: Enrollment Department. If any of the above information is missing, the discharge may not be processed and additional actions may be required.
IMPORTANT: PCPs are asked to provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

Just Causes for Discharging a Member
A member may be discharged from a PCP or disenrolled from YCCO only with just cause. Just causes identified by OHA include but are not limited to the following:
- Missed appointments (except prenatal care patients)
- Drug-seeking behavior
- The member commits or threatens an act of physical violence directed at a medical provider or property, clinic or office staff, other patients or YCCO staff
- Verbal abuse
- Discharge from PCP by mutual agreement between the member and the provider
- Agreement by the provider and YCCO that adequate, safe and effective care can no longer be provided
- Fraudulent or illegal acts committed by a member, such as permitting someone else to

use his or her medical ID card, altering a prescription, or committing theft or another criminal act on any provider's premises.

When a Member *Cannot* Be Discharged
According to OHA Administrative Rule 410-141-0080, members cannot be discharged from a PCP or disenrolled from YCCO solely because of any of the following reasons:
- The member has a physical or mental disability.
- The member has an adverse change in health.
- The PCP or YCCO believes the member's utilization of services is either excessive or lacking, or the member's use of plan resources is excessive.
- The member requests a hearing.
- The member exercises his/her option to make decisions regarding his/her medical care and the provider/plan disagree with the member's decisions

Key Factors When Considering Discharging a Member
In general, the key requisites when considering discharging a member include:
- Timely, early communication and collaboration with YCCO staff to problem solve
- Thorough documentation of events, problems and behaviors
- A plan generated by the PCP to attempt to address the problem or concerns
- YCCO strongly encourages using contracts and case conferences to address problems and concerns. (Call a YCCO for sample contracts and assistance.)
- Consider mental health diagnoses as part of the discharge and disenrollment process.

Prioritized List of Health Services

The OHP covers a comprehensive set of medical services defined by a list of close to 700 diagnoses and treatment pairs that are prioritized and ranked by the Oregon Health Services Commission. This list is called the Prioritized List of Health Services. The state legislature determines funding levels for OHP benefits. To determine if a service is covered by YCCO, check the prioritized list on OHA's website at the following link:
https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx

The line on the prioritized list determines whether or not a treatment is covered by the OHP.
- Diagnosis and treatment pairs that fall **above the line** are covered by the OHP and YCCO.
- Diagnosis and treatment pairs that rank **below the line** are not covered benefits of either the OHP or YCCO. Services below the line generally include conditions that improve by themselves, conditions for which no effective treatments are available or cosmetic treatments.

The list can also be accessed by calling DMAP Provider Services at 1-800-336-6016. If a service is not covered by the OHP and a provider decides that treatment is essential, an authorization request may be submitted with relevant documentation to the Prior Authorization department.

Covered services for OHP members may include, but is not limited to,
- Provider/physician services
- Outpatient hospital

- Inpatient hospital
- Prescription drugs
- Hospice
- ER transportation/ambulance
- Hearing aids, batteries, services
- Durable Medical Equipment and Supplies
- Home Health/private duty nursing
- Physical therapy/occupational therapy
- Speech/language pathology
- Vision exams, therapy and materials
- Chemical dependency services
- Family planning services
- Non-Emergency Medical Transportation (NEMT)
- Mental Health Services
- Dental Services
- Care Coordination and Intensive Case Management Services

*Some of these services are administered directly by YCCO or YCHHS for behavioral health or Capitol Dental Care for dental health, contact information is located on the YCCO member ID card.

Current condition/treatment pairs on the Prioritized List of Health Services can be found on OHA's website. https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx

The PCP has responsibility for the management of the member's health care needs. Note that some benefits that YCCO customarily covers are excluded from the Oregon Health Plan benefit package of covered services. OHA describes non-covered conditions/treatments to Oregon Health Plan clients as "services that get better without treatment, diseases or conditions for which there is no useful treatment, or treatment that is just cosmetic."

Diagnostic services, which are necessary and reasonable to diagnose the presenting condition, are covered regardless of the placement of the condition on the list. Also covered are one-time referrals for diagnostic clarifications and treatment planning. Please note that the member will likely not be able to see that provider again (unless diagnostic clarification makes it appropriate to do so), so treatment planning recommendations made during that visit should be considered for implementation by the referring PCP.

YCCO may, on a case-by-case basis, elect to approve for coverage therapeutic services for those conditions that fall below the line. The following criteria must be met in order for the Plan to consider the request:

1. The condition severely incapacitates the individual, preventing or interfering with function and proposed therapy will significantly improve the condition.
2. Lack of therapeutic treatment will result in deterioration of the condition, which will then require more costly and involved medical care.
3. Patient has a co-occurring diagnosis that is paired with the requested treatment on the prioritized list.

The request for coverage (a benefit exception) must be made in writing and must include documentation of the above as well as all pertinent medical information. The request should be directed to the Quality and Medical Management Department. As medical information will be required, a telephone request will not be adequate to initiate the review.

Covered services are provided in no less than the amount, duration, and scope of the same services to beneficiaries under fee-for-service Medicaid, as set forth in 42 CFR 440.230 and for members under the age of 21, as set forth in 42 CFR 441 subpart B. YCCO ensures:

1. Services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
2. Does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

Excluded Services and Limitations

Certain services or items are not covered under any program or for any group of eligible clients. Service limitations are subject to the Health Evidenced Review Commission (HERC) Prioritized List of Health Services as referenced in 410-141-0520 and the individual program chapter 410 OARs. Information on these services is also located in OAR 410-120-1200.

YCCO places or may place appropriate limits on a service:

1. On the basis of medical necessity criteria.
2. For the purpose of utilization control, provided that:
    a. Services furnished can reasonably achieve their purpose.
    b. Services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports.
    c. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with contractual requirements.

Clinical Practice Guidelines

YCCO, through its Quality Committee reviews and adopts practice guidelines that define standards of practice as they pertain to improving health care quality for major disease/diagnoses.

Practice guidelines are posted at the following link:
https://healthplans.providence.org/providers/provider-support/medical-policy-and-provider-information/
Behavioral health practice guidelines are posted at the following link:
https://yamhillcco.org/wp-content/uploads/YCCO-MH-Levels-of-Care-Model-7.27.16.pdf
Dental Health practice guidelines are posted at the following link:
http://capitoldentalcare.com/providers/practice-guidelines/

Paper copies of these guidelines are available upon request. Please call YCCO Customer Service at 855-722-8205 and ask to speak to someone in our Quality Assurance Department.

Services Covered by OHP Fee-For-Service

Some services are covered by OHP Fee-for- Service but are not covered by YCCO. For more information on these services call OHP Customer Service at 800-699-9075.

Services covered by OHP Fee-For-Service:

- Midwife home delivery
- Mental health medications
- Death with Dignity, physician assisted suicide
- Therapeutic Abortions
- Hospice services for member who live in a skilled nursing facility
- Long term care services
- School based services that are covered services provided under Individuals with Disabilities Act
- Administrative exams request or authorized by another government agency or approved by the Health Systems Division
- Services provided to Citizen Alien Waived Emergency Medical (CAWEM) recipients or CAWEM Plus-CHIP Prenatal Coverage for emergency medical services only

Tobacco Cessation

YCCO pays for medications and telephone counseling with a trained coach to help members stop using tobacco products. If you have a member that uses tobacco products, you can provide Quit for Life, toll-free at 866-784-8454 (866-QUIT-4-LIFE) information.

Prior Authorization

Prior authorization includes helping to contain medical costs, by assessing the need for facility admission and the appropriateness of the proposed level of care before the admission occurs. This also provides an opportunity to initiate pre-admission discharge planning. Please refer to CIM3 for the most up to date Prior Authorization lists.

Second Opinion

A second opinion is performed by an independent clinician and may be requested by a member or Medical Director. The Medical Director may request an external review when clinical indications are not clearly established, or to gather information when the indications for a procedure or treatment do not clearly meet criteria. The review is a 100% paid benefit.

Privacy and confidentiality of their medical records and personal information.

Members have the right to talk with health care providers in private, and to have all communications about their care and all information in their medical records kept confidential. In addition, any personal information that a member gives when they enroll in this plan is protected and will remain confidential. The Plan will make sure that unauthorized individuals cannot see or change anything related to member records.

- The Plan must get written permission from a member, or from their legally appointed representative, before giving medical information to anyone who is not

directly providing their care or responsible for paying for members care, except for purposes that are specifically permitted by State and Federal laws or requirements (such as for use by programs that review medical records to monitor quality of care or to combat fraud and abuse).
- Members have the right to look at, or get a copy of, their medical records or have their medical records transferred to another provider. The member must be informed they may be charged a fee for copying their records.
- Members have the right to ask for changes and/or addendums to their medical record. In this instance the provider and plan would work together to decide if changes should be made.
- Members have the right to know how their health information has been shared with others inappropriately as required by federal and state regulations.

Pharmacy Program

Pharmacy Utilization Management Program
This program, in collaboration with the Oregon Regional Pharmacy and Therapeutics Committee, monitors plan-wide drug utilization trends and implements procedures to improve the quality, safety, clinical efficacy and cost-effectiveness of drug therapy for Health Plan members. This program is used to evaluate inappropriate prescribing or utilization practices; monitor and profile pharmacy provider dispensing patterns; and develops educational materials to inform prescribing providers of the relative efficacy and costs of various drug therapy alternatives.

A Pharmacy Prior Authorization Form and Pharmacy Medical Policy and Criteria are available upon request via CIM3 or the YCCO website www.yamhillcco.org. All covered outpatient drug authorization decisions received notices per section 1927(d)(5)(A) of the Social Security Act. Response is provided by telephone or other telecommunication device within 24 hours of a request for prior authorization.

The YCCO Formulary can be accessed on the YCCO website:
https://yamhillcco.org/wp-content/uploads/PnT-formulary-changes-template-for-member-site_August-2019.pdf

Care Management

Care Management offers a systematic process of assessment, coordination, and intervention in response to a member's care coordination or case management needs. A Standard for Care Management Intervention is available upon request.

Although all populations are at times at risk for suffering from debilitating illness or injury, the YCCO population is particularly vulnerable. Care Management assessment is a critical resource. Care Management staff consists of Registered Nurses (RN), Clinical Support Coordinators (CSC), and Behavioral Health Case Managers. Their services are available to support each provider in the endeavor to identify high-risk members and quickly address health care needs. Care Management's team can provide a plan of care for chronic, medically fragile, or high utilizing patients. Additionally, Care Management can assist members in finding emergency housing, out-of-home placements (foster home, ICF, SNF, etc.), crisis management and access to specialized clinical resources, as well as community resources.

Managing patients complicated or challenging health care needs requires teamwork to cost-effectively deliver high quality care. The content of the care plan is the responsibility of the attending provider in collaboration with consulting providers. Clinically specialized nurses, with oversight from physician advisors, will work closely with the PCP/PP to facilitate coordinated health care management. Care management can assist providers with developing and implementing a patient care plan.

Care Management services may be initiated through direct referral by calling Care Management at 503-574-6428 via email at caremanagement@providence.org,

Exceptional Needs Care Coordination, also called Intensive Care Coordination Services

Members may have special needs that must be met by managed care delivery systems. A system of Exceptional Needs Care Coordination (ENCC) will ensure that these needs are met.

YCCO will make ENCC/ICC services available during regular business hours. Please call 503-574-6428 to reach an Exceptional Needs Care Coordinator.

ENCC services include:

1) Early identification of members with disabilities or special needs.
2) Ensuring that providers consider the unique needs of such patients in treatment planning.
3) Helping medical providers coordinate services.
4) Helping providers link with community support and social services for patients with special needs.
5) Representing people with special needs in Providence Health Plan's internal quality assurance and dispute resolution processes.
6) Identifying and helping remove barriers to necessary covered care.
7) Documenting members' unique needs and steps taken to meet them.
8) Coordinate care with State and/or county caseworkers as appropriate.

ENCC services will be available to assist medical providers to coordinate the care of members with special needs and to keep members, providers, and others from having to make numerous calls to meet these needs.

YCCO, YCCO contractors and subcontractors are available to providers to provide information about ICC and other support services available for members. Any available training regarding ICC is available to patient-centered primary care homes and other primary care staff. For more information you can call a Care Coordinator or YCCO Customer Service.

Fraud Waste and Abuse

Yamhill Community Care takes fraud, waste and abuse very seriously. If you suspect that member benefits aren't being used correctly or want to report a case of waste abuse or fraud, please contact the confidential hotline at 866-329-2309.

To report provider fraud: DHS Provider Audit Unit
3406 Cherry Avenue N.E. 2nd Floor
Salem, OR 97303

Phone: 888-372-8301
Fax: ATTN: HOTLINE at 503-378-2577

YCCO Policies & Procedures:

Please note policies are subject to change when changes take place with the OHA CCO Contract or through Oregon and Federal Law, these policies will be updated as appropriate contact YCCO to insure you have the most recent version.

If you have any questions regarding a YCCO Policy and Procedure please contact YCCO Customer Service at 855-722-8205 or via email at info@yamhillcco.org.

Log of Revision/Review

Date	Revision/Review	By Whom
12/04/2019	Grievance System Time Frame Grid	JRoe, QA Specialist
07/08/2020	Policy Updates	JRoe, QA Specialist

Appendix A

Discharging a Member

Follow these procedures to discharge a member from a PCP or to request disenrollment of a member from YCCO.

Process For Discharging A Member	
MISSED APPOINTMENTS	
RESPONSIBILITY	**ACTION**
PCP or PCP Staff	1. If a member misses an appointment, consider sending a letter to the member emphasizing the importance and expectation of keeping appointments and the expectation of advanced notice of cancellation. 2. If a member misses two appointments in a row after the initial office visit or three appointments over a six-month period, send a letter informing the patient that she/he must contact the clinic manager or other designated staff person before the member can receive further care. 3. Meet with the member. Ask the member to sign a completed contract outlining that she/he must contact the clinic manager or other designated staff person. 4. Fax a copy of the signed contract to the member's caseworker. 5. If the clinic management decides to discharge the member, send a letter to the member informing him or her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be process by YCCO and the letter will be returned to the clinic. **IMPORTANT**: PCPs are asked to provide urgent care for the discharged member for 30 days after the member is notified of the discharge. 6. Send relevant documentation to YCCO Provider Services, including chart notes, copies of letter(s) sent to the member, signed contracts, and/or documentation of case conferences. Fax a copy of the discharge letter to 503-376-7436, Attn: Enrollment Department.

YCCO Care Coordinator	7. Work with YCCO Customer Service to assign the member to a new PCP.

DRUG-SEEKING BEHAVIOR

RESPONSIBILITY	**ACTION**
PCP or PCP Staff	1. Meet with the member to develop a plan to address possible drug-seeking behavior and document meeting. Consider chemical dependency treatment.
YCCO Pharmacy Staff	2. At the PCP's request, restrict the member to one or more designated pharmacies and/or one or more designated prescribers.
PCP or PCP Staff	3. Document any contract violation in member's medical record. If the provider cannot manage the member's care, try to find another provider within the primary care clinic to manage the member's care. If another provider is not available within that clinic and clinic management decides to discharge the member: Send a letter to the member informing him/her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be process by YCCO and the letter will be returned to the clinic. AND Fax a copy of the discharge letter to YCCO, Attn: Enrollment Department, 503-376-7436. **IMPORTANT**: PCPs must provide urgent care for the discharged member for 30 days following notification of the member.
YCCO Care Coordinator	Work with YCCO Customer Service to assign the member to a new PCP.

Process For Discharging A Member

Member commits or threatens acts of physical violence and/or commits fraudulent or illegal activities	
RESPONSIBILITY	**ACTION**
PCP or PCP staff	1. Immediately contact the police to file an official report. 7. Contact YCCO Care Coordinator to describe the incident. 8. Fax chart notes and police report when available to Care Coordinator. A member may be discharged in the following situations: • Member commits act of violence to staff, property or other patients. • Member commits an illegal or fraudulent act that is witnessed or confirmed by police investigation. This includes but is not limited to acts of theft, vandalism and/or forgery.
YCCO Care Coordinator **PCP or PCP staff**	At Care Coordinator's discretion, contact DMAP Coordinator by phone to request disenrollment of member. 1. Fax written documentation to DMAP. 2. Inform PCP of DMAP decision regarding disenrollment. • If DMAP or Care Coordinator decides that disenrollment is not necessary, work with PCP to plan the discharge process and work with YCCO Customer Services to assign the member to a new PCP. • If clinic management decides to discharge the member, send a letter to the member informing him/her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be process by YCCO and the letter will be returned to the clinic. Notify the YCCO Care Coordinator. **IMPORTANT**: PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

Process For Discharging A Member

VERBAL ABUSE – VERBAL ABUSE JUSTIFYING DISCHARGE

Verbal abuse *is abusive language that contains a menacing tone with the intent of threat and is often accompanied by physical and language clues*.

RESPONSIBILITY	ACTION
PCP or PCP staff	9. Document incident(s). 10. At discretion of Clinic Manager, contact police to file an official report. 11. Contact YCCO Care Coordinator to describe incident. 12. Fax chart notes and police report, if one was filed, to YCCO Care Coordinator. 13. If clinic management decides to discharge the member, send a letter to the member informing him/her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be process by YCCO and the letter will be returned to the clinic. 14. Notify the YCCO Care Coordinator. **IMPORTANT:** PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.
YCCO Care Coordinator	3. At Care Coordinator's discretion, contact DMAP Coordinator by phone to request disenrollment. 4. Fax documentation to DMAP. 5. Inform PCP of DMAP decision regarding disenrollment. 6. If DMAP decides not to disenroll member or if Care Coordinator does not feel disenrollment is necessary, work with PCP to plan for appropriate discharge process. 7. Work with YCCO Customer Service to assign the member to a new PCP.

VERBAL ABUSE – VULGAR LANGUAGE

RESPONSIBILITY	ACTION
PCP or PCP staff	• Document incident(s) in member's chart. • Schedule a meeting with the member to negotiate a behavioral contract that clarifies expected behavior and consequences for violations.

Process For Discharging A Member

YCCO Care Coordinator	15. If contract is repeatedly violated, contact the YCCO Care Coordinator to describe the incident(s). 16. Fax chart notes and any behavioral contracts to YCCO Care Coordinator.
PCP or PCP staff	17. If discharge is mutually agreed upon by PCP and member, work with YCCO Customer Service to assign the member to a new PCP. 18. If clinic management decides to discharge the member, send a letter to the member informing him/her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be process by YCCO and the letter will be returned to the clinic. 19. Notify the YCCO Care Coordinator. **IMPORTANT**: PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

DISCHARGE FROM PCP BY MUTUAL AGREEMENT
BETWEEN THE MEMBER AND THE PROVIDER

RESPONSIBILITY	ACTION
PCP or PCP staff	8. Document date and reason for mutual decision. 9. Try to find another provider within the primary care clinic to manage the member's care. 10. If another provider is not available within the clinic and clinic management decides to discharge the member, send a letter to the member informing him/her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be process by YCCO and the letter will be returned to the clinic. 11. Notify the YCCO Care Coordinator. **IMPORTANT**: PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.
YCCO Care Coordinator	5. Work with YCCO Customer Service to assign the member to a new PCP.

Process For Discharging A Member

PROVIDER AND YCCO AGREE THAT ADEQUATE, SAFE, EFFECTIVE CARE CAN NO LONGER BE PROVIDED FOR A MEMBER	
RESPONSIBILITY	**ACTION**
PCP or PCP staff	1. Document date and reason for mutual decision. 2. Try to find another provider within the primary care clinic to manage the member's care. 3. If another provider is not available within the clinic and clinic management decides to discharge the member, send a letter to the member informing him/her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be process by YCCO and the letter will be returned to the clinic. 4. Notify the YCCO Care Coordinator. **IMPORTANT**: PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.
YCCO Care Coordinator	5. Work with YCCO Customer Service to assign the member to a new PCP.

Yamhill Community Care does not discriminate.

Yamhill Community Care (YCCO) must follow state and federal civil rights laws. We cannot treat people unfairly in any of our programs or activities because of a person's:

- Age
- Color
- Disability
- Gender identity
- Marital status
- National origin
- Race
- Religion
- Sex
- Sexual orientation

Everyone has a right to enter, exit and use buildings and services. They also have the right to get information in a way they understand. This includes receiving written material in other formats that work for you (large print, audio, Braille, etc).

If you don't speak English, this also includes free interpretation services and written information/material in the language you speak. YCCO will make reasonable changes to policies, practices and procedures by talking with you about your needs.

To report concerns or to get more information, please contact our Grievance Coordinator one of these ways:

- Phone (toll-free): 1-855-722-8205 (TTY/TDD: 7-1-1)
- Mail: Yamhill Community Care Organization
  Attn: Grievance Coordinator
  PO Box 4158
  Portland, OR 97208

You also have a right to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights.
Contact that office one of these ways:

- Web: www.hhs.gov
- Online Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
- Email: OCRComplaint@hhs.gov
- Phone: 1-800-368-1019, 1-800-537-7697 (TDD)
- Mail: Centralized Case management Operations
  US Department of Health and Human Services
  200 Independence Ave. SW
  Room 509F HHH Bldg.
  Washington, D.C. 20201

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-722-8205 (TTY: 1-800-735-2900).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-722-8205 (TTY: 1-800-735-2900).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-855-722-8205 (TTY: 1-800-735-2900).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-722-8205 (телетайп: 1-800-735-2900).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-722-8205 (TTY: 1-800-735-2900). 번으로 전화해 주십시오

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-722-8205 (телетайп: 1800-735-2900).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855722-8205（TTY:1-800-735-2900）まで、お電話にてご連絡ください。

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855 -722-8205 (رقم هاتف الصم والبكم: 1-800-735-2900).

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-722-8205 (TTY: 1-800-735-2900).

Cambodian: របយ័តន៖ េបីសិនជាអនកនិយាយ ភាសាែខមរ, េសវាជំនួយែផនកភាសា េដាយមិនគិតឈន លួ គឺអាចមានសំរាប់បេំរអីនក។ ចូរ ទូរស័ពទ 1-855-722-8205 (TTY: 1-800-735-2900)។

Oromo: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-722-8205 (TTY: 1-800-735-2900).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-722-8205 (TTY: 1-800-735-2900).

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1- 1-800-735-)2900 TTY: 8205-722-855) تماس بگیرید.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-722-8205 (ATS: 1-800-735-2900).

Thai: เรียน: ถาั คุณพดู ภาษาไทยคุณสามารถใชบั ริการช่วยเหลือทางภาษาไดฟ้ รี โทร 1-855-722-8205 (TTY: 1-800-735-2900).

Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: CM-001	**TITLE:** Intensive Care Coordination Services
DEPARTMENT: Care Management	**APPROVED BY:** Chief Medical Officer & President/Chief Executive Officer
EFFECTIVE DATE: 02/15/2017	**LAST REVISION DATE:** 08/01/2020
REVIEW DATES:	
APPLIES TO: Yamhill Community Care, Contracted Partners, Providers, and Subcontractors	

DEFINITIONS:

Word or Acronym	Definition
Community Health Worker (CHW)	Individual who has expertise or experience in public health; works in urban or rural community in association with a local health care system; to the extent practicable, shares ethnicity, language, socioeconomic status and life experience with the residents of the community served; assists member to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness; provides health education and information that is culturally appropriate to the members being served; assist member is receiving the care they need; may give peer counseling and guidance on health behaviors and may provide direct services such as first aid or blood pressure screening.
Community Integration Manager (CIM)	A Multi-tenant platform designed to perform core health plan administrative functions including provider reimbursement, utilization management, member enrollment and customer service.
Coordinated Care Organization (CCO)	A corporation, governmental agency, public corporation, or other legal entity this is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.
Dual Special Needs Plan (D-SNP or DSN Plan)	Medicare Advantage plan that limits enrollment to Medicare beneficiaries who meet certain eligibility criteria, these plans serve people who have both Medicare and Medicaid benefits.
Exceptional Health Care Needs (EHCN)	Members identified as aged, blind or disabled who have complex medical needs.
Full Benefit Dual Eligible (FBDE)	For the purpose of Medicare Part D coverage, Medicare clients who are also eligible for Medicaid.

Home and Community Based Services (HCBS) Waiver	States can provide specific employment supports to individuals through Home and Community Based Services (HCBS) under Section 1915(c) waivers or Section 1915(i) state-plan services 1915(c) waivers provide long-term care for individuals who would receive institutional care without a waiver. 1915(i) services provide HCBS to individuals who meet state-defined criteria.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	Federal law with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.
Intellectual and Developmental Disabilities (IDD or I/DD)	Intellectual and developmental disabilities (IDDs) are disorders that are usually present at birth and that negatively affect the trajectory of the individual's physical, intellectual, and/or emotional development. Many of these conditions affect multiple body parts or systems.
Intensive Care Coordination (ICC)/Exceptional Needs Care Coordination (ENCC)	Specialized case management for members identified as aged, blind or disabled who have complex medical needs including: I. Early identification of members eligible for ENCC services. II. Assistance to ensure timely access to providers and capitated services; III. Coordination with providers to ensure consideration is given to unique needs in treatment planning; IV. Assistance to providers with coordination of capitated services and discharge planning; and V. Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.
Institution for Mental Diseases (IMD)	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing inpatient 7 psychiatric services such as diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services. Its primary character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.
Managed Care Entity (MCE)	Entity that enters into a contract to provide services in a managed care delivery system including but not limited to managed care organizations, prepaid health plans, and primary care case managers.
Medicare Advantage (MA)	Type of Medicare health plan offered by a private company that contracts with Medicare. Medicare pays the premiums for participants in Medicare Advantage plans.
Participating Provider	A licensed practitioner or provider that is participating in an YCC delegates provider network.
Patient Centered Primary Care Home (PCPCH)	Health care clinic that has been recognized for their commitment to patient-centered care. In a Patient-Centered Primary Care Home, the patient the most important part of the care. The Patient-Centered Primary Care Home Program recognizes clinics as primary care homes and makes sure they meet the standards of

	care. The program is part of the Oregon Health Authority and one of the many efforts to help improve the health of all Oregonians and the care they receive.
Practitioner/Provider	A licensed practitioner or provider that is participating in an YCC delegates provider network.
Prioritized Populations	Individuals with SPMI, children 0-5 at risk of maltreatment, children showing early signs of social/emotional or behavioral problems and/or have a SED diagnosis, individuals in medication assisted treatment for SUD, pregnant women and parents with dependent children, children with neonatal abstinence syndrome, children in Child Welfare, IV drug users, individuals with SUD in need of withdrawal management, individuals with HIV/AIDS, individuals with tuberculosis, Veterans and their families, individuals at risk of First Episode Psychosis, and individuals within the I/DD population, and other prioritized members.
Provider Network (Delivery System)	Participating providers affiliated with the CCO who are authorized to provide services to its members.
Serious and Persistent Mental Illness (SPMI)	Group of severe mental health disorders as defined in the Diagnostic and Statistical Manual (DSM) used by mental health professionals to diagnose. The SPMI category includes major depression, bipolar disorders, schizophrenia, and borderline personality disorder.
Severe Emotional Disturbance (SED)	Children or persons under the age of 18, who have diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified with DSM-V that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school or community activities.
Special Health Care Needs (SHCN)	Members who have health care needs, multiple chronic conditions, mental illness or Substance Use Disorders and either I. Have functional disabilities, II. Live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care), social needs are addressed. Any additional resources are requested via Community Health Workers (CHWs). CHWs often times will reach out directly to members and families in need.
Substance Use Disorder (SUD)	Drug addiction, a disease that affects a person's brain and behavior and leads to the inability to control the use or a legal or illegal drug or medication.
Traditional Health Worker (THW)	Umbrella term for frontline public health workers who work in a community or clinic under the direction of a licensed health provider. The 5 types of Traditional Health Workers: Birth Doula, Personal Health Navigator, Peer Support Specialists, Peer Wellness Specialist and Community Health Workers.

Specialty Providers (Specialist)	Any Provider not acting as a primary care provider who has clinical training in a specified area. Medical specialist are doctors who have completed advanced education and clinical training in a specific area of medicine.

POLICY:

Yamhill Community Care (YCC) delegates all or part of this function or process. Through the oversight, YCC will insure compliance with all applicable federal, state, contractual rules and regulations and requirements.

It is the policy of YCC and delegates to ensure members with special and exceptional needs are identified, provided individual attention, and focused on meeting their special and exceptional health care needs required under Oregon Administrative Rule (OAR), Code of Federal Regulation (CFR) and the Oregon Health Authority (OHA) Coordinated Care Organization Contract (CCO). These needs are met in addition to the care coordination available to all members.

Intensive care coordination services (ICC) are available to members identified with special health care needs or as priority populations including: older adults, individuals who are blind, deaf or hard of hearing or who have other disabilities; members with complex medical needs, high health care needs, or multiple chronic conditions; those receiving Medicaid-funded long-term care services and supports; those who exhibit inappropriate, disruptive, or threatening behaviors in a provider's office or clinic or other health care setting; individuals with behavioral health issues including chemical dependency or serious and persistent mental illness; children with serious emotional disturbance, children with Neonatal Abstinence Syndrome; those in medication assisted treatment for substance use disorder; pregnant women and women with dependent children; IV drug users; individuals with HIV/AIDS; individuals with tuberculosis; veterans and their families; and individuals at risk of first episode psychosis. Children and youth shall be provided ICC and behavioral health services according to presenting needs. All other members shall be offered ICC services if qualified by screening and assessment.

YCC member's privacy will be protected throughout the intensive care coordination process per the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 164, Subpart A and E. YCC will provide coordination and transition that is medically appropriate, trauma-informed linguistically and culturally appropriate manner in accordance to state and federal rules including but not limited to Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and National Culturally and Linguistically Appropriate Services (CLAS) standards as established by the US Department of Health and Human Services.

YCC works with providers, and for FBDE members, works with affiliated MA and DSN plan or Medicare providers, to develop partnerships that allow of access to, and coordination with social and support services, including culturally specific community-based organizations, community-based behavioral health services, DHS Medicaid-funded long term care and home and community based services, DHS Office of Developmental Disability Services, community-based developmental disability providers and organizations and mental health crisis management services.

YCC utilizes data to understand the disparities in members health based on their race, ethnicity, location, age, sex and other member specific data and works to address these disparities to improve the health of our members by achieving improvements in overall quality of care and population health.

YCC and delegates provide members integrated person-centered care and services, assuring that physical, behavioral, and oral health services are consistently provided to members in all age groups and all covered populations.

PROCEDURE:

YCC Integration and Care Coordination services are available during normal business hours, Monday through Friday. Information on ICC services shall be made available when necessary to a member's representative during normal business hours, Monday through Friday. If a Member is unable to receive services outside of normal business hours, the YCC will provide alternative availability options for member.

YCC will provide intensive care coordination services without limiting the foregoing, YCC will:

- Without requiring a referral, automatically screening all members of prioritized population for ICC services within 10 days of completion of the health risk screening, or sooner if required by their health condition. YCC shall make trauma informed, culturally and linguistically appropriate ICC services available to all members of prioritized populations who qualify.
- Provide trauma informed, culturally and linguistically appropriate ICC services and behavioral health services to children and adolescent members according to presenting needs.
- Provide trauma informed, culturally and linguistically appropriate ICC services to members receiving Medicaid funded home or community-based setting for long term care services and supports under the State's 1915(i) or 1915(k) State Plan Amendments or the 1915(c) HCBS Waiver.
- Screen all member not identified above when referred by:
    - The member themselves,
    - The member's representative,
    - A provider, including without limitation an HCBS Provider, and
    - Any medical personnel service as a member's Medicaid LTSS case manager.
- Screen members who exhibit inappropriate, disruptive, or threatening behaviors in a provider's office or clinic or other health care setting for ICC services.
- Provide ICC services to members who are children and adolescents in the custody of DHS and those children and adolescents otherwise identified by the YCC contract Exhibit B, Part 4 and Exhibit M.
- Respond to requests for ICC screening services with an initial response by the next business day following the request.
- Periodically inform all participating providers of the availability of ICC services providing training to PCPCHs and other PCP staff regarding the ICC screenings and services and other support services available to members.
- Ensure that a member's DHS Area Agency on Aging/Aging and People with Disabilities, Office of Developmental Disability Services, long term care, or long-term services and supports care manager, have a direct method to contact the member's ICC Care Coordination Team.
- Ensure that the member's ICC Care Coordinator's name and telephone number are available to agency staff and members or member representative when ICC services are provided to the member.
- Ensure that the number of members who are assigned to each care coordinator does not exceed care coordinator's capacity to meet all the ICC needs of such assigned members.

Services can be requested by the member, member's representative, provider, other medical personnel serving the member, or the member's Authority case manager.

- All requests receive an initial response made by the next working day following the request.

ICC staff facilitates care coordination and continuity of care by:

- Sharing pertinent information with all appropriate providers,
- Collaboration of providers to ensure treatment plan alignment,
- Reporting identified gaps in care,
- Assisting providers and ICC members with transitions of care,
- Providing members with educational materials to cover their specific healthcare needs,
- Working with the members community case workers to ensure all resources and services are provided to members in a timely manner,
- Review of provider treatment plans and development of interventions to support the member's care plan and goals, and
- Documentation of all interventions in the electronic charting system so that it readily available to the health care team.
- Direct access to specialist, if applicable via standing referrals or approved number of visits, as appropriate for the member's condition and identified needs.

YCC will ensure the following:
ICC services are made available to coordinate the provision of the services to members who exhibit inappropriate, disruptive, or threatening behavioral in the provider's office or clinic or other health care setting.
HRA results are shared with participating providers serving the member so activities are not duplicated.

YCC and delegates provide coordination and continuity of care for members with exceptional or special health care needs through nurse case management and YCC Community Health Workers (CHW) by:

1. Documenting ICC and SHCN services in member medical records as appropriate and/or member case file.
2. Providing assistance to members who may require extra help in accessing services with an initial response made by the next working day following the request.
3. Members with exceptional health care needs (EHCN) and special health care needs (SHCN) are determined through an assessment by appropriate health care professionals (consistent with 42 CFR 438.208(c)(2)).
4. Care plan addresses additional care services identified in the assessment and incorporates treatment/recommendations/plans of other agencies and providers of specialized healthcare services. Member and/or their family participate in the care plan development.
5. Those members who do need care monitoring having a system to track and provide quality assurance methods to follow through on findings which may arise from the monitoring.
6. Having mechanisms to allow direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.
7. Delegates and providers shall have and maintain a formal referral system.
8. Information about services available for members with special health care needs is communicated by the most appropriate method including accommodations for:
    A. Hearing impaired
    B. Speech disabled
    C. Visually impaired
    D. Alternative languages, translation and interpretation or other cultural differences.
9. Following all ADA guidelines to ensure all members are receiving the same appropriate care and services based on their individual needs.

YCC will share information among entities serving the member to reduce duplication of services as follows:

- DHS Aging and People with Disabilities and the Office of Developmental Disability Services Case Managers for members enrolled with Medicaid long-term care (LTC) or long-term services and supports (LTSS);
- Other managed care entities serving members;
- Skilled nursing facilities when applicable; and
- Medicare Advantage plans serving dual eligible members.

Care coordination activities include:

- Early identification of members eligible for ENCC;
- Assistance to ensure timely access to medical providers and capitated services;
- Coordination with medical, LTC, and LTSS providers to ensure consideration is given to unique needs in treatment planning;
- Assistance to medical providers with coordination of capitated services and discharge planning;
- Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems; and
- Monitoring to ensure language and disability access are provided consistently across services and settings of care.

Member Identification
Member's identification as being eligible for coordination and continuity of care with SHCN or EHCN services according to their eligibility category in the Division of Medical Assistance Program (DMAP) enrollment files, YCC Health Risk Assessments (HRA) and medical screening criteria.

Members may also be identified for services through self-referral, high utilization, from their Primary Care Physician (PCP) or medical personnel serving the member, agency caseworker, his/her representative or other health care or social service agencies. The member's Medicaid LTC or LTSS case manager may refer or self-refer the member for a health risk screening for ICC services.

Identification of Members for Case Management or Additional Services
All members may be identified for additional services including intensive care coordination by the following:

- State enrollment files; and
- Health risk screening and assessment for each member's needs are completed:
  - Within 90 days of the effective date of enrollment for all new members, or
  - Within 30 days when the member is referred or is receiving Medicaid Long Term Care or Long-Term Service and Support, or
  - As quickly as the member's health condition requires. Screenings are documented as well as subsequent attempts if the initial attempt to contact the member is unsuccessful.
  - Annually, upon a change in responsibility, or change in health status indicating a need for an updated assessment

Prioritized Population
Populations consisting of:
Individuals with SPMI,
Children 0-5 at risk of maltreatment,
Children showing early signs of social/emotional or behavioral problems and/or have a SED diagnosis, Individuals in medication assisted treatment for SUD,
Pregnant women and parents with dependent children,
Children with neonatal abstinence syndrome,

Children in Child Welfare,
Intravenous drug users,
Individuals with SUD in need of withdrawal management,
Individuals with HIV/AIDS or those with tuberculosis,
Veterans and their families,
Individuals at risk of First Episode Psychosis, and
Individuals within the I/DD population, and other prioritized members.

Assessments
Health Risk Assessments (HRA) provide questions regarding the members general health, including diagnosis' the member has had, number of emergency room visits, flu vaccinations, smoking, depression, mental health provider needs, eye exams and dental exams. The member is also asked their primary language and to rate their general health.

Once received the HRA is reviewed by a Care Management Team (RN Care Coordinator, LCSW, CSC or Pharmacist) based on HRA answers identify gaps in care, chronic conditions, safety concerns, and access to care and appropriateness for ICC program. Additional assessments may be completed when member is speaking with care management to determine member needs.

HRA CIM Documentation
HRAs are then forwarded securely to the YCC Community Health Worker Hub with a notation on members who are flagged EHCN or SHCN and those requiring community resource assistance. The CHWs attach them to the member file in CIM and create a flag that indicates the HRA is attached a secure CIM link to the members primary care provider (PCP) is also sent for HRA notification for additional follow up as necessary.

HRA Sharing
In an effort to eliminate duplicate efforts, YCC documents HRA screenings in the CIM system. In the event CIM is not a utilized system by the provider additional efforts will take place to share the HRA results, all privacy requirements are followed in efforts to share the HRA with:

- The state or other MCEs serving the member;
- Members receiving Medicaid-funded LTSS and, if approved by the member, their case manager and LTCSS provider, if approved by the member; and
- Medicate Advantage plans serving dual eligible members.

Response and Documentation of HRA Request
Care Management staff reach out to members telephonically or by mail to complete the HRA. If unable to reach a member on the initial attempt, a letter is mailed, and two additional phone call attempts are conducted. If still unable to reach, the PCP is notified, with a request made to complete the HRA in person during an appointment is arranged. If no contact can be made the member's health care is monitored through utilization and claims tracking.

Requests for ICC services will receive an initial response by the next business day following the request.

Documentation will be maintained on the risk screening process to insure compliance. Risk screenings requiring additional information from the member will indicate documentation of all attempts to reach the member by telephone or mail, including subsequent attempts.
YCC and delegates, with use of appropriate health care professionals, will comprehensively assess each member identified as needing long term services and supports (LTSS) or special health care needs in order to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring as well as identification of members

for referral to DHS for long-term services and supports.

HRAs & Additional Assessments for EHCN/SHCN Members
Member assessments identify physical, mental health and social needs and care gaps. Once a member is identified based on their needs, they are assigned a Care Manager. Care Managers work with members and their providers to bridge members and their healthcare. Care management team coordination is established with the member PCP.

Member Reassessment for ICC Eligibility
YCC shall reassess members for ICC eligibility, revise care plans if necessary and ensure care coordination after notice of any of the following events within 7 days, except that members already in ICC shall be contacted within 3 days upon occurrence of any of the triggering events:

- New hospital visit (ER or admission);
- New pregnancy diagnosis;
- New chronic disease diagnosis (includes behavioral health); (D) New behavioral health diagnosis; (E) Opioid drug use;
- IV drug use;
- Suicide attempt, ideation, or planning (identification may be through the member's care team, through diagnoses, or from the member or member's supports);
- New I/DD diagnosis;
- Events placing the member at risk for adverse child experiences, such as DHS involvement or new reports of abuse or neglect to Child Welfare Services or Adult Protective Services;
- Recent homelessness;
- Two or more billable primary Z code diagnoses within 1 month;
- Two or more caregiver placements within past 6 months; (M) An exclusionary practice, such as being asked not to return to day care, for children aged 0-6, or suspension, expulsion, seclusion, or in-school suspension, for school-aged children;
- Discovery of new or ongoing behavioral health needs;
- Discharge from a residential setting or long-term care back to the community;
- Severe high level of self-reported or detected alcohol or benzodiazepine usage while enrolled in a program of medication assisted treatment;
- Two or more readmissions to an acute care psychiatric hospital in a 6-month period;
- Two or more readmissions to an emergency department for a psychiatric reason in a 6-month period;
- Exit from specialized program.

For members not receiving ICC services, and upon occurrence of a reassessment triggering event YCC will conduct new health risk screenings, and as applicable, will reassess members for ICC eligibility revise care plans, and ensure care coordination efforts are undertaken. ICC care coordinator continues brief contracts with members who have experienced a reassessment trigger as long as deemed necessary by the care team before they revert back t the routine contact requirements.

Member rescreening for ICC, and care plan revision, must be performed annually.

Member rescreening for ICC, and care plan revision if necessary, must be performed upon member request.

A member may decline care coordination and ICC. YCC shall explicitly notify members that participation is voluntary, and that treatment or services cannot be denied as a result of declining care coordination.

Care Coordinator Assignments:

Care coordinator assignments must be made within 3 business days.
If a member is in a specialized program at the time they are determined eligible for ICC, or enters a specialized program, then YCC will appoint that care coordinator of the specialized program as the care coordinator for the member while the member is in the specialized program. After transition from the specialized program, YCC must reassess the member within 7 days and assign a new care coordinator in accordance with the provisions above. YCC shall notify the member of their ICC status by at least two means of communication within 5 business days following the screening. Notifications shall include details of the ICC program and the name and contact information of the care coordinator.

Care/Treatment Plans
Care/Treatment plans are developed with patients and monitored for improvement. These plans are shared with the PCP or participating providers serving the member, other parties identified in OAR 410-141-3865; and, for members receiving Medicaid-funded LTCSS, APD and the Office of Developmental Disability Services. The Care Management staff may include or collaborate with behavioral health, dental health or community services or other inter-disciplinary providers based on the member's individual needs. Plan development by individuals trained in person-centered planning using a person-centered process and plan. Plans are routinely audited to ensure assessment timing standards, appropriate assessment, periodic monitoring, services received requested services, coordination of providers if applicable, appropriate forms and letters are included in the file. This audit is then scored and follow up is performed as appropriate.

YCC ensures that ICC plans are collaborative, comprehensive, integrated, and interdisciplinary-focuses written documents that include:

- Details of the supports;
- Desired outcomes, activities, and resources required for an individual receiving ICC services to achieve and maintain personal goals, health, and safety;
- Explicit assignments for the functions of specific care team members; and
- Interrelated medical, social, cultural, developmental, behavioral, educational, spiritual, and financial needs.

ICC Activities
ICC activities include the following:

- Early identification of members eligible for ICC services;
- Assistance to ensure timely access to and management of medical providers, capitated services, and preventive, physical health, behavioral health, oral health, remedial, and supportive care and services;
- Coordination with medical and LTCSS providers to ensure consideration is given to unique needs in treatment planning;
- Assistance to medical providers with coordination of capitated services and discharge planning;
- Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.

Care Coordinators performing ICC must carry out the following services:

- Meet face to face with the member, or make multiple documented attempts to do so, for the initial and exiting appointments. Thereafter, ICC care coordinators must have face-to-face contact with the member individually at least every 3 months and make contact of any kind (face to face when possible) 175 3 times a month or more frequently if indicated. If unable to do so, YCC must document attempts made, barriers, and efforts/plans to overcome barriers.
- Attempt to contact the member no more than 3 days after receiving notification of a reassessment trigger. ICC care coordinators must continue brief contacts as long as deemed necessary by the care team.

- Contact the member's PCP within 1 month of ICC assignment, no less than once a month thereafter, or more often if required, to ensure integration of care.
- Facilitate communication between and among behavioral and physical health service providers regarding member progress and health status, test results, lab reports, medications, and other health care information when necessary to promote optimal outcomes and reduce risks, duplication of services, or errors. This communication shall provide an interdisciplinary, integrative and holistic care update, including a description of clinical interventions being utilized and member's progress towards goals;
- Convene and facilitate interdisciplinary team meetings monthly, or sooner, based on need. Interdisciplinary team meetings must include the member unless the member declines or the member's participation is determined to be significantly detrimental to the member's health, in accordance with OAR 410-141-3865(7)(d). The care coordinator is responsible for arranging for the PCP or PCP staff to bring material to the meeting. The meetings shall provide a forum to:
    - Describe the clinical interventions recommended to the treatment team;
    - Create a space for the Member to provide feedback on their care, self-reported progress towards their care plan goals and their strengths exhibited in between current and prior meeting.
    - Identify coordination gaps and strategies to improve care coordination with the member's service providers; Develop strategies to monitor referrals and follow-up for specialty care and routine health care services, including medication monitoring; and
    - Align with the member's individual care plan.
- Convening a post-transition meeting of the interdisciplinary team within 14 days of a transition between levels, settings and/or episodes of care.
- Revise treatment plans at least every 3 months.

Other Programs

If a member is enrolled in other programs where there is a care manager, the ICC care coordinator remains responsible for the overall care of the member, while the program-specific care manager supports specific needs based on their specialty within the interdisciplinary team.

Treatment Plans

- Care management will produce a treatment or service plan for members with special health care needs, including members receiving LTCSS that are determined through a health assessment to need a course of treatment or regular care monitoring. Each treatment plan shall:
- Be developed in a person-centered process with providers caring for the member, including any community-based support services and LTCSS providers and the member's participation;
- Include consultations with any specialist caring for the member and DHS long-term services and supports providers and case managers;
- Be approved by YCC in a timely manner if applicable;
- In alignment with rules outlined in OAR 410-141-3835 MCE Service Authorization; and
- In accordance with any applicable quality assurance and utilization review standards.

Care Plans

YCC's care coordinators shall develop, and YCC shall require their provider network to use, individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs, including members with serious and persistent mental illness receiving home and community-based services covered under the state's 1915(i) State Plan Amendment and those receiving Medicaid-funded LTCSS.

Care Plan Requirements:

- Incorporation of information from treatment plans from providers involved in the member's care, and, if appropriate and with consent of the member, information provided by community partners. Contain a list of care team members, including contact information and role, compiled in cooperation with the member.
- Make provision for authorization of services in accordance with OAR 410-141-3835 MCE Service Authorization.
- Be developed within 30 days and updated annually for all members not in ICC or a specialized program. For members enrolled in ICC or a specialized program, care plans must be developed within 10 days of enrollment in the ICC program and updated every 90 days, or sooner if care plan needs change.

Care plans shall reflect the member's preferences and goals, and if appropriate, family or caregiver preferences and goals. Care plans shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered:

- To ensure engagement and satisfaction with care plans, members shall participate in the creation of care plans.
- Members must be provided a copy of their care plan at the time it is created, and after any updates or changes to the plan.
- Care coordinators shall actively engage members and caregivers and shall ensure that they understand their role as outlined in the care plan and that they feel equipped to fulfill their responsibilities.
- If a member's participation would be significantly detrimental to the member's care or health, a member may be excluded from the development of a care plan and denied access to a copy of the plan. YCC will document the reasons for the exclusion, including a specific description of the risk or potential harm to the member, and describe what attempts have been made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue the exclusion must be documented as above.

Care Coordinator Principles:
Care coordinators will perform care coordination in accordance with the following principles:
Care coordinators will:

- Use trauma informed care, culturally responsive and linguistically appropriate care, motivational interviewing and other patient-centered tools to actively engage members in managing their health and well-being;
- Set agreed-upon goals for the member with continued CCO network support for self-management goals;
- Promote utilization of preventive, early identification and intervention, and chronic disease management services;
- Focus on prevention, and when prevention is not possible, manage exacerbations and unanticipated events impacting progress toward the desired outcomes of treatment;
- Provide evidence-based condition management and a whole person approach to single or multiple chronic conditions based on goals and needs identified by the individual;
- Promote medication management, intensive community-based services and supports and, for ICC members, peer-delivered services and supports; and
- Have contact with the active program-specific care team at least twice per month, or sooner if clinically necessary for the member's care.

Care coordinators shall promote continuity of care and recovery management through:

- Shall continue through episodes of care, regardless of location of individual;
- Monitoring of conditions and ongoing recovery and stabilization;
- Adoption of condition management and a whole person approach to single or multiple chronic conditions based on the goals and needs identified by the individual, including avoidance and minimization of acute events and chronic condition exacerbations;

- Engaging members, and their family and caregivers as appropriate

Transition Planning by Care Coordinators
YCC facilitates transition planning for members. Care coordinators must take the following steps to facilitate transitions and ensure applicable services continue after discharge:

- The member's care coordinator must participate and play an active role in discharge planning from a specialized facility.
- For discharges from the State Hospital and residential care, the care coordinator shall have contact with the member no less than 2 times per month prior to discharge and 2 times within the week of discharge. Care coordinators must attempt to engage in a face-to-face warm handoff to relevant care providers during transition of care and discharge planning. The care coordinator shall also engage with the member, face to face, within 2 days post discharge.
- For discharges from an acute care admission, care coordinator shall have contact with the member within 1 business day of admission, 2 times a week while the member is in acute care, and no less than 2 times a week within the week of discharge, on a face-to-face basis if possible.
- Prior to discharge, YCC or delegate will conduct a transition meeting to facilitate development of a transition plan. This meeting must be held prior to the member's return to the Contractor Service Area, 30 days prior to discharge, or as soon as possible if YCC is notified of impending discharge or transition with fewer than 30 days' advance notice. The discharge plan must include a description of how treatment and supports for the member will continue.
- YCC will oversee management of all members who have had a lapse in Medicaid coverage, and work to establish services that may be needed but currently are not available in their region.
- YCC will supervise care coordinators to ensure they are providing appropriate services and supports to members and provide full oversight and supervision to the assigned care coordinators. The individual tasked with such responsibility will be a licensed master's-level mental health professional. This supervisory responsibility is not delegated or subcontracted outside of YCC, and YCC holds care coordinators responsible for ensuring integrated coordination of care.

COMPLIANCE & OVERSIGHT:

1. YCC will routinely verify that delegates have policies and procedures as well as provide oversight of participating providers regarding care coordination.
2. YCC will request delegate internal case management audits to ensure delegates are monitoring files.
3. Referral and care coordination data will be routinely requested by YCC of all delegates for review by appropriate YCC staff and/or committees.
4. YCC will routinely verify that delegates are reviewing the quality assurance data and responding to findings of those members who require monitoring.
5. Routine care plan audits will take place insuring compliance with assessment and notification standards as appropriate using the SCHN Treatment Plan Audit Tool.
6. YCC shall periodically inform all participating providers of the availability of ICC and other support services available for members and provide training for patient-centered primary care homes and other primary care providers' staff.

YCC staff performing care coordination shall meet the following requirements:

- ICC care coordinators shall be available for training, regional OHP meetings, and case conferences involving OHP clients (or their representatives) in the YCC service areas who are identified as being of a prioritized population, aged, blind, or disabled or who have complex medical needs in all their service areas. If a Member is unable to

receive services outside of normal business hours, YCC will provide alternative availability options for member.

- Staff who coordinate or provide ICC services shall be trained for, and exhibit skills in, person centered care planning; and communication with and sensitivity to the unique health care needs of people who are aged, blind, or disabled or who have complex medical needs. YCC shall have a written position description for the staff member(s) responsible for managing ICC services and for staff who provide ICC services.
- No more than 15 members in ICC per care coordinator. However, if a member is in a specialized program, YCC will follow the care coordination staffing standards for that specialized group, if a lower ratio is called for.

REFERENCES:

OAR 410-141-3870; 410-141-0405; 410-141-3860; 410-141-3865
42 CFR 438.208
OHA CCO Contract Exhibit B
Americans with Disabilities Act

RELATED POLICIES & DOCUMENTS:

DO-001 Delegation Oversight Policy and Procedure
CM-002 Care Coordination Policy and Procedure
YCC HRA Questionnaire
YCC HRA Postcard
YCC HRA & CM Letters
SCHN Treatment Plan Audit Tool
Providence Plan Partners Policy and Procedures:
ENCC70 Exceptional Needs Care Coordination Continuity of Care Coordination
ENCC 180 Exceptional Needs Care Coordination Care Transition
ENCC 190 Exceptional Needs Care Coordination Program

LOG OF REVISION

DATE	REVISION	BY WHOM
10/27/2017	Update with additional content and to new format.	JRoe, QA Specialist
11/14/2017	Approved	BRajani MD Medical Director SMcCarthy PhD President/CEO
07/27/2019	YCC branding updates	JRoe, QA Specialist
08/30/2019	Updated with new delegate HRA process and clarification of internal processes.	JRoe, QA Specialist
10/30/2019	Definition Updates, Addition of HRA process and guidelines. ENCC/ICC clarifications and updates due to rule changes.	JRoe, QA Specialist
6/29/2020	Updated language to comply with updated OARs; updated OAR references	SEide, Sr. QA & Compliance Mgr
08/01/2020	Definition additions and formatting updates	Jroe, QA Specialist

Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: CED-002	**TITLE:** Provider Billing & Claim Submission
EFFECTIVE DATE: 01/01/2020	**APPROVED BY:** President/CEO
APPLIES TO: Yamhill Community Care Organization, Contracted Partners, and Subcontractors	**LAST REVISION DATE:** xx/xx/xx

DEFINITIONS:

Word or Acronym	Definition
Action	The denial or limited authorization of a requested service, including the type of level of service; the reduction, suspension or termination of a previously authorized service; the denial in whole or in part of payment for a service; for the member who resides in a rural service area where the CCO is the only CCO, the denial of a request to obtain covered services outside the provider network; the failure to provide services in a timely manner as defined by the Medical Assistance Program (MAP); the failure to act within the time frames as provided in 42 CFR 438.408 and 42 CFR 438.210. Action is also known as denial.
Citizen Alien Waived Emergency Medical (CAWEM)	Aliens granted lawful temporary resident status or lawful permanent resident status under the Immigration and Nationality Act are eligible only for emergency services and limited service for pregnant women. Emergency services for CAWEM are defined in OAR 410-120-1210(4)(d).
Community Integration Manager (CIM)	Multi-tenant platform designed to perform core health plan administrative functions including provider reimbursement, utilization management, member enrollment, and customer service.
Emergency Services	Physical, mental or dental health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a member's discharge from a facility or transfer to another facility.
Non-Participating Provider	A provider that does not have a contractual relationship with YCCO and is not on the panel of providers.
Notice of Action/Adverse	Written document that states the action intended or taken.

Benefit Determination (NOABD)	
Out of Network Coverage	Coverage for services when a patient is seeking care outside the network of doctors, hospitals or health care providers contracted with YCCO and its delegates.
Participating Provider	A provider that has a contractual relationship with YCCO and is on the panel of providers.
Prior Authorization	A prior authorization is a process assisting the health plan to determine medical necessity and appropriateness of health care services under the applicable health benefit plan. Services or supplies that may require prior authorization may be surgical services, items of DME, drugs etc.
Prioritized List	List of condition and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering Oregon Health Plan (OHP) health services.
Referral	A referral verifies the Primary Care Physician (PCP) has approved the member's care to that provider.
Remittance Advice	Medical insurance payment explanation providing details about claims payment including required explanation for denied claims.
Third Party Liability (TPL)	Individual, entity or program that is, or may be, liable to pay all or part of the medical cost of any medical assistance furnished to a member.
835 Transaction File	The electronic data interchange (EDI) transaction set for the transmission and payment information.
OHP 3165 Form and OHP 3166 Form (Pharmacy)	Client Agreement to Pay for Health Services Form. This is an agreement between a Client and a Provider, as defined in OAR 410-120-0000. The client agrees to pay the provider for health service(s) not covered by the Oregon Health Plan (OHP), coordinated care organizations (CCOs) or managed care plans. For the purposes of this Agreement, services include, but are not limited to, health treatment, equipment, supplies and medications.

POLICY:

Yamhill Community Care Organization (YCCO), contracted and sub-contracted partners ensure all YCCO member claims are submitted timely by providers following appropriate notification to or authorization from YCCO, and follow YCCO policy, provider contract and YCCO Provider Handbook guidelines. All activities completed by YCCO, contractors or subcontractors associated with submission and payment of claims will comply with all applicable Medicaid laws, regulations, including applicable sub regulatory guidance contract provisions and per the OHA Health Plan Services Contract. YCCO ensures claims are processed timely, appropriately and allow for processes including auditing, provider reconsideration, member appeal which may result in reprocessing. Notification of claim processing payment or denial is completed timely.

PROCEDURE:

Provider shall submit all billings for YCCO members no more than 4 months (120 days) from the date of service.

Timely Filing

Timely filing may be waived, but must be completed within 12 months, for the following cases:

- Pregnancy;
- Eligibility issues such as retroactive deletions or retroactive enrollments;
- Medicare if the primary payer;
- Other cases that may delay the initial billing, but not including failure of the provider to verify the member's eligibility: or
- Third Party Liability (TPL). Indian Health Services and the amended Public Law 93-638 under the Memorandum of Agreement that Indian Health Service and 638 Tribal Facilities are the payers of last resort and are not considered and alternative liability or TPL.

Provider Requirements

Providers must be enrolled with the Authority and eligible for Medicaid reimbursement to provide services to Oregon Health Plan (OHP) members claims will have the provider Medicaid number as well as their NPI.

- For Medicaid covered services, provider will not bill more than their usual charge or the reimbursement specified in applicable rules;
- Claims will be submitted on the appropriate form per program rules or electronically in a manner authorized in OAR 943, division 120;
- Medicare will send crossover claims to the Authority or contracted health plan after adjudication by Medicare. This requires claims sent to Medicare for primary payment to include the applicable information for all dually eligible Medicaid/Medicare members so that claims can automatically cross-over electronically to the Authority or to contracted health care plans. Medicare shall automatically transmit the correct Medicare payment, coinsurance, and deductible information to the Division or the contracted health plan;
- Claims must be for services provided within the provider's licensure or certification;
- Unless otherwise specified, claims must be submitted after:
  A. Delivery of service; or
  B. Dispensing, shipment, or mailing of the item.
- The provider must submit true and accurate information when billing. Use of a billing provider does not abrogate the performing provider's responsibility for the truth and accuracy of submitted information;
- A claim is considered a valid claim only if all required data is entered on or attached to the claim form. See the appropriate provider rules and supplemental information for specific instructions and requirements;
- A provider or its contracted agency, including billing providers, may not submit or cause to be submitted:
  A. Any false claim for payment;
  B. Any claim altered in such a way as to result in a payment for a service that has already been paid;
  C. Any claim upon which payment has been made or is expected to be made by another source until after the other source has been billed with the exception of (8)(c)(A-D) below. If the other source denies the claim or pays less than the Medicaid allowable amount, a claim may be submitted to the Division. Any amount paid by the other source must be clearly entered on the claim form and must include the appropriate TPL Explanation Code;
  D. Any claim for furnishing specific care, items, or services that has not been provided.

Billing Members

Providers may not seek payment for any services paid by YCCO or OHP fee for service:

- Members will not be billed for missed appointments and missed appointments will not be billed to YCCO or OHA.

- Members will not be billed for services or treatments that have been denied due to provider error (required documentation not submitted, prior authorization not obtained, etc.).

Providers may only bill YCCO members in the following instances:

A. Member did not inform the provider of their OHP coverage or third party insurance coverage at the time of or after a service was provided; therefore the provider could not bill the appropriate payer for reasons including but not limited to lack of prior authorization or the time limit to submit the claim or the time limit to submit claim for payment has passed. Provider must verify eligibility per OAR 410-120-1140 and document attempts to obtain coverage information prior to billing the client.
B. Member becomes eligible retroactively but did not meet all the other criteria required to receive the service.
C. A third-party payer made payments directly to the member for services provided.
D. The client has the limited Citizen Alien Waived Emergency Medical benefit package. CAWEM clients have the benefit package identifier of CWM. Clients receiving CAWEM benefits may be billed for services that are not part of the CAWEM benefits. The provider must document that the client was informed in advance that the service or item would not be covered by the Division. An OHP 3165 or 3166 is not required for these services.
E. The client has requested a continuation of benefits during the contested case hearing process, and the final decision was not in favor of the client. The client shall pay for any charges incurred for the denied service on or after the effective date on the Notice of Action or Notice of Appeal Resolution. The provider must complete the OHP 3165 or 3166 pursuant to section (3)(h) of this rule before providing these services.
F. In exceptional circumstances, a client may decide to privately pay for a covered service. In this situation, the provider may bill the client if the provider informs the client in advance of all of the following:
    1. The requested service is a covered service, and the appropriate payer (the Division, YCCO, or third-party payer) would pay the provider in full for the covered service; and
    2. The estimated cost of the covered service, including all related charges, the amount that the appropriate payer would pay for the service, and that the provider cannot bill the client for an amount greater than the amount the appropriate payer would pay; and
    3. That the client knowingly and voluntarily agrees to pay for the covered service;
    4. The provider documents in writing, signed by the client or the client's representative, indicating that the provider gave the client the information described in section (3)(g)(A-C); that the client had an opportunity to ask questions, obtain additional information, and consult with the client's caseworker or client representative; and that the client agreed to privately pay for the service by signing an agreement incorporating all of the information described above. The provider must give a copy of the signed agreement to the client. A provider may not submit a claim for payment for covered services to the Division or to YCCO or third-party payer that is subject to the agreement.
G. A provider may bill a client for services that are not covered by the Division, YCCO. Before providing the non-covered service, the client must sign the provider-completed Agreement to Pay (OHP 3165 or 3166) or a facsimile containing all of the information and elements of the OHP 3165 or 3166 as shown in Table 3165 and 3166 of this rule. The completed OHP 3165, 3166 or facsimile is valid only if the estimated fee does not change and the service is scheduled within 30 days of the client’s signature. Providers must make a copy of the completed OHP 3165, 3166 or facsimile available to the Division or YCCO upon request.

Diagnosis Code Requirement

- A primary diagnosis code is required on all claims, using the ICD-10-CM diagnosis code set, unless specifically excluded in individual Division program rules;
- The primary diagnosis code must be the code that most accurately describes the client's condition;
- All diagnosis codes are required to the highest degree of specificity;
- Hospitals must follow national coding guidelines and bill using the 7th digit where applicable in accordance with methodology used in the Medicare Diagnosis Related Groups.

Procedure Code Requirement

- For claims requiring a procedure code the provider must bill as instructed in the appropriate program rules and must use the appropriate HIPAA procedure code set such as CPT, HCPCS, ICD-10-PCS, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided;
- For claims that require the listing of a procedure code as a condition of payment, the code listed on the claim must be the code that most accurately describes the services provided. Hospitals must follow national coding guidelines;
- When there is no appropriate descriptive procedure code to bill, the provider must use the code for "unlisted services." Instructions on the specific use of unlisted services are contained in the individual provider rules. A complete and accurate description of the specific care, item, or service must be documented on the claim;
- Where there is one CPT, CDT, or HCPCS code that according to CPT, CDT, and HCPCS coding guidelines or standards describes an array of services, the provider must bill using that code rather than itemizing the services under multiple codes. Providers may not "unbundle" services in order to increase the payment.

Third Party Liability

- Providers must make reasonable efforts to obtain payment first from other resources include determining the existence of insurance or other resources on each date of service by:
- Using an insurance database such as Electronic Verification System (EVS) available to the provider;
- Using the Automated Voice Response (AVR) or secure provider web portal on each date of service and at the time of billing;
- Asking the Medicaid recipient at the point of service or prior to billing if they have other health insurance;
- If the provider identifies from the client or other source third party insurance that is unknown to the state or that is different from what is reported in one of the Division verification systems, the provider must report the coverage to the Health Insurance Group (HIG) using the secure online form at www.reporttpl.org.

Except as noted, when third party coverage is known to the provider prior to billing the Division, the provider must:

- Bill all third-party insurance the client is covered by, which could include Personal Insurance Protection (PIP) or Workers Compensation if the claim is related to a personal injury; and
- Except for pharmacy claims billed through the Division's point-of-sale system, the provider must wait 30 days from submission date of a clean claim and have not received payment from the third party; and
- Comply with the insurer's billing and authorization requirements; and
- Appeal a denied claim when the service is payable in whole or in part by an insurer.
- Provider reconsiderations for a denied claim must be received within 180 days of payment or denial of the claim.

In accordance with federal regulations, the provider must bill the TPL prior to billing, except under the following circumstances:

- The covered health service is provided by an Intermediate Care Facility for Individuals

with Intellectual Disabilities (ICF/ID);
- The covered health service is provided by institutional services for the mentally and emotionally disturbed;
- The covered health services are prenatal and preventive pediatric services;
- Services are covered by a third-party insurer through an absent parent where the medical coverage is administratively or court ordered.

More information on Third Party Liability can be located in the YCCO Third Party Liability and Personal Injury Lien Policy and Procedure.

Information Required for Filing Claims

To ensure timely claims processing, all claims must be submitted on a CMS 1500 form (formerly a HCFA 1500 form); or, for facilities, on a UB-92 form. Information on the claim form must be printed in black ink with a standard 10- or 12-point type face. Place required information only in the appropriate field and be sure to align tie form so that each item is properly located within the box.

The list below includes general categories of information necessary for claims processing. If any of this information is missing from your claim, it could be delayed or returned to you.

1. Patient's full name and date of birth.
2. Patient's PHP/PHA member number (including the identifying suffix).
3. Subscriber's full name and relationship to patient.
4. Group number or name.
5. Information about other insurance coverage.
6. ICD-10 CM codes (code to the highest level of specificity).
7. Description of any accident circumstances.
8. CPT or HCPCS codes for services performed (use current year codes).
9. Place service codes per CMS guidelines (use list effective 8/01 available on the CMS website).
10. Itemized changes, by date of service (only one service per line).
11. Provider's name, UPIN #, TIN# and financial address (Box 33)
12. Name and address of facility where services where rendered (Box 32 on HCFA)

Submission

YCCO will be billed for all services provided to Health Plan members regardless of primary or secondary position. All bills for service to YCCO members should be submitted directly to YCCO.

Claims for YCCO members should be submitted electronically whenever possible.

Paper claims can be mailed to:
Yamhill Community Care Claims
PO Box 5490
Salem OR 97304

YCCO accepts electronic claims through various vendors, providers can call their provider representative or YCCO Customer Service for electronic claim information.

REFERENCES:

OAR 410-141-3520; 410-120-1280; 410-120-1295; 410-120-1300
42 CFR 438.106, 438.230
Oregon Health Plan Health Plan Services Contract

RELATED POLICIES & DOCUMENTS:

ENR-001 Member Rights, Protections and Responsibilities

QA-001 Exclusion Screening
QA-003 Third Party Liability & Personal Injury Liens
SVC-002 Authorization of Services
Provider Handbook

LOG OF REVISION

DATE	REVISION	BY WHOM

OHA APPROVAL LOG

DATE	METHOD OF APPROVAL (SharePoint/CCO and MCO Deliverable)

Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: CM-002	**TITLE:** Care Coordination
DEPARTMENT: Care Management	**APPROVED BY:** Chief Medical Officer & President/CEO
EFFECTIVE DATE: 11/14/2017	**LAST REVISION DATE:** 6/29/2020
REVIEW DATES:	
APPLIES TO: Yamhill Community Care, Contracted Partners, Providers, and Subcontractors	

DEFINITIONS:

Word or Acronym	Definition
Community Health Worker (CHW)	Individual who has expertise or experience in public health; works in urban or rural community in association with a local health care system; to the extent practicable, shares ethnicity, language, socioeconomic status and life experience with the residents of the community served; assists member to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness; provides health education and information that is culturally appropriate to the members being served; assist member is receiving the care they need; may give peer counseling and guidance on health behaviors and may provide direct services such as first aid or blood pressure screening.
Community Integration Manager (CIM)	A Multi-tenant platform designed to perform core health plan administrative functions including provider reimbursement, utilization management, member enrollment and customer service.
Coordinated Care Organization (CCO)	A corporation, governmental agency, public corporation, or other legal entity this is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.
Dual Special Needs Plan (D-SNP or DSN Plan)	Medicare Advantage plan that limits enrollment to Medicare beneficiaries who meet certain eligibility criteria, these plans serve people who have both Medicare and Medicaid benefits.
Exceptional Health Care Needs (EHCN)	Members identified as aged, blind or disabled who have complex medical needs.
Full Benefit Dual Eligible (FBDE)	For the purpose of Medicare Part D coverage, Medicare clients who are also eligible for Medicaid.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)	Federal law with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.
Institution for Mental Diseases (IMD)	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing inpatient 7 psychiatric services such as diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services. Its primary character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.
Intensive Care Coordination (ICC)/Exceptional Needs Care Coordination (ENCC)	Specialized case management for members identified as aged, blind or disabled who have complex medical needs including: I. Early identification of members eligible for ENCC services. II. Assistance to ensure timely access to providers and capitated services; III. Coordination with providers to ensure consideration is given to unique needs in treatment planning; IV. Assistance to providers with coordination of capitated services and discharge planning; and V. Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.
Long Term Services and Supports (LTSS)	Medicaid services and supports provided under a CMS approved waiver to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Home and Community-Based Services and Settings and Person-Centered Service Planning (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services.
Managed Care Entity (MCE)	Entity that enters into a contract to provide services in a managed care delivery system including but not limited to managed care organizations, prepaid health plans, and primary care case managers.
Medicare Advantage (MA)	Type of Medicare health plan offered by a private company that contracts with Medicare. Medicare pays the premiums for participants in Medicare Advantage plans.
Patient Centered Primary Care Home (PCPCH)	Health care clinic that has been recognized for their commitment to patient-centered care. In a Patient-Centered Primary Care Home, the patient the most important part of the care. The Patient-Centered Primary Care Home Program recognizes clinics as primary care homes and makes sure they meet the standards of care. The program is part of the Oregon Health Authority and one of the many efforts to help improve the health of all Oregonians and the care they receive.
Participating Provider	A licensed practitioner or provider that is participating in an YCC delegates provider network.

Practitioner/Provider	A person who is licensed pursuant to Oregon state law to engage in the provision of health care services within the scope of their license or certification. An individual, facility, institution, corporate entity, or other organization which supplies or provides for the supply of services, goods or supplies to covered individuals pursuant to a contract, including but not limited to a provider enrollment agreement.
Provider Network (Delivery System)	Participating providers affiliated with the CCO who are authorized to provide services to its members.
Special Health Care Needs (SHCN)	Members who have health care needs, multiple chronic conditions, mental illness or Substance Use Disorders and either I. Have functional disabilities, II. Live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care), social needs are addressed. Any additional resources are requested via Community Health Workers (CHWs). CHWs often times will reach out directly to members and families in need.
Traditional Health Worker (THW)	Umbrella term for frontline public health workers who work in a community or clinic under the direction of a licensed health provider. The 5 types of Traditional Health Workers: Birth Doula, Personal Health Navigator, Peer Support Specialists, Peer Wellness Specialist and Community Health Workers.
Specialty Providers (Specialist)	Any Provider not acting as a primary care provider who has clinical training in a specified area. Medical specialist are doctors who have completed advanced education and clinical training in a specific area of medicine.

POLICY:

Yamhill Community Care (YCC) delegates all or part of this function or process. Through the oversight, YCC will ensure compliance with all applicable federal, state, contractual rules and regulations and requirements.

YCC and delegates ensure primary care and coordination of healthcare services for all members. This is done by YCC, delegates and participating providers implementing methods of coordination with physical, oral and behavioral care in various ways which can include having written policies, procedures and systems in place to monitor services.

YCC and delegates provide members integrated person-centered care and services, assuring that physical, behavioral, and oral health services are consistently provided to members in all age groups and all covered populations member when medically appropriate and consistent with the needs identified in the community health assessment and community health improvement plan.

YCC works with providers, and for FBDE members, works with affiliated MA and DSN plan or Medicare providers, to develop partnerships that allow of access to, and coordination with social and support services, including culturally specific community-based organizations, community-based behavioral health services, DHS Medicaid-funded long term care and home and community based services, DHS Office of Developmental Disability Services, Type B area

agencies on aging (AAAs) or State Aging and People with Disabilities (APD) district offices in the services area, community-based developmental disability providers and organizations and mental health crisis management services.

YCC utilizes data to understand the disparities in members health based on their race, ethnicity, location, age, sex and other member specific data and works to address these disparities to improve the health of our members by achieving improvements in overall quality of care and population health.

YCC member's privacy will be protected throughout the care coordination process per the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 164, Subpart A and E. YCC will provide coordination and transition that is medically appropriate, trauma-informed linguistically and culturally appropriate manner in accordance to state and federal rules including but not limited to Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and National Culturally and Linguistically Appropriate Services (CLAS) standards as established by the US Department of Health and Human Services.

PROCEDURE:

All members shall have an ongoing source of primary care appropriate to his or her needs and a practitioner or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. Members are provided information on how to contact their primary care provider which is located on their YCC ID Card, welcome letter and customer service can provide contact information.

- Primary care teams are responsible for transitioning members out of hospital settings into the most appropriate, independent and integrated care setting, including home and community based as well as hospice and other palliative care settings.
- Primary Care Providers shall arrange, coordinate, and monitor other medical and mental health or dental care for members who require services from agencies providing health care services under the CCO capitation, except for the following:
    - Members are not required approval from a PCP in order to gain access to mental health and substance use disorder assessment and evaluation services. Members may refer themselves to outpatient mental health services.

YCC will ensure that members have care appropriate to their needs in conjunction with or addition to the following:

1. Delegates and providers shall have and maintain a formal referral system.
2. Children especially those in custody of DHS, who need, or who are being considered for, psychotropic medications, receive medications that are for medically accepted indications.
    - YCC and partners will prioritize service coordination and the provision of other behavioral health services and supports for these children.
3. Provider Network shall consist of consultation and referral providers, including alternative care settings for all services covered by the plan.
4. Provider Network shall have referral services and services received in alternative care settings reflected in member's clinical record.
5. Delegates and providers shall coordinate services for members transitioning between levels of care, including appropriate discharge planning for short term and long-term hospital and institutional stays Traditional Healthcare Workers/Certified Healthcare Workers are utilized when appropriate.
6. Results of identification and assessment of enrollee needs are shared with other health care providers from which the enrollee may be receiving services, so that these activities are not duplicated; such as information sharing between physical health providers and mental health providers with respect to prescribed medications.
7. Member may obtain all covered services either directly or upon referral from the date of enrollment through the date of disenrollment, except when the member is enrolled in

Medicare HMO or Medicare Advantage FCHP or PCO.

8. Denying or review of denied referral requests is done by a health care professional.
9. YCC or delegates will ensure when members that are hospitalized in an inpatient or outpatient setting for covered services have notation in their appropriate PCP's clinical record with admit, discharge, length of stay and applicable chart notes and reports. This information can then be shared as appropriate for transition planning and follow-up.
10. When member's care is being transferred from one health plan to another or for member transferring from fee-for-service to YCC. YCC and delegates shall make every reasonable effort within the laws governing confidentiality to coordinate the transfer of the client into the care of a participating provider.
11. YCC and delegates shall coordinate the services it furnishes to members with the services they may receive from another Prepaid Health Plan (FCHP, PCO, DCO, CDO, MHO, CCO) in accordance with OAR 410-141-0120. PCPs shall ensure that in the process of coordinating care, the member's privacy is protected in accordance with the privacy requirements of 45 CFR parts 160 and 164 subparts A and E to the extent that they are applicable.
12. YCC and/or delegate shall ensure that members receiving services from extended or long-term psychiatric care programs will receive follow-up services as medically appropriate to ensure discharge within five working days of receiving notification of discharge readiness.
13. YCC and/or delegates shall coordinate with community providers, community emergency service agencies, and community social support providers to promote an appropriate response to members experiencing a mental health crisis as well as non-crisis care
14. YCC and/or delegate shall use a multi-disciplinary team service planning and case management approach for members requiring services from more than one public agency, to avoid service duplication and assure timely access to a range and intensity of service options that provide individualized, medically appropriate care in the least restrictive setting.

YCC and delegates coordinate physical health, behavioral health, intellectual and developmental disability and ancillary services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays that reduce duplication of assessment and care planning activities:

- With services that members receive from other CCOs or MCEs;
- With services members receive in Fee For Service Medicaid; and
- With services members receive from community and social support providers.

Non-Discrimination, ADA, and CLAS

YCC ensures that participating providers have the tools and skills necessary to communicate and provide services in a linguistically and culturally appropriate manner in accordance to state and federal rules including but not limited to Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and National Culturally and Linguistically Appropriate Services (CLAS) standards as established by the US Department of Health and Human Services. YCC assists in the facilitation of information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities). YCC requires providers and their employees undergo appropriate education in cultural competence and trauma-informed care in accordance with the Health Equity Plan Training and Education.

PCPCH

PCPCHs are focal points of coordinated and integrated care so members have a consistent and stable relationship with a care team responsible for comprehensive care management. YCC encourages providers to communicate and coordinate care with the PCPCH in a timely manner, using electronic health information technology where available. YCC and/or

delegates has established hospital and specialty service agreements that include the role of the PCPCH and specify processes for requesting hospital admission or specialty services, performance expectations for communication, and medical record sharing for specialty treatment sat the time of hospital admission discharge for after-hospital follow up appointments.

Transitions of Care
YCC ensures members are transitioned out of hospital settings into the most appropriate independent and integrated community settings. This includes transitional services and supports for children, adolescents, and adults with serious behavioral health conditions facing admission to or discharge from acute psychiatric care, residential treatment settings, and the State Hospital. YCC coordinates appropriate referrals to ICC services to ensure that the member's rights are met and that there is post-discharge support.

When a member's care is being transferred from one MCE to another or for OHP clients transferring from fee-for-service to YCC, YCC shall make every reasonable effort within the laws governing confidentiality to coordinate (including but not limited to ORS 414.679) transfer of the OHP client into the care of an YCC participating provider.

YCC has systems to assure and monitor transitions in care so that members receive comprehensive transitional care and improve members' experience of care and outcomes, particularly for transitions between hospitals and long-term care, and ensure providers and subcontractors receive information on the process for members accessing care coordination.

For members who are discharged to post hospital extended care at the time of admission to a skilled nursing facility (SNF), YCC shall notify the appropriate department office and begin appropriate discharge planning. YCC shall pay for the full 20-day post-hospital extended care benefit when appropriate, if the member was enrolled with YCC during the hospitalization preceding the nursing facility placement:

- YCC shall notify the SNF and the member no later than two business days before discharge from post-hospital extended care (PHEC);
- For members who are discharged to Medicare Skilled Care, YCC shall notify the appropriate department office when YCC learns of the admission. Goals of discharge planning coordination include reducing duplication of assessment and care planning activities and services by multiple entities involved in the member's care;
- YCC shall coordinate transitions to Medicaid-funded long-term care, services, and supports, after the PHEC is exhausted, by communicating with local department offices when members are being discharged from an inpatient hospital stay or transferred between different long-term care settings.
- YCC shall ensure that the member and treatment team participate in discharge planning activities and support warm handoffs between levels or episodes of care.

Coordination with Social and Support Services
YCC shall work across provider networks to develop partnerships necessary to allow for access to and coordination with social and support services, including crisis management and community prevention and self-managed programs:

- YCC and/or delegates have procedures for coordinating member health services with long-term care providers or facilities to develop partnerships necessary to allow for access to and coordination of YCC services with long-term care services and crisis management services;
- YCC has a Memorandum of Understanding (MOU) or contract with the local type B Area Agency on Aging or the local office of the Department's APD, detailing their system coordination agreements regarding members receiving Medicaid-funded LTCSS;
- YCC has establish agreements with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area,

maintaining a comprehensive and coordinated behavioral health delivery system and to ensure member access to behavioral health services, some of which are not provided under the global budget.

YCC shall coordinate with Community Emergency Service Agencies, including but not limited to police, courts, juvenile justice, corrections, LMHAs, and CMHPs, to promote an appropriate response to members experiencing a behavioral health crisis and to prevent inappropriate use of the emergency department or jails.

Inpatient Psychiatric Services

YCC may cover and reimburse inpatient psychiatric services, not including substance use disorder treatment at an Institution for Mental Diseases (IMD). The state may make a monthly capitation payment to a CCO using Medicaid capitated funds for inpatient psychiatric services for an alternative service or setting, incorporating all the following requirements as defined in 42 CFR 438.6(e):

- For members aged 21-64;
- As inpatient psychiatric services for a short-term stay of no more than 15 days during the period of the monthly capitation payment;
- The provision of inpatient psychiatric services in an IMD shall meet the requirements for in lieu of services as defined in 42 CFR 438.6(e)(2)(i) through (iii):
  - The alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan;
  - YCC must offer the option to access the state plan services and may not require a member to use the IMD as an alternative service or setting;
  - The approved in lieu of services are authorized and identified in the YCC contract and may be offered to members at YCC's option.

Extended or Long-Term Psychiatric Care

YCC shall ensure that members receiving services from extended or long-term psychiatric care programs, such as secure residential facilities, shall receive follow-up services as medically appropriate to facilitate discharge as soon as reasonably possible. YCC shall coordinate the care of members that enter the Oregon State Hospital and develop agreements with community mental health programs regarding the management of adults who were members upon entering the state hospital and are transitioning from the Oregon State Hospital.

Oregon State Hospital & State Institutions

YCC and partners coordinate with the Oregon State Hospital, other state institutions, an other behavioral health hospital settings to:

- Member transition facilitation into the most appropriate, independent, and integrated community-based settings.
- Appropriate referral coordination to intensive care coordination (ICC) services to ensure that the member's rights are met and there is post-discharge support.

Medicaid-Funded Long-Term Care Nursing or Community-Based Care Facilities

If the member is living in a Medicaid-funded long-term care nursing facility or community-based care facility or other residential facility, YCC shall communicate with the member and the department Medicaid funded long-term care provider or facility about integrated and coordinated care services.

Out of Network or Out of State Care

YCC shall coordinate a member's care even when services or placements are outside the service area. Temporary placements by the Authority, Department, or health services placements for services including residential placements may be located out of the service area; YCC shall coordinate care while in placement and discharge planning for return to the county of origin or jurisdiction. For out of area placements, an out of area exception shall be made for the member to retain the YCC enrollment, while the member's placement is a

temporary residential placement elsewhere. For program placements in Child Welfare, BRS, OYA, and PTRS, OAR 410-141-3800 program specific rules will be followed.

Except as provided in OAR 410-141-3800 (placements in Child Welfare, BRS, OYA, and PTRS) YCC shall coordinate patient care, including care required by temporary residential placement outside the YCC service area or out-of-state care in instances where medically necessary specialty care is not available in Oregon:
YCC enrollment shall be maintained in the county of origin with the expectation of YCC to coordinate care with the out of area placement and local providers;
YCC shall coordinate the discharge planning when the member returns to the county of origin.
If a member loses Medicaid coverage while in an episode of care, the care coordinator will continue to manage the member's care until Medicaid coverage resumes.

YCC shall coordinate and authorize care, including instances when the member's medically appropriate care requires services and providers outside YCC's contracted network, in another area, out-of-state, or a unique provider specialty not otherwise contracted. YCC shall pay the services and treatment plan as a non-participating provider pursuant to OAR 410-120-1295. Authorization of services shall reflect rules outlined in OAR 410-141-3835 MCE Service Authorization.

Identification of Members for Case Management or Additional Services
All members may be identified for additional services including intensive care coordination by the following:
State enrollment files,
Health risk screening and assessment for each member's needs are completed:

- Within 90 days of the effective date of enrollment for all new members, or
- Within 30 days when the member is referred or is receiving Medicaid Long Term Care or Long-Term Service and Support, or
- As quickly as the member's health condition requires. Screenings are documented as well as subsequent attempts if the initial attempt to contact the member is unsuccessful.
- Annually, upon a change in responsibility, or change in health status indicating a need for an updated assessment

Assessments
Health Risk Assessments (HRA) provide questions regarding the members general health, including diagnosis' the member has had, number of emergency room visits, flu vaccinations, smoking, depression, mental health provider needs, eye exams and dental exams. The member is also asked their primary language and to rate their general health.

Once received the HRA is reviewed by a Care Management Team (RN Care Coordinator, LCSW, CSC or Pharmacist) based on HRA answers identify gaps in care, chronic conditions, safety concerns, and access to care and appropriateness for ENCC program. Additional assessments may be completed when member is speaking with care management to determine member needs.

HRA CIM Documentation
HRAs are then forwarded securely to the YCC Community Health Worker Hub with a notation on members who are flagged ENCC and those requiring community resource assistance. The CHWs attach them to the member file in CIM and create a flag that indicates the HRA is attached a secure CIM link to the members primary care provider (PCP) is also sent for HRA notification for additional follow up as necessary and encouraged to integrate the HRA and if appropriate resulting care plans into the member medical record.

Non-ENCC HRA Follow Up

CHW staff review the HRA information for assistance with community resources, identification of social determinant needs, locating providers or obtaining services or supports. CHWs also provide members with dental, behavioral, transportation and traditional health worker contacts for services and supports as needed. All CHW cases with notations, attachments etc. are tracked in CIM.

HRA Sharing
In an effort to eliminate duplicate efforts, YCC documents HRA screenings in the CIM system. In the event CIM is not a utilized system by the provider additional efforts will take place to share the HRA results, all privacy requirements are followed in efforts to share the HRA with:

- The state or other MCEs serving the member;
- Members receiving Medicaid-funded LTSS and, if approved by the member, their case manager and LTCSS provider, if approved by the member; and
- Medicate Advantage plans serving dual eligible members.

A member may decline care coordination and ICC. YCC shall explicitly notify members that participation is voluntary, and that treatment or services cannot be denied as a result of declining care coordination.

Care Plans
YCC's care coordinators shall develop, and YCC shall require their provider network to use, individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs, including members with serious and persistent mental illness receiving home and community-based services covered under the state's 1915(i) State Plan Amendment and those receiving Medicaid-funded LTCSS.
Care Plan Requirements:

- Incorporation of information from treatment plans from providers involved in the member's care, and, if appropriate and with consent of the member, information provided by community partners. Contain a list of care team members, including contact information and role, compiled in cooperation with the member.
- Make provision for authorization of services in accordance with OAR 410-141-3835 MCE Service Authorization.
- Be developed within 30 days and updated annually for all members not in ICC or a specialized program. For members enrolled in ICC or a specialized program, care plans must be developed within 10 days of enrollment in the ICC program and updated every 90 days, or sooner if care plan needs change.
- Be revised at least every 3 months for members receiving ICC services and every 12 months for other members.

Care plans shall reflect the member's preferences and goals, and if appropriate, family or caregiver preferences and goals. Care plans shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered:

- To ensure engagement and satisfaction with care plans, members shall participate in the creation of care plans.
- Members must be provided a copy of their care plan at the time it is created, and after any updates or changes to the plan.
- Care coordinators shall actively engage members and caregivers and shall ensure that they understand their role as outlined in the care plan and that they feel equipped to fulfill their responsibilities.
- If a member's participation would be significantly detrimental to the member's care or health, a member may be excluded from the development of a care plan and denied access to a copy of the plan. YCC will document the reasons for the exclusion, including a specific description of the risk or potential harm to the member, and describe what attempts have been made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue the exclusion must

be documented as above.

Care Coordinator Principles:
Care coordinators will perform care coordination in accordance with the following principles:
Care coordinators will:

- Use trauma informed care, culturally responsive and linguistically appropriate care, motivational interviewing and other patient-centered tools to actively engage members in managing their health and well-being;
- Set agreed-upon goals for the member with continued CCO network support for self-management goals;
- Promote utilization of preventive, early identification and intervention, and chronic disease management services;
- Focus on prevention, and when prevention is not possible, manage exacerbations and unanticipated events impacting progress toward the desired outcomes of treatment;
- Provide evidence-based condition management and a whole person approach to single or multiple chronic conditions based on goals and needs identified by the individual;
- Promote medication management, intensive community-based services and supports and, for ICC members, peer-delivered services and supports; and
- Have contact with the active program-specific care team at least twice per month, or sooner if clinically necessary for the member's care.

Care coordinators shall promote continuity of care and recovery management through:

- Shall continue through episodes of care, regardless of location of individual;
- Monitoring of conditions and ongoing recovery and stabilization;
- Adoption of condition management and a whole person approach to single or multiple chronic conditions based on the goals and needs identified by the individual, including avoidance and minimization of acute events and chronic condition exacerbations;
- Engaging members, and their family and caregivers as appropriate

Exceptional Needs/Intensive Care Coordination
These services are available to members identified as aged, blind, or disabled, who have complex medical needs, multiple chronic conditions, behavioral health issues, and for members with severe and persistent behavioral health issues receiving home and community-based services. YCC will make trauma informed, culturally and linguistically appropriate ICC/ENCC services available to all referred members who qualify for such services.

YCC will provide intensive care coordination services without limiting the foregoing, YCC will:

- Without requiring a referral, automatically screening all members of prioritized members for ICC services. YCC shall make trauma informed, culturally and linguistically appropriate ICC/ENCC services available to all members of prioritized populations who qualify.
- Provide trauma informed, culturally and linguistically appropriate ICC/ENCC services and behavioral health services to children and adolescent members according to presenting needs.
- Provide trauma informed, culturally and linguistically appropriate ICC/ENCC services to members receiving Medicaid funded home or community-based setting for long term care services and supports under the State's 1915(i) or 1915(k) State Plan Amendments or the 1915(c) HCBS Waiver.
- Screen all member not identified above when referred by:
    - The member themselves,
    - The member's representative,
    - A provider, including without limitation an HCBS Provider, and
    - Any medical personnel service as a member's Medicaid LTSS case manager.
- Screen members who exhibit inappropriate, disruptive, or threatening behaviors in a provider's office or clinic or other health care setting for ICC services.
- Provide ICC services to members who are children and adolescents in the custody of

DHS and those children and adolescents otherwise identified by the YCC contract Exhibit B, Part 4 and Exhibit M.
- Respond to requests for ICC screening services with an initial response by the next business day following the request.
- Periodically inform all participating providers of the availability of ICC services providing training to PCPCHs and other PCP staff regarding the ICC screenings and services and other support services available to members.
- Ensure that a member's DHS Area Agency on Aging/Aging and People with Disabilities, Office of Developmental Disability Services, long term care, or long-term services and supports care manager, have a direct method to contact the member's ICC Care Coordination Team.
- Ensure that the member's ICC Care Coordinator's name and telephone number are available to agency staff and members or member representative when ICC services are provided to the member.
- Ensure that the number of members who are assigned to each care coordinator does not exceed care coordinator's capacity to meet all the ICC needs of such assigned members.

Services can be requested by the member, member's representative, provider, other medical personnel serving the member, or the member's Authority case manager.
- All requests receive an initial response made by the next working day following the request.

ENCC/ICC staff facilitates care coordination and continuity of care by:
- Sharing pertinent information with all appropriate providers,
- Collaboration of providers to ensure treatment plan alignment,
- Reporting identified gaps in care,
- Assisting providers and ENCC members with transitions of care,
- Providing members with educational materials to cover their specific healthcare needs,
- Working with the members community case workers to ensure all resources and services are provided to members in a timely manner,
- Review of provider treatment plans and development of interventions to support the member's care plan and goals, and
- Documentation of all interventions in the electronic charting system so that it readily available to the health care team.

YCC will ensure the following:
ENCC/ICC services are made available to coordinate the provision of the services to members who exhibit inappropriate, disruptive, or threatening behavioral in the provider's office or clinic or other health care setting.
HRA results are shared with participating providers serving the member so activities are not duplicated.

Transition Planning by Care Coordinators
YCC facilitates transition planning for members. Care coordinators must take the following steps to facilitate transitions and ensure applicable services continue after discharge:
- The member's care coordinator must participate and play an active role in discharge planning from a specialized facility.
- For discharges from the State Hospital and residential care, the care coordinator shall have contact with the member no less than 2 times per month prior to discharge and 2 times within the week of discharge. Care coordinators must attempt to engage in a face-to-face warm handoff to relevant care providers during transition of care and discharge planning. The care coordinator shall also engage with the member, face to face, within 2 days post discharge.
- For discharges from an acute care admission, care coordinator shall have contact with the member within 1 business day of admission, 2 times a week while the member is in

acute care, and no less than 2 times a week within the week of discharge, on a face-to-face basis if possible.

- Prior to discharge, YCC or delegate will conduct a transition meeting to facilitate development of a transition plan. This meeting must be held prior to the member's return to the Contractor Service Area, 30 days prior to discharge, or as soon as possible if YCC is notified of impending discharge or transition with fewer than 30 days' advance notice. The discharge plan must include a description of how treatment and supports for the member will continue.
- YCC will oversee management of all members who have had a lapse in Medicaid coverage, and work to establish services that may be needed but currently are not available in their region.
- YCC will supervise care coordinators to ensure they are providing appropriate services and supports to members and provide full oversight and supervision to the assigned care coordinators. The individual tasked with such responsibility will be a licensed master's-level mental health professional. This supervisory responsibility is not delegated or subcontracted outside of YCC, and YCC holds care coordinators responsible for ensuring integrated coordination of care.

COMPLIANCE & OVERSIGHT:

1. YCC will routinely verify that delegates have policies and procedures that meet state, federal and CCO contract requirements for care coordination.
2. Referral and care coordination data will be routinely requested by YCC of all delegates for review by appropriate YCC staff and/or committees.
3. YCC will verify that network providers are informed about the availability of ENCC/ICC services, provide training for patient centered primary care homes and other primary care provider's staff on ICC/ENCC services and other support services available for members.
4. YCC communicates its integration and coordination policies via the YCC Provider Handbook to participating providers, regularly monitor providers' compliance via the appropriate delegate, and takes any corrective action necessary to ensure compliance. YCC documents all monitoring and corrective action activities.
5. Treatment plan audits will take place routinely using the Care Coordination File Review Tool to ensure the following:
    a. Development by the member's designated provider with member participation,
    b. Inclusion of consultation with specialist caring for the member,
    c. Approval in a timely manner, and
    d. Any applicable utilization or quality assurance standards are met.

REFERENCES:

42 CFR 438.208
45 CFR parts 160 and 164 subparts A and E
OAR 410-141-0120, 410-141-3170; 410-141-3860; 410-141-3865
Health Insurance Portability & Accountability Act of 1996
OHA CCO Contract
Health Risk Assessment
Care Coordination File Review Tool

RELATED POLICIES & DOCUMENTS:

DO-001 Delegation Oversight Policy and Procedure
CM-001 Special & Exceptional Healthcare Needs
SVC-001 Availability of Services
SVC-003 Systems of Care and Wraparound
SVC-005 Behavioral Health Services

LOG OF REVISION

DATE	REVISION	BY WHOM
03/22/2019	Policy updated with additional CCO contract and OAR requirements for clarity in YCC policy and procedure.	JRoe, QA Specialist
07/25/2019	Policy definitions and additional clarity provided to current content. Branding format changes completed.	JRoe QA Specialist
10/30/2019	Definition Updates, Addition of HRA process and guidelines. ENCC/ICC clarifications and updates due to rule changes.	JRoe, QA Specialist
01/09/2020	Children & psychotropic meds with service coordination.	JRoe, QA Specialist
6/29/2020	Added additional contract language for compliance with EQR.	SEide, St. QA & Compliance Mgr

Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: ENR-001	**TITLE:** Member Rights, Protections and Responsibilities
DEPARTMENT: Quality Management	**APPROVED BY:** President/CEO
EFFECTIVE DATE: 09/14/2016	**LAST REVISION DATE:** 08/01/2020
REVIEW DATES: xx/xx/xx	
APPLIES TO: Yamhill Community Care, Contracted Partners, Providers, and Subcontractors	

DEFINITIONS:

Word or Acronym	Definition
Coordinated Care Organization (CCO)	Entity that is certified as meeting the criteria adopted by the Oregon Health Authority (OHA) to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.
Grievance	A member or their designated representative(s) expression of dissatisfaction for services offered or manages by YCCO or delegate about any matter.
Protected Health Information (PHI)	Information that is identifiable to a specific individual and is maintained or transmitted in any form or medium and contains the provisions of health care or the payment for healthcare services.

POLICY:

Yamhill Community Care Organization (YCCO) delegates all or part of this function or process. Through the oversight, YCCO will ensure compliance with all applicable federal, state, contractual rules and regulations and requirements.

YCCO complies with Oregon Health Plan (OHP) Rights and Responsibilities requirements set by the Oregon Health Authority (OHA), the state of Oregon and The Federal Centers for Medicare and Medicaid Services (CMS) for providing members with information about their rights and responsibilities.

YCCO, partners, and providers are committed to treating members with respect, dignity, privacy, confidentiality, and nondiscrimination. Members are provided information about their rights and responsibilities at enrollment in their member handbook and thereafter whenever subsequent revisions to the handbooks are required. This may be annually but is based upon revision needs set forth by internal and/or state mandated changes.

These member rights and responsibilities are available to contracted providers via the YCCO website and/or provider manual. YCCO ensures that employees and contracted providers take member rights into account when providing services to members and comply with any applicable federal and State laws that pertain to member rights as well as ensures employees and contracted providers observe and protect these rights.

YCCO and delegates grant member's request for communications to be provided by alternate means or methods. It is also the policy to grant a member's written request that YCCO or delegates communicate with them at an alternate location, unless doing so would interfere with YCCO or a delegate's ability to provide or pay for the member's services.

PROCEDURE:

All YCCO OHP members (including full benefit dual eligible members) have the following rights:

- Treatment with respect and with due consideration for their dignity and privacy and the same as non-members or other patients who receive services equivalent to covered services;
- Treatment by participating providers the same as other people seeking health care benefits to which they are entitled;
- Freedom to choose a coordinated care organization (CCO) as permitted in OAR 410-141-3700, a primary care provider (PCP) or service site and to change those choices as permitted in OAR 410-141-3590;
- To refer themselves directly to mental health, chemical dependency or family planning services without getting a referral from a PCP or other participating provider;
- To have a friend, family member, or advocate present during appointments and at other times as needed with clinical guidelines;
- To be actively involved in the development of the member's treatment plan;
- To be given information about the member's condition and covered and non-covered services to allow an informed decision about proposed treatments;
- To consent to treatment or refuse services and be told the consequences of that decision, except for court ordered services;
- To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;
- To have written materials explained in a manner that is understandable to a member;
- To receive necessary and reasonable services to diagnose the presenting condition;
- To receive covered services under OHP that meet generally accepted standards of practice and is medically appropriate;
- To obtain covered preventative services;
- Access to urgent and emergency services 24 hours a day, seven days a week as described in OAR 410-141-3835, OHP CCO emergency and urgent care services;
- Referrals to specialty providers for medically appropriate services;
- A clinical record maintained that documents conditions, services received, and referrals made;
- Access to one's own clinical record unless restricted by statute;
- To transfer a copy of the member's clinical record to another provider;
- Right to execute a statement of wishes for treatment including the right to accept or refuse medical, surgical, chemical dependency, or mental health treatment and the right to execute advance directive and powers of attorney for health care;
- To receive written notice before a denial of or change in a benefit or service level is made unless such notice is not required by federal or state regulations;
- Information on how to make a complaint or appeal with YCCO or request an administrative hearing with the Authority and receive a response per OAR 410-141-3875 - 410-141-3910;
- To exercise his or her rights without adverse treatment by the CCO, its network providers, or the State Medicaid agency.
- To receive interpreter services as defined in OAR 410-141-3515; and
- Timely appointment cancellation notices.
- Require, and cause YCCO in-network providers to require, that members receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition, preferred language, and ability to understand.

Electronic Versions of Member Materials

Electronic versions of member materials are available on the YCCO website, this includes the provider directory, formulary and member handbook. The electronic version can be electronically retained and printed, available in a machine-readable file and format, and readily accessible in language requirements. Required member education materials on the YCCO website informs members that the information is available in paper format without charge upon request by the member or their representative and YCCO will provide it within 5 business days.

Direct member notices related to adverse actions or any portion of the grievance, appeal, contested case hearing or any other member rights or member protection process are not considered member materials.

Confidential or alternate means of communication request:

- All request from members to communicate with them at either an alternate location or through an alternate means should be received in written format. Requests will be reviewed by the YCCO or delegate Compliance Officer for completeness, appropriateness, an endangerment situation. The request will be documented and any communication regarding the request will be included.
- For member request for communication via alternate means or location due to a potential endangerment situation, YCCO and/or delegate will act on the request immediately. The request will be documented and any communication regarding the request will be included.
- The member may terminate their request for location or alternate means communication by sending a letter to the YCCO or delegate Compliance Officer.
- YCCO or delegate may terminate the member's request for communication via an alternate means or location by sending the member a notice of termination of the prior arrangement. YCCO will generally only terminate the agreement for alternate means or location of communication if unable to contact the member at the alternate location or via the alternate means of communication.
    - Documentation of the termination of the alternate means of communication or alternate location of communication.
    - The request will not be terminated if the member had made the request based on potential endangerment to the member.
- All documentation regarding request for alternate means or location will be retained by a minimum of 10 years.

Services Covered by OHP Fee-For Service:
Members have the right to services not covered by YCCO but are covered by OHP Fee-For-Service. This information is located on the YCCO Website and included in the YCCO Member Handbook. Members can obtain information on these services by calling OHP Customer Service at 800-699-9075.
Services covered by OHP Fee-For Service:

- Midwife home delivery
- Mental health medications
- Death with Dignity, physician assisted suicide
- Therapeutic Abortions
- Hospice services for member who live in a skilled nursing facility
- Long term care services
- School based services that are covered services provided under Individuals with Disabilities Act
- Administrative exams request or authorized by another government agency or approved by the Health Systems Division
- Services provided to Citizen Alien Waived Emergency Medical (CAWEM) recipients or CAWEM Plus-CHIP Prenatal Coverage for emergency medical services only

YCCO members have the following responsibilities:

- To choose or help with assignment to a CCO as defined in OAR 410-141-3700, OHP enrollment requirements and a PCP or service site;
- To treat the CCO, providers and clinic staff with respect;
- To be on time for appointments made with providers and to call in advance either to cancel if unable to keep the appointment or if the member expects to be late;
- Seek periodic health exams and preventative services from a PCP or clinic;
- Use of a PCP or clinic for diagnostic and other care except in case of an emergency;
- To obtain a referral to a specialist from their PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;
- Use of urgent and emergency services appropriately and notification to the CCO within 72 hours of an emergency;
- Providing accurate information for inclusion in their clinical record;
- Assistance to the provider or clinic to obtain clinical records from other providers that may include signing an authorization for release of information;
- To ask questions about conditions, treatments, and other issues related to the member's care that is not understood;
- To use information to make informed decisions about treatment before it is given;
- Assist the provider in creation of a treatment plan;
- Follow prescribed agreed upon treatment plans;
- Advise the provider that the member's health care is covered under OHP before services are received and, if requested, to show the provider the OHP coverage identification form or card;
- Notification to OHA worker of a change of address or phone number;
- To tell the OHA worker if any family member becomes pregnant and notify the worker of the birth of the member's child;
- Notification to the OHA worker if any family members move in or out of the household;
- To tell the OHA worker if there is any other insurance available;
- Payment for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;
- To pay the monthly OHP premium on time if a premium is required;
- Assistance to the CCO in pursuing any third-party resources available and to pay the CCO the amount of benefits it paid for any recovery received from that injury;
- To bring issues, complaints or grievances to the attention of the CCO; and
- To sign an authorization for release of medical information so that OHA and the CCO can get information that is pertinent and needed to respond to an administrative hearing request in an effective efficient manner.

Copayments, Cost Sharing & Member Responsibility

YCCO does not have member copays. Members may be billed for services not covered by OHP (non-covered services). Before providing non-covered services, the member must sign the provider-completed Agreement to Pay (OHP 3165 or 3166) or a facsimile containing all of the information elements of OHP 3165 or 3166 as shown in Table 3165 and 3166 of OAR 410-120-1280. The completed OHP 3165, 3166 or facsimile is valid only if the estimated fee does not change and the service is scheduled within 30 days of the member's signature. Providers must make a copy of the completed OHP 3165, 3166 or facsimile available to YCCO or OHA upon request.

YCCO covers cost sharing if the members Medicare Advantage plan does not cover it. Members should not be balance billed for any cost sharing that is not covered by YCCO.

COMPLIANCE & OVERSIGHT:

YCCO will routinely verify that delegates have policies and procedures as well as provide oversight of participating provider regarding member's rights and responsibilities.

Require and cause participating providers to require that members are provided treatment with respect and with due consideration for their dignity and privacy and the same as non-members or other patients who receive services equivalent to covered services.

REFERENCES:

42 CFR 438.100(d); 45 CFR part 80; 45 CFR part 91
OAR 410-141-3515; 410-141-3590; 410-141-3700; 410-141-3835
OARs 410-141-3875 thru 410-141-3910
OARs 410-120-1200, 410-120-1280
OHA CCO Health Plan Services Contract

RELATED POLICIES & DOCUMENTS:

DO-001 Delegation Oversight Policy and Procedure
GA-002 Member Complaints and Grievances Policy and Procedure
GA-003 Denials, Appeal and Contested Case Hearings Policy and Procedure
SVC-002 Authorization of Services
SVC-004 Network Capacity, Service Adequacy and Availability
YCCO Member Handbook
YCCO Provider Handbook

LOG OF REVISION

DATE	REVISION	BY WHOM
12/05/2017	Reformatted, change to current template and content clarification.	JRoe, QA Specialist
02/01/2018	Reformatted, change to current template and content clarification.	JRoe, QA Specialist
02/26/2018	Approved	S. McCarthy President/CEO
08/23/2019	Addition of OHP Covered Services and branding updates	JRoe, QA Specialist
08/01/2020	Formatting updates to ensure policy clarification and OAR updates.	JRoe, QA Specialist

Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: ENR-002	**TITLE:** Member Non-Discrimination/ADA
DEPARTMENT: Quality	**APPROVED BY:** President/CEO
EFFECTIVE DATE: 09/14/2016	**LAST REVISION DATE:** 08/01/2020
REVIEW DATES:	
APPLIES TO: Yamhill Community Care, Contracted Partners, Providers, and Subcontractors	

DEFINITIONS:

Word or Acronym	Definition
Delegate or Delegated Entity	An individual or organization that performs specified administrative or operational health plan or healthcare services on behalf of Yamhill Community Care Organization.
Member	An individual eligible for OHP and enrolled with Yamhill Community Care as their Coordinated Care Organization for covered services.
Section 1557 of the Affordable Care Act	Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in health programs or activities that receive Federal financial assistance or are administered by an Executive agency or any entity established under Title I of the ACA.
Civil Rights Act of 1964	The act outlawed segregation in businesses. It banned discriminatory practices in employment and ended segregation in public places.
Title VI of the Civil Rights Act	Prohibits discrimination of the basis of race, color, and national origin in programs and activities receiving federal financial assistance.
The Americans with Disabilities Act of 1990 (ADA)	A civil rights law that prohibits discrimination against individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public. The ADA also makes it unlawful to discriminate against a person based on that person's association with a person with a disability.
Section 504 of the Rehabilitation Act of 1973 (Section 504)	A civil rights law that prohibits discrimination against individuals with disabilities on the basis of their disability in programs or activities that receive federal financial assistance.
Disability	A person who has a physical or mental impairment that substantially limits one or more major life activity. This includes people who have a record of such an impairment, even if they do not currently have a disability. It also includes individuals who do not have a disability but are regarded as having a disability.

Discrimination	Unfair or unequal treatment (**discrimination**) in a number of settings, when that negative treatment is based on the individual's race, gender, religion, national origin, disability, sexual orientation, age, or other protected characteristic.
Office for Civil Rights (OCR)	The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) enforces federal civil rights laws, conscience and religious freedom laws, the Health Insurance Portability and Accountability Act (HIPAA) Privacy, Security, and Breach Notification Rules, and the Patient Safety Act and Rule, which together protect your fundamental rights of nondiscrimination, conscience, religious freedom, and health information privacy.
Oregon Administrative Rule (OAR)	Official promulgated agency regulations that have the force and effect of law. Generally, these rules elaborate the requirements of a law or policy.
Code of Federal Regulations (CFR)	Codification of the general and permanent rules and regulations published in the Federal Register by the executive departments and agencies of the federal government of the United States.
Oregon Revised Statutes Chapter 659A	Oregon law pertaining to the unlawful discrimination in employment, public accommodations, and real property transactions ; administrative and civil enforcement
Bureau of Labor and Industries (BOLI)	BOLI protects employment rights, advance employment opportunities, and ensures access to housing and public accommodations free from discrimination.

POLICY:

Yamhill Community Care Organization (YCCO) delegates all or part of this function or process. Through the oversight, YCCO will insure compliance with all applicable federal, state, contractual rules and regulations and requirements.

YCCO shall ensure members are aware of their rights under Title VI of the Civil Rights Act and have a right to report a complaint of discrimination by contacting YCCO, or the Office of Civil Rights (OCR).

YCCO and delegates will comply with all regulations and amendments to Title VI of the Civil Rights Act of 1964, The Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973 (Section 504), Section 1557 of the Affordable Care Act, and Title IX of the Education Amendments of 1972 (regarding educations programs and activities). Additionally, YCCO and all contracted delegates and providers will comply with all applicable requirements of state civil rights and rehabilitation statutes and rules.

PROCEDURE:

YCCO and all partners, staff and network providers comply with applicable Federal civil rights laws and do not discriminate against, exclude or treat people differently based on race, color, ethnicity, national origin, age, language, physical or mental disability, religion, sex, sexual orientation, and gender identity or expression.

REAL+D

Understanding the demographics of the population served and how those demographics are reflected in the staff and providers in the agency serving them is an important component of discrimination and equitable provision of service. Providers will be expected to collect REAL+D demographics (race, ethnicity, age, language and disability) about their YCCO member population and staff according to REAL+D requirements of House Bill 2134.

YCCO participates in the state's efforts to promote delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Including but not limited to the following:

- Procedures for communicating with members who have difficulty communicating due to a medical condition or living in a household where there is no adult available to communicate in English or there is no telephone;
- Certified or qualified interpreter services by phone or in person;
- Coordinated care services which are culturally appropriate, i.e. demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the members care; and

Compliance with the requirements of the Americans with Disabilities Act of 1990, including but not limited to street level access or accessible ramp into the facility and wheelchair access to the lavatory.

All members and potential members will be provided the following:

- Enrollment notices, informational materials, and instructional materials in a manner and format that may be easily understood.
- Notice of the nondiscrimination policy via various methods.
- Process to report a nondiscrimination complaint on the basis of the following: race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance with all applicable laws including Title VI of the Civil Rights Act and ORS Chapter 659A.
- Equal access for both males and females under 18 years of age to appropriate facilities, services and treatment be available human services and juvenile corrections programs for children and adults provided by YCCO.
- Access to and instructions on how to obtain Certified or Qualified Health Care Interpreter services available free of charge.
- Access to and instructions on how to obtain written information in member's prevalent non-English languages.
- Access to mechanisms to assist understanding the requirements and benefits of the Oregon Health Plan administered by YCCO

Member Discrimination Prohibition:

A. Members enrolled with YCCO shall not be denied care or assistance because of race, color, or national origin. The Office for Civil Rights (OCR) in the U.S. Department of Health and Human Services (DHHS) enforces Title VI of the Civil Rights Act of 1964 as implemented by regulations of CFR Part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR Part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.
B. YCCO and contracted delegates and providers shall not discriminate, as defined under this policy, against any member(s).
C. For purposes of this policy, discrimination against a member may include, but is not limited to:
    - Denying any covered service or availability of a facility;
    - Subjecting a member to segregation or separate treatment in any manner related to the receipt of the covered service;
    - The assignment of times and places for the provision of services on the basis of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, except where medically indicated.

D. YCCO and contracted delegates and providers shall not discriminate against a member on the basis of:
   - His or her health status;
   - Requirements for health care services during enrollment, re-enrollment, or disenrollment;
   - Adverse change in his or her health status or receive termination of coverage based on this status.

Grievance Process:

A. A YCCO member has the right to file a complaint or grievance about discrimination with:
   - Yamhill Community Care or contracted delegate or provider:
     - A member may file a complaint or grievance directly with YCCO Customer Service;
     - A member grievance is processed according to Member Grievance and Appeals policy and procedures.
   - Office of Civil Rights
     - A member who is covered under YCCO who believes he or she has been discriminated against (as defined under federal law), may file a complaint directly with the Office of Civil Rights.
   - The Bureau of Labor Industries (BOLI)
     - A member may file a complaint or grievance directly with the Bureau of Labor Industries (BOLI).

Confidentiality of Information:
In accordance with all applicable state and federal laws, any member information is required to be kept confidential.

COMPLIANCE & OVERSIGHT:

YCCO will ensure that monitoring will occur by:

A. Requesting and reviewing non-discrimination/ADA policies biennially or when delegate's review/revision dates have been completed.
B. Requesting documentation quarterly for significant problems with discrimination, access or accommodations through a complaint or grievance audits, follow-up as needed with a plan
C. YCCO will insure that all YCCO staff, partners and network providers have implicit bias; structural barriers and systemic oppression; CLAS (culturally and linguistically appropriate services including language access, interpretation, and health literacy); Adverse Childhood Experiences and historical trauma; ADA and accessibility; and REAL+D (race, ethnicity, age, language and disability) training.

REFERENCES:

OAR 407-030-0010 (through 0040)
42 CFR 438.10
45 CFR 80.3
45 CFR 91
OHA CCO Exhibit B- Part 3
OHA CCO Exhibit E
House Bill 2134

RELATED POLICIES & DOCUMENTS:
DO-001 Delegation Oversight Policy and Procedure
ENR-001 Enrollee Rights

LOG OF REVISION

DATE	REVISION	BY WHOM
12/5/2016	Affordable Care Act 1557 added	ebenjamin
9/28/2018	Review and update federal requirement language; Approved	JHarms; Quality & Compliance Manager
10/17/2019	Updated and added REAL+D, Training requirements and additional discrimination	JRoe, QA Specialist
08/01/2020	Civil Rights clarification update	JRoe, QA Specialist

Yamhill Community Care Organization
POLICY AND PROCEDURE

POLICY NUMBER: ENR-003	**TITLE: Restraints and Seclusions**
DEPARTMENT: Quality Management	**APPROVED BY:** President/CEO
EFFECTIVE DATE: 9/1/2016	**LAST REVISION DATE:** 10/01/2018
REVIEW DATES: NA	
APPLIES TO: Yamhill Community Care Organization and Delegates	

DEFINITIONS:

Word or Acronym	Definition
Member	An individual eligible for OHP and enrolled with Yamhill Community Care Organization as their coordinated care organization for covered services.
Delegated Entity	An individual or organization that performs specified administrative or operational health plan or healthcare services on behalf of Yamhill Community Care Organization
Restraint	Refers to any method, physical or mechanical device, or material or equipment, or chemical that immobilizes or reduces an individual's ability to freely move and is used as a means of coercion, discipline, convenience, or retaliation.
Seclusion	The involuntary, solitary confinement of an individual used as a means of coercion, discipline, convenience, or retaliation.
Healthcare Professional	An individual who provides health care services in a systematic way to members.

POLICY:

Yamhill Community Care Organization (YCCO) delegates all or part of this function or process. Through the oversight, YCCO will insure compliance with all applicable federal, state, contractual rules and regulations and requirements. Per CFR §438.100, Yamhill Community Care Organization recognizes that each member has the right to be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation. The use of restraints and seclusions by contracted providers shall be in accordance with applicable federal and state laws. A review of all uses of restraints and seclusions by facilities licensed to do so will be reviewed annually.

PROCEDURE:

- Yamhill Community Care Organization will request a copy of delegate's policy for use of restraints and seclusion to verify that policy is consistent with state and federal laws;

- Yamhill Community Care Organization has the expectation that Delegated Entities monitor contracted provider(s) policies, procedures and use of restraint and seclusion through the credentialing and recredentialing process.
    - If a provider does not use restraints and seclusion, Delegate shall request a written statement of "Prohibited Procedure" on practice letter head as part of the credentialing process;
    - Delegate will provide a copy of the required documentation standards, the member's rights and responsibilities, definitions of seclusion and restraint and the required use of restraint or seclusion in accordance with federal and state law.

COMPLIANCE & OVERSIGHT: (remove if not applicable)

- Yamhill Community Care Organization will collect and review each Delegated Entities policy and procedure either biennially or when review/revision dates are updated;
- Sample documentation or attestation of monitoring the use of seclusion and restraints of contracted providers will be requested from delegates and reviewed;
    - Delegates will provide a copy of all incidents where seclusion or restraint was used for review and determination if the use was appropriate.
- Yamhill Community Care Organization will track and follow-up on cases reported by delegates. If upon review of the incidents, it is determined there is a concern of misuse, a corrective action plan will be put in place and monitored.

REFERENCES:

OAR 410-141-3320 (1) (cc)
42 CFR 438.100(b)(2)(v)
OHA CCO Contract Exhibit B- Part 3

RELATED POLICIES & DOCUMENTS:

DO-001 Delegation Oversight Policy and Procedure
DO-002 Delegation Audit and Monitoring

LOG OF REVISION

DATE	REVISION	BY WHOM
9/1/2016	Approved by President/CEO	J. Carlough
9/24/2018	Transferred to current template, updated language to match definitions and updated monitoring of incidents	T. Heidt
10/1/18	Approved by President/CEO	S. McCarthy

Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: ENR-004	**TITLE:** Advance Directive
DEPARTMENT: Quality	**APPROVED BY:** Chief Medical Officer & President/CEO
EFFECTIVE DATE: 1/31/2017	**REVISION DATE:** 08/01/2020
REVIEW DATES:	
APPLIES TO: Yamhill Community Care, Contracted Partners, Providers, and Subcontractors	

PURPOSE:

Yamhill Community Care Organization delegates shall notify enrollees and established members about their right to be involved in decisions regarding their care including documentation of advance directives and allowance of the member's representative to facilitate care or make treatment decisions when the member is unable to do so.

DEFINITION:

Advance Directive	Written instructions, such as a living will or Durable Power of Attorney for health care, recognized under Oregon law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. A Durable Power of Attorney can be combined with a living will into a single document that describes one's treatment preferences in various situations and names a proxy.
Adult	An individual who is 18 years of age or older, who has been adjudicated, or emancipated minor, or who is married
Healthcare Representative (proxy)	The individual designated to make healthcare decisions on the declarant's behalf in accordance with the terms and order of priority stated in a living will and/or with the member's previously expressed wishes.
Healthcare	Diagnosis, treatment or care of disease, injury and congenital or degenerative conditions, including the use, maintenance, withdrawal or withholding of life-sustaining procedures and the use, maintenance, withdrawal or withholding or artificially administered nutrition and hydration

Incapacitated	A person temporarily or permanently impaired by mental and /or physical deficiency, disability, illness, or by the use of drugs to the extent he/she lacks sufficient understanding to make rational decisions or engage in responsible actions
Living Will	A document specifying a member's preferences regarding medical decisions to withhold or withdraw life-sustaining treatment if the member is seriously ill and unable to communicate his/her decisions.
Durable Power of Attorney or Proxy Directive	A witnessed legal document in which a member names another person to make medical decisions if the member becomes unable to make them. Instructions about treatment preferred or to be provided, such as surgery or artificial nutrition and hydration, can also be included.

POLICY:

Yamhill Community Care ensures that physical health, oral health, and behavioral/ chemical health providers are providing written information to all adult members receiving care with respect to their rights under Oregon law (whether statutory or recognized by the courts of the State) to make decisions concerning their care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives and information regarding the implementation by:

- Honoring a member's advance directive as long as it does not violate State and Federal laws. The existence or lack of an advance directive does not determine an individual's access to care, treatment and services.
- Following a member's advance directive regardless of the member's race, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay and source of payment. No member will be discriminated against with regard to the provision of care or based on whether the member has executed an advance directive
- Ensuring that if a member is incapacitated at the time of initial enrollment or at the time that medical care is initiated and is unable to receive information (due to the incapacitating condition or a mental disorder), or articulate whether or not he or she has executed an advance directive, Yamhill Community Care Organization delegates may give advance directive information to the member's family or surrogate in accordance with Oregon law. If the member's incapacitating condition is temporary in nature, Yamhill Community Care Organization delegates shall ensure communication of this information directly to the member once he or she is no longer incapacitated.

YCCO and any delegate of YCCO will comply with the following advance directives policy and procedures with respect to all adult members receiving medical care through the organization:

- Rights under the state law in which YCCO furnishes services to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
- Will not implement an advance directive as a matter of conscience.

YCCO will use the advance directive form provided in ORS 127.531 with all requirements set forth in the form.

A. Advance Directive for Mental Health Treatment (Declaration for Mental Health Treatment)

Advanced Directives and Declarations for Mental Health Treatment may be implemented in the event that the member becomes incapacitated or is otherwise not able to exercise his/her right to participate in treatment planning decisions. It is the policy of Yamhill Community Care Organization that members are informed of their rights to initiate Advanced Directives and Declarations. Contracted providers will have policies and procedures relating to Advanced Directives and Declarations for members of their programs.

Yamhill Community Care expects that delegate will:

• Make Declaration and Advanced Directive forms available to adult members upon request;

• Establish procedures for informing adult members of their rights to have a Declaration and Advanced Directive;

• Provide assistance to members in the completion of a Declaration;

• Document in a prominent part of the clinical record whether or not the member has executed a Declaration and/or Advanced Directive

B. It is the policy of Yamhill Community Care Organization that all delegates educate and document staff trainings regarding the purpose and completion of Declaration and/or Advanced Directives, member rights related to Declarations and/or Advanced Directives, and right of members to refuse treatment.

C. It is the policy of Yamhill Community Care that documentation shows in member's current physical health, mental, and dental record states an advance directive is in effect.

D. Advance directive information must remain current and reflect changes in Oregon law as soon as possible, but no later than 90 calendar days after the effective date of change to the law.

PROCEDURE:

Upon enrollment, all new Yamhill Community Care members receive a member handbook containing information regarding advance directives that includes the following information:

- The member has the right to accept or refuse treatment under Oregon Law
- The member has the right to complete an advance directive and how to implement that right
- Members or authorized representatives may also contact Yamhill Community Care Organization's Members Services Department or access the plan's web site to request information on Advance Directives.
- Information regarding filing complaints concerning noncompliance with advance directive requirements through the Oregon Health Authority (OHA).
- A guide to Oregon's Declaration for Mental Health Treatment and forms are available on line at the following web site: http://www.oregon.gov/oha/amh/forms/Declaration.pdf

I. Yamhill Community Care Organization delegates' policy regarding advance directives shall be included in their Provider Manual.

II. Yamhill Community Care Organization delegates shall notify enrollees of their rights that includes a statement of any limitation regarding the implementation of advanced directives as a matter of conscience.

COMPLIANCE & OVERSIGHT:

Yamhill Community Care Organization shall monitor delegates to ensure:

1. Policies and Procedures are collected and updated either biennially or when review/revision date have been documented.
2. Sample documentation or attestation for proof of routine monitoring of mental health clinical treatment records will be requested and reviewed annually from mental health delegate as it relates to advance directives.
3. Sample documentation annually from delegates for member notification.
4. Documentation of notification within Provider Manual.
5. Documentation or attestation for staff trainings.

REFERENCES:

OAR 410-141-3320(w), 410-120-1380
42 CFR 422.128, 438.6(i)(1), 489.102(a)(3)

RELATED POLICIES & DOCUMENTS:

Enrollee Rights Policy (ENR-001)

Log of Review/Revisions

Date	Review/Revision	By Whom
1/31/2017	Approved	S. McCarthy, Interim CEO
07/28/2019	Branding and formatting,	Jroe, QA Specialist
08/01/2020	Bulleting to enhance policy information clarifications.	Jroe, QA Specialist

Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: GA-001	**TITLE:** Grievance System
DEPARTMENT: Quality Management	**APPROVED BY:** President/CEO
EFFECTIVE DATE: 01/31/2016	**LAST REVISION DATE:** 08/01/2020
REVIEW DATES:	
APPLIES TO: Yamhill Community Care, Contracted Partners, Providers and Subcontractors	

DEFINITIONS:

Word or Acronym	Definition
Action/Adverse Benefit Determination (AVB)	The denial or limited authorization of a requested covered service, including those based on type or level of service, medical necessity, appropriateness, setting or effectiveness of a covered benefit. The reduction, suspension or termination of a previously authorized service; the denial in whole or in part of payment for a service; 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; the failure to provide services in a timely manner, as defined by the medical assistance program (MAP); The failure of the CCO to act within the time frames as provided by 42 CFR 438.408 regarding the standard resolution of grievance and appeals, and an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other enrollee 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.
Grievance	A member or member's representative expressions of dissatisfaction to Yamhill Community Care, a delegated entity, 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 weren't sure about, but got anyway • Bills for services members did not agree to pay • Disputes on YCCO extension proposals to make authorization decisions
Member/Enrollee	An individual enrolled under the Coordinated Care Organization Yamhill Community Care Organization for their Oregon Health Plan (Medicaid) coverage. Includes the member or member's representative, attorney or provider (with specific written authorization from the member).
Delegate	Affiliate of Yamhill Community Care Organization who provide covered services and share risk.
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.
Notice of Action/Adverse Benefit Determination (NOABD/Notice)	A Notice of Action/Adverse Benefit Determination is a written notification to the member that documents when an action is intended or taken, including, but not limited to denials or limiting prior authorization of a requested covered service(s) in an amount, duration, or scope that is less than requested, or reductions, suspension, discontinuation or termination of a previously authorized service, or any other Action. The notice is in written format, as described in OAR 410-141-3240 and 410-141-0263.
Final Order	The Final Order is the written notification and outcome of a contested case hearing.
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.

POLICY:

Yamhill Community Care Organization (YCCO) delegates all or part of this function or process. Through the oversight, YCCO will insure compliance with all applicable federal, state, contractual rules and regulations and requirements. Therefore throughout this policy YCCO may be referring to a delegated entity performing the function. YCCO does not delegate final adjudication of appeals.

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

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).

Assurances through the Grievance System
Members and/or Providers are assured the following through the grievance system:

- Grievances, complaints, appeals, and contested case hearings are kept confidential and have a timely and appropriate resolution.
- Written notice of any adverse benefit determinations referred to as a Notice of Action/Adverse Benefit Determination (NOADB or Notice).
- YCCO Members have access to a robust process for handling grievances, complaints, appeals, and contested case hearings regarding the services they receive from YCCO.
- Members, with the written consent of the member, a provider or an authorized representative, may file a grievance at any time either orally or in writing on behalf of a member.
- Grievances may be filed directly with YCCO or with the Authority. If filed with the Authority it will be forwarded to YCCO promptly.
- YCCO ensures member grievances and appeals are processed in accordance with Oregon Administrative Rule (OAR) 410-141-0260 through 410-141-0266 and 410-141-3230 through 410-141-3264.
- With the exception of final adjudication of all appeals, all grievances issuing denials, appeal, and contested case hearing processes are delegated functions with appropriate oversight.
- YCCO members are informed that they have a right to file a grievance, appeal or contested case hearing orally or in writing and may have a member representative of their choice. The member or member's representative may also withdraw an appeal or contested case hearing request at any time.
- A member, member's representative, a representative of a deceased member's estate, or a member's provider acting on behalf of and with written consent of the member may file a grievance or appeal and request a contested case hearing. No punitive action will be taken against any provider who files a grievance, appeal, request a contested case hearing or request expedited resolution of an appeal on behalf of a member.
- YCCO will include in each notice of resolution with the determination not found in favor of the member that they may present the grievance to OHP Client Services Unit (CSU) toll free at 800-273-0557 or OHA's Ombudsman at 503-947-2346 or toll free at 877-642-0450.
- If YCCO fail to adhere to the notice and timing requirements in 42 CFR 438.408, the member is considered to have exhausted the CCO's appeal process. In this case, the member may initiate a contested case hearing.
- That YCCO, its delegates, subcontractors, and its participating providers may not:
    - Discourage member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;
    - Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
    - Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.
- Safeguard the member's right to confidentiality of information about grievance or appeal, except where the sharing of information is allowed for the purposes of treatment, payment or health care operations as defined in 42 CFR 164.501. The following pertains to the release of the member's information:
    - YCCO and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal or

hearing may use the information without the member's signed release for purposes of:
    - Resolving the matter; or
    - Maintaining the grievance or appeals log as specified in 42 CFR 438.416.
  - If YCCO needs to communicate with other individuals or entities not listed above to respond to the matter, YCCO will obtain the member's signed release and retain the release in the member's record.
- Safeguard member's anonymity for protection against retaliation in the member grievance and appeal resolution process.
- No incentivized compensation for utilization management activities by ensuring that individual(s) or entities who conduct utilization management activities are not structures so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any member.
- Cooperate with the Department of Human Services Governor's Advocacy Office, the Authorities Ombudsman and hearing representatives in all activities related to member's appeals, hearing requests, and grievances including all requested written materials.
- 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.
- All written grievance system information will be provided with the following guidelines:
  - Easily understood language 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;
  - 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.

Grievance System Process, Policy and Rights Awareness and Sharing
Contracted providers, delegates and subcontractors are made aware of member's grievance, appeal and contested case hearing procedures and timeframes. Including:

- The member's right to a contested case hearing, how to obtain a hearing and representation rules at a hearing;
- Member's right to file grievances and appeals with the requirements and timeframes for filing;
- The availability of assistance to members with filing of grievances, appeals and contested case hearings, toll-free numbers to file oral grievances and appeals;
- Member right to continuation of benefits during the appeal and contested case hearing processes and if the action is upheld in a contested case hearing, the member may be liable for the cost of any continued benefits; and
- The provider appeal rights to challenge the failure of YCCO to cover a service.

Providers, delegates and subcontractors are supplied YCCO's approved written Grievance System policy and procedures to ensure compliance at the time of contract.

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

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

- Assistance from qualified community health workers, qualified peer wellness specialists or personal health navigators to participate in processes affecting the member's care and services;
- Providing free certified and qualified interpreter services to meet language access requirements where required in 42 CFR 438.10;
- Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and certified and qualified interpreter capabilities; and
- Reasonable accommodation or policy and procedure modifications as requested by any disability of the member.
- Forms, notices and correspondence (included but not limited to the member handbook, provider directory, and grievance system forms and correspondence) provided in the members prevalent non-English language.
- The YCCO toll-free telephone number that the member can call to file appeals by phone.

YCCO's grievance system provides the member with the following:

- Toll-free telephone numbers that they can use to file a grievance or appeal by phone and explanation of the written process that follows the oral submission in which the member signs the appeal documentation provided to the Customer Service Representative;
- Availability of assistance in the filing process;
- The rules that govern representation at the hearing; and
- The right to have an attorney or member representative present at the hearing and the availability of free legal help through Legal Aid Services and Oregon Law Center, including the telephone number of the Public Benefits Hotline, 1(800)520-5292, TTY 711.

YCCO administrative office and in physical, behavioral and oral health offices where YCCO has delegated responsibility for appeals, hearing requests or grievances. The following forms will be available:

- OHP Complaint form (OHP 3001);
- Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile;
- Hearing request form (MSC 0443); and
- Notice of hearing rights (DMAP 3030)

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

Electronic Communication

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

Health Information Systems (HIS)

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

Civil Rights

In compliance with Title VI of the Civil Rights 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 racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status, and other identity factors for consideration in improving services for health equity.

Complaint or Grievance
A member or member's representative expressions of dissatisfaction to Yamhill Community Care, a delegated entity, or practitioner about any matter other than an Action, (see definitions).

- Grievances may also be called complaints, concerns, problems, or issues by the member or member's representative.
- The expression may be in whatever form of communication or language that is used by the member or member's representative, but must state the reason for the dissatisfaction.

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

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

        - Grievances regarding denial of expedited resolution, an appeal or involvement of clinical issues.
- Obtain the member's authorization by a signed release of information regarding the grievance or appeal prior to speaking with other individuals regarding the grievance or appeal information, or before any information related to the grievance or appeal is disclosed. The release must be retained in the member's record.
    - The delegate and any other provider whose authorizations, treatments, services, items, quality care, or requests for payment are involved in an appeal or contested case hearing may use information without the member's signed release for the purposes of resolving the matter or maintaining the grievance and appeals log

Notice of Adverse Benefit Determination (NOABD or Notice)
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 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, OAR 410-141-3240, OAR 410-141-3280, OAR 410-141-3300 and 42 CFR 438.404;
- 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 and how to access it;
- Content requirements per 42 CFR 438.404 and OAR 410-141-3240 including clear and thorough explanation of the specific reason for the adverse benefit determination with reference to specific statutes and rules to highest level of specificity;
- Include a statement that member has right to request the services that are being denied pending resolution of the appeal and that the member may be responsible for the cost of those services if the outcome of the appeal upholds the notice of action.
- Provides information on rights to and what to do to ask for appeal and time frame to do so, after appeal resolution a contested case hearing or where CCO failed to meet appeal timeliness outlined in OAR 410-141-3230 and procedures for exercising rights in OAR 410-141-3245;
- 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 410-141-3225 Managed Care Entity (MCE) Service Authorization or otherwise stated in OAR 410-141-3240 and
- Copy of notice will be sent to the requesting provider.

Appeals (Standard and Expedited)
An appeal occurs when a member, member's representative, representative of a deceased member's estate or provider representing the member makes an oral or written request for an action be reviewed. YCCO ensures the following:

- Delegates process and make the initial determination on appeals however the decision is then provided to YCCO for final adjudication. YCCO is the final adjudicator of all appeals.
- Member shall file an appeal with CCO no later than 60 days from date on the notice.
- Appeals can be submitted both orally and in writing. Written submission must follow and oral appeal unless it is an expedited appeal.

- Unless the member or member's representative requests an expedited appeal, an oral appeal must be followed by a submitted written and signed appeal. Notice of Adverse Benefit Determination and Notice of Appeal Resolution (NOAR) meet readability standards, alternative format availability as well as language format requirements found in the OHA Core Contract, OAR 410-141-3240, OAR 410-141-3280, OAR 410-141-3300 and 42 CFR 438.404.
- NOAR 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 and how to access it.
- Content requirements per 42 CFR 438.404 and OAR 410-141-3240 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.
- Appeals are handled in confidence consistent with OARs, HIPAA Privacy Rules and other federal and state confidentiality laws and regulations.
- Compliance with CFR and OAR notification and resolution timeframes. Specific timelines listed in Appeal policy.
- Appeals are acknowledged.
- Appeals are given to the appropriate staff with the authority to act upon it.
- Obtain documentation of all relevant facts concerning the grievance or appeal. This includes taking into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether the information submitted or considered in the initial adverse benefit determination or resolution of the grievance.
- Ensure that staff making decisions on the appeal are:
    - Not involved in any previous level of review or decision-making not a subordinate of any such individual;
    - Healthcare professional, with appropriate clinical expertise in treating the member's condition or disease if the grievance or appeal involves clinical issues or if the member requests an expedited review. Health care professionals shall make decisions for the following:
        - Appeal of a denial based on lack of medically appropriate service or involvement of clinical issues or
        - Grievances regarding denial of expedited resolution, an appeal or involvement of clinical issues.
- Obtain the member's authorization by a signed release of information regarding the grievance or appeal prior to speaking with other individuals regarding the grievance or appeal information, or before any information related to the grievance or appeal is disclosed. The release must be retained in the member's record.
- The delegate and any other provider whose authorizations, treatments, services, items, quality care, or requests for payment are involved in an appeal or contested case hearing may use information without the member's signed release for the purposes of resolving the matter or maintaining the grievance and appeals log

Contested Case Hearings (Standard and Expedited)

YCCO has a system in place in accordance with OAR 137-003-0501 to 137-003-0700 and OAR 410-120-1860 to ensure members and providers have access to appeal for CCO's action by requesting a contested case hearing.

- Member may not request a hearing without first filing an appeal with YCCO.
- Hearings must be filed on form MSC 0443 with the Authority no later than 120 days from the date on the Notice of Appeal Resolution (NOAR). Expedited hearings can be requested on MSC 0443 or other Division approved appeal or hearing request forms.
- Member may request a hearing prior to receipt of NOAR when CCO failed to meet appeal timeliness outlined in OAR 410-141-3230 and procedures for exercising rights in OAR 410-141-3245.

- When member request a hearing with OHA prior to filing an appeal with YCCO it shall be forwarded to YCCO for review, except when YCCO failed to adhere to appeal timing requirements.
- Once a hearing is received by YCCO they shall follow all hearing request standards noted in OAR 410-141-3245 and OAR 410-141-3247. Specific hearing procedures can be found in the hearing policy.
- In the event that a member request a hearing prior to filing an appeal and YCCO had not failed in appeal timing requirements OHA will forward the request and YCCO will:
    - Review the request immediately as an appeal
    - Approve or deny the appeal within the 16 days and provide the member with an NOAR.
- When a hearing results in the overturning of a denial and services have not been provided YCCO should authorize the services or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the decision.
- For services that have been furnished that are overturned through the hearing process YCCO or the state shall pay for the services in accordance with the Authority policy and regulations.

Continuation of Benefits

During the appeal and/or contested case hearing process members have the right to request the services that are being denied pending resolution of the appeal and/or hearing to continue.

- 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.
- When an appeal or hearing results in the overturning of a denial and services have not been provided YCCO should authorize the services or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the decision.
- For services that have been furnished that are overturned through the appeal or hearing process YCCO or the state shall pay for the services in accordance with the Authority policy and regulations.
- If the final resolution of the appeal or contested case hearing upholds YCCO's adverse benefit determination, YCCO may recover from the member the cost of the services furnished to the member while the appeal or hearing was pending per 42 CFR 431.230 to the extent that they were furnished solely because of the appeal or hearing and per the requirements of the CCO/OHA contract Exhibit I, Section 6. Benefits may be requested and received in the same manner and same amount as previously authorized while appeal or hearing is pending. Benefits shall continue as stated below.

Benefit shall continue when:

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

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

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

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

- Member withdraws the appeal or hearing; or

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

PROCEDURE:

Final Adjudication of Grievances and Appeals

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

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

Quality Improvement

YCCO addresses the analysis of grievances in the context of quality improvement activity, consistent with OAR 410-141-3200 and 410-141-3230 incorporating analysis into contract deliverables. Collection of grievances and appeals and the analysis of their data assist in improving the experience and quality of care provided to YCCO members.

- CCO shall monitor the data collected from the grievance system by the CCO and delegates 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.

Reporting & Compliance

- Inclusion of the grievance system in the QAPI program evaluation.
- 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 delegates based on the trending and analysis of the complaint and appeals quarterly report.
- OHA grievance and appeals log reporting, sample Notices and summary as per contract.
- Ad hoc reports as requested.

- Complete auditing and monitoring to ensure delegate meets the requirements consistent with OAR 410-141-3260 through 410-141-3266 by:
    - Performing a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement;
    - Performing review of any providers that filed on behalf of a member to insure that no punitive action was taken against them; and
    - Ensure delegate takes corrective action for any identified areas of deficiencies that need improvement.

Record Keeping

- YCCO will maintain yearly logs and appeal files of all appeals and grievances for ten (10) calendar years with the following requirements:
    - Member's ID number,
    - Date the member filed the grievance or appeal and date received,
    - Nature of the request with general description.
    - 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, 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.
    - 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.
- 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 all grievances and appeals in accordance with OAR 410-141-3255 and 42 CFR 438.416.
- Per OAR 410-141-3245 YCCO shall maintain a complete record for each appeal included in the log for no less than 300 days 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.

COMPLIANCE & OVERSIGHT:

YCCO will monitor and ensure delegates are compliant by:

1. Delegate 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. Delegates 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. Recorded in this log, delegates will demonstrate the following:
    a. Grievance log indicates:
        i. All grievances received in the allotted time frame;
        ii. Issue of the grievance including who/what the issue is pertaining to with all documentation used to resolve the issue;
        iii. Days to resolve issue; and

iv. Notification of resolution date and letter information.

3. Appeal and Hearing log indicates:
    a. All appeals and hearings received;
    b. Appeal and hearing issue;
    c. Days to resolve issue; and
    d. Notification dates including extensions.
4. Other reporting as indicated:
    a. Submit a random sample of ten (10) Notices written during the reporting quarter.
    b. Delegate shall review and report to YCCO complaints that raise issues related to racial or ethnic background, gender, religion, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status and other identity factors for consideration in improving services for health equity.
    c. Ad hoc reports as requested
5. Ensuring Policies and Procedures are updated and collected biennially or when delegate's review/revision date is updated.
6. Documentation that indicates the process for claim payment and preauthorization denials when appeal is overturned.
7. Insurance that delegate meets the requirements consistent with OAR 410-141-3025 through 410-141-3255.
8. Ongoing monitoring of performance.
9. Perform formal compliance reviews at least annually to assess performance, deficiencies, or areas for improvement.
10. Insurance that subcontractors take corrective action for any identified areas of deficiencies that need improvement.

REFERENCES:

OAR 410-141-3585; 410-141-3200; OARs 410-141-3880 through 410-141-3915; OARs 137-003-0501 to 137-003-0700 and OAR 410-120-1860
42 CFR 164.501
42 CFR Subpart F 438.402-438.414
42 CFR 438.10
508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines
OHA OHP CCO Health Plan Services Contract Exhibit B – Part 3 Patient Rights and Responsibilities, Exhibit I Grievance and Appeal System Requirements

RELATED POLICIES & DOCUMENTS:

DO-001 Delegation Oversight Policy and Procedure
GA-002 Member Complaints and Grievances Policy and Procedure
GA-003 Denials, Appeals, and Contested Case Hearings Policy and Procedure
ENR-001 Enrollee Rights Policy and Procedure
Final Adjudication Visio Roadmap

LOG OF REVISION

DATE	REVISION	BY WHOM
12/16/16	• Change in owner of approval to Seamus McCarthy • Update to language to Notice definition • Removed language- Acknowledge receipt of the GRIEVANCE or appeal to the member, action not required per OAR	JRoe, Quality Assurance Specialist

1/18/2017	Approved	SMcCarthy, CEO Interim
01/23/2018	Change to current format, policy updates	JRoe, QA Specialist
01/29/2018	Approved	SMcCarthy, President/CEO
3/08/2018	Updated OAR reference and formatting changes	JRoe, Quality Assurance Specialist
03/08/2018	Approved	SMcCarthy, President/CEO
07/02/2018	Policy reformatting, clarifications with additions from new rules and OHA feedback, contract section I-9, and definition updates	JRoe, Quality Assurance Specialist
08/02/2018	Approved	SMcCarthy, President/CEO
08/22/2018	Additional policy reformatting and clarifications of previous edits	JRoe, Quality Assurance Specialist
08/29/2018	Approved	SMcCarthy, President/CEO
01/16/2019	Additional policy clarifications from OHA feedback from new rules, contract section I-9	JRoe, Quality Assurance Specialist
01/16/2019	Approved	SMcCarthy, President/CEO
10/15/2019	Updated policy with 2020 OHA Contract requirements on written notification of all complaints and continuation of benefit cost recovery when adverse determination is upheld.	JRoe, QA Specialist
08/01/2020	OAR updates, bullet formatting for ease of reading and policy clarification, oral appeal clarification.	JRoe, QA Specialist

Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: MM-001	**TITLE:** Second Opinion
DEPARTMENT: Medical Management	**APPROVED BY:** President/CEO
EFFECTIVE DATE: 7/21/2016	**REVISION DATE:** 08/01/2020
REVIEW DATES:	
APPLIES TO: Yamhill Community Care, Contracted Partners, Providers and Subcontractors	

DEFINITION:

Work or Acronym	Definition
Out of Network Coverage	Coverage for services when a patient is seeking care outside the network of doctors, hospitals or other health care providers contracted with Yamhill Community Care Organization and its delegates.
Provider	A person who is licensed pursuant to Oregon state law to engage in the provision of health care services within the scope of their license or certification.
Referral	A referral verifies that the Primary Care Physician (PCP) has approved the member's care to that provider.
Second Opinion	Face-to-face assessment, evaluation and/or recommendation by a second professional with the same or higher degree to verify or challenge medical necessity, a diagnosis, or methodology of treatment by a current physical, mental health, or dental care provider. Individuals have the right to request and obtain second opinions.

POLICY:

Yamhill Community Care Organization (YCCO) delegates all or part of this function or process. Through the oversight, YCCO will insure compliance with all applicable federal, state, contractual rules and regulations and requirements. Yamhill Community Care Organization (YCCO) ensures that members will be provided with or have access to second opinions in accordance with state and federal regulations. Yamhill Community Care Organization understands that at times, a second opinion is needed to help a member make a choice between available treatment options or resolve controversy. A request for a second opinion may come from a physician or directly from the member or the member's representative.

- Yamhill Community Care Organization delegates will ensure that Individuals and/or those with legal custody of an individual are informed about the right to a

second opinion to determine medically appropriate services, at intake assessment, and at any time dissatisfaction, disagreement, or concern about a clinical decision regarding their treatment is expressed.

- Second opinions are to be rendered by qualified health care professionals or other licensed health care providers who are acting within his or her scope of practice and who possesses a clinical background, including the training and expertise present to make a recommendation regarding the appropriateness of a requested service or procedure.
- Second opinion consultations may be obtained by a qualified health care professional which may include a behavioral health provider within the provider network whenever possible. If a qualified health care professional within the provider network cannot be arranged then the Yamhill Community Care Organization and/or its delegate shall arrange for the member to obtain the second opinion form a non-participating provider at no cost to the member.
- Yamhill Community Care Organization and delegates will ensure that providers and staff are aware of expectations for members in regard to second opinions.

COMPLIANCE & OVERSIGHT:

Yamhill Community Care Organization will ensure that monitoring of delegates is completed by:

1. Requesting Policies and Procedures from delegates biennially or when delegate's review/revision dates have been updated.
2. Request documentation or data annually for frequency of access or requests made by members or providers regarding second opinions.
3. Grievances related to second opinions will be monitored and addressed with delegates as appropriate.
4. Request documentation for education to providers and staff annually regarding second opinions.

REFERENCES:

42 CFR 438.206, 42 CFR 438.100
OHA Health Plan Services Contract

Related Policies & Documents:

ENR-001 Enrollee Rights Policy and Procedure
DO-001 Delegation Oversight Policy and Procedure

Log of Review/ Revisions

Date	Review/Revision	By Whom
7/21/2016	Approved	B. Rajani, MD. Medical Director
11/18/2016	Final Approval	S. McCarthy, Director of Operations and Integration
05/19/2017	Reformatting to current template, addition of definitions, oversight section updated with grievance tracking and specific section of CCO contract listed.	JRoe, Quality Assurance Specialist
05/30/2017	Approved	B. Rajani, MD Medical Director
05/30/2017	Approved	S. McCarthy, President CEO
10/16/2017	Reformatting to current YCCO P&P template and updated definitions.	J.Roe Quality Assurance Specialist
11/14/2017	Approved	BRajani MD Medical Director SMcCarthy PhD President & CEO
08/01/2020	Updates to formatting and addition of second opinion by a behavioral health provider.	JRoe, QA Specialist

Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: MM-002	**TITLE:** Emergency, Urgent Care and Post-Stabilization Services
DEPARTMENT: Medical Management	**APPROVED BY:** President/CEO & Chief Medical Officer
EFFECTIVE DATE: 11/18/2016	**REVISION DATE:** 08/01/2020
REVIEW DATES: NA	
APPLIES TO: Yamhill Community Care and Partners	

DEFINITIONS:

Post Stabilization Services	Covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition.
Behavioral Health	Mental health, mental illness, substance use disorders, and gambling disorders.
Behavioral Health Assessment	A process which determines a patient's need for immediate crisis stabilization through evaluation of the patient's strengths, goals, needs, and current level of functioning.
Crisis	An actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is disrupted, and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental or physical health or to prevent referral to a significantly higher level of care or death.
Crisis Intervention	Short-term services to address an immediate crisis need.
Crisis Stabilization Plan	An individualized written plan defining specific short-term rehabilitation objectives and proposed crisis interventions derived from the patient's mental and physical health assessment.
Cultural Awareness	The process by which individuals and systems respond respectfully and effectively to individuals of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, gender identity, gender expression, sexual orientations, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each.
Emergency Services	Physical, mental or dental health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a member's discharge from a facility or transfer to another facility.

Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity, such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in placing the health of the member (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.
Emergency Dental Condition	A condition manifesting itself by acute symptoms of sufficient severity requiring immediate treatment for conditions such as: a) Acute infection b) Acute abscesses c) Severe tooth pain d) Unusual swelling of the face or gums e) A tooth that has been avulsed (knocked out)
Emergency Psychiatric Hold	Physical retention of a person taken into custody by a peach officer, health care facility, state facility, hospital or nonhospital facility as ordered by a physician or a CMHP director, pursuant to ORS Chapter 426.
Lethal Means Counseling	Best practice research-based counseling strategies to help patients at risk for suicide and their families reduce access to lethal means, including but not limited to firearms.
Mobile Crisis Services	Mental health services for individuals in crisis provided by mental health practitioners who respond to behavioral health crises onsite at the location in the community where the crisis arises and who provide a face-to-face therapeutic response. The goal of mobile crisis services is to help an individual resolve a psychiatric crisis in the most integrated setting possible and to avoid unnecessary hospitalization, inpatient psychiatric treatment, involuntary commitment, and arrest or incarceration.
Post Stabilization Services	Covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition.
Qualified Mental Health Professional (QMHP)	An Licensed Medical Practitioner or any other individual meeting the minimum qualifications as authorized by the Local Mental Health Authority or designee and specified in OAR 309-019-0125.
Qualified Person (QP)	An individual who is a QMHP or a QMHA and is identified by the PSRB and JPSRB in its Conditional Release Order. This individual is designated by the provider to deliver or arrange and monitor the provision of the reports and services required by the Conditional Release Order.
Safety Plan	A best practice research-based individual directed document developed through a collaborative process in which the provider assists the individual in listing strategies to use when suicide ideation is elevated or after a suicide attempt.
Trauma Informed Services	Services that are reflective of the consideration and evaluation of the role that trauma plays in the lives of people seeking mental health, substance use, or problem gambling services, including recognition of the traumatic effect of misdiagnosis and coercive treatment. Services are responsive to the vulnerabilities of trauma survivors and are

	delivered in a way that avoids inadvertent re-traumatization and facilitates individual direction of services.
Triage	A classification process to determine priority needs.

POLICY:
Yamhill Community Care Organization (YCCO) and/or its partners will ensure that urgent and emergent medical, dental and mental health service are available to members. YCCO and partners will insure that these services are available 24 hours a day, seven days a week, and 365 days a year.

YCCO and/or partners make every effort to track and monitor emergency and post-stabilization services to ensure payment and for data purposes for possible quality improvement activities.

Crisis, Urgent and Emergency Services

- YCCO does not require prior authorization for emergency services nor limits what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
    - YCCO does not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, delegate or CCO of the member's screening and treatment within 10 calendar days of presentation for emergency services.
    - Member who has emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose a specific condition or stabilize the patient.
    - Attending emergency physician, or the provider actually treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge which determines the responsibility of payment and coverage by the CCO.
- Providers shall provide an after-hours call-in systems adequate to triage urgent care and emergency service calls, consistent with OAR 410-141-3140 and 42 CFR 438.114. These services should be provided 24-hours a day, 7 days-a-week.
    - Urgent calls appropriate to the member's condition but no event more than 30 minutes after receipt. If information is not adequate to determine if the call is urgent, provider shall return the call within 60 minutes to fully assess the nature of the call. If information is adequate to determine that the call may be emergent in nature, the call shall be returned.
- Providers shall provide medically, behaviorally or dentally appropriate responses as indicated to urgent or emergency calls including but not limited to the following:
    - Telephone or face-to-face evaluation of the member.
    - Capacity to conduct the elements of an assessment to determine the necessary interventions to begin stabilization.
    - Development of a course of action.
    - Provision of services and referral needed to begin post-stabilization care or provide outreach services in the case of a member requiring behavioral health services, or a member who cannot be transported or is homebound.
    - Provision for notifying a referral emergency room, when applicable concerning the arriving member's presenting problem, and whether or not the provider will meet the member at the emergency room; and
    - Provision for notifying other providers, when necessary, to request approval to treat members.

- If emergency room screening leads to a clinical determination by the examining provider that an actual emergency medical condition exists under the prudent layperson standard, the CCO must pay for all services required to stabilize the patient. Exception to this section is located in OAR 410-141-3140 (6).The CCO may not require prior authorization for emergency services:
    - CCO may not retrospectively deny a claim for emergency screening because the condition, which appeared to be an emergency medical condition under prudent layperson standard, turned out to be non-emergent.
    - CCO may not limit what constitutes an emergency medical condition based on list of diagnoses or symptoms.
    - CCO may not deny a claim for emergency services merely because the PCP was not notified, or because the CCO was not billed within ten calendar days of the service.
- When a member's PCP, designated provider, or other CCO representative instructs the member to seek emergency care, in or out of network, the CCO shall pay for the screening examination and other medically appropriate services as listed in OAR 410-141-3140 (5), YCCO will pay for post-stabilization care administered to maintain, improve or resolve the member's stabilized condition that was:
    - Pre-authorized by YCCO or delegated partner;
    - Not pre-authorized by YCCO or delegated partner, if YCCO, or the on-call provider failed to respond to a request for pre-authorization within 1 hour of the request, or the member could not contact YCCO or provider on call; or
    - If YCCO or delegated partner and the treating provider cannot reach an agreement concerning the member's care and a YCCO representative is not available for consultation, YCCO must give the treating provider the opportunity to consult with a YCCO provider. The treating provider may continue with care of the member until a YCCO provider is reached or one of the criteria is met; and
    - YCCO will limit charges to members for post-stabilization services to an amount no greater than what the YCCO would charge the member for the services obtained within their provider network.
- Exception to this section per OAR 410-141-3140 (6) which states that YCCO responsibility for post-stabilization care it has not authorized ends when:
    - The participating provider with privileges at the treating hospital assumes responsibilities for the members care;
    - The participating provider assumes responsibility for the member's care through transfer;
    - A YCCO or delegated partner and the treating provider reach an agreement concerning the member's care; or
    - The member is discharged.
- YCCO shall cover and pay for emergency services, regardless of whether the provider that furnishes the services has a contract with YCCO or its partners, as provided in OAR 410-141-3140. Coverage and payment guidelines for emergency and post-stabilization services per OAR 410-141-3140, 42 CFR 438.114, 42 CFR 438.114 (c)(1)(ii)(B) and CCO contract Exhibit B-Part 2 (4)(a-b). If emergency room screening leads to a clinical determination by the examining provider that an actual emergency medical condition exist under the prudent layperson standard, YCCO must pay for all services required to stabilize the patient, except as otherwise provided above per OAR 410-141-3140(6). YCCO will not require prior authorization for services:
    - YCCO will not retroactively deny a claim for emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergent;
    - YCCO may not limit what constitutes an emergency medical condition based on list of diagnoses or symptoms;

    - CCO will not deny a claim for emergency services mainly because the PCP was not notified, or because YCCO was not billed within 10 calendar days of the date of service.
- YCCO and partners will track inappropriate use of urgent and emergency care and shall take action, including individual member counseling, to improve appropriate use of urgent and emergency care services.
- YCCO and partners shall educate members about how to appropriately access care from emergency rooms, urgent care and walk-in clinics, non-traditional health care workers, and less intensive interventions other than their primary care home
  YCCO shall apply and employ innovative strategies to decrease unnecessary hospital utilization.

Crisis, Urgent and Emergency Services for Behavioral Health
In addition to the above crisis, urgent and emergency YCCO and/or partners have monitoring systems that provide for mental health emergency, including post-stabilization care services and urgent services for all members on a 24-hour 7 day-a-week basis consistent with OAR 410-141-3140 and 42 CFR 438-114.

- YCCO ensures that an emergency response system is provided for members who need immediate, initial or limited duration response for potential behavioral health emergency situations or emergency situations that may include behavioral health conditions, including:
    - Screening to determine the nature of the situation and the person's immediate need for Covered Services;
    - Capacity to conduct the elements of a Behavioral Health Assessment that are needed to determine the interventions necessary to begin stabilizing the crisis situation;
    - Development of a written initial services plan at the conclusion of the Behavioral Health Assessment;
    - Provision of Covered Services and Outreach needed to address the urgent or crisis situation;
    - Linkage with the public sector crisis services, such as Mobile Crisis Services and diversion services.
- The crisis management system must include the necessary array of services to respond to behavioral health crises, which may include crisis hotline, 24-hour mobile crisis team, walk-in/drop-off crisis center, crisis apartment/respite and short-term stabilization unit capabilities.
- YCCO will ensure access to mobile crisis services for all members in accordance with OAR 309-019-105, and 309-019-0300 through 309-019-0320 included below to promote stabilization in a community setting rather than arrest, presentation to an emergency department, or admission to an acute care facility.

Yamhill County Health and Human Services Procedure:
Timeline Guidelines:
Emergent-Member shall be seen within 24 hours or as indicated in initial screening.
Urgent-Member shall be seen within 48 hours or as indicated in initial screening.
Procedure:

1. YCHHS' behavioral health program provides the following services 24-hours a day, 7-days-a-week, at YCHHS' offices during business hours, or at Providence Newberg Hospital and Willamette Valley Medical Center in McMinnville: initial telephone screening and consultation, face-to-face mental health evaluation, hospital authorizations**,** coordination of hospital admit and triage. Newberg Providence Hospital and Willamette Valley Medical Center are staging cites for 24/7 psychiatric

hospitalization evaluations. Hospitalization screening will also be provided at the jail as requested.

2. YCHHS will respond to urgent and emergent requests in the following manner:
    a. Initial Telephone Response: Crises specialists will provide initial screening and triage consultation with the attending physician and/or law enforcement officer, and the YCCO member in psychiatric crisis to determine the nature of the emergency and medically necessary services. In addition, YCHHS will respond to emergent and urgent needs per the following:
        i. Emergent:
            1. A situation requiring attention within 24 hours to prevent a serious deterioration in a person's mental health (imminent risk to self or others).
            2. Requires face to face or telephone screening within 30 minutes of contact to determine the nature and urgency of the situation;
            3. Requires service within timeframes identified by the screening or within 24 hours of contact, whichever is shorter.
        ii. Urgent: A situation requiring attention within 48 hours to prevent a serious deterioration in a person's mental health.
            1. Requires initial face to face or telephone screening within 30 minutes of contact to determine the nature and urgency of the situation;
            2. Requires service within timeframes identified by the screening or within 48 hours of contact, whichever is shorter. Individual is not able to wait for routine mental health intake or next appointment with current mental health provider without serious deterioration to his/her mental health.
    b. Face-to-Face screening and evaluation will be provided for emergent situations immediately. YCHHS will notify the attending physician, or jail staff that they are on their way and ask if the labs can be fast tracked ASAP to assist with the behavioral health assessment of the individual. When talking with law enforcement officers in the field, YCHHS will ask them to perform a breathalyzer test on individuals who may appear intoxicated to aid in the assessment. During office hours, YCHHS will request law enforcement bring the individual in crisis to the YCHHS behavioral health office for screening, if the individual does not appear to need immediate medical care or a danger to others.
3. Outreach and Follow-up Care*:*
    a. The treating clinician and or crisis specialist will initiate outreach calls to clients who are not showing for services with history of suicidal ideation, suicidal attempts, self-injurious behaviors, hospitalization(s), recent losses, abandonment or rejection, homelessness, increased psychosis, other symptoms with significant impairment in functioning, active substance use or relapse, or gambling addiction.
    b. If unable to contact the client, the provider will work with law enforcement to perform a safety/welfare check and/or joint home visits to assess client safety and actively work to engage client in services to promote safety. The provider shall document all outreach efforts and client's response to those efforts.
    c. Crisis staff will coordinate with the treatment team, including George Fox University and the after-hours crisis line, Lines for Life, via email and/or in

person to promote stabilization and coordination of care plan to ensure client safety during and post crisis episode. The provider shall document all coordination efforts.

d. Coordination and follow up care are expected for individuals stabilizing from a crisis episode and/or discharge from acute care or long-term inpatient care. The YCCO member will be scheduled a 7-day follow-up appointment post-hospitalization for a mental health condition.

Crisis Service Requirements

- Crisis line services shall be provided directly or through linkages to a crisis line services provider 24/7.
- Crisis line services shall include but is not limited to:
  - 24/7 accessibility to a QMHP;
  - 24/7 bi-lingual or interpreter availability;
  - 24/7 telephone screening to determine the need for immediate intervention;
  - 24/7 linkage to emergency service providers, including first responders and mobile crisis services;
  - Best practice risk assessment, including suicide risk assessment;
  - Suicide intervention and prevention;
  - Lethal means counseling and safety planning for individuals at risk for suicide;
  - Crisis intervention;
  - Crisis plan development;
  - Triage;
  - Providing information regarding services and resources in the community; and
  - Procedures for de-escalation for calls from suicidal individuals.

Provider Standards

Crisis line services providers shall develop and implement written policies and procedures to address provider standards. Provider standards shall include but is not limited to:

- Training curriculum and ongoing education programs to meet training requirements;
- Coordination with other treatment providers including mobile crisis services and other crisis line services providers to support seamless transitions of care;
- Linkages to emergency services providers including first responders to address imminent risks and to support seamless transitions of care;
- De-escalation procedures;
- Follow-up procedures when indicated and appropriate;
- Documentation;
- Code of ethics; and
- Security of information protocols.

Minimum Staffing Requirements

- At least one QMHP shall be available by phone or face-to-face 24/7 for consultation.
- At least one QMHP shall provide regular clinical supervision to staff.

Training Requirements

- Staff training curriculum shall include but is not limited to:
  - Triage protocol;
  - Referral resources;
  - Crisis plan development;
  - Screening for a Declaration for Mental Health Treatment.
- Staff training curriculum shall include best practices for the following:
  - Risk assessment, including suicide risk assessment;
  - Suicide intervention and prevention;

- Safety planning;
- Lethal means counseling;
- De-escalation methods;
- Crisis intervention;
- Recovery support, including peer delivered services;
- Trauma informed care; and
- Cultural awareness.

Documentation Requirements

- Documentation of calls shall include but is not limited to:
  - Summary of presenting concern, assessment of risk factors, interventions, evaluation of interventions, the plan for the management and resolution of the crisis or emergency situation reported, referrals to other services, and collaboration that occurred with emergency services providers or other treatment providers, when appropriate;
  - If a suicide risk assessment was completed;
  - Summary of safety planning and lethal means counseling, as appropriate.
- A log or report of all contacts with the provider, including the name of each caller, when available, the crisis line worker, and the time and duration of the call shall be maintained for quality assurance review and ongoing staff supervision.

Post Stabilization Care

YCCO is not financially responsible for post stabilization care services it has not pre-approved ends when:

- A plan provider with privileges at the treating hospital assumes responsibility for the members care;
- A plan provider assumes responsibility for the members care through transfer;
- A YCCO representative and the treating provider reach an agreement concerning the members care; or
- The member is discharged.

COMPLIANCE & OVERSIGHT:

Yamhill Community Care Organization will ensure emergency and post-stabilization services with monitoring of partners by:

1. Requesting Policies and Procedures biennially or when delegate's review/revision dates are due.
2. Documentation of regular monitoring of delegate's participating providers' compliance with the above and their internal Emergency and Urgent Care Services policy and procedure.
3. Documentation or attestation from partners to ensure that medical, mental, or dental appropriate responses to urgent or emergent calls are conducted appropriately.
4. Review of emergency services use by members and analysis of appropriate or avoidable use related to lack of access to routine care.
5. Review of data indicating the monitoring of emergency and post-stabilization services payment and denials.

REFERENCES:

OAR 410-141-3840; OAR 410-123-1060; OAR 309-019-0105; 309-019-0300 through 309-019-0320
42 CFR 438.114, 438.210, 422.118
OHA Health Plan Services Contract

RELATED POLICIES & DOCUMENTS:

DO-001 Delegation Oversight
MM-004 Clinical Practice Guidelines
SVC-002 Authorization of Services
SVC-004 Network Capacity, Service Adequacy and Availability
SVC-005 Behavioral Health Services
Yamhill County Health and Human Services Policy 016-102-03-11 YCCO Behavioral Health Urgent and Emergent Care

Log of Review/Revisions

Date	Review/Revision	By Whom
10/10/2017	Change in formatting and updated with additional clarifications.	JRoe QA Specialist
11/01/2017	Approved	BRajani, MD Medical Director SMcCarthy, PhD President/CEO
07/28/2019	YCCO branding updates	JRoe, QA Specialist
10/27/2019	Clarification of OAR and CFR language noted.	JRoe, QA Specialist
11/07/2019	Update of BH Crisis Management System requirements due to changes in OARS and OHA CCO 2.0 contract.	JRoe, QA Specialist
01/09/2020	Addition of YCHHS procedure.	JRoe, QA Specialist
08/01/2020	Updates to formatting for policy clarification, OAR number update	JRoe, QA Specialist

Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: MM – 004	**TITLE:** Clinical Practice Guidelines
DEPARTMENT: Quality	**APPROVED BY:** President/CEO & Medical Director
EFFECTIVE DATE: 05/30/2017	**LAST REVISION DATE:** 11/01/2017, 2/22/2019
REVIEW DATES:	
APPLIES TO: Yamhill Community Care and Delegates	

DEFINITIONS:

Centers for Medicare & Medicaid Services (CMS)	CMS is a federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and the federally facilitated Marketplace.
Clinical Practice Guidelines	Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.
Code of Federal Regulations (CFR)	The Code of Federal Regulations (CFR) is the codification of the general and permanent rules and regulations published in the Federal Register by the executive departments and agencies of the Federal Government.
Health Evidence Review Commission (HERC)	HERC reviews clinical evidence in order to guide the Oregon Health Authority (OHA) in making benefit-related decisions for its health plans.
Oregon Division of Medical Assistance Programs (DMAP)	DMAP is a part of the Oregon Health Authority (OHA) that administers Oregon's medical assistance programs, including the Oregon Health Plan. They are responsible and determine policy and OARs for medical assistance programs including Medicaid and CHIP. DMAP informs clients and providers about policy and OAR changes that affect OHP services and pay claims and contracted payments for covered health services.
Oregon Administrative Rules (OAR)	OAR is any Oregon agency directive, standard, regulation or statement of general applicability that implements, interprets or prescribes law or policy, or describes the procedure or practice requirements of any agency. The Oregon Administrative Rules Compilation is an annual publication containing complete text of Oregon Administrative Rules (OAR) filed through November 15th of the previous year.

POLICY:

Yamhill Community Care Organization (YCCO) delegates all or part of this function or process. Through oversight, YCCO insures compliance with all applicable federal, state, contractual rules and regulations and requirements.

YCCO network providers use evidence based clinical practice guidelines when considering the appropriate medical care and treatment for the health of members. Clinical practice guidelines address physical health care, behavioral health treatment or dental care concerns identified by members or their representatives and implement changes that have a favorable impact on health outcomes and member satisfaction in consultation with the YCCO's community advisory council or clinical review panel.

PROCEDURE:

Requirements:

Practice guidelines pertain to improving health care quality for members. Yamhill CCO's priority is promoting and protecting the overall health and safety of its members. To achieve this, Yamhill CCO expects delegates and their practitioners to adopt and utilize clinical practice guidelines that meet the following requirements:

1. Based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
2. Establish guidelines for those diseases where standardized care would benefit YCCO members and address the needs of special populations.
3. Consideration and review given to any guidelines that DMAP and/or CMS has adopted as a standard benchmark.
4. Adopted in consultation with contracted health care professionals.
5. Reviewed and updated regularly.

Dissemination:

YCCO clinical practice guidelines are disseminated to participating providers via new provider orientation packets, YCCO website, and provider portal with updates being supplied via email and/or by posting to the provider section of the website. Clinical practice guidelines are available upon request to members or potential members by calling customer service and requesting the information.

Application:

YCCO utilization management decisions, member education, coverage of services and other areas where the guidelines apply are consistent with the guidelines.

COMPLIANCE & OVERSIGHT:

YCCO shall ensure through routine monitoring and/or document verification the following from delegates:

1. YCCO delegates shall ensure that current guidelines are provided to providers and when updated there is a process to communicate the updates. As well as to provide guidelines to members or potential members upon request.
2. Delegates shall ensure that guidelines are reviewed to be consistent with current research and national standards. Guidelines shall be reviewed more frequently if they are revised or updated. Any new guidelines established by the Health Services Commission and adopted by DMAP will be incorporated into current processes.
3. To ensure network providers are compliant, YCCO ensures physical, dental and behavioral health delegates review clinical records submitted in connection with prior authorization requests, denials, grievances and appeals of coverage denials to ensure consistency with the Oregon Health Authority's (OHA) evidence-based practice guidelines. Through oversight, Delegates evidence to YCCO reflecting adherence to OHA guidelines.
4. If it is found that guidelines are not being applied consistently, the delegate shall follow their internal process for training and corrective action with notification to YCCO as appropriate.

REFERENCES:

OAR 410-141-3200 (6)

42 CFR 438.236
OHA CCO Contract Exhibit B

RELATED POLICIES & DOCUMENTS:
DO-001 Delegation Oversight Policy and Procedure
MM-003 Over and Under Utilization Policy and Procedure
SVC-002 Authorization of Services Policy and Procedure

LOG OF REVISION:

Date	Revision or Approval	By Whom
05/30/2017	Approved	BRajani MD Medical Director
10/05/2017	Revised with clarity updates and to new YCCO format.	Jroe QA Specialist
10/09/2017	Revisions and updates reviewed and approved by Medical Director	BRajani Medical Director
10/30/2017	Revised with additional information and format updates.	JRoe QA Specialist
11/01/2017	Approved	BRajani MD Medical Director SMcCarthy PhD President/CEO
2/22/2019	Reviewed and Approved	BRajani MD Medical Director

Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: QA-001	**TITLE:** Exclusion Screening
DEPARTMENT: Quality Management	**APPROVED BY**: President/CEO
EFFECTIVE DATE: 11/18/2016	**REVISION DATE:** 10/02/2018
REVIEW DATES:	
APPLIES TO: Yamhill Community Care and Delegates	

DEFINITIONS:

Excluded or Ineligible Individual/Entity	Individual or entity: A. Currently excluded or otherwise ineligible to participate in the federal health care programs or B. Has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded or otherwise declared ineligible. Individuals or entities that are not eligible for any payments made by Medicare or state health care program.
Exclusion	Items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid
Federal Department of Health and Human Services (DHHS)	Cabinet level department of the US federal government with the goal of protecting the health of all Americans and providing essential human services.
Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE)	Office of Inspector General (OIG) has the authority to exclude individuals and entities from Federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE). Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties.
U.S. Government Services Administration System for Award Management (SAM)	A dataset of individuals and entities that are sanctioned or excluded from doing business under a federal contract.

POLICY:
Yamhill Community Care Organization (YCCO) delegates all or part of this function or process. Through the oversight, YCCO will insure compliance with all applicable federal, state, contractual rules and regulations and requirements.

It is the policy of YCCO to ensure that representatives and delegated entities are screened against the U.S. Department of Health and Human Services Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), and Excluded Parties List System (EPLS), also known as the U.S. Government Services Administration System for Award Management (SAM) listings in order to

prevent doing business with or billing for any item or services provided by a sanctioned, excluded individual or entity during the period of exclusion.

To comply with the OIG by ensuring federal and state health care program dollars are not expensed to individuals or entities excluded from federal or state programs. YCCO recommends in accordance with the OIG that initial, monthly, and annual exclusion reviews are completed by delegated entities to ensure employees, contracted providers and business sub-contractors have not been sanctioned or excluded from participating in any federal health care program as prohibited by federal law.

YCCO delegates their employee, delegated entities and governing board member sanction and excluded individual screenings. If exclusions occur, the delegate is to immediately notify YCCO. All YCCO delegated entities conduct their own exclusion screenings of employees, sub-contractors and participating providers per federal and state regulations.

PROCESS:

YCCO and/or delegates will conduct searches against the OIG-LEIE, and SAM exclusions lists of potential or current employees, contractors, sub-contractors, and network providers to determine whether an individual or business may have been excluded. This process will be conducted on an ongoing monthly basis.

Potential Relationship Search Process: YCCO Accounting Department and/or delegate will conduct an individual search with the OIG-LEIE and SAM exclusion list prior to contracting and payment to any entity or individual.

- *Clean Searches:* If the search is clean the contracting will take place and a copy of the search results will be kept for documentation purposes. The entity or individual will then be added to the monthly check.
- *Positive Results on Exclusion Listing(s):* In the instance when and individual or entity is found on the listing a secure email will be sent to the Compliance Department at compliance@yamhillcco.org for investigation and verification.
- *Verification Process:* Compliance Department will do a comprehensive investigation to confirm the positive result. Once the process has taken place an email will be sent to the Accounting Department.
- *Confirmed Positive Matches:* Confirmed individuals or entities will not be offered contracts or employment with YCCO.

Existing Relationship Search Process: YCCO Accounting Department and/or delegate will conduct monthly searches for all entity or individuals against the OIG-LEIE and SAM exclusions lists.

- *Positive Results on Exclusion Listing(s):* In the instance when and individual or entity is found on the listing a secure email will be sent to the Compliance Department at compliance@yamhillcco.org for investigation and verification.
- *Verification Process:* Compliance Department will do a comprehensive investigation to confirm the positive result. Once the process has taken place an email will be sent to the Accounting Department.
- *Confirmed Positive Matches on Existing YCCO Relationships:* Compliance Department will notify the appropriate department responsible for the entity or individuals association with YCCO (Human Resources, Accounting or Provider Contracting) immediately to initiate termination. Screenings and verification documentation shall be maintained for records.

OIG & SAM Notification: Upon a positive verification YCCO Compliance will notify OIG-LEIE and SAM with the individual or entity name, the contact information for notification is:

HHS, OIG, OI
Attn: Exclusions Branch
P.O. Box 23871
Washington, DC 20026

Telephone: (202) 691-2311
Fax: (202) 691-2298

Email: sanction@oig.hhs.gov

A copy of the notification with all documentation including termination and fax coversheet if sent via fax will be maintained in the entity or individual's file.

Re-instatement of Sanctioned or Excluded Employees or Business Sub-Contractors:
A sanctioned, or excluded individual or sub-contractor is eligible for employment, privileges, or to conduct business with YCCO only when reinstatement to participate in Federal or state health care programs has been completed and verified.

Positive Matches Made and Reported to OIG by Delegated Entities:
All OIG reported positive matches applicable to the YCCO delegated business will be reported to YCCO Compliance Officer with all documentation available upon request.

OVERSIGHT & COMPLIANCE:
YCCO compliance will conduct annual audits of YCCO's internal exclusion process verifying documentation of completed exclusion checks.

YCCO will monitor and ensure delegates are complaint by:

1. Ensuring Policies and Procedures are collected from delegates, reviewed, and updated as appropriate or when delegates review/revision dates have been completed;
2. Requesting documentation of delegates' completed exclusion checks and activities annually.

REFERENCES:
OAR 410-180-0326
42 CFR 1001.1901; 42 CFR Ch IV Subchapter C Part 455, 438.608
OHA OHP CCO Contract Exhibit B-Part 8, Part 9
OIG LEIE https://oig.hhs.gov
GSA SAM https://sam.gov

RELATED POLICIES & DOCUMENTS:
DO-001 Delegation Oversight Policy and Procedure
QA-002 Credentialing Process Policy and Procedure
CMPL-001 Prevention, Detection, and Reporting of Fraud, Waste and Abuse

LOG OF REVISION

DATE	REVISION	BY WHOM
11/18/2016	Approved	SMcCarthy, Interim CEO
10/30/2017	Revised to update to current format and inclusion of additional references and related policies & documents.	JRoe, QA Specialist
11/01/2017	Approved	SMcCarthy PhD President/CEO
7/5/2018	Updated procedure to include reporting excluded providers to OIG. Update language to Oversight and Compliance. Aligned documents formatting.	JHarms, Quality Manager

10/02/2018	Updated procedure with current logo and to clarify process and include specifics on reporting excluded entity or individuals to OIG, delegated entities annual oversight requirements and requirements when an individual is verified as excluded and reported to OIG.	Jroe, QA Specialist

Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: SVC-002	**TITLE:** Authorization of Services
DEPARTMENT: Service	**APPROVED BY:** President/CEO & Chief Medical Officer
EFFECTIVE DATE: 2/15/2017	**REVISION DATE:** 08/01/2020
REVIEW DATES:	
APPLIES TO: Yamhill Community Care, Contracted Partners, Providers and Subcontractors	

DEFINITION:

Action	The denial or limited authorization of a requested service, including the type of level of service; the reduction, suspension or termination of a previously authorized service; the denial in whole or in part of payment for a service; for the member who resides in a rural service area where the CCO is the only CCO, the denial of a request to obtain covered services outside the provider network; the failure to provide services in a timely manner as defined by the Medical Assistance Program (MAP); the failure to act within the time frames as provided in 42 CFR 438.408 and 42 CFR 438.210. Action is also known as denial.
Emergency Services	Physical, mental or dental health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a member's discharge from a facility or transfer to another facility.
Notice of Adverse Benefit Determination (NOABD)	Written document that states the action intended or taken.
Out of Network Coverage	Coverage for services when a patient is seeking care outside the network of doctors, hospitals or health care providers contracted with YCCO and its delegates.
Plan of Care	Physician's coordinated plan of care for provision of services. This plan of care shall fully identify the services to meet the individualized needs of the patient.
Prior Authorization	A prior authorization is a process assisting the health plan to determine medical necessity and appropriateness of health care services under the applicable health benefit plan. Services or supplies that may require prior authorization may be surgical services, items of DME, drugs etc.
Prioritized List	List of condition and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering Oregon Health Plan (OHP) health services.

Referral	A referral verifies the Primary Care Physician (PCP) has approved the member's care to that provider.

POLICY:
Yamhill Community Care Organization (YCCO) delegates all or part of this function or process. Through the oversight, YCCO will insure compliance with all applicable federal, state, contractual rules and regulations and requirements.

YCCO and/or delegates have policies and mechanisms in place to ensure consistent application of review criteria for authorization decisions and review decisions are made by a healthcare professional with appropriate clinical expertise in treating the member's condition and taking into consideration the clinical guidelines, will notify the member in writing of any decision to deny the request or to authorize in an amount, duration or scope that is less than requested. Policies and mechanisms are in place for monitoring: standard and expedited service authorizations, decisions to deny or to partially deny and for providing notice to providers and members of the decisions.

YCCO and delegates will ensure that all medically appropriate covered services are furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services furnished to clients under fee-for service as set forth in 42 CFR 438.210, 440.230, and subpart B of 441. The services are sufficient in amount, duration and scope to reasonably achieve the purpose for the reason the services are provided. YCCO and delegates may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.

YCCO or delegates shall not require members to obtain approval of a Primary Care Physician (PCP) to gain access to mental health or Substance Use Disorders Assessment and Evaluation services. Members may self-refer to behavioral health and services available from the YCCO provider network. Members may obtain primary care services in a behavioral health setting, and behavioral health services in a primary care setting without authorization. YCCO and delegates will ensure that utilization or prior authorization standards for mental health or substance abuse disorder benefits and access to both in and out of network providers providing the benefits are no more stringent than standards applied to medical/surgical benefits.

YCCO and delegate's staff and/or contracted providers are notified that compensation is not structured to provide incentives to deny, limit, or discontinue medically necessary services to enrollees and financial incentives are not being utilized to reward underutilization.

PROCEDURE:
Health Record Requirements
Providers are held to the following minimum health record requirements for hospitals and mental hospitals set forth is 42 CFR Part 456:

- Identification of the member;
- Physician name;
- Date of admission, dates of application for and authorization of Medicaid/YCCO benefits if application is made after admission;
- The plan of care;
- Initial and subsequent continued stay review dates;
- Reason and plan for continued stay if the attending physician determines continued stay is necessary;
- Other supporting material the committee believes appropriate to include; and
- For non-mental hospitals only:

    - Date of operating room reservations (if applicable); and
    - Justification of emergency admission (if applicable).

Plan of Care

Before admission to a hospital or before authorization of payment, a physician and other personnel involved in the member's care must establish a plan of care that includes:

- Diagnosis, symptoms, complaints, and complications indicating the need for admission;
- A description of the functional level of the individual;
- Objectives;
- Any orders for:
    - Medications;
    - Treatment;
    - Restorative and rehabilitative services;
    - Activities;
    - Social Services;
    - Diet;
- Plans for continuing care, as appropriate, and
- Plans for discharge as appropriate.

Physician and other personnel involved in the member's case must review each plan of care at least every 60 days.

- Orders:
    - Orders and activities must be developed in accordance with physician's instructions.
    - Orders and activities must be reviewed and revised as appropriate by all personnel involved in the care of the member.

Mental Health plans of care must be reviewed at least every 90 days by attending or staff physician and other personnel involved in the member's care and will include:

- Diagnosis, symptoms, complaints, and complications indicating the need for admission;
- A description of the functional level of the individual;
- Objectives;
- Any orders for:
    - Medications;
    - Treatments;
    - Restorative and rehabilitative services;
    - Activities;
    - Therapies;
    - Social Services;
    - Diet; and
    - Special procedures recommended for the health and safety of the patient;
- Plans for continuing care, including review and modification of the plan of care; and
- Plans for discharge.

Authorization or denial of Covered Services

Documentation submitted when requesting authorization must support the medical justification for the service. YCCO delegates will authorize for the level of care or type of service that meets the member's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. YCCO or delegate shall consult with the provider when appropriate and may request additional information from the provider to determine medical appropriateness or appropriateness of the services requested. The OHP Prioritized List and delegate clinical practice guidelines will be used to make authorization decisions.

YCCO requires any decision to approve or deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a health care professional who has appropriate expertise in treating the member's physical, mental, or oral health condition.

- YCCO will not arbitrarily deny, reduce the amount, duration or scope of the required service solely because of diagnosis, type of illness, or condition of the beneficiary;
- May place appropriate limits on the service:
    - Based on criteria applied to state plan, such as medical necessity; or
    - For purpose of utilization control, provided the services can reasonably be expected to achieve their purpose.

YCCO specifies what constitutes medically necessary services in a manner that:

- Is no more restrictive that that used by the State Medicaid Program including quantitative and non-quantitative treatment limits, indicated in state statutes and regulations, the state plan and other state policy and procedures;
- Addresses to the extent that YCCO is responsible for covering services related to the following:
    - Prevention, diagnosis and treatment of health impairments.
    - Ability to achieve age appropriate growth and development.
    - Ability to attain, maintain, or regain the functional capacity.
- Services supporting individuals with ongoing or chronic conditions, or those who require long term service supports (LTSS) are authorized in a manner that reflects the member's ongoing need for such services and supports; and
- Family planning services are provided in a manner that protects and enables a member's freedom to choose a method of family planning, to be used consistent with contractual requirements.

To remain consistent with Division of Medical Assistance Program (DMAP) Guidelines, YCCO and/or delegates are only able to make a formal Service Authorization Request decision (pended, approval, or denial) when a complete request is received.

In accordance with 42 CFR 438.210 YCCO's authorization decisions shall be made by a healthcare professional with appropriate clinical expertise in treating the member's physical, mental, or oral health condition or disease. Decisions to deny a service authorization request or to authorize in an amount, duration, or scope less than requested will be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

Service Authorization Request

YCCO and/or Delegates will utilize consistent application of review criteria for authorization decisions.

For a Service Authorization Request (SAR) to be considered complete, it must contain all the following elements:

- Member name and contact information
- Date of birth
- Provider contact information and signatures
- Date of request
- Medicaid ID
- Other insurance coverage information
- Services requested
- Date Services are requested to begin or be performed
- Clinical information to support the service(s) requested as well as information that supports the eligibility for service(s) requested.

Failure to provide information with the SAR, will result in the request being unable to process and pended for further information. When requests are unable to process, the delegated

reviewer shall inform the provider and make reasonable efforts to obtain the necessary information form the provider in an effort to avoid denials for lack of information. All attempts to obtain additional information shall be documented with the Service Authorization Request.

Service Authorization Request Processing
All request for service authorizations will be completed within timeline standards as defined in this policy and state and federal rule. YCCO and partners utilizes the following guidelines when processing authorization request:

- Requests are date and time stamped upon receipt. This may be done electronically dependent on the method of submission chosen by the provider via electronic system, fax or secure email submissions can be received outside of business hours. Time of receipt for urgent request is the date received. Time of receipt for non-urgent request is the next business day.
- Validation of the request. SAR must contain the information elements necessary to review the request (listed above).
    - All information is present - request if forwarded for review and determination.
    - Information is not present – request is forwarded to appropriate staff for review of the information present for a determination if the request can be deemed valid, it is forwarded for review. If not the provider is notified.
- Valid request are approved or denied as expeditiously as the member's health condition requires and within timelines as noted below.
- Non-valid request awaiting response from the provider are denied and written notification sent if no additional information is received, this is completed in the authorization timelines noted below.

Service Authorization Timelines (42 CFR 438.210(d))
For Standard Service Authorization Requests, YCCO delegates shall provide notice as expeditiously as the member's health condition requires and may not exceed 14 days following receipt of the request for services, with a possible extension of 14 additional days if the member or the provider requests extension, or if YCCO delegate justifies the need for additional information and how the extension is in the member's interest. If YCCO or delegate extends the period, the member and the provider shall be given written notice of the reason for the extension and information on the right to file a grievance if he/she disagrees with that decision.

If a member or provider requests, or if YCCO or delegate determines, that following the standard timeframes could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, YCCO or delegate must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after the receipt of the request for service. YCCO or delegate may extend the 72-hour period by up to 14 days if the member requests an extension, or if YCCO or delegate justifies the need for additional information and how the extension is in the member's interest. If YCCO or delegate extends the timeframe, it must give written notice of the reason for the decision and inform the member of the right to file a grievance if he/she disagrees with the decision to extend the timeframe. The authorization decision should then be made no later than the date the extension expires or as expeditiously as the member's health condition requires.

For actions affecting previously authorized services the notice must be mailed at least 10 calendar
days before the date of action with the exception of the following:

- Receipt of factual information confirming the death of the member;

- Receipt of a clear, written statement signed by the member that they no longer wish services
  or give information that requires termination or reduction of services and indicates that they
  understand that this must be the result of supplying the information;
- The member has been admitted to an institution where they are ineligible for covered services;
- The member's whereabouts are unknown with receipt of a notice from the post office indicating no forwarding address or they are being provided services from another state;
  territory or commonwealth;
- There is a change in the level of medical care that is prescribed by the member's provide; Notice involves an adverse determination made with regard to preadmission screening requirements.

Notice must be mailed 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.

Service authorizations are considered untimely if they are not made within the standard timeframe or expedited timeframe, whichever is applicable (42 CFR 438.210(c)). Untimely service authorizations constitute a denial and are thus adverse actions.

Service Request Notification
YCCO and/or delegate must notify the requesting provider of any adverse actions and notify the member in writing of any decision to deny the request, or to authorize a request in an amount, duration, or scope that is less than requested. NOABD must be mailed within the decision-making time frames as noted above.

Prescription Drug Prior Authorization Request
Prior authorization request for prescription drugs including a practitioner administered drug (PAD) will be addressed in the following timeframes:
Response completed within 24 hours per CFR 438.210 (d)(3) and Social Security Act Section 1927. A response may include:

- A decision to approve or deny the drug;
- A written, telephonic or electronic request for additional documentation when the prior authorization request lacks sufficient information or documentation to render a decision; or
- A 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 a decision to approve or deny the drug within 72 hours.

COMPLAINCE & OVERSIGHT:
YCCO shall ensure monitoring by routinely requesting and/or verifying the following from the delegates:

1. Maintenance of a policy and/or procedure on authorization of services.
2. Documentation to conduct a desk review of sample inter-rater test scores to ensure authorization decision are consistent with clinical practice guidelines.
3. Documentation of how providers are notified of adverse decisions.
4. Reporting on number of request, decisions and notification timeframes.
5. File review of authorization request to ensure documentation, decision making, time frames and notification.

6. Verification that staff and/or contracted providers are notified that compensation is not structured to provide incentives to deny, limit, or discontinue medically necessary services to enrollees and financial incentives are not being utilized to reward underutilization.

REFERENCES:
OAR 410-141-3820, 410-141-3825, 410-141-3830, 410-141-3835
42 CFR 438.210, 438.404 42 CFR 440.230, 42 CFR 456.
OHA CCO Health Plan Services Contract

RELATED POLICIES AND DOCUMENTS:
GA-001 Grievance System Policy and Procedure
GA-003 Denial, Appeal and Contested Case Hearing Policy and Procedure
ENR-001 Enrollee Rights and Protections Policy and Procedure
DO-001 Delegation Oversight Policy and Procedure

Log of Revision

Date	Revision	By Whom
2/15/2017	Approved	SMcCarthy, Interim CEO
10/27/2017	Revisions made including additional information, new format and policy name change.	JRoe, QA Specialist
11/01/2017	Approved	BRajani, MD Medical Director SMcCarthy, PhD President/CEO
9/21/2018	Updated authorization timelines and language to reflect current contract and OAR language.	THeidt, DO Specialist
10/01/2018	Approved	BRajani, MD Medical Director SMcCarthy, PhD President/CEO
07/25/2018	Updated policy with current logo change, definition additions and previously authorized information	JRoe, QA Specialist
10/15/2019	Prescription Drug prior authorization timeframe clarification and update to definitions	JRoe, QA Specialist
08/01/2020	Formatting to enhance policy clarity, OAR updates, health requirement clarifications.	JRoe, QA Specialist

Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: SVC-004	**TITLE:** Network Capacity, Service Adequacy and Availability
DEPARTMENT: Service	**APPROVED BY:** President/CEO
EFFECTIVE DATE: 11/14/2017	**LAST REVISION DATE:** 08/01/2020
REVIEW DATES:	
APPLIES TO: Yamhill Community Care, Contracted Partners, Providers and Subcontractors	

DEFINITIONS:

Word or Acronym	Definition
Delegation	Delegation of activities occurs when an organization gives another organization the authority to carry out specific activities that it would otherwise perform. The organization who is delegating the specific activities remains accountable for the outcome of the delegated work and has the right to decide which functions will be delegated and how to process them within the parameters agreed upon by the organization and delegated entity.
Fully Dual Eligible	For the purpose of Medicare Part D coverage, Medicare clients who are also eligible for Medicaid.
Long Term Services and Supports (LTSS)	Medicaid services and supports provided under a CMS approved waiver to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Home and Community-Based Services and Settings and Person-Centered Service Planning (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services.
Non-Participating Provider	A licensed practitioner or provider that is not participating in any of the YCCO delegates provider networks.
Participating Provider	A licensed practitioner or provider that is participating in an YCCO delegates provider network.
Practitioner/Provider	A person who is licensed pursuant to Oregon state law to engage in the provision of health care services within the scope of their license or certification. An individual, facility, institution, corporate entity, or other organization which supplies or provides for the supply of services, goods or supplies to covered individuals pursuant to a contract, including but not limited to a provider enrollment agreement.
Patient Centered Primary Care Home (PCPCH)	A clinic that is recognized for their commitment to a patient centered care.

Provider Network (Delivery System)	Participating providers affiliated with the CCO who are authorized to provide services to its members.
Specialty Provider (Specialist)	Any Provider not acting as a primary care provider who has clinical training in a specified area. Medical specialist are doctors who have completed advanced education and clinical training in a specific area of medicine.

POLICY:

Yamhill Community Care Organization (YCCO) delegates all or part of this function or process. Through the oversight, YCCO will insure compliance with all applicable federal, state, contractual rules and regulations and requirements.

YCCO assures the established provider network can serve the expected enrollment in the service area and the network of providers is sufficient in number, mix and geographic distribution and to offer an appropriate range of preventative, primary care, specialty, and long-term service supports for physical, dental and behavioral health. The network will have adequate access and if a participating provider is not available within the network accommodations will be made for out of network coverage.

YCCO assures the network and services provided by the network are sufficient to deliver accessible, high quality, culturally and linguistically appropriate services to Members. Review of providers, network composition, capacity, utilization and other data is done at minimum annually or when a significant change to the network occurs. These reviews assure the appropriate range of preventive, primary care, and specialty services. If through this review, a disparity is identified, YCCO activity works to address the gap through contracting and other strategies.

PROCEDURE:

YCCO uses the following circumstances when evaluating network need:

- Geo-access considerations.
- Provider relationship with a practice group that provides care in a hospital setting where a member has no choice of provider selection (anesthesiology, ER physician, pathology, radiology, urgent care, emergency care).
- Lack of specific provider specialty, unique subspecialty or qualifications within reasonable geographic access.
- Practitioner is critical to on-call schedule with other network providers within a given medical group.
- Other compelling reasons proposed by Provider Relations or Partner Contracting departments.

Cultural Considerations

YCCO and delegates participate in the state's efforts to promote delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Including but not limited to the following:

1. Procedures for communicating with members who have difficulty communicating due to a medical condition or living in a household where there is no adult available to communicate in English or there is no telephone;
2. Certified or qualified interpreter services by phone or in person;
3. Coordinated care services which are culturally appropriate, i.e. demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the members care; and
4. Compliance with the requirements of the Americans with Disabilities Act of 1990.

Delivery System

YCCO and delegates maintain and monitor a provider network supported by written

agreements and has enough capacity and expertise to provide adequate, timely and medically appropriate access to covered Medicaid services (inclusive of non-emergent medical transportation, alternative therapies and access to traditional health care workers) to members of all ages including members who are fully dual eligible. Establishing and maintaining the network considering the following:

1. Anticipated enrollment of Medicaid and fully dual eligible members.
2. Appropriate range of preventative primary care and specialty services and long-term service and supports (LTSS) that is adequate for the anticipated for the population enrolled or expected to be enrolled in the service area.
3. Expected utilization of services, taking into consideration the oral, physical and behavioral health care needs of the members.
4. Number and types (in terms of training, experience and specialization) of providers required to provide services.
5. Number of network providers who are not accepting new Medicaid patients.
6. Geographical location of participating providers and members considering distance, travel time, means of transportation ordinarily used by members and whether the location provides access for members with disabilities.
7. Sufficient in numbers and in areas of practice and geographically distributed in a manner that the covered services provided are reasonably accessible to members.
8. Ability of network to communicate with members with limited English proficiency in their preferred language.
9. Ability of network providers to ensure of physical access, reasonable accommodations, culturally competent communications, and access equipment for members with physical or mental disabilities.
10. Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.
11. Enhancement of efforts to integrate care and care coordination including the use of PCPCH.
12. Considerations that are in the best interest of the enrollees that need long term services and supports (LTSS).

In collaboration, YCCO and delegated network partners define the need within a geographic area utilizing a provider to population model, to assess macro-level provider needs by specialty. This approach incorporates the following elements:

- Defining the geographic area served by the provider.
- A review of nationally published provider-to-population models.
- Identification of current practicing providers within the service area. Applying service area population to published specialty-specific rations, a determination of provider FTEs is made.

Delivery System Collection

Delegated partners are provided the current OHA Delivery Service Network template for reporting their network providers and facilities to YCCO on a quarterly basis. Once received YCCO's Senior Financial and Contract Analyst (SFCA) combines the data received and performs analysis based on the current network against membership utilization data to insure capacity is sufficient to meet the needs of the YCCO population. The SFCA works closely with the contracting departments of the YCCO partners to discuss provider needs as they arise from analysis, grievances or when providers contracts are terminated or they choose to leave the network.

YCCO discusses all network capacity needs with delegated partners during operations meetings, should a need arise that cannot wait for the next scheduled meeting the SFCA will work directly with the delegated partner contact to strategize on how to fit the need as soon as possible. Delivery System Analysis is shared and discussed with the YCCO Quality Clinical Advisory Panel as well as the Delegated Partner Operations meetings with recommendations taken as appropriate.

Adequacy and Availability

YCCO and delegates require participating providers to meet state standards for timely access to care and services considering the urgency of the member's need for services.

1. Ensures that network provider's hours of operation are not fewer than the hours of operation offered to non-OHP members.
2. Services included in the plan are available 24 hours a day, 7 days a week, when medically appropriate.
3. 90% of members in service area, routine travel time or distance to the location of the PCPCH or PCP does not exceed the community standard of accessing health care participating providers.
4. The travel time or distance to PCPCH's or PCPs; primary care, adult and pediatric; OB/GYN; behavioral health (mental health and substance use disorder), adult and pediatric; specialists, adult and pediatric; hospital and emergency services; pharmacy; dental, adult and pediatric; and additional provider types when required by the Authority will not exceed the following:
    A. In urban areas-30 miles, 30 minutes or the community standard, whichever is greater;
    B. In rural areas-60 miles, 60 minutes or the community standard, whichever is greater
5. Scheduling and rescheduling of member appointments are appropriate to the reason for, and urgency of the visit. Members shall be seen, treated, or referred within the following timeframes:
    A. Emergency care-Immediately or referred to an emergency department depending on the member's condition;
    B. Urgent care-Within 72 hours or as indicated in initial screening, in accordance with OAR 410-141-0140 (telephone or face-to-face evaluation, capacity to conduct elements of an assessment, course of action at conclusion of assessment, provision for services and/or referral and provision for notification to other providers);
    C. Well care-Within 4 weeks or within the community standard;
    D. Emergency dental care-Seen or treated within 24 hours;
    E. Urgent dental care-Within one or two weeks or as indicated in initial screening in accordance with OAR 410-123-0160;
    F. Routine dental care-Within an average of eight weeks and within 12 weeks or the community standard, whichever is less, unless there is a documented special clinical reason which would make access longer than 12 weeks appropriate;
    G. Non-Urgent behavioral health treatment-Seen for an intake assessment within 2 weeks from date of request.
    H. Pregnant women and IV drug users must be provided with an immediate assessment and intake.
    I. Members with opioid use disorders must be provided with an assessment and intake within 72 hours.
    J. Veterans and their families must be provided with an immediate assessment and intake.
    K. Member requiring medication assisted treatment must be provided with an assessment and induction no more than 72 hours with efforts to provide care as soon as possible documented and consideration given to providing ICC services as applicable under OAR 410-141-3170. Additionally YCCO must also:
        1. Assistance in navigating health care system and utilize community resources such as hospitals, peer support specialist, and the like as needed until assessment and induction can occur;
        2. Ensure providers provide interim services daily until assessment and induction can occur and barriers to medication removed. Daily services may include using community resources. And in no event will YCCO or provider require member to follow a detox protocol as a condition of providing these members with assessment and induction;
        3. Assessment will include a full physical as well as a bio-psycho-social spiritual assessment and prescribe and deliver any necessary medication taking into

consideration the results of such assessment and the potential risks and harm to the member in light of the presentation and circumstances; and
4. Provide no less than 2 follow up appointments to such members within 1 week after the assessment and induction.

Behavioral Health
YCCO does not require members to obtain approval from their primary care provider (PCP) to access a behavioral health assessment and/or evaluation services. Members may self-refer for these services from the YCCO network. Members may obtain behavioral health services in a primary care setting without authorization.
Program shall use an entry procedure that at a minimum will ensure the following:

- Members will be considered for entry without regard to race, ethnicity, gender, gender identity, gender expression, sexual orientation, religion, creed, national origin, age (except when program eligibility is restricted to children, adults, or older adults), familial status, marital status, source of income, and disability;
- Provider may not solely deny entry to members who are prescribed medication to treat opioid dependence;
- Members shall receive services in the timeliest manner feasible consistent with the presenting circumstances.

Network should be sufficient with specialty behavioral health providers in accordance with OAR 309-019-0135 and 410-141-3220.

1. If timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. The interim services should be as close as possible to appropriate level of care and may include referrals, methadone maintenance, compliance review, HIV/AIDS testing, outpatient services for substance use disorder, withdrawal management, and assessments or other services per OAR 309-019-0135.
2. Pregnant women, veterans and their family, women with children, unpaid caregivers, families, and children ages birth to 5 years, members with HIV/AIDS or tuberculosis, members at risk of first episode psychosis and the I/DD members must receive immediate assessment and intake. If interim services are necessary due to capacity restrictions treatment at appropriate level of care must take place within 120 days from placement on a waitlist.
3. Members with IV drug users must receive an immediate assessment and intake, admission within 14 days of request or interim services due to capacity restrictions admission must take place within 120 days from placement on waitlist.
4. Members Opioid use disorder assessment within 72 hours.
5. Medication assisted treatment: No more than 72 hours for assessment and induction, with efforts to do such as soon as possible.
6. Children with serious emotional disturbance any limits that the Authority may specify in the contract or in guidance.
7. Routine behavioral health care for all other members must be seen for an intake within 7 days from the date of request with second appointment within 14 days and 4 appointments (including the second appointment) within 48 days. Appointments must be therapeutic in nature and expand by administrative activities.

Furnishing of Services
YCCO and delegates will ensure that all medically appropriate covered services are furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services furnished to clients under fee-for service as set forth in 42 CFR 438.210.

YCCO and delegates ensure that covered services are sufficient in amount, duration and scope to reasonable be expected to achieve the purpose for which the services are furnished and include the following:

1. The prevention, diagnosis, and treatment of disease, condition or disorder that results in health impairments or disability;

2. The ability to achieve age-appropriate growth and development; and
3. Ability to attain, maintain or regain functional capacity.

Women's Health Services
YCCO and delegates will provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventative health care services. This access is in addition to the member's designated primary care provider when they are not a women's health specialist.

Family Planning Services
YCCO ensures that the network includes sufficient family planning providers for timely access to covered services. Members are not restricted from freedom of choice of providers for these services and are permitted to self-refer to any provider including those not in YCCO's network.

Services with Specialist
YCCO does not require a referral or prior authorization for an initial visit to a specialist allowing direct access. In the event that a specialist request or requires a referral the member can work with their primary care provider to obtain the specialist office requirement even when this occurs YCCO's claim system will not require an authorization to initial payment of the claim.

Out of Network Services
When YCCO and delegates are unable to provide necessary covered services (including physical, behavioral and dental) which are culturally, linguistically and medically appropriate to a member within the provider network, arrangements will be made for out of network coverage for the member to obtain the services adequately and timely with a non-participating provider. The standards for access to out of network services with a non-participating provider are the same for physical, behavioral, and dental and are no more stringent from one to the other. Coverage will continue until a participating provider is available to provide them. YCCO and/or delegates will ensure the following when out of network services are appropriate:

1. Coordination takes place with non-participating provider in regard to payment.
2. Ensures that cost to member is no greater than it would be is services were provided within the provider network.
3. Authorization will be noted in appropriate systems for payment to be made to the non-participating provider in a timely manner.

In-Network Contracted Provider Contract Termination
YCCO will make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

COMPLIANCE & OVERSIGHT:
YCCO will monitor and ensure delegates are compliant by:

1. Delegates with provide annual input for the YCCO Delivery System Network Exhibit G by completing all required provider and facility fields as well as providing input on the narrative report.
2. YCCO will routinely verify that delegates have and maintain policy and procedures related to network capacity, adequacy, and availability. Delegate will also have and maintain an out of network policy and/or procedure. Network concerns, complaint data and/or deficiencies will be discussed with the delegate at operations meeting as appropriate.
3. YCCO will routinely verify that delegates have policies and procedures as well as provide oversight of participating providers regarding cultural considerations.
4. YCCO will routinely verify that provider network offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to

Medicaid FFS and providers are made aware of all appointment availability standards and adhere to these standards. This information will be shared in appropriate committee meetings as well as with the appropriate delegate with corrective action plans set if necessary. Processes used for verification may include the following:

a. YCCO grievances and appeals received;
b. Review of delegate network provider contracts and provider handbooks; and
c. Request of delegate audits on network provider offices.

YCCO COMPLIANCE:

- YCCO will submit documentation to the state as specified no less frequently than the following:
    - At the time it enters into a contract with the state.
    - On an annual basis.
    - At any time there has been a significant change (as defined by the state) in the operations that would affect the adequacy or capacity and services, including:
        - Changes in YCCO services, benefits, geographic service area, composition of or payments to its provider network; or
        - Enrollment of a new population into YCCO.
- YCCO will analyze out of network encounters and/or request as well as data from the grievance system and use the information to maintain adequate and timely access to all services.
- Delivery Service Network Exhibit G Reporting in the OHA format will be submitted annually.
- YCCO will analyze all grievance, appeals and hearing data for issues regarding availability of services which will be shared with delegates and appropriate committees to set corrective action plans as necessary as well as possible quality improvement projects.
- YCCO insures that members are able to seek initial visits with a specialist without referral or prior authorization The YCCO claims payment system is set to pay claims without authorization for these services.
    - Ad hoc claim denial reports can be reviewed
        - When issues arise YCCO will notify the appropriate delegate with a request a corrective action plan which will be reviewed in operations meetings until fully resolved.
- Deficiencies identified via self-assessment, Exhibit G reporting or EQRO review will be acted on immediately for prompt resolution.
- YCCO Provider Handbook will contain all appointment availability standards with notification that monitoring may take place to ensure adherence to the standards.
- All contracted providers will be provided a YCCO Provider Handbook at time of contracting and current handbook will be posted to YCCO Website.

REFERENCES:

OAR 309-019-0135; 410-141-3840; OAR 410-141-3875-3915; OAR 410-123-0160;
42 CFR 438.68, 438.206, 438.207, 438.10
OHA CCO Health Plan Services Contract Exhibit B, Exhibit G
Americans with Disabilities Act of 1990

RELATED POLICIES & DOCUMENTS:

DO-001 Delegation Oversight Policy and Procedure
ENR-002 Member Non-Discrimination and ADA Policy and Procedure
YCCO Member Handbook
YCCO Provider Handbook

LOG OF REVISION

DATE	REVISION	BY WHOM
07/29/2019	Policy merge with Accessibility and Capacity	JRoe, QA Specialist
10/15/2019	Appointment availability adherence mechanisms clarified. DSN integration, analysis and review clarification.	JRoe, QA Specialist
08/01/2020	Formatting updates for policy clarity, OAR updates,	JRoe, QA Specialist