Authorization Page

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PERMANENT ADMINISTRATIVE RULES

Oregon Health Authority, Division of Medical Assistance Programs	410
Agency and Division	Administrative Rules Chapter Number
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RULE CAPTION

Update and Align OHP Member Education/Information Rules Affecting Members and Potential Members

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND: 410-141-0280,410-141-0300,410-141-3280,410-141-3300

REPEAL:

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 and 414.651

Other Auth.:

Stats. Implemented: ORS 414.725, 414.610 - 414.685

RULE SUMMARY

These rules provide the regulated framework for OHP informational materials and education for OHP members and potential members. The related rules pertaining to 'marketing' have been recently revised, having direct impact on the Member

Education/Information Requirement rules. In the marketing rules, a clear distinction between rules pertaining to members versus potential members was made. This distinction needs to be carried through the Member Education/Information Requirement rules for clarity and symmetry. Additionally, we will update the current alignment with CFRs 438.10, 438.100 and 438.104 as they relate to each of these rules. There is a set for managed care organizations and one for coordinated care organizations for each of these rules.

D Simmitt	DAVID SIMMITT	3/31/2015
Authorized Signer	Printed Name	Date

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410-141-0280 **RULE REWRITTEN**

Managed Care Prepaid Health Plan Potential Member Informational Requirements

(1) For the purpose of this rule, the following definitions apply:

(a) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide;

(b) "Potential Member" means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific MCO or CCO;

(c) "Prevalent Non-English Language" means all non-English languages that are identified as the preferred written language by the lesser of either:

(A) 5 percent of the MCO's total OHP enrollment; or

(B) 1,000 of the MCO's members;

(d) "Health Literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.

(2) Information for potential members shall comply with marketing prohibitions in 42 CFR 438.104 and OAR 410-141-0270, Prepaid Health Plan Marketing Requirements for Potential Members.

(3) The creation of name recognition because of the MCO's health promotion or education activities shall not constitute an attempt by the MCO to influence a client's enrollment.

(4) An MCO or its subcontractor's communications that express participation in or support for an MCO by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client's enrollment. Support for an MCO by subcontractors shall not indicate or express exclusivity to an MCO if the subcontractor is also participating with other MCO's.

(5) The following shall not constitute marketing or an attempt by the MCO to influence client enrollment:

(a) Communications to notify dual-eligible members of opportunities to align MCO provided benefits with Medicare Advantage or Special Needs Plans;

(b) Improving coordination of care;

(c) Communicating with provider service dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(6) MCOs shall update plan access information with OHA on a monthly basis for use in updating the availability charts. OHA shall confirm before posting.

(7) MCOs shall develop informational materials for potential members.

(8) MCOs shall provide the Authority with informational materials sufficient for the potential member to make an informed decision about provider selection. The MCO shall make available to potential members, upon request, information on participating providers.

(9) MCO provider directories shall include notations of the following: names, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and identification of providers that are not accepting new patients. An MCO or the Division may include informational materials in the application packet for potential members.

(10) MCOs shall develop informational materials for potential members in their service area that meet the language requirements as identified in (1) (a) and (c) of this rule. Materials shall be culturally and linguistically appropriate and be sensitive to people with disabilities or reading limitations, including those whose primary language is not English.

(11) MCO's shall honor requests made by other sources such as potential members, potential family members, or caregivers for language accommodation, translating to the potential member's language needs as requested. Alternate formats shall be provided and may include, but are not limited to, braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide:

(a) MCOs shall address health literacy issues by preparing these documents at a 6th grade reading level, incorporating graphics and utilizing alternate format materials for potential members and using a12-point font or larger (18 point);

(b) MCOs shall ensure that all MCO staff who have contact with potential members are fully informed of MCO and Authority rules applicable to enrollment, disenrollment, complaint and grievance policies and procedures, the availability of free certified interpreter services, and which participating providers' offices have bilingual capacity and which are accepting new members.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.725

410-141-0300 **RULE REWRITTEN**

Managed Care Organization (MCO) Member Education and Information Requirements

(1) For the purpose of this rule, the following definitions apply:

(a) "Alternate Format" means any alternate approach to presenting print information to a person with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: Braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide;

(b) "Alternate Format Statement Insert" means an insert developed by the Oregon Health Authority that includes instructions on how to receive an alternate format or oral interpretation of materials translated into the state's top sixteen preferred written languages identified by OHP enrollees. MCOs shall insert their contact information into the template;

(c) "Health Literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness;

(d) "Prevalent Non-English Language" means all non-English languages that are identified as the preferred written language by the lesser of either:

(A) 5 percent of the MCO's total OHP enrollment; or

(B) 1, 000 of the MCO's members;

(2) MCOs may engage in activities for existing members related to outreach, health promotion, and health education. The Division shall approve, prior to distribution, any written communication by the MCO or its subcontractors and providers that:

(a) Is intended solely for members; and

(b) Pertains to requirements for obtaining managed care services at service area sites or benefits.

(3) MCOs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes. The intent of these communications shall be informational only and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health–related events. MCOs shall address health literacy issues by preparing these documents at a 6th grade reading level, incorporating graphics and utilizing alternate formats.

(4) The creation of name recognition because of the MCO's health promotion or education activities shall not constitute an attempt by the MCO to influence a client's enrollment.

(5) An MCO or its subcontractor's communications that express participation in or support for an MCO by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client's enrollment. Support for an MCO by subcontractors shall not indicate or express exclusivity to an MCO if the subcontractor is also participating with other MCO's.

(6) The following shall not constitute marketing or an attempt by the MCO to influence client enrollment:

(a) Communications to notify dual-eligible members of opportunities to align MCO provided benefits with Medicare Advantage or Special Needs Plans;

(b) Improving coordination of care;

(c) Communicating with provider service dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(7) MCOs shall have a mechanism to help members understand the requirements and benefits of the MCO plan. The mechanisms developed shall be culturally and linguistically appropriate.

(8) MCOs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. Member education shall:

(a) Include information about the Exceptional Needs Care Coordination (ENCC) or case management services to members who are aged, blind, disabled, or have complex medical needs consistent with OAR 410-141-0405 and how to access that system, including where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

(b) Clearly explain how members may receive assistance from advocates, including certified health care interpreters, community health workers, peer wellness specialists, and personal health navigators and include information to members that certified health care interpreter services at provider offices are free to MCO members as stated in 42 CFR 438.10 (4).

(9) Within 14 calendar days or a reasonable timeframe of an MCO receiving notice of a member's enrollment, MCOs shall mail a welcome packet to new members and to members returning to the MCO twelve months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory.

(10) Provider directories shall include notation of the following: names, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and identification of providers that are not accepting new patients.

(11) For those who are existing members, an MCO shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. MCOs shall send hard copies upon request.

(12) MCOs shall facilitate materials as follows:

(a) Translate the following written materials into the prevalent non-English languages served by the MCO:

(A) Welcome packets that include welcome letters and member handbooks; and

(B) Notices of medical benefit changes;

(b) Include alternate format statement inserts with:

(A) Communications regarding member enrollment; and

(B) Notice of Action to deny, reduce, or stop a benefit;

(c) Accommodate requests of the member to translate written materials into prevalent non-English languages served by the MCO;

(d) Make oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages, not just prevalent non-English languages;

(e) Notify enrollees:

(A) That oral interpretation is available free of charge for any language, and written information is available in prevalent non-English languages and alternate formats; and

(B) How to access those services;

(f) Make available materials in alternate formats by request. Alternate formats include but are not limited to audio recording, close-captioned videos, large (18 point) type, and braille.

(13) An MCO shall electronically provide to the Division for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory. At a minimum, the member handbook shall contain the following:

(a) Revision date;

(b) Tag lines in English and other prevalent non-English languages, as defined in (1) (d) of this rule, spoken by populations of members. The tag lines shall be located at the beginning of the document for the ease of the member and describe how members may access free sign and oral

interpreters, as well as translations and materials in other formats. Alternate formats may include but are not limited to audio recordings, close-captioned videos, large (18 point) type, and braille;

(c) MCO's office location, mailing address, web address if applicable, office hours, and telephone numbers including TTY;

(d) Availability and access to coordinated care services through a patient-centered primary care home or other primary care team with the member as a partner in care management. Explain how to choose a PCP, how to make an appointment, and the MCO's policy on changing PCPs;

(e) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;

(f) What participating or non-participating provider services the member may self-refer;

(g) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral;

(h) Explanation of Exceptional Needs Care Coordination (ENCC) services and how members with special health care needs who are aged, blind, or disabled, or who have complex medical needs, high health needs, multiple chronic conditions, mental illness, or chemical dependency can access ENCC services;

(i) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, and the process for coordinating Medicaid and Medicare benefits;

(j) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;

(k) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies;

(L) Information on contracted hospitals in the member's service area;

(m) Information on post-stabilization care after a member is stabilized in order to maintain, improve, or resolve the member's condition;

(n) Information on the MCO's grievance and appeals processes and the Division's contested case hearing procedures, including:

(A) Information about assistance in filling out forms and completing the grievance process available from the MCO to the member as outlined in OAR 410-141-3260;

(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141-3263;

(o) Information on the member's rights and responsibilities, including the availability of the OHP Ombudsman;

(p) Information on copayments, charges for non-covered services, and the member's possible responsibility for charges if they go outside of the MCO for non-emergent care; including information specific to copayments, deductibles, and coinsurance for dually-enrolled qualified Medicare beneficiaries;

(q) Information about when providers may bill clients for services and what to do if they receive a bill; including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries;

(r) The transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a PCP or PCD, other prescribing provider, or obtain new orders during that period; including specific communications for members who are becoming new Medicare enrollees;

(s) Information on advance directive policies including:

(A) Member rights under federal and Oregon law 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;

(B) The MCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience;

(t) Whether or not the MCO uses provider incentives to reduce cost by limiting services;

(u) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee and that they may request the record be amended or corrected;

(v) How and when members are to obtain ambulance services;

(w) Resources for help with transportation to appointments with providers;

(x) Explanation of the covered and non-covered coordinated care services in sufficient detail to ensure that members understand the benefits to which they are entitled;

(y) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;

(z) The MCO's confidentiality policy;

(aa) How and where members are to access any benefits that are available under OHP but are not covered under the MCO's contract, including any cost sharing;

(bb) When and how members can voluntarily and involuntarily disenroll from MCOs and change MCOs;

(cc) MCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the MCO's internal changes. If changes affect the member's ability to use services or benefits, the MCO shall offer the updated member handbook to all members;

(dd) The "Oregon Health Plan Client Handbook" is in addition to the MCO's member handbook, and an MCO shall not use it to substitute for any component of the MCO's member handbook.

(14) Member health education shall include:

(a) Information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. MCO providers or other individuals or programs approved by the MCO may provide health education. MCOs shall endeavor to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non-dominant cultures;

(b) MCOs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Division may assist in developing materials that address specifically identified health education problems to the population in need;

(c) Explanation of ENCC services and how to access ENCC services through outreach to members with special health care needs who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, or chemical dependency;

(d) The appropriate use of the delivery system, including proactive and effective education of members on how to access emergency services and urgent care services appropriately;

(e) MCOs shall provide written notice to affected members of any significant changes in program or service sites that affect the member's ability to access care or services from MCO's participating providers. The MCO shall provide, translated as appropriate, the notice at least 30 calendar days before the effective date of that change, or as soon as possible if the participating provider has not given the MCO sufficient notification to meet the 30-day notice requirement. The Division shall review and approve the materials within two working days.

(15) Informational materials that MCOs develop for members shall meet the language requirements identified in this rule and be culturally and linguistically sensitive to members with disabilities or reading limitations, including members whose primary language is not English:

(a) MCOs shall provide free certified health care interpreters for all of their members with hearing impairments and limited English proficiency who request them. This also applies to

family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care;

(b) MCOs shall translate materials into all languages as identified in (1) (d) of this rule. Written and spoken language preferences are indicated on the OHP application form and reported to plans in 834 enrollment updates. MCOs shall honor requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested;

(c) MCOs shall provide written translations of informational materials including their welcome packet, consisting of at least a welcome letter and a member handbook in all languages as specified in (1) (d) of this rule and as identified by members either through the OHP application or other means as their preferred written language;

(d) Form correspondence sent to members including but not limited to enrollment information, choice and member counseling letters, and notices of action to deny, reduce, or stop a benefit shall be sent in the member's preferred written language. If sent in English to members who prefer a different language, the letters shall include tag lines in English and in other prevalent non-English languages as specified in (1) (d) of this rule. The tag lines placed at the beginning of the document shall have instructions on how to receive an oral or written translation of the material.

(16) MCOs shall provide an identification card to members, unless waived by the Division, that contains simple, readable, and usable information on how to access care in an urgent or emergency situation. The cards are solely for the convenience of the MCO, members, and providers.

Stat. Auth.: ORS 413.04

Stats. Implemented: ORS 414.725

410-141-3280 **RULE REWRITTEN**

Coordinated Care Organization (CCO) Potential Member Information Requirements

(1) For the purpose of this rule, the following definitions apply:

(a) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide;

(b) "Potential Member" means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific CCO;

(c) "Prevalent Non-English Language" means all non-English languages that are identified as the preferred written language by the lesser of either:

(A) 5 percent of the CCO's total OHP enrollment; or

(B) 1,000 of the CCO's members;

(d) "Health Literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.

(2) Information for potential members shall comply with marketing prohibitions in 42 CFR 438.104 and OAR 410-141-3270, Oregon Health Plan Marketing Requirements.

(3) The creation of name recognition because of the CCO's health promotion or education activities shall not constitute an attempt by the CCO to influence a client's enrollment.

(4) A CCO or its subcontractor's communications that express participation in or support for a CCO by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client's enrollment. Support for a CCO by subcontractors shall not indicate or express exclusivity to a CCO if the subcontractor is also participating with other CCO's.

(5) The following shall not constitute marketing or an attempt by the MCO to influence client enrollment:

(a) Communications to notify dual-eligible members of opportunities to align CCO provided benefits with Medicare Advantage or Special Needs Plans;

(b) Improving coordination of care;

(c) Communicating with providers' service dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(6) CCOs shall update plan access information with OHA on a monthly basis for use in updating the availability charts. OHA shall confirm before posting.

(7) CCOs shall develop informational materials for potential members.

(8) CCOs shall provide the Authority with informational materials sufficient for the potential member to make an informed decision about provider selection. The CCO shall make available to potential members, upon request, information on participating providers.

(9) CCO provider directories shall include notations of the following: names, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and identification of providers that are not accepting new patients. A CCO or the Division may include informational materials in the application packet for potential members.

(10) CCOs shall develop informational materials for potential members in their service area that meet the language requirements as identified in (1) (a) and (c) of this rule. Materials shall be culturally and linguistically appropriate and be sensitive to people with disabilities or reading limitations, including those whose primary language is not English.

(11) CCO's shall honor requests made by other sources such as potential members, potential family members, or caregivers for language accommodation, translating to the potential member's language needs as requested. Alternate formats shall be provided and may include but are not limited to braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide:

(a) CCOs shall address health literacy issues by preparing these documents at a 6th grade reading level, incorporating graphics and utilizing alternate format materials for potential members and using a12-point font or larger (18 point);

(b) CCOs shall ensure that all CCO staff who have contact with potential members are fully informed of CCO and Authority rules applicable to enrollment, disenrollment, complaint and grievance policies and procedures, and the availability of free certified health care interpreters, and which participating providers' offices have bilingual capacity and which are accepting new members.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635, 414.651

Stats. Implemented: ORS 414.610 – 414.685

410-141-3300

Coordinated Care Organization (CCO) Member Education and Information Requirements

(1) For the purpose of this rule, the following definitions apply:

(a) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide;

(b) "Alternate Format Statement Insert" means an insert developed by the Oregon Health Authority that includes instructions on how to receive an alternate format or oral interpretation of

materials translated into the state's top sixteen preferred written languages as identified by OHP enrollees. CCOs shall insert their contact information into the template.

(c) "Health Literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.

(d) "Prevalent Non-English Language" means: All non-English languages that are identified as the preferred written language by the lesser of either:

(A) 5 percent of the CCO's total OHP enrollment; or

(B) 1, 000 of the CCO's members.

(2) CCOs may engage in activities for existing members related to outreach, health promotion, and health education. The Division shall approve, prior to distribution, any written communication by the CCO or its subcontractors and providers that:

(a) Is intended solely for members; and

(b) Pertains to requirements for obtaining coordinated care services at service area sites or benefits.

(3) CCOs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes. The intent of these communications should be informational only and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health-related events. CCOs shall address health literacy issues by preparing these documents at a low-literacy reading level, incorporating graphics and utilizing alternate formats.

(4) The creation of name recognition because of the CCO's health promotion or education activities shall not constitute an attempt by the CCO to influence a client's enrollment.

(5) A CCO or its subcontractor's communications that express participation in or support for a CCO by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client's enrollment. Support for a CCO by subcontractors shall not indicate or express exclusivity to a CCO if the subcontractor is also participating with other CCO's.

(6) The following shall not constitute marketing or an attempt by the CCO to influence client enrollment:

(a) Communication to notify dual-eligible members of opportunities to align CCO provided benefits with a Medicare Advantage or Special Needs Plan;

(b) Improving coordination of care;

(c) Communicating with providers' service dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(7) CCOs shall have a mechanism to help members understand the requirements and benefits of the CCO's integrated and coordinated care plan. The mechanisms developed shall be culturally and linguistically appropriate.

(8) CCOs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. As a CCO transitions to fully coordinating a member's care, the CCO is responsible only for including information about the care they are coordinating. CCOs shall update their educational material as they add coordinated services. Member education shall:

(a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

(b) Clearly explain how members may receive assistance from advocates, including certified health care interpreters, community health workers, peer wellness specialists, and personal health navigators and include information to members that interpreter services at provider offices are free to CCO members as stated in 42 CFR 438.10 (4).

(9) Within 14 calendar days or a reasonable timeframe of a CCO's receiving notice of a member's enrollment, CCOs shall mail a welcome packet to new members and to members returning to the CCO twelve months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory.

(10) Provider directories shall include notations of the following: names, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and identification of providers that are not accepting new patients.

(11) For those who are existing members, a CCO shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. CCOs shall send hard copies upon request.

(12) CCOs shall facilitate materials as follows:

(a) Translate the following written materials into the prevalent non-English languages served by the CCO:

(A) Welcome Packets that include welcome letters and member handbooks; and

(B) Notices of medical benefit changes;

(b) Alternate format statement inserts with:

(A) Communications regarding member enrollment; and

(B) Notice of Action to deny, reduce, or stop a benefit;

(c) Accommodate requests of the member to translate written materials into prevalent non-English languages served by the CCO;

(d) Make oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages, not just prevalent non-English languages;

(e) Notify enrollees:

(A) That oral interpretation is available free of charge for any language, and written information is available in prevalent non-English languages and alternate formats; and

(B) How to access those services;

(f) Make available materials in alternate formats by request. Alternate formats include but are not limited to audio recording, close-captioned videos, large type, and braille.

(13) A CCO shall electronically provide to the Division for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory. At a minimum, the member handbook shall contain the following:

(a) Revision date;

(b) Tag lines in English and other prevalent non-English languages, as defined in (1) (d) of this rule, spoken by populations of members. The tag lines shall be located at the beginning of the document for the ease of the member and describe how members may access free sign and oral interpreters, as well as translations and materials in other formats. Alternate formats may include but are not limited to audio recordings, close-captioned videos, large (18 point) type, and braille.

(c) CCO's office location, mailing address, web address if applicable, office hours, and telephone numbers including TTY;

(d) Availability and access to coordinated care services through a patient-centered primary care home or other primary care team with the member as a partner in care management. Explain how to choose a PCP, how to make an appointment, and how to change PCPs and the CCO's policy on changing PCPs;

(e) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;

(f) What participating or non-participating provider services the member may self-refer;

(g) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral;

(h) Explanation of intensive care coordination services and how members with the following special health care needs can access intensive care coordination services: Those who are aged, blind, or disabled or who have complex medical needs, high health needs, multiple chronic conditions, mental illness, or chemical dependency.

(i) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, and the process for coordinating Medicaid and Medicare benefits;

(j) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;

(k) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies;

(L) Information on contracted hospitals in the member's service area;

(m) Information on post-stabilization care after a member is stabilized in order to maintain, improve, or resolve the member's condition;

(n) Information on the CCO's grievance and appeals processes and the Division's contested case hearing procedures, including:

(A) Information about assistance in filling out forms and completing the grievance process available from the CCO to the member as outlined in OAR 410-141-3260;

(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141-3263;

(o) Information on the member's rights and responsibilities, including the availability of the OHP Ombudsman;

(p) Information on copayments, charges for non-covered services, and the member's possible responsibility for charges if they go outside of the CCO for non-emergent care; including information specific to copayments, deductibles, and coinsurance for dually-enrolled qualified Medicare beneficiaries;

(q) Information about when providers may bill clients for services and what to do if they receive a bill, including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries;

(r) The transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a PCP or PCD, other prescribing provider, or obtain new orders during that period; including specific communications for members who are becoming new Medicare enrollees;

(s) Information on advance directive policies including:

(A) Member rights under federal and Oregon law 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;

(B) The CCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience;

(t) Whether or not the CCO uses provider incentives to reduce cost by limiting services;

(u) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee and that they may request the record be amended or corrected;

(v) How and when members are to obtain ambulance services;

(w) Resources for help with transportation to appointments with providers;

(x) Explanation of the covered and non-covered coordinated care services in sufficient detail to ensure that members understand the benefits to which they are entitled;

(y) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;

(z) The CCO's confidentiality policy;

(aa) How and where members are to access any benefits that are available under OHP but are not covered under the CCO's contract, including any cost sharing;

(bb) When and how members can voluntarily and involuntarily disenroll from CCOs and change CCOs;

(cc) CCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the CCO's internal changes. If changes affect the member's ability to use services or benefits, the CCO shall offer the updated member handbook to all members;

(dd) The "Oregon Health Plan Client Handbook" is in addition to the CCO's member handbook, and a CCO may not use it to substitute for any component of the CCO's member handbook.

(14) Member health education shall include:

(a) Information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. CCO providers or other individuals or programs approved by the CCO may provide health education. CCOs shall endeavor to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non-dominant cultures;

(b) CCOs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Division may assist in developing materials that address specifically identified health education problems to the population in need;

(c) Explanation of intensive care coordination services and how to access intensive care coordination through outreach to members with special health care needs who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, or chemical dependency;

(d) The appropriate use of the delivery system, including proactive and effective education of members on how to access emergency services and urgent care services appropriately;

(e) CCOs shall provide written notice to affected members of any significant changes in program or service sites that affect the member's ability to access care or services from CCO's participating providers. The CCO shall provide, translated as appropriate, the notice at least 30 calendar days before the effective date of that change, or as soon as possible if the participating provider has not given the CCO sufficient notification to meet the 30-day notice requirement. The Division shall review and approve the materials within two working days.

(15) Informational materials that CCOs develop for members shall meet the language requirements identified in this rule and be culturally and linguistically sensitive to members with disabilities or reading limitations, including members whose primary language is not English:

(a) CCOs shall provide free interpreters for all of their members with hearing impairments and limited English proficiency who request them. This also applies to family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care:

(A) CCOs shall translate materials into all languages as identified in (1) (d) of this rule. Written and spoken language preferences are indicated on the OHP application form and reported to plans in 834 enrollment updates. CCOs shall honor requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested;

(B) CCOs shall provide written translations of informational materials including their welcome packet, consisting of at least a welcome letter and a member handbook in all languages as

specified in (1) (d) of this rule and as identified by members either through the OHP application or other means as their preferred written language;

(b) Form correspondence sent to members including but not limited to enrollment information, choice and member counseling letters, and notices of action to deny, reduce, or stop a benefit shall be sent in the member's preferred written language. If sent in English to members who prefer a different language, the letters shall include tag lines in English and in other prevalent non-English languages as specified in (1) (d) of this rule. The tag lines, placed at the beginning of the document, shall have instructions on how to receive an oral or written translation of the material.

(16) CCOs shall provide an identification card to members, unless waived by the Division, that contains simple, readable, and usable information on how to access care in an urgent or emergency situation. The cards are solely for the convenience of the CCO, members, and providers.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635, 414.651

Stats. Implemented: ORS 414.610 – 414.685