

Differences between 2017 and 2018 CCO member handbook texts

8/1/2017 – Cover page

The latest CFR revisions require updates to OARs and CCO member handbooks. CCO handbooks must be revised by 1/1/2018, either by replacing current handbooks or by inserting addenda. They must include Grievance System updates (Review Tool item 34), and 28 Medicaid-related terms and definitions (Review Tool item 38). The other changes below may be made at the next handbook revision.

Page 1, Review Tool items 4 & 5 – Tag Line for Translation in 18 point font

1. The font size is increased to 18 point per 42 CFR 438.10(d)(2): “Make oral interpretation available in all languages and written translation available in each prevalent non-English language. All written materials for potential enrollees must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services as required by §438.71(a). **Large print means printed in a font size no smaller than 18 point.**”
2. We have adopted the Office of Equity and Inclusion’s approved language access taglines.

Page 2, Review Tool item 9 – What is the Oregon Health Plan (OHP)?

Optional section added that addresses the OHP supplemental and CAWEM benefit packages. This is at the suggestion of advocates who want CCO members to know what packages may be available to them if they are no longer eligible for OHP.

Page 8, Review Tool item 28 – Health-related Services (formerly called flexible services)

Added to explain this special CCO benefit.

Page 9, Review Tool item 34 – Grievance System Information and Appeal Rights

1. Deadlines updated per CMS 2390 changes.
2. Appeals must precede hearings and can no longer coincide.

Page 13, Review Tool item 38 – Required Definitions

Added per new CFR requirements. Preferred heading is *Words to Know*.

2018 MEMBER HANDBOOK TEXT FOR CCOS

4 & 5 - Tag Line for Translation in 18 point font

CCO Language Access Services

Everyone has a right to know about <NAME OF CCO>'s programs and services. All members have a right to use our programs and services. We give free help when you need it. Some examples of the free help we can give are:

- Sign language interpreters
- Spoken language interpreters for other languages
- Written materials in other languages
- Braille
- Large print
- Audio and other formats

If you need help please contact:

Language Access Services Program Coordinator

Call: <phone>, TTY: <TTY number>

Email: _____

Web: _____

Unfair Treatment

Do you think <NAME OF CCO> or a provider treated you unfairly?

We must follow state and federal civil rights laws. We cannot treat people unfairly in any program or activity 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. We will make reasonable changes to policies, practices and procedures by talking with you about your needs.

To report concerns or get more information, please contact our diversity, inclusion and civil rights executive manager: **<CCO CONTACT INFORMATION>**.

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: <http://www.hhs.gov/>

Email: OCRComplaint@hhs.gov

Phone: 800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Department of Health and Human Services Office for Civil Rights

200 Independence Avenue SW, Room 509F HHH Bldg, Washington, D.C. 20201

8 - What is a Coordinated Care Organization (CCO)?

<NAME OF CCO> is a Coordinated Care Organization (CCO). We are a group of all types of health care providers who work together for people on OHP in our community. Some groups in our CCO are:

<LIST AGENCIES AND ORGANIZATIONS PARTICIPATING IN YOUR CCO AND SERVICES THEY PROVIDE IN LAYPERSON LANGUAGE AT 6TH GRADE READING LEVEL>

9 - What is the Oregon Health Plan (OHP)?

The Oregon Health Plan (OHP) is a program that pays for low-income Oregonians' health care. The State of Oregon and the US Government's Medicaid program pay for it. OHP covers doctor visits, prescriptions, hospital stays, dental care, mental health services, help with addiction to cigarettes, alcohol and drugs, and free rides to covered health care services. OHP can provide hearing aids, medical equipment and home health care if you qualify.

[This paragraph is optional and intended to inform members of health care programs they may qualify for in the future:]

OHP Supplemental is for children through age 20, and pregnant women. It covers OHP services plus glasses and additional dental care. CAWEM (Citizen Alien Waived Emergency Medical) covers emergency services for non-US citizens who are not on OHP. CAWEM Plus also covers childbirth.

OHP does not cover everything. A list of the diseases and conditions that are covered, called the Prioritized List of Health Services, is online at www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx. Other diseases and conditions usually are not covered by OHP. Those conditions could be covered if treating them will help a patient's covered condition.

CCOs (Coordinated Care Organizations) are a type of managed care. The Oregon Health Authority (OHA) wants people on OHP to have their health care managed by private companies set up to do just that. OHA pays managed care companies a set amount each month to provide their members the health care services they need.

Health services for OHP members not in managed care are paid directly by OHA. This is called fee-for-service (FFS) because OHA pays providers a fee for services they provide. It is also called an open card. Native Americans, Alaska natives, people on both Medicare and OHP can be in a CCO, but can ask to change to FFS anytime. Any CCO member who has a medical reason to have FFS can ask to leave managed care. OHP Member Services at 800-273-0557 can help you understand and choose the best way to receive your health care.

10 – How We Coordinate Your Care

<NAME OF CCO> coordinates the care you receive by **<DESCRIBE CARE COORDINATION ACTIVITIES IN LAY LANGUAGE AT 6TH GRADE READING LEVEL>**.

We want you to get the best care possible. Sometimes we provide health-related services (formerly called flexible services) that OHP doesn't cover. These are non-medical services that CCOs may pay for in special situations. Health-related services can be for one person, or for a community, to benefit the broader population. Call Customer Service for more information.

Another way we coordinate your care is ask our providers to be recognized by the Oregon Health Authority (OHA) as a Patient-centered Primary Care Home (PCPCH). That means they can receive extra funds to follow their patients closely, and make sure all their medical, dental and mental health needs are met. You can ask at your clinic or provider's office if it is a PCPCH.

11 - Care Helpers

There may be times when you need help getting the right care. Your primary care team may have people specially trained to do this. These people are called Care Coordinators, Community Health Workers, Peer Wellness Specialists, and Personal Health Navigators. Please call Customer Service at **<phone and TTY>** for more information.

16 – Culturally-sensitive Health Education

We respect the dignity and the diversity of our members and the communities where they live. We want to serve the needs of people of all cultures, languages, races, ethnic backgrounds, abilities, religions, genders, sexual orientation, gender identification, and other special needs of our members. We want everyone to feel welcome and well-served in our plan.

We have several healthy living programs and activities for you to use. Our health education programs include self-care, prevention, and disease self-management. They are listed **on page <_>**. For more information about these services, please call Customer Service at **<phone and TTY>**.

17 - Native Rights

American Indians and Alaska natives can receive their care from an Indian Health Service (IHS) clinic or tribal wellness center. This is true whether you are in a CCO or have FFS (fee-for-service) OHP. The clinic must bill us the same as our network providers.

19 - Mental Health Services

Mental health services are available to all OHP members. You can get help for depression, anxiety, family problems and difficult behaviors, to name a few. We cover mental health assessment to find out what kind of help you need. If you need it, we cover case management, therapy, and care in a psychiatric hospital.

Important: *You do not need a referral to get mental health services from a network provider.* Please see our Provider Directory for a list of network providers.

The services and programs we offer are ...

Adult Mental Health Services

Choice Model Services used to be called “Aim high,” for Adult Mental Health Initiative. The Choice Model coordinates care for adults with serious mental illness when they leave the Oregon State Hospital to live in the community. The Choice Model gets discharged clients the community services they need. This could be outpatient or residential treatment, adult foster care, or living in a supported apartment. The goal is to prevent going back to the state hospital.

Children’s Mental Health Services

Children with behavioral challenges are served through Wraparound or intensive care coordination. Intensive care coordination services are individualized to meet the child’s and family’s needs. System of Care and Wraparound planning involve everyone in the child’s life - schools, community organizations, doctors, criminal justice and others - in forming a team around the child and family to plan supportive services.

20 - Mental Health Prescriptions

Most medications that people take for mental illness are paid directly by the Oregon Health Authority (OHA). Please show your pharmacist your Oregon Health ID and your <name of CCO> ID cards. The pharmacy will know where to send the bill.

23 - Getting a Ride

If you need help getting to your appointments, please call <NEMT service> at <phone and TTY>. We can pay for rides to OHP-covered services. We may give you a bus ticket or taxi fare. Or we may pay you, a family member or friend for gas to drive you. We can help if you don't have a way to get to your doctor, dentist, or counselor, and in some emergencies, to a pharmacy.

24 - How to Change CCOs

If you want to change to a different CCO, call OHP Customer Service at 503-378-2666 or 800-699-9075. There are several chances for you to change as long as another CCO is open for enrollment:

- If you do not want the CCO you've been assigned to, you can change during the first 90 days after you enroll.
- If you move to a place that your CCO doesn't serve, you can change CCOs as soon as you tell OHP Member Services about the move. The number is 800-699-9075.
- You can change CCOs once each year.
- If you are a Native American or Alaska native, or are also on Medicare, you can ask to change or leave your CCO anytime.

When you have a problem getting the right care, please let us try to help you before changing CCOs. Just call our Customer Service at <phone and TTY>, and ask for a Care Coordinator. If you still want to leave or change your CCO, call OHP Member Services. Their numbers are at 503-378-2666 and 800-699-9075.

A CCO may ask the Oregon Health Authority to remove you from it if you:

- are abusive to CCO staff or your providers
- commit fraud, like letting someone else use your health care benefits

25 – Rights and Responsibilities

[See end of this document]

26 - Urgent Care, Emergencies and Crises at Home and Away

Always call your primary care provider's (PCP) office first about any health problem. Someone will be able to help you day and night, even on weekends and holidays. If you can't reach your PCP's office about an urgent problem or they can't see you soon enough, you can go to <name of urgent care center> between <hours/days of operation> without an appointment. Urgent problems are things like severe infections, sprains, and strong pain. If you don't know how urgent the problem is, call your PCP.

If you think that you have a real emergency, call 911 or go to the Emergency Room (ER) at the nearest hospital. You don't need permission to get care in an emergency. An emergency might be chest pain, trouble breathing, bleeding that won't stop, broken bones, or a mental health emergency. Please don't use the ER for things that can be treated in your doctor's office. Sometimes ERs have a long, uncomfortable wait and take hours to see a doctor, so you should only go there when you have to.

A mental health emergency is feeling or acting out of control, or a situation that might harm you or someone else. Get help right away, do not wait until there is real danger. Call the **Crisis Hotline at <phone and TTY>**, call 911, or go to the ER.

If You Need Care Out-of-town

If you get sick or injured when you are away from home, call your PCP. If you need urgent care, find a local doctor who will see you right away. Ask that doctor to call your PCP to coordinate your care.

Out-of-town Emergencies

If you have a real emergency when you are away from home, call 911 or go to the nearest Emergency Room. Your care will be covered until you are stable. For follow-up care after the emergency, call your PCP.

OHP covers emergency and urgent care anywhere in the United States, but not outside the US. That means OHP will not pay for any care you get in Mexico or Canada.

Care After an Emergency

Emergency care is covered until you are stable. Call your PCP or mental health provider for follow-up care. Follow-up care once you are stable is covered but not considered an emergency.

28 - Billing Information

OHP members don't pay bills for covered services. Your medical or dental provider can send you a bill only if all of the following are true:

1. The medical service is something that your OHP plan does not cover
2. Before you received the service, you signed a valid Agreement to Pay, OHP form number 3165 (also called a waiver)
3. The form showed the estimated cost of the service
4. The form said that OHP does not cover the service
5. The form said you agree to pay the bill yourself

These protections usually only apply if the medical provider knew or should have known you had OHP. Always show your **<NAME OF CCO>** ID card. These protections apply if the provider participates in the OHP program (but most providers do).

Sometimes, your provider doesn't do the paperwork correctly and won't get paid for that reason. That doesn't mean you have to pay. If you already received the service and we refuse to pay your medical provider, your provider still can't bill you. You may receive a notice from us saying that we will not pay for the service. That notice does not mean you have to pay. The provider will write-off the charges.

If we or your provider tell you that the service isn't covered by OHP, you still have the right to challenge that decision by asking for an appeal and a hearing.

What should I do if I get a bill?

Even if you don't have to pay, please do not ignore medical bills - call us right away. Many providers send unpaid bills to collection agencies and even sue in court to get paid. It is much more difficult to fix the problem once that happens. As soon as you get a bill for a service that you received while you were on OHP, you should:

1. Call the provider, tell them that you were on OHP, and ask them to bill your CCO.
2. Call our Customer Service at <PHONE AND TTY> right away and say that a provider is billing you for an OHP service. We will help you get the bill cleared up. Do not wait until you get more bills.
3. You can appeal by sending your provider and us a letter saying that you disagree with the bill because you were on OHP at the time of the service. Keep a copy of the letter for your records.
4. Follow up to make sure we paid the bill.
5. If you receive court papers, call us right away. You may also call an attorney or the Public Benefits Hotline at 1-800-520-5292 for legal advice and help. There are consumer laws that can help you when you are wrongly billed while on OHP.

I was in the hospital and my plan paid for that, but now I am getting bills from other providers. What can I do?

When you go to the hospital or the emergency room, you may be treated by a provider who doesn't work for the hospital. For example, the emergency room doctors may have their own practice and provide services in the emergency room. They may send you a separate bill. If you have surgery in a hospital, there will be a separate bill for the hospital, the surgeon, and maybe even the lab, the radiologist, and the anesthesiologist. Just because we paid the hospital bill, it doesn't mean that we paid the other providers. Do not ignore bills from people who treated you in the hospital. If you get other bills, call each provider and ask them to bill your CCO. You should follow steps 1.-5. above for each bill you get.

When will I have to pay for medical services on OHP?

- You may have to pay for services that are covered by OHP if you see a provider that does not take OHP or is not part of our provider network. Before you get medical care or go to a pharmacy, make sure that they are in our provider network.
- You will have to pay for services if you weren't eligible for OHP when you received the service.
- You will have to pay for services not covered by OHP if you sign a detailed Agreement to Pay for that specific service before you receive it.

Second Opinion

If you want a second opinion about your treatment options, ask your PCP who could give you another opinion. If you want to see a provider outside our network, you or your provider will need to get our approval first.

30 - A Copy of Your Records

You can have a copy of your medical records. Your PCP has most of your records, so you can ask them for a copy. They may charge a reasonable fee for copies. You can ask us for a copy of the records we have. We <will/will not> charge you a reasonable fee for the copies.

You can have a copy of your mental health records unless your provider thinks this could cause serious problems.

31 - Your Records are Private

We only share your records with people who need to see them for treatment and payment reasons. You can limit who sees your records. If there is someone you don't want to see your records, please tell us in writing. You can ask us for a list of everyone we have shared your records with.

A law called the Health Insurance Portability and Accountability Act (HIPAA) protects your medical records and keeps them private. This is also called *confidentiality*. We have a paper called *Notice of Privacy Practices* that explains in detail how we use our members' personal information. We will send it to you if you ask. Just call Customer Service and ask for our *Notice of Privacy Practices*.

32 - End-of-life Decisions and Advance Directives (Living Wills)

Adults 18 years and older can make decisions about their own care, including refusing treatment. It's possible that someday you could become so sick or injured that you can't tell your providers whether you want a certain treatment or not. If you have written an Advance Directive, also called a Living Will, your providers can follow your instructions. If you don't have an Advance Directive, your providers may ask your family what to do. If your family can't or won't decide, your providers will give you the standard medical treatment for your condition. Some providers may not follow Advance Directives. Ask your providers if they will follow yours.

If you don't want certain kinds of treatment like a breathing machine or feeding tube, you can write that down in an Advance Directive. It lets you decide your care before you need that kind of care - in case you are unable to direct it yourself, like if you are in a coma. If you are awake and alert your providers will always listen to what you want.

You can get an Advance Directive form at most hospitals and from many providers. You also can find one online at http://cms.oregon.gov/dCBS/shiba/docs/advance_directive_form.pdf. If you write an Advance Directive, be sure to talk to your providers and your family about it and give them copies. They can only follow your instructions if they have them.

If you change your mind, you can cancel your Advance Directive anytime. To cancel your Advance Directive, ask for the copies back and tear them up, or write CANCELED in large letters, sign and date them. For questions or more information contact Oregon Health Decisions at 800-422-4805 or 503-692-0894, TTY 711.

If your provider does not follow your wishes in your Advance Directive, you can complain. A form for this is at www.healthoregon.org/hcrqi. Send your complaint to:

Health Care Regulation and Quality Improvement
800 NE Oregon St, #305
Portland, OR 97232

Email: Mailbox.hcls@state.or.us

Fax: 971-673-0556

Phone: 971-673-0540; TTY: 971-673-0372

33 - Declaration for Mental Health Treatment

Oregon has a form for writing down your wishes for mental health care if you have a mental health crisis, or if for some reason you can't make decisions about your mental health treatment. The form is called the Declaration for Mental Health Treatment. You can complete it while you can understand and make decisions about your care. The Declaration for Mental Health treatment tells what kind of care you want if you ever need that kind of care but are unable to make your wishes known. Only a court and two doctors can decide if you are not able to make decisions about your mental health treatment.

This form allows you to make choices about the kinds of care you want and do not want. It can be used to name an adult to make decisions about your care. The person you name must agree to speak for you and follow your wishes. If your wishes are not in writing, this person will decide what you would want.

A declaration form is only good for three (3) years. If you become unable to decide during those three (3) years, your declaration will remain good until you can make decisions again. You may change or cancel your declaration when you can understand and make choices about your care. You must give your form to your Primary Care Physician and the person you name to make decisions for you.

For more information on the **Declaration for Mental Health Treatment** go to the State of Oregon's website at:

<http://cms.oregon.gov/oha/amh/forms/declaration.pdf>

If your provider does not follow your wishes in your Declaration for Mental Health Treatment, you can complain. A form for this is at www.healthoregon.org/hcrqi. Send your complaint to:

Health Care Regulation and Quality Improvement
800 NE Oregon St, #305
Portland, OR 97232

Email: Mailbox.hcls@state.or.us

Fax: 971-673-0556

Phone: 971-673-0540; TTY: 971-673-0372

34 – Grievance System Information and Appeal Rights

How to make a complaint or grievance

If you are very unhappy with <NAME OF CCO>, your health care services or your provider, you can complain or file a grievance. We will try to make things better. Just call Customer Service at <phone and TTY>, or send us a letter to the address on page <_>. We must solve it and call or write you in 5 workdays.

If we can't solve it in 5 workdays, we will send you a letter to explain why. If we need more than 30 more days to address your complaint, we will send you a letter within 5 workdays to explain why. We will not tell anyone about your complaint unless you ask us to. If we need even more time, we will send another letter within 5 days.

Appeals and Hearings

If we **deny**, **stop** or **reduce** a medical service your provider has ordered, we will mail you a **Notice of Action** letter explaining why we made that decision. You have a right to ask to change it through an appeal and a state fair hearing. You must first ask for an appeal no more than 60 days from the date on the **Notice of Action** letter.

How to Appeal a Decision

In an appeal, a different health care professional at <NAME OF CCO> will review your case. Ask us for an appeal by:

- Calling Customer Service at <phone and TTY>, or
- Writing us a letter
- Filling out an Appeal and Hearing Request, OHP form number 3302

If you want help with this, call and we can fill out an appeal form for you to sign. You can ask someone like a friend or case manager to help you. You may also call the Public Benefits Hotline at 1-800-520-5292 for legal advice and help. You will get a **Notice of Appeal Resolution** from us in 16 days letting you know if the reviewer agrees or disagrees with our decision. If we need more time to do a good review, we will send you a letter saying why we need up to 14 more days.

You can keep on getting a service that already started before our decision to stop it. You must ask us to continue the service within 10 days of getting the **Notice of Action** letter that stopped it. If you continue the service and the reviewer agrees with the original decision, you may have to pay the cost of the services that you received after the Effective Date on the **Notice of Action** letter.

If You Need a Fast Appeal

If you and your provider believe that you have an urgent medical problem that cannot wait for a regular appeal, tell us that you need a fast (expedited) appeal. We suggest that you include a statement from your provider or ask them to call us and explain why it is urgent. If we agree that it is urgent we will call you with a decision in 3 workdays.

Provider Appeals

Your provider has a right to appeal for you when their physician's orders are denied by a plan. You must agree to this in writing.

How to get an Administrative Hearing

After an appeal, you can ask for a state fair hearing with an Oregon Administrative Law Judge. You will have 120 days from the date on your **Notice of Appeal Resolution (NOAR)** to ask the state for a hearing. Your **NOAR** letter will have a form that you can send in. You can also ask us to send you an Appeal and Hearing Request form, or call OHP Client Services at 800-273-0557, TTY 711, and ask for form number 3302.

At the hearing, you can tell the judge why you do not agree with our decision and why the services should be covered. You do not need a lawyer, but you can have one or someone else, like your doctor, with you. If you hire a lawyer you must pay their fees. You can ask the Public Benefits Hotline (a program of Legal Aid Services of Oregon and the Oregon Law Center) at 800-520-5292, TTY 711, for advice and possible representation. Information on free Legal Aid can also be found at www.oregonlawhelp.org.

A hearing takes more than 30 days to prepare. While you wait for your hearing, you can keep on getting a service that already started before our original **Notice of Action** decision to stop it. You must ask the state to continue the service within 10 days of getting our **Notice of Appeal Resolution** that confirmed our denial. If you continue the service and the judge agrees with the denial, you may have to pay the cost of the services that you received after the date on the **Notice of Appeal Resolution**.

Fast (expedited) Hearing

If you and your provider believe that you have an urgent medical problem that cannot wait for a regular hearing process, say that you need a fast (expedited) hearing and fax the Appeal and Hearing Request form to the OHP Hearings Unit. We suggest that you include a statement from your provider explaining why it is urgent. You should get a decision in 3 workdays. The Hearings Unit's fax number is 503-945-6035.

35. b - Physician Incentives

We pay a bonus or reward our providers for keeping you healthy. We do not pay or reward our providers for limiting services and referrals.

36 - Involvement in CCO Activities

<NAME OF CCO> has a Community Advisory Council. We invite you to apply to serve on the Council. Most of the Council members are Oregon Health Plan members. Other members are from government agencies and groups that provide OHP services. If you are interested in being a member of the Community Advisory Council, please call Customer Service for an application.

38 – CMS-required Definitions or Words to Know

1. **Appeal** – When you ask a plan to change a decision you disagree with about a service your doctor ordered. You can write a letter or fill out a form explaining why the plan should change its decision. This is called *filing an appeal*.
2. **Copay** – An amount of their own money that a person must pay for health services. Oregon Health Plan members do not have copays. Private health insurance and Medicare sometimes have copays.
3. **Durable medical equipment (DME)** – Things like wheelchairs, walkers and hospital beds. They are *durable* because they last a long time. They don't get used up like medical *supplies*.
4. **Emergency medical condition** – An illness or injury that needs care right away. This can be bleeding that won't stop, severe pain or broken bones. It can be something that will cause some part of your body to stop working right. An emergency mental health condition is feeling out of control, or feeling like hurting yourself or someone else.
5. **Emergency transportation** – Using an ambulance or Life Flight to get medical care. Emergency medical technicians (EMT) give care during the ride or flight.
6. **ER and ED** – *Emergency room* and *emergency department*, the place in a hospital where you can get care for a medical or mental health emergency.
7. **Emergency services** – care that improves or stabilizes sudden serious medical or mental health conditions.
8. **Excluded services** – things that a health plan doesn't pay for. Services to improve your looks, like cosmetic surgery, and for things that get better on their own, like colds, are usually excluded.
9. **Grievance** – a complaint about a plan, provider or clinic. The law says CCOs must respond to each complaint.
10. **Rehabilitation services** – special services to improve strength, function or behavior, usually after surgery, injury, or substance abuse.
11. **Health insurance** – a program that pays for health care. After you sign up for the program, a company or government agency pays for covered health services. Some insurance programs require monthly payments, called *premiums*.
12. **Home health care** – services you get at home to help you live better after surgery, an illness or injury. Help with medications, meals and bathing are some of these services.
13. **Hospice services** – services to comfort a person who is dying and their family. Hospice is flexible and can include pain treatment, counseling and respite care.

14. **Hospital inpatient and outpatient care** – Hospital inpatient care is when the patient is admitted to a hospital and stays at least 3 nights. Outpatient care is surgery or treatment you get in a hospital and then leave afterward.
15. **Medically necessary** – services and supplies that are needed to prevent, diagnose or treat a medical condition or its symptoms. It can also mean services that are accepted by the medical profession as standard treatment.
16. **Network** – The medical, mental health, dental, pharmacy and equipment providers that a coordinated care organization (CCO) contracts with.
17. **Network provider** – Any provider in a CCO’s network. If a member sees network providers, the plan pays the charges. Some network specialists require members to get a referral from their primary care provider (PCP).
18. **Non-network provider** - A provider who has not signed a contract with the CCO, and may not accept the CCO payment as payment-in-full for their services.
19. **Physician services** – Services that you get from a doctor.
20. **Plan** – a medical, dental, mental health organization or CCO that pays for its members’ health care services.
21. **Preapproval (preauthorization, or PA)** – A document that says your plan will pay for a service. Some plans and services require a PA before you get the service. Doctors usually take care of this.
22. **Prescription drugs** – Drugs that your doctor tells you to take.
23. **Primary care provider or**
24. **Primary care physician** – Also referred to as a “PCP,” this is a medical professional who takes care of your health. They are usually the first person you call when you have health issues or need care. Your PCP can be a doctor, nurse practitioner, physician’s assistant, osteopath, or sometimes a naturopath.
25. **Primary care dentist** – The dentist you usually go to who takes care of your teeth and gums.
26. **Provider** – Any person or agency that provides a health care service.
27. **Skilled nursing care** – help from a nurse with wound care, therapy, or taking your medicine. You can get skilled nursing care in a hospital, nursing home, or in your own home with home health care.
28. **Specialist** – A medical professional who has special training to care for a certain part of the body or type of illness.
29. **Urgent care** – Care that you need the same day for serious pain, to keep an injury or illness from getting much worse, or to avoid losing function in part of your body.

18 - OHP Member Rights and Responsibilities

[OAR 410-141-0320, OAR 410-141-3300, 42 CFR 438.100]

As an OHP client, you can...

Be treated with respect and dignity, the same as other patients

Choose your provider

Get services and supports that fit your culture and language needs

Tell your provider about all your health concerns

Have a friend or helper come to your appointments, and an interpreter if you want one

Ask for services as close to home as possible, and in a non-traditional setting that is easier for you to use

Actively help develop your treatment plan

Get information about all of your OHP-covered and non-covered treatment options

Help make decisions about your health care, including refusing treatment, except for court-ordered services

Be free from any form of restraint or seclusion

Complain about different treatment and discrimination

Get a referral to a specialist if you need it

Get care when you need it, any time of day or night, including weekends and holidays

Get mental health and family planning services without a referral

Get help with addiction to cigarettes, alcohol and drugs without a referral

Get handbooks and letters that you can understand

See and get a copy of your health records, unless your doctor thinks it would be bad for you

Limit who can see your health records

Get a *Notice of Action* letter if you are denied a service or there is a change in service level

Get information and help to appeal denials and ask for a hearing

Make complaints and get a response without a bad reaction from your plan or provider

Ask the Oregon Health Authority Ombudsperson for help with problems at 503-947-2346 or toll free 877-642-0450, TTY 711

As an OHP client, you agree to...

Find a doctor or other provider you can work with and tell them all about your health

Treat providers and their staff with the same respect you want

Bring your medical ID cards to appointments, tell the receptionist that you have OHP and any other health insurance, and tell them if you were hurt in an accident

Be on time for appointments

Call your provider at least one day before if you can't make it to an appointment

Have yearly check-ups, wellness visits and other services to prevent illness and keep you healthy

Follow your providers' and pharmacists' directions, or ask for another choice

Be honest with your providers to get the best service possible

Call OHP Client Services at 800-699-9075 when you move, are pregnant or no longer pregnant

Report other health insurance at www.ReportTPL.org.