# Review Tool for CCO Member Handbook and Provider Directory

Contractor is responsible for preparing a Member handbook to provide informational materials and Member education. Mailing of Member handbooks shall occur within 14 calendar days of receiving OHA’s initial 834 listing of Member’s enrollment (or re-enrollment after not being enrolled for 90 days or more) with the Contractor; however Contractor may deliver the Member handbook electronically if the Member has requested or approved electronic transmittal consistent with Exhibit B, Part 3, Section 2.q. and r. of the CCO Contract. Contractor shall notify all existing Members of each revision and its location on Contractor’s website, and offer to send the Member a printed copy on request. Contractor’s Member handbook shall incorporate all of the elements included in the Review Tool in the Appendix to this Exhibit.

For each item listed in the Review Tool, the column labeled “Text Provided by OHA or Contractor” describes whether OHA or the Contractor is responsible for developing the text. OHA will provide OHA text which may be modified and completed as needed for accuracy, and the CCO will develop the text for items identified on the tool as “Text Provided by Contractor.” Contractor shall compile a Member handbook in each prevalent language for the Members who speak those languages.

The Contractor shall review the Member handbook for accuracy at least yearly, updating with new or corrected information as needed to reflect the Contractor’s internal changes and any regulatory changes. Contractor shall submit each version of the CCO handbook to OHP.Materials@state.or.us for OHA approval initially and upon revision or upon OHA request. Compliance with the Review Tool does not replace the Contractor’s obligation to satisfy all the requirements of OAR 410-141-3300; it is just a tool for organizing review.

Date originally submitted:

Coordinated Care Organization:

Status of Document on this Review Date \_\_\_\_\_\_\_\_\_:

* Approved by Agency Date: \_\_\_\_\_\_\_\_\_\_\_\_\_
* Not Approved: Revise and Resubmit

References: OAR 410-141-3300 and 42 CFR 438.10

The readability standard used in this review will be the Flesch-Kincaid standard used in Word.

Evaluation of copies submitted to OHA for review and approval shall include all elements in the following Appendix.

# Appendix - 2018 Review Tool

| **Standard Language Item Number** | **Text provided by OHA or Contractor** | **Page Number & Contractor Comments** | **Requirement** | **For OHA Use Only**  **Item Approved**  **Yes No** | | **OHA Comments** | **CCO Response to OHA Comments** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | Contractor |  | Handbook date (month and year) located on the front cover |  |  |  |  |
| 2 | Contractor |  | Contractor’s Customer Service telephone numbers, including toll free, TTY or Oregon Relay 711, Fax, mailing address, website, office location and hours of operation. |  |  |  |  |
| 3 | Both | *Throughout* | 6th Grade reading level, sentences 20 words or less in length, minimum 12 point font |  |  |  |  |
| 4 | OHA |  | Tag line translation in all required languages (should be located in the front portion of the handbook) offering handbook in alternate languages and formats |  |  |  |  |
| 5 | OHA |  | How to access interpreter services, including qualified and certified health care interpreters, at no cost to the member |  |  |  |  |
| 6 | Contractor |  | Web address for member handbook and offer to send a member handbook anytime on request |  |  |  |  |
| 7 | Contractor |  | Statement that members will be notified of changes in access to benefits 30 days before the effective date of the change or as soon as possible |  |  |  |  |
| 8 | Contractor |  | Description of the CCO including names of member organizations, services offered and areas served |  |  |  |  |
| 9 | OHA |  | Explanation of OHP, coordinated care and fee-for-service |  |  |  |  |
| 10 | Contractor |  | How CCO will coordinate care, including the role of Patient-centered Primary Care Homes (PCPCH) |  |  |  |  |
| 11 | Contractor |  | The roles of community health workers, peer wellness specialists and personal health navigators, and how to access these helpers |  |  |  |  |
| 12 | Contractor |  | Intensive Care Coordination Services and how to access them |  |  |  |  |
| 13 | Contractor |  | Information on CCO’s ID card, Oregon Health ID, and OHP coverage letter |  |  |  |  |
| 14 | Contractor |  | How members choose and make an appointment with a Primary Care Provider |  |  |  |  |
| 15 | Contractor |  | Any restrictions on the member’s freedom of choice among network providers. The extent to which, and how the member may obtain benefits, including family planning services, from out-of-network providers. Explanation of how and where to access any OHP benefits that are not covered under this contract |  |  |  |  |
| 16 | OHA |  | Information on culturally sensitive CCO or provider-based health education programs, including self-care, prevention, and disease self-management |  |  |  |  |
| 17 | OHA |  | Enrollment requirements as they relate to American Indian and Alaska native members, and tribal members’ right to use IHS and tribal health care services (42 USC 1932) |  |  |  |  |
| 18 | Contractor |  | Explanation of covered and non-covered services and how to access those services, and the amount, duration and scope of covered services in sufficient detail to ensure that members understand the benefits to which they are entitled |  |  |  |  |
| 19 | Both |  | Mental health services and programs available, including adult and children’s services |  |  |  |  |
| 20 | OHA |  | How to obtain mental health prescription medication |  |  |  |  |
| 21 | Contractor |  | Provision of educational and pharmacological help for substance abuse and tobacco cessation, including quit line number |  |  |  |  |
| 22 | Contractor |  | Transitional procedures for new members to obtain services in the first month of enrollment if they are unable to establish a relationship with a provider and get new orders during that period |  |  |  |  |
| 23 | OHA |  | How to access transportation services as a part of OHP benefit |  |  |  |  |
| 24 | OHA |  | Disenrollment process: When and how members can voluntarily disenroll from their CCO and change plans, and when and how CCO can request that OHA remove a member from CCO enrollment |  |  |  |  |
| 25 | OHA |  | Member rights and responsibilities, as specified in 42 CFR Section 438.100 |  |  |  |  |
| 26 | OHA |  | Urgent/emergent care and how after-hours and emergency coverage are provided, including:   1. What constitutes an emergency and use of 911; 2. Specify layperson language re: emergencies; 3. The fact that prior approval is not required for emergency services; 4. How to access urgent care services and advice; 5. Crisis services; 6. Urgent and emergent care away from home; 7. Post-stabilization services, with reference to the definitions in 42 CFR Section 438.114 (a); 8. The fact that, within the United States, the Member has the right to use any hospital or other setting for emergency care; 9. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization care services covered under the contract and 42 CFR Section 422.113 (c) and as related to emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or under the circumstances to improve or resolve the member’s condition |  |  |  |  |
| 27 | Contractor |  | Copay requirements and a statement of plan’s intention to ask providers to collect copays |  |  |  |  |
| 28 | OHA |  | Information on member’s possible responsibility for charges, including Medicare deductibles and coinsurance, if they go outside of the plan for non-emergent care, and charges for services not covered, including information about requirements for a written Agreement to Pay, when a provider is prohibited from billing a member for services, what members should do when billed by a provider, and who to call about provider billing |  |  |  |  |
| 29 | Contractor |  | Use of the referral system, including what services must be preapproved and how to obtain a referral |  |  |  |  |
| 30 | Contractor |  | How to obtain copies of member records, including whether contractor charges for copying |  |  |  |  |
| 31 | OHA |  | Explain confidentiality policies, including HIPAA Notice of Privacy Practices and how to request a full copy of it |  |  |  |  |
| 32 | OHA |  | Advance Directives:   1. As set forth in 438.6 (i) (2) – Information about advance directive policies, including a description of member rights under applicable State law; 2. Contractor’s policies for implementation of those rights if any limitation in following advance directives as a matter of conscience is allowed; 3. Complaint process for failure to follow an advance directive |  |  |  |  |
| 33 | OHA |  | Member’s right to execute a Declaration of Mental Health Treatment in accordance with ORS 127.703, and complaint process for failure to follow a Declaration of Mental Health Treatment |  |  |  |  |
| 34 | OHA |  | Grievance System Information:  Grievance, appeal and fair hearing procedures and timeframes, as provided in 42 CFR Section 438.400 – 438.424  Explain the following:   1. The right to file grievances, appeals and administrative hearings; 2. The toll-free numbers that the member can use to file a grievance or appeal by phone; 3. The requirements and timeframes in the filing process for grievances, appeals and hearings; 4. The availability of assistance in the filing process; 5. The method of obtaining an appeal and a hearing; 6. The rules that govern representation at the hearing; 7. The right to have an attorney or 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. 8. The fact that when requested by the member: 9. Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and 10. The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member. 11. Appeal rights available to providers to challenge the failure of the CCO to cover a service |  |  |  |  |
| 35 | a. Contractor  b. OHA |  | Information available upon request including the following:   1. Information on the structure and operation of the CCO 2. Physician incentive plans as set forth in 42 CFR 438.6 |  |  |  |  |
| 36 | Both |  | Opportunities for member participation in plan governance, including the Community Advisory Committee |  |  |  |  |
| 37 | Contractor |  | List of contracted providers, specialists and hospitals in the member’s service area and how to find out if providers are accepting new patients, with each subcontractor’s name, address, phone, non-English languages spoken, and website if applicable. In lieu of a printed Provider Directory, contractor may make an up-to-date online list available and give the web address with an offer to send a printed list of providers on request. Online directory must be updated within 30 days of providers being removed or added to the network. |  |  |  |  |
| 38 | OHA |  | For consistency, plan must include OHA-provided definitions of the following in the member handbook. Instead of a glossary plans may define them in context as they occur in the handbook:   1. Appeal 2. Copay 3. DME – durable medical equipment 4. Emergency medical condition 5. Emergency transportation 6. ER and ED 7. Emergency services 8. Excluded services 9. Grievance 10. Rehabilitation services 11. Health insurance 12. Home health care 13. Hospice services 14. Hospital inpatient and outpatient care 15. Medically necessary 16. Network 17. Network provider 18. Non-network provider 19. Physician services 20. Plan 21. Preapproval (preauthorization) 22. Prescription drugs 23. Primary care provider 24. Primary care dentist 25. Provider 26. Skilled nursing care 27. Specialist 28. Urgent care |  |  |  |  |

# Words to Know

1. **Appeal** - To 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 money that a person must pay themself 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.

1. **Emergency transportation** – Using an ambulance or Life Flight to get medical care. Emergency medical technicians (EMT) give care during the ride or flight.
2. **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.
3. **Emergency services** – care that improves or stabilizes sudden serious medical or mental health conditions.
4. **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.
5. **Grievance** – a complaint about a plan, provider or clinic. The law says CCOs must respond to each complaint.
6. **Rehabilitation services** – special services to improve strength, function or behavior, usually after surgery, injury, or substance abuse.
7. **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*.
8. **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.
9. **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.
10. **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.
11. **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.
12. **Network** – The medical, mental health, dental, pharmacy and equipment providers that a coordinated care organization (CCO) contracts with.
13. **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).
14. **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.
15. **Physician services** – Services that you get from a doctor.
16. **Plan** – a medical, dental, mental health organization or CCO that pays for its members’ health care services.
17. **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.
18. **Prescription drugs** – Drugs that your doctor tells you to take.
19. Primary care provider or
20. 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.
21. **Primary care dentist** – The dentist you usually go to who takes care of your teeth and gums.
22. **Provider** – Any person or agency that provides a health care service.
23. **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.
24. **Specialist** – A medical professional who has special training to care for a certain part of the body or type of illness.
25. **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.