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Member Communication Requirements

Guidance for Oregon Medicaid Managed Care Entities (MCEs)

Contents

Introduction

Compliance with this document does **not:**

- Replace the MCE's obligation to satisfy all the requirements of CFR §438.10(g) and CFR §438.104, the Contract and Oregon Administrative Rules (OARs) 410-141-3575, 410-141-3580 and 410-141-3585. or
- Guarantee approval of its Member Handbook pursuant to 2020 CCO Contract Ex B, Part 3, Section 5.b.(1).

This document is used by OHA to evaluate member handbooks and other member materials for compliance.

- All written informational materials, including, without limitation, Member Handbooks, Provider Directories, and educational programs must meet the requirements in this document.
- For each item listed in the Member Communication Requirements document, the column labeled "Text Provided by OHA or Contractor" describes whether OHA or the MCE is responsible for developing the text. OHA may choose to impose additional requirements beyond CFR, Contract and OAR requirements.
- The document can be modified without a contract amendment.

The language used in this document is not at 6th grade reading level. MCE must develop content for its member materials that meet 6th grade reading level requirements according to the Flesch-Kincaid readability scale.
CCOs may use the Oregon Health Plan Handbook as OHA's model handbook. However, OHA's handbook is in addition to the MCE's Member Handbook. An MCE may not use OHA's handbook to substitute for any component of the MCE's member handbook (OAR 410-141-3585(10)(ee)).

Accessibility requirements

All member communications must meet the following requirements to ensure member access to information on how to access services and exercise member rights.

Requirement	Regulation and Contract Citation	Text provided by:
If provided electronically: • The format is readily accessible. • The information is placed on the OHA or MCE's website in a prominent and readily accessible location. • The information can be electronically retained or otherwise archived and capable of being printed. • The member is informed that the information is available in paper form without charge upon request and the MCE provides it upon request within 5 business days.	42 CFR 438.10(c) Ex. B, Part 3, Section 4c (7) OAR 410-141-3585(5)(c)	N/A
Uses easily understood language and format. • OHA defines "easily understood" as 6th grade reading level or lower using the Flesch-Kincaid readability scale.	42 CFR 438.10(d)(6)(i)	Contractor
Uses a font size no smaller than 12 point.	42 CFR 438.10(d)(6)(ii) OAR 410-141-3580(6)(c)	N/A
Is available in alternate formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency.	42 CFR 438.10(d)(6)(iii)	N/A
Includes a large print (18 point font or larger) tagline on how to request auxiliary aids and services, including the provision of materials in alternate formats.	42 CFR 438.10(d)(6)(iv) OAR 410-141-3580(6)(c)	Contractor
Material is translated or includes taglines in the prevalent non-English languages in the state as well as large print (font size 18) explaining:	OAR 410-141-3585(5)(a)	N/A

Requirement	Regulation and Contract Citation	Text provided by:
• The availability of written translation or oral interpretation to understand the information provided, as well as alternate formats, and • The toll-free and TTY/TDY telephone number of the MCE's member/customer service unit.	OAR 410-141-3595(10)(b)	

Requirements for critical written material

All critical written material must meet the following requirements. Critical material includes:

- Provider directories
- Member handbooks
- Appeal and grievance notices
- Denial and termination notices

Requirement	Regulation and Contract Citation	Text provided by
Material is available in the prevalent non-English languages spoken by members and potential members in the MCE's service area.	42 CFR 438.10(d)(3) OAR 410-141-3585(10)(b)	N/A
Material includes taglines in the prevalent non-English languages in the state, as well as large print (18 point font size or larger), that: • Explains the availability of written translations or oral interpretation to understand the information provided and • Provides the toll-free and TTY/TDY telephone number of the MCE's customer service unit.	42 CFR 438.10(d)(3) OAR 410-141-3585(10)(b)	Contractor

Member handbook information requirements

The information included in the MCE's Member Handbook must be consistent with 42 §CFR 438.10(g) and OAR 410-141-3585 pursuant to 2020 CCO Contract, Ex B, Part 3, 5.a.(1), as well as, but not limited to, any other 2020 CCO Contract requirements that refer to the Member Handbook.

Requirement	Regulation and Contract Citation	Text provided by
Based on OHA's model handbook.	42 CFR 438.10(b)(4)(ii)	OHA
Handbook publication date (the date when a change was made)	OAR 410-141-3585(10)(a)	Contractor
MCE's confidentiality policy and how a member may request a complete copy.	OAR 410-141-3585(10)(aa)	Contractor
MCE's office location, mailing address, web address, office hours, and toll-free customer service telephone numbers including TTY and Oregon Relay 711, fax number. Toll-free numbers for any other partners/subcontractors providing services directly to members, including non-emergency transportation (NEMT) Call Center.	42 CFR 438.10(g)(2)(xiv) OAR 410-141-3585(10)(c)	Contractor
Web address for Member Handbook, offer to send a member handbook anytime on request, and how to request.	OAR 410-141-3585(10)(dd)	Contractor

Requirement	Regulation and Contract Citation	Text provided by
How to access auxiliary aids and services, including additional information in alternative formats or languages. Tag lines in English and other prevalent non-English languages, as defined in this rule, spoken by populations of members. The tag lines must be located at the beginning of the document for the ease of the member and describe how members may access free OHA-approved, qualified and certified health care sign and oral interpreters, as well as translations and materials in alternate formats.	42 CFR 438.10(d)(3) 42 CFR 438.10(g)(2)(xiii) Ex B, Part 3, Section 4c Ex B, Part 3, Section 5 (2) OAR 410-141-3585(10)(b)	OHA and Contractor
Whether or not the MCE uses provider contracts including alternative payment methodologies or incentives.	OAR 410-141-3585(10)(t)	Contractor
Lists the benefits provided by the MCE.	42 CFR 438.10(g)(2)(i)	Contractor
Transitional procedures for new members Including members new to Medicare, to obtain services (including prescriptions, supplies, and other necessary items and services) in the first month of enrollment if they are unable to meet with a PCP or Primary Care Dentist (PCD), other prescribing provider, or obtain new orders during that period. Include specific communications for members who are becoming new Medicare enrollees.	438.10(g)(2)(ii) & (xiv) OAR 410-141-3585(10)(r)	Contractor
Primary Care Providers: How to choose a PCP, how to make an appointment with a PCP, and how to change PCPs, and the MCE's policy on changing PCPs.	42 CFR 438.10(g)(xi) OAR 410-141-3585(10)(d)	Contractor
Access to care Explanation of OHP, covered and non-covered services defined in Ex. B. Part 2 of the Contract, in sufficient detail (amount, duration and scope) to ensure that members understand the benefits to which they are entitled. This includes: • Coordinated care services and how and where to access those services, • How transportation is provided, • Resources for help with how and where to access NEMT to appointments with providers and scheduling process for use of those services, including a toll-free number to request rides.	42 CFR 438.10(g)(2)(i)-(iii) & (xiv) OAR 410-141-3585(10)(w) & (x)	OHA and Contractor
Availability and access to coordinated care services through a patient-centered primary care home (PCPCH) or other primary care team with the member as a partner in care management. Explain the coordinated care approach, how to navigate the coordinated health care system as applicable to Full Benefit Dual Eligibles (FBDE) including coordination of Medicaid and Medicare benefits, and how to access services coordinated or covered by the MCE (defined in Ex. B, Parts 2, 4, 8, 9 and 10 of the 2020 CCO Contract).	OAR 410-141-3585(10)(d) & (i)	Contractor
Contracted hospitals in the member's service area	OAR 410-141-3585(10)(l)	Contractor

Requirement	Regulation and Contract Citation	Text provided by
Contractor shall include in its Member Handbook the benefits and availability of THW services as well as the name and contact information for its THW liaison.	Ex. K, Section 11e (2)	Contractor
Explanation of policies on prior authorization requirements. Information on which services must be preapproved by the MCE, how to obtain a second opinion, and how to obtain a referral to a specialist. Requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider (PCP).	42 CFR 438.10(g)(2)(iv) OAR 410-141-3585(10)(g)	Contractor
Self-referrals, including which participating or non-participating provider services the member may self-refer, as defined in Ex. B Part 2, Section 3b, Ex. M, Section 5f, and OAR 410-141-3870(4)(a).	OAR 410-141-3585(10)(f)	Contractor
Any restrictions on the member's freedom of choice among network providers. Extent to which, and how the member may obtain benefits, including family planning services and supplies, from out-of-network providers. This includes an explanation that the MCE cannot require the member to obtain a referral before choosing a family planning provider. Explanation of when a referral is needed to see providers and how to request a referral; including policies on referrals for specialty care. How and where to access any OHP benefits that are not covered under this contract. How to access information on contracted providers currently accepting new members.	42 CFR 438.10(g)(2)(iv), (vi) & (vii) OAR 410-141-3585(10)(e)	Contractor
For any counseling or referral service not covered because of the MCE's moral or religious objections and such objection is not unlawful: • Information that the service is not covered by the MCE. • How to get information from OHA about how to get the service.	42 CFR 438.10(g)(2)(ii) (A-B) Ex B, Part 2, Section 3c.	Contractor
How and where members may access any benefits that are available under OHP but are not covered under the MCE's contract, including any cost sharing.	OAR 410-141-3585(10)(bb)	Contractor
How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs. How members are to access in-network retail and mail-order pharmacies.	OAR 410-141-3585(10)(y) & (z)	Contractor
Explanation of Intensive Care Coordination services to support eligible members as defined in Ex B, Part 4, Section 2f, including how eligible members may access those services including a toll-free telephone number.	42 CFR 438.10(g)(2)(xiv) OAR 410-141-3585(10)(d)(h) & (i)	Contractor

Requirement	Regulation and Contract Citation	Text provided by
Emergency Services: Extent to which, and how, after-hours and emergency care are provided, both locally and when away from home, including, but not limited to: • What constitutes an emergency health condition and when to use emergency services and crisis services in layperson language, including examples of emergencies and use of 911. • Prior authorization is not required for emergency services. • Within the United States, the member has a right to use any hospital or other setting for emergency care. • How and where members are to obtain ambulance services. **Urgent Care Services:** How and where Members can access urgent care services and advice, both locally and when away from home. MCE must provide an after-hours call-in system adequate to triage Urgent Care and Emergency Service calls from members or a Member's long-term care provider of facility. See Ex. B, Part 2, Section 4a and OAR 410-141-3840(7)(a) for descriptions of the services to be addressed, including post-stabilization services, with reference to the definitions in 42 CFR Section 438.114 (a). 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 CCOs shall educate members about how to appropriately access care from emergency rooms, urgent care and walk-in clinics, non-traditional health care workers, and less intensive interventions other than their primary care home.	42 CFR 438.10(g)(2)(v) OAR 410-141-3585(10)(l)-(m) & (v)	OHA and Contractor
Advance directives: How to exercise an advance directive as set forth in 42 CFR 438.3(j)(3) and Ex E, Section 14. MCE must provide adult members with written information consistent with requirements in 42 CFR 422.128 on advance directive policies, including a description of applicable Federal and State 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.	42 CFR 438.10(g)(2)(xii) OAR 410-141-3585(10)(s)	OHA
Billing: Charges for non-covered services, and the member's possible responsibility for such charges if they go outside	42 CFR 438.10(g)(2)(xvi) OAR 410-141-3585(10)(p)	Contractor

Requirement	Regulation and Contract Citation	Text provided by
of the MCE network for non-emergent care. Information for FBDEs on any responsibility for costs specific to deductibles, copays and coinsurance..		
Requirements for a written Agreement to Pay form, when providers may bill members for services. When providers are prohibited from billing members for services and what to do if they receive a bill from a provider and who to call with questions about a bill.	OAR 410-141-3585(10)(q)	Contractor
Disenrollment: When and how members can voluntarily disenroll from a MCE and change plans, and when and how MCE can request that OHA remove a member from MCE enrollment (involuntary disenrollment).	OAR 410-141-3585(10)(cc)	Contractor
Fraud and abuse: A statement or narrative that articulates MCE's commitment to: • Preventing Fraud, Waste, and Abuse, and • Complying with all Applicable Laws, including, without limitation the State's False Claims Act and the federal False Claims Act Examples of Fraud, Waste, and Abuse. Where and how to report Fraud, Waste, and Abuse, defined by OHA in in Ex B, Part 9, Section 17h(2) and 17.i(2). A Member's right to be report Fraud, Waste, and Abuse anonymously, and to be protected under applicable Whistleblower laws.	Ex B, Part 9, Section 11c. 42 CFR 438.10(g)(xv)	OHA (Ex B Part 9)

Requirement	Regulation and Contract Citation	Text provided by
Grievance, appeal and fair hearing processes: Procedures and timeframes, as provided in 42 CFR Section 438.400 – 438.424, Ex I and OARs. Explain: • The right to file grievances, appeals and hearings; • The toll-free numbers that the member can use to file a grievance or appeal by phone; • The requirements and timeframes in the filing process for grievances, appeals and hearings; • The availability of assistance in filing and completing the grievance process and how to request assistance; • The method of obtaining an appeal and a hearing; • The right to request a hearing after the MCE has made a determination on a member's appeal which is adverse to the member; • The rules that govern representation at the hearing; • 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; • The right that when requested by the member: o Benefits that the MCE seeks to reduce or terminate will continue if the member files an appeal or a request for hearing within the timeframes specified for filing; and o The member may be required to pay the cost of services furnished while the appeal or hearing is pending, if the final decision is adverse to the member; • Appeal rights available to providers to challenge the failure of the MCE to cover a service; and • How to get information about MCE's Grievance and Appeal System, policies and procedures related thereto, Member notice templates, and any other documents to be provided to Members regarding MCE's Grievance and Appeal System.	42 CFR 438.10(g)(2)(xi) Ex B, Part 3, Section 7. Ex I Section 4a (5) OAR 410-141-3585(10)(n) OAR 410-141-3835 OAR 410-141-3875 through 410-141-3910	Contractor
Member rights: Member rights and responsibilities, including: • Elements specified in 42 CFR §438.100 • The availability of the OHP ombudsperson • All rights specified in Ex. B. Part 3, Sections 2a – 2t Member rights must also be provided in plain language narrative and alternative (video or audio formats. Ex B, Part 3 (1)(g).	42 CFR 438.10(g)(2)(ix) OAR 410-141-3585(10)(o) OAR 410-141-3590(2) & (3)	Contractor
Member's right to request and obtain copies of their clinical records as defined in OAR 410-141-3590(2)(u), whether they may be charged a reasonable copying fee,	OAR 410-141-3585(10)(u)	Contractor

Requirement	Regulation and Contract Citation	Text provided by
and that they may request the record be amended or corrected		

Provider directory requirements

Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the MCE receives updated provider information.

Requirement	Regulation and Contract Citation	Text provided by
Provides information for the following provider types in the MCE's network: • Physicians, including specialists; • Hospitals; • Pharmacies; • Behavioral health providers, including specifying substance use disorder treatment providers; • Dental providers • NEMT providers, and • LTSS providers, as appropriate.	42 CFR 438.10(h)(2) OAR 410-141-3585(6),(7) & (8) Ex. B. Part 3, Section 6e.	Contractor
For each network provider, the directory lists: • Each provider or subcontractor's name as well as any group affiliation. • Street address(es). • Telephone number(s). • Web site URL, as appropriate. • Specialty, as appropriate. • Whether the provider will accept new enrollees. • The provider's cultural and linguistic capabilities, including: languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training. • Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.	42 CFR 438.10(h)(1) OAR 410-141-3585(6) Ex. B. Part 3, Section 6(f)	Contractor
The directory encompasses services delivered under the contract with information necessary to ensure member access to an adequate Provider Network.	Ex B, Part 3, Section 6. a.	Contractor

Formulary requirements

Requirement	Regulation and Contract Citation	Text provided by
The MCE's formulary lists: • Which medications are covered (both generic and name brand). • What tier each medication is on.	42 CFR 438.10(i)(1-2) OAR 410-141-3585(6)(j)	Contractor
Formulary drug lists must be made available on the MCE's website in a machine readable file and format.	42 CFR 438.10(i)(3)a	N/A

Member health education requirements

MCEs must provide the following information for Members in compliance with CFR, OAR and Contract, but it does not need to be included in member handbooks.

Requirement	Regulation and Contract Citation	Text provided by
Required notices Member notification that explains: • Oral interpretation is available for any language and written translation is available in prevalent languages • Auxiliary aids and services are available upon request and at no cost for members with disabilities • How to access these services.	42 CFR 438.10(d)(5)	Contractor
Written notice of MCE's nondiscrimination policy and process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance with all applicable laws including Title VI of the Civil Rights Act and ORS Chapter 659A. A complaint of discrimination can be made by contacting the MCE, OHA, the Bureau of Labor and Industries or the Office of Civil Rights.	Ex B, Part 3, Section 2	OHA and Contractor
Written notice of any significant changes in program or service sites that affect the member's ability to access care or services from MCE's participating providers. The MCE shall provide, translated as appropriate, the notice at least 30 days before the effective date of that change, or as soon as possible if the participating provider has not given the MCE sufficient notification to meet the 30-day notice requirement.	OAR 410-141-3585(11)(f)	Contractor
Annual written communication to FBDE members about how to align MCE's benefits with its Affiliated MA or DSPN Plans, or both as may be applicable.	Ex B, Part 3, Sections 4a and 4b.	Contractor
Full Benefit Dual Eligible (FBDE) Explanation of any Medicare deductibles and coinsurance	Ex B, Part 3, Section 4b	Contractor
General Information and Education: The requirements and benefits of MCE's integrated and Coordinated Care Services plan. Written informational materials and educational programs consistent with the requirements of OAR 410-141-3580, 410-141-3585, and 42 CFR §438.10 providing general information to Members and Potential Members about: • Basic features of managed care; • Which populations are excluded from Enrollment, subject to mandatory Enrollment, or free to enroll voluntarily in the program; • MCE's responsibilities for coordination of Member care; • The Services Area covered by the MCE; • Covered Services and benefits; • The Provider directory;	Ex B, Part 3, Sections 4a and 4b.	Contractor

Requirement	Regulation and Contract Citation	Text provided by
• The requirement for the MCE to provide adequate access to Covered Services.		
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.	OAR 410-141-3585(11)(e)	
Information on MCE's ID card, Oregon Health ID, and OHP coverage letter. An identification card to Members which contains simple, readable and usable information on how to access care in an urgent or emergency situation.	Ex B, Part 3, Section 12. OAR 410-141-3585(12)	Contractor
Information available upon request, including the following: • Information on the structure and operation of the MCE. • Physician incentive plans as set forth in 42 CFR 438.6	Ex B, Part 3, Section 4 F.	Contractor
Information specifying that MCEs may not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of a patient for the following: • The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; • Any information the member needs to decide among all relevant treatment options; • The risks, benefits, and consequences of treatment or non-treatment.	OAR 410-141-3585(11)(b)	Contractor
Health education MCE must promptly develop and implement at least one strategy for development and use of Member educational and other materials (print, multimedia, etc.), that are in plain language and alternate formats, utilizes IT and other tools and resources for Members who are blind or deaf, or otherwise disabled (e.g. literacy programs).	Ex K, Section 10c (2)(h)	Contractor
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. MCEs shall make every effort to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non-dominant cultures;	OAR 410-141-3585(11)(a)	Contractor
Information on culturally sensitive MCE or provider-based health education programs, including self-care, prevention, and disease self-management. Member educational programs include, without limitation: • A program that addresses Prevention and Early Intervention of illness and disease; and	Ex B, Part 2, Section 6a (l) Ex B, Part 3, Section 1e. Ex B, Part 3, Section 4d.	Contractor

Requirement	Regulation and Contract Citation	Text provided by
• The promotion and maintenance of optimal health status, to include identification of tobacco use, referral for tobacco cessation intervention (e.g., educational material, tobacco cessation groups, pharmacological benefits and the Oregon Tobacco Quit Line (1-877-270-STOP)).		
Development and maintenance of an individualized health educational plan for members requiring specific educational intervention. The Authority may assist in developing materials that address specifically identified health education problems to the population in need.	OAR 410-141-3585(11)(c)	Contractor
ICC services: Explanation of ICC services and how eligible members may those services. MCEs should ensure that ICC-related education reaches potentially eligible members, including those with special health care needs including those who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, chemical dependency, or who receive additional Medicaid-funded LTCSS.	OAR 410-141-3585(11)(d)	Contractor
Substance use disorder services Provide culturally and linguistically appropriate alcohol, tobacco, and other drug abuse prevention/education and information that reduce Members' risk to SUD.	Ex M, Sections 7c. & 7g.	Contractor
By Jan. 1, 2020, post a document to educate members about best practices, care quality expectations, screening practices, treatment options, and other support resources available to members who have mental health illnesses or substance use disorders. OHA will post a guidance document on or about 11/1/2019 that provides details about this.	Ex. M, Section 1g	Contractor
Peer-delivered services Contractor shall inform members and encourage utilization of peer-delivered services (PDS) by providing members with information that includes a description of PDS, the role of the PDS provider, and how PDS can enhance members' care.	Ex. M. Section 9	Contractor

Requirement	Regulation and Contract Citation	Text provided by
Non-emergent medical transportation (NEMT) services The Member Handbook or a stand-alone document must inform members about: • Member/passenger rights and responsibilities, including right to file a grievance • Approval process of NEMT services • Verifying eligibility for NEMT services • Service modification for passenger and driver safety • Determining the appropriate mode of transportation • Ensuring timely access to NEMT services • Requesting NEMT services • Scheduling, assigning and dispatching trips • Accommodating scheduling changes • Notifying members • Member is not responsible for determining whether arrangements have been made • Adverse weather plan • Contingency and back-up plans • Pick up and delivery • Accidents and incidents • Monitoring and documentation of services	Ex B, Part 2, Sections 5a and 5d OAR 410-141-3920 – 410-141-3965	Contractor

Potential member information requirements

Requirement	Regulation and Contract Citation	Text provided by
Complies with the marketing requirements and prohibitions in 42 CFR § 438.104 and OAR 410-141-3575.	OAR 410-141-3580(1)	N/A
States that Indians enrolled in the MCEs may select an Indian health care provider (IHCP) that is participating as a primary care provider within the network of the MCE, insofar as the individual is otherwise eligible to receive primary care services from such IHCP and the IHCP has the capacity to provide primary care services to such Indian.	OAR 410-141-3580(5)(a)	Contractor
Clearly explains that Indians enrolled in an MCE must also be permitted to obtain primary care services covered under the contract between the state and MCE from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive primary care services. Prior authorization to receive services from an IHCP may not be permitted solely based on criteria that the provider is an IHCP or out of network, and Indians may be referred by out-of-network IHCPs to a network provider without prior authorization or referral from a participating provider. 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).	OAR 410-141-3580(5)(b)	Contractor

Requirement	Regulation and Contract Citation	Text provided by
Is culturally and linguistically appropriate and sensitive to people with disabilities or reading limitations, including those whose primary language is not English.	OAR 410-141-3580(6)(a)	N/A
Prepared at a 6th grade reading level, incorporating graphics and utilizing alternate format materials for potential members and using a minimum 12-point font or large print (18 point).	OAR 410-141-3580(6)(c)	N/A
Which OHP populations are excluded from MCE Enrollment, subject to mandatory Enrollment, or free to enroll voluntarily in a MCE. Information for Dual-Eligible Members regarding enrollment and disenrollment and information specific to Duals.	Ex B Part 3,Section 4a (2)	Contractor

Marketing material requirements

Material subject to OHA review

OAR 410-141-3575 defines “Marketing Materials” as materials that:

- Are produced in any medium by or on behalf of an MCE and
- Can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular MCE..

Any content that meets this definition is subject to OHA approval prior to distribution by the MCE or by another entity on behalf of an MCE.

Material exempt from OHA review

- The creation of name recognition by the MCE through methods such as brochures, pamphlets, newsletters, posters, fliers, websites, bus wraps, billboards, web banners, health fairs, or health-related events.
- Communications to notify dual-eligible members of opportunities to align MCE-provided benefits with Medicare Advantage or Special Needs Plans
- Communications related to improving coordination of care for dual-eligible members
- Communications to providers serving dual-eligible members about unique care coordination needs
- Streamlining communications to dual-eligible members

Marketing material requirements

Requirement	Regulation and Contract Citation	Text provided by
Material : • Uses easily understood language and format • Is in a font size no smaller than 12 point • Is available in other formats for members with special needs or limited English proficiency • Includes a large print tagline and information on how to ask for auxiliary aids and services, including materials in alternate formats	42 CFR §438.10(d)(6)(i-iv)	N/A
The MCE will distribute the material to its entire service area.	42 CFR §438.104(b)(1)(i)	N/A

Requirement	Regulation and Contract Citation	Text provided by
Marketing is accurate and does not mislead, confuse, or defraud Medicaid members or OHA.	42 CFR §438.104(b)(2) Ex. B, Part 3 Section 13(1)	Contractor
Marketing does not suggest that the member must enroll in the CCO to obtain benefits or to not lose benefits.	42 CFR §438.104(b)(2)(i) Ex. B Part 3 Section 13(4)(a)	Contractor
Marketing does not seek to entice enrollment in conjunction with the sale or offering of any private insurance.	42 CFR §438.104(b)(3) Ex. B, Part 3 Section 13(2)	Contractor
Marketing does not include any state or federal trademarks, trade names, service marks, or other designations	Ex. B, Part 3 Section 13(3)	Contractor
Marketing does not suggest that the MCE is endorsed by CMS, the federal or state government, or similar entity.	42 CFR §438.104(b)(2)(ii) Ex. B Part 3 Section 13(4)(b)	Contractor
MCE must clearly and consistently communicate with Members about the benefits and availability of THW services through Marketing Materials and other means and methods. Marketing Materials and other means and methods must be CLAS appropriate and reflective of the REAL+D demographics within MCE's Service Area.	Ex. K, Section 11e (3)	Contractor
Material explains how to access oral and sign language interpretation and written translation services.	Ex. B Part 3 Section 2e	Contractor

Text provided by OHA

Words to know

For consistency, in the context of member materials, the MCE must use OHA-provided definitions listed below.

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 themselves 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 MCEs 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.

Member handbook text

OHA model handbook (OHP Handbook)
https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/he9035.pdf

Tag lines in 18-point font (how to access auxiliary aids and services)

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: <email address>
Web: <website>

Explanation of OHP, coordinated care and fee-for-service

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.

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, or can ask to change to fee-for-service 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.

Urgent Care, Emergencies and Crises at Home and Away

Always call your doctor, or 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 doctor'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 doctor.

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. Please get follow-up care from your PCP or regular doctor.

Advance directives

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 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 www.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

Health education standard text

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