PLAN OPERATIONS	Advantage Dental From DentaQuest		
	Policy and Procedure		
	Policy Name:	**Enrollee Information and Education**	Policy ID:	**PLANCG-25**
	Approved By:	Quality Assurance and Performance Improvement Committee	Last Revision Date:	11/11/2021
	States:	Oregon	Last Review Date:	11/15/2021
	Application:	Medicaid	Effective Date:	11/16/2021

PURPOSE
To establish guidelines on informational and educational materials distributed to enrollees.

POLICY
The Dental Care Organization (DCO) shall provide a welcome packet in order for the enrollee to make an informed decision when choosing a Primary Care Dentist (PCD).

The DCO shall ensure that its staff, who have contact with enrollees, is fully informed of the DCO's and Oregon Health Authority's (OHA) policies.

Enrollee Education:
For enrollees assigned through OHA, the DCO shall mail a printed copy of the Member Handbook within 14 days after receiving notification of the enrollee's enrollment and to enrollees' returning to the DCO 12 months or more after previous enrollment. The Member Handbook, along with all DCO policies, is reviewed annually for accuracy and is updated as applicable with new and corrected information to reflect OHP program changes and DCO internal changes. If changes affect the enrollee's ability to use services or benefits, the DCO shall offer the updated Member Handbook to all enrollees. Enrollees will be notified annually via written correspondence and website announcement of the availability of a Member Handbook and provider directory and how to access those materials. The Member Handbook shall be sent to the enrollee's mailing address. The Member Handbook will include all of the Oregon Health Authority's Member Handbook Evaluation Criteria .

The DCO shall provide enrollees assigned through a CCO, within 14 days of enrollment, a welcome packet which will include the following:

- Welcome Letter
- Member Handbook which includes at a minimum:
    - The revision date, including month, day, and year
    - Tag lines in English and other prevalent non-English languages, spoken by populations of members. The tag lines shall be in large type (18-point font). The tag lines shall be located at the beginning of the document for the ease of the member and describe the following:
        - How members may access free sign and oral interpreters, translations and materials in alternate formats, and auxiliary aids and services;
        - The toll-free and TTY/TDY telephone numbers of the DCO's customer service unit.
    - DCO's office location, mailing address, web address, office hours, and telephone numbers including TTY;
    - The toll-free number for any partners providing services directly to members, including non-emergency medical transportation providers;
    - The DCO's confidentiality policy;

- Information about the structure and operations of the DCO, including whether or not the DCO uses provider contracts, including alternative payment methodologies or incentives, and how this will impact the member;
- Explanation of oral health benefits and covered services available to members without charge in sufficient detail to ensure that members understand the benefits to which they are entitled;
- Explanation of care and services available to members during a transition of care as defined in OAR 410-141-3850 and 42 CFR § 438.62, including DCO contact information to request more information regarding continued access to care and services during a transition of care and instructions on accessing the DCO's written transition of care policy;
- Explanation of transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a Primary Care Dentist (PCD), other prescribing provider, or obtain new orders during that period;
- Explanation of how to choose a PCD, how to make an appointment, how to change PCDs, and the DCO's policy on changing PCDs;
- Explanation that American Indian/Native Alaskan members may choose an Indian Health Care Provider (IHCP) as the member's PCD if:
    - The IHCP is participating as a PCD within the provider network; and
    - The member is otherwise eligible to receive services from such Indian Health Care Provider; and
    - The IHCP has the capacity to provide the services to such members.
- Explanation that American Indian members may obtain covered services from non-participating providers and can be referred by an IHCP to a participating provider for covered services in accordance with 42 CFR §438.14;
- Explanation of access and care standards consistent with the requirements set forth in 42 CFR §438.206 and OARs 410-141-3515 and 410-141-3860;
- Explanation of available telehealth services as described in OAR 410-141-3566 including, but not limited to, the information contained in sections (4) and (5) of 410-141-3566, how to access telehealth services, and information on supports available to the member to assist them in accessing telehealth services.
- Explanation of the health risk screening process;
- Information about tobacco dependency and cessation services and how to access such services through the DCO;
- Explanation of non-emergency medical transportation (NEMT) services, including how the DCO coordinates NEMT services for members and how a member accesses NEMT services.
- Explanation of care coordination services and how the member can request and access a care coordinator, including information that the DCO must coordinate dental services furnished to the member with the services the member receives from other plans and/or from community and social support providers.
- Policies on referrals, prior authorization and pre-approval requirements and how to request a referral, including but not limited to the following:
    - No prior authorization or referral is necessary for urgent or emergency dental services including dental post-stabilization services;
    - Information on how to access specialty dental care furnished by the DCO;
    - Information on how to access specialty care and other benefits that are not furnished by the DCO;
- Information on how to obtain a second opinion;
- How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;

- Information regarding any service not covered, in accordance with law, due to the religious or moral objections of the DCO and how to contact Oregon Health Authority for information regarding accessing the service;
- How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;
- How and when members are to use emergency services, both locally and when away from home, including examples of dental emergencies and use of 911;
- Information on how to contact the DCO's after-hours call-in system to triage Urgent Care and Emergency service calls from members or a member's long-term care provider or facility;
- Explanation that members can access dental services while out of state in an urgent or emergency situation, including information on how to access additional assistance from the DCO with a bill from an out of state provider and any appeal rights available to the member, if applicable;
- Information on when and how members may voluntarily and involuntarily disenroll from DCOs or change DCOs;
- A statement or narrative that articulates the DCO's commitment to preventing fraud, waste, and abuse and complying with all applicable laws including, but not limited to, the State's False Claims Act and the federal False Claims Act;
- Information on where and how to report fraud, waste, or abuse by a provider or a member and a member's right to report fraud, waste, and abuse anonymously and be protected under applicable Whistleblower laws;
- Information on the DCO's grievance and appeals processes and the Authority's contested case hearing procedures, including:
    - Information about assistance in filling out forms and completing the grievance process available from the DCO to the member as outlined in OAR 410-141-3875;
    - Information about the member's rights in the grievance, appeals, and hearings process, including the right to continued benefits as provided in OAR 410-141-3885.
    - The requirements and timeframes related to the processes for grievances, appeals, and hearings.
- Information on the member's rights and responsibilities, including the rights of minors, and availability of the OHP Ombudsperson;
- The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee, and that they may request the record be amended or corrected;
- Explanation of the DCO's nondiscrimination policy and how and where to file a grievance if a member feels they were treated unfairly, including contact information for the DCO's Non-discrimination coordinator;
- Information about the requirement to provide providers and subcontractors with third-party liability information;
- Explanation that the DCO will provide written notice to affected members of any significant changes in provider, program, or service sites that affect the member's ability to access care or services from the DCO's participating providers. Such notice shall be translated as appropriate and provided to the member at least 30 days before the effective date of the change, or as soon as possible if the participating provider has not given the DCO sufficient notification to meet the 30-day notice requirement;
- Information on advance directive policies including:
    - Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

        - The DCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience;
        - Avenues for filing complaints concerning noncompliance with the Advance Directive requirements, including the grievance and hearings process or directly with OHA, and information on how to file such a complaint with OHA;
    - DCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the DCO's internal changes. If changes affect the member's ability to use services or benefits, the DCO shall offer the updated member handbook to all members;
    - (LL) The "Oregon Health Plan Client Handbook" is in addition to the DCO's member handbook, and an DCO may not use it to substitute for any component of the DCO's member handbook.

In the event the DCO issues or receives notice that a provider has been terminated, the DCO shall provide written notice of such termination to the enrollees who received regular care or primary care from the terminated provider. The written notice shall be provided within fifteen (15) days after receipt of issuance of the termination notice.

Upon request of any enrollee, the DCO shall provide additional information that the DCO has created that has been pre-approved by OHA and is otherwise available, including information on the DCO's structure and operations, and any provider incentive plans.

DCO and providers have additional educational materials available for enrollee education regarding general oral health topics. If the provider has suggestions for additional educational topics, they can submit them to the DCO's Member Services Department.

REFERENCES

42 CFR 438.14 Requirements that apply to MCO, PIHP, PAHP, PCCM, and PCCM entity contracts involving Indians, Indian health care providers (IHCPs), and Indian managed care entities (IMCEs)
42 CFR 438.62 Continued services to enrollees
42 CFR 438.100 Enrollee Rights
42 CFR 438.206 Availability of services
OAR 410-141-3515 Network Adequacy
OAR 410-141-3566 Telehealth Service and Reimbursement Requirements
OAR 410-141-3585 MCE Member Relations: Education and Information
OAR 410-141-3850 Transition of Care
OAR 410-141-3860 Integration and Coordination of Care
OAR 410-141-3875 MCE Grievances & Appeals: Definitions and General Requirements
OAR 410-141-3885 Grievances & Appeals: Appeal Process

Revision History

Date:	Description
06/14/2012	Approval and adoption.
06/06/2014	Updates based on annual review.
02/23/2015	Updates based on annual review.
03/26/2015	Updates based on CCO partner audit findings.
02/23/2016	Updates based on annual review.
02/14/2017	Updates based on annual review.
03/12/2018	Updates based on annual review.
04/24/2019	Updates based on annual review.
12/05/2019	Conversion to revised policy and procedure format and naming convention.
11/11/2021	Updates based on annual review.