DMAP Worker Guide V

Managed Health Care Systems

May 2008

Managed health care systems

The Division of Medical Assistance Programs (DMAP) contracts with managed care organizations (MCOs) to provide services to Medicaid clients. In exchange, MCOs receive a monthly capitation payment for each enrolled client.

When the client has been enrolled into an MCO, the MCO provides the client with a handbook outlining the services it provides and how to access them.

Indian Health Services and tribal health clinics either have managed care programs or consider their clinics to be in managed care. When discussing managed care enrollment options for American Indian and Alaska Native clients, specify OHP managed care.

In managed care, services are coordinated through one primary care provider or clinic that manages the client's health care. When necessary, the primary care provider makes referrals to specialty providers, who are paid by the MCO. A comparison chart is included in the OHP application packet (not included in reapplication packets). The comparison chart describes the MCOs that are available in the area where the client lives and unique information about each plan.

Important: Medical Case Management (MCM) and Disease Case Management (DCM) are not managed care plans. A client's Medical Care ID may show an MCM or DCM in Field 8a, which indicates DMAP has assigned them extra services because they have high risk or high cost health conditions such as asthma, diabetes, COPD or heart failure. MCM and DCM clients receive services on a fee-for-service (open card) basis. MCM and DCM are not payers or third party resources and do not affect claim submissions or payments. Questions regarding either of these programs should be directed to DMAP. For more information about MCM and DCM services, see DMAP Worker Guide VI - Other Medical Resources.

Type of Managed Care Organizations

Fully Capitated Health Plan (FCHP)

The most common delivery system is the Fully Capitated Health Plan (FCHP). DMAP pays the FCHP a monthly capitation payment to provide comprehensive services and to manage each enrolled client's health care. FCHPs provide medical services ranging from physician and hospital inpatient care to physical therapy and many medications. FCHPs provide an Exceptional Needs Care Coordinator (ENCC) for clients with special needs. Clients may be exempt from enrollment in an FCHP either temporarily or permanently for various reasons. See Section E – Exemptions from Managed Care in this worker guide for more information.

Physician Care Organization (PCO)

DMAP pays the Physician Care Organization (PCO) a monthly capitation payment to provide comprehensive services and to manage each enrolled client's health care.

Clients enrolled in a PCO receive inpatient hospital services and post-hospital extended care services on a fee-for-service basis.

Clients may be exempt from enrollment in a PCO either temporarily or permanently for various reasons. See "Exemptions from Managed Care" in this worker guide for more information.

Primary Care Manager (PCM)

DMAP also contracts with independent providers to be Primary Care Managers (PCMs). PCMs manage a client's health care for a nominal monthly case management payment and bill DMAP on a fee-for-service basis for services provided to the client. Clients with major medical private health insurance can be enrolled with a PCM. PCMs may be physicians, physician assistants, nurse practitioners with a physician back-up, or naturopathic physicians with a physician back-up. PCMs may also be rural health clinics, migrant and community health clinics, federally qualified health centers, county health departments, Indian health service clinics, or tribal health clinics. PCMs can refer clients to specialty services. PCMs are usually utilized when an FCHP is either not available or is closed to new enrollment.

Dental Care Organization (DCO)

A Dental Care Organization (DCO) is a prepaid dental plan that provides dental services to qualified medical assistance clients. DMAP pays the DCO a monthly capitation fee to provide comprehensive services and to manage each enrolled client's dental care.

Chemical Dependency Organization (CDO)

A Chemical Dependency Organization (CDO) provides chemical dependency services in Deschutes County only to qualified medical assistance clients. DMAP pays the CDO a monthly capitation payment to provide comprehensive services and to manage each enrolled client's chemical dependency care.

Mental Health Organization (MHO)

A Mental Health Organization (MHO) provides mental health services to qualified medical assistance clients. A client's MHO enrollment is determined by the medical plan the client chooses. DMAP pays the MHO a monthly capitation fee to provide comprehensive services and to manage each enrolled client's mental health care.

Clients who are eligible for mental health benefits will receive services through MHOs, which may be an FCHP, community mental health program, or private mental health organization. Services provided by MHOs include:

- Evaluation
- Case management
- Consultation
- Mental health related medication and medication management

- Individual, family, and group therapy
- Local acute inpatient care
- 24 hour urgent and emergency response
- For adults only:
  - ◊ Rehabilitation services
  - ◊ Skills training
  - ◊ Supported housing
  - ◊ Residential care

Enrollment process

Clients are required to be enrolled in the following types of managed care:

- A DMAP contracted medical plan (FCHP or PCO) or PCM (only if a medical plan is not available), and
- A DMAP contracted Dental Plan (DCO), and
- A DMAP contracted Chemical Dependency Plan (CDO), if the client resides in Deschutes County.
- An Addictions and Mental Health Division contracted Mental Health Plan (MHO)

A client's residential address, ZIP code and FIPS code determines which managed care plans are available to them. In certain approved situations, clients may be either temporarily or permanently exempt from managed care enrollment. See "Exemptions from Managed Care" in this worker guide for detailed information.

MCOs and PCMs serve clients in different service areas throughout the state. Each service area is made up of one or more counties. Service areas are considered "mandatory" or "voluntary" based on the number of MCOs available and whether or not they have enough provider access to continue accepting new enrollees. Clients who live in a mandatory service area are required to enroll in an MCO or PCM if an MCO is not available. Enrollment in voluntary service areas is not required, however, it is preferred. The enrollment screen (ENRC) shows if the client lives in a mandatory or voluntary enrollment area. If a client is enrolled and moves to a voluntary ZIP code served by their existing managed care plan, they would not be eligible to disenroll until their next recertification period.

The KSEL screen gives the following information (based on the FIPS/ZIP codes for the client's residence address):

The types of managed care coverage available (*i.e.*, medical plans, dental plans)

- The specific MCOs and/or PCMs available
- The PCM's specialty

- The MCO's enrollment status:
  - ◊ Open or closed for enrollment
  - ◊ If they are accepting re-enrollments
  - ◊ What the time limits are for re-enrollment (*e.g.*, 30 days)
  - ◊ Whether or not they take Standard clients

Sometimes a managed care plan must close enrollment to new members. When attempting to enter an enrollment when a plan is closed, check KSEL to see if there is a re-enrollment period. These are usually 30 days, but can be longer. If the client's break in enrollment was less than the number of re-enrollment days showing on KSEL, the client may be able to get back into the plan. Workers should contact DMAP's Client Enrollment Services (CES) staff to see if the client can be re-enrolled. If a case already has someone enrolled in a plan that is closed, any new or returning family members can also enroll.

Selection process

The MCO and PCM selection process is based on whether the client lives in a mandatory or voluntary enrollment area and how many MCOs are available. An area can be mandatory for one type of MCO (*e.g.*, an FCHP) and at the same time be voluntary for another type of MCO (*e.g.*, a DCO). Whether or not a plan is open for new enrollment and whether an area is voluntary or mandatory is determined by DMAP.

Most clients who live in a mandatory area must select a medical plan (FCHP or PCO) if one is available. If an FCHP/PCO is not available they may enroll with a PCM. They must also enroll with a dental plan (DCO). The date of enrollment in an FCHP or DCO depends on when the enrollment action is taken. Some exceptions to mandatory enrollment would be if the client has a third party resource (TPR) or proof of Native American heritage.

Note: Clients with dental TPR are still required to enroll in a dental plan. Clients with Medicare are not mandatory to enroll but can enroll if they choose.

Clients are auto-enrolled into an MHO based on their medical plan, county of residence or PCM enrollment and are therefore not required to choose a MHO.

If the client was auto-enrolled by the system or their worker chose for them, they have 30 days from the date of enrollment to notify their worker to request an enrollment change. Clients who were enrolled into the MCO and/or PCM of their choice can only change their enrollment for one of the reasons listed in "Disenrollment/Changes in Managed Care."

1. Mandatory area with multiple MCOs

Use this process for clients who:

- Live in a mandatory area, and
- There is more than one MCO available, and
- Either they did not choose a MCO or the MCO they chose is not available. See Client Notification Requirement below.

The worker must choose an MCO based on an alphabetical selection. For example, the worker would enroll the client in the first (alphabetically) available MCO. The next enrollment (in the same service area) would go to the next (alphabetically) available MCO and so on.

If the worker does not enroll the client and the client does not have an approved exemption, the client will be auto-enrolled into one of the available MCOs. See Section 3 - Auto-Enrollment for more information.

2. Mandatory area with a single MCO

Use this process for clients who:

- Live in a mandatory area, and
- There is only one MCO available.

The worker must enroll the client in the available MCO. If the worker does not enroll the client and the client does not have an approved exemption, the client will be auto-enrolled into the MCO. See Section 3 - Auto-Enrollment for more information.

3. Mandatory area with no MCO available

Use this process for clients who:

- Live in a mandatory area, and
- There is no MCO available, but
- There are PCMs available.

The worker must enroll the client in a PCM. The PCM will manage the client's care, but the client will receive services on a fee-for-service basis (also known as open card). Clients are not auto-enrolled into a PCM.

4. Voluntary area

If clients live in voluntary enrollment areas, they are not required to enroll in a MCO or PCM. However, staff should tell them that enrollment in a MCO or with a PCM can increase their access to services and also provide valuable resources.

Clients who are not enrolled in a MCO or PCM receive their services on a fee-for-service basis. The client will continue to receive services fee-for-service until the area changes to mandatory.

Client Notification

If the client chooses a managed care plan or PCM that is not available, the worker must send a notice to the client telling them:

- The name of the managed care plan or PCM they have been enrolled in, and
- They have a right to change to a different managed care plan within 30 days of the enrollment if another plan is available.

Service area changes

1. From mandatory to voluntary

When a client changes from a mandatory to a voluntary service area during their certification, their managed care enrollment status will change as follows:

- If their existing MCO or PCM also provides service in the voluntary area, the client will remain enrolled in their MCO or PCM until their recertification period.
- If their existing MCO/PCM does not provide services, the client will be disenrolled.

2. From voluntary to mandatory

When the client changes from a voluntary to a mandatory service area during their certification, their managed care enrollment status will change as follows:

If the worker doesn't enroll the client in an available MCO, the client will be auto-enrolled unless they meet the criteria to be exempt from auto enroll.

3. Auto-enrollment

Auto-enrollment is a systematic process used by DMAP that enrolls clients in managed care plans in mandatory enrollment areas when caseworkers have not enrolled them. DMAP systems auto-enrolls affected clients on a weekly basis. Clients who have been auto-enrolled can ask (within 30 days from the enrollment) to change to a different MCO if another one is available where they live. However, they cannot go back to fee-for-service (open card) unless they have an approved exemption. DMAP sends notices to inform the client that they have been auto-enrolled and that they can request a change by contacting their caseworker. Clients who are auto-enrolled but do not request a change within 30 days, must wait until they recertify to change to a different managed care plan.

Auto-enrollment does not apply to clients who have been approved for an exemption or are in certain categories (*e.g.*, Medicare). See "Exemptions from Managed Care" in this worker guide for detailed information.

Effective date of MCO coverage — OHP Rule 410-141-0060

New clients. MCO enrollment is done on a weekly basis (this does not apply to newborn or MHO enrollments). When MCO enrollment information is entered into the CMS system:

- Before 5:00 p.m. on a Wednesday, coverage begins the following Monday.
- On Thursday or Friday, coverage begins one week from the following Monday.

Clients receive a Medical Care ID within a few days of enrollment showing two date ranges, one for the client's fee-for-service coverage and one for MCO coverage.

Newborns are retroactively enrolled by DMAP systems back to their date of birth as long

as their birth mother was enrolled in an MCO when the baby was born. This retroactive enrollment pays the managed care plan back to the baby's date of birth. The payment is made at end of month cutoff after the baby is added to the case.

Existing clients who have moved. When an existing client has moved out of their current MCO's or PCM's service area, the address change must be done in the following 2-day sequence:

- Day 1 – Update the client's new address, but DO NOT enter their new plan enrollments on the same day. That evening when DMAP systems processes the new address, the client's existing FCHP and DCO enrollments will automatically close if their existing plans don't serve their new address.

  Critical: If the new address and managed care plan enrollment changes are done on the same day, the system does not end the existing enrollments until the last day of the month. Managed care plans are only responsible to provide emergency services when clients are outside of the plan's service delivery area. If your client has already moved and their old plan enrollments don't change till the end of the month, it means that the managed care plan is not responsible for routine care any more. For clients to be able to access all covered services after they move, it is critical that the address change and new plan enrollments NOT be done on the same day.

- Day 2 – Enter the client's new managed care enrollment choices. The client will be enrolled during the next weekly enrollment.

Workers needing assistance with enrollment errors that occur due to an address change should contact DMAP Client Enrollment Services (CES) for assistance.

	Date	Worker enters	Address change effective	Managed Care Enrollment Existing ends	New begins
Correct	10/1/07	Address change	10/1/07	10/1/07	
	10/2/07	New managed care plan enrollments			10/8/07
Incorrect	10/1/07	Address change and new managed care enrollment information	10/1/07	10/31/07	11/1/07

Disenrollment or changes in managed care — OHP Rule 410-141-0080

Clients may change their MCO or PCM:

- When they reapply, or
- If they move and their existing MCO or PCM does not provide service at their new address, or

- Within 30 days of an auto-enrollment in an area with multiple MCOs, or
- When approved by DMAP.

Contact CES for assistance with managed care enrollment issues. E-mail questions to CES. The contact list is online at http://dhsdesign.hr.state.or.us/MedManual/pdf/CES_List.pdf For additional assistance with managed care related issues, contact a DMAP PrePaid Health Plan Coordinator.

Exemptions from managed care — OHP Rule 410-141-0060

Clients may temporarily or permanently be exempt from enrolling in a MCO if they meet certain criteria and are approved for an exemption. Some exemption codes are restricted and must be entered by CES. Some exemptions may be entered by caseworkers. Exemptions should contain a specific start and end date. Generally, an exemption may be approved to allow a client a small window of time to complete a needed medical service or procedure.

Some exemptions must be approved by the DMAP Clinical Unit, Senior and People with Disabilities (SPD) Medical Director or a DMAP PHP Coordinator. For questions regarding exemptions, contact CES.

Workers should not add an exemption code when the client has private comprehensive medical insurance to prevent auto-enrollment or while waiting for ELGX to be updated.

Workers can add an exemption in a voluntary enrollment area if the client meets the exemption criteria, however, it is only necessary if the client has the potential to move to a mandatory area. Otherwise, it is not necessary to use an exemption code if not enrolling in managed care.

Exemption codes

Use exemptions codes for the reasons listed in this table.

ACC	Access to Care – Use in the rare instance when the client receives the majority of their care from a unique specialist who is out of the client's service area. For example, the client has a complicated seizure disorder and lives in Medford, however, they receive the majority of their care from a specialist in Portland.
CNT	Continuity of Care – Use when MCO enrollment could harm the client's health. For example, the client is receiving care for a chronic or long-term condition from a provider who is not part of an available MCO. The worker must have documentation from the client's medical provider before using this code. Documentation must be kept in the client's case file.
EXL	Only used by DMAP when a managed care plan has requested, with good cause, to have client disenrolled and excluded from enrollment. Some examples of good cause are threatening behavior, fraud and illegal acts. When an EXL is granted, the client receives a notification from DMAP.

HOS	This code can be used for two different reasons, read both descriptions to determine the appropriate code. This code is restricted and must be entered by HMU. 1 — Used by DMAP when the client is an inpatient in a hospital on the day their managed care enrollment was to begin. Client is enrolled after hospital discharge. 2 – Use for clients (adults and couples without children) who applied through the hospital hold process. These clients are exempt from medical plan enrollment for six months. These client would still be enrolled in a DCO and MHO
HRG	Hearing scheduled – Use when enrollment is delayed until after a hearing
MMC	Use only for clients who are dual-eligible (Medicare and Medicaid) and live in an area where the only medical plans available have corresponding Medicare Advantage Plans that the client does not want to enroll in.

PIH	Use when the client has proof of American Indian/Alaska Native (AI/AN) tribal membership or is eligible for benefits through an Indian Health Services Program – the client's case must have an HNA case descriptor. AI/AN clients can choose to enroll in a managed care organization and continue to receive care at an AI/AN facility OR remain fee-for-service and go to any provider who will accept their DMAP Medical Care ID
PRG	Use this code for a pregnant woman when she: 1 – Is in the third trimester of pregnancy when she first applies for OHP, and 2– She has not been enrolled in a MCO during the past three months, and 3 – Is under the care of a provider who is not contracted with an available MCO.
MED	Use when a client's medical condition or medical care requires special handling by DMAP, or the client was diagnosed with End Stage Renal Disease (ESRD) prior to enrollment. Contact CES to use this exemption. The exemption for ESRD clients will have an end date of 2049
OTH	Other reason – Used by DMAP only. All requests for this code require authorization by DHS and will include a review of physician notes. All SPD field staff that want to use this code must make a referral to the SPD Medical Director's Office.
REL	Religious consideration - This is used in the rare instance when religious beliefs would prevent the client from accessing a covered service (e.g., a woman's religion requires she see a female doctor and the MCO did not have female doctors)
RIF	Rehabilitation/Inpatient/Nursing Facility – Use for clients in the Eastern Oregon Training Center, Eastern Oregon Psychiatric Center or Oregon State Hospital and for clients in a nursing facility when the client needs to use the in-house physician of the facility, and the physician is not part of an available MCO. Documentation must be kept in the case file.
SUR	Use when the client has surgery scheduled and the current provider does not participate with one of the available MCOs

Third party resources (TPR)

Private health insurance does not automatically exempt a client from managed care. Depending on the type of private health insurance, a client may still be eligible for enrollment in an MCO or PCM. The Health Insurance Group (HIG) verifies TPR information they receive and determines if the private insurance can be a primary payer. If HIG determines the insurance meets TPR criteria, they update ELGX. They do not disenroll clients from any existing managed care enrollments. Workers who want to be

notified when the TPR files have been updated (so they can enter or disenroll managed care enrollments) will have to request that HIG contact them.

The table below lists the different types of private health insurance coverage a client may have. Each type of coverage has a different code and managed care enrollment requirement. The "X" indicates that the client is required to enroll in an MCO

Note: Clients in mandatory areas with dental private health insurance are still required to enroll in a DCO if one is available where they live.

Enrollment codes for private health insurance

Private coverage type	Code	FCHP/PCO	PCM[1]	DCO	MHO
Accident	AI	X	X	X	X
Champ VA	CA	X	X	X	
Cancer	CI	X	X	X	X
Champus	CS		X	X	X
Major	H12		X	X	
Hospital	H13	X	X	X	X
Surgery	H14	X	X	X	X
Drugs	H15		X	X	X
Dental	H16	X	X	X	X
Visual	H17	X	X	X	X
Private Medical	HM			X	
Medicare Supp.	MS			X	
Medicare HMO[2]	MAB			X	
Nursing Home	NH	X	X	X	X

[1] See Sections A3 - Primary Care Managers (PCM) and B1- Selection Process for PCM enrollment requirements.

[2] System will allow clients with Medicare HMOs to be enrolled in a medical plan. However, workers are not to enroll them unless the Medicare HMO is also a DMAP-contracted medical plan. Medicare clients can also be enrolled with a PCM and must be enrolled in a DCO.

If a caseworker becomes aware that a client's private health insurance is terminated, the worker must submit a completed DHS 415H with termination date to (HIG) and update the private health insurance (PHI) flag on the PCMS screen. If the TPR file (ELGX) contains incorrect information and it is creating a barrier to a client's ability to access care, the caseworker can contact HIG by phone, fax or e-mail and ask for expedited processing of the DHS 415H.

A case is listed on a discrepancy report if there is a difference between the PHI code and the TPR file, (*e.g.*, PHI code is "Y" and there is no private health insurance on ELGX, or the PHI code is "N" and there is private health insurance on ELGX). Discrepancy reports are sent to branch offices and HIG. Branch offices should research the discrepancies and update the client's case or submit a DHS 415H to HIG. HIG also researches the discrepancy report and requests additional information from caseworkers so cases can be updated.

Caution: The PHI field on a client's case does not stop or start enrollment into managed care. This field does not communicate with the TPR file. Workers need to be sure the PHI field contains correct information and send the DHS 415H to HIG. The table below may help. For more information, contact HIG.

Type of managed care enrollment for clients with Third Party Resources (TPR)

This chart indicates what kind of managed care you can enroll clients in, depending on the type of private health insurance they have.

If client has:	Enroll with:			
	FCHP/PCO	PCM	DCO	MHO
Medicaid only (no TPR)	Yes[1]	Yes[1]	Yes[2]	Yes
Medicaid + managed TPR	No	No	Yes[2]	No
Medicaid + non-managed major TPR[3]	No	Yes	Yes[2]	No
Medicaid/Medicare (no private TPR)	Yes[1]	Yes[1]	Yes[2]	Yes
Medicaid/Medicare + private Medicare HMO	No	No	Yes[2]	No
Medicaid/Medicare + other managed TPR (not Medicare HMO) [3]	No	No	Yes[2]	No
Medicaid/Medicare + non-managed major TPR (not Medicare HMO) [3]	No	Yes	Yes[2]	No
Medicaid/Medicare + Medicare supplement (not Medicare HMO) [3]	No	Yes	Yes[2]	Yes[2]

[1]First preference is to enroll with a medical plan. If an MCO is not available, enroll with a PCM. New clients or clients with a break in enrollment who have End Stage Renal Disease (ESRD) or are in Medicare hospice cannot be enrolled in a medical health plan, but should be enrolled with a PCM if possible.

[2]Separate enrollment in a DCO is required in mandatory enrollment areas.

[3]Only clients with comprehensive private medical insurance, like Medicare supplements or major medical, or drug coverage may be enrolled with PCMs rather than MCOs. If the TPR is specialized, such as an accident policy, hospital policy or school insurance, enroll clients as if they had no TPR. Complete the DHS 415H and forward it to HIG.

Dual-eligible medical plan enrollment requirements OHP Rule 410-141-0060

Effective January 1, 2006, "Medicare + Choice 65" was changed to "Medicare Advantage Plan." Before enrolling a dual-eligible client into a DMAP medical plan, review the information in this section.

Medical plan enrollment requirements

Dual-eligible clients (someone who is eligible for both Medicaid and Medicare) can choose to enroll with any DMAP medical plan that is available in their area. However, if the DMAP medical plan has a corresponding Medicare Advantage Plan, the client must also enroll in that plan's Medicare Advantage Plan. If the client does not want to enroll in the corresponding Medicare Advantage Plan, the medical plan can request his disenrollment.

If the client lives in a mandatory medical plan enrollment area, they are required to enroll in a DMAP medical plan. The client can be exempt from medical plan enrollment if the only medical plan available has a corresponding Medicare Advantage Plan that the client does not want to enroll in. For example, if a client lives in Deschutes County and chooses not to be enrolled in Clear Choice (Medicare Advantage Plan), then they cannot be enrolled in Central Oregon Independent Health Solutions (COIHS–the DMAP contracted medical plan in Deschutes Co.).

- DMAP medical plan with corresponding Medicare Advantage Plan
  The client must complete the Medicare Advantage Plan Election form (OHP 7208M) and send it to the DMAP medical plan within 30 days of DMAP medical plan enrollment. Their Medicare and Medicaid covered services will be coordinated between the Medicare Advantage Plan and the DMAP-contracted medical plan. Clients who opt out of the Medicare Advantage Plan enrollment will receive their Medicaid services on a fee-for-service basis.

  Important: Clients who have End Stage Renal Disease (ESRD) or receive routine dialysis treatment, or have received a kidney transplant within the last 36 months cannot enroll in a Medicare Advantage Plan unless they were already enrolled in the plan as a commercial member before being diagnosed with ESRD.

- DMAP medical plan without a corresponding Medicare Advantage Plan
  Enroll these clients in their DMAP medical plan like all other clients. These clients would receive their health care as follows:
  - ◊ Medicare services – from Medicare
  - ◊ Medicaid services – through their DMAP medical plan

- Medicare Advantage Plan election (OHP 7208M) instructions
  Clients who are enrolling in their DMAP medical plan's corresponding Medicare Advantage Plan must complete the OHP 7208M. Clients not completing this form may be disenrolled from their managed health care plan. The following information is needed to complete the OHP 7208M:
  - ◊ Information about the client – name, phone number, address, county, date of birth, gender, Social Security number, and Medicare claim number
  - ◊ Name of the client's Primary Care Provider (PCP)
  - ◊ Name of the client's DMAP medical plan
  - ◊ Name of the Medicare Advantage Plan the client is choosing
  - ◊ Effective date of Medicare:
    Part A – Hospital insurance coverage
    Part B – Medical insurance coverage

Disenrollment requirement

Clients can only be in one Medicare Advantage Plan at a time. To disenroll from a Medicare Advantage Plan, the client must complete the Request to Terminate Insurance form (OHP 7209) and send it to the Medicare Advantage Plan they are disenrolling from.

Choice counseling

It is important for clients to choose managed care plans and/or PCMs that best meet their needs. Usually clients will make their own decisions about which MCO and/or PCM is best for them. To help them decide, DMAP includes MCO comparison charts with all new application packets. The comparison chart is a choice counseling tool and is formatted so that all MCOs in a specific area can be compared to one another.

If the client is unable to choose an MCO and/or PCM, one may be chosen for them by a holder of a power of attorney, a guardian, a spouse, a family member, a team of people, or an agency caseworker.

The checklist in this section lists major discussion areas to cover when helping a client choose a MCO and/or PCM.

Choice counseling checklist:

- □ Does the client reside in a mandatory or voluntary enrollment area?
- □ Does the client's doctor (PCP) or dentist (PCD) participate with an available MCO or could they be chosen as a PCM?
- □ Do the client's children have a PCP? Does the PCP participate with an available MCO?
- □ Is the medical or dental office near the client's home or on a bus line? Can they get to their appointments easily?
- □ Are the PCP's office hours convenient for the client?
- □ Where will they go for medicine? Is there a pharmacy near their home?
- □ Which hospital does the plan require the client to use for general hospital care? Is it near their home?
- □ Does the family have special medical, mental health, or chemical dependency needs to be considered?
- □ Is the client elderly or disabled, requiring Exceptional Needs Care Coordination (ENCC)?
- □ What transportation is available to the client to access medical services?

Educating clients about health care

The case worker or case manager can help educate clients about the managed health care delivery system in these ways:

- Define truly emergent care – These are services that are needed immediately because of a serious injury or illness. Some examples are: broken bones, profuse bleeding, a tooth that has been knocked out, suspected heart attack and loss of consciousness. Refer to the OHP Client Handbook (OHP 9035), for more information.
- Advise clients to cancel appointments at least 24 hours in advance if they can't make it to their appointments.
- Explain that there could be a one to three month wait for a routine appointments, especially with a dentist, so they should make preventive care appointments and not wait until an emergency arises,
- Primary care providers (PCPs) serve an essential function in managed care. The PCP manages the client's health care needs. The PCP works with the client to keep him or her healthy.
- If the client needs a specialist, their PCP may need to make a referral.
- Clients need to bring both their Medical ID and MCO card to all appointments. In some cases identification may be requested.
- Advise clients that some providers may not be taking new patients.
- Explain that clients need to follow the rules of their plan and respect providers and their staff.
- Tell clients to read the OHP Client Handbook (OHP 9035), and give a description of some of the information in the handbook. For example:
  - ◊ How to resolve billing problems.
  - ◊ How to resolve provider care problems.
  - ◊ How the appeal and grievance process works.
- Remind clients to review their Medical ID each time they receive one to ensure it contains accurate information.
- Remind clients to notify their worker of changes in their households, such as pregnancy, change of address, change of household composition.

Remember: Many clients haven't had access to health care, especially dental and mental health care, and don't automatically know doctor's office etiquette. See the Rights and Responsibilities section of the OHP Client Handbook (OHP 9035) for more information.

Problems or questions regarding managed health care issues can be directed to the contact units listed at the end of this section.

Managed health care issues contact list

Who to contact for help *—For DHS staff use only—*		
MCO enrollment and eligibility/billing questions No MCO message or wrong MCO on Medical ID AI/AN exemptions Medical exemptions	Client Enrollment Services Unit (CES)—DMAP 800-527-5772 Fax: 503-947-5221 http://dhsdesign.hr.state.or.us/MedManual/pdf/CES_List.pdf	CES phone contact list is online
MCO claim problems, available services, physicians, etc.	Contact the clients managed care plan	Phone number listed on client Medical ID
ELGC/ELGR and/or case coding problems	Client Maintenance Unit (CMU)—OPAR	503-378-4369
Private health insurance or third party resource (TPR)	Health Insurance Group (HIG)—OPAR	503-945-0358
Unresolved client/MCO problems	DMAP Client Services Unit (CSU)	Clients can call 800-273-0557
Requests for continuity of care exemptions Expedited hearing requests	Clinical Unit—DMAP	503-945-5785
Problems with Mental Health Organizations (MHO)	Addiction and Mental Health (AMHD) Division	503-947-5522
Problems with FCHP/PCO/DCO	PHP Coordinator in the DMAP Delivery Systems Unit (DSU). See DSU assignment list or call...	503-945-5772