DHS Oregon Department of Human Services

Health Services
Office of Medical Assistance Programs

Policy Transmittal

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Program and Policy Section, OMAP

Authorized Signature

Number: OMAP-PT-04-004
Issue Date: 12/1/2004

Topic: Medical Benefits

Transmitting (check the box that best applies):

☐ New Policy ☐ Policy Change ☐ Policy Clarification ☐ Executive Letter

☐ Administrative Rule ☒ Manual Update ☐ Other: (Specify other group here)

Applies to (check all that apply):

☐ All DHS Employees
☐ Area Agencies on Aging
☐ Children, Adults and Families
☐ County DD Program Managers
☐ County Mental Health Directors
☐ Health Services
☐ Seniors and People with Disabilities
☒ Other (please specify): DHS Staff and others identified on the SPD, CAF, OHMAS and OMAP transmittal lists

Policy Title:	OMAP Worker Guide Revision 19		
Topic Area:	Medical Benefits		
Policy Number(s):		Release No:	OMAP-WG-19
Effective Date:	January 1, 2005	Expiration:	
References:			
Web Address:	http://www.dhs.state.or.us/healthplan/data_pubs/wguide.html		

Discussion/ Interpretation:

The Office of Medical Assistance Programs (OMAP) has revised the OMAP Worker Guide. This revision will also be included with the January 1, 2005, release of the CAF Family Services Manual, FSML-36. Changes include:

Worker Guide 1 - Overview

Updated OMAP/Medicaid overview. Updated forms references - all AFS forms are changed to DHS. Removed reference to obsolete form OHP 3060. Updated phone number for Personal Injury Liens in the Field Resources chart.

Worker Guide 3 - Medical Care ID

Added information about issuing replacement and temporary Medical Care ID. Corrected sample Medical Care ID to show Client Advisory Services Unit on back page.

Worker Guide 4 - Benefit Packages

Updated description of the limited hospital benefit for the OHP Standard benefit package. Added information related to closure of OHP Standard to new enrollment effective July 2004. Updated the DHS Medical Assistance Programs chart.

Worker Guide 5 - Managed Health Care

Revised and clarified information on managed health care enrollment process. Updated contact information for Health Management Unit to add new FAX number and email address. Expanded section on dental care to include reference information for clients with questions about benefits.

Worker Guide 13 - Processing Claims

Revised client contact reference information for billing questions.

Worker Guide 14 - Premiums, Copayments and Special Requirements

Added information on Americans with Disabilities Act (ADA) Accommodation for deferral of premium payments. Full section included to correct pagination.

Local/Branch Action Required:

Read and become familiar with policy and procedure changes.

Central Office Action Required:

Read and become familiar with policy and procedure changes.

Field/Stakeholder review: [X] Yes [ ] No

If yes, reviewed by: Worker Guide review list

Filing Instructions:

File this material, dated 8/1/04, in your OMAP Worker Guide. Record the insertion date on the transmittal record on the inside of the front cover.

Remove	Insert
TOC, pp 1-4	TOC, pp 1-4
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Worker Guide 4, pp 1-4, 9-11	Worker Guide 4, pp 1-4, 9-11

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Worker Guide 14, pp 1-6	Worker Guide 14, pp 1-7

If you have any questions about this information, contact:

Contact(s):	Raeann Reese		
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Office of Medical Assistance Programs Worker Guide

Table of Contents

A. OMAP/Medicaid Overview

The Office of Medical Assistance Programs (OMAP) is an office of the Department of Human Services, Health Services cluster, which:

- Determines policy and rules for medical assistance program services including the Oregon Health Plan.
- Is responsible for Title XIX and Title XXI State Plans.
- Distributes OMAP provider information and administrative rules.
- Pays claims for medical assistance covered services.
- Contracts with managed health care plans for the Oregon Health Plan.

Children, Adults and Families (CAF), Seniors and People with Disabilities (SPD), and the Oregon Youth Authority (OYA) are the direct link with clients who receive medical assistance. The various agencies determine eligibility rules for their programs. Branch staff:

- Determine a client's eligibility.
- Ensure a client selects a medical and dental plan in mandatory enrollment areas.
- Provide choice counseling to clients when needed regarding the selection of managed care organizations available in their area.
- Enter eligibility data into the computer system.
- Order replacement Medical Care Identification (ID) on ELGH, or issue temporary Medical ID on MID1, if needed. Although this is usually called a medical card, it is actually a letter-sized sheet of paper. (See samples of the Medical ID in Section 3).
- Prior authorize and arrange for transportation, when needed, to access health care services.

When health services are delivered to the client, the provider completes a claim form and submits it to OMAP unless the client is in a managed care plan. OMAP processes claims through the Medicaid Management Information System (MMIS), a computerized claims processing system. Provider checks are issued weekly, accompanied by a remittance advice which includes an explanation of benefits.

This section contains a list of addresses showing where to send specific forms, as well as an OMAP Field Resources chart.

B. Where to Send Information

DHS 148	CMU - CAF FAX to (503) 373-0357 or send as a Groupwise attachment to MAINTENANCE, Client
DHS 415H	HIG - CAF PO Box 14023 Salem, OR 97309 (also on-line SYSM)
DHS 451, DHS 451NV	PIL - Admin. Svcs. PO Box 14512 Salem, OR 97309
OMAP 502, OMAP 502N	OMAP Claims PO Box 14951 Salem, OR 97309
OMAP 505	OMAP Claims PO Box 14015 Salem, OR 97309
CMS 1500	OMAP Claims PO Box 14955 Salem, OR 97309
CMS 1500 *(admin exams)*	OMAP Claims PO Box 14165 Salem, OR 97309
CMS 1500 *(private duty nurse)*	OMAP Claims PO Box 14018 Salem, OR 97309
CMS 1500 *(death with dignity)*	OMAP Claims PO Box 992 Salem, OR 97308-0992
OMAP 3073 *(private health insurance premium referral)*	HFO - OMAP 500 Summer St. NE, E-44 Salem, OR 97310-1014
UB 92	OMAP Claims PO Box 14956 Salem, OR 97309
DHS 443 Hearing Requests *(medical)*	OMAP Hearings Unit 500 Summer St. NE, E-49 Salem, OR 97301-1079
OMAP 501-D or ADA Form	OMAP Claims PO Box 14953 Salem, OR 97309

OMAP Field Resources

AIS - Automated Information System (client eligibility info)	Provider Svcs Unit - OMAP	**1-800-522-2508**
Billing Questions (for the medical provider, not clients)	In State - HFO - OMAP Out-of-State - CMU - OMAP	**1-800-336-6016** **(503) 945-6522**
Buy-In (Medicare premium buy-in)	Buy-In Unit - CAF	**(503) 378-2220**
Client Complaints CAF (formerly AFS) clients SPD clients Other DHS clients	 Local Branch Offices SPD Administration Governor's Advocacy	 **Operations Managers** **(503) 945-5811 / 1-800-282-8096** **1-800-442-5238 / (503) 945-6904**
***Client Advisory Services Unit** (client calls with problems regarding billing or access, quality and limitations on care)	Client Advisory Svcs Unit OMAP	**1-800-273-0557**
Eligibility History (to correct information on eligibility files)	CMU - CAF	**(503) 378-4369**
Health Insurance Group	HIG - Admin Services	**(503- 378-2220**
Hearings & Expedited Hearings (medical service issues)	Program & Policy OMAP	**(503) 945-5785**
In-Home Services Payments Policy	 Local Branch Offices SPD In-Home Svcs Unit	 **(503) 945-5799/ (503) 945-5990**
Insurance Premiums HIP Private Health Insurance (premium referral)	 CAF OMAP	 **(503) 945-6135** **(503) 945-6562**
Interpreter for the Deaf (medical appointment/care)	ODC/DHHAP	**1-800-521-9615**
Medical Payment Recovery	MPR - Admin Services	**(503) 947-4250**
***OHP Application** (for clients)	OHP Telecommunication Ctr	**1-800-359-9517**
OHP Benefits RNs	Medical Unit - OMAP	**1-800-393-9855 / (503) 945-5772**
OMAP Forms	Order through CICS	**Order on FBOS**
Out-of-State Medical Prior authorization Emergency Claims	 Medical Director-OMAP Claims Mgmt Unit-OMAP	 **(503) 945-6488** **(503) 945-6522**
Premium Billing Questions	OHP Premium Billing Ofc	**1-800-922-7592**
Prepaid Health Plan (questions/ problems on MHC enrollment) or	Health Mgmt Unit	**(503) 945-6531 / (503) 945-6534**
Pharmacy Management Program	OMAP	**(503) 945-6535 / (503) 945-5796**
Transportation Policy Authorization	 OMAP Policy Unit Local Branch Offices	 **(503) 945-6493**
Transplant Services	Medical Director-OMAP	**(503) 945-6488**
Personal Injury Liens	PIL - Admin Services	**(503) 947-9970**

*TTY: 1-800-621-5260

If you cannot find the number you need call OMAP Reception 1-800-527-5772 / (503) 945-5772

A. Medical Care Identification

The OMAP Medical Care Identification (ID) is a letter-sized sheet of paper that is mailed to each qualifying household once a month. When certain changes are made to a case, such as a change in the household or a change in managed care enrollment, the system automatically issues a new Medical ID. The system does not automatically send out a new card for every action taken on a case. ELGH will show the last three dates a Medical ID was sent.

For clients enrolled in an OMAP contracted managed care plan, the first Medical ID they receive may not show their managed care plan. Until their plan choice is listed on the Medical ID, clients may go to any medical provider who will accept their Medical ID on a fee-for-service or open card basis. After the plan is listed on the Medical ID, clients must get their care through their selected managed care plan.

The Medical ID also shows the benefit package for every eligible member in the household (fields 9a and 9b) and copayment requirements (fields 7a and 7b).

Clients have been instructed to contact their worker if information on the Medical ID is incorrect or if information changes (examples include: address change or someone leaves the household). Workers are then responsible for entering changes into the computer system.

Issuing a Replacement Medical Care ID

Sometimes workers may need to issue a replacement Medical ID. Replacements may be necessary if a client moves or if their card has been lost or destroyed. Replacement Medical IDs can be ordered by a worker using the ELGH screen. These are sent to the client's mailing address and are intended to replace their original Medical ID. Replacements are only issued for the current month and cannot be requested for prior or future months.

Issuing a Temporary Medical Care ID

In some situations the client may not have time to wait for a replacement Medical ID to be mailed because they have a medical appointment or need a prescription filled. When this occurs a temporary Medical ID may be generated by the worker using the MID1 screen. Temporary IDs can be handed to the client or faxed directly to a client's medical provider or pharmacy.

A sample of the OMAP Medical Care ID (front and back) is shown on pages 2 and 3. A sample of the temporary ID is shown on page 4.

1 2 3

OMAP Medical Care Identification (ID)

4 **Branch Name** **Division** 5 **Worker** 6 **Phone**

7a Copay Requirements	8a Managed Care/TPR
A $3 for outpatient services not paid for by your Plan (listed in 8a)	**A**
B $2 Generic/$3 Brand – for drugs not paid for by your Medical Plan (listed in 8a)	**B**
	C
	D
	E
	F
	G
	H
	I

9a Benefit Package

A – OHP Plus	**C – Qualified Medicare Beneficiary (QMB)**	**D – Limited Medicaid**
B – OHP Standard		**E – CAWEM Emergency Medical**

All non-emergency care must be approved by applicable Managed Care/TPR shown in field 8a. See OMAP General Rules OAR 410-120-1200 for specific benefit package limitations. All OMAP administrative rules can be found on the OMAP website at: www.dhs.state.or.us/healthplan/

10 Name of Eligible Person(s)	11 Recipient ID	12 Date of Birth	13 Dates of Coverage	7b Copay Req	8b ManagedCare/TPR	9b Benefit Package

IMPORTANT:

- **This is your new OMAP Medical Care ID. Issued on:**
- **Show this ID to all providers, even if you have a Managed Care Plan card.**
- **Not valid outside the United States or US Territories.**

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Message Box:

A monthly DHS message will appear in this space.

State of Oregon Department of Human Services Office of Medical Assistance Programs OMAP 1417 (Rev 6/04)

The first OMAP Medical Care ID may not have the managed care plans listed. Some plans will not provide service until listed on the OMAP Medical Care ID. Until the plans are listed, clients can go to any provider who will accept the OMAP Medical Care ID on a fee-for-service or open card basis.

Clients

If the information on the front is wrong, call your branch office right away (field 6).

Unless it is a true emergency, call your provider before you use the emergency room.

You may have to pay for the service if you use a provider who is not an Oregon Medicaid provider or with your Managed Care Plan.

If you need help making health care appointments or getting a ride, call your branch office (field 6).

For questions about:

- Eligibility – call your worker (field 6).
- Medical benefits – call your Managed Care Plan (field 8a) or provider.

Call the Client Advisory Services Unit (CASU) at 1-800-273-0557 if:

- You have concerns about access, quality, or limitations on your health care, or
- You receive a medical bill.

Your OMAP Medical Care ID shows:

⑤ Your worker's code.

⑥ Your worker's phone number.

⑦a Shows possible copay requirements. For a more detailed description of these copayments, see your OHP Client Handbook or call your worker to get a copy.

⑦b Letters in this space refer to the copay requirements (listed in field 7a) for each family member. If this space shows "NO COPAYS," a copay is not required for the time period listed in field 13.

⑧a Name and phone number of your Managed Care Plans, private insurance, or OMAP pharmacy.

⑧b Letters in this space refer to information listed in field 8a and show where each family member must receive health care services. If this space is blank, the family member can get health care services during the time period listed in field 13 on a fee-for-service basis. This means you can see any provider who will take your OMAP Medical Care ID.

⑨b Letters in this space refer to benefit packages (listed in field 9a) and show which package applies to each family member.

⑪ Health care providers use the recipient ID number to bill OMAP.

⑬ Dates show when family members are:

- Required to make a copayment (see field 7b).
- Covered on a fee-for-service basis or by Managed Care Plans, private insurance, or OMAP pharmacy (see field 8b).

⑭ Message Box. A monthly message from the Department of Human Services.

OMAP Client materials can be found on the OMAP website at: www.dhs.state.or.us/healthplan/

Providers

OMAP will only pay for services according to OMAP's administrative rules and guidelines.

OMAP will only make payment to enrolled providers.

All OMAP administrative rules, guidelines and applications to become an enrolled OMAP provider can be found on the OMAP website at: www.dhs.state.or.us/healthplan/

Remember:

- Clients must be eligible on the date of service.
- Bill all third party resources first.
- Prior authorization is required for all non-emergency care if provider is beyond 75 miles from Oregon. For out-of-state billing information, call the client's Managed Care/TPR (field 8a). If the client doesn't have Managed Care/TPR, call 503-945-6522.

Providers only: If you have questions about eligibility, call AIS at 1-800-522-2508. For billing questions, call OMAP Provider Services toll-free at 1-800-336-6016, or in Salem at (503) 378-3697.

OMAP 1417 (Rev 6/04)

TEMPORARY MEDICAL CARE IDENTIFICATION
Valid for services
Provided from 06/25/2004 through 06/30/2004

Case SCD : XX#### Prog Elig : 4

Benefit Package: A-OHP PLUS B-OHP STANDARD D-LIMITED MEDICAID C-QUALIFIED MEDICARE BENEFICIARY (QMB) E-CAWEM EMERGENCY MEDICAL

Copay: A-OUTPATIENT B-PHARMACY

Recip Prime ID	SSN	Ref Package Copay	---Managed Care/Private Insurance/Restrictions--- Ins Comp / Ins Cov	Pol Nmbr	Grp Pol
DOE, JANE	###-##-####	ABC A AB	A SAFEWAY PHARMACY OMAP PHARMACY		PHARMACY RESTRICTED
			B ODS COMMUNITY HEALTH INC OMAP Dental Plan		OD01
			C GREATER OR BEHAV HLTH INC OMAP Mental Health Plan		

Branch/DHR Div : BAKER MSO SSD Wkr ID : XX
Str : 1768 AUBURN AVE Tele BR : 541-523-5846
City/St/Zip : BAKER CITY, OR 97814

Authorized Signature _____ Date _____

ATTENTION PROVIDERS

OMAP will only pay for services according to OMAP's administrative rules and guidelines. OMAP will only make payment to enrolled providers.

All OMAP administrative rules, guidelines and applications to become an enrol-led OMAP provider can be found on the OMAP website at: www.dhs.state.or.us./healthplan/

REMEMBER:
Clients must be eligible on the date of service. Bill all third party resources first. All non-emergency care must be approved by applicable Managed Care/TPR. See OMAP General Rules OAR 410-120-1200 for specific benefit package limitations.

Prior authorization is required for all non-emergency care if provider is beyond 75 miles from Oregon. For out-of-state billing information, call the client's Managed Care/TPR. If the client doesn't have Managed Care/TPR, call 503-945-6522.

If you have questions about eligibility, call AIS at 1-800-522-2508. For billing questions, call OMAP Provider Services toll-free at 1-800-336-6016, in Salem at (503) 378-3697. (WMMMID1C-A)

A. Benefit Packages

Who Gets What? *General Rules 410-120-1160 through 410-120-1230*
OHP Rule 410-141-0480

Clients may get different medical services depending upon which public assistance program they are eligible to receive. The DHS Medical Assistance Programs chart in this section shows which benefit package goes with which public assistance program.

There are five benefit packages:

- OHP Plus Benefit Package
- OHP Standard Benefit Package *
- Qualified Medicare Beneficiary (QMB)
- QMB + OHP Plus Benefit Package
- Citizen/Alien-Waived Emergency Medical (CAWEM)

The tables in this section show the DHS Medical Assistance Programs and their corresponding benefit packages, as well as services available under each benefit package and copayment information.

* The OHP Standard Benefit Package closed to **new** enrollment July 1, 2004. Clients who were enrolled in OHP Standard on July 1, 2004, may be recertified for OHP Standard as long as they continue to meet all eligibility requirements.

B. What's Covered *OHP Rule 410-141-0480*

1. The OHP Plus Benefit Package

The Oregon Health Services Commission (HSC) developed a list of 745 medical conditions and treatments in order of effectiveness. Currently, covered services are lines 1-546 on the Prioritized List of Health and Dental Services. This includes some mental health conditions/treatments and alcohol/drug dependency conditions/treatments.

Covered services under the OHP Plus Benefit Package include:

Preventive Services

- Maternity and newborn care
- Well-child exams and immunizations
- Routine physical exams and immunizations for children and adults
- Maternity case management, including nutritional counseling

Diagnostic Services

- Medical examinations to tell what is wrong, whether or not the treatment for the condition is covered
- Laboratory, X-ray and other appropriate testing

Medical and Surgical Care

- Family planning services and supplies including birth control pills, condoms, Norplant, and Depo-Provera; sterilizations and abortions
- Medically appropriate treatments for conditions that are expected to get better with treatment. Some examples of problems that might get treatment include, but are not limited to:

Appendicitis	Diabetes
Infections	Asthma
Ear Infections	Kidney stones
Broken bones	Epilepsy
Pneumonia	Burns
Eye diseases	Rheumatic fever
Cancer	Head injuries
Stomach ulcers	Heart disease

The following medically appropriate ancillary services (when provided as part of treatment for covered medical conditions):

- Hospital care, including emergency care
- Home health services
- Private duty nursing
- Physical and occupational therapy evaluations and treatment
- Speech and language therapy evaluations and treatment
- Medical equipment and supplies
- Vision and hearing services including exams, evaluations, treatment, materials and fitting for glasses and hearing aids
- Prescription drugs and some over-the-counter drugs
- Transportation to health care for persons having no other transportation available to them, including ambulance and other methods of transport

Dental services

Outpatient chemical dependency services

Comfort care

- Hospice care and other comfort care measures for the terminally ill, including death with dignity services

Mental health services

2. The OHP Standard Benefit Package *

These clients receive the same health care coverage as the OHP Plus Benefit Package, with some exceptions. This benefit package is similar to private insurance with premiums and benefit limitations. The Prioritized List also applies to the OHP Standard Benefit Package.

* The OHP Standard Benefit Package closed to **new** enrollment July 1, 2004. Clients who were enrolled in OHP Standard on July 1, 2004, may be recertified for OHP Standard as long as they continue to meet all eligibility requirements.

The Standard Benefit Package coverage changes listed below were effective August 1, 2004. As directed by the 2003 Legislature under House Bill 2511, the OHP Standard Benefit Package will consist of the following core set of services (overlaid by Oregon's Prioritized List):

- physician services
- ambulance
- prescription drugs
- laboratory and x-ray services
- limited durable medical equipment and supplies
- outpatient mental health
- outpatient chemical dependency services
- emergency dental services

Although not part of the core set of services, the Standard Benefit Package will also include:

- hospice
- limited hospital benefit

In brief, the limited hospital benefit will include:

1. evaluation, lab, x-ray and other diagnostics to determine diagnosis (line zero on the Prioritized List);
2. hospital treatment for urgent/emergent services;
3. inpatient and outpatient hospital treatment for diagnoses listed in the Limited Hospital Benefit Code list. PA is required for certain services, as indicated.

Services dropped:

The following services are **removed** from the OHP Standard Benefit Package:

- acupuncture, except for treatment of chemical dependency
- chiropractic and osteopathic manipulation
- nutritional supplements taken by mouth

- home health care
- hospital services that are not for urgent or emergency care
- occupational therapy
- physical therapy
- private duty nursing
- speech therapy

Services added:

The following services are **added** to the OHP Standard Benefit Package:

- outpatient mental health and chemical dependency services
- some medical equipment and supplies, limited to:
  - diabetic supplies (including blood glucose monitors)
  - respiratory equipment (e.g., CPAP, BiPAP)
  - oxygen equipment (e.g., concentrators and humidifiers)
  - ventilators
  - suction pumps
  - tracheostomy supplies
  - urology and ostomy supplies
  - urgent and emergency dental services (teeth cleaning, orthodontia, fillings, and other routine services are **not** covered)

Excluded Services - Both Plus and Standard *OHP Rule 410-141-0500*

Services for conditions that the Health Services Commission ranks of lower priority are generally not covered. The Health Services Commission report contains a complete listing of conditions/treatments that are not covered. There may be other limitations depending on the eligibility category to which the client is assigned. The OHP Plus and OHP Standard Benefit Packages **do not** cover **treatments** for the following conditions that have no other complicating diagnosis:

Conditions which tend to get better on their own, such as:

- Measles
- Mumps
- Dizziness
- Infectious mononucleosis
- Viral sore throat
- Viral hepatitis
- Benign cyst in the eye
- Non-vaginal warts
- Minor bump on the head

OHP Standard Benefit Package

This benefit package was redefined on August 1, 2004.

Neither all benefits nor all limitations are listed. See General Rules, Oregon Health Plan, and individual provider Administrative Rules for complete information.

ELIGIBLE CLIENTS:

- Adult clients who do not meet eligibility for OHP Plus Benefit Package - up to 100% Federal Poverty Level
- Do not currently have commercial insurance and have not had coverage during the past 6 months
- If client has employer sponsored insurance they must be evaluated for FHIAP

COPAYMENTS:

- OHP Standard copayments eliminated effective June 19, 2004.

PREMIUMS:

- Premium charge is per member/per month
- No waivers from premiums incurred after February 1, 2003
- Failure to pay premiums will result in 6 months disqualification from program for every household member required to pay premiums
- The following clients are exempt from paying premiums:
  - American Indians/Alaska Natives who are enrolled in a tribe
  - Clients who are eligible for benefits through Indian Health Services

BENEFIT EXCLUSIONS:

- Hospital diagnoses that are **not** on the Limited Hospital Benefit Code list (see OAR 410-125-0047)
- Therapy services (physical therapy, speech therapy, occupational therapy)
- Acupuncture (except for treatment of chemical dependency)
- Chiropractic services
- Home health services/private duty nursing
- Vision exams and materials
- Hearing aids and exams for hearing aids
- Non-ambulance medical transportation

For information on benefits and exemptions for QMB and CAWEM clients, see pages 5 and 6.

Family Health Insurance Assistance Program (FHIAP)

Health Insurance Premium Assistance

ELIGIBLE CLIENTS:

Low-income Oregonians with the ability to obtain employer-sponsored insurance (ESI) or individual insurance.

ELIGIBILITY CRITERIA:

- Reside in Oregon
- Be a US Citizen or a Qualified Non-Citizen
- Have Investments and Savings less than $10,000
- Be uninsured for the previous six months, except for those leaving the OHP/Medicaid program
- Family income less than 185% Federal Poverty Level

DHS Medical Assistance Programs			
Program Code	Program Title	Case Descriptor	Benefit Package
1, A1	Aid to the Aged	See Computer Guide Section 3-L	OHP Plus
2, 82	Temporary Assistance for Needy Families (TANF)	MAA, MAF	OHP Plus
V2	Refugee Assistance		OHP Plus
3, B3	Aid to the Blind	See Computer Guide Section 3-L	OHP Plus
4, D4	Aid to the Disabled	See Computer Guide Section 3-L	OHP Plus
19, 62	DHS Foster Care		OHP Plus
C5	Substitute/Adoptive Care	SAC, SCP, SFC	OHP Plus
GA (CSD)	Non-title XIX Foster Care		OHP Plus
P2, M5, 2, 82	Children's Health Insurance Program (CHIP)	CHP	OHP Plus
P2, M5, 2, 82	Extended Medical Program	EXT	OHP Plus
5	OSIPM-PRS	NCP	OHP Plus
P2	Qualified Medicare Beneficiary (QMB)	QMB	QMB
Any Program except P2	QMB + Any Program	QMM	QMB + OHP Plus
P2, M5, 2, 82	OHP Medical	OPC, OP6, OPP	OHP Plus
P2, M5, 2, 82	OHP Medical	OPU	OHP Standard
P2, M5, 2, 82	Breast & Cervical Cancer Program	BCP	OHP Plus
P2, M5, 2, 82	Senior Prescription Drug Assistance	PDA	N/A
Any Program	CAWEM	CWM	Emergency Medical

A. Overview

Clients covered by the Oregon Health Plan (OHP) receive health care services through managed care plans in areas where they are available. The client chooses a managed care plan or primary care manager (PCM) to coordinate their health care. The managed care plan will ask the client to choose a primary care provider (PCP) from that plan's panel of providers. In areas where available and open to enrollment, clients may choose a dental plan to coordinate his or her dental care. When a client chooses a medical plan they may be automatically enrolled into the mental health organization (MHO) that contracts with the medical plan or with their local county's MHO. In Deschutes County a chemical dependency organization (CDO) provides alcohol and drug services.

This section on managed health care contains information on the following:

- Who Needs to Enroll?
- Enrollment Process
- Effective Date of Coverage
- Disenrollment/Changes in Managed Care
- Exemptions from Managed Care
- Third Party Resources (TPR)
- Dental Care
- Mental Health Care
- Choice Counseling
- Be a Good User

1. Managed Health Care Systems

In managed care, medical services are coordinated through one primary care provider or clinic that manages the patient's health care. The primary care provider then manages referrals to specialty services paid by the managed care plan. A comparison chart is included in the OHP application packet and describes the managed care plans available in the area the client lives and what coverage each plan will provide.

OMAP contracts with managed care plans and certain medical providers to provide services to Medicaid clients in exchange for a monthly capitation payment for each enrolled client. The managed care plan 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 the clinics to be managed care. When discussing managed care enrollment options for American Indian and Alaska Native clients, specify OHP managed care.

2. Fully Capitated Health Plans

The most common delivery system is the fully capitated health plan (FCHP). OMAP pays these organizations a set monthly capitation fee to provide comprehensive services for each enrolled client and to manage the client's health care. FCHPs provide medical services ranging from physician and hospital inpatient care to physical therapy and drugs.

FCHPs provide exceptional needs care coordination (ENCC) for the special needs of the aged and disabled populations in the Oregon Health Plan. Clients in the adults/couples category may be exempt from enrollment in FCHPs if they are hospitalized at the time they are enrolled in managed care. Hospital holds are submitted to the OHP Application Center by the admitting hospital. The exemption period for a hospital hold is six months. These clients would continue to be enrolled in MHOs and dental care organizations (DCOs). See *Exemptions from Managed Care* in this section for further information.

3. Primary Care Managers

In areas where there are not enough medical plans to provide coverage for all clients, OMAP contracts with providers to be primary care managers (PCMs). Clients with major medical private health insurance also choose a PCM, as will some other clients who have special care needs. PCMs may be physicians, physician assistants, nurse practitioners with a physician backup, or naturopathic physicians with a physician backup, who manage a client's health care for a nominal monthly case management payment. They bill fee-for-service to OMAP for actual health care services provided to the client. 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 also refer clients to specialty services. Clients are not enrolled in PCMs if there is a managed care plan available in their area.

4. Dental Care Organizations

Dental care organizations (DCOs) are prepaid dental plans that provide dental services to qualified medical assistance clients. OMAP pays these organizations a set monthly capitation fee to provide comprehensive services for each enrolled client and to manage the client's dental care.

5. Mental Health Organizations

Mental health organizations (MHOs) provide mental health services to qualified medical assistance clients. A client's mental health plan enrollment is determined by the medical plan the client chooses. OMAP pays these organizations a set monthly capitation fee to provide comprehensive services for each enrolled client and to manage the client's mental health care. MHO enrollments are done monthly.

B. Who Needs to Enroll? *OHP Rule 410-141-0060*

All medical assistance clients are required to enroll in managed health care either through a plan or a PCM unless they are determined eligible for an approved exemption. Refer to the DHS Medical Assistance Programs chart in Section 4 for detailed information.

C. Enrollment Process

1. Managed Health Care Plan

Clients should be enrolled in a managed care plan. However, some clients may be exempt from managed care because they have private health insurance or have an approved exemption from enrollment. You should make this determination **before** you enroll a client into managed care. (See sections on *Exemptions and Private Insurance/Third Party Resources*).

Clients may live in a mandatory or voluntary service area depending on the plans available. The ENRC screen will show if the client is in a mandatory or voluntary enrollment area. If a client is exempt from managed health care because of private third-party resource or allowable exemption, they may be enrolled in an MHO or DCO where available.

Once you have determined that a client is not exempt from managed care, you must determine what managed care plans are available to the client. Enrollment in managed care is determined by the client's address and county of residence.

The KSEL screen gives the following information on managed care plans:

- What types of managed health care coverage are available in the client's geographic area
- Which plans are available to the client by residence zip code
- Categories of service the plan covers
- Whether a plan is open for enrollment
- Whether a plan is accepting re-enrollments
- What the time limits are for re-enrollment
- The specialty of the PCM

When KSEL shows a plan is closed, but a client was previously enrolled in that plan, the Health Management Unit (HMU) of OMAP can assist in enrolling the client under certain conditions.

2. Selection of Managed Care Process

HPN (Health Plan New/Noncategorical) applicants must select a managed health care plan (FCHP) and dental plan (DCO). The mental health care plan is part of an auto enrollment process done by OMAP, therefore the applicant is not required to select a MHO.

- **Health Plan New/Noncategorical (HPN) -** *A person who is age 19 or over and is not pregnant is referred to as an HPN person.*

<u>For mandatory enrollment areas:</u>

They must select both a managed health care plan and dental care plan.

Single Plan Area:

If the HPN person has not selected both a managed health care plan and dental care plan, the worker will enroll the HPN person in the health plan available in that area. For a dental plan assignment the worker will follow the same procedure depending on whether the dental plan available is in a single or multiple plan area.

Multiple Plan Area:

If the HPN person has not selected both a managed health care plan and dental care plan, the worker will do an assignment based on a random alphabetical selection. For example: for the first application processed for that particular area, the worker would select a plan based on the first letter (A-Z) of the plan choice or PCM choice in that area. For the second application processed for that particular area, the worker would select the next plan choice or PCM choice, based on alphabetical selection.

The worker will then enroll the HPN person in the health plan randomly selected, sending a notice to the HPN person informing the client of the assignment(s) and their right to change the health and/or dental plan within 30 days of the assignment.

For a dental plan assignment the worker will follow the same procedure depending on whether the dental plan available is in a single or multiple plan area.

In mandatory enrollment counties, if the worker does not enroll the client, and the client does not have an approved exemption, OMAP Systems will auto-enroll the client in a managed health care plan.

In some mandatory areas, there may be no managed care plans available, however PCMs are available. In that instance, HPN persons are required to select a PCM. If they have not indicated on their application a PCM selection, the worker will need to follow the steps listed above for mandatory enrollment areas. **Do not enroll a client in a PCM if a managed care plan is available.**

For voluntary enrollment areas:

- Enrollment is not an eligibility requirement, unless the area changes to mandatory.
- Client has the option of enrollment - if client does not select a plan, the client will receive their health care on a fee-for-service (open card) basis.

♦ **Non-HPN(s)/Categorical Eligibles -** *applicants who are under age 19 or pregnant.*

For mandatory enrollment areas:

- Enrollment is not an eligibility requirement.
- Applicant should select a plan for enrollment - if applicant does not select, the worker will select a plan and notify applicant of plan selection.

If a Non-HPN (Categorical Eligible) does not select a plan, the worker will enroll the Non-HPN(s) in the plan available in that area. If more than one plan exists in that area, the worker will randomly assign applicants to the plans available.

The worker will do an assignment based on a random alphabetical selection. For example: for the first application processed for that particular area, the worker would select a plan based on the first letter (A-Z) of the plan choice or PCM choice in that area. For the second application processed for that particular area, the worker would select the next plan choice or PCM choice, based on alphabetical selection.

For voluntary enrollment areas:

- Enrollment is not an eligibility requirement, unless the area changes to mandatory.
- Client has the option of enrollment - if client does not select a plan, the client will receive their health care on a fee-for-service (open card) basis.

Non-HPN persons are not required to select a managed health care plan and dental care plan as a condition of eligibility. However, workers are advised to encourage Non-HPN(s) to select a managed care plan and a dental care plan, as this could increase their access to health and dental care.

3. County (enrollment area) changes from Mandatory to Voluntary during the client's certification.

If a county changes from mandatory to voluntary during a client's certification, the client will remain enrolled with the plan selected for the remainder of their certification period, unless the client meets the criteria for exemption from managed care enrollment.

4. County (enrollment area) changes from Voluntary to Mandatory during the client's certification.

If a county changes from voluntary to mandatory during a client's certification, the worker will enroll the client at redetermination or as designated by OMAP. If the client is not enrolled by the worker, the client may be auto-enrolled by OMAP Systems in areas with an available plan. Clients auto-enrolled have 30 days to request a plan change.

5. Primary Care Managers

Clients will choose a primary care manager (PCM) if:

1. there are no managed care plans available where they live,
2. the client has other major medical insurance, or
3. the client was diagnosed with end stage renal disease (ESRD) prior to enrollment.

NOTE: In addition to a PCM, the client must also choose a dental plan.

6. Auto Enrollment

If a client is not enrolled in a mandatory enrollment county, OMAP Systems will auto-enroll the client in a managed health care plan unless they have an allowable exemption from managed care. Requests for exemptions are submitted to the Health Management Unit (HMU) in OMAP. OMAP Systems does not auto-enroll clients in managed dental care plans. Workers are advised to enroll clients in managed care plans whenever possible, as this may increase the client's access to health and dental care.

See table below to determine when a client with private insurance may still be enrolled in managed care. In most cases, having Medicare does not exempt a client from enrollment in a medical plan.

Medicare and TPR Coding

Medical Insurance Benefits (MIB)

MIB codes:
1 Medicare part B (physician benefits)
2 Medicare part A (hospital benefits)

3 Both part A and B Medicare	Fill in after verifying the client has Medicare coverage - **if not**, leave blank (If ELGX is not updated, worker must contact HIG)

Private Health Insurance (PHI)

PHI codes:

Y - Yes, the client has private health insurance such as Blue Cross or Champus and an AFS 415H has been sent to the Health Insurance Group.

N - No, the client does not have private health insurance such as Blue Cross or Champus. **Use "N" if the client has no insurance or has medical coverage such as Medicare or Veterans coverage which does not usually disqualify a client from managed care.**

After the worker has entered the MIB and PHI codes on the PCMS screen, enter the enrollment information on the ENRC screen. Enter the ID number of the selected managed care provider (KSEL screen has this information) in the PHP field. The system will automatically enter the beginning and ending dates of coverage.

D. Effective Date of Coverage *OHP Rule 410-141-0060*

Managed care coverage does not take effect until the coverage information appears on the Medical Care ID. Client enrollment in managed care is now done on a weekly basis. (Weekly enrollment does not include newborns or MHOs). Here's how it works:

If the managed care information is entered into the CMS system before **5:00 p.m. Wednesday**, the client's managed care coverage will be effective the **following Monday**. The client will receive a Medical Care ID within a few days of enrollment showing a date range during which the client is fee-for-service and a date range for managed care.

If the information is entered into the system **after Wednesday**, the client's managed care coverage will be effective **a week from the following Monday**

Newborns are retroactively enrolled back to their date of birth when they are added to the grant **if the mother was enrolled at the time of the baby's birth**. This retroactive enrollment pays capitation 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.

MHOs are enrolled monthly. The computer automatically enrolls eligible clients, depending on whether or not they are enrolled in a medical plan that has a corresponding MHO. Between the date of application and the time a plan is listed on the Medical Care ID, clients may get medical care on a fee-for-service (open card) basis from any provider who will take their Medical Care ID. See the ENRC screen for the client's managed care coverage effective date. Clients remain covered in managed care until the information no longer appears on the Medical Care ID.

To arrange exemptions, mid-month disenrollment or retroactive enrollments, **contact HMU via email at omap.hmu@state.or.us (HMU, OMAP in Groupwise).** See chart at the end of this section for additional contact information. Some requests may be forwarded to an OMAP Pre-Paid Health Plan Coordinator for review.

E. Disenrollment/Changes in Managed Care *OHP Rule 410-141-0080*

Clients may change their managed care plan or PCM at the following times:

- When they reapply
- If they move out of the managed care plan or PCM service area
- Other reason approved by OMAP

Clients are instructed to call their worker if circumstances change that will affect their managed care coverage. Workers should contact HMU when enrollment changes are indicated. **Questions regarding disenrollment/changes can be directed via email to omap.hmu@state.or.us (HMU, OMAP in Groupwise).**

F. Exemptions from Managed Care *OHP Rule 410-141-0060*

Clients should be enrolled in a managed care plan, but there are exemptions. Some reasons for exemption:

- A woman in the third trimester of pregnancy who is under the care of a provider not in one of the available plans, and has not been enrolled in a plan during the three months preceding redetermination
- The client needs continuity of care for a current health condition and the treating provider is not in one of the available plans.
- The client has surgery scheduled and the current provider is not in one of the available plans.
- The client has proof of American Indian/Alaska Native (AI/AN) tribal membership or is eligible for benefits through an Indian Health Program. 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 the OMAP Medical Care ID.

- Client has been diagnosed with end stage renal disease (ESRD), as defined in rule.
- Other major medical insurance.
- The client is hospitalized at the time of enrollment choice.
- Clients determined eligible through the hospital hold process. The exemption period for a hospital hold is six months. Clients would still be enrolled in MHOs and DCOs.
- Women eligible under the Breast and Cervical Cancer Medical (BCCM) Program.

Exemption Codes

Some clients may either be delayed or are exempt from managed care enrollment if they meet the eligibility for exemption criteria for the reasons below. Some of the following codes are restricted based on staff level of responsibility. **ALL** exemptions below require an end date (other than 999999) except "PIH".

ACC Access to Care - unique circumstances that prevent the client from receiving/ accessing the medical services from the available plan.

CNT Continuity of Care - the client needs continuity of care for a current health condition and the treating provider is not in one of the available plans.

EXL The client's managed care plan requested, with good cause, to have client disenrolled and excluded from enrollment.

FRP Used by Child Welfare only.

HOS The client is enrolled in a managed care plan **during** hospital stay. Enrolled into plan choice after hospital discharge, OR

HOS Adults and couples without children identified through the hospital hold process, exempt from enrollment into a FCHP during OHP certification period. Clients would still be enrolled in MHOs and DCOs.

HRG Hearing scheduled - enrollment delayed until after results of hearing.

PIH The client has proof of American Indian/Alaska Native (AI/AN) tribal membership or is eligible for benefits through an Indian Health Program. (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 the OMAP Medical Care ID.) Must have an HNA case descriptor.

PRG A woman in the third trimester of pregnancy who is under the care of a provider not in one of the available plans, and has not been enrolled in a plan during the three months preceding redetermination.

LNG Language barrier - plan locating interpreter.

MED A client's medical condition or medical care requires special handling by OMAP. Also, clients with end stage renal disease (ESRD).

OTH Other reason.

REL Religious consideration.

SUR The client has surgery scheduled and the current provider is not in one of the available plans.

Some continuity of care and access to care exemptions must be approved by the OMAP Medical Director. For questions regarding exemptions, contact HMU (see page 14).

H. Dental Care

Depending on where the client lives he or she may get dental care through managed care or as fee-for-service (open card).

Dental care is included for clients who receive the OHP Plus benefit package. The OHP Standard benefit package provides emergency dental services only. Clients can access dental care several ways:

- Enroll in a dental plan. The client should call their dental plan for a list of dentists in their area. The client contacts the dentist directly to make an appointment. It may take from one to three months for a routine appointment.
- If there are no dental plans in the area, clients may go to any dentist who will take their OMAP Medical Care ID on a fee-for-service or open card basis.
- Clients who cannot obtain dental care in their local area qualify for travel reimbursement assistance to allow them to access these services.

Workers are advised to refer clients enrolled in managed dental care to their plans for an explanation of their benefits. Fee-for-service (open card) clients should be referred to Client Advisory Services Unit (CASU) at 1-800-273-0557.

I. Mental Health Care

The Health Services Commission identified 50 mental health diagnoses affecting children and adults to be included on the list of conditions/treatments under the Oregon Health Plan. The 1993 Legislature approved funding to pay for treating 42 of these conditions, including schizophrenia, bipolar disorder, depression, post-traumatic stress, eating disorders, and attention deficit disorders.

Clients who are eligible for mental health benefits will receive services through MHOs, which may be fully capitated health plans, community mental health programs, or private mental health organizations.

Mandatory services for MHOs include:

- Evaluation
- Case management
- Consultation
- 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

J. Choice Counseling

Choice counseling helps a client choose the managed care plans that best meet his or her needs. Most of the time, clients make their own decisions about which health plans to choose. Clients receive a comparison chart to help them make their choice.

Some clients are unable to make their own health plan choices. For clients who are incapable of choosing their own health plan, one may be selected by a holder of a power of attorney, guardian, spouse, family member, a team of people, or an agency caseworker.

Workers who help a client choose a managed care plan may find the checklist in this section helpful. It lists major discussion areas to cover with the client.

During the discussion, workers provide the client with:

- The OHP Application (OHP 7210), which covers the client's rights and responsibilities in the Medical Assistance Program.
- *Oregon Health Plan Comparison Charts*, (OHP 9031), which lists the plans in the area and compares their benefits.
- The worker will also discuss any private insurance resources available to the client.

Choice Counseling Checklist

- ❒ Does the client reside in a mandatory or voluntary plan area?
- ❒ Is the client's doctor (PCP) in a managed care plan or enrolled as a PCM?
- ❒ Do the client's children have a PCP? Which managed care plan does the PCP belong to?
- ❒ 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? 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?

K. Educating Clients About Health Care

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

- Define truly emergent care. (Services that are needed immediately because of a serious injury or illness. Some examples are: broken bones, bleeding profusely, a tooth that has been knocked out, suspected heart attack and loss of consciousness.) Refer to the OHP 9035, *Client Handbook for the Oregon Health Plan* for more information.
- Advise clients to cancel appointments at least 24 hours in advance if they can't make it to the appointment.
- Help clients to understand there may be a wait for a routine appointment, especially with a dentist (usually from one to three months).
- Primary care providers (PCPs) are an essential feature of 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 can refer them to one.
- Clients need to bring both their OMAP Medical Care ID and managed care plan card to all medical appointments.
- Advise clients that some providers are not taking new patients.
- Explain that clients need to follow the rules of their plan and respect doctors and their staff.
- Remind clients to read the *Managed Care Handbook* and the "Rights and Responsibilities" section of the application.
- Remind clients to review their Medical Care ID each time they receive one to ensure it contains accurate information.
- Explain how to resolve billing problems.
- Explain how to resolve provider care problems.
- Explain how the appeal and grievance process works.
- Remind clients to notify workers of changes, i.e. 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 *Managed Care Handbook* "Your Rights and Responsibilities" section 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 Who Can You Contact? (FOR DHS STAFF ONLY)		
Health Plan Enrollment and Eligibility/Billing Questions No MHC message or wrong MHC on Medical ID AI/AN Exemptions Medical Exemptions	Health Management Unit (HMU) OMAP Fax: 503-947-5221 or **Email to:** **omap.hmu@state.or.us** **(HMU, OMAP in Groupwise)**	(503) 945-6534 (503) 945-6535 (503) 945-6558 (503) 945-5796 (503) 945-6523
MHC Claim Problems	Contracted Health Plan	Contact Plan listed on client Medical ID
ELGC/ELGR and/or Coding problems	Client Maintenance Unit (CMU) CAF	(503) 378-4369
Private Health Insurance or TPR (Third Party Resource)	Health Insurance Group (HIG) CAF	(503) 378-2220
Unresolved Client/ MHC Problems	Client Advisory Services Unit (CASU) OMAP	Client number: 1-800-273-0557
Expedited Hearing Requests	Medical Director's Unit, OMAP	(503) 945-5785
Managed Health Care Available Services, Physicians, etc.	Contracted Health Plans	Contact Plan listed on client Medical ID
Problems with Mental Health Organizations (MHOs)	Office of Mental Health and Addiction Services (OMHAS)	(503) 945-9447
Problems with Fully Capitated Health Plans	Delivery Systems Unit (DSU) See OMAP DSU Assignment List or call	(503) 945-5772

A. Processing Claims Overview

OMAP's claims processing system is highly automated. It handles approximately 1 million claims per month. This total number of claims includes capitation payments, point-of-sale, EMC, paper claims and nursing home claims (turn-around document or TAD). If all information is correct, providers who input claims electronically by 2:00 p.m. on Friday could receive a check for payment the following week..

Branch staff are vital to the smooth working of this system.

OMAP depends on field workers to enter timely and accurate eligibility information on clients. Two of the most common errors are that a client changes their name and it is not updated right away or a newborn is not added for medical coverage as soon as possible.

If there is an error on a claim, such as a misplaced code or blank field, the claim could suspend or deny. Then the claim will be reviewed by a staff person, causing a delay in payment of several weeks.

Questions about billings - managed care plan clients

Clients who are covered by a managed care plan should contact their plan if they have questions about billings.

Questions about billings - fee-for-service (open card) clients or clients with a Primary Care Manager (PCM)

Clients who are fee-for-service or have a PCM should contact OMAP Client Advisory Services Unit (CASU) at 1-800-273-0557 if they have questions about billings. It is necessary for CASU to have a copy of the bill in order to answer questions and identify possible solutions. Workers may fax, or have the client fax, a copy of the bill to CASU Billing at 503-945-6898.

B. How a Medicaid Claim is Processed

When a provider submits a fee-for-service claim to OMAP, it is processed primarily by a computer — the Medicaid Management Information System (MMIS). Unlike most private insurance companies, the OMAP claims processing system is highly automated. Claims are entered into the system prior to verification or visual checks for clerical errors. Because of this automation and the high claim volume, a misplaced code or a blank field can cause the claim to suspend or deny.

Here's How it Works:

1. Paper claims submitted by mail go first to the **Office of Forms and Document Management (OFDM) Imaging Unit**. Here the claim is microimaged, given an internal control number (ICN), and batched. Depending on volume, the mail intake and the ICN assignment process may take from one to five working days.
2. Claims are then delivered to the **Data Entry Unit**, where operators manually enter the information appearing on the claims into the MMIS processing system.

ONLY required fields of information are keyed into MMIS. Data entry operators can process a single claim in 45 seconds. Because of quality assurance and time requirements, data entry operators cannot alter the information on the claim forms, or take the time to read and annotate notes or written explanations attached to claims.

3. Providers who bill electronically, by using a modem, computer disks, or tapes, bypass these first two steps and their data is entered directly into the system. **It is not uncommon for providers to bill using electronic media claims (EMC) by 2:00 p.m. on Friday and have a check the next week.**
4. **From this point on, the claim is not seen by any OMAP staff member** unless it suspends for specific medical or administrative review. The only way staff can immediately access submitted claim information is to check certain MMIS screens.
5. When a claim suspends, in essence, MMIS is saying that it cannot make a decision — a claims analyst will have to review the data. It is also possible that *internal* files need to be updated before the claim can be paid; for example, patient eligibility is the most common reason for internal file discrepancy.

   Since eligibility is determined and updated at the local DHS branch level, OMAP depends on caseworkers to supply accurate and timely eligibility information to MMIS. If the claim has suspended for this reason, two weeks are allowed to pass. Then, if OMAP files still show "no eligibility for patient," the system will automatically deny the claim. Providers receive a denial notice on their remittance advice with an explanation of benefits (EOB) message, such as "Patient ineligible on date of service."
6. There are more than 900 potential questions MMIS may ask about a claim before it can make a payment decision. The computer will try to match data from the claim entered into the system with information about this recipient entered previously.
7. Most paper claims are processed within 30 days. Providers receive a remittance advice explaining payments and denials. The fewer questions the computer asks, the more quickly the claim can be processed.
8. Most claims are denied because of incomplete or incorrect patient or provider data. **Please be sure your case information is complete and accurate.** Only those procedures which require "cost documentation" or "by report" will suspend for medical review. The **Medical Unit** analyzes those claims.

The chart on the next page shows how a claim is processed.

A. Premiums Overview

Some clients must pay premiums for their OHP benefits. This section will tell you who must pay, how they pay, when they pay, what happens if they don't pay, and whom to call if you or the client has questions about premium payments.

B. Who Pays Premiums?

General Rules 410-120-1380 and 410-120-1390

Clients who are eligible under the OHP-OPU program are required to pay premiums unless they are exempt. The following OHP-OPU clients (also referred to as HPN persons or clients) are exempt from paying premiums:

- American Indians/Alaska Natives
- Clients eligible for benefits through Indian Health Services
- CAWEM clients

1. Rate schedule

Premium rates are based on the number of people required to pay premiums and household income. **For actual income amounts, refer to CAF Rule 461-155-0235.**

2. Premium Billings and Payment

OHP premiums are collected by the Oregon Health Plan Premium Billing Office. The contractor is the William C. Earhart Co., but workers should always refer to it as the OHP Premium Billing Office. That way, the contractor's other phone lines will not be tied up with OHP premium calls.

OMAP sends data to the billing office monthly. Premium billings are sent to clients during the first week of each month. **Payments are due by the 20th of the current month.**

Clients should pay their premiums using the return envelope that comes with their billing. The address is: OHP Premium Billing Office, P.O. Box 3949, Portland, OR 97208-3949. Anyone may pay premiums on behalf of a client (OAR 410-120-1380 and 410-120-1390). Payments should be made by check, money order or cashier's check. ***Payments cannot be made in cash or by credit card.*** Clients who come to a branch office wanting to pay their premiums should be told to send payments to the above address. **Their premium billing includes a return envelope.** The payment coupon should be included with the payment.

C. Nonpayment of Premiums

1. Arrearage

Clients are given a one month grace period before losing eligibility. If a required premium payment is not received by the OHP Premium Billing Office on or before the 20th of the month following the due date, all premium paying OHP-OPU clients **on the case** will lose eligibility the first of the next month. For example:

Premium is due July 20th for July coverage
Client(s) **must** make that July payment by August 20th, or
Client(s) will lose coverage September 1st

If **one** premium paying adult in a household does not pay their premium, then **all** premium paying adults in that household will lose eligibility. They will **all** be ineligible for OHP coverage for six months. They must pay premium arrearages before becoming eligible again and can only be determined eligible during open enrollment periods. Any OHP Plus or CAWEM members of the household **will not lose coverage**.

Premiums billed after January 2003 cannot be waived. American Indians or Alaska Natives who have proof of tribal membership or are eligible for benefits through an Indian Health Program and CAWEM clients are exempt from paying premiums. Refer to the CAF Family Services Manual for specifics. (OAR 461-135-1100, 461-135-1120, and 461-135-1130)

Past arrearage can be adjusted if the Department is notified a member of the filing group filed for bankruptcy and the arrearage is a debt that has been stayed in a bankruptcy proceeding. The decision whether or not arrearage is adjusted or waived, or only part of the arrearage, depends upon the bankruptcy chapter as well as the period of time the bankruptcy covers. Contact a CAF Medical Program Analyst for further information.

The Department will not attempt collection on any arrearage that is more than three years old. In order to have such an arrearage removed from the system, the worker should contact a CAF Medical Program Analyst.

2. Aid Paid Pending

- In an OHP-OPU client requests a hearing contesting disqualification for nonpayment of premiums and receives continuation of benefits:
- The worker codes the case with an OAP case descriptor and need/resource item.
- Clients with OAP coding continue to receive premium bills. OAP clients will not be disqualified during the aid paid pending period for nonpayment of premiums.
- If the branch decision to disqualify is upheld, the OAP coding is removed and the medical aid paid pending is ended. The client must serve the six month penalty period and pay past due premiums before their OHP-OPU may be reopened.
- If the branch decision to disqualify is overturned, the OAP coding and disqualification coding is removed. The client must pay all past due premiums billed after February 1, 2003, to avoid disqualification.

D. Premium Questions?

- For questions about the billing (whether a payment was received, etc.), call the OHP Premium Billing Office at the number listed on the billing notice, 1-800-922-7592. Workers **only** may call 503-535-1400.
- A client who has questions about whether he or she must pay premiums (i.e., eligibility), should call his or her worker. The worker's name and branch telephone number appears on each client's OMAP Medical Care ID.

E. Copayments *General Rule 410-120-1230*

Some OHP clients will be charged copayment for prescription drugs and/or outpatient services, depending on their eligibility level and benefit package. Copayment information is shown on the client's Medical ID in fields 7a and 7b.

1. Exemptions

OHP Plus clients who are enrolled in Fully Capitated Health Plan, Dental Plan, or Mental Health Plan will not be charged copayments for services covered by their plan. Drugs for mental illness are not covered by managed care plans, and require a copayment.

The following clients also will **not** be charged a copayment:

- Pregnant women
- Children under age 19
- American Indians/Alaska Natives
- Clients eligible for benefits through Indian Health Services
- Any client receiving services under the Home and Community based waiver and Developmental Disability waiver, or is an inpatient in a hospital, Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR)
- CAWEM clients

2. OHP Plus - Copayment Information

Some OHP Plus clients will be charged the following copayments:

- $2 for generic prescription drugs
- $3 for brand name prescription drugs
- $3 for outpatient services (such as office visits to see a doctor, dentist or other health care provider). The copayment is only for the visit to the provider. There is no copayment charged for treatments performed by the provider, such as immunizations, lab, or x-rays.

Services to a client **cannot be denied** solely because of an inability to pay an applicable copayment. This does not relieve the client of the responsibility to pay, nor does it prevent the provider from attempting to collect any applicable copayments from the client.

Services Requiring a Copayment

The following are services for which an OHP Plus client would be charged a copayment:

- Office visits, per visit for:

  Physician/specialist, nurse practitioner, physician assistant or alternative care providers (i.e., chiropractors, naturopaths, acupuncturists)
- Dental services (except for dental diagnostic and preventive routine checkups)
- Mental health and/or chemical dependency (outpatient service)
- Preventive care, per visit for physician/specialist

- Hospital, per visit for outpatient treatments (including surgery) and non-Emergency Room visits (waived if admitted to inpatient care)
- Physical, occupational, or speech therapy services
- Home health services
- Private duty nursing visit and shift
- Enteral/Parenteral IV

Services Exempt from Copayment

OHP Plus clients will **not** be required to pay a copayment for the following services:

- Administrative exams and reports
- Dental diagnostic and preventive routine checkups
- DME supplies
- Emergency services
- Family planning services
- Hospice services
- Routine immunizations
- Total blood cholesterol screenings (men age 35-65, women age 45-64)
- X-ray and lab services (i.e. mammograms, pap smears, fecal occult blood tests, diagnostic sigmoidoscopy (over age 50)

OHP Plus clients will **not** be charged a copayment for the following drugs:

- Prescription drugs for family planning services, like birth control pills
- Prescriptions obtained through the Home Delivery (Mail Order) Pharmacy Program

3. OHP Standard - Copayment Information

Copayments for clients on the OHP Standard Benefit Package were eliminated June 19, 2004. (OAR 410-120-1230)

F. Home Delivery (Mail Order) Pharmacy Program

Clients who have ongoing prescription needs and a stable medication regimen may receive their prescriptions through the OHP Home Delivery Pharmacy Program. Clients on the OHP Plus Benefit package do not have to make copayments on drugs ordered through this program. Clients can use this program even if they are restricted to one pharmacy through the Pharmacy Management Program.

Home Delivery Pharmacy Program is currently contracted through Wellpartner. Prescription order forms are available from the OMAP Web site at:

www.dhs.state.or.us/healthplan/clients/mailrx.html

First time prescriptions and completed order forms are to be mailed to Wellpartner, Inc., P.O. Box 5909, Portland, OR 97228-5909. Clients may enroll themselves by calling Wellpartner at 1-877-935-5797. Healthcare providers can fax the prescription to 1-866-624-5797. (This phone number should only be used by the doctor of healthcare provider).

G. Pharmacy Management Program

1. Overview

The purpose of the Pharmacy Management Program is to minimize drug-seeking behavior by identifying and monitoring high drug utilization and to provide better coordination and management of prescription drugs for beneficiaries. Some clients will be restricted to the pharmacy of their choice to receive prescription drugs.

NOTE: Although clients will be enrolled in a single retail pharmacy, they can still use the Home Delivery (Mail Order) Pharmacy Program.

2. Selection

Clients will be restricted to a single pharmacy, per household once a pharmacy claim is processed through First Health and shows adjudicated at OMAP. First Health will send a weekly file to OMAP by Thursday of each week. The client's TPR file (ELGX) will be automatically updated to show the restricted pharmacy for the entire household and a new Medical ID card will be generated. The client will also receive a system-generated notice explaining the program and allowing a 30-day window to change pharmacies. Clients will be restricted to one pharmacy per household.

The designated pharmacy will show on ELGX effective the following Monday, after the Thursday transmission from First Health. If a client selects a pharmacy that is located in multiple locations throughout the State (chain) they will be allowed access to any pharmacy belonging to that chain regardless of geographical location within Oregon and contiguous service areas.

3. Who Will be Enrolled

All clients who are fee-for-service receiving Medicaid benefits, who are not exempt, will be enrolled into the Pharmacy Management Program.

4. Exemptions from Pharmacy Management Program

Enrollment into the Pharmacy Management Program will be mandatory unless the client:

- Is enrolled in a Fully Capitated Health Plan (FCHP)
- Has private major medical insurance policy
- Has proof they are American Indian or Alaska Native
- Has proof of eligibility for benefits through Indian Health Services
- Is a child in DHS care and custody
- Is an inpatient in a hospital, long-term residential care facility, or other medical institution

5. Changes to a Client's Pharmacy Management Program

Clients may change their pharmacy selection at any time for one of the following reasons:

- They move
- They are reapplying for OHP benefits, or
- They are denied access to pharmacy services by their selected pharmacy

For changes, the worker can either contact OMAP's Health Management Unit (HMU) with the client's pharmacy choice or the client can call the Client Advisory Services Unit (CASU) directly at 1-800-273-0557. CASU will be responsible for giving the information to HMU to update the client's TPR file. New Medical ID cards will be system generated each time a change is made to the client's TPR file.

Branch workers may fax, telephone or mail the client's Pharmacy choice to HMU. Branch Workers can call HMU directly at (503) 945-6523. Mail or fax to:

HMU
500 Summer Street NE
Salem, OR 97301-1079
Fax # (503) 945-6873

E. Americans with Disabilities Act (ADA) Accommodation

Under Title II of the American with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act, OAR 461-105-0190 (Discriminatory Actions) DHS is required to make reasonable modifications in policies, practices or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the modifications would fundamentally alter the nature of the service, program or activity.

If approved, an ADA accommodation for OPU premium payments means the premiums do not have to be paid until the client reapplies at the end of the certification period. When the client reapplies, the worker will pend for the payment of unpaid premiums and any other items needed to determine eligibility. Before the client can establish a new OHP certification period, the premium payments will need to be paid. If the client's OPU medical has already been ended because of a premium disqualification, their medical may be reopened.

If a client or client representative contacts a branch office and wishes to make an ADA request, encourage the client or representative to make the request in writing. (No specific form has been developed but one may be developed in the future.) If that presents a barrier, please gather the information for the client or representative.

The following information is helpful to include with each request:

1. Name of client
2. SSN or prime number
3. Telephone number, if available

4. Disability
5. Description of the disabling conditions and how they affected the client's ability to pay bills on time.
6. Medical documentation of the disability and its affect on the client, if available. Medical documentation is not required to start the process but will be required to make the decision.
7. A release of information if a representative is making a request on the behalf of a client and wants to know the outcome of the request.

Forward the request information by fax or mail to:

Michelle Marks
CAF Medical Program Analyst
Children, Adults and Families
Department of Human Services
500 Summer Street NE
Salem, OR 97301-1066
Fax (503) 373-7032