DHS Oregon Department of Human Services

Health Services
Office of Medical Assistance Programs

Policy Transmittal

Joan Kapowich, Manager,
Program and Policy Section, OMAP

Authorized Signature

Number: OMAP-PT-04-003
Issue Date: 7/26/2004

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 18		
Topic Area:	Medical Benefits		
Policy Number(s):		Release No:	OMAP-WG-18
Effective Date:	August 1, 2004	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 be posted to the OMAP Web site on or after 8/1/2004, but will not be included in the CAF Family Services Manual until the 10/1/04 release. This revision contains updates related to the changes in the OHP Standard benefit package, elimination of copayments for clients on the OHP Standard benefit package and a change in the process for Administrative Hearings. Additional changes include:

Worker Guide 1 - Overview

Updated Field Resource chart.

Worker Guide 2 - The Oregon Health Plan

Updated to include recent changes to the OHP, specifically to the OHP Standard benefit package.

Worker Guide 3 - Medical Care ID

Includes revised Medical Care ID and a sample of the temporary ID.

Worker Guide 4 - Benefit Packages

Updated to include the reduction in covered services on the Prioritized List of Health Services and changes in the OHP Standard benefit package. Revised Benefit package charts and the DHS Medical Assistance Programs chart.

Worker Guide 5 - Managed Health Care

Revised and clarified information on managed health care enrollment, added section on Auto Enrollment.

Worker Guide 6 - Other Medical Resources

Updated program information for the Senior Prescription Drug Assistance Program and the Family Health Insurance Assistance Program

Worker Guide 11 - Client Rights and Responsibilities

Revised information on process for clients requesting Administrative Hearings.

Worker Guide 12 - Medical Transportation/Reimbursement

Updated information on branch responsibility for ensuring medical transportation is appropriate.

Worker Guide 14 - Premiums, Copayments and Special Requirements

Updated information on premium responsibility and added rule references.

Removed OHP Standard copayment information.

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
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If you have any questions about this information, contact:

Contact(s):	Raeann Reese		
Phone:	503-947-5128	**Fax:**	503-373-7689
E-mail:	raeann.reese@state.or.us		

Office of Medical Assistance Programs Worker Guide

Table of Contents

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	Local Branch Offices	**Operations Managers**
SPD clients	SPD Administration	**(503) 945-5811 / 1-800-282-8096**
Other DHS clients	Governor's Advocacy	**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	Local Branch Offices	
Policy	SPD In-Home Svcs Unit	**(503) 945-5799/ (503) 945-5990**
Insurance Premiums		
HIP	CAF	**(503) 945-6135**
Private Health Insurance (premium referral)	OMAP	**(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	Medical Director-OMAP	**(503) 945-6488**
Emergency Claims	Claims Mgmt Unit-OMAP	**(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	OMAP Policy Unit	**(503) 945-6493**
Authorization	Local Branch Offices	
Transplant Services	Medical Director-OMAP	**(503) 945-6488**
Personal Injury Liens	PIL - Admin Services	**(503) 373-0333**

*TTY: 1-800-621-5260

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

A. The Oregon Health Plan

The goal of the Oregon Health Plan (OHP) is to ensure that most low-income Oregonians have access to medical care. The plan was a cooperative effort by health care providers, health care consumers, business, labor, insurers, and lawmakers.

To make this plan work, Oregon devised a new way to provide medical services to the greatest number of people. Instead of limiting the number of people eligible for medical assistance to the extent that most states do, Oregon limits which medical services are covered. Oregon had to obtain federal waivers to make these changes.

After extensive work, public hearings around the state, and revisions to meet federal objections, the Oregon Health Services Commission produced a list of nearly 750 health conditions and their treatment, prioritized from the most to the least effective. The legislature determined what services it could pay for and set the cutoff point on the list. Those services above the cutoff point are funded, while items below the line are not funded.

Extensions to this waiver have been granted to continue running the OHP.

Phase I of the Medicaid demonstration project started February 1, 1994. This meant changes in benefits and service delivery for most current Medicaid clients and new coverage for about 120,000 low income men, women, and children.

On January 1, 1995, Phase II brought additional populations into the managed health care system: the aged, blind or disabled, foster children, and children under the jurisdiction of the Oregon Youth Authority.

Additionally, benefit packages were changed under Phase II. Outpatient alcohol and drug (chemical dependency) treatment was provided through the managed health care system, and expanded mental health services were provided to medical assistance clients.

In 1998 several policy changes were made to the OHP in the areas of eligibility for higher education students, domestic violence survivors, and self-employment income. The income guidelines for pregnant women were also expanded and the Children's Health Insurance Program (CHIP) was implemented which allowed coverage for more children under 19 years of age.

In 2002, Oregon received approval from the federal Centers for Medicare and Medicaid Services (CMS) to implement a five-year Oregon Health Plan 2 (OHP2) demonstration project. OHP2 was designed to stabilize the existing Medicaid demonstration project and to enable Oregon to expand health coverage to more uninsured Oregonians at no additional cost to taxpayers or the State.

As the first phase of OHP2, Oregon began receiving federal funds to provide medical coverage to eligible clients through the Family Health Insurance Assistance Program (FHIAP). FHIAP is a program that subsidizes employer-sponsored and individual health insurance premiums. FHIAP's income guidelines were also expanded slightly. This first

phase of OHP2 went into effect on November 1, 2002. Expansion on the FHIAP side is expected to help thousands of additional Oregonians gain medical coverage.

On January 1, 2003, Oregon implemented a legislative directive separate from OHP2. OHP and other medical assistance programs began requiring copayments for prescription drugs and outpatient services for certain clients.

On February 1, 2003, the second phase of the OHP2 demonstration project took effect (for medical assistance programs administered by the Department of Human Services).

First, income guidelines for pregnant women and some children qualifying for the OHP Plus benefit package were increased slightly to enable more Oregonians to gain coverage.

In addition, the OHP Basic Benefit Package was replaced with two new benefit packages: OHP Plus and OHP Standard. Both of these benefit packages were based on the Prioritized List of Health Services adopted by the State Legislature. Existing OHP clients were transferred to one of these two benefit packages based on their qualifications for medical assistance.

The OHP Standard benefit package was designed to more closely resemble private health insurance. Specifically, it was designed to cover less benefits than OHP Plus and to require mandatory premium payments and higher copayments for many services.

On March 1, 2003, the OHP Standard benefit package experienced cuts that included dental services, outpatient mental health treatment, outpatient chemical-dependency treatment, and durable medical equipment and supplies. The legislature authorized these cuts in order to balance the state budget.

Significant changes continued to occur in 2004 for the OHP Standard benefit package. Effective June 19, 2004, all copayments were eliminated for the OHP Standard benefit package as the result of a court ruling. However, individuals receiving OHP Standard were required to continue paying monthly premiums for coverage.

In early 2004, Oregon voters rejected Ballot Measure 30, which would have authorized a temporary income-tax increase. The failure of Ballot Measure 30 led to a decision to use no state general-fund dollars to support the OHP Standard benefit package starting August 1, 2004.

Efforts were undertaken to preserve a limited OHP Standard program using legislatively approved provider tax revenue. Budget constraints made it necessary to reduce the population served under this limited OHP Standard program. OHP Standard closed to new eligibles on July 1, 2004, as a first step in meeting these new budget constraints. People already on OHP Standard were notified that they must continue to pay their premiums monthly and reapply in a timely manner.

Clients on the Citizen/Alien-Waived Emergency Medical (CAWEM) benefit package who qualified using the same criteria as OHP Standard clients (except for citizen or alien status) will be treated the same way as other OHP Standard clients. If they qualify for CAWEM based on Standard program eligibility requirements before July 1, 2004, there

will be no change for them as long as they reapply on time and are found eligible. If they lose medical coverage, they will not be able to qualify for the OHP Standard program until enrollment re-opens. When an individual applies for medical coverage, regardless of whether enrollment for OHP Standard is open or closed, eligibility for all open medical programs will be explored.

On August 1, 2004, OHP Standard benefits were reconfigured once again, as directed by the 2003 legislative assembly. Certain services were reinstated to the OHP Standard benefit package, including outpatient mental health, outpatient chemical dependency, an emergency dental package, and limited medical equipment and supplies. Other services were cut from OHP Standard, including acupuncture (except for the 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, and speech therapy.

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. Sometimes workers need to issue a temporary OMAP Medical Care ID to a client. (Use screen MID1). Once information on a client is entered into the computer system, the system automatically issues an OMAP Medical Care ID to the client.

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

The OMAP Medical Care ID also shows the benefit package assigned for every 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 OMAP Medical Care 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.

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)
5503 XX#### EF P2
P.O. BOX 14520
SALEM, OR (3)
97309-5044
DO NOT FORWARD: RETURN IN 3 DAYS

OMAP Medical Care Identification (ID)

(4) **Branch Name** | **Division** | (5) **Worker** | (6) **Phone**
OHP Branch | AFS | EF | (503) 378-2666
1-800-699-9075

John Doe
Street Name

City State Zip

(7a) Copay Requirements

A $3 for outpatient services not paid for by your Plan (listed in 8a)

B $2 Generic/$3 Brand – for drugs not paid for by your Medical Plan (listed in 8a)

(8a) Managed Care/TPR

A OMAP MEDICAL PLAN
MEDICAL PLAN NAME
PH # 1-800-555-1234
GRP #

B OMAP DENTAL PLAN
DENTAL PLAN NAME
PH # 1-800-555-1234
GRP #

C OMAP MENTAL HEALTH PLAN
MENTAL HEALTH PLAN NAME
PH # 1-800-555-1234
GRP #

D PRIVATE MAJOR MED/DRUGS
MEDICAL PLAN NAME
PH # 1-800-555-1234
GRP #

E PRIVATE VISION COVERAGE
VISION PLAN NAME
PH # 1-800-555-1234
GRP #

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
DOE, JOHN SSN ###-##-####	XX#####X	10/13/62	3/01-3/31/03	B	A	A
DOE, JANIE SSN ###-##-####	XX#####X	08/10/94	3/01-3/31/03	NO COPAYS	BCDE	B

IMPORTANT:

(14)

- **This is your new OMAP Medical Care ID. Issued on:** 6/25/04
- **Show this ID to all providers, even if you have a Managed Care Plan card.**
- **Not valid outside the United States or US Territories.**

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 Advocate 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.

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 Standard Benefit Package coverage changes are 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 all emergency services;
3. urgent conditions for which prompt treatment will prevent life threatening health deterioration;
4. a subset of number three that will require prior authorization.

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

Excluded Services - Both Plus and Standard (continued) -

Conditions where a "home" treatment is effective, such as applying an ointment, resting a painful joint, drinking plenty of fluids, soft diet. Such conditions include:

- Canker sores
- Diaper rash
- Food poisoning
- Corns/calluses
- Sunburn
- Sprains

Cosmetic conditions, such as:

- Benign skin tumors
- Removal of scars
- Cosmetic surgery

Conditions where treatment is not generally effective, such as:

- Some back surgery
- TMJ surgery
- Some transplants

Other not covered services include, but are not limited to, the following:

- Circumcision (routine)
- Surgical treatment of obesity
- Weight loss programs
- Infertility services

3. QMB - Qualified Medicare Beneficiary Package

QMB-only clients are Medicare beneficiaries who have limited income but do not meet the income or resource standard for full medical assistance coverage. QMB clients have medical and hospital coverage through Medicare Parts A and B. The QMB medical assistance program pays for Medicare premiums, co-payments and deductibles only for services Medicare covers up to the amount Medicare pays.

Clients may NOT be billed by the provider for the deductible and co-insurance amounts which are covered by the medical assistance program for Medicare covered services. The provider may bill QMB patients for services not covered by Medicare.

4. QMB + OHP Plus Benefit Package

These clients are Medicare beneficiaries who receive the same services as the OHP Plus Benefit Package. Service coverage is based on the Prioritized List of Health Services. Their coverage also includes any service covered by Medicare.

5. CAWEM - Citizen/Alien-Waived Emergency Medical

These clients are only eligible for treatment of emergency medical conditions. Labor and delivery services for pregnant women **are** considered an emergency. **CAWEM clients do not pay premiums or copayments.**

The following services are **NOT covered for CAWEM clients:**

- Pre-natal or post partum care
- Private duty nursing
- Administrative medical examinations and reports
- Sterilization
- Family planning
- Preventative care
- Transplants or transplant related services
- Chemotherapy
- Hospice
- Dialysis
- Dental services provided outside an emergency room/hospital setting
- Outpatient drugs or over the counter products
- Non-emergency medical transportation
- Therapy services
- Rehabilitation services
- Medical equipment and supplies
- Home health services

This list is not all inclusive but can be used as an illustration to identify some services that are not covered for CAWEM clients.

CAUTION: CAWEM clients are **NOT COVERED** for services that are ongoing, require prior authorization, payment authorization or that can be scheduled in advance.

Medical Assistance Benefit Packages

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

Benefit Packages	Identifier (BEN on ELGR)

OHP Plus — BMH

- Physician, lab, and X-ray services
- Pharmacy services
- Hospital services (inpatient & outpatient)
- Physical therapy/occupational therapy
- Reasonable diagnostic services
- Durable medical equipment and supplies
- Vision, glasses
- Hearing, speech services
- Hospice services
- Home health services
- Dental services
- Medical transportation
- Preventive services (for example: tobacco cessation services)
- Some over-the-counter drugs
- Chemical dependency services
- Mental health services

OHP Standard — KIT

- Physician, lab, and X-ray services
- Pharmacy services
- Reasonable diagnostic services
- Hospice services
- Preventive services (for example: tobacco cessation services)
- Some over-the-counter drugs
- Emergency medical transportation
- Outpatient mental health services
- Outpatient chemical dependency services
- Limited hospital services (see OAR 410-125-0047)
- Limited durable medical equipment (see OAR 410-122-0055)
- Limited emergency dental (see OAR 410-123-1670)

QMB - Qualified Medicare Beneficiary — MED

Medicaid pays for only:

- Medicare premiums, deductibles and copayments for Medicare covered services

QMB + OHP Plus — BMM

CAWEM - Citizen/Alien-Waived Emergency Medical — CWM

Medicaid pays for only:

- Emergency medical services
- Labor and delivery

Senior Prescription Drug Assistance Program — PDA

Prescription drug assistance for elderly (NOT a Medicaid Program)
See OMAP Worker Guide 6 for detailed information.

OHP Plus Benefit Package

This benefit package replaced the Basic Benefit Package on February 1, 2003.

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

ELIGIBLE CLIENTS:

- Pregnant Women – up to 185% Federal Poverty Level
- Children under age 19 – up to 185% Federal Poverty Level
- Receiving SSI
- Age 65 or older, blind, or disabled and receiving income at or below the SSI standard
- Age 65 or older, blind, or disabled and receiving Department paid long term care services
- Getting Medical Assistance under Temporary Assistance to Needy Families (TANF) or General Assistance
- Presumptive eligibility prior to disability determination
- Children in Foster Care or in Adoptive Assistance

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.

CLIENTS AND SERVICES EXEMPT FROM COPAYMENTS:

- Clients in Managed Care Plans (for services covered by their plans)
- Pregnant Women
- Children under Age 19
- American Indians/Alaska Natives
- Clients who are 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)
- Family Planning Services
- Emergency Services, as defined in OAR 410-120-0000
- Prescription drugs ordered through OMAP's home delivery (mail order) vendor

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

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 services that are not for emergency or urgent care (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	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.

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. You should make this determination **before** you enroll a client into managed care. (See sections on *Exemptions and Private Insurance/ Third Party Resources*).

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.

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.

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 care plan. The client will have 30 days to contact their worker to request a plan change.

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.

HPN and Non-HPN persons still have the option of selecting fee-for-service if they meet the exception criteria provided in OAR 410-141-0060. The HPN person must select a managed health and dental plan on their application or provide information for an exception to enrollment into health and dental plans. Requests for exemption are submitted to Health Management Unit (HMU).

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.

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 unless they have an allowable exemption from managed care. Requests for exemptions are submitted to Health Management Unit (HMU).

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. See chart at the end of this section for contact numbers. 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 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.

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).

G. Third Party Resources (TPR)

Private insurance does not automatically exempt a client from managed care. Depending on the type of private insurance, a client may still be eligible for enrollment in a prepaid health plan, with a PCM, in an MHO or with a DCO. (See tables next page).

If the private health insurance terminates, the branch worker *must* submit a copy of the 415H with termination date to Health Insurance Group (HIG) and update the private health insurance (PHI) flag on PCMS screen.

Valid Enrollment Codes for Private Insurance

Enrollment Codes for Private Insurance					
Private Coverage Type	**Code**	**PHP**	**PCCM**	**DCO**	**MHO**
Accident	AI	X	X	X	X
Champ VA	CA		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 PHP	HM			X	
Medicare Supp.	MS			X	
Medicare HMO*	MAB			X	
Nursing Home	NH	X	X	X	X

* System will allow clients with Medicare HMOs to be enrolled in a medical plan. However, workers are NOT to enroll Medicare HMO members in medical plans (unless the HMO is also an OHP medical plan), or with PCCMs. They may be enrolled in DCOs.

A case is listed on a discrepancy report if there is a difference between the PHI code and the TPR file, (example: 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). Branch offices and HIG receive the discrepancy report. Branch offices should research the discrepancies and update PCMS or submit 415H's to HIG. HIG also researches the discrepancy report and requests additional information from branch workers or requests that PCMS be updated.

A word of caution: The PHI flag DOES NOT stop enrollment into managed care, even if that enrollment is inappropriate because of a client's private insurance. The table below may help. If you have further questions, contact HIG.

Type of Managed Care Enrollment for Clients with 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:			
	PHP	PCCM	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 that is not possible, enroll with a PCM. Clients who have end-stage renal disease or are in Medicare hospice cannot be enrolled with plans, but should be enrolled with PCMs if possible.

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

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

H. Dental Care

Depending on where the client lives and which benefit package they are eligible to receive, he or she may get dental care through managed care or as fee-for-service.

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.

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, suspected heart attack and loss of consciousness.) OHP 9035, *Managed Care Information*, explains this.
- 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 Call? (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	(503) 945-6534 (503) 945-6535 (503) 945-5796
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. Senior Prescription Drug Assistance Program

ORS 414.342, passed by the 2001 Legislature, created the Senior Prescription Drug Assistance Program. It is a non-Medicaid program funded with state dollars. The purpose is to give seniors access to more affordable prescription drugs.

This program has two main provisions:

- The first is that DHS would set a discounted rate, not to exceed the Medicaid rate, at which pharmacies can charge eligible seniors for prescription drugs. DHS issues the senior an enrollment card to take to participating pharmacies. The senior pays DHS a $50 yearly enrollment fee. DHS does not subsidize the purchase of the prescription drug.
- The second provision is that DHS, subject to funds available, may adjust the price to subsidize up to 50% of the Medicaid price of the drug, using a sliding scale based on the income of the senior. The maximum assistance is $2000 per year. The statute funds this provision of the program with cigarette tax revenue if that revenue dedicated to the Oregon Health Plan exceeds $175 million per biennium. The program could also be funded by an appropriation.

Because the second provision of the program (subsidizing the purchase of the drugs) is not funded, DHS currently is implementing the first portion of the statute (the discount portion). The discount program was rolled out in phases beginning late in 2002.

All applications go to the Statewide Processing Center (Branch 5503) to determine eligibility. Seniors can either mail it to that branch or you can route it there.

1. Eligibility requirements for enrollees - Applicants must:

- Be 65 years of age or older;
- Have an income that does not exceed 185% of the federal poverty level;
- Have less than $2000 in resources not counting home or car;
- Not have been covered by any public or private drug benefit program for the previous 6 months.

After Branch 5503 decides the applicant is eligible, a contractor will send the senior a bill for $50. DHS will issue the enrollment card after we receive the entire fee. Applicants are not enrolled in the program until they pay the fee, and are issued the card. In addition to the Medicaid price of the drug, pharmacies may charge a dispensing fee. The fee is the same as for Medicaid clients.
The program also allows an additional fee of $2 if the pharmacy is a critical access pharmacy, and this fee is adjusted every April for inflation. DHS assigns pharmacies this designation if the pharmacies are in locations where access to the program would otherwise be limited or unavailable.

For additional information regarding the Senior Drug Assistance Program, contact OMAP at 1-800-945-5772 and ask for the Senior Drug Assistance Program Manager.

B. Family Health Insurance Assistance Program (FHIAP)

FHIAP was created by the 1997 Oregon Legislature to help low-income Oregonians afford private health insurance. The program subsidizes or pays for a significant portion of a member's health insurance premium — 95% of the premium for members earning less than 125% of the federal poverty level (FPL) or $1,964 a month for a family of four (based on 2004 Federal Proverty Guidelines), a 90% subsidy for those earning up to 150% FPL, a 70% subsidy for those earning up to 170% FPL, and a 50% subsidy for those earning up to 185% FPL.

FHIAP is a subsidy program, not an insurance plan. FHIAP will subsidize the medical portion of the premium only – not vision or dental coverage. FHIAP members must pay deductibles, co-pays or any other coinsurance associated with their health insurance plan.

1. Eligibility Criteria and Enrollment

A FHIAP applicant must meet the following criteria:

- Reside in Oregon
- Be a U.S. citizen or a qualified non-citizen
- Have investments and savings less than $10,000
- Have a three month average income of less than 185% of the Federal Poverty Level
- Be uninsured for the previous six months, except for those leaving OHP/Medicaid
- Must not be eligible for or receiving Medicare
- No individual may be receiving both OHP and FHIAP benefits at the same time

FHIAP members who have health insurance available to them through an employer are required to enroll in that coverage if the employer pays for any part of the premium. Members who have insurance through an employer (also called group insurance or ESI – employer-sponsored insurance) typically have their portion of the premium withheld from their paycheck. FHIAP reimburses them the subsidy portion after receiving proof that the premium was withheld (usually a copy of the pay stub). All other members, including those self-employed, can purchase a policy in the individual health insurance market from one of FHIAP's certified insurance companies. Eligibility for FHIAP enrollees is redetermined every 12 months.

FHIAP has immediate openings for those applicants who have health insurance available through their employer. Those without access to ESI must call FHIAP to be placed on a reservation list. Current waiting period to receive an application is six months, although that could vary.

2. OHP Standard, OHP Plus, TANF, employer sponsored insurance and FHIAP

Some people who apply for OHP/Medicaid must get coverage through FHIAP. This applies only to adults who qualify for the OHP Standard benefit package and have access to employer-sponsored insurance (ESI). OHP Standard clients with ESI available will have their OHP application and a group insurance form forwarded to FHIAP to determine eligibility. If found eligible, they must enroll in FHIAP and disenroll from OHP Standard. OHP Plus clients with access to ESI will have the choice of remaining in OHP Plus or applying for FHIAP. TANF clients may receive cash assistance only (no medical coverage) and use a FHIAP subsidy to purchase health insurance.

American Indian/Alaska Native clients, who would otherwise be eligible for FHIAP, have the option of accepting enrollment in FHIAP or enrolling in OHP-OPU.

3. FHIAP Expansion, Federal Funding and Program Information

The 2001 Oregon Legislature passed House Bill 2519 which, among other things, directed the state to seek a waiver to get federal matching funds for FHIAP and expand the program. The program implemented the expansion on November 1, 2002.

The Insurance Pool Governing Board (IPGB) administers the FHIAP program. Applicants should be directed to call FHIAP at 1-888-564-9669 Monday through Friday from 9 am to 5 pm. Additional FHIAP information can be found on the IPGB web site at **www.ipgb.state.or.us.**

C. Early and Periodic Screening Diagnosis and Treatment (EPSDT) for Children and Teens

The Early and Periodic Screening Diagnosis and Treatment (EPSDT) program, formerly called Medicheck, offers "well-child" medical exams with referral for medically and dentally necessary comprehensive diagnosis and treatment for all children (birth through age 20) covered by the OHP Plus Benefit Package.

As part of the application and reapplication process, workers should:

- Inform applicants about the EPSDT Program. Repeat this information at each redetermination of medical eligibility.
- If the child or teen is covered by other insurance, inform him or her that EPSDT may cover more services (e.g., well child exams, immunizations, dental services).
- Follow the branch procedure to help the client find a doctor or to obtain transportation.
- For CAF, help the applicant check the appropriate box under "You have a right to:" in the **Rights and Responsibilities** form and the EPSDT section of the **AFS 415A** application.
- For SPD, document in the case record that EPSDT information was given to the client.

D. Hearings

General Rule 410-120-1860
OHP Administrative Rule 410-141-0264

Managed Care Plan Clients

Clients enrolled in a managed care plan who have been denied a service must first appeal the decision through their plan before they may request an administrative hearing through DHS. Clients should follow the instructions on the Notice of Action (initial denial notice) to complete the appeal process through their plan.

Once the managed care plan has completed the appeal process, the plan will send the client a Notice of Appeal Resolution stating the plan's decision. If the client is not satisfied with the outcome, they may then elect to follow the instructions on the Notice of Appeal Resolution to request an administrative hearing through DHS.

Please ensure that clients enrolled in a managed care plan have completed the appeal process through their plan before giving them a DHS 443 form and Notice of Hearings Rights form.

Fee-for-service Clients

Clients who are fee-for-service (also known as "open card"), may request an administrative hearing through DHS at the time they receive the Notice of Action (initial denial notice).

Submitting the DHS 443 to OMAP Hearings:

Managed Care Plan Clients

Please ensure that the client has fully completed the DHS 443. Please ask the client for a copy of the Notice of Appeal Resolution (decision notice) from the managed care plan to include with the DHS 443. If they do not have a copy, please forward the DHS 443 to OMAP.

Fee-for-service Clients

Please ensure that the client has fully completed the DHS 443. Please ask the client for a copy of the Notice of Action (denial notice) to include with the DHS 443. If they do not have a copy, please forward the DHS 443 to OMAP.

Forward all OMAP hearing requests, with attachments, to:

Office of Medical Assistance Programs
500 Summer St. NE, E-49
Salem, OR 97301-1079

3. Covered Transports Provided by Volunteers

(These are Title XIX matchable) OMAP will reimburse a DHS Volunteer for a transport provided to any of the above listed services and to the following services as well:

- Family sex abuse therapy
- Transportation to Shriners Children's Hospital or Doernbecher Hospital
- Transportation to Stepping Stones A&D facility for outpatient treatment
- Transportation to Veterans Administration facilities. (Unless the transport is from one Veterans facility to another Veterans facility. Generally, the Veterans Administration contracts with taxi or ambulance providers to provide these rides.)

⇒ **NOTE:** Volunteers may also be reimbursed for mileage expenses incurred when the client fails to keep the appointment. In addition, volunteers using State Motor Pool cars may be reimbursed for miles driven in their personal vehicle from home to the Motor Pool and from the Motor Pool to home.

4. Miscellaneous

A client's family member may be reimbursed for mileage for medically necessary treatment or follow-up visits to Shriners Children, Doernbechers, or VA Hospitals. (Services provided by these are considered to be cost effective.)

Reimbursement for medical transportation is NOT included in spousal support payments. If a person receiving spousal support requests reimbursement for mileage, it may be approved.

Administrative Rule (410-136-0160), Medical Transportation Services Guide, clearly states that client reimbursed travel requires authorization in advance. The rule also defines when retroactive authorization may be made. Once authorized initially, client reimbursement for mileage may be approved for ongoing trips after the fact but only after the client has provided verification of all medical trips taken. Payment for such trips shall be at the rate calculated by the original authorization.

⇒ **Do not authorize continuing trips beyond 30 days in advance.**

B. Authorizing the Transport

1. Branch/Agency Standards

The branch or agency shall not deny an individual services based on grounds of race, color, sex, religion, national origin, creed, marital status, or the presence of any sensory, mental or physical disability.

Each branch or agency will designate a primary contact and backup person for the purpose of authorizing non-emergency medical transportation.

The branch or agency will inform clients regarding:

- The availability of non-emergency medical transportation, and
- The administrative rules regarding authorization of non-emergency medical transportation, and
- The procedures the client must follow to obtain non-emergency medical transportation.

The branch or agency will ensure that the client has actually received the services for which transportation has been authorized. Branch or agency should attempt to confirm with the medical provider that the client actually received services on the date of the transportation for each ride authorized or trip reimbursed.

The branch or agency will ensure that if any request for non-emergency medical transportation is denied, the client receives a written denial notice. Clients will also be informed about the fair hearing process.

The branch or agency should require the client to call with medical transportation requests as soon as medical appointments are made. Clients who call with "same day" requests may be asked to reschedule their appointment if the appointment is not urgent or not essential to maintaining continuity of care or monitoring of client medical condition.

2. Brokerage

There are several regions in the state that are within brokerage areas. These brokerages are consolidated call centers that will verify client eligibility and provide the most cost-effective ride suitable to the client's needs. All requests for transportation originating within a brokerage region, except for ambulance services and client meals and lodging, should first go through the brokerage (this includes client mileage requests).

In some brokerage areas, the brokerage also has the authority to prior authorize mileage, meals, and lodging for clients, DHS volunteers and foster care parents. Check with the brokerage to ensure that the proper prior authorizations arerequested.

Clients who are sent into brokerage areas from non-brokerage areas and need return transportation must have their eligibility information provided by the branch to the appropriate brokerage so the brokerage can arrange for the transportation originating within their area. Clients from one brokerage area going to another brokerage area will be coordinated between the brokerages.

C. Authorization Process

The following information suggests minimal processes that must take place in the authorization of any non-emergency transport. Different client populations and their unique needs or circumstances mean that the process will vary. Certain procedures are required, however, regardless of the client or the specific level of need. This worker guide contains a recommended Medical Transportation Screening Form which the branch may choose to adopt. Regardless of the form used, a "paper trail" clearly documenting the client's need

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