DHS Oregon Department of Human Services

Health Services
Office of Medical Assistance Programs

Policy Transmittal

Allison Knight, Acting Manager
OMAP Program and Policy Section
Authorized Signature

Number: OMAP-PT-06-001
Issue Date: February 1, 2006

Topic: Medical Benefits

Transmitting (check the box that best applies):

☐ New Policy ☒ Policy Change ☐ Policy Clarification ☐ Executive Letter
☐ Administrative Rule ☐ Manual Update ☐ Other: ____________

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, OMHAS and OMAP transmittal lists

Policy/Rule Title:	OMAP Worker Guide Revision 21		
Policy/Rule #(s):	Medical Benefits	Release No:	OMAP-WG-21
Effective Date:	February 1, 2006	Expiration:	
References:			
Web Address:	www.oregon.gov/DHS/healthplan/data_pubs/wguide/main.shtml		

Discussion/Interpretation:

On January 1, 2006, Medicare implemented the new Medicare Prescription Drug Program, Medicare Part D. The changes in this revision are related to Medicare and Part D. The entire worker guide will be revised, effective April 1, and sent with the July 1, 2006, release of the CAF Family Services Manual. Revision 21 includes:

- Worker Guide #3 – The revised Medical Care IDs, and
- Worker Guide #4 – The new OHP with Limited Drug benefit package coverage description

Implementation/Transition Instructions:

Training/Communication Plan:

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: Yes X No

If yes, reviewed by: Worker Guide review list

Filing Instructions:

Replace sections 3 and 4 with this revision

If you have any questions about this policy, contact:

Contact(s):	Tanya Allen		
Phone:	(503) 945-6599	**Fax:**	(503) 945-6873
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OMAP Worker Guide #3

Medical Care Identification

A. Medical Care Identification

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

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

The Medical ID also shows the benefit package for every eligible member in the household (fields 9a and 9b) and copayment requirements (fields 7a and 7b). Clients have been instructed to contact their worker if information on the Medical ID is incorrect or if information changes (examples include: address change, someone becomes pregnant, or someone leaves the household). Workers are then responsible for entering changes into the computer system.

Issuing a Replacement Medical Care ID

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

Issuing a Temporary Medical Care ID

In some situations the client may not have time to wait for a replacement Medical ID to be mailed because they have a medical appointment or need a prescription filled. When this occurs the worker can create a temporary Medical ID through the MID1 screen, or if the DHS system is unavailable, the worker can complete a handwritten temporary Medical ID (OMAP 1086). Temporary IDs can be handed to the client or faxed directly to a client's medical provider or pharmacy. If the client does not have an immediate need, it is preferred that a replacement card is ordered on ELGH.

A sample of the OMAP Medical Care ID (front and back) is shown on pages 2 and 3. A sample of the temporary IDs (OMAP 1086 and MID1) are shown on pages 4, 5 and 6.

(1) (2) (3)

OMAP Medical Care Identification (ID)

(4) Branch Name | Division | (5) Worker | (6) Phone

(7a) Copy 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
B
C
D
E
F
G
H
I

(9a) Benefit Package	
A – OHP Plus	**D – OHP with limited drug**
B – OHP Standard	**E – CAWEM Emergency Medical**
C – QMB	

All non-emergency care must be approved by applicable Managed Care/TPR shown in field 8a. See OMAP General Rules OAR 410-120-1210 for specific benefit package limitations. All OMAP administrative rules can be found on the OMAP website at: www.oregon.gov/DHS/healthplan/

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

IMPORTANT:

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

(14)

Clients

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

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

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

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

For questions about:

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

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

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

Your OMAP Medical Care ID shows:

Your worker's code.

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.

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

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).

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

OMAP Client materials can be found on the OMAP website at: www.oregon.gov/DHS/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.oregon.gov/DHS/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 09/05)

OMAP Temporary Medical Care Identification (ID)

- Show this ID to all providers at the time of service, even if you have a Managed Care Plan card.
- Not valid outside the United States or US Territories.

① This identification is valid for services provided

From ____________________ Thru ____________________ .

Provider: The persons named below are eligible to receive medical assistance through the Department of Human Services. All insurance and other medical resources must be billed prior to billing the Office of Medical Assistance Programs (OMAP). Some services must be prior authorized. If in doubt about services covered, prior authorization or other policy, please refer to the OMAP General Rules and provider guidelines or call the branch office listed below.

Important Note: To insure prompt payment processing, please delay submission of claims on these clients for two weeks following date of services so that eligibility can be recorded on the computer.

2a Managed Care/TPR

A

B

C

D

E

F

G

3a Copay Requirements

A	B
$3 for outpatient services not paid for by your Plan (listed in 2b)	$2 Generic/$3 Brand – for drugs not paid for by your Medical Plan (listed in 2b)

4a Benefit Package

A – OHP Plus	D – OHP with limited drug
B – OHP Standard	E – CAWEM Emergency Medical
C – QMB	

All non-emergency care must be approved by applicable Managed Care/TPR shown in field 2a. See OMAP General Rules OAR 410-120-1210 for specific benefit package limitations. All OMAP administrative rules can be found on the OMAP website at: www.oregon.gov/DHS/healthplan/

5 Name of Eligible Person(s)	6 Recipient ID	7 Date of Birth	3b Copay Req	2b ManagedCare/TPR	4b Benefit Package

8. Branch Office Name and Address	9. Phone Number
	10. Authorized Signature
	11. Date

Distribution: White - Client Copy; Canary - Branch Copy

OMAP 1086 (Rev 01/06)

Instructions for Completing the Temporary Medical Care ID (OMAP 1086)

1. Valid Dates – Enter the days this identification is valid.

2. Managed Care/TPR
   a) Enter all available medical resources for the case. Enter only one resource per letter. This includes OMAP contracted plans, private insurance, primary case managers, and pharmacies.
   b) Enter the appropriate Managed Care/TPR code letter from the choices listed in field 2a.

3. Copay Requirements
   a) Shows possible copay requirements.
   b) For clients who are required to pay copayments, enter "AB." For all other clients, enter "NO COPAYS."

4. Benefit Packages
   a) Shows the available benefit packages.
   b) Enter the appropriate benefit package code letter from the codes listed.

5. Name of Eligible Person(s) – Enter the names of the eligible clients.

6. Recipient ID – Enter the client's prime number; not case number.

7. Date of Birth – Enter the date of birth for each client listed.

8. Branch Office Name and Address – Enter the name and address of the client's branch.

9. Phone Number – Enter the branch's phone number.

10. Authorized Signature – Signature of an authorized branch worker.

11. Date – Enter the date this ID was signed.

Branches

Use this form for clients with immediate medical needs, only when the MID1 screen cannot be used. Issue a replacement Medical Care ID using the ELGH screen as soon as possible after completing this form.

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                TEMPORARY MEDICAL CARE IDENTIFICATION
                        Valid for services
               Provided from 01/25/2006 through 01/31/2006

Case SCD    : XX####                 Prog Elig :  4
Benefit    A-OHP PLUS  B-OHP STANDARD   C-QUALIFIED MEDICARE BENEFICIARY (QMB)
Package:  D-OHP with LIMITED DRUG       E-CAWEM EMERGENCY MEDICAL

Copay:  A-OUTPATIENT   B-PHARMACY
                             ---Managed Care/Private Insurance/Restrictions---
Recip                        Ref  Package     Ins Comp                 Grp Pol
  Prime ID                     Copay             Ins Cov      Pol Nmbr
DOE, JANE                    ABC  A         A  SAFEWAY PHARMACY          PHARMACY
  XX####                       AB               OMAP PHARMACY          RESTRICTED
                                            B  ODS COMMUNITY HEALTH INC   OD01
                                                OMAP Dental Plan
                                            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
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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 resour-ces 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)

OMAP Worker Guide #4

Benefit Packages

A. Benefit Packages

General Rules 410-120-1160 through 410-120-1230

OHP Rule 410-141-0480

Clients receive health care services based on their benefit package. Each benefit package's coverage is different. Clients are assigned to benefit packages based on their program eligibility.

The codes in the "BEN" field on the ELGR screen and corresponding benefit package names are:

- BMH – OHP Plus
- KIT – OHP Standard*
- MED – Qualified Medicare Beneficiary (QMB)
- BMM – QMB + OHP with Limited Drug
- BMD – OHP with Limited Drug
- CWM – Citizen/Alien-Waived Emergency Medical (CAWEM)

** The OHP Standard benefit package closed to* ***new*** *enrollment July 1, 2004.*

B. What's Covered

1. The OHP Plus Benefit Package BEN Code – BMH

The Oregon Health Services Commission (HSC) developed a list of 730 medical conditions and treatments in order of effectiveness. Currently, covered services are lines 1-530 on the Prioritized List of Health Services.

OHP Plus Benefit Package – Covered Services

- 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, even if the treatment for the condition is not covered
  - Laboratory, X-ray and other appropriate testing
- Medical and Surgical Care
- Family Planning Services and Supplies – including birth control pills, condoms, contraceptive implants, and Depo-Provera; sterilizations
- Medically appropriate treatments for conditions expected to get better with treatment – includes, but is not limited to:
  - Appendicitis
  - Infections
  - Ear Infections

  - Broken bones
  - Pneumonia
  - Eye diseases
  - Cancer
  - Stomach ulcers
  - Diabetes
  - Asthma
  - Kidney stones
  - Epilepsy
  - Burns
  - Rheumatic fever
  - Head injuries
  - Heart disease
- 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 clients who have no other transportation available to them, including ambulance and other methods of transport
- Dental Services
- Outpatient Chemical Dependency Services
- Comfort Care – this includes hospice care and other comfort care measures for the terminally ill, and death with dignity services
- Mental health services

2. The OHP Standard Benefit Package* BEN Code – KIT

This benefit package is similar to private insurance with premiums and benefit limitations. The Prioritized List also applies to the OHP Standard benefit package.

** The OHP Standard benefit package closed to* ***new*** *enrollment July 1, 2004.*

OHP Standard Benefit Package – Covered Services

- Physician services
- Ambulance
- Prescription drugs
- Laboratory and x-ray services
- Durable 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
- Outpatient mental health
- Outpatient chemical dependency services
- Limited emergency dental services – teeth cleaning, orthodontia, fillings, and other routine services are **not** covered (see OAR 410-123-1670)
- Hospice services, and
- Limited hospital benefit –includes:
    - Evaluation, lab, x-ray and other diagnostics to determine diagnosis (line zero on the Prioritized List)
    - Hospital treatment for urgent/emergent services
    - Inpatient and outpatient hospital treatment for diagnoses listed in the Limited Hospital Benefit Code list. Prior Authorization (PA) is required for certain services, as indicated.

OHP Standard Benefit Package – Excluded Services

- 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

3. QMB Benefit Package
BEN Code – MED

The QMB benefit package pays for Medicare premiums, co-payments and deductibles for services covered by Medicare. This does not include any cost sharing for Medicare Part D coverage or prescriptions.

Providers are not allowed to bill clients with QMB benefit package coverage for deductible and co-insurance amounts for services covered by Medicare (except for Medicare Part D prescriptions). However, providers may bill these clients for services that are not covered by Medicare and for Medicare Part D prescriptions.

4. QMB + OHP with Limited Drug Benefit Package
BEN Code – BMM

This is a combination of the OHP with Limited Drug and QMB benefit packages. To be eligible for this benefit package, clients must meet the eligibility requirements for both benefit packages. See the QMB and OHP with Limited Drug benefit package descriptions for coverage information.

5. OHP with Limited Drug Benefit Package
BEN Code – BMD

The OHP with Limited Drug benefit package covers the same medical, dental and mental health services as the OHP Plus benefit package. However, the OHP with Limited Drug benefit package does not cover drugs covered by Medicare Part D.

6. CAWEM - Citizen/Alien-Waived Emergency Medical
BEN Code – CWM

These clients are only eligible for treatment of emergency medical conditions. Labor and delivery services for pregnant women are considered an emergency.

Clients on the CAWEM benefit package do not pay premiums or copays.

The following list is not all-inclusive but can be used as an illustration to identify services that are **NOT covered for clients on the CAWEM benefit package:**

- 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

CAUTION: Services that are ongoing, require prior authorization, payment authorization or that can be scheduled in advance are not covered for clients on the CAWEM benefit package.

C. What's Not Covered *OHP Rule 410-141-0500*

Services for conditions that the HSC ranks of lower priority are generally not covered. The HSC's report contains a complete listing of conditions/treatments that are not covered. There may be other limitations depending on the client's benefit package. Treatments for the following conditions that have no other complicating diagnosis are not covered:

- 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
- Conditions where a "home" treatment is effective, such as applying an ointment, resting a painful joint, drinking plenty of fluids, or a 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

D. Benefit Package Overview

The following table lists some of the services that are covered for each benefit package as well as how the package is coded in the "BEN" field on the ELGR screen.

OHP Plus – BMH	
Physician, lab and X-ray services	Hospice services
Pharmacy services	Home health services
Physical therapy/occupational therapy	Dental services
Reasonable diagnostic services	Medical transportation
Durable medical equipment and supplies	Some over-the-counter drugs
Vision, glasses	Chemical dependency services
Hearing, speech services	Mental health services
Hospital services (inpatient and outpatient)	Preventive services (for example: tobacco cessation services)
OHP Standard – KIT	
Physician, lab and X-ray services	Some over-the-counter drugs
Pharmacy services	Outpatient mental health services
Hospice services	Outpatient chemical dependency services
Reasonable diagnostic services	Emergency medical transportation
Limited durable medical equipment (see OAR 410-122-0055)	Limited emergency dental (see OAR 410-123-1670)
Limited hospital services (see OAR 410-125-0047)	Preventive services (for example: tobacco cessation services)
Qualified Medicare Beneficiary (QMB) – MED	
Medicare premiums, deductibles and copays for Medicare covered services	
QMB + OHP with Limited Drug – BMM	
See QMB and OHP with Limited Drug benefit packages	
OHP with Limited Drug – BMD	
The OHP with Limited Drug benefit package covers the same medical, dental and mental health services as the OHP Plus benefit package. However, the OHP with Limited Drug benefit package does not cover drugs covered by Medicare Part D.	
Citizen/Alien-Waived Emergency Medical (CAWEM) – CWM	
Emergency medical services	Labor and delivery
Senior Prescription Drug Assistance Program (SPDAP) – PDA	
Prescription drug assistance for elderly – this is not a Medicaid program (see OMAP Worker Guide #6 for detailed information)	

E. OHP Plus Benefit Package Eligibility and Copay Requirements

This page does not list all requirements or exceptions.

Eligible clients are:
Pregnant women – up to 185% of the Federal Poverty Level (FPL)
Children under age 19 – up to 185% of the FPL
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
Receiving Temporary Assistance to Needy Families (TANF)
Presumptively eligible prior to disability determination
Children in foster care or in adoptive assistance

Copays are (see OAR 410-120-1230 for more information):
$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 copay is only for the visit to the provider. There is no copay for treatments performed by the provider (i.e., immunizations, labs or X-ray)

Copays are not required for the following clients and services:
Clients in prepaid health plans (PHP) – for services covered by the PHP
Pregnant women
Children under age 19
American Indians/Alaska Natives
Clients who are eligible for benefits through Indian Health Services
Clients who are receiving services under the Home and Community Based waiver and Developmental Disability waiver
Clients who are in a hospital as an inpatient, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR)
Family planning services and supplies
Emergency services, as defined in OAR 410-120-0000
Prescription drugs ordered through OMAP's home deliver (mail order) vendor

F. OHP Standard Benefit Package Eligibility and Copay Requirements

This page does not list all requirements or exceptions.

This benefit package closed to **new** enrollment July 1, 2004.

Eligible clients:
Are adults who do not meet eligibility requirements for the OHP Plus benefit package – up to 100% of the FPL
Do not currently have and have not had commercial insurance coverage during the previous six months

Copays
None

Premiums
Premiums are charged per member/per month
American Indians/Alaska Natives are not required to pay premiums
Clients who are eligible for benefits through Indian Health Services are not required to pay premiums
If premiums are not paid on time, the client may lose coverage before the end of their six month enrollment.

The following services are not part of the OHP Standard benefit package:
Hospital services **not** on the Limited Hospital Benefit Code List (OAR 410-125-0047)
Therapy services (physical, occupational, and speech)
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

G. DHS Medical Assistance Programs

Program Code	Program Title	Case Descriptor	Benefit Package
1, A 1	Aid to the Aged	See Computer Guide section 3-L	OHP with Limited Drug
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 with Limited Drug
4, D4	Aid to the Disabled	See Computer Guide section 3-L	OHP with Limited Drug
19, 62	DHS Foster Care		OHP Plus
C5	Substitute/Adoptive Care	SAC, SCP, SFC	OHP Plus
GA (CSD)	Non-title XIX Foster Care		OHP Plus
P2, M5, 2, 82	Children's Health Insurance Program (CHIP)	CHP	OHP Plus
P2, M5, 2, 82	Extended Medical Program	EXT	OHP Plus
5	OSIPM-PRS	NCP	OHP with Limited Drug
P2	Qualified Medicare Beneficiary (QMB)	QMB	QMB
Any Program	QMB + Any Program	QMM	QMB + OHP with Limited Drug
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 and Cervical Cancer Program	BCP	OHP Plus
P2, M5, 2, 82	Senior Prescription Drug Assistance	PDA	N/A
Any Program	CAWEM	CWM	Emergency Medical