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May 2008

Other Medical Resources

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 has only implemented the first portion of the statute (the discount portion). The discount program was rolled out in phases beginning 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.

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 DMAP at 1-800-527-5772 or 503-945-5772 and ask for the Senior Drug Assistance Program Manager.

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), 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 and prescription drug portion of the premium, as well as vision or dental premiums if the coverage (or benefit) is offered by the same medical insurance company. FHIAP members must pay deductibles, co-pays or any other coinsurance associated with their health insurance plan.

In 2006, the Insurance Pool Governing Board became the Office of Private Health Partnerships (OPHP), which administers the FHIAP program.

Eligibility Criteria and Enrollment

To be eligible for FHIAP, the applicant must meet the following criteria:

- Reside in Oregon
- Be a U.S. citizen or a qualified non-citizen
- Have investments and savings of less than $10,000
- Have a three month average income of less than 185% of the FPL
- Be uninsured for the previous six months, except for those leaving OHP/Medicaid
- Must not be eligible for or receiving Medicare

NOTE: Enrollment in both DHS medical and FHIAP at the same time is not allowed. It is considered "concurrent benefits." TANF clients receiving cash-only assistance (*i.e.,* no medical coverage from DHS) may get medical coverage through FHIAP.

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 and the employer's health plan meets minimum standards. 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 currently is not accepting new members. Applicants must call FHIAP to be placed on a reservation list. Applications will be mailed when openings occur. The waiting period varies but is currently about one and a half to two years.

People who don't qualify for OHP Standard benefit package coverage because of ESI may be eligible for FHIAP. These applications should be sent to FHIAP for eligibility determination when FHIAP has openings.

For more information about FHIAP, call 1-888-564-9669, TTY 1-800-433-6313 Monday through Friday, 9 a.m. to 5 p.m. or see <www.fhiap.oregon.gov>.

FHIAP Federal Funding and Program Information

The 2001 Oregon Legislature passed House Bill 2519. Part of this Bill directed the state to create a waiver requesting federal matching funds for the FHIAP program and to expand the program. The expansion was implemented on November 1, 2002. Then in 2008 the Centers for Medicare and Medicaid switched funding for adult FHIAP clients from Title XXI to Title XIX. By June 1, 2008, FHIAP will transfer adults at 85% FPL and lower to DHS for OHP Standard coverage.

Oregon Medical Insurance Pool (OMIP)

OMIP is a high-risk health insurance pool that was established by the Oregon Legislature to cover adults and children who are unable to obtain medical insurance because of their health conditions. This is not an income-based program. Members must have the financial resources to pay the premiums. OMIP does not subsidize premiums or reduce them according to an individual's ability to pay.

OMIP also provides a way to continue insurance coverage for those who exhaust COBRA benefits and have no other options.

To apply, call the customer service unit at 800-848-7280 and ask for an OMIP Packet or download an application at the Web site, <www.omip.state.or.us>.

The Oregon Prescription Drug Plan (OPDP)

OPDP is a statewide prescription drug purchasing pool that uses a discount card. All Oregonians may join. There is no cost to enroll. Average savings are 42%. All drugs prescribed by a licensed clinician are eligible for discounts.

To enroll by phone, call toll-free, 1-800-913-4146, or download a printed application for mailing to the program. Applicants will receive an ID card within a week and can take it to a member pharmacy with their prescriptions to receive the discount.

See <www.oregon.gov/OHPPR/OPDP>.

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 application.
- For SPD, document in the case record that EPSDT information was given to the client.

Disease Care Management and Medical Care Management Programs

Fee-for-service OHP clients with specified, chronic conditions and high-utilization clients receive extra help managing their health care.

OHP clients already enrolled in managed care organizations and Medicare recipients are excluded from these programs on the premise that they receive these services from another source.

Nurse Advice Line

All OHP fee-for-service clients, whether or not they have a chronic condition, have access to a nurse triage telephone line (800-711-6687) 24 hours a day, 7 days a week. The nurses help answer questions about symptoms, illness, injuries or health care. They can help clients decide if they should get care at home, go to the doctor, or go to the hospital.

Disease Management Program

DMAP will place clients in the Disease Management Program (coded "DCM") if they have chronic physical conditions such as diabetes, asthma, chronic obstructive pulmonary disease, congestive heart failure or coronary artery disease. Clients with multiple diagnoses may also be placed in the program.

The program is voluntary and clients may opt out, if they wish, by contacting the DMAP Client Services Unit (800-273-0557). CSU will then contact the DMAP DCM coordinator

for approval to disenroll the client at the end of the month. When the request is approved, the Client Enrollment Services (CES) staff will arrange for the plan enrollment then update the ELGX screen.

DCM client services include:

- 24-hour nurse triage line
- Telephonic education, assessment and coordination of care
- Provider coordination for symptom management and “care alerts”
- Home visits by nurses for referred clients
- Disease-specific educational mailings.

Medical Care Management Program

The Medical Care Management Program is for fee-for-service OHP clients who demonstrate high utilization or high cost utilization of health care services. This program offers all the services listed above, plus

- Management through pre-authorization of services
- Management of hospital utilization and coordination of discharge needs.

DCM and MCM Case Descriptors

Program participation is designated by a “DCM” or “MCM” code in the TPR field in MMIS and on the DMAP Medical ID. However, DCM and MCM are not third party insurance, rather a supplemental benefit for fee-for-service OHP clients.

The DCM or MCM code in the TPR field will block auto and manual enrollment into a managed care organization (MCO). Clients, and/or case workers with clients in these programs, who want to enroll a client into an MCO plan can contact Client Services to:

- Request to be removed ("opt out") from the DCM or MCM program, and
- Specify the MCO to be enrolled in.

DCM or MCM closure occurs once at the end of each month, and enrollment into the MCO is effective the first of the next month.

The Oregon Breast and Cervical Cancer (BCC) Program

This Oregon BCC Program helps low-income, uninsured, and underserved women gain access to lifesaving screening programs for early detection of breast and cervical cancers. The Oregon BCC Program provides screening funds to promote early detection of breast and cervical cancer among Oregon’s medically underserved individuals.

Call 877-255-7070, toll-free, to request information about free mammograms. See also <www.oregon.gov/DHS/ph/bcc>.