

## Action Request Transmittal

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Office of Payment Accuracy and Recovery

**Number:** OPAR-AR-11-001

**Authorized Signature**

**Issue Date:** 09/29/2011

**Topic:** Medical Benefits

**Subject:** Important changes to 415H and HIPP moving to HIG

### **Applies to:**

- |   |  |
|---|--|
| <input type="checkbox"/> All DHS employees                        | <input type="checkbox"/> County Mental Health Directors                  |
| <input checked="" type="checkbox"/> Area Agencies on Aging        | <input checked="" type="checkbox"/> Seniors and People with Disabilities |
| <input checked="" type="checkbox"/> Children, Adults and Families | <input checked="" type="checkbox"/> Other (please specify): DMAP         |
| <input type="checkbox"/> County DD Program Managers               |  |

### **Message:**

This transmittal covers important process changes regarding third party insurance and is intended for workers who determine eligibility for medical benefits.

A new version of the DHS 415H will be released on October 1, 2011. It is very different from prior versions. The changes will simplify third party insurance reporting, and were also needed because determinations for the Health Insurance Premium Payment (HIPP) program are being moved to the Health Insurance Group (HIG) on November 1, 2011. Administration of the PHI (Private Health Insurance) program has already been transitioned to HIG.

### **Timeline Highlights**

October 1, 2011:

- The MSC 415H will be released to branches in hard copy and online on the DHS/OHA forms server. The MSC 415H replaces the DHS 415H (link not available until 10/1/11)

November 1, 2011:

- OR ACCESS will be updated with the revised form.
- HIPP will be deactivated in the CM system and field staff will no longer be able to enter HIPP coding or authorize HIPP payments after this date.
- OR ACCESS and HIG will begin processing all HIPP referrals and payments.
- Workers will no longer issue payments on the 437 form (Special Cash Pay).

January 1, 2012

- New HIPP guidelines and OAR's will be implemented.

**Note:** The Extra Form E (used to report TPL) which is included in the 7210 application packet has also been revised. It is set for release early in October.

## Major changes

1. Clients, caseworkers, managed care plans and providers will use the new form. All paper copies of the DHS 415H should be recycled. Clients are still required to send the MSC 415H directly to their caseworker. All other users will be able to email the form directly to HIG.
2. Workers will use the form to make referrals for potential premium reimbursement for clients who have employer-sponsored or private health insurance.
3. Workers will use this form when they determine eligibility for an employed client who has not signed up for the insurance offered by their employer. HIG will work with the client to determine if the insurance is cost effective in accordance with OAR 461-120-0345. **Action required by worker:** Do not delay your eligibility decision based on cost effectiveness to pursue the insurance. If the client meets all other program guidelines, open benefits and make a referral to HIG on the MSC 415H. At the earliest open enrollment time, HIG will notify the worker by phone or email if the insurance is determined to be cost effective.

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## Instructions for completing the form:

**Office use only section** - Branch staff that are completing and/or submitting the form will use this section to enter their ID and the case number. They can also request "Rush" processing or good cause coding if it is needed. If preferred the MSC 0156 Rush Request form can still be used to request rush processing.

**Note to SPD workers:** The branch, worker ID and case number will auto fill from OR ACCESS, but you will be required to complete the rest of the form manually.

### Section 1 – Contact Information

This section is for the person who is completing the form.

*Example 1:* If a worker fills out the form for the client, the worker will add their name and contact information here as well as the case number, branch and worker ID in the "Office use only" box.

*Example 2:* If a client, provider or managed care plan completes the form and a worker is sending the form to HIG, the worker will need to complete the "Office use only" box.

### Section 2 – Status of the insurance

It is very **important** that this section be completed. This section serves several purposes.

1. It tells HIG if insurance should be added or ended or if the policy has changed.
2. The boxes "insurance is from an employer" and "insurance is paid for privately" and "Insurance is Cobra" are used as an alert that there is the potential for a HIPP reimbursement.
3. The box "Can get insurance from employer" is used to determine if cost effective insurance is available and is for the purpose of complying with OAR 461-120-0345 (Requirement to obtain cost effective insurance). **Action required by worker:** If an employed client is not

signed up for their employer-sponsored insurance, workers will check this box to make a referral to HIG. HIG will work with the client to see if the insurance is cost effective to pursue.

### Section 3 and 4 – Policy information

The form provides space for two different insurance policies. Use Section 3 and/or 4 to report each policy. If more than two policies exist, you can submit additional pages. Please note that the name and social security number of the policyholder are required. Copies of the insurance cards are not required as long as the policyholder information is submitted.

*Example 1:* The client has medical insurance from Blue Cross and dental insurance from Delta Dental. Enter the Blue Cross information in Section 3 and the Delta Dental in Section 4.

*Example 2:* The client has 1 policy from Blue Cross that provides medical, vision and pharmacy, you only need to enter the Blue Cross policy one time in Section 3.

### Section 5 – Premium reimbursement

This section is completed by a client or worker only. During the month of October, if a worker receives the new 415H and a client has indicated that they pay for all or part of their employer-sponsored insurance workers should follow existing processes to see if anyone qualifies for HIPP. After November 1, 2011 workers will not make the HIPP determination, they will make a referral to HIG to make the determination.

### HIPP Transition

Effective November 1, 2011 HIPP determinations will be made by HIG using the existing HIPP guidelines. On January 1, 2012, the criteria to qualify for a reimbursement will change. Some of the changes include; revised OAR's, increased reimbursement amounts on the Medical Savings Chart (MSC) and improvements about who can qualify. These changes are intended to open the program so that more people who have third party insurance will qualify for a reimbursement. All of the changes will be outlined in detail in the DMAP worker guide at the end of December 2011 and an IM will be sent. The FSM and SPD worker guides will also be updated.

HIG is currently working with the clients of all active HIPP cases to prepare for transition so there are no gaps in premium payments. HIG will send all required notices to clients found ineligible for HIPP during the transition or upon "go-live" for the new program. HIG is currently working with the caseworkers and narrating ineligibles as they are identified. The first batch of HIPP payments that will be sent through MMIS will be the December payments. When the DMAP guide is updated in December, it will give instructions on how workers can locate premium reimbursement information in MMIS. Until then, workers can contact the Premium Reimbursement Coordinator at HIG if they have questions. Note: HIPP and PHI payments made by HIG will be narrated in TRACS and OR ACCESS.

Attached below is a copy of the revised MSC 415H. If you have any questions, please contact either Carolyn Thiebes, TPL Analyst, OPAR, 503 378-3507 or Janine Kely, Premium Reimbursement Coordinator, OPAR, 503 378-3324.

*If you have any questions about this information, contact:*

<b>Contact(s):</b>	Carolyn Thiebes, Analyst, Office of Payment Accuracy and Recovery		
<b>Phone:</b>	503 378-3507	<b>Fax:</b>	503 378-3207
<b>E-mail:</b>	carolyn.thiebes@state.or.us		

**Notification of  
Other Health Insurance**

Worker completes →

Use to request good cause  
coding or rush processing →

Office use only		
Branch:	Worker ID:	Case number:
<input type="checkbox"/> Rush processing needed Reason for rush _____ <b>Note:</b> Rush processing should only be requested when there is an immediate/urgent need for health services. Good cause coding: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		

Use this form to report employer sponsored or other private health insurance policies for an individual that may also be receiving or applying for Medicaid.

**Instructions:**

**Applicants** — Complete sections 1— 5 and return this form to your caseworker with a copy of the front and back of your insurance cards.

**Workers, managed care plans and providers** — Complete sections 1 — 4 and return this form to the Health Insurance Group by email or FAX: 503-373-0358.

Section 1: Contact information
Name of person completing this form:
Are you a: <input type="checkbox"/> Applicant <input type="checkbox"/> Caseworker <input type="checkbox"/> Provider <input type="checkbox"/> Managed care plan <input type="checkbox"/> Other
Phone number:
Email address:

**Section 2: Status of insurance - check all that apply**

- Have active insurance
  - Insurance ended on \_\_\_/\_\_\_/\_\_\_
  - Insurance has changed
  - Insurance is from an employer
  - Insurance is COBRA
  - Insurance is paid for privately
  - Can get insurance from employer
- Use to refer potential HIPP (points to Insurance is from an employer)
- Use to refer client that is not taking their employer's insurance (points to Can get insurance from employer)

If you pay for all or part of your insurance, we may be able to reimburse you. For more information, see section number 5 on the next page.

**Section 3: Policy 1 information**

Insurance company:	Policy ID number:	
Policy holder's* name (first, middle initial, last)	Social Security number:	Date of birth (month, day, year)
Type of policy (check all that apply): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision		
<input type="checkbox"/> Other: _____		

\* The policy holder is the **owner** of the insurance policy.

### Section 3: Policy 1 information continued

List all people covered by **policy 1** who are applying for or receiving medical benefits.

Applicant or client name	Date of birth (month, day, year)	Prime number (office use only)
Person 1		
Person 2		
Person 3		
Person 4		
Person 5		

### Section 4: Policy 2 information

Insurance company:		Policy ID number:
Policy holder's* name (first, middle initial, last)	Social Security number:	Date of birth (month, day, year)
Type of policy (check all that apply): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision		
<input type="checkbox"/> Other: _____		

\* The policy holder is the **owner** of the insurance policy.

List all people covered by **policy 2** who are applying for or receiving medical benefits.

Applicant or client name	Date of birth (month, day, year)	Prime number (office use only)
Person 1		
Person 2		
Person 3		
Person 4		
Person 5		

Please make a copy of this form if you need to tell us about more insurance policies.

### Section 5: Possible premium reimbursement

In some cases, the state's Health Insurance Premium Payment (HIPP) program may reimburse people who pay for employer-sponsored or private major medical health insurance if it is cost effective for the state.

**Do you pay for all or part of your private or employer-sponsored health insurance premium?**

Yes  No

If you answered **yes**, we will contact you and ask for more information to see if you qualify for this type of premium reimbursement.

If this box is checked, send 415H to HIG. They will contact the client to get proof of the premium amount; set up the HIPP case; and do all redeterminations. Workers just need to make the referral.

**Section 6:** Use this section for any **additional information** you want to provide about your current or recent insurance coverage.

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- Please return this completed form and copies of your insurance cards (front and back) with your application. Let us know in the space above if you do not have your insurance cards.

**Social Security number (SSN)** – These federal laws say that anyone applying for medical benefits must provide an SSN. Federal laws – 42 USC 1320b-7(a), 42 CFR 435.910, 42 CFR 435.920 and 42 CFR 457.340(b). When you write your SSN on the application it means that you give permission for the Department of Human Services (DHS)/Oregon Health Authority (OHA) to use it and tell others about it for these reasons:

- To help us decide if you qualify for benefits. We will use the SSNs to make sure the income and assets you gave on the application are correct. We will match that information with other state and federal records, such as Internal Revenue Service, Department of Revenue, Medicaid, child support, Social Security, and unemployment benefits.
- To write reports about the Oregon Health Plan or Healthy Kids.
- If the SSN is needed in order to administer the program you apply for or receive benefits from.
- To help us improve the programs by doing quality reviews and other activities.
- To make sure that we have given you the correct amount of benefits and to recover money if we have overpaid benefits.