

Information Memorandum Transmittal

Chuck Hibner, Administrator

Office of Payment Accuracy and Recovery

Number: OPAR-IM-11-025

Authorized Signature

Issue Date: December 28, 2011

Topic: Medical Benefits

Subject: January 1, 2011 HIPP program and Major Medical Definition changes

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): OPAR, DMAP |
| <input type="checkbox"/> County DD Program Managers | |

Message:

The transition of the Health Insurance Premium Payment (HIPP) program to HIG was successfully completed on November 1, 2011. HIG's Premium Reimbursement Coordinators conducted recertifications for each existing HIPP case and those that were determined eligible received November and December payments. All clients determined not eligible received benefit reduction letters.

Reminder to workers that all HIPP and PHI determinations are now done by HIG. Please do not send HIPP approval notices to clients or attempt to issue HIPP payments using the 437 special cash pay process.

Overview of the changes

On January 1, 2012, a new set of guidelines for the HIPP and PHI (Private Health Insurance) programs will go into effect. Also revised is OAR 461-135-1100 that changes the definition of major medical insurance. Following is a brief description of the major changes:

- The [Medical Savings Chart](#) has been revised and limits are higher. HIPP eligibility will be determined by recipient PERC codes. With a higher standard, more people will qualify.
- Cost effectiveness will be determined by adding together the allowable amount for each eligible recipient's PERC and comparing the total to the Medical Savings Chart.
- Policyholders will not have to live in the same household as the medical assistance recipient.
- A new [Special Conditions Chart](#) will allow us to consider higher premium amounts for people who have certain medical conditions.

- HIPP and PHI determinations will no longer be hearable as they are not a medical benefit.
- Clients receiving Medicare Part A and/or Part B will not qualify for HIPP or PHI after 1/1/12. This is because after Medicare pays the claims it is not cost effective for the state to reimburse premiums.
- The 3073 form used to make PHI referrals will become obsolete at the end of this month and all referrals for HIPP and PHI will be done on the [MSC415H](#)
- Private major medical insurance has been clarified to mean a policy that provides inpatient and outpatient hospital, physician, lab, x-ray and prescription benefit. The \$10,000 major medical policy limit has been removed from the OAR and is no longer a factor in determining if a third party insurance policy meets the major medical criteria. (Note: for the purposes of HIPP, the pharmacy benefit must be full coverage and not a discount card).

In addition to the changes above, OAR 461-135-1100, 461-135-0990, 461-155-0360 and 410-120-1960 have all been revised and become effective on January 1, 2012. Updates to the [SPD worker guide](#), [Family Services Manual](#) and [DMAP worker guide](#) will be posted soon. The DMAP guide will be the “go-to” guide for specific program details.

How do you know if a policy is major medical for the purposes of determining eligibility?

If you are having trouble determining whether or not a policy is private major medical insurance you can do one or more of the following:

1. Pend for copies of the front and back of their insurance cards. Often times the cards list the policy benefits *or*,
2. Pend for a copy of the insurance policy or benefits cover page *or*,
3. Call the insurance company *or*,
4. Call the employer if the insurance is employer-sponsored.

How do you know if HIG has authorized a HIPP or PHI payment?

There may be times when a caseworker or other staff may need to verify if a HIPP or PHI payment has been authorized by HIG. Payments can be verified in one of the following ways:

1. From a blank DHR (mainframe) screen type RCIQ and follow the instructions there *or*,
2. The preferred method is to check MMIS. To search in MMIS select “**HIPP Case Search**” from the TPL drop down menu. Enter the payee’s prime number. In the “**HIPP Case Management**” panel, click on “**HIPP Payment History**”. If HIG has authorized a payment, the amount and payment dates will be listed.

Questions?

Please contact one of the Premium Reimbursement Coordinators, Janine Kelty 503 378-3324 or Lori Babcock 503 378-3226, or Carolyn Thiebes 503 378-3507, the TPL Analyst for OPAR. You can also email questions to [HIPP, reimbursements](#) or hipp.reimbursements@state.or.us. Clients may be given the HIPP email address.

Thank you

If you have any questions about this information, contact:

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

DMAP Medical Savings Chart (MSC)

The Medical Savings Chart is used to determine eligibility for the Health Insurance Premium Payment (HIPP) and Private Health Insurance (PHI) programs. Information about how to use this chart as well as eligibility criteria and the referral process can be found in the [DMAP Worker Guide VII](#)

Health insurance eligibility group	PERC Code	Cost-effective premium amount (employee cost)
CEM	HD, HE, HF, HG	\$147
OHP-OPC	H1, H2, H3, H4OHP-OPC	\$239
OHP-OP6	HB, HA	\$448
OHP-OPP	L2, L6, L8, HC	\$705
EXT	XE	\$249
MAA/MAF	2, 82	\$386
SAC	C5	\$1785
OSIP-AB	3, B3	\$495
OSIP-AD	4, D4	\$1141
OSIPM-OAA	1, A1	\$180
Foster Children-SCF	19	\$237
GA	5, GA	\$163

Effective January 1, 2011
Program administered by the Health Insurance Group
Office of Payment Accuracy and Recovery

DMAP
Special Conditions Add On List
For PHI and HIPP

The Special Conditions Chart (SCC) is used to determine eligibility for the Health Insurance Premium Payment (HIPP) or Private Health Insurance (PHI) program when premium amounts exceed the Medical Savings Chart and a recipient has one of the conditions listed below. Information about how to use this chart as well as eligibility criteria and the referral process can be found in the [DMAP Worker Guide VII](#)

CCS2 Code	Description	Average paid per client per month
019	Pancreatic disease – excluding diabetes	\$396
002	Cancer	\$231
009	Blood disorder (sickle cell, hemophilia)	\$213
001	TB, HIV/AIDS, Hepatitis A ,B or C	\$173
018	Liver disease	\$157
015	Cardiovascular disorders	\$137
023	Childbirth (if neonatal delivery - cost PMPM is \$268)	\$105
012	CNS disorder-Multiple sclerosis, Epilepsy, Cerebral Palsey, Plegia (Quad, Para, Mono), Paralysis, Parkinsons, Huntingtons	\$65
027	Spina bifida	\$65
010	Mental Health disorders (Autism, DD)	\$61
016	Chronic lung disease, COPD	\$55
011	Alcohol & Chemical dependence disorders	\$54
021	Renal disorders (kidney disease)	\$50
005	Diabetes	\$40