DHS Policy
Oregon Department of Human Services

Children, Adults and Families

Policy Title:	Medical Services Provided Through the Oregon Health Plan – Policy				
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Approved By: *on file*

Date Approved:

Reference(s):

- ORS 418.325
- http://www.leg.state.or.us/ors/418.html
- ORS 414.025 through 414.815
- http://www.leg.state.or.us/ors/414.html
- OAR 410-141-0000 through 410-141-860
- http://arcweb.sos.state.or.us/rules/OARS_400/OAR_410/410_141.html

Form(s) that apply:

- OHP 7207, Continuity of Care Referral
- http://dhsresources.hr.state.or.us/WORD_DOCS/HE7207.doc
- DMAP 729, Administrative Medical Examination/Report Authorization
- http://dhsresources.hr.state.or.us/WORD_DOCS/OE0729.doc

Policy:

Purpose

This policy describes the method by which medical services, including mental health and chemical dependency services, will be provided to children who are in the custody of the *Department*, have been placed in paid substitute care, and have Oregon Health Plan coverage.

Definitions

(1) "Capitated Services" means those services that a contractor or Primary Care Case Manager agrees to provide for a *Capitation Payment* under an Office of Medical Assistance Programs (OMAP) Oregon Health Plan contract.

(2) "Capitation Payment" means a monthly prepayment to a Prepaid Health Plan contractor to provide all *Capitated Services* as needed for *Oregon Health Plan clients* who are enrolled with the Prepaid Health Plan. Monthly prepayment is made to a Primary Care Case

Manager to provide primary care case management services for an *Oregon Health Plan client* who is enrolled with the Primary Care Case Manager. Payment is made on a per client, per month basis.

(3) "Children, Adults and Families (CAF)" means a policy and program cluster within the *Department*.

(4) "Dental Care Organization (DCO)" means a Prepaid Health Plan that provides dental services, including routine dental care, dental case management and emergency dental services as *Capitated Services* under the Oregon Health Plan. All dental services covered under the Oregon Health Plan are covered as *Capitated Services* by the Dental Care Organization; no dental services are paid by Office of Medical Assistance Programs (OMAP) on a fee-for-service basis for *Oregon Health Plan clients* enrolled with a Dental Care Organization provider.

(5) "Department" means the Department of Human Services.

(6) "Disenrollment" means the act of discharging an *Oregon Health Plan client* from a Prepaid Health Plan's or Primary Care Case Manager's responsibility. After the effective date of *disenrollment*, an *Oregon Health Plan client* is no longer required to obtain *Capitated Services* from the Prepaid Health Plan or Primary Care Case Manager, nor to be referred by the Prepaid Health Plan for medical case managed services or by the Primary Care Case Manager for Primary Care Case Manager case managed services.

(7) "Emergency Medical Services" are the health care and services provided for diagnosis and treatment of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of both the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

(8) "Enrollment" means the process where *Oregon Health Plan clients* become members of a Prepaid Health Plan or Primary Care Case Manager (*PCCM*) that contracts with Office of Medical Assistance Programs to provide *Capitated Services*. An Ore*gon Health Plan client's enrollment* with a Prepaid Health Plan indicates that the client must obtain, or be referred by the Prepaid Health Plan for all *Capitated Services*, and referred by the Prepaid Health Plan for all medical case managed services subsequent to the effective date of *enrollment*. An *Oregon Health Plan client's enrollment* with a Primary Care Case Manager indicates that the Primary Care Case Manager client must obtain or be referred by the Primary Care Case Manager for all preventive and primary care and referred by the *PCCM* for all case-managed services subsequent to the effective date of *enrollment*.

(9) "Fee-For-Service Health Care Providers" means health care providers who bill for each service provided and are paid by Office of Medical Assistance Programs for services as described in Office of Medical Assistance Programs provider guides. Certain services are covered, but are not provided by Prepaid Health Plans or by Primary Care Case Managers. The client may seek such services from an appropriate fee-for-service provider. Primary Care Case Managers may also provide primary care services on a fee-for-service basis and may also refer Primary Care Case Manager clients to specialists and other providers for fee-for-service care. In some parts of the State, the State may not be able to enter into contracts with any managed care providers. *Oregon Health Plan clients* in these areas will

receive all services from fee-for-service providers.

(10) "Fully Capitated Health Plan (*FCHP*)" is a Prepaid Health Plan that contracts with Office of Medical Assistance Programs to provide *Capitated Services* under the Oregon Health Plan. The distinguishing characteristic of a *FCHP* is that it includes coverage of hospital inpatient services.

(11) "Good Cause" or "Just Cause" is a process whereby the *Department* makes a decision on a case-by-case basis, to enroll or disenroll a child in the custody of the *Department* from managed care based on the best interests of the child.

(12) "Medically Appropriate" are services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of an *Oregon Health Plan client* or a provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to an Oregon Medical Assistance Program Member or Primary Care Case Manager member in the *PHP's* or Primary Care Case Manager's judgment.

(13) "Oregon Health Plan Client" is an individual found eligible by the *Department* to receive services under the Oregon Health Plan. The individual may or may not be enrolled in a Prepaid Health Plan or with a Primary Care Case Manager.

(14) "Primary Care Case Manager (PCCM) Case Managed Services" include the following: preventive services, primary care services and specialty services, including those provided by physicians, nurse practitioners, physician assistants, naturopaths, chiropractors, podiatrists, rural health clinics, migrant and community health clinics, federally qualified health centers, county health departments, Indian health service clinics and tribal health clinics; inpatient hospital services; and outpatient hospital services except laboratory, x-ray and maternity management services.

(15) "Prepaid Health Plan (PHP)" is a managed health, dental, or mental health care organization that contracts with the Office of Medical Assistance Programs and/or the Office of Mental Health and Addiction Services on a case managed, prepaid, capitated basis under the Oregon Health Plan. Prepaid Health Plans may be *Dental Care Organizations (DCOs)*, Fully Capitated Health Plans (*FCHPs*), Mental Health Organizations (MHOs), or Chemical Dependency Organizations (CDOs).

(16) "Prioritized List of Services" is the listing of condition and treatment pairs developed by the Health Services Commission for the purpose of implementing the Oregon Health Plan. See OAR 410-141-520, Prioritized List of Health Services, for the listing of

condition and pairs.

(17) "Proof of Indian Heritage" is proof of Native American and/or Alaskan Native descent as evidenced by written identification for the purposes of eligibility under the Indian Health Program.

(18) "Urgent Care Services" are covered services required in order to prevent a serious deterioration of a client's health that results from an unforeseen illness or injury and for dental services necessary to treat such conditions as lost fillings or crowns. Services that can be foreseen are not considered urgent services.

Policy

Medical Services for Children Placed by the *Department* in Paid Substitute Care

(1) All children who are eligible for will participate ~~in~~ the Oregon Health Plan (OHP) will receive the Basic Health Care Benefit Package, as defined by the Office of Medical Assistance Programs (OMAP) Administrative Rule 410-141-0480.

(2) The information on each child placed in substitute care is entered into the IIS system within three working days of placement.

(3) All children in paid substitute care will be referred for:

(a) A medical and a dental assessment within 30 days of entering care; and

(b) A mental health assessment within 60 days of entering care.

(4) The caseworker will be responsible to assure that all covered medical treatment required as a result of the assessments is received.

(5) A child who is visiting outside of Oregon is entitled to emergency and urgent medical services as if he/she were in Oregon.

Health Care Delivery Systems

Children eligible for the Oregon Health Plan will receive medical care through one or more of the following methods:

(1) Fee-For-Service (FFS); or

(2) Managed Health Care. Managed health care consists of:

(a) *Prepaid Health Plans* (*PHP*):

(A) *Fully Capitated Health Plans* (*FCHP*); or

(B) Chemical Dependency Organization (CDO); and/or

(C) *Dental Care Organizations (DCO)*; or

(D) Mental Health Organizations (MHO); or

(b) Primary Care Case Manager (*PCCM*).

Managed Health Care *Enrollment* for Children in the *Department's* Custody

(1) Selection of a *Prepaid Health Plan (PHP)* or Primary Care Case Manager (*PCCM*) will be made by the *Department*. *Department* staff will make the selection based on evaluation of the medical needs of the child, as well as input from the child's parent(s) and/or the child's substitute care provider.

(2) Substitute care providers will be given an opportunity to state a preference for a Prepaid Health Plan or Primary Care Case Manager, as applicable. The preference of substitute care providers will be recorded in the *Department* Integrated Information Systems (IIS). *Department* staff will select the substitute care provider's preference under most circumstances; however, the *Department* retains the responsibility for selecting the Prepaid Health Plan or Primary Care Case Manager.

(3) Children in Adoptive Homes. When the adoption is finalized, the central office adoption unit will assume responsibility for the health plan *enrollment* and data input.

(4) Notification to a Prepaid Health Plan of a child's Special Needs or Care. The Continuity of Care Form (OHP 7207) will be used to notify a prepaid health plan/*PCCM* of a new and ongoing child in *Department* paid substitute care who has complex medical care needs. This notification alerts the prepaid health plan that child has been enrolled in their organization and needs assistance from the Exceptional Needs Care Coordinator (ENCC).

(5) *Department* Enrollees. Children initially placed in substitute care with existing eligibility and *enrollment* in a Prepaid Health Plan or Primary Care Case Manager through another *Department* program should continue their *enrollment* with that Prepaid Health Plan or Primary Care Case Manager if the child continues to reside in the same service area, and if continuity of care is a factor. If continuity of care is not a factor, the child may be enrolled in the substitute care provider's preference of a Prepaid Health Plan or Primary Care Case Manager.

(6) Prepaid Health Plan *Enrollment* Areas. Children who are expected to remain in substitute care more than 30 calendar days, unless exempted by (10) (a) - (j) below, are required to be enrolled in a Prepaid Health Plan if they reside in a service area where adequate access is available to provide *Prepaid Health Plan (PHP)* services for all *Oregon Health Plan clients*. A primary care practitioner (PCP) shall be selected using the Continuity of Care form OHP 2707 for a child at the time of *enrollment* into a Prepaid Health Plan, if continuity of care is a factor. If continuity of care is not a factor, the Prepaid Health Plan will send a membership information to the child's substitute care provider to select a primary care practitioner.

(7) Unless exempted by (10) (a) through (j) below, children are required to be enrolled with a Primary Care Case Manager (*PCCM*) if they reside in a service area where adequate access is not available with Prepaid Health Plans.

(8) *Department* workers shall have the option to have the child remain in the fee-for-service delivery system if the child resides in a service area where Prepaid Health Plan and/or Primary Care Case Manager services are available, but all are presently at contracted capacity and closed to new *enrollment*.

(9) Mandatory Area. Children who reside in a mandatory service area, as defined by Prepaid Health Plan capacity, a combination of Prepaid Health Plan and Primary Care Case Manager capacity or Primary Care Case Manager capacity alone, shall be enrolled in a Prepaid Health Plan or Primary Care Case Manager within 30 calendar days of placement into substitute care.

(10) Just Cause Exemption. The following are exemptions (*Good Cause*) of the requirement to enroll children with a Prepaid Health Plan or with a Primary Care Case Manager:

(a) The child is in the third trimester of her pregnancy when placed in substitute care, and she wishes to continue obtaining maternity services from a practitioner who is not a member of a Prepaid Health Plan. If her practitioner is a Primary Care Case Manager (*PCCM*) with the Office of Medical Assistance Program (OMAP), the child shall be enrolled with her practitioner as her Primary Care Case Manager; if her practitioner is not enrolled with OMAP as a *PCCM*, the child may remain in the fee-for-service delivery system until after the birth of her child;

(b) The child is covered under a major medical insurance policy. If the major medical insurance policy is a private managed care plan like a Health Maintenance Organization (HMO) type the child shall remain in the fee-for-service delivery system. If the major medical insurance policy is other than a private managed care plan (HMO) the child shall be enrolled with a Primary Care Case Manager;

(c) The child has an established relationship with his or her primary care practitioner, who is not a member of a Prepaid Health Plan's panel, and it would be detrimental to the child's health, as determined by the *Department* to change primary care practitioners. If the practitioner is a Primary Care Case Manager (*PCCM*) with the Office of Medical Assistance Program (OMAP), the child shall be enrolled with that practitioner as his or her *PCCM*, if the practitioner is not enrolled with OMAP as a *PCCM*, the child may remain in the fee-for-service delivery system;

(d) The child is a Native American or Alaskan Native with *proof of Indian heritage*, and chooses to receive primary care services from his or her Indian health service facility, tribal health clinic/program or urban clinic and the fee-for-service delivery system;

(e) Children expected to be in substitute care less than 30 calendar days will remain in the fee-for-service delivery system;

(f) Children placed in certain residential programs where their medical needs are best met by medical practitioners who treat children in the facility. The child shall be enrolled with a Prepaid Health Plan if the facility's practitioner(s) is a member of the plan. If the practitioner is not a member of a Prepaid Health Plan and if that practitioner is enrolled with Office of Medical Assistance Programs as a Primary Care Case Manager (*PCCM*) child shall be enrolled with the practitioner as a *PCCM*. If the practitioner is not enrolled as a Primary Care Case Manager, the child may remain in the fee-for-service delivery system;

(g) The child is unable to obtain services due to circumstances beyond his or her control, such as transportation. Use this only if the child's needs are so specialized they

can only be met through a practitioner who is not participating in a Prepaid Health Plan or is not enrolled as a Primary Care Case Manager with Office of Medical Assistance Programs;

(h) The child is in the hospital at the time of placement/eligibility. *Enrollment* in a Prepaid Health Plan or Primary Care Case Manager will be delayed until the child is out of the hospital, usually one month;

(i) Religious considerations of the child may justify an exemption from *enrollment* in a Prepaid Health Plan or Primary Care Case Manager;

(j) Other *just causes* as determined by *Department* staff, and approved by a *CAF* Medical Assistance Resource Coordinator.

(11) From the date of *enrollment* until the effective date of *disenrollment*, children enrolled in a Prepaid Health Plan shall obtain all covered services from the Prepaid Health Plan or from referral from the Prepaid Health Plan. Children enrolled with a Primary Care Case Manager shall receive all covered services from the Primary Care Case Manager (*PCCM*) or by referral from their Primary Care Case Manager.

Disenrollment* from Prepaid Health Plans or from a *Primary Care Case Manager (PCCM)

(1) *Disenrollment* may occur in the following circumstances:

(a) Whenever the child moves out of the service area served by the contracted Prepaid Health Plan;

(b) Whenever the child's medical eligibility ends. The effective date of *disenrollment* shall be the first of the month following the entry of the *disenrollment* in the *Department* IIS;

(c) At any other time with *just cause*.

(A) Other *just causes* as determined by *Department* staff and approved by *CAF* Medical Assistance Resource Coordinator;

(B) Examples of just cause include, but are not limited to:

(i) The child is placed with a substitute care provider within the Prepaid Health Plan's service area, but the child's medical needs are best met by medical practitioners who treat children in the facility. At the time of *disenrollment*, the child shall be enrolled with the facility's practitioner(s), if that practitioner is enrolled with Office of Medical Assistance Programs as a Primary Care Case Manager. If the practitioner is not enrolled as a Primary Care Case Manager, the child may remain in the fee-for service delivery system;

(ii) The child is placed with a residential treatment provider within the Prepaid Health Plan's service area, but the residential treatment provider prefers to have all the children placed with them in the same Prepaid Health Plan or Primary Care Case Manager. This request by *CAF* will be made only when continuity of care is not a factor;

(iii) It would be detrimental to the child's health to remain enrolled in the Prepaid Health Plan;

(iv) The child who is a Native American or Alaskan Native with *proof of Indian heritage*, and chooses to receive primary care services from his or her Indian health service facility, tribal health clinic/program or urban clinic and the fee-for-service delivery system;

(v) The effective date of *disenrollment* for (i) through (iv) above shall be the first of the month following entry of the *disenrollment* in the *Department* IIS system.

(2) *Disenrollment* happens automatically when a child moves outside the prepaid health plan service area. The effective date will be the date it is received at OMAP, usually one or two days following input. If the *disenrollment* is for *just cause*, the effective date of the *disenrollment* shall be the first of the month following entry of the *disenrollment* in the *Department* IIS system.

(a) If *disenrollment* needs to be earlier than the above date the staff must contact the Health Management Unit at OMAP to disenroll.

Personal Injury Claims

When a child in paid substitute care is injured and there is potential insurance coverage, the staff will notify *CAF* by submitting an AFS-451 "vehicle related" or a 451NV "non vehicle related" form. (Medical expenses are reimbursed to *CAF* from any insurance claim.)

Contact(s):

- **Name:** CAF Reception; **Phone:** 503-945-5600