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DENNIS RICHARDSON
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LESLIE CUMMINGS
DEPUTY SECRETARY OF STATE

ARCHIVES DIVISION
MARY BETH HERKERT
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

STATUTORY MINOR CORRECTION

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CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Correcting Outlining for 410-120-1210(4); Changing the Second (f) to (h)

CONTACT: Sandy Cafourek
503-945-6430
sandy.c.cafourek@dhsoha.state.or.us

500 Summer St. NE
Salem,OR 97301

Filed By:
Sandy Cafourek
Rules Coordinator

AGENCY ATTESTS THE FOLLOWING CHANGES HAVE BEEN MADE, ACCORDING TO ORS 183.335(7):

Correcting grammatical mistakes in a manner that does not alter the scope, application or meaning of the rule

AMEND: 410-120-1210

RULE TITLE: Medical Assistance Benefit Packages and Delivery System

RULE SUMMARY: Correcting Outlining for 410-120-1210(4); Changing the Second (f) to (h)

RULE TEXT:

(1) The services clients are eligible to receive are based on their benefit package. Not all packages receive the same benefits.

(2) The Health Systems Division (Division), Medical Assistance Programs benefit package description, codes, eligibility criteria, coverage, limitations and exclusions are identified in these rules.

(3) The limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in any chapter 410 OARs.

(4) Benefit package descriptions:

(a) Oregon Health Plan (OHP) Plus:

(A) Benefit package identifier: BMH;

(B) Eligibility criteria: As defined in federal regulations and in the 1115 OHP waiver demonstration, a client is categorically eligible for medical assistance if he or she is eligible under a federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program (CHIP) and also meets Oregon Health Authority (Authority) adopted income and other eligibility criteria;

(C) Coverage includes:

(i) Services above the funding line on the Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List), (OAR 410-141-0480 through 410-141-0520);

(ii) Ancillary services, (OAR 410-141-0480);

(iii) Substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers;

(iv) Mental health services based on the Prioritized List to be provided by Board licensed, certified, or credentialed providers or through Community Mental Health Programs certified and credentialed providers;

(v) Hospice;

(vi) Post-hospital extended care benefit up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043) or by the Coordinated Care Organization (CCO) for clients enrolled in a CCO.
(D) Limitations: The following services have limited coverage for non-pregnant adults age 21 and older. (Refer to the cited OAR chapters and divisions for details):
(i) Selected dental (OAR chapter 410, division 123);
(ii) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140).
(b) OHP with Limited Drugs:
(A) Benefit package identifier: BMM, BMD;
(B) Eligibility criteria: Eligible clients are eligible for Medicare and Medicaid benefits;
(C) Coverage includes: Services covered by Medicare and OHP Plus as described in this rule;
(D) Limitations:
(i) The same as OHP Plus as described in this rule;
(ii) Drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR chapter 410, division 121 for specific limitations). These drugs include but are not limited to:
(I) Over-the-counter (OTC) drugs;
(II) Barbiturates (except for dual eligible individuals when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications).
(E) Exclusions: Drugs or classes of drugs covered by Medicare Part D Prescription Drug;
(F) Payment for services is limited to the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible;
(G) Cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the benefit package.
(c) Qualified Medicare Beneficiary (QMB)-Only:
(A) Benefit Package identifier code MED;
(B) Eligibility criteria: Eligible clients are Medicare Part A and B beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage;
(C) Coverage: Is limited to the co-insurance or deductible for the Medicare service. Payment is based on the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible but no more than the Medicare allowable;
(D) Providers may not bill QMB-only clients for the deductible and coinsurance amounts due for services that are covered by Medicare;
(E) Medicare is the source of benefit coverage for service; therefore, an OHP 3165 is not required for this eligibility group. A Medicare Advance Beneficiary Notice of Noncoverage (ABN) may be required by Medicare, refer to Medicare for ABN requirements.
(d) Citizen/Alien-Waived Emergency Medical (CAWEM):
(A) Benefit Package identifier CWM;
(B) Eligibility criteria: Eligible clients are non-qualified aliens that are 19 years and older, not eligible for other Medicaid programs solely because they do not meet the citizen and immigration status requirement pursuant to Oregon Administrative Rules (OAR) 410-200-0215;
(C) Coverage is limited to:
(i) Emergency medical services as defined by 42 CFR 440.255: Sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily

functions, or serious dysfunction of any bodily organ or part (the “prudent layperson standard” does not apply to the CAWEM emergency definition);
(ii) Labor and Delivery.
(D) Exclusions: The following services are not covered even if they are sought as emergency services:
(i) Prenatal or postpartum care;
(ii) Sterilization;
(iii) Family Planning;
(iv) Preventive care;
(v) Organ transplants and transplant-related services;
(vi) Chemotherapy;
(vii) Hospice;
(viii) Home health;
(ix) Private duty nursing;
(x) Dialysis;
(xi) Dental services provided outside of an emergency department hospital setting;
(xii) Outpatient drugs or over-the-counter products;
(xiii) Non-emergency medical transportation;
(xiv) Therapy services;
(xv) Durable medical equipment and medical supplies;
(xvi) Rehabilitation services.
(e) CAWEM Reproductive Health Equity Fund (RHEF) benefit:
(A) Benefit Package identifier CWM;
(B) Eligibility criteria: Eligible clients are those individuals eligible under the CAWEM benefit in subsection (d) of these rules;
(C) Coverage: This is a state-funded women’s reproductive health benefit administered by the Public Health Division. For full coverage and criteria, refer to OAR chapter 333, division 004. The Health Systems Division administers a subset of the benefits described in OAR chapter 333, division 004 as follows:
(i) Abortion services occurring in a hospital;
(ii) Sterilization.
(f) CAWEM Plus:
(A) Benefit Package identifier code CWX;
(B) Eligibility criteria: As defined in federal regulations and in the Children's Health Insurance Program (CHIP) state plan, eligible clients are non-qualified aliens that are pregnant women, 19 years and older, at or below 185 percent of the Federal Poverty Level (FPL), and not eligible for other Medicaid programs solely because they do not meet the citizen and immigration status requirement, pursuant to Oregon Administrative Rules (OAR) 410-200-0215;
(C) Coverage includes: services covered by OHP Plus as described above;
(D) Exclusions: The following services are not covered for this program:
(i) Postpartum care (except when provided and billed as part of a global obstetric package code that includes the delivery procedure);
(ii) Sterilization;
(iii) Abortion;
(iv) Death with dignity services;
(v) Hospice.
(E) The day after pregnancy ends, eligibility for medical services shall be based on eligibility categories established in OAR chapters 461 and 410.
(g) CAWEM Plus RHEF benefit:
(A) Benefit Package identifier code CWX;

(B) Eligibility criteria: Eligible clients are CAWEM pregnant women not eligible for Medicaid based on immigration status, at or below 185 percent of the Federal Poverty Level (FPL). These Qualified aliens eligible for the CAWEM Plus prenatal program are also eligible for a state-funded benefit pursuant to ORS 414.432;
(C) Coverage includes:
(i) Postpartum care delivered outside of the global obstetric package not included under the CAWEM Plus benefit, 60 days following the pregnancy end date. Postpartum eligibility period is as described in OAR 410-200-0240;
(ii) Services covered by OHP Plus for 60 days following the pregnancy end date as described in (4)(a)(C) of these rules;
(iii) Services as described in subsection (e)(C) of these rules.
(h) Cover All Kids benefit:
(A) Benefit Package identifier code BMH, PERC CK, CL, CM, CN, CO, CP, CR;
(B) Eligibility criteria: Eligible clients are non-qualified aliens that are under age 19, not eligible for other Medicaid programs solely because they do not meet the citizen and immigration status requirement pursuant to Oregon Administrative Rules (OAR) 410-200-0215. Coverage is a state funded medical benefit pursuit to ORS 414.231;
(C) Coverage is an OHP Plus equivalent benefit that includes:
(i) Services above the funding line on the Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List), (OAR 410-141-0480 through 410-141-0520);
(ii) Ancillary services, (OAR 410-141-0480);
(iii) Substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers;
(iv) Mental health services based on the Prioritized List to be provided by Board licensed, certified, or credentialed providers or through Community Mental Health Programs certified and credentialed providers;
(v) Hospice;
(vi) Post-hospital extended care benefit, up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043), or by the Coordinated Care Organization for clients enrolled in a CCO.
(5) Division clients are enrolled for covered health services to be delivered through one of the following means:
(a) Coordinated Care Organization (CCO):
(A) These clients are enrolled in a CCO that provides integrated and coordinated health care;
(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, substance use disorder treatment and recovery, mental health services or dental care.
(b) Fee-for-service (FFS):
(A) These clients are not enrolled in a CCO;
(B) Subject to limitations and restrictions in the Division's individual program rules, the client can receive health care from any Division-enrolled provider that accepts FFS clients. The provider shall bill the Division directly for any covered service and shall receive a fee for the service provided.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, 414.065, 414.329, 414.706, 414.710, 414.231, 414.432