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# PERMANENT ADMINISTRATIVE ORDER

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## DMAP 90-2022

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

FILING CAPTION: Describes The Benefit Package For The Compact of Free Association (COFA) Dental Program

EFFECTIVE DATE: 01/01/2023

AGENCY APPROVED DATE: 12/13/2022

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AMEND: 410-120-1210

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RULE SUMMARY: Describes the benefit package for the Compact of Free Association (COFA) Dental Program and the Veteran Dental Program, which mirrors the dental benefits an OHP Plus recipient receives.

CHANGES TO RULE:

410-120-1210
Medical Assistance Benefit Packages and Delivery System ¶

(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 they are 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 410-141-3820 through 410-141-3830);¶
(ii) Ancillary services, (OAR 410-141-3820);¶
(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, who are outside of the protected postpartum eligibility period (see OAR 410-200-0135). (Refer to the cited OAR chapters and divisions for details):¶
(i) Selected dental (OAR chapter 410, division 123 and 200);¶
(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 and 200).¶
(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) Citizenship Waived Medical (CWM): Benefit package and supplemental benefits, refer to OAR 410-134-0003.¶
(e) Compact of Free Association (COFA) Dental Program:¶
(A) Benefit Package identifier code XXX;¶
(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0445;¶
(C) Coverage is state funded and includes the types and extent of Dental services that the authority determines will be provided to medical assistance recipients in accordance with OAR Chapter 410 Division 123.¶
(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services.¶
(E) No copayments, deductibles or cost sharing shall be required for eligible clients.¶
(f) Veteran Dental Program:¶
(A) Benefit Package identifier code XXX;¶
(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0445;¶
(C) Coverage is state funded and includes the types and extent of dental services that the authority determines will be provided to medical assistance recipients in accordance with OAR Chapter 410 Division 123.¶
(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services.¶
(E) No copayments, deductibles or cost sharing shall be required for eligible clients.¶
(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 413.042, ORS 414.025, 414.065, 414.329, 414.706, 414.710, 414.432, 414.312, 414.430, 414.690