

Donald Ross, manager
Operations and Policy Section

Number: OHP-IM-16-028

Authorized Signature

Issue Date: 10/13/2016

Topic: Medical benefits

Subject: Oregon Health Plan changes effective October 1, 2016, and January 1, 2017

Applies to:

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

Message:

OHA is making several changes in order to comply with a [January 28, 2016 Informational Bulletin](#) from the Center for Medicaid & CHIP Services (CMCS). That bulletin requires certain changes in the Oregon Health Plan:

Effective October 1, 2016:

Ensured coverage of habilitative services. The Health Evidence Review Commission (HERC) updated Guideline Note 6 to address coverage of both rehabilitative and habilitative therapies.

Effective January 1, 2017:

- **Benefit changes:** New wig benefit of at least \$150 per year; separate coverage limits for habilitative and rehabilitative services; reference to all federally required preventive services
- Removal of all OHP copayment requirements

- **CCO requirements:** CCOs to post drug coverage information, establish a Pharmacy and Therapeutics Committee, allow retail pharmacy access, and cover all FDA-approved birth control methods

To learn more, read the [fact sheet](#) and [staff talking points](#) about the change.

- OHA is keeping coordinated care organization staff informed about upcoming changes through standing workgroup meetings.
- If you get questions not answered by the [fact sheet](#) or [talking points](#), please send them to Jean Hutchinson (see below for contact information). All questions will be reviewed for an ongoing Questions and Answers document.
- OHA is planning a public notice and provider communications about the copayment change, and will update the OHP Handbook ([OHP 9035](#)) to remove mention of copayment requirements.

If you have any questions about this information, contact:

Contact(s):	Jean Hutchinson, HSD Operations and Policy Analyst		
Email:	jean.e.hutchinson@state.or.us	Fax:	503-373-7689

Oregon Health Plan

Staff talking points about changes effective January 1, 2017

Last updated 10/6/2016



Background info

OHP Plus benefit changes

The Affordable Care Act (ACA) requires all Medicaid [alternative benefit plans](#) (ABPs) to provide [essential health benefits](#) (EHBs).

- As part of Oregon's ACA implementation, the Oregon Health Plan (OHP) adopted an ABP as the single benefit package for all OHP populations (OHP Plus).
- For Oregon, any required changes to ABPs mean changes to OHP.
- ABP required changes include covering certain preventive services without cost sharing (copayments).

The Centers for Medicare & Medicaid Services (CMS) released a [January 28, 2016 bulletin](#) about the changes Medicaid state agencies must apply to meet current EHB standards.

Removal of all OHP copayments

The Oregon Health Authority (OHA) also approved removing all copayments from all OHP services for all populations (both fee-for-service and managed care), effective January 1, 2017.

- This means that OHA will no longer collect any copayment amounts from payments made to fee-for-service providers for the services outlined in [Table 120-1230-1](#) of the Medical Assistance Program General Rules ([Chapter 410, Division 120](#)).
- Any coordinated care organizations that currently require copayments for OHP services must also remove their copayment requirements effective January 1, 2017.

With this change, Oregon then becomes eligible for an enhanced federal match rate of 1 extra percentage point for selected preventive services for Medicaid clients.

This change does not affect copayments members may owe to other payers, such as Medicare or private payers.

Additional changes for coordinated care organizations (CCOs)

In addition to the above changes, CCOs must meet the requirements outlined in the Center for Consumer Information and Insurance Oversight (CCIIO)'s [2016 Payment Notice](#). (The [CCIIO](#) oversees the implementation of the ACA provisions related to private health insurance.)

Changes required for 2017 are:

- Post drug coverage information
- Establish a Pharmacy and Therapeutics Committee
- Allow retail pharmacy access
- Cover all FDA-approved birth control methods

Communications

OHA is planning a public notice and communications about the copayment and benefit changes:

- Providers will be informed through OHP provider announcements, *Provider Matters*, Provider Web Portal messages, and remittance advice banner messages.
- Coordinated care organizations will be informed of changes through standing workgroup meetings and email communications.

Members know about their copayment responsibilities through the [OHP Handbook](#) and [OHP coverage letter](#) (sent when a member's name, managed care enrollment, or benefit package change; when household members are added or removed; or when they ask for a replacement Oregon Health ID); and when providers attempt to collect copayment.

- The next time members get a coverage letter, page 2 will show a “No” in the “Copays?” field.
- OHA will also update the OHP Handbook ([OHP 9035](#)) to remove mention of copayment requirements.

Questions and answers

What is an alternative benefit plan (ABP)?

An ABP is a way to provide health insurance benefits based on federal benchmarks. The OHP Plus benefit package serves as Oregon's Medicaid ABP.

What is changing?

- **Effective October 1, 2016:** Clarified coverage of habilitative services. The Health Evidence Review Commission (HERC) updated Guideline Note 6 to address coverage of both rehabilitative and habilitative therapies.
- **Effective January 1, 2017:** New wig benefit of at least \$150 per year and separate coverage limits for habilitative and rehabilitative services; wording changes to clarify that all federally-required preventive services are covered; removal of all OHP copayment requirements; and added requirements for access to prescription medications at retail pharmacies. See OHA's [fact sheet](#) to learn more about the changes.

What are habilitative services?

The [January 2016 bulletin](#) from CMS states the following:

The following definition is now used to define habilitative services and devices at 45 CFR section 156.115(a)(5)(i): “health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may also include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.”

Can providers still collect copayments owed before January 1, 2017?

Yes.

Is OHA going to stop subtracting the copayment amount from fee-for-service claim payments?

Yes.