2018

House Bill 2398 Medicaid Billing Prohibitions: Report to the Legislature

Legislation requires a report from the Oregon Health Authority on how specific Medicaid billing prohibitions have reduced or eliminated improper billings to or collection of claims from medical assistance recipients.

Oregon Health Authority

HEALTH SYSTEMS DIVISION

Acknowledgments

Staff at the Oregon Health Authority prepared this publication and would also like to extend thanks to House Bill 2398 Stakeholder Workgroup members for their contributions in this process.

Oregon Health Authority. HB 2398, Medicaid Billing Prohibitions: Report to the Legislature. Oregon Health Authority. Salem, OR. 2018 November.

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Executive summary

In 2017, the Oregon Legislature passed House Bill 2398. This bill instructed the Oregon Health Authority to gather a stakeholder workgroup to discuss the implementation of requirements that prohibit health care providers from billing medical assistance applicants or recipients except as OHA administrative rules allow. Also, the bill requires health care providers to wait 90 days after submitting a claim before sending it to a collection agency. If the claim remains unpaid for 90 days after submitting the claim to OHA or a coordinated care organization, the health care provider must search the medical assistance program database to check the patient's eligibility for medical assistance before billing the patient.

The stakeholder workgroup gathered by OHA included representatives from the Oregon Law Center, a local Medicaid provider organization (including their coding and billing specialist), a local ambulance company, the Oregon State Ambulance Association, the Oregon Medical Association, and six of our fifteen coordinated care organizations. The workgroup met twice over the summer. During this time, they:

- Reviewed the federal and state legal framework for Medicaid billing in Oregon;
- Received an overview of the agency's process for reviewing and addressing Medicaid member billing questions and issues;
- Reviewed complaint data to better understand:
  - How OHA currently tracks OHP billing issues; and
  - Factors and outcomes for member billing issues;
- Identified some of the key factors that contribute to member billing issues such as:
  - Bills to members from out of state providers;
  - Billing complexities when members have third party coverage;
  - Coverage timing issues resulting from retroactive or reinstated eligibility; and
  - When members seek care at facilities such as hospitals and receive services from a contracted or on-call provider who is not enrolled in Oregon Health Plan;

The workgroup also identified potential factors that may be challenging implementation such as billing by out of state providers that are not obligated to work with OHA and CCOs because they are outside of OHA's jurisdiction. Another issue they identified was providers needing to enroll as an OHP provider to access the medical assistance program database, referred to as the Oregon Provider Portal, to confirm a patient's eligibility. Also, the data related to Medicaid billing that the Oregon Provider Portal currently captures does not reflect the key issues that may be driving Medicaid billing issues. Relying on this data to understand root causes or trends in these issues is difficult.

Ultimately, the workgroup reviewed the actions OHA has taken to mitigate member billing issues and made recommendations to further reduce improper billing and collection of claims from medical assistance recipients. The workgroup was very mindful of the harmful effects of improper billings and collections from Medicaid assistance recipients. Medicaid recipients' rights were a theme throughout the process.

The emphasis of the recommendations was on improving the distribution of existing tools to make sure members understand their rights and responsibilities. There was also a focus on tools to inform providers and other stakeholders of key information related to member billing. This included how to check an individual's eligibility for Medicaid or what to do when a member has other types of health coverage in addition to Medicaid. Finally, they recommended gathering and tracking better data to show the root causes of member billing issues.

Introduction

In 2017, the Oregon Legislature passed House Bill 2398. This bill instructed the Oregon Health Authority to gather a stakeholder workgroup to discuss the implementation of rules that prohibit health care providers from billing medical assistance applicants or recipients except as OHA rules allow. Also, the bill requires health care providers to wait 90 days after submitting a claim before sending it to a collection agency. If the claim remains unpaid for 90 days after submitting the claim to OHA or a coordinated care organization, the health care provider must search the medical assistance program database to check the patient's eligibility for medical assistance.

According to this law, OHA must also report to the Health Care Committees on how these changes have reduced or stopped improper billings and collection of claims from medical assistance recipients. This report provides background on Medicaid billing laws and the process and scope of the Medicaid billing workgroup. It also identifies some of the key drivers of Medicaid billing issues and potential implementation challenges, as well as initiatives and strategies to reduce improper billing and collection of claims from medical assistance recipients.

Background

Federal law requires state's Medicaid programs to limit provider participation to those "who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual."[*] Further, both federal and Oregon law make it a voluntary action on the part of the provider to furnish health services to Oregon's Medicaid clients.[†]

Prior to the passage of HB 2398 (2017), Oregon law prohibited[‡] providers who are enrolled with OHA or providing services to clients enrolled in OHP through a CCO or managed care entity (MCE) from billing OHP clients for any services covered under the program. This rule applied to appointments missed by Medicaid clients, bills for services or treatments due to provider error or billing beyond the usual and customary charge for Medicaid covered services.

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* See 42 CFR 447.15 - Acceptance of State payment as payment in full.
† See 42 CFR 431.51 - Free choice of providers and OAR 410-120-1260(17).
‡ See OAR 410-120-1280 related to Billing

Providers could bill a client or financially responsible representative or relative under the following circumstances:

- For applicable coinsurance, copayments and deductibles, expressly authorized by OHA in rule;
- The client did not inform the provider of their OHP or third-party insurance coverage at the time of service. As a result, the provider could not bill the appropriate payer for reasons including but not limited to:
  - » No prior authorization
  - » The time limit to submit the claim for payment has passed.

  In this case, the provider must verify eligibility pursuant to OAR 41 0-120-1140 and document attempts to find coverage information prior to billing the client;
- The client became eligible for benefits retroactively, but did not meet all the other criteria required to receive the service;
- A third-party payer made payments directly to the client for services provided;
- The client has the limited Citizen Alien Waived Emergency Medical benefit package;
- The client requested a continuation of benefits during the contested case hearing process and the final decision was not in favor of the client;
- In the exceptional circumstance where a client decided to pay for a covered service and all requirements are met; or
- A provider may bill a client for services that are not covered under the state's Medicaid program with "Agreement to Pay" documentation signed by the client and meeting all other requirements.
- Improper billings and collection of claims has negative consequences for any individual, and this is even more so the case for those seeking or receiving

How to verify OHP eligibility

OHA offers three ways for enrolled Oregon Medicaid providers to access eligibility information for OHP members:

Provider web portal -
https://www.or-medicaid.gov
After login, click "Eligibility" to get started. To learn more, see the Eligibility and Copayment Quick Reference.

Automated voice response -
866-692-3864
After login, press 1 for Recipient Eligibility. To learn more, see the AVR Quick Reference.

270/271 Transaction
Register for Electronic Data Interchange (EDI) with OHA or an OHA-registered clearinghouse and do batch submissions of eligibility inquiries for OHA to verify within 24 hours. To learn more, visit the EDI Web page.

For more information, please see: https://www.oregon.gov/oha/HSD/OHP/Pages/Eligibility-Verification.aspx

medical assistance. Medical assistance recipients may be more prone to cultural and linguistic barriers that make it harder to navigate their health insurance coverage and advocate for their rights. Lack of access to stable transportation, housing or communication tools (e.g. phone, internet/email) can also make billing issues harder to resolve. When collections issues cause negative effects to an individual's credit scores, wage garnishments or lawsuits, these events have particularly negative impacts to medical assistance recipients for the reasons describe earlier.

Anticipated impact of house bill 2398

House Bill 2398 expands prohibitions on billing or soliciting of payments to all Oregon providers, not just those enrolled with OHA or credentialed with a managed care entity (MCE) or a coordinated care organization (CCO). The bill further prohibits billing or soliciting of payments to not just OHP enrollees, but also those applying for coverage through OHP until at least 90 days have passed from the date the provider bills OHA or a MCE/CCO. While both members of the stakeholder workgroup as well as staff expressed anecdotally that incidence of improper billings to and collections from medical assistance recipients seems to be on the decline, better data is needed to substantiate these claims.

Rulemaking for medical billing

OHA is also in the process of creating a Medicaid Oregon Administrative Rule (OAR) to incorporate the changes made in the statute. A rule advisory committee will be scheduled in November 2018. After comments are received through this process, the OAR will be filed with the Secretary of State which allows for an additional comment period.

Workgroup composition and process

OHA gathered a stakeholder group comprised of representatives from the Oregon Law Center, a local Medicaid provider organization (including their coding and billing specialist), a local ambulance company, the Oregon State Ambulance Association, the Oregon Medical Association, and six of our fifteen coordinated care organizations. OHA subject matter experts have also attended this workgroup to inform and respond to questions and concerns.

The workgroup has met twice over the summer. During this time, they have:

- Received an overview of the agency's process for reviewing and addressing Medicaid member billing inquiries and issues;*

* For a more detailed overview of OHA's Member Billing and Compliance Process, please see Appendices A and B.

- Reviewed complaint data to better understand the reasons for member billing issues and trends;
- Identified some of the key factors that contribute to member billing issues such as:
  - » Bills to members from out of state providers;
  - » Billing confusion when members have third party coverage;
  - » Coverage timing issues resulting from retroactive or reinstated eligibility; and
  - » When members seek care at a hospital and are seen by a contracted or on-call provider who is not an Oregon Health Plan-enrolled provider.
- Identified potential factors that may be challenging implementation and reviewed the actions the authority has taken to mitigate member billing issues; and
- Has created recommendations to further reduce improper member billing issues and collections of claims from medical assistance recipients.

Factors related to Medicaid billing issues

The workgroup was asked to identify and discuss the top causes for Medicaid billing issues from their experience and perspectives. Among the top responses were the following*:

Members may be billed by out-of-state providers. CCOs cited billing by out-of-state providers as one of their top issues. This is particularly challenging as out-of-state providers are not obligated to work with OHA and CCOs because they are usually outside of OHA's jurisdiction.

OHP members may have third-party coverage. When OHP members have third-party coverage such as commercial health insurance or Medicare, there can be issues related to which insurance should be billed first, even if all the insurances are known at the time of service. Regardless of the types

Qualified Medicare Beneficiary Program

The Qualified Medicare Beneficiaries program (QMB) is a Medicaid program administered by the Oregon Department of Human Services. QMB helps people with Medicare pay for their medical care and is one part of the federal Medicare Savings Programs.

- QMB-BAS (basic): Pays for Medicare Part B premiums, deductible and co-insurance;
- QMB-SMB and SMF (Specified Low-income Medicare Beneficiaries): Pays for Medicare Part B premiums only. QMB-SMF depends on federal funds. It may not always be open to new clients.

* Due to current limitations in how the agency tracks and collects data related to Medicaid billing issues, we are not able to provide data to substantiate and complement the causes identified by the workgroup.

of insurance an individual has, Medicaid is always the payer of last resort. The following tools were developed for providers and other stakeholders to help navigate billing for Medicaid recipients with third party coverage, including those who are Qualified Medicare Beneficiaries:

- Oregon Medicaid third party liability (TPL) requirements
- Qualified Medicare Beneficiary (QMB) Brochure
- Billing for services to Qualified Medicare Beneficiaries (QMBs)

Total medical assistance population, January 2018

Total medical assistance population		1,079,707
Enrollable OHP		
	CCO	840,239
	FFS*	145,892
	Total	**986,131**
Non-enrollable OHP†		**93,576**

Source: DHS/OHA DSS warehouse; January 15th 2018 Final Member Months; dateload: 05/13/2018.
Note: Categories represent distinct counts

* Includes those with and without exemptions for enrolling in a CCO. Types of exemptions include being a member of a Native American Tribe, those dually eligible for Medicare and Medicaid, and/or those with other types of third party coverage.
† Includes those who are Qualified Medicare Beneficiaries (QMB), Qualified Individuals, Specified Low Income Medicare Beneficiaries, or those with Citizen Alien Waived Emergency Medical.

Providers may not know a patient is covered under Medicaid. There are many reasons providers may not know at the time of services that their patient is a Medicaid member. The Medicaid member may have not disclosed to the provider that they were covered under Medicaid or the individual may have experienced retroactive eligibility or have had their eligibility reinstated. Some issues related to this include:

1. Individuals gain coverage on the first day of the month in which they apply;
2. The window for retroactive eligibility determination can vary;
3. Individuals are generally in Open Card or fee-for-service for 1-3 weeks before they enroll in a CCO;
4. When members do have their eligibility confirmed after they have received services, they might not follow-up with their provider to tell them they have coverage (including retroactive eligibility); and
5. Members may wait until they receive collection notices before filing a formal complaint with OHA or DHS.

Members may unknowingly receive services from out-of-network providers. When members seek care at a hospital, they sometimes receive services from contracted or on-call providers such as emergency department (ED) providers or anesthesiologists who may not be enrolled with Medicaid. Members may also receive bills or be sent to collections from an outside laboratory or pathology office that does not see the member directly. Some of the issues noted above regarding member follow-up and communication to providers about their coverage status may also be a factor here.

Potential challenges to implementation

While HB 2398 applies to all licensed providers practicing in Oregon, OHA and state licensing boards and regulators are limited in what they can do to curb the behavior of out-of-state providers. These providers were one of the top reported reasons for Medicaid billing issues.

Further, the bill states that if a claim remains unpaid 90 days after a provider submits the claim to a CCO or to OHA, the provider "shall first query the medical assistance program database to confirm a patient's eligibility for medical assistance." The Oregon Provider Portal* is accessible by providers enrolled with OHP. It gives providers free, real-time information about OHP eligibility, billing, claims and prior authorization information.

While there are other ways for providers to verify OHP eligibility, only providers enrolled with OHA can access this portal, which may be necessary to fulfill the requirements set forth in HB 2398. Enrolling as a provider with OHA does not mean that the provider must see any Medicaid member. However, enrollment is necessary to ensure that a provider meets the qualification to be a Medicaid FFS provider as defined by federal and state law. This includes ensuring a provider is licensed in the state, has good standing and will respect patient confidentiality, among other requrements, before they gain access to patient information through the provider portal. OHA does not have enforcement authority over non-OHP enrolled providers. Further, a provider must be enrolled with OHA as a Medicaid provider to be reimbursed by OHA. For more information on Oregon Health Plan provider enrollment, please see: https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Enroll.aspx.

Currently, consumer complaint data related to billing is only captured in the agency's 1115 Quarterly and Annual Report to the Centers for Medicare and Medicaid Services (CMS). It is compiled from CCO data submitted to OHA and FFS complaint data collected by OHA. This data does not capture all the Medicaid

* For more information on Oregon's Provider Portal, please see: https://www.oregon.gov/oha/HSD/OHP/Pages/webportal.aspx?wp4796=p:2#g_898c9db8_27a9_4b69_913c_4fff6c00d0b3

billing issues that exist. For example, current categories captured for Medicaid client billing issues only include:

1. Co-pays
2. Premiums
3. Billing OHP clients without approved waiver (i.e. client did not sign "Agreement to Pay" documentation)

These issues do not reflect those identified by the workgroup. They are also combined in OHA's quarterly reports to CMS. Work needs to be done to capture more granular data that reflects the causes identified earlier in this report. This would provide both program staff and stakeholders a more accurate idea of what is causing Medicaid billing issues. Work also needs to be done to coordinate processes and data collection efforts with the CCOs. Collecting better data would allow the agency to be more methodical in its efforts to solve these issues from a policy and business standpoint and to drive quality improvement in these areas.

Actions and proposed strategies to reduce OHP member billing issues

The workgroup also reviewed strategies to mitigate improper billings and collection of claims from medical assistance recipients. The approaches included some that OHA already has underway and that can be refined based upon the workgroup's feedback. Below are some of the proposed ideas to address improper billings to or collection of claims from medical assistance recipients.

1. **OHA coverage letter**
   OHA currently provides OHP clients with a formal letter, titled the OHA Approval Notice (see form 640 in Appendix C), that lists their coverage status, right and responsibilities and information on other OHA health care coverage programs. This letter is sent out to members when they have an eligibility change.

   OHA will continue to work with partners to educate members on their rights and responsibilities, including what steps members should take when they experience a coverage change or are seeking care from a new provider or at a new facility. This would include encouraging members to give a copy of this

OHP tools for providers

Additional OHP provider guides and resources can be found here:

Medical assistance (general rules) program: http://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-General-Rules.aspx.

OHP tool for providers: https://www.oregon.gov/oha/HSD/OHP/Pages/Providers.aspx

letter to their provider or to call any providers they see and share with them their Medicaid ID number.

2. **Information in billing notices**
   All billing communication materials should include information about clients' rights, including how to make complaints or file a grievance. OHA has a variety of letter templates that are currently sent to Medicaid members and are modified for each case.

3. **Cease and desist letter**
   OHA is making updates to its cease and desist letter for those submitting improper billings to or collection of claims from medical assistance recipients. The letter is currently under review by the Office of Administrative Hearings.

4. **Client, stakeholder and provider education**
   OHA should update education materials for OHP members and address how this information will be distributed. Opportunities could include making updates to the OHP member handbook, a social media campaign and a fact sheet about provider billing for Medicaid members. This fact sheet would be used to educate clients, providers, Aging and People with Disabilities field offices, Office of Developmental Disabilities Services field offices (which includes the Children's Intensive In-Home Services, Medically Fragile Children's Unit), Self Sufficiency offices and Child Welfare offices, and would be part of a larger client information tool kit.

   a. The group suggested materials that include information on:

      i. The OHP application process;

      ii. How to check the Medicaid Management Information system (MMIS) for coverage information; and

      iii. How to check whether an individual has other insurance as primary, including addressing how QMB and SLMB work.

   b. Because the law applies to all Oregon providers, the group recognized the need to ensure education materials are being created for a broad provider audience. OHA has already developed several education materials for providers that include the following examples:

      i. General Rules Provider Guide.pdf

      ii. Eligibility verification

      iii. Enroll as an OHP provider

      iv. Billing tips

v. Provider tips — Billing OHP members.pdf

vi. Oregon Medicaid third party liability requirements.pdf

vii. Provider tips — OHP and QMBs.pdf

c. In addition to resources for providers, the workgroup discussed resource for facilities, billing specialists and the need for more and better ways to share these types of information. They discussed leveraging an existing communication tool, the OHP Provider Matters newsletter. They also considered holding more trainings and webinars. Overall, they emphasized a more global and aligned approach for CCO's and OHA communications to ensure compliance with the law and to uphold the rights of OHP members.

5. **Data on OHP member billing issues**
As noted earlier, one challenge in determining the efficacy of HB 2398 and the root causes of Medicaid member billing issues is the need to collect more granular data that reflects the causes identified earlier in this report. Work also needs to be done to coordinate processes and data collections efforts with the CCOs.

6. **Requirements on OHP contracted facilities**
A few workgroup members suggested requiring any individual who is contracted with an OHP contracted facility, such as a hospital (including those in a CCO's delivery system network) to become an OHP enrolled provider for the purpose of accessing the provider portal. They also suggested that facilities, particularly hospitals, create processes to identify when a patient is covered under OHP and for the provider or other staff to verify eligibility when services are rendered.

Endnotes

1. To ensure OHA reimburses for services, providers must verify a client's eligibility and benefit coverage in accordance with OAR 410-120-1140, which establishes the requirements and process for a provider to verify that an individual is an eligible OHP client on the date(s) service(s) are rendered and that the person is enrolled in an OHP benefit package that covers the services a provider plans to render. See OAR 410-120-1210 for services covered under each Division benefit package. Providers who do not verify eligibility and benefit coverage with the Division before serving a person shall assume full financial responsibility in serving that person.

2. It is common for Medicaid beneficiaries to have one or more additional sources of coverage for health care services. Third Party Liability (TPL) refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all the expenditures for medical assistance furnished under a Medicaid state plan. By law, all other available third-party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services that are available under the Medicaid state plan. The Deficit Reduction Act of 2005 included several additional provisions related to TPL and coordination of benefits for Medicaid beneficiaries. For more information on Medicaid TPL and COB, see CMS' website: https://www.medicaid.gov/medicaid/eligibility/tpl-cob/index.html.

Appendix A: OHA member billing and compliance process

Oregon Health Plan member billing inquiries and complaints initiation

Member billing inquiries and issues come to OHA's Provider Services Unit through various channels and formats that include but are not limited to:

1. OHA's Client Services Unit which fields questions and issues from OHP members on a variety of issues including how to navigate and effective use the Oregon Health Plan (OHP).

   For more information on OHA's Client Services Unit please see: https://www.oregon.gov/oha/HSD/OHP/Pages/CSU.aspx.

2. The Office of Administrative Hearings may receive complaints about Medicaid member billing issues before the case is undergoes the necessary steps to be elevated to the administrative hearings level.

   For more information on the Oregon Health Plan member complaints and appeals process, including the process for requesting an administrative hearing please see: https://www.oregon.gov/oha/HSD/OHP/Pages/Complaints-Appeals.aspx.

3. OHA's ombudsperson is responsible for constituent services and navigating complex cases surrounding health care for Oregonians. The ombudsperson is a key role within the agency and a true advocate for patients.

4. Other members' representatives or advocates that may include offices of elected officials, attorneys, caseworkers, health care providers, or other types of member advocate representatives.

OHA Medicaid billing complaint documentation and review

Within OHA's Provider Services Unit are staff that focus on provider billing and compliance issues and review the cases in the order they are received. Program analysts within this unit do the following:

1. Formally establish new cases after confirming that a complaint is not a duplicate or had been received previously.

2. Check for retro eligibility or a break in CCO enrollment by reviewing eligibility systems including ONE, TRACS, and other resources as needed for the date of service in question.

3. Audit the Medicaid Management Information System (MMIS)* for paid and/or unpaid claims.

    a. If claim is paid, staff follow up with the provider to confirm that the balance of the member's account is zero.

    b. If the claim is denied, staff review the claim for billing errors and provide technical assistant to the provider to bill correctly for claim adjudication

4. When staff work with a provider they first seek to determine that the provider is an enrolled provider with the Oregon Health Plan. If not, staff have historically asked a provider if they are willing to become a contracted provider with OHP to ensure they are permitted to bill OHP for medical assistance recipients and have access to patient eligibility and claims information.

    a. If the provider is already an enrolled OHP provider, they are asked whether they verified Medicaid eligibility of the patient and if the member supplied their OHP information at the time of services to the provider. OAR 410-120-1360 grants OHA the right to ask for internal documents regarding patient registration, chart notes and business office notes, etc. This includes verifying in MMIS whether the provider verified coverage.

5. After establishing a new case, staff then determine the priority level by assessing whether the member has been sent to collections and was Medicaid eligible. If this is the case, OHA staff contact the collection agency and the health care provider with letter 1210 (see Appendix B for full list of Medicaid billing letters used by OHA).

6. If member is in a CCO, then send letter 1228 (see Appendix B) to the member, plan and provider. Close case as resolved, referred to Managed Care Plan.

7. OHA renders a decision and works to pay the claim and confirms that the patient's account balance is zero if the member was not determined to be responsible for the claim.

8. OHA sends a letter to the member and provider that matches the decision. (Please see crosswalk for various types of letters that are sent out for different scenarios.)

* MMIS is a mechanized claims processing and information retrieval system developed and used by state Medicaid programs that is required by the federal government and meets specified federal requirements.

9. OHA staff document all contact with internal and external parties in the electronic case file as well as the outcome of the case.

Appendix B: OHA Medicaid billing letters

	Use Form Letter:	Include OHP Notice of Health Rights (3030) and Administrative Hearing Request (MSC 443)
Asking provider to bill OHA	OHP 1225	
Asking provider to stop billing client – Termination warning	OHP 1210	
Asking client to send billing information	OHP 1200 EN – RU – SP – VI	
Asking client to send more billing information	OHP 1215 EN – RU – SP – VI	
CAWEM does not cover the service – Client must pay	OHP 1221 Use 3rd drop-down choice EN – RU – SP – VI	X
Client was plan member on DOS – Plan will follow-up	OHP 1228 EN – RU – SP – VI	
Client not eligible on DOS – Client must pay	OHP 1224 Use 2nd drop-down choice EN – RU – SP – VI	
Copay owed	OHP 1220 • 1st drop-down: Use 2nd drop-down choice • 2nd drop-down: Use 3rd drop-down choice, then enter copay amount in the $0.00 blank EN – RU – SP – VI	
Division paid	OHP 1220 • 1st drop-down: Use 1st drop-down choice • 2nd drop-down: Use 2nd drop-down choice, then delete all text in the $0.00 blank • Remaining "Choose an item" boxes: Select the blank field on each one if no pharmacy reminders are needed; select text fields on each one to add pharmacy reminders EN – RU – SP – VI	

	Use Form Letter:	Include OHP Notice of Health Rights (3030) and Administrative Hearing Request (MSC 443)
No Agreement to Pay form	OHP 1220 • 1st drop-down: Use 3rd drop-down choice • 2nd drop-down: Use 2nd drop-down choice, then delete all text in the $0.00 blank EN – RU – SP – VI	
Not covered by client's benefit plan – Client must pay	OHP 1226 EN – RU – SP – VI	X
OOS non-emergency service – Client must pay	OHP 1221 Use 2nd drop-down choice EN – RU – SP – VI	X
Prescription paid by client – Pharmacy will refund	OHP 1223 EN – RU – SP – VI	
Provider didn't know about OHP – Client must pay	OHP 1222 EN – RU – SP – VI	
Prescription paid by client – Client must ask CCO for refund	OHP 1227 EN – RU – SP – VI	
Prescription paid by client – TPL will refund	OHP 1230 EN – RU – SP – VI	
Signed Agreement to Pay form – Client must pay	OHP 1221 Use 1st set of drop-downs EN – RU – SP – VI	X
Unenrolled provider – Client must pay	OHP 1224 Use 1st set of drop-downs EN – RU – SP – VI	

Appendix C: Medicaid Fair Hearing Rights form

HEALTH SYSTEMS DIVISION

NOTICE OF HEARING RIGHTS

If you do not agree with a decision made on your request for Oregon Health Plan (Medicaid) services, you can ask the Oregon Health Authority (OHA) for a hearing to change it. The choice to ask for a hearing is yours.

If you are a member of a coordinated care organization (CCO), dental plan, or mental health plan and want a hearing about a service denied by your CCO or plan, you must first ask the CCO or plan for an appeal. If the CCO or plan still denies the service, then you can ask OHA for a hearing.

WHAT HAPPENS IF I ASK FOR A HEARING?

Before the hearing

An Oregon Health Authority (OHA) staff member will call you to:

- Ask you for more information
- Tell you what will happen at the hearing

The Office of Administrative Hearings will mail you information about:

- The hearing date and time
- Hearing procedures, your right to representation and other hearing rights

At the hearing

You can explain why you do not agree with the decision. You or your doctor can do this in person or in writing. Most hearings are by phone. These people will also be at the hearing:

- Your representative or helper (if you have one)
- Any witnesses you invite
- An OHA hearings representative
- The administrative law judge
- A CCO or plan representative (if the hearing is about a service your CCO or plan denied).

After the hearing

The judge will review the information presented at the hearing and make a decision. You will get a letter (or “Final Order”) about this decision within 30 days.

Hearings follow the Administrative Procedures Act, Oregon Revised Statute (ORS) Chapter 183, and Oregon Administrative Rules 137-003-0501 to 0700, 410-120-1860, 410-141-3247.

HEARING DEADLINES

For a hearing about a service denied by your CCO or plan: OHA must receive your request within 120 days of the date of the Notice of Appeal Resolution (NOAR).

For a hearing about a service denied by OHA: OHA must receive your request within 60 days of the date of the decision notice.

If you ask for a hearing after these deadlines, you must show that you had a good reason for being late.

You can ask for a faster hearing if you need it. This would be when waiting for a regular hearing could put your life, health, or ability to function in danger. OHA staff will review your medical records to decide if you need this.

HOW TO ASK FOR A HEARING:

Fill out one of these forms. Return it to OHA or a Department of Human Services (DHS) office.

- Pages 1 and 2 of the Appeal and Hearing Request (OHP 3302); or
- The Administrative Hearings Request (MSC 443). To get this form and help filling it out, go to a DHS office, or call OHP at 800-699-9075 (TTY 711).

Please include a copy of the NOAR or decision notice with your request.

You can mail or fax request forms to:

OHA Medical Hearings Unit
500 Summer St. NE, E49
Salem, OR 97301-1079

Fax: 503-945-6035
Phone: 503-945-5785

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To get a denied service while you wait for your hearing, you must:

- Have had the service prior to the denial,
- Ask for the service to continue on your hearing request form, and
- Ask for the hearing no later than:
  - 10 days after the date of the decision notice, or
  - The “effective date” of the decision notice (if the notice lists an “effective date.”)

If the hearing does not change the decision, you may have to pay for services you get after the “effective date” on the decision notice.

IF YOU WANT HELP AT YOUR HEARING:

You may have a friend, family member, advocate, doctor or lawyer help at the hearing. If you want a lawyer, you can call here for help:

- Public Benefits Hotline at 800-520-5292, for advice and possible representation. Legal Aid Services of Oregon and the Oregon Law Center provide this hotline.
- Oregon State Bar at 800-452-8260, about free or low-cost legal services.

If you have someone who will help you at the hearing, list their contact information on the hearing request form, or tell the OHA hearing representative.

IF YOUR REQUEST IS LATE OR CANCELED, OR YOU DO NOT ATTEND YOUR HEARING:

You may lose your right to have a hearing on this decision. If this happens, the decision notice is the final decision (or “final order by default”). It will become effective 45 days after the date of *Notice of Appeal Resolution* or OHA decision notice. The record for the final order is the case file used to make the decision, with any materials you submit later about it. You will not get another notice about this decision.

If you cancel your hearing request or miss your hearing, you will get a dismissal order. You may still appeal the decision under ORS 183.482 by filing a petition in the Oregon Court of Appeals. You must do this within 60 days of the date of the dismissal order. The dismissal order will tell you the appeal deadline.

Note to military personnel: The federal Servicemembers Civil Relief Act gives active duty members the right to delay these proceedings. To learn more, you may contact the Oregon State Bar at 800-452-8260, the Oregon Military Department at 800-452-7500, or an Armed Forces legal assistance office, http://legalassistance.law.af.mil.

THE FOLLOWING STATUTES AND RULES MAY APPLY TO YOUR CASE:

Oregon Administrative Rules: 410-120-1210 *(Medical Assistance Benefit Packages)*; 410-141-0480 *(Covered Services)*; 410-141-0500, 410-120-1200 *(Excluded Services)*; 410-141-0520 *(Prioritized List of Health Services)*; 410-120-1860 *(Client Appeals)*; 410-141-3247 *(Contested Case Hearings)*

Oregon Revised Statutes: 183.415(2)(b) – *Notice of Right to Hearing*

OTHER THINGS YOU CAN DO:

You can always ask for the information used to make this decision. To do this, call the phone number listed in the *Questions* section of the decision notice. If you do not want a hearing, or if the final decision is still a denial after your hearing, you can:

1. Ask your doctor about other ways to treat your condition.
2. Ask your provider about paying for the service yourself. Your provider will have you sign an *Agreement to Pay* form (OHP 3165). This form states you understand the service is not covered and you will pay for it.

OHA follows state and federal civil rights laws. It does not treat people unfairly in any of its programs because of a person’s race, color, disability, national origin, religion, sex, sexual orientation, gender identity, marital status or age. You may file a complaint if you believe OHA treated you differently for any of these reasons.

Appendix C: OHP approval notice – Form 640

Statewide Processing Center – 640
PO Box 14015
Salem, OR 97309

Enter the date

Enter the case name
Enter the street address
Enter the city, state and ZIP Code

P.O. Box 14015, Salem, OR 97309-5032
Voice: 1-800-699-9075
FAX: 503-378-5628
TTY: 711
OHP.Oregon.gov

Case ID:

OHP Approval Notice

You or others in your household have been approved for health benefits. This letter will tell you about the program and the type of benefits that have been approved.

If you disagree with any of our decisions, you have the right to a hearing. There is more information about how to request a hearing later in this letter.

Approved for benefits/renewal

The following household member(s) were approved for benefits or renewed benefits.

Name	Program	Benefit level	Start date
Enter name	Choose One:	Choose one:	MM/DD/YY

Please use the "add" button if there are not enough rows for all household members.

Add row Delete row

Please select CAWEM, CAWEM Plus or OHP Plus-Cover All Kids:

☐ CAWEM ☐ CAWEM Plus ☐ OHP Plus-Cover All Kids

You can get this letter in another language, large print or another format that is best for you. Call 1-800-699-9075 (TTY 711).

Questions? Please visit OHP.Oregon.gov or call 1-800-699-9075 or 711 (TTY)

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You must report changes

You or someone in your household is receiving medical assistance. You must report the changes listed below for anyone in your household within 30 days of when the change happens:

- A change in mailing or home address
- When someone moves in or out of the household
- Change of marital status
- Change in the legal name
- When someone becomes pregnant, a pregnancy ends, or a child is born
- When someone dies
- If someone is involved in an injury accident, or has a claim for personal injury
- When someone gets or loses other health benefits or if any other health benefits changes (this includes employer-sponsored health benefits)
- If someone goes to jail or prison or is released from jail or prison
- Change in tax filing status
- Change in source of income
- If you are 19 or older, you must report:
    - A change of more than $50 unearned income
    - When someone starts or stops working, or has a change of more than $100 earned income

You must report the changes listed below within 30 days of when the change happens only if you are receiving medical assistance:

- Change in immigration status
- If someone gets or loses any part of Medicare

To report changes, call OHP Customer Service at 1-800-699-9075 (TTY 711), Monday through Friday 7 a.m. to 6 p.m.

Questions

If you have any questions, please contact us. We want to make sure you have the information you need. You can call us at 1-800-699-9075 (TTY 711), Monday through Friday 7 a.m. to 6 p.m.

Your hearing rights

What you can do when you do not agree with this decision:
You have the right to challenge this decision by asking for a hearing. Hearings are held by the Office of Administrative Hearings, which is independent from the Oregon Health Authority (OHA). If you want a hearing, you must request it on time.

You can also talk to a manager who will review the action and discuss it with you. You can do this by calling 1-800-699-9075. Your deadline date to request a hearing (see part 1 below) does not change even if you are in contact with a manager or are trying to reach one. If you still need further assistance, you may contact the Governor's Advocacy Office at 1-800-442-5238.

Part 1 — Ask for a hearing

What must I do to get a hearing?
You need to ask for a hearing. You can ask for a hearing by doing one of the following:

- Fill out and submit the Administrative Hearing Request form (MSC 0443). You can get this form online at https://apps.state.or.us/Forms/Served/me0443.pdf or by calling 1-800-699-9075.
- Call 1-800-699-9075 and we can fill out a request for you over the phone.
- Send your request by secure email. To do this, email 5503.Hearings@state.or.us and ask them to send you a secure email. Then reply to the secure email to send your request.
- Send your request by fax to: 503-945-6035.
- Send your request by mail to: OHP Eligibility Hearings Unit, P.O. Box 14952, Salem OR 97309.
- Or request a hearing in person. To find an office close to you, go to www.oregon.gov/DHS/Offices.

You have 90 days from the date of this notice to ask for a hearing. If you need help with your hearing request, call 1-800-699-9075.

Note to military personnel:
Active duty service members have a right to stay (delay) these proceedings under the federal Servicemembers Civil Relief Act (SCRA). For more information, you may contact the Oregon State Bar at 1-800-452-8260, the Oregon Military Department at 1-800-452-7500 or the nearest legal assistance office at http://legalassistance.law.af.mil.

Who can help with my hearing?
Anyone may represent you. You may call the Public Benefits Hotline, which is a program of Legal Aid Services of Oregon and the Oregon Law Center, at 1-800-520-5292 for advice and possible representation.

What are my other hearing rights?
At the hearing, you can talk about why you do not agree with the decision. You can have people testify for you. The laws about your hearing rights and the hearing process can be found in Oregon Administrative Rules (OAR) 137-003-0501 to 0700, 410-120-1860, 410-141-0264, 410-200-0145, 410-200-0146, 461-025-0300 to 0375, and Oregon Revised Statutes (ORS) 183.411 to 183.470 and ORS 411.095. Administrative rules can be found online at: http://sos.oregon.gov/archives/pages/oregon_administrative_rules.aspx. Oregon Revised Statutes can be found online at www.oregonlegislature.gov/bills_laws/Pages/ORS.aspx.

What happens if I do not request a hearing in time or if I miss my scheduled hearing?
You may lose your right to a hearing if you do not ask for a hearing on time, or if you withdraw the hearing request, or miss your hearing. If any of the above happens, you will receive a notice from the Oregon Health Authority (OHA). This notice will be the final OHA decision (called a "final order by default"). The case file, along with any materials you submitted in this matter, is the record.

The record is used to support the OHA decision upon default. You may appeal the final order by default by filing a petition in the Oregon Court of Appeals (ORS 183.482). If you do not ask for a hearing, this appeal must be filed within 60 days of the date this notice becomes a final order, by default. If you withdraw a hearing request or miss your hearing, the appeal deadline is set out in the dismissal order.

Part 2 — How do I keep getting benefits until my hearing?

You need to ask to keep getting benefits in your request for a hearing. In your request, you can ask for your benefits to stay the same until the hearing decision. This is called "continuing benefits." You must ask for continuing benefits by either the "effective date" on the notice, 10 days after the date of the notice, or 10 days after receipt of the notice – whichever date is later.

Please note: If you receive continuing benefits and we do not change our decision or the hearing judge supports our decision, you must pay back the benefits you should not have received.

If you don't keep getting benefits and win the hearing, OHA will give you the benefits you should have received.

Part 3 — Can I have an expedited hearing?

You may have the right to an "expedited hearing" if OHA denied your request to keep getting benefits until your hearing. Expedited hearings are held within five working days from the date of request.

OHA follows state and federal civil rights laws. It does not treat people unfairly in any of its programs because of a person's race, color, disability, national origin, religion, sex, sexual orientation, gender identity, marital status or age. You may file a complaint if you believe OHA treated you differently for any of these reasons.

The Oregon Health Authority has several programs

We follow rules and laws to decide who qualifies for each program. Learn more about each program below.

Children's Health Insurance Program (CHIP) or Children under age 19 Program

You qualify for one of these programs if you:

- Are under age 19;
- Are not receiving Supplemental Security Income (SSI);
- Have income below the limits;
- Are not eligible for Parents and Other Caretaker Relatives program or Substitute Care program (see below); and
- Are not covered by other health insurance that meets the definition of minimum essential coverage. This is only true for the CHIP program.

Applicable rules:

410-200-0015 (52) – General Definitions
410-200-0315 – Standards and Determining Income Eligibility
410-200-0410 – Specific Requirements; MAGI CHIP
410-200-0415 – Specific Requirements; MAGI Child

Adult Program

You qualify for this program if you:

- Are age 19-64;
- Have income below the limits;
- Are not pregnant;
- Are not entitled to, or enrolled in, Medicare part A or B;
- Are not receiving Supplemental Security Income;

To qualify for this program, parents or other caretaker relatives who live with a dependent child must have the child enrolled in health insurance that meets the definition of minimum essential coverage.

Applicable rules:

410-200-0015 (52) – General Definitions
410-200-0315 – Standards and Determining Income Eligibility
410-200-0435 – Specific Requirements; MAGI Adult

Parents and Other Caretaker Relatives Program

You qualify for this program if you:

- Have a dependent child in your home;
- Are related to the dependent child, as defined in OAR 410-200-0015 (16); and
- Have income below the limits.

Applicable rules:	410-200-0015 (15), (16), (33) and (61) – General Definitions; 410-200-0315 – Standards and Determining Income Eligibility 410-200-0420 – Specific Requirements; MAGI Parent or Other Caretaker Relative

Pregnant Woman Program

You qualify for this program if you:	• Are pregnant; and • Have income below the limits.
Applicable rules:	410-200-0315 – Standards and Determining Income Eligibility; 410-200-0425 – Specific Requirements; MAGI Pregnant Woman

Extended Medical Assistance (EXT) Program

You qualify for this program if you:	Have a dependent child in the home who has minimum essential coverage, and lost eligibility for the Parent or Other Caretaker Relative program because of an increase in: • Earned income; or • Spousal support (only if you were receiving benefits for three of the six months before receiving the increased spousal support.)
Applicable rules:	410-200-0440 – Specific Requirements; Extended Medical Assistance

Substitute Care Program

You qualify for this program if you:	• Are under the age of 21; and • Live in an intermediate psychiatric care facility for which an Oregon public agency is assuming at least some financial responsibility. This includes placements made by the Oregon Youth Authority.
Applicable rules:	410-200-0405 – Specific Requirements; Substitute Care

Breast and Cervical Cancer Treatment Program

You qualify for this program if you:	• Are not covered by other health insurance that meets the definition of minimum essential coverage, including other OHP programs; • Need treatment for breast or cervical cancer as determined by a screening through the Breast and Cervical Cancer Screening Program; and • Are under the age of 65.

Applicable rules:	410-200-0015 (52) – General Definitions; 410-200-0400 – Specific Requirements; Breast and Cervical Cancer Treatment Program; Oregon Revised Statutes (ORS): 414.534

Other medical programs

Oregon Supplemental Income Program Medical

You qualify for this program if you:	• Are age 65 or older; or • Are blind or have a disability that meets Social Security standard.
Applicable rules:	461-135-0010 – Assumed Eligibility for Medical Programs 461-125-0310 – Basis of Need

Qualified Medicare Beneficiary

You qualify for this program if you:	• Are receiving benefits under Part A of Medicare.
Applicable rules:	461-135-0010 – Assumed Eligibility for Medical Programs 461-135-0730 – Specific Requirements; QMB, SMB, SMF

Refugee Assistance Medical

You qualify for this program if you:	• Have been lawfully admitted to the Unites States as a refugee, or • Have been lawfully granted asylum in the United States.
Applicable rules:	461-135-0900 – Specific Requirements REF, REFM

HEALTH SYSTEMS DIVISION
Phone: 800-527-5772
Email: HSD.WebContent@state.or.us

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OHA 2874 (11/18)