

Mary Lee Fay

Authorized Signature

Number: SPD-AR-05-087

Issue Date: 12/30/05

Topic: Other

Due Date: 12/30/05

Subject: MMA Transmittal-Referral to Central Office Process

Applies to (check all that apply):

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

Action Required: It is likely that our dual-eligible clients will have difficulty understanding the changes in their prescription drug coverage due to the Medicare Prescription program and may have difficulty navigating the new systems that will help them access their new prescription drug coverage. Clients may call local offices for help with the problems they are experiencing with their plan enrollment, exception and appeal processes, being denied required transition services and being charged inappropriate copayments.

In order to assist clients and track problems that are occurring, please use the attached referral form for each client that experiences difficulties with the Medicare Prescription Drug program. The form will function as both a tracking tool and a referral to Central Office.

Central Office will use the form to work with medical providers, pharmacies, Drug plans, and CMS to resolve individual client problems and to resolve systemic issues. The form should be filled out with as much information as possible, showing client's information and what action was taken in the local office to assist the client. This referral process will also allow us to maintain a database of clients who have encountered problems with their new Medicare Part D coverage.

Please submit the form to the Central Office by fax at 503-373-7274 or by email to MMA_Calendar@dhs.state.or.us.

Reason for Action: To help ensure that all dual-eligible clients are assisted with the prescription drug coverage transition to the fullest extent possible.

Field/Stakeholder review: Yes No

If yes, reviewed by:

If you have any questions about this action request, contact:

Contact(s):	Christina Jarmillo, Max Brown, Jane-ellen Weidanz		
Phone:	503-947-5281(C),503-945-6993(M), 503-945-6444(J)	Fax:	503-373-7274
E-mail:	Christina.D.Jarmillo@state.or.us Max.Brown@state.or.us JaneEllen.A.Weidanz@state.or.us		

MMA Problem Solving Referral Form

Client Prime:	Branch:
Client Name:	Case Worker/Person referring: Phone:
Pharmacy:	Pharmacy Phone #:
Prescribing Physician:	Physician's Phone #:
Dual Status Confirmed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug (s) Not Covered:

<u>Description of Problem:</u>	
<input type="checkbox"/> Client charged wrong copay <input type="checkbox"/> Client has no funds to pay copay <input type="checkbox"/> Drugs not on formulary <input type="checkbox"/> Enrolled in wrong plan <input type="checkbox"/> LTC services not provided <input type="checkbox"/> Client charged wrong copay	<input type="checkbox"/> Client has no funds to pay copay <input type="checkbox"/> Drugs not on formulary <input type="checkbox"/> Enrolled in wrong plan <input type="checkbox"/> LTC services not provided <input type="checkbox"/> Additional Information: <i>Please use another sheet</i>
<u>Indicate Probable Outcome without medication:</u>	
<input type="checkbox"/> DD Regional Crisis Referral <input type="checkbox"/> Fatality <input type="checkbox"/> Hospitalization <input type="checkbox"/> Institutionalization <input type="checkbox"/> Nursing Facility Admission	<input type="checkbox"/> Protective Services <input type="checkbox"/> Rapid decline in health <input type="checkbox"/> Slow decline in health <input type="checkbox"/> Other-Please describe <input type="checkbox"/> Additional Information: <i>Please use another sheet</i>
Has a Drug Coverage Exception been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No Status:	
Please provide copies of any requests, denials, or decisions made	
Family Member or other contact:	Phone: