

For January and February 2006, the Department will allow retroactive claims for Medicare Part D costs. Clients must provide proof of payment as described below. Beginning in March, claims cannot be applied retroactively to any preceding calendar month(s) during which the costs were incurred.

The new Medicare Part D need/resource code (Medicare Drug Costs, or MDC) will be used to process Medicare Part D drug copayments and Part D-covered drugs that are not on the plan formulary. For clients who have a stable list of prescription drugs, these costs can be anticipated over a six month period (starting January 1, 2006). For clients whose prescription drugs change monthly, costs must be reported and liability should be adjusted each calendar month. For example, a client may take four name-brand and two generic drugs consistently each month. At \$2 and \$5 copayments, the amount of \$22 can be anticipated over a six month period and adjusted if the client reports a change in prescriptions. A second client may have unstable medical conditions and change prescriptions each month. This client's costs cannot be anticipated, so the client needs to report costs and the liability requires adjustment monthly.

Finally, Form SDS 540M will be used for clients who report Medicare Part D drug costs monthly. The Form notifies the client that:

- His or her medical deduction was approved,
- The client's liability was reduced by the amount of the deduction, and
- That the client's liability will increase to the full amount effective the first of the following month.

Following the "prior notice" rule (OAR 461-175-0300), the Form serves as a 10-day notice because it notifies the client of the increase *and* reduction in benefits. It can be used for other medical costs incurred in a single calendar month. The Form will *not* be used for clients with anticipated costs over a six month period.

The Form is attached to this transmittal. It will be posted on the DHS website in late February and it will be available through OrACCESS in July. You can download the Form through the following hyperlink:

[FORM SDS 540M](#)

Implementation/Transition Instructions:

For Food Stamps:

Per OAR 461-160-0055(1), for OSIPM clients receiving Food Stamps, Medicare Part D premiums above the benchmark premium subsidy (basic prescription drug plans at or below \$30.60 per month) and copayments attributed to the Part D program and non-formulary prescription costs are allowable as medical deductions. These costs are anticipated costs and do not need review each month.

For Client Liabilities:

- Per OAR 461-160-0620(1)(h), medical deductions allowed by OAR 461-160-0055 are allowable for costs not covered under the state plan.
- The portion of the Medicare Part D premium above the benchmark premium subsidy is an allowable deduction and should be coded as an ongoing OHI premium in OrACCESS and CMS. This is an anticipated cost and needs review at redetermination.
- Prescription drug copayments and non-formulary drug costs can be allowed as an MDC and should be reported with verification by clients or by providers. Local SPD eligibility offices will need receipts or proof of payment from pharmacies indicating that clients incurred copayments and non-formulary drug costs.
 - For clients who consistently use the same prescription drugs, copayments and non-formulary drug costs can be anticipated over a six month period. The MDC need/resource code will be used to ensure that the deduction will be reviewed at the end of the six month period. For these clients, code the end date at six months (with the six month period beginning January 1, 2006).
 - If clients with stable medications have new prescription costs within that six month period, they must report the change to their local SPD eligibility office.
 - For clients whose prescriptions vary from month to month, these costs need to be reviewed each month. The MDC need/resource code will be used to ensure that the deduction ends each month; code these clients with an MDC end date at the end of the calendar month. Form 540M will be sent to the client upon approval of the deduction.
- Receipts or other proof of payment should be provided no later than five (5) working days before compute deadline for the end of the six month period or the end of the calendar month, depending on the stability or variance of prescription drug costs described above. Providers and pharmacies may fax receipts to the local SPD eligibility office.
- Before a client can declare non-formulary drugs as an MDC, the client must file an exception with his or her Medicare Part D plan and have that exception denied. The plan's denial notice will be used as verification for deducting the costs of non-formulary drugs.

The process for adjusting client liabilities for the OHIs and MDCs will change based upon the payment system.

For CBC (512):

- Add the OHI or MDC need/resource code to OrACCESS and integrate the case. Wait for batch processing and the next day, "touch" the 512.

- The MDC code will drop off CMS at the end of the six month period or the end of the calendar month, depending on the client and the end date coded. The 512 will need to be readjusted in order to agree with CMS and to provide payment for providers.

For the Pay-In System:

- If the client has not paid the liability for the month, and the local office receives verification that the client has paid copayments and any non-formulary drug costs, the worker will adjust the liability through SFMU. The client will need to pay the remaining liability.
- If the client has paid the liability, and the local office receives verification that the client has paid copayments and any non-formulary drug costs, the worker will adjust the liability through SFMU. The client will receive a refund check for the amount the liability was reduced.
- For clients who maintain stable prescription drug costs, these costs can be anticipated over a six month period as described above.

For Clients with Developmental Disabilities:

Since claims for OIM deductions are new processes for clients with developmental disabilities, specific guidance is required for DD services:

- For clients with developmental disabilities who receive residential services and have a liability (also called an “offset”), they may now also utilize the OIM deduction. To do so, the clients or their providers will need to provide documentation of OIM expenses (e.g., receipts or pharmacy records of payment) to their local SPD eligibility office no later than five (5) working days before the end of the six month period of anticipated costs or calendar month in which the expense was paid.
- Once verification is received, the local SPD eligibility office will enter the OIM using the MDC need/resource code into OrACCESS and adjust the client liability amount.
 - For individuals receiving DD 24 Hour Residential Services or DD Supported Living services, those adjustments will be reflected in the Client Liability Account within eXPRS.
 - For individuals receiving non-relative Foster Care services, those adjustments will be reflected within the Community Based Care payment system.

For Clients with Anticipated Prescription Drug Costs:

If clients have their costs anticipated over a six-month period, their actual, incurred prescription drug costs will be reconciled with the anticipated costs at the end of the six-month period. Again, the MDC need/resource code must have an end date at six months out. For clients with six month, anticipated drug costs, do not use Form 540M.

Instead, notify the client 10 days in advance of the end date that the cost is no longer allowed. After reconciliation, any adjustment in anticipated costs can apply for the remaining six months of the calendar year, after which reconciliation between actual and anticipated prescription drug costs will occur again.

Training/Communication Plan:

The MMA Project Team is developing training materials on this policy. Training will be offered during Spring 2006.

Local/Branch Action Required:

Central Office Action Required:

Field/Stakeholder review: Yes No

If yes, reviewed by: OIM workgroup, Central Office; Operations Committee

Filing Instructions:

If you have any questions about this policy, contact:

Contact(s):	Max Brown, MMA Program Analyst, SPD		
Phone:	Max: 503-945-6993	Fax:	503-373-7274
E-mail:	Max.Brown@state.or.us		

Notice of Planned Action

Medical Costs

Seniors and
People with
Disabilities

SDS 540M

File Name

Client

Date Sent

You have been approved for a medical deduction for medical costs you have paid. This deduction will reduce the amount you have to pay for your services, for the current month.

Case number

During the month of _____, you have provided documentation and been approved for a medical deduction of \$_____.

Prime number

Due to this medical deduction, your service cost will be reduced to: \$_____. (*This reduction will only affect the service cost for the current month.*)

Date of birth

SSN

Your service cost will increase to \$_____, effective _____.

Program

Branch code

RULES: 461-160-0055, 461-160-0610, 461-160-0620, 461-175-0300

Worker

If you have any questions about this notice, please contact your worker. If you disagree with this decision, you have the right to a hearing. Read Part 1 on the back of this form for more information.

Date received

Distribution: One copy to client and record

Your Hearing Rights

Keep this notice! If you ask for a hearing, the Department of Human Services (DHS) will ask you for a copy of it.

Part 1 - About Hearings: *What to do when you do not agree with a DHS decision.*

- a. You have the right to talk with a person in charge. You may ask for a meeting by contacting your branch.
 - b. Under Oregon Revised Statute Chapter 183, you have the right to ask for a hearing if you do not agree with a DHS decision. Hearings are held before an Administrative Law Judge who works for the Office of Administrative Hearings.
 - c. At the hearing, you can tell why you do not agree with the decision. You can have people testify for you. You can have a lawyer or someone else help you. *For General Assistance (GA), childcare and cash for families (TANF)*, only a lawyer or someone from a non-profit legal service can represent you. We cannot pay the costs of witnesses or a lawyer. You may be able to get free legal services through a Legal Aid office or the local Bar Association.
 - d. If you do not ask for a hearing on time, you lose your right to have one. You must ask for a hearing within 45 days (90 days for food benefits) from the date on the notice about the decision. *For cash, childcare or medical benefits*, you must fill out an Administrative Hearing Request form (DHS 0443). You can get this at a DHS office or by going to <http://www.dhs.state.or.us> and clicking on Forms. Someone at your branch office can help you fill out the form. Forms must be returned to a DHS office. *For food benefits*, you can ask for a hearing on a DHS 0443, by phone, in writing, or by asking a DHS staff member in person.
-

Part 2 - Continuing Your Benefits: *How to keep getting benefits until your hearing.*

- a. You can ask that your benefits stay the same until the hearing decision. *For cash, child care, and medical benefits*, you do this on the Administrative Hearing Request form (DHS 0443). *For food benefits*, you can ask for continuing benefits on the DHS 0443, by phone, in writing, or by asking a DHS staff member in person.
 - b. You must ask your branch for a hearing and benefits by a certain date. The date is either the “effective date” on the notice or 10 days after the “date of notice.” To keep getting benefits, you must ask by whichever date is *later*.
 - c. If you keep getting benefits and the hearing is not in your favor, you must pay back the benefits you should not have received.
 - d. If you don’t keep getting benefits and the hearing is in your favor, we will give you benefits you should have received.
-

Part 3 - About “Expedited” Hearings: *Can you have your hearing sooner than usual?*

You have the right to have your hearing within five working days in the following cases:

- a. Your request for Emergency Assistance or Temporary Assistance for Domestic Violence (TA-DVS) is denied.
 - b. You disagree with the amount or form of payment for Emergency Assistance or TA-DVS.
 - c. The department denied your request to keep getting benefits until your hearing.
 - d. Your request to get food benefits within seven days (“expedited” food benefits) is denied or you disagree with a DHS action that affects whether your household can get expedited food benefits.
 - e. You are getting medical benefits and you have been denied a medical service, *and* a medical review by DHS shows your medical condition is an immediate, serious threat to your life or health.
 - f. If you are denied a JOBS support service payment, or it is not issued within the legal time frame.
 - g. If DHS stops or reduces a JOBS payment that you have been getting.
-

DHS will not discriminate against anyone. This means DHS will help all who qualify. DHS will not deny help to anyone based on age, race, color, national origin, sex, sexual orientation, religion, political beliefs or disability. You can file a complaint if you think DHS discriminated against you because of any of these reasons.
