Enrolling Elderly and Disabled Beneficiaries in Medicaid Managed Care: Lessons Learned from the Oregon Health Plan

Final Report

Prepared by:

Janet B. Mitchell, Ph.D.
Health Economics Research, Inc.

and

Paul Saucier, M.A.
Muskie School of Public Service
University of Southern Maine

August 24, 1999

Janet B. Mitchell, Ph.D.
Project Director

Gregory C. Pope, M.S.
Scientific Reviewer

The research presented in this report was performed under Health Care Financing Administration (HCFA) Contract No. 500-94-0056, Paul Boben, Project Officer. The statements contained in this report are solely those of the authors and no endorsement by HCFA or ASPE should be inferred or implied.
Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>E-1</td>
</tr>
<tr>
<td>Background</td>
<td>1</td>
</tr>
<tr>
<td>- Statewide §1115 Programs for All Ages</td>
<td>1</td>
</tr>
<tr>
<td>- Significant Managed Care Infrastructure</td>
<td>1</td>
</tr>
<tr>
<td>- Cost-Sharing Policy for Dually Eligible Beneficiaries</td>
<td>2</td>
</tr>
<tr>
<td>- Broad Participation of Plans Fostered</td>
<td>2</td>
</tr>
<tr>
<td>- Scope of Capitated Services</td>
<td>3</td>
</tr>
<tr>
<td>- Focus of Report</td>
<td>4</td>
</tr>
<tr>
<td>Enrollment Choices</td>
<td>4</td>
</tr>
<tr>
<td>- Enrollment Choices Generally</td>
<td>4</td>
</tr>
<tr>
<td>- Choices for Dually Eligible Beneficiaries</td>
<td>5</td>
</tr>
<tr>
<td>The Enrollment Process for Phase II</td>
<td>9</td>
</tr>
<tr>
<td>- Who Performs the Enrollment Function</td>
<td>10</td>
</tr>
<tr>
<td>- How Does Enrollment Take Place</td>
<td>13</td>
</tr>
<tr>
<td>- Enrollment Protections</td>
<td>23</td>
</tr>
<tr>
<td>- Exceptional Needs Care Coordinators (ENCCs)</td>
<td>24</td>
</tr>
<tr>
<td>- Continuity of Care Referral Forms</td>
<td>25</td>
</tr>
<tr>
<td>- Exemptions Process</td>
<td>27</td>
</tr>
<tr>
<td>- Disenrollment Provisions</td>
<td>29</td>
</tr>
<tr>
<td>OHP Success in Managed Care Enrollment</td>
<td>30</td>
</tr>
<tr>
<td>- Progress to Date</td>
<td>30</td>
</tr>
<tr>
<td>- Implications for Other States</td>
<td>33</td>
</tr>
<tr>
<td>Appendix A  Oregon Health Plan Comparison Chart</td>
<td></td>
</tr>
<tr>
<td>Appendix B  Forms 7208 and 7208A</td>
<td></td>
</tr>
<tr>
<td>Appendix C  Continuity of Care Referral (CCR) Forms</td>
<td></td>
</tr>
</tbody>
</table>
# Table of Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Medicare-Medicaid Combinations for Dually Eligible Beneficiaries</td>
<td>7</td>
</tr>
<tr>
<td>Table 2</td>
<td>Trends in Medicare HMO Enrollment for Dually Eligible and Non-Medicaid Eligible Medicare Beneficiaries: U.S. vs. Oregon (percent enrolled)</td>
<td>8</td>
</tr>
<tr>
<td>Table 3</td>
<td>Trends in OHP Managed Care Enrollment: Dually Eligible vs. OHP-Only Beneficiaries</td>
<td>28</td>
</tr>
<tr>
<td>Table 4</td>
<td>Distribution of Dually Eligible and OHP-Only Beneficiaries Across Managed Care Plans, 1998</td>
<td>32</td>
</tr>
<tr>
<td>Table 5</td>
<td>Distribution of Dually Eligible Beneficiaries by Type of Managed Care Arrangement</td>
<td>33</td>
</tr>
</tbody>
</table>
Enrolling Elderly and Disabled Beneficiaries in Medicaid Managed Care:
Lessons Learned from the Oregon Health Plan

Executive Summary

Oregon launched the Oregon Health Plan (OHP) in February 1994, enrolling both its traditional AFDC and new expansion populations into managed care. Exactly one year later, the State began enrolling its elderly and disabled beneficiaries, including those dually eligible for both Medicare and Medicaid. By the end of 1995, the majority of the elderly and disabled were enrolled in Fully Capitated Health Plans. By early 1998, this figure had climbed to 75 percent, with an additional 6 percent enrolled with a primary care case manager. The remaining beneficiaries remain in fee-for-service, many of them specifically exempted because of a third-party resource (such as supplemental Medi-Gap insurance).

Oregon’s experience with elderly and disabled beneficiaries provides some valuable lessons for other states that may be considering enrolling this population into managed care.

Planning for Enrollment

- Special time and attention should be given to the enrollment of elderly and disabled beneficiaries. In Oregon, State officials did not enroll this population until a full year after enrolling TANF and expansion beneficiaries into managed care. This gave the State additional time to resolve any “start-up” problems before attempting to enroll the more vulnerable Phase II beneficiaries.

- When planning a managed care program for elderly and disabled beneficiaries, significant time should be allowed to develop consensus among key constituents. The State worked with advocacy groups to develop special enrollment procedures and consumer protections prior to implementation. While planning and consensus building may not
appear innovative, some states attempting similar programs failed to do so (and encountered difficulties, e.g., Tennessee).

Involvement of Other Public Agencies

- Gaining the cooperation of sister agencies at both the state and local levels was key to the successful enrollment of elderly and disabled beneficiaries in Oregon. OMAP worked closely with the agency with traditional responsibility for these populations in the State: the Senior and Disabled Services Division (SDSD). Because they felt part of the process, SDSD staff cooperated with, rather than resisted, the implementation of managed care for their populations.

- Giving its sister agency a role in the enrollment of elderly and disabled beneficiaries into managed care plans was key to gaining its political support. Because this agency was widely perceived as an advocate for the elderly and disabled, advocates were reassured that continuity of care was less likely to be disrupted.

Consumer Protections

- Consumer advocacy and enrollment responsibility need not be inconsistent. By delegating the enrollment function to local SDSD or Area Agency on Aging (AAA) offices (rather than to an independent broker), the State helped ensure that choice counseling was performed by the workers most knowledgeable about their clients. Local case workers were best suited to help ensure continuity of care, and were given the authority to exempt individuals from managed care on a case-by-case basis.

- The transition of elderly and disabled beneficiaries to managed care can be eased by the introduction of special protections. In Oregon, these included the use of Continuity of Care Referral Forms (written communications from enrollment workers to managed care plans) and Exceptional Needs Care Coordinators (ENCCs), a staff position created within plans specifically to address the needs of the Phase II population.
Decentralization and Local Control

- In states with strong county or other local governments involved in service delivery for elderly and disabled beneficiaries, it is possible to decentralize the enrollment function and still implement a state-wide managed care program. Because decentralization may introduce some inconsistencies in enrollment practices across areas, states will need to provide ongoing training and other supports to the local entities.

- Local control of the enrollment and disenrollment functions proved critical to the “buy-in” by advocates and others of managed care for elderly and disabled beneficiaries. Dissatisfied beneficiaries are able to change plans simply by contacting their local workers.

- If local offices currently carrying out eligibility and case management functions have sufficient flexibility to allocate their state funds, they may also be able to perform the enrollment function without significant new resources (at least once the initial wave of enrollment is completed).

The Special Challenge of Dually Eligible Beneficiaries

- Enrollment of dually eligible beneficiaries is extremely complex and time-consuming. Despite the considerable amount of time Oregon devoted to this task, the State, the plans, and local enrollment offices all agreed that the challenge had been grossly underestimated.

- States must recognize that enrollment of dually eligible beneficiaries into Medicare HMOs for their Medicare benefits (where appropriate) is a parallel, but separate, process from Medicaid managed care enrollment. Coordination of these two procedures remains the greatest source of frustration among OHP plans.

Choice of Plans

- Many factors may influence plan choices among elderly and disabled beneficiaries. The principal deciding factor appears to where the beneficiary’s primary care provider participates. However, the recommendation of residential staff (at group homes, for example), family members, surrogates, and enrollment workers also can influence choices.

- Over one-third of dually eligible beneficiaries are enrolled in OHP plans.
with a complementary Medicare HMO. The percent of dually eligible beneficiaries enrolled in Medicare HMOs skyrocketed from 10 percent in 1994 to 32 percent one year later (when Phase II was implemented). However, it is not clear how well dually eligible beneficiaries in Oregon understand their Medicare choices.
Background

Statewide §1115 Programs for All Ages

In February 1994, Oregon launched the Oregon Health Plan (OHP), its innovative Medicaid reform program. This program extends Medicaid eligibility to uninsured residents with incomes below the Federal Poverty Level, enrolls all beneficiaries into managed care, and uses a prioritized list of health care services to define the benefit package. Managed care enrollment took place in two stages: Phase I enrolled the AFDC (now TANF) and expansion populations at the outset, while enrollment for the remaining Medicaid beneficiaries began a year later as Phase II (February 1995). This population consisted of SSI beneficiaries (including dually eligible beneficiaries\(^1\)) and foster children, totalling about 71,000 individuals. In this report we describe the process used by Oregon to enroll elderly and disabled beneficiaries into managed care.

Significant Managed Care Infrastructure

Unlike many states, Oregon has a long-standing history of managed care enrollment in both Medicare and the private sector. In 1994, just prior to Phase II implementation, almost one-third of Oregon's Medicare population were already enrolled in HMOs, including 10 percent of those who were dually Medicare-Medicaid eligible. A total of six Medicare HMOs (both TEFRA risk and cost-based) were operating in the State, and Oregon was among the top four states in the country for Medicare HMO enrollment. The existence of a mature managed care market in Oregon undoubtedly eased the transition to managed care.

\(^1\) Also included were a small number of elderly and disabled beneficiaries who are not SSI-eligible but still qualify for Medicaid in Oregon.
for Medicaid beneficiaries. At the same time, it markedly complicated the OHP enrollment process for dually eligible beneficiaries (as we will see below).

Cost-Sharing Policy for Dually Eligible Beneficiaries

Oregon is one of only three §1115 waiver states known to have obtained permission for a now-controversial feature that makes it easier to enroll dually eligible beneficiaries in managed care. In Oregon, Arizona and Minnesota, capitation rates for Medicaid managed care plans include the Medicare cost sharing to which dually eligible beneficiaries are entitled, and the plans are not required to pass on these copayments to providers if beneficiaries go out of network without referral for Medicare services. This provides an incentive for dually eligible beneficiaries to receive Medicare services within the plans' networks even when they have chosen Medicare fee-for-service. This feature gives state Medicaid programs greater control over the care their dually eligible beneficiaries receive and hence over spending as well. It is unclear, however, whether HCFA is likely to approve similar arrangements for other states seeking waivers.

Broad Participation of Plans Fostered

Although Oregon did have one of the nation's highest managed care penetration rates prior to the development of OHP, this managed care activity was largely confined to the western area of the State and HMOs operated in only eight of Oregon's 36 counties. The Office of Medical Assistance Programs (OMAP), the State agency that administers OHP, took a number of steps to foster the participation of managed care plans in OHP throughout the State. First, OMAP chose not to make licensure a requirement for contracting with
plans. This was done to encourage application by plans without commercial managed care activity, including those unlicensed plans that had been participating under the State's 1915(b) waiver. Second, OMAP decided to contract with managed care plans on a county-by-county basis, a strategy that has encouraged the formation of local plans to participate in OHP. In fact, ten of the current 15 contractors are "non-mainstream" plans that either were initially formed to contract with OHP or enroll only Medicaid beneficiaries. Finally, OMAP has a stated "open door" policy of contracting with any plan that meets its requirements and does not limit the number of plans per county. In practice, however, the door is only partly open; new plans have been given an opportunity to enter OHP only once since its inception because OMAP feels that its current contractors provide adequate capacity.

**Scope of Capitated Services**

Elderly and disabled beneficiaries enrolled in OHP managed care plans receive physical, dental, and mental health services on a capitated basis. Physical health services (including acute, post-acute, and substance abuse) are provided by Fully Capitated Health Plans (FCHPs). A small number of these FCHPs also provide mental health services under a separate capitated rate. Members of other plans are enrolled in carve-out mental health organizations (MHOs). Capitated dental care organizations (DCOs) provide all dental services. Nursing homes and other long-term care services are carved out entirely and remain fee-for-service. (Clients living in long-term care facilities are enrolled in OHP for

---

2 OHP managed care plans must meet state contracting standards, however, in areas such as financial solvency, access, and internal quality assurance activities.
their regular medical care services, however.) While the State is considering the integration of long-term care into OHP, there are no plans to do so at this time.

**Focus of Report**

In this report, we describe the process used by OHP to enroll elderly and disabled beneficiaries into managed care, with a special focus on dually eligible beneficiaries. This information was obtained as part of a series of interviews with state Medicaid officials, local enrollment workers, providers, managed care plans, and advocacy groups. In addition, eligibility and enrollment files from both OHP and Medicare were used to produce descriptive tables.

**Enrollment Choices**

**Enrollment Choices Generally**

Except in two small rural counties where there are no FCHPs operating, managed care is mandatory for all populations covered by the Oregon Health Plan (OHP), including the elderly, disabled, and other beneficiaries who comprise the Phase II population.³ Currently, there are 15 managed care plans contracting with OHP, and the majority of beneficiaries have a choice of at least two plans. (About 14 percent of OHP beneficiaries reside in counties with only a single plan.) Beneficiaries in Multnomah County (which comprises Portland, the State's largest city) have a choice of eight FCHPs. Even in more rural Jackson County at the southern end of the State, beneficiaries have a choice of six

---

³ These two counties contain less than one percent of the OHP population.
health plans. The market was perceived by OMAP as more volatile, however, and likely to consolidate into a smaller number of FCHPs over time.

Although the Oregon Health Plan's emphasis is on risk-based managed care through FCHPs, Primary Care Case Management (PCCM) and traditional fee-for-service are also available on a person-by-person exemption basis. These options are considered important to those Phase II beneficiaries with very complex care needs, and local choice counselors are empowered to make them available to Phase II enrollees when needed. (PCCM is also available to those in the two counties without an FCHP.) Traditional fee-for-service (referred to in Oregon as "open card") is considered a last resort for people whose existing array of providers does not fall into any single FCHP, and whose primary care provider is not willing to participate in the State's PCCM program. The goal of the State is to enroll as many beneficiaries as possible into FCHPs, excepting only those who have "special care needs that cannot be met by any of the available FCHPs."4

**Choices for Dually Eligible Beneficiaries**

Dually eligible beneficiaries (those who have both OHP and Medicare coverage) have a unique set of choices, stemming from the broad federal guarantee of Medicare choice.5 Oregon currently has six Medicare HMOs, four of which also have OHP contracts. State officials are concerned that dually eligible beneficiaries not end up receiving services from two unrelated health plans. To avoid this, OHP offers a complex array of linked choices that acknowledge Medicare's choice guarantee while limiting the number of possible

---

4 “Choice Counseling-Goals and Responsibilities.” Enrollment educational material prepared by Senior and Disabled Services Division for enrollment staff. August, 1997.

5 Section 1802 of the Social Security Act guarantees Medicare beneficiaries the choice of receiving “health services from any institution, agency, or person qualified to participate under this title.” This section may not be waived.
Medicare-OHP combinations to those considered rational by State policy makers in terms of care coordination and cost effectiveness. Possible combinations include managed care for both, managed OHP with Medicare fee-for-service, and managed Medicare with OHP fee-for-service. Table 1 includes possible combinations and those that are prohibited.

In theory, Medicare choice trumps any state's Medicaid managed care requirements for dually eligible beneficiaries, and Oregon's array of combinations does anticipate the various Medicare choices that may be made. It is therefore somewhat surprising that Medicare HMO enrollment of dually eligible beneficiaries skyrocketed during Phase II implementation of OHP (see Table 2). The percent of dually eligible beneficiaries enrolled in Medicare HMOs tripled from 1994 to 1995 (Phase II OHP enrollment began in February 1995). By contrast, Medicare HMO enrollment of non-Medicaid beneficiaries has increased at a much more modest pace. (Note, however, that levels of HMO enrollment in Oregon for the two groups are now comparable.)

While it is clear that Phase II implementation of OHP has resulted in significant new enrollment of dually eligible beneficiaries into Medicare HMOs, it is not clear why beneficiaries have chosen Medicare HMOs over Medicare fee-for-service, nor is it clear that dually eligible beneficiaries understand that they have such a choice. Based on conversations with choice counselors, plans, and State officials, and on beneficiary focus groups, possible explanations include the following.

First, it is probably wrong to assume that deliberate Medicare choices are being made first, triggering a limited set of OHP choices. Choice counselors reported that the first order
### Table 1

**Medicare-Medicaid Combinations for Dually Eligible Beneficiaries**

<table>
<thead>
<tr>
<th>MAJOR COMBINATIONS ALLOWED</th>
<th>Medicare</th>
<th>OHP (Medicaid)</th>
<th>State Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare HMO with OHP contract</td>
<td>Same HMO</td>
<td>Care can be coordinated most effectively if beneficiaries receive both Medicare and Medicaid services through a single HMO.</td>
<td></td>
</tr>
<tr>
<td>Medicare HMO without OHP contract</td>
<td>Fee-for-service (&quot;open card&quot;)</td>
<td>Care can not be coordinated effectively if beneficiaries are in two HMOs. OHP’s PCCM option would not make sense, since beneficiary already has a primary care provider through the Medicare HMO.</td>
<td></td>
</tr>
<tr>
<td>Fee-for-service</td>
<td>Managed care (risk plan or PCCM)</td>
<td>Beneficiary receives benefits of managed care for OHP services. May enjoy spill-over of management into Medicare.</td>
<td></td>
</tr>
<tr>
<td>Medicare premium HMO or other Medicare supplemental coverage</td>
<td>Fee-for-service (&quot;open card&quot;)</td>
<td>OHP capitation would be too high for this group, because the OHP rate does not reflect supplemental Medicare coverage.</td>
<td></td>
</tr>
<tr>
<td>Fee-for-service</td>
<td>Fee-for-service (&quot;open card&quot;)</td>
<td>Fee-for-service may be necessary to preserve continuity of care for people with very complex needs. Determined on a case-by-case basis.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MAJOR COMBINATIONS PROHIBITED</th>
<th>Medicare HMO</th>
<th>Managed care (risk plan or PCCM)</th>
<th>Beneficiary should not have two primary care providers; coordination would be undermined.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare premium HMO or other Medicare supplemental coverage</td>
<td>Risk plan</td>
<td>OHP capitation would be too high for this group, because the OHP rate does not reflect supplemental Medicare coverage.</td>
<td></td>
</tr>
</tbody>
</table>
Table 2

Trends in Medicare HMO Enrollment for Dually Eligible and Non-Medicaid Eligible Medicare Beneficiaries: U.S. vs. Oregon (percent enrolled)

<table>
<thead>
<tr>
<th>Year</th>
<th>U.S.</th>
<th>Oregon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dually Eligible</td>
<td>Non-Medicaid</td>
</tr>
<tr>
<td>1994</td>
<td>3.1%</td>
<td>9.2%</td>
</tr>
<tr>
<td>1995a</td>
<td>4.0</td>
<td>11.2</td>
</tr>
<tr>
<td>1996</td>
<td>4.9</td>
<td>13.9</td>
</tr>
<tr>
<td>1997</td>
<td>5.9</td>
<td>17.0</td>
</tr>
<tr>
<td>1998</td>
<td>6.8</td>
<td>19.4</td>
</tr>
</tbody>
</table>

* Phase II enrollment began in February 1995.


of business in the choice process is identifying the beneficiary's existing providers. Given the broad participation of Oregon providers in managed care generally and the high penetration rate of Medicare HMOs (compared to other parts of the country), chances are good that a beneficiary's existing Medicare provider will be in one or more Medicare HMO networks. Thus, it may often be the case that a beneficiary is offered the option of retaining existing providers while simultaneously enrolling in a coordinated OHP/Medicare HMO product. Finding this attractive (or at least not disagreeable), the option is then accepted without necessarily having full understanding of what other choices may be available.

Second, it is possible that beneficiaries simply do not understand how OHP choices can trigger certain Medicare choices. The complex relationship between OHP and Medicare
has been difficult for State and federal officials, plans, providers, and choice counselors to master; it seems quite unrealistic to believe that beneficiaries have a firm grasp of the intricacies.

Beneficiary focus groups conducted in Portland confirm both of these explanations. Dually eligible beneficiaries expressed difficulty simply understanding the differences between Medicare and Medicaid benefits, and some reported that they did not understand that they had the option of remaining in Medicare fee-for-service when they chose an OHP plan that also offered a Medicare HMO. There was general consensus among all focus group participants, however, that their choice of plan was influenced primarily by access to current providers and convenience of location.

It is worth noting that Medicare HMO enrollment by dually eligible beneficiaries sky-rocketed in 1995 both for Medicare HMOs with OHP contracts and for those not participating in OHP. While the overwhelming majority of dually eligible beneficiaries (about 85%) currently enrolled in Medicare HMOs have selected combination HMOs (those with both Medicare and Medicaid contracts), a similar distribution was observed in 1994 prior to Phase II implementation.

The complexity of enrollment choices for dually eligible beneficiaries is further described in following sections.

**The Enrollment Process for Phase II**

Early in the planning of OHP, Oregon decided that the enrollment process for Phase II needed to be different than for Phase I. Because many more Phase II beneficiaries were known to have complex and chronic care needs, careful consideration was given to finding
approaches that would ensure a smooth enrollment process free of serious care disruptions. Also, because many Phase II beneficiaries were already receiving services from existing aging and disability systems (e.g., long-term care, rehabilitation, mental health, MR/DD services), many additional constituencies had to be acknowledged in order to ensure widespread political support for this phase of implementation. The agencies chosen to conduct enrollment, the forms and processes developed for Phase II enrollment, and the reluctance to assign beneficiaries randomly to plans (i.e., auto enrollment), were all deliberate parts of a strategy to tailor the enrollment process to the special populations included in Phase II. By delaying Phase II for a full year after the initial implementation of OHP, the State also meant to ensure that any "start-up" problems were resolved before attempting to enroll elderly and disabled beneficiaries.

**Who Performs the Enrollment Function?**

Enrollment of the Phase II population is overseen at the State level by the Senior and Disabled Services Division (SDSD), a sister agency to the Office of Medical Assistance Programs (OMAP), administratively located within the same umbrella agency, the Department of Human Resources. SDSD is Oregon's designated State Unit on Aging for purposes of the federal Older Americans Act, and administers Oregon's long term care programs for adults of all ages. SDSD's programs are administered through a mix of local SDSD offices and Area Agencies on Aging that contract with the State to administer Medicaid, food stamps and other programs for elderly people and people with disabilities. Area Agencies on Aging (AAAs) are administered either by single counties or by Councils of Government, which span multiple counties.
Enrollment of Phase II has been incorporated into the day-to-day responsibilities of the local agencies. In general, enrollment of elderly people and people with disabilities falls to the same local agency that is responsible for performing eligibility and case management for long term care services. In some counties, these functions are divided by population group, with AAAs responsible for elderly people and local SDSD offices responsible for adults with disabilities under 65 years of age. In Multnomah County (Portland), the AAA performs the function for both populations.

The State created thirty-seven temporary choice counselor positions to perform initial enrollment for the estimated 63,000 Phase II enrollees. Initial enrollment was conducted relatively quickly with over 42,000 beneficiaries (67%) enrolled in managed care within the first six months. When the temporary positions ended, local agencies absorbed the ongoing enrollment function into their existing operations with no new funds earmarked for the purpose. The State argued successfully that performing enrollment would have "zero impact," since the caseworkers, and other workers who would perform this function were carrying out similar tasks in fee-for-service Medicaid. The State argued that the additional time spent to perform choice counseling would be offset by time saved finding willing providers and addressing the fragmentation of fee-for-service medicine. The local enrollment agencies disagree with this assessment, but they have absorbed the function. This appears to have been possible in Oregon for two main reasons:

First, already being heavily involved with and committed to the Phase II population, the local agencies felt it was in the interest of their clients and their organizations to perform this important function. The alternative of a private third party enrollment broker was very alarming to local agencies, who viewed a broker as one more organization for clients and
case workers to interact with in a system already overwhelming to many. Remuneration notwithstanding, the agencies and their supporters in the Legislature wanted the role.

Second, local agencies are given broad discretion to allocate their State funds. Rather than funding specific positions, for example, the State allocates funds, and the local agencies decide which positions are needed to carry out their various functions most efficiently. In some counties, for example, the roles of intake, enrollment, and case management are integrated, with one person taking the applicant through the entire process. In other counties, intake is a specialized position, separate from case management.

This arrangement does not fall neatly into any of the basic approaches that have emerged in other states. To the extent that the local agencies involved view themselves as third parties independent from OMAP, the system resembles an independent broker model, though the local agencies definitely view themselves as a favorable alternative to a private broker. To the extent that the local agencies carry out certain State functions (e.g., Medicaid eligibility, food stamps and case management), Oregon more closely resembles those states that perform enrollment themselves through state and local government employees, except that in other states, such employees are often limited to the eligibility and intake function, operating separately from whatever organization is performing case management for people with chronic conditions. Other states with a less developed community-based services and case management system may find it difficult or expensive to replicate this approach, which does appear to serve both quality of care and political needs.

---

6 For a description of enrollment of special populations around the country, see Mary S. Kennesen, Medicaid Managed Care Outreach and Enrollment for Special Populations, Princeton: Center for Health Care Strategies, Inc., 1998.
Quality of Care. OHP's approach incorporates the population expertise of SDSD and its local agents into the enrollment process. Case workers double as choice counselors who have experience with the population, understand the ongoing needs of individuals on their case loads and can advocate on their behalf. The use of a private enrollment broker was rejected as too impersonal, removed from the existing service system and adding yet another layer of bureaucracy to the lives of beneficiaries and case workers.

Political Considerations. At the State level, OHP's approach has created a significant role for SDSD, a sister agency to OMAP that has obvious interest in the Phase II population. State officials from OMAP and SDSD agree that this role helped create broad buy-in to OHP at the State level, fostering cooperation rather than resistance. It also gave some level of comfort to advocates, who believed that continuity of care was less likely to be disrupted if enrollment was performed by agencies already familiar with the Phase II population. At the local level, involvement of counties and local SDSD offices was key to securing the support of front line workers in the delivery system. It was also important in securing and maintaining support from the Legislature, where local control is highly valued.

How Does Enrollment Take Place?

For Phase II Generally

All prospective Phase II enrollees are referred, or refer themselves, to the designated local (SDSD or AAA) enrollment agencies. Referrals may come from family members, hospitals, nursing homes, other health care providers, group homes, advocates and others. Applicants may be seeking Medicaid coverage based on SSI eligibility, OHP expansion

7 Unlike many states, Oregon does not automatically enroll SSI recipients into Medicaid.
Currently, several FCHPs have MHO contracts in some of their counties of operation. OHP enrollees in these plans (and who reside in the designated counties) are automatically enrolled in the MHO operated by the FCHP. All other OHP beneficiaries are automatically enrolled in the carve-out MHO. There is one carve-out MHO contractor per county, generally run by the county itself or a consortium of counties.

Applications may be submitted and processed by mail, but in-person application is encouraged and conducted as often as possible. Enrollment workers often conduct choice counseling in a person's home or facility of residence, particularly when a long term care assessment is needed.

The enrollment process includes a series of steps, as follows:

1. **Eligibility.** An application is completed and screened for financial eligibility. If the applicant does not meet financial criteria for OHP services, the process ends at this point;

2. **Functional assessment.** If the applicant is seeking assistance for long term care, a functional assessment is completed. This step is not necessary for those needing only primary and acute care;

3. **Choice counseling.** Once an applicant has been found eligible for OHP services, the applicant is assisted with choosing a health plan and a dental plan. (Under OHP's recently implemented behavioral health component, mental health organizations are specifically tied to FCHPs and do not require an additional choice.8)

**Staffing:** Each local enrollment agency decides how to allocate these steps across staff. As previously discussed, this flexibility appears to have been one key factor that enabled the local agencies to absorb the enrollment function with no new dollars from the State. Some have specific staff dedicated to intake and eligibility, who then pass off applicants to case workers for ongoing management and monitoring. Others have integrated the entire process into the case worker position. In Multnomah County, for example, case workers take turns acting as officer of the day, processing all new applications that day from

---

8 Currently, several FCHPs have MHO contracts in some of their counties of operation. OHP enrollees in these plans (and who reside in the designated counties) are automatically enrolled in the MHO operated by the FCHP. All other OHP beneficiaries are automatically enrolled in the carve-out MHO. There is one carve-out MHO contractor per county, generally run by the county itself or a consortium of counties.
start to finish. When a long-term care assessment is required, the process can take two and a half hours or more, and is often not completed in one session.

**Choice Counseling:** Each enrollment agency has a standard comparison chart for the FCHPs serving the county. (See Appendix A, Oregon Health Plan Comparison Chart, Multnomah County.) For each FCHP, the chart lists participating hospitals and describes pharmacy and mental health arrangements. If plans offer additional benefits, they are also listed on the chart. The additional benefits appear to be targeted largely to mothers and children (e.g.; home visits for pregnancy and newborns, WIC screening, week-end pediatric hours), but some plans list benefits presumably attractive to Phase II enrollees, such as osteopathic manipulation, mail order pharmacy, and Medicare HMO.

The comparison chart is the only standardized tool provided to the local agencies to use with enrollees in the choice process. Designed for all OHP populations (Phase I and II), the chart does not fully address issues of particular importance to elderly and disabled people, such as DME suppliers, specialty care, and home health agencies. Local agencies have either developed their own tools to incorporate these concerns (as in Jackson County) or use forms developed by external organizations, such as a decision worksheet prepared by the Oregon Advocacy Center and used in Multnomah County. Apart from the specific device used, the process was similar in the regions we visited: unless the prospective enrollee enters the process with a clear choice in mind, the choice counselor will gather information about the applicant's existing array of providers and vendors, and use this information to identify the plan or plans that include those providers and vendors.

Choice counselors report that most applicants choose on the basis of primary care provider. Availability of provider lists is inconsistent across counties. Multnomah County
has no provider lists whatsoever, while Jackson County has paper lists, which are difficult to use and frequently out of date. Provider lists are not available electronically anywhere in the State. The lack of adequate lists (or of any lists) adds time and effort to the choice counselor's task. Once an applicant in Multnomah County has stated a preference for a provider, for example, the choice counselor must call the provider's office to determine which plans the provider is in. This narrows the choices for the applicant, who may then choose among the provider's plans based on a secondary consideration, such as home health arrangements or DME supplier.

If the provider does not participate in any plans, or if the applicant has several providers who participate with different plans, the choice counselor may exempt the applicant from FCHPs if the counselor determines that the applicant has special needs that cannot be met by any single plan. In these cases, choice counselors will look next at the possibility of enrolling the applicant in the PCCM program. If the primary care provider is not already participating as a PCCM, the choice counselor will call the provider and try to recruit him/her into the PCCM program. If neither FCHPs nor PCCM are found to meet the needs of an applicant, the choice counselor may exempt the person from managed care altogether.

**Surrogate Decision Makers:** For applicants who need assistance with decision making, OHP has defined (by administrative rule) a priority list of possible representatives. The representative may be, "in the following order of priority, a person who is designated as the Oregon Health Plan client's health care representative, a court-appointed guardian, a spouse, or other family member as designated by the Oregon Health Plan client, the Individual Service Plan Team (for developmentally disabled clients), a DHR case manager..."
or other DHR designee." This process was generally described as effective by both choice counselors and advocates. When a group of people is involved (such as the Individual Service Plan Team), that group meets, fills out the necessary forms, and sends them to the enrollment agency for processing.

While the authority of "representatives" is clearly established and the appropriateness of their role in decision making is undisputed, it is less clear how other individuals who are involved with applicants influence choices. The most commonly cited example in Oregon is the group home staff member, who is not formally a representative but who may assist residents of the home in completing applications. Reportedly, some group home staff encourage all residents to choose the same plan and primary care practitioner. Proponents of this practice argue that staff know best which providers understand the disabilities of the group home residents; detractors assert that staff convenience is the real issue. Whatever the motivation, the choice process is susceptible to such influences, but we found little evidence that it has created significant problems.

**Choice Counselor Influence:** Plan officials and choice counselors disagree about the influence exerted by the choice counselors themselves. Most plan officials interviewed felt that choice counselors had significant influence over the choices made by applicants, but the choice counselors see themselves as facilitators who provide important information and help applicants identify important considerations in decision making, such as location of existing providers and vendors.

The disagreement between plans and choice counselors appears to be largely a philosophical one. Choice counselors acknowledge that they sometimes make

---

9 From definition of “Representative,” OHP Administrative Rules.
recommendations to beneficiaries, based on their assessment of beneficiary needs, as opposed to arbitrary preferences for one plan over another. At least some plans find this advocacy stance incompatible with objective, disinterested choice counseling.

**Quality Control:** Some plans complained of inconsistent quality of choice counseling, particularly with regard to the correct completion of forms (especially for dually eligible beneficiaries). No QA system exists to confirm or disprove these claims, but the degree of discretion given the local enrollment agencies certainly allows for inconsistency across the state, and State SDSD officials have acknowledged and taken steps to address it. For example, SDSD facilitates regional meetings for plans and enrollment agencies, where problem areas can be discussed, new procedures can be developed, and existing policy can be reinforced. SDSD also issues OHP transmittals (i.e., written instructions to the field offices) on selected topics as needed.

Clearly, quality control is challenging for SDSD, given the politics of local control in Oregon. Under its "zero impact" argument, the State is not putting any new dollars into the enrollment function, giving it little financial leverage over the agencies. Furthermore, the agencies, most of which are county based, maintain their own relationships with the State Legislature, and do not necessarily view themselves as part of the SDSD hierarchy. This can be viewed as one disadvantage of Oregon's approach to enrollment as opposed to a private third party broker system, in which contractors can more easily be sanctioned financially or terminated for poor performance.
For Dually Eligible Beneficiaries

Enrollment of dually eligible beneficiaries in OHP is very complex and accounts for the majority of complaints from managed care plans about the enrollment process. The State, plans, and enrollment agencies all agree that the amount of resources needed to address enrollment for this sub-set of the Phase II population was grossly underestimated. The same workers carry out choice counseling for dually eligible beneficiaries as for OHP-only beneficiaries, and the steps are similar. For dually eligible beneficiaries, the choices are more complex, however, and for those who choose a Medicare HMO, the application process is more exacting and prone to errors and delays.

Linked Choices: As outlined in Table 1 above, the interplay of State and federal policy has resulted in a number of linked Medicare-Medicaid pairs, in which the selection of an option for one program affects the options in the other. This complicates a decision making process that may already be daunting for beneficiaries. The choice counselors must not only explain what the array of choices is for OHP benefits, but must be able to explain how each of those choices will change the way the person uses Medicare. Alternatively, if the beneficiary makes a certain Medicare choice, the choice counselor must know how that choice limits the OHP options.

Who’s on First, First?: As noted above, the Medicare HMO data presented on Table 2 show a remarkable increase in enrollment of dually eligible beneficiaries into Medicare HMOs coinciding with Phase II enrollment in 1995. Many focus group participants did not appear to understand the difference between their Medicare and Medicaid benefits, let alone the differences in the various managed care arrangement options. Interviews with choice counselors suggest that the order of decision-making may
be one factor influencing the process. As noted earlier, Medicare choice is not the first explicit order of business in the choice counseling process. Rather, beneficiaries are asked about their current providers. Take, for example, a dually eligible beneficiary who has fee-for-service Medicare and is now enrolling in OHP. The first question is not likely to be, "Do you wish to retain fee-for-service Medicare?", as OMAP’s focus is on Medicaid managed care enrollment. Rather, as with OHP-only applicants, the question is more likely to be, "Who is your current primary care practitioner?" If the beneficiary has a PCP, he or she is likely to be a Medicare provider and, given the generally high penetration of Medicare managed care in Oregon, chances are good that the PCP belongs to one or more Medicare HMO networks. This information is then presented to the beneficiary, who sees that it is possible to retain his or her current PCP while receiving both OHP and Medicare benefits from a single plan, a Medicare HMO.

At least one choice counselor reported that dually eligible beneficiaries are advised to choose a Medicare HMO when one is available, but this more overt influence toward HMOs did not appear widespread. Nothing in the written materials produced by OMAP and SDSD suggests that dually eligible beneficiaries should be encouraged to join Medicare HMOs. However, some focus group participants reported that they did not understand that they could choose an OHP plan and still remain in Medicare fee-for-service.

**Application:** A specialized application form (OHP 7208) is used for dually eligible beneficiaries. (See Appendix B). Designed to double as a Medicare HMO application, it must be completed precisely when the beneficiary selects a Medicare HMO. The original form, signed by the beneficiary, must be forwarded to the Medicare HMO, which in turn reports a new Medicare enrollee to HCFA in a parallel but separate process. This is the
single greatest source of dissatisfaction with the OHP enrollment process among plans. The 7208 is often not submitted to the plans, is submitted late, or is submitted but is incomplete or improperly completed. Plans also sometimes receive 7208 forms for beneficiaries who do not qualify for Medicare HMO enrollment. Each of these problems is described below:

**7208 not received.** Plans report that they often do not receive the 7208. They learn that a dually eligible person has been enrolled because OHP enrollment is transmitted electronically from the field to OMAP and retrieved weekly by the plans. Thus, while the plans know that a person has been enrolled and has Medicare (dual eligibility is indicated on the enrollment file retrieved from OMAP), they do not have the 7208, which is needed to process the Medicare enrollment.

**7208 incomplete or improperly completed.** Sometimes the 7208 is received but has not been fully or correctly completed. For example, if the form is not signed by the beneficiary, or is signed but not dated, it is not valid. Also, copies are not acceptable; the form filed at the plan must be the original. Furthermore, if the form is signed by a representative, or if the beneficiary marks it with an X, it must be accompanied by the 7208A, a form that explains why the beneficiary did not sign, and on what authority the representative signed. Sometimes, the 7208 is properly completed but the 7208A is overlooked. Any of these problems can result in penalties for the plan when HCFA conducts audits of Medicare enrollment.

**7208 received too late.** Because Medicare HMO enrollment is voluntary with a month-to-month lock-in, signatures must be no more than 30 days old in order to be valid. Sometimes, when the 7208 does finally arrive at the plan, the signature is more than 30 days old, rendering the application invalid.
**Applicant not qualified.** Under Medicare HMO law, beneficiaries with End Stage Renal Disease or (until January 1999) who were receiving Medicare hospice services do not qualify for Medicare HMOs. Applications are sometimes received for such individuals and must be rejected.

SDSD has spent considerable time on this problem, and will continue to do so. Dual eligibility issues are a common topic at regional meetings, and two OHP transmittals were issued to the field on this topic in 1997. The OHP coordinator at SDSD also helps resolve individual application problems when requested by plans to do so. SDSD can continue to work with local agencies toward more consistent completion of the 7208, but certain aspects of this problem will always be cumbersome because of the challenges of lining up two administratively separate systems.

**Lining up Enrollment Dates:** When a dually eligible person selects a Medicare HMO, OHP enrollment becomes effective very quickly. OHP enrollment information is transmitted electronically from the local agencies to the State, where it is retrieved on a weekly basis by the plans. Even if everything goes very smoothly on the Medicare side, Medicare enrollment still takes at least a month, and more typically takes two to three months to become effective. (The 7208 is sent by mail to the plan, which in turn reports a new Medicare enrollee to HCFA. Enrollment takes effect on the first day of the month following the plan's notification to HCFA.) During the transition, Medicare continues to pay on a fee-for-service basis, which creates considerable confusion and unhappiness among the plans and their providers. Although the parties agree that unified enrollment dates are desirable, the State and plans favor different solutions. The State would like HCFA to recognize retroactive accretion, as it does for employer groups. The plans argue that
retroactive accretion would require an adjustment process in their payments to providers, which may be just as cumbersome as temporary fee-for-service reimbursement. They argue instead that the State should delay OHP enrollment, making it effective on the same day that Medicare enrollment occurs. However, the State then would be accepting potentially significant OHP fee-for-service exposure, which would add to its overall program costs.

**Part B Only Beneficiaries:** Like other states with relatively large numbers of immigrants, Oregon's dually eligible population includes a disproportionate number of elderly (about 8.5%) who are enrolled in Medicare Part B, but not Medicare Part A. These Part B only enrollees are given the same managed care choices as all other dually eligible beneficiaries in OHP. The Medicare Choices provisions of the Balanced Budget Act, however, prohibit the enrollment of Part B only individuals into Medicare HMOs. While those currently enrolled will be allowed to remain, new OHP beneficiaries who are enrolled only in Part B will not be permitted to join a Medicare HMO even when they choose its counterpart OHP plan for their Medicaid benefits. This will greatly restrict the plan's ability to coordinate care for this group of beneficiaries, and will expose OHP to greater fee-for-service liability. Because they do not have Part A, this group receives more Medicaid services than do those with both Part A and Part B.

**Enrollment Protections**

Prior to the implementation of OHP Phase II, many advocacy and consumer groups expressed concern about the possible care disruptions that might result when clients were enrolled in managed care plans. In response to these concerns, OMAP modified some
safeguards that already existed for the Phase I population, and introduced some new ones, specifically for elderly and disabled beneficiaries:

- **Exceptional Needs Care Coordinators (ENCCs)**, one or more staff positions at each managed care plan created expressly to help Phase II clients gain access to needed services; and
- **Continuity of Care Referral forms**, to help ease the transition from fee-for-service to managed care;
- **An exemptions process**, allowing clients to remain in fee-for-service on a case by case basis;
- **Liberal disenrollment provisions**, making it easier for beneficiaries to switch plans.

We discuss each of these in turn.

**Exceptional Needs Care Coordinators (ENCCs)**

OHP originated the concept of ENCCs for their Phase II population, recognizing that this more vulnerable beneficiary group might "fall through the cracks" as they were moved from fee-for-service into managed care. All OHP managed care plans are required to have ENCCs on staff to facilitate the transition for new enrollees and then to coordinate service delivery within the plan. In order to fund these staff positions, the State makes per member per month payments to all participating managed care plans. Since payments are tied to enrollments, plans with relatively more Phase II enrollees are able to hire more ENCCs.

While the State provided guidelines for ENCC implementation, plans were permitted and encouraged to develop the ENCC role independently. This allowed managed care plans to adapt the ENCC role to their individual organizational structures and to the specific needs of their Phase II enrollees. At the same time, it may have produced considerable variation in the effectiveness of ENCCs across plans. Nevertheless, many observers have credited the
use of ENCCs for OHP's apparently smooth implementation of managed care for the elderly and disabled. Because the ENCC concept was unique to Oregon and is being considered by other states, ENCCs are discussed in much greater depth in a separate report.

Continuity of Care Referral Forms

The Continuity of Care Referral (CCR) form was designed to ensure communication of special health care needs to the managed care plan at the time of enrollment. Of particular concern were disabilities requiring assistive devices (such as TTY phones) and the provision of critical ancillary services, such as home oxygen. The CCR form collected information on any impairments, use of DME or other supplies, special treatment procedures, medications, etc. Most of the information was collected in a check-box format, with a small amount of space provided to indicate name of provider, type of disability, etc. A copy of the form can be found in Appendix C.

The CCR forms are completed by the choice counselors (and later the caseworkers) at the time of enrollment and then forwarded to the ENCC at the managed care plan. In some instances, forms may be filled out by clinicians or group home managers. ENCCs report that they received a heavy volume of forms when Phase II was first implemented, but receive far fewer now. There are probably several reasons for the reduced volume of CCR forms. First, there were simply far more beneficiaries involved at the beginning of Phase II, as all OHP eligibles were transitioned into managed care. Current choice counseling is limited to those newly eligible for OHP and those beneficiaries switching plans. Second, caseworkers report that, based on their experiences to date, they are simply less worried about potential disruptions of care. Third, as relationships have developed between caseworkers and ENCCs
over time, caseworkers may telephone the ENCC regarding the needs of a new member rather than using the CCR form. This is reported to be more common in counties outside the Portland metropolitan area.

In some instances, however, local caseworkers apparently are refusing to complete the forms, citing client confidentiality (particularly with regard to people with mental illness). In other instances, heavy caseloads may discourage caseworkers from filling out the forms. Nevertheless, ENCCs report that they would like to receive CCR forms for more beneficiaries. The forms not only provide useful medical information, but vital information on living arrangements, e.g., whether the client resides in a nursing home, a foster home, etc., and whether there is a caregiver or guardian.

OMAP and SDSD have recently revised the CCR forms to make them more useful to plans. A series of regional meetings were held in order to obtain input from the local case workers and ENCCs who actually fill out and use the forms. The new version limits the multiple check-boxes to the eight most common supplies and services that plans need to be aware of during the transition. In addition, the new version includes a series of boxes that can be checked to indicate to the ENCC any special areas of concern, e.g., language or cultural issues that could create a barrier to care, behavioral health conditions that could place the beneficiary at risk, etc. A copy of the revised version can also be found in Appendix C.

While the CCR form is intended to convey clinical information, some observers assert that its most important function has been political in nature. The use of the form helped to allay fears among caseworkers and advocates that managed care transition might have serious, if not fatal, consequences for some frail elderly and disabled beneficiaries.
Exemptions Process

OHP has a process of exempting individuals from managed care enrollment on a case-by-case basis, a process that is managed locally by the enrollment agencies. Reasons for exemption include: continuity of care (i.e., a critical patient-provider relationship would be disrupted), availability of a third-party resource (i.e., other health insurance), American Indian heritage, etc. Surprisingly few Phase II beneficiaries are exempted from managed care because of continuity of care or similar reasons (approximately 1%). In part, this may reflect the extensive provider networks developed by many of OHP's managed care plans, and the large number of plans offered in urban areas, with many Phase II beneficiaries able to find a plan in which their PCPs participate.

As seen in Table 3, however, a relatively large number of Phase II beneficiaries are exempt from managed care, because of a third-party resource (TPR): 21.5 percent of dually eligible beneficiaries and 7 percent of OHP-only beneficiaries in 1997. These individuals have private supplemental policies that cover some medical care expenses. In the case of dually eligible beneficiaries, these typically are Medi-Gap policies that cover Medicare deductibles and copays and that are provided as part of employers' retirement packages. OHP exempts these individuals from enrollment in an FCHP, in order to avoid over-paying for their care. (The services covered by the supplemental policies would otherwise be paid by Medicaid, and are built into OHP's capitation rates.) When possible, however, individuals with TPR and who do not belong to a Medicare HMO will be enrolled with a PCCM. About one-half of all Phase II PCCM enrollees are exempt from a fully capitated plan because of TPR.
Table 3

Trends in OHP Managed Care Enrollment:
Dually Eligible vs. OHP-Only Beneficiaries\(^a\)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dually Eligible Beneficiaries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully Capitated Health Plan(^b)</td>
<td>66.6%</td>
<td>69.4%</td>
<td>70.5%</td>
<td>65.1%</td>
</tr>
<tr>
<td>PCCM</td>
<td>10.1</td>
<td>9.8</td>
<td>7.9</td>
<td>8.1</td>
</tr>
<tr>
<td>Fee-for-Service, exempt for TPR/other reasons</td>
<td>23.3</td>
<td>20.8</td>
<td>21.5</td>
<td>26.8</td>
</tr>
<tr>
<td>Fee-for-Service, not exempt(^c)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>OHP-Only Beneficiaries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully Capitated Health Plan(^b)</td>
<td>72.0%</td>
<td>80.4%</td>
<td>82.1%</td>
<td>77.5%</td>
</tr>
<tr>
<td>PCCM</td>
<td>4.0</td>
<td>3.5</td>
<td>3.1</td>
<td>3.9</td>
</tr>
<tr>
<td>Fee-for-Service, exempt for TPR/other reasons</td>
<td>8.9</td>
<td>7.2</td>
<td>7.0</td>
<td>7.3</td>
</tr>
<tr>
<td>Fee-for-Service, not exempt</td>
<td>15.2</td>
<td>8.9</td>
<td>7.7</td>
<td>11.5</td>
</tr>
</tbody>
</table>

\(^a\) Percentages sum to 100 by year.
\(^b\) The 1995 numbers include a small number of eligibles enrolled in partially capitated plans, known as Physician Care Organizations (PCOs).
\(^c\) All dually eligible beneficiaries by definition are coded as exempt for TPR.

Disenrollment Provisions

All OHP enrollees are "locked in" to their managed care plan for a six-month period. Disenrollment before the six months are up is permitted for "cause". Such requests from Phase I beneficiaries are reviewed centrally at OMAP, and rarely granted. In the case of the Phase II population, however, determinations for cause are made by local caseworkers who interpret cause liberally. The most typical reason for disenrollment is that the beneficiary's PCP or key specialist has switched managed care plans. In some instances, caseworkers report that the request is made explicitly to avoid certain managed care procedures (e.g., a formulary that prevents beneficiaries from obtaining the brand-name drugs they want). In other cases, beneficiaries may want to change plans in order to take advantage of a special benefit offered by another plan (e.g., an adjustable pressure bed in the beneficiary's home, an item not covered by Medicare or traditional Medicaid except in a nursing home).

Managed care plans (and some providers) complain that there has been an excessive amount of plan-switching in the Phase II population, resulting in an increased administrative burden as well as some disruption in continuity of care. State officials believe that this was largely a start-up problem and that switching is now far less common. In fact, our analysis of OHP eligibility and enrollment files found that plan-switching has been relatively infrequent. Voluntary plan-switching among the Phase II population has averaged about 2.5 percent per month in 1995 and had declined to 1.7 percent by 1997.\textsuperscript{10} We found no differences in the rate of plan-switching by age, reason for disability, or dual eligibility status.

\textsuperscript{10} Involuntary plan-switching (resulting from plan withdrawals from a county) probably causes far more disruption to continuity of care. In late 1998, plan-switching increased to 8.2 percent, when HMO Oregon (the single largest FCHP under OHP) withdrew from a large number of counties. An additional 4.4 percent of Phase II beneficiaries reverted to fee-for-service.
OHP Success in Managed Care Enrollment

Progress to Date

In its first year, OHP succeeded in moving the majority of its Phase II population into managed care (Table 3). By the end of 1997, 71 percent of dually eligible beneficiaries and 82 percent of all other elderly and disabled beneficiaries had been enrolled in FCHPs. A relatively small number of beneficiaries were in the PCCM program, about 8 percent of dually eligible beneficiaries and only 3 percent of OHP-only clients. Most of those with PCCMs have private supplemental insurance which makes them ineligible for FCHP enrollment.

One-fifth of dually eligible beneficiaries remained in fee-for-service as of 1997, some of whom were enrolled in a non-OHP participating Medicare HMO which they do not wish to give up. Others may have had employer-sponsored supplemental insurance which would make them ineligible for Medicaid managed care. About 15 percent of OHP-only clients remain in fee-for-service. One-half of these are exempted from managed care because of TPR or some other reason (e.g., continuity of care). The remaining half (7.7%) do not have an exemption and are potentially "enrollable" into a FCHP.

As seen in Table 3, however, there was a marked reduction in the number of Phase II beneficiaries enrolled in FCHPs and a corresponding increase in those in fee-for-service. This resulted from the withdrawal of OHP’s largest FCHP (Regence HMO Oregon) from eight counties in October 1998. Some of these beneficiaries will likely switch to another OHP plan. However, Regence HMO Oregon was the only participating FCHP in three of these counties, and it is unlikely that another plan will enter these very rural areas.
Phase II beneficiaries in managed care were enrolled in 15 different FCHPs as of 1998. (Table 4). About one-half of these are enrolled in just three plans, all large commercial HMOs: Good Health Plan, ODS Health Plan, and Regence HMO-Oregon. There is little difference in the distribution of dually eligible vs. OHP-only beneficiaries across the 15 plans. A relatively greater number of OHP-only clients were enrolled in CareOregon (11.3% vs. 6.7% for dually eligible beneficiaries), however. The CareOregon plan was developed explicitly for OHP, and its provider network includes many of the traditional safety-net providers in the State: the Oregon Health Sciences University, county public health departments, and Federally Qualified Health Centers. OMAP states that the wide array of specialists available at the medical school is undoubtedly one reason that a disproportionate number of disabled beneficiaries have enrolled in CareOregon.

For dually eligible beneficiaries, their combined choice of Medicare and Medicaid arrangements are of greater interest to policymakers than their OHP enrollment alone. Over one-third (34.6%) are enrolled in Medicare HMOs with an OHP contract (Table 5). This is the ideal arrangement from OMAP’s perspective, as they believe it maximizes the plan’s ability to manage all of the beneficiary’s care. A relatively small percent (5.2%) are enrolled in Medicare HMOs that do not participate in OHP, and hence receive their Medicaid services on a fee-for-service basis.

The majority of dually eligible beneficiaries (about 60%) are Medicare fee-for-service. Of these, about one-half (or 30.5% of all dually eligible beneficiaries) are enrolled in an FCHP for their Medicaid services. The remaining beneficiaries receive both their
Table 4

Distribution of Dually Eligible and OHP-Only Beneficiaries Across Managed Care Plans, 1998

<table>
<thead>
<tr>
<th></th>
<th>Dually Eligible</th>
<th>OHP-Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>CareOregon</td>
<td>6.7%</td>
<td>11.3%</td>
</tr>
<tr>
<td>Cascade Comprehensive Care</td>
<td>1.5</td>
<td>2.0</td>
</tr>
<tr>
<td>Central Oregon Independent Health Services</td>
<td>6.0</td>
<td>5.5</td>
</tr>
<tr>
<td>Evergreen Medical Systems</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td>FamilyCare</td>
<td>1.4</td>
<td>2.2</td>
</tr>
<tr>
<td>Good Health Plan</td>
<td>12.1</td>
<td>9.3</td>
</tr>
<tr>
<td>InterCommunity Health Network</td>
<td>4.4</td>
<td>4.3</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>3.0</td>
<td>5.3</td>
</tr>
<tr>
<td>Mid-Rogue IPA</td>
<td>2.0</td>
<td>1.8</td>
</tr>
<tr>
<td>ODS Health Plan</td>
<td>18.3</td>
<td>16.1</td>
</tr>
<tr>
<td>Oregon Health Management Services</td>
<td>2.4</td>
<td>2.7</td>
</tr>
<tr>
<td>Regence HMO Oregon</td>
<td>32.3</td>
<td>29.4</td>
</tr>
<tr>
<td>SelectCare</td>
<td>3.6</td>
<td>4.3</td>
</tr>
<tr>
<td>SureCare</td>
<td>5.4</td>
<td>5.2</td>
</tr>
<tr>
<td>Tuality Healthcare</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>ALL PLANS</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

**SOURCE:** OHP enrollment files, March 1998.

Medicare and Medicaid services on a fee-for-service basis, although a small number receive some primary care case management (PCCM) for Medicaid.
Table 5

Distribution of Dually Eligible Beneficiaries by Type of Managed Care Arrangement

<table>
<thead>
<tr>
<th>Medicare Type</th>
<th>OHP Type</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO</td>
<td>HMO</td>
<td>34.6%</td>
</tr>
<tr>
<td>HMO</td>
<td>Fee-for-service</td>
<td>5.2</td>
</tr>
<tr>
<td>Fee-for-service</td>
<td>HMO</td>
<td>30.5</td>
</tr>
<tr>
<td>Fee-for-service</td>
<td>PCCM</td>
<td>8.1</td>
</tr>
<tr>
<td>Fee-for-service</td>
<td>Fee-for-service</td>
<td>21.6</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

**SOURCE:** Medicare Enrollment Data Base, 1998; OHP eligibility and enrollment files, December 1998.

Implications for Other States

Oregon has been relatively successful in enrolling the majority of its elderly and disabled beneficiaries into managed care, and has managed to accomplish this within a fairly short period of time. Based upon interviews with a wide range of stakeholders (including State and local agency staff, plans, providers, and advocacy groups), this process appears to have gone quite smoothly and without the serious disruptions in continuity of care that had been feared by some providers and consumers. Nevertheless, considerable uncertainty exists about how consumers’ choices are made. It would appear that selection is made based on location of primary care physician, rather than a choice of Plan A versus Plan B. Nevertheless, beneficiary focus groups suggest that dually eligible beneficiaries do not fully
understand the difference between their Medicare and Medicaid benefits, let alone their full range of enrollment options.

There are a number of lessons that other States might learn from Oregon's experience, particularly with regard to: planning for managed care enrollment, involvement of other state agencies, consumer protections, decentralization and local control, and the special challenge of enrolling dually eligible beneficiaries. These lessons are described below.

Planning for Enrollment

- Special time and attention should be given to the enrollment of elderly and disabled beneficiaries. In Oregon, State officials did not enroll this population until a full year after enrolling TANF and expansion beneficiaries into managed care. This gave the State additional time to resolve any “start-up” problems before attempting to enroll the more vulnerable Phase II beneficiaries.

- When planning a managed care program for elderly and disabled beneficiaries, significant time should be allowed to develop consensus among key constituents. The State worked with advocacy groups to develop special enrollment procedures and consumer protections prior to implementation. While planning and consensus building may not appear innovative, other states attempting similar programs failed to do so (and encountered difficulties, e.g., Tennessee).

Involvement of Other Public Agencies

- Gaining the cooperation of sister agencies at both the state and local levels was key to the successful enrollment of elderly and disabled beneficiaries in Oregon. OMAP worked closely with the agencies with traditional responsibility for these populations in the State: SDSD. Because they felt part of the process, SDSD staff cooperated with, rather than resisted, the implementation of managed care for their populations.

- Giving its sister agency a role in the enrollment of elderly and disabled beneficiaries into managed care plans was key to gaining their political support. Because this agency was widely perceived as an advocate for
the elderly and disabled, advocates were reassured that continuity of care was less likely to be disrupted.

Consumer Protections

- Consumer advocacy and enrollment responsibility need not be inconsistent. By delegating the enrollment function to local SDSD or AAA offices (rather than to an independent broker), the State helped ensure that choice counseling was performed by the workers most knowledgeable about their clients. Local case workers were best suited to help ensure continuity of care, and were given the authority to exempt individuals from managed care on a case-by-case basis.

- The transition of elderly and disabled beneficiaries to managed care can be eased by the introduction of special protections. In Oregon, these included the use of Continuity of Care Referral Forms (written communications from enrollment workers to managed care plans) and Exceptional Needs Care Coordinators (ENCCs), a staff position created within plans specifically to address the needs of the Phase II population.

Decentralization and Local Control

- In states with strong county or other local governments involved in service delivery for elderly and disabled beneficiaries, it is possible to decentralize the enrollment function and still implement a state-wide managed care program. Because decentralization may introduce some inconsistencies in enrollment practices across areas, states will need to provide ongoing training and other supports to the local entities.

- Local control of the enrollment and disenrollment functions proved critical to the “buy-in” by advocates and others of managed care for elderly and disabled beneficiaries. Dissatisfied beneficiaries are able to change plans simply by contacting their local workers.

- If local offices currently carrying out eligibility and case management functions have sufficient flexibility to allocate their state funds, they may also be able to perform the enrollment function without significant new resources (at least once the initial wave of enrollment is completed).

The Special Challenge of Dually Eligible Beneficiaries

- Enrollment of dually eligible beneficiaries is extremely complex and time-consuming. Despite the considerable amount of time Oregon devoted to this task, the State, the plans, and local enrollment offices all agreed that the challenge had been grossly underestimated.
• States must recognize that enrollment of dually eligible beneficiaries into Medicare HMOs for their Medicare benefits (where appropriate) is a parallel, but separate, process from Medicaid managed care enrollment. Coordination of these two procedures remains the greatest source of frustration among OHP plans.

• States need to spend more time explaining the Medicare benefit to consumers, as well as the implications of their Medicare choices.

Choice of Plans

• Many factors may influence plan choices among elderly and disabled beneficiaries. The principal deciding factor appears to where the beneficiary’s primary care provider participates. However, the recommendation of residential staff (at group homes, for example), family members, surrogates, and enrollment workers also can influence choices.

• Over one-third of dually eligible beneficiaries are enrolled in OHP plans with a complementary Medicare HMO. The percent of dually eligible beneficiaries enrolled in Medicare HMOs skyrocketed from 10 percent in 1994 to 32 percent one year later (when Phase II was implemented). However, it is not clear how well dually eligible beneficiaries in Oregon understand their Medicare choices.
Appendix A

Oregon Health Plan Comparison Chart
How to Choose a Managed Care Plan

- Every family member must be in the same Managed Care Plan. However, each family member can have a different Primary Care Provider (PCP).
- Do you have a PCP? Is your PCP in a Managed Care Plan? Call and ask which Managed Care Plan your PCP belongs to.
- Do your children have a PCP? Which Managed Care Plan does the PCP belong to?
- Is the dental or medical office near your home or a bus line? Can you get to your appointments easily?
- Are the PCP’s office hours what you need?
- Where will you go for medicine? Are the pharmacies near your home?
- What hospital does the Managed Care Plan want you to use? Is it near your home?
- Does your family need other additional benefits offered by the Managed Care Plan? Look under “Additional Benefits and Features” on this comparison chart.

Covered Services

**Medical Care**
- An exam or test to find out what is wrong
- Treatment for most major diseases
- Hospital stays, x-ray, and lab services
- Prescriptions (medicines)
- Preventive services (check-ups, well-child exams)
- Vision care and glasses
- Hearing services and hearing aids
- Hospice and home health care
- Some transplants
- Outpatient alcohol and drug treatments
- Family planning
- 24 hour emergency coverage
- Specialist care and referrals

**Dental Care**
- Preventive services (cleanings, fluoride treatments, sealants for children)
- Routine services (fillings, x-rays, dentures, extractions)
- 24 hour emergency coverage
- Specialist care and referrals

**Mental Health Care**
- Evaluation
- Therapy
- Consultation
- Case management
- Medication management
- Hospitalization
- Emergency services
- Programs to help with daily and community living

See your Managed Health Care Handbook for more information
<table>
<thead>
<tr>
<th>Hospitals (Upon Plan Referral)</th>
<th>CareOregon</th>
<th>Evergreen Medical Systems</th>
<th>FamilyCare</th>
<th>Kaiser Permanente</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Arrangements</td>
<td>You must choose a DCO listed. See other side.</td>
<td>You must choose a DCO listed. See other side.</td>
<td>You must choose a DCO listed. See other side.</td>
<td>You must choose a DCO listed. See other side.</td>
</tr>
<tr>
<td>Mental Health Arrangements</td>
<td>Served by Multnomah CAPCare. Call 503-365-6087 or 1-800-716-5786, TTY 503-306-5665.</td>
<td>Call the community mental health program.</td>
<td>Call the community mental health program.</td>
<td>Served by Multnomah CAPCare. Call 1-800-286-3587 or 1-800-716-5786, TTY 503-306-5665.</td>
</tr>
<tr>
<td>Additional Benefits</td>
<td>- Home visit for pregnancy and newborn care - Same-day referral for WIC program - 24 hour phone advice nurse - Members' advisory board</td>
<td>- Osteopathic manipulative therapy - Some evening and weekend hours - Female providers - Maternity case management</td>
<td>- Osteopathic manipulative therapy - Some evening and weekend hours - Female providers - Maternity case management</td>
<td>- 24 hour phone advice nurse - After hours urgent care access - Passover service by phone and in each medical office - Lab X-ray, pharmacy &amp; optical at each facility - Accredited by NCQA (quality assurance) - Medicare Plus and Medicare Plus HMO - Mail order pharmacy</td>
</tr>
<tr>
<td>For More Information</td>
<td>(503) 365-5665 or 1-800-286-3587, TTY 503-366-5759</td>
<td>(503) 292-5865, TTY 503-222-1319</td>
<td>(503) 222-2880 or 1-800-458-9518, TTY (503) 222-1319</td>
<td>(503) 813-2000 or 1-800-813-2000, TTY 470-344-4454, 800-882-7557</td>
</tr>
<tr>
<td>Hospitals (Upon Plan Referral)</td>
<td>ODS Health Plan</td>
<td>Providence Good Health Plan</td>
<td>Regence HMO Oregon</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------</td>
<td>---------------------------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OHSU, All Sisters of Providence hospitals, Woodland Park, Eastmoreland, Portland; Willamette Falls, Oregon City; Tuality, Hillsboro/Forest Grove</td>
<td>Providence Med Ctr, St Vincent Med Ctr, Portland; Providence, Milwaukee; Providence, Newberg; Willamette Falls, Oregon City; Tuality, Hillsboro/Forest Grove</td>
<td>Emanuel, Meridian Park, Good Samaritan, Portland Adventist, Portland; Mt Hood, Gresham; Willamette Falls, Oregon City; Tuality, Hillsboro/Forest Grove</td>
<td></td>
</tr>
<tr>
<td>Dental Arrangements</td>
<td>You must choose a DCO listed. See other side.</td>
<td>You must choose a DCO listed. See other side.</td>
<td>You must choose a DCO listed. See other side.</td>
<td></td>
</tr>
<tr>
<td>Mental Health Arrangements</td>
<td>Served by Multnomah CAAPCare. Call (503) 306-5887 or 1-800-716-9769, TTY (503) 306-5866</td>
<td>Served by Multnomah CAAPCare. Call (503) 306-5887 or 1-800-716-9769, TTY (503) 306-5866</td>
<td>Call the community mental health program.</td>
<td></td>
</tr>
</tbody>
</table>
| Additional Benefits           | • 24 hour phone-in advice nurse  
• Maternity Case Management  
• Home visits for pregnancy/newborn care  
• Health and fitness discounts  
• Community resource phone line  
• Medicare Option (Risk)—Medicare HMO | • Prenatal, well-child and immunization incentive programs  
• First Choice Sixty-Five (Risk)—Medicare HMO | |
| For More Information          | (503) 243-2987 or 1-800-342-0526, TTY: (503) 243-3958 or 1-800-433-6313 | (503) 574-8200 or 1-800-899-8174, TTY: (503) 574-8702 | 1-800-541-8981, TTY: 1-800-582-1003. |
Your Dental Plans (DCOs) for Multnomah County. See your Managed Health Care Handbook for covered dental services.

<table>
<thead>
<tr>
<th>Additional Benefits</th>
<th>Capitol Dental Care</th>
<th>Managed Dental Care of Oregon</th>
<th>Multicare Dental</th>
<th>Northwest Dental Services</th>
<th>ODS Dental Plan</th>
<th>Willamette Dental Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanings every 6 months for children &amp; adults.</td>
<td>• Member of Exceptional Needs Dental Services (ENDS), for persons with disabilities.</td>
<td>• Evening and Saturday hours</td>
<td>• Evening and Saturday hours</td>
<td>• Evening and Saturday hours</td>
<td>• Evening and Saturday hours</td>
<td>• Evening and Saturday hours</td>
</tr>
<tr>
<td>Member of Exceptional Needs Dental Services (ENDS), for persons with disabilities.</td>
<td>Dental cleanings every 6 months for adults &amp; children.</td>
<td>Member of Exceptional Needs Dental Services (ENDS), for persons with disabilities.</td>
<td>Member of Exceptional Needs Dental Services (ENDS), for persons with disabilities.</td>
<td>Member of Exceptional Needs Dental Services (ENDS), for persons with disabilities.</td>
<td>Member of Exceptional Needs Dental Services (ENDS), for persons with disabilities.</td>
<td></td>
</tr>
<tr>
<td>Denture relines once a year.</td>
<td>Special children's sedation program to age 21.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For More Information</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(503) 585-5205 or 1-800-525-6800</td>
<td>(503) 538-9604 or 1-800-538-9604</td>
<td>(503) 248-3711</td>
<td>(541) 957-8651 or 1-800-655-8751</td>
<td>(503) 243-2987 or 1-800-942-0526, TTY: (503) 243-3958 or 1-800-433-6313,</td>
<td>Appointments: 644-3200 (24 hours) or Customer Service: 644-6444 (Business hours), TTY: 1-800-735-1232 (Oregon Relay Service)</td>
<td></td>
</tr>
<tr>
<td>TTY: 1-800-735-1232 (Oregon Relay Service) or 1-800-855-1156 (AT&amp;T Operator Service)</td>
<td>TTY: 1-800-669-4041</td>
<td></td>
<td>TTY: (541) 440-6304 or 1-888-587-8304</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

See other side for medical plan information.
Appendix B

Forms 7208 and 7208A
(in effect as of 1998)
Note: If you have End Stage Kidney Disease requiring dialysis or you are a Medicare beneficiary receiving Hospice benefits, you cannot enroll in a health plan. Call your worker to select a Primary Care Case Manager.

OHP Health Plan Enrollment

Complete this part

1. Last Name          First Name          Middle Initial

2. Social Security #  Date of Birth       Phone #

3. Address           City/Zip            County

4. Do you currently reside in a nursing facility, foster care home or residential care facility?  Yes  No  Name of facility ____________________

5. Do you have health insurance besides Medicaid or Medicare?  Yes  No  Name of health insurance/HMO: ____________________ Date insurance ends: ____________________

6. Medicaid Health plan selected: ____________________

7. Primary Care Practitioner (PCP) requested: ____________________  Are you currently a patient of this PCP?  Yes  No

8. Dental plan selected: ____________________

9. Do you have Medicare?  Yes  No  Claim number as shown on Medicare card: ____________________

   Part A (Hospital) Effective Date: ____________________

   Part B (Medical) Effective Date: ____________________

B Complete below only if you are choosing to receive your Medicare services from the same plan selected above.

10. Medicare Plan Selection: Check and enter in the appropriate box the name of the health plan you selected.

☐ Medicare Cost Plan  Name: ____________________

Under this cost plan, I understand:

• If I get any routine medical care through providers NOT under this health plan, my health plan will NOT pay for it. I will be responsible for all charges not paid for by Medicare.

• Except as noted above, I agree I must have my health plan or PCP arrange all medical care. This does not apply to emergencies, or to urgent care out of the plan's service area.

• I understand by enrolling in one of these health plans I will be removed from any other Medicare Managed Care Plan.

☐ Medicare Risk Plan  Name: ____________________

Under this risk plan, I understand:

• If I get any routine medical care outside my health plan, neither Medicare nor my health plan will pay for it, except for emergencies or out-of-area urgent care. I will be responsible for all out-of-plan charges for routine care.

11. Signature ____________________ Date ____________________

(If signer is not the client or client signs with a mark, complete the OHP 7208A.)

C Agency must complete this section before forwarding to plan

<table>
<thead>
<tr>
<th>Plan #</th>
<th>Branch #</th>
<th>Worker #</th>
<th>Worker Phone #</th>
<th>Plan #</th>
<th>Claim #</th>
<th>Referral #</th>
<th>Clin Only</th>
</tr>
</thead>
</table>
Health Plan Enrollment Guidelines

A. Enrollment in Medicaid Managed Care Only

Use this form to indicate the client's choice of a Primary Care Practitioner (PCP). Write in the client's first choice of PCP in space #7. Cross out Section B.

B. Enrollment in Medicaid/Medicare Managed Care

Use this form to enroll clients who choose to receive their Medicare benefits from the Medicaid Health Plans that they have selected. The form must be completely filled out, including Medicare numbers and dates in space #9. Check the appropriate box in space #10 to indicate whether the plan is Medicare Cost or Medicare Risk (See Comparison Chart for this information).

The form must be signed by the client or, if the client is unable to sign, by a state recognized representative.

If the form is signed by anyone other than the client, or if the client signs with a mark, an Addendum to OHP Health Plan Enrollment, OHP-7208A, must be completed, signed, and attached to this form. Attach power of attorney or guardianship papers if available.

Authorization for Release of Information:

The health plan selected, Medicare (HCFA), and the State of Oregon, will need to share information about the client. By signing, the client agrees to the following:

- HCFA may give the health plan any information about the clients' rights to Medicare benefits.
- The health plan or its providers may give HCFA any information it needs about the client's Medicare benefits.

Client: Attach a copy of your Medicare card, if available. Your OMAP Medical Care ID will show when you are a member of the plan.

Agency Worker: Be sure to verify the name on the Medicare account, the Medicare claim number, and effective dates. Mail the original enrollment form to the health plan with a copy of client's Medicare card, if available.
Addendum to OHP Health Plan Enrollment/Disenrollment
For State-Approved Signatures or Signature by Mark
When Enrolling or Disenrolling in a Medicare HMO

A state recognized representative must complete this form when anyone other than the client signs the OHP Health Plan Enrollment form (OHP 7208) or the Request to Terminate Insurance form (OHP 7209) or if the client signs with a mark.

State-Approved Signatures
Reason the client did not sign this form (check box that applies):

☐ Client has the following physical limitations: ________________________________

☐ Client is unable to give informed consent because: __________________________

The signer is (check box that applies):

☐ Person designated in a written advance directive or power of attorney for health care (Attach copy of document, if available)

☐ Court appointed guardian with authority to make health care decisions
  (Attach copy of document, if available)

☐ Other individual recognized by state law (spouse, parent, other family member, agency worker) Relationship: ________________________________

State-approved signature: ____________________________ Date: ________________

Address: ____________________________________________ Day Phone: __________

Signature By Mark
If the client signs with a mark or uses a stamp, signatures of two witnesses are required:

_________________________________  _______________________
Witness  Date

_________________________________  _______________________
Witness  Date
Addendum to OHP Health Plan Enrollment/Disenrollment
For State-Approved Signatures or Signature by Mark
When Enrolling or Disenrolling in a Medicare HMO

A state recognized representative must complete this form when anyone other than the client signs the OHP Health Plan Enrollment form (OHP 7208) or the Request to Terminate Insurance form (OHP 7209) or if the client signs with a mark.

State-Approved Signatures
Reason the client did not sign this form (check box that applies):

☐ Client has the following physical limitations: __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

☐ Client is unable to give informed consent because: ______________________________________
   __________________________________________
   __________________________________________
   __________________________________________

The signer is (check box that applies):

☐ Person designated in a written advance directive or power of attorney for health care (Attach copy of document, if available)

☐ Court appointed guardian with authority to make health care decisions (Attach copy of document, if available)

☐ Other individual recognized by state law (spouse, parent, other family member, agency worker) Relationship: ________________________________

State-approved signature: ____________________________ Date: ________________

Address: ___________________________________________ Day Phone: ____________

Signature By Mark
If the client signs with a mark or uses a stamp, signatures of two witnesses are required:

_________________________________________ Date __________________________
Witness

_________________________________________ Date __________________________
Witness
Appendix C

Continuity of Care Referral (CCR) Forms
**Continuity of Care Referral**

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason for referral</th>
<th>Peeled Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client's Name</th>
<th>Prime Number</th>
<th>Surrogate Decision Maker/Other Contact/Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Care Practitioner</th>
<th>Key Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agency</th>
<th>Branch</th>
<th>Case Worker Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Residential Information (Address/Provider)**
   - [ ] Own Home
   - [ ] Comm Based Care
   - [ ] Nursing Facility
   - [ ] In-Home Services
   - [ ] Other

2. **Disability Information (Describe)**
   - [ ] Vision
   - [ ] Hearing
   - [ ] Mobility
   - [ ] Communication
   - [ ] Behavior
   - [ ] Judgment
   - [ ] Memory
   - [ ] Other

3. **DME/Supplies Used (Type/Provider/Phone)**
   - [ ] Food Supplements
   - [ ] Incontinence Devices
   - [ ] Ostomy Supplies
   - [ ] Diabetic Supplies
   - [ ] Catheter Supplies
   - [ ] Oxygen/Suctioning
   - [ ] Monitors
   - [ ] Wheelchair
   - [ ] Prosthetics
   - [ ] Other

4. **Treatment Procedures (Describe)**
   - [ ] Tube Feeding
   - [ ] Catheter
   - [ ] Oxygen/Trach
   - [ ] Ventilator
   - [ ] Preventive Care
   - [ ] Other

5. **Rehabilitation Therapies (Provider)**
   - [ ] Physical Therapy
   - [ ] Speech Therapy
   - [ ] Occupational Therapy

6. **Diet**
   - [ ] Special Diet
   - [ ] MD Ordered

7. **Diagnosis (Primary/Secondary):**
   - [ ]
   - [ ]
   - [ ]

8. **Current Medical/Dental Problems**
   Abnormal vital signs, ongoing treatment, seizures, etc.

9. **Medications**
   List medication(s):
   - [ ]
   - [ ]
   - [ ]
   List drug allergies:
   - [ ]
   - [ ]
   Identify client's ability to take medication:
   - [ ]

10. **Mental Health/Chemical Dependency Svcs**
    Services used/provider:
    - [ ]
    - [ ]
    Comments:
    - [ ]

11. **Special Instructions:**
    - [ ]
SDSD Guidelines for Use and Completion

1. This form is used to notify a managed health care plan of new and ongoing Medicaid clients who have special care or service needs. It is not used for every client. **Complete only those sections of the form which apply to the client’s special care or service needs.**

2. Use the form to advise the plan that:
   - a client has an ongoing need for services/supplies such as oxygen
   - a client has complex medical care needs that may require coordination through the plan’s exceptional needs care coordination (ENCC) services
   - there are other factors affecting the client’s ability to access medical services

3. Complete the form as part of choice counseling or from known information. Complete for new applicants during the intake/assessment process. Complete also when a significant change occurs requiring ENCC services.

4. If the client has a county mental health or developmental disability case manager, the case manager may complete the form and forward it to the appropriate SDSD/AAA office.

5. **Completion and routing instructions:**
   a. Complete only sections that apply to the individually exceptional need
   b. Send white copy to the health plan
   c. Send yellow copy to dental and/or mental health plan if appropriate
   d. Retain pink copy in agency case file
   e. If form is being completed near compute deadline for newly enrolled clients, fax to the health plan to ensure they are aware of special needs prior to the effective date of coverage

**Special Instructions for DD Services**

1. Check the box, if Exceptional Needs Care Coordination (ENCC) is requested (most people receiving DD services should have the box checked).

2. Fill out only areas that are important. This form is a “red flag” for a managed care organization to identify services that must be arranged.

3. For those receiving resisdential support, indicate the contact person in the box at the top and check “Community Based Care” in Residential Information.

**Special Instructions for Mental Health Services**

1. Complete only the areas that are important to alert a managed care organization about service or care needs of persons with mental disorders (e.g., diagnosis, medical problems, medications, chemical dependency, etc.).

2. Check the box, “ENCC Request” if Exceptional Needs Care Coordination (ENCC) is needed for complex medical problems.
Continuity of Care Referral

<table>
<thead>
<tr>
<th>Date</th>
<th>Client's Name (Last, First, MI)</th>
<th>Prime #</th>
<th>SSN</th>
<th>Medicare</th>
<th>DOB</th>
<th>Primary Language</th>
<th>Care Giver/Decision Maker</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Residential Information
- Own Home
- Homeless
- Group Home
- Foster Care
- Residential Care
- ALF
- Nursing Facility

Primary Care Practitioner Request (1st & last name) __________________________
Is client currently a patient of this PCP? ________________ Specialist Needs? ________________

Transition Request: Check current supplies, services. List item, vendor & immediate need.

<table>
<thead>
<tr>
<th>Item</th>
<th>Vendor</th>
<th>Immediate need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheter Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incontinency Items</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Home Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen/Suctioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tube Feeding/IV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ventilator/Trach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ENCC Request: check primary area of concern, and provide details in comments section.
- Request for care coordination conference with ENCC
- Life-style choice leads to nonparticipation with care, placing client health at risk
- Emotional/behavioral mental health condition places health status and/or service access at risk
- Language/cultural/sensory issues create a barrier to services or places health status at risk
- Medical condition requires intensive monitoring. Please explain below.

Comments:

__________________________________________
__________________________________________
__________________________________________
__________________________________________

White = Plan/ENCC
Yellow = DCO/MHO
Pink = Agency File

OHP 7297 (11/97)