MEDICAID FAQS FOR LOCAL WIC AGENCIES

Why is Oregon Health Plan now the primary payor of medical formulas and nutrition supplements?

WIC has incorrectly been considered the first payor of formulas and oral supplements for infants, children and women who qualify for WIC and Medicaid/Oregon Health Plan (OHP). WIC is a supplemental program and has federal limitations on the amount of formula and/or oral supplement that can be provided. As a result, formula issued by WIC may not provide the full amount of formula needed to meet the caloric and nutrient needs of an infant or child.

The full implementation of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) that went into effect January 1, 2023, provides comprehensive and preventive health care services for OHP and CHIP-enrolled children under 21 years of age. This also provides an opportunity to align with federal regulations, which states that OHP/Medicaid is the primary payor for formulas and nutrition supplements (WIC Policy Memorandum #2015-07). Medicaid is also the first payer for formula administered via tube feeding.

The term medical formula refers to any formula or oral supplement that is not the standard infant bid formula and requires a WIC medical documentation form for issuance. Any non-bid formula that is medically necessary and appropriate is a covered benefit under OHP and is required by EPSDT.

How do I tell the health care provider that WIC is not the first payor of medical formula?

The Oregon Health Authority has communicated with health care providers and Coordinated Care Organizations (CCOs) regarding this change. Additional communication from the state is forthcoming, although we encourage local partnerships with health care providers as well.

Use the following messages as talking points when discussing the changes with health care providers:

- Based on the final Oregon Administrative Rules (OAR) 410-148- 0010, patients needing medically necessary and medically appropriate formulas and/or oral nutrition supplements are to contact their provider to request coverage of their formula and oral nutrition supplements through the Oregon Health Plan, primary payor of formulas and oral supplements for OHP eligible patients.
- Encourage the health care provider to refer to the preauthorization process set by the CCO to initiate the request for medical formulas and oral nutrition supplements.
- WIC can provide the requested formula while the preauthorization form is being processed. Inform the provider and participant that WIC is covering the requested formula for a limited duration.
- Remind the health care provider and participant that Oregon WIC is a supplemental nutrition program and may not be able to provide the full amount of formula needed to meet their child's daily nutrient and caloric needs.

What if a WIC participant needs medical formula?

Ask if they are receiving formula through OHP. If not, issue the medical formula with a medical documentation form. We want to ensure that our shared Medicaid clients leave the WIC clinic with access to the formula they need.

Reach out to the health care provider to provide information about the change and request that they submit the preauthorization request through the participant's CCO.

What steps can I take to get a WIC participant's medical formula covered through OHP?

Communicate with the healthcare provider on the best course of action for obtaining medical formula through OHP. If applicable, refer the participant to their CCO Care Coordinator for individualized treatment and service plans to address the specific physical, behavioral, oral, and social needs are being met for members who qualify.

Reassess the need for medical formulas and when possible, transition the participant back to the applicable alternative (e.g., WIC bid formulas, boost nutrients and caloric density using WIC approved foods).

How does a health care provider initiate an order for medical formula?

Medicaid providers need to submit a prior authorization request. OHP members may be enrolled in a Coordinated Care Organization (CCO) for some or all of their benefits or enrolled in fee-for-service open card, a program where OHA pays the providers directly. There are 16 CCOs in Oregon. CCOs and OHA differ in preauthorization procedures, including for coverage requests of parenteral, enteral, and oral nutritional formulas/supplements.

- For a CCO-enrolled member, the provider should consult the CCO for its specific preauthorization procedures.
- For fee-for-service open card members, the provider should consult the EPSDT provider guide or contact the Oregon Health Authority's Provider Clinical Support Unit.

How can I support a participant who is unable to fill a prescription for medical formula?

Under EPSDT, Durable Medical Equipment (DME) must be covered for an OHP member under age 21 if determined to be medically necessary and medically appropriate through an individual review.

If there are barriers in families receiving formula through a DME vendor, WIC can provide the medical formula shipments through Formula Warehouse, however it may not be the full amount needed.

Refer the family to their CCO Care Coordinator, the Ombuds Team and the assigned Innovator Agent for their CCO. Please refer to the CCO Care Coordination contact list in Basecamp. Reminder – this resource is a snapshot in time and will be updated as needed.

How do I refer a family to OHP care coordinators?

Care coordinators can support medically complex patients and help to identify all possible resources and referrals the family may be eligible for.

After receiving permission from the participant/family, WIC staff can refer to the CCO Care Coordinator directly by referencing the CCO Care Coordinator contact list. When emailing care coordinators, please cc the assigned Innovator Agent.

For Fee-for-service Open Card members, care coordination can be contacted at 1-800-562-4620 or via email at ORCM@acentra.com. Be prepared to provide the particpant's OHP number, name and date of birth.

Does OHP cover 100% of formula needs? How do we tailor food packages when medical formula is being provided by OHP?

Under EPSDT, covered services include all nutritional supplements/medical foods that are deemed medically appropriate, and medically necessary services needed to correct and ameliorate health conditions for an individual child or youth.

Continue reviewing, approving, and issuing food packages according to the medical documentation form (MDF). If OHP is providing the formula the participant needs, document that information in the chart and do not issue formula through WIC. Work with the family to correctly assign the rest of the food benefits based on the participant's category, nutritional risk, feeding and developmental skills and abilities.

What should I tell families who are caught in the middle?

Communicate this change with WIC families. Let them know that WIC can still provide medical formula, however WIC is supplemental and may not be able to provide the full amount needed. Encourage WIC families to talk with their health care provider on what is the best course of action for obtaining a longer-term supply of medical formula through OHP.

WIC can provide formula in our formulary while the family and provider work out OHP issuance.

What should I do if a family is denied coverage of formula through OHP?

OHP providers/CCOs can no longer issue blanket denials for formula. Each denial must be in writing. For open card members, claims and prior authorizations will be evaluated for medical necessity and medical appropriateness by a committee which includes medical directors, nurse reviewers and EPSDT policy analysts. For CCO members, consult the specific CCO for its procedures for medical review and authorization.

When a family shares that a formula has been denied by their insurance/OHP, ask for permission to contact the Ombuds team on behalf of the participant. When you email the Ombuds Team, please include the assigned Innovator Agent for that CCO in that communication. Ombuds and Innovator Agent Teams are working together with WIC to help support shared OHP and WIC participants. Families also have that right to contact the Ombuds team directly.

Additionally, recommend that the participant appeal the decision to their CCO. The written notice will outline the steps needed to do this. The sooner the denial is appealed, the sooner the review process can start.

Client Services Unit can also assist OHP members with questions, concerns, issues, or complaints about OHP and their coverage. They can also help members who have an open card and do not have a Coordinated Care Organization (CCO).

What information should I provide to Ombuds and Innovator Agents?

- Full name of the WIC participant
- Birthday or OHP ID number (8 digits)
- Brief history of the family and the need
- Bonus information: participant's CCO, CCO denial letter, name of the durable medical equipment (DME) supplier.

What if the health care provider or CCO requests WIC dietitian notes?

WIC offices may be asked to submit RD notes to the prescribing health care provider. Signed releases of information are not required for care coordination, although it is best practice to let the family know that this level of coordination is taking place.

What if a child gets a medical formula from WIC but is turning 5 years old soon?

As the child approaches 4 years of age, develop a plan to transfer the provision of medical formula to the CCO before the child turns 5 years of age.

Encourage WIC families to talk with their health care provider about the best course of action for obtaining a longer-term supply of medical formula or offer to reach out to the health care provider on behalf of the participant.

What are best practices for documenting information in TWIST if participants are receiving formula outside of WIC?

If known, document the following in the progress note: type of formula, who is providing the formula, how much is being received, tube feeding details, DME vendor, assigned CCO, OHP number.

Will local agency processes related to medical formula coverage and referrals be evaluated during WIC biennial reviews?

No. The changes regarding OHP being the first payor of medical formulas will not be evaluated as part of the WIC biennial reviews. However, if you have questions, your assigned nutrition consultant or compliance reviewer are available to provide any technical assistance or support in this area.

What is the state doing to support this transition?

The state WIC team is continuing to work with Medicaid partners, as well as the EPSDT, Ombuds Team, and Innovator Agents to uncover system-level barriers and opportunities related to medical formula coverage, DME/pharmacy supply, and the referral process. Please reach out to your assigned nutrition consultant with any questions.